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An Overview of Patient Safety Culture with the AHRQ

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Abstract

Safety has become a global issue, especially for hospitals. Patient safety culture is a product of values, attitudes, competencies, and behavioral patterns of individuals and groups that determine the commitment, style, and ability of health care organizations to patient safety. The purpose of this study was to determine the description of patient safety culture with the AHRQ model. Quantitative research method with cross sectional. The population of all officers in the inpatient installation of RSUD Dr. R. M Djoelham 156 samples found 61 respondents with simple random sampling technique. The results of the study describe the expectations and actions of managers promoting patient safety by 77.04%, organizational learning by 91.8%, cooperation in units of 93.85% (good or strong culture), open communication by 71.04%, feedback on errors 77.05% (good or strong culture), non-punitive response dimension to errors is 61.20% staffing is 59.01% management support for patient safety efforts is 85.8% cooperation between units is 71.32%, Handsoff work and patient transitions are 59.02% (good enough or moderately cultured), the overall perception of hospital staff about patient safety is 68.86% (good enough or moderately cultured), reporting frequency is 73.22% (good enough or moderately cultured). moderate culture). With the results of this study, it is hoped that RSUD Dr. R.M. Djoelham Kota Binjai is expected to continue, maintain, and develop ongoing patient safety programs and maintain the existing patient safety culture.

Introduction

The hospital is a primary health care facility. Thus the hospital must be able to provide integrated health services to patients as service users. Building a patient safety movement in hospitals is a top priority for hospital services because this will benefit various parties, both the hospital and patients as users of health services. Therefore, the main focus of the hospital is to provide safe health services and prioritize the quality of the services provided (Priority, 2019).

Safety has become a global issue, including for hospitals. There are five important issues related to safety in hospitals, namely: patient safety, worker or health worker safety, building and equipment safety in hospitals that can impact patient and staff safety, environmental safety (green productivity) that impact against environmental pollution, and hospital "business" safety related to hospital survival. These five aspects of safety are very important to implement in every hospital. However, it must be admitted that hospital institutional activities can run if there are patients. Because of that patient safety is a top priority to be implemented and this is related to issues of quality and image of the hospital (Mardiani, 2011).

Patient safety culture is a product of values, attitudes, competencies, and individual and group behavior patterns that determine the commitment, style and ability of a health care organization towards patient safety programs. If a health care organization does not have a patient safety culture then accidents can occur as a result of latent errors, psychological and physiological

disturbances to staff, decreased productivity, reduced patient satisfaction and cause internal conflicts.

Patient safety is a process within a hospital that provides safer patient care. This includes risk assessment, identification and management of patient risks, reporting and analysis of incidents, the ability to learn from and follow up on incidents, and implement solutions to reduce and minimize risks.

Hospital patient safety is a system that makes patient care safer, including risk assessment, identification and management of patient risks, reporting and analysis of incidents, the ability to learn from incidents and their follow-up, and implementation of solutions to minimize risks and prevent injuries caused. by mistake as a result of carrying out an action or not taking the action that should be taken. Patient safety incidents are any unintentional events and conditions that result in or have the potential to result in preventable injury to patients (KKPRS, 2015).

Patient Safety Incidents according to Permenkes No. 11 of 2017, are any unintentional events and conditions that result in or have the potential to result in preventable injury to patients. Incidents in health care facilities include: Potential Injury Conditions (KPC), Nearly Injury (KNC), Non-Injury Events (KTC), Unexpected Events (KTD) and sentinel events.

According to data from the World Health Organization (WHO) world health agency, in April 2017 departing from world navigation data, there are 1 in 1 million airplane passengers who have the potential to experience incidents while on board, this is compared to in the medical world that there are 1 in 300 potential patients. had an incident while in the health care facility. WHO's ten facts about patient safety say that, 1 in 10 patients experience an incident while receiving treatment in a hospital in developing countries. From 100 hospitalized patients, at any time 7 patients in developed countries and 10 patients in developing countries experience infections related to health services. Sharing people's experiences and perspectives regarding patient safety is very important to prevent incidents from occurring, as well as to see the development and evaluate patient safety programs (Rangkuti et al., 2018).

Data on patient safety culture in Indonesia, according to the Hospital Patient Safety Committee (KKPRS) report, in several provinces in Indonesia from January 2010 to April 2011, 137 patient safety incidents were reported. East Java Province ranks highest at 27% among eleven other provinces (Banten 22.6%, DKI Jakarta 16.8%, Central Java 13.1%, West Java 8%, Riau 3.7%, Lampung 2.2%, Bali 1.5%, South Sumatra 0.7%, North Sumatra 0.7%, South Sulawesi 0.7%, South Kalimantan 0.7%). Based on the type of incident, out of 137 incidents, 55.47% were adverse events, 40.15% KNC, and 4.38% others. 8.76% resulted in death, 2.19% irreversible (permanent) injury, 21.17% reversible (temporary) injury, and 19.71% minor injury (Amirullah et al., 2014).

