

The Role of Teamwork in Building Patient Safety Culture at Hospital "X" in South Jakarta, Indonesia

Alika Shameela¹, Wahyu Sulistiadi²

^{1,2} Department of Health Policy and Administration, Faculty of Public Health University of Indonesia

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Corresponding author:

Name: Alika Shameela

Address: Faculty of Public Health,
University of Indonesia

E-mail: alika.shameela21@ui.ac.id

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Abstract

Background: Patient safety is an important discipline for improving the quality of hospital health services. By establishing a positive patient safety culture in a hospital, the commitment to create a safer patient safety culture as an act to reduce incidents is also higher. One of the supporting factors of patient safety culture is teamwork. Teamwork is an effort to work with other people cooperatively as a part of the group. Hospital "X" is a hospital located in South Jakarta that in carrying out their mission to improve the quality of their health services, requires a positive patient safety culture.

Objective: This research aims to analyze the role of teamwork in building a safer patient safety culture at Hospital "X". **Method:** This research is qualitative research with a case study approach using in-depth interviews with 4 informants. The research was conducted in August-September 2023. **Result:** The results of the research show the patient safety culture in Hospital "X". Hospital "X" already has a fairly positive patient safety culture by having a patient safety program and good teamwork, but still needs more evaluation on its implementation. In addition, teamwork has an important role in building a patient safety culture in terms of team effectiveness, support for staff, as well as regular reviews and evaluations of the team.

Conclusion: The patient safety program at Hospital "X" already exists and has been running quite well. The factors contributing are teamwork and collaboration, but the effectiveness of teamwork is still not quite effective. **Recommendation:** Therefore, a tiered guidance supervision system is recommended along with a regular seminar or training and support management

Keywords: patient safety culture, patient safety program, teamwork, hospital management

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INTRODUCTION

Patient safety is a discipline in the healthcare sector that aims to minimize an incident or the impact of an undesirable event and to maximize the recovery period from adverse events that occur (1). In Indonesia, patient safety standards are regulated in Minister of Health Regulation Number 1691, they define patient safety in hospitals as a system to provide patient care including assessment, identification, risk management, incident reporting, incident analysis, follow-up on incidents, and solutions to prevent occurrence (2).

Increasing patient safety in hospitals is considered an effort to improve the quality of health services given by the hospital, as well as an act to reduce the occurrence of undesirable events or incidents that can increase service costs (3). In patient safety, unintentional events or conditions related to patient safety are referred to as "incidents".

The Hospital Patient Safety Committee (KKP-RS) requires hospitals to report incidents of every accidental event (KTD) and near injury (KNC) that occurs to a patient (4). Based on patient safety incident reports in 2010, the province in Indonesia with the most adverse events is West Java (33.33%), followed by Banten and Central Java (20%) and DKI Jakarta (16.67%). In Indonesia, it was also found that patient safety incidents in 2019 amounted to 7,465 cases, including 171 deaths, 80 serious injuries, 372 moderate injuries, 1183 minor injuries, and 5659 no injuries (5).

The safety culture of an organization is the result of individual and group values, attitudes, perceptions, competencies, and behavioral patterns that form a commitment and style to create a safe environment in an organization, while patient safety culture is a philosophy, ideology, assumption, attitude, beliefs, expectations, and values of an organization in the field of healthcare (6,7). By establishing a positive patient safety culture, the commitment to create safer patient safety to reduce the incident rate is also higher. Patient safety culture is one of the requirements for accreditation in Indonesia where the measurement of patient safety culture is mentioned in the Hospital Accreditation

Standards Book which states that hospitals must support patient safety culture.

There are four factors related to a patient safety culture that can cause patient safety incidents, including organizational factors, teamwork factors, environmental factors, and individual factors. (7). Out of these four factors, the factor that has the biggest contribution to causing patient safety problems are organizational factors and teamwork. Meanwhile, based on the Safer Culture Framework made by Bisbey et al., teamwork and collaboration are one of the factors that can create a positive patient safety culture. A positive patient safety culture can be built through collaborative behavior such as planning and coordinating a team (7,8).

