RINGKASAN

Penelitian ini mengambil judul "Penentu Keberhasilan Implementasi *Patient Centered Care* (PCC) di Instalasi Gawat Darurat RSUD Cilacap." Perawatan berfokus pasien (PCC) merupakan paradigma asuhan perawatan pasien pada saat ini. Konsep perawatan berfokus pasien dapat diterapkan di semua Fasilitas Pelayanan Kesehatan dan sosial, serta dapat diterapkan untuk perawatan semua jenis penyakit baik akut, kronis maupun emergensi. RSUD Cilacap telah menerapkan konsep PCC di semua unit pelayanannya. Masalah penelitian adalah evaluasi penerapan konsep PCC belum dilakukan dengan baik dan rutin sehingga PCC belum difahami sebagai budaya kerja. Penelitian ini bertujuan untuk memahami lebih mendalam implementasi PCC di IGD RSUD Cilacap, mencari faktor pendorong dan faktor penghambat implementasi PCC serta mencari solusi dan menyusun desain strategi implementasi PCC yang tepat di IGD RSUD Cilacap.

Desain penelitian yang digunakan adalah deskriptif kualitatif dengan pendekatan studi kasus. Subyek penelitian yaitu dokter, perawat, apoteker, nutricien dan pasien. Informan berjumlah 29 orang terdiri dari 8 dokter, 6 perawat, 2 bidan, 1 apoteker, 1 TTK, 1 nutricien, 5 pasien dan 5 informan tambahan. Pemilihan informan dengan metode *purposive sampling*. Obyek penelitian adalah pendapat/opini/pandangan dan sikap/perilaku dari subyek tentang implementasi PCC di IGD RSUD Cilacap. Tehnik pengumpulan data yaitu : (1) Wawancara mendalam, (2) Observasi partisipan, (3) Penelusuran dokumen rekam medis dan regulasi implementasi PCC di IGD, (4) Fokus grup diskusi dengan 11 peserta yang merupakan Pimpinan Rumah Sakit dan
koordinator pelayanan IGD dan unit pelayanan terkait. Validitas data menggunakan uji triangulasi sumber dan metode.

Berdasarkan hasil penelitian dan analisis data menggunakan metode interaktif Miles dan Huberman didapatkan 6 tema yaitu : (1) Konsep implementasi PCC di IGD RSUD Cilacap yang disimpulkan menjadi 16 konsep. (2) Implementasi positif artinya implementasi dimensi PCC yang sudah diterapkan dengan baik di IGD RSUD Cilacap sesuai definisi konsep dan definisi operasional masing-masing dimensi PCC. (3) Implementasi negatif artinya implementasi dimensi PCC yang belum maksimal diterapkan di IGD RSUD Cilacap. Implementasi negatif PCC berkaitan dengan : (a) Asesmen Biopsikososioekonomi, Spiritual, Kultural belum dilakukan dengan maksimal pada kasus tertentu. (b) Pada kasus tertentu pasien dipindahkan dari IGD tidak menunggu hasil pemeriksaan penunjang. (c) Informasi hasil skrining atau triase serta hak dan kewajiban pasien/keluarga belum dikomunikasikan dengan baik kepada keluarga pasien. (d) Triase Bencana belum dipahami dengan baik. (e) Perencanaan pemulangan pasien tidak dilakukan di IGD. (f) Skrining nyeri belum dilakukan untuk semua pasien IGD. (4) Faktor pendorong PCC : (a) *Hard skill* dan *soft skill* Profesional Pemberi Asuhan yang terlibat dalam asuhan pasien di IGD. (b) Kolaborasi, koordinasi dan komunikasi efektif antar PPA. (c) Komunikasi efektif antara PPA dan pasien/keluarga. (d) Kepemimpinan dan konsep pelayanan yang jelas dari pimpinan IGD. (5) Faktor