Based on the results of a preliminary survey conducted by researchers, the implementation of patient safety efforts at RSUD Dr. R.M. Djoelham City of Binjai found problems such as patient safety goals in the form of ineffective communication and a lack of knowledge about patient safety culture. Based on interviews conducted with the head of the room from 10 rooms, 9 people answered that there had been a patient safety incident in the past year, be it a fall incident, the wrong person was giving the drug, and the patient had an infection due to repeated infusions. However, the number of events is not known with certainty due to incomplete reporting.

Inpatient installation regarding patient safety culture and its influence on the implementation of patient safety programs. Research by Nygren et al (2015) revealed that patient safety culture is a supporting factor in the implementation of patient safety programs.

Patient safety culture will motivate officers to report any patient safety incidents that occur. In an effort to minimize the occurrence of adverse events related to aspects of patient safety,

hospital management needs to create a patient safety culture that must be implemented throughout the hospital. Based on the description above, the authors are interested in researching "Description of Patient Safety Culture with the AHRQ Model in RSUD Dr. R.M. Djoelham City of Binjai in 2020".

Methods

This type of research is a quantitative research, namely in this research is an analytic survey with a cross sectional study approach with the aim of knowing the description of patient safety culture with the AHRQ model at RSUD Dr. R.M. Djoelham City of Binjai in 2020. The location of this research is at RSUD Dr. R.M. Djoelham City of Binjai. The reason for conducting this research was because a similar study had never been conducted and based on the initial survey it appeared that there were still patient safety incidents. This research was conducted in July-August 2020. The study population was all staff at the inpatient installation of RSUD Dr. R.M Djoelham 156 people. With a population of 156 nurses, the number of samples found was 61 respondents. Data collection techniques with primary data data obtained by researchers directly from the data source. Primary data was taken directly from the respondents (executive nurses in the inpatient room of Dr. R.M. Djoelham Hospital, Binjai City) by distributing questionnaires that were filled in by the respondents themselves, which had been prepared. Primary data data obtained by researchers directly from the data source. Primary data was taken directly from the respondents (executive nurses in the inpatient room of Dr. R.M. Djoelham Hospital, Binjai City) by distributing questionnaires that were filled in by the respondents themselves, which had been prepared.

Results and Discussion

Description of Respondent Characteristics

Table 1. Overview of Respondents Based on Gender, Marital Status, Last Education, and Contact with Patients at Dr. R.M. Djoelham Hospital, Binjai City in 2020

Characteristic Respondents	F	%
Age		
≤36 Years Old	29	47,5%
>36 Years Old	32	52,5%
Total	61	100,0
Gender		
Man	11	18%
Woman	50	82%
Total	61	100,0
Marital Status		
Unmarried	49	80,3%
Marry	9	14,8%
Widow/Widower	3	4,9%
Total	61	100,0
Terakhrir Education		
Diploma	39	63,9%
BSN	1	1,6%
S1	12	19,7%
Ners (S1 + Profession)	5	8,2%
Total	61	100%

Based on table 1, it is illustrated that the majority of respondents are > 36 years old. the majority of respondents were female, namely 82%. When viewed from the characteristics of marital

status, most of the respondents were not married, namely 80.3%. When viewed from the last education most of the respondents had education with a Diploma qualification of 63.9%.

Characteristics of Respondents

Age determines a person's behavior and ability to work, including how to respond to the stimulus given by the individual. Based on the results of the study the majority of respondents aged> 36 years. The majority of respondents are in the adult stage which is the age where the peak development in applying their knowledge and skills and the habit of rational thinking will increase. This condition will affect nurses in applying their knowledge, skills and creativity, including in implementing a patient safety culture. So that the age of the inpatient nurse at RSUD Dr. R.M. Djoelham Kota Binjai currently belongs to the ideal working age.

Based on the results of the study, the majority of respondents were female, namely 82%. According to nursing management, there is no ideal comparison between male and female nurses. However, in nursing management regarding the arrangement of work schedules, it is recommended that in one shift there are male and female nurses, so that when carrying out actions that are private in nature they can be carried out by nurses of the same sex, for example personal hygiene, elimination, ECG recording, and installation of bedside accessories. monitors.