Teamwork is an effort to work with other people cooperatively as part of a group. Teamwork can be built if the team can create a spirit of collegiality and collaboration between staff, as well as open, safe, and flexible relationships between staff. Teamwork influences individuals in the team to develop themselves so that individuals can facilitate adoption and create a positive patient safety culture in their organizations (5,9).

The teamwork factor is an important component for building a positive patient safety culture because good teamwork and collaboration will also improve the quality of health services, which can also improve the quality of patient safety. Hospital "X" is a hospital located in South Jakarta, Indonesia, which in carrying their mission to provide a better health services quality, needs to build a positive patient safety culture.

Hospital "X" created a team called "Quality and Patient Safety Committee (PMKP)" that in 2022 made a patient safety culture survey. The result of the patient safety culture survey shows that the number of patient safety reports or incidents at Hospital "X" was 34% with a patient safety rating of 64% in the good category. This shows that the incidence of patient safety in Hospital "X" is higher than the KTD value in DKI Jakarta Province which is 16.6%. A higher KTD will lead to the quality of its services, therefore, this study is needed to explore the patient safety culture and the role of teamwork in building a patient safety culture at Hospital "X".

listening to the voice recorder several times and re-checking the transcript from the voice recorder.

OBJECTIVE

This study aims to the role of teamwork in building a patient safety culture at Hospital "X"

METHOD

Design

This research uses a qualitative research design with a case study approach. A case study approach was used to obtain in-depth information and to analyze the role of teamwork in building a positive patient safety culture at Hospital "X". Hospital "X" is a Type C Private Hospital located in South Jakarta, Indonesia.

Sample, sample size, & sampling technique

The research was carried out from August to September 2023. Research informants were selected using a purposive sampling technique because all of the informants were determined based on certain considerations that were by the objectives of the research or objects being studied so that the informants could answer the problems that occurred. The informants in this study were 4 workers at Hospital "X", consisting of 1 doctor and 3 nurses who were directly involved in the implementation of patient safety culture.

Table 1 List of Research Information

Data collection process

Information needed to achieve research objectives. In this research, data was collected through in-depth, semi-structured interviews using interview guidelines created by previous researchers. Apart from that, field observations were also used in the form of documentation, as well as literature reviews and document reviews as supporting data in the research.

The information obtained from the results of in-depth interviews in this research was then tested for validity using the source triangulation method. Reliability is also needed by researchers to know the extent to which the measurements of a test remain consistent after being carried out on several subjects under the same conditions. In this research, the reliability test was done by

Data analysis

The data that has been collected will then be processed to become summary data. The process of processing data in this research is by making transcripts from interview results, coding, and creating schemes. Thematic analysis is used by researchers to analyze data to identify patterns and find the themes of study through the data that has been collected.

RESULT

Informant	Gender	Job Position	Length of Work
Q.1	Female	Head of Medical Services and Support	1 Year
Q.2	Male	Head of PMKP and Head of Emergency Department	15 Year
Q.3	Female	Head of Polyclinic	33 Year
Q.4	Female	Head of Nursing Room (3rd Floor)	18 Year

Patient Safety Program

Hospital "X" is a type C hospital in South Jakarta, DKI Jakarta. In improving their health services' quality, Hospital "X" created a committee by their hospital director's decree where the contents are the composition of members, organizational structure, and job descriptions. The Quality and Patient Safety Committee (PMKP) has committee members consisting of the Committee Chair (nurse), Secretary (nurse), Quality Coordinator (doctor), Patient Safety Coordinator (nurse), and Risk Management Coordinator (HSE Expert). The implementation of the patient safety program has been run by the 6 patient safety goals recommended by The Ministry of Health and Law. However, in the patient safety program at Hospital "X", there has not been a reference that corresponds to the seven steps for patient safety which should be a

comprehensive guide for patient safety. *"...programs related to patient safety are by the SKP for patient safety targets, basically there are 6 SKPs, we have done all of that already..."* (Q.4, Head of Nursing Room (3rd Floor))

Patient Safety Culture

The patient safety culture at Hospital "X" is said to be quite good because it is based on the organizational culture of the hospital which is quite supportive, this means that the patient safety culture at Hospital X is leaning towards a positive patient safety culture.

