The Effect of Implementing Patient Safety on the Quality of Service in the Inpatient Room of Kindergarten General Hospital

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ABSTRACT
Quality service quality with a guarantee of high patient safety produces a good hospital image in the eyes of patients as hospital consumers. The aim of the research was to determine the effect of implementing patient safety on the quality of service in the Inpatient Room at Kindergarten Hospital. II Putri Hijau Medan. Analytical survey research design with a cross-sectional approach. The population of all inpatients was 270 people, and the accidental sampling sample was 73 people. Primary data collection methods, secondary, and tertiary data. The data analysis used is the binary logistic regression test. According to the study's findings, communication had a sig-p value of 1,000 > and patient identification had a value of 0.004 < 0.05, risk of improper site, wrong patient, and surgery sig-p 0.598 > 0.05, drug safety sig-p 0.029 < 0.010, risk of infection 0.010, risk of patient falls 0.025, and risk of patient falls < 0.05. The conclusion in this study is that there is an influence of patient identification, drug safety, risk of infection and risk of patient falls on the quality of service, while communication and the risk of wrong location, wrong patient, and surgery have no influence on the quality of service. It is hoped that the results of this research can become a reference for the Tk Hospital. II Putri Hijau Medan to better understand the importance of patient safety management in accordance with Ministry of Health regulations in order to maximize the quality of health services achieved.

Keywords: Implementation, Patient Safety, Service Quality

INTRODUCTION

The quality of health services is increasingly becoming a central topic in hospital management today, especially since the increasing global attention to patient safety. Various empirical facts over the last ten years show that hospitals are health service facilities that are full of risks and have an impact on patient safety (1).

Diagnostic errors are an issue that receives special attention because this is the cause of high levels of errors and even patient deaths. It is hoped that all parties involved in the health sector will work together to prevent this incident by developing strong partnerships and lines of communication with patients and their families. Meanwhile, in Indonesia the rate of adverse events as per patient safety incident reports in 2014 was 46.2% and in 2015 it was 63% (2). The WHO (World Health Organization) publication in 2016, reported patient safety incidents that between 8% and 12% of inpatient rooms had medical mistakes. While just 23% of EU individuals claimed to having encountered a significant hospital medical error, 18% did so, and 11% said they had received the incorrect pharmaceutical prescription. Evidence of medical mistakes indicates that a thorough, systematic approach to patient safety can avert 50% to 70% of these effects (3).

The Ministry of Health's efforts to prioritize patient safety prioritize patient safety and comfort in the form of: 1) risk assessment, 2) identification and management of patient risks, 3)
incident reporting and analysis, 4) ability to learn from incidents and 5) action progress and implementation of solutions minimize risks. Tk II Putri Hijau Hospital Kesdam I/BB Medan stipulated Decree No. 31A/RSK-BBM/SK/V/2011 concerning the Establishment of a Hospital Patient Safety Unit (PKRS). It was stated that the PKRS Team was tasked with carrying out supervision, monitoring, through patient safety programs and evaluating every activity to prevent the occurrence of sentinel incidents (5).

Patient safety activities at home cannot be separated from management as activities to achieve the hospital's vision and mission. Therefore, hospitals must implement management functions which consist of planning, organizing, actuating and controlling. Hospitals need management because without management all efforts carried out will run slowly or be hampered so that they need to be supported by various parts of the organization in the hospital (6).

Patients or health workers experiencing adverse events can be caused by negligence of the health workers themselves as providers at the hospital. The reporting system is an effort to prevent and handle cases of near-miss injury (KNC), unforeseen accidents, and even sentinel incidents. If health workers do not report adverse events, it can hamper the quality of service in patient safety. However, continued reporting must be followed up to take and make revisions to policies in handling and resolving so that cases can be minimized. According to Iskandar, employees can be given a 20-learning system to look for obstacles they face and find solutions so that cases do not happen again (8).

Hospital management has a PMKP team which plays an important role in patient safety management to achieve the target of finding no adverse event cases with an incidence rate of 0% (zero defects). Using effective or two-way communication, PMKP actions in managing KTD include commitment and coordination amongst all fields/divisions, including heads of units/fields, health workers, doctors, pharmacists, and sanitation (9).

PMKP measures in managing KTD involve commitment and coordination among all fields/divisions, including heads of units/fields, health workers, doctors, pharmacists, and sanitation (9). This is done using effective or two-way communication (9). To minimize patient safety, hospital quality must continue to be improved from all aspects, especially the health service aspect, supported by 159 nurses in the inpatient room and 22 people in the outpatient room (16).

