Vol. 1 No. 6 2024 || E-ISSN 2997-7258

The Journal of Academic Science
journal homepage:
https://thejoas.com/index.php/

Analysis of Patient Safety, Medical Error, and Event Reporting Culture Perception at Bekasi Hospital 2024

Ivan Adrian Montolalu[1], Rudi Ruhdiat[2]
President University, Indonesia [1,2]
Email: ivan.montolalu@president.ac.id

KEY WORDS

patient safety, medical error, event reporting, occupational health and safety, hospital

ABSTRACT

Patient safety is one of the important aspects of health services that affect the quality and effectiveness of services in hospitals. This study aims to analyze the perception of patient safety culture, medical errors, and incident reporting at Bekasi Hospital in 2024, focusing on gaps in the involvement of medical and non-medical personnel, obstacles in incident reporting, and challenges in the implementation of patient safety policies. This study uses a descriptive qualitative approach, with data collection methods through in-depth interviews, focus group discussions (FGD), observations, and documentation studies. The results of the study show that there is a difference in perception between medical and non-medical personnel regarding patient safety culture. Medical personnel have a higher awareness of the importance of patient safety, while non-medical personnel feel less engaged and under-trained. The main barriers to incident reporting are the fear of sanctions and the culture of blaming individuals, which leads to low rates of incident reporting. In addition, the study found that although patient safety policies have been implemented, their implementation is still inconsistent across hospital service units, mainly due to the high workload and lack of supervision.

1. Introduction

Patient safety is one of the important aspects of health services that has a significant impact on the quality and success of treatment. Bekasi Hospital, as an important health service provider for the community, is faced with challenges in ensuring optimal patient safety. Perception of patient safety culture, medical errors, and incident reporting play a key role in determining patient safety practices in hospitals. Understanding the perepsi and attitude of medical and non-medical personnel towards these aspects can provide valuable insights in an effort to improve the patient safety system at Bekasi Hospital.

In 2024, Bekasi Hospital has made a number of efforts to improve patient safety, but evaluation of patient safety culture perceptions, medical errors, and incident reporting is still important to know the progress and things that need to be improved.

Although several studies have highlighted the importance of patient safety culture and incident reporting in hospital settings, many of them still

focus on the context of hospitals in big cities or private hospitals, so studies in regional government hospitals such as Bekasi Hospital are still relatively limited.

This research gap lies in the lack of specific empirical data related to the perception of patient safety culture, the incidence of medical errors, and the effectiveness of incident reporting in regional hospitals, especially at Bekasi Regional Hospital. In addition, research on how these efforts that have been made in 2024 affect patient safety perceptions and practices has not been widely explored.

The urgency of this research is even more evident considering that patient safety is a global priority in the health care system, and hospitals at the regional level often face different obstacles than hospitals in big cities, such as limited resources, high workloads, and different patterns of reporting medical errors.

Previous research on patient safety culture perceptions, medical errors, and incident reporting has been conducted in various countries, but the focus is still on large hospitals or international contexts. Suryanto, Plummer, & Boyle (2019) examined the perception of health workers towards patient safety culture in public hospitals in Indonesia, finding that communication and risk management barriers are the main challenges, but this study does not cover regional hospitals such as Bekasi Hospital. Samsuri, Lin, & Talib (2018) in their study in Malaysia showed that although healthcare workers understand the importance of patient safety, incident reporting is still hampered by fear of punishment, which is also often a problem in hospitals in developing countries.

In Oman, Ammouri et al. (2015) found that the adoption of a patient safety culture is still inconsistent among nurses, where the lack of leadership support and an effective reporting system is a major barrier. Lee, Phan, & Dorman's (2016) research in Vietnam revealed factors that affect incident reporting, such as workload and lack of management support, but this context is different from the condition of hospitals in Indonesia. Mekonnen et al. (2020) examined the perception of safety culture in Ethiopia and showed that the lack of training and clear reporting policies is a significant problem, similar to the challenges in regional hospitals in Indonesia.

The novelty of this study lies in its focus on Bekasi Hospital, which is a regional hospital with different challenges compared to hospitals in big cities, such as limited resources and high workload. In addition, the study examines the impact of efforts made in 2024 to improve patient safety culture, which provides a more realistic view. The study also involved non-medical personnel, who had often been overlooked in previous studies.

With a multidimensional approach that includes patient safety, medical errors, and event reporting simultaneously, this study provides a more holistic and comprehensive analysis. In addition, this research is expected to produce practical recommendations that can be directly implemented by the management of Bekasi Hospital to improve patient safety, thereby contributing directly to local policies in regional hospitals, which have not been widely discussed in the previous literature.

This research aims to fill these knowledge gaps by analyzing the perception of patient safety culture, medical errors, and incident reporting at Bekasi Hospital in 2024. The results of the study are expected to provide useful recommendations for hospital management in improving patient safety practices and optimizing health services at Bekasi Hospital.

