LITERATURE REVIEW: ANALYSIS OF HOSPITAL READINESS IN FACING STANDARD INPATIENT CLASS (KRIS)

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Abstract

The Indonesian government introduced the National Health Insurance (JKN) program to ensure basic health coverage for its citizens. However, challenges emerged during its implementation, including difficulties in accessing adequate healthcare services. To address this, the Standard Inpatient Class (KRIS) concept was introduced in select Indonesian hospitals, aiming to deliver equitable services by standardizing rates and quality of care. This narrative literature review assesses the readiness of various hospitals in adopting KRIS. A search was conducted using Google Scholar, ScienceDirect, and PubMed with keywords related to hospital readiness for KRIS policy. Screening using the PRISMA method resulted in the inclusion of 4 out of 15 articles. Findings reveal variations in hospital preparedness, with Hospital A, B, C, and D demonstrating readiness levels of 75%, 74%, 75%, and 70%, respectively. Hospital A excelled in criteria 6 and 7 (95%), while struggling in criterion 1 (64%). Hospital B demonstrated strong readiness in criterion 7 (85%) but lacked in criterion 8 (49%). Hospital C performed well in criterion 5 (90%) but poorly in criterion 11 (34%). Hospital D exhibited high readiness in criterion 3 (88%) but lacked in criterion 4 (50%). On average, hospitals displayed 73% readiness, with criterion 3 (87%) achieving the highest readiness, particularly in room lighting, while criterion 4 (55%) showed the lowest readiness, specifically in bed completeness. These findings underscore the need for further improvements to enhance hospital readiness for KRIS implementation.

Keywords: *National Health Insurance, KRIS (Standard Inpatient Class), Hospital*

1. INTRODUCTION

Indonesia's National Social Security System (SJSN) consists of the National Health Insurance Program (JKN). The aim of this program is to provide protection in the social insurance system to the entire population of Indonesia, so that they can meet their basic health needs. Every individual who pays contributions, whether paid by the government or paid individually, receives this protection (Minister of Health Regulation No. 28 of 2014).

Health insurance participants have the right to receive individual health services, such as promotive, preventive, curative and rehabilitative. They also have the right to obtain medicines, medical devices and consumable medical materials according to medical needs (Tugiman et al., 2022). The Health Insurance Administering Agency is a state-owned enterprise appointed by the government to ensure that all Indonesian people, especially Civil Servants, Civil Servant Pension Recipients, TNI/POLRI members, veterans, Independence Pioneers, and their families, as well as other business entities or ordinary people, have health insurance. Established on 31 December 2013, BPJS Health and BPJS Employment, previously known as *Jamsostek*, are now part of the National Health Insurance (JKN). On January 1 2014, BPJS Health was officially implemented (Mendrofa and Suryawati, 2016).

Several problems occurred during the implementation of National Health Insurance (JKN), such as people complaining about the difficulty of getting adequate services. Apart from the community perspective, the hospital perspective also experiences problems because the financing rates are too small and do not match the costs of medical services, medicines and the latest reagents or consumables. This rate is regulated in Minister of Health Regulation No. 59 of 2014. As a result, people believe that hospitals only provide minimal services with unfriendly health staff (Dumaris, 2018).

As an implementation of Law No. 11 of 2020 concerning Job Creation, the government issued PP No. 47 of 2021 concerning hospitals based on problems that arise in the JKN program. This will have an impact on the bed regulations that apply to JKN participating patients who are treated in hospital. There are new standards for standard class inpatient services which have 12 criteria that must be met. This standard class inpatient service replaces the abolished concept of class-based inpatient care.

