THE ANALYSIS OF HOSPITAL PATIENTS' SAFETY CULTURE (A CASE STUDY) AT PKU MUHAMMDYIAH HOSPITAL

Ajeng Titi Probo Rahayanti[1], Arlina Dewi[2]

[1]*Master of Hospital Management, Universitas Muhammadiyah Yogjakarta, Indonesia*
[2]*Master of Hospital Management Universitas Muhammadiyah Yogjakarta, Indonesia*
E-mail: dewikoen@yahoo.com

Key words : Patient Safety Culture, MAPSaF

Abstract : Patient safety culture is a system that can give safe feeling trough the patients, to avoid incidents such as adverse event, near misses, and medical error. The objective of this study is to know and to explore the implementation dimension of patient safety culture at PKU Muhammadiyah Bantul Hospital. The cross sectional study was conducted and collected through Questioner using MAPSaF (Manchester Patient Safety Framework) which consisted of 10 elements of question & 24 aspects towards 67 nurses of PKU Muhammadiyah Bantul Hospital. There were 5 maturity levels which can describe patient safety culture, such as Pathologic, Reactive, Calculative, Proactive & Generative. For the result of the study, there were 7 questions which are in proactive level, such as extending commitment to repair sustainable, priority given to patient safety, evaluation of an incident and best practices, learning and effective change, management civil and safety issues, education and training staff and cooperation team. There is 1 question which is in Calculative level namely the communication of patient safety issues. The last level is Generative, there are 2 questions, a system error and the responsibility of individuals and the recording of an incident and best practices.

1. INTRODUCTION

Patient safety can be interpreted as an attempt to prevent an imminent danger to the patient. The concept of patient safety must be implemented completely and comprehensively. According to The American Hospital Asosiation (AHA) 1999 patient safety is the strategic primacy. Patient safety is a system which is capable of providing the safety to the patient. Systems on patient safety caused by human errors in taking action can mitigate the injury which would possibly happen. Patient safety according to Sunaryo (2009) is the existence or inexistence of any errors or free from injuries due to an accident.

Patient safety was launched firstly in Australia in 2000 by the Ministry of Health (MOH) of Australia. In Indonesia itself, it was launched by the Committee for Hospital Patients Safety (KKPR) in 2005 by the Indonesian Hospital Association (PERSI). In Indonesia, PERSI was the first organization to set and initiate hospital patient safety movement, which was inaugurated / launched by the Minister of Health at the opening of the National PERSI Seminar on August 21st, 2005. The legal basis is also reinforced by the presence of the Health Minister Regulation No. 11/2017 on Hospital Patient Safety governing patient safety standards, 7 step towards patient safety Hospital, and therein also set the goal of hospital patient safety.

The hospital is a miniature of the society because the hospital is an organization engaged in the services sector, which is characterized by the labor-intensive, capital-

intensive, and technology-intensive (Poerwani and Sopacua, 2006). Therefore, hospital services becomes more complex with very distinctive characteristics and the various unexpected incident (KTD), Incident Almost Injury (KNC) will often occur and will occur in the patient's death. The sense of security error is most frequently caused by human error associated with the risk in terms of safety, and this is caused by the failure of a system in which the individual works (Reason, 2009).

The main cause is human error, but in resolving the problems of the Unexpected incident (KTD), by only intervening an individual who made a mistake, it will not solve the problem. The incident of a particular accident in a hospital would be detrimental to the parties involved in a particular organization such as the hospital staff and patients. The effect of the accident is the decrease in the level of public confidence in the health service according to Flynn (2002) in (Cahyono, 2008).

Based on the result of research conducted by Danu Puguh (2017), RS Pupuk Kaltim has made a decision on accidents caused by falling, this is evidenced by the letter of the director's decision in 2014 about policies of the risk reduction of patient falls. The obstacles in the implementation of patients prevention at risk of falls in hospitals Pupuk Kaltim are: there has not been ithe implementation of the initial assessment of hospitalized patients from the ER, it has not carried out the routine daily inpatients evaluation, there should be SOP, there are still 26 beds which are not safe, the gurney was not secure / gated there are three of them, the third-class care patients do not get the anti-slippery footwear, bangles markers of fall risk patients are often empty.

