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ANALYSIS OF THE APPLICATION OF PATIENT SAFETY (Case Study at Ratu Aji Putri Hospital Botung Penajam Paser Utara 2016-2021

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ABSTRACT

To prevent nosocomial infections, it is necessary to implement patient safety. Patient safety is a condition of being safe physically, socially, spiritually, financially, politically, emotionally, occupationally, psychologically and avoiding various threats. This study aims to analyze the application of patient safety at Ratu Aji Putri Hospital Botung Penajam Paser Utara. The research method used was a case study with a qualitative approach where the informants were the hospital director, the patient safety team leader, the head of the nurse's room and the patient. Methods of collecting and processing data with observational participants, independent interviews and triangulation. Based on the results of the study, it shows that the leadership behavior of the head of the room is directive, where there are obstacles in its implementation that have not been carried out optimally due to a reporting gap that has not been carried out by the head of the room with the management. The communication made by the head of the room with the nurses has been going well but the management has never received positive feedback and there is no freedom and limited expression of opinions or policy proposals. Coordination and division of tasks have been carried out properly, fairly and evenly. Management pays more attention to completing and seeking officers to actively express opinions, it is hoped that this will develop patient safety training programs for officers.

Keywords: Leadership, Teamwork, The Culture of patient safety

1. INTRODUCTION

The hospital is an institution that provides health services to the community. As a health service agency, the Hospital has a strong role in realizing the highest possible health status (Ministry of Health RI, 2014) . Patient safety is a condition of being physically, socially, spiritually, financially, politically, emotionally, occupationally, psychologically safe and protected from various threats. Patient safety in a hospital is a hospital system in providing patient care safely, preventing injuries caused by errors in taking action or taking an action that should not be taken. In principle, patient safety does not mean there is no risk at all in all actions taken, but to minimize errors that can occur. Patient safety is an effort to guarantee all actions related to patients carried out by health workers so that they take place safely and do not cause harmful effects to patients through all actions that have been regulated in legislation. The process and results of these services must be able to provide guarantees for customers so that they are free from risk and describe the quality of service quality in hospitals (Cahyono, JB and Suharjo, 2018) . Patient safety is a right for every patient and it should be the hospital's obligation to fulfill these patient rights (Hospital Patient Safety Committee (KKPRS), 2020) . The patient safety system is a top priority that must be implemented by the hospital, this is very closely related to both the image of the hospital and patient safety (Salawati, 2020) . A hospital needs a quality improvement and patient safety program to improve the quality of its services. To

achieve maximum results, the implementation of this program requires good coordination and communication from all elements in the hospital (Huriati et al., 2022) . The advantages of implementing patient safety in hospitals are that communication with patients develops, clinical risks decrease, patient complaints are reduced and the quality of service and image of the hospital increases (Putri, 2018) . The successful implementation of patient safety is the responsibility of all components in the hospital (Isnaini & Rofii, 2014) .

Leadership in an organization will determine the performance of the organization, this is no exception in patient safety in hospitals. Transformational leadership style contributes to patient safety. The leadership style of the nursing manager affects whether the results are good or not for patient safety. Leadership style can predict organizational personality and is significant for organizational safety culture (Mulyatiningsih & Sasyari, 2021) . Leadership is an important element for creating a strong culture in implementing patient safety. This culture includes encouraging everyone to be responsible for the safety of themselves, colleagues, patients and visitors (Hartanto & Warsito, 2017) . A patient safety culture will be formed by several factors, one of the factors that influence the implementation of patient safety culture is teamwork (Arini et al., 2018)

Previous research discussing patient safety has been carried out by (Ulva, 2017) with the results of the communication system research used, namely the SBAR technique (*situation, background, assessment, recommendation*) and TBK (write, read, confirm). Effective communication is carried out in an effort to reduce medical errors. Another study was conducted (Dewi, 2012) with the results showing that there was a significant increase in the implementation of handover and implementation of patient safety before and after the implementing nurses were given handover training with an effective communication approach that was integrated with the implementation of patient safety. Research conducted by (Siagian, 2020) showed that there were significant differences in the implementation of patient safety culture between *incharge staff* , *head nurse* and head of room. Research conducted by (Yeni Yarnita, 2019) showed that 56.3% of nurses in the intensive care installation at Arifin Achmad Riau Hospital had a negative safety culture with varying respondent characteristics. The purpose of this study is to analyze the implementation of patient safety at Ratu Aji Putri Botung North Penajam Paser Utara Regional General Hospital for the 2016 -2021 period with the formulation of the problem of how to implement leadership, teamwork and patient safety culture.

