THE IMPLEMENTATION OF STANDARD OPERATIONAL PROCEDURES (SOP) PATIENT FALL RISK IDENTIFICATION IN INPATIENT ROOMS AT X HOSPITAL

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Abstract

Background : A preliminary study conducted at hospital X in September 2022 obtained interview data with nurses in the inpatient room, 3 out of 7 nurses said that the nurse did not carry out an initial assessment or special history taking with the patient safety format and scale provided by the hospital management. The nurse also conveyed that it was not optimal when giving explanations to the patient's family about educating patients at risk of falling. **The purpose of this study** was to determine the application of the SOP for Falling Patient Risk Identification at X Hospital. **The method** is Qualitative descriptive in which the problem formulation that guides research to explore or portray social situations to be studied thoroughly, broadly and deeply. Data collection techniques used is observation. Interviews were conducted with the Director of the Hospital, the Head of Services, the Person in Charge of the Inpatient Room and the managing nurse. **Result**: Five participants stated that the way to overcome identification barriers was to socialize about the procedure and purpose of patient identification since the patient entered the inpatient room. This method is in accordance with the advice given by *Join Commission International*, namely educating patients and families about the risks associated with misidentification. Two participants added that the way to overcome obstacles is to do a variety of questions, such as changing the date of birth with the patient's birthday. Variety as diversity that makes something not monotonous. Variations can be in the form of changes or differences that are deliberately created to give a unique impression. Variation is done by reducing the saturation and increasing the object.

Keywrods : Standard Operational Procedures, Patient, Risk Identification

INTRODUCTION

Data recorded from WHO (Word Health Organization) in 2016, reported patient safety incidents that medical errors occurred in 8% to 12% of inpatient rooms. While 23% of EU citizens, 18% admitted to having experienced a serious medical error in hospital and 11% had been prescribed the wrong drug to a patient.

Patient safety has become a serious concern for health policy makers and healthcare providers worldwide. Patient safety incident reports from the Hospital Patient Committee *(KKP-RS)* in Indonesia from January to April 2014, found that there was a significant increase in cases of patient safety incidents. Based on the type of incident, it was reported that patients who fell were recorded at 5.5%, this figure is still quite large. Fall risk assessment is a method of measuring a patient's risk of falling which is carried out by health workers on all patients who are being treated in a hospital. This is done to pay special attention to patients who are at risk of falling compared to those who are not at risk for falling and to minimize or prevent the number of patient falls and injuries. (Darmojo, 2004). The first assessment of patients at risk of falling is carried out when the patient is admitted to the hospital and when the patient

experiences a change in clinical status. Based on a preliminary study conducted at Bendan Hospital on September 26 2022, interview data were obtained from nurses in the inpatient room, 3 out of 7 nurses said that the nurse did not carry out an initial assessment or special anamnesis with the patient safety format and scale provided by the hospital management party. Nurses also say that sometimes they still forget to explain to the family of patients who have been labeled with a yellow bracelet (risk of falling).

Hospitals are workplaces full of risks such as clinical risks, cost risks, management risks and so on. Patient safety in the hospital is important because it has many risks that must be borne by the patient starting from the patient entering until the patient goes home. Currently, hospitals are not only required to improve service quality, but are required to maintain patient safety consistently and continuously.

Health services in hospitals that prioritize patient safety are something that cannot be bargained for, because in its early history the hospital was based on selfless humanitarian service, full of love for the sake of human dignity and this refers to the origin of the word hospital which comes from Hospitium or Hospitalist (from various sources).

RESEARCH METHOD

This study uses a qualitative descriptive approach, which is a problem formulation that guides research to explore or portray social situations to be studied thoroughly, broadly and in-depth examined. According to Bogdan and Taylor quoted by Lexy. J. Moleong, a qualitative approach is a research procedure that produces descriptive data in the form of written or spoken words from people and observed behavior.

Qualitative research focuses on social phenomena, giving voice to the feelings and perceptions of the participants under study. This is based on the belief that knowledge results from social settings and that understanding social knowledge is a legitimate scientific process (legitimate). The description approach is an approach that intends to understand the phenomenon of what is experienced by research subjects, for example, behavior, perceptions, interests, motivations, actions, by means of descriptions in the form of words and language.

