The 4rd Mitra Husada Health International Conference (MiHHICo) 2024
Volume 4 (2024) ISSN: 2988-3768

IMPLEMENTATION OF STANDARD OPERATIONAL PROCEDURES TO PREVENT THE RISK OF FALLS IN THE INPATIENT ROOM SUNDARI RSU MEDAN

Rina Rahmadani Sidabutar[1], Budiana Yazid[2], Heni Triana[3], Nurul Haflah[4], Youlanda Sari[5], Dahlia Purba[6]
[1-2]Sekolah Tinggi Ilmu Kesehatan Flora
Email: amiradalimunte2016@gmail.com

ABSTRACT

Fall is a serious problem and requires high costs for patients and also for all wellness facilities. Morse Fall Score (MFS) was one of the assessments of risk of falls prevention efforts which was one of the principles of ability and behavior ofnurses in doing work appropriate duties related to compliance implementation Standard Operating Procedures (SOP). One of the factors that influence nurse compliance in the implementation of SOP i.e. motivation and perceptions of nurse against their work. Motivation was one of the important things forsomeone in doingforefront where increasing motivation will lead to increased performance of nurses.This study aimed to know the implementation compliance of standard operating procedures of the risk of fall prevention inpatient care. This study used This study used a qualitative method with phenomenological approach that analysis was used with Collaizi method. The study was done to 5 informants, nurse with a minimum duration of 3 years, education level D3 – S1 Ners. From the analysis results obtained four main themes. The four main themes are : comprehensive assessment of general assessment, patient safety management regulation is not available, uniform headroom initiatives related to patient safety management and the impact of inadequate patient safety management regulation. The implementation of the fall prevention assessment has not been done because the facilities and policy regulations have not been provided by the management patient safety Sundari Hospital of Medan.

Keywords: Compliance,, Risk of fall, Standard Operating Procedure

INTRODUCTION

There are six main indicators of the quality of health services in hospitals, namely 1) patient safety which includes: nosocomial infection rates, the incidence of patient falls or accidents, decubitus, errors in drug administration, and the level of patient satisfaction with health services, 2) management of pain and comfort, 3) level of patient satisfaction with services, 4) self-care, 5) patient anxiety, 6) patient behavior (knowledge, attitudes, skills) (Padu et al., 2023) Patient safety is one of the variables used to measure and evaluate the quality of care services that have an impact on health services. Patient safety has a business program to reduce the number of unexpected events (KTD) that often occur in patients in the ward at the hospital so that it can harm both the patient and the hospital. Unexpected Events can be caused by various factors including high nurse workload, inaccurate communication channels, inappropriate use of facilities (Suryani, 2019). Research conducted by Noorhasanah et al (2019) shows that nurses' knowledge about patient safety is still sufficient but the implementation of patient safety procedures is still lacking in hospitals at Panti Waluya Sawahan Hospital, Malang (Noorhasanah et al., 2019). Patient safety goals are regulated in the Regulation of the Minister of Health of the Republic of Indonesia Number 11 of 2017. National patient safety in Indonesia for all health service facilities, the National Patient Safety Goals (SKP) have been implemented which consist of: SKP.1 Identifying Patients Correctly, SKP. 2 Improving Effective Communication, SKP.3 Improving the Safety