2. METHODS

The research method used is a case study at Ratu Aji Putri Regional General Hospital Botung Penajam Paser Utara with a qualitative approach. Data collection techniques with *participant observational, independent interviews* and triangulation. The informants in this study were the hospital director, the head of the patient safety team, the head of the nurse's room, and the patient.

Preposition of this research:

1. How is patient safety implemented?
2. How is leadership in implementing patient safety?
3. How is teamwork in the implementation of patient safety?
4. How is safety culture in the implementation of patient safety?

3. RESULTS AND DISCUSSION

Application of patient safety

Every medical action has potential risks. The large number of types of drugs, types of examinations and procedures, as well as the large number of patients and hospital staff, is a potential for medical errors to *occur* . Errors that occur in the process of medical care will result in or have the potential to result in injury to the patient, which can be in the form of a *Near Miss* or *Adverse Event* (Unexpected Event/KTD). *Near Miss* or Nearly Injury (NC) is an event resulting from carrying out an action (*commission*) or not taking the action that should be taken (*omission*), which can injure the patient, but serious injury does not occur, due to luck (for example the patient receives a drug contraindicated but no drug reaction), prevention (a drug with *a lethal overdose* will be given, but

other staff notice and cancel it before the drug is given), and mitigation (a drug with a *lethal overdose* is given, caught early and then given the antidote).

Based on the results of the interviews, it was found that patient safety in hospitals had not been implemented optimally, especially in reporting and following up if an incident occurred. Supervision has also been carried out but not carried out continuously and evaluation of patient safety is still not routinely carried out so that the results of implementing patient safety cannot be followed up. The implementation of patient safety so far has not run optimally, some of the efforts made by the leadership include building awareness of the value of patient safety. In the survey results it was found that every person in charge of patient safety, that staff always report any incidents related to patient safety and staff have effective solutions in dealing with these incidents. The second step is to build awareness of the value of patient safety as a way to create open and fair leadership and culture so that the hospital has a good policy in dealing with incidents through data collection that has been provided at the time of reporting by health service staff. If efforts are not made to increase awareness it will have an impact on the implementation of patient safety which only reports the occurrence of the same incident due to the absence of efforts in learning, initiative, concern and calling to carry out better services and prioritize patient safety. The next step is to lead and support staff as a team driving patient safety, they must be disciplined and able to work together to improve the quality of health services. Change will not occur if there is no leadership and commitment and support from one another. Nor can change occur if the leader is incompetent. Leaders are people who can take and do things right and right. In leadership, leaders must dare to take risks, have a commitment to change and communicate ideas. Therefore, a leader is needed who truly understands patient safety and can be responsible. In addition, integrate risk management activities Integrated risk management is when risks and follow-up carried out in a work unit can be a lesson for other work units in the Hospital.

The implementation of risk management activities in hospitals can be done by developing systems and risk management that are integrated with patient and staff safety, there are performance indicators, incident reporting, there are hospital forums for patient safety issues. In addition, the efforts made to develop a hospital reporting system must ensure that staff can more easily report incidents and the hospital arranges reporting to the Hospital Patient Safety Committee (KKPRS) and also reports incidents that have occurred and incidents that have been prevented but still occur because they contain important study material. That every error must be raised as an effort to improve the service system by reporting every error, even though the error does not cause a loss. Apart from that, involve and communicate with patients where guidelines for communication with patients about patient safety already exist, but the patient's family gets clear information about what is happening to their family, and so far the patient's family has had a good response. And based on observations, communication standards regarding patient safety do not yet exist. The step for implementing involving and communicating with patients is to ensure that the hospital has a policy that clearly outlines ways of open communication about incidents with patients and their families, prioritizing notifications to patients and families when incidents occur and immediately providing them with clear and correct information in a timely manner. Communication in the world of health is sending messages between senders and recipients with interactions between the two that aim to build trust, cause security to lead to satisfaction, improve treatment that leads to recovery, because in communication, giving and receiving between patients and health workers is not good communication will increase the risk from a problem, but communication skills can improve patient safety.

