



Analysis of the Implementation of Patient Safety Targets by Nurses in Installations in Regional General Hospital dr. Fauziah Bireuen

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Abstract

Patient safety in a hospital is a service system in a hospital that provides safer patient care, including measuring risk, identifying and managing risks to patients, analyzing incidents, the ability to learn and follow up on incidents and implement solutions to reduce risks. This study aims to describe the implementation of patient safety goals by nurses on the quality of service in the inpatient room at RSUD dr. Fauziah Bireuen. This research is a qualitative research that will take place from November to December 2021. The research informants are the director of the hospital and 2 quality committee members at RSUD dr. Fauziah Bireuen, 7 nurses, 3 patients who are being hospitalized at RSUD dr. Fauziah Bireuen. The research instrument is interviews. The results of the research on the management of patient safety at the dr. General Hospital. Fauziah Bireuen has been implemented based on the Regulation of the Ministry of Health of the Republic of Indonesia in 2015 concerning the National Guidelines for Hospital Patient Safety and the Hospital Accreditation Commission. So that the results of this study can be used as input for making training programs for nurses related to patient safety.

Introduction

Patient safety according to the Regulation of the Minister of Health of the Republic of Indonesia No. 11 of 2017 is a system that makes patient care safer. Patient safety includes risk assessment, identification and management of matters related to patient risk, 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 errors resulting from carrying out an action or not taking action. action that should be taken. Patient safety regulation aims to improve the quality of health care facility services through the application of risk management in all aspects of services provided by health care facilities (Destiani, 2021).

The hospital as one of the health service institutions has autonomy, so that the hospital is required to provide the best service with the most effective management possible. This is due to any improper decision making will result in efficiency and decrease in hospital performance. The success and success of a hospital is largely determined by the quality of service.

Patient safety in a hospital is a service system in a hospital that provides safer patient care, including measuring risk, identifying and managing risks to patients, analyzing incidents, the ability to learn and follow up on incidents and implement solutions to reduce risks (Faluzi et al., 2018).

The strategy for implementing patient safety has been carried out with various efforts in the hospital environment. The Hospital Accreditation Commission explained that the implementation of patient safety must meet the accuracy of patient identification, increased effective communication, increased safety of drugs that need to be watched out, certainty of right-location, right-procedure, right-patient surgery, reduced risk of infection related to health services and risk reduction. patient falls (Haerkens et al., 2016).

Patient safety is currently the spirit in hospital services around the world. According to the Joint Commission International, there are six targets for implementing patient safety, namely the accuracy of patient identification, increasing effective communication, increasing drug safety that needs to be watched out for, ensuring the right location, right procedure, right patient surgery, reducing the risk of infection related to health services and reducing risk. patient falls (Halawa et al., 2021).

Based on data from the World Health Organization in 2018, several studies in measuring patient safety reporting at several hospitals in the world that have been accredited by JCI indicate that there are still many incidents that occur regarding patient safety.

Based on KKPRS data from September 2003-2017 regarding patient safety by type of incident, it was found that there were 249 reports of KTD (Unwanted Events), as many as 283 reports of KNC (Near Injury Events). Based on the causative unit; A total of 207 nursing reports, 80 pharmaceutical reports, 41 laboratory reports, 33 doctors reports and 25 reports of infrastructure.

Patient identification is an action taken before carrying out nursing actions or other procedures, administering drugs, transfusions or blood products, taking blood and taking other specimens for clinical testing. The steps in identifying the initial patient are by asking the date of birth, the patient's name, medical record number and checking the identification bracelet which is then adjusted to the patient data that has been recorded in the medical record. Room or bed numbers cannot be used to identify patients.

Effective communication is the most important key goal to achieve patient safety in hospitals. Most of the causes of sentinel events in patients occur due to inaccurate information caused by communication that is not carried out effectively. According to research by Lombogia et al (2016), it is stated that incidents of violations in the implementation of patient safety are mostly carried out by nurses because nurses are health workers with the most dominating number in hospital institutions, and nurses are also health workers who often take action and interact directly with patients, especially inpatients. The impact that occurs due to hospitals not implementing patient safety is a decrease in the quality of hospital services (Hia, 2019).

Nurses play a very important role to improve patient safety because of their inherent closeness to patients (Neri et al., 2018). This position provides nurses with the insight they need to identify problems in the health system and be part of the patient safety solution. Nurses must be supported and encouraged without fear of punishment, and have an understanding of how organizational culture change can be achieved (Purba, 2019).

To prevent injury to patients, nurses are required to have adequate knowledge and skills about patient safety. Nurses must know (1) the accuracy of patient identification (2) know effective communication (3) increase awareness of drugs that need to be watched out (4) know the right location, right procedure, right patient operation 5) prevention of infection due to action (6) and knowledge of patients at risk of falling. With training or seminars on patient safety knowledge, it is hoped that nurses will be able to increase knowledge, so nurses are able to carry out nursing care well and patient accidents can be prevented as early as possible.

Based on the initial survey data conducted at RSUD dr. Fauziah Bireuen in terms of medical services, it is known that most of the medical service indicator items have not met the ideal

standard. Judging from the Bed Occupancy Ratio (BOR) in 2020 it is 50%, this 50% figure is not included in the ideal range of BOR for type B hospitals, which is 60-85%. The Average Length of Stay (ALOS) indicator in 2020 is 4 days. This number is lower than the parameter value set, which is 6-9 days.

