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# IMPLEMENTATION STRATEGIES OF PATIENT SAFETY CULTURE IN MIDWIFERY CARE: A QUALITATIVE STUDY

*Strategi Implementasi Budaya Keselamatan Pasien Dalam Pelayanan Kebidanan: Studi Kualitatif*

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***ABSTRAK***

*Keselamatan pasien merupakan elemen penting dalam peningkatan kualitas layanan kesehatan, namun implementasinya masih menghadapi berbagai tantangan, khususnya ruang kebidanan yang beresiko tinggi terhadap insiden ibu dan bayi seperti perdarahan karena kesalahan episiotomi, diperlukan strategi efektif di lingkungan kebidanan. Penelitian ini bertujuan mengeksplorasi strategi implementasi budaya keselamatan pasien di RSUD X pada bulan Desember 2024 hingga Januari 2025. Penelitian ini menggunakan pendekatan kualitatif dengan metode Grounded Theory untuk mengeksplorasi strategi dalam implementasi budaya keselamatan pasien. Data dikumpulkan melalui wawancara mendalam tidak terstruktur yang dipilih secara purposive sampling dengan kriteria inklusi mampu berkomunikasi dengan baik, individu yang kaya informasi dan bersedia diwawancara, mendapatkan 9 orang informan terdiri dari 5 tenaga layanan kesehatan, 1 komite mutu, 2 manajemen, dan 1 pasien kebidanan. Kemudian dianalisis dengan tahapan open coding, axial coding, dan selective coding untuk mengidentifikasi tema. Penelitian ini menghasilkan enam tema yang saling berhubungan dalam klaster strategi untuk membangun budaya keselamatan pasien yaitu: peningkatan pengetahuan dan kapasitas tenaga kesehatan, dinamika manajemen visioner melalui evaluasi dan reformasi sistem, penguatan profesionalisme dengan peningkatan etos kerja dan tanggung jawab kolektif, penguatan mitigasi risiko, percepatan kolaborasi strategis antara tenaga kesehatan dan manajemen serta pengembangan sistem pelaporan insiden. Implementasi strategi yang terintegrasi dan berbasis bukti sangat penting untuk memperkuat budaya keselamatan pasien. Dengan penerapan strategi yang tepat, RSUD X dapat menciptakan lingkungan kerja yang lebih aman dan meningkatkan mutu layanan kebidanan. Temuan ini juga dapat menjadi acuan bagi rumah sakit lain dengan karakteristik serupa.*

***Kata kunci**: budaya keselamatan pasien, kebidanan, strategi implementasi*

**ABSTRACT**

Patient safety was a crucial element in improving healthcare quality. However, its implementation continued to face various challenges, particularly in midwifery units that were at high risk for maternal and neonatal incidents, such as hemorrhage due to episiotomy errors. This study aimed to explore the strategies used to implement a patient safety culture in RSUD X from December 2024 to January 2025.This research employed a qualitative approach using the Grounded Theory method. Data were collected through unstructured in-depth interviews with informants selected using purposive sampling based on inclusion criteria: the ability to communicate effectively, being information-rich, and willingness to participate. A total of nine informants were included: five healthcare providers, one member of the quality committee, two management representatives, and one midwifery patient. Data analysis followed the stages of open coding, axial coding, and selective coding to identify key themes. The study identified six interrelated strategic



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themes for building a patient safety culture: improving knowledge and capacity of healthcare workers; promoting visionary management through evaluation and system reform; enhancing professionalism by strengthening work ethic and collective responsibility; reinforcing risk mitigation systems; accelerating strategic collaboration between healthcare workers and management; and developing a modern, flexible, and accountable incident reporting system. The implementation of integrated and evidence-based strategies was essential to strengthening the patient safety culture. With appropriate strategies, RSUD X could establish a safer working environment and enhance the quality of midwifery services. These findings could serve as a reference for other hospitals with similar characteristics.

