

An Analysis Patient Safety Goals in Aspect Implementation Identification and Treatment Medicines in the Inpatient Room of the Tenriawaru Hospital Bone Regency

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ABSTRACT

House sick have obligation for give service in accordance with right patient and safety patient. Accuracy identification patient and storage drug (high alerts) is part from patient safety. In Tenriawaru General Hospital Bone Regency still there is patient which no identified with Correct and still there is drugs (high alerts levels) which no permanent in accordance SOUP. Destination from study this is for knowing implementation identification patient and security drug (high alerts) in Tenriawaru General Hospital Bone Regency with theory system. Method study this is descriptive qualitative and use tool study form guidelines Interview and sheet observation. Interview conducted with Director HOSPITAL Tenriawaru Bone Regency, Secretary Committee quality, Nurse executor and Staff Safety patient . Results study show that identification patient and application security drug (high alerts) permanent walk, however not yet fully in accordance with regulation PMK 1691/MENKES/PER/VII/2011. Thing this caused by source power man which no sufficient, lack of training head room , Disobedient to instructions SOUP which has determined , noncommitment head room, and lateness delivery report safety patient to KMKP. Suggestion from study this is Activation officer TKPRS in ward house sick , maintenance training routine , monitoring obedience to SOUP related identification patient and monitoring security drug through videos surveillance and questionnaire patient for evaluation nurse, and waiver inspection patient must improved. Recording and reporting Culture case patient.

Keywords: Patient Safety Goals, Aspect Implementation Identification, Treatment Medicines

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1. INTRODUCTION

Providing optimal quality health services, hospitals need health workers who are productive at work [15]. These health workers are doctors, nurses, midwives, pharmacists, physiotherapists and other health workers [9]. In providing optimal quality health services, hospitals need health workers who are productive in their work [7]. These health workers are doctors, nurses, midwives, pharmacists, physiotherapists and other health workers (Fatimah, 2012 in [11]).

House sick is service which hold role important in life society. House sick is the place which very complex, there is hundreds drug which different, hundreds test and procedure, there is many help technical , various profession and non- professional , provide care patient 24 o'clock without stop , in where diversity and routine patient , service this if occur use which no appropriate could occur incident not expected which endanger safety patient [2]. House sick is facility health Public with characteristics alone which influenced by development knowledge health, development technology , and life social economy Public [6]. System Accreditation House Sick (KARS) version 2012 state that all activity service house sick must give service which Fulfill standard quality and ensure flavor safe and protection to impact service which given , To use Fulfill right Public on quality and safety patient in nature Thing this house sick apply program quality and safety patient (Qomariah and Ari, 2015) . Safety

patient house sick is something system in where house sick make care patient more safe with prevent error which caused by To do or no To do procedure [12].

Tenriawaru General Hospital Bone Regency also applies implementation six regards safety which four patients target the that is target (2) improve effective communication, target (4) ensures location correct surgery, correct procedure, and surgery on the correct patient, the target (5) is carried out *Hand Hygiene*, and target (6) reduction risk patient injured, yes in accordance with the target set that is 100%. Based on studies preliminary conducted by researchers obtained recapitulation incident carried out by the Tenriawaru Hospital KP-RS team Bone Regency. Found a number of incident with classification as following :

Table 1. Recapitulation Tenriawaru Hospital Incident Bone Regency of the Year 2021

Month	KPC	KNC	KTC	KTD	Total
September	10	16	0	8	34
October	22	18	9	6	55
November	10	21	3	6	41
December	15	14	9	4	42
Total	57	69	21	24	171

Tenriawaru Hospital Management Bone Regency already To do various effort application patient safety and hope no occur incident safety patient and destination 0 achieved, however on in fact still there is implementation which not yet optimal. Based on results studies introduction, there is a number of target safety patient which still need noticed. Researcher find information that still there is a number of case which reported caused by negligence doctor and nurse. Besides that, researcher also find information that still many entity which deliver Report Case Safety Patient (PCI) monthly to Committee Quality and Safety Patient after deadline time which set.

