PATIENT SAFETY CULTURE IN DEALING WITH COVID 19 IN Dr. ISKAK HOSPITAL TULUNGAGUNG

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IN Dr. ISKAK HOSPITAL TULUNGAGUNG

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ABSTRACT

COVID-19 is a deadly contagious disease. This bad condition has a huge impact on patient safety, to put health workers as a priority, it is hoped that it can reduce and break the chain of the spread of Covid-19 and be able to provide optimal service to patients. In this Covid-19 pandemic situation, prevention and control of infection are truly maintained.There are five important components related to patient safety in the hospital. Patient safety is influenced by how the individual culture and systems that run within the organization. The purpose of this study was to analyze the patient safety culture in Dr. Iskak Tulungagung. This study used an analytical observational research design. The data were taken using the AHRQ (Agency Health Research and Quality) questionnaire. The subjects of the study were all employees in all units who had direct or non-direct contact with patients as many as 475 samples. The results showed the highest dimension of response. the positive is the organizational learning dimension (91.79%) and the lowest dimension is staffing (60.89%). For statistical results using SEM, it was found that the patient safety culture at the unit level had a direct effect on the patient safety culture at the hospital level (0.382), the patient safety culture at the hospital level had a direct effect on the Patient Safety Incident Report (1.675) but the patient safety culture at the hospital level. unit level has no significant effect on the Patient Safety Incident Report (-0.337). Obstacles encountered in implementing patient safety culture are the low awareness of reporting due to fear of being scolded and given sanctions. Recommendations given are the formation of a KPRS team (Hospital Patient Safety), education and monitoring evaluation.

Keywords: patient safety culture, covid 19, hospital,

I. PRELIMINARY

The COVID-19 pandemic has caused many hospitals around the world to experience difficulties both in terms of management and infrastructure in providing services because the number of patients has increased in a short period of time. COVID-19 is a deadly infectious disease with time from the start of the disease to becoming severe in one week .. The patient may experience system failure acute breathing and requires special facilities and infrastructure such as ICU, special isolation rooms, oxygen or ventilators. This bad situation has a huge impact on patient safety, especially if the hospital does not strictly enforce the Disaster Management Plan in the hospital (Hospital Disaster Plan, HDP), a mechanism and procedures for dealing with a pandemic in hospital services

At normal capacity for hospitals in developed countries, 1 in 10 patients have the chance to experience a patient safety incident, for example a fall patient, wrong side surgery, wrong patient operation, medication error or other incidents while undergoing hospitalization. The safety of services will be greatly affected by

compliance of health workers and patients with procedures, availability of standard personal protective equipment (PPE), standardized training, and understanding of health workers on COVID-19 handling protocols. Meanwhile, service effectiveness is greatly influenced by the availability of infrastructure, the accuracy of handling and treatment, which for the COVID-19 case is very time-consuming.

Patient safety is at the core of quality health care. To achieve this, a strong individual and team commitment is required. The combination of various elements in the hospital together results in a high risk situation. To be able to understand the risks involved in a complex process in medical / health care, information is needed about various cases of error and near miss that have and can occur. From there we can learn to close the existing gaps, reduce morbidity and mortality to achieve the expected quality of service (WHO Patient Safety Curiculum, 2011).

At present, efforts to improve the quality of services and improve patient safety efforts in hospitals have become a universal movement. Various developed countries have even shifted the "quality" paradigm towards a new quality-safety paradigm which means not only improving the quality of service, but more importantly maintaining patient safety consistently and continuously. Safety has become a global issue including for There are five important issues related to safety in hospitals and patient safety is one of them. These five aspects of safety are very important to be implemented in every hospital. However, it must be admitted that hospital institutional activities can run if there is a patient,

Efforts to improve safety in patient care are becoming a global movement. This has led to a tremendous transformation in the perspective of patient safety. However, the current state of patient safety around the world is still a cause for concern. By collecting data on the causes of errors and adverse events or unexpected events (KTD) that are getting better, it is increasingly clear that unsafe services are a real picture of every aspect of health services (Donaldson, in WHO Patient Safety Curiculum, 2011)

