THE ROLE OF FAMILY IN SUPPORTING THE IMPLEMENTATION OF PATIENT SAFETY IN INPATIENTS AT A PRIVATE HOSPITAL IN BANDAR LAMPUNG: A MIXED METHODS STUDY

(Thesis)

By

KEVIN HENDRI
2118011002

MEDICAL EDUCATION STUDY PROGRAM
FACULTY OF MEDICINE
UNIVERSITAS LAMPUNG
2025

THE ROLE OF FAMILY IN SUPPORTING THE IMPLEMENTATION OF PATIENT SAFETY IN INPATIENTS AT A PRIVATE HOSPITAL IN BANDAR LAMPUNG: A MIXED METHODS STUDY

By
KEVIN HENDRI
2118011002

Thesis

As One of The Requirements to Obtain a Degree
BACHELOR OF MEDICINE

At

Medical Education Study Program
Faculty of Medicine Universitas Lampung

FACULTY OF MEDICINE
UNIVERSITAS LAMPUNG
BANDAR LAMPUNG
2025

Thesis Title	:	**THE ROLE OF FAMILY IN SUPPORTING THE IMPLEMENTATION OF PATIENT SAFETY IN INPATIENTS AT A PRIVATE HOSPITAL IN BANDAR LAMPUNG: A MIXED METHOD STUDY**
Student Name	:	Kevin Hendri
Student Number	:	2118011002
Study Program	:	Medical Education
Faculty	:	Medicine

AGREEMENT

Supervisory Commission

Supervisor I	Supervisor II
Ns. Bayu Anggileo Pramesona, S. Kep, MMR, Ph. D, FISQua.	**dr. Maya Ganda Ratna, S. Ked, M. Biomed.**
NIP. 198608022009031001	NIP. 198708122020122012.

ACKNOWLEDGEMENT

Dean of Faculty of Medicine

Dr. dr. Evi Kurniawaty, S. Ked., M. Sc.
NIP. 197601202003122001

VERIFICATION

1. **Examiner Team**

Chief : **Ns. Bayu Anggileo Pramesona, S. Kep, MMR, Ph. D, FISQua.**

Secretary : **dr. Maya Ganda Ratna, S. Ked, M. Biomed.**

Examiner : **Dr. dr. Rika Lisiswanti, S. Ked, M. Med. Ed.**

2. **Dean of Faculty of Medicine**

Dr. dr. Evi Kurniawaty, S. Ked., M. Sc.

NIP. 197601202003122001

Thesis Exam Pass Date: January 20th 2025

STATEMENT

I hereby declare that:

1. The thesis with the title "The Role of Family in Patient Safety Toward Inpatients in Private Hospital Bandar Lampung: A Mix-Methods-Study" is my own work and does not plagiarize the work of other authors in a way that is not in accordance with the scientific ethics that apply in academia or what is meant by plagiarism.
2. The intellectual rights to this scientific work are fully handed over to the University of Lampung.

For this statement, if in the future it is found that there is untrue statement, I am willing to bear the consequences and sanctions given to me.

Bandar Lampung, January 13th, 2025

Statement maker,

Kevin Hendri

CURRICULUM VITAE

The author was born in Lampung on March 26th, 2003 as the first child of two siblings, Mr. Hendri and Mrs. Yuliana.

The author attended elementary school at SD Xaverius Terbanggi Besar, junior high school at SMP Xaverius Terbanggi Besar, and senior high school at SMA Xaverius Bandar Lampung.

The author then continued his education as a student of the Medical Education Study Program, Faculty of Medicine, University of Lampung in 2021 through the SNMPTN. During his pre-clinical lectures, the author was an assistant lecturer in clinical pathology for the 2023-2024 period. The author is an active member at Lampung University Medical Research (LUNAR) as a member of public relations division.

Sebanyak apapun diri ini belajar,

itu semua tidak akan pernah cukup,

manusia penuh keterbatasan.

" Ketika ’keadaan belajar’ dimulai, maka kebanggaan,
kesombongan dan delusi kebodohan berakhir."
-Bhante Vangisa Deva.

”Hidup”
Masa lalu hanyalah suatu kenangan
Masa depan hanyalah suatu harapan
Hidup yang sebenarnya adalah ’hari ini’."
-Hendri.

" Whatever come to me, accept it, face
it, solve it, leave it."
-Yuliana.

"As I keep walking against the wind, I see
the future just beyond my outstretched
hand, I keep looking into the mist of
time. I believe in the path I choose,
tomorrow can be changed, I will create a
new future, to the infinite tomorrow.”
"-Timeranger.

FOREWORD

Praise to God Almighty for His blessings and guidance, this thesis can be completed with the title " The Role of Family in Supporting the Implementation of Patient Safety in Inpatients at a Private Hospital in Bandar Lampung: A Mixed Methods Study " as a requirement to obtain a Bachelor of Medicine degree.

The preparation of this thesis cannot be separated from prayers, suggestions, guidance, and support from various parties so that the author with all humility would like to express his deepest gratitude to:

1. Prof. Dr. Ir. Lusmeilia Afriani, D. E. A. IPM., as the Rector of the University of Lampung.
2. Dr. dr. Evi Kurniawaty, M. Sc., as the Dean of the Faculty of Medicine, University of Lampung.
3. dr. Intanri Kurniati, Sp. PK., as the Head of the Medical Education Study Program, Faculty of Medicine.
4. Ns. Bayu Anggileo Pramesona, S. Kep., MMR., Ph.D, FISQua., as Supervisor I for all the willingness of time, energy, and thoughts to provide knowledge, direction, and constructive motivation, as well as knowledge that is so useful that the writer can complete the thesis well. He is like a candle that always burns itself in order to bring light to others and illuminate the way from the darkness of idiocy. Hopefully the little fire that the author has obtained can make the writer light the way for others as well.
5. dr. Maya Ganda Ratna, M.Biomed. as Supervisor II who is willing to take the time, provide direction, encouragement, and motivation to the author in the process of completing this thesis.

6. Dr. dr. Rika Lisiswanti, M.Med.Ed. as examiner for all his willingness to provide knowledge, corrections, suggestions, and directions needed by the author to complete the thesis properly.
7. Dr. dr. Khairun Nisa Berawi, M. Kes., AIFO., as an Academic Advisor who is willing to guide the author while carrying out education at the Faculty of Medicine, University of Lampung.
8. All teaching lecturers, staff, and the academic community of the Faculty of Medicine, University of Lampung for the knowledge that has been provided during the author's preclinical education and his assistance in the process of preparing the author's thesis.
9. Ns. Renny Sarah Asih Nababan, S.Kep., M.Kep., who always helps researchers whenever they encounter difficulties in the research process and always gives the author invaluable advice and assistance so that the author can complete the research well.
10. All heads of inpatient installation rooms, nurses, doctors, staff and families of the patients for their help in the research process so that the author can complete the research well.
11. Prof. Ann Sofie Sundqfist as the corresponding author of the research article entitled "The Family Involvement in Care Questionnaire An instrument measuring family involvement in inpatient care" who is always ready to answer every question from the author, gives the author permission to use the FICQ questionnaire and provides instructions when the author experiences difficulties.
12. The author's father, Hendri, who always provides supports, sacrifices, love, information and inspiration in every step of the author’s life. A meaningful one line verse which makes one tranquil upon hearing is better than a thousand meaningless verses collected together. He always says it’s better to master one major rather than an amateur in every major.
13. The author's mother, Yuliana, for her prayers, supports, sacrifices, love and affection in every trial and tribulation of the author's life, is the main reason why the author chose and can survive until now to undergo Medical Education at the Faculty of Medicine, University of Lampung. Hopefully

one day life will be better, may you be free from physical and mental suffering, from all the attachment and may you gain salvation from your own hand.

14. My brother Geraldo who always provides support, information and inspiration, especially regarding views and ways of life that have different magnetic poles from the writer so that the writer often makes the writer realize the dualism of life. The glass is half empty and the glass is half full.
15. My teacher Bhante Vangisa Deva who always teaches about mindfulness, conscience in every step made, lifelong study and honing skill for a better future cause a big step was once made of small steps. Just like the flower, it will bloom when the time and all the conditions was met, not due to our greed and will.
16. Friends of the author “SSR Keeper” who always accompany the author, give insights especially for life lessons and make the author can survive to this day. If the fruit of one’s thoughts, one’s works are still intact and carried on by the people who believe in them, then the person is still alive.
17. Friends of the author of "Ngapain ini ya" for their support and friendship during the education process.
18. My friends, Daniatul and Alina, who have always provided assistance, support both academic and non-academic since the beginning of the semester until now.
19. My friends, Keisha and Dita who have been college friends since the third semester until now who always provide advice, prayers, assistance and become friends in participating in the student creativity program (PKM) so that the author gets a lot of experience and new knowledge.
20. My friends, Paulo, Rifqi, Dina, Yohanna, Dea, Mori, Nixon, Alin, Daniatul, Kamila, Dina, Keisha, Dita, Liza, Cahya, Rini, Miranda, Aaron, Hazima Nasya, Morica, Mrs. Ellen who have helped me in the process of proposal seminars and results seminars, are willing to be my committee, spectators and helpers at critical times.
21. Purin Pirimidin Class of 2021 as part of the author's family at the Faculty of Medicine, University of Lampung, and

22. All parties who have assisted during the process of writing the author's thesis that cannot be mentioned individually.

Finally, the author is aware that there are still many things that can be improved from this thesis. Therefore, the author hopes to get constructive suggestions and criticism from various parties. Hopefully this work can provide benefits for readers.

Bandar Lampung, January 13, 2025

Writer

Kevin Hendri

ABSTRAK

PERAN KELUARGA DALAM MENDUKUNG IMPLEMENTASI KESELAMATAN TERHADAP PASIEN RAWAT INAP DI RS SWASTA BANDAR LAMPUNG: *A MIX-METHOD-STUDY*

Oleh

KEVIN HENDRI

Belum banyak penelitian yang membahas terkait peran keluarga terhadap keselamatan pasien terutama di Indonesia. Penelitian ini bertujuan untuk mengeksplorasi peran keluarga terhadap keselamatan pasien rawat inap. Penelitian *cross sectional* studi ini dilaksanakan pada September – Desember 2024 di ruang rawat inap RS Swasta Bandar Lampung. Responden adalah keluarga pasien dari seluruh kelas rawat sebanyak 201 orang yang diambil secara *purposive*. Peran keluarga diukur dengan kuesioner *Family Involvement Care Questionnaire* (FICQ). Informan adalah dokter, perawat dan keluarga pasien sebanyak 25 orang yang diwawancara dengan *in-depth interview* secara. Data kuantitatif diukur menggunakan mann-whitney dan kruskal-walis. Berdasarkan analisis tidak terdapat hubungan umur (p=0,425), jenis kelamin (p=0,784), tingkat pendidikan (p=0,962), kelas rawat inap (p=0,445), dan lama rawat inap (0,425) dengan keterlibatan keluarga. Data kualitatif dianalisis dengan analisis tematik dan terdapat enam tema yang dihasikan (1) Pemahaman dan pengetahuan; (2) Keluarga terlibat dalam perawatan pasien; (3) Kerjasama dan komunikasi yang adekuat; (4) Dukungan emosional; (5) Dukungan instrumental; (6) Dukungan informasional. Kesimpulan meskipun keluarga tidak memiliki pengetahuan terkait keselamatan pasien, namun keluarga tersebut turut mendukung keselamatan pasien karena saran dari tenaga kesehatan dan tidak ada hubungan antara umur, jenis kelamin, tingkat pendidikan, kelas rawat inap dan lama rawat inap terhadap peran keluarga dalam keselamatan pasien.

Kata kunci: keselamatan pasien, *mix-method,* peran keluarga dalam keselamatan, rawat inap, rumah sakit.