The selection of informants was carried out using a purposive sampling method. Selection of informants based on certain considerations, for example people who know best or have authority over the object or situation to be studied. So that the informant is able to provide directions where researchers can collect data.

Informants who are sources of primary data collection in hospitals include:

a. Hospital Director
b. Head of Services
c. Head of the inpatient room
d. Hospital Committee Chair
e. Executive Nurse

FINDINGS AND DISCUSSION

From the above research, the following results were obtained:

Table 1 Distribution of Participant Characteristics

Code	Age	Last education	Length of working
P1	56 th	S2	20 years
P2	43 yrs	Nurse	15 years
P3	36 yrs	S1 Kep	10 years
P4	34 yrs	S1 Kep	10 years
P5	32 yrs	S.KM	7 years

Interview data in the form of interview recordings and important notes from researchers written on paper arranged into a complete transcript. The data that has been collected and recorded is then scrutinized so

that keywords are found. The keywords were then regrouped so that two themes were formed, namely the analysis of guidelines for implementing fall risk identification in patients being treated stay at hospital X and apply the risk of falling in the inpatient room at hospital X.

1. **Guidelines according to the Regulation of the Minister of Health of the Republic of Indonesia Number 1691/MENKES/PER/VIII/2011 concerning Patient Safety in Hospitals**

   Article 1 paragraph 1: Hospital patient safety is a system where hospitals make patient care safer which includes risk assessment, identification and management of matters related to patient risk, incident reporting and analysis, ability to learn from incidents and their follow-up and implementation of solutions to minimize risks and prevent injuries caused by mistakes due to carrying out an action or not taking the action that should be taken.

   In this case, hospital X has implemented Patient Safety Guidelines in accordance with the results of an interview on January 7, 2023 with the Chair of the X Hospital Committee, and there is documentary evidence. The document already has an issue date of August 6, 2022.

2. **Guidelines for the Implementation of Fall Risk in Patients in the Inpatient Room**

   Based on the results of the study, it was found that five participants stated that the method of patient identification was by asking the name and date of birth of the patient, then matching it with the patient's identity bracelet or with the patient's medical record. This method is in accordance with the procedures stipulated by the Minister of Health in *Permenkes* No. 1691 of 2011 concerning goal 1 (first) Patient safety in hospitals that there are at least two ways to identify patients, such as patient name, medical record number, date of birth, identity bracelet with a bar code and others (RI Ministry of Health, 2011)

   From the results of my research mentioned that the obstacle in identifying patients was that patients felt burdened and bored when asked to state their identity. This situation is the same as the findings by *the International Joint Committee* in several countries that one of the obstacles in patient identification is patient discomfort due to repeated questions (Greenly, 2006)

   Five participants stated that the way to overcome identification barriers is by socializing about the procedure and purpose of patient identification since the patient entered the inpatient room. This method is in accordance with the advice given by JCI, namely educating patients and families about the risks associated with misidentification (JCI, 2007).

3. **How is the implementation of the risk of falling in the inpatient room at X Hospital**

Table 3 Identification of Fall Risk Patients

Keywords	Category
New patient…. fall risk assessment Using Morse	How to do a fall risk assessment
Every shift is reviewed	
Give it a yellow triangle sticker Install bed guards	Mark the risk of falling
Check….the floor is smooth or not Do not let any water stagnate on the floor	How to prevent falls
Cables should not be untidy (messy) Education for patients and patient families	

From the results of the interviews, data were obtained, namely five participants stated that the way to prevent the risk of falling was to conduct a fall risk assessment. The format used is *the morse fall scale* , in which there are 6 indicators including history of falls, disease diagnosis, walking assistance, intravenous therapy, gait and mental status. Each component has a value, if the total value is more than 25 then the patient is at risk of falling. *Morse fall scale* is a fast and simple method used to assess the probability of falling in patients.

