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Analysis of Patient Safety Culture in Dental and Oral Health Services at RSGM Unimus

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A B S T R A C T

The Dental and Oral Hospital (RSGM) as a part of health care facilities, especially teeth and mouth, do not rule out unexpected events / near-injury events that have an impact on patient safety. The safety incidents at RSGM are only reported when an incident occurs. Solving this problem requires changing the culture of health care from one in which errors are viewed as the result of individual failure to one in which errors are viewed as opportunities to improve from one in which errors are viewed as the system. This study aims to determine the culture of patient safety in dental and oral health services at RSGM Unimus. This type of research is descriptive research with mixed methods research approaches, namely quantitative and qualitative. The study involved a sample of 65 respondents, where the study was conducted from March to April 2020. Quantitative data collection techniques used AHRQ (Agency for Healthcare Research and Quality instrument questionnaire) and qualitative through interviews. The results of the study show that in all dimensions of the AHRQ questionnaire, the highest positive response results are in the very good/strong category, which means that the level of patient safety at RSGM Unimus is already supportive. This study shows that the dissemination of patient safety has not been routinely carried out, errors in communication often occur, reporting only when unexpected incidents occur, and it is necessary to increase feedback between medical personnel and evaluation of intentional or accidental errors that is related to patient safety still needs to be improved.

Kata kunci:

Keselamatan pasien
AHRQ
Rumah sakit

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A B S T R A K

Rumah Sakit Gigi dan Mulut (RSGM) sebagai bagian dari sarana pelayanan kesehatan khususnya gigi dan mulut tidak menutup kemungkinan terjadinya kejadian yang tidak diharapkan/near injury event yang berdampak pada keselamatan pasien. Pelaporan terkait insiden keselamatan hanya di RSGM hanya dilakukan saat terjadi insiden. Masalah ini dapat dipecahkan dengan perubahan budaya keselamatan pasien dimana kesalahan seorang individu dipandang sebagai sebagai peluang untuk memperbaiki sistem. Penelitian ini bertujuan untuk mengetahui budaya keselamatan pasien dalam pelayanan kesehatan gigi dan mulut di RSGM Unimus. Jenis penelitian ini adalah penelitian deskriptif dengan pendekatan penelitian metode campuran, yaitu kuantitatif dan kualitatif. Penelitian ini melibatkan sampel sebanyak 65 responden, dimana penelitian dilakukan pada bulan Maret – April 2020. Teknik pengumpulan data kuantitatif menggunakan instrumen AHRQ (Agency for Healthcare Research and Quality instrument kuesioner) dan kualitatif melalui wawancara. Hasil penelitian menunjukkan bahwa pada semua dimensi

kuesioner AHRQ, hasil respon positif tertinggi berada pada kategori sangat baik/kuat yang artinya tingkat keselamatan pasien di RSGM Unimus sudah mendukung. Beberapa indikator yang masih perlu ditingkatkan adalah sosialisasi keselamatan pasien yang belum rutin dilakukan, kesalahan komunikasi yang sering terjadi, pelaporan hanya bila terjadi insiden yang tidak diharapkan, perlu peningkatan umpan balik antar tenaga medis dan evaluasi kesengajaan atau kesalahan kecelakaan yang berkaitan dengan keselamatan pasien masih perlu ditingkatkan.

INTRODUCTION

A hospital is an organization in which there is professional medical personnel who cover medical service facilities and infrastructure, continuous nursing care, to determine a diagnosis and treatment plan to treat a disease (Supartiningsih, 2017). The hospital aims to provide and serve the community with high-quality care and meet the needs and expectations of patients. Patient's assessment of service quality affects the image of the hospital (Ghahramanian, Rezaei, Abdullah zadeh , & Sheikh ali pour, 2017). The quality of service provided is inseparable from the principle of prioritizing patient safety. These efforts are implemented to minimize the occurrence of patient safety incidents, hospital management needs to build a patient safety culture to improve the quality and service of patients in the hospital. Patient safety is a system that makes patient care safer, including risk assessment, identification and management of patient risks, incident reporting and analysis, the ability to learn from incidents and their follow-up, and implementation of solutions to minimize risks and prevent injuries caused by mistakes of the result of taking an action or not taking the action that should have been taken (Permenkes, 2017).

