INTISARI

Resep racikan diberikan kepada pasien pediatrik untuk mendapatkan dosis yang tepat. Resep racikan ini sangat berpotensi menimbulkan *medication error (ME)*. Berdasarkan laporan dari *United States Pharmacopeia Medication Errors Reporting Program*, 377 kesalahan pada fase *dispensing* disebabkan oleh kesalahan dari pihak farmasi. Faktor sistem memegang peranan utama sebagai penyebab terjadinya ME.

Penelitian ini merupakan penelitian observasional deskriptif. Rancangan penelitian adalah *cross sectional*. Tujuan penelitian ini untuk mengetahui bentuk-bentuk dan presentase kejadian *ME,* serta mengetahui penyebab, usaha pencegahan, pengatasan, dan perbaikan yang sebaiknya dilakukan. Metode penelitian menggunakan observasi dan wawancara mendalam.

Hasil penelitian menunjukkan bahwa terjadi kesalahan pada interpretasi (3,1%); pengambilan obat (6,8%); peracikan (4,6%); pelabelan (0,4%); kalkulasi dan rekalkulasi dosis (1,5%); dan pengemasan (0,2%); serta penyebutan nama pasien (0,2%). Penyebab *ME* di farmasi adalah kesalahan pada desain dan implementasi sistem. Usaha pencegahan yang telah dilakukan meliputi dilakukannya pemeriksaaan ulang, pencatatan ulang resep, adanya prosedur kerja, pengaturan letak obat, dan memperbaiki jadwal kerja. Usaha pengatasan berupa memberikan penjelasan kepada pasien dan menyelesaikan masalah. Usulan usaha perbaikan dapat berupa perubahan alur kerja, penambahan kolom berat badan pada resep, perubahan jadwal kerja, peningkatan sumber daya, dan penggantian obat berdasarkan persetujuan dokter.

Kata kunci : *medication error, dispensing, transcribing*, resep racikan, dan pasien pediatrik.

ABSTRACT

Many compounding prescription is prescibed to pediatric patient for getting the right dosage. The service of compounding prescription have a prone to medication error. According to the report of United States Pharmacopeia Medication Errors Reporting Program, 377 medication errors could be identified as pharmacy technician errors at dispensing phase. System factor play a major role in increasing the likelihood that an individual will make error.

This research is a descriptive-observational research. Design of this research is cross sectional. From this research, hopefully we can know the type of medication errors that are happened and how many precentase of it's kind, factors cause medication error, prevention efforts, efforts to deal the problem, and recommendations to repair the system. To obtain that purposes, this research uses observation and indepth interview methods.

Based on the observation, the types of medication errors that were happened are error in interpretation (3,1%); labeling (0,4%); incorrect medicine (6,8%); dosage calculation (1,5%) packaging (0,2%); compounding (4,6%), and calling patient name (0,2%). Factors cause medication error at pharmacy are error in design and implementation of system. The prevention efforts that have done are checking, recording the prescription, work procedure, arranged medicine places, and arranged the work schedule. The efforts to deal medication error that were happen are giving some explanation to patient and finish the problems. Recommendations to repair the system are arranged work procedure, give a column weight patient in prescription, arranged work schedule, increase technology and human resources, and switch the medicine at prescription must have legalization from the medical doctor.

Key word : medication error, dispensing, transcribing, compounding prescription, dan pediatric patient.