Vol.1 No.1
Issn:xxx-xxx
Penerbit: unpripress (Anggota Ikapi)

Analysis Of Organizational Factors And Organizational Structural Characteristics In The Implementation Of Clinical Risk Management At Raden Hospital Mattaher Jambi

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ABSTRACT

This research is a combination research (mixed method). The combined research method is a combination of quantitative and qualitative methods to determine the analysis of the implementation of clinical risk management and influencing factors at Raden Mattaher Regional Hospital, Jambi. Qualitative data analysis is inductive, The results of the research show that the respondents' perception of the condition of the work unit in supporting a safety culture is that the majority responded positively, namely 75.23%, the respondents' perception of superiors in the work unit in supporting the safety culture, the majority responded positively, namely 82.55%, The respondents' perception Regarding communication in work units in supporting safety culture, the majority responded positively, namely 66.73%. Respondents' perceptions of the frequency of incident reporting in work units in supporting safety culture were 53.16% of respondents who responded positively. The majority of respondents stated that they had never reported IKP, namely 69.8%. Respondents' perceptions of the work atmosphere in the work unit in supporting safety culture were 73.08% of respondents who responded positively. It is necessary to improve PMKP and Safety Culture education for staff and units through training and supervision of units
Keywords *: clinical risk management, organizational factors*

INTRODUCTION

Patient safety incidents are unintentional events and conditions that result in or have the potential to result in preventable harm to a patient. Patient safety incidents can result in death, disability, and suffering for the victim and their family. The losses not only affect the victim and their family but also the health service. health. If the incident is publicized, it can lead to a decrease in public trust in local health services. Health care workers involved can also suffer psychologically, have deep feelings of guilt, and self-criticism (WHO, 2021).

The World Health Organization (WHO) noted that there were 134 million adverse events that occurred each year and 2.6 million deaths per year due to unsafe services. Patient safety incidents that medical errors occurred in America, England, Denmark, and Australia found KTD with a range of 3.2% - 16.6%. Meanwhile, in Brazilian hospitals, there were 21.8% of surgical side effects from 60 cases, 90% of which were preventable incidents, and more than 2/3 resulted in mild or moderate damage. (WHO, 2020). According to a report on the National Reporting and Learning System (NRLS), from August 2021 to July 2022, there were 2,410,311 reports of patient safety incidents in the UK (England NHS, 2022). According to data from the Ministry of Health (MoH) Malaysia, there were 151,225 patient safety incidents in 2021.

Indonesia reported a significant increase in the total number of Patient Safety Incidents (PSI) in 2015-2019. PSI in 2015 was 289, in 2016 it was 668, in 2017 it was 1647, in 2018 it was 1489 and in 2019 it was 7465 incidents. The total PSI incidents based on the results of incidents that occurred in 2019 were described as 171 deaths, 80 serious injuries, 372 moderate injuries, 1183 minor injuries and 5659 no injuries. The National Patient Health Learning Reporting System in 2019, obtained data on 12% of the Patient Safety Incident (IKP) figures based on hospitals reporting a total of 7465 cases with a percentage of Near Missing Events (KNC) of 38%, Non-Injury Events (KTC) 31%, and Unexpected Events (KTD) 31% (Putri, 2021).

Based on data from the Indonesian Ministry of Health, the total number of hospitals reporting patient safety incidents in Indonesia in 2018 was 5%, more specifically in the province of South Sulawesi, the IKP report was 4.5%. Then in 2019, the total reporting of patient safety incidents in Indonesia increased by 7% to 4-12%, and in the province of South Sulawesi it increased by 4.5% to 9% (Daud, 2020).

RSUD Raden Mattaher Jambi is the largest hospital in Jambi Province with 1449 employees in 2019. Based on the Patient Safety Incident report data from RSUD Raden Mattaher Jambi in 2016, it was recorded that KTD occurred with a percentage of 58.9%, KNC 11.8%, and KTC 33.3%. Then in 2017 there were KTD 61.9%, KNC 14.3%, and KTC 4.7%. Then in 2018 there were KTD incidents as many as 3 incidents, KNC 0 incidents and KTC 1 incident (Data as of July 6, 2018). Next in 2019 there was KTD as many as 1 incident, KNC 1 Incident, and KTC as many as 5 incidents (Data as of January 10, 2019).

Risk management is closely related to the implementation of patient safety and has an impact on achieving Hospital targets. Patient safety is an important aspect in every medical action, both minor and major medical actions.

