

Patient Safety Program for Oral Surgery Services at Hospital at Universitas Sumatra Utara

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ABSTRACT

This research uses qualitative research with a phenomenological approach conducted in-depth interview. Samples of 7 people working in USU hospitals. The results of the study analyzed 6 patient safety targets and 8 contributor factors. Implementation of Implementation of Patient Identification Using Min 2 Identity in Patient Bracelets and Stickers, Confirming Identity Before Medical Actions, Effective Communication is done Readback/ Tulbakon, Writing Patient Referrals with SBAR, Beware of High Alert Drugs by prescribing drugs into pharmacy and storing lidocaine and ephineprin in special containers there are high-alert stickers In X-ray photos and informed consent, prevention and control of infection risk is done hand washing, use of PPE, use of a safe needle and removing sharp objects in a safety box, the risk of falling risk is carried out the patient's review process, giving yellow bracelets and patient assistance. Patient contributors, differences in perception and emotional levels affect the occurrence of incidents. Factors of officers such as fatigue and double work are the cause of stressors. SPO is available at the hospital, can be accessed at any time. Communication factors are carried out verbally and non-verbally. The work environment, the building is appropriate, but the maintenance of facilities and infrastructure is not good, resulting in a postponement of care for patients. The leadership supports the staff but reporting is a weak point because of the lack of staff awareness in reporting incidents. Team factors there are differences in quantity between nurses and doctors. Educational factors are required repetition of patient safety orientation to the staff. Hospitals are advised to improve infrastructure, evaluate the quantity and qualification of the team and increase awareness in reporting incidence.

KEYWORDS

patient safety; patient safety goals; patient safety contributors.

INTRODUCTION

Hospital is a health service provider that has a complete individual health service, there are inpatient services, outpatient and emergency department (Permenkes Republik Indonesia No. 30, 2022). The hospital has the responsibility of conducting an analysis of the operating system, whose main purpose is to improve the expected results of the patient. The quality of health services in hospitals can be assessed through 3 aspects namely input, process and output. Input aspects in the form of the availability of physical facilities, finance, equipment needed, organization and management and human resources. The process aspect is all the activities of professional health workers in carrying out their duties and their relationships to patients include the procedures for health services. Output aspects are the activities and

actions of health workers felt by patients, namely by increasing the health degree and satisfaction of patients. One of the most important patient outcome indicators is patient safety, is expected to produce optimal services and adverse incidents for patients not to occur.

The implementation of safe health in hospitals requires a comprehensive approach, because the hospital is a labor -intensive, professional, technology -dense, technology, therefore hospitals must be managed properly. Many risk factors have the potential for incidents in hospital health services.

Preventing the incidence of system designed to ensure that individuals who receive medical treatment are not in the dangers and the treatment they receive does not cause losses (Swatikarini, S., Yuliharsi, Y., & Susanti, M., 2019). Patient safety has become a global issue since the report "to err is human" explains the results of research at Utah and Colorado Hospitals, found unexpected events including death by 2.9%, of which 6.6%. 5.28 out of 100,000 population per year experienced an incident in the hospital.

Patient safety incidents can be in the form of unexpected events that cause injury (KTD), non -injury events (KTC), almost injured (KNC), potentially injured conditions (KPC) and Sentinel that cause died or severe injury. The incident that occurred in Indonesia in 2010-2011 was a KTD (54.47%) consisting of 21.17% injury, 19.7% minor injury, 21.9% permanent injury and 8.76% of death. In 2019 there were 7,465 cases, including 171 died, 80 heavy events, 372 mild and 5,659 were not injured (KPP RS, 2011) (Daud A., 2020). This is a display of health service problems that must be handled optimally, because it can be found in the quality of services and losses for patients in terms of physical health and social life.

