



## Application of Patient Safety Targets in Hospital: A Literature Review

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### ABSTRACT

Patient safety is the basic value of service to avoid undesirable incidents to patients. Patient safety targets as a strategy to reduce the risk of near misses, undesirable or unexpected events. One of the hospital's obligations is to improve the quality of hospital services, including patient safety. The purpose of this study was to identify patient safety targets in hospitals. The study design used was a literature review using keywords based on a database of research articles, such as Scopus, ScienceDirect, PubMed, Google Scholar, and Garuda from 2012 to 2022. There were 1408 articles with 10 relevant articles for review and analysis. Knowledge, attitudes, competences, awareness, and culture are important to build the application of patient safety so that a good organizational system, nursing care, and teamwork will increase and also quality of service will be improved in hospital.

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### Kata kunci:

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### ABSTRAK

Keselamatan pasien merupakan nilai dasar pelayanan untuk menghindari kejadian yang tidak diinginkan kepada pasien. Target keselamatan pasien sebagai strategi untuk mengurangi risiko kejadian nyaris celaka, kejadian yang tidak diinginkan atau tidak diharapkan. Salah satu kewajiban rumah sakit adalah meningkatkan mutu pelayanan rumah sakit, termasuk keselamatan pasien. Tujuan dari penelitian ini adalah untuk mengidentifikasi target keselamatan pasien di rumah sakit. Desain penelitian yang digunakan adalah literature review dengan menggunakan kata kunci berdasarkan database artikel penelitian, seperti Scopus, ScienceDirect, PubMed, Google Scholar, dan Garuda dari tahun 2012 hingga 2022. Terdapat 1408 artikel dengan 10 artikel yang relevan untuk direview dan dianalisis. Pengetahuan, sikap, kompetensi, kesadaran, dan budaya penting untuk membangun penerapan keselamatan pasien sehingga sistem organisasi, asuhan keperawatan, dan kerjasama tim yang baik akan meningkat dan juga kualitas pelayanan di rumah sakit akan meningkat.

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### INTRODUCTION

Patient safety is the basic value of health services to avoid unwanted incidents to patients. Non-compliance with patient safety standards can result in near-injury, or even death, which is a global concern. Therefore, patient safety

should be given the highest priority (Heideveld-Chevalking et al., 2018). Patient safety is a system that makes patient care safer, including risk assessment, patient risk identification and management, incident reporting and analysis, the ability to learn from incidents and their follow-up, and implementing solutions to minimize risk and

prevent injury caused by error where is the result of doing or not doing the action that should be done (Permenkes, 2017).

Every year thousands of patients lose their lives as a result of preventable medical events, such as hospital-associated infections (HAIs), surgical errors, and sentinel events that occur patients (Davis, Henry, Landon, & Lockhart, 2014). Nurses have an important role in patient safety because they serve 24 hours such as in providing information to patients and families, reporting incidents, and promoting effective communication (Purwaningsih & Herawati, 2017). Patient safety is a preventive strategy that aims to reduce the risk of adverse events or near misses (Gurková, Kalánková, Kurucová, & Žiaková, 2020).

One of the hospital's obligations is to improve the quality of hospital services; One of them is patient safety. Improving patient safety can convey a sense of security and comfort for patients. Hospitals must carry out outpatient safety targets with applicable regulations (Kementerian Kesehatan Republik Indonesia, 2017). In countries with limited resources, every year there are 134 million unsafe events which result in >2.6 million deaths every year. Research conducted in African and Middle Eastern countries reported that in developing countries, adverse events were 8.2% and 8.3% of these could be prevented and the cause of adverse events was the lack of training and difficulties for health workers in implementing hospital protocols (Albolino et al., 2021).

Patient safety incidents are unwanted incidents that bring harm to patients which are clinical problems that occur globally. In the Organization for Economic Co-operation and Development countries, patient losses reach more than 6% and more than 7 million in hospital inpatients. Incident Patient safety is the third reported death rate in the United States. According to a European Commission survey, 27 percent of Europeans, or their family members, have experienced an adverse event while receiving treatment. Some researchers also say that elderly patients are three times more likely to fall. Patient Safety Incident Reports to improve strategy, monitoring, and prevention, and reduce unwanted events (Shin & Won, 2021).

From 2006 to 2011, the Hospital Patient Safety Committee recorded 877 patient safety incidents. From 2015-2019 there were 11,558 patient safety incidents, and the increase in types of incidents rose by 7-12%. The death rate for patients due to patient safety incidents in 2019 was

171 cases, which resulted in a lack of hospital services and only reported incidents with minor injuries or no injuries (Daud, 2020). Patient safety awareness is considered important worldwide and it aims to influence the development of a positive patient safety culture for hospitals (Nurumal, Sabran, Hamid, & Che Hasan, 2020).

