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Evaluation Of Patient Safety Steps In General Hospital Of Yogyakarta City (RSUD Yogyakarta City)

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ABSTRACT

Background: Patient Safety of hospital is a system where the hospital makes patient adoption safer. In giving a quality of guarantee provide health and patient safety, this hospital is applying patient safety program. The result of our acknowledgements show SOP that has not been working as accurately. At this incident should be told 2x24 hours maximal, sometime there is exceeding the line and it is not reported.

Objective :The purpose of this project isto evaluate the step of patient's safety that has been applied at the inpatient installation in the regional hospital of Yogyakarta.

Methodology : this research is a qualitative research with case approach to 6 informan that used an interview guidance and check list which is refering to the minister of health on Patient's Safety. Analysis data used data reduction, data display and conclusion.

Result: the result of this research showed six of seven steps of patient safety has been working with the rule of minister of health about of patient safety, althought in progressing need an increasing . However, your leaders and proponents has not been working with the rule of minister of health about of patient safety.

Conclusion : this research is one of seven steps of patient safety, 6 steps has been working with the rule of minister of health about of patient safety.

***Key words** : Evaluation, Patient Safety, Hospital*

1. INTRODUCTION

Evaluation is a systematic way of learning from experience to improve the achievement, implementation and planning of a program through careful selection of possibilities available for future implementation[1]. Hospital patient safety is a system whereby hospitals make safer patient care that includes risk assessment, identification and treatment of issues related to patient risk, incident reporting and analysis, incident learning and follow-up skills and implementation of solutions to minimize risks and prevent injury caused by errors resulting from an act or take unnecessary actions[2]. Patient safety is an effort to protect the rights of everyone, especially in health services in order to obtain quality health services and safe[3].

Patient safety is the main priority to carry out the survival of the hospital and this is related to the quality and image of hospital issues. Regulatory programs such as the application of hospital service standards, implementation of *Quality Assurance, Total Quality Management, Countinuos Quality Improvement*, Licensing, Accreditation, Credentialing, Medical Audit, Clinical Indicators, Clinial Governance, ISO (*International Organization for Standardization*) have been proven to improve service quality. In quality services, there are still Unwanted Events(KTD=KejadianTidakTerduga), so a program is needed to further improve the service process. The program which later became known as *patient safety*[4].

Advers Events (AEs) can simply be defined as KTD caused by medication / treatment errors and can even have a negative impact on patients[5]. KTD can occur anywhere and anytime. Medical services in hospitals are complex and the units or service types vary greatly[6]. Data in Indonesia regarding KTD especially the Near Miss Events are still rare, but on the other hand there are increasing accusations of "practice malls", which are not necessarily in accordance with the final proof. As much as 28.3% of incidents of violations of patient safety were carried out by nurses[7]. The first study at 15 hospitals with 4500 medical records in 2000 regarding the issue of patient safety found KTD figures varying greatly, namely 8.0% -98.2% for diagnosis errors and 4.1% -91% for medication errors[8].

The results showed that patient safety in RSUD Yogyakarta City has been running around 2014, but Quality Installation and Patient Safety was formed in 2015. SOP (Standard Operational Procedure) that exist in this installation consist of SOP reporting and patient safety incident, SOP analysis root problem , Simple investigation SOP. This installation is already running a patient safety program.

2. RESEARCH METHODS

The type of research is Qualitative research[9] with case study approach[10] with 6 subjects included 1 chairman of quality and patient safety, 2 staff of quality installation and patient safety, 1 nursing coordinator and 2 nurses. Technique determination of the research subject by using purposive sampling method that is researcher chose respondent based on subjective and practical consideration[22]. The data collection methodsused by conducting in-depth interviews, direct observation and document review used Milles and Huberman[9] model method analysis. The data validity used source triangulation and triangulationmethod[11].

