

Review Of Electronic Medical Record Data Processing To Support Quality Reporting Activities At The Medical Records Installation Of Umar Wirahadikusumah Regional Hospital

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Abstract.

Electronic Medical Records play a vital role in providing accurate and complete data to support hospital quality reporting. However, incomplete medical record entries remain a barrier to producing optimal quality reports. This study aims to review the processing of Electronic Medical Record data to support quality reporting activities at the Medical Record Installation of Umar Wirahadikusumah Regional General Hospital. The study used a quantitative method with a descriptive approach. The study population consisted of 128 Electronic Medical Record data from inpatients for the period of December 2025, and the entire population was sampled using a total sampling technique. Data collection was carried out through observation, structured interviews, and a medical record completeness checklist. Data were analyzed descriptively. The results showed that Electronic Medical Record data processing had been carried out through the stages of sampling, data collection, data processing, and presentation of quality reports. The level of completeness of medical records reached 75% (96 files), while 25% (32 files) were still incomplete, especially in diagnosis, patient identity, service forms, and authentication. This study concludes that the Electronic Medical Record data processing process has supported quality reporting, however, increasing compliance in filling out medical records through continuous monitoring and evaluation is still needed to improve data quality and hospital quality reporting.

Keywords: *Electronic Medical Records, Health Information Management, Hospital Quality Reporting, Medical Record Completeness and Quality Improvement.*

I. INTRODUCTION

A hospital is a healthcare institution that provides comprehensive individual health care through inpatient, outpatient, and emergency services. The quality of care provided is a crucial factor in building trust and establishing a hospital's image in the public eye. The entire service process is supported by medical records, which serve as the primary document for documenting all examination results, procedures, diagnoses, and services received by patients during their treatment. Therefore, maintaining good medical records is an integral part of efforts to improve the quality of healthcare services in hospitals (Ministry of Health of the Republic of Indonesia, 2020).

Along with the development of information technology, medical record management has transformed from a manual system to an Electronic Medical Record (EMR) that can record, store, and manage patient health information digitally. The implementation of EMR plays a crucial role in maintaining the integrity, accuracy, and completeness of medical data, while simultaneously increasing the effectiveness and efficiency of health information management in hospitals (Effectiveness et al., 2025). In addition to accelerating access to patient data, EMR also supports data analysis, service evaluation, and clinical and managerial decision-making, thus contributing to improving the overall quality of hospital services (Nurmiana, 2025).

Maintaining high-quality medical records requires competent healthcare professionals, as the quality of medical record data is crucial to the success of hospital quality reporting. Quality reporting requires complete, accurate, and timely data, largely sourced from Electronic Medical Records. In this regard, the medical records unit plays a strategic role in managing and processing data to produce information that supports the preparation of quality reports. Medical records are considered high-quality if they meet the indicators of completeness, accuracy, timeliness, and legal requirements, thereby supporting improvements in the quality of healthcare services.

Despite the advancements in the implementation of Electronic Medical Records (EMR), issues related to the completeness of medical records remain a challenge in quality reporting. Completeness of medical

records is essential for describing a patient's medical history, examination results, diagnosis, and follow-up action plans. Incompleteness of medical records has the potential to hinder data processing and the preparation of quality reports. Previous research indicates that identification completeness reaches 100%, critical reports completeness is 62.96%, authentication completeness is 16.05%, and correct recording completeness is 72.84%. Quantitative analysis results show an average completeness of 84.13% with an incompleteness rate of 15%. The critical report or notes component has the highest completeness rate at 99.27%, while the good recording component has the lowest completeness rate at 52% (Sari et al., 2024). This condition was also found at Umar Wirahadikusumah Regional General Hospital, based on the results of a preliminary study, it was found that the indicator for the completeness of filling in inpatient medical records within 24 hours after service in 2025 had not reached the established standard of 100%.