This can be seen from the implementation of the ongoing patient safety program and the good organizational culture, although it is still said that improvements are needed, such as the need for re-socialization of standard operational procedures (SOPs) relating to patient safety, so that patient safety culture can be further improved.

Factors that can hinder the development of a patient safety culture at Hospital X are the lack of staff understanding and knowledge of procedures, intentions, and awareness that is still lacking, and frequent employee restructuring, resulting in frequent changes to the committee structure that is the core responsibility in building a patient safety culture.

Meanwhile, factors that support the development of a patient safety culture are good teamwork, high support or encouragement from management to staff, good adaptability from the PMKP, and the existence of rewards in the form of allowances for the PMKP Chair. The results of in-depth interviews showed that the informants felt that the supporting factors were leadership, teamwork, communication, and support from management. Meanwhile, the factors that hinder patient safety culture are individual staff factors such as lack of knowledge and low awareness.

"...the patient safety culture is already good, although there are some that need to be further

socialized regarding SOPs..." (Q.2, Head of PMKP)

"... the first supporting factor is that the PMKP has been going on for quite a long time, now what is getting into the inhibiting factors is the mutual change of structure, restructuring can causes, maybe, such as missing information, when the change doesn't take place, it will feel like we have to start all over again on the program. but the current PMKP chairman's adaptability is quite high... so the supporting factor is probably motivation, right... maybe the motivation is quite high because the head of PMKP got an allowance..." (Q.1, Head of Medical Services and Support)

The Role of Teamwork

Based on interviews conducted by all informants, all of them said that teamwork and collaboration have a role in building a safer patient safety culture (safer outcome) and teamwork influences the implementation of patient safety culture because with teamwork, complete and clear information delivery will be achieved.

"... in my opinion, teamwork is important, yes, there are concerns like this, if there is no good teamwork, communication from different units will be hard, right... If you don't work together well, sometimes things go wrong... the key again is real communication..." (Q.2, Head of PMKP)

The effectiveness of team collaboration at Hospital X is still not effective and needs to be improved further. Factors that prevent teamwork effectiveness from being carried out well are problems related to communication, as well as a lack of staff knowledge and awareness, which hinders the team from building effective teamwork.

"...teamwork needs to be improved both in terms of communication and training..." (Q.2, Head of PMKP)

The workload of the team at Hospital "X" has been divided evenly and each staff has their workload. Support for staff in

implementing patient safety culture at Hospital "X" still needs improvement such as the support of the management in providing a seminar related to patient safety, support in terms of proper facility to conduct good patient safety, and reward to staff.

"...it's enough but it needs to be improved, yes, that's what I meant by taking part in the seminar about patient safety culture again.... Or by supporting through the proper facilities...." (Q.4, Head of Nursing Room (3rd Floor))

Periodic reviews and evaluations at Hospital "X" have been carried out. If seen based on the PMKP, the monitoring and evaluation are used for a few indicators such as KTD, KNC, sentinel, RCA, and FMEA. There is also a form of review and evaluation carried out at Hospital X, namely by holding regular meetings and routine reporting regarding patient safety.

DISCUSSION

Patient Safety Program

Patient safety is a system in hospitals for providing safer health services, where the system consists of risk assessment, patient risk management, incident reporting and analysis, the ability to learn more, and implementation of solutions to minimize risk (10). Based on Minister of Health Regulation Number 11 of 2017, patient safety standards must be implemented in health service facilities including hospitals and their assessment will also be a requirement in hospital accreditation instruments (11).

Implementation of patient safety standards in hospitals is carried out through the formation of a patient safety team which will develop a patient safety program in the form of an information system for recording and internal reporting on incidents, implementing seven steps towards patient safety, developing medical service standards based on analysis results, and monitoring evaluation in implementation. patient safety in the work unit (3).

