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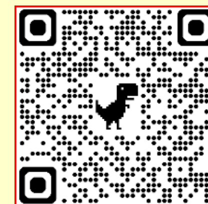

Evaluating Patient Safety Policy Implementation in a Middle-Class Private Hospital in Indonesia

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ABSTRACT

Patient safety remains a critical component in the delivery of high-quality healthcare globally. Despite the existence of formal patient safety management policies in many Indonesian hospitals, challenges in policy implementation persist, affecting overall patient safety outcomes. This study aims to analyze the implementation of patient safety management policies at a private hospital in Indonesia (Hospital X) using a qualitative descriptive approach grounded in the Donabedian framework, focusing on input, process, and output dimensions. Data were collected through purposive in-depth interviews with key informants and analyzed via data reduction, display, and conclusion drawing. Findings reveal that although the hospital has established policy documents and organizational structures to support patient safety, the dissemination and operational understanding of these policies remain limited. Positive factors include an active patient safety committee and ongoing internal training, while challenges such as underreporting of incidents, lack of incentives, and suboptimal interprofessional communication were identified. The study concludes that the implementation of patient safety policies is underway but not yet optimal, emphasizing the need to strengthen safety culture, improve training programs, and develop an incident reporting system free from punitive perceptions. Management support and continuous monitoring are essential to enhance patient safety outcomes. These findings contribute valuable insights for healthcare institutions aiming to improve patient safety policy execution.

KEY WORDS: Patient Safety; Policy Implementation; Healthcare quality;Donabedian model

Introduction

Patient safety remains a cornerstone of high quality health care worldwide. Despite global initiatives, preventable harm continues to affect millions of patients each year, especially in low and middle income countries (Bernales-Turpo et al., 2022; Carayon et al., 2013). In Indonesia, the implementation of national safety policies in hospitals has accelerated since 2020, yet evidence on how these policies translate into practice at the facility level is still limited. This study investigates the implementation of patient safety management policies at a private hospital in Indonesia using the classic Donabedian quality of care framework (Donabedian, 1988)

The World Health Organization (WHO) emphasizes that patient safety is defined as “the absence of preventable harm to a patient and the reduction of risk of unnecessary harm associated with health care” and promotes the International Classification for Patient Safety (ICPS) as a standardized taxonomy for reporting and learning from incidents (Runciman et al., 2009)

Indonesia’s Ministry of Health issued the National Patient Safety Policy to standardize safety culture, reporting systems, and staff training across hospitals (2020). However, implementation gaps—particularly in reporting mechanisms and cultural barriers—persist (Wood et al., 2024)

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Although Indonesian hospitals have adopted the national safety guidelines, preliminary reports indicate inconsistent incident reporting, limited staff engagement, and ongoing "no blaming" cultural challenges (Dhamanti et al., 2019). The research gap lies in a systematic, evidence based evaluation of how the hospital's structural assets, processual practices, and safety outcomes align with the Donabedian framework and WHO's ICPS taxonomy. The objectives of this study is to assess the structural components (leadership commitment, resource allocation, and safety management infrastructure) supporting patient safety policy implementation.

Methods

The present study adopted a qualitative descriptive design to explore how patient safety management policies are interpreted and enacted by health care professionals at the Hospital X (a private hospital in Eastern Indonesia). This design was chosen because it allows a close to the data description of participants' lived experiences without imposing extensive theoretical reinterpretation, which aligns with the purpose of this study(Sandelowski, 2000). A recent overview of qualitative descriptive research further supports its suitability for health service investigations Qualitative descriptive design overview (2020).

Research Participants

Purposive (criterion) sampling was employed to recruit a heterogeneous group of key and supporting informants (Pyo et al., 2023). Key informants comprised senior personnel directly involved in patient safety policy implementation – the Head of Patient Safety Unit, the Hospital Director, and heads of medical and nursing departments as well as quality assurance officers. Supporting informants included front line clinicians (doctors, nurses, midwives), administrative or technical staff, and, when appropriate, patients or family members. Approximately twenty participants were selected to ensure variation in professional role, length of service, and prior exposure to safety training initiatives.

