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Experience of Nurses in Implementing Patient Safety Culture at USU Hospital

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ABSTRAK

A holistic patient safety program requires a crucial and fundamental component: patient safety culture. It is also critical in the evaluation of hospital safety and service quality. The purpose of the study was to find out how nurses at USU Hospital implemented a patient safety culture. The Collaizzi approach to descriptive phenomenology was applied in the study design. Purposive sampling was used to choose fifteen participants who met the inclusion criteria. In-depth interviews were used to acquire the information. Verbatim description was used in the analysis and interpretation. Five themes emerged from the study, namely: (1) accomplishment of patient safety goals with the support form the hospital management, (2) information provision about patient nursing care to improve patient safety, (3) report of patient safety incidents, (4) obstacles encountered by nurses in implementing patient safety culture, and (5) expectation that nurse implement safety culture. It suggested that nursing services facilitate nurses with training on patient safety culture regularly to improve their behaviors in reporting any patient patient safety incidents.

Keywords: experiences, nurses, patient safety culture

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INTRODUCTION

The nursing programs service paradigm leads to the quality-safety paradigm of consistenlty and continuously preserving patient safety, as wel as the need to boost service quality since the higher the service quality, the higher the patient safety (1). According to Minister of Health Regulation No. 11 of 2017, a patient safety incident (PSI) is an accidental event or circumstance that can result in patient injury and can be avoided. Unexpected events, near misses, non-injury incidents, and possible injury events are all included in PSI. Because these situations frequently result in litigation, comprehensive services and strong service programs including patients and their families can be help to prevent them (2).

The issue of mistreatment was originally raised by the Institute of Medicine (3) in a groundbreaking report titled "To Err is Human, Building a Safer Health System." Medication mistakes are estimated to cause 1,000,000 injuries and 98,000 fatalities in the United States yearly. According to the National Patient Safety. Agency., there were 1,879,822 patient safety events reported in the United Kingdom between January and December 2016, 2,769 incidents in Malaysia, and 877 occurrences in Indonesia between January and December 2016 (4).

According to patient safety incident data published by the Hospital Patient Safety Committee in 2012 , there were 145 incidents in Indonesia, with Adverse Events accounting for 46%, Potential Injury Events for 48%,

and Others accounting for 6%. The locations of these incidents by province were DKI Jakarta (37.9%), Central Java (15.9%), DI Yogyakarta (13.8%), East Java.(11.7%), South Sumatra (6.9%), West Java (2.8%), and Bali (1.4%) (5).

For fear of being blamed, many instances involving the workplace were not reported (6). Reporting is the foundation for detecting patient safety issues and providing information to health care providers. According to Yoo and Kim (7), incident reporting is influenced by the work environment, and the perception of safety culture is needed to encourage employees to.report.every.event. The adoption of a patient safety culture is difficult for nurses, despite the fact that it appears strategic and practical. Creating a safety culture may appear straight forward, but its execution is difficult, and nurses are challenged. In addition to other health professionals, nurses become health workers who play a part in increasing patient safety in hospitals. Nurses are essential in preserving and promoting patient safety in hospitals, therefore their talents to avoid and limit errors are required (1). Nurses spend more time directly in patient care activities than other professionals, thus they are required to play a critical role in implementing safety culture behavior in hospitals to maintain patient safety (8).

USU Hospital is a teaching hospital where health students can exercise their skills. The incident report at USU Hospital is still low, according to the patient safety quality committee, because health staff are unaware of the need to report it. According to this data, efforts to reduce the frequency of patient safety incidents related to patient safety aspects at USU hospitals have not been successful because the incidence rate is high and nurse report events remain low.

METHOD

The study employed qualitative with design descriptive phenomenology. Purposive sampling was used to select fifteen nurses who volunteered to participate in this study. The following were the inclusion criteria: 1) nurses who had worked at USU Hospital for at least 6 months, 2) willing to be interviewed and have their activities recorded during the interview or study by signing informed consent, and 3) able to tell their stories well so that more information could be gathered. In-depth interviews were employed to collect data, and the probing technique was used to ask the questions in order to obtain detailed information about their experiences, which were recorded using a voice recorder. The goal of the study was explained to each participant, and they signed a consent form ensuring their anonymity and confidentiality. The participants had the option to leave the study at any time. Data analysis consists of the following steps: 1) reading and rereading all transcripts of interviews disclosed by participants, 2) extracting significant statements, 3) describing the meaning contained in the significant statements, 4) organizing the meaning formulated into the theme group, 5) developing a complete theme description, 6) identifying the structural basis of the phenomenon, and 7) returning to the participant to validate the finding of a phenomenon.

