EVALUATION OF PATIENT SAFETY REPORTING SYSTEM AT TUBAN HOSPITAL

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ABSTRACT

Background: The incident reporting system is designed to obtain information about patient safety which is used for organizational and individual learning. Objective: The purpose of the study was to evaluate the implementation of a patient safety incident reporting system in hospitals. The research is in the form of observational descriptive supported by qualitative data. The evaluation in this study used the Health Metrics Network (HMN) model.

Results: The results of the evaluation of the patient safety incident reporting system at a hospital in Surabaya indicate that in terms of input there has been a policy that regulates patient safety incident reporting but unfortunately the implementation of this policy is still not appropriate, there is no direct funding but facilities are provided for In making reports, officers have been given socialization but there are differences in understanding and sense of responsibility of officers, the organizational structure of the patient safety team already exists, problem solving methods have not used PDSA (Plan, Do, Study, Action), the technology used is computerized.

Conclusion: Evaluation in terms of process, indicators are in accordance with regulations, data sources are in accordance with patient safety incident guidelines and guidelines, and collection, processing, presentation, and analysis are in accordance with theory. Evaluation in terms of output, submission of incident reports has not been on time, reports are complete and in accordance with existing guidelines, and reports have been used for decision making. Hospitals are expected to improve incident reporting guidelines and improve human resource capabilities.

Keywords: evaluation, incident, patient safety, reporting

INTRODUCTION

The medical record is a file containing records and In 2007, the World Health Organization declared patient safety to be a priority in health services. Health care providers must put patient safety as a priority. RI Law No. 44 of 2009 concerning Hospitals explains that hospitals are required to apply patient safety standards and are carried out through incident reporting, analyzing and implementing problem solving in order to reduce the number of unexpected events.

Patient safety is a system that makes patient care safer. The system consists of risk assessment, patient risk identification and management, incident reporting and analysis, the ability to learn from incidents and their follow-up, and implementation of solutions to minimize risks and prevent injuries caused by mistakes due to taking an action or not taking appropriate action. should have taken. A patient safety incident is any unintentional event and condition that results in or has the potential to result in preventable injury to a patient (Ministry of Health of the Republic of Indonesia, 2017).

Incident reporting systems are designed to obtain information about patient safety that can be used for organizational and individual learning (Stavropoulou et al., 2015). Good patient safety incident reporting is able to support efforts to identify risks in incidents that have the potential to cause patient safety threats (Gunawan et al., 2015). Patient safety incident reporting is a system for documenting patient safety incident reports, analysis and solutions for learning (Ministry of Health of the Republic of Indonesia, 2017).

Reporting of patient safety incidents, according to the Hospital Patient Safety Committee (2015) is carried out internally and

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externally. Internal reporting is a report about incidents that occur in the hospital environment. External reporting is carried out by reporting from the hospital to the National Hospital Patient Safety Committee (KKP-RS). The results of safety incident reporting are used for decision making and serve as lessons learned. In order to make these decisions right on target, it is necessary to evaluate patient safety incident reporting.

Evaluation of reporting implementation can be evaluated using a Health Metrics Network (HMN) framework developed by the World Health Organization (WHO) in 2008. The Health Metrics Network (HMN) framework does not only focus on information about disease but the entire statistical and information system. health. The framework is used as a universal standard to guide the collection, reporting and use of health information. The HMN framework aims to develop and strengthen country health information systems and assist in the implementation of continuous monitoring and evaluation (WHO, 2008). In addition, the framework helps identify gaps and important issues that can be seen from the perspective of stakeholders involved in health information systems (Mbondji et al., 2014).

*Health Metrics Network*has six main components, namely health information system resources, health indicators, data sources, data management, information products, and dissemination and use of health information (Jakti, 2016). One of the country's health information is information about patient safety. Information about the country's patient safety is obtained from the existence of an external reporting system or reporting on patient safety incidents sent from the hospital to the National Hospital Patient Safety Committee.

The hospital that is the location of this research is one of the private hospitals that has implemented a patient safety program and has had a patient safety incident reporting system since 2016. According to the results of interviews with the Quality Improvement and Patient Safety Committee (PMKP) officers, one of the problems that There is a reporting system that has not been running optimally. This study aims to evaluate the implementation of the patient safety incident reporting system in the hospital. The results of this study can be used as input for hospital management in improving the implementation of a better patient safety incident reporting system so that it can support patient safety programs.

RESEARCH METHODS

This research is an observational descriptive study with a cross sectional design supported by qualitative data. Informants in this study include the Chair of the PMKP Committee, Secretary of the PMKP Committee, Coordinator of Hospital Patient Safety, Quality and Patient Safety Champion in the unit who frequently reports on patient safety incidents. The variables in this research are based on the components of the Health Metrics Network (HMN) evaluation model that are tailored to the needs of the researchers consisting of inputs, namely policies, funding, human resources, organization, problem solving methods, technology. Indicators, data sources, data collection, data processing, data presentation, data analysis were analyzed as components of the process. Timeliness, completeness of data, and decision makers are included in the output components. Collecting data by conducting interviews with informants who are directly involved in the patient safety incident reporting system, making observations, and reviewing documents. Secondary data was obtained from a review of the hospital's Quarter II Patient Safety Incident report document. The data that has been collected is then analyzed using the Miles and Huberman model which consists of three stages, namely data reduction, data

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presentation, and verification. The presentation of the data used in the research is narrative text. The technique of examining the data uses the triangulation method of sources and theory. The limitation of this study is that it was only conducted for one month to evaluate the implementation of the existing patient safety incident reporting system.

