Analisis faktor penghambat dan pendukung pelaporan near miss sebagai bagian dari program K3 dan patient safety suatu rumah sakit swasta = Analysis of barriers and supporting factors for near miss reporting as part of occupational health and safety program and patient safety program in a private hospital

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Abstrak

Latar Belakang: Insiden yang menimpa pasien juga menimbulkan risiko pada pekerja RS, sehingga akar penyebab dan solusi pemecahan masalah untuk mengurangi risiko insiden terjadi kembali seringkali sama. Dari near-miss sampai terjadinya insiden serius merupakan suatu rangkaian kejadian yang mempunyai pola penyebab yang mirip. sehingga fokus pada laporan near-miss lebih bernilai pada perbaikan kualitas. Diperkirakan 50%-96% kejadian tidak diinginkan termasuk near-miss, yang terjadi di fasilitas kesehatan tidak dilaporkan sehingga organisasi kehilangan kesempatan belajar dari laporan near-miss untuk memperbaiki sistem serta mengurangi risiko terjadinya bahaya pada pekerja dan pasien.
Tujuan: Mengidentifikasi faktor penghambat dan pendukung terhadap pelaporan kejadian near-miss oleh staf RS, baik yang menimpa staf dan pasien sehingga dapat dihunakan untuk perbaikan program K3 dan Patient Safety RS.
Metode: Penelitian rancangan kualitatif, yang menggunakan kerangka fenomenologi. Pengumpulan data dilakukan dengan wawancara mendalam kepada pimpinan RS dan diskusi kelompok berfokus kepada kelompok staf RS. Melibatkan unit ER, rawat inap, OR, rawat jalan, dental, fisioterapi, radiologi, laboratorium, farmasi, rekam medis. Jumlah informan keseluruhan 37 orang.
Hasil dan Kesimpulan: Faktor-faktor organisasi dan individu yang menghambat atau mendukung pelaporan kejadian near-miss oleh staf RS: Faktor organisasi penghambat yaitu kejadian near-miss yang sama terjadi berulang, kerahasiaan terhadap pelapor; Faktor organisasi pendukung yaitu adanya edukasi dan sosialisasi dalam program K3 dan program Patient safety RS, alternatif alur pelaporan kejadian near-miss, serta adanya nilai dari pelaporan kejadian near-miss; Faktor individu penghambat yaitu kurangnya kemampuan untuk mengenali kejadian near-miss, kurangnya pengetahuan mengenai alur pelaporan, pemahaman terbatas mengenai manfaat pelaporan; Faktor individu pendukung yaitu adanya pengetahuan dasar tentang kejadian near-miss.
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Background: Incidents that affect patients also pose a risk to hospital workers, so that often the root causes and the solution to decrease the likelihood of recurrence are similar. The chain of events from a near-miss to a serious incident are similar, so that focusing on near-miss reports, may add value and increase the quality of improvements. It is estimated that 50%-96% of adverse events including near-miss in healthcare industry are not reported, which leads to missed opportunities for the organization to learn from the event and improve the system in order to further reduce the risk for workers as well as for patients.
Objectives: to identify barriers and supporting factor for near-miss reporting that afflicted patient or worker by hospital workers, so that it can be used to improve Occupational Health and Safety program, and also patient safety program.

Method: A qualitative design study was conducted with phenomenology framework, using in-depth interview for hospital management and focus group discussion for hospital workers. Including representatives from ER, Inpatient wards, Outpatient clinics, Operating Room, Dental, Physiotheraphy, Radiology, Laboratory, Pharmacy and Medical Record Unit. Total informants covered were 37 persons. Result and Conclusion: Organizational and individual factors as barriers or supporting near-miss reporting according to hospital workers: Organizational barrier factors are reoccurence of already reported type of near-miss events and reporter anonymity; Organizational supporting factors are education and socialization companent in Hospital Occupational Health & Safety program also Patient Safety program, near-miss reporting alternative route, also value of near-miss reporting; Individual barrier factors are lack of near-miss event recognition, lack of knowledge on near-miss event reporting process, limited understanding of near-miss reporting benefit; Individual supporting factor is basic knowledge of near-miss.