Judging from the Turn Over Interval (TOI) in 2020 is 5 days. The TOI value in 2020 has exceeded the ideal parameter, which is in the range of 1-3 days. Bed Turn Over (BTO) in 2020 is 38 times. Ideally in one year, an average bed is used 40-50 times. This shows that the BTO RSUD dr. Fauziah Bireuen has met the ideal parameters. The Gross Death Rate (GDR) in 2020 is 56.3‰. This GDR figure has increased compared to 2019 of 38‰ and 2018 of 26‰. This shows that the services at RSUD dr. Fauziah Bireuen experienced a significant increase when compared to the GDR standard which was set at 45‰. The Net Death Rate (NDR) in 2020 is 19.2‰. The NDR figure has increased compared to 2019 of 17‰ and 2018 of 14‰. This shows that the services of RSUD dr. Fauziah Bireuen in terms of NDR has increased, although the NDR figure is still in the ideal range of 25‰.

The number of inpatients in 2020 as many as 9,731 also decreased compared to 2019 as many as 13,959 people and in 2018 as many as 16,287 people. The number of maternal deaths in 2020 is 5 people. This has decreased compared to 2019 as many as 8 people and in 2018 as many as 7 people. The number of beds in 2020 is 263 beds. This has decreased compared to 2019 as many as 319 beds and in 2018 as many as 343 beds. The provision of class III beds has exceeded the requirements set for class B hospitals, which is 30% of the total number of beds. Meanwhile, the provision of intensive care beds has not yet reached 5% of the total number of beds.

Then the researchers also conducted a survey in the inpatient room of dr. Fauziah Bireuen, it is known that there are still many data on the Patient Safety Target Indicators for 2020 that have not been achieved, including the achievement of the DPJP compliance indicator to sign the TBAK confirmation stamp (Write, Read and Confirm) not reaching the target and only reaching 78.9%, the storage security indicator and the labeling of high alert drugs by the pharmacy only reached 81.5%, the Compliance indicator of Health workers in carrying out hand hygiene with the 6 (six) steps and 5 (five) moments method only reached 73.1, the indicator of compliance with wearing a fall risk bracelet only reached figure 89%. If one of the indicators is not met, it can endanger patient safety. As for the types of patient safety incidents, from January 2020 to April 2021, there were 261 near misses (KNC), 36 cases, and 3 cases of potential injury (KPC).

Based on an interview with the head of the inpatient room at RSUD dr. Fauziah Bireuen concerned, it is known that training and seminars on patient safety for the head of the room, deputy head of the room, katim and several implementing nurses have attended both training and seminars on patient safety, the implementation of patient safety has been carried out by nurses even though there are several patient safety goals which has not been optimally implemented. Like the incidence of falling patients, it often occurs in low-risk people. Patients who are at low risk are considered to be less likely to fall, so they are not given socialization about the risk of falling as is given to patients at high risk of falling. In fact, the realization of patient safety in hospitals requires good involvement and communication with patients and building awareness of the value of patient safety in accordance with the tasks assigned. Therefore, patient safety management in RSUD dr. There is a possibility that Fauziah Bireuen is still not optimal. Then one incident of inaccuracy in drug administration, and inaccuracy in giving intravenous fluids according to indications but the incidence is not known with certainty due to incomplete reporting.

The results of the initial interview with the Nursing committee about implementation of patient safety goals that have decreased considerably Significantly caused by errors or omissions of nurses and other health workers, lack of control and support from management.

Based on interviews conducted by researchers to nurses, of the 5 people interviewed, 2 people said there were carrying out proper hand washing, namely by washing hands according to the standards set by WHO, and there were washing hands every 5 moments (Yusuf, 2017). 3 out of 5 people said they did not wash their hands according to the 5 steps and also every 5 moments due to incomplete hand washing facilities. However, there are nurses who do not perform hand hygiene, resulting in nosocomial infections such as bloodstream infections, pneumonia, urinary tract infections (UTI), and surgical wound infections (Thrisia, 2018).

The importance of patient safety goals being implemented is to promote certain improvements in patient safety, which highlighting problematic areas in health care, providing evidence and consensus-driven solutions based on expert advice (Valencia, 2017). Taking into account that providing safe and high-quality healthcare requires good system design, the goal is usually to focus on solutions that apply to the entire system as much as possible. Patient safety and high quality of health services are also the final goals expected by hospitals, managers, teams of health service providers, health insurance parties, as well as patients, families and communities.

Methods

This study uses a descriptive qualitative method, which examines objects that reveal the phenomena that exist contextually through the collection of data obtained, by looking at the elements as a unit of interrelated study objects and then describing them. The phenomenon can be in the form of forms, activities, characteristics, changes and differences between one phenomenon and another.

Results and Discussion

Results of Interviews with Key Informants “Patient Safety Committee”

The results of interviews with the patient safety committee were interpreted based on the following three questions:

Question 1 "how is the management of patient safety in this RSU?"

Patient Safety Committee: *“The first implementation of patient safety in this hospital is referring to the Ministry of Health of the Republic of Indonesia in 2015 concerning the National Guidelines for Hospital Patient Safety. The second refers to the Hospital Accreditation Commission. Well... this hospital has an organizational structure, especially patient safety, which is chaired by myself. The implementation of patient safety is a team work, yes... it cannot be done by one person, one group, so what I mean is that the implementation is carried out by all elements of health workers, including nurses, doctors, pharmacists, and nutritionists. Indeed, in day-to-day practice, nurses are the spearheads, yes, you know that nurses are near patients 24 hours a day.”*

Based on the results of the interviews above, it can be concluded that the management of the implementation of patient safety at the dr. Fauziah Bireuen has been implemented based on the Regulation of the Ministry of Health of the Republic of Indonesia in 2015 concerning the National Guidelines for Hospital Patient Safety and the Hospital Accreditation Commission.