ABSTRACT

THE ROLE OF FAMILY IN SUPPORTING THE IMPLEMENTATION OF PATIENT SAFETY IN INPATIENTS AT A PRIVATE HOSPITAL IN BANDAR LAMPUNG: A MIXED METHODS STUDY By

KEVIN HENDRI

There were not many studies that discuss the role of the family in patient safety, especially in Indonesia. This study aims to explore the role of family in patient safety toward inpatients. The *cross sectional* research of this study was carried out in September – December 2024 at Bandar Lampung Private Hospital. Respondents were the families of patients from all inpatient classes with 201 people who were taken *purposively*. Family roles are measured with the *Family Involvement Care Questionnaire* (FICQ). The 25 informants were doctors, nurses and patient's family who were interviewed with *in-depth* interviews. Quantitative data were measured using Mann-Whitney and Kruskal-Walis. Based on the analysis, there was no relationship between age (p=0.425), gender (p=0.784), education (p=0.962), inpatient class (p=0.445), and length of hospitalization (0.425) with family involvements. Qualitative data was analyzed by thematic analysis and there were six themes that emerged: (1) Understanding and knowledge; (2) Families are involved in patient care; (3) Adequate cooperation and communication; (4) Emotional support; (5) Instrumental support; (6) Informational support. Conclusion although the families don't understand about patient safety, the family supports patient safety because by doing the advices from health workers and there is no relationship between age, gender, education level, hospitalization class and length of stay on the role of family in patient safety.

Keywords: family role in patient safety, hospital, inpatient department, mix-method, patient safety.

TABLE OF CONTENTS

Page

LIST OF TABLES

Table Page

LIST OF FIGURES

Figure Page

APPENDIX LIST

Appendix Page

CHAPTER I
INTRODUCTION

1.1 Background

Patient safety continues to evolve every year as technology becomes more sophisticated (Dwiana & Saudi, 2010). This does not free patients from safety risks in hospitals, especially since hospitalized patients are at risk of patient safety incidents (Hafezi et al., 2022). Patient safety incidents (PSI) have the potential for injury that should not have occurred. Patient safety incidents (PSI) themselves include Near Miss Incident (*Kejadian Nyaris Cedera*/*KNC*), *Kejadian Potensial Cedera* (*KPC*), Adverse Event (*Kejadian Tidak Diharapkan*/*KTD*), No Harm Incident (*Kejadian Tidak Cedera/KTC*) and Sentinel (Ministry of Health of the Republic of Indonesia, 2017). Data obtained in Utah and Colorado related to *KTD* (2,9%) with a mortality rate of 6,6%. Data in New York stated *KTD* (3,7%) with a mortality rate of 13,6%. The number of deaths in America caused by unexpected accidents is 33600000 people each year and 44-98000 people died due to medication errors in 2000 (Najihah, 2018). The National Health Service (NHS) report in 2015 stated that there were 82416 cases in the UK, with a mortality rate of 0,22%. According to the National Patient Safety Agency (NPSA) report, between January and March 2017, 1879822 *KTD* occurred in the UK. The Malaysian Ministry of Health recently reported 2769 incidents in 2013 (Lee, 2016).

Patient safety is a system that aims to improve the quality of health services and reduce unexpected events (Alhababy, 2016; Calado, 2014). Most accidents occur due to errors in the service system and not due to health service providers (Churruca et al., 2021). Every patient has the right to receive health services and patient safety so that a culture and habit of patient safety is created in the hospital (Afridawati et al., 2020;Chegini et al., 2020). Patient safety programs can prevent risks and staff know what to do if an incident occurs as a step in patient safety management (Voskanyan, 2018). Hospitals also need to have policies regarding operational procedure systems for staff so that incidents can be avoided (Rodziewicz et.al., 2024).

PSI reporting is a system for documenting patient safety incident reports, analysis and solutions for learning (Pramesona et al., 2022). Safety principles need to be understood by all parties involved in patient safety in order to prevent patients from unwanted incidents (Oikonomou et al., 2019). However, there are still many PSI that are not reported due to various factors, namely individual factors, psychological factors and organizational factors. Individual factors are related to knowledge, abilities and skills. Psychological factors are related to attitudes, perceptions and organizational factors are related to the work environment and culture (Nurislami et al., 2023).

The current health system is only designed to detect negligence originating from health care staff, which makes the current patient safety system a blame culture (Indriani et al., 2022). The health system ignores that in patient safety itself there is a role for patients and their families. In addition, patients and their families play the most important role in patient safety because they interact and experience directly with the related staff (Ramsey et al., 2022).

The family also has an important role in patient safety, especially regarding effective communication between healthcare providers and the patient's family (Coombs et al., 2020). In addition, the family needs to be educated about the patient's condition so that the family is involved in the service, especially in patients with diseases that can endanger patient safety. Thus, the patient's family can know what the clinical symptoms are and the initial

management of the patient as emergency care before being handed over to health workers can be done. As a result, the patient's chances of survival will increase (Mackintosh et al., 2020). Family participation and decision making do improve patient safety through effective communication, adequate education, and involvement in patients both inpatients and outpatients. However the impact of family involvement on patient safety varies based on the patient's family, strategies, and how to care for the patient itself (Mackintosh et al., 2020; Lee et al., 2020)

Poor health service regulations from health workers will have a negative impact on patients and most people who see it will assume that the undesirable incident occurred due to an error by the health worker (Najjar et al., 2015; Brborović et al., 2019). Therefore, the behavior of punishing health workers will not be a solution in solving patient safety problems in patients (Hafezi et al., 2022).

Hospital incidents are events resulting from poor rapport building between health workers and patients, lack of information collected by health workers, lack of information conveyed by both patients and their families, limited clinical assessment, and lack of social attention so that diagnoses are often inaccurate (Butt, 2021). As a result, the patient's condition worsens due to the wrong management algorithm, especially in patients who have comorbidities such as heart problems (Sendlhofer et al., 2019). Therefore, further observation and monitoring related to health incidents need to be carried out so that things that can cause accidents to patients can be avoided (Macrae, 2016). Some things that can be improved are through training and supervision of health workers who deal directly with patients so that each staff understands their respective roles and capabilities (Payne et al., 2023).

Family involvement in care reduces the risk of hospital admissions for hospitalization, and patient falls, and helps patients have better health in patients with complications leading to lower healthcare costs (Patel & Tumlison, 2017). Medical personnel and hospital policies play a role in ensuring patient safety and the Person and Family Centered Care (PFCC)

method is key to improving health in terms of communication, patient satisfaction, and patient safety (Adugbire et al., 2024). This is because the method used is a partnership system that involves health service providers, families, and patients themselves so that patients play a role in decision-making (Correia et al., 2023).

Therefore, further studies on cases involving patient safety and what the main causes are need to be identified further. However, research on patient safety involving families is still rare and the research journal states that further research is needed due to the lack of evidence and many obstacles in understanding the complex relationship in patient safety (Gorman et al., 2023). This is because patient safety involves the role of the patient and the patient's family is still rarely done. In the conclusion of one of the journals, it states that there is a lack of data so that it cannot be concluded the significance of the patient's role in patient safety (Sarkhosh et al., 2022).

There is an increase in the patient safety aspect when the family is involved in caring for the patient through optimal collaboration between health workers and the patient's family in the process of caring for the patient (Rosse et al., 2016). The number of cases involving patient safety is still high. According to the Committee for Quality Improvement and Patient Safety, data on PSI incidents at Dr. H. Abdul Moeloek Hospital in 2022 showed two incidents, namely one *KTD* incident in the oncology-radiology department and one *KTD* incident in the emergency installation (Quality Improvement and Patient Safety, 2022). Based on the results of a presurvey study at a private hospital in Bandar Lampung, PSI data was obtained of 754 cases from January to December 2023. The PSI consisted of 103 *KPC* cases (13,7%), 368 *KNC* cases (48,8%), 264 *KTC* cases (30%), 19 *KTD* cases (2,5%) and 0 sentinel cases (0%). In addition, based on 2022 data, it was reported that there were 1729 cases of *KTD*, 1689 cases of *KNC* (near injury), and 1541 cases of *KTC* (no injury) (Ministry of Health, 2022). Therefore, patient safety is a major problem, especially in hospitals. This is the reason for researchers to conduct a study on " The Role of Family in Patient Safety toward Inpatients in Private Hospital Bandar Lampung: a Mix-Method-Study " with a focus on research

involving families and patients because until now this information is still minimal and further research is needed, especially regarding family involvement in Indonesia.

1.2 Formulation of the problem

Based on the above, the problems can be described as follows:

"How is the role of the family in patient safety at Bandar Lampung Private Hospital in 2024 and what are the associated factors of family involvement in care?"

1.3 Research Objectives

1.3.1 General Objectives

This study aims to explore the role of the family and to find any correlation among age, gender, education, inpatient class, and the duration of inpatient toward the safety of inpatients at Bandar Lampung Private Hospital in 2024.

1.3.2 Specific Objectives

1. Exploring the role of family in the safety of inpatients at Bandar Lampung Private Hospital.
2. To determine the relationship between age and the family involvement at Bandar Lampung Private Hospital.
3. To determine the relationship between gender and the family involvement at Bandar Lampung Private Hospital.
4. To determine the relationship between education and the family involvement at a private hospital in Bandar Lampung.
5. To determine the relationship between inpatient class and the family involvement at Bandar Lampung Private Hospital.
6. The relationship between length of hospitalization and the family involvement at Bandar Lampung Private Hospital.

1.4 Benefits of research

1.4.1 Theoretical Benefits

The results of this study are expected to provide benefits by providing information regarding the role of the family in patient safety at Bandar Lampung Private Hospital.

1.4.2 For Researchers

Researchers hope that this research can provide the following benefits:

1. The results of this study are expected to increase insight and knowledge about the role of the family in patient safety.
2. The research results can be used as a reference and input for further related research.

1.4.3 For Science

This study can contribute to providing evidence on the role of the family in improving patient safety during hospitalization.

1.4.4 For Families and Patients

The results of this study can provide information, insight and knowledge that families have a role in improving the safety of inpatients.

CHAPTER II
LITERATURE REVIEW

2.1 Patient Safety

2.1.1 Definition of Patient Safety

Patient safety is a system that guarantees the safety and security of patients in receiving health services to reduce the risk of unnecessary injury (Ministry of Health of the Republic of Indonesia, 2015). Minister of Health Regulation Number 11 Article 1 of 2017 describes patient safety as a system that makes the care received by patients safer, starting from risk assessment to solution implementation. The goal of patient safety is to encourage hospitals to improve specific aspects of patient safety, thereby minimizing risks and preventing injuries due to incorrect actions or not carrying out actions (Ministry of Health of the Republic of Indonesia, 2017). Patient safety is an attribute of the health service system so that it can avoid incidents and the impact of unwanted events. In its application, patient safety applies a layered system known as the "swiss cheese" model. Patient safety using the "swiss cheese" system is expected to avoid accidents by considering the factors that cause unwanted events (Wang, 2024). Therefore, patient safety requires cooperation from all parties, both from health workers who treat patients directly, medical staff and also from the patient (Vincent, 2010).

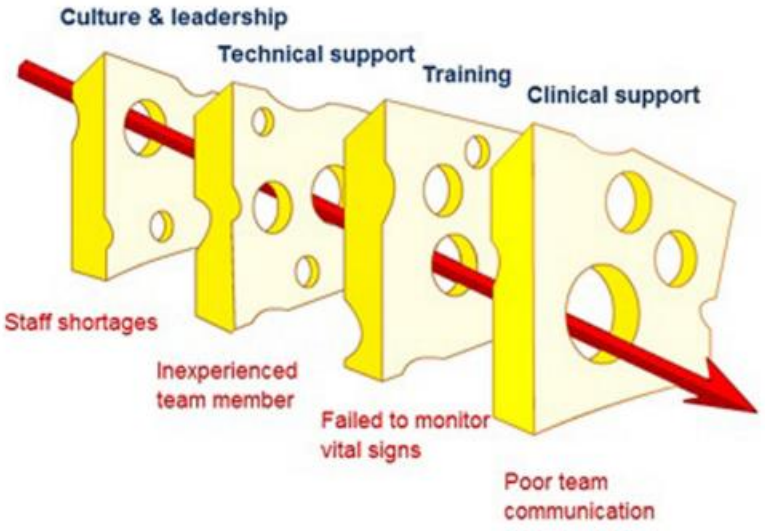

Figure 1. *Swiss Cheese* Diagram

Source: Bajracharya et al., 2019.

