Jurnal Cakrawala Promkes
Vol. 7, No. 1, February 2025, pp. 1-12
p-ISSN: 2654-9980 e-ISSN: 2656-0534
http://journal2.uad.ac.id/index.php/cp/index

Implementation of the seven steps of patient safety in primary healthcare

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ARTICLE INFO

Article history
Received : July 26, 2024
Revised : December 12, 2024
Accepted : December 27, 2024

Keywords:
Patient safety;
Seven steps of patient safety;
Seven steps of patient safety in health care

ABSTRACT

Public health efforts and first-level individual health efforts organize primary health. One of the quality management indicators is patient safety. The safety steps are building awareness of the value of patient safety, leading and supporting staff, integrating risk reporting activities, developing reporting systems, involving and communicating with patients, learning and sharing experiences about patient safety, and preventing injuries through the implementation of patient safety systems. The study aimed to determine the implementation of the seven steps of patient safety at one of the primary healthcare facilities in Yogyakarta City. Qualitative research with phenomenological design. Determination of research subjects using a purposive sampling technique. The informants selected were the head of health care, the person in charge of individual health efforts, the patient safety team, the quality team, and the person in charge of pharmacy, laboratory, nurses, doctors, and midwives. Data collection techniques used include field observations, interviews, and document review. The results showed that one of the primary healthcare facilities in Yogyakarta City had implemented seven patient safety steps. The reporting culture has not been fully implemented, and not as much as expected. The patient safety assessment survey was used for the assessment process in patient safety, and there has never been a patient safety training program for primary health care officers. The seven patient safety steps have been implemented, but the incident reporting culture is still less than optimal.

1. Introduction

Primary health care is a health service organization responsible for organizing public and first-level individual health efforts [1]. Health efforts in promotion, prevention, treatment, and rehabilitation are one of the healthcare responsibilities in a working area [2]. Improving the quality of health services is not an easy thing, not only for advanced health facilities, such as hospitals, but also in primary health care [3]. One of the quality management indicators in healthcare institutions is patient safety. The implementation of patient safety is stipulated in the Minister of Health Regulation No. 04 of 2019 concerning Technical Standards for Fulfillment of Basic Service Quality at Minimum Service Standards in the Health Sector [4]. The community obtains health services in hospitals and primary health services in community health care. Primary health care must consider patient safety, health workers at work, and visitor safety, as in the Minister of Health Regulation No.

11 of 2017 concerning patient safety [5] and the Minister of Health Regulation No. 75 of 2014 concerning Community Health Centers [6].

To avoid medical errors that can impact the quality of health services, healthcare facilities must always maintain the security of the healthcare process [7]. Preventing and reducing patient safety incidents is crucial to implementing a patient safety system. In reality, healthcare facilities are complex environments with many patients, dozens, if not hundreds, of types of drugs, various procedures, and numerous medical and non-medical professionals, all of whom have the potential to make errors [8]. Healthcare facilities should reference the seven steps to patient safety when implementing a patient safety program. These steps include building awareness of the importance of patient safety, leading and supporting staff, integrating risk-reporting activities, developing reporting systems, engaging and communicating with patients, learning and sharing experiences about patient safety, and preventing injuries through implementing patient safety systems [9]. At the primary healthcare level, one factor supporting accreditation is patient safety, specifically the implementation of safety and risk management to ensure satisfaction with the services provided.

Yogyakarta City has 18 primary healthcare facilities (Puskesmas) that play a significant role in providing health services [10]. Previous research conducted at these 18 primary healthcare facilities assessed the knowledge of healthcare workers about patient safety. The data revealed that 15 healthcare facilities (83.3%) had staff with good knowledge about patient safety, while three facilities (16.7%) had staff with sufficient knowledge. The average knowledge score indicated that the highest score among the primary healthcare facilities was 8.5, whereas the lowest score was 4 [10]. Therefore, the primary healthcare facility with the lowest average score in Yogyakarta was chosen for the research location.

