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Effectiveness of ASWAJA An Nahdliyah-based caring training on caring behavior, performance in patient safety and service quality

Eficacia basada en ASWAJA An Nahdliyah sobre el comportamiento de cuidados, el desempeño de seguridad del paciente y la calidad del servicio

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SUMMARY

Objective: *To analyze the effectiveness of ASWAJA An Nahdliyah-based caring training on caring behavior, performance in patient safety goals, and service quality.* **Methods:** *Quasi-experimental research design. The population was nurses and patients in the internal medicine and surgery rooms at the Surabaya Islamic Hospital A. Yani and Jemursari. Samples were taken from all practicing nurses working in the Az Zahrah 1 room at the Jemursari Islamic Hospital as the intervention group (n=19) and nurses working in the Shofa and Marwa rooms at the Surabaya Islamic Hospital A. Yani Islamic Hospital (n=19) were taken as the control group. The sample size for each group of patients was 38 people. Sampling was purposive sampling. The research instrument used a questionnaire. Data analysis was Wilcoxon and Mann-Whitney test.* **Results:** *The Mann-Whitney test showed that there was a significant difference in caring behavior and compassion between the treatment and control groups (p<0.005). Caring training also had a significant effect on performance in patient safety goals at SKP 1, SKP 5, and SKP 6 (p<0.05). It also influenced service quality in all dimensions (p<0.05).* **Conclusion:** *Caring training based on ASWAJA An Nahdliyah has a significant effect on caring behavior, performance in patient safety goals, and quality of nursing services. Continuing training and education are important to be programmed on an ongoing basis to improve the abilities of nurses both cognitive, affective, and psychomotor to improve the quality of service.*

Keywords: *Caring, performance, patient safety, quality.*

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RESUMEN

Objetivo: *Analizar la eficacia de la formación en cuidados basada en ASWAJA An Nahdliyah sobre el comportamiento de cuidados, el desempeño en los objetivos de seguridad del paciente y la calidad del servicio.* **Métodos:** *Diseño de investigación cuasi-experimental. La población fueron enfermeras y pacientes en las salas de medicina interna y cirugía del Hospital Islámico de Surabaya A Yani y Jemursari. Se tomaron muestras de todas las enfermeras practicantes que trabajaban en la sala Az Zahrah 1 del Hospital Islámico Jemursari como grupo de intervención (n=19) y enfermeras que trabajaban en las salas Shofa y Marwa del Hospital Islámico Surabaya A. Del Hospital Islámico Yani (n=19) se tomó como muestra el grupo control. El tamaño de la muestra para cada grupo de pacientes fue de 38 personas. El muestreo fue mediante muestreo intencional. El instrumento de investigación utilizó un cuestionario. El análisis de datos se hizo usando las pruebas de Wilcoxon y Mann-Whitney.* **Resultados:** *La prueba de Mann-Withney mostró que hubo una diferencia significativa en el mantenimiento del cuidado y la compasión entre los grupos de tratamiento y control (p<0,005). El entrenamiento en cuidados también tiene un efecto significativo en el desempeño de las metas de seguridad del paciente en SKP 1, SKP 5 y SKP 6 (p <0.05). También influye en la calidad del servicio en todas las dimensiones (p<0,05).* **Conclusión:** *la formación en cuidados basada en ASWAJA An Nahdliyah tiene un efecto significativo en el comportamiento de cuidados, el desempeño en los objetivos de seguridad del paciente y la calidad de los servicios de enfermería. La formación y educación continua son importantes para ser programadas de manera permanente para mejorar las habilidades de las enfermeras tanto cognitivas como afectivas y psicomotoras para mejorar la calidad del servicio.*

Palabras clave: *Cuidar, desempeño, seguridad del paciente, calidad.*

INTRODUCTION

Patient Safety is a global and national issue for hospitals, an important component of the quality of health services, a basic principle of patient care, and a critical component of quality management (1). Patient safety is still a problem in various countries, millions of patients worldwide may suffer from disabilities, or injuries or die every year due to unsafe health services (2). Adverse events still occur frequently (3), but there are still many hospitals or officers who do not report these incidents (2). Reports from the quality improvement and patient safety committee from Jemursari Islamic Hospital in 2020 indicate that there were still 7 Adverse Events and in the 1st trimester of 2021, there were still quality indicators that had not been achieved, including efforts to prevent the risk of falling still not being achieved, and patient satisfaction has not been identified. Nurses have an important role related to patient safety through caring behavior.

