The Effect Of Implementation Of Patient Identification Based On The Pall Accreditation Standards On Improving The Patient Safety Program At Royal Prima General Hospital In 2022

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Abstract.
Patient safety is a variable to measure and evaluate the quality of nursing services that have an impact on health services. One of the safety services in hospitals starts from the accuracy of patient identification. Patient identification errors at the beginning of the service will continue to the next service error. The purpose of this study was to determine how the effect of implementing patient identification based on JCI accreditation standards on improving the Patient Safety program at Royal Prima Hospital. This type of research is a quantitative study with a cross-sectional design. Sampling technique The sampling technique in this study was to use the Slovin formula with a total sample of 124 patients. Data analysis in this study used univariate and bivariate analysis. The results of the study explained that there was an influence between the implementation of patient identification based on the Plenary accreditation standard to the improvement of the Patient Safety program at the Royal Prima Hospital Medan with ap value of <0.007. Through this research, it is hoped that the Royal Prima Hospital Medan can improve the quality of nursing services, especially in the implementation of identification based on the Plenary Accreditation Standards.

Keywords : Patient identification, accreditation standards, patient safety.

I. INTRODUCTION

In the current era of globalization, Indonesia is still not able to compete with hospitals abroad. Public distrust of the quality of health services in hospitals is due to the increasing frequency of allegations of malpractice and misdiagnosis by health workers. For this reason, it is necessary to increase hospital patient safety in the hope that public trust in hospital services can increase. Patient safety programs can reduce unexpected events (KTD) that can have an impact on increasing service costs, causing conflicts between health workers and patients, giving rise to lawsuits, allegations of malpractice, which ultimately lead to negative opinions on hospital services. Currently, an important issue facing globalization in health care is patient safety. (Ministry of Health RI, 2015) In Permenkes no 11 of 2017 states that every hospital is obliged to strive for the fulfillment of Patient Safety Goals. Patient safety goals include achieving accurate patient identification, increasing effective communication, increasing drug safety that needs to be watched out for, ensuring right-location, right-procedure, right-patient surgery, reducing the risk of infection related to health services, and reducing the risk of patient falls. (Ministry of Health RI, 2017) Patient safety is a variable to measure and evaluate the quality of nursing services that have an impact on health services. According to Sumarianto et al (2013) patient safety is a system established by hospitals to prevent and reduce errors in patient care resulting from negligence or errors in care provided. Hospital patient safety is a form of health service to patients in hospitals that is safe and does not harm patients. All components of hospital health services include doctors, nurses and other health workers.

Hospital patient safety is a system where the hospital makes patient care safer which includes risk assessment, identification and management of matters relating to patient risk, 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 errors resulting from carrying out an action or not taking the action that should have been taken (Sumarianto, et al, 2013) According to WHO (2017) hospitalized patients are at risk of experiencing unexpected events. Therefore, health services have an important role in providing 2 nursing care to patients, namely ensuring patient safety and reducing Unwanted Events (KTD) in hospitals.The patient safety standards that have been set by JCI (Joint Commission International) are the targets for implementing patient safety in hospitals or what is called the National Patient Safety Goals for Hospitals

including identifying patients correctly, improving effective communication, using drugs safely, ensuring the right location, procedures and appropriate to the patient, lowering the risk of infection, and identifying the patient's risk of falling. The patient safety program aims to reduce the number of Unexpected Events (KTD) that often occurs in patients during hospitalization so that it is very detrimental to both the patient himself and the hospital (Afridawaty, 2017).Patient safety is a patient's right guaranteed in Law no. 44 of 2009 concerning Hospitals, for that the hospital needs to minimize errors that may occur in every action taken against patients in the hospital. One of the efforts to minimize these incidents is to form a Patient Safety Team at the Hospital in charge of identifying and reviewing incidents related to patient safety.In Indonesia, the patient safety movement began when the Indonesian Hospital Association (PERSI) took the initiative to form a Hospital Patient Safety Committee in 2015, which later changed to the Hospital Patient Safety Institute (IKPRS). In 2012, the Minister of Health established the Hospital Patient Safety Committee (KKPRS). Reports of Patient Safety Incidents in Indonesia based on their type, from 145 incidents reported, there were 69 cases of near-injury (KNC), 67 cases (46.2%), and 9 cases (6 ,2%). Based on the data above, it shows that there are still many patient safety problems that should be prevented by implementing the IPSG (International Patient Safety Goal). (Ministry of Health RI, 2015)

