



Safety Culture of Private Primary Care: A Pilot Study in Yogyakarta

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Abstract: Patient safety is an important but neglected issue in primary health care. The lack of research on safety culture in primary health care compared to hospitals and finding out how start-up clinic who has not been accredited implements safety culture, became the objective in this study. This research is a mixed methods research. The research quantitatively used patient safety culture questionnaire, adopted from AHRQ and qualitatively used deep interview. In order to conduct and analyse both of quantitative and qualitative methods, the researcher deployed sequential explanatory method. From 12 dimension of patient safety, three dimensions in high score, 7 dimensions in medium score, but two dimensions were reporting system and punishment in low score. The major themes based on the deep interview conducted were the comprehension of patient safety culture of all staff and stakeholders, the implementation of patient safety programme, and management support. We concluded that accreditation is a sustaining factor that can be used as a framework for shaping patient safety culture. Patient safety is not a simple technique to gain quality in healthcare. We need continuous, multifaceted, and comprehensive approach to establish and maintain the implementation of safety culture

1 INTRODUCTION

Patient safety is a priority concern of world health. Estimated that 1 in 10 patients are harmed while receiving services. Hundreds of millions of patients are affected each year in both developed and developing countries (WHO, 2012). In 2011, American publication showed that 1 in 3 patients who had got hospital treatment, and the most common types of errors are nosocomial, medication errors, operating error and procedures (Clasen, 2011). According to the National Patient Safety Agency, to improve patient safety, a system has to design for making patients safer, including risk assessment and reduction, identification and management of risk-related issues to the patients, incident reporting and analysis, to minimize risks and prevent injuries caused by error while taking

action and taking action should not be taken (Leatherman, 2008)

Safety culture is an important, especially in health organization because it affects directly to the patients and paramedic or medical staff. The impacts that occur in the patients are increasing treatment period and cost, disability even to the mortality. Meanwhile for the health care workers are injury, job dissatisfaction, malpractice demands, infection by diseases of the patients and accidents while working. These have a direct impact on the office, hospitals, health centers, and clinics where paramedic and medical staff are working. Thus, it becomes a conflict between paramedic whose working and also lawsuits from the patients due to inadvertence of a paramedic (Fisher, 1997, Depkes RI, 2006). The Safety culture is one element of the broader construct of organizational culture about which there has been considerable sociological and organizational research (Krik, 2007). Each

organization has different standard of safety culture. Health care organization has a complex standard because it deals with patients and staff at once.

In 2004 WHO established a “World Alliance for Patient Safety as an effort to improve the patient safety with international scale. At the United State JCAHO (Joint Commission on Hospital Accreditation) every year apply the National Patient Safety Goals (NPSG) containing criteria, guidelines for achieving patient safety goals. Meanwhile, in Indonesia it is the Hospital Patient Safety committee (KKPRS) which has the main duty to encourage the movement of Patient safety in all health care facilities in Indonesia (KKPRS, 2007).

The Institute of Medicine (IOM), *To Err is Human* published by Khon (2000) highlights the risks of medical care in the United States, where a study estimates that around 44,000 to 98,000 Americans die each year resulting from preventable medical errors (IOM, 2004). In a study conducted by Brennan (1991) in New York, it was found that among 30,121 patients were treated in 51 hospitals about 3.7% had disability caused by side effects during the therapy. Further analysis showed that 69% of these side effects occurred due to medical error. Wilson (1995) reported higher rates in Australia, found that adverse of medical effects occurred in 16.6% of patients, who experienced a permanent disability of 13.7% and 4.9% of mortality. Further analysis showed that half of the side effects were actually.

Patient safety is also a main issue in primary care (Gandhi, 2010). The primary health care concerns everyone in the community because of making first contact with the patient, but due to severe and complicated cases requiring special care and have to collaborate at the hospital. Both providers and communities often underestimate the importance of primary health care. Primary health care is susceptible about errors that give serious consequences (Kuzel, 2004). Although serious adverse events are rare in outpatient care in primary care, but better systems are needed to recognize, trace and assess its cause and is desirable; therefore, we can reduce or prevent the occurrence of adverse events in primary care (Fisher, 1997).