**Keywords:** implementation strategy, midwifery, patient safety culture

## INTRODUCTION

Patient safety is a fundamental element in improving the quality of health services in hospitals. The World Health Organization (WHO) affirms that patient safety is a key pillar in an effective and efficient health system. However, various challenges in the implementation of patient safety culture are still faced by many health facilities, including in Indonesia.[1]

The WHO report for 2024 shows that patient safety incidents, such as mismedications, nosocomial infections, and fall injuries, are still occurring with significant frequency. Patient safety incidents in Indonesian hospitals, data from the Indonesian Ministry of Health include patient identification errors by 1.5%, medical errors by 12%, and surgical error incidents by 8%. The obstetric room is an area of high risk for maternal and infant safety incidents such as unwanted events of pregnant women bleeding heavily during childbirth due to errors in the episiotomy. This incident shows that the implementation of a patient safety culture is not optimal and still requires a more effective strategy.[2]

Patient safety culture refers to the values, attitudes, and practices adopted by all healthcare workers in preventing errors and improving the quality of service. Some of the factors that contribute to the successful implementation of a patient safety culture include leadership commitment, staff engagement, incident reporting systems, and ongoing training and education.[2] According to the Swiss Cheese Model developed by James Reason, failures in the healthcare system are often caused by numerous gaps in the various layers of defense that exist. Therefore, a systematic and continuous approach to building a safety culture is essential.[3]

Previous research by Effective patient safety implementation strategies can improve healthcare worker adherence to safety procedures, improve patient satisfaction, and reduce patient safety incidents. However, there are still gaps in practice in the field, especially in the aspects of procedural compliance and continuous evaluation of patient safety policies.[4]

Therefore, this study aims to analyze strategies that can be applied in the implementation of patient safety culture to improve the quality of services in hospitals. With the hope that evidence-based strategic recommendations can be formulated to improve the overall patient safety system.

## METHODS

The research method in this study uses a qualitative approach with *Grounded Theory*. *Grounded theory* is a qualitative research design that focuses on creating general explanations (theories) related to processes, actions, or interactions formed from the views of a number of participants. This research aims to explore phenomena related to patient safety culture through the process of collecting and analyzing data


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inductively. This research was carried out from December 2024 to January 2025 for approximately 3 weeks in the obstetrics room of RSUD X.

The instrument of this research is the researcher himself and uses unstructured *in dept interview* guidelines. The informants who were selected *purposively* were obtained as many as 9 informants with consideration of the sample selection criteria including being able to communicate well, individuals who are rich in information and willing to be interviewed and involved in the implementation of patient safety culture, with the composition of 1 midwifery inpatient room staff, 1 VK staff, 1 head of the midwifery inpatient room, 1 head of VK room, 1 former head of VK room, 1 quality committee member, 2 management or representative directors, 1 obstetric patient.

Ethical considerations follow the principles *of respect for person*, *beneficence*, *justice*, *veracity*, *confidentiality*, and *non-maleficence* or *do no harm*, in accordance with the general principles of health research. This research has received ethical feasibility approval from the Health Research Ethics Commission, Faculty of Medicine, University of Brawijaya Malang with Number 450/EC/KEPK-S2/12/2024.

This study uses a qualitative approach, so the determination of variables is different from quantitative research, in this study the variables used are included in the categorization of themes, namely the strategy of implementing patient safety culture.

To ensure the validity of the data, this study applied the triangulation technique of sources and methods. The researcher triangulated by observing the results of interviews with events in the field. The data obtained was analyzed using *the grounded theory* method, which includes *the stages of open coding* by identifying categories from raw data*, axial coding* by arranging relationships between categories*,* and *selective coding* by arranging the core of categories and forming a theory of relationships between concepts.