Even though adverse events may arise from human error, they do not occur because individuals intentionally harm patients; rather, they result from the complexity of the current healthcare system. The success of patient safety depends on numerous factors, not solely on the competence of healthcare providers. This system is often referred to as swiss cheese where each piece represents a weakness in a system, while the holes in the model explain that if a layer of the system has made an error, the next system will compensate to prevent negative outcomes. However, adverse events can occur when multiple systems fail to perform their functions effectively. Therefore, when an incident occurs, responsibility lies with various parties (Park, 2018).

2.1.2 Patient Safety Objectives

The purpose of implementing patient safety is to improve health services so that if an undesirable incident occurs, staff can immediately take action to deal with the incident and learn so that the incident does not happen again (Ministry of Health of the Republic of Indonesia, 2017).

1. Creating a culture of patient safety in hospitals.
2. Improving the safety of high risk treatments.
3. Improving effective communication.

4. Reducing the risk of health care-associated infections.
5. Reduces the risk of patient injury due to falls.
6. Eliminating patient identification errors, surgical procedure errors.

2.1.3 Patient Safety Goals

Patient safety goals are specific objectives designed to prevent patient harm in the healthcare environment. The following are patient safety goals (Ministry of Health of the Republic of Indonesia, 2017):

1. Identifying Patients Correctly.
2. Patients do not get their beds mixed up, treatments mixed up, etc. The way to identify patients is by looking for the patient's name, date of birth or medical record number.
3. Improving Effective Communication.
4. Improving the Safety of High-alert Drugs.
5. Ensuring the Correct Surgical Site, Correct Procedure, Surgery on the Correct Patient.
6. Reducing the Risk of Healthcare-Induced Infections.

2.1.4 Relationship between Patient Safety and Patient Safety Culture

Patient safety culture is a critical component of healthcare that encompasses various elements, including openness, a non-blaming environment, effective reporting, and learning (Salawati, 2020). Many healthcare professionals, particularly nurses, often fear being blamed due to the inadequate reporting culture (Pramesona et al., 2023). To foster a robust patient safety culture, it is essential to establish effective regulations and promote collaboration among multidisciplinary teams. Additionally, all staff, including cleaners, must be cognizant of infection risks within the hospital, while nurses should be vigilant regarding equipment that may pose safety hazards. Consequently, it is vital to consider the workload and working hours of healthcare workers to minimize preventable accidents (Kakemam et al., 2021). A patient safety culture must be continuously reinforced, as it is closely linked to the incidence of accidents involving hospital patients. Therefore, instilling

strong morals, promoting appropriate behaviors, and providing training for staff are crucial steps in developing a professional patient safety culture tailored to their specific roles (Bieder, 2018).

2.1.5 Basic Patient Safety Rights

According to WHO, there are ten basic rights to patient safety. The ten basic rights to patient safety include (WHO, 2024):

1. The right for punctual, effective and appropriate care.
2. The right for safe health care processes and practices.
3. The right for qualified and competent health workers.
4. The right for safe medical products and their safe and rational use.
5. The right for safe and secure health care facilities.
6. The right for dignity, respect, non-discrimination, privacy and confidentiality.
7. The right for information, education and supported decision-making.
8. The right for access medical records.
9. The right for be heard and a fair resolution.
10. The right for patient and family involvement.

2.1.7 Steps for Implementing Patient Safety

The following are the steps for implementing patient safety according to the Minister of Health's regulations (Regulation of the Minister of Health of the Republic of Indonesia, 2011):

1. Pay attention to the drug name, appearance and also similar pronunciation.
2. Ensure patient identification.
3. Correct communication during patient handover.
4. Make sure the correct action is on the correct side of the body as well.
5. Control concentrated electrolyte fluids.
6. Ensure the accuracy of patient medication administration during service transfers or transfers.
7. Avoid catheter misconnection and tube misconnection.

8. Use single-use injection devices or consumables.
9. Improve hand hygiene to prevent nosocomial infections.

2.2 Patient Safety Incidents

2.2.1 Definition of Patient Safety Incident

According to KKPRS, Patient Safety Incidents are potentially detrimental events that should not have occurred. The events mentioned include *KPC, KNC, KTC, KTD* and sentinel events (Ministry of Health, 2017). *Kejadian Tidak Diharapkan* still often occur, causing public dissatisfaction and leading to lawsuits. All of this is the responsibility of the hospital in providing medical services. If an error occurs, it can have a negative impact on the patient. These negative impacts include minor injuries, physical disabilities, and even death (Wianti et al., 2021).

2.2.2 Prevalence of Patient Safety Incidents

The results of another study in several JCI-accredited hospitals found that there were 52 incidents in eleven hospitals in five countries. The majority of cases (31%) occurred in Hong Kong, (25%) Australia, (23%) India, (12%) America, and (10%) Canada. Further data from this study showed as many as 52% of incidents, namely 25% of patients fell, 30% occurred in the ward, 94% resulted in losses, and 3% resulted in death. Then, there were around 7.6% of cases in Brazil(Magalhães et al., 2017) and there are 60% of hospitals that do not implement patient safety dimensions in Taiwan(Lee, 2016). The above conditions are not in line with the Decree of the Indonesian Minister of Health Number 129/Menkes/SK/II/2008 which states that the number of patient safety incidents in hospitals should be 0% or it should be said that there are no incidents at all (zero accidents) (Ministry of Health of the Republic of Indonesia, 2008).

2.2.3 Types of Patient Safety Incidents

Patient Safety Incidents (PSI) are classified as follows (WHO, 2019):

1. Dangerous incident

   An incident that causes harm and causes harm to the patient so that the treatment plan does not meet expectations.
2. A harmless incident

   Incidents that are not dangerous and do not harm the patient.
3. Near miss incident

   Incidents that do not cause harm to patients but have the potential or risk of causing harm and loss.

In reporting accident cases that occur in hospitals, there are several terms that are always used in reporting so that every health worker has the same perception regarding the type of accident or potential accident that has occurred. The following are some terms used in reporting patient safety cases (Ministry of Health of the Republic of Indonesia, 2011). Types of Patient Safety Incidents (PSI) according to KKPRS are divided into five, namely (Ministry of Health, 2017;Nashifah et al., 2019):

1. *Kejadian Potensial Cedera* (*KPC*): A situation that had the potential to cause harm to a patient but no actual harm occurred.
2. *Near Miss*/*Kejadian Nyaris Cedera (KNC):* An incident that almost caused an injury but was successfully avoided.
3. No Harm/*Kejadian Tidak Cedera* (*KTC*): An event that does not result in injury to the patient, even though an incident occurs.
4. Adverse Event/*Kejadian Tidak Diharapkan (KTD):* An incident that results in injury to a patient, which should not have occurred in the care process.
5. Sentinel Event: An incident that results in death or serious injury that is unrelated to the patient's disease course and results in permanent disability or death.

This incident can occur due to various reasons that do not meet patient service standards, treatment that is not based on the hope of recovery, treatment and compliance risks, and lack of patient consent in the process of taking medication. PSI is classified based on its impact on health services as follows (Cooper et al., 2018):

1. Without loss

   The treatment process is carried out until completion by the patient without any harm to the patient.
2. No loss due to mitigation results

   Any incident that has the potential to cause harm but does not result in harm.
3. Minor loss

   The incident experienced by the patient was an injury but did not require intervention or only minimal care was given.
4. Moderate loss

   Patients who require short-term medical care to receive mild-level assessment and treatment in the ED or hospital ward.
5. Serious vandalism incident

   Patients who experience an incident that has a long-term impact on their physical, mental or social well-being, thereby shortening their life expectancy.
6. Death

   Any incidents that occur during treatment due to inappropriate diagnosis, initial treatment, etc.
7. Incident lacking details

   An incident that occurs when insufficient information is received to assess the severity of a hazard, thereby creating a risk of errors in care outcomes.

2.2.4 Factors Influencing the Occurrence of Patient Safety Incidents

Table 1. Examples of Contributing Factors Based on CADYA (Categorization of Errors in Primary Care) Dimensions and Subdimensions

Item	Examples of patient safety incidents
Environmental factors, patient social context	Elderly, suffering from dementia, inappropriate support plan
Unplanned consultation care	A woman took a promise just for herself and came with her son
Place of care	The health check was incomplete because the patient was examined at home.
Workload management	Workload increases by adding too many consultations
Disturbing elements	Phone call causes doctor to dismiss patient
Health system health services	A medical specialist is needed but is not available on weekends.
Financial or administrative problems	No general practitioners are listed on social security
Human factors related to patients	Aggressive patients (who feel rejected by their doctor)
Related to service provider	Stressed doctor (bad news needs to be announced)
Related to other providers	Pharmacist distracted while dispensing medication
Related to third parties	The indiscretion of a patient's mother towards her daughter
Failure, malfunction, unavailability of equipment	Computer server failure
Incorrect use of tools	Wounds after improper use of pedicure equipment
Data information system is incorrect or missing	Lack of discharge letter after patient hospitalization
Communication system failure	Ultrasound results cannot be read via the internet
Lack of initial training	Ignorance of drug contraindications
False memories (after training)	Inadequate exploration of thromboembolic risk
Synthesis error	Minimizing chronic kidney disease
Inadequate procedures	Coronary patients who stop statins on their own
Lack of protocol implementation	Medical appointment for emergency set late by secretary
Communication failure	Nurse did not call doctor despite unusual dose
Lack of monitoring	Lack of specific eye monitoring despite serious uveitis
Lack of response after feedback	diabetes mellitus is unbalanced, without medical appointment, for several months

Source:Chaneliere et al., 2018.

The prevalence of unwanted incidents due to patients in a fairly large category. This is because patients are the biggest cause of things that cause accidents in patient safety. Therefore, building relationships and connecting feelings is very important, especially during rapport building so that patients can convey what they want, ask, etc. Therefore, the main key to preventing unwanted incidents due to patient errors is to communicate well and effectively (Donaldson et al., 2021).

2.3 Family

2.3.1 Definition of Family

Definitions of the family vary widely and encompass a variety of different forms and features. Despite the difficulty in reaching a consensus, the family remains an important social unit with significant functions and roles in society. Social and economic changes continue to affect the structure and functions of the family, making it a dynamic and evolving concept (Iosif et al., 2014). The family is a social institution consisting of a mother, father, and children, who perform economic, psychological, biological, legal, and social functions in society (Arslan, 2023). The family is the smallest social unit consisting of parents and children, formed by marriage and blood relations between partners, children and siblings (Weigel, 2008).

2.3.2 Role of the Family

Family is a group of people with ties of marriage, birth, and adoption that aims to create, maintain culture and improve the physical, mental, emotional and social development of each family member. The family has a function, one of which is the task of family health, namely the family is able to provide care for sick family members, the family is able to maintain or create a healthy home atmosphere and the family is able to make the right health action decisions. The family plays an important role in patient care by providing information related to the patient's condition by interacting with nurses, support, and collaboration in the

treatment process. As a result, the role of the family has a positive impact and increases the overall success of care (Keitner, 2024; Paula, 2020). The role of the family during patient care includes meeting patient needs, providing support during care, and improving quality of life through nutritional management (Choline et al., 2022).

