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GADJAH MADA
PELAKSANAAN PENDOKUMENTASIAN DAN PELAPORAN INSIDEN KESELAMATAN PASIEN DI RSUD WATES
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ABSTRAK

Latar belakang: Rekam medis berisi seluruh bukti pelayanan termasuk dokumentasi insiden dan pelayanan setelah terjadi insiden pada pasien. Pendokumentasian dan pelaporan insiden keselamatan pasien dapat meningkatkan mutu pelayanan dan keselamatan pasien. Di RSUD Wates terdapat hambatan yaitu pembuatan laporan insiden melebihi batas maksimal 2x24 jam.
Tujuan: Mendeskripksikan pelaksanaan pendokumentasian dan pelaporan insiden keselamatan pasien di RSUD Wates.
Metode: Jenis penelitian kualitatif dengan rancangan penelitian studi fenomenologi. Subjek penelitian terdiri dari sekretaris tim keselamatan pasien, kepala ruangan rawat inap, penanggung jawab pelaporan, dan empat orang perawat. Objek penelitian: pelaksanaan pendokumentasian dan pelaporan insiden keselamatan pasien. Teknik pengambilan data: wawancara, studi dokumentasi, dan observasi. Keabsahan data menggunakan triangulasi teknik.
Hasil: Tenaga kesehatan belum mendokumentasikan insiden dan tindakan setelah terjadi insiden pada rekam medis. Pembuatan laporan secara manual dengan formulir insiden. Analisis laporan insiden dilakukan oleh tim keselamatan pasien. Penyajian berupa tabel dan narasi yang dilaporkan kepada direktur. Hambatan pelaporan: faktor *man* karena kurangnya kesadaran, kurangnya informasi terkait insiden, adanya persepsi negatif, dan petugas tidak melaporkan insiden dengan tepat waktu. Faktor *material* formulir pelaporan yang sulit dijangkau. Faktor *methode* panduan pelaporan sulit dijangkau. Upaya perbaikan: sosialisasi pendokumentasian dan pelaporan, pengadaan fasilitas berupa formulir dan umpan balik terhadap pelaporan.
Kesimpulan: Pelaksanaan pendokumentasian dan pelaporan insiden di RSUD Wates masih terdapat hambatan. Monitoring pendokumentasian insiden dan tindakan setelah terjadi insiden pada rekam medis sebagai bukti pelayanan perlu ditingkatkan.
Kata Kunci: Pendokumentasian, Pelaporan Insiden, Rekam Medis

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ABSTRACT

Background: *Medical record contains all evidence of service, including documentation of incidents and services after an incident occurred to the patient. Documentation and patient safety incident reporting can improve service quality and patient safety. In RSUD Wates incident reports over 2x24 hours.*
Objective: *Describe the implementation of documentation and patient safety incident reporting at RSUD Wates.*
Methods: *This research is a qualitative with phenomenology design. The subjects consisting of the secretary of the patient safety, the head of the inpatient room, the person in charge of patient safety incident reporting, and four nurses. Object of the research: implementation of documentation and patient safety incidents reporting. Data collection techniques: interviews, documentation studies, and observations. The validity of the data use technical triangulation.*
Results: *Health workers have not documented the incident and action after an incident in the medical record. Making reports manually by incident form. Analysis of incident reports conducted by the team of patient safety. Presentation in the form of tables and narratives reported to the director. Reporting barriers: man factors due to lack of awareness, lack of information, negative perceptions, and health workers not reporting incidents on time. The material factor is the difficult forms to reach. The methods factors is difficult to reach guidelines. Improvement efforts: socializing documentation and reporting, providing facilities in the form and feedback on reporting.*
Conclusion: *The implementation of documentation and reporting of incidents in Wates Hospital still has obstacles. Monitoring the documentation of incident and services after incident on medical records as evidence of service needs to be improved.*
Keywords: *Documentation, Incident Reporting, Medical Records.*