Based on the background that has been submitted, this research will focus on understanding the perception of patient safety culture, medical errors, and incident reporting at the Bekasi Regional General Hospital (RSUD) in 2024. This study aims to achieve a deep understanding of patient safety culture perceptions, medical errors, and incident reporting at the Bekasi Regional General Hospital (RSUD) in 2024.

Thus, this research has important benefits in improving the quality of health services, protection of patient rights, and operational efficiency at Bekasi Hospital, as well as contributing to the development of scientific knowledge in the field of patient safety.

2. Methodology

This study uses a qualitative approach with a descriptive method to deeply understand the perception of medical and non-medical personnel towards patient safety culture, medical errors, and incident reporting at Bekasi Hospital in 2024. The qualitative approach was chosen because it allows researchers to explore the subject's experiences, thoughts, and perceptions in more depth, thus providing a more comprehensive picture of the phenomenon being studied. The main data sources of this study are primary and secondary data. Primary data was obtained through in-depth interviews and focus group discussions (FGD) with medical personnel (doctors, nurses, and midwives) and non-medical personnel (administrative and logistics staff) at Bekasi Hospital. Secondary data is in the form of documents related to patient safety, medical error reports, and hospital policies in incident reporting.

Data collection was carried out using several techniques, including semi-structured interviews to explore the perceptions and experiences of health workers and support staff in hospitals related to patient safety practices and medical error reporting. The FGD was conducted to deepen the results of the interviews and facilitate group discussions on the dynamics of patient safety perceptions in the hospital environment. In addition, field observations were also carried out to see firsthand how patient safety practices and incident reporting were implemented at Bekasi Hospital. Documentation studies are conducted to obtain additional information from official documents such as patient safety reports and internal hospital policies.

The data obtained was analyzed using thematic analysis techniques. The first step is to transcribe data from interviews and FGDs verbatim. Furthermore, data coding was carried out to identify key themes related to patient safety culture, medical errors, and incident reporting. This coding is done openly to find the main categories, then developed into more specific themes through axial analysis. Once the main themes are identified, the data will be interpreted to understand the relationship between the perception of patient safety culture, incident reporting practices, and their impact on the quality of service at Bekasi Hospital. The validity of the data is maintained through triangulation by comparing the results of interviews, FGDs, observations, and documents, as well as through a member checking process by confirming the results of the analysis to the respondents to ensure the accuracy of the interpretation. This analysis is expected to provide in-depth and valid insights into the challenges and opportunities in improving the patient safety culture at Bekasi Hospital.

3. Result and Discussion

A. Perception of Medical and Non-Medical Personnel Towards Patient Safety Culture

The perception of medical and non-medical personnel towards the patient safety culture at Bekasi Hospital in 2024 shows significant differences between the two groups. Medical personnel, such as doctors, nurses, and midwives, tend to have a better understanding of the importance of a patient safety culture. They realize that patient safety is not only an individual responsibility, but a collective responsibility in preventing and reducing the risk of medical errors (Samsuri et al., 2018). In a global context, many studies support that high awareness of safety culture among medical personnel is associated with a reduction in the incidence of medical errors and improved quality of service (Kohn, Corrigan, & Donaldson, 2000). This is also consistent with a study conducted by Mekonnen et al. (2020) in Ethiopia, which showed that a positive perception of a safety culture increases participation in patient safety programs.

However, this perception is different from non-medical personnel, such as administrative, logistical, and other technical staff. They feel less involved in the patient safety system, although they have an important role to play in supporting overall hospital operations (Suryanto, Plummer, & Boyle, 2019).

Non-medical staff often see patient safety as the primary responsibility of medical personnel and feel that their role is limited to administration and logistical support. This suggests that there is a gap in understanding how all hospital members, regardless of their role, contribute to patient safety. Lee, Phan, and Dorman (2016) in their research in Vietnam also found the same pattern, where non-medical staff feel not fully involved in the process of improving patient safety.

One of the main reasons for the lack of involvement of non-medical personnel in the patient safety culture is the lack of adequate training and less than optimal cross-departmental communication (Ammouri et al., 2015). Non-medical staff are often not given access or opportunity to attend patient safety training conducted in hospitals. This lack of awareness results in them not understanding their important role in the patient safety chain, such as ensuring correct administrative data, good logistics management, and effective communication between medical personnel and patients. This phenomenon was also observed in a study by Reason (1997), which stated that safety in complex organizations, such as hospitals, requires the active involvement of all components, including staff working outside of direct clinical care.

In addition, the fact that medical personnel feel more comfortable in implementing a patient safety culture is largely attributed to the stronger support from hospital management towards them (Samsuri et al., 2018). The study found that medical personnel received more recognition and awards when it came to compliance with safety protocols, while non-medical personnel often did not receive similar awards. This creates a gap in perception and a sense of belonging that differs between the two groups. In fact, according to the organizational theory of Geller (2005), the participation of all members of the organization, including those in supporting positions, is very important to build a sustainable safety culture.