Question 2 "Who is responsible for monitoring and evaluating the implementation of patient safety by nurses in this hospital?"

Patient Safety Committee: *“The one who is responsible for monitoring and evaluating the implementation of patient safety is management, as one of the tasks of management is to carry out monitoring and evaluation of each work program. However, in terms of*

patient safety, eee... y is the patient safety committee who is fully in charge of conducting money. This money is carried out periodically or continuously. What we apply here is that every month we go down to the room to observe how it is implemented to patients, then we also check how the documentation of its implementation is. Now, from the results, we evaluate eee... how far has this patient safety been achieved."

Based on the results of the interviews above, it can be concluded that those who are responsible for monitoring and evaluating the implementation of patient safety by nurses at the Regional General Hospital, dr. Fauziah Bireuen is the Patient Safety Committee.

Question 3 "What are the most common incidents related to patient safety in this RSU?"

Patient Safety Committee: "Hmm... an incident... an incident where the patient fell when he wanted to go to the bathroom, an error in giving the medication, the mistake I meant was that patient A's medication was given to patient B, indeed it wasn't until the patient was injured. So, these two things often happen in the room."

Based on the results of the interviews above, it can be concluded that, incidents that often occur are related to patient safety at the dr. Fauziah Bireuen is a patient who fell and gave the wrong medicine.

Results of Interviews with the Main " Room Nurse"

The results of interviews with seven ward nurses were interpreted based on the following five questions:

Question 1 "How is patient safety in the room?"

"The implementation of patient safety is going well, it's just that in its implementation it must involve patients. well... sometimes it's the patient who makes the implementation of patient safety... sometimes it doesn't work out well. This is it, sir... later on, we will limit the activities of the patients, so that if you use the bedpan to defecate, eh... the patient will come down and fall."

Based on the results of the interviews above, it can be concluded that the implementation of patient safety in the dr. Fauziah Bireuen has been carried out according to the procedure, but sometimes in its implementation involving patients experiencing problems.

Question 2 "What incidents have occurred in the room related to patient safety?"

"The incident that happened in the most recent room... the patient fell, but this is actually not our fault, sir, because we have previously informed the patient and his family that the patient is not allowed to get out of bed. We also convey that when urinating is done in bed using a bedpan, we have provided the bedpan in the bathroom and we have one in every patient's bathroom, sir."

Based on the results of the interviews above, it can be concluded that the incidents that have occurred in the room are related to patient safety in the dr. Fauziah Bireuen is a patient who fell when he wanted to go to the bathroom and the nurse was wrong when giving medicine to the patient.

Question 3 "what is being done to prevent incidents related to patient safety?"

"To prevent errors in surgery, a marking is carried out at the surgery site, ensuring the name of the patient who wants to be operated on by directly asking the patient the name of the date of birth and if the patient is not communicative, the nurse asks the question to the patient's family."

Based on the results of the interviews above, it can be concluded that what was done to prevent incidents related to patient safety in the dr. Fauziah Bireuen include: identifying patients clearly

by looking at identity bracelets, implementing effective communication such as spelling drug names using the alphabet method, marking the surgical area, washing hands at five moments, installing bed bars, locking bed wheels, ensuring adequate support.

Question 4 “what are the obstacles in implementing patient safety?”

“I think the obstacles we have experienced so far are... the patients themselves, many patients do not want to listen to the advice we convey even though it is for their own good, sir, if I say the patient and his family are a bit stubborn. For example, we advise the patient not to get out of bed eh... instead he gets down and as a result he falls”.

Based on the results of the interviews above, it can be concluded that the constraint factors in implementing patient safety in the dr. Fauziah Bireuen paieen was neither cooperative nor willing to listen to the advice given by the nurse.

Question 5 “what are the supporting factors in implementing patient safety?”

“What is supporting is that this hospital has been accredited and this safety goal has been implemented, management always searches the room so we are always reminded directly, fellow nurses work together so that there are no fatal things in carrying out tasks in the room”.

Based on the results of the interviews above, it can be concluded that the supporting factors in implementing patient safety in the dr. Fauziah Bireuen includes monitoring and evaluation from management, good cooperation between nurses, and good cooperation with other health workers.

Results of Interviews with Supporting Informants “Patients”

The results of interviews with three patients were interpreted based on the following four questions:

Question 1 “Did the nurse give you the patient bracelet in the Inpatient Room at RSUD dr. Fauziah Bireuen in your opinion?”

Informant 2: “I was given a bracelet, sir, now this is the bracelet in my hand, I put it on when I first entered, sir, so-and-so, sir... the identity bracelet, the nurse said and what else... oh... yes, you can't take it off while you're in this hospital unless you're in the hospital. if you want to go home sir.”

Based on the results of the interviews above, it can be concluded that the installation of patient bracelets in the Inpatient Room at RSUD dr. Fauziah Bireuen was carried out at the beginning of the first time the patient entered the hospital in the emergency room, the nurse had not carried out routine observations of the patient so that there were still patients whose identity bracelets were removed and two days later they were put back on by the nurses.

Question 2 “did the nurse explain the purpose of the bracelet to you?”

