Experience of health workers in improving patient safety in hospitals through interprofessional collaboration: study qualitative

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ABSTRACT

Introduction: Patient safety is a global problem because patient safety incidents that occur are estimated to be 134 million incidents due to unsafe care and 2.6 million resulting in death. Indonesia recorded a patient safety incident rate of 23.5%, so interprofessional collaboration is necessary to minimize this condition. This study aims to identify the experience of health workers in improving patient safety in hospitals through interprofessional collaboration. The method in this study is a qualitative design with an interpretive descriptive approach.

Methods: The method in this study is a qualitative design with an interpretive descriptive approach. The method in this study is qualitative with a descriptive-interpretative approach design. Implementation method with FGD on five professional health workers.

Result: The results of the study contained 8 (eight) themes showing the experience of health workers in improving patient safety in hospitals through interprofessional collaboration including understanding health workers in improving patient safety, implementation of patient safety for health workers in interprofessional collaboration, hospital management support, obstacles and expectations health workers in improving patient safety through interprofessional collaboration.

Conclusion: The results of the study contained the experience of health workers on the implementation of patient safety in hospitals through interprofessional collaboration, namely identifying actions in providing services with uniform documentation and also coordinating actions according to Standard Operational Procedures (SOPs), creating communication according to Situation, Background, Assessment, Recommendation (SBAR), joint commitment in providing services in hospitals, uniform training in hospitals, reducing barriers in both personal and management services, awareness, interest and motivation from each profession, facilities that support the implementation of patient safety open and transparent system, monitoring evaluation regularly and facilitating staff.

Keywords: Interprofessional collaboration, patient safety, experience of health workers
INTRODUCTION
Patient safety is a global concern because the number of patient safety incidents increases every year, based on the World Health Organization (WHO) report that patient safety incidents that occur in the world are estimated at 134 million incidents due to unsafe care and around 2.6 million causing death (Schiff & Shojania, 2021; WHO, 2021). In Indonesia, the incidence of patient safety also increases every year averaging of 23.5%. Patient safety incidents occur due to unsafe services provided by health workers from various health professions as caregivers including doctors, nurses, pharmacists, nutritionists, and other Caregiver Professions (PPA) (WHO, 2021). Patient safety incidents that occur such as medical errors, misdiagnosis, medication prescribing errors, medication errors, transfusion errors, patient falls, inappropriate prescriptions, medication dispensing errors, patient identification errors, laboratory procedures errors and diets that do not match the history of the disease patient (Kuo et al., 2020). Therefore, to prevent these unexpected events, efforts are needed to improve patient safety in hospitals (Joint Commission, J, 2020). These efforts are carried out not only by implementing standard protocols, safe drug management, and positive relationships in increasing patient satisfaction but also by implementing interprofessional collaboration (Golom & Schreck, 2018; Kartika, 2019).

Interprofessional collaboration is a process of two or more health professions with different backgrounds working together to solve various health problems in providing services in hospitals (Adamson et al., 2018). This interprofessional collaboration is carried out to improve patient safety by combining knowledge and ideas from various scientific fields on the basis of partnership, interaction, integration, contribution and commitment from professionals by demonstrating their respective expertise based on responsibility, accountability, coordination, communication, collaboration, autonomy, mutual trust and respect (Sillero & Buil, 2021). Interprofessional collaboration that occurs in health services is seen as a reference towards higher service quality and lower costs (Asmirajanti et al., 2018; Purnaswi & Jenie, 2021; Rawlinson et al., 2021). Based on the Report of the Institute for Healthcare Improvement (IHI) states that the implementation of interprofessional collaboration can reduce the incidence of infection, reduce errors in treatment, reduce treatment costs, reduce patient falls accidents, reduce errors in medication and unwanted events, improve safety behavior and improve patient safety (Dinius et al., 2020; Ma et al., 2018; Mawarni et al., 2019). Based on the above background, researchers are interested in identifying the experiences of health workers in improving patient safety in hospitals through interprofessional collaboration.

METHODS & MATERIALS
This research is a qualitative study with an interpretive descriptive approach. The design of this study used the Focus Group Discussion (FGD) method. Through this FGD, researchers can find out the reasons, motivations, views and arguments or the basis of the opinion of a person or group (Klagge, 2018).