Nurse in the inpatient unit of RSUD Dr. R.M. Djoelham Kota Binjai currently has both male and female nurses although there are only 11 male nurses out of 50 nurses. So in the nursing management of the inpatient nurse unit at RSUD Dr. R.M. Djoelham Binjai City, private actions can be carried out by male nurses.

And when viewed from the last education most of the respondents had education with a Diploma III qualification of 63.90%. The criteria for a professional nurse are graduates of higher education in nursing with a minimum of DIII Nursing, complying with the code of ethics, being able to communicate with patients and families, and being able to utilize available health facilities in an efficient and effective manner, able to act as a reforming agent and develop nursing knowledge and technology. The higher the level of education, the more rational and creative and open in accepting the existence of various renewal efforts and can adapt to renewal. A person's level of education has an effect on responding to something that comes from outside. So that the nurses at the Inpatient Unit of Dr. R.M. Djoelham Kota Binjai is considered by the ideal nurse with professional criteria.

The average respondent also had 2.86 years of service in the unit and an average of 10 years of service in the hospital. This shows that most of the respondents have been practicing their profession as nurses for a long time. The longer a nurse works, the more cases she handles, so her experience increases, conversely, the shorter a person works, the fewer cases they handle. Work experience provides a lot of expertise and work skills (Yasmi & Thabrany, 2018).

Overview of 12 Factors of Patient Safety Culture in the Inpatient Unit of RSUD Dr. R.M. Djoelham City of Binjai

Patient safety culture is the perception that is shared among members of the organization aimed at protecting patients from management errors and injuries resulting from interventions. This perception includes a collection of norms, professional standards, policies, communication and responsibility in patient safety. This culture then influences individual beliefs and actions in providing services. The safety culture measured in this study also measures nurses' perceptions of patient safety culture in the Inpatient Unit of RSUD Dr. R.M. Djoelham City of Binjai. Perception as measured in the culture of safety in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai was generated with answers that agreed, strongly agreed, disagreed and strongly disagreed which were then categorized into positive responses and negative responses.

There are 12 dimensions measured in patient safety culture, along with an explanation of each dimension.

Dimensions of Manager's Expectations and Actions Promoting Patient Safety

Based on the results of the study, on the dimensions of expectations and actions of managers promoting patient safety, there are 4 statements that are measured in this dimension. In this dimension, the positive response was 77.04% which can be categorized as a good or strong culture of patient safety in this dimension. In the dimensions of expectations and actions of managers promoting patient safety, what is meant by the manager here is the direct superior of each nurse, namely the head of the room.

The head of the room is a nurse who has the authority to organize and control the activities of nurses in the ward and has a greater responsibility than the implementing nurse in ensuring safe care for patients (Rangkuti et al., 2018). The head of the room as a first-line manager has a critical role in supporting patient safety culture with effective leadership in creating a positive environment for patient safety. This is supported by research conducted by Wagner, et al 2009 that nurse managers have a more positive perception of a culture of patient safety by rehabilitation care than executive nurses in hospitals in the United States and Canada.

Based on the results of the study, the head of the room at the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai has provided support for patient safety as evidenced by several points in the questionnaire which received a high positive response including the manager giving praise if he sees work completed in accordance with patient safety procedures, can hear and consider suggestions from his subordinates to improve patient safety. These things are part of effective leadership in creating a positive environment for patient safety.

Strong leadership, one of which must be possessed by the head of the room, can build a patient safety culture that allows the entire team to support and improve patient safety. The efforts of the head of the room in carrying out effective leadership in his room affect the implementation of patient safety culture. The head of the room can influence strategies and efforts to mobilize nurses within the scope of their authority to jointly implement a patient safety culture.

Based on the results of the study, the head of the room has the ability to manage the work of his team even with a high workload, and can anticipate adverse events so that they do not occur repeatedly as evidenced by the high positive responses obtained on the questionnaire. This shows that the head of the room carries out effective leadership in his room that influences the implementation of patient safety culture.

Instilling safety values can be carried out by the Patient Safety Committee of RSUD Dr. R.M. Djoelham Kota Binjai and the Head of the Room through formal and informal socialization methods, for example holding morning tea sessions as well as instilling patient safety values through storytelling. Socialization can also be done through walk the walk or MBWA (Management By Walking Around). Leaders regularly visit their staff, apart from controlling, they also remind them of the importance of patient safety. Slogans, posters and symbols that promote safety should be installed in strategic places in the hospital so that all employees and patients participate in instilling a culture of patient safety. Overall safety culture on the dimensions of expectations and actions of managers in promoting patient safety in the inpatient unit of RSUD Dr. R.M. Djoelham Kota Binjai can be said to be good because of the positive response from questions of 75% and above. So it can be concluded that the role of the manager/head of the room has carried out its role well in promoting patient safety and needs to be maintained.