Five participants stated that after a patient is known to be at risk of falling, the patient will be given a marker, namely a yellow sticker attached to the infusion tube that reads *fall risk.* Furthermore, participants will carry out interventions related to the risk of falling such as installing bedside guards and paying attention to the surrounding environment that causes patients to fall, accompanying patients when mobilizing, and educating families about the risks of falls experienced by patients. This procedure is included in the *fall prevention strategy guide* which states how to prevent the risk of falling by providing markers to patients, carrying out standard interventions on falling risk, and educating patients and families.

During the observation on January 7, 2023, the results were obtained, namely in the class II patient's bathroom a dead patient bell was still found, so it was necessary to monitor the patient's family going to the bathroom. After conducting deeper interviews, data was obtained from the room section, in this case the head of the room said that the findings had been submitted to the hospital management department and were still in the process of being repaired.

CONCLUSIONS

The hospital has carried out an SOP in accordance with *Permenkes* Number 1691 of 2011. The effort made in the patient identification process is to ask the patient to state 2 identities and then match them with the identity on the RM or the patient's bracelet attached. Efforts made to prevent the risk of falling are by conducting a fall risk assessment and carrying out fall prevention interventions. Implementation of patient safety goals still encounters various obstacles. Participants have their own way of overcoming each of these obstacles.

Hospitals can update the knowledge of implementing nurses regarding patient safety by holding regular training or through online seminars or *zoom meetings* related to patient safety. In addition, hospitals can provide *rewards* to individual nurses who have implemented patient safety optimally.

REFERENCES

Departemen Kesehatan RI. (2008) Panduan Nasional Keselamatan Pasien Rumah Sakit (*Patient Safety*). Edisi kedua. Jakarta: Departemen Kesehatan RI.

Greenly M. (2006). Helping Hippocrates: *A Cross fuctional approach to patient identification. Join Commision Journal on Quality and Patient Safety*, 32 : 473-469

Joint Committee International (2007). *Patient Identification*. Dalam patient safety solution. Vol 1: 2007

KKPRS. 2012. Laporan Insiden Keselamatan Pasien (IKP). Jakarta: Komite Keselamatan Pasien Rumah Sakit.

KKPRS. 2015. Pedoman Pelaporan Insiden Keselamatan Pasien (IKP). Jakarta: Komite Keselamatan Pasien Rumah Sakit.

Najihah. 2018. "Budaya Keselamatan Pasien dan Insiden Keselamatan Pasien Di Rumah Sakit: Literature Review," *Journal of Nursing and Midwifery*.

Notoatmojdo, S. 2010. Etika dan Hukum Kesehatan. Jakarta: Rineka Cipta.

Permenkes, RI. 2011. Peraturan Menteri Kesehatan Republik Indonesia Nomor

1691/MENKES/PER/VIII/2011 Tentang Keselamatan Pasien Rumah Sakit.

Permenkes, RI. 2014. Peraturan Menteri Kesehatan Republik Indonesia Tentang

Kewajiban Rumah Sakit dan Kewajiban Pasien.

Putri, Dian Pratama 2017. Analisa Pelaksanakaan Assesmen Pencegahan Risiko Pasien Jatuh Oelh Perawat Di Rumah Sakit Universitas Tanjungpura Pontianak.

SNARS. 2018. "Standar Nasional Akreditasi Rumah Sakit." Komisi Akreditasi Rumah Sakit.

Sugiatro, E. 2015. Menyusun Proposal Penelitian Kualitatif Skripsi dan Tesis. Yogyakarta: Suaka Medika.

Tutiany, Lindawati dan Krisanti, P. 2017. Bahan Ajar Keperawatan: Manajemen Keselamatan Pasien, Pusat Pendidikan Sumber Daya Manusia Kesehatan

Kementerian Kesehatan RI. Doi:10.3732/Ajb.1100457.

Undang-Undang Republik Indonesia Nomor 38 Tahun 2014 Tentang Keperawatan"

_____.(2009). Pedoman Pencegahan Dan Pengendalian Infeksi Di Rumah Sakit Dan Fasilitas Kesehatan Lainnya (Cetakan kedua)