The incidence is caused by many factors, active error factors and latent conditions. Active errors directly affect the occurrence of incidents, namely individual factors, health personnel factors and the application of patient safety that is not in accordance with standards. Latent factor is an inevitable condition, in the form of work pressure, the availability of human resources and infrastructure, organizational structure, organizational culture, and involvement of the ability of hospital leaders in developing patient safety science in employees (Henriksen, 2008).

Health service facilities are encouraged to develop research and patient safety mechanisms, in addition to instructing medical professionals, such as doctors, dentists, nurses, and pharmacists to pay attention to the treatment procedures and service systems they use to prevent incidents.

The declaration of the patient safety movement initiated by the Minister of Health of the Republic of Indonesia (Kemenkes RI, No. 34, 2021). this movement consisted of 7 different projects. Persi who is a hospital association in Indonesia played a major role in realizing this. Following the issuance of "Regulation of the Minister of Health Number 1691 of 2011" and "Minister of Health Regulation Number 11 of 2017" and in 2021, WHO issued a global patient safety action plan for 2021-2030.

Patient safety is no less important in the health service process in the field of dentistry, where every dental action there is a significant risk or medical error. According to research findings conducted for 5 years at the Japanese hospital, there were a total of 1,185 patient safety incidents including KTD and KNC, in 2014-2018 there were various cases, namely, 285 events (2014), there were 320 events (2015), 189 events (2016), there were 197 events (2017) and in 2018 there were 194 events. In this incident the dentist was involved in the patient safety incident as much as 42% of all health professions (Anzai et al., 2020).

There is a case report, the patient underwent surgery for the case of the removal of the third molar right, after surgery the patient had jaw fracture (Dos Santos Silva et al., 2017). The incidence of oral surgery patients that occurred in Japanese hospitals for a period of 5

years of 155 cases, with an average of 31 cases per year, contributed 13% of all incidents in the hospital and 31% of all dental incidents (Anzai et al., 2020).

Based on the results of a preliminary survey conducted at H. Adam Hospital conducted at USU Hospital in Medan, revealed that the number of patient safety events was not specific and not all safety problems were reported. In 2021 there were 21 cases, including 17 KTD cases, 2 KTC cases and 3 KPC cases. In 2022 there was an increase, namely 27 cases of patient safety incidents including 11 cases of KTD, 6 KNC cases, 1 KTC and 7 KPC cases in the report, there were no reports of oral surgery services.

To identify the implementation of patient safety programs in oral surgery services at USU Hospital, Medan City.

RESEARCH METHODS

This research is qualitative research with a phenomenological approach. Phenomenological research is a kind of qualitative research focusing on the investigation of how an individual interprets the experience he has experienced. The research informant is all oral and nurse dentists who are assigned to the oral surgery service and PMKP USU Hospital Medan City. This research was conducted in -depth interviews to obtain more information from respondents based on self -report, or personal knowledge and beliefs. The initial part of the data analysis procedure is to compile data obtained through in -depth interviews, document studies, recording. The material is then organized and categorized.

RESULTS AND DISCUSSION

Implementation of Patient Safety Goals

RI PERMENKES RI No. 11 of 2017 and KMK-No. 1128 of 2022, the target of patient safety or SKP is a standard set by KARS as one of the standards in the hospital accreditation instrument that must be met by every hospital (Kemenkes RI, 2022; Kementerian Kesehatan Republik Indonesia, 2017; Kementerian Kesehatan Republik Indonesia, 2019).

Implementation of Achieving Patient Identification. The first standard is the determination of patient identification. Patient identification not only includes physical identification but also techniques that can increase the accuracy of patient identification. The hospital must provide a guarantee of the correct identification process when the patient first registered (Anggraini et al., 2014).

Table 1. Patient identification

Interview result	Observations
<ul style="list-style-type: none"> - The use of bracelets and stickers using a minimum of 2 patient identities. - Confirm identity before taking medical action. 	There was an identity sticker installed in the patient's medical record, containing the name, number of medical records, gender, and date of birth.

