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Individual and Organization Affects Perceptions of Reporting Patient Safety Incidents in Medan City Hospital

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Abstract : ***Patient safety incidents must be minimized to avoid unwanted dangers during hospitalization. Reporting of patient safety incidents in the Hospital is still low. Low reporting of patient safety incidents are related to individual and organization factors. This study aimed to identify the individual and organization factors on reporting patient safety incidents in the inpatient Hospital. The study was a survey method with a cross-sectional approach. The population in this study were all nurses inpatients in Medan city Hospital as many as 168 people and a sample of 88 people. Data were collected with primary, secondary, and tertiary data and analyzed with a statistical test of Multiple Logistic Regression with a confidence level of 95%. The results showed that individual factors (knowledge with p-value=0.021 and experience with p-value=0.021) affected the reporting of patient safety incidents and organizational factors (organizational environment with p-value=0.038 and power with p-value=0.014). Most influence reporting Patient safety incidence in the hospital was a knowledge variable (OR=155.6).***

Keywords:Individual factors, Organization factors, **Reporting of patient safety incidents**

1. INTRODUCTION

Incidents of patient safety are circumstances that pose a danger that patients do not want during the nursing process [1]. Incidents of patient safety should be minimized to avoid unwanted harm during hospital treatment. Patient safety incidents include potential injury conditions, near-injury events, uninjured events, and unexpected events [2]. The Institute of Medicine (IOM) in the Ministry of Health [3]published the first report on the incident under the title To Err was Human: Building a Safer Health System in 2000 obtained data that there were 58% of the 98,000 errors that resulted in death each year due to preventable negligence. Between October 2011 and October 2012, there were 12.1 unexpected incidents per 100,000 total hospitalization days in Minnesota.

The results stated that the negative response within the organization will create nurses and doctors who are afraid to report errors that occur when performing medical procedures. To do so, health organizations must be able to create a un punitive environment with the aim that every element is not afraid to report events [4]. A no-judgmental response is an attitude of not punishing or cornering someone for mistakes that have been made [4]. Nurses are at the forefront of providing nursing care to patients, where safe care is important in patient safety [5]. Reporting of patient safety incidents still needs to be improved because there is still a high fear of severe penalties when reporting on patient safety [6].

Some errors threaten patient safety such as drug administration errors (wrong type or prescribed dosage of the drug), surgical procedure errors (performing surgery on the wrong part, using incorrect techniques, or postoperative complications), incorrect diagnosis (delayed or incorrect or undiagnosed diagnosis), equipment failure used in the action given to the patient, and other problems such as nosocomial infection, the patient falls, baring wounds, and incorrect treatment [7]. The Hospital Patient Safety Committee has provided socialization on reporting patient safety incidents to nurses, if incidents are found both potential injury conditions, near-injury events, uninjured events, and unexpected events and sentinel incidents should be reported. However, there are still cases of mis-administering drugs in the inpatient room but not reported by nurses.

Patient safety is influenced by the behavior of individuals and organizations, based on beliefs and shared values that are continuously sought to minimize patient harm, which may result from the process of providing care[8]. Mulyana's [9]stated that individual characteristic factors are the dominant factors that influence patient safety incidents. The research is in line with Audyawardani's [10] stated that individual factors, organizational factors influence the reporting of patient safety incidents. Individual factors are the basic factors inherent in a particular individual. The dimensions of individual factors include knowledge, experience, and motivation [11]. While the dimension of organizational factor consists of organizational culture and organizational environment and power [12].

Based on interviews conducted with 10 nurses to see the nurse's knowledge of patient safety incidents 6 of them mentioned not knowing the specifics of the type of incident, the benefits of reporting and still hesitate to fill out the safety incident reporting form due to the uncertainty of the incident to be reported. Based on the experience of nurses that 6 nurses mentioned inexperienced fill out a patient safety incident reporting form and fear of reporting patient safety incidents for fear of the consequences of applicable law and the Register Letter was revoked. The environmental aspect of the nursing organization mentioned that the organizational environment in the hospital will be a sensitive issue if there are findings of patient safety incidents in the room. From the aspect of the power of nurses mention that fear of being sanctioned or fired when making mistakes that cause incidents of patient safety.

2. METHODS

This study was designed using a survey method with a cross-sectional approach to explore the influence of individual and organizational factors on nurse perception in reporting patient safety incidents in the inpatient room of the true partner hospital of Medan city in 2019.The population in this study was nurses in the hospital inpatient room in Medan as many as 168 people. The study sample selected in this study as many as 88 nurses using probability random sampling with simple random sampling techniques.