of Medicines to Watch Out for, SKP.4 Ensuring the Correct Location of Surgery, SKP.5 Reducing the Risk of Infection Due to Health Care, SKP.6 Reducing the Risk of Patient Injury Due to Falls (Wijayanti et al., 2022). Falling is a serious problem and requires high costs for patients and also for all health facilities. The World Health organization (WHO) states that the probability of a hospital accident occurring is 1: 300 (Fauziah et al., 2019). This requires health services, especially in hospitals, to pay attention to the main issues to reduce the risk of injury experienced by patients as service users. The majority of patient falls occur within the first week of hospitalization (Hilda Hijrianti et al., 2022). Another study was conducted by Healey, Scobie, Oliver, Pryce, Thomson, and Glampson (2018) conducted at the English and Welsh Hospital, found 100 cases of falls per 1000 beds each month. In England and Wales there are approximately 152,000 incidents reported to occur in hospitals each year, approximately more than 26,000 reported from mental health units and 28,000 from public hospitals. The results of a research survey in 2013 reported data as many as 700,000-1,000,000 people experience falls every year in United States hospitals (Maha, 2019). The XII PERSI (Indonesian Hospital Association) Congress in Jakarta on November 8 2019 reported that the incidence of patient falls in Indonesian hospitals from January to September 2018 was 14%, thus making the percentage of patient falls included in five medical incidents other than medication errors (Sarah et al., 2022). Data in Indonesia related to unwanted events, especially falls, is still scarce, because nurses do not document falls, and sometimes even hide cases when there are cases on the grounds of hospital imaging. Accidents of patients falling at Pamekasan Hospital were reported that there were accidental patient falls allegedly due to the nurse's error, the incident occurred when the nurse asked the patient to change beds because they were going to be cleaned, after asking the patient to move, the nurse left the room and when she returned found the patient had fallen and experienced broken left arm (Harun et al., 2022). The annual report in 2019 submitted by the Malang Islamic Hospital obtained data that the incidence of falls still ranks fourth out of all KTD (Marpaung, 2019). Based on initial observation the target and realization of the accreditation assessment of the Sundari General Hospital in Medan in 2022 state that the assessment of patient safety standards for reducing the risk of falling patients is still low, namely 27% of the achievement target of ≥ 80%. The results of a preliminary study on January 3-8 2022 at Sundari Hospital reported that there had been an incident where a patient fell, one of them in the Melati room. Data obtained from the Hospital Patient Safety Team (KPRS) at Sundari Medan Hospital, in 2020 8 patient falls were recorded and in 2022 0 patient falls. The data on patients who fell came from adult patients, in addition to that, interviews were conducted with the head of the room in the Orchid room and Cempaka room, the results were that at Sundari Hospital there was already a fall risk assessment and intervention format and already had SPO related to fall prevention, but from 10 indicators the implementation of SPO to prevent the risk of falling patients, the nurse in the Cempaka room does not lower the bed of the patient who is at risk of falling, while in the Anggrek room the nurse lowers the bed of the patient who is at risk of falling. This study aimed to know the correlation between the motivation of nurses and theimplementation compliance of standard operating procedures of the risk of fall prevention inpatient care.

METHOD

This research is research qualitative with a phenomenological approach. This research aims to understand the description of the implementation of the assessment prevention of the risk of patient falls by nurses in Sundari Hospital. The population in this study is all nurses who work at Sundari Hospital. The sample in this study were nurses who work in rooms with levels. Patient dependency is quite high starting from partial to total (with level of fall risk higher) namely nurses in the emergency room, ICU and surgical ward. Number of samples in this study were 5 home nurses Sundari Hospital included including 1 key informant, namely the Head Nursing Field.

The sampling technique used was a purposive sampling technique with the criteria for a D3 educated nurse up to S1 with minimum 3 work experiences year.

RESULT AND DISCUSSION

Description of Informant Characteristics

Informants who participated in This study consisted of 5 people, in all Woman. The reason the researcher chose the number. There were 5 research informants, because The informant is divided into several rooms, namely 1 in the surgical ward as head of the room, 2 in the ER room, one of which is the Head room, as well as 2 others in the ICU and one including the Head of Division Nursing. All informants are Active workers with a minimum of 3 years of service years at Sundari Hospital.

Informant 1 (P.1)

Informant 1, 30 years old, type female gender, Bachelor of Nursing education, with a working period of 5 years. During observation informant 1 looks calm and ready to interviewed. During the interview Informant 1 is very open. That attitude shown during the interview greatly cooperative. The first interview was conducted at ICU room with more interview time less than 10 minutes. A second interview was conducted one week later with more time less than 5 minutes for the purpose of clarification results of previous interviews.