Every organization has a culture that can have a meaningful influence on the attitudes and behavior of its members. The competence and values of staff and leaders play a key role in determining the effectiveness and success of the organization (Lunenburg, 2011). Patient safety is influenced by how individual culture and systems are affected. running within the organization. So that a personal / individual approach must be made as well as the management system within the institution. The safety culture in various industries is growing very rapidly. The number of work accidents has decreased because it is supported by the awareness of the importance of the value of safety in the organization, but in medical practice the patient safety program has only been exhaled widely after external coercion (Cahyono, 2012)

In an effort to minimize the occurrence of adverse events related to patient safety aspects, hospital management needs to create a patient safety culture that must be implemented in the entire scope of the hospital. AHRQ (Agency Health Research and Quality) suggests that patient safety culture consists of 12 dimensions (Sohra, 2018). This study aims to describe the patient safety culture

for each dimension of patient safety culture in each work unit and to determine the direct and indirect effects on reporting patient safety incidents in Dr. Iskak Tulungagung

II. RESEARCH METHODS

The design in this research is analytic observational, which is an observational study (survey) that tries to find a description of the variables without intervening with the research target (Setiadi, 2007). This research is done by observing and measuring variables in a certain time. Measurement of unlimited variables must be on time at the same time, but it means that each subject is only subjected to one measurement, without any follow-up or repeated measurements (Saryono & Anggraeni, 2012).

The population in this study were all employees of RSUD Dr. Iskak Tuluangagung, regardless of employment status, consists of the Public Service Agency (BLU) of Civil Servants (PNS), BLU non PNS and PPPK with a total of 1487 people.

The sample size is calculated based on the Slovin formula with a smaller margin of error to obtain more precise survey results. The sample size estimation of this research uses the formula for descriptive data. By using the value of α (level of significance) = 0.5, the population size is 1487 and taking into account the response rate of 90%, an estimate of the sample size is 475 people. The sample of this study was taken using probability sampling (random method) with a proportionate cluster random sampling technique because the population has members / elements that are not homogeneous. Statistical analysis uses SEM. In multivariate statistical analysis using the Structural Equation Modeling method or better known as SEM using assistance AMOS program. SEM is a statistical modeling technique that is highly cross-sectional, linear and general in nature. Included in this SEM are factor analysis, path analysis and regression

III. RESULTS AND DISCUSSION

A. Respondent Characteristics

From the results of this study it was found that:

Table 1. Respondent Characteristics

No.	Characteristics	Total	%
1.	Age		
	a. ≤ 20 years	2	0.4
	b. 21 - 44 Years	393	80.4
	c. 45 - 59 Years	78	16
	d. ≥ 60 years	2	0.4
2.	Last education		
	a. SD	3	0.6
	b. Junior High	2	0.4
	c. High school	54	11.4
	d. Diploma	235	49.5
	e. Bachelor	174	36.6
	f. > S2	7	1.5
3.	Respondent Position Characteristics		
	a. Doctor	7	1.5
	b. Nurse	241	50.7
	c. Pharmacist	13	2.7
	d. pharmacist assistant	25	5.3
	e. Nutritionists	14	2.9
	f. Admin / Management	48	10,1
	g. Physiotherapist	4	0.8
	h. Lab Analyst	17	3,6
	i. Technician	7	1.5
	j. Radiographer	4	0.8
	k. security	7	1.5
	l. Others	88	18.6

No.	Characteristics	Total	%
4.	Period of service at Dr. Isaac		
	a. <1 year	7	1.5
	b. 15 years	187	39.4
	c. 6 - 10 years	120	25.3
	d. 11-15 years	81	17.1
	e. 16-20 years	37	7,8
	f. > 20 years	43	8.8
5.	Period of Work in the Profession		
	a. <1 year	8	1.7
	b. 15 years	178	37.5
	c. 6 - 10 years	100	21.1
	d. 11-15 years	88	18.5
	e. 16-20 years	54	11.4
	f. > 20 years	47	9.9
6.	Position		
	a. Managerial	10	2.1
	b. Staff	395	83.2
	c. Non Staff	70	14.7
	Employment status		
	a. Civil servants	216	45.5
	b. Contract	259	54.5
7.	Hours Worked Within 1 week		
	a. <20 hours	8	1.7
	b. 20 - 39 hours	170	35.8
	c. > 40 hours	297	62.5
8.	Interaction with Patients		
	a. Interact	358	75.3
	b. Not Interacting	117	24.6

From this survey, it was found that the characteristics of respondents who were dominated by women and in the range of young adults at the productive stage were considered beneficial for the organization, where according to Setiowati women were better at implementing a patient safety culture than men (Rolinson, 2001). young a person has the peak development of his physical condition. At this stage, individuals try to form a more stable and stable life structure (Lubis, 2011).