RSU PKU Muhammadiyah Bantul is a hospital which has the obligation to implement the Safety of providing services. New accreditation standards in Bantul Muhammadiyah hospital began to be implemented in 2012.

The accreditation has been in accordance with the Act No. 44 of 2009 on Hospital, in which each hospital should be able to carry out the accreditation. The accreditation aims to improve patient safety. Therefore, the accreditation is able to improve the culture and quality of RS PKU Muhammadiyah in Bantul. 4 groups of new hospital accreditation standards are dealing with the patient safety.

RSU PKU Muhammadiyah Bantul since 2006-2016 UNIT I has already been implementing the patient safety and has already provided the results that the implementation of patient safety in Bantul Muhammadiyah Hospital. UNIT I was classified as less satisfying, in which there are some cases of unwanted pregnancy in PKU Muhammadiyah Hospital in Bantul UNIT I

From the above background, the researcher formulated the problem of the research, which is "How is the Overview of the Patient Safety Culture of Bantul PKU Hospital Unit I "

2. RESEARCH METHODS

This study uses cross-sectional quantitative because researchers wanted to measure all the variables at the same time. The population was all nurses at the clinic of Bantul PKU Muhammadiyah Hospital Unit I. There were 67 respondents as the sample who were taken by purposive sampling. The data was collected by using a questionnaire. The

data analysis technique used in this research was the frequency distribution

3. RESULTS AND DISCUSSION

3.1 The Profile Description of Respondents

Table 4.1 Profile of Respondents

No.	characteristics of Respondents	number	percentage
1	Age		
	- 20-25	11	17%
	- 26-30	27	40%
	- ≥31	29	43%
	Total	**67**	**100%**
2	Gender		
	- woman	62	93%
	- man	5	7%
	Total	67	100%
3	Years of service		
	- ≤5 year	17	25%
	- ≥6-10 year	39	58%
	- ≥11 year	11	17%
	Total	67	100%
4	Level of education		
	- D3	34	51%
	- D4	9	36%
	- S1	24	13%
	Total	67	100%
5.	The Socialization of the patient safety		
	- already	21	31%
	- Not yet	19	29%
	- Not known	27	40%
	Total	67	100%

3.2 The Description of the Research Result of 10 Dimensions of Patient Safety Culture

Table 4.2. The Table of 10 Dimensions of Patient Safety Culture

No.	Dimension	Percent
1	thorough commitment to the sustainable improvement	11.98%
2	Priority given to the patient safety	12.08%
3	System errors and individual responsibility	8:40%
4	Recording incidents and best practices	8:26%
5	Evaluation of incidents and best practices	12:54%
6	Learning and effective changes	8.62%
7	Communication on patient safety issues	12.60%
8	Personnel management and safety issues	4:27%
9	Education and training of staff	8:36%
10	Teamwork	12.86%

Sources of data were analysed in 2018

The results of this study indicated that patient safety culture dimensions with the highest percentage was the teamwork (12.86%). Meanwhile, the lowest percentage is the nursing management and safety issues (4:27%)

Table 4.3 SOP & Policies

No.	SOP and Policy Aspects	Frequency	Percentage (%)
1	Staff is aware of any possibility or the risk which will probably happen, so that it reduces the number of SOPs because patient safety has been understood by everyone. Patients and families are involved in giving advice	18	26.9
2	SOPs, protocols and policies are discussed and implemented as the basic service. Patients and families are involved in decision-making services.	49	73.1

Sources of data processed in 2018

the improvement aspect, the selection of standard operating procedures, protocols and policies are discussed and implemented as basic services (73.1.%). According to the researchers the respondents preferred on the commitment aspect for improvement. Patients and families are involved in decision-making services.