Informant 2 (P.2)

Informant 2, age 31 years, education D3, with 5 years of work, genderWoman. During the observation informant 2 was very enthusiastic and willing to interviewed. During the interview Informant 2 was very open, fluent and clear in answering the questions given researcher. The attitude shown during Very cooperative interview. Interview The first was carried out in the ICU room over time, Interview approximately 10 minutes. Interview the second was carried out one week later with a time of approximately 5 minutes the aim of clarifying the results of the interview previously.

Informant 3 (P.3)

Informant 3, age 31 years, type Female, Bachelor's degree in nursing, long work 5 years. When observing informant 3 willing to be interviewed. During The interview took place with informant 3 quite open, fluent and clear in answering questions given by researchers. Attitudes shown during the interview is lacking cooperative. The first interview was conducted at surgical ward with interview time approximately 10 minutes. Second interview carried out one week later with time approximately 5 minutes with the aim clarify the results of previous interviews.

Informant 4 (P.4)

Informant 4, age 31 years, type female gender, Bachelor of Nursing educationwith 6 years of service. During observation Informant 4 was willing to be interviewed. During the interview, informant 4 very open, fluid and clear inside answer the questions given researcher. The attitude shown during quite cooperative interview.Interview The first is carried out in the emergency room over time Interview approximately 10 minutes. Interview the second was carried out one week later with a time of approximately 5 minutes the aim of clarifying the results of the interview previously.

Informant 5 (P.5)

Informant 5, age 31 years, type female, D3 education with length of service 9 years. During the informant's observation 5 very eager and willing to interviewed. During the interview Informant 5 was very open, fluent and clear in answering the questions given researcher. The attitude shown during Very cooperative interview. Interview The first is carried out in the emergency room over time The interview lasted approximately 10 minutes. The second interview was conducted one week later with a time of approximately 5 minutes the aim of clarifying the results of the interview previously.

Thematic Analysis

This section explains in detail the description of the theme identified from the results of interviews.

These themes are:

1) Implementation of the General Assessment Comprehensive
2) Patient Safety Management Regulations no available.
3) Equal initiative of the Head of Room related to Patient Safety Management.
4) Impact of Patient Management Regulations

Inadequate safety.

Themes generated in This research is discussed separately for disclose analysis of the implementation of the assessment prevention of fall risk by nurses at home ill at Sundari Hospital. Although separately, but these themes interconnected with each other others in explaining coping analysis mechanism written in this research.

DISCUSSION

Implementation of General Assessments Comprehensive

The research results show that implementation of general assessments is carried out regularly comprehensive, such as biodata, disease history and so on, but nurses don't use a special format for reviewing patients at risk of falling. Look at the response from several informants that the nurse was in the room studied very well. Condition implementation of assessments carried out regularly general and uses this usual format resulting in no patient safety assessment adequate. However, patient risk assessment the correct fall is to use the format standards or falling scales that have been determined by the hospital, as well as assessments not only carried out at the beginning of the patient's admission only, the patient at risk of falling have the right to be studied and observed repeatedly. One of them the nurse said that implementation The assessment is carried out together with staff other health such as doctors, can it was concluded that the implementation of the assessment In general this is done very comprehensively. Efforts to anticipate and prevent the occurrence of patient falls with or without injury It is necessary to carry out an initial assessment and then re-assess periodically regarding the patient's risk of falling, including risks schedule-related potential administering medication and taking action to reduce all risks that have been identified. Fall risk assessment can be done carried out from the time the patient first enters, starting register, using a falling scale.

Patient Safety Team or Safety Team

Patients formed by Panti Hospital Waluyo Surakarta has appointed Morse Fall Scale (MFS) as an instrument used to identify patients who risk of falling. Calculating MFS is a way to determine a patient's fall risk and necessary fall prevention management carried out according to standard procedures existing fall prevention operations and applies to all units in the hospital, especially in the inpatient room (Budiono, 2014).