RESULTS AND DISCUSSION

The analysis of in-depth interviews with participants reveals five themes: 1) accomplishment of patient safety goals with the support from the hospital management, 2) information provision about patient nursing care to improve patient safety, 3) report of patient safety incidents, 4) obstacles encountered by nurses in implementing patient

safety culture, 5) an expectation that nurse implements safety culture.

Thema 1: the accomplishment of patient safety goals with the support from the hospital management.

Patient safety goals can be used to assess patient safety in hospitals. Enforcing patient safety goals with nurses is optimal and based on SOP, especially if the hospital is preparing for hospital accreditation. Hospital managers have resumed patient safety training so that nursing staff can follow procedures to implement outpatient safety goals. The following statement explains this:

"...So first we look at the patient's bracelet is appropriate or not while we ask your father's name, what date of birth while we see the patient bracelet is appropriate or not .. "(Nurse demonstrates the patient's identity with the patient's bracelet, Participant 2)

The majority of nurses provide effective communication with patients and their families in the form of training, and effective communication of patient-related information between nurses and other nurses and caregivers is integrated. It will be recorded on the sheet. The following statement explains this:

"We always educate patients to come in ... to educate their families to wash their hands ... and their functions or whenever they wash their hands ..." (Participant 3)

Thema 2: information provision about patient nursing care to improve patient safety

The nurse interaction with the nurse between the rooms occurs in the nursing practice during the transfer of the patients in the room, and the nurse performs the operands related to the care of those patients, such as: previous assessments, treatments offered, diagnostic tests, etc. Everything about the patient is recorded in the medical record, and all caregivers can access the record to know the patient's condition. This is explained in the following statement.

"... Surrender the nurse later, I will send the patient to the room after the operand at the nurse station will be informed about the patient's diagnosis, what drugs have been given, what actions have been taken ..." (Participant 2).

Thema 3: report of patient safety incidents

Reporting is an important part of patient safety and is the first step in the learning process to avoid repeated incidents. For a variety of reasons, nurses do not report all incidents that occur in nursing services. The majority of nurses say they disclose patient safety issues because the consequences of not reporting can affect the care itself, the patient, the hospital and there is no point in hiding it as it will be discovered later. I did. This is explained in the following statement:

"It's better to know the truth, even if it's bitter, than to be hidden later, everyone, the results will be bad ..." (Participant 6).

Some nurses are afraid to be punished by the hospital if they find a mistake. You are always asked for information about the incident and there is no compensation for the nurse who reported the incident. The following statement proves this:

"No ... because there is no reaction right ... I see. If you react then you can report it ... "(the nurse gave an example of a drug reaction in his hand and the nurse's face looked a little tense, Participant 5).

Thema 4: Obstacles in applying a patient safety culture

One of the barriers to practicing a patient safety culture is caregiver behavior. The nurse showed that he had not yet followed the procedure and was not wearing personal protective equipment. The following statement explains this:

"Yes, I have entered without using a mask ... That is so ... So judging sometimes it's still lacking ... sometimes it's trivial huh ..." (The nurse smiled slightly because she felt guilty about her actions, Participant 11)

Hand-washing soap is a frequently consumed handkerchief, and the room may spend money to improve the sterile equipment of the room, which is an obstacle to limited facilities. Other means, such as stickers and yellow labels, are often used as markers of a patient's fall risk. The following statement explains this:
"Since I work here I have never seen either a yellow sticker or a yellow bracelet. But indeed the patient is at risk of falling ..." (nurses try to convince the information conveyed by staring at researchers' faces, Participant 2)

Thema 5: expectation that nurse implement safety culture
Nurses promote hospital management to implement hospital safety programs designed to complete hospital training attendance, vaccine screening, and management monitoring and facilities that are expected to increase staff. He explained that he wants to foster a culture of safety. Nurses said they were concerned about the risks to themselves and their patients due to limited facilities such as hand-washing soaps, tissues and other PPE equipment. Due to the limited number of bed movements in the ER, caregivers also want relevant infrastructure such as bed movements in the ER. The following statement explains this.
"Sometimes there are no stickers ... usually we are at Standby right there ... I ask for it but sometimes it runs out ..." (the nurse's face shows a disappointed expression, Participant 1) "For the transfer of the patient the bed is the transfer for the patient is not a bed like in the room .. indeed the equipment is expensive ..." (Nurse tries to convince the information conveyed by looking at the faces of researchers, participant 8)