Hospitals are the main place for health services for the community, even though there are challenges to health services in realizing optimal services. However, medical errors often occur to patients, so the application of patient safety by nurses to patients is to improve quality, service quality, and feel safe and comfortable for patients. Therefore, this literature review aimed to identify the application of patient safety targets.

## METHOD

In this present study, a literature review was conducted. The results of scientific articles published between 2012 and 2022 were collected by scanning five databases, including; Google scholar, Pubmed, Scopus, Science Direct, and Garuda, using keywords based on Patients, Intervention, Comparison, and Outcome (PICO). The keywords are patients safety AND target OR goals AND application OR Implementation AND hospital. According to the screening results, ten articles met the inclusion criteria and were related to the study topic (Figure 1.). The following are the inclusion criteria for this literature review: (1) articles in English and Indonesia; (2) published articles reporting original data; (3) articles published from 2012 to 2022; and (4) the application of patient safety targets in hospital. Non-indonesia and non-English published studies, duplicate studies, publication that did not satisfy the study subject, abstract, chapter book, incomplete text, and review study were exclusion criteria. Data analysis conducted reviewing matrix that includes various important things from research articles, completing data from data reduction results, presenting data, validating data using credibility test, using reference materials in the form of theories discovered, and drawing conclusion are all expels of data analysis used descriptively.

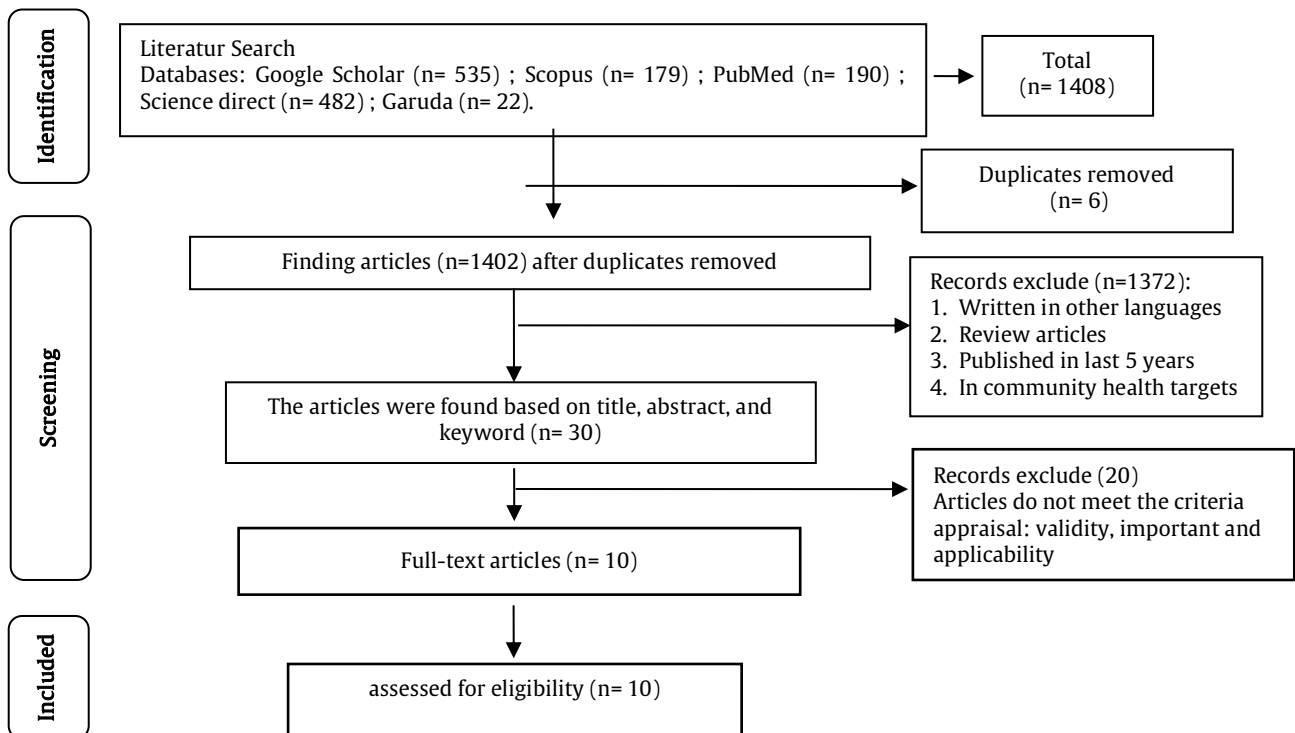


Figure 1. The serach process on the article search engine

**RESULTS AND DISCUSSION**

**Table 1.**  
**Characteristics of the findings articles included in the research on the patients safety targets in hospital**