The report on patient safety incidence in Indonesia states that out of 145 incidents, there were 68 Nearly Injury Incidents (47.6), 67 Unexpected Incidents (46.2%), and 9 other cases (6.2%) (Thisna, 2015). Patient safety incidents will be detrimental to parties including the hospital, staff, and patients as service users at the hospital (Diena, 2014). RSGM Unimus is a type C hospital this is used as a center for dental and oral health services that is already operational and open to the public, besides Unimus Dental and Oral Hospital is also used as an educational facility for Unimus dental faculty students. In the scope of RSGM Unimus, medical personnel comes from different understanding backgrounds and various institutions, therefore it does not rule out unexpected events / near-injury events that have an impact on patient safety in the hospital (Mulyati, Lia, & dkk, 2016).

The medical staff at RSGM come from different backgrounds and perceptions so that there is allow for unexpected events or near-injury events to occur that have an impact on patient safety in the hospital. The safety incidents at RSGM is only report when an incident occurs. Solving this problem requires changing the culture of health care from one in which errors are viewed as the result of individual failure to one in which errors are viewed as opportunities to improve from one in which errors are viewed as the system.

The purpose of this study was to analyze the culture of patient safety in dental and oral health services at RSGM Unimus. The analysis of safety culture was measured using the Hospital Survey on Patient Safety Culture issued by the AHRQ (*Agency for Healthcare Research and Quality*) (Thini, Maya, & Anang, 2019). Patient safety culture is measured from the perspective of hospital staff which consists of dimensions, among others: Cooperation related to patient safety programs within the work unit, expectations and actions of superiors in supporting patient safety, organizational learning and continuous improvement, management support for patient safety, overall staff perceptions related to patient safety, feedback and communication regarding errors, open communication, frequency of incident reporting, cooperation between units in the hospital; staffing, patient handover and transition, non-punitive response to errors (Thini, Maya, & Anang, 2019).

METHOD

This type of research is descriptive research, with a mixed-methods research approach. Mixed method research is a quantitative research method with descriptive research type and qualitative research methods with in-depth interviews and case studies. The variables of this study consist of : Cooperation related to patient safety programs within the work unit, expectations and actions of superiors in supporting patient safety, organizational learning and continuous improvement, management support for patient safety, overall staff perceptions related to patient safety, feedback and communication regarding errors, open communication, frequency of incident reporting, cooperation between units in the hospital; staffing, patient handover and transition, non-punitive response to errors. This study was conducted at RSGM Unimus in March - April 2020. This study has been declared ethical by KEPK with letter number No. 035 / EC / FK / 2020.

The population of this study was 181 medical staff at RSGM Unimus. The sample was collected by proportional random sampling. The sample in this study was 65 respondents consisting of 10 dentists, 48 young dentists, 7 medical staff. The data collection technique is done by filling out the questionnaire online using google forms. The qualitative methods conducting in-depth interviews with informants that collected by purposive sampling. The informant who will be interviewed is 10 people consisting of the Hospital Directors, the Patient Safety Team, the RSGM Patient Safety Executor. The instrument of this study was generate by the guidance of AHRQ Hospital Survey on Patient Safety Culture. The results was presented by calculate the frequency of response for each survey item. AHRQ has established the Hospital Survey on Patient Safety Culture Comparative Database. This database is a central repository for survey data from hospitals that have administered the AHRQ patient safety culture survey instrument.

The data analyse base on the AHQR instruments. The data was analyzed based on the AHQR instruments. The safety culture assessment is said to be strong if the positive response is equal to 75%, and it is moderate if the positive response is equal to 50-70%, and said to be weak if the positive response is less than 50%.

RESULTS AND DISCUSSION

The results of research on patient safety culture in dental and oral health services were conducted at RSGM Unimus on 65 respondents by filling out the AHRQ questionnaire via google forms.

Table 1.
Data on the results of filling out the questionnaire on all dimensions of the AHRQ questionnaire

No	Dimensions	Response Positive	Response Negative	amount Response	Percentage Response Positive	Category Culture
1.	Internal cooperation assessment (within the work unit)	975	131	1.165	88,2%	Strong / very good
2.	Assessment of managers / supervisors	236	24	260	90.76%	Strong / very good
3.	Assessment of communication in the work unit	351	39	390	90%	Strong / very good
4.	The frequency of reports of unexpected actions / events	161	34	195	82.56%	Strong / very good
5.	Assessment of the level of safety patient	60	5	65	92.30%	Strong / very good
6.	Assessment of the overall hospital management	625	90	715	87.41%	Strong / very good
	Total	2.408	323	2.790	Strong / very good	
	Percentage	86.30%	11.57%	100%		

Based on table 1. Data on the results of filling out the questionnaire on all dimensions of the AHRQ questionnaire, the highest positive response results are in the dimension of assessment of the patient's safety level (92.30%) which is included in the very good/strong category, which means that the level of patient safety at RSGM Unimus has supported. In the indicator of reports of errors in action / unexpected events, it is expected to have the lowest positive response (82.56%) it can be categorized as very good/strong but still needs to be improved reports of errors in action at RSGM Unimus. It can be concluded that the implementation of safety culture in RSGM Unimus is in the strong or very good category with a percentage of 86.30%.

