

# Implementation of Permenkes Number 1691 the Year 2011 Concerning Patient Safety in Palu Undata Hospital

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## ABSTRACT

Implementation of Patient Safety is the obligation of the hospital to fulfill the rights of patients to be free from injury and potential injury (disease, physical/social psychological injury, disability, and death) involving health workers/officers (medical, paramedical) and non-medical, to work together to improve patient safety. The researcher aims to determine the implementation of patient safety at the Update Hospital Palu, as regulated in Permenkes number 1691 of 2011. The type of research used is qualitative, namely observation, interviews, and documentation. The results showed that some health workers/health workers still ignored informed consent/consent for small but risky actions in carrying out their duties. Incidents that occur due to equipment that does not meet standards should be facilitated by KMKP (Patient Safety Quality Committee) at Update Hospital Palu but have not been implemented, but only reduce incidents that occur due to medical personnel errors/paramedics. The need to build individual awareness of staff/officers in carrying out their duties, the need to integrate if there is an incident either due to equipment or due to an error of the officer in one container, namely KMKP Hospital as a report to be evaluated.

**Keywords** - Policy, Patient Safety

## INTRODUCTION

Based on Permenkes RI number 1691 / MENKES / PER / VIII / 2011 concerning Hospital Patient Safety, establishes Patient Safety Standards: 1) Patient rights, 2) Educating patients and families, 3) Patient safety and continuity of service, 4) Use of methods performance improvement to conduct patient safety evaluation and improvement programs, 5) Leadership role in improving patient safety, 6) Educating staff about patient safety, and 7) Communication is the key for the team to achieve patient safety (1).

Patient safety is the patient's condition free from injuries that should not have occurred or free from potential injuries (illness, physical / social-psychological injury, disability, death) related to health services (2). Patient safety is every patient's right and should be the hospital's obligation to fulfill the patient's requests (KARS, 2006). The implementation of patient safety in Indonesia is still not optimal, as evidenced by the number of malpractice cases reported by the mass media (3).

Patient safety is carried out to achieve six goals, including patient identification; enhancing effective communication; increased drug safety that needs to be watched out for; safety of surgical procedures; prevention of the risk of infection; and prevention of the risk of falling patients (4).

This study aimed to explain the implementation of patient safety at the Update hammer Regional General Hospital (RSUD).

## **METHODOLOGY**

This type of research is qualitative, namely observation, in-depth interviews, and documentation. This study's informants were crucial, regular informants, and additional informants. The technique used in determining informants is purposive sampling, namely the sampling technique with specific considerations (5).

## **RESULTS AND DISCUSSION**

### **Implementation of Permenkes Number 1691 of 2011 concerning Patient Safety at UNDATA Hospital, Palu**

After conducting observations and interviews with the Director of the Undata Hospital Palu, the results can be grouped based on the variables studied in this study. Conclusions can be drawn from the results of the survey through the variables looked including:

#### **Policy**

The policy is a series of program plans, activities, actions, decisions, attitudes, act or not to act by the parties (actors), as a stage for solving the problems at hand. Policy setting is an essential factor for an organization to achieve its goals (6). This was revealed from the results of interviews with respondents as follows:

*“Thank you, a fundamental question in achieving patient safety itself based on Law 44 of 2009 article 43 paragraph 1 concerning patient safety standards, it has indicated that when the operation of hospital services is related to workforce aspects and infrastructure, it must be of good quality, The substance of the questions you asked earlier is about the elements of medical facilities and equipment. Of course, we already have common standards to maintain and systematically implement the flow. From the maintenance aspect, we have periodically carried out several steps, including eeee maintaining and avoiding calibration errors and others, in the operation of our facilities and infrastructure; in every tool, there are specific standard operating procedures in using these tools. So, with the area system, we have*

*attached it to each device so that it can be implemented according to the system, thanks kai "(KA, June 23, 2020).*