## RESULT

This research identifies six main strategies in strengthening patient safety culture, namely increasing the knowledge and capacity of health workers**,** visionary management dynamics for system reform**,** optimizing professionalism in clinical practice**,** strengthening risk mitigation systems to prevent incidents**,** accelerating strategic collaboration to increase work effectiveness**,** and the development of a more modern and accountable incident reporting system**.** This strategy is designed based on research findings classified into several sub-themes that explain implementation at the operational level as seen in Table 2.

### Increased Knowledge and Capacity with Patient Safety Culture

Training is the main strategy in increasing the understanding of health workers about patient safety culture. However, this training is often only conducted when approaching accreditation, so the understanding of midwifery staff tends to decline afterwards. This is reflected in the following quote:

> *"I think it has to be refreshed, Sis, yesterday was just when I was in Acre.. it should be refreshed every year.. Remember, the culture of patient safety is what we do, not just when we do."* (Informant 3)

One key strategy in strengthening a culture of patient safety is sharing experiences through case discussions and knowledge transfer. The concept of knowledge transfer, or peer-to-peer sharing, offers a solution for disseminating insights gained from training or clinical experience to colleagues.

> *"Because the function of knowledge transfer is also important. It's not just*


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*about one person understanding or being knowledgeable, but about passing that knowledge on to others… what's the term… peer sharing or something like that." (Informant 7)*

**Visionary Management Dynamics for System Revitalization and Reform**

Monitoring and evaluation were carried out through direct visits to the midwives' workspaces as well as periodic evaluations to ensure the implementation of a patient safety culture. A clear reward and punishment system is needed to ensure staff compliance with patient safety standards.

"There needs to be a firm reward and punishment mechanism to maintain adherence to patient safety standards." (Informant 5).

Periodic evaluations using checklists are considered a more systematic approach to ensuring the implementation of a patient safety culture.

*"Routine evaluations structured with checklists can help implement a more measurable patient safety culture." (Informant 7).*

Gap analysis within the hospital system aims to identify weaknesses based on survey results to improve service quality at the regional public hospital (RSUD). The findings from this study serve as an evaluation tool for hospital management to support continuous improvement.

*"We need input and feedback from this research, whether written or verbal, so that we can see the problems from a broader perspective. We will sincerely accept any feedback, and we will make every effort to follow up on issues that can be addressed." (Informant 8)*

The results of this study show that intensification of monitoring, management's commitment to improvement, and non-punitive incident investigation approach play an important role in building a better patient safety culture.

**Maximizing Professionalism at Work**

Improving work ethic in the midwifery team is carried out by instilling the principles of rigor, independence, and responsibility in work. This includes reminding staff to be more thorough in matching patient data, asking midwives to be more active in asking seniors, and ensuring that all actions are done carefully and collaboratively.

*"There was a mistake in filling out the form. The patient's actual blood type was B, but it was mistakenly written as A. People rely on the form, so it's important to double-check if the name and blood type are correct and who the information is intended for." (Informant 1)*

*"What we really need is shared awareness. That our work is not just about routine tasks." (Informant 7)*

Maintaining focus at work is a challenge for healthcare workers, particularly female staff who often carry emotional burdens from home into the workplace. This can impact their concentration in adhering to patient safety procedures.

*"If someone isn't aware they've made a mistake, how can they report it? We must be thorough and focused while working—leave the burdens from home behind. As women, it's tough. Unlike men, who seem to come to work without emotional baggage, women are thinking about their husbands, their children, their neighbors... even venting in the hospital. Especially during menstruation, when the mood is low." (Informant 3)*

Staff are expected to understand that the patient safety culture is not merely about procedures but a fundamental principle of healthcare services. This awareness is crucial to ensure that patients receive safe and high-quality care.



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*"Patient safety culture is very important. It must be prioritized. We have to be careful, and above all, put the patient's well-being first." (Informant 2)*

The results of this study show that professionalism in work is greatly influenced by teamwork ethic, awareness of shared responsibility, and concern for patient safety as a top priority in health services.