Based on the results of interviews with informants about patient identification, information is obtained that the hospital has an integrated information system and processes hospital services. The system stores medical data and is digitally stored in a computer database. In outpatients, the patient registers at the counter by showing a KTP, then the registration window issues an identity sticker containing a medical record number, name, date of birth and gender. Before taking action, nurses and doctors always confirm the patient's identity and adjust to the medical record.

Implementation of identification that is not according to standards will cause the risk of injury in patients will increase. Service security at the hospital begins with an identification

of inventions where in the event of an error in the first phase it will have an impact on the completeness of services in the next process (Anggraini, 2014). Patient identification errors can occur in all aspects of diagnosis and action. The safety incident related to the identification of patients in Padang Pariaman Hospital obtained the results of the accuracy of the patient's identification not yet optimal and has not reached the standard of 50%, found a vacuum for the patient's stock so that some inpatients do not use bracelets for patient identity.

Errors in patient identification can be caused by many things, for example lack of nurses' knowledge about patient safety, influenced by the work environment and not optimal managerial support. The existence of guidelines and SOPs that have been made by the hospital can be a reference in the application of patient identification. The process of accuracy of patient identification in oral surgery services at USU's magic home has been carried out correctly, when observations found an installed identity sticker and print out on the medical record, such as using a minimum of 2 identities in the bracelet or patient sticker, confirming identity before taking medical actions and have done computerized technology to increase the accuracy of the accuracy of patient identification.

Overview of Implementation of Effective Communication. The implementation of effective communication is the second point of the patient safety target. Effective communication is one of the processes in supporting the success of nursing care provided (Syagitta El Al., 2017). Communication can run effectively if the informant can be understood and accepted by other health workers can be carried out immediately without any obstacles. Based on interviews about improving effective communication, information obtained:

Table 2. Effective Communication

Interview result	Observations
Communication with SBAR and Tulbakon (write confirmation and do readback)	Obtained a tulbakon/readback stamp with writing or notes instruction/therapy/action on CPPT

Based on the results of interviews with informants, an understanding of effective communication is carried out to patients, according to KARS the effective communication that must be met by the hospital is interprofessional communication. The application of communication with readback techniques has been carried out when referring to other patients. The doctor is also documenting between professions used an integrated patient development record (CPPT). The clerk wrote the patient's condition based on the results of the history in completely in the medical record and then referred the patient to another poly, and the instructions were recited to avoid errors.

Effective communication if on time, accurate, complete, not ambiguous and received by the recipient of information aimed at reducing errors and improving patient safety. Communication can be done orally, written or electronically. Communication that experiences a lot of potential errors is oral or telephone communication, this is due to the pronunciation of similar names, sound disorders and unusual terms.

Handover communication (handover) in the hospital can use the method or form. Handover forms between PPA must be ascertained to whom the responsibility of the service is handed over, given a complete signature, date and time of recording.

If communication runs badly can cause information exchange to be ineffective and care errors that can endanger patient safety. Research studies conducted by Chrismilasari et al (2019), as many as 26 people (60.5%) nurses in the inpatient room of Tamiang Layang Regional Hospital who were compliant with effective communication SBar-Tulbakon.

Effective communication in USU Hospital Oral Surgery During interviews and observations has implemented Tulbakon/Readback and SBAR techniques so as to minimize the risk of errors that can cause incidents. Conduct nonverbal communication, such as approval of medical action before taking action to the patient, confirmed by the nurse. The existence of writing or notes on CPPT by writing down the therapy instructions of what action that has been done in detail and complete is expected to minimize errors in communication. At the time of observation, the confirmation made can be seen with the tulbakon stamp and the writing on CPPT by writing instructions/ therapy of action.