3. RESULTS

The results of the study on the characteristics of respondents in hospitals were mostly the age of respondents with the age of 26-30 years as many as 43 people (48.9%). This indicates that the age of nurses in hospitals dominated by a young age. Where at this age nurses have the good physical strength required in providing nursing care quickly and thoroughly to patients. But young nurses cannot provide proper care without guidance from senior nurses so that nursing services can improve and quality becomes good. The gender of respondents was mostly female as many as 73 people (83.0%). This suggests that nurses at the Hospital have more female nurses. Female nurses can provide nursing care with patience, care, and compassion. Although women are patient, conscientious and provide nursing care with

compassion, it does not mean that men cannot work as nurses because the decision to become a nurse is not seen from the gender but based on one's interests.

The education of respondents was mostly a diploma of nursing as many as 60 people (68.2%). This shows that nurses in hospitals have more vocational personnel who already have practical experience in providing nursing care. If it is associated with patient safety reporting according to researchers there is no relationship between education and reporting behavior or not reporting incidents that occur in patients in hospitals.Theworking period of respondents was >5 years as many as 44 people (50.0%). The working period is related to the ability to adjust to the situation that occurs in each individual. Although the average experience of nurses was >5 years nurses must still get guidance and coaching through socialization and training to anticipate the occurrence of incidents in patients. (Table 1.)

Table 1: Frequency distribution of respondents' characteristics in hospitals in Medan (n=88)

No	Characteristics	Frequency	%
Age			
1	≤ 25 Year	24	27,3
2	26-30 Year	43	48,9
3	31-35 Year	18	20,5
4	> 35 Year	3	3,4
	Total	88	100,0
Gender			
1	Man	15	17,0
2	Woman	73	83,0
	Total	88	100,0
Education			
1	Diploma 3 Nursing	60	68,2
2	Nurse Profession	28	31,8
	Total	88	100,0
Working Period			
1	≤ 1 Year	19	21,6
2	2-5 Year	25	28,4
3	>5 Year	44	50,0
	Total	88	100,0

Based on table 2, it was obtained that the knowledge of expertise about reporting patient safety incidents in hospitals in Medan mostly had 51 people of not good knowledge (58.0%). Lack of knowledge is caused by the lack of exposure of nurses to the implementation of safety incident reporting because the feedback from the head of the room is less optimal and the lack of willingness of nurses to find sources of information both through print, books, and other literature and less ask other nurses about the perception of nurses in reporting patient safety incidents.

Table 2:Distribution of knowledge frequency of implementing nurses in hospitals in Medan (n=88)

No	Knowledge	F	%
1	Good	37	42,0
2	Not Good	51	58,0
	Total	88	100,0

The experience of implementing nurses in hospitals was mostly good as many as 45 people (51.1%). Although the experience of nurses was more in a good category experience was not an indicator of a person who will not make mistakes cause incidents in patients. Based on observations obtained that less experienced nurses fill outpatient safety incident reporting forms because it was a new regulation (table 3).

Table 3: Distribution of experience frequency of implementing nurses in hospitals in Medan (n=88)

No	Experience Category	F	%
1	Good	45	51,1
2	Not Good	43	48,9
	Total	88	100,0

The organizational environment in reporting incidents of patient safety in hospitals was mostly good as many as 45 people (51.5%). This was supported by the hospital's efforts to create a conducive environment to support patient safety programs and minimize patient safety incidents (Table 4).

Table 4: Distribution of organizational environmental frequencies in hospitals in Medan City (n=88)

No	Organization Environment	F	%
1	Good	45	51,1
2	Not Good	43	48,9
	Total	138	100,0

The category of organizational power in hospitals was mostly not as good as many as 45 people (51.5%). The not good power, in this case, can be highlighted from the low level of training and reward given by the leadership to nurses.

Table 5: Distribution of organizational power frequency in hospitals in Medan City (n=88)

No	Organizational Power	F	%
1	Good	43	48,9
2	Not Good	45	51,1
	Total	138	100,0

The multivariate test used double logistic regression method with entering method obtained that free variable that is knowledge with p-value 0.021 ($p<0.05$), experience with p-value 0.030 ($p<0.0$ 5), an organizational environment with a p-value of 0.038 ($p<0.05$) and a strength with a p-value of 0.014 ($p<0.05$) affects the reporting of patient safety incidents at hospitals in Medan.The results of the double logistic regression test analysis showed that the most dominant variable affecting the reporting of patient safety incidents in hospitals in Medan was the knowledge variable that was at the coefficient of regression OR 155.6 (95% CI=2,159-11213,011). This indicates that these variables have a significant influence on the reporting of patient safety incidents at hospitals in Medan.Positive knowledge variables indicate that the variable has a one-way (positive) relationship to the reporting of patient safety incidents at hospitals in Medan. So it could be interpreted theoretically that patient safety incident reporting increases much higher if knowledge is further enhanced.