The next effort is to learn and share experiences about patient safety where the application in hospitals to share experiences about patient safety is to carry out a root cause analysis, namely by analyzing the root causes, which includes all incidents that have occurred. The steps of the root cause analysis are incident investigation, determine the investigator team, collect data (observation, documentation, interview), map the chronology of events, problem identification, information analysis, recommendations and work plans.

The results of interviews and observations obtained information that some of the problems that led to less than optimal implementation of patient safety such as facilities and facilities that did not

support, limited human resource competence, work culture and sources of financing. Therefore, in upholding patient safety investment in human resources and equipment alone will not be enough without system reform and changes in work culture. Investment is essential, as well as human resources, existing staff need to be supported both in terms of incentives and work environment to motivate them to practice patient safety in their work. The *bottom-up* approach is something that needs to be considered, voices and suggestions from *front-liner* staff are needed to find the most basic problems in upholding patient safety.

Leadership in implementing patient safety

Leadership is a process of directing and giving influence to the activities of a group of members whose duties are interrelated. Leadership is the most important part of management, which is the ability that a person has to influence other people to work towards goals and objectives. Unexpected events or near misses were not only the fault of the human factor/negligence of the service provider but there were other factors that contributed to the occurrence of events that were detrimental to the patient. There are four layers that make up the occurrence of an accident, namely: *organizational influences* (the influence of organizing and management policies on the occurrence of accidents, unsafe supervision), *preconditions for unsafe acts* (conditions that support the emergence of unsafe activities).

Delegation of tasks is an integral part of managing the room. Delegation is classified into 2 types, namely planned and incidental. Planned delegation is a delegation that actually occurs automatically as a consequence of the assignment system implemented in the inpatient room, the form can be delegating the duties of the head of the room to the team leader, to the person in charge of the shift. Incidental delegation occurs when one of the inpatient room personnel is unable to attend, then the delegation of tasks must be carried out.

Based on the results of interviews with informants about the delegation of authority from the head of the room to his subordinates regarding the implementation of patient safety, information was obtained that the director and wadir of services had delegated their authority to implement patient safety in the installation, but they were afraid to report patient safety issues to management because they were never followed up on reports. This makes the application of safety not optimal.

Employee perceptions of leaders and management have the greatest influence in building a patient safety culture. In order to optimally achieve goals, managers/leaders must synergize with employees at various levels, therefore the most suitable leadership model is a transformational leadership model. Transformational leadership is a process in which leaders and their subordinates try to achieve a higher level of morality and motivation, this is different from the transactional leadership model to motivate subordinates to carry out their responsibilities, transactional leaders rely heavily on a system of rewarding and punishing their subordinates.

So it can be concluded that the implementation of patient safety incident reporting has not been carried out optimally. This can be seen from the fact that there are still reporting gaps carried out by hospital employees and the results of research conducted on informants who concluded that the implementation of patient safety incident reporting was not optimal yet actually came from the unit itself, namely there was still a fear of a culture of blame which resulted in the unit's reluctance / individual to report the incident that occurred. And management support that is less than optimal by not immediately providing *feedback* on patient safety incident reports is a very strong reason. Supervision is an important part of nursing management, because supervision can solve problems in the organization quickly. The task of supervising or supervising cannot be separated from the leadership function. Supervisors or supervisors in the eyes of employees are considered as father figures with a role that is not only supervising, directing must also be able to accommodate all complaints both related to work and personal problems that hinder work. The supervisor must also know the extent of the abilities of his subordinates and the level of cooperation among the employees under him. The supervisor must be able to step in to help solve the problem without delay. So that you can create a comfortable and pleasant work atmosphere. A supervisor must also be able to motivate

employees to work and complete tasks, for example by giving praise or appreciation for what employees have done with good results and in accordance with what is expected.

Based on the results of interviews with informants regarding awarding by the director and wadir of services for those who have performed well in improving patient safety programs, they have never been given awards for those who have performed well in improving patient safety programs. Although the planning has been carried out properly, *the output* of the program is not optimal. In carrying out the managerial function, a manager is expected to have sufficient ability to organize his employees. One of the capabilities in question is the motivational ability of existing human resources. Managers and nursing assistants should provide motivation to generate encouragement in nurses. By providing motivation such as awards given to nurses, it is hoped that nurses will be enthusiastic in carrying out patient safety implementation programs.

