Patient identification in wards: what influences nurses' compliances?

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INDEXING

Keywords:

Patient
identification;
Nurses' compliance;
Hospital;

ABSTRACT

Patient safety is important because people have easy information and hospitals reports related to medical errors. Patient identification is the most important causes in patient safety incidents. In 2019, 12 near misses due to misidentification of patients in the inpatient, laboratory, and pharmacy at the private class D hospital in Blitar. This prompted the authors to conduct case study and analyse the causal factors of the problems. The method used in this research is descriptive and case study approach. Identification of the root problems was done by observation and interviews with implementing inpatients room's nurses using observation sheets. Determination of the root problems is determined through two-stage focus group discussion (FGD) using a fish bone diagram. Six root problems was found that affect the low compliance in the implementation of patient identification in inpatient installations, they are low supervision and supervision from the leadership, no resocialization regarding patient identification, small number of patients, lack of safety culture, lack of supporting tools, and patients' willingness to be served quickly. Knowing the root factors that affect the officers' compliance is essential so supervision methods that are appropriate to the conditions of the hospital can be conducted.

Kata Kunci:

Identifikasipasien;
Kepatuhanperawat;
RumahSakit;

Keselamatan pasien penting saat ini karena orang memiliki akses informasi yang mudah dan banyak laporan rumah sakit terkait dengan kesalahan medis. Kesalahan identifikasi pasien merupakan salah satu penyebab paling penting dalam insiden keselamatan pasien. Tahun 2019 terdapat 12 kejadian nyaris cidera karena kesalahan identifikasi pasien pada ruang rawat inap, laboratorium, dan farmasi di RS swasta Kelas D Kota Blitar. Ini mendorong penulis melakukan studi kasus dan menganalisis faktor-faktor penyebab masalah. Metode yang digunakan dalam penelitian ini adalah deskriptif dan pendekatan studi kasus. Identifikasi masalah akar dilakukan dengan observasi dan wawancara dengan menerapkan perawat ruang rawat inap menggunakan lembar observasi. Penentuan akar masalah ditentukan melalui dua tahap diskusi kelompok terarah (FGD) menggunakan diagram tulang ikan. Ditemukan enam akar masalah yang mempengaruhi rendahnya kepatuhan dalam pelaksanaan identifikasi pasien di instalasi rawat inap, yaitu rendahnya pengawasan dan pengawasan dari pimpinan, tidak ada sosialisasi mengenai identifikasi pasien, sejumlah kecil pasien, kurangnya budaya keselamatan, kurangnya alat pendukung, dan kesediaan pasien untuk dilayani dengan cepat. Mengetahui akar masalah yang mempengaruhi kepatuhan petugas sangat penting sehingga metode pengawasan yang sesuai dengan kondisi rumah sakit dapat dilakukan.

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Article History: Received 2020-04-03; Revised 2020-07-04; Accepted 2020-07-25

INTRODUCTION

The current National Health Insurance System has made it easier for the public to obtain health services that are able to guarantee the quality and safety of patients (Surahmat et al., 2018). Patient safety is a matter that needs to be considered in the era of globalization that we face today because people are starting to make many demands regarding medical

errors that occur in patients. With the existence of a patient safety system in the hospital, all patient care becomes safer, starting with risk management, identification, reporting, incident analysis to reduce injuries and risks as well as follow-up that must be taken and solutions that can be applied to improve patient safety. In the Minister of Health Regulation Number 11 of 2017 has been regulated regarding patient safety. The preparation of patient safety targets uses a reference from the Nine Life-Saving Patient Safety Solutions from the World Health Organization (WHO), which is also used by the Hospital Accreditation Commission and the Joint Commissions International (JCI).

One of the goals of the patient's safety is patient identification. Patient identification is the most important cause in patient safety incidents. Errors in identifying patients are found in many aspects from the stages of diagnosis, treatment and action to patients through patient safety incident reports (Mulyana, 2013). Errors in identifying patients occur in the following situations, among others, patients who are unconscious after sedation or sedative use, experience orientation disorder, patients with physical and mental limitations so that they are switched beds, or rooms in health care facilities (Kementerian Kesehatan Republik Indonesia, 2017). Patient identification activities in patient safety targets include: (1) identification of patients with two identities, may not use the number or name of the room where the patient is being treated, (2) patients are identified before diagnostic and therapeutic procedures or procedures, (3) identification of patients is carried out before administration of drugs, blood or blood products (4) patients are identified before taking blood and other specimens, and (5) guidelines and procedures for implementing identification that are standard and applicable in all situations and locations (KARS, 2017). Implementation of patient identification is not only to do the bracelet and before taking medical action and nursing care, but there must be communication and the role of the patient and family in terms of: (1) provide information to patients and families the importance of the identification process, the risk of misidentification that still respects privacy, (2) involves the patient in reassuring patient identity in the process of health care, and (3) confirming the correct identity of the patient in accordance with all forms of identity (Wardhani, 2017).

