



# Nurse's perception of patient safety culture in an effort to improve service quality in the operating room of Riau Province Hospital

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## **Abstract:**

*The aim of the study is to find out Nurse's perception of patient safety culture in an effort to improve service quality. This study uses qualitative research methods with a phenomenological approach. The result of the study is obtained that the informants assume that the socialization carried out by the hospital in the context of increasing knowledge related to patient safety is not effective. Education and training for patient safety is carried out continuously to increase knowledge, improve and maintain staff competence. While the socialization carried out by the hospital did not have much influence to increase the informant's knowledge related to patient safety.*

## **Keywords:**

*Nurse's perception; patient safety; service quality*

## **I. Introduction**

Nurses are the most paramedics available at the hospital and are on duty 24 hours serving patients. Nurses play an important role in improving patient safety, namely as a provider of information to patients and families about the likelihood of an incident occurring, reporting if an incident occurs, improving communication with patients, patients' families and other medical personnel, as well as playing an active role in assessing safety and quality service and help measure the improvement of patient safety (Choo, 2010).

Research on nurses' perceptions about patient safety culture has been carried out, according to research conducted by the AHRQ (Agency for Healthcare Research and Quality) in 2018 which stated that only 63 percent of nurses had positive perceptions of patient safety culture. Another study conducted by Alquwez (2017) at Saudi Arabia and Ammouri hospitals (2015) in Oman found that nurses' positive perception of patient safety culture was still very low.

The medical risk due to surgery in developing countries is 19 percent higher when compared to developed countries, and 25 percent of the drugs used in developing countries are fake. Of the 20 countries surveyed by WHO, 60 percent of patient safety incidents and the use of fake drugs occur in developing countries. Other research shows that medical equipment in developing countries is almost half unsuitable for use and rarely receives periodic maintenance. Indonesia is one of developing countries and potential for patient safety incidents (Purwanto, 2018).

Data on patient safety incidents in Indonesia is very minimal due to the lack of culture to report when patient safety incidents occur. But we still see a lot in the media that there are many mall practices in hospitals, this indicates that there are still many patient safety incidents that occurred in Indonesia. According to the National Hospital Patient Safety Commission (KNKPRS) in 2019 the number of injuries was almost 2534, the number of non-injuries was

2554, and the number of unexpected events was 2567 cases. While 243 deaths were caused, 89 severe injuries, 449 moderate injuries, 1247 minor injuries and 5630 non-injuries. Many incidents occurred in the productive age group, namely 15-30 years, 1125, and 30-60 years age group, 3821 cases (Ministry of Health) RI, 2019). From the above data, we can see that the number of patient safety incidents in Indonesia is still high and most often in the productive age and of course this is very influential.

The occurrence of patient safety incidents in Riau Province Hospital is one indicator that hospitals have not yet provided quality services. Other indicators of service quality are the number of appropriate sleep usage or Bed Occupancy Rate (BOR) of 45 percent, Average Length of Stay (AVLOS) or the average length of patient treated by 45 days, Bed Turn Over (BTO) is also called the bed turnover rate of 37 times, the Turn Over Interval (TOI) of six days.

## II. Review of Literature

### 2.1 Perception

According to Sthepens P. Robbins (2008) perception is the process by which individuals or individuals organize and interpret the sensory impressions they feel in order to give meaning to their environment. Another definition of perception according to Thoha as written by Tahir (2014) is the cognitive process experienced by everyone in understanding information about their environment through vision, appreciation, feeling and smell. According to Rahmat in Tahir (2014) perception is the experience of objects, events or relationships that are obtained by concluding information and interpreting messages.

### Factors that influence perception

There are three factors that influence one's perception according to Sthepens P. Robins (2008) viz:

#### 1. Characteristics of perception maker

When someone sees something and tries to interpret what he sees, then this is influenced by several personal characteristics of the maker of perception, namely attitudes, personality, motives, interests, past experiences and expectations about the maker of perception.

#### 2. Object or target interpreted

The characteristics of the target or object to be interpreted by individuals affect what will be interpreted. The object or target factor that influences one's perception is something new, movement, sound, size, background, closeness, and similarity.

#### 3. Situation

There are 3 situation factors that influence one's perception, namely time, work conditions and social conditions.

Meanwhile, according to Thoha in Tahir (2014) there are three factors that influence perception, namely psychology, family or family such as parents, children and culture. Culture here is the environment and culture in which a person lives.

### 2.2 Patient Safety

Patient safety is protected from preventable dangers and reduces unnecessary minimum risks obtained during the health care process (WHO, 2018). Whereas according to Permenkes NO 11 of 2017 is a system where hospitals make patient care safer. IOM defines that patient safety is preventing harm to patients by providing a good care system, preventing mistakes, learning from mistakes and building a culture of patient safety for all health professionals both nurses, organizations and patients.