Based on these conditions, this study aims to review the processing of Electronic Medical Record data to support quality reporting activities at the Medical Record Installation of Umar Wirahadikusumah Regional General Hospital through identifying the data processing process, the level of data completeness, factors causing incompleteness, and efforts that have been made to meet the indicators of completeness of medical records. This study is important because quality Electronic Medical Record data processing is the basis for producing accurate and timely quality reporting as part of improving the quality of hospital services. The novelty of this study lies in the focus of the study which reviews the processing of inpatient Electronic Medical Record data based on the aspect of data completeness in relation to the implementation of quality reporting activities at the Medical Record Installation of Umar Wirahadikusumah Regional General Hospital.

II. METHODOLOGY

This study employed a quantitative research method with a descriptive approach. Descriptive research is used to systematically describe research results to provide an overview, explanation, and validation of the phenomena being studied (Priadana & Sunarsi, 2021). A quantitative approach is used to examine a specific population or sample through data collection using research instruments, which are then analyzed statistically (Sugiyono, 2017). In this study, a descriptive quantitative method was used to describe the Electronic Medical Record data processing process and the level of completeness of inpatient medical records to support quality reporting activities at the Medical Records Installation of Umar Wirahadikusumah Regional Hospital.

The research instruments used included interview guidelines, a medical record completeness checklist based on quality indicators, stationery, and a calculator. The checklist was used to assess the completeness of each medical record component by classifying data into complete or incomplete categories, then calculating the percentage of completeness. Data collection was conducted through observation and interviews. Direct observations were made of the activities of the Quality Unit and Medical Record Report officers in the process of processing Electronic Medical Record data used as the basis for reporting quality indicators at the Medical Record Installation of Umar Wirahadikusumah Regional Hospital. Structured interviews were conducted with one Quality Unit and Medical Record Report officer who was directly involved in the process of processing and reporting quality indicators for medical record completeness and was willing to be a research respondent. The interviews focused on the stages of data processing, the process of verifying and validating data completeness, reporting quality indicators, obstacles encountered, and compliance with Standard Operating Procedures (Notoatmodjo, 2018). The data obtained were then analyzed descriptively to describe the Electronic Medical Record data processing process and the level of completeness of medical records filling based on quality indicators.

The research population is all Electronic Medical Record data used as a source for reporting the quality indicators of completeness of medical records of inpatients at the Medical Record Installation of Umar Wirahadikusumah Regional Hospital in December 2025, amounting to 128 medical record data (Sugiyono, 2017). The sampling technique used total sampling, namely all members of the population were used as research samples so that the total sample was 128 electronic medical record data (Sugiyono, 2017). The research sample met the inclusion criteria in the form of Electronic Medical Record data of inpatients for

the period of December 2025 with general patient financing status and BPJS, while the exclusion criteria were Electronic Medical Record data of inpatients outside the period of December 2025.

The research procedure began with sample determination based on predetermined criteria, followed by observations of the Electronic Medical Record data processing process at the Medical Record Installation and structured interviews with officers from the Quality Unit and Medical Record Reports. Furthermore, an assessment of the completeness of the Electronic Medical Record filling was carried out using a checklist sheet based on applicable quality indicators. The results of the observations, interviews, and completeness assessments were then processed and analyzed descriptively to provide an overview of the Electronic Medical Record data processing process, the level of data completeness, factors causing incompleteness, and efforts that have been made to support quality reporting activities at the Medical Record Installation of Umar Wirahadikusumah Regional Hospital.

III. RESULTS AND DISCUSSIONS

Electronic Medical Record Data Processing

Electronic medical record data processing at the Medical Records Unit of Umar Wirahadikusumah Regional Hospital has been carried out in accordance with applicable Standard Operating Procedures (SOPs). Data processing is carried out routinely every month in stages to support the hospital's quality reporting activities. This process includes data sampling, data collection, data processing, and presentation of quality report data output. This process is carried out by quality unit officers and medical record report officers.

1. Data Sampling

During sampling, medical records staff at Umar Wirahadikusumah Regional Hospital collected monthly data based on general and BPJS patients who received services at the hospital during a specific period. Sampling was conducted from inpatient data in accordance with the hospital's quality indicators used in quality reporting activities.

