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DIMENSION OF PATIENT SAFETY CULTURE

Agung Purnomo[1], Yuly Peristiowati, Agusta Dian Elina
STRADA Health Science Institute
agungpurnomo1976@gmail.com

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ABSTRACT

Background: Patient safety is a serious public health issue. Several studies reported security problems in healthcare systems in various countries. The impacts were varied, starting from mild pain, disability, death, and high cost of service.
Aim: This study attempted to review the culture of patient safety from several studies and to identify factors that influence them.
Method: This study was conducted with systematic mapping studies related to patient safety culture. There were 10 research articles were evaluated from various online sources that related from data base ProQuest,Oxford Academic, Wiley Online Library, Google Schoolar, and Springer. It was conducted by entering keywords which appropriate to the topic, the obtained results were analyzed and discussed to produce conclusions.
Findings: Adverse events were common problems. Healthcare employees had roles in creating safe and high quality services. One of them was through implementation of a culture of patient safety. There were several factors which support a culture of patient safety, namely leadership, teamwork, patient care, evidence-based, communication, learning, just, and patient-centered.

KEYWORDS

Culture, patient safety, dimension, quality, health care

INTRODUCTION

Safety has become a global issue as well as hospitals. There are five important aspects related to safety in hospitals, namely patient safety, worker safety or health workers, building safety and equipment in hospitals that can have an impact on patient and officer safety, environmental safety (Green productivity) which impacts environmental pollution and hospital business safety related to hospital survival. These five aspects of safety are very important to be implemented in every hospital. But it must be recognized that the activities of hospital institutions can run if there are patients. Therefore, patient safety is a top priority to be implemented and it is related to the issue of quality and image of the hospital (Padgett et al., 2017).

Patient safety is very important in the field of health services, so that health care providers have full responsibility for the safety and security of patients. If the safety system carried out by health workers within the scope of the hospital is effective then it will have a good impact on the level of patient safety. This can certainly benefit hospitals, especially health workers to avoid patient demands when medical errors occur. An effective safety system will create a good patient safety culture, in line with what is stated by (Loh et al., 2019) regarding a good patient safety culture containing five component elements, namely openness culture, justice culture, reporting culture, learning culture, and information culture. These five things must exist in each individual to produce a good culture of habits implemented by the patient safety system (Loh et al., 2019).

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The Institute for Healthcare Improvement recommends 10 approaches to building a culture of patient safety in the health service, namely conducting patient safety leadership, walkingrounds, creating reporting systems, forming patient safety teams, engaging patients in safety initiatives, delivering safety reports on shift shifts, appointing safety champions for each unit, understanding possible risks, conducting safety briefings and forming a team that responses to unexpected events (al Omar et al., 2019).

The demands of managing the Occupational Health and Safety program in hospitals (K3RS) in this era of globalization are getting higher. Workers or health workers, visitors, patients and the community around the hospital want to get protection from health problems and work accidents, both as a result of the process of service delivery activities and because of the condition of facilities and infrastructure in the hospital (Baylina et al., 2018).

Health worker professionalism is demonstrated from the behavior of health workers in providing health services including the implementation of patient safety programs based on independent, responsible and responsible health care standards, and developing capabilities in accordance with the development of science and technology. Nursing as a professional service must act based on science, including knowledge of patient safety, so that nursing care provided is qualified and useful in preventing incidents of unwanted events (Wagner et al., 2019).

The application of a culture of patient safety nationally and internationally is still low when viewed from various research results that have been conducted in several existing hospitals. Viewed from a national point of view collected different research data including, in a journal found a number of incidents about poor hospital services, the incident precisely occurred in Japan. A quantitative study conducted using data published from the Japan Council For Quality Healthcare analyzed the level of clinical experience of near miss events. In a study involving 17,105 cases analyzed, 14,896 cases of near-missed drug administration, 1857 incidents of near-missed medical devices and 162 incidents of near-woeful care. The study included respondents with an average of 2.3 years of work. Statistically significant differences between clinical experience, incidence, drug administration and the medical devices used were observed. Yet no difference was found in terms of near-wretched nursing care. The length of work and experience in the workplace department greatly influence the incidence of patient safety incidents. Safety incidents that occur only at the beginner level are not done at the advanced level. The implications of this study are important as a reference to develop a new education system for nursing training in the workplace (Akiyama et al., 2020).

The results of research conducted at several accredited hospitals of joint commission international (JCI) found 52 incidents in 11 hospitals in 5 countries. The highest cases were in Hong Kong with a total of 31% of cases, followed by Australia with 25% of cases, India with 23% of cases, the United States with 12% of cases, and Canada with 10% of cases. In Brazil, there are about 7.6% of cases (Bukhari, 2019). Patient safety incidents that occurred in Indonesia based on Daud's report (2000) it is known that there were 7465 cases in 2019, consisting of 171 deaths, 80 severe injuries, 372 moderate injuries, 1183 minor injuries, and 5659 no injuries (Habibah & Dhamanti, 2021).