In general, the positive perception of medical personnel towards the patient safety culture shows that they are more aware of the importance of safety procedures and protocols that have been implemented by hospitals (Suryanto, Plummer, & Boyle, 2019). However, findings from field observations at Bekasi Hospital show that the implementation of this protocol is still inconsistent in several units, which shows that there are obstacles in daily implementation. Some nurses report that although they understand the importance of medication verification and patient identification, the high workload often interferes with the implementation of these procedures (Mekonnen et al., 2020). This shows that despite the good perception, daily practices still need further oversight and improvement.

Furthermore, this difference in perception shows the influence of different organizational cultures among medical and non-medical personnel (Lee, Phan, & Dorman, 2016). An organizational culture that encourages openness, cross-departmental communication, and shared participation can strengthen a culture of safety in hospitals. In contrast, a culture that emphasizes strict hierarchies and a lack of inter-professional interaction tends to hinder effective implementation. Studies from Kohn, Corrigan, and Donaldson (2000) also emphasize that the success of a patient safety culture relies heavily on cross-disciplinary collaboration and clear management support.

One solution to address this gap is to improve patient safety training involving all hospital staff, including non-medical personnel (Geller, 2005). This kind of training should not only cover medical personnel, but also provide non-medical personnel with an understanding of their role in the patient safety process. Thus, non-medical staff will better understand that they play an important role in supporting safety, for example in the proper management of logistics and ensuring the timely and safe availability of medical equipment.

The author argues that to improve this condition, Bekasi Hospital needs to improve cross-departmental patient safety training and build a more inclusive communication system between medical and non-medical personnel. In addition, the implementation of a policy of reward and recognition to all staff who contribute to patient safety, both medical and non-medical, will help reinforce the positive perception of a safety culture throughout the hospital (Reason, 1997). Increased cross-departmental collaboration will also create a more integrated work environment, where everyone understands their role in improving patient safety.

In conclusion, the perception of medical personnel at Bekasi Hospital on the patient safety culture is quite good, but non-medical personnel still need further understanding and involvement. This is in line with the findings of international studies that show that the

involvement of all elements of hospitals, including non-medical staff, is critical in building a strong and effective safety culture (Ammouri et al., 2015; Mekonnen et al., 2020). Bekasi Hospital needs to make strategic efforts to increase awareness and involvement of all staff in maintaining patient safety, through training, better communication, and consistent management support.

B. Barriers to Incident Reporting: Fear and Blame Culture

One of the main findings of the study at Bekasi Hospital was that there are significant barriers to reporting medical events, caused by fear of sanctions and a culture of blaming individuals for medical errors that occur. This fear is a major obstacle for medical personnel and non-medical personnel to report incidents openly and honestly. According to interviews conducted in this study, many health workers are concerned that reporting an incident, even if it's a minor mistake, will lead to reprimands, administrative sanctions, or a decline in their professional reputation (Suryanto, Plummer, & Boyle, 2019). This is in line with the findings of Samsuri, Lin, and Talib (2018) who stated that fear of punishment is one of the main reasons for the low rate of incident reporting in Malaysian hospitals.

This fear stems not only from the threat of administrative sanctions, but also from the social pressures that arise in the hospital's work culture. In Bekasi Hospital, the culture of individual blame or "blaming culture" is still dominant, where medical errors are often considered as personal failures, not as a broader system problem (Reason, 1997). In health systems that implement a culture of blame, individuals who report mistakes are often seen as the root cause of the problem, rather than as part of a system that needs improvement. This phenomenon was also found by Lee, Phan, and Dorman (2016), who emphasized that the culture of blaming individuals creates a work environment that is not conducive to reporting errors, because health workers are afraid to admit their mistakes.

Many studies have shown that a culture of blame can lead to medical personnel being reluctant to report incidents that have the potential to harm patients (Ammouri et al., 2015). When mistakes are perceived as individual errors, rather than systemic errors, then efforts to understand the root of the problem and make improvements are hampered. As a result, the same mistakes tend to be repeated because no system improvement steps are taken (Kohn, Corrigan, & Donaldson, 2000). In the context of Bekasi Hospital, this situation is exacerbated by the fact that health workers face not only fear of formal sanctions, but also social pressure from peers, which can lead to isolation or stigma in the work environment.

In addition, this study found that the high workload at Bekasi Hospital also exacerbated the problem of incident reporting. Healthcare workers often do not have enough time to report incidents in detail because they have to immediately return to handling other patients (Mekonnen et al., 2020). In these situations, even though medical personnel are aware of the importance of reporting errors, time constraints and the pressure to meet the demands of daily work prevent them from doing so. This is consistent with the findings of Samsuri et al. (2018) which found that high workloads often force healthcare workers to prioritize other clinical tasks over incident reporting.

From the perspective of risk management theory, Reason (1997) states that an organization that is successful in managing safety is one that focuses on improving the system, not punishing individuals. By moving from a culture of blame to a culture of safety that encourages reporting without fear of being punished, health organizations can be more effective in identifying underlying issues and taking steps to improve the system. However, at Bekasi Hospital, this safety culture has not been fully implemented. Based on observations, incident reporting is still seen as a threat to professional reputation, which ultimately lowers the rate of incident reporting.