The characteristics of the workforce status are related to organizational culture, Sukasih and Suharyanto in their research found that the discipline / compliance of officers in carrying out the time out procedure had a significant relationship with patient safety (Robbins, 2011). Bird states that one of the reasons staff did not report incidents was There is a feeling of fear (Setiowati, 2010). This fact is also corroborated by research (Fung, et al., 2012) and the results of a preliminary study where nurses generally express reluctance to report an incident for fear of being scolded by their superiors if an incident is known. This situation is related with a culture of seniority and high loyalty to superiors.

Setiowati stated that tenure is positively and weakly related to the application of patient safety culture. A person's work experience is related to performance which is supported by an opinion which states that there is a significant relationship between the tenure of executive employees and work culture.

The results of patient safety training that are attended by almost all nurses are a form of anticipation for the driving force faced by individuals and at the same time minimizing resistance factors that can hinder changes in patient safety culture (Safitri, 2012). Changes in service towards patient safety-oriented services are related to the driving force in the form of intellectual and managerial skills regarding patient safety generated by patient safety training that nurses accept with reluctance to carry out patient safety-oriented services.

Respondents who participated in this study came from all components of the work unit in the hospital, whether they are

directly related to patients or not. In accordance with the proportions based on profession, of the 475 respondents the most professions are nurses (Wijono, 2012). This is consistent with research conducted in China (Nie Y et al, 2013), Taiwan (Chie C, 2010) Cairo (Abdoul Futuh, 2012) and Iran (Davoodii, 2013) which also have more specific respondents, namely employees who provide services. directly to patients such as nurses and doctors who work daily from every element in the hospital, including the leadership, service implementers and support staff. The Institute of Medicine (IOM) states that the biggest challenge in moving change towards a safer health care system is changing the culture of patient safety, where an error is seen as an opportunity to improve the quality of care and prevent patient safety incidents. In response to IOM's recommendations, since 2006 health service providers have begun to focus on safety culture in their work units. The first step is to establish the status of safety culture in hospitals). The concept of patient safety culture is defined as a product of the values, attitudes, perceptions, competencies and behavior patterns of individuals and groups that will affect the commitment and ability of the organization to manage safety management. Positive culture has been associated with improved patient safety. since 2006, health care provider organizations have begun to focus on safety culture in their work units. The first step is to establish the status of safety culture in hospitals). The concept of patient safety culture is defined as a product of the values, attitudes, perceptions, competencies and behavior patterns of individuals and groups that will affect the commitment and ability of the organization to manage safety management. Positive culture has been associated with improved patient safety. since 2006, health care providers have begun to focus on safety culture in their work units. The first step is to establish the status of safety culture in hospitals). The concept of patient safety culture is defined as a product of the values, attitudes, perceptions, competencies and behavior patterns of individuals and groups that will affect the commitment and ability of the organization to manage safety management. Positive culture has been associated with improved patient safety. competencies and patterns of individual and group behavior that will affect organizational commitment and ability to manage safety management. Positive culture has been associated with improved patient safety. competencies and patterns of individual and group behavior that will affect organizational commitment and ability to manage safety management. Positive culture has been associated with improved patient safety.

1. **Reporting Culture**

   a. An understanding of the incidents reported

The assessment result for the dimension of incident reporting frequency is 66%, while the target for this dimension is 75%. This means that the target value has not been achieved, the frequency of incident reports needs to be considered and monitored. Based on the results, the highest value is in D4, namely the understanding of Potential Injury Conditions (KPC), which reaches 73.68%. Meanwhile, the lowest understanding was D2

about the incidence of injury, which was 57.47%. This means that respondents should understand that the incidents that must be reported are not only KNC but also KTC

b. An understanding of the incidents reported

Based on the data there are no incident reports per year. This figure raises speculation whether there were indeed no incidents or incidents but there were no reports. "Incidents in the unit had the highest percentage, namely 69%. Then followed by 1-2 reports with a result of 16%. Meanwhile, the lowest reported incidence rate was> 11 reports.

