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The Relationship Of Organizational Climate And Nurse Handover To Patient Safety Incidents In Porsea General Hospital Items

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Abstract

Nurses as one of the largest human resources in hospital health care institutions have an important contribution in providing nursing care. Health services can be at risk of causing patient safety incidents. This condition can be caused by the quality of the organizational climate and the ineffective implementation of handovers. The purpose of this study was to analyze the relationship between organizational climate and nurse handovers on patient safety incidents in the Porsea Hospital Inpatient Room. Analytical descriptive research design with a cross sectional approach. The sample is 45 nurses using purposive sampling. Chi Square test results obtained p-value = 0.868 There is no significant relationship between organizational climate with patient safety incidents and p-value = 0.005 There is a significant relationship between handovers and patient safety incidents. Hospitals need to pay attention to the rights of nurses, such as the issue of unequal pay and conduct ongoing evaluations of the organizational climate and the effective implementation of handovers.

Keywords: Handover, Organizational Climate, Patient Safety Incidents

INTRODUCTION

Nurses as one of the largest Human Resources in hospital health service institutions have an important contribution in providing nursing care. In the delivery of hospital services, nursing staff as the majority staff with a total of 50-60% have a contribution and role in caring for and being by the patient's side 24 hours a day (Purwanti, 2017). Hospital services for patients with good quality are determined by whether or not reliable resources are good. The performance of a nurse can be seen from several elements. Aspects of nurse performance levels can be grouped as: individual abilities, level of effort given, and organizational support (Sari & Suryalena, 2017).

The level of effort in the performance of nurses can be perceived as an effort to meet the high community needs for health services which causes nurses to expend a lot of energy. Research conducted by Astuti et al., (2017) regarding workload with fatigue explained that as many as 29 nurses with very high mental workload of 82.9% experienced moderate and severe category work fatigue more than 12 nurses with mental workload high category of 52.2%. This is due to the stressors that nurses get apart from the demands of the task but also from the head of the room, often the task of nursing care is delegated from senior nurses to junior nurses, and providing nursing actions to patients with various psychiatric conditions making it very difficult to communicate properly. Nurses who experience fatigue will have an impact on the quality of health services provided.

Nurse performance that is not optimal can result in unexpected events. Research conducted by Triwijayanti et al., (2020) found that out of 57 total respondents, 56.1% of nurses' performance was classified as not good, so the resulting performance was not optimal. The results of Fatimah & Rosa's research (2016) stated that medication administration errors based on correct principles were included in the bad category, namely in patients where the error was 59.4% due to non-optimal nurse performance.

An organization experiences different working environment conditions. These environmental conditions affect the views and attitudes of individuals within the organization, such as attitudes towards superiors, co-workers and jobs. Circumstances directly or indirectly that can be felt by members in the work environment are considered capable of influencing the behavior of organizational members called organizational climate (Runtu, 2018). Research conducted by

Aristiawan & Dirdjo (2017) entitled "Relationship of Nurse Knowledge About Patient Safety and Organizational Climate with Measures to Prevent the Risk of Falling Patients at X Samarinda Hospital" found that 32.3% of the organizational climate was not good and most of the organizational climate was good 67.7%, that is, there is a relationship between organizational climate and prevention of the risk of falling patients, which is (OR = 14.250). The OR value means that nurses with a good organizational climate have 14 times the chance of taking action to prevent high-risk patients from falling compared to nurses with a bad organizational climate where in these actions there is an influence from communication between the health team.

Effective communication in nursing services creates patient safety in hospitals. Serious errors in patient care indicate that about 80% are due to communication problems during patient handovers (Joint Commission Center for Transforming Healthcare, 2010). The transfer of information and responsibilities from one health care provider to another at the time of shift change is known as patient handover (Triwibowo et al., 2016)

Handover activities still need serious attention in maintaining patient safety. Research by Triwibowo et al., (2016) found that 46.8% of the handover implementation was not good. Handovers that are not carried out properly, the actions to be given can cause problems due to the lack of information received as a basis for providing nursing actions (Nindi et al., 2017). Ineffective handovers can affect safety errors including medication errors, surgical errors, and patient death (Sulistyawati et al., 2020).

Based on the Regulation of the Minister of Health of the Republic of Indonesia number 11 of 2017 that patient safety as a system in implementing health care for patients is safer. The implementation consists of risk assessment, identification, reporting, incident analysis, ability to follow up on incidents, and implementation in a way to prevent and minimize the risk of injury resulting from errors in implementing actions or taking actions that are not supposed to. Every incident that is unintentional has the potential to cause preventable injury to patients called patient safety incidents (Ministry of Health of the Republic of Indonesia, 2017).

