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Patient Safety Culture: A Comparative Study from Ahmad Yani and Jemursari of Islamic Hospital in Surabaya, Indonesia

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Abstract-Safety has become global issue as well as in hospital. Hospital patient safety is a system where hospital held a safe patient care. Patient safety incident in Ahmad Yani of Islamic Hospital consist of adverse events as much as 77.32%, near miss 21.65%, and sentinel 1.0%. In the middle of 2015, in July, there were an increasing number of patient safety incidents as much as 42.9%. This study aimed to identify patient safety culture in Ahmad Yani of Islamic Hospital and to compare with other islamic hospital. This is analytic observational study. Sample are came from work units in two hospitals is member of Islamic Hospital Foundation. Sampel from 10 units in Ahmad Yani and Jemursari of Islamic Hospital were selected using stratified random sampling. This study showed that patient safety culture in the work unit in two islamic hospital in Surabaya, as much as 50% work unit has fairly good safety culture, and 40% work unit has good safety culture. Patient safety culture has significant influence towards patient safety incident in two islamic hospital in Surabaya.

Keywords: culture, patient safety, hospital, health services,

1. INTRODUCTION

Increasingly, healthcare organizations are becoming aware of importance of transforming organizational culture in order to improve patient safety. Growing interest in safety culture has been accompanied by the need for assessment tools focused on cultural aspects of patient safety improvement efforts (1). Patient safety is an important component of healthcare quality. Several studies in various countries have shown that 2.9% to 16.6% of patients in acute care hospitals experience one or more adverse events (2). Safety culture is an aspect of the organisational culture. A positive safety culture guides the many discretionary behaviours of healthcare professionals toward viewing patient safety as one of their highest priorities (3).

Patient safety incident in Ahmad Yani of Islamic Hospital consist of adverse events as much as 77.32%, near miss 21.65%, and sentinel 1.0%. It concluded that patient safety incident happened in Ahmad Yani of Islamic Hospital is adverse events. In the middle of 2015, in July, there were an increasing number of patient safety incidents as much as 42.9%. Therefore, if hospitals want to improve patient safety, it is important to know more about the culture regarding patient safety. Several instruments are available to make an assessment of the safety culture in hospitals (4,5).

2. METHOD

This is analytic observational study. Sample are came from work units in two hospitals is member of Islamic Hospital Foundation. Sampel from 10 units in Ahmad Yani and Jemursari of Islamic Hospital were selected using stratified random sampling. This study involved staff on works unit such as physician, nurse and other health worker.

3. RESULTS

The safety culture of patients is an integrated pattern of individual and organizational behavior in providing safe and injury-free services. Safety culture is an output of individual and group values, behaviors, competencies, and patterns and habits that reflect the commitment and style and abilities of organizational management and health safety. There are three important aspects to assessing the patient's safety culture, namely, aspect of safety culture level units, aspect of safety culture level units, and outcomes.

3.1 Unit Level Aspect of Safety Culture

Assessment of the level of aspect of patient safety unit is assessed on five dimensions. These dimensions such as supervisor/management expectation and action promoting, organizational learning, teamwork within units, nonpunitive response to error, and staffing.

Supervisor/management support expectation and action dimension, The high assessment on statement of the head ofunit received suggestions for improvement of patient safety with an average of 3.4. This indicates that high supervisor/management support expectation and action unit at two Islamic Hospital because the head unit or the head of the installation would receive advice from its members to improve patient safety in the work unit.

Organizational learning dimension, the work unit at the two Islamic Hospital gave the highest response to the statement of the active work unit performing improvement efforts for improving patient safety and on the statement of patient safety assessment result gave positive change for the work unit with the mean value 3,4. This shows that high organizational learning due to work units in two Islamic Hospital actively make improvements to improve patient safety in the work unit.

Teamwork within units dimension, the work unit provides the highest response to the statement of the work unit member can work together well to perform the service with attention to patient safety with average of 3.5. This indicates that the high level of cooperation within the work unit occurs because members of the work unit can work together as a team to complete the work or service with attention to aspects of patient safety.

Nonpunitive response to error dimension, The work unit in two islamic hospital gave the highest score to the incident reporting statement focusing on the incident occurring, not to the name of the employee who made a mistake with a mean of 3.0. This indicates that the reporting of patient safety incidents of the work unit at two islamic hospital did not focus on the employee who made the mistake. So the work unit does not judge employees who make mistakes, but rather focuses on analyzing the cause of the patient's safety incident.