The low value of the reporting frequency dimension when an incident occurs is supported by data regarding the low number of incident reports during the last 12 months. As many as 41% of respondents said they had never reported a patient safety incident. A low reporting culture was also found in research conducted in Saudi Arabia (Alahmadi, 2010) which was 43%, in Iran as much as 53% (Davoodii, 2013) and in Turkey as much as 84%. (El Jardali, 2014) states that the fear of reporting is an obstacle to the formation of a positive culture. An environment where employees feel free and confident in reporting incidents will increase the maturity of a unit in providing patient-centered services. (WHO, 2008) explains that the three dimensions of culture are fair culture,

c. The level of patient safety in the unit

Based on patient safety data, each unit has a very good level of 60.2% and the second with an acceptable level of 37.3%.

2. Just Culture

a. Non-punitive response to the occurrence of errors

The reliability of this dimension is 67%, while the target in this dimension is 75% which means that the target value has not been achieved, the non-punitive response to the occurrence of an error needs improvement. From the data, 51.16% of respondents gave a positive response to the statement of reversion A16 This means that there are still many respondents who expressed concern that their mistakes would be recorded in their personal files. This result is related to the low number of incident reporting. This is because not all employees in Dr. Iskak understands the purpose of reporting patient safety incidents. It requires written regulations / commitments that reporters of patient safety incidents do not get a penalty. Meanwhile, the highest positive response was obtained by the A8r reversion statement (74. 74%) which is about employees' feelings that mistakes made by employees will be used to blame them. This shows that employees do not understand the incident report, which focuses more on the

problem so that it does not happen again, not to find the subject of the wrongdoer. This fact shows that there are still a small proportion of respondents who prefer to talk about people who made mistakes than discuss the mistakes they did and feel doubtful. -Doubt about the focus of the discussed orientation if there are errors in service. Continuously talking about individuals who make mistakes will have an impact on the emergence of feelings as the accused in that individual which will cause distress and feelings of failure (Yulia, 2010). From the description of the respondent's answer, it shows that the respondent feels the impact of the punishment in the form of anger from the boss or the feeling of being threatened by his personal integrity if something goes wrong even though it is not intentional. This situation needs attention because based on the research results that the response not to punish / blame gives statistically different results on the implementation of good service (Beginta, 2012).

3. Flexible Culture

a. *Teamwork* in the hospital unit

From the data, it was found that all inpatient services were in the "Good" category, but for the service element the highest value of the IKM was in the ICU 1 room related to facilities and infrastructure with a score of 89.17 which was in the "Very Good" category. The reliability of this dimension is 88%, while the target achievement in this dimension is 75%, meaning that the target value has been achieved, teamwork in the hospital unit needs to be maintained or even improved so that it runs well again. picture.

The data on the graph shows that the aspect that gets the lowest positive response is helping between areas within a busy unit. It can be seen that statement no. A11 only shows 68.84% of respondents who responded positively. Cooperation only occurs if there is a common interest in the unit, but there is no cooperation between areas within the unit because they feel that the areas already have their respective responsibilities. Meanwhile, the most positive responses were in statement number A1 (95.16%), namely employee support in the unit.

In addition to the dimensions that have not reached the standard number, the results of this survey indicate that RSUD Dr. Iskak has strengths that can be used as capital in making improvements in patient safety culture. It is the dimensions of staff cooperation within one unit and between units in the hospital, management support for patient safety efforts and continuous improvement that must be optimized. The similarity of goals shared by most of the respondents illustrates that as a work team they have a high sensitivity and willingness to help each other in providing care. This

is one of the characteristics of an effective team, while an effective work team is the backbone of an organization's success. (Smits, 2009) states that the patient safety culture in the work unit is the main factor that describes the safety culture in the hospital and the high and low incidence of patient safety. The dimensions that describe the culture of the hospital management level are only three, namely, cooperation between units, placement of efforts to improve patient safety. The rest of the other dimensions describe cultural activities in the work unit.

b. *Staffing*

Based on there, two aspects of the staffing dimension that still get a low positive response value are the statement reversion No. A5r (46.74%) regarding unit employees working with a longer time than normal time for patient care as well as the statement reversi no A7r (56%) about units using more than normal personnel for patient care: This could indicate that they feel short-staffed and time to handle too many patients. This can affect the results of service performance and patient safety. The reliability of this dimension is 61%, while the target achievement in this dimension is 75%, meaning that the target value has not been achieved, the staffing dimension requires improvement. Aspects of the staffing dimension that still need improvement can be seen in the graph.