3. FINDING OF THE RESEARCH

1) Building Awareness Regarding Patient Safety Value

Table 1. The Results of Implementation of Observation Steps Building Awareness Regarding Patient Safety Value

Observation Elements	Description
The hospital has policies that define the role and accountability of individuals in the event of an incident	There is already a policy
Culture reporting and learning from incidents grown in hospitals	Already running
The hospital conducts an assessment using a patient safety assessment survey	Already running
The colleagues are able to talk about caring and dare to report in the event of an incident	Already running
Demonstrate to the team about the measures used in the hospital to ensure all reports are made openly and there is a learning process and the implementation of appropriate actions / solutions	Already running contained in SOP and incident reporting form

Activities to build values for patient safety in RSUD Yogyakarta City are already running. The hospital also has a policy of describing individual roles and accountability when incidents occur in SOPs and policies on patient safety, and there is also a flow for reporting in the event of an incident. Providing motivation, enthusiasm and socialization are always provided so that every staff member who knows, sees, performs incidents which always reported the incidents. In the medical record of each patient, there is a fall risk assessment which is an assessment of patient safety. RSUDYogyakarta City ensured employee concern for incidents and is able to speak and report in the event of an incident with socialization, motivational giving and a reporting atmosphere that has no blame for any incidents that occur. The reports made openly by the presence of SOPs and the same incident reporting form in one hospital to make reporting made uniformly. This is evidenced by the results of in-depth interviews as follows:

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*"In essence, we have an SOP for reporting incidents, because the SOP reporting becomes uniform, every time there is an incident including which one is KNC, KTD, such sentinel becomes the final uniform ..."**(S1)***
*"That is the provision of training, because there is already a simultaneous training of one hospital. There are also SOPs and reporting forms used the same, so one hospital will be the same ... "**(S2)***
*"Educating, there is not pure can directly fill out the incident reporting form, we as the investigation team, as a team that takes care of the patient's safety incidents, we extract as much information as possible, by interview. There are SOPs and the same form, so it will be uniform later ... "**(S3)***

The action of the solution made after the incident, whoever knows, sees and performs the incident is required to perform initial management as a solution given to the patient. So that every incident incident occurs in the patient, the health worker provides an initial solution to help the patient. This is evidenced by the results of in-depth interviews as follows:

*"Anyone who sees, experiences, or knows the occurrence of an incident is required to provide initial management, then the reporting is in line ...." **(S1)***
*"So, if there is an incident handled first, for example in the incident of falling from the bed, the nurse immediately provides first aid to the patient, then seen someone who is injured or not, such as an injury immediately report to the doctor who is maintaining ..." **(S3)***
*"… for example the patient fell, reported, the officer reported on his border, then checked if there is an injury there is his grade, if for example the weight will report to the medical officer, then medical determine whether to do investigation or not"**(S4**)*

2) Lead and Support Staff

Table 2. Result of Observation of Implementation of Lead and Supporting Staff

Observation Elements	Description
Make sure there are directors or leaders who are responsible for patient safety	Already running
Identify in each hospital section, people who can be relied upon to become "movers" in the patient safety movement	No special identification
Prioritize patient safety on the agenda of the board of directors / leaders and hospital management meetings	Already running
Put patient safety in all of your hospital staff training programs and ensure that this training is followed and measured for effectiveness	Not running yet
Nominate "mover" to lead the Patient Safety Movement	There is no special nomination
Explain to the team the relevance and importance and benefits to them by running the patient safety movement	Already running
Grow the attitude of knights who appreciate incident reporting	Already running

RSUD Yogyakarta City already has responsible person of patient safety that is director of hospital. Every installation in RSUD Yogyakarta City already have member of team of patient safety. Patient safety team in every installation at RSUD Yogyakarta City has been determined that all head of installation and head of space have duties and responsibility for each installation and room. This is evidenced by the results of in-depth interviews as followed:

*"There are typically that have tupoksi for management such as incoming installation heads, entrance space coordinators ... To identify the patient's safety driver specifically does not yet exist, so involved usually the head of the installation and space coordinator ... There is no specifically nominations for mover the patient's safety, there is still the SK of the director who is involved in patient safety ... "**(S1)***
*"There is the coordinator of the room and the head of the installation ... No specific identification, we directly chose the space coordinator or installation head because they are responsible for installation ... Nothing, because here directly chose the chief of staff and direct installation head as drive on the ward or installation ... "(**S3)***

