INTISARI

Sistem *unit dose dispensing* (UDD) merupakan sistem distribusi obat yang dianjurkan bagi pasien yang menjalani rawat inap, namun, dalam menerapkan sistem ini dibutuhkan sumber daya yang banyak. Oleh sebab itu, diperlukan upaya efisiensi dengan tetap mengutamakan aspek kualitas dalam penerapan sistem distribusi obat secara UDD sehingga keselamatan pasien terkait penggunaan obat berkelanjutan dapat terjamin. Tujuan penelitian ini adalah mengidentifikasi aktivitas proses distribusi obat secara UDD dengan pendekatan konsep *lean management*, mengidentifikasi *waste* dan faktor penyebab terjadinya di Instalasi Farmasi Rawat Inap RS Panti Rapih Yogyakarta.

Penelitian ini merupakan penelitian kualitatif dengan pendekatan studi kasus. Data diperoleh dari observasi langsung, wawancara semiterstruktur kepada petugas instalasi farmasi rawat inap serta dokumen standar prosedur operasional proses distribusi obat secara UDD dan laporan kinerja instalasi farmasi. Analisis data sifatnya induktif dan prosesnya interaktif. Aktivitas-aktivitas dalam proses distribusi obat secara UDD diklasifikasikan dalam kategori aktivitas *value added, non-value added* dan *necessary but non-value added*, kemudian dihitung persentase masing-masing aktivitas. Hasil identifikasi disajikan melalui *current state value stream map* dan diidentifikasi *waste* dalam proses tersebut. *Waste* selanjutnya dianalisis akar penyebab masalah menggunakan *fishbone diagram*.

Hasil penelitian menunjukan persentase *value added*, *non-value added* dan *necessary but non-value added* pada proses distribusi obat secara UDD berturut-turut adalah 73,02%, 3,97% dan 23,01%. Adapun *waste* yang teridentifikasi pada proses distribusi obat secara UDD adalah *waste of defect, overprocessing, transportation* dan *waiting*. Berdasarkan analisis akar masalah penyebab *waste* yaitu pemanfaatan resep elektronik semi-otomatis, fasilitas tidak bekerja optimal, distraksi dan interupsi dalam pelayanan, kebijakan yang berlaku mengharuskan proses penyiapan setiap waktu minum obat, terapi lama belum *stop* secara sistem, ketidakkonsistenan sistem dalam memberikan *warning sign* dan terbatasnya petugas yang melakukan penyiapan obat unit dosis rutin.

Kata Kunci: Distribusi obat, rawat inap, *unit dose dispensing, lean management*

ABSTRACK

Unit dose dispensing (UDD) is a recommended drug distribution system for patients undergoing inpatient care, however, implementing this system requires a lot of resources. Therefore, efficiency efforts are needed while still prioritising quality aspects in the implementation of the drug distribution through UDDs in order to ensure patient safety related to sustainable drug use. The purpose of this study is to identify activities of UDD system in drug distribution process with lean management concept approach, identify waste and factors that cause waste in Inpatient Pharmacy Department of Panti Rapih Hospital.

This research is a qualitative study with case study approach. Data were collected from direct observations, interviews with inpatient pharmacy department officers, also standar operating procedure documents of UDD system in drug distribution process and pharmacy department performance report. Data analysis is inductive and interactive. Activities of UDD system in drug distribution process were classified into categories of value added, non-value added and necessary but non value added activities, then percentage of each activity was calculated. Activity identification result were presented through current state-value stream map and identified waste in the process. Waste furthermore were analyzed for the root cause of the problem using fishbone diagram.

The results showed that the percentage of value added, non-value added and necessary but non-value added of the UDD system in drug distribution process was 73,02%, 3,97% and 23,01%, respectively. Therefore, waste identified on the UDD system in drug distribution process is waste of defect, overprocessing, transportation and waiting. Based on rood cause analysis, the causes of waste are the utilization of electronic prescriptions semi-automatic, facilities not working optimally, distractions and interruptions in service, existing policies mandating preparation process at every dosing time, old therapies have not been stopped in system, inconsistency of system in providing warning sign and lack of personnel who prepare routine unit doses drugs.

***Keywords**: Drug distribution, inpatients, unit dose dispensing, lean management*