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An Implementation of Patient Safety Program at Hospital Royal Prima Medan in 2021

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Abstract: This research aims to know and analyze the implementation of the Patient Safety program and the factors that influence it at the Royal Prima Hospital Medan in 2021. This research is a mixed methods research that is a combination of qualitative and quantitative research. The research informants consisted of 1 person from the hospital health committee, 1 head of the inpatient ward, and 4 implementing nurses in the inpatient ward. The population is all implementing nurses in the inpatient rooms as many as 319 people. the sample was taken using the Taro Yamane formula for as many as 76 people. Data collection techniques through interviews, questionnaires, and documentation. Data analysis methods consist of qualitative analysis with descriptive methods and quantitatively using univariate, bivariate, and multivariate analysis using p multiple linear regression equation. The results of the study that the implementation of the patient safety program at the Royal Prima Hospital Medan in 2021 is quite good; there is an influence of the knowledge, attitude, workload, and supervision of the head of the room on the implementation of the Patient Safety program at the Royal Prima Hospital Medan in 2021.

Keywords: Implementation; Patient safety program; Qualitative; Quantitative

Introduction

Health services are efforts made by an organization or group to improve health and prevent and treat individual or community diseases. Health services that are still consistent in providing health services to individuals or community groups regularly are hospitals. health services hospitals can be said to be effective if the services provided are by the principles of good clinical governance through a comprehensive and integrated system that can be assessed through various service indicators. (Salsabila and Dhamanti, 2023).

Health programme implementation is influenced by many factors, including the local context, external policies and lead- ership support.6 The use of structured frameworks suchas the Consolidated Framework for Implementation Research (CFIR) can identify important influencing factors for programme implementation (Hall *et al.*, 2022).

The patient safety program aims to avoid incidents and reduce the number of unexpected events (KTD) that often occur in patients during hospitalization it is very detrimental to patients and can also harm the hospital. This is still many safety incidents. The National Patient Safety Agency (2017) reports that there have been 1,879,922 patient safety incidents in the UK in 2016. The Ministry of Health (MOH) 2013 reported the number of patient safety incidents in Malaysia in 2013 was as many as 2,769 incidents.(Purwanda and Amartiani, 2022).

Indonesia based on reports of patient safety incidents in Indonesia by province found in DKI Jakarta 37.9%; Central Java 15.9%; DIY 13.8%; East Java 11.7%; South Sumatra 6.9%; West Java 2.8%; Bali 1.4%; Aceh 10.7%; and South Sulawesi 0.7% (Hospital Patient Safety Committee, 2015). Meanwhile, patient safety incident

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reports in 14.4% of KTD and 18.5% of KNC cases were caused by clinical procedures 9.3%; and the patient fell 5.15% (Mudayana, 2015)).

The low incidence in Indonesia is because not all incidents are reported. Generally, incidents are not reported, not recorded, and even escape the attention of health workers because only incidents that are found by chance are reported. Several factors that influence the low incidence of reporting are: 1) Incident reporting is still perceived as a nurse's job, it should be anyone or all staff who first discovered the incident and were involved in the incident; 2) Incidents that occur are often underreported, incidents are reported but are often late and the reports are poor in data; 3) The existence of a blame culture is the cause of delays in reporting incidents for fear of being blamed by management and related units (there is a fear of officers to report); 4) Lack of leadership commitment; 5) Lack of socialization and training to all parties in the organization so that officers do not know what and how to report when incidents occur; 6) There is no reward from the hospital for reporting, and 7) High workload. This is a challenge for all parties (Ningsih and Endang Marlina, 2020).

Based on the initial survey at Royal Prima Hospital that the researchers conducted using the observation method and interviews with informants, it was found that there were still unwanted events. one of them was the patient slipping on the floor due to the slippery and steep floor.