Then according to research conducted by Mulyati et al. (2016) in Kuningan hospital found some components of the patient safety culture whose application is still not good, including the work team that is less supportive there are 39 people (90.7%), perception of poor management there are 35 people (94.6%), stress there are 42 people (77.8%), and poor working conditions

there are 37 people (62.7%). In this study, the leadership element had a significant influence in creating a culture of patient safety. Leaders have the authority to implement the system that applies in organizations, therefore leadership style, communication techniques and managerial skills are things that need to be considered in creating a conducive work atmosphere as an effort to create a culture of patient safety. Based on the results of research that transformational leadership model is the appropriate model applied to improve the culture of patient safety, effective communication skills training and the development of educational models between professions as an effort to improve collaborationcapabilities.

Research conducted by (Kumbi et al., 2020) in Ethiopia showed results from an overall level of patient safety culture of 44%. Analysis of factors according to the Agency for Health Research and Quality showed that working hours per week, participation in patient safety programs, reporting of side effects, communication problems, teamwork in hospitals, organizational learning and feedback on errors were all significant factors related to safety culture.

The creation of a culture of poor patient safety will have an impact on hospitals, especially health workers and patients. If it occurs within the scope of the hospital, as a result the hospital will experience a large financial expenditure caused by the poor performance of health workers in terms of patient handling. Then, another impact is that health workers will ignore the reporting system regarding the incidence of medical errors that are happening. The absence of evaluations carried out by the managerial to health workers makes the incident happen again (Bates & Singh, 2018).

In modern times, patient safety cannot leave any information technology in the field of health. In a study in England and Wales conducted in retrospective study analysis for 10 years, patient safety events related to health IT failures were found. 2106 (82%) were safety incidents of non-harming health IT failures, 331 (13%) caused minor damage, 102 (4%) caused moderate damage, 14 (1%) caused severe damage and 4 (<1%) contributed to the damage to a patient's death. Overall, 1964 (75%) of patient safety incidents in it health buses can be prevented (Martin, 2018).

A good patient safety culture is important in supporting the success of the patient safety system in hospitals. In a study on attitudes affecting the culture of patient safety in health services in Iran involving 236 health workers consisting of doctors, nurses and paramedikal staff with an average age of 29 years and an average work experience of 6, there was a positive correlation between the patient safety culture and aspects that affect it. Cooperation between departments has the highest correlation. Similarly, an understanding of the culture of patient safety scored highest (13.53%) but there were significant differences in aspects of openness and honesty in communicating among health workers. Based on the results of this study improving the culture of patient safety is very important in the management of health facilities services that can be done by conducting collaborative and instructive workshops, developing educational programs and designing training of patient safety reporting systems to improve the knowledge and skills of hospital employees about patient safety (Laal et al., 2016).

Health and managerial personnel also need to build effective communication and teamwork between individuals. Health workers are also required to be aware in seeking cultural development to report medical errors. Such reporting can be used as a lesson for organizations

in evaluating the performance of teams and individuals to improve the hospital service system (O'Donovan & McAuliffe, 2020).

According to the above data, it can be concluded that a culture of poor patient safety is still dominated on a national and international scale.

METHOD

The study was conducted by means of systematic mapping of patient safety culture. A total of 10 research articles were evaluated from various online information sources: ProQuest, Oxford Academic, Wiley Online Library, Google Schoolar and Springer Searches were conducted by entering keywords in accordance with the topic of patient safety culture and influential factors. Based on the results obtained, analyzed and discussed to produce conclusions.

RESULTS AND DISCUSSION

According to KKP-RS, patient safety is a system where hospitals make patient care safer. This includes risk assessment identification and management of matters related to patient risk and reporting and analysis of incidents. This system prevents injuries caused by carrying out an action or not taking action that should be taken. The goal of the hospital patient safety system is the creation of a culture of patient safety in hospitals, increasing hospital accountability for patients and the community, decreased KTD in hospitals and the implementation of prevention programs so that there is no repetition of KTD (Tutiany et al., 2017).