The family plays a very important role in patient safety because the patient and the patient's family are partners in hospital services. Therefore, the family is expected to play an active role in caring for the patient (Regulation of the Minister of Health of the Republic of Indonesia, 2011):

1. Provide correct, clear, complete and honest information.
2. Know and carrying out the obligations and responsibilities of patients and families.
3. Asking questions about things you don't understand.
4. Understand and accept the consequences of service.
5. Comply and respect hospital regulations.
6. Demonstrate respect and consideration in the process of working with the health team to manage patients.
7. Fulfill financial obligations

2.4 Factors Causing PSI

Table 2. Distribution of Main, Secondary and Total Contributing Factors to the Occurrence of PSI

Dimensions	Major Contributing Factors N (%)	Secondary Contributing Factors N (%)	Total Contribution Factor N (%)
Environmental factors	93 (22.8)	37 (20.3)	130 (22)
Patient's social context	5 (1.2)	5 (2.7)	10 (1.7)
Background of care	38 (9.3)	20 (11)	58 (9.8)
Unplanned consultation	10 (2.4)	0 (0)	10 (1.7)
Place of care	6 (1.5)	8 (4.4)	14 (2.4)
Workload management	22 (5.4)	12 (6.6)	34 (5.7)
Disturbing elements	27 (6.6)	7 (3.9)	34 (5.7)
Health system	23 (5.7)	5 (2.7)	28 (4.7)
Health services	20 (5)	2 (1)	22 (3.7)
Financial or administrative problems	3 (0.7)	3 (1.7)	6 (1)
Human factors	89 (21.8)	86 (47.3)	175 (29.7)
Related to the patient	45 (11)	31 (17)	76 (12.9)
Connect with a healthcare provider	35 (8.6)	41 (22.5)	76 (12.9)
Connecting to another provider	4 (1)	7 (3.9)	11 (1.9)
Regarding third parties	5 (1.2)	7 (3.9)	12 (2)
Technical factors	67 (16.4)	9 (4.9)	76 (12.9)
Equipment	21(5.2)	2 (1)	23 (3.9)
Failure, malfunction, unavailability	19 (4.7)	1 (0.5)	20 (3.4)
Incorrect use	2 (0.5)	1 (0.5)	3 (0.5)
Information Systems	46 (11.3)	7 (3.9)	53 (8.9)
Incorrect or missing data	34 (8.3)	4 (2.2)	38 (6.4)
Communication system failure	12 (3)	3 (1.7)	15 (2.5)
Treatment process	159 (39)	50 (27.5)	209 (35.4)
Cognitive dimension	56 (13.8)	9 (5)	65 (11)
Lack of initial training	26 (6.4)	3 (1.7)	29 (4.9)
Incorrect withdrawal (after training)	13 (3.2)	2 (1)	15 (2.5)
Wrong synthesis	17 (4.2)	4 (2.2)	21 (3.6)
Maintenance procedures	34 (8.3)	14 (7.7)	48 (8.1)
Inappropriate or unfulfilled procedures	31 (7.6)	13 (7.1)	44 (7.5)
Lack of protocol	3 (0.7)	1 (0.6)	4 (0.6)
Coordination of care	69 (16.9)	27 (14.8)	96 (16.3)
Communication failure	59 (14.5)	22 (12.1)	81 (13.7)
Lack (or incorrect) monitoring	9 (2.2)	5 (2.7)	14 (2.4)
Lack of response after feedback	1 (0.2)	0 (0)	1 (0.2)
Total	408 (100)	182 (100)	590 (100)

Source:Chaneliere et al., 2018.

Based on the distribution data of the causes of *KTD*, it can be seen that the largest contributor to *KTD* is in the process of patient service which contributes 35 percent of *KTD*. Meanwhile, environmental factors are the second largest cause with a total of 22 percent. Meanwhile, the least causal factor is the lack of response after feedback. Therefore, improvements are needed, especially in creating a safe work culture in patient safety so that it becomes a patient safety culture in hospitals to minimize the occurrence of *KTD* and improve patient safety.(Chaneliere et al., 2018).

2.5 Frequency Distribution Based on PSI Type

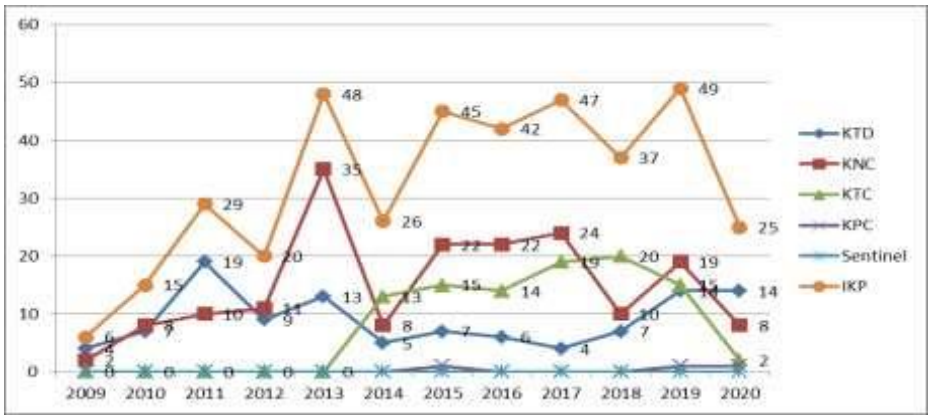

Figure 2. PSI Trends

Source: Muaziz & Irnawati, 2022.

The *KNC* and PSI trends increased in 2009-2013. Then experienced a fluctuating movement since 2014-2020. While in 2020 there was a drastic decline in *KTC* (Muaziz & Irnawati, 2022).

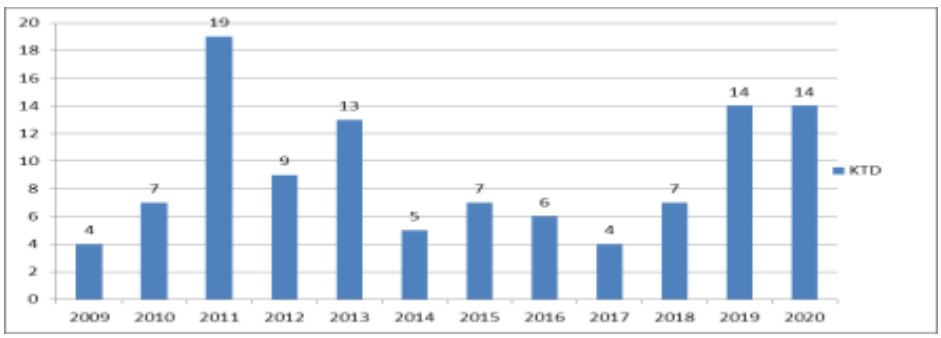

Figure 3. *KTD* Trends

Source: Muaziz & Irnawati, 2022.

The highest number of adverse events in one of the Private Hospitals in Pekalongan Regency for the period 2009-2020 was in 2011 with 19 cases, and the lowest in 2009 and 2017 with 4 cases each. The most common type of adverse event was patient falls with 81 cases (74.31%) and the most cases of patient falls occurred in 2020 with 14 cases (12.8%) (Muaziz & Irnawati, 2022).

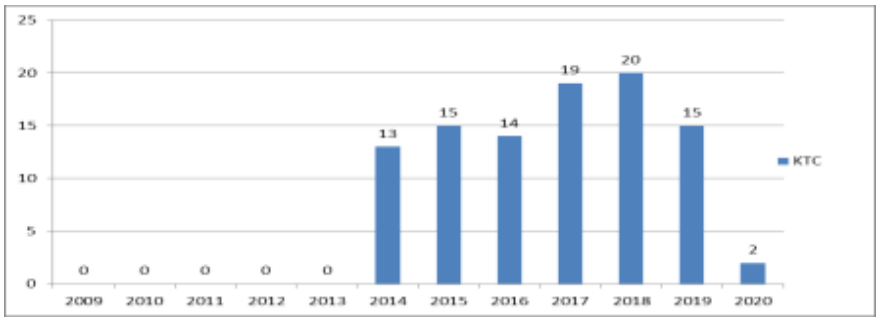

Figure 4. *KTC* Trend

Source: Muaziz & Irnawati, 2022.

The figure shows the trend of *Kejadian Tidak Cedera* in one of the Private Hospitals in Pekalongan Regency for the period 2009-2020, the highest in 2018 with 20 cases. New *KTC* cases emerged in 2014 with 13 cases and in 2020 were the lowest cases with 2 cases. The most common type of *KTC* is wrong medication or blood or dose or route as many as 41 cases (41.8%) and the most cases in 2017 were 13 cases (13.3%) (Muaziz & Irnawati, 2022).

2.6 Safe Health Services According to NQF (National Quality Forum)

The National Quality Forum (NQF) was established to create a credible, consensus-based framework for improving the quality of healthcare. Its primary goals are to enhance patient safety, improve healthcare outcomes, and foster the implementation of effective healthcare practices across multiple settings. The NQF plays a critical role in setting healthcare quality standards in the United States. Its initiatives are critical to creating a culture of safety

and accountability, which ultimately leads to better patient care and outcomes across the healthcare system (Leape, 2021).

Here are the Standards *Safe Practice According to NQF (National Quality Forum):*

1 Create a culture of healthcare safety.
2 For high-risk elective surgical procedures or other specialized care, patients should be clearly informed of the potential for reduced risk of adverse outcomes at care facilities that have demonstrated superior outcomes and should be referred to such facilities according to the patient's stated preference.
3 Define explicit protocols that will be used to ensure adequate levels of nursing care based on the institution's usual patient mix and the experience and training of its nursing staff.
4 All patients in general intensive care units (both adults and children) must be managed by physicians who have specific training and certification in critical care medicine (“certified critical care”).
5 Pharmacists must actively participate in the medication use process, including at a minimum being available to consult with prescribers regarding medication orders, interpretation and review of medication orders, preparation of medications, dispensing of medications, and administration and monitoring of medications.
6 Verbal orders should be recorded whenever possible and read back to the prescriber immediately; that is, the health care provider receiving the verbal order should read or repeat back the information given by the prescriber to verify the accuracy of what was heard.
7 Use only standard abbreviations and dosage designations.
8 Patient care summaries or other similar records should be prepared with all source documents immediately available i.e., they should not be prepared from memory.
9 Ensure that care information, especially order changes and new diagnostic information, is delivered in a timely and clearly

understandable form to all of the patient's current healthcare providers who need the information to provide care.

10 Ask each patient or legal surrogate to recount what he or she was told during the informed consent discussion.

11 Ensure that written documentation of the patient's preferences for life-sustaining care is prominently displayed in his or her chart.

12 Implementing a computerized physician order entry system.

13 Implement standard protocols to prevent mislabeling of radiographs.

14 Implement standard protocols to prevent wrong-site or wrong-patient procedures.

15 Evaluate every patient undergoing elective surgery for the risk of acute ischemic cardiac events during surgery and provide prophylactic treatment to high-risk patients with beta-blockers.

16 Evaluate each patient on admission, and regularly thereafter, for risk of developing pressure ulcers. This evaluation should be repeated periodically throughout treatment. Clinically appropriate preventive measures should be implemented as a consequence of the evaluation.

17 Evaluate each patient on admission, and periodically thereafter, for risk of developing deep vein thrombosis (DVT). Use clinically appropriate methods to prevent DVT/VTE.

18 Use dedicated antithrombotic (anticoagulation) services that facilitate coordinated care management.

19 Evaluate each patient for risk of aspiration.

20 Adhere to effective methods to prevent central venous catheter-associated bloodstream infections.

21 Evaluate each patient preoperatively based on the planned surgical procedure for risk of surgical site infection (SSI), and implement appropriate antibiotic prophylaxis and other precautions based on that evaluation.

22 Use validated protocols to evaluate patients at risk for contrast media-induced renal failure and use clinically appropriate methods to reduce

the risk of renal injury based on evaluation of the patient's renal function.

23 Evaluate each patient upon admission, and periodically thereafter, for risk of malnutrition. Use clinically appropriate strategies to prevent malnutrition.

24 Whenever a pneumatic tourniquet is used, evaluate the patient for risk of ischemic and/or thrombotic complications, and use appropriate prophylactic measures.

25 Decontaminate hands by hygienic hand rubbing or by washing with disinfectant soap before and after direct contact with patients or objects around patients.

26 Vaccinate healthcare workers against influenza to protect them and patients from influenza.

27 Keep the work area where medications are prepared clean, orderly, well-lit, and free from clutter, distractions, and noise.

28 Standardization of drug labeling, packaging and storage methods

29 Identify all “high alert” medications (e.g., intravenous adrenergic agonists and antagonists, chemotherapeutic agents, anticoagulants and antithrombotics, concentrated parenteral electrolytes, general anesthetics, neuromuscular blockers, insulin and oral hypoglycemics, narcotics, and opiates).

30 Dispensing medications in unit dose or, if appropriate, unit-of-use forms, whenever possible.

2.7 Aspects of Professionalism in the Medical Field

Professionalism in medicine refers to a series of attitudes, behaviors, and values that a doctor must have in carrying out his medical practice. This concept is very important because it is directly related to patient trust and the quality of health services so that health workers need to develop it (Hanif & Mabbob, 2023).