Vision achievement Royal Prima Hospital Medan one of them is implementing patient safety but the rate of achieving patient safety goals is still around 50-80%. This data proves that the achievement of patient safety goals has not reached the set target of 100%. Seeing that the 100% target has not been achieved, the researchers are interested in researching the implementation of patient safety in this hospital with the title"Implementation of the Patient Safety Program at the Royal Prima Hospital Medan in 2021 (Qualitative and Quantitative Methods)."

Method

This type of research is mixed research (mixed methods) is a research step by combining two forms of research, namely quantitative and qualitative research. the combined research method (mixed methods) is a research method that combines or combines qualitative methods with quantitative methods to be used together in a research activity, in order to obtain more comprehensive, valid, reliable, and objective data.

This type of qualitative research with a descriptive approach intended in this study aims to obtain information about implementation of the Patient Safety program at the Royal Prima Hospital Medan in 2021 through interviews and direct observation by researchers. Quantitative research in this study is an analytical survey with a cross sectional study approach.

The aim is to study the factors that influence Implementation of Patient Safety at Royal Prima Hospital Medan in 2021 observed in the same time period through filling out questionnaires by respondents. The location of this research is in Hospital Royal Prima Medan. The population in this study were all implementing nurses who worked in Royal Prima Hospital Medanamount319 people consisting of 158 people on duty in Building A and 161 people on duty in Building B.

Result and Discussion

The results of this study are about the implementation of patient safety programs at the Royal Prima Hospital Medan in 2021 with qualitative and quantitative methods. Research results are presented systematically in accordance with the order of research objectives stated in the introductory chapter. The research objectives are to determine and analyze the implementation of the Patient Safety program at the Royal Prima Hospital Medan in 2021 and to determine and analyze the factors that influence the implementation of the Patient Safety program at the Royal Prima Hospital Medan in 2021.

Furthermore, the results of the research discussion are carried out on the research results by comparing them with theories related to the research topic and with relevant research findings carried out by other parties previously. The presentation of data includes data on the characteristics of informants and respondents, results of research on implementation and factors that affect patient safety programs collected through interviews and distributing questionnaires.

Informants in this study are the parties that meet the parameters that can reveal things about the problem inresearch. The number of informants set is 7 people, namely from Health Committee 1 person, from the acting Head of Room 1 person and fromImplementing Nurse in Building A and Building B2 people each.The informants were selected purposively based on the consideration of the researcher with the criteria of the informants: have worked at RSU Royal Prima for more than 2 years; male and female gender; have duties related to the implementation of patient safety in hospitals and are willing to be interviewed directly. As for identityinformants are described as follows:

Table 1. Characteristics of Informants in the Hospital Inpatient RoomRoyal Prima Medan in 2021

Informant	No. Informant	Initials	Gender	Age (Years)	Education
Health Committee	1	L	Woman	46	S1
Head of Room	2	R	Woman	39	S1
ImplementingNurse	3	F	Woman	37	S1
	4	I	Man	24	D-III
	5	A	Woman	25	S1
	6	D	Woman	31	S1

Informant statement from the Patient Safety Committee regardingThe implementation of Patient Safety atthe Royal Prima Hospital Medan in 2021 was studied in depth through interviews as the following informants said.

Table 2. The Patient Safety Committee Answer Matrix on the Implementation of the Patient Safety Program at the Royal Prima Hospital Medan year 2021