The study conducted in the Kingdom of Saudi Arabia by Atallah Alenezi et all (2019) under the title "Clinical practitioners' perception of dimensions of patient safety culture in government hospital : A on sample of correlational survey" using the study method one-sample correlation survey design using The Hospital Survey of Patient's Safety Culture (HSOPSC) developed by the Agency of Health Research and Quality (AHRQ) took a sample of 181 personnel. health in the Royal Saudi Arabia hospital between December 2018 - January 2019. The HSOPC survey used a structured questionnaire with 42 items, but did not include sociodemographic variables. Results in the study found that nine of the 12 dimensions measured were identified as weaknesses in patient safety culture, including management support for patient safety (49.2%), cross-unit teamwork (44.2%),reporting frequency and incidence (43.1%) communication openness (41.3%), overall perceptions of patient safety (38.7%), supervisors/expectations and actions that promote patient safety (32.9%), staff (23.7%), supervisors/expectations and actions that promote patient safety (32.9%), staff (23.7%), hospital delivery and transition (19.6%) and non-punitive responses to errors (15.85%). None of the dimensions were identified as strength by the respondents. The number of hours worked per week and the positions of staff were identified as significant predictors.

Patient safety issues are affected by many factors. Hesitation to speak is one of the factors that can contribute to communication errors and/or side effects. Many junior doctors and nurses have the experience of being hesitant to voice their concerns over patient safety, even when they are aware of the risks and shortcomings of such neglect. If health care professionals frankly talk about their concerns for patient safety, this can provide a good opportunity to avoid mistakes in the health service (Stewart, 2016).

The study conducted in Turkey by Hasan & Seyda (2017) under the title "The work environment and empowerment as predictors of patient safety culture in Turkey"used cross-sectional descriptive design methods by evaluating data, descriptive statistics and hierarchical regression analyses from 274 samples of nurses working at university hospitals in Izmir, Turkey. The results showed that the work environment and the provision of structural empowerment access related to the patient safety culture could help health care organizations to improve the patient safety culture (55%). The most significant predictors were support for optimal patient care, nurse/physician relationships and staff involvement in organizational affairs.

Patient safety culture is a product of the values, attitudes, complements and patterns of behavior of individuals and groups that determine the commitment, style and ability of a health care organization to the patient safety program. The consequences resulting from organizations that do not have a culture of patient safety in the form of latent errors, psychological disorders and physiology in staff, decreased productivity, reduced patient satisfaction and can cause interpersonal conflicts. If a healthcare organization does not have a culture of patient safety, then accidents can occur and result in latent errors, psychological and physiological disorders in staff, decreased productivity, reduced satisfaction in patients and able to cause interpersonal conflict (Ege et al., 2019).

Characteristics of the patient safety culture:

1) Communication is formed from openness and mutual trust.
2) Good flow of information and processes
3) Perception of the importance of safety
4) The realization that mistakes cannot be completely avoided
5) Proactive identification of safety
6) Organizational learning
7) Have a committed leader and a responsible executive
8) Approach to not blaming and not giving punishment to reported incidents (al Nadabi et al., 2020)

López-Liria et al. (2017) reported that the culture of patient safety is compiled from seven sub-cultural factors as follows.

Leadership

Leaders recognize the health environment as a high-risk environment and strive to align vision/mission, staff competence, fiscal and human resources from boardroom to front liner. The literature points to the role of senior leadership as a key element for designing, developing, and maintaining a culture of safety. Senior leaders are essential to achieving successful organizational development and safety culture. Engaged leaders drive a culture of patient safety by designing building strategies and structures that guide safety processes and outcomes (Chegini et al., 2020).

Teamwork

Healthcare organizations that treat patients with increasingly complex disease technologies and processes and technologies that require stronger efforts against the application of teamwork and collaboration to achieve a culture across patient safety systems. A spirit of

collegiality, collaboration, and cooperation that exists among executives and staff, and independent practitioners. Open, secure, respectful, and flexible relationships (Welp & Manser, 2016).

Evidence-Based

Patient care practices are based on evidence. Standardization aims to reduce the variation of errors that occur at every opportunity. Some literature reports health organizations are supported with evidence-based best practices, including standardized processes, protocols, checklists, and guidelines, considered to indicate a culture of safety.

Communication

Communication culture is a condition in which an individual / staff, able to handle work problems, has a job description, has the right and responsibility to talk with patients (Rahmawati et al., 2018). Some previous studies have suggested applying forms of communication such as briefings. Briefings are effective discussions to ensure equipment procedures, medicines, and supporting documents are in place. A debriefing occurs again at the end of the procedure to allow for a review (Klemenc-Ketis et al., 2018). In the end, the communication of the staff can be heard and recognized by the manager. Providing feedback or building trust and openness is an important trait of a safety culture (Ryan et al., 2019).

Learning

Hospitals need to learn from mistakes and look for new opportunities to improve performance. Learning is a value that must be implemented by all employees including medical personnel. According to Kang et al. (2021) an e-culture of learning exists within hospitals as organizations seek to learn from mistakes and improve performance into the system of providing care (Diskin et al., 2021).

