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The Role of Teamwork in Improving Patient Safety Culture

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INDEXING

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ABSTRACT

Since the declaration of patient safety culture in the hospital X in 2015, there were 171 cases of patient safety incident until December 2018, with Near Injury Incidence (KNC) dominated at 56%. Of all the patient safety incidents, about 60% occurred in the treatment facility. Poor coordination among nurses has led to the absence of the same perception on the filling of incident reporting formats, the choice of incidents that had not been so precise, and a feeling of fear of being blamed when reporting an incident. The purpose of this research is to analyze the influence of leadership styles, teamwork, and knowledge of the safety culture of patients at X Hospital, Bekasi. The study aims to analyse the influence of leadership style, teamwork, and knowledge on patient safety culture at X Hospital, Bekasi. This research method uses the analytical causality approach, conducted by a survey method and its correlation technique with the time dimension of one short study. The sample in this study were nurses in the inpatient installation. Sampling size determined using the Purposive Sampling technique resulting in 98 samples. Data analysis uses multiple regression test. The result showed that leadership style, teamwork, and knowledge influence either partially or simultaneously to patient safety culture at X Bekasi Hospital. The dominant of independent variables is teamwork. Finding: In-hospital services, the role of teamwork is significant in creating the patient safety culture. Implications: Hospital management must involve the active role of each team member in improving patient safety culture.

Kata kunci:
Gaya kepemimpinan;
Kerjasama tim;
Pengetahuan;
Budaya keselamatan pasien;

Sejak dideklarasikannya pelaksanaan budaya keselamatan pasien di Rumah Sakit X pada tahun 2015, hingga Desember 2018 terjadi 171 kasus Insiden Keselamatan Pasien dengan didominasi Kejadian Nyaris Cedera (KNC) sekitar 56%. Dari semua insiden keselamatan pasien tersebut sekitar 60% terjadi di ruang perawatan. Koordinasi yang tidak optimal diantara tenaga perawat menyebabkan belum adanya persepsi yang sama tentang pengisian format pelaporan insiden, pemilihan insiden yang belum begitu tepat, dan adanya perasaan takut disalahkan jika melaporkan suatu insiden yang teridentifikasi. Tujuan penelitian ini adalah untuk menganalisis pengaruh gaya kepemimpinan, kerjasama tim dan pengetahuan terhadap budaya keselamatan pasien di Rumah Sakit X Bekasi. Metode penelitian ini menggunakan pendekatan kausalitas eksplanatoris, dilakukan dengan metode survey dan teknik korelasinya dengan dimensi waktu *one short study*. Sampel pada penelitian ini adalah perawat di instalasi rawat inap, diambil menggunakan teknik *Purposive Sampling* sebanyak 98 orang. Analisis data menggunakan uji regresi berganda. Hasil penelitian menunjukkan bahwa gaya kepemimpinan, kerjasama tim dan pengetahuan mempengaruhi baik secara parsial atau simultan terhadap budaya keselamatan pasien di Rumah Sakit X Bekasi. Temuan: Pada pelayanan di rumah sakit peran kerjasama tim sangat penting dalam menciptakan budaya keselamatan pasien. Implikasi: Manajemen rumah sakit harus melibatkan peran aktif setiap anggota tim dalam meningkatkan budaya keselamatan pasien

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INTRODUCTION

Patient safety is the most important global issue in medicine today, with many patients reported to file complaints for medical errors that occurred to them. Patient Safety is a system

to make patient care safer, which includes risk assessment, identification and management of patient risk, reporting and analysis of incidents, the ability to learn from incidents and their follow-up, and implementation of solutions to minimize risks and prevent injuries from mistakes resulting from carrying out an action or not taking the action that should have been taken. Patient Safety Incidents, hereinafter referred to as Incidents, are any unintentional events and conditions that result in or have the potential to cause injury that can be prevented to the patients. (Permenkes, 2017)

