ABSTRAK

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GAMBARAN FAKTOR – FAKTOR PENDOKUMENTASIAN *NURSING CARE PLAN* OLEH PERAWAT DI SATU RUMAH SAKIT SWASTA INDONESIA BAGIAN BARAT

(xiv + 52 halaman + 9 tabel + 1 bagian + 5 lampiran)

Pendokumentasian yang tidak lengkap akan memberikan kerugian bagi pasien karena informasi penting terkait perawatan dan kondisi kesehatannya terabaikan. Terdapat berbagai faktor pendokumentasian pelaksanaan *nursing care plan* yaitu umur, lama kerja, pendidikan, dan pelatihan. Tujuan umum penelitian ini adalah untuk mengetahui gambaran faktor-faktor pendokumentasian *nursing care plan* oleh perawat di *emergency* dan *outpatient department* rumah sakit swasta Indonesia bagian Barat. Metode penelitian ini adalah deskriptif kuantitatif. Instrumen yang digunakan adalah kuesioner. Populasi penelitian adalah perawat *emergency* dan *outpatient department* rumah sakit swasta di Indonesia bagian Barat sebanyak 39 orang perawat. Sampel pada penelitian ini menggunakan *total sampling* dengan analisa data menggunakan univariat. Hasil penelitian dari empat faktor-faktor pendokumentasian *nursing care plan* menggambarkan umur muda 92 % dan umur dewasa awal 8%, lama bekerja > 3 tahun 72% dan ≤ 3 tahun 28%, tingkat, pendidikan mayoritas DIII 51%, dan telah mengikuti pelatihan pendokumentasian 71%. Berdasarkan hasil dari penelitian, gambaran faktor-faktor pendokumentasian *nursing care plan* yaitu didominasi oleh perawat dengan umur muda, lama bekerja > 3 tahun, tingkat pendidikan DIII, dan telah mengikuti pelatihan pendokumentasian.

Kata Kunci : Faktor-faktor pendokumentasian, *Nursing care plan*, Perawat
Daftar pustaka : 47 (2007-2018)

ABSTRACT

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DESCRIPTION OF NURSING CARE PLAN DOCUMENTATION FACTORS BY NURSES IN A PRIVATE HOSPITAL IN WEST INDONESIA.
(*xiv *+ 52 pages + 9 tables + 1 chart + 5 attacments)

Incomplete documentation will deprive patients because important information related to care and health conditions is neglected. There are various factors documenting the implementation of nursing care plan that is age, duration of work, education, and training. The general objective of this study was to determine the factors of documentation of nursing care plans by nurses in emergency and outpatient departments of a private hospital in west Indonesia. The research method is descriptive quantitative. The instrument used is questionnaire. The population of this study were 39 emergency nurses and outpatients department of a private hospital in west Indonesia. The sample in this study used was total sampling. Data analysis is using univariate. Based on the results of the study of four factors of documenting nursing care plan describes 92% of young age and 8% young adult age, working time > 3 years 72% and ≤ 3 years 28%, associate degree 51% and documenting training 71%. The conclusion from this research is description of nursing care plan documentation factors by nurses are dominated in young age, working time > 3 years, associate degree, and had already participated documentation training.

Key words : Factors documentation, Nursing care plan, Nurse
Reference : 47 (2007-2018)