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Implementation of Patient Safety Management to Improve the Quality of Health Services at Patut Patuh Patju Hospital

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Abstract. *The implementation of patient safety management is a fundamental component in efforts to improve the quality of healthcare services in hospitals. This study aims to analyze the implementation of patient safety management at Patut Patuh Patju Hospital and to identify the supporting and inhibiting factors in its application. A qualitative research approach was employed, using in-depth interviews with the head manager, head of security, and medical personnel directly involved in patient care. The findings reveal that patient safety principles have been applied through risk identification, the implementation of double-check procedures, and the provision of adequate facilities and infrastructure. However, limitations in human resources, insufficient facilities, and a lack of routine evaluation remain major challenges. A strong culture of patient safety, interprofessional collaboration, and continuous training were found to play significant roles in preventing incidents and improving service quality. In conclusion, a comprehensive and sustainable implementation of patient safety management plays a strategic role in creating a safe working environment, increasing public trust, and supporting the achievement of high-quality healthcare services.*

Keywords: *patient safety, service quality, hospital management, safety culture, healthcare quality*

1. INTRODUCTION

Patient safety management is essentially a policy or regulation implemented by healthcare providers to ensure patient safety. Every healthcare institution must carry out patient safety management, as without its implementation, patient safety often remains a neglected priority. Medical personnel sometimes become trapped in routine work, losing sensitivity to the importance of human life. Consequently, life, safety, and health may seem ordinary and insignificant. Therefore, patient safety and the commitment to improve health services should be the main focus of every medical worker (Harigustian et al., 2019).

Patient safety management represents a systematic approach to improving patient safety within healthcare services. It involves risk identification, incident analysis, implementation of evidence-based practices, and the establishment of a safety culture within healthcare organizations. According to Rachmawati (2019), key strategies in patient safety management include standardization of procedures, improved communication among medical teams, use of technology to minimize errors, and continuous learning from near-miss and adverse events. Furthermore, Ariyanti et al. (2023) emphasize the importance of patient and family involvement in the care process to enhance safety. This comprehensive approach aims to create a safer healthcare system and reduce preventable adverse events.

Patient safety and service quality are the core priorities of every healthcare institution. Thus, all elements within the healthcare system must commit to continuously improving the excellence of healthcare delivery. Sumarni (2019) describes several implementation frameworks and strategies for patient safety management in healthcare institutions.

However, implementing patient safety management faces complex challenges in modern health systems. One major issue is resistance to organizational culture change, as staff may be reluctant to report errors due to fear of punitive consequences (Budiman et al., 2024). Limited financial and human resources often hinder the implementation of comprehensive patient safety programs (Slawomirski & Klazinga, 2024). The complexity of healthcare systems themselves also poses challenges, with numerous interaction points that increase the risk of error (Carayon et al., 2024). The lack of standardization in reporting and analyzing patient safety incidents across healthcare institutions further complicates systemic learning and improvement (Panagioti et al., 2023). Additionally, patient involvement in safety processes is often overlooked, even though patients can serve as valuable sources of information and oversight (Berger et al., 2023). Addressing these challenges requires a multifaceted approach that includes cultural transformation, resource investment, and long-term commitment from all stakeholders in the healthcare system.

Several major factors contribute to the rising incidence of patient safety events in healthcare facilities. One significant factor is the persistent "blame culture" within many health institutions. According to Lee et al. (2023), 67% of medical staff are reluctant to report mistakes due to fear of punishment or professional stigma, thereby hindering learning from errors and increasing the risk of recurrence. Fatigue and burnout are also major contributing factors. Aiken et al. (2024) found that high burnout levels among nurses are associated with a 63% increase in reported patient safety incidents. Long working hours, psychological stress, and excessive workloads exacerbate this condition.