In addition to filling out the questionnaire, the research results were also in the form of in-depth interviews with 7 respondents at RSGM Unimus. Which consists of 10 questions.

Tabel 2.
Result of in-depth interviews related to patient safety culture at RSGM Unimus

No	Question	Answer
1.	*"Has patient safety at Unimus Dental Hospital been going well?"*	According to dentists, it has been going well, according to young dentists so far it has been good, according to the medical staff the patient safety is quite good. Overall, the medical staff thought that patient safety at the Unimus Dental Hospital was going well.
2.	*"Are there frequent socialization related to patient safety at RSGM Unimus?"*	According to dentists, there has been socialization but not often (sometimes), according to young dentists, there has been socialization about patient safety but the intensity is rare, according to medical staff, socialization is not often carried out for socialization once every 6 months. Overall, medical personnel thinks that socialization related to patient safety at RSGM Unimus has been carried out but for the intensity it is rare.
3.	*"In the work unit, do medical personnel at the Dental Hospital of Unimus cooperate well and treat their colleagues well?"*	According to the dentist, all work units work well together, according to the young dentist, all units have worked well together, but sometimes communication errors (miscommunication) still occur, according to the medical staff, they are working well together. Overall, medical personnel thinks that the cooperation at the Unimus Dental Hospital has been carried out well between work units.
4.	*"Does the manager / supervisor (supervisor) give praise when the job is well done or pay attention to patient safety procedures?"*	According to young dentists and dentists, managers/supervisors have given praise and have not given praise when a job is done well. According to the medical staff, the manager/supervisor has given praise when a job is done well.
5.	*"In carrying out their duties, every medical staff at the Dental Hospital of Unimus has the same right to ask questions about matters related to patient safety?"*	According to young dentists and dentists, every medical staff has the same rights, according to the medical staff, the admin of RSGM Unimus has the same right to ask questions about matters related to patient safety.
6.	*" Is reporting of patient safety incidents routine? both unexpected events that happened and those that did not happen?"*	According to the dentist, routine reporting is done once a month, quarterly. According to the young dentist, the reporting has been done to prioritize patient safety, according to the medical staff, the reporting has been done but only when an incident is not expected to occur.

No	Question	Answer
7.	*"Does RSGM Unimus create a work climate that is oriented towards patient safety?"*	According to dentists, it is patient safety-oriented, according to young dentists, the work system at the Dental Hospital of Unimus certainly prioritizes patient safety because patient safety is the most important thing, according to medical staff in working to provide patient safety-oriented services. As a whole, medical personnel thinks that RSGM Unimus creates a working climate that is oriented towards patient safety.
8.	*"Do errors often occur in the implementation of informing and recording medical records that will affect patient safety at RSGM Unimus?"*	According to dentists, we hope that there will be no negative or undesirable things to patient safety. According to the young dentist, some think it has never happened and has happened before but not often, according to the medical staff none. Overall, the medical staff believes that the implementation of information and recording of medical records related to the safety of patients at the Unimus Dental Hospital is going well.
9.	*"Is the feedback between medical personnel going well at RSGM Unimus?"*	According to the dentist, feedback is going well. According to young dentists, some of the feedback was going well and some were not going well. According to the medical staff, it was running quite well. Overall, feedback has been carried out by the medical staff at the Unimus Dental Hospital at Unimus Dental Hospital but they still need to be improved.
10.	*"Is an evaluation carried out when there is an intentional or unintentional error related to patient safety at RSGM Unimus? "*	According to the dentist, an evaluation has been carried out, according to a young dentist, the evaluation has been carried out but the intensity is still rare, even though there is still much to be evaluated, according to the medical staff an evaluation has been carried out by the superiors. Overall, medical personnel thinks that an evaluation of intentional or unintentional errors related to patient safety has been carried out but still needs to be improved.

The results of in-depth interviews were conducted with 7 respondents are in table 2. The results of in-depth interviews related to patient safety culture at RSGM Unimus, it is known that overall, the application of patient safety at RSGM Unimus is good. Some indicators that still need to be improved are the dissemination of patient safety that has not been routinely carried out, errors in communication that often occur, reporting only when unexpected incidents occur, it is necessary to increase feedback between medical personnel and evaluation of intentional or accidental errors that is related to patient safety still needs to be improved.

