

The Relation of Team Work and Communication With Patient Safety Implementation in Nursing Staff

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ABSTRACT

Background: patient's safety is a basic principle of health service. Safety is also a right for the patient in receiving health services. The change of the health service paradigm from *safety* to *safety-quality* means not only to increase the quality but also to keep patient safety. In 1999 the Institute of Medicine (IOM) in the USA stated that 44000-98000 / death was caused by medical errors. In Indonesia since 2006-2011 adverse events obtained 249 reports, 207 reports for Nursing units, and 437 reports for Hospitalization. The implementation of patient safety is implemented by nurses affected by some factors such as teamwork and communication. **Purpose:** the study is to know the correlation between teamwork and communication by implementing patient safety implemented by nurses. **Method:** research design used correlation analysis with a cross-sectional method involved 125 samples. The instrument of this study is used communication and teamwork questionnaire instrument which is filled by a nurse. The data analysis is using Spearman rank. **Result:** the study proved that teamwork has a correlation with the implementation of patient safety ($p=0,006$) and communication has a correlation with the implementation of patient safety ($p=0,026$). Our study find that teamwork and effective communication can increase the implementation of patient safety. **Conclusion:** This study recommends to increase patient safety through the implementation of effective communication to increase the implementation of patient safety.

Keywords: *Teamwork, Communication, Patient Safety Implementation*

1. INTRODUCTION

Patient safety is a basic principle of the health service who believe that salvation is the right of every patient to receive health care. IOM(2006) to make the rights of patients as a standard first seven standards of patient safety in the hospital. World Health Organization (WHO) Collaborating Center for Patient Safety Solutions in collaboration with the Joint Commission and Joint Commission International has put the issue of patient safety by using six patient safety program activities in 2005 and the Nine patient safety solutions guide at the hospital in 2007.

Patient safety is a care delivery system that is safe for patients at the hospital.[1] According to the Canadian Nurses Association (2004) the provision of safe care is the reduction of unsafe acts to patients and providing the best action to obtain optimal health status of patients in the healthcare system. Patient safety can also be interpreted as a state of the patients were free from injury which is not supposed to happen or free from the risk of injury that can occur.[2]

In 1999, the Institute of Medicine in the United States submits his report that about 44000-98000 patient deaths occur each year as a result of errors made by health personnel (medical error). The publication by the World Health Organization (WHO) in 2004 also found the incident is not expected to range from 3.2 to 16.6% at hospitals in various countries, namely the US, the UK, Denmark, and Australia.[1] Recent publications in the United States in the year 2011 showed that 1 in 3 patients admitted to hospital experienced something unexpected. The most common types are medication errors, incorrect operation, and procedures as well as nosocomial infections. Patient safety in Indonesia Data owned Hospital Patient Safety Committee of September 2006-2011 by type of incident is not expected to be obtained as much as 249 incident reports, the incident almost as many as 283 injured and the cause of most reports on a total of 207 nursing report .6 Score of unexpected events very varied occurred, ie 8.0% to 98.2% for diagnostic error and 4.1% to 91.6% for medication error.

Based on the results of preliminary studies and interviews obtained the implementation of the safety of patients still had not been optimal to six targets associated with patient safety is the identification with the provision of patient identification bracelets, effective communication and do plebeian patient's risk of falling. Incident to adversely affect patient safety and the toll of death, impaired body functions, financial loss, and lowered public confidence in the hospital services. Prevention and control of the incident need to be done to reduce the incidence of patient safety.

The behavior to reduce the harm and eliminate losses due to health care by creating a safety culture related to safety systems, communication, and teamwork to facilitate the achievement of patient safety and quality of care, minimizing the risk of harm to the patient, improve professional collaboration and increase the job satisfaction of staff and patient satisfaction. [3]

Build communication and teamwork effectively contribute to the formation of safe behavior patients in hospitals and are aspects that affect each other and are needed in the organization.[4] Factors to be a challenge for nurses in providing nursing care that is safe and contributes to patient safety namely clinical environment, the issue of energy, teamwork, communication, caregiver perspective on patient safety, patient perspectives on patient safety, technology, and culture of blaming the incidence of errors.[2] Clinical Governance Research Unit Metro South (2014) also states fewer unexpected events occur when the cooperation within the team is established strong. Safety can be achieved when every member of the team knows their own responsibilities and trust the team members' opinions related to patient safety.[5]

The purpose of this study knowing Relations Teamwork and Communication with the Patient Safety Implementation by nurse executive inpatient wards of hospitals

2. METHOD

This research uses correlational analysis research with a cross-sectional approach, the independent variables are Teamwork and Communication and the dependent variable is the Implementation of patient safety by nursing staff. Sampling using purposive sampling with a large sample of the study was 125 nurses, inpatient, in the room. Measuring instruments used in the form of a questionnaire teamwork and communication questionnaire. The data analysis using the spearman rank test.