The lowest score of all dimensions is regarding staffing. This means that almost all respondents stated that staff allocation and placement were inadequate when compared to the workload of handling patients safely, which can be seen from the ratio of patients, employees are not balanced. Similar results were obtained in studies in China and Taiwan.

c. Openness of Communication

The high involvement of nurses in discussions and rounds with superiors illustrates that the level of staff participation is quite high. Fitriani said that in an organization that must continue to develop, it requires high creativity in its management, the support and involvement of employees plays a big role. This is because the advice and input and information provided by staff will influence leadership decision making (Amanullah, 2014)

The assessment result for the openness of communication dimension is 65%, while the target achievement in this dimension is 75%, meaning that the target value has not been achieved, communication openness in the unit needs to be improved or needs to be improved. Based on the data, it can be seen that the employee aspect is free to speak if he sees something that has a negative impact on patient service get the lowest positive response value, namely 58.74%. Likewise with the

statement that employees are free to question decisions made by their superiors. This means that some respondents in the unit feel that there is no disclosure of information about the unit's decision.

Most respondents feel they have the freedom to express their opinions and discuss if there is something negative or negative impact occurs on the patient while doing treatment. The opportunity to express opinions and discuss will support the analysis of the root of the problem and to find appropriate solutions. Experiencing success in managing an incident will increase the confidence of professionals and help prevent the incident from recurring (Lestari, 2013). Lestari in her research found that statistical openness of communication gives different results on the implementation of good service (Mulyana, 2013).

d. *Teamwork* between units in the hospital

From the table it can be seen that the aspect no. F2r has the lowest value, namely 76.63%. This aspect decreases when compared to the previous survey (86%). The results of the assessment for the teamwork dimension between units in the hospital are 85%, while the target achievement in this dimension is 75%, meaning that the teamwork dimension between units in the hospital has more than met the target.

e. *Handoffs* and Shift Changes at the Hospital

The high involvement of nurses in discussions and rounds with superiors illustrates that the level of staff participation is quite high. Fitriani said that an organization that must continue to develop requires high creativity in its management and support. The results of the assessment for the dimension of handoffs and turnover at the hospital are 74%, while the target achievement in this dimension is 75%, meaning that the target value is almost achieved, the dimensions of handoffs and shift changes at the hospital need to be improved. From the data it is obtained that the survey results (No. experienced a significant decrease when compared to the results of the previous survey (78.90%), and only part of the respondents felt that the exchange of information between units and transfer of patients between units was still a frequent problem.

4. Learning Culture

a. Expectations and activities of superiors that support patient safety.

The assessment results for the expectation dimension and supervisor / manager activities that support patient safety are 82%, while the target achievement in this dimension is also 75%, meaning that the expectations and activities of the supervisor / manager that support patient safety have met the criteria and need to be maintained.

It can be concluded that superiors in the unit are considered to have influenced the strategies and efforts to move other staff within the scope of their authority to jointly implement a patient safety culture.

From the research results, it can be seen that only some respondents feel that when the workload is high, managers or supervisors ask to work fast even though they take shortcuts, this can be seen from the lowest positive response, namely 72.00%. This is certainly very stressful for employee work, which could be with such a thing that patient safety is neglected. This problem must be resolved immediately.

b. Hospital management support

The assessment results for the dimensions of hospital management support for patient safety are 85%, while the target achievement in this dimension is 75%, meaning that the dimensions of hospital management support for patient safety exceed the target and must be maintained.

Based on the research results, the aspect that still needs improvement is the perception that management only cares about patient safety after an adverse event. This is because not all employees know that the management has committed to prioritizing patient safety, because the training activities and patient safety outreach have not covered all employees. This also indicates that tiered socialization has not yet been carried out, because the officer (head of the unit) who received training and dissemination of patient safety did not inform the results of the training / socialization to other officers in his unit.

c. Communication and feedback

Based on the results of the study, it can be seen that the results of the assessment that have the lowest positive response are in the statement that unit employees get feedback about changes made on the basis of the incident report results of 67.11%. This indicates that the communication and feedback from incident reporting have not been comprehensive.
The results of the assessment for the dimensions of feedback and communication about errors are 73%, while the target achievement in this dimension is 75%, meaning that feedback and communication about errors have not met the target.