Safety culture was initially determined by the Advisory Committee on Safety at the Nuclear Installation of Thailand as "a product of individual and group values, attitudes, perceptions, competencies, and behavioral patterns that determine the commitment, style and organizational management skills, health and safety. Organizations with positive safety culture are characterized by communication established on the basis of mutual trust, by sharing perceptions about the importance of security and by confidence in the success of preventive actions". (Lee et al., 2015)

Hospital is a health service facility for sick people who need help to save their condition. Over time and the development of science and technology, hospitals are not only a place to save patients. Various services can be accessed by patients who need help. Patients who need 24-hour comprehensive and intensive assistance can access inpatient services. Inpatient care has an important role in care services for observation, diagnosis, treatment or other health care efforts. Patient safety in hospitals involves the participation of all health workers, especially nurses.

Nurses are one of the most dominant health workers in hospitals, which is 50% to 60% of the total number of health workers available. Nursing care services provided to patients are integrated services to other health services and have an important role in the realization of patient health and safety(Herawati, 2015).

The safety culture of patients according to Carthy dan Clarke (Carthey & Clarke, 2009), healthcare organization will have a positive patient safety culture, if it has these cultural dimensions. i.e. open culture, just culture, reporting culture, learning culture and informed culture.

The occurrence of patient safety incidents in a hospital will have a detrimental impact on the hospital, staff, and patients, as the service recipients. Another effect is the decreasing level of public trust in health services. These indicate the low quality of care provided by the hospital because patient safety is part of the overall quality (Cahyono Suharjo B, 2008).

Patient safety is an effort to reduce the risk of unwanted injuries in health care to the lowest acceptable value. This lowest limit is determined by the current knowledge, facilities owned, existing resources, and procedures executed must be worth more than without any other handling or procedure (Parand et al., 2014). Patient safety involves cultural changes that are influenced by Learning Culture. Individual conditions cannot be changed but changes in individual work conditions can be looked to improve performance in patient safety.

Working conditions that lead to safety culture will optimize the role and performance of individuals in supporting patient safety programs, as Henrisken and Dayton(Barton, 2009) told knowledge enhancement is the expected output from a training. In quality and safety areas, training is one of the means to increase the need for new knowledge and to improve

individual performance and system performance. Knowledge that would enhance affective skills as well as motoric and cognitive, and therefore obtain an improvement in productivity or better outcomes (Indartono, 2014).

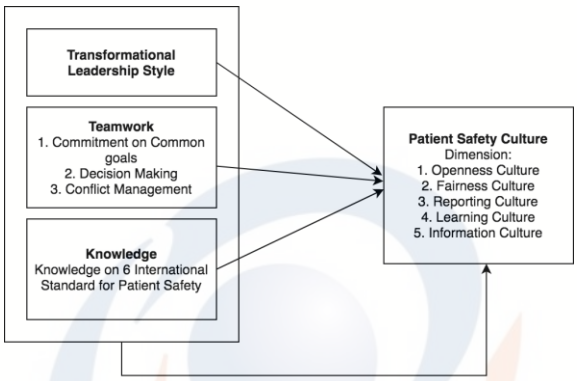
Since the declaration of patient safety culture implementation at X Hospital in Bekasi in 2015, there were 171 cases of Patient Safety Incidents as of December 2018. Of those cases, 34.5% were related to medication use and 65.5% were related to incidents such as patients falling, wrong identity, wrong laboratory results, and others. Based on the Patient Safety Incident, around 18% was classified as Unexpected Events, around 9.4% as Non-Injury Events, and around 56% as Near-Injury Events. Of all the patient safety incidents at X Hospital in Bekasi, around 60% occurred in the treatment room.

At present there are no official records of incidents that harm patients or involve patient safety at X Hospital. Nurses often have to be motivated to report incidents that they find. The reporting process, which is often only verbal, also makes it difficult to monitor incidents. In this case a good leadership style is needed. Inadequate teamwork causes different perceptions about the incident reporting format. The choice of incidents that are not exact and the fear of being blamed for reporting an incident are found as obstacles. To the author's knowledge, a study of safety culture at X Hospital had never been carried out, as with the implications for health policies in the institution (hospital).