**Strengthening Risk Mitigation Systems for Incident Elimination**

The quality committee has implemented various preventive measures to reduce the risk of patient incidents. This effort is carried out by installing handrails in beds and toilets, installing fall risk stickers, and using patient wristbands adjusted to the level of risk. These measures aim to improve patient safety and minimize the potential for unwanted events.

*"We have probably done our part in terms of prevention. For example… bed rails, handrails in the toilets, we also provide fall risk stickers. We've also adjusted the wristbands according to the identified risks. Those measures are in place." (Informant 8)*

One of the risk mitigation strategies is to strengthen existing SOPs. Hospital management is committed to revising and adjusting SOPs to be more effective in preventing incidents in the hospital environment.

"*Then strengthening the SPO.."* (Informant 8)

The results of this study show that risk mitigation in the patient safety culture has been carried out through various preventive measures and strengthening of SOPs. However, a more comprehensive monitoring system is needed so that the effectiveness of implementing a patient safety culture can be measured more systematically and sustainably.

**Accelerating Strategic Collaboration for Seamless Work Effectiveness**

The effectiveness of the implementation of a patient safety culture is highly dependent on synergy and good coordination between health workers. The division of duties between the staff of the implementing midwife and the team leader must be proportional to ensure a balance of workload.

The solidity of the midwifery team is a key element in supporting the implementation of a patient safety culture. Effective communication between team members is necessary to prevent procedural errors and increase awareness of incident risks. Reminding each other and providing guidance in the team is a crucial mechanism in maintaining patient safety standards.

*"The team in the ward often gives reminders—they understand, but they need frequent reminders." (Informant 1)*

A harmonious relationship between health workers in the field and hospital management is a determining factor in the successful implementation of a patient safety culture. Strong cooperation between patient safety subcommittee teams, medical committees, and medical service units is required to support a sustainable patient safety system.

*"Sometimes, even when we are ready, the management does not conduct proper assessments, so the fall risk scoring is not accurately captured. Essentially, they also fail to pay attention to patient safety measures." (Informant 5)*

The results of this study show that accelerating strategic collaboration in the culture of patient safety requires a balance in the division of tasks, the solidity of the midwife team, and close cooperation between the implementing staff and hospital management. Optimal coordination and effective



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communication are expected to create a safer, more efficient, and health-oriented work environment.

**Development of Reporting Systems in a Patient Safety Culture**

In an effort to improve the effectiveness of patient safety incident reporting, hospitals are beginning to adopt more modern reporting mechanisms. The effectiveness of the reporting system is highly dependent on the speed and ease of information delivery. Therefore, there is a need to develop more flexible reporting features, which allow healthcare workers to report incidents more quickly without neglecting formal procedures.

*"Well… if we want things to be quick, actually communication via WhatsApp or phone is fine. But it still has to be followed up—meaning they still have to write a formal report and submit it to us as soon as possible." (Informant 7)*

The results of this study show that that modernization of reporting systems by utilizing communication technology can improve the efficiency of incident reporting. However, a mechanism is needed to ensure that non-formal reporting is followed by formal documentation to ensure accountability and continuity of patient safety system improvements.

**Table 1. Characteristics of Informants**

| Code | Time/ Duration *In depth Interview* | Work Unit | Information | Education | Length of Service (years) |
|---|---|---|---|---|---|
| I01 | 11-12-2024/ 70 minutes | Inpatient Maternity Ward Staff | | D III Midwifery | 5 |
| I02 | 03-01-2025/ 65 minutes | Delivery Room (VK) Staff | | D IV Midwifery | 3 |
| I03 | 04-01-2025/ 83 minutes | Head Nurse, Inpatient Maternity Ward | | D IV Midwifery | 5-6 |
| I04 | 08-01-2025/ 52 minutes | Head Nurse, Delivery Room (VK) | | D IV Midwifery | 17 |
| I05 | 11-01-2025/ 88 minutes | Radiology | KMKP Team Leader | Radiology Specialist | 10 |
| I06 | 14-01-2025/ 48 minutes | | Obstetric Patients | Bachelor | |
| I07 | 16-01-2025/ 92 minutes | General Affairs Subdivision Head | Hospital Management | S1 Nursing | 17 |
| I08 | 18-01-2025/ 55 minutes | Medical Services Division Head | Hospital Management | D III Nursing | 3 |
| I09 | 18-01-2025/ 72 minutes | Verifier | Head of Delivery Room (2013–2021) | D III Midwifery | 12 |