Furthermore, in May 2020, the government issued PP No. 64 of 2020 which changed the number of premium contributions for JKN participants according to class level. In December 2020, the government collaborated with professional organizations, institutions and associations of health institutions to analyze and review JKN which prioritizes KRIS (Standard Inpatient Class). The aim of this collaboration is to ensure that in the future there will only be one fare with the same facilities that applies to JKN participants. There are twelve KRIS criteria that focus on medical and non-medical infrastructure, such as living rooms. These criteria include room density, air ventilation conditions, room temperature and bathroom conditions, etc. This KRIS-related policy will be implemented in stages in all hospitals until early January 2023 (Presidential Decree No. 64 of 2020). Therefore, it is necessary to assess the readiness of each hospital to establish a KRIS system. This literature review was created as an illustration in preparing hospitals that will implement the KRIS system.

2. LITERATURE REVIEW

2.1. Standard Inpatient Class (KRIS)

According to the Technical Instructions for the Readiness of Hospital Facilities in the Implementation of National Health Insurance Standard Inpatient Classes (KRIS-JKN), Number HK.02.02/1/1811/2022, JKN inpatient classes must meet a minimum of twelve criteria to be accepted by hospitals in the JKN program which is covered by the Health Social Security Administering Agency (BPJS). There are four factors that influence the implementation of standard inpatient class services: (1) readiness of standard class beds; (2) standard class of care rates; (3) contributions that must be paid by JKN-KIS participants; and (4) stakeholder perspective regarding the application of standard inpatient classes. Most hospitals still provide VIP I, II and III services in terms of bed readiness. The change to standard inpatient classes will result in changes to hospital infrastructure, which must be designed to meet the need for beds for the Indonesian people. Thus, it is hoped that there will be a technical guideline to help prepare hospital infrastructure in implementing standard inpatient classes for the national health insurance program in all hospitals in Indonesia (Kurniawatiet al., 2021).

2.2. Government Regulation No. 47 of 2021 concerning KRIS

In Government Regulation Number 47 of 2021 concerning the Implementation of the Hospital Sector which has been issued. Article 18 states "The number of inpatient beds for standard class inpatient services is at least 60% of all beds for hospitals owned by the Central Government and Regional Governments and 40% of all beds for privately owned hospitals." and Article 84 B which reads "When this Government Regulation comes into force: a) Hospitals can still provide inpatient services in accordance with the class of care they have until standard class inpatient services are provided as referred to in article 18, b) class inpatient services standards as intended in letter a shall be implemented no later than 1 January 2023" (Government Regulation, 2021).

This regulation brings a number of significant changes to hospital management in Indonesia, including in terms of hospital buildings. One of them is in the inpatient system, previously, inpatient hospital care was divided into classes 1, 2, 3, and premium. However, with the issuance of PP No. 47, the inpatient system is only divided into standard classes and non-standard classes. The minimum percentage of beds for standard class is set at a minimum of 60% for government hospitals and a minimum of 50% for private hospitals. Apart from that, this regulation also stipulates that isolation rooms must provide a minimum of 20% of the total beds. There was also a change in the ratio of intensive care beds compared to total beds, increasing to 10% from the previous 5%. This change will have an impact on the size of hospital rooms and buildings. However, converting a building is not an easy task as it requires systematic steps and significant costs. Therefore, deep thought is needed so that hospitals can fulfill the requirements in accordance with this latest regulation efficiently and effectively.

This is also stated in Presidential Decree 64 of 2020, especially in Article 54 A which reads "For the continuity of Health Insurance funding, the Minister together with related ministries/institutions, professional organizations and health facility associations conduct a review of Health Insurance benefits according to basic health needs and inpatient class standard no later than December 2020" and Article 54 B reads "The benefits as intended in Article 54 A are implemented in stages until no later than 2022 and the implementation is carried out continuously to improve Health Insurance governance" (Presidential Decree, 2020).

2.3. Principles of Drug Management in the JKN Era

The government, through the Ministry of Health, has established a National Formulary (FORNAS) to monitor the quality and electronic catalog of medicines to control costs, because according to the National Social Security System Law (SJSN) and the Health Law, the government is responsible for ensuring the availability of medicines to the public and compiling a list of medicines and The price is guaranteed in the health insurance system managed by BPJS Health. Minister of Health Regulation Number 5 of 2019 concerning Planning and Procurement of Medicines Based on Electronic Catalogs explains how to procure medicines for the Health Insurance program by government and private institutions through Electronic Purchasing Based on the Electronic Catalog, the JKN drug e-Catalogue system is an electronic information system that contains information about the name of the drug, type of drug, smallest unit price, technical specifications and factory/industry providing the drug. The smallest unit price, which

includes taxes and distribution costs, is listed in the e-Catalogue (Raharni, Supardi and Sari, 2018).