Accurate

One way to define accuracy in a patient safety culture is to consider two sides of the fairness scale. One side of scale is individual accountability and the other side is system failure (Zhang et al., 2020). The method used for health organizations is to determine whether an individual error or system failure is by asking four questions: (a) Is the behavior of this service provider aware of the dangers? (b) Is the treatment provider under the influence of alcohol or drugs? (c) Is the care provider aware he or she made a mistake? (d) Did two or three of these fellow care providers create a good problem? (Waring et al., 2016).

Focusing on Patients

Service to the patient and family, in this case involving the patient to actively participate to maintain his health. The patient-centered culture includes patients and families as the sole reason for the hospital's existence (Sheard et al., 2017). It is promising to reward patients by providing an environment to support healing during hospitalization and also for health promotion and advanced care. Hospitals focus on enabling and empowering patients to be participatory in their care decision-making (Skagerström et al., 2017).

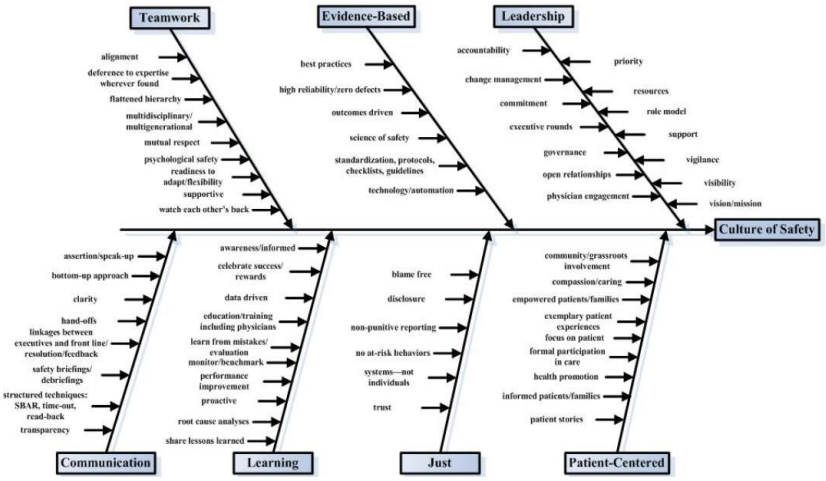


Figure 1. Hospital patient safety culture

To assess patient safety culture, researchers generally use self-completion questionnaires. This is done by providing questionnaires to all staff in health care organizations, then will calculate the average value of response to each factor assessed. The first step in developing a patient safety culture is to assess the existing culture. One of them is by using the framework "Manchester patient safety". The statements used for the cultural dimension of patient safety are 1) Statements to measure values, understandings andattitudes; 2) Statements to measure activities or behaviors aimed at developing a culture of patient safety such as leadership, policies and procedures (Kang et al., 2021).

There are several steps in developing a culture of patient safety (Noviyanti et al., 2018):

1) Declaring patient safety as a priority
2) Determine executive responsibility in patient safety programs
3) Renew medical knowledge and expertise
4) Civilize the reporting system without blaming the relevant parties
5) Building accountability
6) Education reform and building learning organizations

Accelerating change for improvementwithin a healthcare organization can be known to have turned into a culture of patient safety through (Cheikh et al., 2016):

1) People will see that the management / leadership team has a commitment to safety, by preventing errors and not by punishing the culprit.
2) Healthy and happy staff are an essential part of a safe health service. Staff take personal health and safety and other team members seriously and can be aware when something goes wrong.
3) Problems and errors are proactively anticipated by the system. Each staff will consistently reprimand other staff for unsafe actions, and put safety over efficiency first.
4) Staff and management consistently implement remedial actions
5) Patient safety is seen as essential and attractive.

Developing a patient safety culture is not easy. There are many challenges faced to transform an existing culture into a culture of patient safety. This can be done in the form of making patient safety as one of the main parts in health care organizations (Waring et al., 2016). In terms of its implementation, supported from the organization ranging from executives, clinic teams, and staff at various levels of the organization, cultural change is closely related to the opinions and feelings of individuals in organizations. Freedom of speech openly in the accommodation system will allow any individual to report unwanted events. The habit of blaming each other can allow individuals to report and discuss unwanted events without fear of the law as well as ensuring each individual is responsible for the implementation of the patient safety culture. All parties are responsible for creating patient safety (Heckemann et al., 2019).

CONCLUSION

Patient safety has not been a culture by healthcare organizations. Unexpected events (KTD) such as the iceberg phenomenon. Efforts to develop factors that support the culture of patient safety need to continue to be encouraged by health care organizations.

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