Dimensions of Organizational Learning / Continuous Improvement

Based on the results of the study, the dimensions of organizational learning/continuous improvement regarding patient safety are measured from 3 statements. In this dimension the

positive response obtained was 91.8% which could be interpreted as a safety culture in the organizational learning dimension at the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai is categorized as good or has a strong culture. Organizational learning or continuous improvement is carried out by the core team to determine strategies for cultivating patient safety values. The team regularly meets to analyze RCA (Root Cause Analysis) or find the root cause of every patient safety incident. The team also determines socialization patterns and evaluates programs that have been implemented through applied research. Through continuous improvement efforts, implicit and explicit knowledge will be obtained to deal with patient safety incidents. Every line in the organization, both nurses and management use incidents that occur as a learning process. Nurses and management are committed to learning what happened. Take action on the incident to implement so as to prevent the recurrence of the error. Feedback from organizations and teammates is a form of organizational learning and is one of the efforts to evaluate the effectiveness of programs that are already running. Based on the results of the study, the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai has made mistakes that occur as a trigger for a better direction and always evaluates the effectiveness of services as evidenced by the high positive response results on the questionnaire. This illustrates that the inpatient unit of RSUD Dr. R.M. Djoelham Kota Binjai is an organization that learns from mistakes. So it can be said that the nurses at the Inpatient Unit of RSUD Dr. R.M. Djoelham, Binjai City, has made the mistakes that occur as a continuous improvement effort in his unit in order to ensure patient safety at the hospital. With these results it is hoped that the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai can maintain organizational learning that has been running and it would be better if it continues to be improved. In addition to improvements at the organizational level, improvement efforts at the individual level are also important in patient safety programs. A safety culture at the individual level needs to be fostered through increased knowledge, changes in attitudes and behavior that are more safety oriented. This can be achieved by disseminating information related to patient safety through hospital bulletins and other media. The results of the study also corroborate this as evidenced by the fact that nurses actively carry out outreach activities, exchange information, and discuss patient safety, which receives a high positive response to the questionnaire. The learning process can also be carried out from incident reports which are submitted routinely by both the team and the hospital management at every meeting and meeting. Incident information that has been packaged with solutions from the results of root cause analysis, can be valuable information for each individual to increase their knowledge of patient safety. Without a culture of blaming individuals for existing incidents, it will be able to improve attitudes and behavior as well as the courage to report each incident as part of the learning process.

Dimensions of Cooperation in Units

On the dimension of cooperation within the unit, a positive response of 93.85% was generated, which could mean that the safety culture on the dimension of cooperation within the unit at the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai is categorized as good or has a strong culture.

Cooperation within units shows the extent to which members of a division are compact and work together in teams. Collaboration is defined as a collection of individuals with specific skills who work together and interact to achieve common goals (Hasmy, 2018). Meanwhile Thompson (2000) in (Setiowati, 2010) defines a team as a group of people who are interrelated with information, resources, skills, and trying to achieve common goals.

According to the Canadian Nurse Association in 2004, one of the factors that becomes a challenge for nurses in providing safe nursing and contributing to patient safety is teamwork. Impaired teamwork performance is also one of the causes of patient safety incidents which are a combination of system failures. The probability of an incident occurring is due to certain

conditions. Conditions that facilitate the occurrence of errors such as environmental disturbances and teamwork that does not work.

According to Manser (2009) in Lestari et al (2013) communication barriers and unequal division of tasks are the cause of not working effective teamwork. The effectiveness of teamwork is very dependent on communication within the team, collaboration, supervision and division of tasks. An observational study and retrospective analysis of safety incidents shows that poor teamwork contributes more than weak clinical skills.

Based on the results of the study, nurses in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai at work supports each other, works together as a team if there is a lot of work, and feels mutual respect for one another as evidenced by the results of a high positive response regarding this matter. Teamwork in hospital services can affect the quality and safety of patients. Potential conflicts that may occur in team interactions can result in the implementation of teamwork in service. Working in teamwork is a value that must be built as a safety culture. Conflicts that arise can reduce individual perceptions of teamwork, which can disrupt the service process and lead to the possibility of incidents occurring. A study shows that individual perceptions that are lacking in teamwork have the potential to be 3x more likely to have a safety incident.

The dimensions of cooperation within the unit at the Inpatient Unit of RSUD Dr. R.M. Djoelham Binjai City received a positive response of 93.85% which was categorized in a strong safety culture. This shows that teamwork in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai has been running well and needs to be maintained.