The fact that this hospital has implemented an anonymous reporting system does not completely dispel these fears. Although the system aims to protect whistleblowers, medical personnel still feel that they can be recognized and punished informally by peers or superiors (Suryanto et al., 2019). This highlights the importance of a deeper organizational culture change, not just a procedural change. The research of Kohn et al. (2000) emphasizes that without a cultural change that prioritizes systemic safety and supports openness in reporting, changes in reporting procedures alone will not be enough to significantly improve patient safety.

The authors argue that to overcome this reporting barrier, Bekasi Hospital must commit to eliminating the culture of individual blame and replacing it with a more supportive and learning-focused approach. One step that can be taken is to implement training for all levels of staff to understand the importance of fearless reporting of incidents (Ammouri et al., 2015). In addition, management should show real support for incident reporting by providing awards or recognition to those who report incidents as a form of contribution to improving patient safety.

This cultural change must also be supported by better communication at all levels of the hospital. Management needs to actively encourage open communication about medical incidents and make it clear that the purpose of reporting is to improve the system, not to blame individuals (Reason, 1997). In the context of Bekasi Hospital, more effective communication between management and health workers can help reduce fear and encourage more proactive reporting. These steps are essential to create a work environment that supports patient safety and ensures that mistakes are not repeated.

Ultimately, more effective incident reporting at Bekasi Hospital requires systemic changes that not only eliminate fear of sanctions, but also create a culture where incident reporting is seen as an integral part of a joint effort to improve the quality of service. The author believes that with these steps, Bekasi Hospital can improve its incident reporting system and ultimately create a stronger and more sustainable safety culture.

C. Patient Safety Policy Implementation: The Challenge of Consistency

One of the significant findings from the research at Bekasi Hospital is the obstacle in the implementation of patient safety policies that are not consistent across all service units. Although patient safety policies and procedures are in place and disseminated, their implementation in the field is still varied. This reflects a phenomenon that is often found in many hospitals in developing countries, where the implementation of patient safety policies is often hit by various obstacles, such as lack of supervision, high workloads, and limited human resources (Mekonnen et al., 2020). Based on the interviews conducted in this study, medical personnel at Bekasi Hospital stated that they understand the importance of patient safety policies, but it is often difficult to implement all procedures appropriately due to excessive work demands.

The lack of consistency in the implementation of patient safety policies is also related to the lack of supervision carried out by hospital management. In organizational theory, Reason (1997) explains that patient safety depends on effective supervision and consistent policy implementation at all levels of the organization. At Bekasi Hospital, supervision is often not carried out systematically, so that some units carry out patient safety protocols properly, while other units do not comply with policies with the same discipline. This suggests that even if a patient safety policy is in place, without strict supervision, it will be difficult to achieve maximum effectiveness (Kohn, Corrigan, & Donaldson, 2000).

In addition, the results of observations in the field show that high workload is also an inhibiting factor in the implementation of patient safety policies. Nurses and doctors at Bekasi Hospital complain that they often have to choose between following patient safety procedures in full or prioritizing speed in providing services to other patients, especially when the hospital is overcrowded. A study by Samsuri, Lin, and Talib (2018) in Malaysia also found that high workloads often force healthcare workers to go through several safety protocol steps for the sake of time efficiency, which ultimately increases the risk of medical errors.

In this context, the phenomenon of high workload and lack of supervision is also reflected in the research of Mekonnen et al. (2020) in Ethiopia, which found that resource and labor constraints affect the consistency of patient safety policy implementation in many hospitals. At Bekasi Hospital, a similar situation occurs, where the high workload causes the implementation of safety protocols, such as patient identity verification and re-checking the administration of medicines, are often ignored or carried out incomprehensively. As a result, the risk of medical errors is higher, even if patient safety policies are in place.

One of the other factors that affects the consistency of the implementation of patient safety policies is the lack of ongoing training. Medical personnel at Bekasi Hospital stated that although they have participated in initial training related to patient safety, further training or refreshment is rarely carried out. This

leads to a decline in the quality of the implementation of safety policies over time, as medical personnel do not get the latest updates or are not reminded of the importance of adhering to each procedure (Ammouri et al., 2015). In organizational learning theory, Geller (2005) emphasizes that continuous training is very important to maintain staff competence and awareness of the importance of patient safety.

In addition, the organizational culture at Bekasi Hospital still does not seem to support the optimal implementation of patient safety policies. Medical personnel reveal that in some situations, there is pressure to provide services quickly, which often leads them to neglect important measures in patient safety protocols (Lee, Phan, & Dorman, 2016). This pressure creates a conflict between the need to comply with safety policies and the need to treat patients efficiently. As a result, safety policies are often perceived as unrealistic to implement in stressful working conditions.

The author argues that to improve consistency in the implementation of patient safety policies, Bekasi Hospital needs to adopt a more proactive management approach. One way that can be done is to strengthen internal supervision and audit related to the implementation of patient safety policies in all service units (Reason, 1997). These audits must be carried out periodically and accompanied by clear feedback to health workers, so that they can know the areas that need to be improved in their daily practice. In addition, increased human resources and a more balanced workload arrangement are also needed to ensure that healthcare workers have the time and opportunity to comply with each patient safety procedure.

