EVALUASI STRATEGI PENCEGAHAN INSIDEN PASIEN JATUH DI BANGSAL RAWAT INAP RSUP DR. SARDJITO

INTISARI

Latar Belakang: Insiden pasien jatuh merupakan masalah yang serius apabila terjadi di rumah sakit karena berkaitan dengan keselamatan pasien dan dapat berdampak kepada kualitas pelayanan rumah sakit. Sekitar 30% pasien rumah sakit yang mengalami insiden jatuh dengan adanya cedera fisik sebanyak 4% hingga 6% mengakibatkan cedera serius. Selain itu, dampak lain insiden jatuh pasien adalah menyebabkan kualitas hidup menjadi buruk, lama hari rawat semakin panjang hingga bertambahnya biaya perawatan di rumah sakit. Meskipun telah dilakukan berbagai upaya, insiden jatuh di RSUP Dr Sardjito masih terjadi pada 20-30 insiden per tahun pada 2017-2019

Tujuan: Mengevaluasi strategi pencegahan dan penerapan regulasi terkait insiden pasien jatuh di bangsal rawat inap dan mengidentifikasi rencana perbaikan strategi pencegahan insiden pasien jatuh

Metode: Penelitian ini dilaksanakan dengan rancangan studi kasus eksplanatori. Pengumpulan data dilakukan dengan studi dokumen 67 rekam medis pasien yang mengalami insiden jatuh di bangsal rawat inap, wawancara dan diskusi kelompok terarah kepada 30 orang, yaitu perwakilan manajemen (kepala bidang, bagian, instalasi, komite), dan staf perawat, observasi terhadap, ketersediaan tanda risiko jatuh dan fasilitas sarana prasarana rumah sakit di instalasi rawat inap 1, serta data laporan indikator mutu

Hasil : Pasien yang mengalami insiden jatuh terbanyak pada usia lansia, jenis kelamin perempuan, dan masalah kesehatan multidiagnosis. Kondisi multidiagnosis berdampak pada kompleksitas pengobatan yang diberikan, hal ini meningkatkan risiko jatuh. Regulasi tentang pencegahan pasien jatuh meskipun tersedia lengkap dan mudah diakses, namun instrumen pengkajian risiko jatuh belum detil mengatur skoring masing - maisng kriteria, sehingga manajemen risiko jatuh yang dilakukan menjadi belum optimal. Lingkungan fasilitas dan sarana juga berkontribusi terhadap terjadinya insiden.

Kesimpulan : Pasien jatuh di RSUP Dr. Sardjito disebabkan oleh pelaksanaan manajemen risiko jatuh yang belum tepat sesuai regulasi. Hasil evaluasi penerapan strategi pencegahan pasien jatuh di RSUP Dr. Sardjito masih belum optimal, karena kendala dari faktor regulasi, pelaksanaan supervisi, keterbatasan penggunaan penanda status risiko jatuh, dan kendala pelaksanaan pengukuran indikator mutu pencegahan jatuh

Kata Kunci: insiden, jatuh, keselamatan pasien

EVALUATION OF PATIENT FALL INCIDENT PREVENTION STRATEGIES IN THE INPATIENT WARD OF SARJITO GENERAL HOSPITAL

ABSTRACT

Background: Patient fall incident is a serious problem when it occurs in the hospital because it is related to patient safety and can have an impact on the quality of hospital services. Approximately 30% of hospital patients who experience a fall incident with physical injury as much as 4% to 6% result in serious injury. In addition, another impact of the patient's fall is that the quality of life becomes worse, the length of hospital stay is longer and the cost of hospitalization increases. Despite various efforts, the patient fall incidents at Sardjito General Hospital still occur at 20-30 incidents per year in 2017-2019.
Objective: To evaluate prevention strategies and implementation of regulations regarding falls in the inpatient ward and identify plans for improving strategies to prevent falls.
Methods: Data collection was carried out by studying 67 medical record documents of patients who experienced a fall in the inpatient ward, interviews and focus group discussions with 30 people, namely management representatives and nursing staff, observations of the availability of signs of fall risk and hospital infrastructure facilities in the inpatient ward, and quality report data
Results: Patients who experienced the highest incidence of falls were elderly, female gender, and multidiagnosis health problems. The multidiagnosis condition has an impact on the complexity of the treatment given, thus increases the risk of falling. Even though the regulations od falling patients prevention are complete and easily accessible, the fall risk assesment instrumen has. not been detailed in the scoring of each criteria, o the fallrisk management is not optimal. The facility and environment also contributes to the occurrence of incidents
Conclusion: The patient fell in Sardjito General Hospital was caused by the implementation of fall risk management that was not in accordance with the regulations. The results of the evaluation of the implementation of fall prevention strategies in Sardjito General Hospital is still not optimal, due to constraints from regulatory factors, the implementation of supervision, the limited use of fall risk status markers, and obstacles to measuring the quality of fall prevention indicators

Keywords: incidents, falls, patient safety