Preliminary studies at one primary healthcare facility in Yogyakarta revealed frequent patient safety incidents related to medical record errors, such as switched medical records, wrong name-calling, and mistaken identity issues. Preliminary observation interviews indicated that while patient safety incident reports were being made, some officers considered minor errors that could be immediately resolved within the unit as standard and did not record them, despite their relevance to patient safety. Mistaken patient identity that is recognized before action is an example of a near-miss or close-call incident. This relates to the fourth step of patient safety, which involves developing a reporting system that impacts the completeness of incident reporting and the quality of healthcare services.

In observation interviews, the person in charge of the patient safety team at both locations mentioned that patient safety training had never been conducted for officers due to budget constraints at the primary healthcare facilities. This relates to the second step of patient safety: leading and supporting staff by implementing patient safety training programs. The observations revealed that there are still healthcare workers with a low level of knowledge about patient safety and that implementing the seven steps of patient safety is less than optimal. Frequent minor incidents occur, and officers rarely record these incidents. Based on these findings, the researcher is interested in conducting further research on “Implementation of the Seven Steps of Patient Safety at one of Primary health care in Yogyakarta City.”

2. Method

The type of research used is qualitative research with a phenomenological design. The location chosen by the researcher is primary healthcare in Yogyakarta City. Subject selection was determined using a purposive sampling technique, with informants chosen based on various considerations. The informants selected include the head of the health center, the person responsible for individual health efforts, the patient safety team, the quality team, medical staff such as the pharmacy manager,

laboratory staff, nurses, doctors, and midwives. Instruments used in this research include interviews, observations, and document reviews. The instrument used was an interview guide created by the researcher referring to the Minister of Health Regulation No. 11 of 2017 concerning Patient Safety, a smartphone for voice recording, a camera, and writing materials. Data management stages will be analyzed qualitatively, including data collection, reduction, and conclusion.

3. Results and Discussion

3.1. Results

The patient safety program at the representative health center with the lowest average score has been implemented with a dedicated team fully responsible for overseeing it. This primary healthcare facility has a prevention, infection control, and patient safety team that conducts motivation, education, consultation, monitoring, and assessment regarding implementing patient safety programs. They record and report incidents, analyze them—including Root Cause Analysis (RCA)—and develop solutions to enhance patient safety, continuously sending incident reports according to reporting guidelines. RCA is a process of identifying the root causes of a problem using a structured approach and techniques designed to focus on resolving issues related to patient safety incidents [11]. According to the implementation theory proposed by G. Edward III, four factors influence the process and outcomes of implementation: communication, resources, disposition, and bureaucratic structure. Communication fosters a shared understanding among policy actors, influencing attitudes, actions, and behaviors that affect implementation. Resources are crucial, as policies cannot be effectively implemented without adequate resources.

The disposition or attitude of implementers relates to their compliance with established policies. Additionally, the bureaucratic structure pertains to the division of work, authority, and responsibilities that impact achieving policy goals. Implementation involves providing authorized and interested parties the means to undertake actions that produce the intended impacts, thereby realizing the established aspirations and goals through programs.

Building Awareness of The Value of Patient Safety

Based on the document review conducted by the researcher, evidence was found in the form of Decree No. 037 the Year 2018 from one of primary healthcare. Decree No. 043 Year 2019 concerning incident handling and reporting, as well as standard operating procedures (SOP) in each unit of the health center regarding the establishment of the patient safety program and SOP that explains the role of staff in the event of an incident to foster a culture of reporting and learning from incidents. Based on the interview results regarding the policies in place and explaining the role of staff in the event of an incident to foster a culture of reporting and learning from incidents, the findings are as follows.

> *"If from the policy side, we have guidelines and team decrees, inside of which there is a framework of its work reference, a schedule of its activities, and then there are documents resulting from the team's activities, like that." (Informant 1).*

The existing policy at the research site explains how the roles of the personnel responsible for patient safety incidents are defined. However, in its implementation, the culture of incident reporting has not been fully implemented, and not as much as expected. Informants still consider resolved incidents unnecessary for creating incident forms or recording reports:

> *"... it cannot be said that it has been cultured yet because our duty is not only to serve one patient, there are quite a lot of patients in this health center so sometimes when we want to record an incident, colleagues tend to postpone it and eventually sometimes forget it." (Informant 3).*

The challenge in raising awareness about the value of safety lies in human resources, who rarely report patient safety issues, believing that these can be handled independently. This indicates that awareness of the value of patient safety is still lacking. This statement is also supported by observations and review of research documents, revealing the few incident reports recorded by primary health care prevention, infection control, and patient safety teams. The patient safety team concluded that the incidents that occurred were minor. In the patient safety steps at primary health care, it is stated that a patient evaluation survey has never been used to assess patient safety.