RESULTS AND DISCUSSION

The informants of this study consisted of main informants who provided information about the implementation of patient safety incident reporting in hospitals and supporting informants as a source of information to test the credibility of the results of interviews with key informants. The main informants consisted of three people. The positions of the three main informants are Chair of the PMKP Committee, Coordinator of Patient Safety, and Champion of Quality and Patient Safety. While the supporting informant is the secretary of the PMKP committee. The last education of all informants is strata one with more than three years of work experience

Overview of Making Patient Safety Incident Reports in Hospitals

Reporting patient safety incidents in hospitals is carried out when an incident occurs. The patient safety incident reporting flow consists of two types, namely internal and external incident reporting flows. The patient safety incident report of the Hospital Patient Safety Sub-Committee is a written report faithfully to Unexpected Events (KTD), Non-Injury Events (KTC), Potential Injury Conditions (KPC) or Near Injury Events (KNC) that befell the patient or incident others that afflict families and visitors. While the KKP-RS Patient Safety Incident report is an anonymous and written report to the KKP-RS every KTD or KNC that occurs in a patient which is then analyzed for causes, recommendations and solutions.

Evaluation of Patient Safety Incident Reporting System

In this study, the evaluation of the patient safety incident reporting system uses the Health Metrics Network (HMN) evaluation model that has been adapted to the needs of the researcher. In terms of input and process consists of six aspects, while in terms of output consists of three aspects.

Evaluation of the Patient Safety Incident Reporting System in terms of Input

Evaluation of the patient safety incident reporting system in terms of input consists of six aspects. The six aspects are policies or guidelines owned by the hospital, funding, human resources (HR), organization or management, problem solving methods, and technology.

Evaluation of the Patient Safety Incident Reporting System in terms of Process

Evaluation of the patient safety incident reporting system in terms of the process consists of six aspects, namely indicators, data sources, data collection, data processing, data presentation, and data analysis.

Based on the Decree of the Minister of Health of the Republic of Indonesia Number 129 of 2008 concerning Minimum Service Standards for Hospitals that the number of patient safety incidents in hospitals should be 0% or it can be interpreted that there are no events that can endanger patients such as patient falls, medication errors, and incorrect delivery of results. inspection.

The results of reporting patient safety incidents in the second quarter of 2017 at this hospital found that the types of patient safety incidents reported had four dimensions, namely Near Injury Events (KNC), Non Injury Events (KTC), Unexpected Events (KTD), and Sentinels. During April to June 2017, there were 54 near-injury incidents (KNC), 14 non-injury events (KTC), 3 unintended events (KTD), and no sentinel events. In Quarter 2 of 2017 the number of incidents was 71 incidents. Even though there are few adverse events

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and there are no sentinels, reporting must still be done because it can be used as data for prevention and the data can be used to improve the quality of hospital services.

The source of data used to compile patient safety incident reports in hospitals comes from the incident report form which is submitted to the patient safety sub-committee. The report form is confidential and only authorized parties can access the data.

The data source used is in accordance with the guidelines for reporting patient safety incidents issued by the KKP-RS in 2015 and the patient safety incident guidelines that are owned. Data for the preparation of patient safety incident reports comes from the incident report form. According to Elliot, Martin, and Neville (2014), the development of a patient safety incident recording and reporting system must be done in an anonymous, confidential, and can be used by multiple users simultaneously. Therefore, it can be concluded that the data sources used in incident reporting are in accordance with the applicable provisions of the patient safety incident guidelines and guidelines.

Based on the results of the review of the patient safety incident report form document and the quarterly patient safety incident report. The completeness of this hospital patient safety incident data is in accordance with the provisions in the hospital patient safety incident guide. Completeness of patient safety incident data is very important because the data will be used for decision making and the learning process. If there is incomplete data then management will find it difficult to correct and prevent the same error.

The results of patient safety incident reports are used as material for decision making and learning for individuals and organizations. The results of the report on patient safety incidents in this hospital have been used as a basis for decision making, especially for the learning process and improving the quality of services. Based on interviews from informants, the report was used by the top ranks of the hospital foundation, the board of directors, and managers, and the PMKP committee. The information generated will be used by various levels of the health system in health services such as the planning and development system (WHO, 2008). Health information systems are an important component for health coordination and for good decision making (Ceken, 2014).

One of the uses of the results of patient safety incident reports for decision making is the existence of outreach activities about patient safety which are carried out regularly every year as an effort to increase employee knowledge about patient safety. The existence of a plan to take part in patient safety training held outside the hospital for hospital employees can also be determined from this report. It can be concluded that patient safety incidents have been used by decision makers as a basis for consideration of improving hospital services

CONCLUSION

This hospital already has a patient safety incident reporting system. The patient safety incident reporting system is in accordance with the Regulation of the Minister of Health Number 11 of 2017 concerning Patient Safety. Policies and guidelines governing the reporting of patient safety incidents in practice are still not up to standard. This hospital is expected to be able to revise the guidelines regarding patient safety incident reporting. Improvement of human resource capacity also needs to be planned because the evaluation on all aspects shows the system failed due to the weakness of human resources. This improvement in the quality of human resources must also be accompanied by developing a computerized system for patient safety incident report forms.

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