Participants
The research participants were 5 (five) health workers consisting of doctors, nurses, analysts, nurtisionists and pharmacists to explore the experience of each profession as a care provider profession obtained by purposive sampling technique. The inclusion criteria for participants to be taken in this study are: a) Participants are selected who are relevant (or experienced) with the issues being studied; b) Comes from a background similar to the research objectives; c) Having skills and willing to talk or discuss (skills are able to interact, discuss actively in the ongoing FGD process).
Data collection
The data collection of this research is by using FGD technique. The implementation steps are shown in table 1.

Table 1. The implementation of FGD technique

<table>
<thead>
<tr>
<th>No</th>
<th>Step of FGD Technique</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preparation</td>
<td>At this stage the researcher determines the number of participants consisting of 5 participants, determines the composition of the group followed by 1 person as a facilitator, 1 co-facilitator, 1 note taker and documentation, providing a comfortable and easy-to-reach environment, seating arrangements and preparing invitations.</td>
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<td>2</td>
<td>Implementing Stage</td>
<td>At this stage the researcher conducts FGD in an open-ended question method that allows participants to provide answers with explanations that answer questions, focus on problems or topics that are discussed and discussed together, clarification, namely repeating participants' answers in the form of questions to ask for detailed explanations. Furthermore, reorientation is using one participant's answer to ask other participants to make the atmosphere interesting but effective, paying attention to the dominant participant, paying attention to the silent participant and during the FGD the facilitator also uses pictures or photos. The FGD lasted for 120 minutes.</td>
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<tr>
<td>3</td>
<td>Closing Stage</td>
<td>At this stage the researcher concludes the results of the FGD, then asks the participants if there are other suggestions from the conclusions and conveys that the results of the discussion conclusions will be used as input in the study.</td>
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Here are some questions asked:
1. What do you understand by patient safety?
2. What has been done to maintain patient safety?
3. What kind of professional involvement in caring for patients is already taking place?
4. Are there parties that support improving patient safety in hospitals through this interprofessional collaboration?
5. What are the obstacles in applying patient safety principles through this interprofessional collaboration?
6. What are the desired expectations in applying safety principles to patients through interprofessional collaboration?

Data Analysis
Data analysis in this study used inductive thematic analysis. Data analysis in this research uses thematic analysis. Thematic analysis is a process of coding information that can produce a list of themes, a complex model of themes or indicators, or a combination of those mentioned by Boyatzis. Data analysis is done manually not using the application.

Research Ethics
Ethical considerations related to this research were carried out through permission from the ethics committee of the Faculty of Nursing, University of Indonesia with Number: Ket-174/UN2.F12.D1.2.1/PPM2021.
RESULT

From the results of the FGDs that have been carried out, in the five participants as shown in the following table, there are 8 (eight) themes that show the experience of health workers in improving patient safety in hospitals through interprofessional collaboration, namely:

Table 2. Participant Characteristics

<table>
<thead>
<tr>
<th>Participant Code</th>
<th>P1</th>
<th>P2</th>
<th>P3</th>
<th>P4</th>
<th>P5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant name</td>
<td>Mrs. I</td>
<td>Mrs. R</td>
<td>Mrs. C</td>
<td>Mrs. V</td>
<td>Mrs. T</td>
</tr>
<tr>
<td>Age</td>
<td>38</td>
<td>28</td>
<td>34</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Profession</td>
<td>Nurse</td>
<td>Doctor</td>
<td>Nutrisonist</td>
<td>Farmasist</td>
<td>Analist</td>
</tr>
<tr>
<td>Education</td>
<td>S1+Ners</td>
<td>S1</td>
<td>Diploma</td>
<td>Diploma</td>
<td>Diploma</td>
</tr>
<tr>
<td>Years of service</td>
<td>15</td>
<td>10</td>
<td>8</td>
<td>12</td>
<td>9</td>
</tr>
</tbody>
</table>

1. Patient safety through interprofessional collaboration in understanding health workers.
   Some of the participant statements include:
   
   “. Identifying every action in service delivery (P2).”
   “. Reducing the risk of injury by applying the principles of patient safety (P5).”
   “. Coordination of actions in prescribing drugs and carried out in accordance with SOP (P4).”

2. The principle of patient safety in the understanding of health workers
   Some of the participant statements include:
   
   “... Self-awareness of every profession for the sake of patient safety (P1).”
   “. Integrating patient safety principles in risk management, and preventing the occurrence of Unexpected Events or Near Injury Events (P3).”
   “... Creating good communication, namely effective communication (P5).”