Open Communication Dimension

On the dimension of open communication in this study, a positive response was received by 71.04% which was categorized as a moderate patient safety culture. Communication in patient safety has become a standard in the Joint Commission Accreditation of Health Organization since 2010. According to Nazhar (2009) in Hamdani (2007) open communication can be realized during handover, briefings, and nursing rounds. Nurses use open communication at handover by communicating to other nurses about the risk of incidents, involving patients at handover. Briefing is used to share information about patient safety issues, nurses can freely ask questions about patient safety that have the potential to occur in daily activities. Nursing rounds can be carried out every week and focus only on patient safety (Iskandar et al., 2016).

Based on the results of the study, nurses in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai is free to express opinions, free to ask about decisions or actions to be taken, and is not afraid to ask questions when he knows something is wrong in patient care as indicated by the high positive response value regarding this matter. This illustrates that by the nurse in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai communicates openly in serving patients.

According to Salim (2006) in Hamdani (2007) on patient safety culture, communication must occur in a two-way pattern, from leaders to frontline personnel and vice versa. Likewise, silent action against mistakes, must be replaced with openness, honesty regarding incidents related to patient safety. Reporting and compliance with safety procedures are parameters that are used as a benchmark for effective safety communication and are important elements for realizing safe services and leading to a culture of safety.

In communication matters become an important subject one of which is effective communication. Effective communication is one of the strategies to build a culture of patient safety. Effective communication plays a very important role in reducing adverse events in a patient's medical care. This strategy was established by The Joint Commission on Accreditation of Healthcare Organization (JCAHO) as a national goal of patient safety. This is based on the

Agency of Healthcare Research and Quality (AHRQ) report that communication is 65% the root cause of KTD.

The strategy implemented by JCAHO to create an effective communication process is the standardized approach to communication in patient handover (Kinanti & Kusniati, 2020). Communication during the patient care transition process can be at risk of errors when the information provided is inaccurate.

By a nurse at the Inpatient Unit of RSUD Dr. R.M. Djoelham City of Binjai openness in communication includes freedom of expression, freedom to ask fellow nurses/doctors about the actions to be taken, freedom from fear if you see something is wrong in the service, has a fairly high positive response value, which is above 70%. So it can be judged that nurses in this unit have good openness in communicating with fellow nurses, doctors, and other health workers.

Hospitals with quite a lot of professional interaction, need the right strategy in the process of communication between related professions. The SBAR method (situation, background, assessment, recommendation) in the inter-professional communication process can be used as an option. Based on the situation, background, assessment and recommendations that are well communicated will provide a more informative, clear and structured patient treatment condition. This will reduce the potential for unwanted incidents to occur.

Another communication strategy is the communication process between clinicians. Continuity of care and communication between medical colleagues greatly affects patient safety. Through the implementation of discharge summaries especially for post-hospitalized patients, it can be used as an effort to build communication between doctors. This will reduce the rate of hospital readmission (Nur, 2018).

Openness to communication also involves the patient. The patient gets an explanation of the action and also the events that have occurred. Patients get information about conditions that will cause the risk of errors. Nurses provide motivation to provide everything related to patient safety. Strategies that can be taken include providing access for patients and their families to the information on the services they receive. Providing sufficient time for patients to communicate with staff and increasing patient education regarding safety are several efforts that can be made. The SPEAK UP method is the method recommended by JCAHO for effective communication between patients and staff.

Based on the results of the positive response research on the dimensions of open communication at the Inpatient Unit of RSUD Dr. R.M. Djoelham Binjai City at 71.04% which can be interpreted that the open communication that runs between nurses and other medical personnel can be said to be quite good and needs to be improved.

Dimensions of Feedback and Communication of Errors

On the feedback and communication dimensions of errors, there was a positive response of 77.05% which was categorized as a strong patient safety culture. Feedback and communication of errors is paramount after reporting patient safety incidents. One of the core principles in incident reporting according to Manhajan (2011) in Hamdani (2007) is that reporting can only provide benefits if it is responded to constructively. At least there is feedback from the analysis of the findings. Ideally there are recommendations for changes to the process or system. Feedback from organizations and teammates is a form of organizational learning. One form of obstacle in the incident reporting system is the lack of feedback from incident reports.

Based on the research results, managers have provided feedback based on incident reports, received information about errors that occurred, and often discussed with fellow nurses/doctors to prevent adverse events as evidenced by the positive response results of more than 75% regarding this matter. This shows that feedback and communication of errors in the Inpatient

Unit of RSUD Dr. R.M. Djoelham City of Binjai runs quite optimally. The existence of feedback from reported events is expected to provide corrective action on the patient safety system that has been running.