Hospital organizations have unique and different shape other organizations in general. Hospital has a specificity that is born from its existence relationships that occur between Medical staff along with other functional personnel and Administrator or CEO (management) as well Governing Body. As a result of these relationships, formal authority exists represented by the Administrator or CEO (management) must be able to accommodate scientific authority and expertise possessed by groups of doctors and nurses, where historically they have held that role very large guarantee the running of the system wheels health services provided (Prasetyo,2017).

Patient Safety Management Regulations do not available.

From the research results obtained that the Sundari hospital management team has not yet created a format standard assessment. Standard assessment format in accordance with SPO patient safety strictly important in maintaining security and patient safety, making it easier for nurses monitor the condition of patients in need intensive care. Apart from that, it doesn't exist yet fall risk patient assessment format, parties Sundari Hospital management does not yet provide patient facilities safety such as providing identity bracelets patient, yellow/red triangle label, installation of bed railings, as well as implementation of restraint interventions, even SOP patient risk of falls has not been published.Party Sundari hospital management promised to socialize it SPO and other facilities and infrastructure if has been published. This is very related with a managerial system or policy Available at Sundari Hospital, procurement of facilities and administration big responsibility of the house managerial team Sick.

Prevention of patient risk of falls is a series of nursing actions is a reference in implementing steps to maintain safety patients who are at risk

of falling by doing assessment via the Morse Fall Scale (MFS).

MFS aims to provide safety adult patients in hospital, preventing its occurrence The patient fell in the hospital. Preventive intervention patient falls include MFS assessment, wear a risk patient identification bracelet falls yellow on the wrist patient, fall prevention sign (triangle label yellow/red) on the bed board, write on the whiteboard at the nurse station, adjust the height of the bed accordingly with procedures to prevent patient falls, ensure the safety fence of the bed When installed, the patient is restless using restraints or Apollo clothes. (Hasibuan, 2018).

Patient safety a hospital is a system in which the home illness makes patient care safer.

The system includes risk assessment, identification and management of things that related to patient risk, reporting and incident analysis, the ability to learn from incidents and their follow-up and implementation solutions to minimize risks. It is hoped that this system can prevent this the occurrence of injuries caused by error resulting from carrying out an action or not taking appropriate action done. (National Safety Guide Hospital Patients, R.I. Ministry of Health. 2018).

Implementation of risk patient screening falls are carried out by nurses with use a risk patient screening form There are three falls, namely the Morse Fall Scale (MFS) for adult patients. Humpty Dumpty Scales for pediatric patients and assessment checklists fall of old age/parents. (Barnet, 2008).

According to Setyarini, et al (2013), that nurses who have received socialization or understanding related to the assessment risk of falling based on the Morse scale tend to be better at doing it fall risk assessment compared with nurses who don't understand and get it socialization of fall risk SPO.

Patient Safety Goals (SKP) is a requirement to be applied in all hospitals accredited by the Commission Hospital Accreditation. Target setting this refers to the Nine Life-Saving Patients Safety Solutions from World Health Organization (WHO) in Sutanto (2014) Patient Safety (2007) which is also used by Hospital Patient Safety Committee PERSI (KKP-RS, PERSI), and from Joint Commission International (JCI). Intent of The goal of Patient Safety is to encourage specific improvements in patient safety.

Goals highlight those parts problems in health services and explain the evidence and solutions from the consensus based on evidence and expertise on the problem This. It is recognized that good system design intrinsically is to give safe and quality health services high, as far as possible general targets focused on solutions comprehensive.

Equal Headroom Initiative related to Patient Safety Management

The research results show that informant and several other nurses in ER, ICU and surgery rooms carry out management of patient risk of falls on the basis of the head of the room's own initiative, because Sundari Hospital fall risk patient management team have not provided the facilities and infrastructure optimal. Like the initial assessment carried out in the ICU room, head of the ICU room take the initiative to assess the patient with using the Morse Fall Scale (MFS). Installation of restraints, installation of fences bed, yellow/red markings too carried out based on the nurse's initiative room. There should be some of these things provided optimally by the parties Sundari hospital management, because of the risk of falls in hospitals This is quite high, it is feared that it will causing material harm to the patient and causes increased hospitalization time long.

