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Evaluation of the implementation of patient safety goals at the Oputa YI Koo heart and blood vessel hospital, Southeast Sulawesi Province

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Abstract

Introduction: Patient safety is a major component in efforts to improve the quality of health services in hospitals.

Objective: This study aims to evaluate the implementation of six Patient Safety Objectives (PSOs) at Oputa Yi Koo Heart and Blood Vessel Hospital, Southeast Sulawesi. This hospital, which has just started operating in 2023, faces challenges in ensuring the implementation of SOPs in accordance with national and international standards, especially in the context of a newly established facility and a relatively low workload.

Method: This study used a qualitative design with a case study approach. Key informants consisted of the Hospital Director, Head of the Quality Committee, and Head of the Patient Safety Objectives Sub-Committee, while supporting informants included the Head of the Emergency Room, Head of Pharmacy, Head of the VIP Room, and representatives from the PPI Committee. Data were collected through in-depth interviews, participatory observations, and document analysis related to hospital policies, reports, and procedures. The analysis was carried out using a content analysis model with the steps of data reduction, data presentation, and drawing conclusions.

Results: The results of the study indicate that although the SOP policy has been designed in accordance with the Regulation of the Minister of Health (PMK) No. 11 of 2017, its implementation has not been optimal in all aspects. Factors such as limited training of health workers, inadequate facilities, and minimal routine monitoring and evaluation mechanisms are the main obstacles. In addition, the operating room that is not yet functioning means that the fourth target (ensuring that surgery is performed correctly) cannot be fully implemented. Other findings indicate a gap between health workers' understanding of the SKP policy and daily practice.

Conclusion: This study recommends increasing ongoing training for health workers, providing facilities and infrastructure that meet standards, and implementing a more structured monitoring and evaluation system. This approach is expected to strengthen the culture of patient safety and increase the efficiency of SKP policy implementation, so that hospitals are able to meet national and international accreditation. This study contributes to the development of literature related to patient safety evaluation, especially in new hospitals, and provides a basis for hospital management to identify improvement priorities in an effort to create safe, quality, and sustainable health services.

Keywords: Evaluation; Patient Safety Goals; Heart Hospital; Healthcare Risk Management; Hospital Safety Standards

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1. Introduction

In the current global era, the demand for health services, including professional nursing services with international standards, is right before our eyes. Services are no longer only focused on patient satisfaction but more importantly patient safety. It is hoped that in the future, higher quality professional services that focus on patient safety and satisfaction can be implemented well in all health service centers [1]

According to the World Health Organization (WHO), patient safety is a fundamental principle in health care and a critical component of quality management. WHO launched the "World Alliance for Patient Safety" program in 2004, which emphasizes the importance of creating a safe environment for patients and reducing Adverse Events (AEs) during care. Patient safety includes systems designed to prevent harm from errors in medical procedures, both because of actions taken incorrectly and because of actions that should have been taken but were not taken [2]

Research in America, 6.5 % of patients experience Adverse Events (AEs) during surgical procedures. Comparison of AE prevalence in hospitals between America and developing countries is 3-4% compared to 8-16%. The prevalence of Patient Safety Incidents (IKP) in the United States and Canada was found to be 2.9 % and 16.6%, including incidents of clinical procedures that were not in accordance with SOP. Patient safety incidents at King Fahad Hospital in Almadinah Almunawwarah in 2019 showed that 25% of patient safety incidents were related to lack of socialization resulting in ineffective communication, poor teamwork and minimal learning in the organization, this caused hospital staff to feel less confident with the patient safety culture within the institution [3]

As one of the measuring tools for improving the quality and services of hospitals to patients, the Indonesian Government has also issued several regulations related to Patient Safety. These regulations are Law No. 17 of 2023 concerning Health, PMK No. 11 of 2017 concerning Patient Safety Targets, PMK No. 12 of 2020 concerning Hospital Accreditation, Decree of the Minister of Health No. HK.01.07/Menkes/1596/2024 concerning Hospital Accreditation Standards [4]

Although Oputa Yi Koo Heart, Vascular and Brain Hospital has committed to implementing Patient Safety Goals. However, based on a preliminary study conducted in September 2024, a gap was found between the established policies and the reality of their implementation in the field. As a relatively new hospital and coupled with the hospital's special status, there are problems found in the field related to human resources, facilities, infrastructure, monitoring and evaluation in the implementation of Patient Safety Targets. This shows a gap between existing policies and actual implementation, which requires in-depth evaluation to ensure the hospital's readiness to face the increasing number of patients in the future.