2.7.1 Definition of Professionalism

Professionalism in medicine can be defined as the integration of three main domains (Irnanda & Wanasida, 2022):

1. Cognitive Ability (Knowledge): In-depth knowledge of medical science.
2. Psychomotor Ability (Skill): Practical skills in performing medical procedures.
3. Affective Ability (Attitude): Attitudes and behaviors that reflect ethics and morals in interacting with patients.

2.7.2 Components of Professionalism

Some key components of medical professionalism include (Irnanda & Wanasida, 2022):

1. Excellence: Continuous effort to improve competence and knowledge.
2. Accountability: Responsibility for actions and decisions made in patient care.
3. Altruism: Putting the patient's interests above personal interests.
4. Humanism: Respecting patient dignity and committing to service

2.7.3 The Importance of Professionalism

There is a significant relationship between doctor professionalism and patient satisfaction. For example, research conducted at the Faculty of Medicine, Brawijaya University identified that components such as attitude, clinical competence, and knowledge greatly influence the perception of doctor professionalism in the eyes of patients. A doctor's professionalism involves evaluating various aspects that reflect their behavior, attitude, and competence in medical practice (Irnanda & Wanasida, 2022).

2.8 The Role of the Family in Patient Safety

Family support according to Friedman (2013) is an attitude, action of family acceptance towards its family members, in the form of informational support, assessment support, instrumental support and emotional support. So family support is a form of interpersonal relationship that includes attitudes, actions and acceptance towards family members, so that family members feel that someone cares. People who are in a supportive social environment generally have better conditions than their peers who do not have this advantage, because family support is considered to be able to reduce or buffer the effects

of individual mental health. Friedman (2013) divides the forms and functions of family support into 4 dimensions, those are:

1) Emotional Support

Emotional support is a family as a safe and peaceful place to rest and recover and help control emotions. Aspects of emotional support include support that is manifested in the form of affection, trust, attention, listening and being heard. Emotional support involves the expression of empathy, attention, encouragement, personal warmth, love, or emotional assistance (Friedman, 2013). With all behaviors that encourage feelings of comfort and lead individuals to believe that they are praised, respected, and loved, and that others are willing to provide attention.

2) Instrumental Support

Instrumental support is the family being a source of practical and concrete help, including in terms of financial needs, food, drink, and rest (Friedman, 2013).

3) Informational Support

Informational support is the family functioning as an information provider, where the family explains about giving advice, suggestions, information that can be used to reveal a problem. Aspects in this support are advice, suggestions, suggestions, instructions and providing information (Friedman, 2013).

4) Assessment or Award Support

Support for appreciation or assessment is the family acting as a guide and mediator in problem solving, as a source and validator of family member identity, including providing support, appreciation and attention (Friedman, 2013).

2.9 Framework Theory

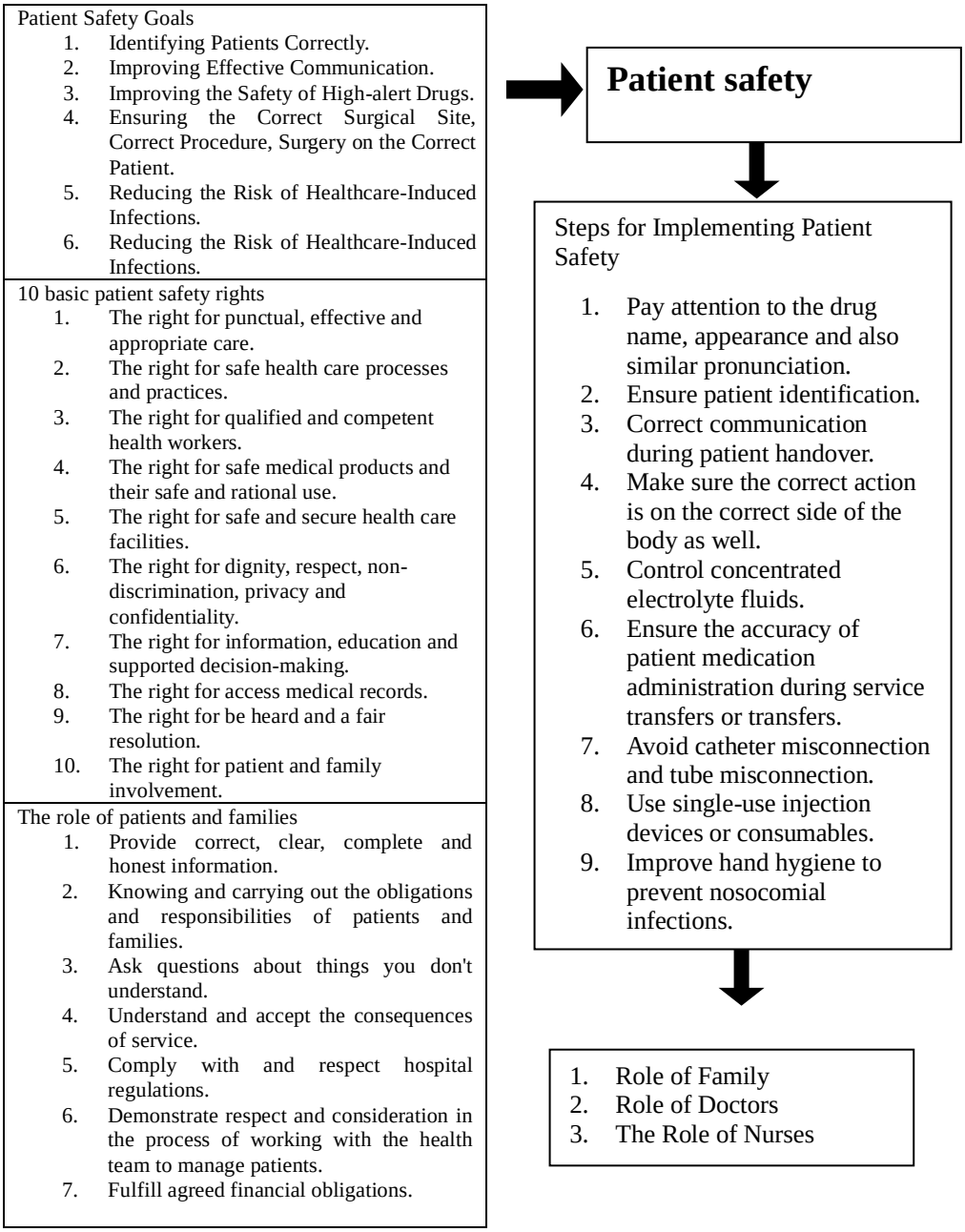

Figure 5. Theoretical Framework

(WHO, 2024; Ministry of Health of the Republic of Indonesia, 2017; Regulation of the Minister of Health of the Republic of Indonesia, 2011)

2.10 Conceptual Framework

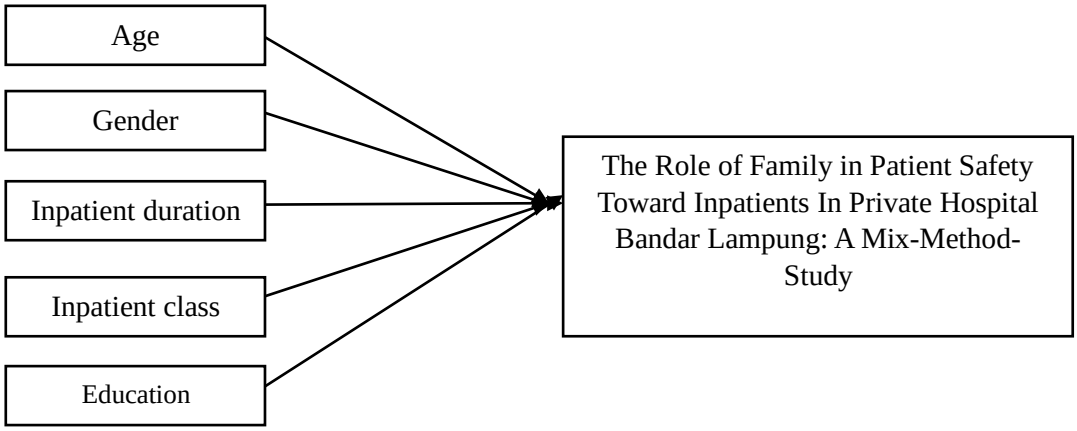

Figure 6. Conceptual Framework

2.11 Hypothesis

1. H0: There is no relationship between age and the family involvement care questionnaire score.
   H1: There is a relationship between age and the family roles.
2. H0: There is no relationship between gender and the family involvement care questionnaire scores.
   H1: There is a relationship between gender and the family involvement care questionnaire score.
3. H0: There is no relationship between length of hospitalization and family involvement care questionnaire scores.
   H1: There is a relationship between the length of hospitalization and the family involvement care questionnaire score.
4. H0: There is no relationship between inpatient class and family involvement care questionnaire scores.
   H1: There is a relationship between inpatient class and family involvement care questionnaire scores.
5. H0: There is no relationship between education and the family involvement care questionnaire scores.
   H1: There is a relationship between education and the family roles

CHAPTER III
RESEARCH METHODS

3.1 Research Design

This research employs a descriptive design utilizing a mixed-methods approach, incorporating both quantitative and qualitative methodologies. The study follows a sequential explanatory design, which integrates quantitative and qualitative methods in a stepwise manner. In the first phase, qualitative methods were employed, followed by quantitative methods in the second phase (Sugiyono, 2014). The quantitative aspect of this study utilized a simple descriptive analysis of the Family Involvement in Care Questionnaire (FICQ) to assess the role of families in ensuring the safety of inpatients. Conversely, the qualitative component involved case studies through interviews with informants, aimed at deepening, expanding, and validating the quantitative data obtained (Sugiyono, 2014). In conclusion, this study offers valuable insights into the role of families in the safety of inpatients at Bandar Lampung Private Hospital.

3.2 Place and Time of Research

3.2.1 Research Location

This research was conducted in the inpatient department of Bandar Lampung Private Hospital, specifically in the internal medicine, surgery, and pediatric departments.

3.2.2 Research Time

This research was conducted from October to December 2024.

3.3 Research Variables

The variables in this study are the role of the patient's family in the safety of inpatients department

3.4 Research Focus

The focus of this research is useful in research as a limitation regarding qualitative research objects to sort out relevant and irrelevant data (Moeloeng, 2004). The limitations in this qualitative research are more based on the urgency of the problems faced in this study, namely the role of the patient's family in the safety of inpatients in October-December 2024 at Bandar Lampung Private Hospital.

3.5 Population, Sample and Research Informants

The population, samples and informants in this study include the following:

3.5.1 Quantitative Methods

a. Population

The population of this study used all families of patients who were being treated as inpatients at private hospitals, namely the internal medicine, surgery and pediatric departments. The researcher took the class 3 room type consisting of Mahoni, Kenanga, Cemara, Tapis and Akasia rooms. The target population obtained by finding the average number of inpatients in a month from January to July 2024 with the result of 328 people.

b. Sample

The sample and sampling in this study consisted of families of patients who were being hospitalized selected using purposive sampling, namely families of patients who were being hospitalized from October to December 2024 were selected based on the researcher's choice.

3.5.2 Qualitative Methods

In this study, informant selection was conducted using purposive sampling, which aims to identify individuals who possess the most relevant knowledge regarding the research topic. This approach facilitates the researchers' investigation of the subjects and enables them to obtain comprehensive responses. The primary informants consist of the families of patients currently hospitalized, while inpatient nurses and doctors serve as supporting informants. Data collection from these informants is scheduled to take place from October to December 2024 at Bandar Lampung Private Hospital.

3.6 Inclusion and Exclusion Criteria

In addition, there are also inclusion and exclusion criteria in this study to detail the samples in this study, including the following:

3.6.1 Quantitative Methods

a. Inclusion criteria
    1. Family of a patient who is being hospitalized.
    2. The patient's family must be at least 18 years old.
    3. The patient's family can read and write well.
    4. The patient's family can communicate well.

b. Exclusion Criteria
    1. The patient's family refused to participate in the research.
    2. The patient's family is participating in another research.