Leadership and Supporting Staff

Based on the results of interviews conducted regarding the existence of a leader responsible for patient safety, motivating and fostering a work ethic within the team or unit. Both patient safety teams in each health center have involved other units through the coordinators in each clinic within the patient safety team. The patient safety program is already included in routine meetings of the leaders or management of the health center. This is evidenced by:

"...here, it is not every... As far as I know, it is not discussed in every meeting; sometimes it is discussed, sometimes it is not, depending on whether there are issues or not. If there are issues, they are definitely discussed immediately. If there are no issues, then things just go on as usual. What this means for our routine meetings is that the coordination meetings and inter-unit meetings are usually held monthly." (Informant 7)

The research location has never had a patient safety training program for health center staff. Regarding patient safety, the training described by the informants consists of workshops or seminars.

"The doctor responsible for patient safety used to teach, but that was the previous person in charge. There were practical drills for earthquake preparedness and first aid, for example, if a patient suddenly goes into cardiac arrest. For other topics, we mostly just listened, like in a seminar. As I recall, we've had fire drills only twice, I think? They did happen, but it was a long time ago. In my opinion, it's still necessary to refresh these trainings." (Informant 9)

The informant's statement is supported by the discovery of a training certificate held by one of the staff members who attended a patient safety training.

Integrating Risk Management Activities

Based on the interviews, the integration of risk management activities in implementing clinical and non-clinical risk management has already incorporated the patient safety program with the availability of a risk register book with assessment categories determined by each patient safety team. Each program unit compiles Risk identification at the beginning of each year as preventive and corrective measures. Furthermore, from the available reporting system, informants stated that there is already clear and accurate information obtained from the incident reporting and risk assessment system to proactively increase patient awareness at the health center. Before providing services, patients undergo a risk assessment as part of the risk assessment process at the primary health care:

"Yes, especially during this pandemic, we are much more careful in conducting risk assessments. Upon entering the health center, we implement screening for patients who exhibit symptoms of infectious diseases. The hope is that if they are identified, they will be advised to undergo an examination in the infection clinic where we have a special room. So, we hope that those in this room are truly patients whose illnesses are not contagious to other patients, staff, or the family members accompanying them. From the registration section, we ask about their complaints, but even so, sometimes something still slips through during the anamnesis." (Informant 5).

Developing a Reporting System

Implementing incident reporting within and outside the health center involves developing a system to report every incident to the patient safety team. Based on in-depth interviews, from 2018 to 2020, all incidents were resolved internally, either within the unit or by the patient safety team. Incidents reported to the head of the health center require funding and new policies, and it was found that some staff members still do not routinely record incidents. Hence, informants stated that motivation is provided through actions that remind each other. Motivation is crucial for staff to ensure proper record-keeping. The following informant supports this statement:

"...So, the approach is just to remind each other. It's really about individual awareness of the incidents, you know. Building that awareness in each person. Sometimes they are aware but forget to write it down. Then, there's the matter of filling out the forms... and also being busy with patients." (Informant 4).

Involving and Communicating with Patients

There is a primary health care policy that clearly outlines open communication with patients and their families regarding incidents during the care process. This is evidenced by the existence of SOPs held by the pharmacy unit concerning the SOP for providing information on medication use, SOP for informing about side effects or adverse effects of medications, and an SOP for incident reporting Geld by the prevention, infection control, and patient safety team—guidelines on communicating patient safety incidents openly to patients and their families. When incidents occur, staff always ensure that patients and their families receive clear and accurate information and respect and support the involvement of patients and their families. This aligns with the following informant's statement:

"Yes, there should always be communication in such cases. We need to ensure that there are no misunderstandings, that's automatic. For example, if I took a blood sample and it couldn't be tested, and I couldn't immediately visit the patient's home when the patient asks about the results, we explain that the blood could not be tested…" (Informant 6)

Learning and Sharing Experiences About Patient Safety

Implementing patient safety measures in primary health care utilizes a root cause analysis system, meaning incidents are investigated and analyzed using RCA (Root Cause Analysis). Identifying units or areas with potential risks is conducted informally through discussions among staff, who observe and attempt to minimize risks by remaining cautious. The patient safety framework used by Primary health care involves root cause analysis. RCA is applied for incidents categorized as yellow or red. Based on observations, there was one incident in 2019 for which an RCA was conducted involving a laboratory staff member being pricked by a used needle. The RCA detailed the incident's chronology, problem analysis, follow-up plan, and future repair schedule.

Preventing Injuries Through Implementing Patient Safety Systems

As a basis for policy formulation, clear and accurate information from the reporting system, risk assessments, incident reviews, audits, and analyses have been obtained. This is consistent with:

"Yes, it's clear. During the monthly coordination meetings, it's communicated if something requires a new policy, and that is also conveyed." (Informant 9)

Incident reviews and analyses produce accurate and precise information aimed at determining resolutions. Solutions may include a reevaluation of the system adjustments related to patient safety. According to the informants, there has been socialization of each (Follow-Up Plan) for patient safety incidents based on the active involvement of all units in incident learning interviews. The team is

involved in improving patient care to make it safer, as evidenced by observations showing steps for collecting incident fact forms and documents. However, the documentation remains somewhat disorganized within the patient safety team at primary health care.

From the document review that utilized reports and records supporting this research for the years 2018, 2019, and 2020, only documents from 2018 and 2019 were obtained. This is because in 2020, health facilities, including health centers, were focused on the COVID-19 pandemic response, which led to delays in incident documentation. However, patient safety continued to be a priority, as evidenced by documentation showing that facilities and infrastructure were well-equipped for patient safety during the pandemic. This includes acrylic barriers at service desks, queue numbers managed by security, separate service pathways for infectious and non-infectious patients, social distancing in waiting areas, availability of PPE, routine room sterilization after service, screening, and scheduling of staff working from home or on-site. The research findings can be more clearly seen in Table 1: Implementation of the Seven Patient Safety Steps at Primary Health Care as follows:

Tabel 1. Implementation Of The Seven Patient Safety Steps At Primary Health Care

No	The Question	Yes	No
Building Awareness of the Value of Patient Safety			
1.	Primary health care has created a policy regarding the value of patient safety.	✓	
2.	Primary health care has a policy that requires every officer to be responsible for patient safety incidents.	✓	
3.	There is a culture of reporting and learning from patient safety incidents at primary healthcare	✓	
4.	There is an assessment carried out using patient safety research surveys at primary healthcare		✓
5.	Officers have concerns and dare to report when patient safety incidents occur at primary healthcare	✓	
6.	Standards are used to ensure that all reports are made by the Primary health care openly.	✓	
Leading and Supporting Staff			
1.	There is a team of officers who are responsible for patient safety in primary health care.	✓	
2.	There is a patient safety program promoter in each unit that has the potential for incidents (outpatient, inpatient, pharmacy, and laboratory) in primary health care.	✓	
3.	Patient safety is included in routine meetings of the leadership or management of primary health care.	✓	
4.	There is a patient safety training program for Primary health care staff.	✓	
Integrating Risk Management Activities			
1.	Clinical and non-clinical risk management has been integrated into patient safety programs at primary health care.	✓	
2.	There are performance indicators developed for patient safety risk management systems in primary health care.	✓	
3.	Is there clear and correct information obtained from the incident reporting and risk assessment system to be able to proactively increase care for patients at primary health care?	✓	
4.	There is a discussion forum on patient safety issues in primary health care.	✓	
5.	There is a risk assessment for individual patients in the risk assessment process at the primary health care.	✓	
6.	Risk assessment is used as an assessment and determination of risk in primary health care.	✓	
Developing a Reporting System			
1.	There is a plan to implement incident reporting into and out of primary health care.	✓	
2.	There is motivation for officers to actively report every incident that occurs at the primary health care.	✓	
Involving and Communicating with Patients			
1.	There is a policy from Primary health care that clearly explains ways of open communication during the care process regarding patient safety incidents for patients and patient families.	✓	
2.	Responding to patients and their families to receive clear and correct information when an incident occurs.	✓	
3.	There is training support and encouragement for staff to always be open to patients and their families.	✓	