Data Collection Instruments

The primary instrument was an in depth semi structured interview guide derived from the Donabedian framework and the WHO International Classification for Patient Safety(Group et al., 2009). The guide contained open ended questions that encouraged participants to describe structural resources, safety related processes, and perceived outcomes of the policy. Supporting tools included a digital voice recorder (smart phone), and field note sheets.

Data Collection Procedures

Interviews were conducted face to face in a private hospital room or via a secure video conferencing platform when participants preferred remote participation. Each interview lasted 45–60 minutes, was audio recorded with written consent, and subsequently transcribed verbatim. Transcripts were validated through member checking, whereby participants reviewed their recordings for accuracy. In addition to interviews, the researcher performed document analysis of relevant hospital policies, standard operating procedures, and incident reporting forms, and recorded field notes capturing non verbal cues and contextual observations. These three sources (interviews, documents, field notes) constitute the triangulation strategy highlighted in the thesis to enhance credibility .

Data Analysis

All textual data (transcripts, documents, field notes) were processed using reflexive thematic analysis as articulated by Braun & Clarke (Braun & Clarke, 2022). The six step procedure—familiarisation, generation of initial codes, searching for themes, reviewing themes, defining/naming themes, and producing the final report—was carried out in NVivo 12. Coding was primarily inductive but guided by the a priori structural, process, and outcome categories drawn from the Donabedian model, allowing both expected and emergent patterns to surface.

Trustworthiness

The study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007). Credibility was reinforced through data triangulation (interviews, documents, field notes), member checking, and an audit trail of analytic decisions (Ahmed, 2024). Transferability is supported by thick description of the hospital setting. Dependability and confirmability were demonstrated by maintaining detailed logs of methodological choices and by peer debriefing with the supervisory committee, as described in the original thesis under the sections dependability and confirmability.

Ethical Considerations

Ethical clearance was obtained from the Ethic Committee of Universitas Qamarul Huda Badaruddin approval Number 23/XI/ECQH/2025 All participants provided written informed consent after being briefed on the study's purpose, procedures, potential risks, and their right to withdraw without penalty. Anonymity was ensured by assigning alphanumeric codes to each informant, and all audio files and transcripts were stored on an encrypted, password protected server accessible only to the principal investigator.

Results

This study investigated the implementation of patient safety management policies at a private hospital in Indonesia, focusing on key thematic areas. Findings reveal nuanced perspectives concerning the hospital setting, structural resources, procedural enactments, outcomes, and the challenges faced by healthcare personnel.

Context and Structural Inputs

This study was done in a private Type C general hospital, located in Indonesia. The hospital has achieved a prestigious Full accreditation status, which underscores institutional commitment to quality and safety.

Participants confirmed the existence of comprehensive structural inputs that serve as a foundation for patient safety activities. These include detailed policy documents such as Standard Operating Procedures (SOPs), official decrees (SK), and patient safety guidelines that have been formally endorsed. One participant succinctly acknowledged,

"… We have policy documents ready, including SOPs, decrees, and patient safety guidelines" highlighting the presence of established regulatory frameworks intended to guide practice.

While a patient safety committee (The Patient Safety Committee) is operational within the institution, the extent of its outreach or awareness across different units was reportedly limited. As a respondent explained,

"…A patient safety committee is in place, but outreach is still limited among frontline staff…" indicating that the committee's role and activities have not permeated fully into all levels of hospital staff, potentially impacting the policy's practical effectiveness.

With regard to training activities, internal programs were reportedly held regularly. However, full participation among health professionals was inconsistent, a point reflected in the statement:

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"Internal training is provided, but not all healthcare workers attend it routinely.," suggesting that although efforts exist, coverage gaps remain a concern.

Process Components

Regarding the procedural dimension, findings revealed a generally heightened awareness and understanding of patient safety principles among staff. Many informants expressed confidence and a proactive attitude toward prevention, as illustrated by one participant's assertion:

"...We make sure we truly understand [the procedures] so that no problems arise." (B2) This points to a growing cognizance that patient safety is integral to everyday clinical work.

Nevertheless, this awareness was not universally experienced. Some respondents conveyed a perception of stagnation, noting a lack of visible progress compared to previous years. For instance, an informant candidly remarked,

"...What I feel remains the same from year to year; there has been no improvement at all." (B5) This highlights the existence of differential experiences and possibly varying levels of commitment or understanding among personnel.