In the number of events related to patient safety in Europe, patients had an infection risk of 83.5 % and evidence of medical error showed 50-72.3 %. The results of research in various countries found Adverse Events with a range of 3.2 - 16.6 % (4). Patient safety incident reports in Indonesia found cases of adverse events (14.41 %) and near misses (18.53 %) caused by clinical processes or procedures (9.26 %), medication (9.26 %), and patient falls (5.15 %) (2,5).

Nurse behavior plays an important role in the implementation of patient safety. Unsafe behavior, forgetfulness, lack of attention/motivation, carelessness, inaccuracy, and ability that does not care about and maintain patient safety is at risk for errors and will result in injury to the patient, in the form of a near miss or an adverse event. Furthermore, error reduction can be achieved by modifying behavior, namely by caring behavior. Caring is an application of the nursing process as a form of performance displayed by a nurse (6). Nursing performance reflects the quality of care provided and the results will be felt by patients. Caring will enable harmonious interpersonal relationships to be established between nurses and patients and can help meet patient needs to provide satisfaction (7). Patient satisfaction is an indicator of the quality of nursing/health services (8,9).

Efforts to overcome those problems are to improve the performance of nurses in the target of patient safety through training in caring behavior based on ASWAJA An Nahdliyah, which is suitable for application in Islamic hospitals, with the hope that service quality will increase. Caring based on ASWAJA An Nahdliyah is a development of the Carolina Care Model which adapts Swanson Caring Theory, by modifying it

based on Islamic caring which consists of four main types, namely: 1) God's Caring for humans 2) Human caring for themselves, 3) Caring for others, and 4) Human caring for nature and vice versa. God's caring (love) for humans covers the other three types of caring.

The implementation of ASWAJA An Nahdliyah-based Caring is also based on the values shared by ASWAJA An Nahdliyah, namely; 1) tasamuh (tolerant, respectful), 2) tawassuth & i'tidal (moderate, straight, middle, fair); 3) amar ma'ruf nahi munkar (doing good/beneficial and leaving bad/harmful) and 4) Istiqomah (consistent, obeying rules, continuously). The ASWAJA An Nahdliyah-based Caring Model views humans as holistic beings with a body and soul, and physical and mental aspects must be considered simultaneously in care, thus it is hoped that this will improve performance in patient safety goals and will increase patient satisfaction. Based on the research in the previous stage, it was found that Caring based on ASWAJA An Nahdliyah is the most powerful factor affecting performance in patient safety goals.

METHODS

General background of research

This study used a quasi-experimental research design with the untreated control group design with dependent pre-test and post-test samples. This study involved two groups of subjects, namely the intervention group and the control group.

Sample of research

The population in this study were nurses and patients in the internal medicine and surgery rooms at the Surabaya Islamic Hospital and Jemursari Islamic Hospital in Surabaya. Samples were taken from all practicing nurses working in one of the medical surgical rooms at RSI Jemursari, namely those working in the Azzahrah 1 room as the intervention group and nurses serving in the medical surgery room at RSI Surabaya A. Yani, namely the Shofa and Marwa rooms, as the control group. Each room has 19 nurse respondents. The sample size for patients was calculated using the sample size formula for a two-population hypothesis test (Lemeshow, et al., 1990), obtained for each group of 38 people. Sampling was taken using purposive sampling, namely selecting the sample according to what the researcher wanted based on inclusion and exclusion criteria. The inclusion criteria for nurses were nurses with more than 1 year of service and were willing to be respondents, while the exclusion criteria were nurses who were on leave or sick during the study. The inclusion criteria for patient samples were consciousness, and awareness, treated for 3-7 days. Exclusion criteria were patients who were not willing to be respondents. This research has passed the ethical test at the Surabaya Islamic Hospital Jemursari with Number 065/KEPK-RSISJS/VII/2022.