The prevalence of adverse events was 3.7 per 100,000 clinic visits over a 5 1/2 year period. As many as 29 out of 35 (83%) experienced by adverse events due to actual medical errors who can be prevented. Causes of adverse events

include; 9 diagnostic errors (26%), 11 treatment errors (31%), and 9 other errors (26%). Of adverse events caused by medical error, 4 (14%) resulted in permanent injury and paralysis and 1 (3%) resulted in mortality (Fisher, 1997). Commonly adverse event happened to be regarded as the fault of the health worker and the possibility of such errors is related to the organization or system in the health care facility (Conelly, 2005).

In Indonesia, there is not really much research about patient safety at the clinic or primary health care than in the hospital. This is interesting to do a research on how the Clinic keeps the quality of service, although it has not been accredited, and how the star up clinic shapes the patient safety team. The purpose of the study was to identify the implementation, obstacles, and contributing factors of safety culture of Private primary clinic.

2 RESEARCH METHOD

This research is combination approach by means of mixed methods research. The research quantitatively used patient safety culture questionnaire, which was adopted from AHRQ survey of medical officer about patient safety (MOSPS) and qualitatively used deep interview. The population was all of the medical staff and paramedic staff in private clinic on February to Mei 2017. The quantitative method deployed was total sampling (n= 22) and qualitative by means of purposive sampling technique by the specific purposive sampling (n= 4). In this study, researchers used the technique of face to face interview according to John W Creswell's theory (1994), with a semi-structured and open-ended question type. The data analysis used in this study was sequential explanatory to analyze two research methods, where quantitative data analysis as the main method while qualitative analysis describes deeply. Qualitative data analysis is used to prove, deepen, expand and complete the obtained from quantitative data analysis by describing the words in the sentence (Creswell, 2016). Analysis of qualitative data used was constant comparative analysis method.

The data collection method deployed was based on questionnaires in which the instrument in this study was questionnaires containing 12 dimension of safety culture or patient safety. This study used a questionnaire from AHRQ. This questionnaire has been used globally to evaluate

patient safety culture. Meanwhile, deep interview was containing of questionnaires of safety culture and for the validity of qualitative data using triangulation from Denzin Theory. This research used deep interview techniques and aims to analyze the problems of different status, positions and professions, so the research using the technique of examination with triangulation of data (Patton, 2009).

This study was conducted at one of clinic in Yogyakarta, and the clinic is also an outpatient clinic that organizes medical services beside a hospital. A preliminary study was conducted in November 2016 and data collection began in February to May 2017.

3 RESULT AND DISCUSSION

3.1 Result

This research is focused on health care workers, doctors, nurses, midwives and pharmacists who work in the private primary clinic. The qualitative data in this study are 77% of respondents consisting of 6 general practitioners, 4 Dentists, 5 Nurses, 1-person Midwife and 1-person pharmacist who have varying working period, less than 1 year up to more than 5 years. However, the duration of respondents working in the Private primary clinic has not been more than 5 years. This is because the clinic was established in 2014.

The results of the study found obstacles of implementation safety culture in clinics were; lack of awareness of reporting events directly, Inadequate infrastructure (leaked roof, leaked ac, sometimes risk of slippery floor when it rains, and no holder on the wall for elderly), ineffective communication (Communication with the patients who have special condition and with elderly is difficult), drugs system (computer systems of high-risk drugs have not been marked, and human Resources (patient safety team has been active, but not maximized, membership has not been ideal). Meanwhile supporting factors for implementation of patient safety in clinic are: teamwork and Role model.

The result of quantitative method shows that the average of 12 dimensions safety culture of Private clinic has medium score. The research showed Safety Culture is complex phenomenon, healthcare system, staff and environment connected each other. The interview result has found that staff understand about the patient safety

but sometimes still neglect in applying it, low of awareness.