2. Method

This study is a qualitative study with a case study design. Data collection was conducted through in-depth interviews, observations and document reviews. The research informants consisted of 3 key informants, namely the Hospital Director, the Head of the Hospital Quality and Patient Safety Committee and the Head of the Patient Safety Target Sub-Committee, and 3 supporting informants, namely the Head of the Emergency Room, Pharmacist, Head of the VIP Treatment Room and the Head of the Hospital PPI Committee.

3. Results And Discussion

3.1. Human Resources

One of the main challenges in implementing patient safety targets is the lack of understanding and knowledge of human resources regarding the importance of patient safety policies and the procedures to be followed. This lack of understanding can lead to non-compliance with patient safety protocols. One example seen from the results of an interview with the Head of the Emergency Room is as follows:

> *"There was once an incident where an ER doctor reported a new patient who had just entered but did not use the SBAR form, so he did not carry out the doctor's instructions at that time. He should have injected 1 ampoule of dexamethasone before the transfusion, but the nurse did not inject dexamethasone because the SBAR was not filled in."*

In this case, the SBAR form has been available in each patient status. However, this incident was due to the lack of skills of the attending physician who was not used to using the SBAR form as a guide to report the patient's current condition.

The doctor still feels more comfortable reporting the patient's condition with a sheet of notes and the results of the notes are used as a guide to carry out the instructions of the consulting doctor.

The SBAR format is a standard format for conveying information between health workers. This format is used to convey the current condition of the patient being treated. If the ER doctor reports the patient using SBAR, important information such as the patient's condition (Situation), medical history (Background), assessment results (Assessment) and recommended actions (Recommendation) will be conveyed systematically. This will prevent confusion and misinterpretation of information that can lead to inappropriate therapy.

Reporting patients using the SBAR form helps healthcare professionals provide structured, clear and complet information that supports timely and effective decision making. The use of SBAR can reduce the risk of errors, speed up action, and improve patient safety. Implementation of the SBAR form should be a priority in hospital communication standards.

> *"….the implementation of Patient Safety Goals is highly dependent on Human Resources (HR) factors , which are one of the crucial elements in the successful implementation of patient safety policies. Several problems that arise in the implementation of patient safety goals in our hospitals today are often related to the quality, quantity, and readiness of HR in the hospital…"* (Key Informant AL, 47 years old)

> *"….I understand that the problem of implementing Patient Safety Targets is greatly influenced by the Human Resources (HR) factor in the hospital. HR is a very crucial factor in ensuring that every patient safety procedure is carried out properly. Without the support and active involvement of all medical and non-medical staff, the successful implementation of Patient Safety Targets will be difficult to achieve. We need to periodically refresh our knowledge and train the skills of the HR that we currently have, but sometimes it is constrained by the budget provided by the hospital…"* (Key Informant YB, 45 years old)

The main factor causing this is the lack of adequate training or insufficient knowledge of medical – non-medical staff regarding patient safety procedures. Limited time and budget for training results in a lack of opportunities for structured and ongoing training. In addition, over time trained staff may experience a loss of skills if they are not practiced frequently [5]