3. RESULTS

Respondent characteristics such as age, education level, years of service at the hospital, the working period inwards

Table Frequency distribution of respondents by age, period work in hospitals and wards

Characteristic	Mean	Standard Deviation
Age	29.76	4.456

Period work in Hospitals	7.4	4.238
Period Work Inwards	3.9	1.944

Table 1. The above describes the characteristics of the age of inpatient at the room with an average value of 29 years. Tenure at the hospital and years of all subjects showed that the average period of working nurses in hospitals is 7.4 and nurse's inpatient wards is 3.9 years.

Characteristics by Gender and Level of Education.

Table 2.Frequency Distribution of Respondents by Gender, Level of Education, Training have been followed in the patient wards.

Characteristic	value	%
Gender		
Male	35	28
Female	90	72
Level of Education		
Nurses/Bachelor	87	69,6
LVN	38	30,4

Table 2. describe the characteristics of nurses inpatient wards in the hospital. based on gender is male as many as 35 people (28%) and Women 90 people (78%). According to Education namely, Education Degree/nurses that as many as 87 people (69, 6%) and education level Vocational Nurse as many as 38 people (30.4%).

Cooperation Relations Team With Patient Safety.

Cooperation Relations Team With Patient Safety Application. The test results rank spearman that the value ($p = 0.000$) $< (\alpha = 0,05)$, then H_a , H_o accepted and rejected. It can be concluded that there is a relationship between teamwork with the implementation of patient safety in the inpatient in the hospital.

The correlation coefficient test results Spearman rank that the value of $r = 0.440$, which means that the correlation between teamwork with the implementation of patient safety in space inpatient in hospital shows the level of relationship, with the direction of the positive correlation means the better the teamwork, the better application of safety patients by nurses of patient wards in the hospital.

Communication With Patient Safety

Spearman rank test results showed that the value ($p = 0.012$) $< (\alpha = 0,05)$, then H_a , H_o accepted and rejected. It can be concluded that there is a relationship between Communication with the application of patient safety in the inpatient hospital.

The correlation coefficient test results from Spearman rank that the value = 0223 which means that the correlation between communication with the application of patient safety inpatient wards, shows the level relationship is weak, the direction is a positive correlation means the better the communication the better the application of patient safety by implementation nurses in an inpatient hospital.[6]

Communication is an exchange process of thought, feeling, opinion, and advice between two people who are working together.[7] Poor communication will make the process of the organization to achieve the goal. [8]. The result of the study agree with the theory from Mc Fadden et al (2009), it said that the degree of service implementation correlates with patient safety in which affect to the patient safety output in form of the frequency of incident genesis, perception, and caution of patient safety. [9]

The results of the relationships, teamwork, and communication with the application of the safety of patients by nurses inpatient wards

4. DISCUSSION

1. Teamwork With Patient Safety Implementation.

The test results from Spearman rank indicates that values ($p = 0.006$) $<(\alpha = 0,05)$, It can be concluded that there is a relationship of safety culture to the implementation of patient safety in the inpatient and indicates the level of relationship is with the direction of positive correlation means that the better the teamwork, the better application of the safety of patients by nurses in inpatient.

Teamwork in service at the Hospital may affect quality and patient safety.[10] Potential conflicts that may arise in team interactions may result in the implementation of teamwork in the service. Conflicts that arise can reduce the individual's

perception of teamwork, which can disrupt the service process and lead to the possibility of the occurrence of the incident[11]. A study shows the perception of individuals who lack the potential to greater teamwork to safety incidents occur.[12]

2. Communication With Patient Safety implementation.

Spearman rank test results showed that the value ($p = 0.012$) $<(\alpha = 0.05)$. It can be concluded that there is a communication link with the implementation of patient safety in the inpatient hospital and indicates the level of weak relationships with the direction of positive correlation means that the better the communication, the better application of the safety of patients by nurses in the room inpatient hospital.