Based on a preliminary survey using interview techniques and document study which was carried out at the Tk II Putri Hijau Hospital Kesdam I/BB Medan, patient safety has received attention and has become a shared commitment within the hospital environment. The patient safety program has been carried out from the planning stage to the evaluation stage. Patient safety management has been established since 2008 called the Patient Safety Committee (KKP) and in 2012 it was revised to become the Quality Improvement and Patient Safety Committee (PMKP). Based on the 2018 PMKP report, there were 27 Potential Injury Events (KPC), 8 Non-Injury Events (KTC), 7 Near Injury Events (KNC), and 7 Unexpected Events (KTD), while there were no sentinel incidents. found (16).

Patients stated that the quality of service was not good because there were still beds used by patients with broken barriers so that patients fell out of bed, there were patient bells that were still broken in the inpatient room. If the patient's bell is functioning well but the nurse in the room is not responding quickly to the patient's bell. Apart from that, there are still errors in identifying patients when the patient is unconscious and swapping beds. Lack of effective and accurate communication also creates misperceptions in providing services. Then there are still location errors in providing services to patients and there are still patients falling due to a lack of evaluation of the risk of patient falls. The implementation of patient safety has allegedly not been as effective as it could have been due to a lack of accurate patient identification, ineffective communication,
a disregard for drug safety, the continued risk of the wrong location, wrong patient, and surgery, the continued risk of infection, and the continued risk of the patient falling.

METHODS
This research uses a research design. The design in this research uses an analytical survey with a cross sectional approach. This research will be carried out at Rumkit Kindergarten II Putri Hijau Medan Jalan Putri Hijau No. 17 Kesawan Medan. The research will be carried out from January to November 2021 consisting of an initial survey, determining the title, conducting research, collecting data, processing data, preparing reports, guidance and research seminars. The population is all 270 patients hospitalized at Rumkit Tk II Putri Hijau Medan from January-February 2021. The research sample was inpatients at Rumkit Tk II Putri Hijau Medan. The sampling technique was accidental sampling.

RESULTS & DISCUSSION
Description of Characteristics

| Table 1. Based on Communication, Drug Safety in the Inpatient Room at Kindergarten Hospital. II Putri Hijau Medan in 2021 |
|-----------------|--------|-------|
| **Variable**    | **F**  | **%** |
| Communication   |        |       |
| Good            | 29     | 39,7  |
| Not good        | 44     | 60,3  |
| Total           | 73     | 100,0 |
| Drug Safety     |        |       |
| A man           | 36     | 49,3  |
| Not safe        | 37     | 50,7  |
| Total           | 73     | 100,0 |
| Risk of Wrong Location |        |       |
| No Risk         | 24     | 32,9  |
| Risky           | 49     | 67,1  |
| Total           | 73     | 100,0 |
| Risk of infection |       |       |
| No Risk         | 36     | 49,3  |
| Risky           | 37     | 50,7  |
| Total           | 73     | 100%  |
| Risk of Patient Falls |       |       |
| No Risk         | 33     | 45,2  |
| Risky           | 40     | 54,8  |
| Total           | 73     | 100%  |

Based on table 1, it can be seen that of the 73 respondents, 36 respondents (49.3%) stated that they identified patients well and a further 37 respondents (50.7%) stated that they identified patients not well. Drug Safety: Of the 73 respondents, 36 respondents (49.3%) stated that drug safety was in the safe category and a further 37 respondents (50.7%) stated that drug safety was in the unsafe category. The risk of wrong location from 73 respondents, 24 respondents (32.9%) stated the risk of wrong location, wrong patient and riskless surgery and then 49 respondents stated the risk of wrong location, wrong patient and riskless surgery and then 49 respondents...
(67.1%) stated the risk of wrong location, wrong patient and wrong operation. risky.

Based on the risk, of the 73 respondents, 36 respondents (49.3%) stated that the risk of infection was in the no risk category and a further 37 respondents (50.7%) stated that the risk of infection was in the risky category. The risk of falling is that of the 73 respondents, 33 respondents (45.2%) stated that the patient's risk of falling was in the no-risk category and a further 40 respondents (54.8%) stated that the patient's risk of falling was in the risky category. Of the 73 respondents, 29 respondents (39.7%) stated that the service quality was in the good category and a further 44 respondents (60.3%) stated that the service quality was in the not good category.

The Effect of Identifying Patients on the Quality of Service in the Inpatient Room of Kindergarten Hospital

In order to improve the identification process, particularly when identifying patients when delivering medications, blood, or other products and specimens for clinical assessment, or administering treatment and other procedures, collaborative policies or processes are devised. A patient must be able to be identified in at least two methods, according to the policy or process, such as by name, medical record number, date of birth, patient identification bracelet with barcode, etc. In order to ensure that all potential circumstances are identified correctly and promptly, policies or procedures are developed through a collaborative process. Checking the patient's medical record number by health workers is usually carried out through the patient's care book. This condition is not in accordance with the Republic of Indonesia Minister of Health Regulation No. 11 of 2017 which explains the use of patient identity bracelets containing the name, date of birth and medical record number in the process of identifying patients (9).