Table 1. 12 Safety culture dimension of Private Primary Clinic

	Dimension	Skor (%)
1	Perception of patient safety	74%
2	Frequency of event reported	47%
3	Supervision	68%
4	Teamwork	78%
5	Organizational learning	59%
6	Communication Openness	55%
7	Feedback	56%
8	Punishment	49%
9	Staffing	56%
10	Management Supporting	54%
11	Teamwork across unit	76%
12	Handoffs and transitions	80%

One of the events concerning patient safety in the Private primary clinic is that patient almost fall down. Moreover, it is reported that the patient safety incident followed up by investigation has been made as RCA (Root Cause Analysis). The number of incidents reported during the study results was 35% said in 3-5 reports, 29% said in 1-2 reports, 12% of respondents said in 6-10 reports, and 24% said in no reports. For other reports, the data input was error, in which the patient who have entered the treatment room has different data in the computer, but there has not been a dangerous thing. There is no exact report yet about the frequency. One of the respondents said

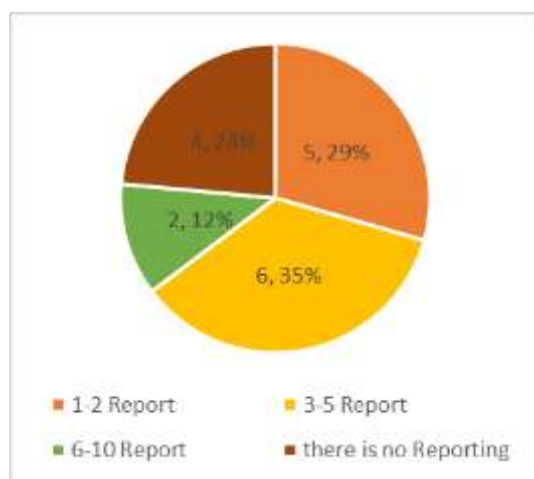
“Sometime there are patient switch a number of queue, so I ask the name and date of birth. But if the others patients I ask the history of services that they ever get, if match I continue the treatment. That’s why we do double check.”

Some of the obstacles that found during interviews regarding the reporting system:

“Actually we have a reporting system, few days before we invite a Muhammadiyah surveyor, also for learning in once. From there we know there are a lot of weakness both of the document and implementation.”

“They have to be asked first about the reporting, to make a report directly without being asked, it hasn't”

Diagram 1 Frequency of Reported Incident



3.2 Discussion

This study showed the report of frequency got the lowest score then followed by dimension of Punishment. The result supported by interviews finds that it is caused by the lack of awareness of making a report in case there is an adverse event. While the document reporting system in the private primary clinic has already existed, the application has not been maximized. A good reporting system creates safety culture as an environment reporting system supports and no blaming (Kuzel, 2004). Bann (2004) said that it is important to do the reporting at the time of the error, because it can be made as a lesson and evaluation of healthcare procedures performed. A safe and secure reporting system that relies on voluntary reporting from all of the staff it may be successfully implemented in primary care. To improve patient safety, information from confidential reports appears better than anonymous reports and may be more useful in understanding errors and prevention (Fernald, 2004).

One of the questions in the questionnaire of the reporting section of the event that got the

lowest score was question number three that is “When a mistake is made that could harm the patient, but does not, how often is this reported?”. It means not all immediate events are reported. The Quantitative data result shows that reporting system is in less-category of 47%.

The clinic is working on every incident have to make a report with their awareness. The events will be evaluated after taking place, and regular evaluation schedule is every month at the meeting. Then the evaluation results grading is followed up as required. As an example of its output, it is to prevent the patient from falling, clinic use carpet. The clinic has done the evaluation, assessment, follow-up and improvement result, in compliance with Peraturan Menteri Kesehatan (regulation of health minister) No 1691 about Patient Safety.