To increase this dimension, the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai can take five steps towards an incident reporting system according to NPSA (2009) in Setiowati (2010) including providing feedback to staff when they provide incident reporting, focusing on learning about incidents with root causes, training on reporting, internal reporting competitions , creating an event-friendly tool for recording incident reports, turning reporting into a quality improvement effort (Iskandar et al., 2016).

Dimensions of Non Punitive Response to Mistakes

Nurses and patients are treated fairly when incidents occur. When an incident occurs, you should not focus on finding individual errors but rather studying the system that causes the error to occur. The culture of not blaming nurses needs to be developed in fostering a culture of patient safety. The nurse will make an incident report if it is sure that the report will not be punished for the error that occurred. An open and fair environment will help make reporting a lesson in patient safety.

Focusing on the mistakes made by nurses will affect the psychology of nurses. Errors made by nurses will have a psychological impact which will reduce errors that occur more due to system errors, so the focus on what is being done, the obstacles that lead to errors and other risks that can occur can be used as learning instead of just focusing on who is doing it.

Based on the research results, nurses are worried that the mistakes we make will be recorded in our personal documents by the leadership and if we make mistakes in serving patients, nurses feel that these mistakes will threaten which is evidenced by the results of a positive response that tends to be low about this. This illustrates that there are still nurses who are worried that the mistakes they make will be recorded in personal documents by the leadership and are worried that they will be blamed or punished.

Therefore, the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai is expected to increase motivation in reporting incidents by eliminating the fear of being blamed by the nurse who gives the report, not giving punishment when making mistakes, not blaming the incident reporter, making patient safety incident reporting procedures simple and easy to implement.

Dimensions of Staffing

The staffing dimension is measured as having a positive response of 59.01% which illustrates that the staffing dimension can be interpreted as moderately cultured. Human resources in the hospital as individual direct executors of services must meet the adequacy of both quantity and quality.

Aspects of individual quality seen from the education and competency standards possessed. Competence of human resources in hospitals can be done by trying to meet competency standards by each officer in accordance with the standards set in each profession. Hospitals can take efforts such as sending officers to take part in competency-based training for each existing profession. This step is integrated with hospital HR planning, especially the hospital education and training department. For officers who do not meet the competency standards for their profession, the hospital can provide facilities to meet these standards.

Based on the results of the study, nurses have a perception that the number of staff is insufficient to handle the workload in this unit because it only has a positive response of 59.01%. which can illustrate that according to respondents in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai does not have enough nurses to handle the workload in one unit.

Calculation of the right staff requirements for nurses in hospitals is needed to avoid an increase in workload for each individual. The calculation of the ratio of the number of staff to the number of patients and the service time must be owned by the hospital. Calculation of needs with the workload analysis method is one alternative that can be done. This will be very useful in planning hospital nurses with a limited number of staff.

Hospital Management Support for Patient Safety Efforts

Based on the results of the research, the management support for RSUD Dr. R.M. Djoelham City of Binjai towards patient safety efforts that received a positive response including hospital management providing a working climate that supports patient safety, hospital management policies showing that patient safety is a priority and hospital management cares about patient safety in the event of an adverse event or KNC. Safety culture on the dimensions of management support for patient safety efforts at the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai is categorized in a strong culture. This illustrates that RSUD Dr. R.M. Djoelham Kota Binjai has provided support to the management of patient safety efforts.

Cooperation Between Hospital Units

On the dimensions of cooperation between units in the Inpatient Unit of RSUD Dr. R.M. Djoelham Binjai City generated a positive response of 71.32% which can be categorized as moderately cultured. Health services in hospitals are a series of services by various units. Cooperation between units shows the extent of cohesiveness and teamwork across units or departments in serving patients. Collaboration is defined as a collection of individuals with specific skills who work together and interact to achieve common goals.

Cooperation between units is needed if there is a transfer of patients between units or certain cases involving between units. This positive cooperation between units can be seen when another nursing unit needs assistance, another unit will help.

According to the Canadian Nurse Association in 2004, one of the factors that becomes a challenge for nurses in providing safe nursing and contributing to patient safety is teamwork (1) Impaired teamwork performance is also one of the causes of patient safety incidents which are a combination of system failures. The probability of an incident occurring is due to certain conditions. Conditions that make it easier for errors to occur, for example environmental disturbances and teamwork that doesn't work (Rivai et al., 2016).

Collaboration between units in the Inpatient Unit of RSUD Dr. R.M. Djoelham Binjai City is categorized in a moderate culture, so the hospital needs to grow, improve, and develop inter-unit collaboration at RSUD Dr. R.M. Djoelham City of Binjai.