Based on data from Patient Safety Incident Reports in Indonesia in 2019, it was found that the percentage of types of incidents reported was 38% near misses (KNC), 31% non-injury (KTC), and 31% unexpected events (KTD) (National Patient Safety Commission (KNKP), 2020). Data on patient safety incidents from the Porsea Hospital Patient Safety team in 2022 found 8 near misses (KNC), 4 unexpected events (KTD), 2 non-injury (KTC) events, and potential injury conditions (KPC)) for 1 event.

One of the goals of patient safety is to reduce unwanted events (KTD) which are part of patient safety incidents. Therefore, hospitals must implement a patient safety culture (Najihah, 2018). The safety culture adopted by an organization is the result of values, attitudes, perceptions, competencies and behavior patterns that can form a commitment to patient safety (Agency for Healthcare Research and Quality, 2016). There are factors that influence the development of safety culture, namely individual and organizational attitudes, leadership, teamwork, communication, and workload (Mulyati et al., 2016).

The results of a preliminary study conducted by researchers at Porsea General Hospital based on interviews found 6 nurses (100%) experienced changes in the work environment, namely an organizational structure that was too rigid. Most other things are like the awards given from the hospital, namely rewards that don't match the workload. When carrying out the handover there are external factors such as disturbances which are time-consuming and this creates obstacles and impacts on the provision of inaccurate information.

Based on the description above, researchers want to conduct research on the Relationship between Organizational Climate and Nurse Handover on Patient Safety Incidents at Porsea Hospital.

RESEARCH METHODS

The research design used descriptive analytic with a cross sectional approach. The independent variables in this study are organizational climate and handover and the dependent variable is patient safety incidents. The research location was in the inpatient room of RSU Porsea. The research sample was nurses in the inpatient room of RSU Porsea totaling 45 nurses. The sampling technique used is purposive sampling, namely the sampling technique with consideration of specific aims and objectives. Data analysis used univariate analysis and bivariate analysis used the chi square test. The data collection instrument was a questionnaire containing organizational climate statements adopted from (Rani, 2017), handover statements from (Plunkett, 2015) adopted by (Dewi, 2016) and patient safety incident statements adopted by (Aisyah, 2019) with statements using a Likert scale. Respondents in filling out the questionnaire were asked for prior approval by filling out informed consent.

RESULTS AND DISCUSSION

Table 1 Distribution of Characteristics of Nurse Respondents in the Inpatient Room of RSU Porsea (n=45).

Variable	Frekuency	Persentase
Age		
< 30 years	11	24,4%
≥ 30 years	34	75,6%
Gender		
Man	3	6,7%
Woman	42	93,3%
Education		
D3	23	51,1%
S1.Ners	22	48,9%
years of service		
< 5 years	10	22,2%
≥ 5 years	35	77,8%

Based on Table 1, most of the 45 nurses were nurses aged ≥ 30 years, with a total of 34 nurses (75.6%), and some nurses aged <30 years, namely there were 11 nurses (24.4%). The results of the research are in accordance with Aisyah (2019) found that 20 respondents were mostly aged ≥ 30 years while a number of 8 respondents were aged < 30 years. Research conducted by Deciliawati, (2019) found that 21 respondents were mostly aged ≥ 30 years and 5 respondents aged <30 years. This is in accordance with Anggoro et al., (2019) that age greatly influences a person's level of maturity and behavior. Respondents with increasing age in accepting a job will also increase in terms of responsibility and experience in carrying out their duties.

The results showed that of the 45 respondents, most were female with 42 nurses (93.3%), while male with 3 nurses (6.7%). The results of the study are in accordance with Agritubella et al., (2017) in their conclusion showing that 82.9% of the majority of nurses in the hospital are women. This is in line with Aisyah's research, (2019) where there were 4 male respondents (14.3%) and 24 female respondents (85.7%). It can be concluded that the community has a view of the work of nurses that is in accordance with the soul of women in caring for. It takes patience, patience, and compassion in the work of nurses. Surahmat et al., (2019) stated that gender does not affect the ability to learn and act. There is no difference between men and women in carrying out patient safety because they have the same responsibilities.

The results showed that of the 45 respondents, the majority of nurses in the inpatient ward had D3 Nursing education, there were 23 respondents (51.1%) and 22 respondents (48.9%) had a Bachelor's degree in Nursing education. The results of the study are in accordance with Agritubella et al., (2017) in their conclusion showing that half of the nurse's education of 56.1% is D3 Nursing. This is in line with Deciliawati's research, (2019) which found 21 respondents (80.8%) had a Diploma in Nursing education and 5 respondents (19.2%) had a professional education. This is because the course time for lectures is short compared to the time taken for academic or professional education. Based on Nursing Law no. 38 of 2004 concerning Nursing stipulates that the minimum vocational education is D3 Nursing.

