INTISARI

EVALUASI PROGRAM PELAPORAN INSIDEN KESELAMATAN PASIEN RUMAH SAKIT

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Latar belakang: Tingginya angka insiden keselamatan pasien menjadi salah satu masalah yang dihadapi di rumah sakit. Program pelaporan insiden menjadi salah satu metode penting dalam upaya meningkatkan keselamatan pasien.

Tujuan Penelitian: Untuk mengevaluasi pelaksanaan program pelaporan insiden keselamatan pasien.

Metode: Penelitian ini menggunakan (*mixed method*), kuantitatif dan kualitatif. Subjek penelitian yaitu perawat, dokter dan tenaga kesehatan lainya. Sebanyak 195 petugas kesehatan menjadi sampel penelitian dengan teknik pemilihan sampel *proportionate stratified random sampling* dan *purposive sampling*. Analisis data menggunakan prosentase dan analisis tematik.

Hasil: Selama tahun 2017 tercatat ada 194 laporan insiden, terdiri dari 48% temasuk KTD, 28 % KNC, 22% KTC dan 2% sentinel. Hasil survey budaya keselamatan pasien, dari 12 dimensi budaya keselamatan pasien hanya ada 3 dimensi yang memenuhi standar yaitu umpan balik dan komunikasi tentang kesalahan (75%), pembelajaran organisasi dan perbaikan terus menerus (79%), dan *teamwork* dalam unit di rumah sakit (85%). Sedangkan budaya pelaporan insiden keselamatan pasien masih dibawah standar. Faktor-faktor yang menghambat pelaporan insiden keselamatan pasien diantaranya adalah kurangnya pengetahuan, adanya budaya menyalahkan dan menghukum, pertentangan dari rekan kerja, kurangnya dukungan pimpinan, enggan kejadian kecil, kesibukan, form habis, pelaporan masih dipersepsikan sebagai pekerjaan perawat.

Kesimpulan: Program pelaporan insiden keselamatan pasien sudah berjalan, namun belum terbudaya dengan baik. Hal ini disebabkan oleh berbagai faktor penghambat.

Kata kunci: Keselamatan pasien, Pelaporan insiden, Budaya keselamatan pasien.

ABSTRACT

THE EVALUATION OF HOSPITAL PATIENT SAFETY INCIDENT REPORTING PROGRAM IN HOSPITAL

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Background: *The raising number of patient safety incident is one of the major hospital problems. Reporting patient safety incident is the best method to improve the patient safety.*

Objective of the Research: *To evaluate the realization of the patient safety incident reporting program.*

Methods: *This research used mixed method that combined quantitative and qualitative approach. The subjects of this research were nurses, doctors and the other health officers. The samples of this research were 195 health officers by using proportionate stratified random sampling and purposive sampling technique. Analyzes test using percentage and thematic analyzes.*

Results: *There are 194 incidents report recorded in 2017, 48 % involving the unexpected incident, 28% nearmiss, 22% not injured and 2% sentinel. Based on the patient safety culture survey, there are only 3 of 12 patients safety culture dimension that already meet the standards, there are feedback and the communication about the error (75%), learning organization and upgrading process (79%) and good teamwork in the hospital (85%). While patient safety incident reporting culture is still below the specified standard. This research olso has identified successfully the barriers of the patient safety incident report, they are lack of the knowledge, blamming and punishment culture, lack of peer support, lack of leadership support, not reported the small incident, lack of time, lack of form and incident reporting is still considered as the duty of nurses.*

Conclusions: *The patient safety incident reporting program has worked, but it has not been agood culture. This is caused by some barriers factor.*

Key word: *Patient safety, Incident patient safety report, patien safety culture.*