Pengembangan Budaya Patient Safety pada Ruang Rawat Inap: Analisis Sentinel Events dan Just Culture

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Abstrak

Latar belakang: Patient safety merupakan dimensi kualitas pelayanan kritis dengan estimasi 134.000 kematian/tahun akibat medical error di Indonesia. Tujuan: menganalisis tingkat budaya patient safety dan distribusi sentinel events di 4 RS tipe B Jakarta. Metode: Mixed-method 10 bulan pada 384 perawat di 16 ruang rawat inap. HSOPSC (Hospital Survey on Patient Safety Culture) versi AHRQ + analisis root cause analysis sentinel events. Hasil: Skor positif HSOPSC rata-rata 56% (di bawah benchmark 75%). Dimensi terendah: non-punitive response to error (38%), staffing (42%), handoff (51%). Sentinel events 12 bulan: 47 kasus (medication error 38%, jatuh pasien 26%, hospital-acquired infection 19%). Just culture implementation menurunkan underreporting 41%. Kesimpulan: Perlu transformasi budaya dari blame culture ke just culture, peningkatan staffing, dan standardisasi handoff (SBAR). **Kata kunci:** patient safety, sentinel events, just culture, HSOPSC, manajemen risiko klinis, akreditasi RS

Abstract (English)

Patient Safety Culture Development in Inpatient Wards: Analysis of Sentinel Events and Just Culture

Background: Patient safety is a critical care quality dimension with estimated 134,000 deaths/year from medical errors in Indonesia. Objective: To analyze patient safety culture level and sentinel events distribution in 4 type B Jakarta hospitals. Methods: Mixed-method 10 months on 384 nurses in 16 inpatient wards. HSOPSC (AHRQ version) + RCA on sentinel events. Results: Mean positive HSOPSC score 56% (below 75% benchmark). Lowest dimensions: non-punitive response to error (38%), staffing (42%), handoff (51%). 12-month sentinel events: 47 cases (medication error 38%, patient falls 26%, HAI 19%). Just culture implementation reduced underreporting 41%. Conclusion: Need cultural transformation from blame to just culture, staffing improvement, and SBAR handoff standardization.

1 Pendahuluan

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