Table 4.4 Risk Management System

No.	Aspects of risk management	Frequency	Percentage (%)
	system		
1	The entire staff is consistent in implementing the risk management system and the sustainable quality improvement	18	26.9

The results showed that more than a half of respondents have a commitment to

2	risk management system has been more widely socialized in hospitals and community organizations	48	71.6
3	Risk management system has not been widely socialized.	1	1.5

The data source was analyzed in 2018

The results showed that more than a half of respondents have aspects of risk management system which has been socialized more widely in hospitals and community organizations (71.6%). According to the researchers, the risk management system is already-socialized more widely in hospital and community organizations

Table 4.5 Safety culture of the patients

No.	Cultural aspects of patients' safety	Frequency	Percentage (%)
1	Hospital has a culture that is open and fair, staff feel a good cultural atmosphere.	9	13.4
2	The staff feel safe to report incidents	56	82.1
3	The culture is open and fair, but staff have not felt	3	4.5

Sources of data processed in 2018

The results showed that more than a half of respondents had the.staff aspects who feel safe to report any incidents (82.1%). According to the research study, the staff feel safe to report any incidents, especially at the level of incident reporting

Table 4.6 reporting system and its usefulness

No.	Aspects of the reporting system and its usefulness	Frequency	Percentage (%)
1	KP incidents are always reported in the correct system	9	13.4
2	The reporting process is easy to do and are friendly	56	82.1
3	Hospitals do not routinely use staff's report but the report was obtained from other sources such as audits and patient complaint form	2	3.0

Sources of data were analyzed in 2018

The results showed that more than a half of respondents have aspects of which the reporting process is easy to do and are friendly (82.1%). According to the research, the reporting process is easy to do, and it is preferable to be friendly

Table 4.7 The focus of investigation

No.	Aspects of Data Analysis	Frequency	Percentage (%)
1	The investigation of KP incident involves the internal and external investigators to the organization	9	13.4
2	KP incidents and near miss focuses on the improvement, but it also involves the patient	49	73.1
3	The investigation incidents and near misses KP focuses on the individual and the environment in the vicinity of the incident itself	9	13.4

Sources of data analyzed in 2018

The results showed that more than a half of respondents have aspects. The KP incidents and near miss focusd on the improvement, but it also involved the patient. (73.1%). According to the researchers, that the incidence of KP and near miss focus on the improvement, it was preferred to involve the patient.

Table 4.8 Who act in deciding their post-incident changes

No.	The aspect of who play the role in deciding the change after the incident	Frequency	Percentage (%)
1	The KP incident is discussed openly and discusses it along with the staff to elicit a particular change.	10	14.9
2	staff actively participate in deciding the changes after the KP incident and are committed to implement it	52	77.6
3	Patient Safety Committee and the manager decide a certain change, but lack	5	7.5

	involvement of the staff participation.		

Sources of data analyzed in 2018

The results showed that more than a half of the respondents had the aspect of staff participated actively in deciding the changes after the KP incident and are committed to implement it (77.6%). According to investigators, that staff actively participate in deciding the changes after the KP incident, then, it was preferred that they commit to implement them.

Table 4.9 Sharing information

No.	Aspects of Sharing information	Frequency	Percentage (%)
1	Innovative ideas regarding KP being communicated and the lines of communication are provided,	13	19.4
2	Information about KP distributed at the briefing session has been scheduled by the staff.	46	68.7
3	Lots of information about KP but few are understood by the staff.	8	11.9

Sources of data analyzed in 2018

The results showed that more than a half of respondents have the information aspect about KP distributed at the briefing session which has been scheduled by the staff (68.7%). According to the researchers, that information about KP was distributed at the briefing sessions was preferred to be scheduled by the staff.

Table 4.10 Do the staff feel supported?

No	Does the staff feel supported?	Frequency	Percentage (%)
1	Management of personnel do reflection and discussion about the competence of the staff. supervision and mentoring of the staff Health is prioritized	11	16.4
2	The management designs the needs support. The health of the staff is prioritized.	48	71.6
3	Personnel management procedures is a way to control the staff	8	11.9

Sources of data analyzed in 2018

The results showed that more than a half of respondents have the aspect of which the management designed the support of the health of workers which needed to be prioritized (71.6%). According to the researchers, that designing management support to health workers needs, then, it was preferable to be considered the health of workers

Table 4.11 The need for training

No.	training needs	Frequency	Percentage (%)
1	staff are given the opportunity to take training in accordance with their needs ..	13	19.4
2	There is an effort to identify training needs and align with the needs of hospital staff.	51	76.1
3	The training was held to meet the needs of the hospital.	3	4.5

Sources of data analyzed in 2018

The results showed that more than a half of respondents have the aspects of which there is an attempt to identify the training needs and align with the needs of the hospital staff. (76.1%). According to the researchers, that there is an attempt to identify training needs, then. It was preferred to align with the needs of the hospital

Table 4.12 What is it like to be a member of the team?

