

## INTISARI

**Latar Belakang:** Pelaksanaan transportasi intrahospital pada pasien kritis berpotensi menimbulkan *adverse events*. *Adverse events* yang dapat terjadi selama proses transfer pasien dari Unit Gawat Darurat ke ruang rawat inap dan *Intensive Care Unit* (ICU) antara lain Hipoksia, Hipertensi, Disritmia, dan Arrest yang dapat menyebabkan semakin lama hari perawatan pasien dan meningkatnya angka mortalitas di ICU. Berbagai intervensi perbaikan berdasarkan *evidence* untuk peningkatan keamanan pasien telah diupayakan, namun belum ada *evidence* penerapan metode *Failure Mode and Effect Analysis* untuk meminimalkan risiko pada proses transfer intrahospital pasien kritis.

**Tujuan:** Untuk mengembangkan proses transfer intrahospital pasien kritis yang lebih aman.

**Metode:** Desain penelitian yang digunakan adalah *Action Research* dengan metode *Failure Mode and Effect Analysis* (FMEA). Dilakukan di Unit Gawat Darurat (UGD) RSUD Jailolo sejak bulan April-Agustus 2016. Subyek dalam penelitian ini adalah semua kejadian transfer yaitu 10 proses transfer pada tahap *diagnosing* dan 9 proses pada tahap *evaluation*. Subyek untuk wawancara adalah semua petugas UGD yang terlibat dalam proses transfer intrahospital pasien kritis yaitu sebanyak 19 responden (12 responden pada tahap *diagnosing* dan 7 responden pada tahap *evaluation*). Analisis data kuantitatif secara deskriptif statistik dan data kualitatif dengan cara *coding*, kategori dan interpretasi.

**Hasil:** Sebanyak 26 *failure modes* dari 30 subproses berhasil diidentifikasi. Terdapat 2 RPN tertinggi yaitu tidak dilakukannya pengecekan persediaan oksigen (RPN=100) dan tidak dilakukannya *monitoring* kondisi pasien di ruang Radiologi (RPN=100). Intervensi peningkatan mutu yang dilakukan adalah membuat SOP, alur pelayanan, rujukan internal pretransfer dan ceklis transfer intrahospital pasien kritis serta membuat format *informed consent*. Hasil evaluasi menunjukkan penurunan RPN pada semua *failure modes*. Evaluasi tingkat kepatuhan menunjukkan belum ada petugas UGD yang patuh terhadap SOP transfer intrahospital pasien kritis.

**Kesimpulan:** Aplikasi manajemen risiko menggunakan metode FMEA efektif dalam meningkatkan keamanan proses transfer intrahospital pasien kritis ditandai oleh menurunnya angka prioritas resiko pada setiap *failure mode*.

**Kata Kunci :** Transfer intrahospital pasien kritis, manajemen risiko, dan *Failure Mode and Effect Analysis*

## ABSTRACT

**Background:** Implementation of intrahospital transportation in critically ill patients has the potential to cause adverse events. Adverse events that may occur during patient transfer process from the Emergency Room (ER) and Intensive Care Unit (ICU) are Hypoxia, Hypertension, Dysrhythmias, and Arrest that can lead to the longer length of stay and increased mortality in ICU. Various improvement interventions based on evidence for improved patient safety has been attempted, but there is no evidence the application of Failure Mode and Effect Analysis methods to minimize the risks involved in the process of intrahospital transfer of critically ill patients.

**Objective:** To develop a safer process of intrahospital transfer in critically ill patients.

**Methods:** Action Research were conducted by Failure Mode and Effect Analysis (FMEA) methods. Carried out in the Emergency Room of Gilolo regional public hospital since April-August 2016. The subjects in this study were all transfer events which are 10 transfer process at the stage of diagnosing and 9 process at the stage of evaluation. The subjects for the interview is all ER personnel involved in the process of intrahospital transfer in critically ill patient (19 informant), 12 informant at diagnosing stage and 7 informant at evaluation stage.

**Results:** A total of 26 failure modes of 30 subprocesses were identified. There are 2 highest RPN, does not check the oxygen supply (RPN = 100) and did not commit monitoring the condition of patients in the Radiology (RPN = 100). Quality improvement intervention that were done are develop SOP, service flow, internal referral pretransfer and intrahospital transfer of critically ill checklist as well as making an informed consent form. The evaluation results showed a decrease in the RPN on all failure modes, but all of ER personnel noncompliance to the new procedure.

**Conclusions:** Application of risk management using FMEA method is effective in increasing the security of intrahospital transfer process in critically ill patients shown by reduced risk priority number to each failure mode.

**Keywords:** Intrahospital transfer, Critically ill patient, Risk management, and Failure Mode and Effect Analysis