Staffing dimension, the work unit at the Surabaya Islamic Hospital gave the highest statement to the member of the unit performing the patient's service calmly, even though the patient's condition was busy with a mean of 3.1. It shows that members in the work unit do well to implement patient safety with no haste in doing the work.

3.2 Hospital Level Aspect of Safety Culture

Assessment of work unit to hospital level aspect of safety culture consists of three dimensions. These dimensions include; Hospital management support for patient safety, teamwork across hospital units, hospital handoffs and transtition.

Hospital management and support for patient safety dimension, in a statement of management actions reflects that patient safety is a top priority with an average of 3.3. These results indicate that hospital management support for the implementation of a high patient safety program is reflected by creating safe working procedures, conducting activities that support patient safety, and making patient safety a top priority in hospital care.

Teamwork accross hospital units dimension, in the statement of the work unit members feel comfortable if in cooperation with other work unit members and work units in the hospital work well with the average of 3.1. This shows that the high teamwork accross hospital units because members in the work unit feel comfortable working with other work unit members, and established good cooperation between work units in the hospital.

Hospital handoffs and transition dimension, In the information statement about the patient is delivered well when the work unit cooperates between work units in the hospital with a mean value of 3.1. The results indicate that the transfer of patients from one work unit to another work unit can work well because the information transfer process runs well when shift work shift and transfer patient to another work unit.

3.3 Outcomes

The outcome assessment consists of two dimensions. These dimensions include overall perceptions of safety, and frequency of event reporting.

Overall perception of safety dimension, the work unit provides the highest response to the statement of patient safety implementation in the work unit, can prevent the patient's safety incident with a mean of 3.2. These results indicate that the work unit persepi on the safety of patients is high, because the work unit in two Islamic Hospital Surabaya believes that the implementation of patient safety can prevent the occurrence of patient safety incidents.

Frequency of event reporting dimension, the work unit provides the highest value on non-injury events reporting with a mean of 2.8. This indicates that the frequency of incident reporting in the Islamic Hospital reported more frequently about non-injury events.

4. DISCUSSION

Culture is a complex framework of national, organizational, professional and value attitudes within individual and group functions. Guidelines from WHO state that health care institutions should develop a patient safety culture. Patient safety culture is a

unified pattern of individual and organizational behavior in providing safe and injury-free services. Safety culture is an output of individual and group values, behaviors, competencies, and patterns and habits that reflect the commitment and style and competence of organizational management and health safety (1). The result of assessment of patient safety culture at work unit at two islamic hospital shows that 50% of work unit in two Islamic Hospital Surabaya has good patient safety culture. While 50% of work units in two islamic hospital has a good patient safety culture. Culture in an organization can encourage effectiveness or weaken the effectiveness of the organization. Patient safety culture is important because building a patient safety culture is a way to build an overall patient safety program. An organization that has a positive culture, then has many people right to promote patient safety. If all work units in two islamic hospitals have a good patient safety culture, then the patient's safety program can work effectively.

Assessment of patient safety culture in the hospital can be seen through several aspects. The Agency for Health Care Research and Quality explains that there are three important aspects to assessing the patient's safety culture, namely, aspect of safety culture level units, aspect of safety culture level units, and outcomes (1). Patient safety culture in two islamic hospital when viewed based on aspect of safety culture level unit, 80% of work units have good aspect of safety culture level unit. Work units that have high aspect of safety culture level units tend to have employees who support each other in the work, the work unit has good organizational learning, has a good cooperation within the work unit, open communication inside, the work unit to give feedback and communicate every mistakes that occur in the work unit, do not judge employees when things go wrong, and leadership behaviors reflect support for patient safety (6).

The highest appraisal of the work unit to the aspect of safety culture level unit is the teamwork within units, which shows that the members of the work unit help each other to provide patient service in accordance with the patient safety guidelines. The results of this study indicate that teamwork in the work unit to help each other, support each other, and coordination is one important factor to strengthen the level of aspect of safety culture unit. The results of this study are consistent with previous research indicating that, teamwork within the unit (86.5%) is a strong factor for improving patient safety culture. Teamwork is one of the subcultures in safety culture, teamwork is a form of collegiality, collaboration, and collaboration between executives, staff and independent practitioners, and establishing open, safe, respectful and in-service relationships (7).

Based on the results of research on the level of aspect of safety culture unit in two islamic hospital, there are still 20% work units that have a good safety culture. This shows that several work units in two islamic hospital have a safety culture that has not been maximized. The lowest rating of the working unit on the aspect of safety culture level unit in this research is on nonpunitive dimension response to error. This indicates that members of the work unit are afraid that their mistakes will be recorded in performance records and may threaten careers. The results of this study in accordance with some previous research. The results of previous research indicate that nonpunitive response to error has a low value of 21.46% positive respone from nurses at the hospital. In addition other studies have also shown that the fear of employees to report patient safety issues has a significant relationship to the high risk of patient safety issues.

