

ABSTRAK

Latar Belakang : Pengamatan pada RSUD Kabupaten Sorong di rawat inap bulan Maret 2019 menunjukkan bahwa 10 dari 22 pasien mengalami lama rawat inap yang memanjang. Sebanyak 9 orang mengalami perubahan diagnose perawatan dan intervensi perawatan selama rawat inap, secara berkala 40- 60% terjadi pada setiap ruangan rawat inap karena proses pemberian pemberian dan pencatatan dokumentasi perawatan pasien yang kurang lengkap. Administrasi kepulungan, rata-rata 5 orang/ hari atau 10% karena data pemeriksaan darah yang perlu perbaikan disertai perubahan intervensi asuhan perawatan. Pemanjangan lama rawat inap 20-25% oleh proses administrasi kepulungan. Dari hasil catatan perawatan yang dilakukan oleh perawat, laporan pengkajian pasien 60% tidak lengkap, sehingga dalam menetapkan rumusan masalah perawatan dan menetapkan intervensi terhadap masalah yang dialami oleh pasien terjadi pernyataan diagnose berulang-ulang 50%, perubahan intervensi juga dilakukan 30% berubah setiap harinya hal ini menyebabkan waktu lama rawat pasien bertambah, untuk dapat meminimalisir semua hal diatas adalah dengan menerapkan metode PDCA.

Tujuan: Untuk mengetahui apakah penerapan siklus PDCA dalam catatan dokumentasi perawatan pasien dapat meningkatkan efisiensi terhadap proses pelayanan pasien rawat inap diruang interna RSUD Kabupaten Sorong.

Metode: penelitian ini termasuk dalam pendekatan penelitian kualitatif dengan metode deskriptif yaitu dengan melakukan penelitian terhadap kenyataan. Intervensi yang digunakan adalah sistem manajemen kualitas menggunakan *siklus Plan-Do-Check-Act* (PDCA) dan penggunaannya dalam meningkatkan kualitas pelayanan kesehatan serta menurunkan angka kejadian kesalahan dalam pencatatan. Proses kegiatan analisis data dalam penelitian ini dimulai dari pengumpulan data dari sumber data berupa, observasi dan serta dokumentasi dan individual in *depth interview*. Untuk data kualitatif dilakukan analisa data kualitatif dengan mengumpulkan hasil wawancara kemudian dipilih dan dipilah hasil wawancara tersebut dengan membandingkan fenomena yang di temukan dilapangan dengan analisis teori *Edward III*, Model ini disebut dengan *Direct And Indirect Impact On Implementation*. Analisis data yang digunakan dalam penelitian kualitatif mencakup transkrip hasil wawancara, reduksi data, analisis, interpretasi data dan triangulasi.

Hasil dan Pembahasan: Setelah dilakukan penelitian telah diperoleh data bahwa pengetahuan perawat terhadap pendokumentasian asuhan keperawatan cukup baik yaitu sebanyak 46 orang responden (86,8%) dianggap telah mewakili sikap perawat dalam menerapkan metode PDCA sudah sesuai dengan teori yang ada, serta model yang telah diterapkan yaitu model pengkajian, menetapkan diagnosa, perencanaan, tindakan dan evaluasi yang telah sesuai dengan metode PDCA yang berarti bahwa setiap tim perawat dan Nakes lainnya yang berada di Ruang Rawat Inap Internal baik itu perawat, dokter, sanitarian maupun farmasi wajib mengisi lembar catatan dokumentasi pasien tersendiri.

Kesimpulan: Penerapan model pendokumentasian asuhan, terintegrasi menurut beberapa perawat sebenarnya sudah sesuai, hal ini dibuktikan dengan hasil wawancara dengan responden telah diperoleh data bahwa 46 responden (86,8%) menjawab sangat setuju, namun mereka dituntut untuk bekerja secara optimal dalam pengisian pendokumentasian dengan jumlah tenaga perawat pershift itu bagi mereka masih kurang yang akibatnya mereka lebih fokus mengisi dokumentasi dari pada fokus pada pasien. Manfaat dalam model pendokumentasian yang telah terintegrasi yaitu mengurangi komunikasi antar sesama tim medis lainnya.

Kata Kunci: Pelayanan Kesehatan, Mutu Pelayanan, PDCA, Dokumentasi, Rumah Sakit

ABSTRACT

Background: Observations at the Sorong District Hospital were hospitalized in March 2019 showed that 10 out of 22 patients experienced a prolonged length of hospitalization. A total of 9 people experienced changes in the diagnosis of care and treatment interventions during hospitalization, periodically 40-60% occurred in each inpatient room because the process of giving and recording patient care documentation was incomplete. Discharge administration, an average of 5 people / day or 10% because of blood test data that need improvement accompanied by changes in nursing care interventions. Length of stay in hospital is 20-25% by discharge administration process. From the results of care records carried out by nurses, 60% of patient assessment reports were incomplete, so that in determining the formulation of treatment problems and determining interventions for problems experienced by patients, 50% of the diagnosis statements were repeated, changes in intervention were also made 30% changed every day. This causes the length of stay of patients to increase, to be able to minimize all of the above is to apply the PDCA method.

Objective: To find out whether the application of the PDCA cycle in patient care documentation can improve the efficiency of the inpatient service process in the internal room of the Sorong District Hospital.

Methods: this research is included in a qualitative research approach with descriptive methods, namely by conducting research on reality. The intervention used is a quality management system using the Plan-Do-Check-Act (PDCA) cycle and its use in improving the quality of health services and reducing the incidence of errors in recording. The process of data analysis activities in this study started from collecting data from data sources in the form of observation and documentation and individual in depth interviews. For qualitative data, qualitative data analysis was carried out by collecting interview results and then selecting and sorting the results of the interviews by comparing the phenomena found in the field with the analysis of Edward III's theory, this model is called Direct and Indirect Impact on Implementation. Data analysis used in qualitative research includes interview transcripts, data reduction, analysis, data interpretation and triangulation.

Results and Discussion: After conducting the research, data has been obtained that nurses' knowledge of nursing care documentation is quite good, as many as 46 respondents (86.8%) are considered to have represented the attitude of nurses in applying the PDCA method in accordance with existing theory, as well as the model that has been developed. applied, namely the assessment model, establishing diagnoses, planning, actions and evaluations that are in accordance with the PDCA method which means that every team of nurses and other health workers in the Internal Inpatient Room, be it nurses, doctors, sanitarians or pharmacists, must fill out patient documentation records. separately.

Conclusion: The application of the integrated care documentation model according to some nurses is actually appropriate, this is evidenced by the results of interviews with respondents that data has been obtained that 46 respondents (86.8%) answered strongly agree, but they are required to work optimally in filling out documentation with the number of nurses per shift for them is still lacking, as a result they are more focused on filling out documentation than focusing on patients. The benefit of the integrated documentation model is that it reduces communication between other medical teams.

Keywords: Health Services, Quality of Service, PDCA, Documentation, Hospitals