Based on the data and background above, it can be concluded that health services that prioritize patient safety require best nursing roles. They include a proper leadership style, optimal teamwork both intra-unit and inter-unit, and nurses' knowledge of the 6 patient safety goals, which are indicators of quality in their respective units.

RESEARCH METHOD

This study used a survey method with an associative and causality questionnaire. The aim was to determine the effect of variables by analyzing the factors related to patient safety culture by the research object. The study was conducted with a comparative quantitative analytical survey approach using causality research design with a time dimension of one short study. Sampling in this study used a purposive sampling technique. Purposive sampling is one of the non-random sampling techniques where the researcher determines sampling by determining specific characteristics that are proper to the purpose of the study so that it can answer the research problems. The sample in this study consisted of 98 nurses.



Picture.1 Conceptual Research Framework

RESULT AND DISCUSSION

Characteristics of Respondents

Table 1. Distribution of Respondents' Characteristics at X Hospital Inpatient Installation in 2019

Age Category	N	Percentage
20-35 years	87	72%
35-50 years	12	28%
Total	98	100%
Gender Category		
Male	12	12%
Female	87	88%
Total	98	100%
Education Category		
Diploma	91	92%
Bachelor	7	8%
Total	98	100%
Patient Safety Training Category		
Yes	63	77%
No	35	23%
Total	98	100%

Source: Data Analyzed, (2019)

Based on the data above, most respondents were in the age range of 20-35 years, which were 87 people (72%); those in the age range of 35-50 years were 12 people (28%). Because most nurses in the inpatient unit were in the productive age, it was expected that the Patient Safety Culture can be pursued maximally. In the gender category, there were more female nurses (87 people or 88%) than male nurses (12 men or 12%). Genders are not a problem in the nursing profession, but female nurses are usually more thorough in their work, which is an important point. Therefore, with the large number of female nurses in the inpatient unit, it is expected that the number of unwanted events can be avoided so that the Patient Safety Culture can be realized optimally.

In the education category, most nurses were DIII (of Associate Degree) graduates, (91 people or 23%), and 7 nurses (8%) were S1 (of bachelor's degree) graduates. In Figure 4.7, 8% of all nurses in the inpatient unit had DIII competence. Nurses with DIII education level should have good competence in implementing the Patient Safety Culture. Based on the patient safety training category, 63 nurses (77%) had received training, more than nurses who had not received training (35 nurses or 23%). This indicates that the Patient Safety Culture has better chance to succeed so that quality indicators can be achieved.

Descriptive Analysis

Patient Safety Culture

According to respondents as shown on Appendix 1.1, the patient safety culture was categorized as "moderate" with an average index value of 64.43. This shows that the hospital had implemented a patient safety culture, but it was not yet optimal.

The learning culture dimension got the lowest average index value, which was 53.9, followed by the reporting cultural dimension with a value of 60.6, the openness cultural dimension with a value of 63.3, the information culture dimension with a value of 70.43 and the fairness cultural dimension with a value 80.85.

Leadership Style

According to respondents, the leadership style in the hospital was in "good" category with an average index value of 75.94 (Appendix 1.2). The highest index value (80) indicates that the leaders encourage the subordinates to submit ideas/opinions in order to solve problems. With the good assessment of nurses on the leadership style, it is expected that the quality of patient safety culture will be maintained.

Teamwork

According to respondents on Appendix 1.3, teamwork at the hospital was in "good" category with an average index score of 78.95. The highest index value (85.8) indicates that many team members showed a desire to participate in achieving common goals in order to improve the quality of Patient Safety Culture.

Patient Safety Knowledge

According to respondents as shown on Appendix 1.4., knowledge of patient safety was in "good" high category with a value of 76.58. The highest index value (80) indicates that nurses' knowledge of the hand washing Standard Operating Procedure aimed at reducing the risk of infection was good, which means that nurses were disciplined in washing their hands which is the main requirement of patient safety.