The implementation of the patient safety program in Hospital "X" is carried out through the Quality Improvement and Patient Safety (PMKP). The implementation of the patient safety program has been running by the 6 patient safety goals recommended by The Ministry of Health, which include correct patient identification, increasing effective communication, increasing drug safety, ensuring the correct surgical location, reducing the risk of infection, and reducing the risk of injury (11).

The program is also run by the law where there is risk assessment, risk identification and management, reporting, and analysis of incidents, the ability to learn incidents and follow up, as well as implementing solutions. However, in the patient safety program at Hospital "X", there has not been a reference that corresponds to the seven steps for patient safety which should be a comprehensive guide for patient safety. Based on Minister of Health Regulation Number 11 of 2017, guidance and supervision in hospitals must be carried out periodically through patient safety evaluation activities carried out by the relevant hospitals (11).

Hospitals are obliged to provide guidance and supervision in the form of monitoring and evaluation in work units related to the implementation of patient safety (3). Guidance and supervision in the patient safety program have been carried out in the form of resocialization and monitoring through existing quality sheets and standard operational procedures, but it still needs to be monitored again.

This is because there is no tiered system to ensure coaching and supervision run well. Guidance and supervision through a tiered system can ensure implementation is running, reporting is by standards, and implementation is running to guarantee quality services (12).

Patient Safety Culture

The patient safety culture at Hospital "X" is said to be quite good leaning towards a positive patient safety culture. This can be seen from the implementation of the ongoing patient safety program and the good organizational culture. The patient safety culture of an organization is the product of values, perceptions, attitudes, competencies,

and behavioral patterns of individuals and groups which will determine commitment to implementing patient safety programs (13).

A positive patient safety culture influences increasing patient safety efforts in health services because safety culture is a factor that determines how health workers in hospitals react to the reporting, analysis, and prevention of errors that can develop into potentially life-threatening incidents (14,15). Vincent (2006) identified seven elements that have an influence on patient safety which are management and organizational factors, work environment, teamwork, assignments, individual factors, patient characteristics, and the external environment. While Sammer et al. (2010) said that patient safety culture is composed of 7 factors that influence patient safety culture, namely leadership, teamwork, evidence-based, communication, learning, justice (just culture), and primary focus on patients (16,17). The results of in-depth interviews showed that the informants felt that the supporting factors were leadership, teamwork, communication, and support from management.

Meanwhile, the factors that hinder patient safety culture are individual staff factors such as lack of knowledge and low awareness. The results of this study are on several aspects that influence patient safety culture based on research from Vincent (2006) and Sammer et al. (2010), namely individual factors, teamwork, communication, leadership, and learning (1,16).

The Role of Teamwork

Teamwork is one of the aspects of patient safety culture. Teamwork in the health sector is important because of the complexity of health services and the need to adapt quickly to changes in health developments. Apart from that, teamwork is also important because it can reduce the occurrence of medical errors and increase patient safety. Poor teamwork can hurt patient safety culture (18).

Teamwork can be created by the form of respect between staff, collaboration, and cooperation that occurs between staff, managers, and other independent practitioners as well as relationships that are open, safe, mutually respectful, and flexible (16). Based on interviews conducted by all informants, all of

them said that teamwork and collaboration have a role in building a safer patient safety culture (safer outcome) and teamwork influences the implementation of patient safety culture because with teamwork, complete and clear information delivery will be achieved.

This is in line with research conducted by Arini et al. (2018) who say that there is a relationship between teamwork and the implementation of patient safety culture, apart from that, research from Silaen (2020) also explains that teamwork is the focus of system-based interventions that improve patient safety (17,19).

Teamwork in work units shows us how they can coordinate and cooperate in providing the best health services, this includes the effectiveness of the work team, workload within the team, regular observations and evaluations in improving patient safety as well as support for staff in the implementation of patient safety culture program (9).

Work effectiveness is a measurement related to the achievement of a task or goal, which in this research is defined as a good patient safety culture. Research conducted by Schmutz et al. (2019), said that the effectiveness of good teamwork represents a strong process in improving health services (20). The effectiveness of team collaboration at Hospital X is still not effective and needs to be improved further. Factors that prevent teamwork effectiveness from being carried out well are problems related to communication, as well as a lack of staff knowledge and awareness, which hinders the team from building effective teamwork.