During the JKN period in hospitals, drug management began with drug planning, which involved all relevant stakeholders. To produce a Hospital Formulary, the Pharmacy and Therapeutics Committee will conduct research on the choice of drugs to be used in the hospital. Once agreed, a Drug Needs Plan (RKO) is created every year with data on usage from the previous year. In accordance with RKO and budget availability, purchases are made periodically according to needs and requests (Nugraha, 2023).

Drug procurement is carried out based on RKO and is carried out every month or at time intervals determined by the pharmaceutical division. Medicines are procured through an e-catalog system for medicines included in the national formulary. Before procuring an e-catalog, the PBF must verify the drugs that can be ordered. The pharmacy department handles the receipt of drugs, which will verify and check the type, quantity and conformity between the invoice and the order letter. Non-conformities are discussed with the procurement or distributor to resolve them (Nugraha, 2023).

BPJS drug control is no different from ordinary drug control. Inventory control is carried out to ensure that supplies are available in the right quantities and at the right time. When there is a shortage of BPJS medicine, hospitals will negotiate so that the price they get is the same as the price of BPJS medicine. The ROP calculation for BPJS drugs is different from the ROP calculation for regular drugs because the waiting time for drugs is sometimes longer than the waiting time for regular drugs. As a result, the drug stock in the service section is less than the safety stock (Nugraha, 2023).

The national formulary is a guideline used to administer drugs to outpatients and inpatients. This formulary contains the name of the generic drug and the maximum number of drugs prescribed. Billing for drugs in the INA CBG package in inpatient settings depends administratively on the patient's diagnosis. There are two types of billing for outpatient care: INA CBG and chronic drug packages. Chronic medication can only be billed for 23 days of use to BPJS, and the remaining 7 days are given to the INA CBG outpatient package. Non-chronic drugs can also be billed in the INA CBG package, and according to hospital regulations, drugs can be given for a maximum of 7 days (Suryawati and Jati, 2016).

3. RESEARCH METHODS

This article is a narrative literature review. A literature review means understanding a topic that has been studied, researched by other people on the main topics. Article searches are carried out by searching for article sources obtained through searches on Google Scholar, and ScienceDirect, PubMed, using the keywords "Hospital Readiness to Face KRIS, KRIS Policy, Hospitals" which have been published in the last 10 years. Based on the keywords that have been entered, an assessment will then be carried out using the PRISMA method on the article search results obtained which will then be adjusted to the research objectives. The inclusion criteria selected were articles published in the past ten years, namely 2014 to 2024. Articles that discussed JKN, hospital readiness to face KRIS. Then screening is carried out to remove any duplicates, namely journals with the same title. After that, articles were excluded based on the following criteria:

articles were incomplete, inaccessible, or not included in the main topic, namely hospital readiness to face KRIS. So based on the inclusion and exclusion criteria, there were found as many as 4 research journals that match the topic being searched for further discussion. The flow of the PRISMA method used is shown in Figure as follows:

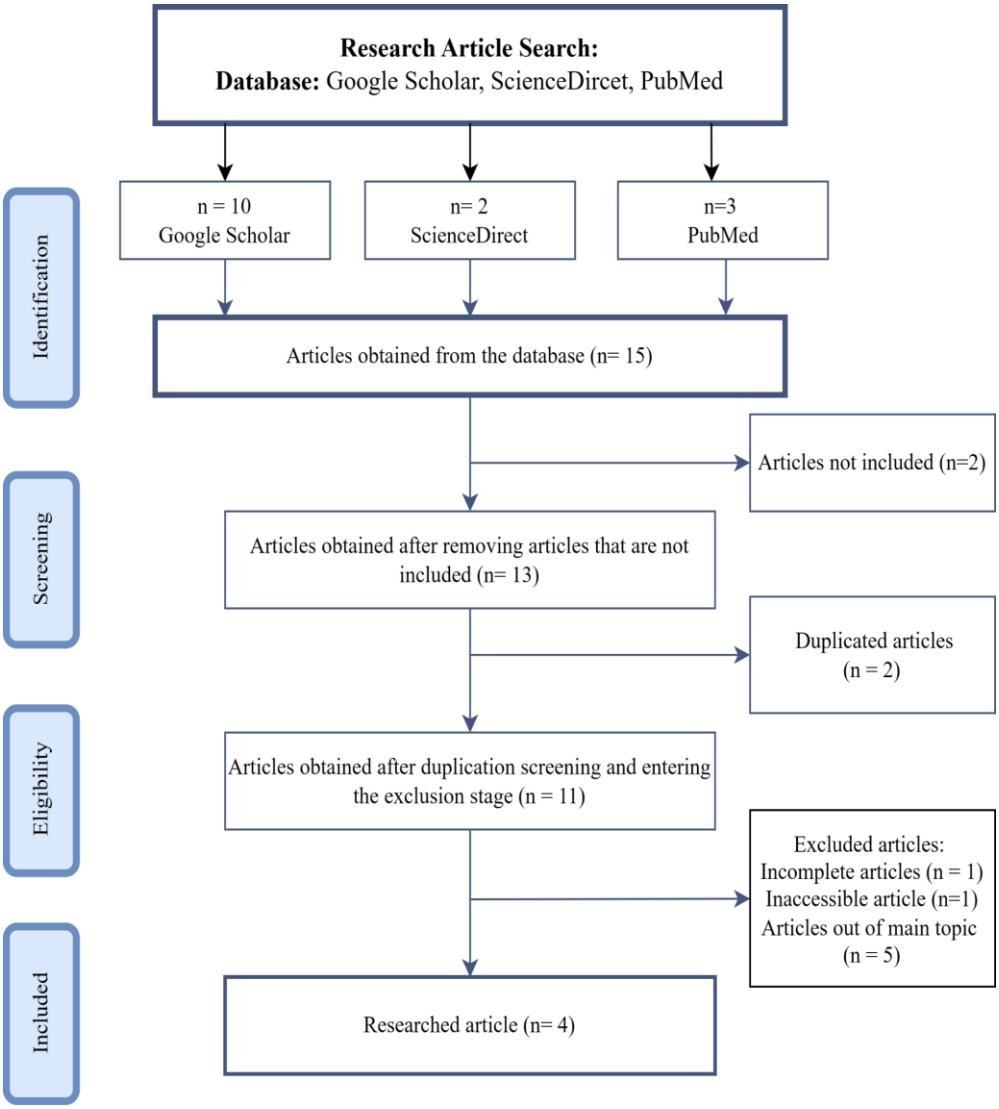

Figure 1. PRISMA Method

4. RESULTS AND DISCUSSION

4.1. Research Results

To implement the standard inpatient class system (KRIS), the relevant hospital must meet several facility and infrastructure standards. There are twelve criteria that must be met, namely:

1. The building components used must not have a high level of porosity.
2. Air ventilation (minimum 6 air changes per hour, for natural ventilation it must be more than this value, for isolation rooms a minimum of 12 air changes).
3. Room lighting (standard 250 lux for lighting and 50 lux for sleep lighting).
4. Bedding.
5. Nightstand per bed.
6. Room temperature and humidity (room temperature).
7. Treatment rooms are divided based on gender, age, disease (infectious and non-infectious) and combined treatment rooms.
8. Treatment room density and bed quality, provided that:

- Between the edges of the bed at least 1.5 m (the distance between the edge of the bed to the edge of the next bed)
- The maximum number of beds per inpatient room is 4 beds
- Minimum bed size L: 200 cm W: 90 cm H: 50-80 cm
- The bed uses a minimum of 2 positions, namely elevation of the head area and foot area (2 cranks) and uses safety guards on the sides of the bed