Hypothesis

Table 2. Hypothesis testing result

Model	Unstand Coeff.		Stand Coeff Beta	t	sig	Note
	B	Std. Err				
(Constant)	-10.520	3.31		-3.159	.002	
1 Leadership Style	.262	.122	.164	2.141	.035	H2 Accepted
2 Teamwork	.240	.045	.422	5.278	.000	H3 Accepted
3 Knowledge	.402	.080	.373	5.015	.000	H4 Accepted
Model	**Sum of Square**	**df**	**Mean Square**	**F**	**.000**	**Note**
Regression	1550,910	e	516.970	48.3776	.000	H1 Accepted
Model	**R**	**R Square**	**Adjusted R Square**	**Std Error of the Estimate**		
1	.779*	.607	.594	3.269		

From the results of simultaneous hypothesis testing, it was known that the Sig. value was 0,000 and the calculated F value was 48,374. Because the Sig. value of 0,000 <0.05 and calculated F value of 48.374> F table of 2.70, it could be concluded that the hypothesis (H1)

was accepted, or in other words, leadership style, teamwork, and patient safety knowledge **simultaneously affected** the Patient Safety Culture at Ananda Hospital, Bekasi.

From the partial test results, it was known that the Sig. vale of Leadership Style was 0.035 (p <0.05) and the t value was 2.141> 1.989. This means that the hypothesis was rejected; Ho was rejected, and Ha was accepted, or in other words, the leadership style **had a positive influence** on patient safety culture.

From the Teamwork variable in the table above, it was known that the Sig. value was 0,000 (p <0.05) and the calculated t value was 5.278> 1.989, therefore the hypothesis was rejected; Ho was rejected and Ha was accepted, which means Team Cooperation **had a positive influence** on patient safety culture.

From the Knowledge variable in the table above, it was found that the Sig. value was 0,000 (p <0.05) and the t value was 5.015> 1.989. This means that the hypothesis was accepted; Ho was rejected, and Ha was accepted, or in other words, patient safety knowledge **had a positive influence** on patient safety culture.

Meanwhile, the coefficient of determination or Adjusted R Square was 0.594 or 59.4%. This figure indicated that the variables of Leadership Style (X1), Teamwork (X2) and Knowledge of patient safety (X3) simultaneously **influenced** the patient safety culture variable (Y) by **59.4**%, while the remaining **40.6**% was influenced by other variables which were not examined by the author, such as openness of communication, management support, staff placement, nurses' attitude style, job satisfaction, work loyalty, and productivity

Discussion

H1. Effects of leadership style, teamwork, and knowledge on patient safety culture

Based on the results of the study, it was known that the Sig. value was 0,000 and the calculated F value was 48,374 and because of the Sig value. of 0,000 <0.05 and calculated F value> the F table (48,374> 2.70), it can be concluded that the hypothesis (H1) was accepted, or in other words leadership style, teamwork, and knowledge simultaneously **affected** the Patient Safety Culture at X Hospital, Bekasi.

Knowledge is a major factor that has a direct impact on service quality. Individual knowledge includes individual qualities such as skill level, experience, intelligence, ability to detect, education and training, alertness, fatigue, and motivation. The leadership style directly or indirectly reflects a leader's belief in the abilities of their subordinates. This means that leadership style includes behavior and strategy, as a result of a combination of philosophy, skills, traits, attitudes, which are often applied by a leader when they try to influence the performance of his subordinates. Many studies suggest that having a team makes goals achieved more effectively than traditional hierarchical structures because in a team, decision-making can be done more quickly and efficiently. Dramatic changes can be seen from support for input and feedback to employees.

A study(Dwi Setiowati, 2010) showed that leadership carried a positive influence on patient safety culture. Another study(Beginda, 2012) stated that teamwork, patient safety culture and leadership style affected perception. In the knowledge category, it has also been studied(Hidayati, 2015) that internal factors in nurses and midwives that significantly influenced the application of patient safety culture were knowledge and attitude.