Table 2. Recapitulation Incident Most in Tenriawaru Hospital Bone Regency of the Year 2021

Month	Error Identification Patient	Lack of Security Drug	Total
September	9	1	10
October	2	1	3
November	4	1	5
December	5	3	8
Total	20	6	26

Judging from the monitoring results, it was found that the most incidents were KNC (Near Injury) incidents such as patient identification errors and a lack of safety for drugs that must be watched out for (high alert) [6]. Patient identification is carried out before carrying out nursing actions, giving blood transfusions or blood products, taking other elements for clinical trials [4]. Patient identification is carried out by providing patient identification such as using an identification bracelet for inpatients as follows: the identity on the bracelet has at least two pieces of information, namely name, date of birth, and medical record number [1].

Patient identification must be carried out properly and correctly by the responsible medical personnel. In 2016 the accuracy of patient identification at Tenriawaru Hospital was still 80% and had not reached the target set at 100%. Based on preliminary study interviews, there was an error in blood transfusion to a patient because the nurse did not identify the patient first. From the observation results, it was found that there were still nurses who did not provide identity bracelets to patients.

While increasing the safety of drugs that need to be watched out for (High Alert Medication) are drugs that often cause serious errors and drugs that have a high risk of causing unwanted effects [2]. High alert drugs have a higher risk of causing an incident when not properly managed [16]. Labeling is the first step to identify high alert drugs so that they are treated according to applicable safety standards. The label must be filled in on the drug in a part that does not cover the identity of the drug [8]. If the drug is not given a high alert label according to the standard, it must be reported as KNC (Near Injury). In 2016, drug safety that needs to be watched out for (high alert) at Tenriawaru Hospital is still 80% and has not reached the target set at 100%. Based on the preliminary study interviews there were still high alert drugs in the inpatient unit that were not labeled and the nurses forgot to return the drugs to the pharmacy after use.

In addition, some staff in the quality and patient safety committee hold two responsibilities or double jobs which makes him less focused on carrying out his duties on the quality and patient safety committee [14]. Tenriawaru Hospital has also provided training related to patient safety, but not all staff on duty have received this training.

In terms of system theory, the accuracy of patient identification and increased safety of drugs that need to be watched out for are the outputs. To achieve good output, good input and processes are also needed [3]. Based on the preliminary study, the researchers found problems with input related to human resources for health workers in

reducing patient safety incidents, infrastructure, and processes related to organization and implementation. Therefore the researcher intends to explore this problem [13].

Based on the above phenomenon, research is needed that seeks to find out the adherence of nurses in implementing patient safety goals in reducing the risk of infection by using personal protective equipment (gloves and masks) at Tenriawaru General Hospital, Bone Regency.

2. METHOD

The type of research used in this study is exploratory research with a qualitative approach. The respondents who were used as the main informants were inpatient nurses who had KNC, inpatient nurses who did not have KNC and a member of patient safety. And to test the validity of the data, triangulation informants were selected, namely the head nurse in the inpatient unit who had KNC, the head nurse in the inpatient unit where there was no KNC and the secretary of the Quality and Patient Safety Committee. Which aims to explore and explore and describe patient safety goals from the aspect of implementing patient identification and drug safety which will be carried out in February 2022 at Tenriawaru Hospital, Bone Regency.

3. RESULTS AND DISCUSSION

Results

Table 3 Characteristics Informant Study

No	Initials	Age (year)	Type Sex	Education	Position	Working Period (year)
1	IU1	25	P	D3 Academy	Nurse	4
2	IU2	30	P	D3 Academy	Nurse	10
3	IU3	40	P	D3 Academy	CP member	15
4	IT1	50	P	Nurse	Head Nurse	28
5	IT2	51	P	Nurse	Head Nurse	28
6	IT3	40	P	S2 MARS	Secretary KMKP	10

Based on table 3 above , it is known that informant have working time over 15 years with education finally D3 Academy Nursing. Temporary for informant triangulation have education finally S2.

Analysis Source Power

In analyze source power man in study this seen from two criterion , that is quality and quantity the power involved . Quality seen from level education and training related safety patients who have followed by a nurse executors and members team safety patient . Patient safety training has been organized by parties house sick, training patient safety includes seminars and activities contest intelligent careful with patient safety theme. House pain also supports nurse for follow training organized by the party outside house sick ie KARS however no all nurse could follow training the because many patients in the ward stay . A number of nurse even state no once though follow training.