Based on the description of the problems above, the author is interested in researching "Analysis of Organizational Factors and Structural Characteristics of the Organization in the Implementation of Clinical Risk Management at Raden Mattaher Regional Hospital, Jambi".

LITERATURE REVIEW

Understanding Clinical Risk Management

Risk is defined as an uncertainty about the occurrence of an event in the future. The higher the level of uncertainty, the higher the possibility of risk that will occur (Zaboli et al., 2011).

The scope of risk management in the health world consists of:

a. Risks associated with patient care
b. Risks associated with medical staff
c. Risks related to employees
d. Risks associated with buildings/equipment
e. Financial risk
f. Others (Carroll, 2009)

Clinical Risk Management itself is a specific part and form of risk management that focuses on clinical processes related to patients, both processes that directly touch patients and those that indirectly. So it can be said that Clinical Risk Management is the entire structure of processes, instruments and activities that enable hospitals to identify, analyze, and handle risks that may arise during care and service delivery (Briner et al., 2010).

Key elements in Risk Management

a. Risk strategy; defining the context of external and internal risk management, developing criteria and establishing a risk management structure.
b. Risk identification; identifying what, when, where, how and why an incident could occur.
c. Risk analysis: determining the consequences and incidents that may occur and the level of risk.
d. Risk evaluation: comparing risks against criteria And determine priority. Decide what action is needed.
e. Problem solving: identifying available options. Preparing and implementing an action plan (Briner et al., 2010)

METHODS

This study is a combination research (mixed method). The combination research method is a combination of quantitative and qualitative methods to determine the Analysis of Clinical Risk Management Implementation and Influencing Factors at Raden Mattaher Jambi Regional Hospital, the sampling technique is total sampling. Data collection using a questionnaire by filling out the questionnaire. The study was conducted at Raden Mattaher Jambi Regional Hospital. Qualitative data analysis is inductive, namely an analysis based on the data obtained which is then developed through in-depth study into a quantitative hypothesis using descriptive statistical data analysis techniques.

RESULTS AND DISCUSSION

Table 1. Analysis, monitoring, evaluation and follow-up using the Planning, Do, Study and Action (PDSA) method

Hand Hygiene Compliance	
Planning	Maintaining Hand Hygiene Compliance Achievement ≥85%
DO	Periodic resocialization of hand hygiene has been carried out Infection Prevention and Control (PPI) training has been implemented in August 2022 Providing facilities and infrastructure for hand hygiene Conduct monitoring and evaluation (monev) of hand hygiene
Study	The achievement in 2022 has met the standard of ≥85%, but must be maintained and increased to 100%.
Action	Maintain the achievement of Hand Hygiene Compliance indicators in each work unit. Conduct regular and periodic socialization in work units regarding Hand Hygiene Planning for Infection Prevention and Control (IPC) Training in Fiscal Year 2023 for officers who have not been trained. Select hand washing ambassadors in each work unit by involving the PPI Committee Monitoring of implementation by Head of Unit, PPI and Quality Committee
Compliance with the Use of Personal Protective Equipment (PPE)	
Planning	Increasing the Achievement of Compliance with the Use of Personal Protective Equipment (PPE) according to the 100% standard
DO	Periodic resocialization regarding the use of Personal Protective Equipment (PPE) has been carried out. Infection Prevention and Control (PPI) training for hospital staff has been implemented in August 2022. Coordination with related sectors regarding the need for facilities and infrastructure for Personal Protective Equipment (PPE) has been carried out. Creating a routine monitoring and evaluation (monev) schedule for Compliance and Accuracy of Use of Personal Protective Equipment (PPE) has been carried out
Study	Achievement of Compliance in the Use of Personal Protective Equipment (PPE) in 2022 has not met the 100% standard, this is because there are still officers who use Personal Protective Equipment (PPE) that does not comply with the indications and guidelines.