Instrument

The research instrument used the caring module based on ASWAJA An Nahdliyah, as a medium for training/intervention. Caring behavior used a questionnaire referring to Caring Caroline with modified ASWAJA An Nahdliyah values, for performance using a questionnaire with a Likert scale designed based on Standard Operating Procedure 6 patient safety goals. Instruments for service quality were also measured using a questionnaire with a Likert scale based on the quality dimension, namely RATER (Responsiveness, Assurance, Tangibles, Empathy, Reliability).

Data analysis

Data analysis was performed using descriptive analysis and inferential analysis. Descriptive analysis aims to describe each research variable. Numerical data are presented in the form of central tendency (mean, standard deviation, minimum and maximum, and 95 % CI). Meanwhile, categorical data displays data in the form of frequency and percentage. The inferential analysis was performed with normality and homogeneity tests. The normality test using Shapiro-Wilk was used to assess the distribution of data in each variable. Levene's test was used to evaluate homogeneity between groups. If the distribution of data is

normally distributed, the statistical test used was paired t-tests to assess differences in caring values and pre- and post-nurse performance in each group. The independent t-test was used to study the difference in delta values between groups. If the distribution of data is not normally distributed, statistical tests were carried out using non-parametric tests. Non-parametric tests used were Wilcoxon tests to assess differences in caring values and performance between pre-and post-in each group. The Mann-Whitney test was used to evaluate differences in the delta values of performance, quality, and patient safety between groups. The research hypothesis was accepted if the p-value <0.05.

RESULTS

Respondent demographic characteristics

Table 1 shows that the treatment and control groups were almost entirely equal or homogeneous (p>0.005), except for education (p<0.05) and marital status (p=0.026) which indicated that education and marital status between the control and treatment groups were not equal (not homogeneous). Almost all (84.1 %) of the respondents were aged between 26-35 years in both the treatment and control groups. Most of the sexes were female, namely 78.9 % in the treatment group and 73.7 % in the control group. Employment status in the two groups showed that almost all were regular employees (94.7 %) in the treatment group and 89.5 % in the control group. The level of education in the two groups was not equal, in the treatment group there were 57.9 % Nursing associate degrees, whereas, in the control group, almost all (89.5 %) had nurse professional education. In marital status, almost all (84.5 %) of the respondents in the intervention group were married, while in the control group, 68.4 % were married.

For patient respondents, shows that the two groups of respondents each were 38 people. Gender and length of stay for the two groups were not equivalent (p<0.05), for age, the respondents were equal ($p \geq 0.05$). Based on gender, in the intervention group, almost all of the respondents were male (81.6 %), while the majority of the control group (57.9 %) were female. The age of the respondents in the intervention group was mostly 56-65 years (26.3 %), in the control group, the most were 66-75 years old (21.1 %). The highest length of stay was 3 days for the intervention group (47.4 %), while in the control group (52.6 %).

Table 2 shows that caring behavior in the intervention group showed a significant difference in average between pre-and post-ASWAJA An Nahdliyah-based caring training (p<0.05) on all indicators. In the intervention group, there was a significant increase in the average value of caring after being given training. In the control group, there was no difference in the average caring between pre-and post-training (p>0.05) on all indicators.

Table 3 shows that there is a significant difference (delta) between caring maintaining, caring compensation, and caring ASWAJA compositely between the treatment group and the control group (p<0.05). Whereas for caring competence there was no significant difference (p>0.05).

Performance in Patient Safety Goals

Table 4 shows that there was a significant difference in the average performance in SKP 1, SKP 4, SKP 6 and performance in the composite SKP before and after the ASWAJA and Nahdliyah-based caring training was carried out in the intervention group (p<0.05). Meanwhile, there was no significant difference in the performance of SKP 2, SKP 3, and 5, although there was an increase in post-training (p = 0.005). In the performance control group in SKP, there was no difference in the average score between pre and post.

Table 5 shows that in the performance in SKP 1, SKP 5, and SKP 6 there is a significant difference between the treatment group and the control group (p <0.05). There is no significant difference in performance in SKP 2, SKP 3, and SKP 4 (p>0.05). The performance in SKP as a whole (composite) shows that there is a significant difference between the treatment group and the control group (p<0.05).