The results showed that of the 45 respondents, most of the 35 respondents (77.8%) had worked with a working period of ≥ 5 years and there were 10 respondents (22.2%) with a working period of < 5 years. The results of the study are in accordance with Deciliawati, (2019) found (34.6%) with a working period of < 5 years and (65.4%) with a working period of ≥ 5 years. This is in line with Rani's research, (2017) which found (38.8%) with a working period of < 5 years and (61.2%) nurses with a working period of ≥ 5 years. The long working period increases the experience of nurses in providing nursing care and holds a high commitment to being in the work environment.

Table 2 Distribution of Organizational Climate, Handover, and Patient Safety Incidents in Inpatient Rooms at RSU Porsea (n=45)

Variable	**Frekuency**	**Persentase**
Organizational Climate		
Open	22	48,9%
Closed	23	51,1%
Handovers		
Effective	23	51,1%
Ineffective	22	48,9%
Patient safety incident		
Incident Happened	20	44,4%
No Incident Occurred	25	55,6%

Based on Table 2, it describes the mostly closed organizational climate as many as 23 respondents (51.1%) and there are 22 respondents (48.9%) experiencing an open organizational climate. The results of the study are in accordance with Rani, (2017) found (38.8%) with an open organizational climate and (61.2%) with a closed organizational climate. The results of this study are not in accordance with Aristiawan & Dirdjo, (2017) found 10 nurses (32.3%) with a bad organizational climate and 21 nurses (67.7%) with a good organizational climate. This shows that there is a standard of work implementation. Based on the analysis contained in the inpatient room, the occurrence of changes in organizational climate has several dimensions such as awards related to problems regarding rewards, namely the salary given by the hospital does not meet the needs with the amount of workload given. This proves the lack of appreciation given from the hospital.

The results showed that out of 45 respondents, 23 respondents (51.1%) carried out the handover effectively and 22 respondents (48.9%) experienced an ineffective handover. The results of the study are in accordance with Nindi et al., (2017) that as many as 18 respondents (56.3%) had a good handover and 14 respondents (43.8%) had a poor handover. The results of the analysis showed that nurses in the inpatient room carried out effective handovers (51.1%), that is, information handover activities in the provision of nursing care could run well.

The results showed that of the 45 respondents, there were 25 respondents (55.6%) who did not play a role in the occurrence of patient safety incidents and 20 respondents (44.4%) played a role in the occurrence of patient safety incidents in the inpatient room. From the results of the analysis, it was found that most of the nurses in the inpatient room did not play a role in the occurrence of

patient safety incidents. However, there were 20 respondents who had carried out patient safety incidents and there were still nurses who had not carried out the standards set so that there was the potential for patient safety incidents to occur. The results of the study are in accordance with Deciliawati, (2019) found that 12 respondents (46.2%) played a role in the occurrence of patient safety incidents and 14 respondents (53.8%) did not play a role in the occurrence of patient safety incidents. Research according to Handayani, (2017) found that 30 respondents (39.5%) had had a patient safety incident and 46 respondents (60.5%) had never had a patient safety incident.

Table 3 Relationship between Nurse Characteristics and Patient Safety Incidents in the Inpatient Room of Porsea Hospital (n=45)

Variable	Patient safety incident				P value	OR (95% CI)
	Patient safety incident		Incident Occurred No Incident Occurred			
	N	%	N	%		
Age						2,827 (0,690-11,577)
< 30 years	7	63,6	4	36,4	0,261	
≥ 30 years	13	38,2	21	61,8		
Gender						
Man	0	0,0	3	100	0,316	1,909 (1,431-2,547)
Woman	20	47,6	22	52,4		
Education						0,643 (0,197-2,009)
D3	9	39,1	14	60,9	0,665	
S1 Ners	11	50,0	11	50,0		
Yearsofservice						0,792 (0,190-3,306)
< 5 years	4	40,0	6	60,0	1,000	
≥ 5 years	16	45,7	19	54,3		