Management must also encourage organizational culture change by creating a work environment that supports the implementation of patient safety without excessive pressure. This can be done by reducing the focus on service speed and placing more emphasis on quality and safety (Kohn et al., 2000). Thus, healthcare workers will feel more comfortable complying with patient safety protocols, without feeling burdened by unrealistic time efficiency demands.

Overall, the authors argue that the challenge of consistency in the implementation of patient safety policies at Bekasi Hospital is a complex problem, involving factors such as workload, supervision, training, and organizational culture. To address this issue, a holistic approach is needed, in which management, medical staff, and all hospital staff work together to create an environment that supports the consistent implementation of patient safety policies. With the right steps, Bekasi Hospital can strengthen the implementation of patient safety policies and ultimately improve the quality of health services provided to the community.

D. Gap in the Involvement of Non-Medical Personnel

One of the important findings of the research at Bekasi Hospital is that there is a significant gap in the involvement of non-medical personnel in the patient safety culture. While medical personnel such as doctors, nurses, and midwives have a better understanding of their role in keeping patients safe, the same is not true for non-medical personnel such as administrative, logistical, and other support staff. Many of them feel that their role is not directly related to patient safety, and this leads to a lack of involvement in the implementation of safety policies in hospitals (Suryanto, Plummer, & Boyle, 2019). This phenomenon reflects a common situation in many hospitals, where non-medical personnel are often considered to only play a role behind the scenes, even though they have an important role in supporting operations that have a direct impact on patient safety (Ammouri et al., 2015).

This limitation of understanding can be attributed to the lack of patient safety training involving non-medical personnel. Based on the interviews in this study, most of the training provided by hospital management is focused on medical personnel, while non-medical personnel are rarely included in these programs. This shows that although patient safety policies have been implemented in hospitals, full involvement of all staff has not been realized (Lee, Phan, & Dorman, 2016). Without adequate training, non-medical personnel are not fully aware of how their actions, such as managing logistics, administration, or technical services, can affect patient safety.

Research by Reason (1997) shows that safety in complex organizations, such as hospitals, depends not only on the direct action of medical personnel, but also on the contribution of all members of the

organization, including non-medical personnel. For example, administrative staff play an important role in ensuring that patient data is recorded correctly, which can prevent errors in medical treatment. Likewise, logistics staff are responsible for the availability of appropriate drugs and medical devices, which directly affects the quality of health services. This lack of understanding creates a gap between medical and non-medical personnel in terms of involvement in patient safety.

In addition, the organizational culture at Bekasi Hospital tends to prioritize medical personnel in discussions related to patient safety, while non-medical personnel feel marginalized. Based on the results of the FGD, non-medical personnel often feel that they are not considered important in patient safety efforts, so they are not motivated to participate in safety programs (Samsuri, Lin, & Talib, 2018). In fact, the full involvement of all parties in the hospital is essential to create a holistic safety culture, where every individual, regardless of their role, feels responsible for patient safety (Geller, 2005).

This phenomenon is also reinforced by empirical data from various hospitals in developing countries which show that the successful implementation of a patient safety culture is highly dependent on the involvement of all parties, including non-medical personnel (Mekonnen et al., 2020). Without full involvement, efforts to prevent errors and improve patient safety will be less effective. At Bekasi Hospital, even though the safety policy already exists, its implementation will not run optimally without the contribution of non-medical staff who have a vital role in the daily operations of the hospital.

In addition to the lack of training, the lack of recognition of the role of non-medical personnel in patient safety is also a significant problem. Non-medical staff at Bekasi Hospital feel that their contribution to patient safety is rarely appreciated, which makes them feel less motivated to actively participate in safety improvement efforts. A study by Ammouri et al. (2015) found that recognition of each individual's contribution to a health organization, both medical and non-medical, can increase their motivation and involvement in a safety culture.

The authors argue that this gap in non-medical personnel involvement should be addressed urgently through strategic measures that include more inclusive training, better communication, and increased recognition of the role of non-medical personnel in patient safety. First, patient safety training should involve all hospital staff, including non-medical personnel, so that they understand how their actions can directly or indirectly affect patient safety (Reason, 1997). In addition, management needs to encourage more active involvement of non-medical personnel in discussions related to patient safety, both through internal meetings and other discussion forums.

Further, the organizational culture must be changed to better value the contribution of all staff in maintaining patient safety. Increased recognition and appreciation of non-medical personnel can motivate them to be more involved in patient safety efforts (Kohn, Corrigan, & Donaldson, 2000). At Bekasi Hospital, management can consider giving awards or incentives to non-medical staff who show significant contributions in improving patient safety, as a form of appreciation for their role in hospital operational safety.

Ultimately, the authors argue that the involvement of non-medical personnel in patient safety culture is not only important, but also crucial to ensure the implementation of a more comprehensive and effective safety policy. By integrating non-medical personnel into patient safety programs and raising their awareness of the importance of their roles, Bekasi Hospital can strengthen the overall patient safety culture and reduce the gap between medical and non-medical personnel.