*"So, if we talk about the existing facilities, if we look for a common thread, there is a connection, but the problem is that in the main task of managing the patient safety system, we don't regulate the technicalities, so this is how there is an IPSRS for infrastructure. It is included in quality improvement. If we are like this, the overall quality is included in maintaining patient safety so that quality maintains quality, including standard equipment, standardization of quality equipment is for patient safety in the end. Still, the quality that is the size of the house is quality. Equipment that standardizes eee increases human resources' capacity and means that quality is reflected in improving the hospital's quality, so patient safety is only one system; if an incident occurs, he is not the one who takes care of it. Patient safety, he manages the incident, becomes a recommendation if the problem is later, for example, this is because, for example, this is the case, for example, in one case we have the results of the evaluation, the evaluation is that we make a process of analyzing the root of the problem. It turns out that the tool does not match the tool's standard. The Director, the Director stated that please evaluate this means there is an error in standardization, so the intervention is not from us, we only recommend that this is the problem, for example, problems in HR, the human resources are not qualified, it means the human resources are lacking, why are their incidents because of HR it is lacking so there is an error, it turns out that the resources are not enough, we don't take care of it" (GZ, May 18, 2020).*

*"So concerning medical equipment, we call it medical equipment following standards. Also, in safety facility management, in terms of hospital accreditation, the hospital must make guidelines for all medical equipment used both medical equipment and hospital equipment. Then medical equipment, mostly what is done, is maintenance and maintenance every quarter, so care is every quarter. If there are no reports, so if you mean routine quarter, but there is a complaint, there is a AAA report, it will still be maintained. Then for equipment that is for more excellent safety every year during Hijri, a calibration test is carried out; yes, the feasibility test is carried out because it is also accredited that documents are always asked, which documents for calibration of medical equipment, especially radiology, operating rooms, HD, aaa, it is ever asked to be routinely planned, it has been programmed there that the calibration is a must every year if the equipment is being maintained every three months or there are complaints about the report every month "(HN, May 13, 2020).*

Based on the interview results above, the patient safety aspects related to facilities and infrastructure, both medical devices (electro-medical), which are medical support/diagnosis, are means for quality improvement as regulated in Law Number 44 of 2009 Article 43 paragraph 1 concerning patient safety standards; currently, the undata hospital already has it. Namely, a standard periodically to maintain and systematically use its implementation flow by attaching the SOP to use its equipment. And suppose there is a patient safety incident that occurs. In that case, the officer reports to the person in charge and is forwarded to the hospital leadership to make recommendations and process them according to applicable regulations; this proves that the hospital's accountability is very

credible. Still, if there is a patient safety incident, it is from HR health workers, there needs to be an evaluation if due to a lack of human resources it will be added. The hospital's medical equipment is currently following standards, and to improve quality in patient safety, the hospital routinely carries out maintenance (calibration tests) every three months and every year (7).

### **Patient Safety Culture**

Patient Safety Culture is an integrated pattern of individual and organizational behavior in providing services that are safe and free from injury (8). This was revealed from the results of interviews with respondents as follows:

*"Thank you, informed consent is essential in the present era because it is related to responsibility and accountability so that informed consent is a necessity for us before carrying out an invasive medical procedure related to the countermeasures that will be carried out on patients, for example, every eye. Before it is done, medical action must be given a sequential and scientific explanation, and then consent is asked for the patient or the person in charge of the patient after that medical action can be done" (KA, June 23, 2020).*

*"So, if we talk about the existing facilities, if we look for a common thread, there is a connection, but the problem is that in the main task of managing the patient safety system, we don't regulate the technicalities, so this is how there is an IPSRS for infrastructure. It is included in quality improvement. If we are like this, the overall quality is included in maintaining patient safety so that quality maintains quality, including standard equipment, standardization of quality equipment is for patient safety in the end. Still, the quality that is the size of the house is quality. Equipment that standardizes eee increases human resources' capacity and means that quality is reflected in improving the hospital's quality, so patient safety is only one system; if an incident occurs, he is not the one who takes care of it. Patient safety, he manages the incident, becomes a recommendation if the problem is later, for example, this is because, for example, this is the case, for example, in one case we have the results of the evaluation, the evaluation is that we make a process of analyzing the root of the problem. It turns out that the tool does not match the tool's standard. The Director, the Director stated that please evaluate this means there is an error in standardization, so the intervention is not from us, we only recommend that this is the problem, for example, problems in HR, the human resources are not qualified, it means the human resources are lacking, why are their incidents because of HR it is lacking so there is an error, it turns out that the resources are not enough, we don't take care of it" (GZ, May 18, 2020).*

