



DESIGN OF COMPUTER-BASED PALIATIVE NURSING AND PALIATIVE SCREENING DOCUMENTATION INFORMATION SYSTEMS

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ABSTRACT

The development of health information systems is currently quite rapid, one of which is the nursing care documentation system, including psychiatric nursing. Several psychiatric hospitals now use a lot of computer-based documentation systems and some are even Android-based. Health education is a producer of graduates of health workers, which is expected to be able to meet the needs of graduate users. For this reason, every health graduate must be able and skilled in carrying out the nursing care documentation process. The purpose of this research is to design a psychiatric nursing documentation that can be used in health education. This type of research is design research. The research activity began with the creation of a diagram of the nursing care documentation process flow system. After the flowchart system is made, the researcher begins to design a system that is in accordance with the flowchart design. The final results of the research on the design of the psychiatric nursing care documentation system design. The results of this study can be used to study computer-based mental nursing documentation.

Keywords: design; information system; psychiatric nursing documentation

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INTRODUCTION

Mental nursing in Indonesia has experienced developments, one of which is in the field of documentation of nursing care. Just like care in general nursing today in mental hospitals, many care documentation information systems have been developed that facilitate the work of nurses. Nursing documentation is a form of accountability for a nurse's duties.(Swedarma et al., 2023)The results of his research explained that the existence of a mental nursing documentation system could increase the work efficiency of mental nurses in hospitals. Nursing documentation that is carried out needs to apply the principle of documentation.(Leniwita & Anggraini, 2019)explaining nursing documentation it is necessary to pay attention to the principles of documentation including being confidential, consistent, carried out by those who carry out the action, carried out immediately chronologically, accurately containing the time of implementation, name and initials.

The approach to creating a nursing documentation system is based on the SDKI, SLKI, and SIKI as reference standards for nursing documentation.(Sugiyanto, 2022)explained in his research applying the use of SDKI, SLKI, and SIKI for the preparation of the root system of nursing intervention documentation. This explanation can be the basis for developing a

documentation system that can be used by nursing students.(Mulyono, 2023)explaining the development of a nursing documentation system in educational institutions can help students to be able to recognize and practice the use of a nursing documentation system. The purpose of this research is to design a psychiatric nursing care documentation system.

METHOD

This type of research uses design research, by planning an expert system.(Mulyono, 2021)The activity begins with system requirements analysis, database planning, application planning (Use Case Design, Activity Diagrams, Sequence Diagrams), the last is User Interface Design.

RESULTS

After entering the system, nurse students can then input assessment data including demographic data, predisposing factors, and assessment of the client's mental status. Furthermore, data showing symptoms of psychiatric nursing problems will automatically be grouped according to the category. Next, a selection of nursing problems will appear according to the signs and symptoms that appear, and can be selected according to the patient's nursing problems. can choose one from the list of existing nursing problems or can select more than one symptom by pressing the Ctrl key on the keyboard. After completing the data collection related to the patient, the nurse can press the Save button to save the data entered.

The image displays two overlapping screenshots of a web-based application titled "Sistem Informasi Keperawatan Jiwa".

The top screenshot shows the "Formulir Pengkajian Saat Ini dan Masuk" (Current and Past Assessment Form). It includes a navigation bar with "Pengkajian", "Jenis Masalah", "Ganti Password", and "Logout". The form is divided into sections: "Tanggapan Masuk" (Initial Response), "Riwayat/Gejala" (History/Symptoms), "Rt. Riwayat Masuk" (Initial History), "Uraian Masuk" (Initial Description), and "A. IDENTITAS" (Identity). The identity section includes fields for "Nama" (Name), "Umur" (Age), "Jenis Kelamin" (Gender), "Agama" (Religion), "Suku Bangsa" (Ethnicity), "Pendidikan" (Education), "Pekerjaan" (Occupation), and "Alamat" (Address). There is also a "Kontak Darurat" (Emergency Contact) field.

The bottom screenshot shows the "ANALISIS DATA" (Data Analysis) section. It features a table with the following data:

NOCM	POG002108
Nama Pasien	MULYONO
Umur	45
Masalah Utama	Marah Diri Rendah
Masalah Tambahan	Melutuskan Marah Diri Rendah Resiko Perilaku Kekerasan

Below the table is a "Simpan" (Save) button. The bottom of the interface shows a copyright notice "© 2021".

