Jurnal Aisyah: Jurnal Ilmu Kesehatan

Volume 8, Issue 1, March 2023, p. 107–110
ISSN 2502-4825 (print), ISSN 2502-9495 (online)

The Relationship Between Group and Organizational Factors on Misbehavior Performance in the Implementation of Patient Safety Incident Reporting

Terivenna Wijaya[1*)], Fathiyah Rahmah[2], Djazuly Chalidyanto[3]

[1,2,3] Department of Health Policy and Administration, Faculty of Public Health, Universitas Airlangga

ARTICLE INFO

Article history:

Received 10 October 2022
Accepted 31 January 2023
Published 20 March 2023

Keyword:

Patient Safety
Performance misbehavior
Reporting

**) corresponding author*

dr. Terivenna Wijaya

Department of Health Policy and Administration, Faculty of Public Health, Universitas Airlangga
Jalan Dr.Ir.H Soekarno, Mulyorejo, Surabaya, Indonesia, 60115

Email: vennawijaya88@gmail.com
DOI: 10.30604/jika.v8i1.1486

A B S T R A C T

One issue in patient safety still a concern is the timeliness of reporting patient safety incidents. This study aims to analyze the relationship between the group, organizational, and mediator factors on misbehavior performance in implementing patient safety incident reporting in hospitals. The study was a descriptive study with a cross-sectional design conducted on all units in the hospital involving 174 respondents. Data was collected using a questionnaire that measured all variables on group factors, organizational factors, mediator factors, and misbehavior performance. Cross tabulation is used to analysis with a percentage difference of >20%. The results showed several groups and organizational factor namely cohesiveness, leadership, constructive type organizational culture, organizational climate, and control systems related to the ability to internalize organizational values and norms, belief in deviant behavior, and intentions to engage in deviant behavior. There is a correlation between mediator factors consisting of normative force, instrumental force, and intention to misbehave with deviant behavior in reporting patient safety incidents. Group and organizational factors are related to mediator factors, including internalization of organizational values and norms, beliefs of deviant behavior, and intentions. In addition, there is also a relationship between mediator factors and deviant behavior in reporting patient safety incidents.

INTRODUCTION

A patient safety incident is an unintentional event and condition that results in or has the potential to cause injury to a patient that should have been prevented, including unexpected events, near misses, non-injury events, and potential injury conditions.(Amaniyan et al., 2020; Madden et al., 2018; Martin et al., 2019) Follow-up efforts on patient safety incidents are carried out based on patient safety incident reporting.(Cooper et al., 2018; Farokhzadian et al., 2018) Patient safety incident reporting is a system that documents patient safety incident reports as a learning process, and evaluation material for voluntary, confidential, and non-blame health care systems in improving the quality of patient safety.(Alotaibi & Federico, 2017; Kellogg et al., 2017; O' Hara et al., 2018) Every incident that occurs in the hospital must be reported to the Patient Safety Team no later than 2x24 (twenty-four) hours using the incident report form.(Agustian et al., 2020; Nasution, 2020; Tamara et al., 2020) This is done to obtain a comprehensive picture of a patient safety incident in a work unit as material for preparing follow-up efforts and improving the service quality.(Akdere et al., 2020; Lawton et al., 2017)

Reporting patient safety incidents that are not timely is a form of irregularity in the workplace that can hinder hospital risk management efforts.(Cooper et al., 2018) The number of patient safety incidents at the Surabaya A. Yani Islamic Hospital in the January-May 2019 period was 569 incidents, with the number of correct reports as many as 373 and those exceeding 2x24 hours as many as 196 events. Inaccuracy in reporting patient incidents at the Surabaya A. Yani Islamic Hospital in the January-May 2019 period was 34.0%, which

should have been 0.0%. Good patient safety incident reporting can support creating a patient safety culture.(Berry et al., 2020; Lawati et al., 2018) This is supported by efforts to learn and improve health systems and services from an incident.(Narwal & Jain, 2021) Of course, this requires strong support and commitment from both leadership and health workers, and hospital employees to realize patient safety.(Alingh et al., 2019; Lotfi et al., 2018; Wagner et al., 2019)

Organizational misbehavior is one of the concepts developed from employee deviance.(Al-Abrrow et al., 2019) organizational misbehavior is any behavior that individuals intentionally carry out in the organization that violates organizational rules and social norms.(Vardi & Weitz, 2018) This study aimed to analyze the relationship between the group, organizational, and mediator factors on misbehavior performance in implementing patient safety incident reporting in hospitals.

