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The Implementation Of A Patient Safety Culture Is Crucial In Preventing Adverse Events In Healthcare Settings

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Abstract. *The occurrence of patient accidents is like an iceberg phenomenon. Medical errors remain a global issue in the healthcare sector. The culture of safety aims to create safer patient care, considering that Adverse Events can not only increase healthcare service costs but also bring hospitals into a blaming area. This study aims to describe the patient safety culture at Melati Perbaungan General Hospital. This descriptive study observes the implementation of patient safety culture in preventing adverse events in the inpatient department at Melati Perbaungan General Hospital using a total sampling technique with criteria including human resources in the inpatient department, such as executors, responsible persons, and department heads, totaling 65 people. The measurement of patient safety culture uses the Hospital Survey on Patient Safety Culture (HSPSC) questionnaire with 12 dimensions of patient safety culture. The results show that the majority of respondents' characteristics in terms of age and length of work greatly support the creation of a patient safety culture, as most staff are in their productive age (31-40 years) and have an optimal working period (1-5 years) in performing their duties. The implementation of the patient safety culture by staff at Melati Perbaungan General Hospital is in the Positive Response category at 77.9%. This indicates that the patient safety culture has been well implemented.*

Keywords: *Patient Safety Culture, Adverse Events, Healthcare, Hospital Survey on Patient Safety Culture (HSPSC), Inpatient Department*

INTRODUCTION

Based on a report from the World Health Organization (2021), medical errors are the third largest cause of death in the United States. Meanwhile, in England, an injury incident occurs every 35 seconds. Similarly, in low- and middle-income countries, a combination of many unfavorable factors such as staff shortages, inadequate structures, overcrowding, lack of commodified health care, lack of equipment, and poor hygiene and sanitation, contribute to poor care. unsafe patients (Suwarto, 2021). Safety culture is the values and beliefs shared within an organization to create safer patient care. Cultural measurements are important to assess how attitudes, perceptions, individual competencies and behavior of people/groups determine commitment to minimizing incidents in hospitals. This focus on patient safety is driven by the still high number of adverse events (AE) in hospitals. Data from WHO (2023) shows that the incidence of adverse events in various countries is estimated to be around 3-16% and almost 50% of them are preventable events (Sitepu, 2020).

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Hospital Survey on Patient Safety Culture (HSPSC) is a survey of patient safety culture from the perspective of hospital employees. This survey can measure the patient safety culture for all hospital employees from housekeeping, security, to doctors and nurses. AHRQ assesses that patient safety culture is influenced by 3 aspects divided into 12 dimensions. Adverse Events or Undesirable Events, apart from having an impact on increasing health service costs, can also bring hospitals into the area of blame. This condition can cause conflict between doctors/other health workers and patients, and often ends in lawsuits that are very detrimental to the hospital.

KTD data in Indonesia is still difficult to obtain completely and accurately, but it can be assumed that the incidence rate is not small (PERSI-KKP-RS, 2021). At this time, society is not only demanding the need for healthy living, but people's mindset is also increasingly advanced in providing responses and demands to health services so that they receive quality health services (Haryoso & Ayuningtyas, 2019). The National Patient Safety Agency recorded 1,879,822 incidents related to patient safety in the UK. Meanwhile, in the neighboring country of Malaysia, the Malaysian Ministry of Health (Ministry of Health Malaysia) recorded a total of 2,769 incidents related to patient safety in a span of seven months. Meanwhile in Indonesia, KPRS recorded that the number of incidents amounted to 877 patient safety incidents (Ulumiyah, 2018).

According to WHO, the results of reporting in countries where adverse events or adverse events in inpatients are 3% to 16%, in New Zealand adverse events are reported to be around 12.9% of the number of inpatients, in England, adverse events (KTD) around 10.8%, in Canada, adverse events (KTD) are around 7.5%. The Joint Commission International (JCI) reports that adverse events are around 10% in the United Kingdom, while in Australia it is 16.6% (Basri, 2021). According to a study conducted in Canada regarding adverse events, the average adverse event rate in hospital in pediatric patients was 9.2% of 3669 children. 75% of adverse events also occur in babies due to medical procedures, while 75% of adverse events occur in pediatric patients over one year old due to medication administration. In children over five years old, adverse events related to surgery also occurred in 64%, diagnostic examinations in 47% and medication administration in 43% (Simamora, Zulfendri, Simamora, & Nasution, 2020).

Patient safety incidents with an incidence rate of 3.2% -16.6% also occur in hospitals in various countries including America, England, Denmark and Australia (Gunawan & Hariyati, 2019). Patient safety in hospitals has become an important issue because of the large number of medical error cases that occur in various countries. Every year in America

nearly 100,000 hospitalized patients die due to medical errors. Apart from that, research also proves that 50% of deaths due to medical injuries can actually be prevented (Jayanti & Fanny, 2021).

The World Health Organization (2021) states that currently patient safety is a global health priority, because it has become the most important indicator in the health service system. The good and bad of patient health services implemented in health service facilities can be seen from how the health service systems are implemented. applies to the health service facility. The lower the number of medical errors that can be prevented, the better the quality of health facility services, thus the public's trust in health facility services will be higher (Huriati, Salahuddin, Hidayah, Suaib, & Arfah, 2022).

According to the Indonesian Ministry of Health, which issued Minister of Health Regulation No. 11 of 2017 concerning patient safety in hospitals, which is the main milestone in the operationalization of patient safety in hospitals throughout Indonesia. Currently, hospitals have made efforts to build and develop patient safety, but these efforts are carried out according to an understanding of patient safety management. This ministerial regulation is a guide for management in hospitals so that they are able to fully implement the spirit of patient safety (Wianti et al, 2021).