Overview of Implementation of High Alert Drugs. Increasing drugs to watch out for is the third point of the patient safety target. Drugs that need to be watched out are drugs that have a risk can endanger the patient if an error occurs and must be monitored when given to the patient. Based on interviews conducted, information obtained:

Table 3. High Alert Drugs

Interview result	Observations
<ul style="list-style-type: none"> - There are different supervision and placement for high alert/LASA drugs - Re-check before the drug input to the pharmaceutical unit 	<ul style="list-style-type: none"> - Obtained a special place to store local anesthesia and epinephrine and labeled High Alert - Double check prescription medicine

The application of the alertness of high alert drugs is that medical personnel prescribe the drugs needed by patients to a system that is connected to pharmacy. The drug is given from the pharmaceutical unit to the patient in accordance with what is written in the system. To take medical actions, oral surgery is inseparable from lidocaine or local anesthesia and epinephrine stored in a special container given a clear marking in the form of red stickers with high alert, this is done in order to minimize the medication error that causes incidents.

The vigilance of high alert drugs is applied in the pharmaceutical unit, but in the out-patient unit is also applied. General Principles of Handling High Alert Drugs, Storage must be locked or cabinets that are locked and separate from other products, given labels on the packaging side, anesthetic drugs are stored in a place that can only be accessed by medical personnel. The prescribing of high alert drugs must be in accordance with the practice guidelines, the prescription writing must be clear and complete, and do double checks before administering drugs.

According to the ISMP, independent re -examination can prevent up to 95% of errors before giving to patients. A review of the study of drug errors in hospitals found in 16 studies, interruptions and the presence of distraction significantly resulting in errors. One of the drugs, wrong dosage calculation and wrong time in giving is a frequent error. According to research conducted by Tampubolon, the occurrence of errors in drug administration was also in fact in fact several factors, namely the unavailability of drug administration with the principle of 7 correctly, socialization that was not carried out continuously and the absence of training programs or training at hospitals (Tampubolon, 2018).

Effective efforts in dealing with the mistakes of drug administration are to improve the storage system, by separating high alert drugs and given special markers to prevent drug administration (Tusholihah, 2018). The application of the principle of using high alert drugs at the time of observation in accordance with the interview, has been carried out by officers such as storing local anesthesia and epinephrine in a special place and labeled high alert, and conduct repeated checks before the prescription drug is inputted to the pharmaceutical unit.

Implementation of the correct implementation of surgery, patients, procedures, and surgical measures. Elimination of location errors, patient recognition, and surgical

procedure errors are the target points of patient safety. Health Ministry (Kemenkes RI No. 34, 2011) states that the location and one of the operating patients are fatal and often occur due to ineffective communication between teams of health service officers. Based on interviews, information is obtained:

Table 4. Surgery, Patients, Procedures and Surgical Measures

Interview result	Observations
<ul style="list-style-type: none"> - Site-Marking on the X-ray of Patient Teeth Photos - Approval of medical action 	<ul style="list-style-type: none"> - Obtained a doctor doing a site marking on the patient's tooth x -rays in front of the patient and reconfirmation - Obtained the patient signed the approval of medical action after understanding the doctor's explanation.

Application of the correct location, patient, procedure and surgical measures carried out by medical personnel in outpatients using a site marking on the X -ray of photos of the patient before performing minor surgery or tooth extraction. Site marking is carried out if it involves two sides of the tooth to the extract, then requested approval and signature by the patient. This is done to avoid the region of tooth extraction region.

Location errors, patients, surgical procedures and actions are very worrying and can occur in the hospital. This error occurs due to ineffective communication between the medical team and the lack of patient involvement in the marking of the location. Patients enter and then site marking is carried out before minor surgery, site marking is marked by a marker. Site marking is done for if there are 2 or more sides. The location for all procedures involving the incision, must be seen until before the patient is carried out action and marking must be carried out in conjunction with the patient's X -ray (Kepmenkes RI, 2022).