Action	Periodic resocialization of the use of Personal Protective Equipment (PPE) by the PPI Team. Planning for Infection Prevention and Control (IPC) Training in Fiscal Year 2023 for officers who have not been trained. Coordination with related fields regarding the provision of PPE Monitoring of implementation by Head of Unit, PPI and Quality Committee
Patient Identification Compliance	
Planning	Improving Patient Identification Compliance Achievement according to 100% standard
DO	Carrying out resocialization regarding Patient Safety Targets periodically Patient Safety Target Training for hospital staff in August 2022 has been implemented. Reminding officers that the SOP for installing patient bracelets has been implemented. Routine monitoring and evaluation (monev) of patient quality and safety in work units is not yet optimal. Coordination with related fields regarding the provision of facilities and infrastructure in the implementation of patient identification activities has been carried out.
Study	Achievements in 2022 have not met the 100% standard. This is because there are still officers who identify patients when carrying out actions that are not in accordance with SOP.
Action	Periodic resocialization of patient identification by the PPI Team. Resocialization of SOP for installing patient bracelets. Fulfilling the supporting needs for patient identification facilities and infrastructure. Increase monitoring of implementation by Unit Heads and Quality Committee.
Compliance with Specialist Doctor Visit Time	
Planning	Maintaining Compliance Achievement of Specialist Doctor Visit Time ≥80%
DO	Reminding DPJP that the visiting hours are 06.00 – 14.00 WIB has been carried out. Coordination with related fields has been carried out.
Study	Achievements in 2022 have met the standard of ≥80%
Action	Remind DPJP to carry out visits on time (06.00–14.00 WIB). Remind the DPJP that the visit is conducted by a specialist doctor. Conduct data validation, monitoring implementation by the Unit Head and Quality Committee Improve communication and motivation by the Hospital Board of Directors
Compliance with Fall Risk Prevention Efforts	
Planning	Increasing the Achievement of Fall Risk Prevention Effort Compliance according to the 100% standard
DO	Socialization about the indicator profile has been carried out. Socialization of filling out the fall risk monitoring form has been carried out. Coordination with related fields regarding need for facilities and infrastructure Supporting measures such as handrails in patient bathrooms and fall risk stickers have been implemented. Create a routine monitoring and evaluation (monev) schedule for

	quality and patient safety activities in work units.
Study	Achievements in 2022 have not met the 100% standard. This is due to the lack of knowledge of officers regarding Fall Risk Prevention Efforts and supporting facilities and infrastructure which are still limited.
Action	Resocialization of indicator profiles. Resocialization of filling out the fall risk monitoring form. Conducting Patient Safety Target training activities. Fulfilling the need for supporting facilities and infrastructure for efforts to prevent the risk of falls. Monitoring of implementation by the Head of Unit and Quality Committee.
Laboratory Results Reporting	
Planning	Maintaining 100% Laboratory Critical Time Reporting Achievement
DO	Socialization regarding indicator profiles has been carried out. Socialization regarding data collection has been carried out. Laboratory coordination with inpatient rooms has been implemented.
Study	The achievement in 2022 has met the 100% standard, but must be maintained.
Action	Maintain 100% critical laboratory result reporting achievement. Perform Communication between Installations. Conduct data validation and monitoring of implementation by the Head of Laboratory Installation and Quality Committee.
Outpatient Waiting Time	
Planning	Improving Outpatient Waiting Time Achievement according to standards ≥80%
DO	Socialization regarding indicator profiles has been carried out. Socialization of outpatient service hours has been carried out. Creating a routine monitoring and evaluation (monev) schedule for patient quality and safety activities in work units is not yet optimal.
Study	Achievements in 2022 on average have not met the ≥80% standard due to officers' lack of understanding of indicator profiles, validation data that is not yet optimal and compliance with service hours.
Action	Resocialization of indicator profiles. Remind the officer about the service hours. Improve communication and motivation by the Hospital Board of Directors. Monitoring of implementation by the Head of Outpatient Installation and the Quality Committee.
Emergency Operation Response Time Ses area	
Planning	Improving the Achievement of Response Time for Caesarean Section Emergence according to the standard ≥ 80 % .
DO	Socialization regarding indicator profiles has been carried out. Coordination with related units regarding recording and reporting has been carried out but is not yet optimal. Creating a routine monitoring and evaluation (monev) schedule for improving patient quality and safety has been done but is not yet optimal.
Study	Achievements in 2022 have not met the standard of ≥80%. This is due to the lack of understanding of the indicator profile among officers and coordination between units is not yet optimal.
Action	Resocialization of indicator profiles. Coordination with related units regarding the services provided.