Table 1. Characteristics of respondents in the intervention group and control group

Characteristics	Intervention Group n (%)	Control Group n (%)	Equivalence test
Nurse Respondents			
Age (years)			
≤ 25	2 (10.6)	1 (5.3)	
26-35	16 (84.1)	16 (84.1)	0.618
36-45	0 (0)	1 (5.3)	
46-55	1 (5.3)	1 (5.3)	
Age (years)			
1-5 years	4 (21.1)	14 (73.7)	
6-10 years	11 (57.9)	3 (15.8)	0.414
> 10 years	4(21.1)	2 (10.5)	
Gender			
Male	4 (21.1)	5 (26.3)	0.460
Female	15 (78.9)	14 (73.7)	
Education			
Nursing associate degree	11 (57.9)	2 (10.5)	0.0001
Nurse professional	8 (42.1)	17 (89.5	
Marital status			
Single	3 (15.8)	6 (31.6)	0.026
Married	16 (84.2)	13 (68.4)	
Employment status			
Contract employee	1 (5.3)	2 (10.5)	0.239
Regular employee	18 (94.7)	17 (89.5)	
Patient respondents			
Gender			
Male	31 (81.6)	16 (42.1)	0.0001
Female	7 (18.4)	22 (57.9)	
Age (years)			
≤ 25	5 (13.2)	7 (18.4)	
26-35	5 (13.2)	7 (18.4)	
36-45	4 (10.5)	4 (10.5)	
46-55	9 (23.7)	6 (15.6)	0.154
56-65	10 (26.3)	6 (15.6)	
66-75	5 (13.2)	8 (21.1)	
Length of stay			
3 days	18 (47.4)	20 (52.6)	
4 days	9 (23.7)	11 (28.6)	0.017
5 days	1(2.6)	5 (13.2)	
6 days	6 (15.8)	0 (0)	
7 days	4 (10.5)	2 (5.3)	

Table 2. Test the difference in mean pre and post-caring between the intervention group and the control group

Variable	Mean ± SD Intervention (n= 19)			Mean ± SD Control (n=19)		
	Pre	Post	P value	Pre	Post	P value
Maintaining	18.74±2.825	21.37±2.432	0.004[a]	22.11±1.663	21.95±2.272	0.776[a]
Compassion	39.21±5.643	42.89±4.228	0.026[b]	44.21±3.409	44.53±3.611	0.551[a]
Competence	25.05±2.838	26.84±2.292	0.006[a]	26.89±1.370	26.95±2.172	0.383[a]
Caring Composite	83.00±10.541	91.11±8.103	0.002[a]	93.21±5.564	93.42±7.074	0.407[a]

[a]: Wilcoxon Signed Ranks test, [b]: T-test

Table 3. Test the difference between the intervention group and the control group

Variable	Intervention group			Control group			p-value
	Mean Δ ± SD	CI 95 %	Normality test	Mean Δ ± SD	CI 95 %	Normality test	
Maintaining	3.05 ± 3.440	1.39 - 4.71	0.176a	-0.16 ± 2.500	-1.36 - 1.05	0.038	0.002[c]
Compassion	4.79 ± 6.373	1.72 -7.86	0.096a	0.32 ± 4.347	-1.78 - 2.41	0.075	0.017[b]
Competence	2.00 ± 2.560	0.77 - 3.23	0.006a	0.05 ± 2.527	-1.17 - 1.27	0.0001	0.109
Caring ASWAJA	9.84 ± 11.211	4.44 – 15.25	0.120a	0.21 ± 7.432	-3.37– 3.79	0.006	0.025[c]

Table 4. Results of the test of difference in the average of Pre- and Post-performance in patient safety goals in the intervention group and the control group

Variable	Mean ± SD Intervention group (n= 19)			Mean ± SD Control group (n=19)		
	Pre	Post	P value	Pre	Post	P value
SKP 1	11.58±1.710	13.00±1.795	0.002[b]	12.68±1.250	12.84±1.068	0.604[a]
SKP 2	17.53±1.982	18.11±1.370	0.079[a]	17.11±0.875	16.89±1.049	0.458[a]
SKP 3	25.21±2.275	25.32±2.405	0.796[a]	25.47±1.541	24.95±1.433	0.172[b]
SKP 4	11.05±1.268	11.53±1.124	0.041[a]	11.79±0.535	11.63±0.955	0.496[a]
SKP 5	22.47±2.170	23.21±1.960	0.078[a]	23.63±0.831	22.95±1.929	0.160[a]
SKP 6	17.68±1.493	18.84±1.573	0.007[a]	19.26±1.046	19.3684±1.25656	0.587[a]
SKP composite	105.53±7.855	108.95±9.378	0.028[a]	109.95±4.183	108.63±6.282	0.363[a]