3.6.2 Qualitative Methods

a. Inclusion Criteria
    1. Informants are people who are directly involved and most knowledgeable in patient services and are on duty in inpatient care. Informants consist of patient families who accompany inpatients, nurses, and doctors who work in inpatient rooms with at least one year of work experience.
    2. The informant is still on duty at the Bandar Lampung Private Hospital.

b. Exclusion Criteria

1. Samples refused to be informants or were involved in other research.

3.7 Sample Size and Sampling Techniques

Determining the sample size using the Slovin formula, namely:

$$n = \frac{\mathrm{N}}{1 + N(d)^2}$$

Information:

N = population size

d = error rate of population size (0.05 or 5%)

So the calculation of the number of research samples is as follows:

$$n = \frac{\mathrm{N}}{1 + N(d)^2}$$

$$n = \frac{328}{1 + 328(0{,}05)^2}$$

$$n = \frac{328}{1{,}82}$$

$$n = 180$$

The calculation results obtained a research sample of 180 people. The number of samples was increased by 10% to maintain the possibility of drop out with the following formula:

$$n' = \frac{\mathrm{n}}{(1 - f)}$$

Information:

n' = expected number of samples

n = minimum number of samples

f = estimated drop out

So, the expected sample size is as follows:

$$n' = \frac{180}{(1 - 0{,}1)}$$

$$n' = 198$$

Based on the calculation above, the number of samples used in this study was 198 people. Then the sample was selected using the purposive sampling technique through the following formula. Purposive sampling, namely sampling where the researcher determines the sample according to the researcher's wishes according to the criteria that have been determined with the number of members from each sub-population of all patients and patient families to fill out the questionnaire that meets the inclusion and exclusion criteria to become the research sample. There were a total 30 samples which have been taken for validity test and 201 samples has been taken for the research samples. So the total respondents that was taken were 231 people.

3.8 Operational Definition

Table 3. Operational Definition

No.	Variables	Definition	Equipment	Results	Scale
1	Age	Chronological age is defined as “one of the stages of life,” focusing on “an individual’s development measured in terms of the years requisite for like development of an average individual (Notthoff & Gerstorf, 2015).	Identity form	0= < 37 years old 1= ≥ 37 years old	Nominal
2	Gender	Gender is a multifaceted concept that encompasses the social identities, roles, and behaviors associated with being male or female, distinct from biological sex (Cahill, 2000).	Identity form	0= male 1= female	Nominal
3	Education	Education is seen as the development of cultural wisdom, enabling individuals	Identity form	0= high education 1= low education	Nominal

No.	Variables	Definition	Equipment	Results	Scale
		to navigate complex challenges and fulfill societal duties (Newell, 2014).			
4	Inpatient Class	Inpatient classes are designed to categorize patients based on clinical characteristics, resource use, and treatment requirements (Ashcraft et al., 1989).	Identity form	0= VIP 1= class I 2= class II 3= class III	Nominal
5	Length of hospitalization	Length of Stay (LOS) refers to the duration of time that an individual spends in the hospital. It is the time from a patient's admission to their discharge from the hospital (Ramurs et al., 2023).	Identity form	0= < 3 days 1= ≥ 3 days	Nominal

3.9 Data Collection Techniques

1. FICQ Questionnaire

   This study employs the FICQ questionnaire, which will be used to the families of hospitalized patients to assess their involvement in providing care for these patients. Completing the questionnaire will take approximately 5 to 10 minutes. The researcher will be present alongside the respondent to address any questions related to the questionnaire. The method utilized is a self-report approach.

2. Interview (In-depth Interview)

   Interviews for this qualitative study will be conducted in October 2024, targeting families of hospitalized patients, inpatient nurses, and doctors responsible for overseeing the inpatient rooms at Bandar Lampung Private Hospital. Each interview will last between 30 to 45 minutes. The researcher will conduct structured in-depth interviews, utilizing interview

guidelines to steer the conversation. Additionally, interviews will be recorded using a tape recorder, and the results will be documented in writing. For this study, the researcher has developed a comprehensive interview guideline.

3.10 Research Instruments

The instruments in this study are as follows:

1. **Interview Guidelines**

   The interview conducted in this study utilized a structured instrument consisting of a list of questions designed to meet the study's objectives. The purpose of the interview was to identify the extent of the family's role in ensuring the safety of inpatients and to explore the obstacles that families face in promoting inpatient safety in private hospitals.

2. ***Family involvement in Care Questionnaire*** **(FICQ)**

   FICQ was developed with the aim of measuring family involvement in hospitalized patients consisting of 18 items, 16 of which have been reformulated. FICQ is a questionnaire created based on the PIQ (Patient Involvement Questionnaire) and SFS-ICQ (Swedish Family Satisfaction Intensive Care) questionnaires. The first stage is the selection of relevant items from both questionnaires as FICQ material. There are 24 questions selected from both questionnaires, then a content validity test was carried out and the results showed that only 16 questions could be maintained with 8 questions excluded based on the results of three questionnaire trials.

   FICQ is a validated instrument that can be used to evaluate the role of family towards hospitalized patients. This instrument generally contains 16 (sixteen) questions with 5 (five) Likert scales.

   In calculating the FICQ instrument, the researcher used the Likert scale. This Likert scale has 5 (five) choices that have their own points. The choices consist of:

   0. Not Relevant has 0 points

1. Fully Disagree, has 1 point
2. Somewhat Agree, has point 2
3. Largely Agree, has 3 points
4. Fully Agree has 4 points

3.11 Validity and Reliability Test Results

1. Quantitative Methods

   Validity and reliability tests will be conducted on 30 people using the following methods:

   a. Validity test results

      Validity test is the extent to which the accuracy of the measuring instrument used to measure data. To measure an instrument (questionnaire) is done by conducting a correlation between the scores of each variable with the total score variable. A variable is said to be valid if the score of the variable correlates significantly with the total score, the correlation technique used is the Pearson product moment correlation (Hastono, 2006).

      Test results:

      If the calculated r is greater than the table r then Ho is rejected, meaning the variable is valid.

      If the calculated r is smaller than the table r then Ho fails to be rejected, meaning the variable is invalid.

      Validity test was conducted on 30 people. Based on the number of respondents used in the validity test, the r table value using df = n - 2 at the 5% level obtained an r table figure of 0.361. In addition, the researcher conducted a validity test by conducting a questionnaire test on three experts who have competence and experience in the field of patient safety. Question items that have a CVI score above 0.80 are declared to have adequate validity content and question items with a CVI score below 0.70 are declared irrelevant and need to be eliminated. The CVI/Ave from the experts score are 0,97.

b. Reliability test results

Reliability is a measure that shows the extent to which measurements remain consistent when carried out with measurements twice or more against the same symptoms with the same measuring tool. Questions are said to be reliable if a person's answer to the question is consistent or stable over time. Reliability testing is done by testing validity first, so if the question is not valid, the question is discarded. Questions that are already valid are then jointly measured for reliability (Hastono, 2006)

To determine reliability, a Cronbach Alpha test is carried out.

Test results:

1. If Cronbach Alpha ≥ 0.6, it means the variable is reliable.
2. If Cronbach Alpha < 0.6, it means the variable is not reliable.

Reliability testing was conducted after validity testing was conducted on the entire questionnaire. Reliability testing in this study was conducted on 30 respondents and calculated using a data processing application to conduct the Cronbach Alpha test. The results of the reliability test obtained on all questionnaires used obtained the following results.

Table 4. Results of Validity and Reliability Test of Family Engagement Care Questionnaire (FICQ) (n=30)

Question Items	Corrected Item- Total Correlation	R table	Information	Cronbach Alpha	Information
Q_1	0.723	0.361	Valid	0.937	Reliable
Q_2	0.552	0.361	Valid		
Q_3	0.680	0.361	Valid		
Q_4	0.591	0.361	Valid		
Q_5	0.695	0.361	Valid		
Q_6	0.557	0.361	Valid		
Q_7	0.872	0.361	Valid		
Q_8	0.648	0.361	Valid		
Q_9	0.872	0.361	Valid		
Q_10	0.669	0.361	Valid		
Q_11	0.625	0.361	Valid		
Q_12	0.683	0.361	Valid		
Q_13	0.690	0.361	Valid		
Q_14	0.601	0.361	Valid		
Q_15	0.751	0.361	Valid		
Q_16	0.714	0.361	Valid		

2. Qualitative Methods

Researchers use triangulation to check the accuracy of information, where triangulation refers to a data validation technique that uses something else to compare the results of interviews with research subjects (Moeloeng, 2004). In addition to being used to verify the accuracy of data, triangulation is also used to enrich data and is useful in determining the accuracy of the researcher's interpretation of the data because triangulation is reflective (Nasution, 2003). In this qualitative method, researchers use triangulation of data sources, theories and methodologies. Triangulation of data sources means comparing and cross-checking the degree of reliability of information obtained at different times and in different ways in qualitative research (Moeloeng, 2004). The data sources used are primary and secondary data. Primary data was obtained from interviews while secondary data was in the form of FICQ questionnaires from October to December 2024. Meanwhile, in theory triangulation, researchers verified data using Donabedian's (1988) evaluation theory. And in methodological triangulation,

researchers verified by combining quantitative and qualitative methods. The purpose of this triangulation is to test the truth or validity of the data that has been obtained (Moeloeng, 2004).

3.12 Research Flow

This research uses the following flow:

1. This research began with the preparation of a research proposal as a preparatory stage for field research.
2. Then the research proposal that has been made is submitted to the Research Ethics Committee of the Faculty of Medicine, University of Lampung to examine the research rules and ethics.
3. The next step is to conduct informed consent on research respondents, consent sheets, and distribute questionnaires on patient safety culture at Bandar Lampung Private Hospital and ask respondents to fill out the questionnaire.
4. After the questionnaires are collected, the data obtained is inputted into the computer.
5. Data that has been inputted into the computer will be analyzed by researchers to obtain research results and continued with a discussion of the results.
6. After discussing the results of the research presentation, conclusions are drawn from the research that has been conducted.
7. The researcher continued with qualitative research by conducting interviews with informants.
8. Researchers conducted verbatim and compiled the answers given by informants according to themes and subthemes.

3.13 Data Processing

The collected data will be processed using statistical testing software. The stages in processing data include:

a. *Editing*

   Data completeness will be checked after data collection.

b. *Coding*

Provide certain codes and group the data to make it easier to analyze. For qualitative data, it will be coded according to the theme

c. *Entry*

The coded data is entered into the program after first being scored.

d. *Cleaning Data*

All data entered into the computer will be rechecked to avoid errors in data entry.

e. *Saving*

Data that has been inputted and checked again is then saved for further analysis.

3.14 Data Analysis

1. **Quantitative Data Analysis**

   It is done by descriptive analysis of the FICQ questionnaire to find out quantitative data on the role of the patient's family in the safety of inpatients, then the data is processed using SPSS software. Some of the data analysis used is Descriptive analysis. This analysis is to describe how good the role of the patient's family is in the safety of inpatients. This analysis is used to obtain an overview of the characteristics of respondents by presenting frequency distribution data and percentages for each variable.

2. **Qualitative Data Analysis**

   The qualitative data analysis technique used is thematic analysis technique. Thematic analysis is one way to analyze data with the aim of identifying patterns or finding themes through data that has been collected by researchers (Braun & Clarke, 2006). There are 2 (two) main steps in conducting thematic analysis, including (Liamputtong, 2009):

   a. The researcher reads the entire contents or transcripts of the interviews and tries to give meaning to the transcript data in the form of coding. Coding is the process of examining and testing

existing raw data by labeling it in the form of words, phrases or sentences. There are 2 (two) stages in coding, namely: initial coding or open coding and axial coding.

b. The researcher creates concepts or theoretical ideas related to the codes and themes. The researcher connects the concepts and relates them to Donabedian's (1988) evaluation theory.

3.15 Research Ethics

Research ethics is a set of rules and ethical principles that are mutually agreed upon regarding the relationship between researchers on the one hand and all parties involved in the research or research participants on the other hand (Flick, 2007). The activities in implementing research ethics include the following:

1. Before collecting data, the researcher conveys the research objectives.
2. Informed consent obtained from all informants and samples used as research subjects by paying attention to the confidentiality aspect, namely protecting the confidentiality of respondents' identities and guaranteeing the confidentiality of information provided by informants.
3. Ethical clearance will be submitted to the Ethics Committee at Bandar Lampung Private Hospital

CHAPTER V
CONCLUSION AND SUGGESTIONS

5.1 Research Conclusion

The conclusion of the quantitative research is as follows

5.1.1 There are no relationship between age and the family involvement care questionnaire scores.

5.1.2 There are no relationship between gender and the family involvement care questionnaire scores.

5.1.3 There are no relationship between the length of hospitalization and the family involvement care questionnaire scores.

