

# The Implementation of Patient Safety Culture in Hospital: A Qualitative Research

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## ABSTRACT

This study explores the implementation of patient safety culture in one of General Hospitals in the central part of Aceh Province, Indonesia. The research used a qualitative method with a phenomenological design, collected data using in-depth interviews with eight participants in inpatient and outpatient rooms. The Collaizi method was used to analyze the data and produced three themes, namely: (1) conditions needed to improve the directing function, (2) leaders' response and concern, and (3) team support and coordination in implementing patient safety. The results of this study indicate that the problem of implementing a patient safety culture needs to be considered by hospital management to improve patient safety. It is recommended that service leaders at the hospital improve the directing function to improve the implementation of patient safety culture and the quality of hospital services.

**Keywords:** Patient safety, leadership, communication, teamwork.

## INTRODUCTION

As a place of healing (curative) and rehabilitative health services, the hospital has an important role in improving health status. In hospitals, there are hundreds of drugs, tests and procedures, technological tools, and various types of professional and non-professional staff. It provides safe, effective, quality, anti-discriminatory health services that prioritize patient safety and provide patient services continuously for 24 hours. If this diversity of services is not managed properly, it can result in patient safety incidents.<sup>1</sup>

Patient safety culture (PSC) is a broad, complex, and multi-dimensional conceptual

framework, making it possible to assess individual and organizational behavior based on shared beliefs and values. The goal is to reduce injuries and improve patient safety. High safety standards mean small errors occur. These errors can be reported immediately for follow-up.<sup>2</sup>

The patient safety program refers to the Nine Saving Safety Solution from WHO Patient Safety 2007, which is used by the Hospital Patient Safety Committee (KPPRS), and from Joint Commission International (JCI), which is the first world body accredited by International Quality Standards (IQS) which makes Patient safety goals are one of

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the benchmarks in accreditation. However, patient safety problems still occur, including in Indonesia.<sup>3,4</sup>

The Joint Commission International (JCI) received reports of sentinel events with varying numbers, namely the number of incidents that started in 2014 had a total of 763 incidents and increased in 2015 with a total of 934 incidents, then decreased in 2016 with a total of 824 incidents and finally in 2017 with a total of 805 incidents. There were six sentinel events reported to The Joint Commission in 2017, namely five incidents of transfusion errors, 66 incidents of delay in treatment, 32 incidents of medication errors, 95 incidents of wrong patients, wrong positions, and wrong procedures, 19 incidents of surgical/postoperative complications, and 114 incidents of falls.<sup>5</sup>

Although this data already exists in general in Indonesia, it is also proven by Kusumawati<sup>6</sup>, which states that there has been a decrease in the incidence of adverse events, namely a decrease in side effects from 5.0% to 3.7% in patients with acute myocardial infarction and a decrease in the proportion of patients who had one or more side effects from 26.0% to 19.4%. However, incident reporting records related to patient safety culture in hospitals have not been developed thoroughly by all hospitals, especially in Indonesia. Therefore, the record of reporting patient safety incidents is still very limited, and incidents in patient safety that are detected are generally adverse events that are found incidentally. Others tend to go unreported, not recorded, or even escape our attention.<sup>6,7,8,9</sup>

Results of interviews with heads of inpatient and outpatient rooms in one of general hospital in the central region of Aceh Province, Indonesia, indicated that the implementation of safety culture in terms of leadership, communication, and teamwork in implementing patient safety culture still requires special attention. Based on the explanation from the heads of the rooms, the application of patient safety culture needs to be explored further so that its implementation

can be understood. This is important to do to improve the quality of hospital services.

## METHODS

This research employed a qualitative method with a phenomenological design. This research was conducted at one General Hospital in Gayo Lues, Aceh. Sampling criteria include: (1) Heads of the rooms who work in inpatient and outpatient rooms, (2) Have at least one year of working experience, (3) Willing to share their experience directly, (4) Not currently on annual leave/maternity leave/study leave. The interviews lasted between 10-25 minutes and were recorded and transcribed word for word. After data saturation was reached, data collection was stopped.

Colaizzi's phenomenological approach was used to examine the data in this study: (1) recorded interviews are listened to with great attention; (2) critical statements are organized to provide highly relevant data; (3) the three themes are made by grouping and categorizing; (4) the study themes of phenomena are utilized to organize a comprehensive overview further; and (5) participants are allowed to view the data that has been analyzed.<sup>10</sup>

## RESULTS

This research was conducted in June 2022 by interviewing eight key participants. The themes that emerged from the data included: The conditions needed to improve the directing function, response and concern from the leaders, team support, and coordination in implementing patient safety.

