RINGKASAN

Pelayanan keperawatan merupakan ujung tombak utama pelayanan kesehatan di Rumah Sakit dan merupakan cermin utama dari keberhasilan pelayanan kesehatan secara keseluruhan. Pelayanan keperawatan yang bermutu tinggi harus dilaksanakan oleh tenaga keperawatan professional dengan cara yang professional juga. Setiap aspek dari pengobatan dan perawatan pasien yang dilakukan oleh tim pelayanan kesehatan harus didokumentasikan sehingga dapat memberikan gambaran secara keseluruhan dari kondisi kesehatan pasien, serta merupakan alat bukti yang legal bagi pasien, keluarga, tim kesehatan lain maupun pihak lain yang memerlukan.

Rumah Sakit Umum Daerah Dr. Soetomo merupakan Rumah Sakit rujukan tertinggi untuk Indonesia bagian timur sekaligus sebagai rumah sakit pendidikan. Sebagai rumah sakit rujukan tertinggi sudah selayaknya rumah sakit Dr. Soetomo memberikan pelayanan dengan mutu baik.

Dalam upaya mengembangkan dan meningkatkan mutu pelayanan di rumah sakit Dr. soetomo dibentuk kelompok kerja (POKJA) antara lain tim pengembangan dan evaluasi proses keperawatan yang bertugas mengevaluasi pelaksanaan asuhan keperawatan. Adapun hasil dari evaluasi tersebut evaluasi keperawatan mempunyai angka terendah yaitu 49,66% (1999), 59,90% (2000) dari standar kendali 70%.

Adapun tujuan dari penelitian ini adalah menyusun upaya peningkatan pelayanan keperawatan berdasarkan analisis format dokumentasi asuhan keperawatan di Instalasi rawat inap RSUD. Dr. Soetomo Surabaya.

Hasil penelitian menunjukkan bahwa format dokumentasi perlu direvisi dengan system check list sesuai dengan spesialisasinya. Bentuk format dan kemudahan format dokumentasi asuhan keperawatan tidak menunjukkan adanya kesulitan. Hanya soal waktu pengisian yang masih kurang sehingga perlu pengaturan waktu sesuai supaya pengisian format tersebut diisi dengan baik. Sebagian besar perawat sudah termotivasi untuk mengisi format dokumentasi keperawatan. Beban kerja pada waktu pagi dan sore hari didominasi oleh kegiatan fungsional, sedangkan pada malam hari waktu istirahat terlalu lama. Kinerja perawat berdasarkan penerapan dokumentasi asuhan keperawatan menunjukkan bahwa perawat sering tidak mengisi : 1) format dokumentasi evaluasi (81,7%) 2) format dokumentasi intervensi (59,8%) dan 3) format rencana keperawatan (51,2%).

Untuk meningkatkan pengisian format asuhan keperawatan dalam rangka peningkatan kualitas pelayanan keperawatan diperlukan suatu bentuk format yang sederhana dan lengkap, adanya standar penulisan yang jelas, persediaan lembar format yang cukup. Supervisor harus dari ruangan itu sendiri sehingga tahu respon pasien. Untuk meningkatkan sumber daya manusia perlu adanya pelatihan, lokakarya, diskusi antar perawat secara rutin.

SUMMARY

Efforts to Improve nursing Care Quality Based on Analysis of Nursing Care Documentation Format at the Inpantient Wards of Surabaya Dr. Soetomo General Hospital

Nursing care is the front line of hospital service at hospitals and it reflects the overall quality of healthcare service. High quality nursing care is performed by professional nursing personnel with high integrity and strong profesionalism.

Every aspect of therapy and patient care provided by healthcare team, should be documented to be able to illustrate patient's comprehensive health condition for patient's family, other health teams or for any concerned parties.

Documentation of nursing care is an important proof of vendered professional nursing service. Meanwhile, professional nursing service is not merely being skillful in executing nursing procedure, but it comprises of adequate interpersonal, intellectual, and technical skills.

Dr. Soetomo General Hospital (DSGH) in Surabaya, is the top referral hospital for the eastern part of Indonesia which also serves as a teaching hospital. Being the highest-ranked hospital, DSGH should provide the best quality in health service.

In order to develop and improve it's service quality, DSGH had established working teams. One of there teams was Nursing Development and process evaluation team, whose major took was to evaluate the implementation of nursing care. The evaluation result revealed that nursing evaluation had the lowest rate of 49,60% (1999) and 59,90% (2000) from the control standard of 70%.

The objective of this study was of formulate a nursing care improvement efford based on the analysis of nursing care documentation format at the inpatient wards of Surabaya Dr. Soetomo General Hospital. This was an observational cross-sectional study carried out at DSGH inpatient wards from June 2002 to March 2003. the samples were taken by proportional random sampling comprising of 82 nurses at DSGH inpatient wards.

The result of the study showed that nurses had asseesed the documentation format as too many overlapped date, writen more than once and too many forms to fill. They expected the forms to be practical , clear, simple and complied to the specialties. The form did not have to be totally changed, but it should be revised / modified by applying a checklist system according to each specialization. Most nurses (79,3%) had been motivated, they were not forced to fill the forms and they had the intention to fill nursing documentation because they were aware of their responsibilities their motivation was sufficient, workload in the morning and afternoon shifts were dominated by functional activities. Whereas in the evening they did more personal deeds such as rest, pray and dinner. Nurses performances based on the implementation of nursing care documentation showed that 81,7% did not fill the evaluation forms, 59,8% did not fill the intervention documentation format and 51, 2% did not have nursing plans.

Suggestions for : 1) working nurses are write down any patient's response as nursing documentation. Improving nursing care quality and socializing accurate documentation culture, and holding a pre and post conference between working nurses and wards supervisors ; 2) nursing institutions is to revise / modify nursing care documentation with checklist system which had been done by the researcher ; 3) hospital management is to maintain stock of nursing care documentation format to secure documentation.

ABSTRACT

Efforts to Improve nursing Care Quality Based on Analysis of Nursing Care Documentation Format at the Inpantient Wards of Surabaya Dr. Soetomo General Hospital

Dr. Soetomo General Hospital (DSGH) is the top referral hospital for the eastern part of Indonesia which also serves as a teaching hospital. Being the highest ranked referral hospital, Dr. Soetomo General Hospital should provide the best quality in health service.

Dr. Soetomo General Hospital had enstablised working teams in order to develop and improve its service quality. The evaluation of this team revealed that nursing evaluation had the lowest rate of 49, 66% in 1999 and 59,90% in 2000 from the control standard of 70%.

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Nurses performance based on the implementation of nursing care documentation showed that 81,7% did not fill the evaluation forms, 59,8% did not fill the intervention documentation format and 51,2% did not have nursing plans.

Key word : nursing documentation format, workload, motivation, performance