9. Curtains/Partitions between beds (curtain distance 30 cm from the floor and minimum curtain length 200 cm, curtains use non-woven materials order, brightly colored, and easy to clean).
10. Bathroom in the inpatient room (each inpatient room has at least 1 bathroom, the direction of the exit door is open, the door lock can be opened from both sides and ensures ventilation).
11. Bathrooms comply with accessibility standards:
    - There is an inscription or symbol "disable" on the outside
    - Has sufficient space for wheelchair users
    - Equipped with a handle (handrail)
    - The floor surface is not slippery and does not cause puddles
    - Nurse bell connected to the nurse's station
12. Oxygen outlet (each bed has an oxygen outlet equipped with a flowmeter located on the wall behind the patient's bed)

An analysis was carried out regarding hospital readiness from 4 hospitals from various regions. The results of this analysis are shown in the following table.

Table 1. Percentage of Readiness for Each Hospital

No	Journal	Criteria												Total Percentage
		1	2	3	4	5	6	7	8	9	10	11	12	
1.	Hospital A	64 %	73 %	91 %	55 %	68 %	95 %	95 %	59 %	68 %	77 %	77 %	77 %	75%
2.	Hospital B	71 %	75 %	83 %	69 %	70 %	80 %	85 %	49 %	69 %	78 %	75 %	80 %	74%
3.	Hospital C	75 %	85 %	85 %	44 %	90 %	85 %	80 %	85 %	65 %	85 %	34 %	82 %	75%
4.	Hospital D	68 %	70 %	88 %	50 %	65 %	80 %	75 %	55 %	65 %	80 %	65 %	80 %	70%
Average Percentage		70%	76%	87%	55%	73%	85%	84%	62%	67%	80%	63%	80%	73%

The chart depicting the average hospital readiness to fulfill the 12 KRIS criteria is illustrated in the subsequent figure.

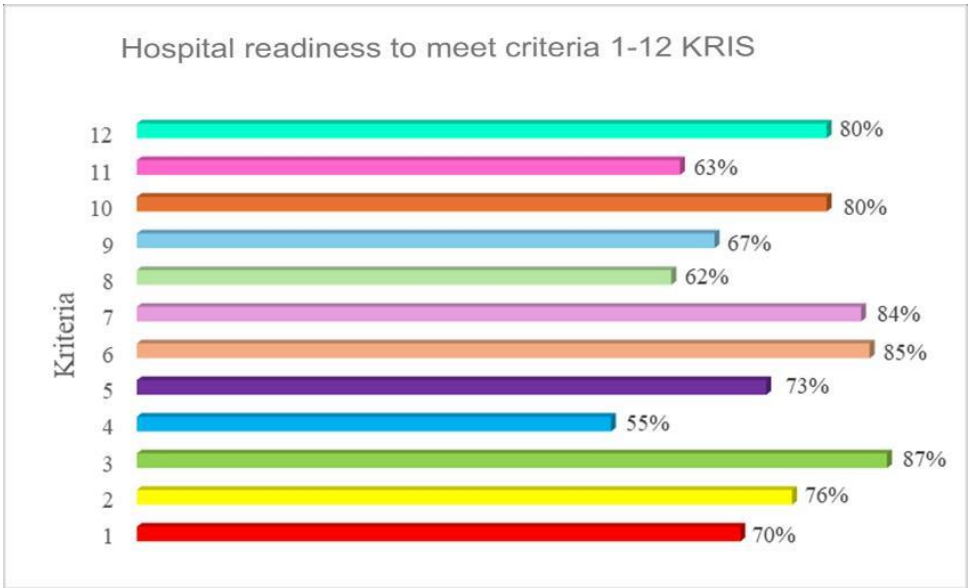

Figure 2. Average Hospital Readiness for 12 KRIS Criteria

4.2. Discussion

Based on the analysis of the four hospitals, the average readiness for each criterion is different. The following is the average readiness for each criterion from the highest readiness to the lowest.