Communication among professional groups was generally perceived as improved and constructive, with one participant noting,

"…...has improved because it provides comprehensive support for everything related to understanding patient safety." (B3), indicating that dialogue and information sharing have become more supportive in advancing safety aims.

However, weaknesses emerged in specific instances, particularly in incident reporting. An illustrative example included the account of a cleaning service staff who experienced a needle-stick injury but felt their report was inadequately addressed:

"...a cleaning service staff member was pricked by a needle... I reported it myself to the coordinator, but it was not taken seriously." (B4) This incident underscores gaps in response commitment and possibly a lack of a robust reporting culture within certain staff groups.

Outputs and Incident Reporting

The hospital's patient safety records for 2023 documented seven reported incidents, which primarily involved medication errors and patient falls. Medication-related mix-ups were more frequent in the early part of the year, whereas falls were recorded mainly during the later months. These quantitative data provide an objective measure of safety events and align with participant concerns expressed qualitatively.

Barriers to Policy Implementation

The study highlighted significant barriers impeding full policy enactment. A prevailing culture of blame and fear was identified as a core obstacle, discouraging open incident reporting. This cultural inertia was summarized by participant insights that emphasized a lack of a "no-blaming" mindset:

"no-blaming mindset not yet embedded; staff fear reprimand," which impedes transparency and learning.

Additional barriers included insufficient managerial support for safety initiatives, limited understanding or clarity regarding reporting procedures, and inadequate monitoring activities to ensure ongoing policy adherence and improvement.

Discussion

This study sheds light on the complex dynamics involved in the implementation of patient safety management policies at Hospital X. The discussion is structured around four key themes: policy implementation, patient safety culture and incident reporting, leadership and managerial support, and structural/resource constraints. Each theme is critically examined with reference to contemporary literature published from 2017 onward to reflect current academic discourse and practical challenges.

Implementation of Patient Safety Policies

The foundational step for improving patient safety is the establishment of clear, accessible policies, such as Standard Operating Procedures (SOPs) and formal safety guidelines. The presence of these formalized documents in the hospital confirms alignment with global trends advocating for documented protocols as a cornerstone of patient safety programs (ElSayed et al., 2023). However, the study revealed a noticeable gap between policy existence and effective dissemination among frontline staff, indicating persistent challenges in bridging the policy-practice divide (Mohammed et al., 2021).

This deficiency in communication and training has been identified in numerous recent studies as a critical impediment that undermines policy effectiveness (Abbas, 2020; Alzahrani, 2021). These studies emphasize the necessity for comprehensive and continuous educational initiatives to enhance healthcare workers' understanding of patient safety policies. Without adequate awareness and operational clarity, policies remain underutilized and fail to influence daily clinical practices effectively (Bernales-Turpo et al., 2022).

Thus, this study highlights the urgent need for tailored and sustained training efforts that engage all levels of hospital personnel. Such programs should also incorporate feedback mechanisms to constantly adapt and improve policy communication, ensuring that the intended standards translate into consistent and practical actions at the bedside.

Patient Safety Culture and Incident Reporting

Despite structural efforts, a culture of fear persists among healthcare workers, which inhibits transparent incident reporting. This recurring theme aligns with recent empirical literature highlighting that punitive workplace cultures severely constrain open communication related to medical errors and near misses (Liu, 2019; Mannion & Davies, 2018). Fear of blame leads to underreporting, compromising learning opportunities and perpetuating unsafe conditions.

This study's findings underscore the importance of transitioning toward a "just culture" that emphasizes learning and accountability without fear of retribution (Suarez, 2021). Such a cultural transformation requires multifaceted interventions, including leadership endorsement of non-punitive responses, education about the value of reporting, and protecting staff confidentiality.

The continued presence of fear-based responses signifies a critical barrier to achieving the transparent safety culture advocated in modern healthcare quality frameworks (Hamed & Konstantinidis, 2021). Hospitals must actively dismantle these cultural barriers through targeted strategies that foster psychological safety—a condition where workers feel secure in reporting mistakes and discussing errors openly for collective improvement.