Currently, patient safety has not fully become a culture in health services. Implementing good patient safety can reduce incidents related to patient safety. The presentation of events that threaten patient safety should be 0%. For this reason, researchers are interested in conducting further research regarding the Implementation of Patient Safety Culture in Preventing Adverse Events at Melati General Hospital.

METHODS

This research is a descriptive study to see a picture of the implementation of patient safety culture in preventing adverse events. This research was carried out in an inpatient installation at the Melati General Hospital. The sampling technique was total sampling with the criteria of human resources in the inpatient installation including 65 executive staff, those in charge and department heads. Measurement of patient safety culture in this study used the Hospital Survey on Patient Safety Culture (HSPSC) Questionnaire Version 2.0 published by the Agency for Healthcare Research and Quality (AHRQ) (Rockville et al., 2019).

RESULT

The results of the study showed that respondents were mostly aged 31-40 years (81.1%), there were more female respondents than male (69.1%), the most respondents with executive positions (90.9%) , the highest level of education of respondents is professional education (51.8%). Meanwhile, respondents with the most work experience were 1-5 years (41.8%). Patient safety culture is described from the dimensions of expectations and actions of superiors in promoting patient safety at Melati General Hospital received a positive response of 86.4%, the Organization Learning dimension received a positive response of 96.6%, the cooperation dimension within the unit received a positive response of 98.1%, the Open Communication dimension received a positive response of 85.1%, the Feedback and Communication Regarding Errors received a positive response of 93.03% and the Non Punitive Response dimension to errors received a positive response of 43.3%.

DISCUSSION

The gender characteristics of female respondents are more numerous than male respondents. The most common position characteristic of respondents is executor. The educational characteristics of most respondents have a professional education level. Characteristics of the work period of most respondents' nurses were 1-5 years of work. Overall, the research results show that there is a culture of patient safety at Melati General Hospital is included in the good category because it received an average positive response value of 77.9%. This exceeds the 2021 AHQR standard of 71%. In line with research by Baihaqi and Etlidawati (2020) that the implementation of patient safety has a significant relationship with staff knowledge.

According to the researchers' assumptions, the implementation of patient safety culture is considered a positive response as a common hope and is above the standard category set by AHQR 2021. Percentage of the implementation of patient safety culture in Melati General Hospital can be related to the characteristics of the staff's working period with the highest percentage being 1-5 years, during which time working actively is more optimal compared to working for too long. Long periods of work provide good and positive knowledge and experience for nurses to take better actions over time. The length of time health workers work is considered to have passed the orientation period and is considered more competent to work (Yuliati, Malini, & Muharni, 2019)

This is in accordance with the opinion of the Agency for Healthcare Research and Quality (AHRQ) which defines patient safety culture as a product of individual and group values that describe the attitudes, perceptions, competencies and behavior of its members, so that the organization's commitment to patient safety management is visible. Organizations with a positive safety culture are characterized by an attitude of mutual trust, a shared perception of the importance of patient safety by prioritizing preventive measures (AHRQ, 2021).

The results of research on each sub-variable to see the perceptions and habits of nursing staff in each hospital unit can be explained in an assessment of the positive response to patient safety culture in the dimension of inter-unit cooperation which received a positive response of 73.4%. According to AHRQ (2021), the patient safety survey at the unit level describes how teamwork works to overcome high workloads, staff perceptions of a blame culture and to see strategies for improving patient safety in each unit.

Based on the results of sub-variable research regarding the assessment of the role and support of supervisors in a patient safety culture, dimension 1 (Expectations for superiors' actions in promoting patient safety) was 86.4% and dimension 8 (Management support for patient safety) was (90.3%) . This shows that supervisors and management play a maximum role in implementing patient safety. Direct support and involvement from supervisors and administrators is important when practicing patient safety. Therefore, supervisors must provide active support to staff to ensure patient safety. (Watkins Jr & Milne, 2014).

Based on the results of examining the communication subvariable, the assessment of the patient safety communication aspect resulted in a positive response of 85.1%. A common form of communication between teams is handoff as a form of conveying information on patient clinical status between shifts. Approximately 80% of issues that lead to medical errors involve handovers, leading to errors and patient safety. (Trinesa, Arif, & Murni, 2020). One thing that influences the implementation of this communication is the support of colleagues in the team. According to researchers' assumptions, communication can be established and create a sense of trust and interpersonal relationships between staff which facilitates the implementation of patient safety reporting. According to AHRQ (2021), each staff member will be asked for their opinion regarding their freedom to communicate and learn from incidents that occur without worrying about being blamed.

Assessment of reporting dimensions with a positive response of 65.4%. Incident reports are submitted by staff if a Near-Injury or Non-Injury occurs in the unit where they work. Positive perceptions are obtained based on experiences experienced by someone who

provides good values for patient safety. The staff's positive perception of the implementation of this patient safety culture is a good thing that increases the staff's ability to provide services to prevent injury to patients. The implementation of patient safety in hospitals depends on internal factors, such as knowledge, training, and working hours, as well as external factors, such as motivation and support from health system leaders, facilities and infrastructure, and monitoring health system performance.

CONCLUSION

Based on the research results, it can be concluded that the characteristics of the staff at Melati General Hospital in terms of age and length of work really supports the creation of a patient safety culture, because most of the staff are of productive age and have optimal working years in carrying out their work. Implementation of patient safety culture by staff at Melati General Hospital is in the Positive Response category with 77.9%. This shows that the patient safety culture has been implemented well.

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