Based on Table 3, it shows the relationship between age and patient safety incidents, showing that the majority of nurses are aged ≥ 30 years with a total of 34 nurses, of which 13 nurses (38.2%) contributed to patient safety incidents and 21 nurses (61.8%) did not contribute to safety incidents. patient. Whereas nurses aged <30 years with a total of 11 nurses including 7 nurses (63.6%) contributed to patient safety incidents and 4 nurses (36.4%) did not contribute to patient safety incidents. The results of the statistical test showed that the p-value was greater than 0.05, the value of p = 0.261 meant that Ho was accepted, Ha was rejected, meaning that there was no relationship between age and patient safety incidents. OR = 2.827 (95% CI = (0.690-11.577). OR > 1 means that the group of respondents aged ≥ 30 years has a 2.827 times greater risk of making mistakes which can lead to patient safety incidents. The results of this study are supported by research by Deciliawati (2019) obtained a p-value of 0.635 which indicated that there was no significant relationship between age and patient safety incidents. The results obtained from statistical tests showed that age did not have a significant relationship with patient safety incidents. Age affects the ability to analyze the problems involved With increasing age, it will be wise to follow regulatory policies, standard operating procedures and flow in administering health services so as to avoid patient safety incidents (Najihah, 2018).

The results showed that the relationship between gender and patient safety incidents showed that the majority of nurses were female with a total of 42 nurses of which 20 nurses (47.6%) contributed to patient safety incidents and 22 nurses (52.4%) did not contribute to patient safety

incidents . Meanwhile, nurses with a male gender with a total of 3 nurses (100%) did not contribute to patient safety incidents. The results of the statistical test showed that the p-value was greater than 0.05, the value of p = 0.316 meant that Ho was accepted, Ha was rejected, meaning that there was no significant relationship between gender and patient safety incidents. OR value obtained OR = 1.909 (95% CI = 1.431-2.547). The OR value > 1 stated that female respondents had a 1.909 times higher risk of making mistakes that could result in patient safety incidents. The results of the above study are in line with Deciliawati's p-value of 0.391 which indicates that there is no significant relationship between gender and patient safety incidents. The results obtained from statistical tests showed that gender did not have a significant relationship with patient safety incidents. Gender does not affect the ability to learn and act. There is no difference between men and women in carrying out patient safety because they have the same responsibilities (Surahmat et al., 2019).

The results showed that the relationship between education and patient safety incidents showed that most of the D3 Nursing education had 23 nurses, of which 9 nurses (39.1%) contributed to patient safety incidents and 14 nurses (60.9%) did not contribute to patient safety incidents. While nurses with S1 education. Nurses with a total of 22 nurses including 11 nurses (50%) contributed to patient safety incidents and 11 nurses (50%) did not contribute to patient safety incidents. The results of the statistical test showed that the p-value was greater than 0.05, the value of p = 0.665, which means that Ho was accepted, Ha was rejected, meaning that there was no significant relationship between education and patient safety incidents. OR value obtained OR = 0.643 (95% CI = 0.197-2.009). The OR value < 1 indicates that D3 education has a protective factor or an opportunity factor of 0.665 times not to make mistakes that can result in patient safety incidents. The results of the above study are in accordance with Deciliawati (2019) obtained a p-value of 1,000 indicating that there is no significant relationship between education and patient safety incidents.
The results obtained from statistical tests showed that education did not have a significant relationship with patient safety incidents. Education as a process of developing one's attitude towards newly introduced values. The higher a person's education will increase knowledge and the easier it will be to obtain information about patient safety (Sriningsih & Marlina, 2019).

The results showed that the relationship between tenure and patient safety incidents showed that most nurses had a working period of ≥ 5 years with a total of 35 nurses of which 16 nurses (45.7%) contributed to patient safety incidents and 19 nurses (54.3%) did not contribute to patient safety incident. Whereas nurses with a working period of < 5 years with a total of 10 nurses including 4 nurses (40%) contributed to patient safety incidents and 6 nurses (60%) did not contribute to patient safety incidents. The results of the statistical test showed that the p-value was greater than 0.05, the value of p = 1.000 meant that Ho was accepted, Ha was rejected, meaning that there was no significant relationship between years of service and patient safety incidents. The OR value was obtained OR = 0.792 (95% CI = 0.190-3.306) The OR value < 1 indicated that the working period < 5 years had a 0.792 times higher chance factor not to make a mistake which could result in a patient safety incident. The results of the above study are in line with Deciliawati (2019) who obtained a p-value of 0.683 which indicates that there is no significant relationship between length of work and patient safety incidents. The results obtained from the statistical tests showed that the length of service did not have a significant relationship with patient safety incidents. Based on these results, most cases occur with a working period of ≥ 5 years. This may happen to still make mistakes if the provision of nursing care does not apply safety standards. This is not in line with the results of a study by Rahayu et al., (2018) which stated that if the working period is long or increases, there will be a decrease in patient safety incidents by 0.068 points. Health workers with long tenure will be wise in following regulatory policies, standard operating procedures and flow in administering health services so as to avoid patient safety incidents.