Table 6 shows that there are differences in patient satisfaction with the quality of service between the intervention group and the control group in all dimensions of quality of nursing care ($p<0.05$). In the intervention group, almost all patients stated that they were very satisfied with the quality of nursing services, while in the control group, some of them stated that they were satisfied with the quality of services. In both groups, the lowest satisfaction is in the responsiveness variable, and the highest satisfaction in both groups is in the assurance variable.

Table 5. Test Results of Difference (Delta) Performance in Patient Safety Goals Between the Intervention Group and the Control Group

Variable	Intervention group			Control group			*p-value*
	Mean Δ ± SD	CI 95 %	Normality test	Mean Δ ± SD	CI 95 %	Normality test	
SKP 1	1.42± 1.742	0.58 - 2.26	0.191	0.16 ± 1.135	-0.51 – 0.83	0.135	0.018[b]
SKP 2	0.58 ± 1.346	-0.07 -1.23	0.014	-0.21 ± 1.134	-0.76 – 0.34	0.072	0.079[c]
SKP 3	-0.11 ± 1.695	-0.71 – 0.92	0.028	0.53 ± 1.611	-1.30 – 0.25	0.247	0.245[c]
SKP 4	0.47 ± 0.905	0.04 – 0.91	0.0001	-0.16 ± 1.015	-0.86 – 0.33	0.0001	0.057[c]
SKP 5	0.74± 1.759	-0.11 – 1.58	0.001	-0.68± 2.187	-1.74 – 0.37	0.004	0.044[c]
SKP 6	1.16 ±1.463	0.45 1.86	0.099	0.11± 1.696	-0.71 – 0.92	0.002	0.041
SKP composite	4.47±5.501	1.82 – 7.13	0.544	-1.32 ± 6.905	-4.64 – 2.01	0.002	0.005

[a]Shapiro-Wilk, [b]Independent t-test, [c]Mann-Whitney
SKP 1: Correctly identify the patient
SKP 2: Effective communication
SKP 3: Increase in medication to watch out for
SKP 4: Surgery is done properly
SKP 5: Reduce the risk of service-associated infection
SKP 6: Reduce the risk of patient injury from falls

Table 6. The results of the analysis of patient satisfaction with the quality of service between the intervention group and the control group

Variable	Intervention group			Control group			*p-value*
	Mean ± SD (n 38)	CI 95 %	Normality test	Mean ± SD (n= 38)	CI 95 %	Normality test	
Reliability	19.71± 0.927	19.41 - 20.02	0.0001	18.42±2.250	17.68 - 19.16	0.0001	0.002
Assurance	19.74±0.978	19.42 - 20.06	0.0001	18.68±1.847	18.08 - 19.29	0.0001	0.0001
Tangibles	19.66±0.994	19.33 - 19.98	0.0001	18.45±2.152	17.74 -19.15	0.0001	0.003
Empathy	19.66±1.021	19.32 - 19.99	0.0001	18.58±2.101	17.89 - 19.27	0.0001	0.005
Responsiveness	19.63±0.998	19.30 - 19.96	0.0001	18.29±2.130	17.59 - 18.99	0.0001	0.001

DISCUSSION

The results showed that in the intervention group, there was an influence of nurses' caring behavior on patients after receiving ASWAJA Annahliyah-based caring training with $p<0.05$ for each caring component. Whereas in the control group, there was no increase in caring behavior with a value of $p>0.05$. The increase in nurse caring behavior that occurs is supported by an increase in nurse knowledge and understanding of caring behavior after being given training. The caring behavior of the intervention group in the maintenance component showed an average increase of 3.05 and a decrease of -0.16 in the control group. The compassion component showed an average increase of 4.79 in the treatment group and an average increase of 0.32 in the control group. Meanwhile, the competency component showed an average increase of 2.00 in the intervention group and an average increase of 0.05 in the control group.