Patient safety or patient safety according to Supari in Purwanto (2018) is free from or avoided a patient from an incident or injury caused by medical care and treatment during the patient being treated. Patient safety is preventing, avoiding and repairing the results of actions that are bad or dangerous for patients who come from the treatment process (Vincent, 2011). Meanwhile, according to Emanuel in Purwanto (2018) said that patient safety is a discipline of nursing and health that emphasizes patient safety to create reliable health services.

Patient safety began to be discussed since the report made by the Institute of Medicine (IOM) in America in 1999 entitled to err is human and an organization with a memory (2000). The results of this study say at least 44,000 to 98,000 people die each year in America due to medical error. In 2008 in the United States 3.2 percent - 5.4 percent, Latin America 10 percent, New Zealand 12.7 percent, Denmark nine percent and Britain 11.7 percent. While in Taiwan there were 14,945 cases reported in 2007.

### **2.3 Patient safety culture.**

Patient safety culture must be applied in all parts of the hospital without exception, starting from the system, hospitals, departments and units in all parts. A patient safety culture requires appreciation, support from management. Patient safety culture must also be in accordance with what is desired and must be accepted by all staff in the hospital (AHRQ, 2018).

The core component of patient safety culture. The positive implementation of patient safety culture is influenced by six core components, namely: Leadership culture. According to Huber D in Suarli (2015) leadership is an activity to influence people's behavior so they want to work together to achieve goals or the art of leading to want to influence others to behave as we want. A leader must be able to change the behavior of nurses to work and create a patient safety culture in hospitals, prioritizing that patient safety is the main thing and must be applied in hospitals. The leader not only makes policies but participates in creating a safe culture and rewards nurses who provide services that support patient safety. A leader according to Permenkes no 11 of 2017 on patient safety has duties and roles in order to improve patient safety culture, namely:

### **2.4 Quality of Service**

Quality of health services is a health service that is needed, in this case determined by the health care profession, as well as desired by patients at affordable costs. According to The Health Foundation (2013), improving the quality or quality of service is the responsibility and role of all staff in the hospital. Improving quality means making health care / services safer, more effective, patient-centered, timely, efficient and fair.

Quality or quality is the extent to which health services for individuals and the community in order to improve health services desired and carried out professionally (IOM, 2000). Quality includes the ability to do the right things, for the right patient with good results and affordable costs. Quality improvement means that the management process is carried out continuously and organized which involves everyone in the organization in an effort to improve the performance of an organization. Service quality is the effect that results from a complicated but understandable cause and effect service process. The success of an organization to provide quality services depends on how each unit works to meet customer needs, meaning that the quality of service in a hospital depends on how each unit and person in the hospital that is health workers provide services needed by patients (Wright and Hill, 2003).

### III. Research Method

This study uses qualitative research methods with a phenomenological approach. Qualitative research is research conducted to obtain answers or in-depth information from an informant about a person's opinions and feelings in the form of behavior, perception, motivation and action (Moleong, 2016).

Phenomenology studies are used as a method of applying qualitative research in order to explore and uncover the common meaning of a phenomenon that is experienced by groups or individuals. This design seeks to understand the meaning of events in certain situations. The advantage of phenomenological design is that it can reveal hidden and real experiences in the psychological and physiological aspects of the informant so that the researcher can understand the experience felt by the informant. The research location is inpatient surgery in Riau Province Hospital. And when this research was conducted from September 2018 until July 2, 2019.

### VI. Discussion

The results obtained that the informants assume that the socialization carried out by the hospital in the context of increasing knowledge related to patient safety is not effective. Education and training for patient safety is carried out continuously to increase knowledge, improve and maintain staff competence. While the socialization carried out by the hospital did not have much influence to increase the informant's knowledge related to patient safety.

Suggestions for increasing knowledge. The results of the interviews obtained related to what advice should be done to improve the knowledge of informants related to patient safety are as follows:

*"At least we were given one day of training, this is two days of socialization with lots of information" (P9L124-125)*

*"The time given for training should be added not only for a short time (P12L73-74)*

*"I want to hold training at least once a year, so that the knowledge we get is the latest, every year science will continue to develop (P18L37-39)*

*"... if you want to effectively socialize it over and over" (P29L153-154)*

The results of the above study indicate that the informant had hopes that the hospital would conduct special training related to patient safety. Training is not only for accreditation preparation but is carried out on an ongoing basis.

According to research conducted by Fatimah and Rosa (2016) that training is effective in reducing errors in drug administration by injection by nurses. According to *Permemkes* No 11 of 2017 that every hospital institution has an education and training program that contains topics about patient safety in accordance with their respective duties. Every health facility must integrate patient safety in every training or education activity that is carried out continuously.