This is by the factors that influence team collaboration based on Robbins (2007), namely goals, relevant skills, mutual trust, and mutual commitment. Workload is several activities that must be completed by an organizational unit or position within a specified period. The workload of the team at Hospital "X" has been divided evenly. Providing an even and appropriate workload will enable staff to complete the assigned tasks (21).

This is a factor that can strengthen good team collaboration because each staff can carry out their tasks according to what they have been given. Support for staff from

management includes aspects of hospital-level patient safety culture that influence teamwork. Support includes management that provides an environment to promote patient safety and makes patient safety a priority (22). Support for staff in implementing patient safety culture at Hospital "X" still needs improvement. Leaders in a team, senior managers, or all leaders in an organization must support the team to achieve team success because when a team gets support, especially from management, employee satisfaction and the quality of work life will increase, so productivity and team collaboration will also increase (23).

Regular reviews within a team are needed to make changes to improve patient safety, while evaluations need to be carried out for changes to improve patient safety (9). Hospital leaders are required to provide guidance and supervision in the form of monitoring and evaluation of work units in the hospital related to the implementation of patient safety in the hospital (3). Periodic reviews and evaluations at Hospital "X" have been carried out by monitoring and evaluation, regular meetings, and reports.

CONCLUSION

The patient safety program at Hospital "X" already exists through the Quality and

Patient Safety Committee, The implementation has gone quite well and is by the 6 SKPs, but the implementation is still not optimal, and further review is needed. Teamwork and collaboration have an important role in the patient safety culture at Hospital X, especially in establishing communication and conveying information.

The effectiveness of teamwork is still not effective at Hospital "X" because communication is still not running well and staff knowledge is still uneven.

RECOMMENDATION

1. Create a tiered guidance and supervision system to ensure implementation is running, reporting is by standards and can provide the best health services.
2. Conduct a regular seminar or training regarding patient safety culture for all staff to equalize the staff knowledge regarding patient safety
3. Hospital management is advised to provide more support to the staff in implementing patient safety by giving more training related to patient safety, giving rewards, and providing adequate facilities to implement patient safety

REFERENCES

- (1) Emanuel L, Berwick D, Conway J, Combes J, Hatlie M, Leape L, et al. What Exactly Is Patient Safety? *J Med Regul.* 2009;95(1):13-24.
- (2) Flores Y. No Title. *Phys Rev E [Internet].* 2011;24. Available from: http://ridum.umanizales.edu.co:8080/jsp/ui/bitstream/6789/377/4/Muoz_Zapata_Adriana_Patricia_Artculo_2011.Pdf
- (3) Kementerian Kesehatan RI. Pedoman Penyelenggaraan Keselamatan Pasien di Rumah Sakit. 2011;48.
- (4) KKPRS. Pedoman Pelaporan Insiden Keselamatan Pasien (IKP). Jakarta: KKP-RS. Kom Keselam Pasien Rumah Sakit. 2015. Retrieved from: <chrome-extension://efaidnbmnnnibpcajpcglclefndmkaj/https://rspmanguharjo.jatimprov.go.id/wp-content/uploads/2020/02/1.-PEDOMAN-PELAPORAN-INSIDEN->
- (5) Bardan RJ. Analisis Penerapan Keselamatan Pasien di Rumah Sakit Umum Daerah Inche Abdoel Moeis Tahun 2017. Universitas Hasanuddin, Makassar
- (6) Abdelaliem SMF, Alsenany SA. Factors Affecting Patient Safety Culture from Nurses' Perspectives for Sustainable Nursing Practice. *Healthc.* 2022;10(10):1889. doi: 10.3390/healthcare10101889.
- (7) Rivai F, Sidin AI, Kartika I. Faktor yang Berhubungan Dengan Implementasi Keselamatan Pasien Di RSUD Ajjappanngge Soppeng Tahun 2015. *JKebijak Kesehat Indones.* 2016;05(04):152-7
- (8) Kilcullen MP, Bisbey TM, Ottosen MJ, Tsao K, Salas E, Thomas EJ. The Safer Culture Framework: An Application to