The case that occurred at the Nagasaki University Hospital in April 2021, oral surgery dentists made a mistake in the extraction of the wisdom tooth, which was withdrawn next to it. The hospital acknowledged that there was a problem with organizational culture . According to research conducted at Semarang Hospital on Compliance with Surgical Safety Checklist implementation, as many as 93.2% of respondents obedient and 6.7% were not compliant, in this study there was no significant relationship between compliance with patient safety incidents (Nurhayati & Suwandi, 2019). This is contrary to WHO, the implementation of checklists can significantly reduce the morbidity and mortality of patients (WHO, 2017). According to KARS the hospital uses the same provisions about the right location, the right procedure, the right patient, if the operation is performed, including medical procedures and teeth outside the operating room.

Implementation of the Right Target Location, Procedures, Patients and Actions in oral surgery outpatient units at the time of observation seen a site-parking on the X-ray of the patient's tooth photo and the patient signs the approval of medical action. The use of Surgical Safety Checklist in the outpatient unit has not been carried out, because the actions taken are only minor surgery and mild cases.

A picture of implementing the prevention and control of infection risk in health services. Prevention and control of infection risk is a challenge in health services, this can be dangerous not only patients but medical personnel as well. Infection due to health services is an infection that occurs during patient care in the hospital, where the infection was not found when he first entered. Get information about the prevention and control of infection risk:

Table 5. Implementation of the Right Target Location, Procedures, Patients and Actions in oral surgery outpatient units

Interview result	Observations
<ul style="list-style-type: none"> - Preventing the infection must do 6 steps to wash hands according to SPO and 5 moments of washing hands - Throwing sharp objects in a safetybox - Use of APD 	<ul style="list-style-type: none"> - Obtained a 6 -step hand washing and 5 moments of hand washing, but not yet applied properly. - Hanscrub is on the doctor's desk and the entrance. - There is soap in the sink - Use of APD Level 2 and replace handscoon for each patient's change - Sharp objects discarded in safetybox.

Application of Prevention and Control of Infection Risk in Care in Oral Surgery Poly is done by washing hands, use of PPE, use of a safe needle, and removing sharp objects in a safety box. In reality, medical power has not done hand cleanliness with 5 moments of hand hygiene, namely before contact with the patient, before the asepsis action, after being exposed to the patient's body fluids, after contact the patient, and after contact with the environment around the patient and immediately after releasing gloves.

One thing that was done to prevent hospital infection by maintaining hand cleanliness with six -step techniques and five moments of hand washing (Ningsih et al., 2017). The non-compliance of nurses in carrying out the right hand washing can cause nurses to become barriers (carriers of germs) who transmit to patients, colleagues, or themselves (Syamsulastri, 2017).

Application of prevention and control of infection risk has not been done properly, because it has not applied 5 moments of washing hands, this is due to a lot of workload and patients who have accumulated so they do not have time to wash their hands. The use of PPE and the disposal of sharp objects has been carried out in a special safety box, this is in accordance with the Indonesian Minister of Health.

Implementation of Injury Patient Risk Prevention. The risk of falling in patients in hospitals is an accident that can be avoided, but remains a patient safety problem that often occurs with negative impacts on the health system. Obtained information obtained from the results of in -depth interviews, namely:

Table 6. Injury Patient Risk Prevention

Interview	Observations
<ul style="list-style-type: none"> - Giving markers/bracelets for the risk of falling - Patient assessment is carried out for the risk of falling during screening 	<ul style="list-style-type: none"> - Obtained SPO Assessment Patient Falling and Morse Scale Form. - Patients are risky using a yellow bracelet, using a wheelchair and there is a companion. - After medical action the doctor evaluates the patient's condition.

All patients get risk assessments falling during initial visits (both intensive and ordinary). Implementation of Patients Risk Falling on outpatients is assessment when the patient comes and is done screening in the registration. Reducing the risk of falling starts from the patient study process as an initial stage in carrying out the nursing care process. After the patient is known to have a risk of falling, the patient will be given a marker or yellow bracelet that shows that the patient has a risk of falling.