The point of reporting system is to find out how many events experienced in the clinic, for evaluation and prevention. Frequency events have reported is one of the points in applying safety culture. Grade of patient safety is an organization, known from the reporting system and disclosure (Flin, 2006). The evaluation and reporting system intend to improve the grade, the quality of services and the improvements of the clinic. It is expected to reduce the frequency of adverse events in order to avoid repetition. Therefore, the patient's safety goals are achieved (Depkes RI, 2006).

The analysis of 12 dimension of safety culture has found some of the obstacles and supporting factors. Thus, dimensional perception, in which the perception is characteristic of organizational culture; perceptions of paramedic and medical staff on the importance of patient safety and how they make safety culture as a organizations culture in Private primary clinic. This research is similar to AHRQ (2004), saying that safety culture reflects the attitudes, beliefs, perceptions and the role value of employee connection to safety (Nieva and Sora, 2004).

Interview results shows all of staff clinic have been understood the theory of patients safety culture, and they also really understand which events are dangerous and are not, so it can be concluded by perception they understand theoretically but the practice is minimal. Clinics should instill a concept in every staff that theory is not quite enough to improve patient safety culture, should be balanced with the action. Private

Primary clinics is one of the organizations of the health services, so basic assumption how important a safety culture it should be realized. Basic assumption is attitude that underlies the members of an organizational culture (Schein, 2004). It means the perception of health care worker have a role as a supporting factor of safety culture in the Private primary clinic.

Support of supervisors on related staff is one of supporting factor in creating a safety culture, is expected to improve the quality of safety culture and make safety culture as a culture in the clinic. Supervisors are expected to be able to develop their expertise as supervisors at Private primary clinic. Supervisors are expected to be able to develop their expertise as supervisors at Private primary clinic. So the duties of the supervision department work well according to the responsibility of theirs department/clinic. The level of supervisor support can be affected the employee performance, can even cause employees being stress. If the stress employee feels uncomfortable working this will be bad and high risk during services. A supervisor should be able to create a comfortable climate for his work. The most important thing to be done by a supervisor is being able to facilitate the performance of the employee by providing the main needs of the employees in this case such as equipment in health care at the Clinic. Its means that even the staff knows what they should do, they may not be able to perform their tasks maximally due to lack of material support (eg. infrastructure) (Guzzo, 1988). Supervise aims to provide assistance directly to employees because supervision is also a direct representative of the organization that can meet face to face every day with employees. It is expected that with this assistance employees can have sufficient provision in carrying out their duties and work with satisfactory results (Suarli and Bahtiar, 2009).

According to Robin (1999), the ability of supervisor determines the success or failure of an organization in implementing a policy. The role of leadership and support of staff determine the realization of the safety culture as a culture in the clinic. The clinic's commitment to improve safety culture is an evident from the establishment of patient safety team, trainings and evaluation on

each month. The progress of patient safety culture in Private primary clinic is an evident from the seriousness of the clinic to create patient safety programs, started from queuing systems, medical measures and storage to taking drugs (Robbin, 1996).

The elements in the organization are interconnected. Patient safety culture cannot only be realized in terms of individual or sub-department. The individual or sub department is interconnected with other individuals or departments because the clinic has a goal in patient safety culture. To create a safe environment for patient care, clinic has to improve of patient safety culture to a way of understanding why and how the shared values of staff working within a healthcare organization may be operationalized (Krik, 2007). Accordingly, teamwork is required in this organization. According to Coper, Safety culture is

“Patients safety plays a role as avoidance, prevention, and amelioration of adverse outcome or injuries stemming from the processes of healthcare” (Cooper, 2000).

This study shows that cooperation between personnel and teamwork across units are going well. It means that they help each other to complete the tasks in the sub-section that they do, it can help improve the working of each unit. This is seen during the crowded hours, many of patients who visit at the same time. The staff had understood about the duties and responsibilities of each in completing the jobs. Individual support in every part will facilitate that the jobs completed properly. The diversity of profession background, as well as the individual ego greatly affected the making decision actions to the patient. Cooperation in the healthcare world not only between professions in the team but there will also be different teams in each unit, for example a different team operating room with treatment room. Therefore teamwork is the focus to improve patient safety and medical education (Manser, 2009). Teamwork in one of supporting factor to create patient safety culture in clinic and role model for the staff motivate them to be better.