Based on research Anggraeni et al (2014) stated that nurses do not always identify patients, especially when carrying out routine nursing actions, for reasons of being busy or not having time and avoiding patient boredom. When there is an error in patient identification or inaccuracy in the implementation of the identification procedure, the nurse does not record and report because there is still a bad feeling or are reluctant to other officers who do not carry out the identification procedure correctly.One of the safety services in hospitals starts from the accuracy of patient identification. Due to incorrect identification of patients identified as the root cause of many errors that occur. Patient identification is the first patient safety goal. Errors due to patient identification errors occur in almost all aspects or stages of diagnosis and treatment so that accurate patient identification is required. Patient identification is carried out before carrying out medical or other procedures, administering drugs, transfusions of blood or blood products, taking blood and taking other specimens for clinical trials. The patient identification method is by date of birth, patient name, medical record number and bar coded bracelet. Room or bed numbers cannot be used for identification (Arbianti, 2015) Patient identification errors can occur in almost many aspects, which can lead to serious impacts for patients such as medication errors, medication errors, wrong blood transfusions, giving treatment procedures to the wrong person, and can even lead to handing over the baby to the wrong family. Patient identification errors at the beginning of service will continue to the next service error (Tutiany, 2017).

Hospital accreditation is an acknowledgment given by the government to hospital management because it has met the established standards.Royal Prima Hospitalreceived Plenary accreditation, namely passing the perfect level of 15 accreditation standards version 2012 which refers to the International accreditation standards from JCI-USA. This accreditation was obtained after an assessment visit from the Indonesian Ministry of Health KARS on 27-29 June 2016.Based on the results of an initial survey conducted by researchers at the Royal Prima Hospital regarding how to carry out patient identification, it was found that there were still some errors in identifying patients. Another problem is that there are still patient complaints in terms of identifying patients such as errors in giving drugs, medical personnel who do not explain treatment procedures, taking blood samples from patients whose purpose is not explained and patients who are still confused about the drugs they take while hospitalized. .Researchers also asked 10 patients who were hospitalized. The patient said that the medical staff did not explain the treatment process to be carried out, when giving medicine the medical personnel sometimes did not call the patient's name, the medical staff did not explain the benefits of the injection given and the lack of information from health workers about the disease being experienced by the patient.Based on this phenomenon, the researcher is interested in conducting research with the title "Influence"implementationidentification of patients based on Plenary accreditation standards for improving the Patient Safety program at the Royal Prima General Hospital".

II.   METHODS

The type of research used is quantitative research with a cross-sectional design. This research was conductedat the Royal Prima Hospital Medan because this hospital has used the Plenary Accreditation standard in 2016. This research is planned in March 2022 for approximately two weeks with the hope that the required sample is met.After going through the process of processing the research data, it is then analyzed to get answers or information related to the research carried out. The analysis gets answers or information related to the research carried out. This data analysis aims to obtain an overview of the research results that have been formulated in the research objectives. In addition, data analysis can also prove the research hypothesis that has been formulated. Analysis of the data in this study using a computer program through the stages of univariate and bivariate data analysis.

III.   RESULT AND DISCUSSION

Based on the results of the research that has been carried out, it shows that the majority of the implementation of patient identification was not carried out as many as 142 people and the minority of the implementation of patient identification based on the Plenary accreditation standard was in the implemented category as many as 82 people.Patient identification and matching of patients with treatment are activities that are carried out routinely in all treatment settings. For this reason, before taking action, the patient must be identified first, the patient must be identified by two checks, namely: first, to identify the patient as an individual who will receive services and treatment, and secondly for the suitability of the service or treatment for the individual. (Ministry of Health RI, 2017) Patient identification errors can occur in almost many aspects, which can lead to serious impacts for patients such as medication errors, medication errors, wrong blood transfusions, giving treatment procedures to the wrong person, and can even lead to handing over the baby to the wrong family. Patient identification errors at the beginning of the service will continue to the next service error.Based on research by Anggraeni et al (2014), it is stated that nurses do not always identify patients, especially when carrying out routine nursing actions, for reasons of being busy or not having time and avoiding patient boredom. When there is an error in patient identification or inaccuracy in the implementation of the identification procedure, the nurse does not record and report because there is still a bad feeling or are reluctant to other officers who do not carry out the identification procedure correctly.