Poor communication among healthcare providers is another contributing factor. The Joint Commission (2023) reported that more than 70% of serious medical errors involve communication failures between or within professional teams and shifts. Failure to communicate vital information about a patient's condition can result in diagnostic, therapeutic, or procedural errors. Moreover, the complexity of healthcare delivery systems increases risk. Carayon et al. (2024) mapped over 100 potential interaction points in a typical inpatient journey, each representing a potential source of error or miscommunication if not well managed. These factors highlight that patient safety is influenced not only by individual

competence but also by organizational culture, system design, and communication effectiveness within healthcare environments.

Patient safety in hospitals has now become a crucial global issue due to the high frequency of medical errors worldwide. In Indonesia, there were 7,465 reported patient safety incidents in 2019, including 171 deaths, 80 severe injuries, 372 moderate injuries, 1,183 minor injuries, and 5,659 no-injury incidents (Daud, 2020).

The urgency of patient safety management as a means to improve hospital service quality represents a critical aspect of modern healthcare delivery. Effective patient safety management directly enhances service quality and patient outcomes. According to a recent study, implementing a comprehensive patient safety program can reduce adverse events by up to 30% (Smith et al., 2023).

Based on observations conducted at Patut Patuh Patju Hospital, West Lombok Regency, researchers identified several issues in patient safety management implementation, including weak safety culture, lack of leadership and staff commitment, resistance to change, poor communication and miscommunication among medical staff and departments, limited patient involvement in care processes, staff shortages leading to excessive workload, limited resources, inadequate implementation of standard operating procedures (SOPs), insufficient monitoring and evaluation, underreporting of incidents due to fear of punishment, and complex or non–user-friendly reporting systems.

Given these findings, the researcher is interested in conducting a study entitled "Implementation of Patient Safety Management in Efforts to Improve the Quality of Health Services at Patut Patuh Patju Hospital, Gerung."

2. METHODE

This study employed a descriptive qualitative design as proposed by Creswell (2013), aiming to systematically and accurately describe the phenomenon of implementing patient safety management to improve the quality of healthcare services at Patut Patuh Patju Regional General Hospital (RSUD Patut Patuh Patju) in Gerung. This approach emphasizes understanding "what is happening" in the field by exploring the relationship between the independent variable patient safety management and the dependent variable—quality improvement of healthcare services. The study was conducted on June 20, 2024, at the Patient Safety Management Unit of RSUD Patut Patuh Patju, located in West Lombok Regency, West Nusa Tenggara, Indonesia. The research subjects included three heads or coordinators of patient safety management programs, two heads of quality management programs, and one

hospital manager, serving as triangulation informants. The research objects covered aspects such as organizational structure, policies and regulations, resources, leadership, communication, and the implementation of standard operating procedures (SOPs). Data were qualitative in nature and collected through in-depth interviews, direct observation, documentation, and focus group discussions (FGDs). The data sources consisted of primary data obtained directly from interviews and observations, and secondary data derived from supporting documents, including patient safety incident reports, service quality indicators, and internal hospital policies. Data were analyzed interactively using the Miles and Huberman model (as cited in Sugiyono, 2019), which includes data collection, data reduction, data display, and conclusion drawing. The validity of the data was ensured through source and methodological triangulation to enhance the credibility of the findings. The analysis results are expected to describe the effectiveness of patient safety management implementation in improving healthcare service quality at RSUD Patut Patuh Patju Gerung.

3. RESULT AND DISCUSSION

a. Research Findings: Implementation of Patient Safety in Daily Practice

Interviews with the hospital manager (KM) and head of safety (KKM) revealed that patient safety principles have become a major focus in the hospital's daily service practices. One informant stated:

> ***"Patient safety is always our top priority in every medical procedure we perform. We ensure that every step of patient care follows the established procedures, such as verifying patient identity before any procedure and reviewing the complete medical history. However, challenges sometimes arise, for example when a patient arrives in an emergency condition and there is not enough time to complete all verification steps." (KM)***

Another informant added that double-checking patient identity has become a standard procedure, though limited medical staff often hinder consistent implementation:

> ***"We always perform repeated checks before administering medication or conducting medical procedures. The main challenge we face is the shortage of staff." (KM)***