Efforts to maintain maintenance quality of health services in hospitals cannot be separated from the important role of the profession nursing. In the power inpatient unit Nursing is in the service setting leading health with first contact and the longest time with the patient, namely for 24 hours per day and 7 days per week therefore nurses hold key positions within build the image of the hospital. (Lumenta, 2006) It seems that the role of nurses is very important maximum in implementing management patient risk of falling even though it is not available literally at the Sundari hospital. Nurses are aware that implementation preventive management of patients at risk of falling what they do is very important to quality improvement and hospital accreditation.

Nurses as health workers has the largest number in hospitals (40 – 60%) have a good job description are required to always implement patient safety so it has a key role in determine the success of JCI accreditation. Attitude nurses in supporting patient implementation safety is a priority to guarantee patient safety. Nursing care has a very important role in prevent adverse events that occur in patients and nursing environment. Nursing services 24 hours is required by the patient so have the most contact time compared to other health workers for direct contact with patients.

Nurses must be aware of their role so you must be able to actively participate in it realizing patient safety. Hard work nurses cannot reach optimal levels if not supported by infrastructure, hospital management and health workers others (Anwar, 2019).

Impact of Patient Management Regulations Inadequate safety.

The research results show that this occurs One fall occurred in the emergency room at home Sundari Hospital. Nurse said that this incident was not due to nurse negligence, however This incident happened because he didn't do it restraint intervention and patients This has not been studied comprehensively by room nurse.

The number of falls incidents recognized by nursing only happened once, however not based on definite records by side of the room, so that the data on fall events not detected. Risk management closely related to implementation hospital patient safety and impact towards achieving hospital quality targets.

Components included in Patient safety management is: assessment risk, risk identification and management patients, incident reporting and analysis, the ability to learn from incidents and actions he continued as well as implementing solutions for minimize the risk. This system prevent injuries from occurring by errors resulting from carrying out something action or not taking action should be taken (Yulia, 2011).

CONCLUSION

There were five informants who participated in this research. The results were obtained four related themes. There are four themes

These are: implementation of general assessments comprehensively, management regulations patient safety is not available, chief initiative equal space regarding patient management safety and the impact of patient management regulations inadequate safety.

REFERENCES

Anwar, A. Irwandy, dan Noor N.B. (2019). *Hubungan Pengetahuan,Motivasi dan Supervisi dengan Kinerja Perawat dalam Melaksanakan Patient Safety di RSUP Dr. Wahidin Sudiruhusodo tahun 2012. Skripsi tidak diketahui. Bagian Manajemen Rumah Sakit Fakultas Kesehatan Masyarakat : Universitass Hasanuddin.*

Ariastuti, Ni Luh Putu, Margawati A., Hidayati W. (2017). *Analisis Faktor-Faktor yang Mempengaruhi Perawat dalam Melaksanakan Patient Safety di Kamar Bedah RS Telogorejo Semarang.*

Borkowski, Nancy. (2011). *Manajemen Pelayanan Kesehatan: Perilaku Organisasi, Edisi 2, Alih Bahasa.* Jakarta: Buku Kedokteran EGC.

Budiono, S., Alamsyah, A., Wahyu Tri, S. (2018). *Pelaksanaan Program Manajemen Pasien dengan Risiko Jatuh di Rumah Sakit*. Jurnal Kedokteran Brawijaya, Vol. 28, Suplemen No.1, 2014. Program Studi Magister Manajemen Rumah Sakit Fakultas Kedokteran Unversitas Brawijaya Malang.

Fletcher, C.E. (2016). *Hospital RN's Job Satisfaction and Dissatisfactions.* Journal of Nursing Administration, 31 (6), Hal. 324-331.

Ganz D.A. Huang C., Saliba D., Shier V. (2013). *Preventing Falls in Hospital: A Toolkit for Improving Quality of Care Agency for Healthcare Research andQuality.* Boston University School of Public Health, and ECRI Prepared by RAND Corporation.