A report from a national patient safety institute in the United Kingdom found 236 incidents regarding patients who lost a bracelet as a patient's identity and misidentification of a patient's bracelet from November 2003 to July 2005. Erroneous patient identification was also found in more than 100 root cause analyzes of January 2000 to March 2003 by the United States Department of Veterans Affairs (VA) National Center for Patient Safety (Anggraeni et al., 2014). Based on research conducted by Fadwa *et.al* (2019), reported 94 (out of 801) sentinel incidents associated with wrong patient, wrong site, and wrong procedure, ranking third out of all sentinel events in 2018. Reports on patient safety incidents in Indonesia from JCI data in 2012 found errors in the identification of patients occurred in 68% of blood transfusion events and 13% in surgery errors. In 2013, there were reports of incidents of patient identification errors increased from 46% in 2012 to 56% in 2013 at one hospital in Madiun, East Java, this shows the implementation of the patient identification process has not been fully carried out by officers (Harina, 2003). Based on research conducted by Fadwa *et.al* (2019), the majority of healthcare providers ($n = 350$, 87.1%) and almost half of non-healthcare providers ($n = 186$, 47.8%) reported high levels of

knowledge of patient identification standards, including the need to use two patient identifiers. However, audit results revealed that health-care providers used two identifiers in only 33 observations (18%), with the majority (147 observations, 82%) of health-care providers checking the patient's name only and not his/her medical record number. The results highlight the need for further attention to improper identification of patients, including understanding the causes and ways to enhance the translation of patient identification standard into practice.

Class D private hospital located in Blitar City has 116 beds and class 1, 2, 3, VIP, and VVIP inpatient rooms. Guidelines for identifying patients in the hospital in Class D private hospital in Blitar is performed before the administration of medications and diagnostic or therapeutic procedures or procedures, before administering drugs, blood or blood products, before taking blood and other specimens. Reports on patient safety incidents (IKP) at Class D private hospital in Blitar in semester 1 of 2019 showed unexpected events (KTD) and Nearly Injured Events (KNC) in the emergency room, Muzdalifah, Jedah, pharmaceutical, radiology, and laboratory inpatients. Twelve (12) near misses (KNC) events in semester 1 of 2019 were due to a patient identity error that occurred in the inpatient, laboratory and pharmaceutical rooms. The data shows the problem of the low compliance of nurses in the implementation of patient identification in the inpatient installation which is at risk of occurrence of unwanted events. This study was conducted to look for factors that cause the problem of compliance with patient identification in inpatient room Class D Private Hospital In Blitar City.

RESEARCH METHOD

This research uses descriptive research method with a case study approach. Analysis conducted to look for any factors that influence the low compliance with the implementation of patient identification in inpatients in Class D Private Hospital in Blitar City is to identify the root of the problem by means of observation, interviews, and focus group discussions (FGD) through two stages, namely the stage first do observations and interviews, the purpose of observations here is to find out what factors influence compliance with identification of patients in hospitalization using observation sheets containing nurse profile criteria consisting of age, sex, patient safety training, last education and years of service to the implementing nurse who are on duty in class 1, 2, 3, VIP, and VVIP inpatients, the patient profile contains diagnoses, therapies and nursing care and factors that affect compliance with patient identification include adherence to patient identification activities including: to use two patient identities, must not use the room number or location of the patient being treated, identification before administration of the treatment and diagnostic or therapeutic actions or procedures, identification of the patient is done before administration of drugs, blood, or blood products, identification before drawing blood and other specimens, after performing the stages Observation was carried out while stage 2 (two) was the determination of the root of the problem using focus group discussions (FGDs) aimed at obtaining input or information on issues raised as an internship topic, namely the low compliance with implementing patient identification in the inpatient room, among others, regarding understanding of patient identification, using a fishbone diagram with 5-why analysis with 6 implementing nurses from 5 inpatient rooms, 1 emergency room nurse, 5 head of inpatient

room, head of emergency room, head of medical record room, nursing manager, and SKP team.

RESULT AND DISCUSSION

General description of the respondent's characteristics and nurse's compliance in the implementation of patient identification in the Inpatient Installation at the Class D Private Hospital in Blitar City in the form of Table.1.