In this survey, the results showed that the percentage of communication and feedback on patient safety culture was still 73% and it had not reached the target. Where employees in the unit have not received feedback on changes made based on the results of the incident report. In a culture of truth in patient safety, communication must occur in a two-way fashion from leadership to frontline personnel, and vice versa. Likewise, silence against mistakes

must be replaced by openness, honesty about events that involve patient safety. Reporting and compliance with safety procedures are parameters that can be used as benchmarks for effective safety communication as well as an important element in realizing safe services and leading to a culture of safety (Salim 2006)

d. Organizational Learning

Kim argues that organizational learning emphasizes the use of the learning process at the individual level to transform the organization in various ways that can increase stakeholder satisfaction (Absah, 2008). If the organization employs people who have certain competencies and knowledge obtained from their work or from formal education, the organization will benefit from the various activities of these educated individuals.

Based on the data, it can be seen that the lowest positive response is obtained by the statement of the unit error that occurs is used to make changes towards a positive, which is 91.37%. This cannot be ignored because each unit must contribute to improving its performance to simultaneously create patient welfare.

The assessment result for the organizational learning dimension - continuous improvement is 92%, while the target achievement in this dimension is 75%, meaning organizational learning - continuous improvement meets the target and needs to be maintained.

Mental models and team learning that are positively illustrated by almost all respondents benefit the organization because a positive mental model allows humans to work more quickly (Hikmah, 2010) while team learning shows the ability to have insight into thinking about important issues, abilities to act in innovative and coordinative ways and the ability to play different roles on different teams.

e. General perception

Perceptions of patient safety culture appear to correspond to the total score at the hospital. In the study, the sub-analysis was taken, there were only work units that were directly related to patients, all of which were under the Directorate of Medicine and nursing. With a value range of 75.79%, it means that the positive culture in the unit has achieved the target but is still very minimal, so it needs more supervision and improvement. The relationship between staff and superiors appears to be poor, as seen from the low positive value on open communication and non-punitive responses when errors are found

The assessment results for the perception of patient safety in general are 76%, while the target achievement in this dimension is 75%, meaning that the perception of patient safety in general has exceeded the target.

Based on the results of the study, it can be seen that the aspect that received a little positive response was the A10r statement, only 59.79% of respondents stated that they did not agree that it was only a coincidence that there was no serious incident in the unit. This means that they feel that their unit still has the potential or space for a serious patient safety incident to occur.

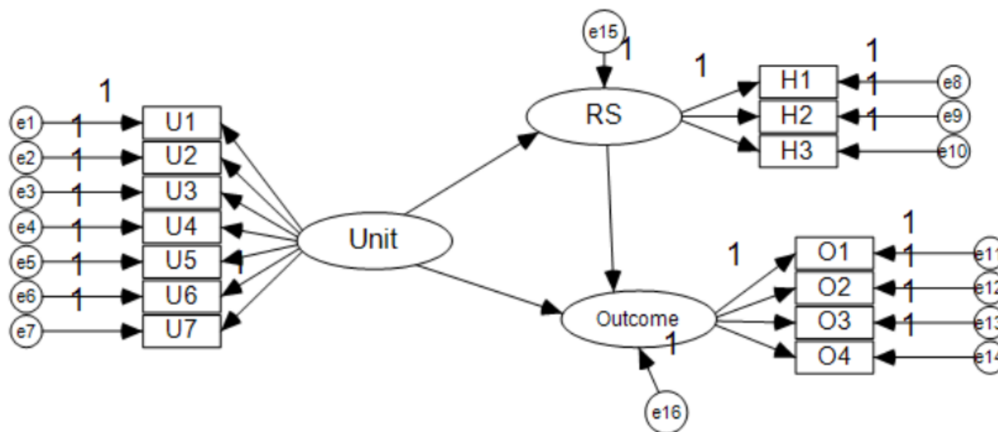
Only 74.74% of respondents do not agree that in their unit there are many patient safety problems. This means that some employees have the perception that patient safety problems still occur. This allows for many incidents that the unit has not reported to the Patient Safety Committee