1. First, the criterion with the highest percentage is in criterion 3, namely room lighting at 87%. These criteria are the criteria with the highest readiness because fulfilling these criteria is relatively easy. Lighting can use direct sunlight as natural

lighting or artificial lighting, namely from incandescent lamps with standard provisions of 250 lux for lighting and 50 lux for sleeping lighting.

2. Second, there is criteria 6 of 85% regarding room temperature and humidity (room temperature). This criterion is included in the criteria that are easy to fulfill because the temperature can be adjusted easily with the air conditioner.
3. Third, there is 84% in criterion 7, namely treatment rooms divided according to gender, age, infectious and non-infectious diseases and combined treatment rooms. On average, hospitals have divided their inpatient rooms based on infectious and non-infectious diseases, but some hospitals have not divided inpatient rooms based on gender and age, so the fulfillment of these criteria is not 100%.
4. The fourth is in criterion 10, namely regarding the bathroom in the inpatient room with a percentage of 80%. Readiness regarding these criteria is not optimal because several standards for bathrooms in inpatient rooms have not been met, such as still having a one-way lock and the direction of the bathroom door opening is still inward.
5. Fifth, there is criterion 12, namely regarding the oxygen outlet which has a percentage of 80%. The readiness of these criteria is not yet optimal because in some hospitals it is still necessary to add oxygen outlets that are adjusted to the position of the bed.
6. Sixth, criteria 2 is 76% related to air ventilation. The difficulty for hospitals in meeting these criteria is that some hospitals still use fans as mechanical ventilation so that air changes are not optimal and there are still several rooms with room windows that are not connected to the outside.
7. Seventh, there is criteria 5 related to nightstands and beds at 73%. This is easy to fulfill even though some hospitals in certain classes do not yet have nightstands for each bed.
8. Eighth, criterion 1 is 70% regarding building porosity. Based on the analysis of the four hospitals, on average hospital buildings already have a low level of porosity. However, several buildings in hospitals, such as walls and ceilings, still use porous materials such as gypsum, so readiness regarding these criteria is still not optimal.
9. Ninth, there is criterion 9 regarding curtains/partitions between beds at 67%. Regarding these criteria, readiness is not yet 100% because several hospitals still have curtains made from porous materials.
10. Tenth, there is criterion 11 regarding bathrooms in accordance with accessibility standards of 63%. The difficulty in fulfilling these criteria is that some bathrooms in hospitals do not meet accessibility standards for disabled patients, and some bathrooms do not have sufficient space for wheelchair users.
11. Eleventh, there is criterion 8 related to the density of treatment rooms and the quality of beds at 62%. These criteria are quite difficult to fulfill, because some hospitals still have rooms with more than 4 beds. So, it is necessary to expand the land to add more rooms so that each room contains a maximum of 4 beds.
12. Twelfth, there is criterion 4 regarding bed completeness of 55%. This criterion has the lowest readiness because of the four hospitals studied, most of them still use the old type of bed non-electric, so they need to change the type of bed to a semi-electric bed. This requires a lot of money, so fulfilling these criteria is quite difficult.

Based on the analysis of the 12 criteria in implementing the KRIS system, each hospital has a different level of readiness. There are 4 hospitals discussed in this literature review. First, Hospital A has 75% readiness to face KRIS. The highest readiness criteria (95%) are criteria 6 and 7 regarding room temperature and humidity and the division of inpatient rooms according to gender, age, infectious and non-infectious diseases and combined treatment rooms. The criteria where readiness is still very minimal is the completeness of the bed with a percentage of 56%. Second, at Hospital B the readiness to face KRIS is already 74% with the most prepared criteria being room lighting (83%) according to the results of interviews with informants. Criterion 8 (49.5%) regarding room density and sleeping facilities is an obstacle in its readiness, for example the distance between the bed and its edge and bathroom accessibility still do not meet KRIS standards.