Good communication and teamwork is essential to provide safe services during services (Leonard, 2004). Effective communication and teamwork also help prevent of errors and reduce the risk of action on the patient. Applying patient

safety as a behavior is a simple way to improve patient safety, and it will be improved perceptions of teamwork (Mills, 2008). By applying SOP in every action and mutual reminders / correction between staff is expected to improve the accuracy of every individual in the conduct of medical action, and also it takes an open mind to receive feedback, input and critics.

Teamwork and communication training should be standard in every faculty of medicine and health school. The whole process of health care requires doctors, nurses, and other health professionals to work in a team. In the patient's safety literature, it's widely acknowledged that team performance is essential to providing safe patient care (Kohn, 2000). Poor coordination between health care providers within the organization appears to affect the quality and safety of patient care, treatment, and conflicting information. Therefore, teamwork is the focus to improve patient safety and medical education (Manser, 2009).

In health care services, miscommunication or poor delivering information may give an error therapy to the patient. Miss communication takes place not only among staff but also between staff and the patients, for instance, a patient with special condition (disability) and the elderly. Sometimes it's too difficult to communicate with them due to the patients limit in understanding staff explanations. Private primary Clinic is learning from incidents, how to prevent the incident, and how it's followed up as well as how it is handled. Good communication and openness are the keys to give a good service. Accordingly communication needed that mutually support, open and no blaming (Flin, 2007). The results of the questionnaire also found some of staff who are afraid to ask unusual things about patient safety, and feeling fear of being blamed or considered unknown. In the health care organization of errors communication will be bring about fatal things.

Communication failure is one of the main causes of adverse events. Joint Commission on Accreditation of Healthcare Organizations (2004) published that of 2,445 sentinel incidents reported to the hospital accreditation commission said that more than 70% of the root or the main cause of the incident was caused by communication failure and 75% of the patients died. its illustrate how important communication is. Many factors causing communication failure is include doctors and nurses in training to communicate in a slightly different way nurses are taught to be more narrative in describing the patient's clinical

situation, while doctors are more concise and fast. Nurses are notified during education that they do not make a diagnosis. This has an impact on telling doctors both directly and by telephone, and explaining it with a broad narrative in their description and the doctors who can not wait to find out what the nurse wants to convey (Leonard, 2004). This is can be overcome by creating a communication system that has been socialized to all staff both doctors and nurses in the clinic. So they have the same guidelines and references in communicating, thus expected to reduce miss communication during service.

The dimensions of organizational learning is active in improving safety culture, all of the mistakes be expected for increasing, learning for the better and to evaluate the mistakes that have been made. In Private primary clinic every incident report will be evaluated every month. To prevent the things happened again. At the time of evaluation, find a solution to solve the problem. Then expected to produce the output of the problem that they found. This encourage clinic to be better and careful in every service. This proves the clinical commitment to maintain safety culture. This proves the clinic's commitment to maintain safety culture, it is expected that they always make continuous improvement, its can be an input for the clinic in order to make continuous improvement or sustainable. By studying the history of the service or adverse events that have occurred in the clinic, it is hoped that no adverse events will occur. So the clinic desire to create a safe clinic and support patient safety culture can be more easily realized even with the turnover staff. Although every individual learning pattern is different, but if things about the application of patient safety in the clinic have been running regularly and continuously this will also affect the new staff join in the organization. Clinic is learning how to make safety culture as a culture in clinic. Organizational behavior in learning is based on three things, routine (March, 1963), history (Lindblom, 1959), and target (Simon, 1955) so that organizational learning is seen as a routine based activity, dependent on history and target oriented, so that it is seen as learning by encoding conclusions from history into routines that guide behavior. The section on organizational memory discusses how organizations organize, store, and take historical lessons despite personnel turnover and the passage of time (Levitt, (1988).