METHODS

Participant characteristics and research design

This study is a descriptive study with a cross-sectional design. The dependent variable used is misbehavior performance in reporting patient safety incidents. The independent variables in this study include group factors, which consist of norms, cohesiveness, group dynamics, and leadership. Organizational factors include organizational culture, organizational climate, and control systems reporting patient safety incidents. This research has received ethical approval from the Health research ethics committee faculty of nursing Universitas Airlangga with number 2042-KEPK.

Sampling procedures

The total sample in this study was 60 units consisting of 174 people who were selected using Total Population Sampling. The inclusion criteria is:

1. Head of the work unit or person in charge of the unit
2. Staff with a working period of more than five years.

Measures and covariates

This research was conducted at the Islamic Hospital Surabaya A. Yani. Research data collection was carried out from July-November 2020. Intention to misbehave is based on normative and instrumental encouragement as measured through a questionnaire.

Data analysis

The analysis was cross tabulation with a percentage difference of >20%.

RESULTS AND DISCUSSION

The table 1 shows that in normative force, the highest variable is cohesiveness, and the lowest is norms, group dynamics, and leadership. The highest variable in instrument force is cohesiveness, and the lowest is group dynamics, leadership, and control system. The highest variable in intention to misbehave is cohesiveness, and norms, leadership, and organizational climate are the lowest. The cohesiveness variable correlates with the mediator factor, instrumental force. Meanwhile, the lowest level of correlation is shown in the relationship between leadership and normative force.

Table 1. The relationship between group factors and organizational factors with mediator factors

Variable	Normative force	Instrument force	Intention to misbehave
Norms	0.0	0.1	0.0
Cohesiveness	0.4	0.5	0.3
Group dynamics	0.0	0.0	0.1
Leadership	0.0	0.0	0.0
Organizational culture	0.1	0.2	0.2
Organizational climate	0.2	0.3	0.0
Control system	0.1	0.0	0.2

Table 2. The relationship between mediator factors and performance behavior

Variable	Performance behavior
Normative force	0.2
Instrument force	0.4
Intention to misbehave	0.3

From the table 2, it can be seen that the instrumental force has the highest correlation with performance misbehavior with a value of 0.4, and the lowest level is a normative force with a value of 0.2.

High instrumental force can be due to poor working relationships and lack of justice in the workplace, creating poor performance. In general, the work unit tends to assess that the timeliness of reporting patient safety incidents has no impact on the work unit.(Orejudo et al., 2020) This has led to the notion that patient safety incidents should not be reported on a timely basis. Individual understanding of deviant behavior and its consequences in reporting patient safety incidents encourages individual opportunities to commit deviant behavior (Gunawan et al., 2015).

The intention to commit a deviant act arises from understanding something.(Gunawan et al., 2015) Ways to prevent the generation of intentions from misbehaving at the organizational level are to provide fairness to members of the organization, redesign jobs that can reduce the inherent opportunities for misbehavior, create systems to facilitate communication, and implement behavioral policies that conform to the prevailing norms.(Shamnadh & Anzari, 2019)

Individuals may follow norms because of an instrumental desire to avoid punishments that will be given to violators. In contrast, others may follow the same rules for their own

sake, regardless of whether it is an obligation to live by the norm or not.(Kelly & Hoburg, 2017) This further strengthens norms' tendency towards the ability of work units to internalize organizational values and norms. Staff did not report patient safety incidents because there was no feedback or rewards from the reporting of patient safety incidents.(Iskandar et al., 2014) Cohesiveness in a very cohesive work environment will encourage adopting behaviors considered reasonable by a group of people in a work unit. Therefore, cohesiveness can influence lousy behavior, similar to how organizational culture influences the intention to misbehave.(Vardi & Weitz, 2016)

Members of dynamic groups may not help each other or compete to achieve their goals as they begin to accept their values, norms, and roles. So there is a feeling of wanting to be recognized and wanting to be superior to other group members.(Alikhani & Bagheridoust, 2017) Good or lousy leadership can still make employees comply with organizational rules or normative forces either by force or voluntarily so that it can be interpreted that good or bad leadership tends to produce good normative forces in work units in the timely reporting of patient safety incidents.(Taucean et al., 2016)

Organizational culture constructive tends to make employees have confidence in deviant behavior. Organizations with a solid organizational culture tend to have uniform values and norms, which indicate a strong normative commitment to the organization so that it will encourage positive motivation for employees in working.(Zulkarnain & Hadiyani, 2014) Ethical organizational policies and practices (ethical climate) influence how employees work. When the work unit is required to complete the task, it will encourage it to delay completing it. Therefore, it can be interpreted that organizational climate is related to instrumental force in the timely reporting of patient safety incidents.(Shafer et al., 2013) An inadequate control system can provide loopholes for employees who intend to commit deviant acts, and the lack of strict penalties and sanctions also need to be improved to prevent the emergence of intentions from committing deviant behaviour.(Chu & So, 2020)

Normative force tends to cause individuals to engage in deviant behavior, reporting patient safety incidents. Bad behavior occurs collectively or separately at various levels of the organization through the mediators of normative force and instrumental force in several factors such as individuals, tasks or positions, groups, and organizations. An organization's members tend to misbehave even though some rules and norms apply due to other factors such as individual, environmental and cultural factors.(Orejudo et al., 2020) To improve individual performance in improving patient safety, it can be done by increasing non-technical abilities by increasing skills by conducting simulation training.(Lynch, 2020)

LIMITATION OF THE STUDY

This research was only conducted in one hospital. Results from other hospitals may show different findings.