> *"….Despite the existence of safety policies and procedures, lack of discipline or reluctance of staff to comply with the existing safety protocols remains a problem. staff often feel rushed or unaware of the importance of certain safety procedures, such as the 5 Moments of Handwashing or proper patient ID checks…"*
> (Key Informant YB, 45 years old)
> *"…Medical staff may view safety procedures, such as the 5 Moments of Handwashing or proper patient identification , as merely administrative or routine procedures that have no direct impact on medical outcomes. Furthermore, without close oversight and regular evaluation , staff may feel that there are no consequences or oversight if they do not fully follow these protocols…"……..*(AP supporting informant, 39 years old)

The adequate number of health workers in one shift also has a significant influence on the implementation of patient safety targets. The availability of sufficient human resources ensures that important procedures, such as the double check process, can be carried out optimally. This double check is very crucial in situations such as confirming patient examination results in the ER or clarifying a doctor's prescription that is difficult to read at the pharmacy. With sufficient personnel, the risk of error can be minimized, thus maintaining patient safety.

Inadequate number of health workers can be a significant barrier to the implementation of patient safety. Insufficient number of health workers can cause high workload for existing officers. In an emergency situation, health workers tend to ignore details in patient safety protocols such as patient identity verification, reporting with SBAR or proper hand washing procedures. High workload with inadequate number of health workers is directly related to increased patient safety incidents, such as errors in patient identification and treatment [6]

> " *There was a prescription that came in from the heart polyclinic with a doctor's handwriting that was difficult for the pharmacist to read and caused a misinterpretation by the pharmacist. The pharmacist did not double check with other pharmacists and would immediately prepare the medicine based on his interpretation. However, the error could be prevented because I then read the prescription and reconfirmed it with the DPJP who wrote the prescription so that there was no mistake in giving the drug dose to the patient* ."(Supporting informant DS, 44 years old)

The double check process is an important step in preventing medication errors due to illegible doctor's handwriting or other misinterpretations. This almost- happening incident shows the importance of confirmation and re-verification to protect patient safety, maintain quality of service, and improve interprofessional communication in the hospital. Consistent implementation of double checks must be part of the operational standards of pharmaceutical services.

Lack of effective monitoring and evaluation can be a major factor in the failure to implement patient safety goals in hospitals. Without adequate supervision, healthcare workers tend not to consistently adhere to patient safety protocols. Research shows that the compliance of officers in reporting patient safety incidents is still low, which is often caused by a lack of supervision from hospital management. This results in incidents that should be reported not being detected, thus reducing the opportunity to make improvements [7]

> *"…there is indeed no well-structured evaluation system. Plus, we ourselves still lack auditors…"* (Key informant AP, 39 years old)

Ineffective communication between teams contributes significantly to problems in implementing patient safety goals. This can lead to incidents that harm patients and reduce the quality of health care. Unclear or incomplete communication can lead to errors in medical decision-making. Research shows that communication errors are a leading cause of patient safety incidents, with many adverse events occurring due to a lack of critical information or misinterpretation of information [8] .

Healthcare teams often consist of a variety of professionals with different backgrounds and education. Without effective communication, coordination between team members can be disrupted, creating gaps for errors in patient care. Research shows that lack of collaboration and communication can result in errors in patient handovers and care management [9]

3.2. Means

An unintegrated health information system can be an obstacle in implementing patient safety targets in hospitals. Information systems that are not interconnected between various hospital units or departments can cause disruptions in communication flows, loss of important information, and errors in decision making.

> *"….the infrastructure in our hospital is still developing as well as the need for electronic medical records that we are still developing. Indeed, at this time we have not been able to fully integrate all the documentation needs of the hospital but we will gradually develop it…"*
> (key informant AL 47 years old)

When health information systems are not integrated, data is often collected separately by different units or systems. This can result in data duplication and inaccurate information. A study shows that inaccurate data can lead to errors in diagnosis and treatment, increasing the risk of patient safety incidents [10]

Unintegrated health information systems limit the ability of hospital management to conduct comprehensive data analysis. Strategic decisions related to improving the quality of service and patient safety become difficult to make without access to comprehensive and accurate data [11]

Lack of adequate facilities for infection prevention and fall prevention tools is a serious challenge in implementing patient safety targets in hospitals. The lack of facilities such as sufficient sinks for washing hands, standard handwashing equipment, handrails along corridors, and slippery floor markers, for example, can increase the risk of unwanted events that endanger patient safety.