Agency Health Research and Quality (2003) reveals communication problems such as the failure of verbal and nonverbal communication, miscommunication between staff, between shifts, communication is not well documented, it can lead to errors.[13] This study according to the AHRQ (2003) in Joint Comision Accreditation (2006) which states the cause of patient safety events that occur most often communication problems. Canadian Nurses Association (2004) specifies the communication is still the factor that hinders the implementation of nursing care that is safe for the patient. The nurse's role in patient safety namely maintaining the security of patients through the transformation of the nursing environment more supportive of patient safety. [14]

Variable	value		
	r count	z count	p-value
Relationship	0.440	4.899	0.000
Communication	0.223	2.483	0.012

the study teamwork has a correlation with the implementation of patient safety ($p=0,006$) and

communication has a correlation with the implementation of patient safety ($p=0,026$).

5. CONCLUSION

Teamwork by nurses in implementing patient safety is a variable that has a significant relationship with the implementation of patient safety. Communication by nurses in implementing patient safety is a variable that has a significant relationship with the implementation of patient safety.

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Expected results of this research be a benchmark to improve patient safety in hospitals.

REFERENCES

[1] N. P. S. A. (NPSA)., "Seven step to patient safety: the fullreference guide," *London.*, 2004.
 [2] Canadian Nurse Asosiation, "Nurses and patient safety: Discussion paper.," *Can. Nurse Assoc. Univ. Toronto Fac. Nurs.*, 2004.
 [3] A. Gunawan,I. & Mudayana, "Hubungan antara Pengetahuan, Sikap dan Motivasi dengan perilaku

pengunaan Alat pelindung Diri pada pekerja bagian produksi PT.Katingan Indah Utama, Kabupaten Kota Waringin Timur, Provinsi Kalimantan Tengah.," *Unnes J. Public Heal.*, vol. 5, no. 4, p. 336-347, 2016.
 [4] R. S. Tajuddin, I. Sudirman, and A. Maidin, "Faktor Penyebab Medication Error di Instalasi Rawat Darurat," 2012.
 [5] B. Ulrich and T. Kear, "Patient safety and patient safety culture: Foundations of excellent health care delivery," *Nephrol. Nurs. J.*, vol. 41, no. 5, pp. 447-456, 2014.
 [6] J. (2005). Blegen, M. A., Pepper, G. A., & Rosse, "Safety climate on hospital units: A new measure. Agency For Healthcare Research And Quality," 2015.
 [7] A. A. Mudayana, "Peran Aspek Etika Tenaga Medis dalam Penerapan Budaya Keselamatan Pasien di Rumah Sakit," *Maj. Kedokt. Andalas*, vol. 37, pp. 69-74, 2015.
 [8] N. A. Rokhmah and A. Anggorowati, "Komunikasi Efektif Dalam Praktek Kolaborasi Interprofesi Sebagai Upaya Meningkatkan Kualitas Pelayanan," *J. Heal. Stud.*, vol. 1, no. 1, pp. 65-71, 2017.
 [9] S. Elrifda, "Budaya patient safety dan karakteristik kesalahan pelayanan: implikasi kebijakan di salah satu rumah sakit di Kota Jambi," *Kesmas Natl. Public Heal. J.*,

- vol. 6, no. 2, pp. 67–76, 2011.
- [10] T. P. Astuti, “Analisis Penerapan Manajemen Pasien Safety Dalam Rangka Peningkatan Mutu Pelayanan Di Rumah Sakit Pku Muhammadiyah Surakarta Tahun 2013.” Universitas Muhammadiyah Surakarta, 2013.
- [11] L. A. Sulistiani, “Korelasi budaya keselamatan pasien dengan persepsi pelaporan kesalahan medis oleh tenaga kesehatan sebagai upaya peningkatan keselamatan dan kesehatan kerja di rumah sakit x dan rumah sakit y Tahun 2015.” UIN Syarif Hidayatullah Jakarta: Fakultas Kedokteran dan Ilmu Kesehatan, 2015, 2015.
- [12] I. A. D. U. Pidada and G. S. Darma, “Kerja Sama Tim Perawat Dalam Meningkatkan Keselamatan Pasien Berbasis Tri Hita Karana,” *J. Manaj. dan Bisnis*, vol. 15, no. 2, pp. 139–150, 2018.
- [13] D. E. Solehati and Y. D. Hastuti, “Hubungan Persepsi Supervisi dengan Perilaku Perawat dalam Menerapkan Patient Safety di Instalasi Rawat Inap RSUD Tugurejo.” Faculty of Medicine, 2017.
- [14] I. Hadi, *Manajemen Keselamatan Pasien (Teori Dan Aplikasi)*. Jogjakarta: Deepublish, 2017.