Metode constraint lean six sigma sebagai upaya perbaikan efektivitas dan efisiensi pelayanan radiologi Rumah Sakit Pusat Otak Nasional = Constraint lean six sigma method to improve effectiveness and efficiency of radiology services National Brain Center Hospital

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Abstrak

Penelitian ini bertujuan merancang usulan perbaikan efektivitas dan efisiensi pelayanan radiologi RS Pusat Otak Nasional dengan menerapkan metode constraint lean six sigma. Penelitian ini dirancang dengan desain kualitatif dan kuantitatif. Data kuantitatif didapat dari hasil observasi lamanya waktu pelayanan radiologi di RS Pusat Otak Nasional. Jumlah sampel penelitian sebanyak 30 sampel.

Hasil penelitian ini yaitu rata-rata lead time pelayanan sebesar 2 jam 13 menit. Waktu NVA tertinggi terdapat pada siklus pengolahan ekspertise. Waktu NVA tertinggi terdapat pada jenis waste yaitu waiting dan processing. Penyebab utama NVA pada kedua waste tersebut adalah PACS system error dan waktu tunggu hasil baca foto/scaning.

Hasil penelitian menemukan 7 sampel memiliki waktu tunggu pelayanan radiologi > 3 jam. Sebesar 57 dari total defect pelayanan dikontribusi oleh pemeriksaan di luar jam kerja dan hari libur. Usulan perbaikan yang diperlukan yaitu Standardize work berupa Standar Prosedur Operasional SPO pengiriman foto/scaning pemeriksaan CITO di luar jam kerja dan hari libur, evaluasi rutin alat PACS, dan penerapan radiology information system RIS yang terintegrasi.
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This study aims to design a proposal to improve the effectiveness and efficiency of radiology service of National Brain Hospital by applying the method of constraint lean six sigma. This research is designed with qualitative and quantitative design. Quantitative data obtained from the observation of the length of time radiology services at National Central Medical Center. The sample size is 30 samples.

The results of this study is the average service lead time of 2 hours 13 minutes. The highest NVA time is in the experimental processing cycle. The highest NVA time is in the type of waste that is waiting and processing. The main causes of NVA in both waste are PACS system error and waiting time of reading radiograph.

The results of the study found 7 samples have radiology service waiting time 3 hours. 57 of the total service defect was contributed by after hours and holidays. The proposed improvements required are Standardize work in the form of Standard Operating Procedures SPO of sending radiograph CITO in after hours and holidays, routine quality control of PACS tools, and integrated radiology information system RIS application.