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**Table 2. Grouping Strategy Theme Clusters in the Implementation of Patient Safety Culture**

| Theme Cluster | Theme | Sub Theme |
|---|---|---|
| Strategies in the implementation of patient safety culture | Increased knowledge and capacity cultured patient safety | Improve knowledge and abilities by attending training<br>Improve understanding of the reporting process<br>Build awareness of the value of patient safety<br>Invite learning and sharing experiences about patient safety |
| | Visionary management dynamics for system revitalization and reform | Maximizing monitoring, evaluation, and improvement by management<br>Improve management support<br>Realizing a commitment to continuous improvement<br>Analyzing gaps in hospital systems<br>Improve the decision-making structure in the organization |
| | Maximizing professionalism at work | Improve the work ethic of the implementation team with a focus on work<br>Unload the mind outside of work<br>Realize that midwives must have a sense of work integrity and shared responsibility<br>Considers a patient safety culture important |
| | Strengthen risk mitigation systems for incident elimination | The quality committee implements preventive measures to avoid patient incidents<br>Anticipate potential incidents by completing and tightening SOPs<br>Hospital management monitors work procedures to prevent unwanted incidents from occurring or recurring. |
| | Accelerating strategic collaboration for seamless work effectiveness | Ensure teamwork and coordination<br>Reminding teams of midwives about solid performance<br>Requires cooperation between service implementing staff and hospital management |
| | Develop a reporting system | Modernizing the reporting system mechanism<br>Need more flexible reporting features |

**Source: Data processed (2025)**

It can be seen in Figure 1. The interaction between themes in the strategy for implementing a safety culture at RSUD X. That increasing the capacity of health workers is the main foundation in the implementation of a culture of patient safety. Supported by visionary management, system transformation can be sustainable. Healthcare workers' professionalism and robust risk mitigation ensure compliance with safety standards, while strategic collaboration between stakeholders optimizes work effectiveness. The development of a flexible and accountable reporting system supports incident detection and analysis for continuous improvement. The integration of this strategy creates a safer service environment and improves the quality of health services.



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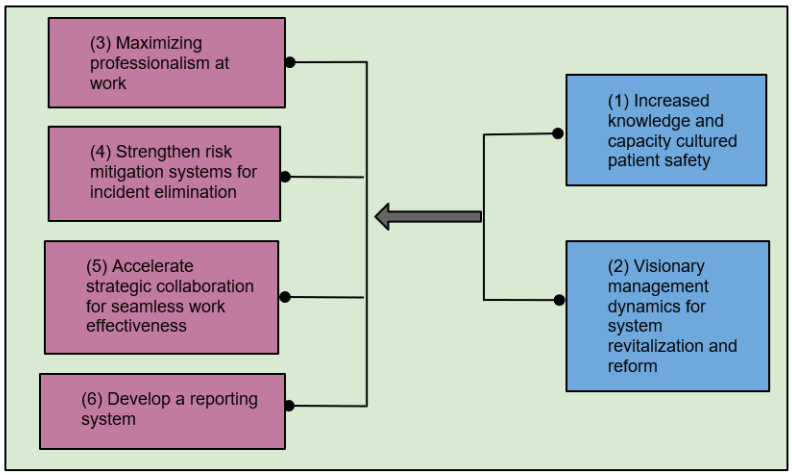


