

Original Research Article**INFLUENCE ANALYSIS OF ORGANIZATIONAL FACTORS ON WORKPLACE BEHAVIOR IN THE IMPLEMENTATION OF RECORDING AND REPORTING PATIENT SAFETY INCIDENTS AT X HOSPITAL IN SURABAYA**

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ABSTRACT

Introductions. Work behavior is characterized by the implementation of recording and reporting patient safety incidents in accordance with applicable procedures. The problem in this research is the delay in recording and reporting patient safety incidents at Hospital This research aims to analyze the influence of organizational factors (perceived organizational support, organizational culture, ethical work climate, and trust in management) on workplace behavior in the implementation of IKP recording and reporting at Hospital X Surabaya. **Method.** This study used a cross-sectional design. The research was conducted in 35 work units at Hospital X Surabaya involving 77 work unit members as informants. Primary data collection using a questionnaire was carried out to measure all variables. Meanwhile, workplace behavior is measured using primary data using a questionnaire supported by using secondary data in the form of IKP reports. Meanwhile, workplace behavior is measured using primary data using a questionnaire supported by using secondary data in the form of Patient Safety Incident reports. **Results & Analysis.** The research results show that there are variables that have a p-value smaller than 0.05. Caring (dummy variable) from the ethical work climate variable (p-value=0.002). **Conclusion.** There are several recommendations given based on the results of this research. First, increasing cooperation between work unit members who support patient safety behavior related to recording and reporting patient safety incidents. Second, develop programs and policies related to the implementation of recording and reporting patient safety incidents.

Keywords: Patient Safety Incidents, Recording, Reporting, Workplace Behavior.

INTRODUCTION

Failure organizations to achieve organizational goals because there is employee behavior that deviates from organizational goals or is usually referred to as Deviant Workplace (DWB). Deviant Workplace Behavior (DBW) is behavior that

violates organizational norms, both written and unwritten so that it can be detrimental to the organization and hinder organizational goals. There are 4 DWB categories, one of which is production deviation. Production deviance is defined as behavior that

violates formal norms that describe the minimum quality and quantity of work to be completed, one example is deliberately working slowly (Robinson & Benett, 1995). All form of behavior including production deviance have an impact on organizational productivity (Kidwell, 1995).

The problem raised in this research is the delay in recording and reporting patient safety incidents at Hospital Delays in recording and reporting patient safety incidents are a behavior that violates the rules and has a negative impact on organizational productivity and can even be detrimental to the organization. The loss that hospitals gain from late reporting events is that it will hinder the identification of the risk of injury to patients. If risk identification does not go well, the risk of injury to the patient will increase. If a patient injury occurs, the hospital will face a number of financial and non-financial losses. Financial losses include having to bear patient claims. Meanwhile, non-financial losses are a decrease in public confidence in the services provided at hospitals because the quality of the hospitals is questionable. Delays in reporting patient safety incidents can be said to be a form of DWB which can impact productivity and cause losses to the organization, so this problem needs to be studied and resolved.

This study aims to analyze the influence of organizational factors

(perceived organizational support, organizational culture, ethical work climate, and trust in management) on workplace behavior in the implementation of recording and reporting Patient Safety Incidents at Hospital X Surabaya.

METHOD AND ANALYSIS

This research uses a cross-sectional design. The research was conducted in 35 work units at Hospital X Surabaya involving 77 work unit members as informants. This research was conducted at Hospital X Surabaya, namely the patient care unit and support unit. Research data collection was carried out in January-February 2019. The research population was all service units and support units at Hospital X Surabaya so that the research sample was some of the service units and support units at Hospital X Surabaya.

Sampling used a random sampling technique, namely the simple random sampling technique. The research sample size was calculated using the formula, namely $N-1$, so that based on the results of this calculation, the sample size in this study was 35 work units. Research informants are individuals who provide information about everything related to the work unit (research sample) towards recording-reporting patient safety incidents at Hospital X Surabaya.

Informants in this study were selected using the following criteria: 1. head of the unit or person in charge of the unit being studied, and 2. champion of the patient safety program in the unit being studied. The selection of these criteria is based on the consideration that the unit head and patient safety program champion in the selected unit know and understand the implementation of the patient safety program in their workplace.