According to researchers' assumptions, patient identification is a factor that influences the quality of service and is the most dominant factor that has an influence on service quality, namely 74 times. In general, identification has actually been carried out in fairly good stages, but sometimes there are still officers who are negligent in recording, such as health workers who only ask for the patient's name, but forget to record the date of birth and RM number. Furthermore, based on the results of observations, the obstacles in implementing patient identification are still not effective in its implementation, this is because there are still health workers who are negligent in recording the completeness of patient identity.

For patients who undergo a clinical examination in the laboratory, this is done before carrying out a clinical examination. Similar to other sections, the laboratory section also provides identity bracelets containing name, date of birth and RM number. The process of implementing patient identification has not gone well because the availability of bracelets is not in stock due to the large number of patients coming and the bracelets are damaged when used and there are no two checks on the patient's identity. Based on these results, the quality of service felt by patients is still not good so patients feel less satisfied.

The Influence of Communication on Service Quality in the Kindergarten Hospital Inpatient Room

According to the researchers' assumptions, it shows that communication has no influence on service quality. The effective communication in the complex is actually in a fairly good category, although it is still not running effectively. This can be seen from the results of research where, health communication is very important, because if there is no communication, nurses will lack information about patients, everyone needs communication, whether when taking action, patient administration, diagnosing a patient's illness or when handing over a patient, everything is needed. communication, there is even communication training such as communication training.
which contains the 4S, namely smile, greet, salute and touch.

For services in the room, 4S is prioritized as a form of communication, apart from that there is also SBAR communication during patient handover and therapeutic communication in providing care to patients. According to the findings of observations, the implementation of communication has not gone well since patients occasionally find it difficult to understand the language used by nurses, which makes them less satisfied with the services offered.

The Influence of Drug Safety on the Quality of Service in the Inpatient Room of Kindergarten Hospital

Hospitals collaboratively develop a policy or procedure to create a list of drugs that require caution based on existing data at the hospital. Policies or procedures can also identify areas that require concentrated electrolytes, such as in the emergency room or operating room, as well as properly label electrolytes and how they should be stored in those areas, thereby limiting access, to prevent accidental/careless administration. (9).

Medicines that need to be watched out for (high-alert medications) are drugs that have a high percentage of causing errors and sentinel events, drugs that have a high risk of causing undesirable effects (adverse outcomes) as well as drugs that looks similar/similar speech (Drug Name, Similar Appearance and Speech/NORUM, or Look-Alike Sound-Alike/LASA). The best method to lessen or stop these instances is to create a procedure for handling potentially dangerous drugs, which includes transferring concentrated electrolytes from the patient care unit to the pharmacy (9).

According to research assumptions, drug safety has an influence on service quality. In delegating medicines, the hospital, especially in the pharmacy department, applies the 8 correct principles with the following steps: first, check the patient's identity again. Second, check the name of the drug and adjust it to the doctor's prescription/program, and ensure that the drug has not expired. Third, look at the amount and units, micrograms, milligrams or grams. Fourth, look at the frequency of drug administration, whether in the morning, afternoon or evening. Fifth, identify the route and method of administration. Sixth, provide an explanation of the actions to be taken, their functions and side effects. Seventh, ensure that the drug given produces a response that is in accordance with what is expected from administering the drug. The last one is to record the date, time of administration, name of the drug, dose and route, as well as provide a check mark on the drug therapy list and initial in the column provided.

Based on research results, drug safety is still in the poor category, resulting in poor quality of service for patients. This is because hospitals often neglect to develop a policy or procedure to create a list of medicines that need to be watched out for based on existing data in the hospital, there is a lack of socialization and awareness of Look Like and Sound Alike (LASA) or Similar Names of Medicines. (NORUM) and does not implement Double Check and Counter Sign activities for every drug distribution and drug administration at each service agency.

The Influence of the Risk of Wrong Location, Wrong Patient and Operation on the Quality of Service in the Inpatient Room at Tk Hospital

All cases involving surgery, whether on the side (laterality), numerous structures (fingers, toes, lesions), or several levels (spinal region), had the surgical site marked. The goal of the preoperative verification process is to confirm that the patient, procedure, and location are correct; that all pertinent records, images, and test results are available, properly labeled, and displayed; and that any necessary implants or specialized equipment is readily available. All queries or faults can be accurately and correctly resolved during the "Before Incision" (Time Out) phase (9).
Time out is carried out at the place where the action will be carried out, right before the action begins, and involves the entire operations team. The hospital determines how the process is documented concisely, for example using checklists and so on. The element that is used in the assessment of target IV is to mark the correct skin marker on the surgical site (Surgical Site Marking) in a way that is clearly understood and involves the patient in this matter (Informed Consent) (9).