Third, KRIS readiness at Hospital C which has 75% readiness. The best readiness is that each bed is equipped with a nightstand with a percentage of 90% (criterion 5). However, in criterion 11 (34%), namely the readiness of the bathroom does not fully meet the criteria because the bathroom in Hospital C is not completely disability friendly, such as the absence of the "disable" symbol and not all of them are equipped with creeper handles. Fourth, readiness Hospital D in facing KRIS of 70%, with the most qualified criteria to face KRIS is criterion 3, namely room lighting (88%) according to observations made, the inpatient room at Hospital D has sufficient lighting. However, for the completeness of beds (criterion 4), Hospital D's readiness is still very minimal, namely 50%.

The results of the analysis from the four hospitals based on the most prepared criteria showed that criterion 3 had a percentage of 87% and the least prepared criterion was criterion 4 with a percentage of 55%. Criterion 3 explains the hospital's readiness in terms of room lighting with a standard of 250 lux for room lighting and 50 lux for bed lighting. This is the best criteria because for lighting hospital rooms you can use natural lighting (sunlight) and artificial lighting (incandescent lamps), with lighting from these two sources the light intensity can adjust to the KRIS standard, namely 250 lux for lighting and 50 lux for sleeping and controlled by a switch located in each inpatient room. Meanwhile, the criteria that are not ready is the 4th criterion, which is related to the completeness of the bed. There are several things that underlie this criterion to be the lowest level of readiness, because these four hospitals still do not have complete equipment such as nurse call which is connected to the nurse's room (nurse station) and a semi-electric bed that can make it easier for patients if they need help from medical personnel. Semi-electric beds have not been fulfilled because most of the beds in hospitals are old types of beds (non-electric), so hospitals need to replace existing bed types.

In the KRIS program, the emphasis on space is the main thing, where there will only be one type of tariff with the facilities and services obtained being the same as the applicable standards based on KDM (Basic Human Needs). So, in this literature review, an assessment of the rooms of each hospital studied was also carried out. Hospital A is able to fill isolation rooms, namely 10% of the total number of beds in only 36% of hospitals. Most of the others are in progress. There are several obstacles faced, most of which are limited existing space and the level of availability of isolation rooms that meet standards. Hospital A is still experiencing problems in the process of preparing intensive

beds, which is 10% of the total beds available in the hospital. Only 23% of hospitals in Tangerang City can fill 10% of the total intensive beds. Apart from that, there are still obstacles in terms of costs, such as providing ventilators and monitoring equipment which is quite expensive. The support expected from the hospital is tax relief from the government in terms of procuring expensive medical equipment such as ventilators.

At Hospital B, based on the results of interviews and observations, it was found that the readiness of the inpatient room was quite good. However, several requirements criteria do not meet the standards, such as minimal movement space and impassable for wheelchair users. Hospital C, in terms of rooms, has 298 beds with various class groups based on gender, age, types of infectious, non-infectious and maternity diseases. Then the bathroom in the treatment room does not meet the technical standards for the readiness of KRIS Hospital facilities and infrastructure. The result is that only 10% of bathrooms are equipped with grab rails and 8% are nurse calls which are connected to the inpatient room, and the bathroom in the inpatient room does not have a symbol “disable” on the outside of the door (0%). Hospital D has 205 beds, in one room there are 4 beds. However, some rooms still contain 5-6 beds, such as the rooms in the Covid ward. To be able to implement KRIS, it is necessary to expand the land so that one room only contains 4 beds.

4.2.1. Resource Readiness

Implementation of the KRIS policy cannot be separated from the important role of resources. Human resources—the provision of medical personnel such as specialist doctors and nurses who are competent in their fields—is one of the resources mentioned in policy PP no. 47 of 2021, which includes all resources used to support the success of the policy, including human resources, facilities and infrastructure, funds and time. Minister of Health Regulation No. 14 of 2021 stipulates that hospitals must have permanent workforce resources who work full time at least 80% of the entire workforce. Hospital A is still having difficulty fulfilling these provisions. In terms of quantity, the number of specialist doctors is sufficient, but in terms of quality they cannot practice for 8 hours in the hospital. Apart from that, it is difficult to obtain ICU nurses who have an ICU certificate because they are limited in carrying out training at educational centers.