penghambat PCC. Faktor penghambat utama implementasi PCC di IGD adalah lokasi IGD yang jauh dari unit pelayanan pendukung. (6) Masalah/solusi/strategi implementasi PCC di IGD. Permasalahan dalam implementasi PCC di IGD RSUD Cilacap terjadi akibat dampak dari lokasi IGD serta keterbatasan fasilitas dan sarana prasarana dalam waktu-waktu tertentu. Solusi permasalahan implementasi PCC di IGD RSUD Cilacap adalah (a) Koordinasi dan kerjasama tim IGD dan unit pelayanan terkait. (b) Membangun integrasi pelayanan IGD dengan unit pelayanan lain berbasis tehnologi informasi. (c) Konsep desain vertikal pembangunan gedung rumah sakit. (d) Menciptakan inovasi audiovisual dalam komunikasi, edukasi, informasi sebagai umpan balik hasil pelayanan IGD kepada pasien dan keluarga. (e) Menambah gedung rawat inap kelas tiga. (f) Menyediakan fasilitas telekomunikasi *wireless* untuk mendukung efisiensi dan efektifitas pelayanan IGD. Strategi pelayanan yang tepat di IGD RSUD Cilacap dalam implementasi PCC adalah penguatan skrining dan integrasi pelayanan internal dan eksternal rumah sakit berbasis tehnologi informasi. Penentu keberhasilan implementasi PCC di IGD RSUD Cilacap adalah konsep pelayanan yang jelas dari pimpinan IGD dengan memaksimalkan faktor-faktor pendorong implementasi PCC. Penentu keberhasilan implementasi PCC di IGD RSUD Cilacap adalah konsep pelayanan yang jelas dari pimpinan IGD dengan mengoptimalkan faktor-faktor pendorong implementasi PCC.

Implikasi dari kesimpulan di atas yaitu : (1) Penelitian ini dapat menjadi sarana evaluasi dan telaah pelayanan IGD dan unit pelayanan terkait di RSUD Cilacap serta mendorong terciptanya integrasi pelayanan di seluruh rumah sakit. (2) Memberikan masukan bagi pimpinan rumah sakit tentang rancangan skenario masa depan sistem perawatan pasien di IGD RSUD Cilacap. (3) Mendorong pelaksanaan survei rutin tentang pengalaman pasien IGD dari pelanggan internal maupun eksternal supaya kepuasan pasien dapat diukur dengan lebih tepat. (4) Memberikan inspirasi untuk melakukan penelitian lebih lanjut tentang pemanfaatan tehnologi dalam menjamin kecepatan pelayanan IGD. (5) Mendorong koordinasi pimpinan RSUD Cilacap, Dinas Kesehatan dan Pemerintah Daerah dalam penguatan kembali SPGDT dengan pemanfaatan Call Center 119 untuk mengatur alur rujukan pasien semua kasus penyakit dan masalah kesehatan. (6) Mendorong membangun ruang komando dan ruang intervensi modern di IGD RSUD Cilacap dalam rangka penguatan SPGDT untuk meningkatkan keselamatan pasien.

Kata Kunci : Implementasi, Patient Centered Care, Instalasi Gawat Darurat

SUMMARY

Research took the title of " Determinants of the Successful Implementation of Patient Centered Care (PCC) in the Emergency Departement (ED) of Cilacap Regional Public Hospital (CRPH). " Patient Centered Care (PCC) is the current paradigm of patient care. The concept of patient centered care can be applied in all health and social care facilities, and can be applied to the treatment of all types of diseases both acute, chronic and emergency. Cilacap Regional Public Hospital has implemented the PCC concept in all of its service units . The research problem is that the evaluation of the application of the PCC concept has not been carried out properly and routinely so that PCC has not been understood as a work culture. This study aims to understand more deeply the implementation of PCC in the ED of CRPH, look for driving factors and inhibiting factors for the implementation of PCC as well as finding solutions and designing the right PCC implementation strategy in the ED of CRPH.

