Analisis kinerja perawat pelaksana dalam pendokumentasian asuhan keperawatan di Unit Rawat Inap RS X tahun 2003

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Abstrak

Salah satu standar untuk menilai kinerja perawat dalam pelaksanaan asuhan keperawatan adalah penilaian terhadap pendokumentasian asuhan keperawatan. Penelitian ini dilakukan dengan tujuan untuk mengetahui: kinerja perawat pelaksana dalam pendokumentasian asuhan keperawatan; tingkat pengetahuan perawat pelaksana tentang pendokumentasian asuhan keperawatan; persepsi perawat pelaksana tentang pelaksanaan supervisi pendokumentasian asuhan keperawatan; hubungan antara tingkat pengetahuan tentang pendokumentasian asuhan keperawatan dengan kinerja perawat pelaksana dalam pendokumentasian asuhan keperawatan; hubungan persepsi perawat pelaksana terhadap pelaksanaan supervisi pendokumentasian asuhan keperawatan dengan kinerja perawat pelaksana dalam pendokumentasian asuhan keperawatan.
Metode yang digunakan adalah kuantitatif dengan pendekatan cross sectional. Sampelnya seluruh perawat pelaksana di ruang rawat inap kelas 2 dan 3 (46 orang). Instrumen dengan memakai Instrumen Studi Dokumentasi Penerapan Standar Asuhan Keperawatan di Rumah Sakit (Instrumen A darj Depkes 1995), kuesioner dan wawancara mendalam.
Pada hasil penelitian didapatkan sebanyak 100% perawat pelaksana kinerjanya kurang dalam seluruh proses pendokumentasian asuhan keperawatan. Pengetahuan perawat pelaksana tentang pendokumentasian asuhan keperawatan 100% mempunyai skor diatas 70. Persepsi perawat pelaksana tentang pelaksanaan supervisi pendokumentasian asuhan keperawatan 80% mempunyai skor diatas 70. Tidak terdapat hubungan antara pengetahuan pendokumentasian asuhan keperawatan dengan kinerja perawat pelaksana dalam pendokumentasian asuhan keperawatan. Tidak terdapat hubungan antara persepsi perawat pelaksana terhadap pelaksanaan supervisi pendokumentasian asuhan keperawatan dengan kinerja perawat pelakisana dalam pendokumentasian asuhan keperawatan.
Dengan hasil penelitian ini disarankan agar manajemen keperawatan RS X segera menyempurnakan Standar Asuhan Keperawatann dan mendistribusikan buku pedoman Standar Asuhan Keperawatan di setiap ruangan rawat inap.
.....The Analysis of Nursing Performance in Documenting Care in In-Patient Care Unit of "X" General HospitalDocumenting care is one of several nursing activities which is measurable to asses the nursing performance that influence the quality of nursing care in a hospital. The objectives of this study were to asses the nursing performance in documenting care, to figure out factors which were involved (level of nurses' knowledge about documenting care and nurses' perception about supervision in documenting care); and to asses any relation between those factors and the nursing performance.
This was a cross sectional quantitative study, using questioners and interviews to collect information about nursing performance in documenting care from 46 nurses in the class 2 and 3 of In-Patient Care Unit. Then the nursing performance was compared with the Instruments for Study in Documenting the Application of Standard Nursing Care in a Hospital, published by Ministry of Health as the Instrument A, 1995. (Instrumen Studi Dokumentasi Penerapan Standar Asuhan Keperawatan di Rumah Sakit, Instrumen A dari Depkes

1995).

This study showed all respondents (100%) had good level of knowledge about documenting care (knowledge score above 70). Most of respondents (80%) had good perception about supervision in documenting care (perception score above 70). Even though, all respondents (100%) had poor performance in the whole aspects of documenting care. There were no relation not only between the level of nurses' knowledge and the nursing performance in documenting care, but also between the nurses' perception about supervision and nursing performance in documenting care.

The overall result of nursing performance in In-Patient Care Unit of "X" General Hospital was poor in documenting care.

This result suggested the management of Nursing Department of "X" General Hospital to improve the Standard of Nursing Care booklets, and then distribute them to all wards of In-Patient Care Unit.