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An Analysis of Patient Safety Management by The Hospital Quality Committee: A Case Study on Inpatient Nurses at The Islamic Hospital of Surakarta (2025)

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ABSTRACT

Background & Objective: Patient safety is a critical component in improving the quality of hospital services. However, various patient safety incidents are still occurring due to suboptimal implementation. The Quality Committee plays a strategic role in managing patient safety, including program development, incident investigation, reporting, and evaluation. This study aims to analyze patient safety management by the Quality Committee, focusing on inpatient nursing services at Rumah Sakit Islam Surakarta. **Method:** This research employed a qualitative approach with a phenomenological method. Data were collected through in-depth interviews with six inpatient nurses and direct field observations. Thematic analysis was conducted through data reduction, data presentation, and conclusion drawing. **Result:** The findings indicate that the implementation of patient safety management by the Quality Committee has not been fully optimized. Key obstacles include underreporting of incidents, limited staff understanding of standard operating procedures (SOPs), lack of regular education and training, and weak documentation and coordination systems. The committee's role has not yet fully integrated the functions of planning, organizing, implementing, and controlling in the context of patient safety. **Conclusion:** Patient safety management at Rumah Sakit Islam Surakarta requires strengthening in terms of system structure, safety culture, and active nurse involvement. Stronger leadership support, enhanced human resource capacity, and optimal performance of the Quality Committee are essential to establish a structured and sustainable patient safety system.

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Introduction

Patient safety is one of the main pillars in improving the quality of hospital services. In modern healthcare systems, patient safety is not only the responsibility of medical staff but is an integral part of the hospital's quality management system, which must be fully integrated. The Hospital Quality Committee, particularly the Patient Safety Subcommittee, plays a strategic role in identifying, managing, and preventing patient safety incidents through structured and sustainable programs.

The Hospital Accreditation System (KARS) 2012 edition states that all hospital services must provide care that meets quality standards and ensures safety and protection from the effects of the care provided, in order to fulfill the public's right to quality and safe care. High-quality care combined with strong patient safety guarantees will create a positive reputation for the hospital in the eyes of patients as users of hospital services. Patients not only require good services but also a situation that assures them the services are safe and will not harm them. (Ministry of Health Regulation, 2011)

The World Health Organization (WHO) states that approximately 134 million adverse events occur annually in healthcare facilities in low- and middle-income countries, resulting in approximately 2.6 million preventable deaths. In Indonesia, according to data from the National Patient Safety Committee (KNKP), the rate of reporting patient safety incidents remains low. Although regulations such as Ministry of Health Regulation No. 1691 of 2011 and Ministry of Health Regulation No. 11 of 2017 have detailed provisions on patient safety systems, their implementation in the field still faces various challenges, such as low staff awareness, a blame culture, and weak reporting and investigation systems for incidents. According to a report by the Institute of Medicine (IOM) in the United States released in 1999, it was directly stated that at least 44,000 to 98,000 patients die in hospitals each year due to preventable medical errors. This has led to an increase in legal claims against hospitals.

The National Patient Safety Agency in the UK recorded 236 near-miss incidents related to the loss of identification bracelets between November 2013 and July 2015 (Setiyani, 2016). Patient safety has become a major concern in healthcare services. Patient safety is more important than mere efficiency in service delivery. Various risks arising from medical procedures can occur as part of patient care. It turns out that service quality alone is insufficient. The number of legal proceedings in hospitals continues to rise. Hospitals and medical professionals often become targets of allegations. Patient safety brings about a shift from a blame culture to a safety culture and reduces litigation in hospitals. (Hillary Clinton and Barack Obama 2006)

Failure or delay in reporting incidents related to patient safety can lead to serious consequences if not handled properly. Potential impacts include threats to patient safety, inappropriate service and medication administration, and potential losses for the hospital (McFarland & Doucette, 2018). Nurses' knowledge of patient safety is crucial, as inadequate understanding of patient safety can negatively impact their ability to implement patient safety measures in hospitals.

In accordance with the provisions of Law No. 44 of 2009, hospitals have a responsibility to continuously improve the quality of services and patient safety through effective hospital quality management. The Quality Committee, as the driving force behind patient safety, should ideally perform managerial functions

comprehensively, from planning, implementation, evaluation, to continuous improvement. However, in reality, many hospitals face challenges in optimizing the role of the Quality Committee, whether due to limited human resources, insufficient managerial support, or staff unfamiliarity with the applicable standard operating procedures (SOPs).

Surakarta Islamic Hospital is one of the health care institutions that has established a Quality Committee and is committed to implementing patient safety programs. However, based on the results of a preliminary study conducted by the researcher, it was found that the implementation of patient safety management is still not optimal. Indicators include: low rates of safety incident reporting, weak understanding of patient safety procedures among nurses, and ineffective training and documentation systems.

In this context, a thorough evaluation and analysis of the implementation of patient safety management by the Quality Committee at Surakarta Islamic Hospital is necessary. This research is important as an effort to determine the extent to which the managerial functions of the Quality Committee are carried out within the framework of patient safety, as well as a basis for strategic decision-making by the hospital in strengthening its quality system and hospital accreditation.