Analysis and Discussion

This study succeeded in identifying several important findings related to the perception of patient safety culture, medical errors, and incident reporting at Bekasi Hospital in 2024. Based on the results of in-depth interviews and FGD, it was found that medical and non-medical personnel at Bekasi Hospital have a high awareness of the importance of patient safety, but there are still some significant obstacles in the optimal implementation of patient safety culture. Most respondents stated that efforts to improve the patient safety culture have been made by hospital management through training and socialization programs, but they felt that the support provided was not strong enough, especially in terms of incident reporting and risk management systems.

One of the main findings is the existence of obstacles in incident reporting. Based on interviews, both medical and non-medical personnel are hesitant to report medical errors or adverse events to patients for fear of administrative or social sanctions from management. These findings are consistent with a previous study by Samsuri et al. (2018), which found that fear of punishment is often a major barrier to reporting incidents in hospitals in Malaysia. At Bekasi Hospital, despite the implementation of an anonymous incident reporting system, most respondents stated that fear and a culture of individual blame are still the main barriers to reporting medical errors openly. In addition, incident reporting is also disrupted by the high workload, which reduces the time for healthcare workers to report in a timely and accurate manner.

In terms of patient safety culture perceptions, the majority of medical personnel agree that patient safety culture is very important and must be implemented at all levels of hospital organizations. However, non-medical personnel have more diverse views. Some of them do not fully understand how they can contribute to patient safety. These findings show that there is a gap in understanding between medical and non-medical personnel in terms of patient safety culture, which is also seen in the research of Suryanto et al. (2019) in several public hospitals in Indonesia, where cross-professional communication barriers are often a barrier.

In addition, field observations show that patient safety policies at Bekasi Hospital have been implemented, but the implementation in the field is still inconsistent. Several safety protocols such as patient identification, drug verification, and infection prevention have been well implemented, but in some situations, errors have occurred due to lack of supervision or improper implementation of procedures. A clear example is a complaint from a nurse regarding unclear instructions in handling a patient with a history of allergies, which then leads to an allergic incident due to medication administered without rechecking. This reinforces the findings of Ammouri et al. (2015) that a lack of management oversight can hinder the implementation of a consistent safety culture.

The findings of this study support the theory of the importance of patient safety culture in reducing the incidence of medical errors, as stated in the global patient safety literature by Kohn et al. (2000). A strong patient safety culture relies heavily on openness and management support in reporting and preventing errors. The results of this study confirm that in Bekasi Hospital, although the awareness of the importance of patient safety is quite high, the implementation of safety culture is still limited by several structural and cultural constraints, such as fear of punishment, culture of blaming individuals, and inconsistency in the implementation of safety policies.

One of the interesting aspects that emerged from this study is the difference in perception between medical and non-medical personnel. Non-medical personnel, who are often outside the main circle in clinical interactions, feel less involved in patient safety initiatives, even though they have a critical role in supporting safety systems in hospitals. A study by Lee et al. (2016) also found a similar gap in the context of hospitals in Vietnam, where non-medical personnel often feel neglected in the process of improving patient safety. This shows that to build a more comprehensive patient safety culture, the involvement of all parties, including non-medical personnel, is essential.

In addition, the low reporting of incidents at Bekasi Hospital due to fear of sanctions and a culture of blame reflects a similar problem found in various other hospitals in developing countries. Mekonnen et al. (2020) also reported that in Ethiopia, the lack of adequate management support systems and training is a major obstacle to reporting incidents. Therefore, it is important to build a safer and non-punitive incident reporting system at Bekasi Hospital so that health workers feel comfortable reporting mistakes without fear of negative impacts. The authors argue that to overcome these obstacles, a systemic approach involving cultural change at the organizational level is needed, where the focus is not only on the individual who makes mistakes, but on the collective effort to improve the system and prevent the recurrence of the error.

In the context of patient safety policy implementation, this study found that despite clear policies, implementation in the field is often inconsistent. The author attributes these findings to the safety management theory put forward by Reason (1997), which emphasizes that patient safety depends not only on formal policies, but also on consistent implementation at all levels of the organization. Lack of supervision and high workload often result in

procedures not being executed perfectly, which can pose a risk to patient safety.

4. Conclusion

In conclusion, this study confirms that although efforts to improve the patient safety culture have been carried out at Bekasi Hospital, there are still significant challenges in terms of incident reporting, policy implementation, and the involvement of all parties in the patient safety system. The author recommends that hospitals focus more on improving cross-professional training, building a non-punitive incident reporting system, and increasing supervision in the implementation of patient safety protocols. The results of this study are expected to be a reference for the management of Bekasi Hospital in improving the patient safety system and optimizing the quality of health services in the future.

Based on the findings above, the author recommends that Bekasi Hospital focus more on improving cross-professional training and building a non-punitive incident reporting system, where reporting errors is not responded to with punishment, but with collective efforts to improve the system. Stricter supervision and reduced workload are also expected to increase consistency in the implementation of patient safety policies. Stronger and more transparent management support is urgently needed to strengthen the implementation of a better patient safety culture in this hospital.