No	Answer	Conclusion
01	Duties of the Patient Safety Committee Team: - Evaluating problems, following up, compiling hospital indicators, recording achievements, documenting, following up on adverse events, compiling SOPs, coordinating between work units in the event of an adverse event and coordinating patient safety and rismanagement	The duties of the Patient Safety Committee Team are well understood by the implementers
02	Patient Safety Committee Team Members: - Consists of chairman, secretary, data PIC,coordinators and fields	Membership of the Patient Safety Committee has met the requirements
03	Role of the Patient Safety Committee Team: - Socialization is carried out by each person in charge of the unit in the form ofachievement indicators and patient safety	The Patient Safety Committee team plays an active role in achieving goals and regularly
04	Internal regulations for the implementation ofPatient Safety: - Internal regulations are in accordance withSOPs and are evaluated regularly	There is already a SOP
05	The role of the Patient Safety Committee Team in the socialization of the Minister of HealthRegulation Number 11 of 2017: - Not routinely socialized directly. However, the training, SOPs, and achievement indicators that are socialized are formed based on this Permenkes	Socialization activities are rarely carried out
06	Patient Safety Committee Team Preparation: - Consists of experienced personnel, appropriate education, recruitment through rigorous evaluation, understanding of SOPs, achievements being evaluated and revised regularly and making regular recording and reporting	The team already consistsof people who meet the needs
07	Patient Safety Implementation: - It is in accordance with Permenkes Number11 of 2017 - This is because all programs are formedaccording to the Permenkes.	Implementation of Patient Safety is in accordance with Permenkes
08	Committee accountability mechanism Program monitoring Committee - Report preparation, indicator monitoring - Report the results of monitoring and otherquality activities - Data and information processing - Providing information	The Committee's accountability mechanism is carried out according to procedures
09	Monitoring and evaluation of implementation inhospitals: - Periodically in the form of recordings and reports and reported once a year by audit or by direct meetings with representatives fromeach unit	Monitoring and evaluation according to the procedure in the Minister of Health

No	Answer	Conclusion
10	Internal and external reporting mechanismsrelated to incidents in the hospital: - From the implementing nurse → PJ room →Head of the room → Doctor on duty →DPJP → Committee/Directors - Problems that can be handled are recorded in the report, not directly reported to the committee/board of directors. Incidence of severe disability, or death (sentinel) is reported immediately and followed up immediately	Incident reporting mechanism is carried out according to the rules

Knowledge in this research is everything that the implementing nurse in the inpatient room knows about the implementation of the patient safety program. The level of knowledge begins with knowing which means being able to remember or recall, understand, apply, analyze and evaluate everything related to patient safety while in hospital care. The results showed that the majority of nurses had quite good knowledge about patient safety while in hospital care.

Good nurse knowledge is caused by the level of education and experience possessed by nurses. The level of education and experience is one of the factors that influence nurses' knowledge. Nurse education level in the emergency room of RSUD dr. Dradjat Prawiranegara. In their daily education, a person is related to social life and behavior in providing nursing actions. The higher one's education, the better one's behavior will be. Therefore, nurses who have a high level of education tend to have a good level of knowledge.(Supriatin and Lindayani, 2021)

The results of this study were evident from the nurses' answers to statements about knowledge, that the majority of nurses stated it was true that spatient safety guidelines require the use of wrist bands on patients for identification; reassessment of the risk of falling in patients who move from one unit to another must be carried out; the patient's name, date of birth, medical record number can be used for patient identification; and the nurse records the documentation of the sign in – time out is one of the right procedures for the patient when the operation is performed.This is in line with the results of interviews which among other things show that nurses know the importance of maintaining the safety of medicines that must be watched out for according to SOPs, the need to apply hand washing and maintain the cleanliness of medical equipment; the need for nurses to put colored bracelets and use bars on the bed for patients and nurses know the need for reporting incidents to superiors.

The results of the bivariate analysis showed that the knowledge p value of 0.000 was smaller than 0.005; it means that there is a relationship between knowledge and the implementation of patient safety programs at the Royal Prima Hospital Medan in 2021. The results of multivariate analysis based on multiple linear regression tests obtained a knowledge B coefficient value of 0.701; implies that every increase in knowledge will result in an increase in the implementation of patient safety programs by 0.701.

