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Patient Safety Implementation among Nurse in Inpatient Department at Daha Husada Hospital Kediri

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ABSTRACT

Patient safety is a hospital system aimed at minimizing risks and preventing injury caused by errors in action or inaction. This study aims to explore the implementation of patient safety by nurses at RSUD Daha Husada Kediri using a qualitative case study approach. Data were collected through in-depth semi-structured interviews with inpatient nurses selected by purposive sampling. Source triangulation was used for credibility, focusing on six patient safety goals: patient identification, effective communication, medication safety, correct procedure and site, fall prevention, and infection risk reduction. The findings showed that five of the six safety goals were fully implemented (100%), while others had not achieved maximum outcomes due to nurses' habits, awareness, and lack of routine training. Supporting infrastructure and SOPs were already in place. The study suggests improving orientation for new staff, empowering unit heads as role models, and strengthening routine monitoring and evaluation to ensure consistent and optimal patient safety practices across all units.

I. Introduction

Patient safety is a fundamental aspect in the provision of quality health services in hospitals. This concept emphasizes the importance of preventing injuries caused by medical errors or negligence in taking appropriate action. Therefore, hospitals need to implement a comprehensive patient safety system to ensure the safety of every patient receiving health services. According to Juniarti and Mudayana (2018), patient safety is a system that aims to make patient care safer, through efforts to prevent events that harm patients. This includes avoiding errors in medical actions and failure to provide appropriate interventions. In other words, patient safety is not only reactive but also proactive in managing potential risks.

The Indonesian government has formulated patient safety guidelines through the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017. This regulation states that patient safety includes risk assessment, identification and management of patient risks, reporting and analysis of incidents, and implementation of solutions that can prevent injuries. This regulation aims to create a service system that is not only effective, but also safe for patients.

Nurses as professional health workers have a central role in the implementation of patient safety. They are the ones who most often interact directly with patients in various clinical situations. Therefore, it is important for nurses to have a deep understanding and adequate skills in implementing patient safety principles to avoid adverse events (AEs) (Arumaningrum, 2014). The implementation of patient safety principles includes key targets such as correct patient identification, effective communication between health workers, safe medication management, accuracy in medical procedures, infection prevention, and fall prevention. All of these procedures require high commitment and consistency from all health workers, especially nurses, in carrying them out.

In addition to patient safety, occupational safety and health (K3) in hospitals is also a major concern. Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 66 of 2016, hospital managers are required to ensure the health and safety of workers from various potential hazards. The implementation of a comprehensive and sustainable K3 system is very important to minimize the risk of work accidents and occupational diseases.

Data from the Hospital Patient Safety Committee (KKP-RS) shows that patient safety incidents still occur in various regions of Indonesia. For example, incidents were recorded at 0.68% in Aceh, 11.7% in East Java, and reached 37.9% in Jakarta (Basri, 2021). This fact shows that the implementation of the patient safety system is not evenly distributed and still needs to be improved nationally. Judging from the hospital ownership status, data shows that local government-owned hospitals have higher patient safety incidents than private hospitals, at 16% and 12% respectively (Basri, 2021). This difference indicates variations in the management of patient safety systems based on hospital institutional governance.

The type of patient safety incident that is quite often found is the incident of patient falls. This incident occurs most often in inpatient units, including in internal medicine units, surgical units, and pediatric units. According to Raswati et al. (2021), the highest incidence of patient falls was recorded in the pediatric service unit, which was 56.7%, which is an indicator of the need for increased supervision and routine evaluation of high-risk areas. Considering the various data and regulations available, it is clear that patient safety is a shared responsibility of all elements of the hospital. An integrated strategy is needed that combines aspects of education, risk management, and safety culture so that incidents that harm patients can be minimized and health services can take place safely, efficiently, and sustainably.

The study aims to explore the implementation of patient safety by nurses at RSUD Daha Husada Kediri using a qualitative case study approach

II. Methods

This study employed a qualitative research method using a case study approach. A case study is an in-depth qualitative research strategy that focuses on understanding an individual, group, institution, or situation over a period of time. The aim of this approach is to explore meaning, investigate processes, and gain a deep understanding of a particular phenomenon. In this study, the case being explored is the implementation of Patient Safety Goals (SKP) by nurses in the inpatient unit of RSUD Daha Husada Kediri. Data were gathered directly from participants through face-to-face interactions and semi-structured interviews. In qualitative research, the concept of a “social situation” is used instead of traditional terms like population or sample. According to Sugiyono (2016), a social situation consists of three main elements: place, actors, and activities, all of which interact in a synergistic manner. Similarly, Yusuf (2019) states that in qualitative research, the use of the term "social situation" is essential to describe the context and behavior of a specific group being studied. These elements are essential to understanding the dynamics and practices that occur in real-life settings.