Objective

This study uses a phenomenological approach to explore the experiences of inpatient nurses in interacting with the patient safety system implemented by hospitals. By understanding the reality in the field, this study is expected to provide practical recommendations for strengthening the patient safety management system, particularly in medium-sized hospitals in Indonesia.

Method

This study uses a qualitative approach with a phenomenological method. The research subjects are six inpatient nurses selected using purposive sampling. Data collection techniques were conducted through in-depth interviews and participatory observation. Data validity was tested through source and technique triangulation. Data analysis was conducted using a thematic approach: data reduction, data presentation, and conclusion drawing.

Results

The research data was obtained through interviews. Interviews were conducted with six respondents who were considered relevant to the subject matter of the study. The following is data from the six respondents in the study:

TABLE 1. Characteristics of Research Respondents

Kode Responden	Jk	Umur	Pendidikan	Lama Bekerja
MR	P	29	S1	3 tahun
NH	P	47	DIII	4 tahun
F	L	36	DIII	10 tahun
AR	P	23	DIII	4 tahun
E	P	48	S1	20 tahun
N	P	25	DIII	1 tahun

Based on interviews and questionnaires conducted with six inpatient nurses at Surakarta Islamic Hospital, three major themes were identified in the implementation of patient safety by the Quality Committee, namely: 1) minimal reporting of patient

safety incidents (PSIs); 2) lack of training and socialization; 3) weak implementation of patient safety standards in service units.

Incident reporting remains low
Some respondents stated that they had reported PSIs, but the process was not yet systematic. One respondent stated:
Quote 1
"Yes, when there is a patient safety incident report, it is reported to the unit supervisor. However, not all incidents are recorded." (MR, 29 years old)
Some respondents had never been involved in reporting, indicating a weak reporting culture. This aligns with the findings of the WHO (2021) study, which noted that insufficient reporting is an indicator of a weak patient safety culture in healthcare facilities (1).

Training and education are unevenly distributed
Not all respondents reported having received patient safety training. Some stated:
Quote 1
"Never, even though training is important so that all staff know the procedures." (F, 36 years old)
Other respondents mentioned that training had been conducted, but only during specific in-house training sessions. This gap highlights the need for a continuous training program implemented periodically by the Quality Committee.

Implementation of standards is not comprehensive
Regarding the implementation of the 6 Patient Safety Goals, some respondents stated that only some procedures were implemented. For example:
Quote 1
"The use of fall risk bracelets, allergy risk markers, and patient identification has been implemented." (AR, 23 years old)
However, some respondents stated that patient safety standards have not been fully implemented across all units. Some SOPs have also not been adequately socialized. A nurse stated:
Quote 2
"Not all medical and non-medical staff are aware of the importance of patient safety SOPs." (E, 48 years old)
This condition reinforces previous findings that the implementation of patient safety is still partial and has not become a shared culture within the organization.

Evaluation by the Quality Committee is still limited
Although some respondents mentioned monitoring by the Quality Committee, the form of evaluation is not yet uniform. Some are only done passively, without clear feedback or follow-up.

Discussion

This study shows that although Surakarta Islamic Hospital has established organizations and policies related to patient safety, their implementation is still far from optimal. The reporting culture among internal staff remains weak, as evidenced by the limited number of reports originating from direct service units. This indicates

a sense of discomfort or fear in reporting incidents, which should serve as a basis for evaluating and improving the system continuously. Delays and lack of detail in incident reporting also hinder effective follow-up on incidents.

These findings are reinforced by the findings of Rezeki et al. (2022), who concluded in their study at Royal Prima Hospital in Medan that the implementation of patient safety is highly dependent on five key elements: patient safety culture, facilities and infrastructure as well as monitoring, risk management, an effective reporting system, and patient involvement in every medical procedure. The hospital demonstrated strong managerial commitment and a more structured reporting system through daily supervision and quarterly evaluations. This indicates that management support and active staff involvement significantly influence the achievement of optimal patient safety goals.

Inadequate education and training for staff on patient safety procedures contributed to low compliance with operational standards. Interdisciplinary collaboration, particularly from the pharmacy and nutrition teams, was also limited, despite the success of the patient safety program heavily relying on cooperation among various units. The use of fall risk signs and identification bracelets has not been fully implemented, while hygiene procedures such as handwashing have not become a habit throughout all areas. Cases such as medication shortages, administration errors, and duplicate entries in the SIMRS indicate the need for system strengthening and ongoing training, not only administrative but also related to safety culture.

Conclusion

Based on research and data analysis conducted from January to May 2025, it can be concluded that patient safety management at Surakarta Islamic Hospital faces a number of challenges. Although policies and reporting systems are in place, their implementation is still not optimal. The level of internal reporting culture is relatively low and is more dominated by external reports, indicating a lack of courage and systematic support for reporting incidents from within the organization. Education on patient safety procedures, such as handwashing, the use of identification bracelets, and fall risk marking, has not been consistently implemented. There are also recurring incidents indicating a lack of systematic improvement. Cross-professional participation, including pharmacy, nutrition teams, and SIMRS teams, remains low in supporting patient safety. Therefore, enhanced training, a safe and user-friendly reporting system, and strict oversight are necessary to ensure that patient safety measures are actively and continuously implemented.

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