The results shows that caring training based on ASWAJA An Nahdliyah has a significant effect on the domain of caring, maintaining belief, and compassion. These two dimensions are very important in improving the interpersonal relationship between nurses and patients (11). In

the knowing process, the nurse tries to understand what the current situation means for the patient, and how physical and psychological conditions can affect a person as a whole. By knowing what the patient is experiencing, the nurse can then continue the process (do for) to provide therapy and intervention for him (12). With caring facilitates the nurse's ability to recognize patient, identify his problems, and find and implement solutions. The behavior of a caring nurse towards a patient can strengthen his coping mechanism to maximize the healing process (13). The training given to nurses causes them to experience the process of adopting nursing knowledge so that they can input new knowledge or recall existing knowledge which will ultimately improve the abilities and skills of nurses in providing care.

Our results agree with those of Fawzi et al., (2021) who stated that there were significant differences in caring behavior between the intervention and control groups after receiving training. It also is in line with Surbakti et al., (2019), who indicated that caring efficacy training increases the caring behavior of nurses in the intervention group. Increased knowledge after the intervention is a process that is carried out systematically to increase knowledge and skills, as well as behavior. Caring behavior based on ASWAJA Annahliyah nurses can be seen from several dimensions of caring that nurses carry out, especially in the dimensions of maintaining, compassion and competence. Some statement items from 3 dimensions have not been implemented by nurses before receiving ASWAJA Annahliyah-based caring training, including nurses who have not explored patient perceptions about the pain, do not invite patients to seek meaning and wisdom from illness, nurses very rarely sit for a few moments accompanying patients, and assessing the patient's psychological needs. Services provided are more fulfillment related to complaints of physical pain after receiving training, most nurses apply caring based on ASWAJA An Nahdliyah, which was given during the training. Some important actions that were not carried out before the training, after the training was carried out. The nurse arranges a schedule to go around the patient for whom she is responsible while identifying the patient's needs that need to be addressed immediately such as dealing with pain and dealing with other discomforts, occasionally taking time to sit for a while with the patient while discussing and exploring perceptions about pain, the meaning of the wisdom of pain for clients.

ASWAJA Annahliyah-based caring in this study is a development of caring from Swanson and Caroline's theory by incorporating ASWAJA An Nahdliyah values. In stage 1 of maintaining belief, the nurse needs to understand who the patient is with a attitude of tolerance (tasamuh), respect, and respect for the patient's beliefs and beliefs. At this stage of maintaining belief, the nurse needs to understand the patient in the transition period experiencing pain, the nurse invites the patient to draw closer to Allah, asking him for healing, because according to the Islamic view, health and illness are gifts, and to Allah, humans ask for healing. As stated in the verse of the Qur'an Surah Asy-Syu'ara verse 80 which means "when I am sick, He (Allah) heals me". Allah has no power that can stop him. At the compassion stage, providing services with full compassion, full understanding, balanced (tawazun), avoiding prejudice, and taking time to sit with patients to explore important matters by paying attention to the values of middle and fair (tawasuth and I'tidal). The stage of competence while providing care, accompanied by prayer, before praying is added with tawasul (means of getting closer to Allah) to the Prophet Muhammad SAW. Implementation of caring based on ASWAJA An Nahdliyah in daily nursing services as implemented by Carolina at the University of North Carolina Hospitals (UNCH), namely by using Multilevel rounding nurses regularly go around visiting patients, assessing whether the patient feels comfortable (handling the patient's feelings of pain/pain), assessing the need for a change in position (mobilization), the need to go to the toilet, and other needs, such as assistance to purify before prayer for those who are Muslim and identify the bell to call the nurse if it functions properly and always maintain patient privacy by closing the door/curtain when providing services to patients. Actions like this by Carolina abbreviated as "ROUND" (16).