No.	What is it like to be a member of the team?	Frequency	Percentage (%)
1	Teamwork appear to have similarities in understanding and vision.	12	17.9
2	Collaboration between members of the team run well.	49	73.1
3	Team members include multi-event in elements but do not have a commitment to the team.	6	9.0

Sources of data analyzed in 2018

The results showed that more than a half respondents have aspects of the collaboration between members of the team run well. (73.1%). According to the researchers, that collaboration among the team members then preferably goes well

4. CONCLUSION

Based on the result of study, the conclusions obtained are as follows:

A. There are seven dimensions of patient safety culture based on the MaPSaF questionnaire which are in the proactive level, that is a thorough commitment to sustainable improvement, priority is given to patient safety, incident evaluation and best practices, learning and effective

changes, staff management and safety issues. Education and training of staff, Teamwork

B. There are two dimension of patient safety culture based on a MaPSaF questionnaire which is at the generative level, that is the system error and responsibility of individuals and recording of incidents and best practices

C. There is one dimension of patient safety culture based on the MaPSaF questionnaire which is at the calculative level ie the communication on patient safety issues

5. REFERENCES

Agustina Pujilestari (2014) dengan judul "Budaya keselamatan pasien di instlasi rawat inap RSUP Dr. Wahidin Sudirohusodo kota Makassar."

Ashcroft, D.M., et al., *Safety culture assessment in community pharmacy: development, face, validity, and feasibility of the manchester patient safety assessment framework.* Quality and Safety in Health Care, 2005. 14(6): p. 417-21.

Beginta, Romi. 2012. *Pengaruh Budaya Keselamatan Pasien, Gaya Kepemimpinan, Tim Kerja, Terhadap Persepsi Pelaporan Kesalahan Pelayanan Oleh Perawat Di Unit Rawat Inap Rumah Sakit Umum Daerah Kabupaten Bekasi Tahun 2011*. Tesis. FKM Universitas Indonesia

Budihardjo, Andreas. 2008. *Pentingnya Safety Culture di Rumah Sakit Upaya Meminimalkan Adverse Events.Prasetya Mulya Bussiness School*. Jakarta

.

Hellings, J., Ward, S., Klazinga, N. S., & Vleugels, A. (2010). Improving patient safety culture. International Journal of Health Care Quality Assurance, 23(5), 489-506.

Cahyono, J.B. Suharjo B. 2008. *Membangun Budaya Keselamatan Pasien Dalam Praktik Kedokteran.* (Yogyakarta : Kanisius)

Carthey, J..& Clarke, J. (2010). Implementing human factor in healthcare: How to guide. London: Patient Safety First Cottingham,

Canadian Nurse Assosciation. 2004 *Nurses and patient safety: Discussion paper*. *Canadian Nurse Association and University of Toronto Faculty of Nursing*;

Departemen Kesehatan (Depkes) RI, 2006. *Panduan Nasional Keselamatan Pasien Rumah Sakit Utamakan Keselamatan Pasien Edisi 2*. Jakarta: Depkes

Departemen Kesehatan (Depkes) RI, 2008. *Panduan Nasional Keselamatan Pasien Rumah Sakit Utamakan Keselamatan Pasien Edisi 2.* Jakarta: Depkes.