5.1.4 There are no relationship between inpatient class and family involvement care questionnaire scores.

5.1.5 There are no relationship between education and the family involvement care questionnaire scores.

Qualitative data showed that even though the patient's family did not understand patient safety, they participated in caring the patient which support the patient safety. They did what they should do because of the suggestions from the nurses and doctors, so the family could promote patient safety in the right way.

5.2 Research Suggestions

In further research, it is possible to take data that has been specified such as looking at the role of the family based on age or education categories that increase the generalizability of the results. Researchers are expected to consider other factors that influence the level of family involvement such as the patient's disease diagnosis, patient condition and patient fall risk scoring.

BIBLIOGRAPHY

Adugbire BA, Jordan PJ, Cornelle Y. 2024. Nurses Views of Patient and Family Centered Care and Its Practices in Peri-Operative Contexts in Hospitals in Northern Ghana. *BMC Nursing.* 23(1): 1–13. doi:10.1186/s12912-024-01747-w.

Afridawati MJ, Neherta M, Yeni F. 2020. Studi Fenomenologi Budaya Keselamatan Pasien dari Perspektif Kepala Ruang Instalasi Rawat Inap di RSUD Raden Mattaher Jambi. *Jurnal Ilmiah Universitas Batanghari Jambi*. *20*(1): 334-337.

Alhababy AM. 2016. Hubungan Pengetahuan Perawat dengan Penerapan Identify Patient Correcly di RSUP Ratatotok Buyat Kabupaten Minahasa Tenggara. 14(5): 1–23.

Arikunto, Suharsimi. 2006. Prosedur Penelitian : Suatu Pendekatan Praktik. Edisi Revisi VI. Jakarta: PT Rineka Cipta.

Arslan A. 2023. Characteristics Types and Functions Of Family Concept. *African Educational Research Journal*. 11(1): 45–48. doi:10.30918/aerj.111.23.001.

Arnetz JE, Höglund AT, Arnetz BB, Winblad U. 2008. Development and Evaluation of a Questionnaire for Measuring Patient Views of Involvement in Myocardial Infarction Care. *Eur J Cardiovasc Nurs*. 7(3): 229-38. doi: 10.1016/j.ejcnurse.2007.11.003.

Ashcraft ML, Fries BE, Nerenz DR, Falcon SP, Srivastava SV, Lee CZ, Berki SE,

Errera P. 1989. A Psychiatric Patient Classification System. *Medical Care*, 27(5): 543–557. https://doi.org/10.1097/00005650-198905000009.

Babaei, Abolhasani. 2020. Family's Supportive Behaviors in the Care of the Patient Admitted to the Cardiac Care Unit: A Qualitative Study. *Journal of Caring Sciences*, 9(2): 80–86. https://doi.org/10.34172/jcs.2020.012.

Bajracharya DC, Karki K, Lama CY, Joshi RD, Rai SM, Jayaram S, Kilgore PE. 2019. S*ummary of the International Patient Safety Conference*. *Patient Safety in Surgery*. 13(1): 36.

Bezmez D, Shakespeare T, Yardimci S. 2019. Family Role in Inpatient Rehabilitation: the Cases of England and Turkey. *Disability and Rehabilitation*. 43(4): 559–567. https://doi.org/10.1080/09638288.2019.1632941.

Bieder C. 2018. Can Safety Training Contribute to Enhancing Safety. *SpringerBriefs in Applied Sciences and Technology*. doi:10.1007/978-3-319-65527-7_12.

Brborović O, Brborović H, Nola IA, Milošević M. 2019. Culture of Blame-an Ongoing Burden for Doctors and Patient Safety. *Int J Environ Res Public Health.* 16(23): 1-16. doi: 10.3390/ijerph16234826.

Braun V, Clarke V. 2006. Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*. *3*(2): 77–101.

Butt MF. 2021. Approaches to Building Rapport with Patients, Clinical Medicine. *Journal of the Royal College of Physicians of London.* 21(6): 662–663. doi:10.7861/clinmed.2021-0264.

Cahill LS. 2011. Gender and Christian Ethics. *In Cambridge University Press eBooks*: 103–116. https://doi.org/10.1017/ccol9781107000070.009.

Calado, Monteiro JA, Santos. 2014. Safety Culture in the Surgical Services: Case Study. *Tékhne*. 12(2): 37–47. doi:10.1016/j.tekhne.2014.10.001.

Chaneliere M, Koehler D, Morlan T, Berra J, Colin C, Dupie I, Michel P. 2018. Factors Contributing to Patient Safety Incidents in Primary Care: a Descriptive Analysis of Patient Safety Incidents in a French Study Using CADYA (Categorization of Errors in Primary Care). *BMC Fam Pract*.

19(1): 1-13. doi: 10.1186/s12875-018-0803-9.

Chegini Z, Kakemam E, Asghari Jafarabadi M, Janati A. 2020. The Impact of Patient Safety Culture and the Leader Coaching Behaviour of Nurses on the Intention to Report Errors: a Cross-Sectional Survey. *BMC Nurs*. 19(89): 1-9. doi: 10.1186/s12912-020-00472-4.

Churruca K, Ellis LA, Pomare C, Hogden A, Bierbaum M, Long JC, Olekalns A, Braithwaite J. 2021. Dimensions of Safety Culture: a Systematic Review of Quantitative, Qualitative and Mixed Methods for Assessing Safety Culture in Hospitals. *BMJ Open*. 11(7): 043982. doi: 10.1136/bmjopen-2020-043982.

Cooper J, Williams H, Hibbert P, Edwards A, Butt A, Wood F, Parry G, Smith P, Sheikh A, Donaldson L, Carson-Stevens A. 2018. Classification of Patient-Safety Incidents in Primary Care. *Bull World Health Organ.* 96(7): 498-505. doi: 10.2471/BLT.17.199802. PMID: 29962552; PMCID: PMC6022620.

Correia T, Martins MM, Barroso F, Pinho L, Longo J, Valentim O. 2023. The Family's Contribution to Patient Safety. *Nurs Rep*. 13(2): 634-643. doi: 10.3390/nursrep13020056.

Donaldson L, Ricciardi W, Sheridan S, et al. 2021. Textbook of Patient Safety and Clinical Risk Management. *Springer*. doi: 10.1007/978-3-030-59403-9.

Drakenberg A, Prignitz Sluys K, Ericsson E, Sundqvist AS. 2023. The Family Involvement in Care Questionnaire-An Instrument Measuring Family Involvement in Inpatient Care. *Plos One*. 18(8): 1-16. doi: 10.1371/journal.pone.0285562.

Dwiana N, Saudi S. 2010. Efisiensi dan Pandangan Etis Terhadap Penggunaan Teknologi Modern dalam Menunjang Pelayanan Kesehatan. *Jurnal MKMI*. 6(2): 117–122.

Friedman MM, Bowden O, Jones M. 2003. Family Nursing: Research, Theory, & Practice. 5th Edition. New Jersey: Pearson Education Inc.

Geijer-Simpson E, Kaner E, Lingam R, McArdle P, McGovern R. 2023. Effectiveness of Family-Involved Interventions in Reducing Co-Occurring Alcohol Use and Mental Health Problems in Young People

Aged 12–17: A Systematic Review and Meta-Analysis. *International Journal of Environmental Research and Public Health*. *20*(19): 6890. https://doi.org/10.3390/ijerph20196890.

Georgia G. 2007. The Contribution of Family in the Care of Patient in the Hospital. Available at: https://www.semanticscholar.org/paper/Thecontribution-of-family-in-the-care-ofpatienteorgia/3024afcabff5c24004f7599012c3f6535424a6bf.

Gorman LS, Littlewood DL, Quinlivan L, Monaghan E, Smith J, Barlow S, Webb RT, Kapur N. 2023. Family Involvement, Patient Safety and Suicide Prevention in Mental Healthcare: Ethnographic Study. *BJPsych Open*. 9(2): 1-13. doi: 10.1192/bjo.2023.26.

Hafezi A, Babaii A, Aghaie B, Abbasinia M. 2022. The Relationship Between Patient Safety Culture and Patient Safety Competency with KTD: a Multicenter Cross-Sectional Study. *BMC Nurs*. 21(1): 1-8. doi: 10.1186/s12912-022-01076-w.

Hansson KM, Romøren M, Hestmark L, Heiervang KS, Weimand B, Norheim I, Pedersen R. 2023. The Most Important Thing is that Those Closest to You, Understand You: a Nested Qualitative Study of Personswith Psychotic Disorders Experiences with Family Involvement. *Front Psychiatry*. doi: 10.3389/fpsyt.2023.1138394.

Hastono SP. 2006. Analisis Data. Fakultas Kesehatan Masyarakat Universitas Indonesia

Hodgson CR, Mehra R, Franck LS. 2024. Child and Family Outcomes and Experiences Related to Family-Centered Care Interventions for Hospitalized Pediatric Patients: A Systematic Review. *Children*. 11(8): 949. https://doi.org/10.3390/children11080949.

Indriani M, Kusumapradja R, Anindita R. 2022. Leadership Style, Blame Culture, and Perceived Organizational Support for Patient Safety Incident Reporting at RSIA at Jakarta. *European Journal of Business and Management Research*. 7(6): 304–312. doi:10.24018/ejbmr.2022.7.6.1674.

Iosif FM. 2014. The Family - a Biological, Social and Juridical Reality. *Agora*

International Journal of Juridical Sciences. 8(1):104-108. doi: 10.15837/AIJJS.V8I1.945.

Kakemam E, Chegini Z, Rouhi A, Ahmadi F, Majidi S. 2021. *Burnout and* Its Relationship to Self-Reported Quality of Patient Care and KTD During COVID-19: a Cross-Sectional Online Survey Among Nurses. *J Nurs Manag*. 29(7):1974-1982. doi: 10.1111/jonm.13359.

Keitner, Gabor I. 2024. Family Involvement in Patient Care One Key to Success. Psychiatric News. *American Psychiatric Publishing*. 59(02): 1-13. https://psychiatryonline.org/doi/full/10.1176/appi.pn.2024.02.12.41. doi: 10.1176/appi.pn.2024.02.12.41.

Kementerian Kesehatan. 2008. Keputusan Menteri Kesehatan Republik Indonesia Nomor 129 Tahun 2008 Tentang Standar Pelayanan Minimal Rumah Sakit. Jakarta: Kementerian Kesehatan.

Kementerian Kesehatan. 2013 Peraturan Menteri Kesehatan Republik Indonesia Nomor 82 Tahun 2013 Tentang Sistem Informasi Manajemen Rumah Sakit. Jakarta: Kementerian Kesehatan.

Kementerian Kesehatan. 2015. Buku Saku Keselamatan Pasien (Patient Safety). Edisi 2. Jakarta: Direktorat Bina Upaya Kesehatan RSPI Prof. Dr. Sulianti Saroso.

Kementerian Kesehatan. 2017. Peraturan Menteri Kesehatan Republik Indonesia Nomor 11 Tahun 2017 Tentang Keselamatan Pasien. Jakarta: Kementerian Kesehatan.

Kementerian Kesehatan. 2022. Laporan Insiden Keselamatan Pasien Rumah Sakit. Jakarta: Kementerian Kesehatan.

Khan A, Sodhi S. 2016. Professionalism Sans Humanism: a Body Without a Soul. *Academic Medicine*. 91(10): 1331–1332. https://doi.org/10.1097/acm.0000000000001348.

Komite Peningkatan Mutu dan Keselamatan Pasien (PMKP). 2022. Laporan Internal Insiden Keselamatan Pasien. Bandar Lampung: RSUD Dr. H. Abdul Moeloek Bandar Lampung.

