ABSTRAK

SOSIALISASI KEPATUHAN PERAWAT DALAM KELENGKAPAN PENDOKUMENTASI ASUHAN KEPERAWATAN DI RUANGAN IGD RSUD WELAS ASIH PROVINSI JAWA BARAT

Syahrully Subagyo[1], Susan Irawan Rifai[2]
[1]Mahasiswa Profesi Ners, Fakultas Keperawatan Universitas Bhakti Kencana Bandung[2]Dosen Profesi Ners, Fakultas Keperawatan Universitas Bhakti Kencana Bandung

Pelayanan di Instalasi Gawat Darurat (IGD) memiliki karakteristik yang kompleks dan menuntut kecepatan serta ketepatan, termasuk dalam pendokumentasian asuhan keperawatan. Dokumentasi yang lengkap, akurat, dan sesuai standar berperan penting dalam menjaga mutu pelayanan, keselamatan pasien, dan perlindungan hukum bagi perawat. Namun, hasil observasi di IGD RSUD Welas Asih Provinsi Jawa Barat menunjukkan masih terdapat ketidaklengkapan dokumentasi, khususnya pada tahap implementasi dan evaluasi, yang umumnya dicatat secara umum tanpa detail waktu, metode, atau respons pasien. Tujuan kegiatan ini adalah meningkatkan kepatuhan perawat dalam pendokumentasian asuhan keperawatan melalui kegiatan sosialisasi dengan media Standar Operasional Prosedur (SOP) pengisian asuhan keperawatan. Metode yang digunakan meliputi analisis situasi, identifikasi masalah menggunakan diagram fishbone, penetapan prioritas, perencanaan, pelaksanaan sosialisasi, dan evaluasi. Hasil pelaksanaan menunjukkan peningkatan pemahaman perawat terhadap pentingnya dokumentasi sesuai standar, serta adanya perbaikan kelengkapan catatan implementasi dan evaluasi. Kegiatan ini berkontribusi pada peningkatan mutu pelayanan keperawatan, mendukung keselamatan pasien, dan memperkuat profesionalisme perawat di IGD. Disarankan agar sosialisasi dilakukan secara berkala dan disertai supervisi berkelanjutan untuk mempertahankan kepatuhan pendokumentasian.

Kata kunci: dokumentasi keperawatan, IGD, kepatuhan perawat, sosialisasi.
Sumber: 15 Jurnal (2020-2025)
5 Buku (2001-2017)

ABSTRACT

SOCIALIZATION OF NURSES' COMPLIANCE WITH COMPLETE NURSING CARE DOCUMENTATION IN THE EMERGENCY DEPARTMENT OF RSUD WELAS ASIH, WEST JAVA PROVINCE

Syahrully Subagyo[1], Susan Irawan Rifai[2]
[1]*Nursing Professional Student, Faculty Of Nursing Bhakti Kencana University Bandung*
[2] *Nursing Professional Lecturer, Faculty Of Nursing Bhakti Kencana University Bandung*

Services in the Emergency Department (ED) are characterized by complexity and demand both speed and accuracy, including in the documentation of nursing care. Complete, accurate, and standardized documentation plays a crucial role in maintaining service quality, patient safety, and legal protection for nurses. However, observations in the ED of RSUD Welas Asih, West Java Province, revealed incomplete documentation, particularly in the implementation and evaluation stages, which were generally recorded in a general manner without detailed information on time, method, or patient response. This activity aimed to improve nurses' compliance in nursing care documentation through socialization using the Standard Operating Procedure (SOP) for filling out nursing care records. The methods used included situation analysis, problem identification using a fishbone diagram, priority setting, planning, socialization implementation, and evaluation. The results showed an increase in nurses' understanding of the importance of documentation according to standards, as well as improvements in the completeness of implementation and evaluation records. This activity contributed to enhancing the quality of nursing services, supporting patient safety, and strengthening nurses' professionalism in the ED. It is recommended that socialization be conducted regularly and accompanied by continuous supervision to maintain compliance in documentation.

Keywords: *emergency department, nurse compliance, nursing documentation, socialization*
Source: 15 *Journals (2020-2025)*
5 Books (2001-2017)