The social situation in this research includes: (1) the place, which is the inpatient installation of RSUD Daha Husada Kediri; (2) the actors, who are the nurses responsible for implementing patient safety measures; and (3) the activities, which involve the daily practices and procedures related to the implementation of the Patient Safety Goals (SKP). The participants in this study were 10 nurses selected through purposive sampling, allowing the researcher to choose those with specific knowledge and involvement in SKP practices.

Data collection was conducted through semi-structured in-depth interviews, allowing the researcher to explore the nurses’ experiences, perceptions, and challenges regarding the implementation of patient safety goals. The direct approach of meeting with participants ensured rich and detailed data. The researcher also conducted triangulation with additional key informants such as the Head Nurse, SKP Committee, Infection Control Team (PPI), and the Patient Safety Task Force to enhance the validity and credibility of the findings.

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III. Results and Disscussion

Results

This study involved 13 informants who were health workers at RSUD Daha Husada Kediri who had direct responsibility for the implementation of Patient Safety Targets (SKP). Informants were taken using the purposive sampling method, where informants were selected based on the consideration that they understood and were directly involved in the implementation of SKP. To ensure the validity of the data, the researcher conducted source triangulation by confirming and clarifying with the Head Nurse, Head of the SKP Working Group, Head of PPI, and the hospital's SKP Committee.

The results of the study show that the implementation of SKP at RSUD Daha Husada Kediri has begun since 2019 and is ongoing until now. Implementation is carried out gradually and continuously, adjusting to applicable policies and the readiness of resources available at the hospital. In the process, the hospital continues to evaluate and continuously improve so that the implementation of the six patient safety targets can be carried out optimally.

1. SKP 1 – Patient Identification
   Based on the results of interviews with nurses, the implementation of patient identification has been in accordance with the standards, namely using at least two patient identities such as full name, medical record number, gender, and date of birth. Identification is carried out when administering medication, nursing actions, or taking specimens. However, several nurses revealed that sometimes there were technical obstacles such as the writing on the patient's bracelet had faded, so reconfirmation had to be carried out with the patient or family.
2. SKP 2 – Effective Communication
   Effective communication has been implemented optimally with 100% achievement. The interview results showed that nurses have understood the importance of clear and structured communication, especially in giving and receiving medical instructions. The SBAR communication method has been applied, and the readback procedure is carried out to ensure the accuracy of the information. However, several informants mentioned obstacles in implementing this communication, especially in emergency situations or when involving health workers who are not used to using these communication standards.
3. SKP 3 – High Risk Drug Safety
   The achievement of this target also reached 100%. regarding the safety of drug use that needs to be watched out for also **be**en implemented well. The hospital has a high alert medication list that is updated regularly. These medications are stored under special security and used only under close supervision. Nurses reported that they understand the procedures for using high-risk medications and have received training related to medication management.
4. SKP 4 – Ascertainment of Correct Location, Procedure, and Patient of Surgery Compliance in marking the operation site (site marking) reached 100%. the hospital has implemented a patient verification procedure before surgery. The marking of the surgical site is done correctly and involves the patient to verify the body part that will be operated on. Each action is also documented as evidence that the procedure has been carried out in accordance with the SOP. Nurses stated that the implementation of this SKP has been running optimally and has become part of their work habits.
5. SKP 5 – Prevention of Infection Risk (HAIs)
   This target achievement has not reached 100%, with a gradual percentage increasing from 94.53% (October) to 97.65% (December). related to reducing the risk of infection, the informant said that washing hands by following the principle of 5 moments of hand hygiene has become a work habit. The hospital has also provided hand sanitizer facilities and hand washing facilities in strategic areas. Although the level of compliance is quite high, nurses admit that there are still some conditions where the implementation of hand washing is less than optimal, such as when personal protective equipment (PPE) is limited or in very dense work situations.
6. SKP 6 – Prevention of Patient Fall Risk

The achievement is still below 100%, with the reason being that post-action re-assessment was not carried out on patients whose conditions changed. The use of fall risk bracelets and triangle labels has been implemented, but preventive measures such as bed height adjustment and use of bed side rails have not been maximized.

From the overall interview, it was found that the implementation of SKP has brought positive changes in the behavior and performance of nurses. They became more careful and aware of the importance of patient safety. Support from the SKP Committee and hospital management was also felt by health workers, both in the form of training, supervision, and the provision of clear work policies. There were also obstacles felt by informants, especially related to limited facilities and infrastructure. Several nurses said that limited tools or supporting media such as identity bracelets, hand washing facilities, and the availability of PPE were still obstacles in the maximum implementation of SKP. Overall, the results of this study indicate that although there are still challenges, the implementation of Patient Safety Targets at RSUD Daha Husada Kediri has been going quite well. There is a commitment from all elements of the hospital to continue to improve the quality of service and create a safe environment for patients.

Disscussion

The implementation of patient safety at RSUD Daha Husada Kediri shows that this hospital has had a clear legal basis through a director's decision since 2019. This shows the management's commitment to improving service quality and prioritizing patient safety. The existence of this policy is a very important first step in creating a culture of safety in the hospital environment.Although the policy has been formed, there are still challenges in its implementation, especially in terms of health workers' compliance with the established guidelines. This is in line with the findings of several studies stating that the success of the patient safety system is highly dependent on the behavior of individual health workers (Juniarti & Mudayana, 2018).