No	The Question	Yes	No
4.	Ensure that staff appreciate and support the involvement of patients and their families when an incident occurs.	✓	
5.	Staff always notify patients and families when an incident occurs with clear and correct information.	✓	
Learning and Sharing Experiences About Patient Safety			
1.	Staff are skilled in conducting appropriate incident studies that can be used to identify incidents.	✓	
2.	There is a policy that describes the existence of each incident and RCA (Root Cause Analysis) will be carried out.	✓	
3.	The RCA results are used as discussion material as a learning process.	✓	
4.	There is identification of other units or parts that allow the potential for the same incident to occur.	✓	
Preventing Injuries Through Implementing Patient Safety Systems			
1.	There is correct and clear information obtained from reporting systems, risk assessments, incident studies and audits and analysis to be used as a basis for policy making.	✓	
2.	The existence of instruments that guarantee patient safety programs.	✓	
3.	There is an assessment of the risk of injury.	✓	
4.	There is socialization of each patient safety incident follow-up plan.	✓	
5.	There is feedback to staff from every patient safety incident report.	✓	
6.	Involve the team in developing better and safer patient care.	✓	
7.	There is a review of every change made by the team and ensures the implementation of each change.	✓	
8.	Ensure the team receives feedback on any follow-up on reported incidents.	✓	

Based on Table 1, the implementation of the seven patient safety steps in primary health care shows that the steps, which include building awareness of the value of patient safety, leading and supporting staff, integrating risk reporting activities, developing a reporting system, involving and communicating with patients, learning and sharing experiences about patient safety, and preventing injuries through the implementation of a patient safety system, have been implemented. However, the first step of building awareness of the value of patient safety, as assessed by using a patient safety survey at the health center, has not yet been implemented in primary health care.

3.2. Discussion

Based on the research conducted at one primary health care in Yogyakarta city through interviews and observations, it was found that primary health care has not fully implemented the seven patient safety steps. Implementing patient safety steps does not have target achievements, and it is considered good if each step complies with the Ministry of Health regulations on patient safety. The health care is still unfamiliar with or unaware of the seven steps toward patient safety due to the lack of specific guidelines and socialization. There is a link between knowledge and the application of patient safety, where services that prioritize safety and optimal quality from good patient safety practices have a broad impact. According to G. Edwards III's implementation theory, policymakers' decisions will not be successful without effective implementation [12]. All healthcare workers must be involved in the implementation of patient safety efforts. Patient safety must be well understood for these efforts to run smoothly and achieve their goals [2].

Building Awareness of the Value of the Patient

Implementing the patient safety step to build awareness of the value of patient safety has been carried out by the management of Primary health care by establishing policies, guidelines, and several SOPs. However, no documents have been found detailing implementing the seven steps towards patient safety. According to G. Edward III's implementation theory, the program implementation mechanism is established through SOPs that clearly, systematically, straightforwardly, and understandably outline the policies or programs, serving as a reference for the implementers or healthcare staff in their work. This step aligns with the theory in terms of the bureaucratic structure variable [13]. This is consistent with a study where several policies, SOPs, and guidelines for patient

safety implementation are present at Puskesmas Mangkang. However, no relevant documents explain implementing the seven steps toward patient safety, which reduces the staff's understanding [14]. Limited knowledge among staff can lead to incidents such as mistreatment and errors in task execution [15]. The staff at Primary Health Care of Kotagede 1 have already taken responsibility for patient safety incidents according to their respective policies. However, implementing a reporting culture in the Primary health care of Kotagede 1 has not been fully adopted. Document reviews from 2018-2020 show only a few incident report records, and in-depth interviews revealed that the staff does not report minor errors that can be immediately resolved, such as identity mistakes. This aligns with research indicating that the patient safety incident reporting system is not yet optimal; incident reports are typically internal, coming from staff or patient safety team coordinators, due to the non-severe or non-fatal nature of the incidents [7].