It can be concluded that the hypotheses built in this study have in common with and strengthen earlier studies, that every medical measure holds a potential risk and no doctors or other health workers want the patients to be harmed. Therefore, patient safety is important and is continuously socialized within the health facility environment.

Patient safety is a prominent issue in a health facility, and in a hospital, patient safety is also a principal factor to assess in an accreditation process.

H2. Effects of Leadership Style in Patient Safety Culture

Leadership styles are defined as various behavioral patterns preferred by leaders in directing and influencing workers(Stoner et al., 1996). Based on the research results, it was known that the Sig. value for the Leadership Style was 0.035 ($p < 0.05$) and the calculated t value was 2.141 (> 1.989), and therefore the hypothesis was rejected, which means that Ho was rejected and Ha was accepted, which means the leadership style **affected** the patient safety culture.

The success of an organization in achieving its goals depends very much on the quality of the organization leadership. The quality of leadership in organizations is reflected in the ability of the leaders in: understanding the factors that become organizational strengths, recognizing organizational weaknesses, taking advantage of the available opportunities, eliminating various threats, being proactive and anticipatory to change, encouraging subordinates to work with optimum efficiency, effectiveness and productivity, and creating a favorable working climate. The following are definitions of leadership style:

Leadership Style is a set of traits used by a leader to influence the subordinates to achieve the organizational goals, or the patterns of behavior and strategies that are preferred and often applied by a leader(Veithzal & Jauvani, 2010).

A research entitled "The Relationship of Effective Leadership of Head Nurse and Patient Safety Culture by Executive Nurses at RSUPN Dr. Cipto Mangunkusumo Jakarta, University of Indonesia" (Dwi Setiowati, 2010) showed that leadership has a positive influence on patient safety culture.

The results of this study are in line with the theory and the results of previous studies. A strong safety culture requires the ability of a leader to establish and communicate a vision of safety clearly, respect and empower staff to achieve the vision, be actively involved in efforts to improve patient safety, be a role model for subordinates, focus on system problems rather than individual mistakes, and continue to do system improvements.

To achieve goals optimally, managers and leaders, including the room managers, must work together with staff at various levels. According to a research by Firawati (Firawati et al, 2012), involving team in mitigating the risk of Patient Safety seen as a token of commitment from the director, staff, medical officers and other involved within the healthcare facilities. Therefore, the most appropriate model of leadership is the transformational leadership model, where the leader and the subordinates strive to achieve a higher level of morality and motivation. This is different from the transactional leadership model that motivates subordinates to carry out their responsibilities; transactional leaders rely heavily on a system of rewards and punishments to their subordinates.

The implementation of a patient safety culture primarily focuses on human resource management procedures and performance behaviors in patient safety related to supervision,

individual discipline, and effective leadership. This shows that to build a strong safety culture, a strong leadership, motivation and individual discipline in patient safety performance and human resource management systems are needed (Firawati et al, 2012; Xie et al., 2012).

H3: Effects of Team Cooperation on Patient Safety Culture

Teamwork is defined as a group of individuals with specific skills that work together and interact to achieve a common goal (Ilyas, 2003) while Thompson (Peluchette, 2011) defines the team as a group of people who are intertwined with information, resources, skills, and strive to achieve a common goal.

Based on the test results, it was known that the Sig. value was 0,000 ($p < 0.05$) and the t-value was 5.278 (> 1.989), therefore the hypothesis was rejected, meaning that Ho was rejected and Ha was accepted, which means that Team Cooperation affected the patient safety culture.

Differences between team members mention a potential that makes a team creative and innovative. To achieve good teamwork, positive attitudes among team members need to be developed, such as the habit of listening to each other so that excellent communication is created, supplying support to team members in need, and appreciating the contributions and achievements made by each team member. Supervision, although it is important, does not always improve the quality of the teamwork, for example, when it is done ineffectively (Sukesi et al., 2015). A teamwork will be the determinant of whether the organization's journey is smooth. For this reason, good cooperation is needed in carrying out organizational responsibilities (Gary, 2018).