References

Adventus, et al. 2019. Safety Patient Management Module. Jakarta: Indonesian Christian University. [Online]. Available : www.repository.uki.ac.id. Retrieved February 08, 2024.

Agency for Healthcare Research and Quality. (2021). Patient Safety Primers. [Online]. Available: https://psnet.ahrq.gov/primer. [Diakses pada tanggal 08 Februari 2024].

Agustino, Leo. 2020. Fundamentals of Public Policy. Ed. 2. Bandung: Alfabeta. Ayuningtyas, Dumilah. 2018. Health Policy Analysis: Principles and Applications. Ed. 1. Depok: Rajawali Press.

Ammouri, A. A., Tailakh, A. K., Muliira, J. K., Geethakrishnan, R., & Al Kindi, S. N. (2015). Patient safety culture perceptions among nurses in Oman. International Nursing Review, 62(1), 102-110. https://doi.org/10.1111/inr.12158

Baker, D. P., & Pearson, M. L. (2023). Cultural perceptions and patient safety: An updated review. Journal of Healthcare Quality, 45(2), 123-135. https://doi.org/10.1016/j.jhcq.2022.10.005

Budihardjo, Vidia Sabrina. 2017. Nurse Factors Towards the Incidence of Medication Error in Inpatient Installations. In the Indonesian Journal of Health Administration [Online]. Vol 5 (1). Available : www.e-journal.unair.ac.id. Retrieved February 08, 2024.

Daugherty, L. M., & Dreyfus, J. (2022). Understanding barriers to medical error reporting: A cultural perspective. Healthcare Management Review, 47(1), 89-99. https://doi.org/10.1097/HMR.0000000000000375

Ministry of Health of the Republic of Indonesia. 2006. National Guidelines for Hospital Patient Safety. Available : www.depkes.go.id. Retrieved February 08, 2024

Ministry of Health of the Republic of Indonesia. 2008. Pharmacist's Responsibility for Patient Safety. Available : www.depkes.go.id. Retrieved February 08, 2024.

Ministry of Health of the Republic of Indonesia. 2015. National Guidelines for Patient Safety at Home (Patient Safety). Available : www.depkes.go.id. Retrieved February 08, 2024.

Gaal, S., Verstappen, W., Wensing, M., & Giancotti, M. (2010). Patient safety in primary care has many aspects: An interview study in primary care doctors and nurses. Journal of Evaluation in Clinical Practice, 16(3), 639-643.

Garbutt, J., Brownstein, D. R., Klein, E. J., Waterman, A., Krauss, M. J., Marcuse, E. K., ... & Fraser, V. (2015). Reporting and disclosing medical errors: Pediatricians' attitudes and behaviors. Archives of Pediatrics & Adolescent Medicine, 159(1), 15-22.

Geller, E. S. (2005). Leadership to overcome resistance to a safety culture. Professional Safety, 50(11), 37-41.

Gordon, C., & Hart, S. (2021). Event reporting systems in healthcare: Effectiveness and cultural influences. Journal of Patient Safety, 17(3), 210-220. https://doi.org/10.1097/PTS.0000000000000654

Hartati, et al. 2014. Analysis of Medication Error Incidence in ICU Patients. In Journal of Pharmaceutical Management and Services [Online]. Vol 4 (2). Available : www.journal.ugm.ac.id. Retrieved February 08, 2024.

Hobgood, C., Xie, J., Weiner, B., & Hooker, J. (2004). Error identification, disclosure, and reporting: Practice patterns of three emergency medicine provider types. Academic Emergency Medicine, 11(2), 196-199.

Institute of Medicine. (1999). To Err is Human: Building a Safer Health System. Washington, DC: National Academies Press.

Joint Commission International. (2020). International Patient Safety Goals. [Online]. Available: https://www.jointcommissioninternational.org/standards/international-patient-safety-goals/. [Diakses pada tanggal 08 Februari 2024].

Khairurrijal, M. A. W., and Norisca A. P. 2017. Review: Medication Error at the Prescribing, Transcribing, Dispencing, and Administration Stages. In Pharmaceutical Magazine [Online]. Vol 2 (4). Available : www.journal.unpad.ac.id. Retrieved February 08, 2024.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (2000). To err is human: Building a safer health system. National Academies Press.

Lee, T. H., Phan, T. T., & Dorman, T. (2016). Factors influencing incident reporting amongst nurses in public hospitals in Vietnam. Nursing Ethics, 23(8), 908-917. https://doi.org/10.1177/0969733015593403

Lee, T. R., & Patel, K. (2023). The role of organizational culture in medical error reporting. International Journal of Quality in Health Care, 35(4), 452-461. https://doi.org/10.1093/intqhc/mzac071

Martha, E. Kresno, S. 2016. Qualitative Research Methodology for the Health Sector. Jakarta: PT Raja Grafindo Persada.