3. Implementation of patient safety for health workers in interprofessional collaboration
   Some of the participant statements include:
   
   “. Creating patient care with SBAR standards and communication (P2).”
   “. Increasing the safety of drugs that must be watched out (P4).”
   “. Whatever action is made, it must still be written in the Integrated Patient Development Record (IPDR) (P3).”

4. Hospital management support for health workers in the implementation of patient safety
   Some of the participant statements include:
   
   “. There is joint training such as codeblue at the hospital (P3).”
   “. All areas of the hospital are already filled with patient safety education posters (P5).”

5. Personal barriers of health workers in the implementation of patient safety
   Some of the participant statements include:
   
   “... Lack of staff awareness and motivation (P1).”
   “. Not doing according to the SOP (P5).”
   “. Patient safety culture is not optimal (P4).”

6. Barriers to management in the implementation of patient safety for health workers
   Some of the participant statements include:
   
   “. Lack of awareness, belief, motivation from each profession (P3).”
“...The work mechanism is not directed, meaning that there is no guidance regarding the implementation of interprofessional collaboration (P2).”
“...The management does not carry out evaluations in seeing the implementation of services (P4).”
“...There is no room for discussion about the patient's condition (P5).”

7. Expectations of health workers in the implementation of patient safety
Some of the participant statements include:
“...Lack of staff awareness and motivation in implementing interprofessional collaboration (P4).”
“...There is no SOP regarding the implementation of interprofessional collaboration (P1).”
“...The culture of patient safety is not yet optimal which affects aspects of improving patient safety and also the implementation of interprofessional collaboration (P2).”

8. Expectations of health workers towards hospital management
Some of the participant statements include:
“...Monitoring evaluations from management on a regular basis which is carried out every week (P5).”
“...The service system is open and transparent so that information is obtained evenly from each profession (P3).”
“...There are facilities and infrastructure for the implementation of interprofessional collaboration (P2).”

**DISCUSSION**
Researchers have identified eight themes that are the result of this study.
Patient safety through interprofessional collaboration in the understanding of health workers identified in this study is identifying every action in providing services, reducing the risk of injury by applying patient safety principles, coordinating drug prescribing actions and implementing them according to SOPs. This is in line with research (Stewart-Parker et al., 2018) that patient safety through interprofessional collaboration has a significant influence where overall 95% of the application of collaboration has good or even very good relevance in clinical practice, being able to increase 55% integration in critical situations, 97% of staff use skills with patient identification, coordination and communication 88% prevent making mistakes and 94% are able to improve patient safety. Health workers who implement patient safety through interprofessional collaboration are able to provide better outcomes for patients, increase patient satisfaction and improve patient safety, this is in accordance with research from (Dinius et al., 2020) which states that interprofessional collaboration has a very high influence on increase in patient safety.

Theme 2 - Principles of patient safety in the understanding of health workers. The principle of patient safety in the understanding of health workers identified in this study is awareness of patient safety by preventing the risk of injury, creating effective communication and being committed to providing services in hospitals. This is in line with research (Pelzang & Hutchinson, 2020) which states that awareness of patient safety in the form of individual perceptions, motivation, understanding and self-projection that occurs in the health care environment, teamwork, communication, and managing communication lines and minimizing the risk of errors is an important part in improving patient safety. An understanding of the principles of safety in the hospital starts from increasing patient confidence in the services provided by health workers so as to reduce the number of patient safety incidents ranging from Near Injury Events to sentinel events.
Theme 3 - Implementation of patient safety for health workers in interprofessional collaboration. The implementation of patient safety by health workers in interprofessional collaboration identified in this study is a form of implementing coordination between staff, communication of Situation, Background, Assessment, Recommendation (SBAR), improving drug safety, evaluating actions and also integrating actions in the Integrated Patient Development Record (IPDR). This is in line with the research of (Suryani et al., 2021) where staff knowledge, supervision, motivation, and implementation of patient safety goals are the most important factors related to improving hospital quality and influencing the implementation of patient safety goals where (p-value <0.05 ). It is also supported by research by (Disch et al., 2020) which states that communication and coordination in collaboration are the main qualities and are very important to provide safe patient care and documentation of clinical information is also one of the fundamental factors in improving patient safety. An understanding of the implementation of patient safety for every health worker is very important because being able to create safe services for patients ensures safer patient care, is able to carry out risk assessments, creates a reporting culture, minimizes risks and prevents injuries caused by errors due to errors in carry out an action or not perform the action that should be done.