4. DISCUSSION

The results of the study obtained that the knowledge of nurses about reporting incidents of patient safety with a category of not good in hospitals in Medan by 90.2%. Based on the

double logistic regression test obtained results there was a significant influence between the knowledge of nurses on reporting incidents of patient safety in hospitals with a value of p=0.021<α=0.05.Referring to the results of the statistical test, it can be explained that the better the knowledge of nurses is expected to report incidents of patient safety increasing in hospitals in the city of Medan. The low knowledge of nurses about reporting patient safety incidents is characterized by a lack of understanding of nurses about documenting patient safety incident reports, conducting analysis and solutions for learning, even there are still nurses who do not know about the type of reporting of patient safety incidents that include unexpected events, occurrences of injuries, potential injuries, uninjured events and sentinels and not knowing that patient safety incident reporting should be reported no later than 2x24 hours.Knowledge influences the reporting of patient safety incidents. Nurse knowledge plays an important role in reporting patient safety incidents. The hospital's efforts to increase knowledge can be supported through internal and external seminars, education, training, and orientation for new staff on the topic of patient safety. This is following and strengthens Hwang's [13]states that patient safety knowledge affects the intention to report, the lack of understanding of officers to report incidents of patient safety [14].

Based on the double logistic regression test obtained results there was a significant influence between the experience of nurses on the perception of reporting patient safety incidents at the True General Hospital of Medan with a value of p=0.021<α=0.05. Referring to the results of these statistical tests it can be explained that a good nurse experience in reporting patient safety incidents will further improve the reporting of patient safety incidents and conversely the experience of poor reporting will further decrease the reporting of patient safety incidents at hospitals in Medan.Experiences that support nurses to report patient safety incidents in the form of nurses who make mistakes are not sanctioned but rather fostered so as not to repeat the same thing. This coaching will further improve the upcoming performance of nurses. The experience of nurses who were not good at reporting patient safety incidents at the previous time was 48.9%. This indicates that hospitals are still high in providing penalties or reprimands or sanctions to nurses who report incidents of patient safety, it is very influential for nurses to report back in case of incidents of patient safety.According to Beginta [15]that the patient safety system should be built properly by not blaming in case of incidents of patient safety, but more to find the root of the problem for a mistake to be able to further make corrections so that no similar errors occur. Punishing staff as a repair effort will reduce error reports instead of fixing the system and minimize the risk of future errors.

The results of the study found that the organization's environment in reporting incidents of patient safety with a good category in hospitals in the city of Medan amounted to 77.8%. Based on the double logistic regression test obtained results there is a significant influence between the organizational environment on the reporting of patient safety incidents in hospitals in the city of Medan with a value of p = 0.038< α=0.05.In this study, the organization's environment in question in the form of peers supported to report in case of incidents related to patient safety, the head of the room still gave confidence to staff even though the staff had made mistakes that could potentially harm the patient. peers provide support if nurses make potentially dangerous mistakes in patients, Hospital Patient Safety Committee provides comfort to nurses who make mistakes related to reporting patient safety incidents, Hospital Patient Safety Committee does not give severe sanctions when nurses make mistakes related to reporting patient safety incidents, hospitals make incident prevention training to avoid incidents.According to Budihardjo [16]mentioned that the characteristic that most determines success in reporting is an environment that is not punishing, either for the whistleblower or other individuals involved in the incident. According to Arfella [17]said that a good organizational environment creates coordination

between members so that patient safety programs run well. One form of coordination activities is to hold regular weekly and monthly meetings aimed at conveying the results of monitoring and evaluation of the implementation of patient safety programs. However, reporting of patient safety incidents has not fully worked following the existing reporting flow.

The results of the study found that the power in reporting incidents of good category patient safety was 79.1%. Then based on the double logistic regression test obtained results there was a significant influence between the power on the reporting of patient safety incidents at hospitals in the city of Medan with a value of $p = 0.014 < \alpha = 0.05$.In this study, the hospital instructed all staff to report patient safety incidents to the hospital patient safety committee was no later than 2x24 hours, nurses will be sanctioned if they do not report any findings of patient safety incidents, hospital management rewards rooms that report numerous patient safety incidents, hospital patient safety committee actively socializes continuously how to avoid patient safety incidents, management actively conducts training on patient safety.However, there is a power that makes nurses reluctant to report incidents of patient safety such as abuse of hospital management makes nurses reluctant to report incidents by 21.6% and nurses in this hospital will be dismissed for misconduct that causes patient safety incidents by 23.9%.From the results of this study, it is expected that there is an increase in reporting of patient safety incidents by not punishing errors such as by evaluating the reporting system so that it can be known the cause. Also, there needs to be a follow-up on how to reduce the incidence rate of incidents for example by finding the root of the problem to be found or designed a new system so that there are no similar incidents and there is feedback to the reporting unit so that they know the cause of the incident.

5. CONCLUSIONS

This study shows that individual factors (knowledge with p-value=0.021 and experience with p-value=0.021) affect reporting of patient safety incidents and organizational factors (organizational environment with p-value=0.038 and power with p-value=0.014) affect reporting of patient safety incidents. The most affected reporting of patient safety incidents in hospitals is the knowledge variable (OR=155.6).

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