RSUD Yogyakarta City has conducted training for all staff in hospital about patients safety which is held by internal of RSUD Yogyakarta City. However, not all training always includes patient safety in training. In the training, it has been explained about the importance, benefits and relevance of patient safety so that staff in the hospital already know about patient safety. To appreciate the reporter who reported the incident is usually given a grateful, because the reward itself did not exist, and there is no punishment for any incidents that occurred in RSUD Yogyakarta. This is evidenced by the following interview results:

"Reward in the form of money is not, but reward in the form of opportunity, and grateful .." (S4)

"With say thanks, for the reward is not materially .." (S5)

"By saying thank you and providing a positive reinforment .." (S6)

3) Integrating Risk Management Activities

Table 3. Results of the Implementation of Steps to Integrate Risk Management Activities

Observation Elements	Description
Review the existing structures and processes in clinical and non-clinical risk management, and make sure they covered and are integrated with patient and staff safety	Already running
Develop indicators performance for risk management systems that can be monitored by directors / hospital leaders	Already running
Use correct and clear information obtained from the incident reporting system and risk assessment to proactively increase care for patients	Already running
Make forums in hospitals to discuss patient safety issues to provide feedback to related management	Already running but not maximized yet
Ensure to provide a risk assessment for individual patients in the hospital risk assessment process	Already running
Perform a risk assessment process on a regular basis to determine the acceptability of each risk	Already running
Make sure the risk assessment is submitted as input to the assessment process and the hospital's risk recording	Already running

RSUD Yogyakarta City in clinical and non-clinical risk management is also carried out by the patient safety department so it has been ascertained that clinical and non-clinical risk management is integrated with patient safety and because risk management is very important for patient safety at the hospital. To assess the risk of the patient when the patient enters, the risk assessment has actually been carried out. To develop indicators performance for a risk management system will usually go through a meeting. Patient safety installation often cross checks regarding incidents that have been reported to get clear and correct information about the incident in order to get correct information about incidents that occurred in the hospital. This is evidenced by the results of in-depth interviews as follows:

"There is a coordination meeting every month, but the journey is still stagnant, for the feed back we make it written ..." (S1)

"There is. It should be once a month, but this is rather difficult to get together so I give feedback, I gave a report then he wrote the analysis of how he gave back to me ... "(S2)

4) Developing a Reporting System

Table 4. Observation Results of Implementation Step Develop Reporting System

Observation Elements	Description
Complete the planned incident report both inside and outside, which should be reported to the National Committee for Hospital Patient Safety	Already running
Encourage co-workers to actively report any incidents and incidents that have been prevented but also occur	Already running

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Reporting incidents of RSUD Yogyakarta City every month always reports to the National Patient Safety Committee via online through the website of the National Hospital Patient Safety Committee. The reporting flow was available, so it easy to facilitate the reporting process. This is reinforced by the results of observations and the results of in-depth interviews as follows:

"For the mechanism, the nurse reports to the head of the new chamber head that reports to the patient's safety installation. There is already a form to report the incident, and the form is the same for one hospital that has SOPs ... If some an incident is later recorded on the ward, it will be reported to the patient safety section because there is already a reporting form "(S2)
"That's according to SOP ... It's in the SOP, every ward also has an incident reporting form" (S3)

5) Engaging and Communicating with Patients

Table.5 Observation Results of Implementation of Engaging and Communicating with Patients

Observation Elements	Description
The hospital has a policy that clearly describe the ways of open communication during the care process about incidents with patients and their families	Already running
Make sure patients and their families get correct and clear information when an incident occurs	Already running
Provide support, training and encouragement to staff so that they are always open to patients and their families	Already running
Appreciate and support patients and families involvement in the event of an incident	Already running
Prioritize notifications to patients and families in the event of an incident and provide clear and correct information appropriately	Already running
The team showed empathy to patients and families after the incident	Already running

Involving and communicating with patients, RSUD Kota Yogyakarta already has SOPs and policies that regulate how to communicate with patients. Patients and families get clear information about the incident, it because the patient's right to know how the condition is. Families and patients are always involved in the event of an incident that afflicts the patient, as it relates to patient safety and health care workers as well as supporting and appreciating the involvement of patients and their families. Priority notifications to patients and families already exist for each incident. In the medical record there is also an educational form, then confirms to the family what happened and provided a solution. This is evidenced by the results of in-depth interviews as follows:

"Yes, it must be notified first and they also known that it happens ... In our medical record, every education should be written what is delivered there are signatures of the duty that provide information and there is evidence that the patient's family has been informed ..." (S4)
"There is a priority, because every action is straightforward, for example on the recap of identification we immediately follow-up. Clarify to the patient's family about correct identification.... "(S5)

After the incident to the patient, the team gives empathy to the patient in the form of accompanying the patient, so that the incident did not happen again to the patient.