“The nurse said...the purpose of the identification bracelet is to find out the patient's personal data eee...name and date of birth”.

Based on the results of the interviews above, it can be concluded that the nurses in the Inpatient Room at RSUD dr. Fauziah Bireuen the nurse has explained the purpose of the bracelet installation to the patient.

Question 3 “did the nurse check your ID bracelet before taking action?”

“Yes, sir, if you inject the nurse, the nurse sees my bracelet, sir, maybe you see my name, that's often the case, sir... basically every time they inject it, sir”.

Based on the results of the interviews above, it can be concluded that the nurses in the Inpatient Room at RSUD dr. Fauziah Bireuen checks your ID bracelet before taking action.

Question 4 “Does the nurse always put bars on your bed?”

"Yes, it's always installed, sir, if later the bar is lowered by my family and forgets to put it back on and suddenly the nurse comes in, eee... it's immediately installed by the nurse, sir".

Based on the results of the interviews above, it can be concluded that the nurses in the Inpatient Room at RSUD dr. Fauziah Bireuen always puts up the bars on the patient's bed and sometimes the patient lowers the bars on the bed.

Observation Results

The results of observations that have been made on the implementation of the six patient safety goals can be seen in the following table:

Table 1. Results of Observations on the Implementation of Six Patient Safety Goals in the Inpatient Installation of RSUD dr. Fauziah Bireuen

Statement	Yes	No
Target Patient Identification		
a. Patients are identified using two patient identities (patient's name according to the patient's identification and date of birth), may not use the patient's room number or location	√	
b. The patient is identified at the time of administration of the drug, blood or blood product	√	
c. The patient is identified at the time of taking blood and other specimens for examination	√	
d. The patient is identified at the time of administering the treatment or performing the procedure	√	
Effective Communication Goals		
a. Verbal orders by telephone or the results of the examination are written in full by the recipient of the order	√	
b. Verbal orders or by telephone are read back by the recipient of the order	√	
c. Verbal orders or examination results confirmed by the recipient of the order	√	
Targets to Improve Drug Safety What to Look Out for		
a. Store high-alert drugs in a separate place	√	
b. Store concentrated electrolytes in a separate place	√	
c. Concentrated electrolytes are not in the patient care unit unless needed	√	
d. Concentrated electrolytes stored in patient care units are clearly labeled and stored in a strictly restricted area	√	
The target of the implementation of the process is the right location, the right procedure, the right patient who undergoes the procedure		
a. Before the patient enters the sterile area of the operating room, verification is carried out first in the patient reception room	√	
b. Provide clear markings for operation identification	√	

Target of Reducing the Risk of Infection Related to Health Services		
a. Wash hands before taking action		√
b. Wash hands before contact with patients		√
c. Wash hands after disposing of containers of sputum, secretions or blood	√	
d. Wash hands before handling equipment on patients such as infusion sets, catheters, urine drain bags, minor operations		√
e. Washing hands after touching the area around the patient		
f. Wash your hands with the right hand washing steps	√	
Goal of Reducing Injury Risk Due to Patient Falls		
a. Perform an initial assessment of the patient's risk of falling	√	
Statement	Yes	Not
Patient Identification Goals		
e. The patient is identified using two patient identities (the patient's name corresponds to the patient's id and date of birth), should not use the patient's room number or location	√	
f. The patient is identified at the time of administration of the drug, blood or blood products	√	
g. Patients are identified at the time of blood draw and other specimens for examination	√	
h. The patient is identified during the administration of treatment or carrying out actions	√	
Objectives of Effective Communication		
a. Oral commands by telephone or examination results are written in full by the commandee	√	
b. Oral or telephone commands are read back by the commandee	√	
c. Oral commands or examination results confirmed by the commandee	√	
Goals to Improve the Safety of Drugs To Watch Out For		
a. Storing High-alert Drugs in a separate place	√	
b. Storing the concentrate electrolyte in a separate place	√	
c. Electrolyte Concentrate is not in the patient care unit unless needed	√	
d. Concentrated electrolytes stored in patient care units are clearly labeled and stored in strictly restricted areas	√	
The Target of Implementing the Process on Location, Right Procedure, Right Patient Who Undergoes the Procedure		
c. Before the patient enters the sterile area of the operating room, verification is carried out first in the patient's reception room	√	
d. Provide clear marks for operation identification	√	
Target of Reducing the Risk of Infections Related to Health Services		
a. Wash your hands before performing the action		√
b. Washing hands before contact with the patient		√
c. Washing hands after disposing of sputum containers, secrets or blood	√	

d. Washing hands before handling utensils in patients such as infusion sets, catheters, urinary drain sacs, small operative actions		√
e. Washing hands after handling the area around the patient		
f. Wash your hands with the right handwashing steps	√	
Goal of Reducing the Risk of Injury Due to Falling Patients		
a. Conducting an initial assessment of the patient's risk of falling	√	
b. Implement measures to reduce the risk of falling for those whose assessment results are considered at risk	√	

Based on the table above, it is known that the suggestions are to identify patients correctly, the goals are to improve effective communication, the targets are to increase the safety of drugs that must be watched out for, the targets are to implement the process at the right location, the right procedure, the right patient undergoing the procedure, and the goal is to reduce the risk of injury. because the patient fell has been carried out properly by the nurse. However, the target of reducing the risk of infection related to health services has not been carried out optimally where nurses do not wash their hands before taking action, do not wash hands before contact with patients and do not wash hands before handling equipment on patients such as infusion sets, catheters, urine drain bags.