The results of this study are in accordance with the results of (Nuaristia Dewi *et al*., 2019)iresearch) which shows that the respondents' knowledge about patient safety in the Intensive Care Unit (ICU) of PHC Surabaya Hospital is mostly at a fairly good level, but there is also a lack of knowledge. Multivariate analysis there is a significant effect between knowledge on the application of patient safety. The results of this study are also supported by the research of (Agustina, Handiyani and Afriani, 2022) who found one of the factors thatinfluencePatient safety implementation is knowledge about patient safety including knowledge of using tools for staff introduction. (Yuliana, 2018)states that knowledge is one of the factors thatinfluence patient safety.As science and technology continue to develop, the learning process to increase knowledge must continue to be carried out.

The research of (Firdaus, 2019)findings that the level of patient safety culture results related to the frequency of reporting patient safety incidents has been carried out but related to incidents that do not have the potential for injury when reporting is not appropriate, the perception of patient safety at the patient safety level, the number of reporting incidents at the Yogyakarta City Hospital has well done. (Ramadhaini, Fitriani and Nuraini, 2021)research, it is stated that incidents of violations in the implementation of patient safety are mostly carried out by nurses because nurses are the health workers with the most dominating number in hospital institutions, and nurses are also health workers who most often take action and interact directly with the hospital. patients, especially inpatients.

The results of the research on the inhibiting and supporting factors for the application of patient safety according to the results of the research by (Ghofar, Zuliani and Ukhrowi, 2022) from analyzing patient safety management on the quality of hospital services. Efforts to ensure the quality of patient safety implementation properly in the hospital. There are several important factors that influence patient safety

management activities, namely safety management systems, subjective norms, behavioral control, and behavioral intentions.

The inhibiting factor, the social factor, is that there are nurses who do not understand well the existing SOPs and lack the motivation to learn and nurses are still lacking awareness of maintaining their safety. Technical factors are limited time and funds in conducting training, and the number of patients with nurses on duty is not balanced. One of the private hospitals located in the city of Medan is the Royal Prima Hospital, which is a type of teaching hospital with type B. This hospital provides health services in an inpatient room supported by several nurses.319 people consisting of 158 people on duty in Building A and 161 people on duty in Building B.Based on the preliminary survey, the results of interviews with 10 nurses in the Inpatient Room showed that there had never been an unexpected event (KTD), near-injury (KNC), non-injury (KTC), potential injury (KPC) or sentinel events that resulted in death or serious injury in royal Prima Hospital Medan. Meanwhile, according to the head of the room, there was an unexpected incident that occurred but was not reported as it should be. KTD such as the patient almost fell due to lack of supervision of nurses and families in adjusting the position of the patient's bed. The system for planning and organizing patient safety in this hospital has not been maximized and this can be seen from the lack of reports on patient safety. The Head of the Room provided information that the hospital had a standard operating procedure (SOP) regarding patient safety goals, especially for falling patients, but the implementation process was still lacking. Based on interviews with nurses in the inpatient room, information was obtained that a large number of patients, especially in the era of the Covid-19 pandemic, made nurses experience fatigue at work, especially since the number of nurses was not proportional to the number of patients being treated. In addition, hospitals are also still lacking in providing rewards to staff. The benefit of this reward is that it can increase employee morale in carrying out their duties and responsibilities. The gender of nurses working in the X Hospital did not show any significant relation with their compliance level. It proved that gender diffe- rence did not determine nurse compliance in implementing IPSG 1, IPSG 2, IPSG 5, and IPSG 6 in the X Hospital. Researchers thought that male and female nurses in the X Hospital worked similarly and did not show any signi- ficant difference in providing services to pa- tients, because they worked consistent with the existing SOP.(Alhidayah, Susilaningsih and Somantri, 2020)

According to (Garrett, 2016) As the perioperative environment continues to evolve, peri- operative leaders and team members must strive to maintain patient safety, improve outcomes, and reduce associated costs of care using communication and collaboration skills. Nurse leaders play an instrumental role in maintaining the culture of open communication between all members of the entire perioperative team, from managers and directors to frontline staff members.