Whereas quantity seen availability and adequacy nurse executor in the take care stay, Safety Team patient House Hospital (TKPRS) and the Committee Quality and Safety Patient (KMKP) in implementation identification patient and care security drug seen still weak from side availability and adequacy source power because burden work borne by each nurse executor enough heavy because amount lots of patients as well as many must action conducted to patient the. In the inpatient unit hospitalization and general poly there are 143 nurses with with take care stay 1st floor public poly there are 20 nurses implementers, 20 nurses this already including with head room. 19 nurses executor work shared according to shift, there is three shifts namely morning, afternoon and night shifts. Few nurses, influential to implementation identification and security drug because with amount few nurses and many patients make nurse no To do identification with good dean in accordance with the SOP reason limitations time . Meanwhile , besides darin nurse implementers , the patient safety team is also influential in identification patient and safety medicine . Amount patient safety team at home sick already has 20 members including with chairman and deputy as well secretary . However of 20 members patient safety team, only part secretariat namely 2 members who work full time in safety patient, 18 others no work full time because have other structural positions . this of course it just really burdened 2 members full time team and stuff this make committee quality and safety patient (KMKP) to be hassle . This resulted no there is a monitoring TKPRS or monitoring identification and security medication in the ward stay because bustle member team the .

Analysis Policies and SOPs

The policies and SOPs in this study are the availability of policies, regulations, SOPs, or guidelines regarding patient safety goals, especially the implementation of patient identification and drug safety at Tenriawaru General Hospital, Bone Regency. Regarding patient safety policies, Tenriawaru Hospital Bone Regency issued a decree from the Director of Tenriawaru Hospital, Bone Regency Number 022/A/IX/2015 concerning Policy for Implementing Patient Safety Goals on 7 September 2015 which was previously revised. In addition, there is also an SOP regarding the installation of an identity bracelet, namely Document No 240/A/IX/2021. SOP for identification with two identities, namely Document No 237/A/IX/2021. The SOP for improving drug safety that needs to be watched out for is Document No 443/A/14/IX/202. However, related to nurse compliance in implementing SOP, it still needs to be further controlled and monitored because KMKP and TKPRS, with their busy schedules and multiple tasks, are owned by most TKPRS, making monitoring of SOPs not run smoothly.

Facility and Infrastructure Analysis

Facilities and infrastructure for patient safety, especially patient identification and maintaining drug safety, are available and adequate. In patient safety goals from the aspect of patient identification, a patient identity bracelet is needed, there are 4 types of bracelets, pink bracelets for female patients, blue bracelets for male patients, red bracelets for patients who have a history of allergies, yellow bracelets for patients who are at risk of falling. In addition to the identity bracelet, there are also patient medical records, patient data, and patient identification incident reporting forms. Patient safety from the aspect of drug safety that needs to be watched out for has available special labels for high alert drugs, special high alert medicine cabinets, special electrolyte concentrate cabinets and drug safety incident reporting forms.

Analysis Organizing

There is a patient safety organizational structure in the hospital, the organizational structure is posted on the wall in the quality and patient safety committee room, as well as in the inpatient unit section. There is also a clear job description of each party involved in patient safety goals from the aspects of implementing patient identification and improving drug safety that need to be watched out for. However, there are no guidelines regarding how many nurse human resources should be needed to serve patients in inpatient rooms. According to Permenkes No. 56 of 2014 concerning Hospital Licensing and Classification, that the number of nursing staff required for type B hospitals as referred to in Article 21 is the same as the number of beds in inpatient installations.

Analysis of Implementation of Policies and SOPs for Patient Identification and Drug Safety

Implementation of policies and SOPs, namely the suitability of implementing patient identification and labeling of high alert drugs with policies and SOPs. In stating what steps must be taken, the implementing nurse can state precisely and clearly in accordance with the policies and SOPs that apply in the hospital. But that doesn't mean they are doing their job according to the SOP, the implementing nurse feels that every time they take an action they don't need to ask the patient's name over and over again. Because the nurse feels that she already remembers the patient's name. The nurse's actions are actually included in the near miss incident (KNC) because there could have been 2 or more patients who had the same name, the names of these patients could also be different in pronunciation and writing. In the act of administering drugs and blood transfusions, of course this is very dangerous if the nurse does not ask the patient's name and adjust it to the patient's blood type.