The sampling process is carried out after the patient has completed their treatment and the data has been stored in the hospital system. The medical records officer then selects the patient's medical record data to be sampled and then checks the completeness of the electronic medical record.

During the sampling process, medical records officers collect inpatient medical record data according to the hospital's quality indicators for the monthly reporting period. Sampling is conducted to facilitate the process of monitoring the completeness of electronic medical records and to determine whether they have been completed according to hospital standards. From the samples collected, medical records officers can identify any incomplete medical records or those that do not comply with hospital medical record requirements.

The results of this sampling are then used as the basis for data processing for hospital quality reporting activities. The sample data obtained will then undergo data collection, processing, verification, and validation before being presented in the form of a hospital quality report.

2. Data collection

Data collection is conducted monthly on inpatients who have completed treatment and have been designated as samples for hospital quality reporting activities. The data collected represents patients who have completed inpatient care and are stored in the hospital system.

At the data collection stage, medical records officers take several data components needed in hospital quality reporting activities, including: No. rm, Patient identity, Date of admission/discharge, Time, Anamnesis results

, Results of physical examination and medical support, Diagnosis, Action, Clinical observation notes and action results, Discharge summary, Medication given on discharge, Doctor's name, Doctor's signature.

The medical records officer then records and summarizes the necessary data according to the hospital's quality indicators used in quality reporting. During this process, the medical records officer not only collects patient data but also conducts an initial check for completeness and/or incompleteness of the medical record.

This check is conducted to determine whether all components of the medical record have been completed by the healthcare professional providing care to the patient.

After all the data is collected, the medical records officer summarizes the data according to the hospital's quality indicator format. The data is then grouped by service type and the level of completeness or incompleteness of the medical records. This recapitulation aims to simplify the data processing process and assess the level of completeness and incompleteness.

3. Data processing

Data processing is carried out by medical records staff to obtain valid, complete, and usable data to support hospital quality reporting activities. Data processing is performed monthly on inpatient data sampled during a specific reporting period.

At this stage, officers group, check, calculate, and summarize data based on quality indicators determined by the hospital.

The data processing process is carried out systematically through several stages as follows:

A. Grouping data based on type of patient service

The collected data is grouped based on the service categories the patient received, such as inpatient care. This grouping aims to simplify the analysis process and ensure that each quality indicator is calculated according to the defined scope of services.

B. Checking the completeness of patient data entry

Regarding the completeness of filling out medical record documents, an examination is carried out on the components that are the assessment indicators, including rm No., Date of admission/discharge, Time, Anamnesis results, Results of physical examination and medical support, Diagnosis, Action, Clinical observation notes and action results, Discharge summary, Medication given at discharge, Doctor's name, Doctor's signature, and other supporting forms. This stage aims to determine the conformity of data filling with standard operating procedures (SOP) and hospital quality provisions.

C. Counting the number of complete and incomplete medical records

The reviewed data was then calculated to determine the number of medical records that met the complete and incomplete criteria. The results of this calculation were used as a basis for determining the completeness of medical records and as a basis for evaluating the quality of medical record completion.

D. Recapitulation of data processing results

After the calculations are completed, the staff compiles the results into a summary format provided by the hospital. This summary includes the total number of samples, the number of complete and incomplete medical records, and the percentage of completeness according to applicable quality indicators.

E. Inputting the recapitulation results into the hospital quality report

The final stage of data processing involves entering the summary results into the hospital's quality reporting system or format. This data is then used to monitor and evaluate the achievement of quality indicators and as a basis for decision-making to improve service quality.

During the data processing process, medical records officers found several incomplete electronic medical records. These included incomplete patient diagnoses, incomplete patient identification, and incomplete service forms completed by healthcare workers. This situation prevented the data from being used directly in the quality reporting process, as it could potentially impact the validity of the results.

For incomplete data, medical records officers record and identify incomplete medical records on a medical record monitoring form, which then requires follow-up with the relevant service unit. Follow-up involves confirming and returning the medical records to the responsible officer or unit for data correction. After corrections are made, the medical records are reviewed again before being included in the hospital's quality report summary.