To overcome these challenges, the hospital formed a Patient Safety Team (PST) and an Infection Prevention and Control Team (PPI). This team plays a role in conducting routine evaluations periodically, whether monthly, quarterly, or annually. This evaluation is an important component of the continuous quality improvement cycle in health services. The implementation of Patient Safety Objectives (PSO) based on Joint Commission International (JCI) standards includes six main aspects. The first objective related to patient identification showed very good results with an achievement of 100%. This indicates that nurses have carried out identification procedures according to standards, including using two patient identities and conducting verification before medical procedures. However, technical constraints are still found, such as the writing on the patient's ID bracelet is no longer legible. This condition can increase the risk of medical errors. Therefore, it is important for hospitals to improve the quality of ID bracelets and ensure the availability of adequate tools to support the patient identification process.

The second target on effective communication also shows maximum achievement results. The implementation of communication methods such as readback and SBAR (Situation, Background, Assessment, Recommendation) has been carried out systematically and supported by documents and standard operating procedures (SOP). Good communication between health workers is crucial to prevent errors due to miscommunication, especially in emergency situations. In the third SKP related to the safety of high-risk medication use, the achievement of 100% shows that the hospital has implemented good medication management. Policies regarding high alert medication and identification of critical areas such as operating rooms or ERs are the main strategies to reduce the potential for medication errors.

The fourth target regarding the certainty of the location, procedure, and patient of the operation has also been implemented very well. The site marking procedure before the operation is carried out by involving the patient directly, in accordance with the principle of patient-centered care. This is important to prevent unexpected events such as wrong surgery or wrong patient. However, in the fifth target, which is reducing the risk of infection, the achievement has not reached the ideal number. Although it is quite high (above 94%), compliance with hand hygiene procedures still needs to be improved. Several factors

causing low compliance include lack of understanding, limited facilities, and minimal awareness of individual health workers.

The hand hygiene program adopted from WHO has been implemented, but the success of this program is greatly influenced by ongoing socialization and training. Jamaluddin (2012) emphasized the importance of education and motivational approaches in increasing compliance with hand washing at five critical moments. The sixth target, namely prevention of patient fall risk, shows that there is still room for improvement. Although the achievement is close to 100%, there are still cases where reassessment is not performed after changes in the patient's condition post-operatively. This indicates the need for increased clinical awareness in conducting repeated evaluations of fall risk.

Preventive measures such as the use of yellow bracelets and marking of beds for patients at risk of falling have been carried out. However, technical implementation such as adjusting the height of the bed and the use of bed rails has not been fully optimal. This shows that strengthening in terms of supervision and technical education is still needed. Based on interviews with nurses, the main barriers to implementing patient safety are individual factors, such as habits and self-awareness. This shows that even though systems and procedures are in place, the behavioral aspect of health workers remains a key factor in determining the success of implementing a patient safety program. Regular monitoring by the patient safety team has become a good practice. The systematically collected data is then evaluated to find the root cause and establish relevant recommendations. This supports the creation of a continuous learning system in the hospital environment. Quarterly evaluation and follow-up of recommendations are important instruments in improving patient safety implementation. This strategy is in line with the continuous quality improvement approach in health service quality management. This implementation also reflects the hospital's efforts in fostering a culture of patient safety in a sustainable manner. Overall, RSUD Daha Husada Kediri has shown significant progress in implementing the six patient safety targets. However, there are several aspects that still need to be improved, especially related to the compliance of individual health workers and the availability of supporting facilities. This improvement can be achieved through training, socialization, and strengthening the commitment of hospital leaders in supporting a culture of safety.

IV. Conclusion

Based on the research conducted at Daha Husada General Hospital Kediri, it can be concluded that the implementation of patient safety by nurses in the inpatient ward has generally been carried out well. Five out of six Patient Safety Goals have achieved maximum compliance with 100% results, while one goal has not yet met the target due to several challenges in the field. The main issues include individual factors such as nurses' habits and awareness, as well as a lack of regular training and socialization.

The implementation of patient safety is supported by established policy documents, standard operating procedures (SOPs), and adequate facilities and infrastructure, such as patient ID bands, designated drug storage, mobility aids, and other safety equipment. Routine monthly monitoring is already in place; however, further strengthening is needed in cultivating consistent practice and compliance among healthcare workers with the existing procedures.

To achieve more optimal implementation, it is recommended that the hospital conducts regular socialization programs, provides onboarding training for new staff and head nurses as role models, and ensures thorough monitoring and evaluation in all service units. Nurses are also encouraged to improve their personal awareness and habits in applying patient safety standards and to actively report any encountered obstacles. This research is expected to serve as a reference and comparison for future studies to expand and deepen investigations related to patient safety practices.

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