6) Learning and Sharing Experiences about Patient Safety

Table 6. Observation Results of Implementation ofLearning and Sharing Experiences about Patient Safety

Observation Elements	Description
Ensure that the relevant staff are trained to conduct incident assessments appropriately, which can be used to identify causes	Already running
Develop a policy that clearly described the implementation criteria for root cause analysis that includes incidents that occurred and a minimum of once a year conducting Failure Modes and Effects Analysis (FMEA) for high risk processes	Already running, but FMEA has only been done once
Discussion in the experience team from the results of the incident analysis	Already running

Identify other units or sections that may be impacted in the future	Already running

The implementation of learning and sharing of experiences about patient safety, in doing a proper review done grading first on each incident, then will be done a simple investigation or RCA (Root Cause Analysis) discussed in the meeting. This is evidenced by the results of in-depth interviews as follows:

"If the reporting process in the form of grades that is provided in the SOPs, there is a reporting form there plot, such as yellow or red grade RCA, RCA team will be formed involving structural, IMKP related units and then they meet. We have the guidebook so we use it, there is the risk management manual there is FMEA then for the RCA there is a SOP and we use it ... FMEA should be at least 1 year, but in the implementation not yet. For RCA depends on the incident. If there are no incidents, yes no. For each year can vary depending on the incident .... "

"If there is a problem that must be done RCA will be explained what the problem is what happened then done RCA together. For FMEA less know ... It depends on the problem if for example RCA is done. For FMEA only once, when you want to accreditation ... "

"There will be a risk management book to explain it, the incident is often not, then what impact and consequences, for example often occur and the impact is injured and still in green grading, so we explain it still racing on the book ... For the root of the problem in a year is uncertain, because RCA is carried out if there is an incident. FMEA has been done but only once ... "

The discussions about the experience of the results of the incident analysis, it were carried out during the monthly meeting. Commemorate other units so that the incidents occur in certain units do not occur in other units discussed through monthly meetings.

7) Preventing Pain Through Patient Safety System Implementation

Tabel 7. Observation Result of Implementation of Preventing Pain Through Patient Safety System Implementation

Observation Elements	Description
Use the correct and clear information obtained from the reporting system, risk assessment, incident review, and audit and reporting systems to determine local solutions	Already running
Those solutions may include system translation (structure and process), adjustment of staff training and / or clinical activities, including the use of instruments that ensure patient safety	Already running
Conduct a risk assessment for any planned changes	Already running
Socialize about solutions developed by National Patient Safety Committee of the Hospital	Already running
Provide feedback to staff about any action taken on reported incidents	Already running
Involve the team in developing various ways to make patient care better and safer	Already running
Review the changes the team made and make sure of the implementation	Already running
Make sure the team received feedback on any further action on reported incidents	Already running

Based on the results of in-depth interviews on preventing injuries through the implementation of patient safety systems, RSUD Yogyakarta used information obtained from reporting systems and risk assessment to determine solutions to prevent injuries. The training was conducted to socialize the solution developed by the National Committee for Hospital Patient Safety. This is evidenced by the results of in-depth interviews as follows:

"For the socialization through training, we had invited resource persons from Sardjito, but for the constituency of Implementation in the hospital that is through routine meeting and coordination meeting, feed back ..." (S1)

"Through training, every meeting, for example, there is an incident of re-socialization ..." (S2)

"With meetings and training ..." (S3)

To ensure that any changes have been made or not, the patient's safety installation will do the inspection. Feedback provided regarding incidents reported in the form of monthly reports which