Primary data collection using a questionnaire was carried out to measure all variables in organizational factors, namely perceived organizational support, organizational culture, ethical work climate, and trust in management. Workplace behavior was measured using primary data using a questionnaire supported by using secondary data in the form of Patient Safety Incident reports.

The influence test between the independent variable and the dependent variable was carried out using a multiple linear regression test with a value of α (0.05). The research results show that there are variables that have a p-value smaller than 0.05. This variable is caring (dummy variable) from the ethical work climate variable (p-value=0.002). Thus, it can be concluded that Caring (dummy variable) from the ethical work climate variable has the opposite relationship with workplace behavior (b value = -0.526).

This means that the more a work unit tends to have a caring work ethic climate, the less likely they will have good work behavior in terms of recording and reporting patient safety incidents.

RESULTS

The results of the research related to variables in organizational factors will be presented, namely perceived organizational support, organizational culture, ethical work climate, and trust in management as well as variables in workplace behavior.

Table 1 Results of test the Influence of Organizational Factors on Workplace Behavior

No	Independent	B	p-value	Result
1	Perceived Organizational Support	0.137	0.550	Not significant
2	Organizational Culture			
	Clan	Reference group		
	Adhocracy	-0.284	0.077	Not significant
	Market	0.060	0.723	Not significant
	Hierarchy	-0.080	0.596	Not significant
3	Ethical Work Climate			
	Caring	-0.526	0.002	Significant
	Law and code	-0.150	0.384	Not significant
	Rules	Reference group		
4	Trust in Management	-0.364	0.062	Not significant

It can be seen that there is one variable that value=0.002). A smaller p-value than has a p-value smaller than 0.05. This means that there is a significant variable is caring (dummy variable) from influence between variables on workplace the ethical work climate variable (p-behavior).

DISCUSSIONS

Perceived Organizational Support

Perceived organizational support describes the work unit's assessment of the support provided by KKPRS in carrying out recording and reporting patients safety incidents (hereinafter referred to as IKP). Indicators in assessing this support can be seen in terms of policies issued by the Hospital (fairness), supervision carried out by KKPRS (supervisor support), as well as awards and work conditions (organizational rewards & job conditions). It can be seen that the perceived organizational support of the majority of work units is still low, with a percentage of 51.4%. This shows that they feel that they still receive low support from KKPRS in carrying out IKP recording and reporting.

Organizational Cultures

Organizational culture describes the work unit's assessment of the habits that apply in the work unit in recording and reporting patient safety incidents. The measurement results are in the form of organizational culture types which consist of 4 tendencies, namely culture types, namely clan culture, adocracy culture, market culture and hierarchy culture. The results of the organizational culture assessment describe the work unit's assessment of the type of culture or habits that apply in the work unit in carrying out IKP recording and

reporting in their work unit. It can be seen that the majority of work units have a clan culture type in carrying out IKP recording and reporting, with a percentage of 77.1%. These results indicate that most of the habits that work units have in carrying out IKP recording and reporting are characterized by:

1. The work unit is a comfortable place to work, work unit members are like their own family, they are always open and share.
2. The head of the work unit leads his subordinates by always assisting a facilitator.
3. The work unit has a good work team in carrying out tasks related to recording and reporting patient safety incidents.
4. The work unit has confidence that recording and reporting patient safety incidents is able to bring their workplace to success in providing the best service to patients.

Ethical Work Climate

Ethical work climate describes the work unit's assessment of the conditions of their internal environment which influences all their work unit's decisions in carrying out recording and reporting of patient safety incidents in their work unit. There are 4 types of ethical work climate in the concept previously developed by Victor & Cullen (1988), namely caring,

law and code, rules, instrumental, and independent. The results of the assessment of the ethical work climate variable are the climate tendencies in the work unit which influence decisions on all matters relating to IKP recording and reporting activities. It can be seen that the majority of work units have an ethical work climate with a rules type, with a percentage of 51.4%. These results show that the majority of work units carry out recording and reporting activities because there are rules that are binding and require them to carry out these activities. So, having clear policies/rules regarding the mechanism for recording and reporting IKP will definitely influence the success of IKP recording and reporting activities at Hospital X Surabaya.