In the competence sub-variable, the results showed that there was no difference between the treatment group and the control group. There is no difference in caring behavior in this competence sub-variable because competence is a requirement before a nurse carries out her

responsibilities. As contained in the Law of the Republic of Indonesia Number 36 of 2014 article 21 paragraph 1 explains that students in the health sector at the end of the vocational and professional education period must take a national competency test. In paragraph 3 it is explained that the competency test is aimed at achieving graduate competency standards that meet work competency standards. Article 26 it is explained that health workers who have been placed in health service facilities must carry out their duties according to their competence and authority (17). From the time they enter work as nurses, they must master 12 basic competencies. So, since the beginning of their admission, nursing credentialing has been carried out, namely the process of evaluating nursing staff to determine the feasibility of granting clinical authority, and evaluation will be carried out once every 3 years to determine their career path. This is also regulated in the Nursing Act no. 38 of 2014, in chapter IV, which regulates the registration, license to practice, and re-registration, and in chapter V which regulates nursing practice.

Caring training based on ASWAJA An Nahdliyah has a significant effect on performance in patient safety goals. The results show that there is a significant difference in the average performance in SKP 1, SKP 4, SKP 6 and performance in the composite SKP before and after the implementation of ASWAJA Annahliyah-based caring training in the intervention group ($p<0.05$). In the performance control group on patient safety goals, there was no significant difference between pre-and post-on all goals. In addition, there was a significant difference between the intervention group and the control group in SKP 1; correct patient identification, SKP 5; reducing the risk of infection related to health services, and SKP 6; Reducing the Risk of Patient Falls.

Increasing the application of performance in patient safety goals is supported by changes in nurse caring behavior. Nurses are more concerned, paying attention to patient needs and increasing professional responsibility which will result in adherence to standard operating procedures in carrying out patient safety goals. Nurse compliance with standard operating procedures for patient safety goals, namely correctly identifying patients, increasing effective communication, increasing drug safety to watch out for, the certainty of the right location, right procedure, right patient surgery, reducing the risk of infection related to health services, reducing patient risk fall, will affect patient safety. These findings support the observation that that training will improve performance (18), and that training improves teamwork in patient safety, as well the statement that training will increase work motivation and performance.

The results showed that there were differences in service quality between the intervention group and the control group on all dimensions of quality of nursing care after being given training ($p<0.05$). Service quality assessment is based on patient satisfaction with service quality, including the reliability of nurses in carrying out appropriate nursing actions (reliable), the responsiveness of nurses acting to respond quickly (responsiveness), security guarantees of nurses in carrying out nursing actions (assurance), understanding attitudes of nurses paying attention in serving patient needs (empathy), and physical evidence of services nurse and in appearance (tangible) (20). The results of this study support the findings by Abdurrouf et al., (2013), who indicated that Islamic Caring improves patient quality and satisfaction, and the research by Fadhillah et al., (2020), who demonstrated that performance in caring-based patient safety goals influences patient satisfaction. Based on the research results, the average level of satisfaction with service quality is almost the same in each dimension. This shows that in essence, the services provided by nurses are good, but the responsiveness dimension needs to be improved again because this dimension shows the lowest value compared to the other dimensions. So, nurses need to improve the quality of service, among others; respond immediately to patient needs, come immediately when the bell rings, respond to patient complaints, offer assistance to patients, willingness to help patients go to the toilet, change positions, walk and fulfill other patient daily needs.

ASWAJA An Nahdliyah-based caring is very important in fostering interpersonal relationships between nurses and patients, where a relationship of mutual trust between nurses and patients will increase acceptance of positive and negative feelings between nurses and patients, and nurses

must accept patients' feelings and understand their behavior (23). Nurses providing nursing care, among others, must be based on human values, be able to increase sensitivity to themselves and others, build trusting relationships, understand the expansion of clients emotionally and intellectually, and create an internal and external environment that influences individual health and disease. Therefore, caring behavior must grow from within the nurse and come from the nurse's deepest heart and caring not only shows what the nurse does which is a physical action, but also reflects the sincerity of the nurse in providing nursing care to the patient, and all of this is done on behalf of the patient, basis of devotion to God as a form of worship. ASWAJA An Nahdliyah-based caring originates from Islamic caring which has 4 dimensions, namely God's caring for humans, humans caring for themselves, human caring for other humans, and human caring for the natural environment, where God's caring influences the other three types of caring (24).

CONCLUSION

Caring training based on ASWAJA An Nahdliyah has a significant effect on performance in patient safety goals, especially on the goals of correctly identifying patients, reducing the risk of infection related to health services, and reducing the risk of patient falls. Caring training based on ASWAJA AN Nahdliyah also influences the quality of nursing services and patient satisfaction.

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