ABSTRAK

Medication error merupakan salah satu insiden keselamatan pasien yang paling sering terjadi di rumah sakit dan berdampak pada morbiditas, mortalitas, serta mutu pelayanan. Di Aulia Hospital Pekanbaru, insiden ini masih terjadi secara berulang, namun faktor penyebab mendalamnya belum diketahui.

Penelitian ini bertujuan menggali faktor-faktor penyebab *medication error* berdasarkan perspektif tenaga kesehatan. Pendekatan yang digunakan adalah kualitatif fenomenologi, dengan informan terdiri dari perawat, dokter, apoteker, dan anggota komite keselamatan pasien yang dipilih secara *purposive* dan *snowball*. Data dikumpulkan melalui wawancara mendalam, observasi, dan telaah dokumen, kemudian dianalisis menggunakan metode Colaizzi melalui reduksi, pengkodean, kategorisasi, dan penarikan tema.

Hasil penelitian menunjukkan tujuh faktor utama penyebab *medication error*: (1) faktor individu (kelelahan, *multitasking*, kurang teliti, kurang pengetahuan, tidak melakukan *double check*); (2) beban kerja tinggi dan kekurangan SDM; (3) faktor sistem dan organisasi, termasuk penggunaan sistem *One Day Dose* (ODD) tanpa verifikasi farmasi; (4) kemiripan obat (*Look-Alike Sound-Alike/LASA*); (5) komunikasi antarprofesi yang tidak efektif; (6) lingkungan kerja yang kurang mendukung, seperti pencahayaan redup dan label manual; serta (7) budaya keselamatan pasien yang lemah (rendahnya pelaporan insiden akibat rasa takut terhadap sanksi). Temuan ini menegaskan bahwa *medication error* bersifat multifaktorial dan sistemik, bukan sekadar kesalahan individu, melainkan kegagalan lapisan-lapisan sistem secara bersamaan.

Rekomendasi untuk rumah sakit meliputi penguatan sistem pemberian obat melalui penerapan UDD, pelaksanaan *double check*, standardisasi komunikasi (SBAR), pelabelan LASA, perbaikan lingkungan kerja, dan pembangunan budaya *Just Culture* agar staf dapat melaporkan insiden tanpa rasa takut.

Kata kunci: *medication error*, keselamatan pasien, faktor sistemik, fenomenologi, LASA, komunikasi klinis, *Just Culture*

ABSTRACT

Medication errors are among the most common patient safety incidents in hospitals, impacting morbidity, mortality, and quality of care. At Aulia Hospital Pekanbaru, these incidents continue to recur, yet the underlying contributing factors have not been thoroughly explored.

This study aimed to explore the factors contributing to medication errors from the perspective of healthcare professionals. A qualitative phenomenological approach was employed, involving nurses, physicians, pharmacists, and patient safety committee members selected through purposive and snowball sampling. Data were collected via in-depth interviews, observation, and document review, and analyzed using Colaizzi's method through reduction, coding, categorization, and theme identification.

The study identified seven main factors contributing to medication errors: (1) human factors (fatigue, multitasking, lack of accuracy, limited knowledge, absence of double-checking); (2) high workload and insufficient staffing; (3) system and organizational factors, including the One Day Dose (ODD) system without pharmacy verification; (4) Look-Alike Sound-Alike (LASA) medications; (5) ineffective interprofessional communication; (6) inadequate work environment, such as poor lighting and manual labeling; and (7) weak patient safety culture characterized by fear of reporting incidents. These findings confirm that medication errors are multifactorial and systemic, not merely individual mistakes but failures of multiple system layers.

Recommendations include strengthening the medication administration system through UDD implementation, double-check procedures, SBAR communication standardization, LASA labeling, workplace improvements, and fostering a Just Culture to encourage incident reporting without fear.

Keywords: medication error, patient safety, systemic factors, phenomenology, LASA, clinical communication, Just Culture

The hospital should strengthen its medication safety system by implementing a Unit Dose Dispensing (UDD) system, increasing staffing, enforcing double-check practices, standardizing communication using SBAR, improving the work environment, applying LASA labeling, and fostering a Just Culture to encourage non-punitive incident reporting.

Keywords: medication error, patient safety, phenomenology, LASA, clinical communication, Just Culture