The results obtained that nurses' perceptions related to the advice to be done by the hospital is the hospital held special training related to patient safety by increasing training time. Competence is a combination of employees' knowledge, skills and attitudes so that they are able

to carry out their work well. Competency improvement can be done by providing various types of training for employees. The results obtained in the field that the informants felt the socialization provided was not effective to increase their knowledge because it was delivered in a short time. Apart from a short time, many discussion topics also prevented them from absorbing whatever information was conveyed. The hospital should organize training with adequate time so that the information conveyed can be absorbed by the informant.

Communication about patient safety is still not effective. Effective communication is one of the goals of patient safety that must be implemented. Communication in patient safety is open communication between management, nurses, and patients.

Social acceptability is one of the dimensions of quality of health services according to Maxwell RJ in Wright and Hill (2003) which means hospitals make regulations on how to regulate communication to patients, communication with patients' families and communication in providing care by health workers. When the communication that occurs in the hospital is good, it will be followed by quality service.

There is one theme: the environment does not support communication as shown in the table below:

**Table 6.** Theme 5 Communication in Supporting Patient Safety Is Not Effective yet

Category	Sub theme	Theme
There is no open communication Still blaming	The environment does not support communication	1. Communication in supporting patient safety has not been effective

The environment does not support communication. Communication in patient safety is the absence of open communication and a culture of blame.

There is no open communication. The results of interviews with informants related to whether there is open communication of the policies taken in order to support patient safety are as follows: "How dare we protest, our only protest is here, just us" (P6L233-234)

*"Yes, thank you, what do you know about this hospital? Later, when we talk about fear, how will it be immediately stamped? arguably against. It's hard to talk here" (P10L152-154)*

*"It's lazy to ask, there isn't a solution either, later on we don't think we want to work anymore" (P14L128-129)*

*"I have, but there is no change because it has become a policy (P16L77)*

*'It's hard to protest now, we will be deemed not to accept it later (P32L96)*

From the interview results above shows that the informant is not free to talk when there is a policy related to patient safety taken by management and afraid if deemed not complying with the policies or regulations made.

According to research conducted by Agustina and Warsito (2018) that effective communication has an important role in patient safety. Meanwhile, according to Sari (2016) who

conducted research at Medan Hajj Hospital that open communication is important to create patient safety.

Nurse's perception that there is no open communication about patient safety. Informants find it difficult when they have to ask a policy taken by management. The hospital should create open communication between all staff in the hospital, the management and communication to patients that aims to create a culture of patient safety. When open communication has been established, it is hoped that a patient safety culture can be realized.

Still blaming. The results of interviews with related informants whether there is still a response to blame if an incident occurs is as follows:

*"How are we going to report to management, let's say, all of you fools ..."* (P4L168-169)

*"If we report the medicine that forgot the checklist, I don't know what will happen, whatever your work, they will say later. There is no solution that we will also be blamed ....."* (P10L136-137)

*"They still blame us as nurses, sometimes the wrong ones are not nurses, but they are always blamed, the incident is also discussed ..."* (P13L105-107)

*"The person must be discussed as well, just when it happened, who was in the service"* (P17L96-97)

*"If something goes wrong, it remains, what people are discussing, the official is still blamed. The problem is still being discussed, but the person is also ...."* (P24L116-118)

*"Yes, we are blamed, so we are lazy to report"* (P27L71)

*"... nurses are also afraid to report"* (P31L71)

The interview results show that the informants were still blamed if an incident occurred and they were afraid to report because it was discussed by the relevant officer.

Research conducted by Gunawan (2015) in a hospital in Malang about the cause of the low reporting of patient safety incidents is the fear of nurses to the head of the work unit. At this hospital it was found that the patient safety incident rates were greater than those reported by the patient safety team. Low reporting due to lack of understanding of patient safety incident reporting concepts.

The evaluation is only limited to finding the cause of the patient safety incident. Evaluation of incidents is very important as a lesson so that the same incident does not happen again. Studies in Australia show that 10 percent of all incidents reported nationally will reappear more than once every 2 months, therefore evaluation of incidents is very necessary.

The sub-theme in this study is that there is no learning after a patient safety incident occurs as shown in the table below:

**Table 7.** Theme 6 Evaluations are only limited to finding the cause of a patient safety incident

Category	Sub theme	Theme
Report to supervisor	Tidak ada	2. The evaluation is only limited to finding the cause of the patient safety incident
Look for the root of the problem	pembelajaran setelah terjadi insiden	
Investigations were carried out by the patient safety team	keselamatan pasien	
The patient safety team comes only when an incident occurs		
There is no learning going forward		
No investigation results were announced		

If an incident occurs in a hospital, the first step taken is to investigate the chronology of the incident. The results of the interview regarding the investigation process are as follows:

*"Usually in the first trace, ask the nurse" (P3L100)*

*"After we report to the supervisor, they usually ask us questions, after that the office will come tomorrow to find out what the cause is (P10L156-158)*

*"They only came to look for the root of the problem, just an investigation" (P16L48-149)*

The results of the interview above show that if an incident occurs, the informant reports to the supervisor, after that the cause of the incident is investigated and an investigation is carried out by looking for the root of the problem.