Table 4 Relationship between Organizational Climate and Nurse Handover with Patient Safety Incidents in the Inpatient Room of RSU Porsea (n=45)

Variable	Patient safety incident				p value	OR (95% CI)	
	Incident Happened		No Incident Occurred				
	N	%	N	%			
Organizational Climate						0,755	(0,232-2,457)
Open	9	40,9	13	59,1	0,868		
Closed	11	47,8	12	52,2			
Handover							
Effective	5	21,7	18	78,3	0,005	0,130	(0,034-0,493)
Ineffective	15	68,2	17	31,8			

Based on Table 4, it shows the relationship between organizational climate and patient safety incidents. It shows that most of the nurses experienced a closed organizational climate with a total of 23 nurses, of which 11 nurses (47.8%) contributed to patient safety incidents and 12 nurses (52.2%) did not contribute. of patient safety incidents. Whereas nurses who experienced an open organizational climate with a total of 22 nurses including 9 nurses (40.9%) contributed to patient safety incidents and 13 nurses (59.1%) did not contribute to patient safety incidents. The results of the statistical test showed that the p-value was greater than 0.05, p = 0.868, which means that Ho was accepted, Ha was rejected, meaning that there was no significant relationship between organizational climate and patient safety incidents. OR value obtained OR = 0.755 (95% CI = 0.232-2.457) OR value < 1 indicates an open organizational climate has a 0.755 chance factor not to make mistakes that can result in patient safety incidents. The results of the above study are in line with Aisyah (2019) who obtained a p-value of 0.634 which indicates that there is no significant relationship between organizational factors and patient safety incidents. This is not in accordance with Aristiawan & Dirdjo's research (2017) with p-value = 0.006, namely there is a relationship between organizational climate in nurses and the implementation of patient safety goals, namely preventing the risk of falling. In this study there was an influence from communication between the health team so that in the actions of nurses it can affect the prevention of the risk of falling. The results of the analysis show that nurses in inpatient rooms still have a closed organizational climate due to a lack of maintaining a quality organizational climate related to a relatively rigid organizational structure, namely a lack of flexibility in acting and forms of rewards, namely rewards that are still considered not commensurate with the amount of workload given. So with good or open organizational climate factors, nurses are able to maintain the quality of the organizational climate.

The results showed that the relationship between handover and patient safety incidents showed that most of the nurses carried out effective handovers with a total of 23 nurses of which 5 nurses (21.7%) contributed to patient safety incidents and 18 nurses (78.3%) did not contribute to patient safety incidents. . Meanwhile, nurses with the implementation of handovers were ineffective with a total of 22 nurses, of which 15 nurses (68.2%) contributed to patient safety incidents and 17 nurses (31.8%) did not contribute to patient safety incidents. The results of the statistical test showed that the p-value was smaller than 0.05, the value of p = 0.005 meant that Ho was rejected, Ha was accepted, meaning that there was a significant relationship between handover and patient safety incidents. The OR value was obtained OR = 0.130 (95% CI = 0.034-0.493) The OR value < 1 indicated that the implementation of an effective handover had a 0.130 times higher chance factor not to make a mistake which could result in a patient safety incident.

The above description is in line with Triwibowo et al., (2016) which obtained a p-value of 0.004 which indicates that there is a significant relationship between handover and increased patient safety. The results of the above study are also in line with Wisdayana et al., (2020) which obtained a p-value of 0.000 which indicates that there is a significant relationship between the implementation of handovers and patient safety. Handovers that can run well can contribute to the implementation of patient safety. The results of the analysis were obtained by nurses in the inpatient room, even though there were still obstacles in carrying out the handover, such as external factors, interference due to calls from the patient's family, but the handover activities were carried out according to the principle of conveying information from both leaders and staff present and participating in handover activities. The handover information received is easy to follow and clearly communicated. Effective handover supports information to improve patient safety.

CONCLUSION

Based on the results of the study it can be concluded that there is no relationship between organizational climate and patient safety incidents with a p-value = 0.868 and there is a relationship between handovers and patient safety incidents with a p-value = 0.005. It is recommended for hospitals to pay attention to the rights of nurses such as issues regarding compensation that are not commensurate and carry out continuous evaluations of organizational climate in various units to create a good organizational climate so as to provide high motivation and morale and can improve service standards and quality in hospital. For nurses, having a disciplined attitude in carrying out handover activities effectively as nursing care providers can prevent patient safety incidents from occurring and is useful in improving the quality of management in hospital services.

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