> *"…in hospitals there are still no adequate handwashing facilities, such as sufficient handwashing facilities , antiseptic soap , and alcohol-based hand sanitizers in every area of the hospital, especially in treatment rooms and other public facilities…"*(Supporting informant HJ , 35 years old)

Based on the results of observations in the study, it was found that the number of sinks for washing hands was inadequate to accommodate the estimated large number of visitors. In addition, although antiseptic liquid-based hand washing facilities have been provided in several strategic locations, most of the antiseptic liquid bottles were found to be empty or without contents. This indicates the need to improve the availability and management of hand hygiene facilities to support the optimal implementation of patient safety targets.

Conditions found in observations indicate a gap between the need for hand hygiene facilities and actual availability in hospitals. Insufficient number of sinks for handwashing can hinder easy access for visitors and health workers to maintain hand hygiene, especially in situations with large visitor volumes. Meanwhile, although alcohol-based antiseptic liquid has been provided, the presence of empty bottles indicates a weak monitoring and refill management system.

These two issues have the potential to hinder the implementation of patient safety standards, particularly those related to infection prevention and control (IPC). Hand hygiene is a critical step in breaking the chain of infection transmission in healthcare facilities. Inadequate facilities and the absence of antiseptic fluids can increase the risk of spreading pathogens, both among visitors and health workers.

Hospitals need to increase the number of sinks in strategic areas, such as the main entrance, waiting room, emergency room, inpatient wards, and around the canteen. The adequate number of sinks should be based on the estimated number of visitors and the operational needs of the hospital. The placement of bottles of alcohol-based antiseptic liquid should be increased at points with high activity, such as registration areas, waiting rooms, and entrances and exits to patient rooms.

In the context of PPI, the limited number of sinks or handwashing facilities in patient service areas can hinder health workers from complying with handwashing procedures according to the 5 moments and 6 steps that have been established. When health workers have difficulty reaching or need more time to access these facilities, their compliance with hand hygiene is likely to decrease. This opens up the opportunity for the spread of nosocomial infections that have the potential to threaten patient safety and reduce the quality of service [12]

Some fall prevention features, such as bathroom grab bars or mobility aids , are not yet fully available in all spaces.

> *"We are of course committed to ensuring patient safety. And we recognize that reducing the risk of patient falls is a key focus in efforts to improve the quality of service. However, in implementing this Sixth Target, we face several obstacles, especially related to the availability of fall prevention facilities that are not yet fully available in all areas of the hospital. Some treatment rooms and certain medical units still lack supporting equipment such as handrails along the hallways, safe floor coverings, and clear warning signs regarding potential fall hazards."*(Key informant , YB 45 years old)

The absence or limited fall prevention facilities, such as handrails in corridors, non-slip floors and fall risk markers can increase the risk of patient falls. Patients who are physically weak, elderly, or who use mobility aids are particularly dependent on these facilities.

The incident of patient falls can reflect the weak implementation of patient safety policies in hospitals. This will also impact public perception of service quality and can affect public trust in the future.

3.3. Infrastructure

With a 17-story building design, the electrical system is certainly the main capital in general hospital operations. This will certainly have a direct impact on the implementation of patient safety targets. Medical equipment, such as ventilators, patient monitors, radiology equipment and even other supporting equipment are very dependent on a stable electricity supply.

> *"...A newly established hospital that does not yet have a reliable and safe electricity network . It is natural that problems such as power outages , power outages , or irregular electrical installations can occur in a hospital that is in the development stage like our hospital..."*
> (Key Informant YB, 45 years old)

A poor electrical system can affect the performance of medical equipment. This has the potential to lead to errors in diagnosis or treatment, as well as increase the risk of patient safety incidents. Poorly planned electrical systems can create an unsafe physical environment for patients and staff. For example, lack of adequate lighting and room temperature that is completely dependent on air conditioning.