	Conducting data validation and monitoring and evaluation (monev) by the Unit Head and Quality Committee. Communication and motivation by the Hospital Board of Directors. Monitoring of implementation by the Head of Unit and Quality Committee.
Postponement of Elective Surgery	
Planning	Maintaining Elective Surgery Postponement Achievements.
DO	Socialization regarding indicator profiles has been carried out Socialization regarding data collection has been carried out. Scheduling of elective operations and use of operating rooms has been done.
Study	Achievements in 2022 have met the standard of ≤5% but must be maintained.
Action	Coordinate with related fields regarding maintenance of operating rooms and their facilities and infrastructure. Coordination with related fields to fulfill the required infrastructure facilities. Perform tool calibration according to schedule. Conduct data validation and monitoring of implementation by the Head of the Central Surgical Installation (IBS) and the Quality Committee.
Compliance with the Use of the National Formulary	
Planning	Maintaining National Formulary Compliance Achievement ≥80%
DO	Socialization regarding indicator profiles has been carried out. Socialization regarding data collection has been carried out. Preparation of daily census forms for data collection has been carried out. Appeal to DPJP to use the National Formulary in drug prescription has been done.
Study	The achievement in 2022 has met the standard of ≥80% , but it is still maintained and is a concern to maintain the quality of service.
Action	Appealing again to DPJP to use the National Formulary in prescribing drugs to patients. Coordination with related fields regarding the fulfillment of hospital drug needs. Conduct data validation and monitoring of implementation by the Head of Pharmacy Installation and Quality Committee Communication and motivation from the Hospital Board of Directors.
Complaint Response Time Speed	
Planning	Maintaining Complaint Response Time Speed Achievement of 100 %
DO	Socialization regarding indicator profiles has been carried out Socialization regarding data collection has been carried out. Preparation of daily census forms for data collection has been carried out. Proactive complaint handling by UPPRS has been carried out. Effective Communication Training has been conducted.
Study	The achievement in 2022 has met the 100% standard , but is still maintained and is a concern to maintain the quality of service.
Action	Coordination of related fields for maintenance, repair and fulfillment of facilities and infrastructure needs. Communication and education of patients and families, especially when entering the hospital. Proactive complaint handling by each work unit and UPPRS.

	Carry out internal training activities on Effective Communication in all PPAs gradually. Conduct data validation and monitoring of implementation by the Head of UPPRS and Quality Committee. Communication and motivation from the Hospital Board of Directors.
Compliance with Clinical Pathway	
Planning	Increase the Achievement of Compliance with Clinical Pathway according to standards ≥80%.
DO	Socialization regarding indicator profiles has been carried out. Coordination with related units regarding recording and reporting has been carried out but is not yet optimal. Creating a routine monitoring and evaluation (monev) schedule for improving patient quality and safety has been done but is not yet optimal.
Study	Achievements in 2022 have not met the standard of ≥80%. This is due to the lack of understanding of the indicator profile among officers and coordination between units is not yet optimal.
Action	Resocialization of indicator profiles. Coordination with related units regarding the services provided. Conducting data validation and monitoring and evaluation (monev) by the Unit Head and Quality Committee. Communication and motivation by the Hospital Board of Directors. Monitoring of implementation by the Head of Unit and Quality Committee.
Patient Satisfaction	
Planning	Maintaining Patient Satisfaction Achievement ≥76.61 %.
DO	Satisfaction survey has been carried out by the Education and Training Division. Monitoring and evaluation of the implementation of the satisfaction survey has been carried out.
Study	Achievements in 2022 have met the standard of ≥76.61% , with an achievement of 79.31% but still being maintained/improved and a concern to maintain the quality of service.
Action	Coordination of related fields for maintenance, repair and fulfillment of facilities and infrastructure needs. Communication and education of patients and families, especially when entering the hospital. Proactive complaint handling by each work unit and UPPRS. Monitoring and evaluation of quality improvement and patient safety activities in work units by the Quality Committee.

From the results of the National Quality Indicators (INM) above, the following conclusions can be drawn:

1. Root of the Problem:

   From the description of the analysis of each National Quality Indicator (INM) above, it can be concluded that there are several reasons why the National Quality Indicator (INM) has not been achieved according to the established standards, as follows:

   a. Officer awareness/compliance is still low
   b. Lack of monitoring and evaluation
   c. Data validation is not yet optimal
   d. PIC Data's understanding of the National Quality Indicator profile is inadequate

e. There are differences in understanding regarding operational definitions
f. Availability of supporting infrastructure

2. Recommendation :
Based on the root of the problem, the Quality Committee provides recommendations as an effort to improve the quality and safety of patients as reflected in the achievement of National Quality Indicators (INM) according to the established standards, as follows:
   a. Increase staff knowledge of Patient Safety Goals
   b. Improve monitoring and evaluation by creating a routine supervision schedule for work units.
   c. Forming a Data Validation Team
   d. Conduct Resocialization on the National Quality Indicator profile
   e. Conduct training activities for all staff on Quality Improvement and Patient Safety, especially for new employees.
   f. Coordination with related sections regarding the fulfillment of supporting facilities and infrastructure needs
   g. Conducting coordination meetings with the Board of Directors and committees at Raden Mattaher Regional Hospital regarding follow-up on the achievements of the quality improvement and patient safety program and risk management.