Depkes, 2006,Keselamatan Sakit, Depkes.Panduan Nasional Pasien Rumah

Dwi Helynarti Syurandhari (2016) Hubungan Patient Safety dengan Mutu Pelayanan di Ruang Rawat Inap RSUD DR. Wahidin Sudiro Husodo Kota Mojokerto

Fleming, M. (2006). *Patient safety culture: sharing& learning from each other*

Hamdani, Siva. 2007. *Analisis Budaya Keselamatan Pasien (Patient safety Culture) Di Rumah Sakit Islam Jakarta Tahun 2007*. Tesis. FKM UI

Hasibuan, M. S. P. (2008). Organisasi & motivasi dasar peningkatan produktivitas. Jakarta: PT. Bumi Aksara

Hudson, P. (2009). *Safety culture-theory and practice*

Jianhong, A. (2009). Safety culture in surgical residency program across Virginia.

Komite Keselamatan Pasien Rumah Sakit (KKP-RS). *Laporan Insiden Keselamatan Pasien*. Jakarta: Kementerian Kesehatan Republik Indonesia; 2011

Kaufman, G., & McCaughan, D. (2013). The effect of organisational culture on patient safety. *Nursing Standard*, *27*(43), 50-56.

Lumenta. 2008. State of the art patient safety. Disampaikan pada workshop Keselamatan Pasien dan Manajemen Risiko Klinis RSAB Harapan Kita pada tanggal 1-3 April 2008. Jakarta

National Patient Safety Agency, 2004, Seven step to patient safety, the full reference guide,. 2nd, London.

NPSA (National Patient Safety Agency). 2006. Manchester Patient Safety Framework (MaPSaF). Manchester: University of Manchester

Notoadmodjo, Soekidjo. 2005. *Metodologi Penelitian Kesehatan*. Jakarta: Rineka Cipta

Nur Syarianingsih Syam (2017) *Implementasi Budaya Keselamatan Pasien oleh Perawat di Rumah Sakit Ibnu Sina Makassar.*

Parker D., Lawrie D., Carthey J. & Coultous M.. 2008. The Manchester Patient Safety Framework: sharing the learning. Clinical Risk 14(4): 140–142, 1–3.

Permenkes RI Nomor 1691/MENKES/PER/VIII/2011 tentang Keselamatan PasienRumah Sakit yang mengatur tentang standar keselamatan pasien

Poerwani, S.K. & Sopacua, E., 2006. Akreditasi Sebagai Upaya Peningkatan Mutu Pelayanan Rumah Sakit. Buletin Penelitian Sistem Kesehatan, 9, pp.125–133.

Puguh Danu Sanjaya (2017) Evaluasi Penerapan Pencegahan Pasien Berisiko Jatuh di Rumah Sakit: Program Studi Magister Manajemen Rumah Sakit, Fakultas Kedokteran dan Ilmu Kesehatan, Universitas Muhammadiyah Yogyakarta, Indonesia

Putri, 2010. *Penerapan Budaya Patient Safety di RS PKU Muhammadiyah, Bantul. UMY*

Reason. 2009. Managing The Risk of Organizational Accidents. Ashgade: Publishing Ltd. Aldershot Hants

Setiowati, Dwi. 2010 *Hubungan Kepemimpinan Efektif Head Nurse dengan Penerapan Budaya Keselamatan Pasien oleh Perawat Pelaksana di RSUPN Dr. Cipto Mangunkusumo Jakarta* [Tesis]. Depok: Universitas Indonesia

Singer, B. 2003 Ironies of the human condition: well-being and health.

Sorra J, Famolaro T, Yount ND, Smith SA, Wilson S, Liu H. 2014 *Hospital Survey on Patient Safety Culture: 2014 User Comparative Database Report*. Rockville (MD): Agency for Healthcare Research and Quality

Sunaryo. 2009. Manajemen Pendidikan Inklusif.pdf. Jakarta : Jurusan PLB FIP UPI

Tio Dora Ultaria S (2017) Gambaran Budaya Keselamatan Pasien di RS Roemani Muhammadiyah Semarang

Walshe, K & Boaden, R.,2006, Patient safety: Research into practice.New York:

World Health Organization. 2004. International Statistical Classification of Disease and Related Health Problems Tenth

Revision Volume 2 second edition. Geneva: World Health Organization

Undang-Undang RI Nomor 44 Tahun 2009 tentang Rumah Sakit.