The next aspect of patient safety culture is the hospital level aspect of safety culture. This aspect consists of three dimensions of hospital management and support for patient safety, teamwork accross hospital units, and hospital handoffs and transition. Patient safety culture at work unit in two islamic hospital, based on hospital level aspect of safety culture, 50% of work unit has hospital level aspect of safety culture is good, and 50% work unit has hospital level Aspect of safety culture is good enough. It shows that there are still work units in two islamic hospital that do not have a good patient safety culture. Work units that have a good hospital aspect level of safety culture will tend to feel the hospital support in the patient safety program, the cooperation between work units in the hospital and the transfer of patients from the work unit to another work unit goes well. The highest appraisal of the working unit on the hospital level aspect of safety culture is on the teamwork of acrross hospital units. This indicates that the high level of aspect of safety culture occurs because hospital work units can work together and coordinate with each other to provide the best and safest patient care (8).

Teamwork is essential to providing safe and effective health services. Teamwork is important in healthcare to create a high quality service. The identification of some adverse events indicates that, most adverse event events can be prevented by good communication and teamwork. Previous research has shown that teamwork accross units, and hospital handoffs and transitions are factors that can improve safety culture. Cooperation and coordination between work units in hospitals to provide the best service for patients can improve the safety culture of the patient (safety culture). With good coordination and cooperation, the service needs, information on patient care, so that the security of patient care will be better. Assessment of work units in two islamic hospital on hospital handoffs and transition dimension and hospital management

and support for patient safety is quite low. Based on the assessment on hospital handoffs and transition dimensions, the transfer of information and patient movement at two islamic hospital still do not support patient safety culture. Handoffs are a transfer of information, along with authority and responsibility in patient care, including the process of asking questions, clarifying and confirming responses. Past research has shown that, handoffs have been linked with adverse clinical events ranging from emergency department to ICU. When handoffs do not go well, often important information about the patient is not delivered properly.

Communication failure or non-conveyance of important information related to patient care is a major factor in error in service. In hospital management and support for patient safety the highest assessment of the work unit is on the statement of hospital management actions reflecting that patient safety is a top priority in service. These results indicate that the role of hospital management in the implementation of patient safety programs is very important. Management is the key to the success and encouragement of its work unit to implement patient safety. The role of hospital management support for patient safety is described in some previous studies (9). Research in the United States shows that hospital management activities have a significant relationship to service quality and safety of clinical outcomes, processes, and performance in hospitals. Several studies have also shown that senior management support and engagement is a major factor in service quality and program success in hospitals.
The third aspect of patient safety culture is the outcome aspect of safety culture consisting of dimensions of overall perceptions of safety, and frequency of event reporting. Patient safety culture in two islamic hospitals based on outcome aspect of safety culture, 55% of working units have a good aspect of safety culture outcome, and 45% of work units have outcome aspect of safety culture pretty good. This shows that most of the work units in two islamic hospital have a patient safety culture that is not maximal yet.

The highest assessment of the work unit on the outcome of safety culture is on the overall dimension of perception of safety culture. Overall perception of safety culture is a perception of the work unit against good procedures and systems to prevent errors and can reduce the lack of patient safety issues. Work units at two islamic hospital feel that applying patient safety in their work units can prevent patient safety incidents. Assessment on frequency of event reporting dimension in two islamic hospital is still low. These results indicate that awareness of reported patient safety incidents is still not maximized. This may be influenced by other dimensions such as nonpunitive response to error, and hospital management support for patient safety is still not maximal in two hospitals. Reporting of patient's safety errors or incidents is fundamental to prevention. The focus of health services on the occurrence of patient safety incidents begins from the report of the Institute of Medicine's (IOM) report To Err Is Human: Building a Safer Health System. So the role of reporting has an important role in safety culture. Often employees in the hospital are afraid to report mistakes, for fear of threatening their careers. Although the reporting is actually an input to prevent possible incidents. Therefore, hospitals should create nonpunitive culture for patient safety by implementing medical record system, developing patient safety reporting system, and increasing employee commitment to patient safety (10).

5. CONCLUSION

Patient safety culture has significant influence towards patient safety incident in two islamic hospital in Surabaya. Therefore patient safety team need to increase hospital support towards each unit related to implementation of patient safety. Hospital management necessary to simplify work processes and standardization of patient safety, can prevent patient safety incidents caused by the complexity of hospital services

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