Tenriawaru General Hospital, Bone Regency has SOPs for maintaining drug safety (high alert) that must be implemented, one of the SOPs states that high alert drugs must be placed in a pharmacy in a separate cupboard from other drugs. Each inpatient unit has its own pharmacy in it. On Monday to Friday the nurse returns the medicine to the inpatient unit pharmacy, but on Saturday and Sunday the inpatient pharmacy is closed, so the nurse has to go to the hospital pharmacy, which is quite far away. According to the implementing nurse, this is an obstacle because with many patients and piling up tasks, nurses feel that they are wasting their time by going to the hospital pharmacy. therefore the nurse places high alert drugs in the inpatient room if they have not been used up or will be consumed by the patient in the near future. This is of course very dangerous and violates the established hospital SOP. Analysis

Commitment Officer

Officer commitment is an attitude of willingness that comes from officers, in this case, namely nurses and the hospital patient safety team to carry out the rules that exist in the hospital in carrying out their duties. committed to their work and also comply with existing regulations, but in practice nurses do not always carry out patient identification according to SOP. A large number of patients make the nurse busy and ignore the rules that should be applied, for example when identifying a patient, the nurse does not ask the patient's name because they feel they

clearly remember the patient and reason that asking the patient's name continuously will only distract the patient and waste time.

In maintaining drug safety in the inpatient unit, nurses also do not carry out in accordance with the SOP that applies to the hospital on the grounds that the inpatient unit pharmacy is closed and must take drugs in the hospital pharmacy which is quite far from the inpatient unit, therefore the nurse puts drugs (high alert) on the patient's inpatient table without supervision. This proves that nurses are less committed to complying with policies and SOPs in the hospital.

Reporting Analysis

Patient safety incident reporting, hereinafter referred to as incident reporting, is a system for documenting patient safety incident reports, analysis and solutions for learning. Reporting is a mechanism carried out by nurses in the inpatient unit to the quality and patient safety committee regarding the incident or incident experienced. Patient safety reports are recorded every day on the reporting form, the reporting forms are different. The report is recorded daily and recapitulated monthly by the head of the inpatient room in the inpatient department and submitted to the quality and patient safety committee. The report will then be held every three months with the head of quality and all members of the patient safety team to analyze the problem and find the best solution.

The flow of making this report will be different if an adverse event or KNC occurs in the inpatient unit. Based on the interview results, it was found that if there is an adverse event or KNC, the incident will first be reported to the head of the room and then immediately reported to the quality and patient safety committee right away without having to wait for the monthly report. The implementing nurse concerned with the KTD and KNC incidents was then asked to describe the incident in full on a form provided. After that the incident will be immediately held by the quality and patient safety committee to get the best solution regarding the problems that occurred at that time. Constraints in making reports, namely reports cannot be done during working hours because during working hours there are quite a lot of patients, therefore patient safety reports are made outside working hours. In addition, nurses also admitted that they were confused and did not understand how to fill out reports because reports were not made every day and were made monthly. And the report should be made by the head of the room but made by the implementing nurse.

4. CONCLUSION

Human resources, namely nurses and TKPRS are not sufficient, policies and SOPs for Patient Identification and High Alert Drug Safety are available. Facilities and infrastructure for patient identification include pink, blue, yellow and red identity bracelets, medical records and reporting forms. In maintaining drug safety, drug labels, separate medicine cabinets and reporting forms are available. In identifying patients, it is still not in accordance with PMK 1691/MENKES/PER/VIII/2011 and the decision letter of the Hospital Director, the commitment of the implementing nurse and TKPRS to policies and SOPs in carrying out their duties is still lacking in commitment, submission of monthly reports to KMKP often experiences delays, and reports that should be carried out by the head of the room are carried out by implementing nurses, organizational structures and job descriptions are available but do not yet have guidelines regarding the standard number of nurses in inpatient units.

Suggestions from this study are to activate the person in charge of the patient safety team for each inpatient unit, need to hold routine training, need to follow up on SOP compliance related to monitoring patient safety in the inpatient unit by installing CCTV and giving assessment questionnaires to inpatients as nurse evaluation methods and the culture of recording and reporting patient safety cases needs to be improved.

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