Figure 1. Data input for Psychiatric Nursing Patient Assessment

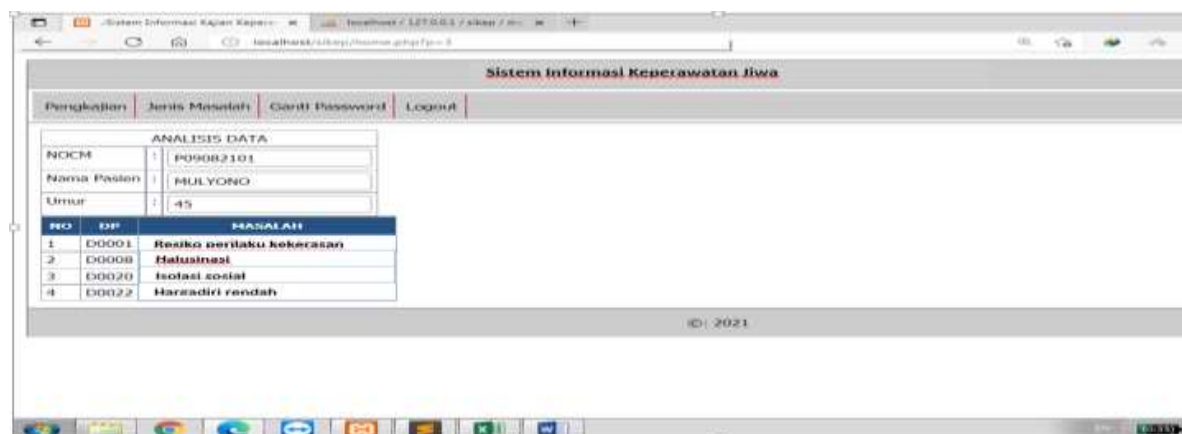


Figure 2. Outcome Nursing diagnosis

DISCUSSION

Nursing care includes comprehensive activities starting from assessment, formulation of diagnoses, planning, implementation of actions and evaluation. (Tampubolon, 2020) explained that the nursing care process includes several stages including assessment, formulation of diagnoses, planning, implementation of actions and evaluation. Documentation of the process is of course important to do. Some of the obstacles encountered in the documentation include the lack of efficiency in terms of time, it takes more time and energy to do nursing documentation. (Maha, 2018) Good documentation reflects not only the quality of care but also proves the accountability of each member of the care team in providing care. Nurses Currently, efforts are being made to overcome these obstacles, including by creating a nursing documentation system whose goal is to facilitate nurses in documenting their care. (Baderi, 2018) Explaining Information and Communication technology contains a broad understanding, namely all activities related to processing, manipulation, management, transfer of information between media.

Information and communication technology has now been developed in order to facilitate the work of several professions, including nurses. (Prasetyanto, 2019) Computer-based management information systems are now widely used, one of which is in the field of nursing. Apart from being a hospital institution, this technology was also developed at a nursing education institution. (Hallila LE, 2014) who discussed that currently nursing students in their studies use a lot of the internet and computers besides that, the results of their research show that computers and the Internet help students achieve their learning goals. (Arizal*, 2018) His research identified that the implementation of integrated documentation is because it is more efficient than paper based and its use is more practical. Factors affecting information systems include the level of understanding of computerized-based documentation.

The development of a nursing information system (SIKEP) uses a root system with a causal approach. Other methods are used with clinical padways. (Meo, 2015) explained that the Clinical pathway is an action plan for patients who are multidisciplinary, and contains details about the steps for treating a patient from entering the hospital to leaving the hospital. (Meo, 2015) (Swedarma et al., 2023) (Hamzah, 2016) explains how a system was developed to assist the process of nursing care with various methods. One of the methods used is to use an expert system. In this research, an expert system for psychiatric nursing documentation was developed based on the SDKI, SLKI, and SIKI.

CONCLUSION

The nursing information system aims to facilitate nurse performance. The nursing information system was not only developed in the health service unit but also developed in the nursing education unit. This function is to provide real and direct experience for students, especially in the use of health information technology. Further information systems need to be developed, namely a system for preparing basic nursing interventions and a system for implementing basic nursing actions.

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