Medical waste, especially infectious, pharmaceutical and sharps, contains hazardous materials that can cause infection or injury to patients, hospital staff and visitors if not managed properly. Medical waste that is not immediately transported or processed safely can become a source of the spread of pathogenic microorganisms. This is contrary to patient safety goals, particularly in efforts to reduce the risk of infections associated with patient care.

> *"…The condition of the drainage, waste processing, and clean water supply is not optimal and can affect the safety of patients and medical personnel. Currently, we are still constrained by the processing of medical waste because we cannot do it ourselves…"* **(Key Informant YB 45 years old)**

Hospitals are required to comply with regulations regarding medical waste management, such as KMK RI No. 1204/Menkes/SK/X/2004. Non-compliance in waste management can result in legal sanctions and affect the hospital's reputation [13]. The limited evacuation routes in a new hospital with a 17-story building design can be a serious problem in implementing patient safety targets. Evacuation routes that are inadequate or not designed to safety standards can threaten the lives of patients, visitors and healthcare workers, especially in emergency situations such as fires, earthquakes or urgent medical evacuations.

High-rise buildings have unpredictable risks. Therefore, occupational health and safety procedures in high-rise buildings are very important. In this case, the ease of access for evacuation of high-rise buildings in the event of an accident due to natural disasters or other factors becomes very important. Evacuation routes are made to provide information and convenience for anyone to read them, so that the information on the signs installed can be easily understood, and later the building occupants can evacuate to the assembly point easily and quickly [14]

Hospitals often treat patients with a variety of conditions, including those with limited mobility. If the designed evacuation route does not accommodate patient needs, patients may become trapped during evacuation. Research shows that existing evacuation systems often do not consider accessibility for individuals with physical disabilities, increasing the risk of patient safety [15]

Research shows that healthcare facilities should have multiple evacuation routes to ensure that everyone can get out safely and quickly in an emergency. If a hospital only has one or two main evacuation routes, this can cause congestion during evacuation, especially when many people are trying to get out at the same time [16]

3.4. Monitoring

Effective monitoring requires competent human resources, supporting tools, and reliable information systems to ensure that the service process runs according to safety standards. Therefore, hospitals need to strengthen resource allocation for monitoring allocation, such as special training, adding experts, and adopting supporting technology.

> *"…We are still constrained by limited* ***resources*** *, both in terms of medical personnel, administrative staff, and equipment to monitor patient safety…"* **(Key Informant AL, 47 years old)**

The lack of resources for monitoring emphasizes the importance of the role of the hospital's quality and patient safety committee as the main implementer in ensuring optimal implementation of patient safety targets. The quality committee is responsible for monitoring and evaluating various safety indicators such as compliance with medical protocols, incident reporting, and the effectiveness of corrective actions [17]

According to the Regulation of the Minister of Health of the Republic of Indonesia No. 80 of 2020 concerning the Hospital Quality Committee, this committee is responsible for assisting the head or director of the hospital in implementing and evaluating quality and patient safety. The quality committee has a strategic function to identify potential risks, ensure the implementation of operational standards, and conduct routine audits to support a culture of safety across all lines of hospital services.

Strengthening the role of hospital quality and safety committees, including adequate resource allocation, is essential to face the challenges of monitoring in newly established hospitals. This includes training of committee members, development of a technology-based incident reporting system, and establishment of transparent evaluation procedures. Thus, the existence of a hospital quality and patient safety committee is not only the main foundation in maintaining patient safety, but also contributes to improving the overall quality of service [18]

> *"…Standard Operating Procedure (SOP) for safety monitoring patients are not completely clear, we are still compiling it. Without clear SOPs, officers may have different understandings about how to monitor patient safety.*
>
> **(AP Supporting Informant, 39 years old)**