Table.1 Table of the characteristics of respondents and nurse compliance

Respondents' Characteristics	IP 1 (n=12)		IP 2 (n=5)		IP 3 (n=10)		IP 4 (n=12)	
	Obey	Not Obey	Obey	Not Obey	Obey	Not Obey	Obey	Not Obey
Age								
<25 yo		3		1		2		3
25-30 yo		3		2		4		4
>30 yo	1	5	1	1	1	3	1	4
Gender								
Male	1	2	1	1	1	2	1	2
Female		9		3		7		9
Education								
Diploma		9		4		9		9
Bachelor	1	2	1		1		1	2
Patient Safety Training								
Taken	1	10	1	3	1	8	1	10
Not taken yet		1		1		1		
Duty Duration								
<5 years		3		1		2		3
5-10 years		4		3		4		4
>10 years	1	4	1		1	3	1	4
Duty Status								
On Contract		7		3		7		7
Permanent	1	4	1	1	1	2	1	4
Supervisor								
Present								
Not Present	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

(Note: IP 1: Identify before giving treatment and diagnostic and therapeutic actions or procedures, IP 2: Identify the patient before administration of drugs, blood or blood products, IP 3: Identify before taking blood and other specimens, IP 4: Involving patients in terms of reassuring the same identity of patients in each process of health care).

Resources: results from interviews and observations.

Based on the data description of table.1 above, it can be seen that the adherence of the officers to the identification before the administration of medication and the compliant diagnostic and therapeutic (IP 1) procedure or procedure is 1/12 (0.8%), and the non-compliance with IP 1 is 11 / 12 (92%). The identification of patients is carried out before the administration of drugs, blood, or blood products that are compliant is 1/5 (20%) and non-compliant 4/5 (80%). Compliance with identification before drawing blood and other specimens (IP 3) of 10/10 (100%) and non-compliant 0/10 (0%), while adherence in involving patients in terms of reassuring the same identity of patients in each process of health care is 1/12 (8.3%) and which did not involve patients in reassuring patient identity in the health care process were 11/12 (91.7%).

Table.2 Frequency Enabling Factors Compliance Patient Identification in the Wards.

Enabling Factors	N	Percentage
Patient Identification Regulation		
Having	5	100%
Not having	0	0
Reporting of incidents / errors in patient identification and no documentation in the ward		
Reported	5	100%
Not reported	0	0
Document proof of socializing patient identification in the ward		
Present	0	0
Not present	5	100%
Document proof of audit or supervision of patient identification in the ward		
Present	0	0
Not Present	5	100%

Resources: results from interviews and observations.

Based on the table.2 data description of the completeness of the supporting factors supporting compliance of patient identification in inpatient installations, it can be seen that the regulations (guidelines and SOP) of patient identification are found in all inpatient rooms (100%), reporting incidents / incidents of misidentification of patients already running but no documentation in the room (100%), there was no evidence of socialization document identification of patients in all inpatient rooms (100%), and no evidence of audit documents / supplementary identification of patients in all inpatient rooms (100%). Data from these observations are then collected and processed to deepen the root of the problem found through the Focus Group Discussion (FGD) method with 5 why analysis found root problems related to nurse compliance in implementing patient identification in inpatient installations which are elaborated through Fishbone diagram (Figure 1).

Figure 1. Fishbone Diagram of Root Problems Disobedience of Patient Identification in the Wards.

Resources: results from FGD research.

Table 3. Results of Identifying Root Problems with Fishbone Diagrams.

No	Factors	Problems	Root Problems
1	Man	Nurses memorized the patient's name Nurses do not understand the importance of patient identification Nurses are afraid to report if there is a misidentification of the patient	Small number of patients No re-socialization yet No safety culture team yet
2	Method	Coordination meetings and SKP team members are not active, SOP has not been implemented	Coordination meetings and SKP team members are not active Standard Operating Procedures have not yet been implemented
3	Machine	Bracelet late printing	Broken printer
4	Time	At night emergency room patients so many officers forget to put the patient's identity bracelet until the patient has entered the room	Patients want to be served quickly
5	Environment	Patients do not understand the benefits of the patient identification process; officers are not accustomed to providing an understanding of the installation of identity glasses.	Lack of supervision
6	Material	The identity bracelet is late from the window because it is still in the process	There are no patients' list books or documentation between the clerks in the registration window.

Resources: results from FGD research.

In the analysis with the fishbone diagram, it was found 6 root problems of nurses' compliance in the implementation of patient identification in inpatient installations, among others: low supervision and supervision from the leadership, no re-socialization regarding patient identification, the number of patients is small, safety culture has not been formed, the lack of tools support, patients want to be served quickly. Based on the results of the FGD, it can be seen some comments on the implementation of patient identification during the FGD.