- Healthcare Based on a Multi-Industry Review of Safety Culture Literature. *Hum Factors*. 2022;64(1):207-27
- (9) Sorra J, Gray L, Streagle S, Famolaro T, Yount N, Behm J. Hospital survey on patient safety culture: user's guide. [Internet]. Agency of Healthcare Research in Quality. 2018. 1-50 p. Available from: www.ahrq.gov
- (10) Toyo EM, Leki KGB, Indarsari F, Woro S. Evaluasi Sistem Pelaporan Insiden Keselamatan Pasien Dengan Metode HMN Di Rumah Sakit. *Maj Farmasetika*. 2022;8(1):56.
- (11) Kementerian Kesehatan Republik Indonesia. Peraturan menteri kesehatan republik indonesia nomor 11 tahun 2017 tentang keselamatan pasien. 2017;87(1,2):149-200.
- (12) Apriliani W, Ernawati A. Faktor- Faktor Yang Mempengaruhi Pelaksanaan Sasaran Keselamatan Pasien d Rumah Sakit: Literatur Review. *Univ Tanjungpura*. 2020;1-6.
- (13) Idris H. Dimension of Patient Safety Culture. *J Ilmu Kesehat Masy*. 2017;8(1):1-9.
- (14) Hanifa YNM, Dhamanti I. Instrument for Measuring Patient Safety Culture: Literature Review. *JMMR (Jurnal Medicoeticolegal dan Manaj Rumah Sakit)*. 2021;10(2):158-76.
- (15) Kaware MS, Ibrahim MI, Shafei MN, Mohd Hairon S, Abdullahi AU. Patient Safety Culture and Its Associated Factors: A Situational Analysis among Nurses in Katsina Public Hospitals, Northwest Nigeria. *Int J Environ Res Public Health*. 2022;19(6): 3305. doi: 10.3390/ijerph19063305
- (16) Sammer CE, Lykens K, Singh KP, Mains DA, Lackan NA. What is patient safety culture? A review of the literature. *J Nurs Scholarsh*. 2010;42(2):156-65.
- (17) Arini TP, Yulia S, Romiko. Hubungan Kerjasama Tim Dengan Penerapan Budaya Keselamatan Pasien Di Ruang Rawat Inap Rumah Sakit Bhayangkara Palembang Tahun 2018. *Masker Med*[Internet]. 2018;6(2):406-16. Available from: <https://jmm.ikestmp.ac.id/index.php/maskermedika/article/view/247>
- (18) Nurati OE, Hastono SP, Ayubi D, Mulyatsih E, Anisah S. Hubungan kerja sama tim perawat dengan budaya keselamatan pasien di Rumah Sakit Pusat Otak Nasional. 2018. Unpublish thesis. Retrieved from: <https://lontar.ui.ac.id/detail?id=20477051&lokasi=lokal>
- (19) Silaen MFO. Pentingnya Kerja Sama Tim Dalam Menerapkan Budaya Keselamatan Pasien. 2020; Available from: <http://dx.doi.org/10.31219/osf.io/vp6jr>
- (20) Schmutz JB, Meier LL, Manser T. How effective is teamwork really? The relationship between teamwork and performance in healthcare teams: A systematic review and meta-analysis. *BMJ Open*. 2019;9(9):1-16.
- (21) Arifin H. Penerapan Metode Analisis Beban Kerja untuk Meningkatkan Produktivitas di Bagian Case Assy Up di PT. Yamaha Indonesia. *Teknoin*. 2020;26(2):83-95
- (22) Arini T. Budaya Keselamatan Pasien Berbasis Pemberdayaan Struktural Dengan Kepuasan Kerja Perawat. *Tesis*. 2018;83-100
- (23) Pathirage Y, Jayawardena L, Rajapaksha T. Impact of Management Support for Team Performance: A Sri Lankan Case study in the Apparel Industry. *Trop Agric Res*. 2012;23(3):228.