If an incident has occurred, the hospital must immediately follow up on the report which is useful to reduce the impact of the incident. After an incident occurs a maximum of 2 x 24 hours reports must have been made by reporting to the direct supervisor ie the head of the room or supervisor. Immediately after making a report, the supervisor immediately analyzes the incident causing the incident. After completing the reporting, the cause of the incident is found and the risk grading is determined.

The implementation of teamwork does not yet support patient safety. The team consists of two or more individuals who have specific roles or tasks to carry out and coordinate with other members to achieve the same goal namely patient safety. The task of team members is independent of interaction with other members and is an interdependent component of performance. According to AHRQ (Agency Health Research and Quality) teamwork in creating a culture of patient safety is collaboration within the unit itself and cooperation between units in the hospital. Cooperation within the unit is how each employee respects, values and coordinates one another in order to provide quality services. Team members must be involved in the process of working on assignments to achieve common goals.

An assessment of the culture of patient safety in 630 hospitals in the United States found a positive perception of teamwork was 62% (AHRQ, 2018). Suboptimal teamwork can pose a risk of patient safety incidents. According to research conducted by Allen and Lyn (2013) that teamwork is one of the variables that influence the quality of hospital services.

Still losing information when changing shifts / handovers Cooperation within the unit includes personal relationships between staff in a unit, whether each staff works together in providing services that support patient safety. The interview results obtained about how the patient handover / handover during shifting is as follows:

*"We have directly operated to the room, from morning to evening directly to the room, immediately asked to the patient, so we know which patient" (P2L55)*

*"The cooperation is good, the operands are already in the sphere. For example there is a new patient directly to the patient, what patient is this? immediately indicated where the patient was. Add more now the patient's bracelet is there so it's easy to confirm the patient "(P8L41)*

*"Cooperation is good, but there is still a loss of information, sometimes things that make me doubtful. Usually after that we call back to the previous service (P13L110)*

From the interview results above, it shows that the informant has handed over the patient well by handover directly to the patient. Although the handover they have done by doing a handover to the patient's room, but there is still a loss of patient information when changing shifts.

Regulations that do not support the creation of teamwork. The hospital is a work unit that consists of many - many parts that are interconnected. The following are the results of interviews obtained about how to collaborate with other units in the hospital:

*"For example anemic patients but the patient is a history of cancer that has finished treatment, entered the surgical care room and should enter the internal medicine room. Sometimes there are patients who want to be amputated, but they don't take X-rays when they are in the emergency room, so if that's the case for the patient "(P7L21)*

*"But here is a regulation made for cito or sudden laboratory examinations. The new regulation is that the laboratory has a schedule for when to take patient samples, so outside the schedule, nurses take samples for examination. yes. If there are patients who check blood sugar, nurses do the work, even though it is not our job "(P13L120)*

*"For patients who have just entered from the emergency room, sometimes it is still incomplete, sometimes the examination is incomplete, sometimes there is no examination" (P19L80)*

*"The emergency room may convey information, but the one who delivers the inpatient room is kak Idet (a junior high school graduate employee assigned to take care of the patient room), with the reason that many patients are in the emergency room so that nurses cannot accompany to deliver the spatial patient. it "(P19L57)*

*"... .. if the labor results are slow" (P28L86).*

From the results of the above research it can be shown that there are two units whose collaboration is not very supportive for patient safety, namely laboratories and emergency departments. Informants assume the rules made related to hours of blood sampling for examination of patients are regulations that can cause the risk of patient safety incidents. In addition, the officer who took the patient to the inpatient room was not accompanied by a nurse to be one of the causes of information loss when delivering the patient, because the officer did not understand the patient's condition and what happened to the patient.



## V. Conclusion

The conclusions of this study found seven themes, namely:

1. Management support in creating patient safety is focused only on accreditation assessments.
2. There are still facilities and infrastructure available in a state of damage and do not meet the needs.
3. Lack of socialization about reporting systems for patient safety incidents and many of their patient safety incidents that are not reported.
4. There is no specific training related to patient safety
5. There is no open communication and there is still a culture of blame if an incident occurs.
6. There is no future learning after the incident
7. Policies made by hospitals do not support the creation of patient safety.

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