DISCUSSION

Hospital patient safety is a system where the hospital makes patient care safer (Iskandar, 2017). The purpose of creating patient safety is to improve hospital accountability, create a patient safety culture, take precautions so that unwanted things do not happen again (Lestari & Qurratul, 2012). RSGM Unimus as a health service facility and used as a means of education for Unimus dental faculty students are inseparable from the application of safety culture.

This safety culture can be measured or identified through a survey that is used in the quantitative patient safety assessment. The survey used the Hospital Survey on Patient Safety Culture questionnaire instrument issued by AHRQ (Agency for Healthcare Research and Quality). Patient safety culture is measured from the perspective of medical personnel and hospital staff (Thini, Maya, & Anang, 2019). The AHRQ questionnaire instrument is designed for all hospital staff, both medical and non-medical personnel and can be used at the unit, department or hospital organization level, the patient safety assessment is reliable and valid because the survey development is used carefully and thoroughly, is comprehensive and specific. and provides detailed information that can help identify patient safety, and is easy to use (Diena, 2014).

Based on the results of research on the application of safety culture in RSGM Unimus in the strong or very good category (88,2%). **The aspect of Internal cooperation assessment** was demonstrated that all medical staff in work units was support each other and work very well. Then according to indepth interview, show that the work system at the Dental Hospital of Unimus certainly prioritizes patient safety because patient safety is the most important thing. As a whole, medical personnel thinks that RSGM Unimus creates a working climate that is oriented towards patient safety.

Patient safety culture is the result of individual or group attitudes, perceptions, competencies and behaviors that explain the commitment to health and safety management in the hospital. A patient safety system must be built within a culture that does not blame, but rather solves problems for correction and introspection to avoid the same mistakes (Thini, Maya, & Anang, 2019).

Based on the study was demonstrated that **assessment of managers / supervisors** in the strong or very good category (90,76%). Based on qualitative results, showed that managers/supervisors have given praise and have not given praise when a job is done well to young dentists and dentists. According to the medical staff, the manager/supervisor has given praise when a job is done well.

The realization of a good patient safety culture at RSGM Unimus is inseparable from the good participation of various parties ranging from leaders to human resources. Hospital management creates a work climate that is oriented towards patient safety, between units within the hospital must be well-coordinated and work together, prioritizing patient safety in every action, changing the shift does not cause problems for patients in the hospital. Supervise in the form of supervision from the supervisor / leadership in question is the head of the hospital unit, leadership plays an important role in the implementation of effective safety management. When managers / supervisors prioritize patient safety, there is a decrease in the number of medical errors (Apriliani, 2015).

The managers or supervisors must leading a change effort must engage and educate about the relevance and content of a proposed practice, execute change to implement the practice, and then evaluate whether the change made a difference.(Katherine, 2008).

This study was demonstrated that **assessment of communication in the work unit** in the strong or very good

category (90%). Based on qualitative results, showed that sometimes communication errors (miscommunication) still occurred. The socialization about patient safety was carried out in every 6 months. The medical personnel said that the socialization related to patient safety at RSGM Unimus has been carried out but for the intensity it is rare.

Some things that still need to be improved in the implementation of safety culture at the Unimus Dental Hospital, namely socialization activities regarding patient safety that have not been routinely carried out. The importance of socialization or training related to patient safety must be carried out regularly because the knowledge about patient safety is knowledge that health workers acquire through formal or non-formal education, which can be in the form of training and courses (Lany, 2015). Socialization greatly affects knowledge about handling and progress regarding patient safety at the hospital. One of the efforts made to reduce the impact of patient safety incidents is by conducting socialization / training related to patient safety[14]. Therefore, RSGM Unimus needs to conduct socialization regularly.

These results are consistent with the view that organizations contain microcultures that are influenced by the flow of information that is controlled by leaders. These results also demonstrate the influence of differences in safety culture training within health care professions

In addition to the existence of communication supervision measures are an important part of creating a safety culture. In RSGM Unimus for effective communication, there are still errors in communicating, increasing feedback between medical personnel still needs to be improved. In the scope of health-related to patient safety, communication must occur in two directions so that there is no mistake in receiving or conveying information that can have fatal consequences for patient safety (Diena, 2014). Effective communication is one of the supporters of patient safety that can improve patient safety and minimize errors in administering treatment plans, actions, and medications (Fatimah , 2014). This communication also involves feedback between the two parties. Feedback regarding changes regarding mistakes that have occurred and has the same right to ask questions or have an opinion without being differentiated, meaning that communication at the Unimus Dental Hospital has supported patient safety with two-way communication. In the implementation of communication, it shows that there is an inability to speak in matters that have the potential to injure patients and have the right to question these matters to their superiors (Lany, 2015).