Some of the knowledge gaps are related to care settingsoutside of academic medical centers and hospitals. These include clinics and small hospitals, long-term care facilities, and social services organizations. Extending further, there has been little attention to ensuring safety of home care and by family caregivers. Knowledge is lacking about effective ways to engage patients and families in safety. Many subpopulations have been largely ignored. These include groups defined by race and ethnicity, income, sex and gender, and disabilities, unhoused people, and those with mental health conditions or chemical dependency. Patient safety information from fragile conflict areas is lacking, as it is also from low and middle income countries (LMICs).(Mandela, 2023)

In Policy application culture safety patient at hospital of Asia, internal strengthening of the team very needed . In create team service health at hospital's solid is needed a collaboration within and between teams, effort enhancement quality and safety patient and supervisor and support hospital management for give away evaluation if obtained happen incident not expected , as well appreciation to staff who have run culture safety patient with good.(Damayanti and Bachtiar, 2019)

According to (Yulia *et al.*, 2022) from analysis of the relationship between the characteristics of nurses and the application of patient safety. The study found that the average patient safety application was 147.88 (92.43%) from a maximum target of 160 with a target of 90.8%, effective communication 93.2%, drug management 93.82%, accuracy of procedures 94.00 %, reduce the risk of infection 91.97% and reduce the risk of falling 86.82%. There is no relationship between the characteristics of age, gender, education and work experience with patient safety ($\alpha > 0.05$).

Low compliance of officers, unsupportive facilities and infrastructure, and low management commitment are some of the factors that have not yet optimized the implementation of patient safety goals in the hospital. Therefore, it is necessary to improve technical assistance, supervision, and support for adequate facilities and infrastructure.(Larasati and Inge Dhamanti, 2021)

Effective communication is a way to minimize the risk of errors in the interaction process between health workers. The results showed that the implementation of patient safety goals in this dimension was not in accordance with accreditation standards. This study found a 20% difference due to not reconfirming orders

and not writing them down, causing misperceptions in understanding orders. In order for information to be conveyed properly accurately and accurately in decision making, it can use communication standardization through the method of Situation Background Assessment Recommedatation (SBAR) method.(Kusumaningtyas, Arbianti and Niam, 2022)

This self-management program model is a short and simple method for improving patients' safety and quality of life. Self-management means that patients actively participate in the self-care and management of their disease. The main goal of self-management programs is for patients to achieve maximum independence and self- determination by relying on their abilities and, as a result, increasing their quality of life.(Javanvash, Nodehi and Khani, 2023)

According to the researcher's assumption, the results of this study indicate that nurses already have a fairly good knowledge of the implementation of patient safety goals, because it is supported by the average nurse's education which is quite high, namely S1 Nursing. This is one of the factors for the high level of knowledge of nurses, with the knowledge possessed by a nurse will provide more effective action in patient safety management. The advantage in this study is the management of the formation of the royal prime hospital patient safety team determined by the leadership and human resource management is always given training every month in order to prevent unwanted events.

Conclusion

Based on the analysis of research results and discussion by comparing with the theory and results of previous studies, it can be concluded that: The implementation of the Patient Safety program at the Royal Prima Hospital Medan in 2021 has been quite good, although not optimal. There is an influence of knowledge factor with implementation program Patient Safety at RoyalPrima Hospital Medan in 2021. There is an influence of attitude factor with implementationprogramPatient Safety at RoyalPrima Hospital Medan in 2021. There is an influence of workload factor with implementation program Patient Safety at RoyalPrima Hospital Medan in 2021.

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Author Contributions

David Calvin writing-original draft preparation, result, discussion; Chrismis Novalinda Ginting, methodology, conclusion; Intan review, and editing; Sri Wahyuni Nasution analysisand proofreading.

Conflicts of Interest

The authors declare that there is no conflict of interest regarding the publication of this paper.

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