### **Conditions necessary to improve the directing function**

This theme explains that awarding has never been done to improve patient safety programs. Strict and written sanctions are needed regarding implementing patient safety and developing nurse capacity building related to patient safety. The following are participant statements:

*“So far, our leaders have never given appreciation to employees who perform well in improving patient safety programs” (P1)*

*“At least they were given routine warnings. There have never been strict sanctions. So, that’s what makes the implementation of patient safety in this hospital not optimal” (P5)*

*“Training has been carried out but not about patient safety” (P8)*

### **Leaders’ response and concern**

This theme explains that there has been no follow-up when reporting patient safety incidents, and staffs still have limitations in expressing opinions regarding the implementation of patient safety. The following are participant statements:

*We have reported it to the leaders, but there has been no follow-up from them; for example, the facilities must be replaced because they are no longer suitable for use and can cause patients to have accidents” (P3)*

*“Sometimes there are limitations when we provide policy proposals” (P2)*

### **Team support and coordination in the implementation of patient safety**

This theme explains that team support, discussion, and joint coordination in improving the implementation of patient safety culture have been carried out well. In general, participants expressed their experiences as follows:

*“I always support patient safety programs to increase patient satisfaction further so that unwanted incidents do not occur to patients” (P5)*

*“We, together with the director and deputy director, always discuss and coordinate how to improve patient safety programs” (P8)*

## **DISCUSSION**

In this study, the results showed that there was no reward (appreciation), no strict and written sanctions, and no nurse capacity-building activities related to implementing

patient safety culture. Rewards given to heads of rooms who have implemented a patient safety culture can be a solution to increasing and maintaining staff motivation in implementing patient safety culture. Reward is an appreciation given in both material (financial) and non-material (commendation) forms. A word of thanks can be used as a reward and has extraordinary power.<sup>11</sup> Work that is motivated by gratitude from a superior to a subordinate can be a source of inspiration for time discipline to complete the work.<sup>12</sup>

The absence of strict and written sanctions against staff makes staff less disciplined in carrying out their work. Punishment is needed to improve discipline and educate staff to comply with hospital regulations. With justice and firmness, the target of giving punishment will be achieved. Regulations without being accompanied by strict punishment for violators will make staff undisciplined.<sup>11</sup>

The leaders should give a warning to staff, not just a warning but by giving a warning letter so that it can be a deterrent effect for staff who make mistakes. Reprimands/ sanctions are notifications to people about mistakes that have been made so that they know the rules that should be obeyed.<sup>13</sup>

Capacity building for nurses related to the implementation of patient safety culture can be in the form of training. This is related to how the hospital develops nurse knowledge to increase the knowledge of the heads of the rooms. The application of a patient safety culture is supported by previous studies that show a relationship between nurse knowledge and efforts to implement patient safety in hospitals.<sup>14,15</sup>

Training can add new knowledge and improve individual and system performance.<sup>16</sup> The results of interviews about patient safety training for employees and the service director concluded that training by leaders to increase staff knowledge could reduce the incidence of patient accidents.

Staff development programs through training and education are effective programs

to increase nurse productivity.<sup>20</sup> Adequate support in the form of professional training and knowledge development is one of the efforts to create a positive work environment for nurses so that safe care can be provided. Based on this, the leaders need to implement the directing function in implementing patient safety culture so that the entire team and existing resources can work to achieve common goals.

Based on the experience of the heads of the rooms, the leaders were less responsive and concerned about giving a response or feedback after they reported incidents of implementing patient safety. Given the importance of patient safety, a fast response from the leaders is expected to improve the implementation of a patient safety culture.<sup>18</sup>

Judging from the results of achieving the goal of implementing patient safety culture, the researcher seeks to link King's nursing theory with the goal achievement model as the hospital's responsibility for implementing patient safety culture.<sup>19</sup> Based on the experience of the heads of the rooms, it was found that the leaders needed to follow up on incidents reported from the room and provide opportunities for staff who wished to express opinions regarding the implementation of a patient safety culture.

Based on the results of interviews with participants in this study, the obstacles and complaints they experience regarding the implementation of patient safety culture need to be followed up by the leaders so that the implementation of patient safety culture can be carried out properly.

The hospital is a health service facility that is labor-intensive, capital-intensive, and technology-intensive and has a role in implementing complete health services. This is done by prioritizing healing and recovery efforts that are carried out in harmony and integrated with improvement and prevention, as well as carrying out referrals and organizing education and research.<sup>20</sup> Faridah states that in carrying out their duties, the hospital has the function of medical services, medical support

services, nursing services, rehabilitation and prevention services, and health promotion.<sup>15</sup>

Concerning services at the hospital, the system and its parts are units that must function properly. This function allows for unity that is integration and harmony between units, between officials and between organizations. For the hospital to achieve its goals, the coordination function plays an important role in creating optimal quality of service for patients.<sup>7</sup>

Things that need to be assessed on hospital staff include knowledge about work, productivity, ability to complete tasks, behavior at work, ability to make decisions and cooperation with others.<sup>20</sup> Thus, coordination between units and between professions and forms of interaction and cooperation between one unit and the existing units in the organization becomes important. Health service performance, as a measure of employee performance in providing health services, and satisfaction is one of the goals of providing health services.<sup>16</sup>

Based on the interviews with informants, it can be concluded that they support the hospital in improving patient safety programs. They always carry out joint discussions and coordination in improving better patient safety programs because the implementation of patient safety culture in the hospital is still not optimal.

## CONCLUSION

The results of this study show that the problem of implementing a patient safety culture needs to be considered by hospital management to improve patient safety. It is recommended that service leaders at the hospital improve the directing function to improve the implementation of patient safety culture and the quality of hospital services.

## RESEARCH LIMITATIONS

Data was limited, only collected from the heads of nursing rooms. The involvement of other elements of hospital leadership to

provide more comprehensive views need to be considered for further research.

## ETHICAL CONSIDERATIONS

The Study was approved by the Nursing Research Ethics Committee of the Nursing Faculty of Universitas Syiah Kuala, Banda Aceh, with registered No: 112008180322.

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## CONFLICT OF INTEREST

No conflict of interest to be disclosed.

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