Theme 4 - Hospital management support for health workers in the implementation of patient safety. Hospital management support for health workers in the implementation of patient safety identified in this study were seminars, uniform training and educational posters in the hospital area. This is in line with research (Je et al., 2018) which states that sharing information, training, medical error reporting, safety climate, job satisfaction, communication, hospital management quality and management support shows a change in attitudes towards safety among health care providers and is able to develop several programs that are able to change the patient care process for the better. Also supported by research (Craig et al., 2020) in his qualitative research which states that support for health practitioners in team collaboration by means of actively communicating (building relationships, providing information, and discussing problem solving), proactively educating staff (training teams, advocating patients, and teaching about systems) and managing risk (shared problem solving, supporting facilities and evaluating every action) can improve patient safety.

Theme 5 - Personal barriers of health workers in the implementation of patient safety. The personal barriers of health workers in the implementation of patient safety identified in this study are the lack of awareness of the staff, lack of self-motivation, not carrying out service actions according to SOPs, the existence of a blame culture and a patient safety culture that has not run optimally in hospitals. This is in line with research by (Larasati & Dhamanti, 2021) where the low compliance of officers, unsupportive facilities and infrastructure, and low management commitment are some of the inhibiting factors that cause the implementation of patient safety in hospitals to be not optimal, so it is necessary to provide guidance, supervision, and support. adequate facilities and infrastructure. Likewise, research from (Simanjuntak, 2019), namely obstacles in implementing patient safety in hospitals, namely the low motivation and awareness of officers in verifying the implementation of patient identification correctly.
Theme 6 - Management barriers in implementing patient safety for health workers. Barriers to management in implementing patient safety for health workers identified in this study were no provisions for visiting hours, lack of transparency, lack of monitoring evaluation from management to measure the level of success of services, work mechanisms have not been directed and partially inadequate infrastructure. This is in line with (Nurdin, 2021) where obstacles in the implementation of patient safety are due to system failures from management, namely poor communication at the unit/inter-unit level, unclear information, high work volume, and lack of hospital facilities.

Theme 7 - Expectations of health workers in implementing patient safety. The expectations of health workers in implementing patient safety identified in this study are Lack of staff awareness and motivation in implementing interprofessional collaboration, interest and motivation of each profession, There is no SOP regarding the implementation of interprofessional collaboration, and The culture of patient safety is not yet optimal which affects aspects of improving patient safety and also the implementation of interprofessional collaboration. This is in line with research (Larasati, 2021) where the support of adequate facilities and infrastructure is important to facilitate health workers in improving patient safety and research is also followed (Jakked, 2019) which states that the expectations of health workers are the creation of open communication, staff empowerment and the existence of a patient safety culture to be able to reduce the incidence of adverse events in hospitals.

Theme 8 - Expectations of health workers towards hospital management. The expectations of health workers towards hospital management identified in this study are that there are more the service system is open and transparent so that information is obtained evenly from each profession, monitoring evaluations from management on a regular basis which is carried out every week, facilitating staff, and there are facilities and infrastructure for the implementation of interprofessional collaboration. This is in line with research (Folkmian, 2019) where management support is able to develop the role of its staff in integrating patient safety in both education and service so as to provide outcomes that have an impact on patient satisfaction and are able to make the necessary changes in the setting of a good service system. This is also supported by research (Wagner et al., 2019) where in a qualitative study of the implementation of patient safety, that intense team meetings enabled communication and discussion of complex cases and were able to manage a better collar change (better clinical team support, better patient care), could spanning the varied roles of team members, the evolution of interpersonal roles and the structure of the team leader or manager in collaborative team execution.

CONCLUSION
The results of the study can be concluded that the experience of health workers regarding the implementation of patient safety in hospitals through interprofessional collaboration, namely through interprofessional cooperation by identifying actions in providing services, uniform documentation and also coordinating actions according to SOP, creating communication according to SBAR, integration with CPPT, getting seminars, uniform training on patient safety, increasing awareness, motivation and improving patient safety culture, directed work mechanisms, equipped with adequate facilities and supported by hospital management, namely a transparent service system, periodic monitoring of evaluations, facilitating staff and providing facilities and infrastructure.
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