Handsoff and Transition

Based on the results of the study, the handsoff and transition dimensions between service units had a positive response of 59.02% which illustrates that the dimensions of patient handsoff and transition work can be interpreted as quite good or moderately cultured.

Transition is the process of moving patients from one environment to another. Transfer of patients from one environment to another can be in the form of moving patients from the ER to the unit in order to get treatment. In this transfer, an error can occur that endangers the patient, such as falling of the patient and misinformation when there is an exchange of information about the patient. Misinformation about these patients can also occur during shift changes between nurses.

Based on the results of the study, the handsoff and transition dimensions are categorized in a moderate culture so that RSUD Dr. R.M. Djoelham Kota Binjai needs to pay attention to the handsoff process and transitions between service units so that it can run optimally.

Perceptions of Nurses Regarding Patient Safety

Based on the results of the study, the overall perception dimension regarding patient safety has a positive response of 68.86% which illustrates that the overall dimension of hospital staff's perception of patient safety can be interpreted as quite good or moderately cultured.

Perception is the process of interpreting sensations so as to make those sensations meaningful. Perception is a process of observing a person that comes from the component of cognition which is influenced by factors of experience, learning process, insight and knowledge. Factors that affect perception can come from the party that forms the perception, in the object or target that is perceived, or in the context of the situation where the perception is made (Yarnita, 2019).

Perception of the whole in patient safety means the process of observing a person originating from the cognition component which is influenced by experience, learning processes, insights and knowledge of the components in patient safety including risk analysis, incident reporting and incident analysis, the ability to learn from incidents, and feedback from incidents.

Nurses' perceptions of patient safety in the Inpatient Unit of RSUD Dr. R.M. Djoelham City of Binjai received a fairly good positive response and was categorized in a moderate safety culture, this illustrates that nurses have a fairly positive perception of patient safety in the hospital. this dimension.

Frequency of Reporting Incidents

According to Jeff et al., reporting is an important element of patient safety. Adequate information in reporting will be used as material by the organization in learning. Organizations learn from previous experiences and have the ability to identify risk factors for incidents so that they can reduce or prevent incidents from occurring (Yasmi & Thabrany, 2018).

Obstacles or obstacles in reporting have been identified so that the incident reporting process becomes easier. Barriers that can occur in reporting include: feelings of fear of being blamed, feelings of failure, fear of punishment, confusion in the form of reporting, lack of trust from the organization, lack of awareness of the benefits of reporting (Yasmi & Thabrany, 2018).

Nurses will make a report if they feel safe if they make a report they will not receive punishment. The involved nurse feels free to tell or be open about what happened. Fair treatment of nurses, not blaming individuals but the organization is more focused on the running system will improve reporting culture.

A safety culture in the implementation of a strong safety management system includes: encouraging everyone to take responsibility for the safety of themselves, co-workers, patients and visitors; prioritize safety and profit above profit and organizational goals; encourage and reward the identification, reporting, and resolution of safety issues; provide learning opportunities from unfortunate events; allocate resources, structures and responsibilities, as appropriate to maintain an effective safety system; as well as avoiding absolute recklessness.

Another activity that can describe a patient safety culture is systematic incident reporting. Incident reporting is the starting point in a patient safety program. Through a good reporting mechanism, it will be able to identify problems which can then be formulated for improvement solutions. Making reporting a source of information in the learning process requires at least two things that must be prepared by the hospital. The first is the availability of human resources capable of conducting incident analysis. The second thing is that there is a policy developed by the hospital to outline the criteria for carrying out root cause analysis and impact and failure analysis.

Based on the results of the study, nurses in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai reports less frequently incidents when errors occur but these are immediately recognized and corrected before they affect or impact the patient, when errors occur, but do not

have the potential to harm patients, and when errors occur, which have the potential to harm patients, even if things are bad did not occur in patients as evidenced by the results of a positive response of 73.22% which illustrates that the dimension of reporting frequency is as large as which can be interpreted as good enough or moderate culture.

The frequency dimension of incident reporting in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai is categorized in medium culture. This illustrates that the reporting of incidents by nurses in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai still needs to be improved. RSUD Dr. R.M. It is hoped that Djoelham, Binjai City, can increase the motivation for incident reporting by eliminating the fear of being blamed by the nurse who gave the report, not giving punishment and not blaming the incident reporter, making the procedure for reporting patient safety incidents simple and easy to implement.