**Figure 1. Interaction Between Themes of Patient Safety Culture Implementation Strategy**

## DISCUSSION

Implementation strategy is a systematic approach to ensure patient safety policies can be effectively implemented in clinical practice. According to Leeman et al. (2024), the success of implementation is influenced by the readiness of the organization, resources, and the involvement of all stakeholders.[5] The strategy implemented must be flexible and adaptive to the dynamics of health services.[6]

The effectiveness of an implementation strategy also depends on structural, behavioral, and organizational cultural factors.[4] An evidence-based approach is needed to identify determinants of success as well as optimize the monitoring and evaluation of patient safety programs.[7] Thus, the implementation strategy must be dynamic, data-driven, and require a collective commitment to improve patient safety and overall health service quality.

### Increased Knowledge and Capacity in a Patient Safety Culture

Health workers' understanding of patient safety principles plays a crucial role in preventing unexpected events.[8] Ongoing training is proven to improve compliance with safety standards and reduce the risk of incidents.[6] However, there are still gaps in the implementation of a patient safety culture due to a misperception of patient safety responsibilities.[9]

Organizational cultures that support patient safety must be strengthened through regular training, resource provision, and health care worker involvement in incident reporting systems.[10] In the context of this research for midwifery personnel, knowledge can be increased through training, socialization, and refreshment of patient safety procedures. The head of the room is expected to have a central role in ensuring that midwives understand safety protocols and adopt transparent reporting practices without fear of sanctions.

Therefore, a capacity building strategy is needed through *periodic workshops, clinical simulations, and the use of digital technology* such as e-learning and medical education applications. Additionally, rewards for healthcare workers who are active in incident reporting can be an incentive to strengthen a culture of patient safety.

### Visionary Management Dynamics for System Revitalization and Reform

Visionary management plays a key role in driving sustainable health system change by building a collective commitment to patient safety.[11] Leadership that supports a culture of safety has been proven to lower medical



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incidents and increase service effectiveness.[12, 13]

Therefore, system revitalization in this study can be carried out through routine monitoring and evaluation, adequate resource provision, and incident investigation with *a no-blame culture* approach. Continuous learning programs and *gap analysis* in the system are also needed to identify weaknesses and design evidence-based improvements. The hospital's commitment must be realized through the implementation of transformational leadership guidelines, as well as open communication between management and health workers to ensure that policies taken are in accordance with the needs in the field.

**Maximizing Professionalism at Work**

The professionalism of health workers includes competence, integrity, responsibility, effective communication, and adherence to professional ethics.[14] High professionalism contributes to lowering patient safety incidents and improving service quality.[15]

Increasing professionalism can be done through continuous training, compliance with SOPs, and updating knowledge according to medical and technological developments.[16] Effective communication is also an important aspect in preventing medical errors and improving team coordination.[17]

Therefore, from the results of this study, midwifery staff can improve professionalism by maintaining a focus on work, building a sense of shared responsibility for patient safety, and creating a work environment that supports accountability without fear of reporting mistakes. In addition, *the reward and recognition* system can be applied to motivate health workers in maintaining high work standards.

**Strengthening Risk Mitigation Systems for Incident Elimination**

Hospitals must have an early detection mechanism for potential risks in health services. A risk-prediction-based approach using electronic data and incident reports can improve the effectiveness of hazard identification before an incident occurs.[18] *Root Cause Analysis* (RCA) and *Failure Mode and Effect Analysis* (FMEA) methods can be used to analyze the main causative factors of incidents, so that the resulting solution is more targeted.[19]

The results of this study show that risk mitigation can be carried out with preventive measures such as the installation of *handrails*, fall risk stickers, patient wristbands, and strengthening SOPs based on *evidence-based practice*. Hospital management must also conduct regular monitoring and establish specific indicators to ensure the patient safety culture runs well.

