Analisis kejadian tidak diharapkan di departemen obstetri dan ginekologi rumah sakit Dr. Cipto Mangunkusumo tahun 2015 = Analysis of adverse events in the department of obstetrics and gynaecology Cipto Mangunkusumo Hospital in 2015

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Abstrak

Latar belakang: Kesalahan dalam pelayanan medis merupakan ancaman serius karena dapat menyebabkan pasien cedera, meninggal, dan meningkatkan biaya perawatan kesehatan yang tinggi. 1 Berdasar laporan Institute of Medicine (IOM) tahun 2000, terdapat 3-16% Kejadian Tidak Diharapkan (KTD) pada pelayanan pasien rawat inap di Amerika Serikat, Denmark, Inggris, dan Australia. Laporan JOGC tahun 2015 didapatkan 10% KTD terjadi di bidang obstetri. Data tentang KTD di Indonesia masih sulit didapatkan. Tahun 2007, Jakarta menduduki posisi teratas tentang laporan insiden keselamatan pasien yaitu 37,9%. Dari data Komite Mutu, Keselamatan Pasien, dan Kinerja (KMKK) RSUPN dr Cipto Mangunkusumo tahun 2015 dilaporkan 198 kasus KTD. Tujuan: Mengetahui distribusi kasus KTD di Departemen Obstetri dan Ginekologi RSCM tahun 2015 berdasarkan (1) tempat kejadian, (2) penyebab terjadinya, (3) jenis kegagalan, dan (4) penambahan masa rawat. Metode: Penelitian ini merupakan penelitian deskriptif analisis terhadap kasus KTD yang terjadi di Departemen Obstetri dan Gineklogi RSCM dari Januari hingga Desember 2015. Data didapatkan dari Koodinator Pelayanan Masyarakat (Koyanmas) yang telah dilakukan audit klinik dengan metode Root Cause Analysis (RCA). Hasil: Sepanjang tahun 2015 dilaporkan 36 kasus KTD dan dilakukan audit klinik oleh Tim Manajemen Risiko Klinis. Dari 36 kasus, yang memenuhi kriteria inklusi adalah 24 kasus. Berdasar tempat kejadiannya, terdapat 13 kasus (54%) terjadi di IGD, 4 kasus (17%) di ICU, 4 kasus (17%) di Ruang Operasi, dan 3 kasus (12%) di Ruang Rawat Inap. Berdasar penyebab terjadinya, terdapat 18 kasus (75%) disebabkan kurangnya pengetahuan dan kemampuan tenaga medis, 4 kasus (17%) karena penyebab lain, dan 2 kasus (8%) karena kesalahan teknis. Berdasar jenis kegagalannya, didapatkan 8 kasus (33%) terjadi penundaan perawatan atau tindakan medis, 6 kasus (25%) terjadi kegagalan tindakan medis, 5 kasus (21%) terjadi misdiagnosis, 3 kasus (13%) terjadi ketidaktepatan tata laksana, dan 2 kasus (8%) terjadi kegagalan memberikan peringatan untuk mencegah cedera. Berdasar penambahan masa rawat, data menunjukkan distribusi data yang tidak normal dengan nilai Shapiro-Wilk <0,05. Maka digunakan nilai median yaitu 2 hari. (0-34 hari; 95% IK). Kesimpulan: Sebagian besar KTD di Departemen Obstetri dan Ginekologi RSCM tahun 2015 terjadi di IGD (54%), penyebab terbesar adalah kurangnya pengetahuan dan kemampuan tenaga medis (75%), dan sebagian besar kegagalan terjadi penundaan perawatan atau terapi (33%).

.....Background: Medical errors are a serious threat because they can cause injury, death and increase the cost of high health care.1 According to Institute of Medicine (IOM) report in 2000, there are 3-16% of adverse events (AEs) in the care of nursing patients stay in the United States, Denmark, United Kingdom and Australia. In 2015, JOGC report 10% of the AEs occurred in obstetrics. Data on AEs in Indonesia is still difficult to obtain. In 2007, Jakarta occupied the top position regarding patient safety incident reports which is 37.9%. In 2015, from Quality, patient Safety and Performance Committee RSUPN dr. Cipto Mangunkusumo reports 198 cases of AEs. Aim: To obtain the distribution of AEs in the Department of

Obstetrics and Gynecology RSCM in 2015 based on (1) place where AEs occured, (2) factor contributing to the AEs (3) failure to prevent the occurrence of the AEs, and (4) the additional length of the stay. Method: This research is a descriptive analysis of the AEs case that occurred in the Department of Obstetrics and Gynecology RSCM from January to December 2015. Data were obtained from the Koordinator Pelayanan Masyarakat (Koyanmas) which had been carried out by a clinical audit using the Root Cause Analysis (RCA) method. Result: In 2015, 36 cases of AEs were reported and a clinical audit was carried out by the Clinical Risk Management Team. From 36 cases, which met the inclusion criteria were 24 cases. Based on the place where AEs occurred, there were 13 cases (54%) in the ER, 4 cases (17%) in the ICU, 4 cases (17%) in the OR, and 3 cases (12%) in the Ward. Based on the factor contributing to the AEs, there were 18 cases (75%) due to lack of knowledge and ability of medical personnel, 4 cases (17%) due to other causes, and 2 cases (8%) due to technical errors. Based on the failure to prevent the occurrence of the AEs, there were 8 cases (33%) delayed treatment or medical treatment, 6 cases (25%) malpractice, 5 cases (21%) misdiagnosis, 3 cases (13%) failure to act based on test results, and 2 cases (8%) failure to take precautions in order to avoid injuries. Based on the additional length of stay, the data showed an abnormal distribution of data with a Shapiro-Wilk value <0.05. We use the median value which is 2 days. (0-34 days; 95% CI). Conclusion: Most of the AEs in the Department of Obstetrics and Gynecology RSCM in 2015 occurred in the ER (54%), the biggest cause was the lack of knowledge and ability of medical personnel (75%), and most of failure due to delay in treatment or therapy (33%).