Lee WY. 2016. The Interacting Effect of Cognitive Failure, Consciousness, and Job Stress on Safety Behavior and Accidents. *Korean Journal of*

Industrial and Organizational Psychology. 19(3): 475–497.

Liamputtong P. 2009. Qualitatitive Data Analysis: Conceptual and Practical Considerations. *Health Promotion Journal of Australia*. 20(2): 133–139.

Macrae C. 2016. The Problem with Incident Reporting. *BMJ Quality and Safety*. 25(2): 71–75. doi:10.1136/bmjqs-2015-004732.

Magalhães AMM, Costa DGD, Riboldi CO, Mergen T, Barbosa ADS, Moura GMSS. 2017. Association between Workload of the Nursing Staff and Patient Safety Outcomes. *Rev Esc Enferm USP*. doi: 10.1590/s1980-220x2016021203255.

Muaziz H, Irnawati I. 2022. Retrospective Study: Trends in Patient Safety Incidents in a Private Hospital in Pekalongan Regency. *In Prosiding University Research Colloquium*: 634-642.

Najjar S, Nafouri N, Vanhaecht K. 2015. The Relationship between Patient Safety Culture and KTD: a Study in Palestinian Hospitals. *Saf Health.* 16: 1-10. https://doi.org/10.1186/s40886-015-0008-z.

Najihah. 2018. Budaya keselamatan pasien dan insiden keselamatan pasien di rumah sakit: literature review. *Journal of Islamic Nursing.* 3(1): 1–8. Available at: https://doi.org/10.24252/join.v3i1.5469.

Nashifah NSA, Adriansyah AA. 2021. Analisis Pelaporan Insiden Keselamatan Pasien: Studi Kasus di Rumah Sakit Islam Jemursari Surabaya. *Motorik Jurnal Ilmu Kesehatan.* 16(2): 50-55.

National Safety Council. 2017. Fatigue in Safety-Critical Industries: Impact, Risk, and Recommendations. Singapura: National Safety Council.

Naziyah, Suharyanto T, Pratiwi IA. 2019. Hubungan Dukungan Keluarga dengan Perawatan Diri (Self Care) Pasien Dengan Stroke Non Hemoragik Di Ruang Rawat Inap RS Islam Jakarta Cempaka Putih Tahun 2018. *Jurnal Ilmu Keperawatan dan Kebidanan Nasional*. http://journal.unas.ac.id/ health.

Newell T. 2014. Summary: What is Education. *In Palgrave Macmillan US eBooks.* 145–155. https://doi.org/10.1057/9781137391803_7.

Nisrina NN. 2023. Edukasi Pasien Dan Keluarga Terkait Keselamatan Pasien Di RSU Melati Perbaungan Kabupaten Serdang Bedagai. *Sevaka.* 1(1): 01-

04. https://doi.org/10.62027/sevaka.v1i1.88.

Notthoff N, Gerstorf D. 2015. Age and Time in Geropsychology. *In Springer eBooks*. 1-12. https://doi.org/10.1007/978-981-287-080-3_106-1.

Nurislami S, Pramesona BA, Wintoko R, Oktarlina RZ. 2023. Faktor-Faktor yang Memengaruhi Pelaporan Insiden Keselamatan Pasien: Literature Review. *Jurnal Penelitian Perawat Profesional*. 5(2): 551-558.

Oikonomou E, Carthey J, Macrae C, Vincent C. 2019. Patient Safety Regulation in the NHS: Mapping the Regulatory Landscape of Healthcare. *BMJ Open.* 99(7). doi: 10.1136/bmjopen-2018-028663. PMID: 31289082.

Park MS. 2018. Quality Improvement in Pediatric Care. *Korean J Pediatr.* 61(1): 1-5. doi: 10.3345/kjp.2018.61.1.1.

Payne R, Clarke A, Swann N, Van Dael J, Brenman N, Rosen R, Mackridge A, Moore L, Kalin A, Ladds E, Hemmings N, Rybczynska-Bunt S, Faulkner S, Hanson I, Spitters S, Wieringa S, Dakin FH, Shaw SE, Wherton J, Byng R, Husain L, Greenhalgh T. 2024. Patient Safety in Remote Primary Care Encounters: Multimethod Qualitative Study Combining Safety I And Safety II Analysis. *BMJ Qual Saf.* 33(9): 573-586. doi: 10.1136/bmjqs-2023-016674.

Paula, Andrea, Anduquia, Vásquez., Adriana, Maria, Ramírez, Barrientos., Martha, Adiela, Lopera, Betancur., Constanza, Forero, Pulido, Luisa, Fernanda, Córdoba, Pérez. 2020. La familia es la voz del paciente en la interacción con la enfermera. doi: 10.15649/CUIDARTE.1015.

Patel J, Tumlinson A. 2017. Engaging Family Caregivers Translates to Better Health Outcomes and Lower Costs. *Iproceedings*, *3*(1). https://doi.org/ 10.2196/iproc.8705.

Peraturan Menteri Kesehatan. 2017. Peraturan Menteri Kesehatan Republik Indonesia Nomor 11 Tahun 2017 Tentang Keselamatan Pasien. Jakarta: Menteri Kesehatan Republik Indonesia.

Pramesona BA, Sukohar A, Taneepanichskul S, Rasyid MFA. 2023. A Qualitative Study of the Reasons for Low Patient Safety Incident Reporting among Indonesian Nurses. *Revista Brasileira de Enfermagem*. *76*(4): 20220583.

Pramesona BA, Wardani DWSR, RahmawatiS, Nurmumpuni D, Rasyid MFA.

2022. In House Training Pelaporan Insiden Keselamatan Pasien Sebagai Upaya Meningkatkan Mutu Pelayanan dan Keselamatan Pasien di Rumah Sakit. *JCOMENT (Journal of Community Empowerment)*. 3(3): 194-204.

Ramsey L, McHugh S, Simms-Ellis R, Perfetto K, O'Hara JK. 2022. Patient and Family Involvement in Serious Incident Investigations from The Perspectives of Key Stakeholders: A Review of the Qualitative Evidence. *J Patient Saf*. 18(8): 1203-1210. doi: 10.1097/PTS.0000000000001054.

Ramurs VHCS, Bangalore RA. 2023. Prediction of Length of Stay in Hospitals Using Ensemble Machine Learning Models. *IEEE*. 1–6. https://doi.org /10.1109/incoft60753.2023.10425377.

Rachmawaty R, Hamid F, Gaffar I, Tombong AB, Razak, PNA, Angraini F. 2023. Edukasi Patient Safety pada Pasien dan Keluarga Pasien di Instalasi Poliklinik Rumah Sakit Umum Daerah Sayang Rakyat Kota Makassar. *Poltekita Jurnal Pengabdian Masyarakat*, 4(2): 317–328. https://doi.org/ 10.33860/pjpm.v4i2.1703.

Reusink R. 1996. A Study of Family Involvement and Personal Change in Alcohol and Chemical Dependency Treatment. *FHSU Scholar Repository*. https://doi.org/10.58809/ukxl1642.

Rodakowski J, Rocco PB, Ortiz M, Folb B, Schulz R, Morton SC, Leathers SC, James AE. 2017. Caregiver Integration During Discharge Planning for Older Adults to Reduce Resource Use: a Metaanalysis. *Journal of the American Geriatrics Society*. *65*(8): 1748–1755. https://doi.org/10.1111 /jgs.14873.

Rodziewicz TL, Houseman B, Vaqar S, Hipskind JE. 2024. Medical Error Reduction and Prevention. *Treasure Island (FL): StatPearls Publishing*. PMID: 29763131.

Rogers, S. 2002. A Structured Approach for he Investigation Of Clinical Incidents in Healthcare: Application In a General Practice Setting. *British Journal of General Practice*, 52(supp): 30–32.

Rosse VF, Suurmond J, Wagner C, de Bruijne M, Essink-Bot ML. 2016. Role of Relatives of Ethnic Minority Patients in Patient Safety in Hospital Care: a

Qualitative Study. *BMJ Open.* 6(4):e009052. doi: 10.1136/bmjopen-2015-009052. PMID: 27056588; PMCID: PMC4838722.

Salawati L. 2020. Penerapan Keselamatan Pasien Rumah Sakit. *Averrous: Jurnal Kedokteran dan Kesehatan Malikussaleh*, 6(1), p. 98. doi:10.29103/averrous.v6i1.2665.

Sarkhosh S, Abdi Z, Ravaghi H. 2022. Engaging Patients in Patient Safety: a Qualitative Study Examining Healthcare Managers and Providers' Perspectives. *BMC Nurs.* 21(1): 1-10. doi: 10.1186/s12912-022-01152-1. PMID: 36581873; PMCID: PMC9801597.

Sendlhofer G, Schweppe P, Sprincnik U, Gombotz V, Leitgeb K, Tiefenbacher P, Kamolz LP, Brunner G. 2019. Deployment of Critical Incident Reporting System (CIRS) in Public Styrian Hospitals: a Five Year Perspective. *BMC Health Serv Res*. 19(1): 1-8. doi: 10.1186/s12913-019-4265-0. PMID: 31234858; PMCID: PMC6591923.

Sihotang SR, Hartini MI, Jati SP. 2020. Pelaksanaan Patient Safety Aspek Tujuh Langkah berdasarkan Peran Komite Medik di Rumah Sakit Islam Nahlahatul Ulama Demak. *Media Kesehatan Masyarakat Indonesia*. 19(1): 26–30. doi:10.14710/mkmi.19.1.26-30.

Siregar CT, Zulkarnain, Nasution SZ, Harahap MPH. 2022. The Role and Function of Family in Improving the Quality of Patients Life: Managing Nutrition During Hemodialysis in Medan, Indonesia. *International Journal on Advanced Science, Engineering and Information Technology.* 12(4): 1599–1605. https://doi.org/10.18517/ijaseit.12.4.9020

Sjetne IS, Bjertnae OA, Olsen RV. 2011. The Generic Short Patient Experiences Questionnaire (GS-PEQ): Identification of Core Items from a Survey in Norway. *BMC Health Serv Res.* 11(88): 1-11. https://doi.org/10.1186/1472-6963-11-88

Soikkeli JA, Mishina K, Virtanen H, Charalambous A, Haavisto E. 2021. Supportive Interventions for Family Members of Very Seriously Ill Patients in Inpatient Care: a systematic Review. *Journal of Clinical Nursing*, *30*(15–16), 2179–2201. https://doi.org/10.1111/jocn.15725

Sugiyono. 2014. *M*etode Penelitian Pendidikan Pendekatan Kuantitatif, Kualitatif,

dan R&D. Bandung: Alfabeta.

Vincent C. 2010. Patient Safety: 2nd edition, *BMJ Books*. doi:10.1002/9781444323856.

Voskanyan YV. 2018. Bezopasnost' Patsientov I Sviazannye S Neĭ Neblagopriiatnye Sobytiia V Meditsine. Safety Of Patients nd Adverse Events Related Thereto in Medicine. *Angiol Sosud Khir*. 24(4): 11-17. Russian. PMID: 30531764.

Wang Y, Zhang R, Wang H. 2024. How Effective Is The Early Warning And Risk Management Systems of Psychiatric Patients Based on The Swiss Cheese Model.

Weigel D. 2008. The Concept of Family. *Journal of Family Issues.* 29: 1426 - 1447. https://doi.org/10.1177/0192513X08318488.

Wianti A, Setiawan A, Murtiningsih M, Budiman B, Rohayani L. 2021. Karakteristik dan Budaya Keselamatan Pasien Terhadap Insiden Keselamatan Pasien. *Jurnal Keperawatan Silampari*. 5(1):96–102. Tersedia dari: https://doi.org/10.31539/jks.v5i1.2587.

Witzel DD, Chandler KD, Stawski, RS. 2022. Affective Reactions to Daily Interpersonal Stressors: Moderation by Family Involvement and Gender. *Journal of Social and Personal Relationships*, *40*(3), 1044–1066. https://doi.org/10.1177/02654075221125431

WHO. 2019. Patient Safety. Jenewa*:* World Health Organization. https://apps.who.int/gb/ebwha/pdf_files/wha72/a72_26-en.pdf

WHO. 2024. Patient Safety Rights Carter. Jenewa: World Health Organization. https://www.who.int/publications/i/item/9789240093249