Implementation of Patient Identification

Patient identification is an identification system for patients to distinguish between one patient and another so as to facilitate or facilitate the provision of services to patients. The accuracy of patient identification is important, even related to patient safety. In cases of patient identification errors, it is not only the patients who are harmed because they experience a threat to patient safety, nurses also bear the impact in the form of accusations of malpractice which of course creates its own pressure. Not to mention if the matter goes into the realm of law, the reputation of the hospital is at stake. Because of this importance, in the National Hospital Accreditation Standard (SNARS), hospitals are required to establish regulations to ensure the accuracy of patient identification.

Based on the results of research conducted in the Inpatient Room at RSUD dr. Fauziah Bireuen is known that the accuracy of the bracelet installation is 6 colors, namely (1) yellow is used by patients with a risk of falling or requiring extra supervision, (2) red is used by patients who have high allergies to drugs, (3) Purple is used by patients who have low life expectancy or Do Not Resuscitation (DNR), (4) gray is used by patients undergoing chemotherapy, (5) pink for female patients, (6) Blue for male patients. Therefore, before taking or giving action to the patient, the nurse must first identify the patient. Identification is carried out using a minimum of 2 (two) identities from the specified 4 identities, namely name, gender, date of birth and RM number (medical record). The nurse on duty in the Inpatient Room at RSUD dr. Fauziah Bireuen is not allowed to identify patients by using the patient's room number or the location of the patient being treated in accordance with hospital regulations. The patient's wristband should only be removed when the patient is about to leave the hospital. The release can only be done by a nurse who is on duty and is responsible for the patient. The patient wristband can be removed after all procedures have been performed.

The nurse on duty in the inpatient room also stated that there were frequent occurrences of patients with the same name. If this happens, every nurse on duty must receive this information. As identification, the patient record sheet with the same name is given a sticker label in the form of a red star at the top right corner. Sticker labels also need to be pinned on the medication sheet and the action sheet. On the patient's bed will usually also be given a card marked in red.

The card is affixed to the bed so that the officer can easily verify it. Ideally, nurses who are responsible for patients are distinguished so that mistakes can be avoided.

The patient identification process is always carried out from the beginning of the patient's admission to the hospital, which then the identity will always be confirmed in all processes at the hospital. Patient identification is carried out before the action, diagnostic procedure, and therapeutic. Patient identification is carried out before administering drugs, blood, blood products, taking specimens, and administering diet. Patients should also be identified prior to administering radiotherapy, receiving intravenous fluids, hemodialysis, taking blood or other specimens for clinical examination, cardiac catheterization, and diagnostic radiological procedures. Identification should also be carried out in comatose patients.

To facilitate the identification process at the time of placing an identity bracelet, the patient must be informed about the purpose and purpose of wearing an identity bracelet. The purpose of the identification bracelet is to ensure the correct identity of the patient in getting services and treatment while in the hospital. In addition to the purpose, the color of the identity bracelet and its meaning must also be explained.

Patients and their families in the Inpatient Room at RSUD dr. Fauziah Bireuen should also be given an explanation by the nurse that during treatment, the nurse will always confirm identity by asking the patient to state their name and date of birth to be matched with the data on the identification bracelet. The confirmation procedure will always be carried out before the treatment or procedure mentioned above. This is so that patients and their families are not irritated and bored when they are often asked to name their identity.

The explanation that must be given also includes the dangers if the patient refuses to put on the identity bracelet, destroys, and closes the identity bracelet. The patient is also reminded that the patient has the right to remind if the nurse forgets not to see the bracelet when performing the procedure. The patient bracelet must always be worn until the patient is allowed to go home, and should only be removed by the officer/nurse/doctor. When finished providing an explanation, the nurse should not forget to verify to find out that the patient and family understand the information.

The nurse must also put an identification bracelet on the patient's dominant wrist (according to the condition). The nurse must ensure that the bracelet is properly attached and comfortable for the patient. If the bracelet cannot fit on the patient's wrist, put it on the ankle. If it cannot be attached to the ankle, the bracelet can be attached to the patient's clothing in a clearly visible area. It should be noted on the patient identification bracelet that the wristband must be put back on if the patient changes clothes and must be with the patient at all times.

Furthermore, the nurse in the Inpatient Room at RSUD dr. Fauziah Bireuen identifies patients correctly by means of the nurse being obliged to ask the patient directly, namely the patient's name and date of birth, using open-ended questions to rule out the possibility of many patients with the same name, and if the nurse uses closed questions, the patient will tend to nod and answer "yes" which of course will risk identification errors.

The nurse also stated that for unconscious patients, the patient's name and date of birth could be asked directly to the patient's family/guardian. Match the name and date of birth or medical record number on the patient's wristband with the data on the corresponding form.

This research is in line with research conducted by Sari (2019) which states that the hospital must be more active in making quality programs. Hospital patient safety is a system where the hospital makes patient care safer which includes risk assessment, identification and management of matters relating to patient risk, 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 errors resulting from carrying out an action or not taking the action that should have been taken.

Based on the researcher's assumptions to prevent patient identification errors, patient identification procedures must be carried out uniformly, correctly and appropriately in all health care units, with the aim of ensuring patient safety in hospitals. With proper identification, patients get the correct and appropriate standard of care and treatment according to medical needs/instructions, patients avoid the possibility of errors in providing services, feel safe and comfortable and can cooperate in undergoing treatment or service procedures at the hospital.