Based on the results of interviews with informants regarding the imposition of sanctions by the director and wadir of strict service against mistakes made by employees related to the implementation of patient safety, namely all informants said that they had never given strict sanctions but were only given ordinary warnings about mistakes made by employees related to implementation patient safety. Giving sanctions to work units or individuals who make mistakes is the most difficult thing for the hospital to do. Sanctions for mistakes must be used as a valuable lesson and if necessary accompanied by sanctions in accordance with procedures to prevent the occurrence or recurrence of the same mistake. But this must be kept away from *blaming culture* , but rather as an effort to improve in an effort to improve patient safety.

Based on the results of interviews about providing guidance and encouragement to employees regarding the implementation of patient safety, it can be concluded that they, namely employees, are always given guidance and motivation to improve the implementation of patient safety in hospitals and to reduce patient accident rates. Hospitals are health service facilities that are labour-intensive, capital-intensive, technology-intensive and have a role in carrying out plenary health by prioritizing healing and recovery efforts that are carried out in harmony and integrated with efforts to increase and prevent as well as carry out referrals and organize education and research. In relation to services at the hospital, the system whose parts are the existing units must function properly. This function allows for unity, integration between units, between officials and harmony between organizations. In order for the hospital to achieve its goals, the coordination function plays an important role in the process, so as to create optimal service quality for patients.

Based on the results of interviews with informants about the ability to coordinate well to realize patient care in accordance with patient safety procedures, it can be concluded that they are very capable of coordinating well by helping each other because it is their obligation to provide patient care in accordance with procedures. patient safety.

Teamwork in implementing patient safety

The team is an element of organizational life because a job involves people with various skills to work together for one goal. Team events are dynamic processes that involve two or more people in an activity to accomplish a goal. Almost all hospital work is carried out by various disciplines, for example; operating room teams, shifts between workers, and medical and nursing units. Patient safety in hospitals involves the participation of all health workers, especially nurses. Nurses as one of the health workers who have a fairly dominant number in hospitals, namely 50 to 60% of the number of existing health workers. Nursing care services provided to patients are integrated services from other health services and have a fairly important role for the realization of patient health and safety.

Based on the results of interviews with informants about support for this hospital in improving better patient safety programs, namely that they really support hospitals in improving better patient safety programs because implementation in hospitals has not been maximized. Improving patient safety *can* be done by conducting training for nurses. Based on the results of interviews with informants regarding coordination with the head of the room for activities related to improving patient

safety programs, namely that they always coordinate with the head of the room when it is related to improving patient safety programs.

Collaboration is a form of *attitude* from nurses in working in a team because it makes individuals remind each other, correct, communicate so that opportunities for mistakes can be avoided. The results of this study are in line with the reality in the field that in carrying out nursing care for patients, nurses do it only for patients who are their responsibility rather than working in a team. Each nurse has their own responsibilities and duties towards patients so that other nurses do not know each other about the work of their colleagues. The head of the room must carry out briefing activities in coordination with nurses through: mutually motivating, helping problem solving, delegating, using effective communication, collaborating and coordinating. Motivating each other is an important element in the implementation of nursing care and nursing duties in the room. The things that need to be done by the head of the room are always to provide *reinforcement* for positive things, provide feedback, call nurses who are less motivated, maybe the achievements that have been achieved need to be rewarded.

In teamwork, a clear division of labor is required. The division of labor is one of the most important factors because the division of labor will be able to provide clarity for employees to be able to carry out their duties properly in accordance with the workload they are responsible for and prevent the possibility of overlapping work, waste and throwing responsibilities when they occur. mistakes and difficulties. But the division of labor must be followed by the placement of employees in the right place (*the right man in the right place*). In addition to placing employees in the right place, it is also necessary to pay attention to workload adjustments. The division of labor must be adjusted to the ability of an employee, because it is possible for an employee to be given many tasks, but whether he is able to complete them. The division of labor is carried out with the assumption that the smaller the task assigned, the faster it will be completed in terms of time, the lighter in terms of the energy used, the easier it is to use the mind, the more cost-effective it is used.