CONCLUSIONS AND SUGGESTIONS

There are group and organizational factors related to mediator factors, including internalization of organizational values and norms, beliefs of deviant behavior, and intentions. In addition, there is also a relationship between mediator factors and deviant behavior in reporting patient safety incidents.

Acknowledgment

Not Applicable.

ETHICAL CONSIDERATIONS

The authors certify that they have obtained all appropriate patient consent forms. The family understands that names and initials will not be published, and due efforts will be made to conceal the identity, but anonymity cannot be guaranteed.

Funding Statement.

No funding was received for conducting this study.

Conflict of Interest Statement

The authors declared that there is not any conflicting interest in this study.

REFERENCES

Agustian, I., Lubis, A. N., & Siregar, F. L. S. (2020). Individual and organization affects perceptions of reporting patient safety incidents in Medan City Hospital. *Eur J Mol Clin Med*, *7*(10), 1228–1234.

Akdere, M., Top, M., & Tekingündüz, S. (2020). Examining patient perceptions of service quality in Turkish hospitals: The SERVPERF model. *Total Quality Management & Business Excellence*, *31*(3–4), 342–352.

Al-Abrrow, H., Alnoor, A., Ismail, E., Eneizan, B., & Makhamreh, H. Z. (2019). Psychological contract and organizational misbehavior: Exploring the moderating and mediating effects of organizational health and psychological contract breach in Iraqi oil tanks company. *Cogent Business & Management*, *6*(1), 1683123.

Alikhani, M., & Bagheridoust, E. (2017). The Effect of Group Dynamics-Oriented Instruction on Developing Iranian EFL Learners' Speaking Ability and Willingness to Communicate. *English Language Teaching*, *10*(11), 44–59.

Alingh, C. W., van Wijngaarden, J. D. H., van de Voorde, K., Paauwe, J., & Huijsman, R. (2019). Speaking up about patient safety concerns: the influence of safety management approaches and climate on nurses' willingness to speak up. *BMJ Quality & Safety*, *28*(1), 39–48.

Alotaibi, Y. K., & Federico, F. (2017). The impact of health information technology on patient safety. *Saudi Medical Journal*, *38*(12), 1173.

Amaniyan, S., Faldaas, B. O., Logan, P. A., & Vaismoradi, M. (2020). Learning from patient safety incidents in the emergency department: a systematic review. *The Journal of Emergency Medicine*, *58*(2), 234–244.

Berry, J. C., Davis, J. T., Bartman, T., Hafer, C. C., Lieb, L. M., Khan, N., & Brilli, R. J. (2020). Improved safety culture and teamwork climate are associated with decreases in patient

harm and hospital mortality across a hospital system. *Journal of Patient Safety*, *16*(2), 130–136.

Chu, A. M. Y., & So, M. K. P. (2020). Organizational information security management for sustainable information systems: An unethical employee information security behavior perspective. *Sustainability*, *12*(8), 3163.

Cooper, J., Williams, H., Hibbert, P., Edwards, A., Butt, A., Wood, F., Parry, G., Smith, P., Sheikh, A., & Donaldson, L. (2018). Classification of patient-safety incidents in primary care. *Bulletin of the World Health Organization*, *96*(7), 498.

Farokhzadian, J., Dehghan Nayeri, N., & Borhani, F. (2018). The long way ahead to achieve an effective patient safety culture: challenges perceived by nurses. *BMC Health Services Research*, *18*(1), 1–13.

Gunawan, G., Harijanto, H., & Harijanto, T. (2015). Analisis Rendahnya Laporan Insiden Keselamatan Pasien di Rumah Sakit. *Jurnal Kedokteran Brawijaya*, *28*(2), 206–213.

Iskandar, H., Maksum, H., & Nafisah, N. (2014). Faktor Penyebab Penurunan Pelaporan Insiden Keselamatan Pasien Rumah Sakit. *Jurnal Kedokteran Brawijaya*, *28*(1), 72–77.