Falling risk assessment is chosen based on evidence based and modified according to the condition at the hospital. The latest falling risk assessment consists of several risk factors

studied, namely: 1. Fall history (in the last 3 months); 2. Confusion/Disorientation; 3. sedation; 4. Dizzy/weakness; 5. History of neurological disease; 6. Use of walking aids, and 7. The force of walking is unstable.

Understanding of the Risk Assessment does not guarantee nurse compliance in its implementation. Cooperation in the room, supervision, monitoring and ongoing evaluation is needed to support the implementation of falling risk prevention. The Importance of the Role of Supervision of the Head of the Room in Prevention of Falling Risk is also supported by other researchers.

Contributor Factors in Patient Safety Incidents

In order to carry out a patient safety program, the role of patients and families is needed in the health service process. These factors can affect the occurrence of incidence is the clinical condition of the patient, physical condition, social condition, mental/ psychological condition, and interpersonal relationships. Obtained information obtained from the results of in -depth interviews, namely:

"Patients submit and assume what doctors do and the best doctor's decision. Stress, the inoperative due to the disease he experienced, then we educate it telling what risks and complications will occur ... well the patient immediately panicked and was afraid of yaa. Things can change the trust of patients who initially believed in a doctor so he did not believe"

Based on the results of the interview stated that acute pain, stress experienced by patients can complicate communication to patients. Things that can inhibit communication to patients are differences in perceptions between doctors and patients, the patient's emotional level and the patient's inoperative.

Contributor factors for officers/individuals to the patient's safety incident. Factors officers have a large contribution so that they can see how the identification of the capacity and quality of medical personnel such as physical, psychological conditions such as stressors, motivation, social conditions, personalities and cognitive factors. Obtained information obtained from the results of in -depth interviews, namely:

"The number of nurses here is lacking, so there are drgs who have no nurses. We also have to be good at seeing the conditions, which drg is more in need of nurses "

Based on the results of interviews about the officers' contributor factors are fatigue and dual work that causes stressors during tasks, so that it requires a strategy to overcome this. Fatigue and stress can affect the implementation of patient safety, especially effective communication and become a potential for medical errors. The physical and psychological conditions experienced by medical personnel are ordinary and can be overcome with strategies or workflows, this is influenced by the tenure of > 5 years.

The long time of work will provide a positive experience and good knowledge can carry out their duties effectively and efficiently in accordance with the required performance standards, the low knowledge of medical personnel is one of the factors that are offered an incident. This allows some medical personnel to have a shorter service period that has good knowledge but in an inadequate work experience so that it becomes the potential for patient safety incidents.

Task contributor factor for patient safety incidents. The task factor describes how standard operational procedures (SPO), how to make decisions and availability of supporting tools. Obtained information from in -depth interviews, as follows:

"Everyone is given the SOP in the form of softcopy, not all SOPs are in the room in the room. All the SOPs are complete from the hospital ... Yes, I don't understand understand the times "

The interview results stated that SPO is available in the hospital, everyone holds SPO in the form of soft copy, SPO files are not posted in the room but are in poly, which can be opened or read whenever needed. But medical personnel do not understand the SPO enough.

The results of the study of the SPO of Patient Safety in Malang, that the cause of the non-implementation of SPO Patient Safety is that officers still do not understand the SPO of Patient Safety, not optimal Supervise Sub -Committee for Patient Safety Hospital, lack of management support in the form of information, communication and socialization, lack of funds for patient safety training and high workload.

In the Jati NI study (2017) there were 47 nurses, known to be 26 nurses (55.3%) who were less compliant and 21 nurses (44.7%) who carried out well compliance in carrying out operational procedure standards (SPO) at Hospital X Surabaya. This study shows that the higher the motivation, the higher the nurse compliance in carrying out SPOs in the hospital. Work motivation will have an impact on the performance of the nurse that will be displayed and supports attitudes in implementing the SPO of the Patient Safety Program.

In research conducted in Oral Surgery USU Hospital there is the availability of SPO material held by medical personnel but knowledge of the implementation of patient safety is not optimal.