Risk mitigation also includes the implementation of a transparent and non-punitive incident reporting system, which has been proven to increase the number of reports by up to 40% and encourage continuous system improvement.[20] Therefore, the application of technologies such as *the Clinical Decision Support System* (CDSS) and barcode system to drug administration can help prevent medical errors. In addition, it is important for hospitals to develop resilience strategies in the face of crises, such as shortages of medical personnel, disruptions in drug distribution, or power outages, to ensure services remain optimal.

**Accelerating Strategic Collaboration for Seamless Work Effectiveness**

The effectiveness of work in health services is highly dependent on the level of collaboration between professions and between units. Strong strategic collaboration between healthcare workers, hospital management, and other stakeholders creates a more responsive, efficient, and patient-safety-oriented system. Hospitals that implement a collaboration-based work model experience a 35% reduction in patient safety incidents compared to hospitals that still work in a silo system.[21]


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Good cooperation between doctors, nurses, midwives, and other healthcare workers can ensure that clinical decisions are more comprehensive and evidence-based. Multidisciplinary teams have higher levels of adherence to patient safety standards than healthcare workers who work individually.[22] The use of standard communication methods such as *SBAR* (*Situation, Background, Assessment, Recommendation*) can improve the clarity of information and reduce errors due to miscommunication.

The results of this study show that the acceleration of collaboration can be carried out by ensuring solid teamwork, a balanced division of tasks in the midwifery room and PONEK, and better collaboration between units. Cooperation between the midwifery staff and hospital management is also required, including in the assessment of incident risk by the quality committee and the involvement of the director if the incident is more complex.

Therefore, to increase the effectiveness of collaboration, hospitals can implement electronic medical records to improve the accessibility of patient data in real-time for all healthcare teams. In addition, the establishment of a cross-disciplinary team that oversees the implementation of a patient safety culture will help address operational challenges. Implementing a zero-tolerance policy against the silo mentality will encourage each unit to share information and work together without bureaucratic barriers. Hospitals can also leverage technologies such as telemedicine, medical chatbots, and virtual discussion platforms to accelerate healthcare coordination.

**Development of Reporting Systems for Patient Safety**

An effective incident reporting system allows healthcare workers to identify risks early, analyze the causes of incidents, and implement corrective actions. However, challenges such as lack of awareness, fear of sanctions, and lack of management support are still major obstacles, so the reporting system must be non-punitive, transparent, and based on organizational learning.[23]

RSUD X needs to modernize the reporting system with more flexible features, including application-based or web-based digital reporting. Every report must be followed up immediately to have a real impact on system improvement.[24] The Patient Safety Committee (KPRS) at RSUD X has played a role in analysis and recommendations, but it needs to be strengthened with periodic evaluations and integration of reporting data into more effective patient safety policies. Hospitals must therefore provide an easily accessible reporting system, either through digital *mobile* applications , electronic forms, or web-based platforms.

## CONCLUSION

This study identifies the main strategies in strengthening the patient safety culture in the midwifery room and the hospital as a whole. Capacity building of health workers through continuous training is a fundamental step, not only in the technical aspect, but also in communication and risk management. Reform of the management system is needed by strengthening monitoring and evaluation mechanisms, as well as ensuring a commitment to continuous improvement.

The professionalism of health workers must be improved through transparency and accountability in services, so that patient safety is a top priority. In addition, a more systematic risk mitigation system must be implemented to reduce unwanted events in the obstetric room. Cross-team collaboration between health professions also needs to be strengthened so that patient safety becomes a shared responsibility, not just an individual burden.

The development of a more modern incident reporting system is a crucial


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step in improving the effectiveness of patient safety incident detection and analysis. By implementing this strategy comprehensively, the patient safety culture at RSUD X can be stronger, create a safer work environment for health workers, and improve the quality of service for patients, with implications for policies through strengthening the implementation of SOPs, including monitoring and evaluating the running of the patient safety culture.

Patient safety is not only an individual responsibility, but is the result of the synergy of all organizational elements, including health workers and hospital management, to realize a better and sustainable health system. Of course, this strategy can be applied to other hospitals with similar characteristics.

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