Nurses working in rooms at risk of infection require hospitals to screen and vaccinate as follows: B. Hemodialysis room, emergency and intensive care unit. Not only patients but also nurses are tested and vaccinated. The following statement explains this:
"Hopefully all the nurses here are screened because we don't know that they aren't punctured but there are wounds without us knowing that this patient has HIV, hepatitis for personal safety ..." (Participant 13)

According to research. Introduction patient safety programs successfully with Hospital management assists nurses, improves their knowledge, and brings skills and abilities to implementation. Aims. Of patient safety through internal patient safety training and guidance by. It will be resolved independently. According to a study by Sithi and Widiastuti (9), patient safety training can improve nurses. Understand the importance of patient safety and compliance of 97% of monitoring results.

Communication between implementers, teams, and managers is important for work efficiency and coordination. Providing verbal information about the patient is called communication between the operands. According to the findings of Sohi et al. (10) Effective communication Shorten the receipt weighing time. According to these studies, it is effective. Communication can save time when performing weighing and provide more complete information for weighing. Patient care and continuity of treatment. Communication in progress for operands such as forwarding. Information and professional responsibility is a form of effective communication. Effective communication of operands improves collaboration, reduces

implementation time, and makes the information provided more effective (11).

According to the results of the investigation, the majority of caregivers are involved in the case report. Team leader. Because all efforts to hide it are also exposed, harming the patient, family, hospital, and the caregiver themselves. According to Joolaee et al. (12) The nurses involved in the incident reported an error rate of 19.5% (3 months or more) and an average error reporting rate of 1.3 nurses. Awareness of the work environment and patient safety culture affects nurses who are aware of incident reports. The scope of incident reporting is closely related to the working environment and internal policies, including reporting procedures. According to Yu and Kim (7), nurses who are positively aware of the working environment and patient safety culture are likely to report the incident.

Nurses who take care of patients try to avoid risks such as the spread of nosocomial infections. When caring for a patient or family, the caregiver can use personal protective equipment (PPE) according to the hospital's SOP. According to Harrods et al. (13) The type of precautionary measure requires the use of PPE. This may include the use of gowns, gloves, eye protection, and face masks or respiratory equipment. PPE used by healthcare professionals aims to reduce the transmission of infectious microorganisms to themselves and their patients, but findings show that some nurses still do not use PPE.

Another obstacle is that the majority of nurses may express restrictions on limited equipment such as handwashing soaps and frequently used tissues, and the room may spend money to fill the room's sterile equipment. .. Mandriani, Hardisman, and Yetti (14), who interviewed whistleblowers, found that the behavior and management support of healthcare professionals in completing the facility is a barrier to implementing a patient safety culture. I found. However, according to a study by Ernawati, Tri, and Wiyanto (15), the integrity of hand hygiene equipment in the hospital room is good, but the level of hand hygiene compliance is still low (35%). According to the findings, the majority of nurses wanted managers to complete facilities such as hand soaps, tissues, and fall risk markers. According to Ammouri et al. In the study (8), nurses, who had high expectations for managers and supervisors, became one of the most important predictors for implementing a patient safety culture. In their study, Cho and Choi (16) explained that managers' expectations are related to nurses' attitudes and abilities towards patient safety.

Nurses want more talent because it is difficult to reach safety goals with a limited staff and a large number of patients, as well as patients arriving at the same time. According to different studies, the software of protection subculture to the personnel size stays low whilst as compared to different dimensions. About 70% of nurses believe that they do not have enough staff to handle the workload of nurses in the intensive care unit (17)(18)(19).

RESEARCH ETHICS

The Research Ethics Commission of the Faculty of Nursing, University of North Sumatra, granted ethical approval for this study under the number 1840/VII/SP/2019. Furthermore, according to seven 2011 WHO standards, this research is ethically appropriate: 1) social values, 2) scientific values, 3) distribution of expenses and benefits, 4) risk and benefit potentials, 5) exploitation, 6) confidentiality and privacy, and 7) consent after explanation. The standards are based on the 2016 CIOMS guideline, and compliance with each standard is indicated.

CONFLICTS OF INTEREST

The authors declare that there is no conflict of interest.

CONCLUSION

The experience of implementing nurses in the culture of implementing patient safety in hospitals necessitates support from hospital management in the form of facilities and infrastructures in implementing patient safety programs and with incidents of patient safety by creating a positive work environment and safety culture by not punishing those who make mistakes, avoiding blaming culture, and rewarding those. Who report incidents of patient safety.

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