Patient identification errors can occur in all aspects of diagnosis and treatment. Circumstances that can make patient identification incorrect are if the patient is anesthetized, disoriented, not fully conscious, in a coma, when the patient changes beds, changes bedrooms, changes locations in the hospital environment, sensory dysfunction occurs, forgets self-identity. or experience other situations.

Implementation of Effective Communication

Communication is a fundamental thing that is one of the factors for patient safety and customer satisfaction. In contrast to other communications such as communication in the fields of education, business and so on, effective communication in the field of hospital services has a fairly high level of complexity. This is because there is a lot of communication involved, a lot of information is needed, and it relates to the emotions of the patient/patient family, and the health nurse is quite high.

The high public need for effective information and communication services in hospitals is an interesting thing to discuss. Effective communication is communication that is able to produce an attitude change in the people involved in the communication. Effective communication process means the process where communicators and communicants exchange information, ideas, beliefs, feelings and attitudes between two people or groups whose results are in line with expectations. Simply put, effective communication is a communication process where the communicant understands what is being conveyed and does what the communicator wants. There are several factors that become obstacles for a person to communicate, including: Fear of communicating, Feeling unnecessary, Feeling insecure, Feeling that they have communicated well, Error opening a "stupidquestion" conversation.

Based on the results of research conducted in the Inpatient Room at RSUD dr. Fauziah Bireuen, in addition to communication problems, communication errors in hospitals can also cause problems, including: Errors between health nurses can result in wrong actions that result in disability and even death. Therefore, all communication processes that occur must be recorded so that communication is more secure and protected from lawsuits and in terms of personal services, communication errors can lead to conflicts and lead to lawsuits / lawsuits.

Management of effective communication in the Inpatient Room at RSUD dr. Fauziah Bireuen is carried out in a concise, accurate, complete, clear and easy to understand manner by the recipient of the message, which will reduce errors thereby increasing patient safety. Communication can be electronic, oral, or written. Patient care can be affected by poor communication including verbal or telephone orders for patient management, or telephone communication for critical examination scores, and handover communications.

Reporting the critical value of a diagnostic test is an issue in patient safety. For this reason, The Joint Commission Journal on Quality and Patient Safety in 2010 stated that health nurses who received critical score results verbally from other health nurses must write down the critical result/value information and read back the information to the informer and the message giver confirming that what is written and reread by the recipient of the message is correct. Critical value information is often transmitted via handwriting, email, or text messages which can have

serious consequences if a communication error occurs, so the process of delivering messages/instructions/reporting of critical value results must use effective verbal communication (verbal or telephone) using the TBaK Method.

Communication must be carried out in a planned, patterned, effective and systematic manner in order to avoid misunderstandings that can cause problems. One of the communication methods that can be used during patient handovers between health nurses is SBAR. The SBAR method provides an opportunity for health nurses to ask questions and respond to the content of the communication that occurs.

TBAK Method: Write, Read and Confirm, namely Write instructions or therapy and the time the information is received in the integrated record of the medical record file by the recipient of the information; Read back the patient's name and date of birth by the health nurse receiving the information for verification; Re-confirm the correctness of the name and date of birth as well as instructions or patient therapy which is read back by the health nurse who receives the message.

The giver of instructions must immediately complete the verification documentation in writing in the integrated record in the stamp column of the verification of effective communication within 1 x 24 hours and for words that are difficult to hear, the giver/receiver of information/instruction can spell the alphabet so as not to be misinterpreted according to International Phonetic Alphabet as follows:

Patient handover communication is the process of transferring information and responsibility for patient care from one health nurse to another, which can occur in the following activities: Fellow health workers: between doctors, from doctors to other health workers, or between health workers when changing work shifts, Between care units: inpatients are usually transferred to the ICU, or from the ER to the operating room. From the patient care room to the radiology department for radiological diagnostic tests.

This study is in line with the Tampubolon research (2019) Communication with the SBAR technique is a component of implementing patient safety standards so that it can reduce the incidence of patient safety incidents. The SBAR technique helps in focused and easy communication between all health workers, especially during the delivery of patient health and communicating via telephone to convey the patient's condition to all health workers.

According to the researcher's assumption, effective communication activities with SBAR techniques in nursing have an impact on improving the quality of nursing care services provided, because it speeds up the provision of nursing care or interventions to patients, streamlines nurses' time in delivering the condition and health of patients between doctors, nurses and other health workers. Effective communication with the nursing SBAR technique is useful for improving the performance of nurses, improving the quality of nursing care. if effective communication with the SBAR technique is carried out in accordance with the SBAR technique, and nurses use the SBAR technique properly, it will have an impact on the quality of nursing care or intervention, one of which is to improve the quality of services provided to patients, as well as to assist nurses in communicating effectively between doctors or other health workers so as to get a good collaborative relationship between nurses, doctors, and other health workers to minimize instructional errors and help communicate effectively and efficiently. The ability to communicate with nurses' SBAR techniques, if they are good but not driven by hospital policies, automatically nurses will be lazy and negligent to carry out effective SBAR communication.

The influence of the policies given by the hospital has such a large effect that it becomes a force that must be followed by nurses, effective communication with the SBAR technique is said to be good because of the policies that bind nurses, from the results of the study it was

found that nurses had good abilities and were good enough to carry out effective communication with SBAR technique, nurses know about effective communication with SBAR technique.