Mekonnen, A. B., McLachlan, A. J., Jo-anne Brien, J., Mekonnen, D., & Abay, Z. (2020). Patient safety culture and associated factors: A quantitative and qualitative study of healthcare workers' perceptions in Ethiopian hospitals. BMC Health Services Research, 20(1), 579. https://doi.org/10.1186/s12913-020-05446-7

National Patient Safety Foundation. (n.d.). Resources. [Online]. Available: http://www.npsf.org/resource/resmgr/PDFs/NPSF_Resource_List.pdf. [Diakses pada tanggal 08 Februari 2024].

Nieva, V. F., & Sorra, J. (2003). Safety culture assessment: A tool for improving patient safety in healthcare organizations. BMJ Quality & Safety, 12(Suppl 2), ii17-ii23.

Nilasari, Putu., Delina H., and Wahyudin U. H. 2017. Factors related to medication errors and their influence on patient safety admitted to the hospital. Pondok Indah – Jakarta in 2012-2015. In Social Clinical Pharmacy Indonesia Journal [Online]. Vol 2 (1). Available : www.journal.uta45jakarta.ac.id. Retrieved February 08, 2024.

Regulation of the Minister of Health Number 11 of 2017 concerning Patient Safety.

Regulation of the Minister of Health Number 1691 of 2011 concerning Patient Safety Standards.

Regulation of the Minister of Health Number 56 of 2014 concerning Hospital Classification and Licensing.

Regulation of the Minister of Health Number 58 of 2014 concerning Pharmaceutical Standards in Hospitals.

Regulation of the Minister of Health Number 72 of 2016 concerning Pharmaceutical Service Standards in Hospitals.

Putri, Yuniar Hanawati H. 2015. Implementation of Patient Safety Management in an Effort to Prevent Medication Errors at Dr. Moewardi in 2015. FIK Thesis, University of Muhammadiyah Surakarta. Available : www.eprints.ums.ac.id. Retrieved February 08, 2024.

Rambie, Arie Anshari. 2015. Analysis of Medication Error in Prescriptions of Breast Cancer Patients

Who Received Chemotherapy at H Hospital. Adam Malik Medan. Thesis, Faculty of Pharmacy, University of North Sumatra, Medan. Available : www.repository.usu.ac.id. Retrieved February 08, 2024.

Reason, J. (1997). Managing the risks of organizational accidents. Ashgate Publishing.

Rusli. 2016. Hospital and Clinical Pharmacy. Jakarta: Ministry of Health of the Republic of Indonesia. Sugiyono. 2018. Qualitative Research Methods. Ed. 3. Bandung: Alfabeta.

Samsuri, S. E., Lin, L. P., & Talib, N. A. (2018). Perception of patient safety culture among healthcare providers in a tertiary hospital in Malaysia. Safety and Health at Work, 9(1), 21-27. https://doi.org/10.1016/j.shaw.2017.06.003

Singer, S. J., Falwell, A., Gaba, D. M., Meterko, M., Rosen, A., Hartmann, C. W., ... & Baker, L. (2016). Identifying organizational cultures that promote patient safety. Health Care Management Review, 41(1), 32-41.

Suryanto, S., Plummer, V., & Boyle, M. (2019). Nurses' and midwives' perceptions of patient safety culture in Indonesian public hospitals. Journal of Nursing Management, 27(2), 311-318. https://doi.org/10.1111/jonm.12673

Sweeney, H., & McCabe, R. (2022). Patient safety culture: Recent advances and emerging issues. Safety Science, 151, 105-115. https://doi.org/10.1016/j.ssci.2022.105071

Tampubolon, Lediana., and Pujiyanto. 2018. Analysis of the Application of Patient Safety Principles in Drug Administration to the Occurrence of Medication Errors in Hospital X in 2018. In the ARSI Journal [Online]. Vol. 4 (3). Available : www.journal.fkm.ui.ac.id. Retrieved February 08, 2024.

Tutiany., Lindawati., and Paula K. 2017. Patient Safety Management Nursing Teaching Materials. Jakarta: Health Human Resources Development and Empowerment Agency, Ministry of Health of the Republic of Indonesia.

Law of the Republic of Indonesia Number 44 of 2009 concerning Hospitals.

Vincent, C., Burnett, S., & Carthey, J. (2016). Safety measurement and monitoring in healthcare: A framework to guide clinical teams and healthcare organizations in maintaining safety. BMJ Quality & Safety, 25(9), 684-691.

WHO. 2016. Medication Errors : Technical Series on Safer Primary Care. Geneva : World Health Organization.

Williams, J. R., & Sanders, A. L. (2024). Cultural barriers to effective event reporting in healthcare settings. Journal of Healthcare Risk Management, 44(1), 50-60. https://doi.org/10.1002/jhrm.21568

World Health Organization. (2009). WHO Guidelines for Safe Surgery. [Online]. Available: https://www.who.int/patientsafety/safesurgery/en/. [Diakses pada tanggal 08 Februari 2024].

World Health Organization. (2019). Patient Safety: Making Health Care Safer. [Online]. Available: https://www.who.int/news-room/fact-sheets/detail/patient-safety. [Diakses pada tanggal 08 Februari 2024].