A frequently recurring incident is identity errors, which are classified as near-miss incidents. It is crucial to document activities properly to provide effective and efficient healthcare services. Accurate and complete written incident reporting records serve as a foundation for delivering healthcare services through precise communication [16]. Much of the educational material comes from narrative reports by clinical staff who report patient safety incidents, and these reports are a key component of many reporting systems [17]. The implementation of assessment using patient safety evaluation surveys has not been conducted at either research location. This is not in line with a previous study that conducted patient safety surveys [14]. Assessment must be conducted regularly to evaluate progress, as this evaluation only reflects the level of culture at a specific point in time. [18].

Leadership and Supporting Staff

Based on the research findings, implementing patient safety steps shows that the leadership is responsible for patient safety and plays a key role in fostering a work ethic through the specialized patient safety team, Infection Prevention, Control, and Patient Safety, in collaboration with leadership. Effective control, guidance, and direction will benefit the team members who carry out their tasks and responsibilities. However, leaders cannot achieve much without the participation of team members. Leadership attitudes can influence team members' behavior [19]. Patient safety implementation has been included in the routine meetings of the leadership or management of the health care to identify risk factors for unwanted incidents. Generally, these meetings focus on enhancing preventive measures through improvements and additions to facilities that support implementing patient safety programs at primary health care. The effort to implement patient safety cannot be carried out solely by the patient safety team or staff with patients; it involves all organization members as a form of support and collaboration from management [2].

The patient safety training program is implemented through workshops and conferences. One of the staff members participated in a patient safety training program and obtained a certificate, as observed. This staff member then shared their knowledge with other team members. Staff who have undergone patient safety training are more likely to successfully implement patient safety goals than those who have not received training. The number of training sessions attended will significantly impact whether the staff effectively implements patient safety practices [20]. According to implementation theory, every policy must be supported by adequate resources, including both human and financial resources. Both aspects must be considered in implementing patient safety programs, especially [21]. The expected impact of training is an increase in knowledge and a change in attitudes, which can be measured by improved job performance and, at the same time, aligns with the growing demands of patient safety implementation. Training is crucial for developing effective leaders and is used to transform behavior to meet desired expectations [19].

Integrating Risk Management Activities

Establish an incident reporting and learning system to prevent errors from recurring [17]. Based on the research findings, the implementation of patient safety steps in clinical or non-clinical risk management shows that the patient safety plan has been integrated into the patient safety program with the availability of a register book and statements explaining that risk identification is routinely conducted at the beginning of each year based on quality and patient safety indicators developed for the patient safety risk management system at primary health care. Non-clinical activities, such as public health efforts, also pose safety risks, so it's not only clinical services that have risks to patients. Risks need to be identified and appropriately managed to minimize them [22].

Clear and accurate information from incident reports and risk assessments is available, which can proactively enhance patient care at the health care. According to the Ministry of Health Regulation No. 11 on patient safety from 2017, it involves integrating risk management activities, developing risk management systems and processes, and identifying and assessing potential issues [5]. Risk assessments are carried out with evaluations categorized into blue, green, yellow, and red grades. Risk assessments are differentiated based on the incidents and the time required to resolve issues. Blue-grade incidents are resolved within a maximum of 1 week. In contrast, red-grade incidents take up to 45 days, involving a comprehensive investigation followed by further analysis to facilitate improvements and prevent recurrence [19].

Developing a Reporting System

From in-depth interviews and document reviews, the reporting system is crucial for the patient safety team to ensure that staff report incidents internally and externally. Each room has a designated format for reporting patient safety incidents [7]**.** This statement aligns with research findings that incident forms are available in all rooms; however, because incidents are rare in some units, staff sometimes forget where to store the forms. This contributes to a low reporting culture. While primary health care has provided the forms, individual staff members still often delay recording. This is consistent with previous research showing that staff are inconsistent in recording incidents, and some only document patient safety incidents without reporting them within the specified time due to confusion with the reporting process [2]. Reporting patient safety incidents has become a crucial part of the patient safety system, and the organization will use this information for learning purposes. The reports focus on the groups involved in service issues [23].