Based on the results of interviews with informants about comfort and no difficulty when dividing tasks with co-workers, all informants stated that they were very comfortable and never experienced difficulties when distributing tasks with co-workers because they felt this was fair. Based on the results of interviews with informants about the ability to coordinate well to realize patient care in accordance with patient safety procedures, it can be concluded that they are very capable of coordinating well by helping each other because it is their obligation to provide patient care in accordance with procedures. patient safety. Thus, coordination between units and between professions forms of interaction and cooperative relationships between one unit and the existing units in the organization becomes important. Health service performance as a measure of employee work results in providing health services, and satisfaction is one of the goals of providing health services.

Patient safety culture in implementing patient safety

The safety culture in the hospital can be interpreted as a collaborative environment that emphasizes the behavior of all staff who emphasize the safety of patients, officers, infrastructure and the environment. All service providers in the hospital treat each other with respect by involving and empowering patients and families. Leaders encourage all staff to work together in a team that is effective, professional, and prioritizes patient safety. Safety culture reflects individual and group behavior patterns that are based on human values, ethics and professionalism. In implementing a safety culture, it requires commitment from all actors and management capabilities in managing all existing potentials leading to a complete service. Which is characterized by effective communication, collaborative and integrated services in all hospital activities.

Implementing a patient safety culture will bring benefits to patients and health care providers, because it will detect errors that might occur, increase the awareness of health care providers to report if an error is made that causes a patient safety incident. The application of a patient safety culture will also reduce material expenses for patients or health care providers. Safety culture is also the result of the values, attitudes, perceptions, competencies and behavior patterns of individuals and groups,

which determine the commitment to safety, as well as the ability of hospital management, characterized by communication based on mutual trust, with the same perception of the importance of safety, and with a belief in the efficacy of preventive measures.

Based on the results of interviews with the leadership, information was obtained that the hospital director created and supported a culture of safety in all areas of the hospital in accordance with statutory regulations. Hospital directors encourage clinical staff providing care to work together in effective teams and support processes of interprofessional collaboration in patient-focused care. Safety and quality thrive in an environment that promotes cooperation and respect for others, regardless of their position within the hospital. The hospital director demonstrates his commitment to safety culture and promotes a safety culture for all hospital staff and all staff are responsible for supporting a safety culture and avoiding behavior that does not support safety culture .

In creating a culture of patient safety, several things are carried out by the hospital staff, knowing that the operational activities of the hospital are high risk and determined to carry out their duties consistently and safely. regulations and the work environment encourage staff not to fear punishment for making reports of adverse events and near misses. Hospital directors encourage patient safety teams to report patient safety incidents to the national level in accordance with laws and regulations encourage collaboration between clinical staff and leaders to Find solutions to patient safety issues. Patient safety culture refers to various aspects, namely aspects of obtaining services that are humane, fair, honest and without discrimination. receive quality health services in accordance with professional standards and standard operating procedures. obtain privacy and confidentiality of the disease suffered including medical data. obtain information which includes procedures for medical action, purpose of medical action, action, risks and complications that may occur, and the prognosis of the action taken as well as the estimated cost of treatment , obtain approval or refuse for the action to be taken by health workers for the disease they are suffering from , obtain security and safety himself while in hospital treatment. implement a patient safety culture.

Based on the results of the interviews, information was obtained that a patient safety culture such as a reporting system was still lacking even though the reporting system was very vital in gathering information as a basis for analysis and conveying recommendations. Reporting on hospital safety culture is carried out by ensuring confidentiality and ensuring there is no impact on those who report it and is explained in the SPO for reporting hospital safety culture. Reporting on patient safety culture is explained in a separate guide with an explanation: Incident reporting system internally (locally) and externally (national). Activities carried out by the hospital are internal reports to the owner, reporting incidents nationally to the National Patient Safety Committee (KNKP). Reporting on safety culture every month to the director through each head of the work unit is required to make a safety culture report to the director through the head of the legal and community sub-section (Ka.SuBag.HUKMAS) which is continued to the hospital ethics committee to be carried out review and follow-up , this has never been done.

4. CONCLUSION

The leadership style of the director and deputy director of services has delegated authority very well so that they can be accepted by their subordinates, but there are obstacles in reporting patient safety incidents that have not been maximized due to a reporting gap with management resulting in less optimal management support by not immediately providing feedback on incident report. Teamwork, namely interpersonal effectiveness in employees who are very capable of coordinating well, it is the employee's obligation to realize patient care in accordance with patient safety procedures. The work culture in implementing patient safety is going well where nurses carry out work according to standard operating procedures

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