The number of patients is small:

Pp 1: "..... Well there are only a few patients in the room, of course we memorized the name, it can't be mistaken ..."

Pp 2: "... We did not identify the patient before the action because the patient was little and we memorized "

Pp3: ".... feel free to go back and ask the patient's name and date of birth because in the patient's room it's just him ..."

Patients want to be served quickly:

Pp 4: ".... nowadays patients want to be directly treated and enter the room so we emergency room staff like to forget to put on a bracelet..."

Pp 4: "..... in the emergency room when patients come with many officers like to forget to put a bracelet ..."

Lack of supporting tools:

Pp 5: "... ... the printing device is broken so that the patient brought back does not wear the patient's identity bracelet ..."

KRM: "... sometimes the paper runs out and the machine breaks but it doesn't take long, just a shortage at the counter there are no operand books so the ticket clerk forgets that there are still patients who have been sent to the inpatient yet an identity bracelet ..."

Safety culture has not yet been established:

Pp 5: "... nurses don't report because they don't like the supervisor ..."

Pp 6: "... Reply to report because it's not good with friends..."

KR 1: "... if there is an incident directly to the KPRS it is only rarely that reports are afraid of being scolded by superiors"

There has been no re-socialization about patient identification:

KR 2: "... just know the identification, just put an identity bracelet, don't know the other identification process ..."

KR 3: "... many officers don't understand, so they never do identification at the hospital ..."

Pp 1: "... long time no socialization about 1 year ago ..."

Pp 5: "... Most if we want to get accreditation after that, I never ..."

Lack of supervision and supervision from leaders:

Pp 3: "... there has never been any supervision and supervision ..."

KR 4: "... there should be supervision of the leadership ..."

KR 5: "... there has never been any supervision about patient identification so far"

KR 1: "... need support and motivation from the leadership by giving rewards and routine supervision from the leadership ..."

SKP: "... there is no follow-up from the patient safety incident report related to identification because SKP members are busy with the main task, never meeting and never monitoring evaluation."

The results of the characteristics of the correspondent showed that the majority of ages between 25 to 30 years, this is an age that is still productive and has good performance so that it has the potential to work better (Harina, 2003). In one study it was said that ages 30-39 were mature and had good thinking and a good grasp of science (Simamora, 2019). In the world of nursing so far the most are women, this is because nurses are identical to the role of the mother or woman (mother instinct) who treats with better work results (Harina, 2003), but the results in Table 1 show compliance with identification made possible by men this happens because of a lack of sampling. Nurses whose more than 10 years of service work for correspondents. People who have a longer service life will experience a decline in performance. This can arise due to fatigue, boredom, and boredom. Age and work experience have a relationship with fatigue performance at work where the higher the fatigue at work will lead to lower work productivity (Suardi *et al.*, 2019). The level of adherence in table 1 shows that nursing education is more compliant compared to having a diploma education level (D3) (Harina, 2003). A higher level of education has an effect on staff compliance. Nurse knowledge is also influenced by work environment factors such as facilities for obtaining information about patient identification including the availability of reference books, easy access to researches, fixed procedures regarding the implementation of patient identification and materials about patient identification (Tarigan & Alemina, 2018). The hospital needs to do a map of the nurse's knowledge of patient safety by conducting periodic

training or through hospital newsletters and magazines that contain the latest information on patient safety (Darmawan, 2016).

The level of knowledge gained through patient safety training and those not yet trained did not produce significant results, this is likely due to the small number of samples. External factors such as the presence or absence of supervisors or observers cannot be evaluated because at the time of observation there were no supervisors. Employee status seems to have the result that permanent employee status increases compliance more than contract employee status.

Several causes of wrong-patient identification were identified by survey participants, with the most commonly reported being the similarity of patients' names, miscommunication, distractions, multitasking, not following hospital policies relevant to patient identification, and applying shortcuts while doing tasks (Fadwa *et al.*, 2019). The key to accurate patient identification is having knowledgeable staff who are educated about the correct identification processes. Patient misidentification that results in wrong patient errors can be related to poor knowledge, education, or training and lack of compliance with the appropriate processes and procedures for accurate patient identification. Shaheen and Swaminathan (2019) said that regular auditing and counselling the staff can increase compliance which help in reducing patient misidentification as well as increase in effective communication among the healthcare staff. Medical errors can further be reduced by doing regular audits. Counselling and supervision helps in improvement in patient safety. Regular audits should be done to ensure patient safety, encourage patients to participate in all stages of the process.