Other earlier research in the Inpatient Unit of Bekasi Regional General Hospital (Beginda, 2012) and Bhayangkara Hospital Palembang (Arini et al., 2018) have also stated that teamwork and patient safety culture have significantly influenced perceptions of patient safety incident reporting.

The results of this study and previous studies are both following the theories that have been put forward. The author concluded that teamwork is more than just traditional work groups. In teamwork, accountability is demanded, both individually and in groups.

In the hospital context, a team is formed by professionals who work as a team and are committed to achieving a goal, which is to realize good quality service, in line with Buchholz (Buchholz et al., 1987) stating that process of working in a group by participative leadership, shared responsibility, aligned on purpose, intensive communication, future focused, focused on task, creative talents and rapid response to get the aims of the organization.

Teamwork is fundamental in improving the quality of care and patient safety culture because it is the work team that influences the work atmosphere. Consequently, the hospital management needs to ensure the work team's effectiveness and conductivity. In addition to creating a culture of work safety, efforts must be made to synergize leaders, team leaders and team members who interact directly with patients.

H4: Effects of Knowledge on Patient Safety Culture

Knowledge can be defined as a process by using someone's senses upon to a certain object to generate knowledge and skills (Idris, 1987).

Based on the test results, it was known that the Sig. value was 0,000 (p <0.05) and the t-value was 5.015 (> 1.989), therefore the hypothesis was accepted, which means that Ho was rejected and Ha was accepted, which means that knowledge **influenced** patient safety culture.

Knowledge is the result of knowing, and this happens after people sense a certain object. Sensing occurs through the five human senses, namely vision, hearing, smell, taste and touch. Most of human knowledge is obtained through the eyes and ears. Knowledge is a very important domain in shaping one's actions (overt behavior). Based on research, it was found that behavior based on knowledge will be more lasting than behavior that is not based on knowledge (Notoatmodjo, 2010).

A study entitled The Relationship between Knowledge and Attitudes of Nurses and the Implementation of Patient Safety in Inpatient Rooms of RSUD Liun Kendage Tahuna (Bawelle et al., 2013) showed that nurses' knowledge about patient safety in each room was good. This was indicated by the finding that the respondents had good knowledge, with a value of 90.8%.

From research on nurses' knowledge about each aspect of the 6 patient safety targets, it is known that reducing the risk of infection related to health care is the thing most understood by nurses. A good understanding of this is due to a well socialized Patient Safety Culture program that is applied to the nurses.

The main element that must be considered in realizing quality service is safety, while the key to quality and safe service is to build a patient safety culture. Nurses play an important role in developing the quality of service. To build patient safety commitment that is influenced by the knowledge of nurses is required. Nurses with good knowledge about patient safety certainly have a good attitude in improving the quality of health services.

Nurses must recognize their role to actively participate in realizing hospital patient safety. Knowledge is an important factor in deciding, but someone's knowledge does not always prevent them from unwanted events. This means that nurses who have a good level of knowledge do not always implement patient safety culture properly because all actions have the risk of triggering mistakes.

Research Findings

Teamwork became the dominant variable in this study. The statement with the highest score was "team members show a desire to participate in achieving a common goal". This statement was contained in the dimension of commitment to the joint goal of teamwork. A good team has a clear direction or goals. A team has a common goal to be achieved from collective, instead of individual, work results. A definite team goal will be of great benefit if the team have clear task details. Team members use their time and energy to focus on goals and are willing to devote more time and energy to the new tasks needed to achieve the goals.