Kellogg, K. M., Hettinger, Z., Shah, M., Wears, R. L., Sellers, C. R., Squires, M., & Fairbanks, R. J. (2017). Our current approach to root cause analysis: is it contributing to our failure to improve patient safety? *BMJ Quality & Safety*, *26*(5), 381–387.

Kelly, D., & Hoburg, P. (2017). A tale of two processes: On Joseph Henrich's the secret of our success: How culture is driving human evolution, domesticating our species, and making us smarter. *Philosophical Psychology*, *30*(6), 832–848.

Lawati, M. H. A. L., Dennis, S., Short, S. D., & Abdulhadi, N. N. (2018). Patient safety and safety culture in primary health care: a systematic review. *BMC Family Practice*, *19*(1), 1–12.

Lawton, R., O'Hara, J. K., Sheard, L., Armitage, G., Cocks, K., Buckley, H., Corbacho, B., Reynolds, C., Marsh, C., & Moore, S. (2017). Can patient involvement improve patient safety? A cluster randomised control trial of the Patient Reporting and Action for a Safe Environment (PRASE) intervention. *BMJ Quality & Safety*, *26*(8), 622–631.

Lotfi, Z., Atashzadeh-Shoorideh, F., Mohtashami, J., & Nasiri, M. (2018). Relationship between ethical leadership and organisational commitment of nurses with perception of patient safety culture. *Journal of Nursing Management*, *26*(6), 726–734.

Lynch, A. (2020). Simulation-based acquisition of non-technical skills to improve patient safety. *Seminars in Pediatric Surgery*, *29*(2), 150906.

Madden, C., Lydon, S., Curran, C., Murphy, A. W., & O'Connor, P. (2018). Potential value of patient record review to assess and improve patient safety in general practice: a systematic review. *European Journal of General Practice*, *24*(1), 192–201.

Martin, G., Ghafur, S., Cingolani, I., Symons, J., King, D., Arora, S., & Darzi, A. (2019). The effects and preventability of 2627 patient safety incidents related to health information technology failures: a retrospective analysis of 10 years of incident reporting in England and Wales. *The Lancet Digital Health*, *1*(3), e127–e135.

Narwal, S., & Jain, S. (2021). Building resilient health systems: patient safety during COVID-19 and lessons for the future. *Journal of Health Management*, *23*(1), 166–181.

Nasution, S. S. (2020). Nurse's perception of patient safety culture in an effort to improve service quality in the operating room of Riau Province Hospital. *Britain International of Exact Sciences (BloEx) Journal*, *2*(1), 84–94.

O'Hara, J. K., Reynolds, C., Moore, S., Armitage, G., Sheard, L., Marsh, C., Watt, I., Wright, J., & Lawton, R. (2018). What can patients tell us about the quality and safety of hospital care? Findings from a UK multicentre survey study. *BMJ Quality & Safety*, *27*(9), 673–682.

Orejudo, S., Navarro, J.-J., Vicente, E., & Cardoso, M. J. (2020). Student misbehaviour and teacher coercion. A comparative study of contextual factors in primary and secondary education teachers. *International Journal of Environmental Research and Public Health*, *17*(24), 9429.

Shafer, W. E., Poon, M. C. C., & Tjosvold, D. (2013). An investigation of ethical climate in a Singaporean accounting firm. *Accounting, Auditing & Accountability Journal*.

Shamnadh, M., & Anzari, A. (2019). Misbehavior of school students in classrooms-main causes and effective strategies to manage it. *International Journal of Scientific Development and Research (IJSDR)*, *4*(3), 318–321.

Tamara, A., Latief, Y., & Machfudiyanto, R. A. (2020). The development of safety plan to improve OHS (occupational health and safety) performance for construction of irrigation channel based on WBS (work breakdown structure). *IOP Conference Series: Earth and Environmental Science*, *426*(1), 12016.

Taucean, I. M., Tamasila, M., & Negru-Strauti, G. (2016). Study on management styles and managerial power types for a large organization. *Procedia-Social and Behavioral Sciences*, *221*, 66–75.

Vardi, Y., & Weitz, E. (2016). *Misbehavior in organizations: A dynamic approach*. Routledge.

Vardi, Y., & Weitz, E. (2018). Antecedents of organizational misbehavior among caregivers. In *Current topics in management* (pp. 99–116). Routledge.

Wagner, A., Rieger, M. A., Manser, T., Sturm, H., Hardt, J., Martus, P., Lessing, C., & Hammer, A. (2019). Healthcare professionals' perspectives on working conditions, leadership, and safety climate: a cross-sectional study. *BMC Health Services Research*, *19*(1), 1–14.

Zulkarnain, Z., & Hadiyani, S. (2014). Peranan komitmen organisasi dan employee engagement terhadap kesiapan karyawan untuk berubah. *Jurnal Psikologi*, *41*(1), 17–33.