Habibi, B. (2015) *Faktor-faktor yang Mempengaruhi Motivasi Kerja Karyawan di PT.Askes Regional VI Jawa Tengah dan D.I.Y bagian Sumber DayaManusia dan Umum Semarang. Diakses pada web Lib.unnes.ac.id.http:lib.unenes.ac id/408/1/1102.pdf.* Diakses pada 4 April 2018.

Hasibuan, M.S.P. (2018). *Organisasi dan Motivasi Dasar Peningkatan Produktivitas.* Jakarta : PT. Bumi Aksara

Healey F., Scobie S., Oliver D., Pryce A., Thomsom R., Glampson B. (2008). *Fall in English and Welsh Hospital: A National*

Observational Study Based on Retrospective Analysis of 12 Months of Patient Safety Incident Reports. Journal Error Management: Qual saft Health Care, 17, Hal. 424-430, doi. 10.1136/qshc.2007.024695.

Myers, D.G. (2019). *Psikologi Sosial.* Jakarta: Salemba Medika

Nanda Internasional. (2017). *Diagnosis Keperawatan Definisi & Klasifikasi 2015- 201, Edisi 10.* Penerbit Buku Kedokteran: EGC

Natasia Nazvia, Loekqijana Ahas, Kurniawari Janik. (2014). *Faktor yang Mempengaruhi Kepatuhan Pelaksanaan SOP Asuhan Keperawatan di ICU- ICCU RSUD Gambiran Kota Kediri.*

Jurnal Kedokteran Brawijaya, Vol.28, Suplemen No. 1, 2014.

Niven, N. (2000). *Psikologi Kesehatan: Pengantar untuk Perawat dan ProfesionalKesehatan Lain, Ed. 2.* Jakarta : EGC.

Notoatmodjo. (2018). *Ilmu Perilaku Kesehatan.* Jakarta: PT. Rineka Cipta.

Nugraheni, M., Widjasena B., Kurniawan B. Ekawati. (2017). *Faktor – Faktor yang Berhubungan dengan Pencegahan Jatuh pada Pasien Risiko Jatuh Oleh Perawat di Ruang Nusa Indah RSUD Tugurejo Semarang*. Jurnal Kesehatan Masyarakat (e-Journal) Volume 5, Nomor 2, April 2017. ISSN: 2356-3346

PERMENKES. (2020). *Keselamatan Pasien Peraturan Menteri Kesehatan Republik Indonesia Nomor. 11 Tahun 2017 Tentang Keselamatan Pasien.*

Potter dan Perry. (2018). *Buku Ajar Fundamental Keperawatan: Konsep, Proses, dan Praktek, Edisi 4.* Jakarta: EGC.

Prabowo, N.Y., dan Khoiriati. (2019). *Hubungan Tingkat Pengetahuan Perawat Terhadap Pelaksanaan Pengkajian Resiko Jatuh Skala Morse di RS PKU Muhamadiyah Yogyakarta Unit 2.* Naskah Publikasi Yogyakarta: Program Studi Ilmu Keperawatan Fakultas Kedokteran dan Ilmu Kesehatan Universitas Muhammadiyah Yogyakarta.

Prasetyo, Bagus Indra Dwi DAN Hartanti Rita D. (2017). *Gambaran Upaya Pencegahan Risiko Jatuh oleh Perawat di Ruang Rawat Inap RSUD Kajen Kabupaten Pekalongan.* Program Ners Stikes Muhammadiyah Pekajangan Pekalongan.

Reid, J. dan Bromiley, M. (2018). *Clinical Human Factors: The Need to Speak Up to Improve Patient Safety.* Journal Art & Science Patient Safety Series: 4, Vo. 26, No. 35.

Robbins, S.P. (2019). *Perilaku Organisasi*. Jakarta: PT. Indeks Kelompok GramediaWHO. 2018. Key strategies for promotion of bresfeeding: facts and figures. World Health Organization Western Pasific Region.http://www.wpro.who.int/internet/resources.ashx/NUT/Global+Facts+and+ Figures.pdf [diakses 9 April 2018]