Leadership and Managerial Support

Leadership emerged as a pivotal determinant for the success of

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patient safety initiatives. Consistent with contemporary research, clear, visible, and empowering leadership profoundly influences staff engagement and the embedding of safety priorities in organizational ethos (Braithwaite, 2017; Rivard, 2020). In this study, leadership efforts were apparent but inconsistent, suggesting an area needing reinforcement to secure sustainable safety improvements.

Effective leadership in patient safety involves more than policy endorsement; it includes the allocation of sufficient resources, continuous performance monitoring, and actively recognizing safety behaviors. Recent analyses have shown that when leaders model safety commitment and facilitate open dialogue, they accelerate cultural change and improve safety outcomes (Smith, 2022; Wang, 2023).

Notably, this study points toward a partial disconnect between managerial intent and frontline realities. To bridge this gap, robust leadership development programs are essential, focusing on transformational leadership styles that foster collaboration, transparency, and resilience among healthcare teams.

Structural and Resource Constraints

Although the hospital has attained structural milestones—such as accreditation and formal documentation—operational challenges remain, notably inconsistent training participation and limited socialization of the safety committee's role. Contemporary studies emphasize that both structural inputs and process elements operate synergistically to enhance patient safety (Hussein et al., 2021; Lyu, 2019; Pronovost, 2018). Structural readiness without effective process implementation yields suboptimal outcomes.

The uneven engagement in training and unclear committee function reflect operational gaps that compromise safety culture advancement. Healthcare institutions must continuously evaluate both infrastructure and workflow processes, ensuring these align with safety objectives and staff capacities.

Recommendations for Enhanced Patient Safety

Drawing upon the findings and reinforced by recent literature, several actionable recommendations are advanced:

Comprehensive and Continuous Education: Implement ongoing training programs using interactive and adult learning principles to enhance policy comprehension and practical application. Incorporate regular refresher sessions customized to distinct staff roles to maintain engagement and competency (Alzahrani, 2021).

Fostering a Just Culture: Institutionalize non-punitive policies and psychological safety to encourage open reporting. Leadership should model supportive behaviors and initiate campaigns underscoring the value of transparency for improvement rather than blame (Smith, 2022; Suarez, 2021).

Strengthened Leadership Engagement: Develop leaders at all levels through targeted programs emphasizing communication skills, safety prioritization, and transformational leadership techniques. Active leadership presence in safety rounds and feedback mechanisms should be institutionalized (Braithwaite, 2017; Wang, 2023).

Structured Monitoring and Feedback Systems: Establish systematic data collection on safety incidents combined with timely feedback loops and action plans. Such evidence-based monitoring enables rapid identification of gaps and informs continuous quality improvement (Pronovost, 2018).

Recognition and Incentives: Create formal mechanisms that recognize and reward safety-enhancing behaviors, motivating continuous adherence to safety practices and fostering intrinsic commitment among staff (Rivard, 2020).

Conclusion

Although the hospital has established policies and standard operating procedures supporting patient safety, there remain significant obstacles in the implementation and dissemination of these policies. Organizational culture, still influenced by fear of sanctions when reporting incidents, along with limitations in training and managerial support, are primary factors contributing to the suboptimal execution of patient safety management. Therefore, increasing awareness, education, and fostering a transparent and supportive safety culture are critically important to enhance the hospital's patient safety management performance.

The ongoing challenges in implementing patient safety management at Hospital X reflect universal themes in healthcare safety research, where policy frameworks coexist with cultural and operational barriers. Advancing toward an integrated, transparent, and learning-oriented safety environment requires deliberate leadership, robust education programs, and structural-process alignment. Addressing fear-based cultures and resource disparities is essential to harness the full potential of patient safety initiatives and elevate care quality

Based on the study's findings, it is recommended that the management of the hospital intensify support through continuous and comprehensive patient safety training and education for all healthcare personnel. Moreover, a work culture that encourages openness and incident reporting without fear of sanctions should be established to promote transparency and learning from errors. The management is also advised to strengthen the role and function of the patient safety committee by ensuring routine supervision and monitoring. Additionally, increasing leadership involvement in consistently overseeing policy implementation is crucial to achieve overall improvement in the quality and safety of patient care.

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