Authors	Title	Objects	Method	Results
(Galatama Purwadi, Sulistiadi, & Asyary, 2019)	Understanding Application of Patient Safety Targets Framework at Inpatient Unit of Ciracas General Hospital, Indonesia	To understand the application of patient safety targets	Qualitative	Patient Safety Target indicators have not been run yet well in Ciracas Hospital.
(Surahmat, 2018)	The Application of Patient Safety Targets by Nurses Post Accredited Hospital Palembang, South Sumatra, Indonesia	To understand the application of patient safety targets by nurses after accreditation in a hospital in Palembang.	Quantitative using analytic survey	Application of patient safety targets is good (84.1%). Application of patient safety targets by post-accredited nurses has not been fully assessed by the Hospital Accreditation Commission during the accreditation process with results obtained at the plenary level.
(Yani, Hamid, & Syafwani, 2016)	Study Phenomenology: Nurse Perceptions of Patient Safety Targets Application Measures in Hospital X 2016	To understand nurses' perception about the application of patient safety targets in hospitals.	Qualitative	There are some obstacles to the application of patient safety targets, namely: the behavior of nurses, lack of facilities for identity bracelets and documentation forms
(Heideveld-Chevalking et al., 2018)	Development and validation of a Self-assessment Instrument for Perioperative Patient Safety (SIPPS)	To measure safety patients domain.	Evaluate and questionnaires measure	Improvement of perioperative patient safety compliance.
(Mascioli & Carrico, 2016)	Spotlight on the 2016 National Patient Safety Targets for hospitals	To increase patients' safety	Descriptive qualitative	The study showed that there are 72 to 99% of patients' safety there are 72% to 99% of ineffective patient safety-related medical devices.
(Abdelwahed Shams-Eldin, 2016)	Patient Safety Assessment at Primary Health Care Centers in Cairo, Egypt	To evaluate some items of patient safety programs in a primary health center.	Quantitative with cross-sectional	Only a third of clinics in the center of El-Hagana demonstrate compliance with the use of PPE.
(Girginer, N., İskenderoğlu, 2020)	Sigma Levels Analysis of International Patient Safety Targets For A Private Hospital	To support the IPSPG process managed well.	Quantitative analysis	The Sigma level of Infection Prevention is lower than others compared to the higher sigma level of effective communication.
(Isnaini & Rofii, 2014)	Experience of Implementing Nurses in Implementing Patient Safety	To find out the experience of implementing nurses in implementing the 6 patient safety targets	Qualitative	Participants encountered various obstacles in implementing patient safety. Participants also have their way of overcoming every obstacle they experience.
(Helsanewa, Rifai, & Jamaluddin, 2019)	Descriptive Study of Application of Patient Safety Targets According to Kars Instructions Version 2012 in the Emergency Room at TNI AD Hospital TK IV 02. 07. 04 Bandar Lampung	To describe the extent to which the application of the standard patient safety targets following the 2012 version of the KARS Instructions at the Emergency Installation of the TNI AD Tk. IV 02.07.04 Bandar Lampung.	Qualitative	The application of patient identification, application of effective communication, application of increased safety of drugs that need to be watched out for, application of exact-location certainty, right-procedure, right-patient surgery, and application of infection risk reduction related to health services is by the 2012 version of the KARS instrument. patient falls not by the 2012 version of the KARS instrument. The application of the standard targets I, II, III, IV, and V for patient safety are by the 2012 version of the KARS Installation, while the VI target is not by the 2012 version of the KARS Instructions.

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(Pambudi, 2018)	Factors influencing nurses in implementing 6 SKP (Patient Safety Targets) at JCI Accreditation (Joint Commission International) in the Inpatient Room of Panti Waluya Hospital, Malang.	To determine the factors that influence nurses in the application of 6 SKPs.	Analytical descriptive with the cross-sectional approach.	Someone who knows tends to be better at implementing 6 SKPs compared to nurses who have low knowledge.
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Identifying patients is very important for patient safety and patient satisfaction because it is the first thing in patient safety targets, so it is necessary to make standard operational and supervisory policies in complying with the application of patient identification correctly (Surahmat, 2018). Errors in identifying patients can lead to errors in drug administration, fatal treatment, wrong diagnostics, and wrong treatment procedures to patients (Davis et al., 2014). When a patient does not match the patient record because the data is wrong and the data is the same as other patient data in the laboratory, radiology, and other examinations, there will be potential errors in the laboratory, treatment, and actions in surgery (Riplinger, Piera-Jiménez, & Dooling, 2020). Identifying patients before treating or taking action is the basis for patient safety. Empowerment of the organizational structure is expected to influence, not only the culture of patient safety but also the behavior of nurses in implementing patient safety (Kim & Kim, 2018).