According to the researchers' assumptions, it shows that the marking has reached a good standard. In marking patients who will undergo surgery, there has never been a marking error or mistake in carrying out the operation. So, in site marking the quality of service is running optimally. However, sometimes the doctor has not yet marked the patient, so when surgery is to be carried out, the nurse will give the doctor a sign.

According to the study's findings, the doctor neglected to notify the patient who was scheduled for surgery about the reasons that led to the marking. Even though there was negligence in the case of forgetting to give a mark in the poly, this did not have an impact on quality because when in the inpatient room the marking would be carried out and in the operating room the marking would also be double checked. So, this factor has no influence on service quality.

The Influence of Infection Risk on the Quality of Service in the Inpatient Room of Kindergarten Hospital

According to researchers' assumptions, the risk of infection has an influence on the quality of service. This is because health workers have never developed an approach to reduce the risk of infection related to the health services provided, the hospital does not want to increase costs to treat infections related to health services, the hand hygiene guidelines that have been created do not work effectively and hand rub on every room is still often empty and there is no training on effective hand washing. These results are also in line with data on nosocomial infections or Healthcare Associated Infections (HAIs) from hospitals which found the incidence of Decubitus was 10%, SSI (Surgery Area Infections) 2.1%, Phlebitis 1.8%. Meanwhile, the target that must be achieved by Tk Hospital. II Putri Hijau Medan is Decubitus is ≤ 10%, SSI ≤ 2%, Phlebitis ≤ 1%. Some of these results make the risk of infection very influential on the quality of service provided to patients.

The Effect of Patient Fall Risk on Service Quality in the Inpatient Ward of a Kindergarten Hospital

According to the findings of their observations, when the researchers encountered patients who had a high risk of falling, the high-risk patients did not wear yellow stickers on their bracelets, but the nurses put yellow stickers on their bracelets for bed use and yellow stickers were put up on the doors at that time. Therefore, the researcher agrees with the patient's statement that he did not know about preventing the risk of falls. The implementation of fall risk prevention has not run optimally because there are obstacles in terms of inadequate facilities which can cause unexpected events. Even though the literature specifies that every incident should be recorded and will be assessed, the incidence of fall risk incidents has not been reported to the PMKP (Patient Safety Quality Improvement), which will have an influence on the quality of service. Furthermore, the observation results also showed that there were no bells in each room, so patients could not call a nurse when needed and there were no yellow stickers on patient wristbands so that nurses could distinguish patients who were at risk of falling.

CONCLUSION

Based on the research results, there is an influence of identifying patients on the quality of
service in the Inpatient Room at Tk Hospital. II Putri Hijau Medan in 2021. There is no influence of communication on the quality of service in the Inpatient Room at Tk Hospital. II Putri Hijau Medan in 2021. There is an influence of drug safety on the quality of service in the Inpatient Room at Tk Hospital. II Putri Hijau Medan in 2021. There is no influence of the risk of wrong location, wrong patient and surgery on the quality of service in the Inpatient Room at Tk Hospital. II Putri Hijau Medan in 2021. There is an influence of the risk of infection on the quality of service in the Inpatient Room at Tk Hospital. II Putri Hijau Medan in 2021. There is an influence of the risk of patient falls on the quality of service in the Inpatient Room at Tk Hospital. II Putri Hijau Medan in 2021. Identifying patients is the most dominant factor that has an influence on the quality of service in the Inpatient Room at Tk Hospital. II Putri Hijau Medan in 2021.

Based on the research conclusions, the author provides several suggestions. For research sites, it is hoped that the results of this research can become a reference for the Tk Hospital. II Putri Hijau Medan to better understand the importance of patient safety management in accordance with Ministry of Health regulations in order to maximize the quality of health services achieved. It is hoped that the results of this research will provide an illustration in improving patient safety management.

It is hoped that the results of this research will provide an illustration of the implementation of patient safety to improve the quality of health services through hospital achievements so that it can be used as a basis for adopting further policies and increasing the satisfaction of every patient who comes.

It is hoped that this research can be used as a basis for consideration in efforts to improve the quality management of health services generally. It is also anticipated to provide input for improving the implementation of patient safety through hospital management as well as input for healthcare professionals in providing quality healthcare by giving patient safety a high priority.

REFERENCES