The analysis between the patient safety culture survey variables used SEM analysis. Each variable was analyzed multivariate with other variables,

B. Analysis of the Dimensions of Organizational Culture and Patient Safety Culture

Efforts to improve the quality of services in the hospital will be very meaningful and effective if patient safety is the daily work culture of every element in the hospital, including leaders, service implementers and support staff. The Institute of Medicine (IOM) states that the biggest challenge in the movement to change towards a safer health care system is changing the culture of patient safety, where a mistake is seen as an opportunity to improve the quality of care and prevent patient safety incidents. In response to IOM's recommendations, since 2006 health service providers have begun to focus on safety culture in their work units. The first step is to establish the status of safety culture in hospitals). The concept of patient safety culture is defined as a product of the values, attitudes, perceptions, competencies and behavior patterns of individuals and groups that will affect the commitment and ability of the organization to manage safety management. Positive culture has been associated with improved patient safety.

The analysis between the patient safety culture survey variables used SEM analysis. Each variable was analyzed multivariate with other variables, so that the following model was obtained:



Picture 1. SEM Analysis Model

Efforts to improve the quality of services in hospitals will be very meaningful and effective when patient safety becomes a culture

The results of the SEM analysis are as follows

1. Unit culture has a direct effect on RS Culture with a parameter coefficient of 0.382 with a CR of 4.827 which is greater than T-table = 1.96 or the significance of p = 0.000 which is smaller than α = 0.05.
2. Hospital culture has a direct effect on outcome with a parameter coefficient of 1.675 with CR
3. of 2.995 which is greater than T-table = 1.96 or the significance of p = 0.002 which is smaller than α = 0.05.
4. Unit culture has no significant effect on the outcome with a parameter coefficient of -0.337 with a CR of -1.425 which is smaller than T-table = 1.96 or the significance of p = 0.154 which is greater than α = 0.05.

The results of this survey state that the patient safety culture in the unit affects the safety culture at the hospital level, this is because all medical actions are handled in the unit, so that when that culture has been properly implemented in each unit there will be a patient safety culture in the hospital. Of course this is to build a better patient safety culture in the unit, there needs to be positive influence or support by effective leadership. One of the scope of leadership in the unit is the head of the room. The head of the ward will be able to influence strategies and efforts to mobilize nurses or other staff within the scope of their authority to jointly implement a safety culture

CONCLUSION

The results showed that the employees of Dr. Iskak has a sufficient working period in the hospital and in the unit according to his respective profession. With 40 hours of work or more a week in serving patients directly, selected respondents are considered eligible as samples to represent the employee

pulation at RSUD Dr. Iskak in assessing patient safety culture in 2020.

The total value of a positive culture in Dr. Iskak is 65.97% which means that the patient safety culture is not good. These results are supported by the data of each dimension. Of the 13 dimensions measured, only six had a positive value> 75%, namely the teamwork aspect within the unit, teamwork between units in the hospital, superiors' expectations that support patient safety, hospital management support, organizational learning and perceptions of safety culture as a whole. Meanwhile, the dimension that has very little value is staffing.

SUGGESTION

1. Held a re-launching of the "Patient Safety Culture" movement at Dr. Iskak Tulungagung with the aim of equalizing perceptions and unifying steps to cultivate patient safety as a work culture.
2. Conducting socialization again about Patient Safety Culture "at RSUD Dr. Iskak Tulungagung through various media at the hospital.
3. It takes a role model for employees that reporting this incident is not as scary as imagined by employees.
4. Enabling clinical audits and medic audits on a regular basis to minimize patient safety incidents.
5. Make regular assessments and give awards to work units that actively provide patient safety incident reports, as well as promulgating them in the information media in the scope of Dr. Iskak Tulungagung.
6. Re-evaluate staffing more carefully according to staff competence and unit workload.
7. Provide regular patient safety training programs in the hope that employee understanding can be better.
8. Revise patient safety guidelines by adding a commitment that there are no penalties for reporting patient safety incidents.
9. Patient safety culture must be implemented properly in accordance with the SOP in order to avoid patient safety incidents, for that employees should focus more on optimal patient care
10. Save and keep the report confidential even if for discussion, do not mention which unit to reduce the gap between units.
11. There is socialization to the patient's family so that they can collaborate in caring so that the family and employees can help each other to create patient safety.

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