Unstructured monitoring procedures are one of the problems in implementing patient safety targets in newly established hospitals. When monitoring procedures are not designed clearly and systematically, hospitals will have

difficulty in identifying, measuring and following up on risks related to patient safety. Without clear monitoring procedures, patient safety reporting becomes inconsistent. Hospital staff may not know when and how to report incidents resulting in many incidents going unreported. This can lead to the loss of important data about safety incidents that can hinder improvement efforts [4]

Unstructured monitoring will result in difficulties in analyzing incident data effectively. Without systematic data collection, hospitals cannot identify patterns or trends in incidents that occur. This can hinder evidence-based decision making for patient safety and lead to a lack of follow-up on reported incidents. If there is no systematic follow-up on incident reports, then the identified problems will not be addressed properly, increasing the risk of similar incidents recurring in the future [19] .

In newly established hospitals, irregularities in monitoring are also often caused by the limited experience of the management team and the unavailability of standard tools and guidelines. As a result, efforts to ensure compliance with patient safety goals, such as correct patient identification, effective communication, and fall risk prevention, are less than optimal. In addition, unstructured monitoring can also create the perception that patient safety is not a top priority, which ultimately has the potential to weaken the safety culture in the hospital environment.

Thus, the development of structured monitoring procedures supported by adequate training and resources is a crucial step to ensure the successful implementation of patient safety targets. This will help hospitals identify problems more effectively, take corrective action proactively, and create safe and quality service standards.

3.5. Evaluation

Clear and measurable evaluation parameters are essential to assess the effectiveness of a patient safety program. Ambiguity in this regard can lead to a variety of negative consequences. Poorly defined evaluation parameters can lead to ambiguity in assessing the success of a patient safety program. Without clear and measurable evaluation guidelines, it is difficult for health workers and management to identify whether targets have been achieved or where deficiencies need to be corrected. This has the potential to hinder data-driven decision-making that should be the basis for improving patient safety.

> *"…The ambiguity of evaluation parameters is one of the main problems in the implementation of **Patient Safety Goals** in hospitals. Evaluation parameters that are not clearly defined cause irregularities in measuring the success of patient safety programs. Without specific, measurable, and monitorable indicators, we have difficulty assessing the extent to which health workers comply with safety protocols such as patient identification, effective communication, infection prevention, and fall risk prevention…"* **(Key Informant YB, 45 years old)**

Ambiguity in evaluation parameters can hinder identification of underlying problems in the patient safety system. If indicators are not well formulated, hospitals may not be able to detect areas that need improvement, thereby increasing the risk of safety incidents. Effective monitoring requires measurable parameters to provide accurate information about safety performance. Ambiguity of evaluation parameters can create a culture where staff feel that patient safety is not a priority. If they do not see the results of their efforts or if the results are not well measured, motivation to participate in the patient safety program may decrease. A strong safety culture requires clear indicators and evaluation parameters so that all team members feel involved and accountable [20]

As a newly established hospital, the existence of comprehensive evaluation guidelines is very important in implementing patient safety targets. This guideline serves as a primary guide to measuring success, ensuring consistency in policy implementation, and identifying areas for improvement. Without comprehensive evaluation guidelines, efforts to assess the effectiveness of a patient safety program can become disoriented, leading to gaps in implementation and achievement of goals. Comprehensive evaluation guidelines should include specific, measurable, relevant, and time-based performance indicators, and take into account the unique characteristics of a new hospital.

With clear guidance, healthcare workers and management can understand what to expect, monitor progress, and report results systematically. It also facilitates data-driven decision-making for continuous improvement. In addition, these guidelines help instill a culture of patient safety from the start, building a strong foundation to ensure optimal quality of care. Comprehensive evaluation guidelines help standardize patient safety procedures across hospital units. With clear standards, all health workers can follow established procedures, thereby reducing variation in procedure implementation and improving service quality [21]

Comprehensive evaluation guidelines also include processes for identifying and addressing risks related to patient safety. This includes incident analysis and reporting of adverse events, which are critical to preventing similar problems from occurring in the future. Incident reporting is a critical part of a patient safety system to enhance learning from mistakes [22]

Incident reporting plays a critical role in improving patient safety in new hospitals. This process serves not only as a mechanism for recording adverse events, but also as a tool for continuous system analysis and improvement. Incident reporting allows hospitals to identify problems and risks that exist in the health care system. By recording every incident that occurs, hospitals can analyze patterns and trends of an incident. Systematic reporting helps patient safety teams understand the risk factors that can lead to medical errors and other safety incidents.