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### **Openness**

Openness is a culture where those who regulate and operate the system have the latest knowledge about the factors that explain safety in a system (9). This was revealed from the results of interviews with respondents as follows:

*"Thank you, informed consent is essential in the present era because it is related to responsibility and accountability so that informed consent is necessary before carrying out an invasive medical procedure related to the countermeasures that will be carried out on patients, for example, every eye. Before it is done, medical action must be given a sequential and scientific explanation, and then consent is asked for the patient or the person in charge of the patient after that medical action can be done" (KA, June 23, 2020).*

*"Yes, the patient is outpatient, there is a risk initial system, and the risk grading has been determined. For example, the patient comes, it has been explained that the patient cannot walk; he must use a tool that the patient family must accompany. Initially, there is indeed a risk assessment, children, for example, we have had children of this age, prone to fall, that they could fall in our room. We have made this book, and the risk management is there " (GZ, May 18, 2020).*

*"It has been carried out but not all under certain circumstances sometimes ignore that too, but the procedures must be carried out anyway, such as surgery patients, other actions, ICU patients means not life-threatening, yes, but all patients enter patient safety standards, all conveyed, we say we have modalities. We have a hospital with this doctor, and this is too, we have a tool that does not yet exist, this is still conveyed so that there are special considerations from the patient to whether it is done here" (HN, June 15, 2020).*



Based on the interview results above, in principle, informed consent has been carried out by officers both before and after taking action with a scientific explanation following procedures aimed at protecting patients against the actions taken. On the other hand, in its implementation, the hospital makes risk grading to prevent potential patient safety incidents, but some officers still ignore it.

### **Justice**

Justice is a culture that brings an atmosphere of trust (atmosphere of faith). Members are willing and motivated to provide data and information sensitive to acceptable and unacceptable behavior (10). This includes a nonpunitive environment (no blame culture) when staff makes mistakes. Every level in the organization needs to be honest and open.

*"Thank you. In carrying out the duties contained in our respective job disks, as we know that a hospital is an institution or a multi-disciplinary institution. The system has indicated that we work in teamwork in the description of each task. Hence, in carrying out our duties, of course, each profession already has a strong motivation to follow their respective professional oaths of office. In its implementation, we already have one flow of how the information comes out and entered into the system in each eye component's job descriptions in the hospital patient safety team structure. The value of cultural values about how to process the data into accurate and accountable information is consistent with the existing hospital patient safety team "* (KA, June 23, 2020).

*"Small and large incidents, including incidents we have socialized in the culture of the patient safety system, so whoever finds it, whoever finds it must be reported to, there is already an SOP for each installation, head of the room or the nearest unit. Unit head, unit head, installation from the smallest yes, for example, in the room, the room's head in the room makes a simple analysis. He looks for the root of the problem, why, chronologically, he makes it, he makes grading later, there is a category or eee there is no incident he has already grading it"* (GZ May 18, 2020).

*"So for patient safety, the head of the hospital has arranged it so that there are two parts which are responsible there, if the incident related to the patient is in the patient safety section of the patient safety section, then there is one more thing if the incident concerns the safety of the officer, that means the worker. Its part is K3RS; these two elements collaborate with PPI also to indicate if an error procedure occurs so that the patient's safety is compromised or the safety of the staff is threatened; it's PPI's job to identify whether the threat is infectious or not, so if there is an indication of infection then the incident a report is made to each team, so if he is a patient, the name of incident identification is done, the chronology is whether the procedure was wrong, whether it was purely from the patient or was it from the facility or due to the human resources of the officer who carried out the wrong procedure. Because we are talking about patients, there are two human errors because of the staff, or because the patients themselves are different from those in the industry or companies or others, then it is pure if human error means from the officer if the tool means the machine used here if we don't exist The reports are all Mr. Hijri "* (HN May 13, 2020).

Based on the interview results above, the hospital is a multi-disciplinary institution with a system that contains job descriptions of each profession in one teamwork. Every time an incident is reported because there is an SOP by making a superficial analysis, looking for the root of the problem, the chronology of the incident, and the grading is made to determine the category. Meanwhile, suppose the incident occurs due to an error by the officer that threatens the patient's safety due to infection. In that case, the PPI is involved in handling the problem by identifying it and then reporting it to each team.