The research design used is descriptive qualitative with a case study approach. The research subjects were doctors, nurses, pharmacists, nutritionists and patients. There were 29 informants consisting of 8 doctors, 6 nurses, 2 midwives, 1 pharmacist, 1 TTK, 1 nutritionist, 5 patients and 5 additional informants. Selection of informants using purposive sampling method . The research object is the opinions/views and attitudes/behaviors of the subjects regarding the implementation of PCC in the ED of CRPH. Data collection techniques are : (1) In-depth interviews, (2) Participant observation, (3) Searching for medical record documents and implementing regulations for PCC in the ED, (4) Focus group discussion with 11 participants who are hospital leaders. and coordinator of emergency services and related service units. The validity of the data used the triangulation test of sources and methods .

Based on the results of the research and data analysis using the Miles and Huberman interactive method, 6 themes were obtained, namely: (1) The concept of PCC implementation in the which was concluded into 16 concepts. (2) Positive implementation means the implementation of the PCC dimensions that have been implemented properly in the ED of CRPH according to the concept and operational definitions of each PCC dimension . (3) Negative implementation means that the implementation of the PCC dimension has not been maximally applied in the ED of CRPH. The negative implementation of PCC is related to:
(a) Biopsychosocioeconomic, spiritual, cultural assessments have not been carried out optimally in certain cases. (b) In certain cases the patient is transferred from the ED without waiting for the results of the investigation. (c) Information on the results of screening or triage and the rights and obligations of patients / families have not been communicated properly to the patient's family.
(d) Disaster Triage is not well understood. (e) Planning for patient discharge is not carried out in the ED. (f) Pain screening has not been performed for all ED patients. (4) PCC driving factors: (a) Hard skills and soft skills of Care givers Professionals involved in caring for patients in the ED. (b) Collaboration, coordination and effective communication between Care Givers Professionals (CGP). (c) Effective communication between CGP and patient / family. (d) Clear

leadership and service concepts from ED leaders. (5) PCC inhibiting factor . The main inhibiting factor for the implementation of PCC in the ED was the location of the ED which was far from the support service unit. (6) Problem / solution / strategy implementation of PCC in the ED. Problems in the implementation of PCC in the ED occurred due to the impact of the location of the ED and limited facilities and infrastructure at certain times. The solution to the problem of implementing PCC in the ED at the CRPH is (a) Coordination and collaboration between the ED team and related service units. (b) Building an integration of ED services with other service units based on information technology. (c) The concept of a vertical design for the construction of a hospital building. (d) Creating audiovisual innovations in communication, education, information as feedback on the results of emergency services to patients and families. (e) Adding third class inpatient buildings. (f) Providing wireless telecommunication facilities to support the efficiency and effectiveness of ED services. The appropriate service strategy in the ED in the implementation of PCC is strengthening screening and integration of internal and external services based on information technology hospitals. The determinant of the success of the implementation of PCC in the ED is a clear service concept from the ED's leadership by maximizing the driving factors for the implementation of PCC. The determinant of the success of PCC implementation in the ED is a clear service concept from the ED leadership by optimizing the driving factors for the implementation of PCC.

The implications of the above conclusions are: (1) This research can serve as a means of evaluation and review of ED services and related service units at CRPH and encourages the creation of service integration throughout the hospital. (2) Providing input to hospital leaders about the future scenario design of the patient care system in the ED. (3) Encouraging the implementation of routine surveys about the experiences of emergency patients from internal and external customers so that patient satisfaction can be measured more precisely. (4) Provide inspiration to conduct further research on the use of technology in ensuring the speed of ED services. (5) Encouraging the coordination of the leadership of the CRPH, the Health Office and the Regional Government in strengthening the SPGDT by utilizing Call Center 119 to regulate the flow of patient referrals for all cases of disease and health problems. (6) Encourage the building of command rooms and modern intervention rooms in the Emergency Room at the Cilacap Regional Hospital in order to strengthen SPGDT to improve patient safety.

Keywords: Implementation , Patient Center Care , Emergency Departement