From the facility perspective, most of the hospital's infrastructure supports patient safety, although several areas were reported to require renovation:

> ***"The hospital facilities generally support patient safety with well-maintained medical equipment. However, some parts of the hospital are quite old and in need***

of renovation, such as the ICU and inpatient rooms. We also lack some personal protective equipment for technicians." (KKM)

Additionally, cleanliness and room congestion were noted as important issues for maintaining patient safety:

"The facility's security is fairly good, but we often face issues regarding the cleanliness of crowded inpatient rooms. Sometimes it is difficult to maintain all hospital areas properly, especially at night." (KKM)

b. Discussion: Implementation of Patient Safety in Daily Practice

The findings indicate that the hospital has implemented fundamental patient safety principles in its medical service practices, although several challenges remain. This aligns with the *World Health Organization* (WHO, 2021), which defines patient safety as a systematic effort to prevent risks, errors, and harm during the provision of healthcare services.

1) Implementation of Protocols and Standard Operating Procedures

Based on interview results, the implementation of patient identification and double-checking procedures before medical interventions demonstrates compliance with patient safety standards as regulated in the Indonesian Ministry of Health Regulation No. 11 of 2017 on Hospital Patient Safety. However, limited human resources remain a major constraint in maintaining consistency. Alshammari et al. (2022) reported that a high ratio of patients to healthcare workers increases the risk of human error and decreases the quality of safety standard implementation.

2) Facility and Work Environment Support

The availability of well-maintained medical equipment reflects the hospital's commitment to ensuring a safe working environment. Nevertheless, complaints about limited personal protective equipment and overcrowded rooms indicate that environmental risk management has not been fully optimized. Khan et al. (2020) emphasized that poor hygiene and inadequate ventilation can increase the risk of nosocomial infections and reduce overall patient safety.

3) Patient Safety Culture

Field observations highlighted the importance of a strong safety culture within the hospital. Informants' emphasis on verifying patient identity and reporting incidents shows awareness of safety principles, although not all staff demonstrate

equal understanding. A positive safety culture is characterized by open communication, strong teamwork, and management support for incident reporting without fear of punishment (Nieva & Sorra, 2003).

4) Need for Training and Supervision

Beyond structural factors, the study underscores the necessity of continuous training for both medical and non-medical staff on patient safety implementation. Informants noted that basic training has been conducted but does not yet cover risk management or emergency simulation. Setiawan et al. (2021) found that simulation-based training significantly improves healthcare workers' readiness to handle critical situations that could endanger patients.

5) Evaluation and Follow-Up

The lack of systematic evaluation of patient safety implementation can result in the absence of constructive feedback for staff. In an ideal safety system, each incident or near-miss should be evaluated to identify root causes and implement systemic improvements. This aligns with the principle of *Continuous Quality Improvement (CQI)*, where incident reports form the basis for hospital policy enhancements (Reason, 2000).

4. CONCLUSION

Based on the findings of this study, it can be concluded that the implementation of patient safety management is an essential component in improving patient safety and the overall quality of healthcare services in hospitals. The implementation of patient safety management encompasses risk identification, policy development, and the application of clinical procedures and practices designed to prevent injury or harm to patients. The success of this program largely depends on effective collaboration among medical teams, the appropriate use of technology, continuous professional training, and systematic monitoring and evaluation. Furthermore, the effectiveness of patient safety management is not solely determined by the availability of regulations and standard operating procedures but also by the safety culture embedded throughout all organizational levels. This culture requires the active involvement of all hospital personnel from management to healthcare providers in making patient safety a top priority in every aspect of service delivery. By applying principles of risk identification and mitigation, strengthening human resource capacity through education and training, and utilizing health

information technology to support clinical decision-making, hospitals can create a safe, responsive, and patient-centered work environment. This demonstrates that a comprehensive and sustainable approach to patient safety management plays a strategic role in enhancing service quality while reinforcing public trust in the healthcare system.

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