According to the researcher's assumptions, the implementation of patient identification by nurses at the Royal Prima Hospital in Medan needs to be improved because it has a huge impact on the quality of nursing services. Nurses are also expected to have an awareness of their duties and responsibilities in carrying out their duties every day.Based on the results of the research that has been carried out, it shows that the majority of the increase in the Patient Safety program at the Royal Prima Hospital is in the unattainable category of 144 people and the minority of the increase in the Patient Safety program at the Royal Prima Hospital is in the achieved category of 780 people. Patient safety is a patient's right guaranteed in Law no. 44 of 2009 concerning Hospitals, for that the hospital needs to minimize errors that may occur in every action taken against patients in the hospital. One of the efforts to minimize these incidents is to form a Patient Safety Team at the Hospital which is tasked with identifying and reviewing incidents related to patient safety.According to Sumarianto et al (2013) patient safety is a system established by hospitals to prevent and reduce errors in patient care resulting from negligence or errors in care provided. Hospital patient safety is a form of health service to patients in hospitals that is safe and does not harm patients. All components of hospital health services include doctors, nurses and other health workers.According to the researcher's assumption that patient safety needs to be further improved, this is because there are still many nurses who do not carry out patient safety programs when carrying out their duties.

IV.   CONCLUSION

Based on the results of the study, it can be concluded that carrying out patient identification not implemented as many as 142 people and minorities the implementation of patient identification based on the Plenary accreditation standard was in the implemented category as many as 82 people, increasing the Patient Safety program at the Royal Prima Hospital majority improvement of Patient Safety program at Royal Prima

Hospitalare in the unattainable category as many as 144 people and minorities improvement of Patient Safety program at Royal Prima Hospital are in the category achieved as many as 780 people, there is an influence between the implementation of patient identification based on the Plenary accreditation standard to the improvement of the Patient Safety program at the Royal Prima General Hospital Medan 2022 based on the chi-square results obtained a p value <0.007 meaning that there is an effect on the implementation of patient identification based on the accreditation standard Plenary on improving the Patient Safety program at the Royal Prima General Hospital Medan 2022..

V.   ACKNOWLEDGMENTS

VI.   ETHICAL CONSIDERATIONS

The research will be conducted after the researcher has obtained ethical clearance from the Prima University Ethics Committee. Ethical considerations are standards of behavior that distinguish between acceptable behavior and unacceptable behavior (Tappen, 2016). To ensure accountability to participants, a study requires the protection of human rights which include autonomy, privacy, confidentiality, and justice (Wood and Ross-Kerr, 2011).

REFERENCES

[1]   Abdellatif A, Bagian JP, Barajas ER, Cohen M, Cousins D, Denham CR, et al. Patient Identification: Patient Safety Solutions, Volume 1, Solution 2, May 2007. *Jt Comm J Qual Patient Saf.* 2007;33(7):434–7

[2]   Arbianti, K., Suparman, A., & Aini, Q. (2015). Tinjauan Penerapan Nine Live Saving Patient Safety Solutions (Studi Kasus di RS PKU Muhammadiyah Bantul). *ODONTO Dental Journal,* 2(2), 28–35. https://doi.org/http://dx.doi.org/10.30659/odj.2.2.28-35

[3]   Anggraini D, Hakim L, Imam CW. Evaluasi Pelaksanaan Sistem Identifikasi Pasien di Instalasi Rawat Inap Rumah Sakit. *J Kedokt Brawijaya*. 2014;28(1):99–105

[4]   Afridawaty MJ. (2017). Studi Fenomenologi Budaya Keselamatan Pasien dari Perspektif Kepala Ruangan di Instalasi Rawat Inap RSUD Raden Mattaher Jambi

[5]   Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC; 2017

[6]   Chinta GLM, Suryoputro A, and Jati SP. Analisis Pelaksanaan Idenifikasi Pasien Dalam Rangka Keselamatan Pasien Di Unit Rawat Inap Rumah Sakit Umum Daerah Kota Bekasi. *Jurnal Kesehatan Masyarakat (e-Journal),* 2016: Volume 4, Nomor 4

[7]   Harus, B. D. A. S. (2015). Pengetahuan Perawat Tentang Keselamatan Pasien dengan Palaksanaan Prosedur Keselamatan Pasien Rumah Sakit Panti Waluyo Sawahan Malang. CARE, 3(1), 25–32.