### **Reporting**

Reporting is a Reporting (Report Culture) is a culture where members are ready to report errors or near misses (11). In this culture, the organization can learn from previous experiences. Consequently, the better the reporting culture, the more incident reports will be. This was revealed from the results of interviews with respondents as follows:

*"Thank you, so the question about this reporting is still related to the previous question about the reporting system, as explained earlier that in the regulation, at least two times twenty-four hours each incident related to patient safety is in the form of undesirable conditions which are always systematic and completely reported to the related parties according to the level in the structure. Of course, supervisors and supervisors in patient safety have quite an important task in answering any problems related to KTD to be quickly taken to a team. Action is taken, which is a solution to the eee aspects of the ee inside aspects earlier. Thank you" (KA, June 23, 2020).*

*"That psti is reported to the director, and then a recommendation is made for the next evaluation" (GZ, May 18, 2020).*

*"All incidents are reported aaa ... eeeee as input to management. After all, the grading is made from the incident, so grading is identified and then chronologically grading, greeding it to determine what actions should be taken to find a solution. It needs immediate action or not if it is a fatality, fatal for the patient. Of course, progress must be carried out immediately, so all of that is included in PMKP, PMKP makes a report to the Director. Now the eee quality control group that we used to form a quality control group in the form of gum yes, a quality control group has been contested, PMKP to raise problems in the room, how to solve if something happens in that room but all incidents have been reported because of us it has gone through the accreditation process because if it is not done, we are not accredited" (HN, May 13, 2020).*

Based on the interview results above, all incidents were reported systematically and thoroughly 2 x 24 hours to the related parties. Because the hospital already has a structure, grading is made for every potential incident or incident by identifying its chronology to find a solution. The PMKP Team makes a report for the Director.

### **Reporting**

Learning (Learning Culture) is a culture where each member is able and willing to explore knowledge from the experience and data obtained, as well as the willingness to implement change and continuous improvement (learning culture) is a learning culture

from incidents and near-miss (12). This was revealed from the results of interviews with respondents as follows:

*"Thank you, in the learning mechanism system in the undata area public hospital there are two methods used, the first is internal eee or we send our energy to study a competent place. Before forming the hospital patient safety team, we sent competent personnel to participate in this training. After the return and the formation of the hospital patient safety team, periodically every year, we will hold in-house training related to patient safety, of course with different goals intended to All hospital components have the same view of patient safety standards in the hospital until all hospital personnel is exposed to knowledge about maintaining patient safety. In our coordination with the hospital's eye PKM, we also include safety as one of the aspects that becomes material in outreach for patients and their families. It is also carried out regularly in rooms that gather patients and their families' gathering points. Thank you" (KA June 23, 2020).*

*"If not routinely, but every time a new officer enters the hospital, there are people who work to enter the hospital, we always make it as a class enters, that class often enters the hospital before entering one of the materials of patient safety, if In of officer training, usually before the accreditation we make it again, so it is not routine, but if there are officers who come in regularly, we will socialize for patient safety" (dr, Gazhali.Sp.BM May 18, 2020).*

*"So eee according to that reference, the hospital yesterday made eee identification of rooms that need improvement, especially for rooms that have great potential for that, such as the ER, the ICU is a vital place, yes the operating room, HD is already included in the schedule every year at least two people must take part in training both internally held by the hospital itself and externally held by external parties, so there is always that commitment, then the results of training from that friend if from nursing are required to socialize returned after returning from hiring friends" (HN, June 15, 2020).*

Based on the interview results above, the learning system at undata hospital has two methods, namely internal and external. Still, on the other hand, routine training activities are not carried out. Always, every officer who will work in the hospital is given socialization about patient safety, training every year periodically The hospital carries out in-house movement, namely internal hospital itself and external parties, involving two emergency staff, ICU, operating room, and HD (Haemodialysis), because they see that there is great potential for patient safety. After training and it has become a commitment to disseminate the training results to other officers.

## **SUGGESTION**

Researchers should be made; the researchers suggest to all officers, especially health workers who have directly involved with patients, the need to build individual awareness. Incidents that occur due to equipment that does not meet standards should be facilitated by the KMKP (Patient Safety Quality Committee) at Undata Hospital Palu but have not been implemented. They only reduce incidents that occur due to medical errors personnel/paramedics.



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