Based on the results of the study, it shows that clinical risk management at Raden Mattaher Regional Hospital is included in the successful category which can be seen from the achievement of each aspect. This study is in line with research conducted by Olii et al., (2019) which states that there are several factors that generally tend to be key factors in the implementation of clinical risk in hospitals, namely leadership, staff knowledge, and the existence of a situation that is responsible for the clinical risk management program and strategic hospital policies.

Nurses who are obedient and disciplined in carrying out risk management in every action to patients will be useful in protecting patients and nurses themselves from possible risks that may exist such as clinical and non-clinical risks. The implementation of risk management carried out by nurses greatly influences risk prevention and can also affect the quality of nursing services provided. This is in accordance with research conducted by Budiono et al., (2014) stating that nurses in the inpatient ward of Unisma Malang Hospital with a Diploma III Nursing and S1 Nursing educational background have been able to apply appropriately according to the Standard Operating Procedure (SOP) for risk management. It is known that nurses have screened new patients, then patients will be treated according to their illness and the handling of risks that have been identified in accordance with existing standards.

Another study conducted by Santoso & Sugiarsi, (2017) stated that the implementation of risk management monitoring in the filing unit of Dr. Moewardi Hospital has been carried out well, but its supervision and implementation have not been well documented. The implementation of a risk management program can effectively reduce the number of medical errors.

This study shows that risk management that has been carried out by nurses at Raden Mattaher Jambi Regional Hospital obtained results that all respondents have carried out risk management with a successful category. The better the risk management that is carried out, the more it can suppress, prevent and reduce the level of risk events in patients and other health workers.

Several factors that influence clinical risk management are the length of service of nurses. The length of service of nurses can affect the competence, ability, skills of nurses in providing nursing care and implementing risk management in accordance with existing operational standards. The longer a person's service period, the more experience they gain. And the skills they have

also increased. This is in accordance with research conducted by Zulkifli & Sureskiarti (2020) which stated that the majority of nurses' service periods at the Samarinda Regional General Hospital were dominated by nurses who had worked >3 years. This shows that there is a renewal of nurses that the workforce who have a service period of more than 3 years is increasing.

Based on the data above, it can be concluded that most nurses at Raden Mattaher Jambi Regional Hospital have worked for >5-10 years. The longer a person's work period, the better they will be in doing their job because they already have better knowledge, experience, and ability in working, both in providing nursing care, quality of service and in risk management actions.

CONCLUSION

1. Respondents' perceptions of the work unit's condition in supporting safety culture were mostly positive, namely 75.23%, and those who responded negatively were 24.77%. The data shows that the unit provides opportunities for staff to implement a safety culture.
2. Respondents' perceptions of superiors in work units in supporting safety culture were mostly positive, namely 82.55% and those who responded negatively were 17.45%. The data shows that superiors provide opportunities for staff to implement a safety culture.
3. Respondents' perceptions of communication in the work unit in supporting safety culture were mostly positive, namely 66.73%, and those who responded negatively were 33.27%. The data shows that communication between staff in the unit provides opportunities for staff to implement a safety culture.
4. Respondents' perceptions of the frequency of incident reporting in work units in supporting safety culture, namely respondents who responded positively were 53.16% and those who responded negatively were 46.85%. From these data, it shows that reporting on safety culture is still not optimal, so adequate education is needed for staff.
5. Most respondents stated that they had never reported IKP, which was 69.8%. This is a menu.
6. demonstrate the need for staff education on understanding IKP and developing an IKP reporting system
7. Respondents' perceptions of the work atmosphere in the work unit in supporting a safety culture, namely respondents who responded positively were 73.08% and those who responded negatively were 26.92%. From these data, it shows that the work atmosphere supports the hospital's safety culture.

ACKNOWLEDGEMENT

Need support from the Board of Directors in improving the quality and safety of patients, especially in policy making, can use PMKP quality data and Safety Culture Survey Results. Need to improve PMKP and Safety Culture education to staff and units through training and supervision to units. Need to improve education to staff directly related to safety culture. Need to support safety culture through implementation in providing services and providing IKP Reports if IKP is found.

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