Implementation of Drug Safety Improvement that Needs to be Watched Out in the Inpatient Room at RSUD dr. Fauziah Bireuen

Patient safety has become a global issue including for hospitals. Patient safety has become a matter of great concern for every hospital in achieving accreditation or recognition and achieving quality of service and health for its patients. For this reason, as nurses who provide nursing care to patients, they must always pay attention to safety.

Nurses must also involve cognitive, effective, and actions that prioritize patient safety which must still be given with great care. In carrying out patient safety is influenced by 2 factors in general, namely, internal and external factors. The patient's health safety factor can also be a benchmark for determining the quality of the hospital itself, one of which is the target of patient safety in hospitals, namely, increasing drug safety that needs to be watched out for (Permenkes No. 11 of 2017).

Every drug if misused can harm the patient, even the danger can cause death or disability of the patient, especially drugs that need to be watched out for. Drugs to watch out for are drugs that carry an increased risk if we use them incorrectly and can cause great harm to patients.

Nurses who work in the Inpatient Room at RSUD dr. Fauziah Bireuen stated that the drugs that need to be watched out for consist of: 1) high-risk drugs, namely drugs that if an error occurs, it can cause death or disability, such as insulin, heparin, or chemotherapeutics; 2) drugs whose names, packaging, labels, clinical use look/look the same (lookalike), sound like Xanax and Zantac or hydralazine and hydroxyzine or are also called names of similar speech-like drugs (NORUM); 3) concentrated electrolytes such as potassium chloride with a concentration equal to or more than 2 mEq/ml, potassium phosphate with a concentration equal or greater than 3 mmol/ml, sodium chloride with a concentration of more than 0.9% and magnesium sulfate with a concentration of 20%, 40%, or more.

There are many drugs that belong to the NORUM group. These confusing names are generally the cause of medication errors all over the world. The reasons for this are: (1) inadequate knowledge of drug names; (2) there are new products; (3) same packaging and labeling; (4) the same clinical indications; (5) the same form, dosage, and directions for use; (6) there was a misunderstanding when giving orders.

A list of high-alert medication is available in various health organizations such as the World Health Organization (WHO) and the Institute for Safe Health Medication Practices (ISMP), in various literatures, as well as hospital experience in terms of adverse events or sentinel events.

Issues regarding the use of drugs are the wrong or accidental administration of concentrated electrolytes. For example, potassium chloride with a concentration equal to or more than 2 mEq/ml, potassium phosphate with a concentration equal or greater than 3 mmol/ml, sodium chloride with a concentration of more than 0.9%, and magnesium sulfate with a concentration of 20%, 40% or more.

Errors can occur if the nurse is not oriented well enough in the patient care unit and if the nurse is not oriented enough or during an emergency. The most effective way to reduce or eliminate this occurrence is to establish a process to manage high alert medications and transfer concentrated electrolytes from the patient care service area to the pharmacy unit.

The hospital makes a list of all high-alert drugs using information or data related to drug use in the hospital, data about "adverse events" or "near misses" including the risk of misunderstanding about NORUM. Information from the literature such as from the Institute

for Safe Health Medication Practices (ISMP), the Ministry of Health, and others. These drugs are managed in such a way as to avoid inadvertent care in storing, administering, and using them including their administration, for example by labeling or instructions on how to properly use drugs on high-alert drugs.

This research is in line with Tambunan's (2019) research. Safety is a global issue, including in hospitals. Hospitals are required to strive to fulfill patient safety goals as regulated in Minister of Health Regulation number 11 of 2017. Patient Safety Goals are a part of Hospital Accreditation Standards that must be implemented in hospitals that are useful in improving quality health services. Knowledge of health workers in Patient Safety Goals consists of accurate patient identification, increased effective communication, increased safety of drugs that need to be watched out for, certainty of the right location, right procedure, and right patient operation, reducing the risk of infection related to health services, reducing the risk of falling patients. Health workers, especially doctors and nurses, are required to know about the Patient Safety Goals. This assessment is carried out using the comparison method of one journal with another journal. The benefit of this assessment is to find out safety targets that aim to improve service quality.

According to the researcher's assumptions, to improve the safety of drugs that need to be watched out for, hospitals need to determine the specific risks of each drug while still paying attention to the aspects of prescribing, storing, preparing, recording, using, and monitoring them. High-alert drugs must be stored in the pharmacy installation/unit/depot. If the hospital wants to store outside this location, it is recommended that it be stored at a pharmacy depot which is under the responsibility of the pharmacist.

Implementation of Infection Risk Reduction in the Inpatient Room at RSUD dr. Fauziah Bireuen One way to reduce the risk of infection is to wash your hands.

According to WHO, 6 steps of hand washing can minimize the spread of infection in hospitals. Hand hygiene refers to the process of cleaning hands by washing hands using an alcohol-based antiseptic solution.

In healthcare settings, proper hand washing is the simplest way to reduce cross-transmission of microorganisms associated with infection leading to increased length of stay, increased treatment costs, and even death.

Compliance with the 5 Moment Implementation is defined as the number of Health Service Providers who perform five moments of hand washing correctly divided by the number of Health Service Providers surveyed, multiplied by 100 and expressed as a percentage. Inpatient Room at RSUD dr. Fauziah Bireuen adopted the guidelines of the World Health Organization "WHO" on "5 Moments of Hygiene", namely: Before touching a patient, before performing invasive procedures, after touching excretions, after touching a patient, and after touching the patient's environment.