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provided to each installation and space and ensured that each room and installation has received reports in the presence of a blank report. In making the care carried out monitoring to ensure its journey. This is evidenced by the results of in-depth interviews as follows:

"The socialization related to parties such as nurses and doctors, provided with education and guided by its chairman. Make flyers, improve communication with patients more. Monitoring evaluation for improvement "(S2)

"Meeting, looking for referrals from other hospitals. We did monitoring evaluation "(S3)

4. DISCUSSION

1) Building Awareness Regarding Patient Safety Value

The implementation of awareness raising on patient safety in RSUD Yogyakarta City was in accordance with the Minister of Health Regulation concerning patient safety. In practice, the hospital already had a policy that described individual accountability whenever incidents are listed in the policies and SOPs on patient safety. The most important aspect of management and health law is health policy[12].

Providing motivation, enthusiasm and socialization is always done to foster a culture of reporting and learning from incidents, because it was very important. According to the *KKPRS* / HPSC (Hospital Patient Safety Committee)[13] the reporting system will invite everyone in the organization to care about the dangers or potential hazards that may occur to the patient. The incident reporting was important because reporting will be the beginning of the learning process to prevent the same occurrence from happening again. In the incident reporting itself there was no special reward given, only limited thanks and no punishment that made the reporting atmosphere to be comfortable. A non-conditional response will improve the reporting[14].

However, there are still obstacles in the way such as reporting culture that was still low, so there are some reports that are not reported and the incident was reported to exceed the maximum time limit that has been determined that is 2x24 hours. In ensuring that the reports are made to public, RSUD Yogyakarta City had SOP and the same incident registration form in each hospital, which means reports can be made uniformly in the hospital.

2) Lead and Support Staff

In leading and supporting staff at RSUD Yogyakarta City was not in accordance with the Regulation of the Minister of Health on patient safety, in the patient safety movement there are already members of the board of directors or leaders responsible for patient safety. RSUD Yogyakarta City chose directly the head of the installation and head of the room as a driver of patient safety, because it was considered the most responsible in the installation and the room.

According to Thompson[16], the space chief's efforts in implementing effective leadership in the room affect the application of patient safety culture. The head of the space will be able to influence the strategy and effort of mobilizing the nurse within the scope of his or her authority to jointly implement the patient safety culture. According to The Health Foundation Inspiring Improvement[17] the culture of salvation is the value of beliefs, behaviors adopted by individuals in an organization concerning safety that prioritizes and supports quality improvement.

In 2015, all members of the hospital have received training on patient safety. According to Budiharjo[18], patient safety culture is important, patient safety culture will lower Adverse Event (AE) so that hospital accountability in the eyes of patient and society will increase. According to Jeff et.al[19]reporting is an important element of patient safety. Adequate information will serve as a learning process to improve patient safety.

3) Integrating Risk Management Activities

The integration of risk management activities at RSUD Yogyakarta City has been run in accordance with the Regulation of the Minister of Health of the Republic of Indonesia concerning patient safety. The clinical and non-clinical risk management has been integrated with patient safety.

Ensure individual assessment of patients in the risk assessment process of the hospital, each time the patient is always entered the risk assessment, for self-assessment there was a fall risk assessment, 24-hour risk assessment. Assessment of fall risk is done because of the patient to avoid injury from fall, so it can be avoided. Risk assessment was done regularly at RSUD Yogyakarta City. To minimize an existing risk in the hospital, the hospital collected the risks that exist in each installation and space and then grading to determine which risks are the most severe and must be completed as soon as possible.

In developing performance indicators conducted through the meetings. In raising awareness of patient safety installation, patients used correct and clear information by cross checking the nurses from incident reporting and from risk assessment, this is done to ensure patient safety. Forums addressing patient safety issues are available, and scheduled every month to gather.

4) Developing a Reporting System

In developing the reporting system at RSUD Yogyakarta City has been running well and in accordance with the Minister of Health Regulation about patient safety. RSUD Yogyakarta Cityin every month is always reported to the report of the National Committee on Patient Safety Hospitals online and report into the hospital every month walk well. As the ideal reporting system (not punitive, confidential, timely, analyzed by experts, and system-oriented), the results can be utilized as learning, determining the scale of problem-solving priorities, and monitoring and evaluation of failures or successful implementation of the program[6].