Trust In Management

Trust in management describes the work unit's trust in KKPRS that the recording and reporting of the IKP they carry out will have a good impact, namely increasing the productivity of the work unit. Indicators in assessing trust can be seen from work unit satisfaction with KKPRS performance (competence), KKPRS openness and honesty, KKPRS attitude towards work units (concern of employees), KKPRS reliability in making recording and reporting activities a success (reliability), and similarities in goals, values, and norms between work units and KKPRS (identification). It can be seen that the

majority of work units have low trust or confidence in KKPRS, with a percentage of 57.1%.

Workplace Behavior

Workplace behavior is assessed based on the availability of records and reports, recording and reporting mechanisms, as well as the quality of documents recorded and reported by work units to KKPRS.

1. Availability of records and reports.

The availability of records and reports is assessed based on the existence of IKP records and reports received by KKPRS when an incident occurs in the work unit. It can be seen that of the 35 work units that were the research sample, there were incidents in 23 work units which stated that there were incidents that occurred in their work units in January 2018- January 2019. It can be seen that the majority of the work units that were the research sample (51.4%) do not record and report IKP when patient safety incidents occur or do not occur. This shows that the majority of work units have poor IKP recording and reporting behavior.

2. Recording and reporting mechanisms

The reporting mechanism is assessed based on the timeliness of reporting and the reporting flow in the work unit which records and reports IKP that occurs in the work unit to the Patient

Safety Sub-Committee. This recording and reporting mechanism assessment was carried out in 17 work units that recorded and reported IKP to the Patient Safety Sub-Committee. It can be seen that the reporting mechanism for the majority of work units that report IKP to the Patient Safety Sub-Committee (52.9%) is still not good.

3. Document quality

The quality of the IKP report document is assessed based on the completeness of filling in the IKP recording and reporting form and the clarity of the information produced by the report. This assessment is also only carried out in work units that record and report IKP that occurs in their work units to the Patient Safety Sub-Committee, namely 17 work units. It can be seen that the documents recorded and reported by most work units related to patient safety incidents are of poor quality, with a presentation of 82.4 %.

The 3 assessment indicators, namely the availability of IKP records and reports, the accuracy of the IKP recording and reporting mechanism, and the quality of the IKP report documents. The results of this assessment are divided into 2 categories, namely Deviant Workplace Behavior (hereinafter referred to as DWB) if the work unit has bad behavior in recording and reporting IKP and non- deviant Workplace Behavior if the work unit has good behavior

in carrying out IKP recording and reporting.

In the summary of the test results of the influence of organizational factors on workplace behavior, the influence test was carried out simultaneously between the independent variables perceived organizational support, organizational culture, ethical work climate, and trust in management on the dependent variable (workplace behavior).

Caring (dummy variable) from the ethical work climate variable has a significant influence on workplace behavior in terms of recording and reporting IKP compared to reference groups, namely rules. Ethical work climate describes the climate tendencies in the work unit that influence decisions on all matters relating to IKP recording and reporting activities.

Based on the statistical test results obtained, it means that work units that have a climate tendency in the form of caring are proven to influence the behavior of work unit members in carrying out IKP recording and reporting activities compared to work units that have a climate tendency in the form of rules. However, the more the work unit tends to have a caring work ethic climate, the more likely they will not have good work behavior in terms of recording and

reporting IKP, because caring has the opposite relationship with workplace behavior (negative b value 0.526).

CONCLUSION

Most work units fall into the Deviant Workplace Behavior (DWB) category in terms of recording and reporting IKP. The majority of work units use the basis of policies/rules when making decisions in carrying out all matters relating to IKP recording and reporting activities in their work units. The work unit has an organizational culture in the form of a clan which is characterized by the existence of work groups that support each other in carrying out IKP recording and reporting.

Suggestions from the research results regarding the influence of organizational factors on workplace behavior related to recording and reporting IKP that management can do is to increase the commitment of all members of the work unit, for example by making a jointly signed agreement that all incidents that occur in the work unit must be recorded and reported to the Sub-Committee. Patient Safety. As well as preparing programs and policies related to the implementation of recording and reporting IKP, including creating guidelines and SOP (Standart Operational Prosedure) for recording and reporting IKP, SOP for monitoring and evaluating IKP recording

and reporting activities, as well as SOP for supervision that must be carried out by the Patient Safety Sub Committee to increase their trust. In order for the policy to be implemented, it needs to be socialized through posters, leaflets or other media posted in all work units containing an appeal to carry out recording and reporting activities properly and correctly in accordance with applicable policies.

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