Involving and Communicating with Patients

During the care process with patients at the health care, the implementation of open communication about incidents with patients and their families has been quite optimal among all staff involved in patient safety. Primary health care has a policy on open communication methods, which serves as a guideline to ensure that every mistake is addressed. Patients and their families receive clear and accurate information. This aligns with G. Edward III's implementation theory on the communication variable, which indicates that policies will be effectively executed if effective communication between implementers and targets and the communication process, clarity, and consistency are well understood [12]. Communication is crucial in optimizing work and coordination between implementers, teams, and leadership. One key to successful communication is ensuring a shared understanding between the communicator and the recipient to establish mutual comprehension [24]. Communication barriers, such as when the message is unclear to the sender, can be influenced by emotions or situational factors [19].

Learning and Sharing Experiences About Patient Safety

The management has developed RCAs (Root Cause Analyses) for each incident based on implementing patient safety steps. However, staff are not yet skilled in conducting precise incident

reviews that can be used to identify incidents. The framework for patient safety involves analyzing root causes using the RCA method for incidents categorized as yellow or red grade. Hazard severity varies widely between classification systems for patient safety incidents in primary care. Generally, the assessment using incident codes will vary depending on the clinical role of each coder, their level of clinical knowledge, and experience [17]. This theory aligns with the findings of this study, where the patient safety team at primary health care creates grades based on team consensus, leading to variations in RCA implementation between health centers. Root Cause Analysis is required for incidents categorized as extreme and high-risk, necessitating further investigation by the RCA team. For low-risk incidents, a more straightforward investigation is conducted by the supervisor. Red category incidents, representing extreme risk, and yellow category incidents, representing moderate risk, must undergo Root Cause Analysis [22].

Preventing Injuries Through Implementing Patient Safety Systems

Injury prevention can be achieved by implementing a patient safety system, addressing injuries caused by errors resulting from actions taken or not taken as necessary. Based on in-depth interviews and observations, Primary health care already has accurate and precise information from the reporting system, risk assessments, incident reviews, audits, and analyses to support policy decisions. In the available documents, each recorded incident in the incident report is explained, showing how each Follow-Up Plan is created to provide feedback to staff. The implementation involves socializing through meetings with all staff, with changes made based on monitoring and evaluation reviews. This is supported by research indicating that strategies to enhance patient safety have been well established, targeted, and aligned with goals through stages of identification, problem-cause analysis, and effective and efficient decision-making [6].

The seven patient safety steps at primary health care of Kotagede 1 have been implemented, with the average indicator of patient safety targets achieving 100% based on incident reports from 2018-2019. In 2020, there were no recorded reports because the healthcare facility was struggling with and focusing on the COVID-19 pandemic, which caused all reporting to be halted. In its implementation, patient safety has become a top priority in health care, with the addition of facilities and resources to ensure the safety of both patients and staff. The results of in-depth interviews show that staff have indirectly implemented nearly all patient safety steps.

4. Conclusion

Building awareness of the importance of patient safety in primary healthcare has been implemented with a patient safety policy in the health center. However, the culture of incident reporting is still lacking. Leading and supporting staff has been implemented with a positive response from the patient safety team. However, the patient safety training program has not been effective and needs to be refreshed annually in primary health care. Integrating risk management activities in primary health care has been implemented to develop performance indicators and integrate patient safety programs into clinical and non-clinical management. A reporting system has been implemented with patient safety measures, but staff still do not consistently record every minor incident. Involving and communicating with patients has been implemented in primary health care by being open about what has happened and immediately discussing problems. Learning and sharing experiences about patient safety have Root Cause Analysis (RCA). Injury prevention through implementing a patient safety system has not been fully maximized, as evidenced by the lack of active learning from incidents between units that may be at risk. A follow-up plan has been communicated to staff.

Acknowledgment

All authors would like to thank all respondents and parties involved in this research.

Conflict of Interest

The authors declare no conflicts of interest.

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