Developing effective feedback from incident reporting systems during health care is essential for

the organization if they want to improve the reliability and security of the service process. Several important reports regarding patient safety highlight the importance of developing an effective system, learning from failure to reduce the occurrence of a patient preventable safety incident (AHRQ, 2001). In the world of international health organization the implementation of incident reporting systems in organizations has been promoted as a means of prevention of safety in service delivery, and for this purpose WHO has developed effective reporting system guidelines (WHO, 2005).

Effective feedback relies on timely corrective action, improved system and broad information dissemination to raise awareness of current vulnerability. The success of feedback should also be supported by dialogue on security issues with staff directly in touch with patients to provide effective solutions and encourage good reporting systems in the future. Timely and appropriate feedback on security issues is more effective for promoting the development of a positive safety culture within the organization. Feedback should be continuously performed not only in case of a particular case or current security issue. So It will be detect immediately through reporting and inquiry, resulting in practical security solutions being followed up to prevent repeated failures (Been and Vincent, 2009).

Of the reports so far there has been no serious incident that endangers patients. Reward and punishment are closely related in motivating employees. The hedonic nature of rewards has the potential to lead to behavioral approaches and a sense of fun after getting a reward, serves to strengthen or motivate behavior (Schultz, 2000). Dimension of punishment private primary clinic got low score after reporting dimension. Modern health care services today present the most complex challenge with regard to safety. Policy on reward and punishment, which is the main concern of how big the role of punishment in giving deterrent effect so that staff becomes more thorough. To create safety it is necessary to design a system which of risk and prevention is the responsibility of everyone. Implementation of this system is very difficult with regard to the effectiveness of the punishment, a deterrent to error and understanding is reinforced by the legal system and the public media. To prevent errors from happening then made some rules. Ironically, it is not a mistake reduction but they are afraid to report the mistakes or hide it, so analysis,

prevention is more difficult (Leape, 1998). There has never been serious error and mistakes caused by the staff in the clinic, so that has never been given sanctions, in addition to a warning. There is no punishment should be a support to make the reporting system works in the clinic. Clinics has not given a reward (material) to the staff who are considered achievement, because the clinic is newbie and the patient has not been too crowded, so to give material as a reward is hard for clinics.

In 2000 the Institute for Healthcare Improvement's (IHI's; Boston) assembled a group of organizational experts and assigned them the task of maintaining a health-care system built around the ideal medical environment. The group recognizes that building an ideal system requires not only technology, administration, and drug delivery systems but also a good attitude from leaders and health workers (Frankle and Gandhi, 2003).

The worrying thing from the questionnaire analysis on the question is "Hospital management seems interested in patient safety only after an adverse events happens", it should not happens, and the clinic should think about its prevention. It is expected that this will motivate the clinic to improve the quality of management support for the better. Management support is essential an organization to create a safety culture. In the clinic has been got management team formed for patient safety, for quality and others. Among the training that followed for example are infection prevention and control, and patient Safety. This is show the commitment of management to support the quality of service, and safeguarding the safety culture at the Clinic. The management of Private primary clinic is consistent towards improving the quality of serving patient safety. This is evident from the trainings provided to the staff both in the clinic and outside. Then also the management provides orientation to new staff and evaluating the service each month. Management support at the Private primary Clinic has been seen, as evidenced by the good training held in the direct clinic and, workshops outside the clinic. The clinic always provides and support to new staff whose needs orientation and adjustment. Private primary clinic is learning how to make safety culture as a culture in the clinic, and how the understanding of health care workers about

safety culture, then applies it in every service conducted as well as support from management in as an aware of patient safety culture.