The dimension of teamwork with the lowest score was conflict handling within the team. The statement that received the lowest score was "the debate is aimed at finding the best way and not because of personal/emotional problems". Conflicts which are disagreements among individuals on the team are the result of differences in influencing the team. The debate in the team is intended to find the best way and be resolved by negotiation, not by unilateral decisions. Team debates should only occur within the scope of work and

must not interfere with relationships between individuals outside working hours. In the debate, everyone is given the opportunity to express their thoughts and desires.

A good teamwork is also strongly supported by effective communication patterns, common perceptions of team goals, and similar norms and values shared by the organization. In the field of health, a team's job and teamwork depend on how much different the profession is in work settings.

To build good perception, leaders/managers must show their commitment to patient safety. In other words, leaders must become role models, where each of their behaviors must demonstrate patient safety efforts. One of the factors in creating a patient safety culture is the reporting of incidents/unexpected conditions and the presence of a feedback system. This condition, however, as not been entrenched in health care agencies because there is a fear or worry related to the notion that incidents are a disgrace for health workers that must be covered. The culture of learning from mistakes and not blaming employees who make mistakes must be demonstrated by the leadership.

Nurses' knowledge of Patient Safety Culture plays a key role in encouraging the implementation of the Patient Safety Culture program. Nurses must know the definition, goals, and efforts of patient safety culture. The Patient Safety Culture Program is a system where the hospital supplies safer patient care. The system includes assessing risks such as the risk of falls or cross-infection, identification and management of matters related to patient risk, reporting and analysis of incidents or unexpected events, the ability to learn from incidents and their follow-up, and the solution implementation to minimize the risk.

Implication

Teamwork has a positive effect on patient safety culture. This means that good teamwork will result in an increase in patient safety culture. The implication is that patient safety culture can be improved by increasing teamwork. A good team has a clear direction. The entire team in the work unit understands the organization's vision, mission, and goals. And the hospital's goals must be aligned with the team's goals.

Each team member takes part in achieving a common goal, uses their time and energy to focus on the goal and is willing to devote more time and energy to the new tasks needed to achieve the goal. Decision-making together in a team also provides benefits such as creating synergies, stimulating creative ideas, making better decisions, and accepting better decisions.

Conflict handling in a team also influences teamwork. Conflicts or disagreements among individuals or groups in a team are the result of differences in influencing the team.

In creating shared goal commitments in the team, making decisions and handling conflicts, the role of a leader is needed. A leader can encourage team members to apply patient safety culture effectively. That way patient safety culture can be applied by nurses at all levels, from executive nurses to the managers. One of the functions of a leader in a team is to supervise. Implementation of patient safety culture by executive nurses requires supervision to realize patient safety in nursing services at the hospital. If patient safety culture has been implemented well and effectively, the quality of service in the aspect of patient safety will increase and be of higher quality. The hospital needs to conduct standard evaluation criteria for a team leader and selects a leader who can encourage team members to

cultivate open communication. Team evaluation, both individual and in groups, will build awareness about the value of patient safety through the implementation of a patient safety culture in all lines of the hospital setting, from nurses to managers.

CONCLUSION

Teamwork has major influence on patient safety culture. This means that the better the teamwork done by nurses in doing their duties and the less conflict among them, the better patient safety culture can be kept. Nurses' knowledge about patient safety goals has significant influence on patient safety culture. This means that the higher the nurse's knowledge, the more skilled they will be in carrying out the work, mastering each job description, and avoiding mistakes that patient safety will be achieved. Leadership style has significant influence on patient safety culture. This means that the better the leadership a leader has in motivating nurses, the bigger the chance to achieve the target patient safety quality indicators.

Taking a persuasive approach by hospital leaders in dealing with conflicts, consequently, problems can be assessed objectively. Familiarizing reporting culture and learning culture of every incidence to prevent the same occurrences from returning. Simplifying the procedures for patient safety reporting, making simple and easy to implement. Initiating regular coordination meetings and gathering events to further enhance the sense of engagement among team members. Providing training for nurses on the latest update on the Patient Safety culture. Actively circulating information related to patient safety through hospital bulletins, wall magazines, and other media, hence, information accessed more easily and efficiently.

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