Providing enthusiasm, motivation and education to the staff was importantto always report every incident incident. It was intended that there will be an improvement to the incident, perhaps by replacing prevention with other plans. The previous results, staff research reported incidents that have been prevented but still occur because they contain important lessons[15]. Each incident should be reported, as it is an important lesson and also by reporting any incident can be done to improve the service system.

5) Engaging and Communicating with Patients

Steps involving and communicating with patients at RSUD Yogyakarta City have been running well and in accordance with the Minister of Health Regulations on the Safety of Hospital Patients. RSUD Yogyakarta city has already a policy that describes and regulates how to communicate with patients. In the event of an incident to the patient's family and the patient getting correct information about the incident occurring, with good communication with the patient's family, the patient's family response is good.

Patient and family training helped patients participate better in the care provided and got the information in making decisions about the care they received. RSUD Yogyakarta City always support and appreciate the involvement of patients and families when an incident occurs. Involving the family in the care of the patient will get better care and the family felt that they are properly noticed[3]. Priority notice to the family regarding the incidents occurring in patients is done by providing clear and correct information appropriately. So the priority of notification to the patient was very important because the patient was entitled to know his condition[20]. Effective communication was very important to do when informing and explaining the incidence occurring in patients to their families[15]. RSUD Yogyakarta Cityneeded to made effective communication which can be used as a method of giving empathy to family of patient with more assisting patient and communicate effectively will make patient and patient's family became comfortable to communicate with staff about the condition experienced by patient and tell its progress.

6) Learning and Sharing Experience About Patient Safety

The implementation of learning steps and experience sharing on patient safety in RSUD Yogyakarta City has been implemented and in accordance with the Minister of Health Regulation concerning Hospital Patient Safety. As the results of previous research have been done and have used the root analysis system problem, it means the management has tried to make a root cause analysis of each incident that happened, and has been able to investigate the incident occurred[15]. Discussion of the team's experience of the incident analysis results was conducted at the meeting, as well as commemorating

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other units about the incidents occurring in other units in order to prevent it will occur in other units. Problem-solving and self-discussed discussion forms already exist. As previous research results shared experiences were made during meetings, meanwhile hospital observation results have used a frame of reference on patient safety by analyzing the root of the problem using RCA[15].

7) Preventing Injury Through Patient Safety Implementation

Steps to prevent injury through the implementation of patient safety in RSUD Yogyakarta City has been running and in accordance with the Minister of Health Regulation on patient hospital safety. In determining the solution, RSUD Yogyakarta Cityused information obtained from the reporting system and risk assessment conducted on any planned changes. Installation of patient safety RSUD Yogyakarta City do unannounced inspections to see every change that has been done already or not. If any change is always done risk assessment, it was likely to minimize the risk that may occur to the changes made[15].

In terms of disseminating the solutions developed by the Hospital Patient Safety Committee conducted by training. The solution developed by the Patient Safety Committee was to conduct Root Cause Analysis (RCA) or root problem analysis which is a structured investigation aimed at identifying the cause of the underlying problem and to determine the action so that the same event did not reoccur. Meanwhile, in order to improve proactively hospital need to develop method of failure mode and effects analysis (FMEA)[6].

The feedback given to each installation and room is always provided in the form of monthly reports and assured acceptance of reports in the form of monthly report receipt. RSUD Yogyakarta City has provided feedback for each report which was reported, so that staff knew about any incidents that occurred in the hospital and how the treatment and the solution can prevent the incident that has happened did not happen again. Evaluation monitoring is important to keep patients safe. By providing quality services it is certain that hospitals make safe and good care for their patients[21].

5. CONCLUSION

The implementation of patient safety measured at RSUD Kota Yogyakarta City, six of the seven steps have been run in accordance with the Minister of Health Regulation on patient safety but still needed improvement in each step. However, in improving patient safety the management of RSUD Yogyakarta City is more active in setting up forums that address patient safety issues should be done routinely so that staff gain knowledge about patient safety issues and can prevent incidents that have occurred so as not to happen again.

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