Communication contributor factor for patient safety incidents. Communication contributors discuss how the communication process applied by medical personnel during health services, communication is carried out to patients and medical staff. Obtained information through interviews, as follows:

"From the patient coming until the patient comes home I communicate with the patient, asking the patient's complaint whether the patient is referred to the oral surgery or not, tells the DPJP, the patient's name and gives an integration sheet to the doctor. I communicate with doctors and patients, do what the doctor ordered and helped the doctor before, when and after providing services to the patient "

The interview results stated that communication was carried out verbally and non-verbally. Verbal and written communication in this case communication between nurses, nurses with doctors, doctors with patients and nurses with patients or with other professions. Communication is carried out to explore information from patients, patient education related to diseases suffered, diagnosis, actions, transfer of other nursing patients, including until the patient is at home always involving the patient and family if there is a patient companion. Communication that is not optimal or missed, becomes an opportunity for incidents.

Based on the results of research on 2840 cases of KTD and fatal, it was concluded that the cause of the problem was caused by 65% due to communication errors and 75% of communication errors resulting in death. In 2016, a study at the American hospital by The Joint Commission reported in January - December 2015 obtained 744 cases of patient safety incidents due to communication errors.

In line with research conducted by Qomariyah and Uyan, (2015) the results of 13% of patient safety incidents occurred because of lack of communication and occurred in the process of weighing this due to verbal and written communication nurses were lacking during the weighing. Research conducted a communication relationship at handover with Patient Safety. The results of the analysis conducted by the study were caused by effective communication integrated with patient safety in handover and thoroughly in nurses will increase effectiveness and coordination in communicating important information so as to increase the continuity of services to support the implementation of Patient Safety.

Work environment contributors to patient safety incidents. Work environment contributor factors discuss the physical design of the environment, facilities, availability of tools and their maintenance:

"For the tools are good, we submit the cleanliness of the cleanliness to CSSD, every time it has been finished, CSSD comes to take and sterilize the tools that have been used"

Based on the results of the interview, the informant stated that the building or building was feasible but maintenance was not good in some rooms or bathrooms that were rarely used. Lighting, noise, or distraction there is no disturbance. Maintenance of facilities and infrastructure is carried out if there are reports from units to superiors, to make reports and the best of the tool requires a long time until the unit delays treatment to patients. Tool calibration is done routinely every 3 months.

To guarantee the quality of service in the hospital, the building and all existing equipment and equipment must get the attention of the hospital manager, especially from the aspects of regular and timely maintenance to avoid more severe damage and high repair costs. In achieving optimal patient safety not only with the hard work of the nurse, but supported by infrastructure.

Organizational and management contributor factors for patient safety incidents. Organizational and Management factors There are several components are supervision and support, patient safety culture, as well as the standards and objectives of patient safety. Supervision and support are carried out to ensure a systematic and quality program to describe the services provided.

"Yes, support ... many posters or banners within the hospital about patient safety"

Based on this description, supervision is the process of providing support that is needed by medical personnel in completing their duties to achieve a goal. Support provided such as reporting systems that have been changed from manual to electronic, education, training and posters or banners about patient safety programs in the hospital environment. Evaluation of the program has not been carried out optimally and distribution of information about patient safety must be re -evaluated.

The support of leaders in the good category. The form of support carried out is to provide education, socialize equitably about the patient safety program, such as seven steps, six targets, and seven standards towards patient settlement, suggesting to help each other between units and provide input to nurses in patient safety actions, and ascertain whether the program is carried out in their respective rooms. Management support can also be given in the form of material or appreciation, it can motivate staff and increase support to continue to commit in improving the culture of patient safety.

Team Contributor Factors in IKP. The team factor defines how a group of individuals with special skills that work together and interact to get the same goals. Description of interviews regarding team work as follows:

"As long as I have never had a problem here. We are together to overcome it. Personal conflicts may be more common, but at work, just professionals, keep helping each other and remind each other "

Based on the description above, team work is done by helping and reminding each other. The difference in quantity between nurses and doctors is a problem that is still ongoing, when there are many nurses for 2 operators, thus slowing down services and tends to be a potential incident.