Communication is an important liaison strategy in care because it connects different boundaries (Debono, Robertson, & Travaglia, 2019). Effective communication is one of the targets of patient safety where there is open communication between management, nurses, and patients (Yulisnawati, Zulfendri, & Siti Saidah Nasution, 2020). The overall SBAR technique has been shown to improve communication between nurses and reduce time in shift reporting. This SBAR protocol sets expectations for nurses and doctors in communicating the patient's condition (Burgener, 2020). Communication has different ways of expressing emotions in different cultures and religions. Nurses have sufficient knowledge about culture, language, and patient beliefs in communicating with patients so that culture can be interpreted as a facilitator as well as an obstacle in communicating (Puspita Dewi, 2018).

Drugs are part of treatment planning for patients that require clear management for patient safety such as Drug Name, Appearance, and Similar Speech as well as being the cause of drug dispensing so it is necessary to socialize, label drugs, and implement management systems and drug storage. It is an important concern because drug safety is the duty of nurses and other medical personnel for patient safety (Surahmat, 2018). A very dangerous incident due to drug injections that must be watched out for, and the most problematic is related to medication errors (Lu et al., 2013). The application of patient safety in drug administration is not an easy thing to do, due to the high workload, non-standard nurse salaries, educational background and experience, and competencies possessed by nurses, so there are frequent complaints to nurses such as medication errors to patients (Lediana Tampubolon, 2018).

The factors that cause the procedure are not good, the location of the patient and the right patient due to the absence of standard operating procedures and policies. Efforts that must be made to prevent errors can be prevented by verifying the treatment process, the collaboration of nurses with other medical teams is aimed at influencing patient satisfaction, service quality, and evaluation for the hospital accreditation team's assessment (Surahmat, 2018). The study by Yani et al. (2016) stated that delivering patients to the patient room with handovers and a checklist of operations is recommended by World Health Organization (WHO). The responsible doctor and witnesses for marking the location are patients and nurses. Site marking by surgeons and anesthetists. Each patient who will be operated on is given a location tag, identification of the patient, and what action will be taken.

Transmission of infection to patient care in hospitals is a danger to patients being treated and health workers a source of infection. According to WHO, infection occurs in patients during the hospitalization process or the occurrence of incubation at the time of admission to the hospital but appears after discharge from the hospital, and during the work interaction of health workers. Infections are transmitted from patient to patient through the hands of health workers, hand hygiene is a solution to reduce infection transmission and improve patient safety (Uneke et al., 2014). The study by Isnaini and Rofii (2014) stated that five participants wash hands within five moments and the obstacle to washing hands is forgetting to increase compliance in washing hands by changing the mindset so as not to contract the disease from the hospital.

Patient falls in the hospital are the most frequent incidents in hospitals and can cause complications in patients, affect the patient's quality of life, patient discomfort, and financial loss to the patient. The prevalence of falls in inpatient hospitals varies widely and according to regulations and incident reports from hospitals. Patients have the right to patient safety and quality management to avoid injury (Cho & Jang, 2020). Nursing staff knowledge, attitudes, workload, culture, environmental factors, and culture affect the application of fall prevention strategies. The documented fall prevention strategies are placing a fall warning sign above the patient's bed, using the patient's bed, establishing toileting rules, supervising the patient when going to the bathroom, ensuring that walking aids are within reach and health education about the risk of falls. National Health Safety and Quality Standards that patients and families have a role in falling risk and are involved in strategies and management plans for fall risk prevention (Yasan, Burton, & Tracey, 2020).

## CONCLUSIONS AND SUGGESTIONS

Based on 10 research articles that have been reviewed, namely the Application of Patient Safety Targets in Hospitals, knowledge, attitudes, competencies, awareness, and culture to build patient safety are formed by a good organizational system and nursing care and teamwork so that the quality of service in hospitals increases. To reduce patient safety incidents, hospitals are required to implement patient safety targets. The authors hope that further researchers can develop this systematic review by exploring patient satisfaction with the application of patient safety in services.

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### Conflict of Interest Statement

The author declares that there is no potential conflict of interest concerning the authorship and publication of this article.

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