Analysis with fishbone diagrams found 6 (six) root causes which were the factors causing the low compliance of officers in the implementation of patient identification in inpatient installations, including:

Low supervision and supervision from the leadership

Supervision has the role of directing and supervising in the form of clinical supervision. In the clinical supervision of nursing, the supervisor has the role to make observations on all activities of nurses in performing actions or nursing care. Clinical supervision provides guidance, direction, observation, and evaluation so that nurses can develop their abilities and overcome their limitations in conducting nursing care in accordance with standards (Aeni, 2016). The head of the room who has a supervisory role cannot yet carry out his duties as a supervisor because he is busy with service assignments (Lestari Sri, 2012). Conducting clinical supervision on routine and scheduled patient identification can improve patient safety (Surahmat *et al.*, 2018) and nurses' compliance (Wirawan *et al.*, 2018). Supervision has the benefit of increasing nurse compliance in identifying patients, so the implementation of supervision by the head of the room must be improved (Rachmawati, 2015).

There has been no re-socialization regarding patient identification

The implementation of the socialization is very important to introduce the officers about their knowledge and skills in accordance with the guidelines and procedures applicable in their organizations (Suryaningrum & Silvianita, 2018). Hospitals can conduct direct and indirect socialization to employees and social media. Direct socialization can be through the orientation of new employees, meetings and regular face-to-face meetings in the room or unit

in the hospital, while indirect socialization can be through brochures, leaflets and social media(Hendyca Putra &Siswanto, 2016).

The number of patients is small

The number of patients that is very small influences the compliance of officers in carrying out patient identification because officers assume memorized by the name of the patient which is only a small number and continue to make efforts to identify patients even though the number of patients is small. Based on research conducted by Fadwa *et.al* (2019), several causes of wrong-patient identification were identified by survey participants, with the most commonly reported being the similarity of patients' names, miscommunication, distractions, multitasking, not following hospital policies relevant to patient identification, and applying shortcuts while doing tasks. If there is an error identification of the patient will make a risk to patient safety and lawsuits in hospitals.

Safety culture has not yet been established

Patient safety culture has a significant effect on employee attitudes in reporting incidents in hospitals, so it needs an effort to be continuously improved in the framework of organizational learning and non-punitive responses to mistakes by providing feedback on reports provided, with the existence of policy regulations, guidelines, guidelines and the SPO regarding patient safety incident reporting will support the formation of positive individual attitudes in incident reporting so that the hospital knows the deficiencies of the prevailing system so as to provide improvement efforts(Anggraeni et al., 2016). Building a culture of safety is highly recommended within the organization because it is one of the efforts that can shape safe behavior in a job so that work safety is realized(Irivoranty et al., 2016).

Lack of supporting facilities

The presence of incomplete facilities becomes an obstacle in the implementation of patient identification in hospitalization, for example, the wristband wears out, the printing machine wears out, the absence of a report book between the guards, this is the cause of reduced compliance of patient identification by the officer, with this, we must start planning the right equipment and infrastructure in each unit or section.The availability of facilities and infrastructure is important in supporting the implementation of patient safety programs, including patient identification (Neri et al., 2018).

Patients want quick services

Demands in the modern era and fast paced also affect health services in hospitals, this is also one of the factors inhibiting the implementation of patient identification because officers forget to perform patient identification procedures according to standards so that patients are not attached an identity bracelet. Based on research conducted by Shaheen and Swaminathan (2019), effective communication helps the patient safety when the nurse communication is strong and the patient should also be aware about the condition. Basic communication skills on identifying patient helps in reducing medical errors which consists of shared perceptions and feelings regarding the situation of the patient, background of patient and then assessment and recommendation done by Doctor that helps in the

treatment. Educate patients on the importance and relevance of correct patient identification in a positive way that also respects concerns for privacy, training on procedures for checking/verifying a patient's identity. Making innovations to improve patient services so that more quickly.

CONCLUSION

The results of the study can be seen that the factors causing the low compliance of patient identification in an inpatient care of private class D hospital in Blitar City are among others low supervision and supervision from the leadership, no re-socialization regarding patient identification, the number of patients is small, safety culture has not been formed, lack of supporting facilities, and patients want to be served quickly. An implications for hospitals to solve problems related to the low compliance of patient identification is through conducting supervision with appropriate supervision methods, carrying out direct and indirect socialization, forming a culture of patient safety in hospitals to improve compliance with patient safety incident launches, breakthroughs in marketing, planning supporting facilities and innovating to improve services to patients.

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