[8]   Irawan AG, Yulia Sri, M. (2017). Hubungan Supervisi dengan Penerapan Budaya Keselamatan Pasien di ruang Rawat Inap Rumah Sakit XX, 5, 241–254.

[9]   KKPRS. (2015). Pedoman Pelaporan Insiden Keselamatan Pasien (IKP). KKPRS KEMENKES RI. Retrieved from

[10]   Kemenkes RI. Peraturan Menteri Kesehatan Republik Indonesia No 11 Tahun 2017 tentang Keselamatan Pasien. Berita Negara Republik Indonesia, 308 2017

[11]   Kemenkes RI. Pedoman Nasional Keselamatan Pasien Rumah Sakit. 3rd ed. Jakarta: Kementerian Kesehatan Republik Indonesia; 2015

[12]   Komisi Akreditasi Rumah Sakit. Standar Nasional Akreditasi Rumah Sakit Edisi 1.2017

[13]   Pambudi, Y. S. A. Y. D. (2018). Faktor-faktor yang mempengaruhi perawat dalam penerapan 6 SKP (sasaran keselamatan pasien) pada Akreditasi JCI (joint commision International) di Ruang rawat inap Rumah Sakit Panti Waluya Malang. Nursing News, 3(1), 729–747.

[14]   Putri, Y. H. H. (2015). Implementasi Manajemen Keselamatan PAsien dalam usaha pencegahan Medical eror di RSUD Mawardi.

[15]   Rio Hardiatma, Arlina Dewi, A. L. (2015). Analisis Imlementasi Sasaran Keselamatan Pasien Dalam Menghadapi Akreditasi di Klinik Trio Husada Kota Batu, 14

[16] Rivai, FMF, Mangilep, A. (2016). Implementation Descriptive of Patient Safety Goals by Nurse at Hasanuddin University Hospital ' s Inpatient. UNHAS, 75. Retrieved from http://repository.unhas.ac.id/handle/123456789/18933

[17] Sakinah, S. putri asmita W. pawelas A. (2017). Analisis Sasaran Keselamatan Pasien Dilihat Dari Aspek Pelaksanan Identifikasi Pasien dan Keamanan Obat di RSPAD Gatot Subroto Jakarta. Masyarakat, *Jurnal Kesehatan,* 5(4), 145–152

[18] Sunarti S. Analisis Faktor-Faktor Yang Berhubungan Dengan Pelaksanaan Ketepatan Identifikasi Pasien Oleh Perawat Pelaksana Di RS X Pekanbaru. 2016

[19] Tutiany, Lindawati, P. K. (2017). Bahan Ajar Keperawatan MANAJEMEN KESELAMATAN PASIEN. PPSDM KEMENKES RI Undang-Undang Republik Indonesia No. 44 Tahun 2009 tentang Rumah Sakit. 2009

[20] WHO. (2015). Panduan Kurikulum Keselamatan Pasien. (L. K. B. K. K. B. Kemuliaan, Ed.) (Multi Prof). Lembaga Kesehatan Budi Kemuliaan. Retrieved from http://www.who.int/iris/handle/10665/44641

[21] Wuri, P., Nizar, A., & Indahati, P. (2015). Expert Systems with Applications Strategic hospital services quality analysis in Indonesia. EXPERT SYSTEMS WITH APPLICATIONS, 42(6), 3067–3078. https://doi.org/10.1016/j.eswa.2014.11.065

[22] Yulia, Sri, A. Y. H. (2012). Peningkatan Pemahaman Perawat Pelaksana Dalam Upaya Penerapan Keselamatan Pasien Melalui Pelatihan Keselamatan Pasien. Jurnal Keperawatan Indonesia, Volume 15, 8.

[23] Yusuf, M. (2017). Penerapan Patient Safety Di Ruang Rawat Inap Rumah Sakit Umum Daerah Dr . Zainoel Abidin Patient Safety Implementation In Ward Of Dr . Zainoel Abidin General Hospital. *Jurnal Ilmu Keperawatan,* 5(1), 1– 6.

[24] Yudhawati DD, and Listiowati E. Evaluasi Penerapan IdentifikasiPasien Di Bangsal Rawat Inap RSI Siti Aisyah Madiun. 2016.