> *"…The current documentation system in hospitals is not optimal, so important data for evaluation, such as patient safety incident reports, are difficult to access or even not recorded…"* **(Key Informant YB, 45 years old)**

Documentation serves as an official record that reflects the patient care process, communication between teams , and reporting of patient safety incidents. Inaccurate, incomplete, or delayed documentation can result in the loss of critical information that could potentially impact clinical decisions, reduce the quality of care, and increase the risk of errors. In hospitals, inadequate documentation can hinder communication between health care providers, complicate internal audit processes, and reduce the effectiveness of patient safety evaluations. Additionally, when patient safety incident documentation is incomplete, data that should be used for system analysis and improvement becomes inaccurate, delaying the implementation of effective solutions.

Inaccurate or incomplete documentation can lead to misinformation regarding the patient's condition, treatment and procedures performed. This can lead to miscommunication between healthcare professionals. If important information is not recorded or communicated clearly, members of the medical team may have a different understanding of the patient's care plan, which increases the risk of errors [23]

Feedback and follow-up on patient safety incident reports are crucial components in implementing patient safety goals. Patient safety incident reports should be a tool to identify risks, analyze root causes and develop corrective solutions. This mechanism is very important to ensure that every incident that occurs and is reported is not only recorded, but also analyzed and followed up with appropriate corrective steps.

> *"…Monitoring and evaluation should be carried out continuously. However, in new hospitals, the focus is often more on initial operations so that evaluation mechanisms have not been formed systematically…"***(Key Informant YB, 45 years old)**

A follow-up mechanism is needed to ensure that each incident is responded to with appropriate corrective action. If incident reports are not followed up, the problems identified will not be corrected. When staff do not see any follow-up on incident reports, they will feel that their efforts to report the problem are not appreciated. This reduces their motivation to report incidents in the future which will create a negative culture where patient safety issues are not disclosed or ignored [20]

4. Conclusion

Human resources at Oputa Yi Koo Heart and Vascular Hospital play an important role in implementing the six Patient Safety Goals. However, limitations in numbers, competence, and compliance with safety protocols are the main challenges that hinder optimal achievement of targets. Continuous education and training is needed to increase the awareness and competence of health workers.

This study found that supporting facilities, such as handwashing facilities, fall prevention signs, and health information systems, were not fully available or functioning optimally. These limitations affect the effectiveness of implementing patient safety targets, especially in reducing the risk of infection and preventing patient falls.

Hospital infrastructure, including physical infrastructure and evacuation routes, still requires improvement to meet patient safety standards, especially to support the operation of high-rise hospitals. This mismatch has the potential to hinder the hospital's efforts to create a safe environment for patients and healthcare workers.

Unstructured monitoring is an obstacle in implementing patient safety targets. The absence of effective oversight mechanisms makes it difficult to detect and prevent potential patient safety incidents. More targeted monitoring is needed to improve compliance with safety standards.

The lack of comprehensive evaluation and clear parameters leads to a gap between patient safety policy and implementation. A structured evaluation is needed to identify problems more systematically and generate relevant improvement recommendations.

Compliance with ethical standards

Disclosure of conflict of interest

The authors have no conflict of interest in this research

Statement of ethical approval

This research received a permit or recommendation from Health Reserch Ethics Committee (KEPK) of the Regional Management of the Indonesia Public Health Experts Association (IAKMI) of Southeast Sulawesi Province with Number 255/KEPK-IAKMI/XII/2024.

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