At Hospital B, everything is quite good, but there are still many shortcomings in implementing KRIS regulations with doctors and pharmacies when providing drug services. Human resources and financial resources are the most important aspects in achieving successful implementation of the KRIS policy at Hospital C. This is supported by research by Kurniawan & Maani in 2019 that utilizing available human resources can be one of the steps to successful implementation of a policy. Hospital C has around 56 doctors divided into 23 polyclinics.

Human resources at Hospital D are sufficient with a total of 13 General Practitioners, 43 Specialist Doctors, 32 Midwives, 78 nurses, 50 other health workers and 145 non-health workers. Apart from that, the structural and functional officials at Hospital D are people who are competent in their fields. However, there are several hospital employees who still do not understand the KRIS policy. So, the number of human resources at Hospital D is sufficient, but education regarding KRIS is needed evenly for employees.

In the journal which discusses Hospital A in implementing KRIS, the hospital will make adjustments to KRIS by maintaining the current class types in the hospital, the hospital management room will be changed to an inpatient room due to adjusting the previous room density level. However, non-government hospitals will have difficulty meeting full-time staff, 80% of each medical staff, especially specialist doctors, will be difficult for hospitals to meet. In non-government hospitals, some have collaborated with several medical educational institutions to create specialist doctors who can serve and work in these hospitals and become full-time staff by being compensated with reimbursement of education costs and sufficient wages as well as by providing scholarship programs to general practitioners. To become a specialist doctor so that he can meet the hospital's resource needs.

4.2.2. Social Environment

Failure to implement policies can be caused by an unsupportive social environment. In order to launch the KRIS program, outreach is needed from related parties such as the Ministry of Health, DJSN, PERSI and BPJS Health through webinars. In this case, Hospital A held outreach to employees to gain a clear understanding of the standardization and requirements for KRIS, isolation rooms and intensive rooms. In Hospital A, SOP implementation is carried out in each room and covers all service areas up to hospital management. Because there are some employees who do not comply with the SOP properly, hospitals need to provide innovation to ensure that all employees comply with the SOP.

In contrast to Hospital B, there has not been much outreach regarding the KRIS program to employees so they still have to wait for BPJS to provide an explanation regarding the determination and determination of KRIS. This is also influenced by uncertain government regulations.

Apart from that, socialization was carried out at Hospital D by the Ministry of Health, DJSN, and Persi to the Head of the Hospital during the Technical Work Meeting in Surabaya and Zoom Meeting regarding the implementation of KRIS has not yet been distributed evenly to all parties involved. Hospital leaders do not hold meetings or meetings with hospital management, all specialist doctors, general practitioners, nurses, and everyone related to the hospital and patients. Socialization to patients was carried out by BPJS and the City Health Service where Hospital D is located. Likewise, socialization at Hospital C has not been conveyed thoroughly to everyone stakeholder, that is only around 10% of hospital employees are new to this regulation. Apart from that, BPJS has not carried out outreach to all hospital employees.

5. CONCLUSION

Based on the analysis that has been carried out, the average readiness of hospitals in facing KRIS is 73%, with the best readiness being in criterion 3, namely regarding room lighting, at 87%. Criterion 3 is the criterion with the highest readiness because it is easy to fulfill, lighting can use sunlight for natural lighting and artificial lighting in the form of incandescent lamps. Meanwhile, the criterion with the lowest readiness is criterion 4 regarding the completeness of beds at 55%. This criterion is still the criterion with the lowest readiness because most hospitals do not yet have semi-electric beds and

other equipment such as nurse call. Hospitals that will implement the KRIS system need to prepare beds and inpatient rooms that meet standards. Apart from that, in order to implement the system KRIS If it is running well, there is a need for comprehensive outreach to every employee in the hospital.

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