Based on other study, was demonstrated that 21 of the Nation's smallest hospitals can make improvementsin safety culture by implementing practices that support all components of an informed, safe culture. These practices must include a voluntary error reporting system that uses a standardized taxonomy to support a reporting culture; Reason's algorithm for determining the blameworthiness of unsafe acts to support concept of a just culture; teamwork training that emphasizes the knowledge, skills, and beliefs necessary to function as a team within and across departments to support a flexible culture; and multiple approaches to communicate about and learn from errors (e.g., Leadership WalkRounds™, safety briefings at the unit/department level, aggregate RCA of nonharmful errors, and individual RCA of harmful errors) to support a learning culture.(Katherine, 2008).

This study was demonstrated that **the frequency of reports of unexpected actions or events** in the strong or very good category (82,56%). It means that the frequency of reports of unexpected actions was low rated than the other aspects of AHQR dimensions. Evaluation of intentional or unintentional errors related to patient safety at RSGM Unimus also still needs to be improved. RSGM Unimus has evaluated matters related to patient safety. This evaluation is carried out for that to improve patient safety the evaluation of each action must be improved. Mistakes that will cause harm to patients can be handled and resolved properly. Based on qualitative results, the reporting of unexpected incidence has been done when it occured.

The impact of providing a structured reporting system as the foundation of an informed, safe culture. The use of a structured reporting system provides a common language that hospital personnel can use to understand errors in the context of the interdependent structures and processes that make up their systems (Katherine, 2008).

The Patient safety culture in implementing is not easy, it has to do with building awareness of patient safety, leading and supporting staff in the application of patient safety is important in improving patient safety (Athifah, Pasinringi, & Kapalawi, 2014). Efforts to improve patient safety that must be done are to support each other when there is work that must be completed quickly and does not ignore procedures that should be done or do not take shortcuts that are not appropriate for the procedure because this can affect patient safety (Athifah, Pasinringi, & Kapalawi, 2014).

Improvements need to be made for the application of safety culture at RSGM Unimus, namely reporting related patient safety incidents. The reporting done at RSGM Unimus is only when an unexpected incident occurs. The same thing often happens that nurses and doctors often do not report medical errors that occur due to the absence of feedback from the reporting activities carried out (Lany, 2015). This culture needs to be changed and improved so that reporting related to patient safety is better monitored. The frequency of incident reports is not expected to be needed to prevent recurring errors that can have a negative impact on patients, be they errors that have the potential to harm or do not harm the patient.

This study was demonstrated that **the assessment of the level of safety patient** in the strong or very good category (92,30%). It is the highest rated than the other AHQR aspects. The qualitative results was demonstrated that patient safety at the Unimus Dental Hospital was quite good. The Medical staff said that the work system at the Dental Hospital of Unimus certainly prioritizes patient safety because patient safety is the most important thing. The medical personnel said that RSGM Unimus creates a working climate that is oriented towards patient safety.

Then, **the Assessment of the overall hospital management** was rated in the strong or very good category (87,41%). The qualitative results was demonstrated that an evaluation of intentional or unintentional errors related to patient safety has been carried out but still needs to be improved.

The directors of nursing and quality improvement must engineer these interactions whileoften continuing to provide care at the bedside. Consequently, they require support from their senior leaders and education and tools from network hospitals, quality improvement organizations, and other organizations that advocate for rural hospitals. This study exemplifies the type of field-based, mixed-methods research that is necessary to understand how patient safety interventions can change the beliefs and practices that define an organization's safety culture. (Katherine, 2008).

CONCLUSIONS AND SUGGESTIONS

The overall safety culture at RSGM Unimus has been good in implementation. In providing services, RSGM Unimus has been oriented to prioritizing a work climate with a culture of patient safety. The weakness that exists in the application of safety culture at the Unimus Dental Hospital is that reporting related to safety incidents is only done when an unexpected incident occurs. Therefore, it is necessary to increase the reporting of incidents more regularly, not only when unexpected incidents occur. This Study show that the dissemination of patient safety has not been routinely carried out, errors in communication that often occur, reporting only when unexpected incidents occur, and it is necessary to increase feedback between medical personnel and evaluation of intentional or accidental errors that is related to patient safety still needs to be improved. It is necessary to understand how patient safety interventions can change the beliefs and practices that define an organization's safety culture.

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Technical assistance and advice can be described at the end of the text. Then the names of individuals that are included in this section, the author is responsible for the written consent of every person who communicates personally or recognized by the individual in the text.

Conflict of Interest Statement

The authors declare that there is no potential conflict of interest in connection with the writing and publication of this article.

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