According to the researcher's assumptions, compliance with the 6-Step Handwashing Implementation is defined as the number of officers who perform the 6-step hand-washing correctly divided by the number of officers surveyed, multiplied by 100 and expressed as a percentage. Health Service staff training on hand hygiene was carried out in conjunction with orientation for new employees, posting of posters on hand washing techniques placed in strategic locations, holding hand washing rounds, educating patients and visitors during the healing garden, has increased awareness of Health Services about the importance of hand hygiene.

Implementation of Falling Patient Risk Reduction in the Inpatient Room at RSUD dr. Fauziah Bireuen

The number of cases of falls is quite significant as a cause of injury for hospitalized patients. In the context of the population or community served, the services provided by the facility, the hospital needs to evaluate the patient's risk of falling and take action to reduce the risk of injury if the patient falls. Evaluation may include a history of falls, medication and review of medication consumption, gait and balance, and assistive devices used by the patient. The program must be implemented by the hospital. The hospital is a process of initial assessment of the patient against the risk of falling and reassessing the patient if it is indicated that there is a change in condition or treatment, and others. Measures are implemented to reduce the risk of falling for those who are assessed as having a risk of falling. Measures are monitored for results, both the success of reducing injuries from falls and the impact of unexpected events. Policies and/or procedures are developed to direct the ongoing reduction of the patient's risk of injury from falls in the hospital.

Conclusion

The implementation of patient safety in the room has been carried out in accordance with the procedure, but sometimes in its implementation involving patients experiencing problems. Incidents that have occurred in the room related to patient safety were the patient fell when he wanted to go to the bathroom and the nurse was wrong when giving medicine to the patient. What is done to prevent incidents related to patient safety include: identifying patients clearly by looking at identity bracelets, implementing effective communication such as spelling drug names using the alphabet method, marking the surgical area, washing hands at five moments, installing bed bars, locking bed wheels. , ensuring adequate coverage. The obstacle factor in carrying out patient safety is not cooperative or unwilling to listen to the advice given by the nurse. Supporting factors in implementing patient safety include monitoring and evaluation from management, good cooperation between nurses, and good cooperation with other health workers.

References

- Depkes RI. (2009). Undang-Undang Republik Indonesia Nomor 44 Tahun 2009 Tentang Rumah Sakit. Jakarta.
- Destiani, J. (2021). Pelaksanaan Sasaran Keselamatan Pasien (Patient Safety Goals) di Ruang Rawat Inap Rumah Sakit Universitas Sumatera Utara Tahun 2019.
- Faluzi, A., Machmud, R., & Arif, Y. (2018). Analisis Penerapan Upaya Pencapaian Standar Sasaran Keselamatan Pasien Bagi Profesional Pemberi Asuhan Dalam Peningkatan Mutu Pelayanan di Rawat Inap RSUP Dr. M. Djamil Padang Tahun 2017. *Jurnal Kesehatan Andalas*, 7, 34-43.
- Haerrens, M. H., van Leeuwen, W., Sexton, J. B., Pickkers, P., & van der Hoeven, J. G. (2016). Validation of the Dutch language version of the Safety Attitudes Questionnaire (SAQ-NL). *BMC health services research*, 16(1), 1-8.
- Halawa, A., Setiawan, S., & Syam, B. (2021). Development of Nurse Role Model in Improving Patient Safety. *Jurnal Keperawatan Soedirman*, 16(2).
- Hia, Y. (2019). Kebijakan Peningkatan Mutu Dan Keselamatan Pasien Dirumah Sakit. osf.io
- Joint Commission International. (2015). Hospital Patient Safety Goals. 4th Edition. Oakbrook Terrace-Illinois: Department of Publication Joint Commission Resources.
- Komite Keselamatan Pasien Rumah Sakit. (2015). Pedoman Pelaporan Insiden Keselamatan Pasien (IKP) (Patient Safety Incident Report). Jakarta: KKPRS, 2015.

- Lombogia, A., Rottie, J., & Karundeng, M. (2016). Hubungan perilaku dengan kemampuan perawat dalam melaksanakan keselamatan pasien (patient safety) di ruang akut instalasi gawat darurat RSUP Prof. DR. RD Kandou Manado. *Jurnal Keperawatan*, 4(2).
- Neri, R. A., Lestari, Y., & Yetti, H. (2018). Analisis Pelaksanaan Sasaran Keselamatan Pasien Di Rawat Inap Rumah Sakit Umum Daerah Padang Pariaman. *Jurnal Kesehatan Andalas*, 7, 48-55.
- Purba, N. A. S. (2019). Pentingnya Perawat Menerapkan Kebijakan Keselamatan Pasien Untuk Meningkatkan Mutu Pelayanan. osf.io
- Thrisia, M. (2018). *Analisis Hubungan Kompetensi Kepala Ruangan Dalam Pelaksanaan Fungsi Manajemen Dengan Kinerja Perawat Dalam Penerapan Sasaran Keselamatan Pasien Di Rumah Sakit Umum Mayjen Ha Thalib Kerinci*(Doctoral dissertation, Universitas Andalas).
- Valencia, V. (2017). *Analisis Pelaksanaan Program Keselamatan Pasien Berdasarkan Standar Keselamatan Pasien Rumah Sakit Di Rsud Lubuk Basung* (Doctoral dissertation, Universitas Andalas).
- World Health Organization. (2018). Tobacco Or Health: A Global Status Report. 2018
- Yusuf, M. (2017). Penerapan patient safety di ruang rawat inap rumah sakit umum daerah Dr. Zainoel Abidin. *Jurnal Ilmu Keperawatan*, 5(1), 84-89.