Patient Safety Culture in the Inpatient Unit of RSUD Dr. R.M. Djoelham City of Binjai

Based on the results of the research on the overall picture of patient safety culture in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai in 2020 is 76.74% which is categorized in a strong safety culture. According to Blegen, patient safety culture is the perception that is shared among members of the organization aimed at protecting patients from management errors and injuries resulting from interventions (Rangkuti et al., 2018). This perception includes a collection of norms, professional standards, policies, communication and responsibility in patient safety. This culture then influences individual beliefs and actions in providing services. Patient safety culture in the Inpatient Unit of RSUD Dr. R.M. Djoelham City of Binjai is said to have a strong culture. Hospital unit nurse Dr. R.M. Djoelham, Binjai City, can be said to have a set of beliefs, norms, behaviors, roles, and social and technical practices in minimizing exposures that harm or harm patients. This shows the perception that nurses have in protecting patients from management errors and injuries due to interventions that are already in good condition and need to be maintained. The culture of patient safety that is said to be strong at the Dr. R.M. Djoelham Kota Binjai is expected to influence individual beliefs and actions in providing safe and quality services.

In the 12 dimensions of patient safety culture, there are 5 dimensions of patient safety culture which are categorized in a strong culture with a positive response of >75% including the dimensions of cooperation within the unit (93.85%), the dimensions of expectations and the actions of managers in promoting patient safety (81.25%) , organizational learning-continuous improvement dimensions (91.8%), management support dimensions for patient safety (85.8%), and feedback and communication dimensions for errors (77.05%). This shows that the nurse in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai has a good perception regarding efforts to learn from mistakes which are included in continuous improvement (organizational learning), quite good in cooperation within units and between units, both in terms of open communication, and the RSUD Dr. R.M. Djoelham Kota Binjai has properly promoted and provided support for patient safety.

There are 7 other dimensions of safety culture which are categorized as moderate safety culture, namely with a positive response of 50-74.9%, including the dimension of open communication (71.04%), nurses' perceptions of patient safety (68.86%), the dimension of incident reporting frequency (73.22%), dimensions of staffing (59.01%), handsoff and transition (59.02%), dimensions of cooperation between units (71.32%), and dimensions of non-punitive responses to mistakes (61.20%) . The lowest percentage of positive responses is the staffing dimension, which is 59.01%. This shows that the most visible problem in the patient safety culture in the Inpatient Unit of RSUD Dr. R.M. Djoelham Kota Binjai is a staffing dimension.

According to Lin et al., staffing is defined as the process of affirming skilled workers to fill the organizational structure through the selection and development of personnel. With staffing, it is hoped that the number and skills possessed by nurses will be fulfilled according to the needs

in each unit needed. The number of nurses in the hospital affects the quality of service that patients receive in the hospital because adequate staff is fundamental for quality care as evidenced by the number of nurses equivalent to better patient safety. Based on the results of the study, it illustrates that according to nurses' perceptions, the number of nurses working in the Inpatient Unit of RSUD Dr. R.M. Djoelham City of Binjai is inadequate compared to the patients served. Aiken, et al., stated that there is a direct relationship between nurse staffing and its impact on patient safety, outcomes, and professional nurse satisfaction in hospitals (Yarnita, 2019).

The purpose of implementing patient safety is to improve the quality of service and the image of the hospital, so that patient trust in the hospital will certainly increase. In this case, general patients who visited RSUD dr. R.M. Djoelham Binjai is increasing every year, which is an effect of the hospital's strong patient safety culture.

Conclusion

Based on the results of the study on the description of patient safety culture using the AHRQ model at RSUDDr. R.M. Djoelham Kota Binjai in 2020 It is known that the dimensions of expectations and actions of managers promote patient safety by 77.04%. This shows that the patient safety culture on this dimension is good or has a strong culture. It is known that the dimension of organizational learning/continuous improvement regarding patient safety is 91.8% which can be interpreted as good or has a strong culture. It is known that the dimension of cooperation within the unit is 93.85% which can be interpreted as good or has a strong culture. It is known that the dimension of open communication is 71.04% which can be interpreted as quite good or moderately cultured. It is known that the feedback dimension regarding errors is 77.05% which can be interpreted as good or has a strong culture. It is known that the dimension of non-punitive response to errors is 61.20% which can be interpreted as quite good or moderately cultured. It is known that the staffing dimension is 59.01% which can be interpreted as quite good or moderately cultured. It is known that the dimension of management support for patient safety efforts is 85.8% which can be interpreted as good or has a strong culture. It is known that the dimension of cooperation between units is 71.32% which can be interpreted as quite good or moderately cultured. It is known that the dimension of the overall perception of hospital staff about patient safety is 68.86% which can be interpreted as quite good or moderately cultured. It is known that the dimension of reporting frequency is 73.22% which can be interpreted as quite good or moderately cultured.

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