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**Konsentrasi Administrasi Rumah Sakit**

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**ABSTRAK**

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**Analisis Perencanaan, Implementasi dan Evaluasi Program *Patient Safety* Rumah Sakit di Rumah Sakit Permata Medika Semarang**

**xvii + 85 halaman + 4 tabel + 9 lampiran**

*Patient safety* merupakan keharusan bagi rumah sakit untuk dilaksanakan agar rumah sakit dan pasien dapat terhindar dari dari potensi kerugian. Di Rumah Sakit Permata Medika Semarang, Kejadian Tidak Diharapkan (KTD) tidak terdokumentasi dengan baik serta pihak manajemen belum merespon insiden dengan perubahan pada sistem pelayanan. Penelitian bertujuan untuk menganalisis upaya perencanaan, implementasi dan evaluasi *patient safety* rumah sakit.

Metode observasional dilakukan dengan pendekatan kualitatif. Data dikumpulkan melalui wawancara mendalam, observasi partisipan, dan studi dokumen. Subyek penelitian terdiri dari 3 orang informan utama dari top manajemen dan informan triangulasi yang terdiri dari 2 orang dari Tim Keselamatan Pasien Rumah Sakit (TKPRS), 2 orang dokter dan seorang perawat Rumah Sakit Permata Medika. Pengolahan data dilakukan dengan *comprehending, synthesizing, theorizing dan recontextualizing*. Analisis data menggunakan analisis isi.

Hasil menunjukkan bahwa perencanaan telah dilaksanakan dengan membuat program kerja tahunan. Akan tetapi pihak manajemen rumah sakit belum memilih dan melatih penggerak keselamatan pasien rumah sakit. TKPRS telah melakukan sosialisasi dan edukasi *patient safety.* Pendidikan dan latihan bagi karyawan, penyusunan standar prosedur operasional serta pemenuhan standar fisik dan bangunan telah dilaksanakan. Pelaporan dan analisis insiden keselamatan serta pelaporan kepada direktur telah dilaksanakan TKPRS, tetapi belum ada mekanisme monitoring pelaksanaan program *patient safety.* Peran regulasi, sosialisasi dan membangun kultur *safety* belum terlaksana. Pengendalian kesalahan dalam rumahsakit belum terlaksana.

Simpulan TKPRS belum melaksanakan tugas pokok dan fungsinya dengan baik. Disarankan rumah sakit memilih penggerak keselamatan pasien, pelatihan *root cause analysis* bagi pengurus TKPRS serta TKPRS lebih aktif melaksanakan tugasnya.

Kata kunci : *Patient safety*, perencanaan, implementasi, evaluasi, pengendalian kesalahan

Kepustakaan : 46 (1990-2014)

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**ABSTRACT**

**Tri Rini Pramuningsih**

**Analyses of Planning, Implementing, and Evaluating of Hospital Patient Safety Program at Permata Medika Hospital in Semarang**

**xvii + 85 pages + 4 tables + 9 enclosures**

Patient safety is compulsory to be implemented in a hospital to prevent adverse effects for both a hospital and a patient. At Permata Medika Hospital in Semarang, unexpected events had not been well documented. In addition, the hospital management had not responded an incidence through updating a service system. This study aimed to analyze aspects of planning, implementing, and evaluating of hospital patient safety.

This was observational research using qualitative method. Data collection used indepth interview, participatory observation, and documentation study. Main informants consisted of 3 persons who worked as top managers. Meanwhile, informant for triangulation purpose consisted of 2 persons who were a member team of hospital patient safety, 2 physicians, and 1 nurse worked at the Permata Medika hospital. Data were processed using the methods of *comprehending, synthesizing, theorizing, and recontextualizing*. Furthermore, data were analyzed using content analysis.

The results of this research showed that aspect of planning had been implemented by making an annual work plan. However, the hospital management had not selected and trained a specific person for implementing hospital patient safety. The team of hospital patient safety had socialized and educated the program. Educating and training for employees, arranging standard operating procedure, fulfilling physical standard and building had been implemented. In addition, reporting and analyzing incidence of safety and reporting to a hospital director had been implemented by the team. Nonetheless, a mechanism of monitoring the implementation of the program was not available. The roles of regulation, socialization, and development of safety culture had not been optimally implemented. Error control at the hospital had not been applied yet.

In conclusion, the team of hospital patient safety had not well implemented main tasks and function. As suggestions, the hospital management needs to select a specific person to implement the program, to provide training of root cause analysis for the committee of the hospital patient safety team. In addition, the team needs to be more active in accomplishing tasks.

Key Words : Patient Safety, Planning, Implementing, Evaluating, Error

Control

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