In a company, HR is the most expensive thing. For example, to improve the quality of human resources it needs training. The dimensions of staff and employees greatly influence the formation of a patient safety culture. The usual problems are the lack of manpower and work under pressure, creating an uneasy environment for staff. And the new employee where training has not been done and it takes time to adjust to the environment, excessive workload, working time and employee competition. Research results show in the clinic there is no problem about the time of working, even in accordance with the provisions of the law. And the research finding of staff problems in the Private primary clinic is new employees who are still in the orientation stage. This is usually due to the high of employee turnover in the clinic. Patient safety is related to the quality of nursing practice in the work environment and the nursing leadership in tackling the work environment, reducing the workload of nurses. The adequacy of staff directly affects emotional exhaustion, and the care skills they possess can shorten service time. Both of them directly affect to the patient safety. If the nurse's skill takes the time to do the service, it will also be more efficient. On the staff dimension the lowest score on the question points of "staff in this unit work longer hours than is best for patient care". Working beyond working hours with considerable workload can be stressful. Stress and fatigue can lead to bad attitudes and performance (Lascheiger, 2006). Aiken (1994), has shown that patients in Magnet hospitals in the United States have lower rates of hospitalization compared to non-magnet hospitals. Magnet Hospital is an institution that supports professional nursing practice by ensuring nurse autonomy, controlling practice settings, and relationship of nurse / doctor. Nurses in this system have lower burnout rates, better job satisfaction, and lower turnover intentions. With lower burn out staff can provide maximum service.

On the dimensions of transfer and handoff, and teamwork is actually related to cooperation and coordination between health workers at the turn of shift or transfer of patients. The result of this study is not much different from the dimensions of teamwork and both in good score. At the time of shift exchange is risking to error or a miss about patient information. The

problems will happen if displacement activities do not receive special attention. At the time of transfer there is data that is not appropriate this may cause service to be disturbed, because at the time of shift changes can be a problem for patients, and also occurs when the transfer of patients takes place. Joint Commission defines handoff as a contemporary interactive process and presents the specific information from one caregiver to others for the purpose of ensuring the continuity of the patient's medical care. Therefore, handoff is considered a clinical activity that occurs at all levels of the organization starting from the individual level (eg, between nurse or doctor) to the organizational level (eg between hospitals for patient transfer) (Abraham, 2012). In the Private primary Clinic also has established cooperation with the hospital because in the clinic currently only serve outpatient. If the drug required by the patient runs out the clinic is also willing to provide a prescription so that patients can seek drugs in other pharmacies outside the Clinic. According to Aurora (2006) Handoff inefficiency leads to degradation of information marked by negligence and inaccuracies of information shared among staff so that it can result in one of the major supporting factors of sentinel events (Singh, 2007). To overcome some of these errors, Joint Commission has required all hospitals in the United States to standardize communication activities between doctors and nurses during the transition by implementing protocols and secure interfaces (Abraham 2012). Standardization is very useful when performing patient transfers and staff turnover, so the time spent on transfer and replacement is less and effective.

4 CONCLUSION

The staffs of Private primary clinic have understood about the theory of safety culture, but to apply it as a habit or culture in the clinic is hard. And the implementation of safety culture in clinic has been carried out but has not been maximal nor entrenched and not according to expectations. In order to make safety culture as a culture in clinic needs great commitment, support from management and all of the staff. Interview result finds out some of the obstacles and supporting factors. Although, relatively the clinic's safety culture is in the category of sufficient, but a lot of things still need to be fixed, especially the part of incident reporting. At the reporting system, it is found that some staff who do not directly do the

reporting when the incident happens must be asked first then the new report is made. It means that they have less awareness. The progress of safety culture in the clinic has commenced, but not all of them are running well. A document for clinic accreditation has guidance, 80% of patient safety guidance already exists, but the application has not reached 50%. The recording and reporting of every incident are important elements, playing the role of creating a patient safety culture in a health care organization. Reporting system is a benchmark for improving safety culture in the clinic, with a good reporting system it will facilitate learning and prevention of adverse events in the future.

There's has no punishment at the clinic it should be easier for the staff making report of an incident. But the fact remains that the reporting remains difficult as soon as possible when something happens, it needs to be reviewed by the clinic how to motivate staff to make a report without being asked.

Accordingly accreditation has an important role in improving patient safety and provide a safe work environment. Accreditation of hospitals and clinics must be carried out by an independent institution of applicable accreditation standards (Permenkes No 9 about clinic, 2014)

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