To achieve good cooperation, positive attitudes among team members need to be developed, such as the habit of listening to each other so that good communication is established, providing support to team members who need it, and respect the contributions and achievements achieved by each team member. Team collaboration is a good determinant of the organization's journey. For this reason, good cooperation is needed in carrying out responsibilities at the hospital.

Educational and Training Contributor Factors for Patient Safety Incidents. Educational and training factors explain how the education process, seminars and training on patient safety. Description of educational and training contributors as follows:

"Yeah. We've attended the training at the beginning of entering the hospital, after there was no deck ... for education about the reporting of the incident had never been educated deck, so we have never reported "

Based on the results of the interview above, medical personnel have received training when entering into a team in the hospital. Orientation seminars and training are conducted for a team that has just entered, but for repetition of orientation about patient safety has never been carried out again, and there has been no knowledge of knowledge in the hospital environment.

Training on nurses is related to the application of patient safety at Tugu Mrs. Mrs. Depok Hospital. The process of internalizing knowledge about patient safety towards individuals is something that must be pursued and becomes the basis of joint learning of every event or case regarding patient safety. A person will avoid making mistakes because of the correct of decision making process obtained from the cognitive impact of a training. There was a significant relationship between safety training in the last 1 year with patient safety attitudes.

CONCLUSIONS

Implementation of Patient Safety Program in Oral Surgical Services for USU Medan Hospital is:

- a. Implementation of Patient Safety Targets in Oral Surgical Services for USU Medan Hospital:
 - The accuracy of patient identification has been carried out in accordance with those directed in the Minister of Health Regulation of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - Effective communication has been carried out in accordance with those directed in the Minister of Health Regulation of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - The vigilance of high-alert drugs has been carried out in accordance with those directed in the Minister of Health Regulation of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
 - True the location of surgery, patients, procedures, and surgery actions has been carried out in accordance with those directed in the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety.
 - Prevention and control of infection risk has not been fully carried out in accordance with those directed in the Minister of Health Regulation of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety, which has not implemented 5 moments of washing hands.
 - Prevention of Risk of Falling Patient Injury has been carried out in accordance with those directed in the Minister of Health Regulation of the Republic of Indonesia Number 11 of 2017 concerning Patient Safety
- b. Contributor factors in patient safety incidents
 - Patient factors for patient safety incidents such as imbalance of patient knowledge, perception, health status, and experience.
 - Factors Officers influence incidents such as fatigue, stress due to a lot of workload, lack of medical personnel and double jobs become one of the obstacles and potential incidents

- The task factor influences the incident, the availability of SPO but knowledge of the implementation of patient safety is not optimal.
- Communication factors affect the occurrence of incidents such as communication has been going well, verbal and non-verbal communication is applied in health services. Communication is carried out not only to patients but the family is also involved if the patient is difficult to be invited to communicate.
- Work environment factors affect the occurrence of incidents such as poor maintenance systems can hamper services and trigger incidents.
- Organizational and management factors of patient safety incidents are staff support, safety culture that has not been maximized such as the low reporting rate caused by the knowledge and awareness of medical personnel that have not been optimal.
- The team factor has been going well, even though the quantity of nurses and doctors is not appropriate.
- Educational and training factors for patient safety incidents namely education and training received at USU hospitals are not evenly distributed, routine re-orientation must be carried out for all medical personnel regarding patient safety and reporting flow.

Suggestion

1. Monitor and evaluate the patient safety program in USU Hospital
2. Improve programs and policies related to reporting patient safety incidents in accordance with the development of existing problems
3. Make SOP Surgical Safety Checklist for minor surgery actions carried out in poly or in local anesthesia.
4. Periodic measurement / maintenance of the work environment

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