This data processing process aims to produce accurate information, improve the quality of electronic medical record data, and support the implementation of hospital quality reporting effectively and in accordance with applicable standards.

4. Presentation of Quality Report Data Output

After all data processing stages are complete, the next step is to present the output data in the form of a hospital quality report. Presenting the output is the final stage in the electronic medical record data management process, which aims to produce structured, accurate information that can be used as a basis for evaluating the quality of healthcare services in the hospital.

Data that has been declared appropriate and meets completeness standards is then processed into a report output presented in a format specified by the hospital. This output presentation ensures that the resulting information is easy to understand, analyze, and can be used by management in decision-making.

The quality report output is compiled in several forms, namely:

A. Summary table of data processing results

The data that has undergone the review process is presented in a summary table containing the total number of medical records analyzed, the number of complete medical records, the number of incomplete medical records, and the calculation results according to the quality indicators used. The tabular presentation aims to facilitate the identification of quality outcomes and the distribution of data by service category.

B. Percentage of completeness of electronic medical records

In addition to tabular form, the processing results are also presented as percentages to illustrate the level of completeness of electronic medical records. Percentages are obtained by comparing the number of medical records meeting the completeness and incompleteness criteria to the total number of medical records reviewed. Presenting percentages allows hospitals to more objectively and measurably assess the level of achievement of quality indicators.

The Medical Records Department prepares these quality reports monthly and then submits them to hospital management or the quality committee for monitoring and evaluation. Submission of these reports allows management to assess the level of achievement of quality indicators and identify areas requiring improvement.

Based on the quality report output, hospitals can obtain information about the state of electronic medical records management. This information is used as a basis for evaluating and planning service quality improvements.

Specifically, the quality report output is used to:

A. Knowing the level of completeness of electronic medical records

The report output provides an overview of the number and percentage of medical records that have been filled in completely and those that have not yet met the filling standards so that the level of compliance with filling in medical record documents can be determined.

B. Identifying obstacles in processing electronic medical record data

Through the report results, it can be identified that obstacles are still found during the data management process, such as late input, incomplete diagnoses, incomplete patient identities, and service forms that have not been filled out optimally.

C. Become evaluation material for service units

The data generated is used by the relevant service unit to evaluate the process of recording and filling in electronic medical records so that improvements can be made in the next reporting period.

D. Supporting the improvement of the quality of hospital services

Information obtained from quality reports forms the basis for developing improvement strategies, increasing compliance with medical record filling, and strengthening coordination between units to produce more effective and high-quality health services.

With the presentation of data output that is carried out systematically and continuously, the results of electronic medical record processing not only function as an administrative complement, but also become an important source of information in supporting the implementation of quality reporting and efforts to improve the quality of service in hospitals.

Level of completeness of medical record data

The level of completeness of medical record data is one of the indicators used to assess the quality of healthcare documentation and support quality reporting activities. Completeness assessment is carried out on inpatient medical records which include components of patient identity, examination results, and treatment given during the treatment period. The results of the percentage of completeness of the contents of inpatient medical records based on the medical record completeness checklist for the period of December 2025 at Umar Wirahadikusumah Regional General Hospital with a sample of 128 inpatient medical records, obtained are as follows:

Table 1. Level of Completeness of Inpatient Medical Records at Umar Wirahadikusumah Regional Hospital

No	Completeness of Filling	Frequency (f)	Percentage (%)
1	Complete	96	75%
2	Incomplete	32	25%
	Total	128	100

Based on the table above, the research results obtained regarding the completeness of medical records, with 96 complete records, representing 75% of the total. Meanwhile, 32 incomplete records, representing 25%.

Incompleteness Factor

Factors contributing to incomplete medical record data originate from the Professional Care Provider (PPA). PPA are healthcare workers responsible for providing services to patients and documenting the services rendered in the medical record.

Incomplete medical record data caused by PPA occurs because some forms or medical record items that are the responsibility of healthcare workers have not been completed. These incompleteness can be found in patient assessments, diagnoses, integrated patient progress notes (CPPT), medical orders, nursing care forms, and authentication such as the signatures of staff providing services.

Based on observations and interviews conducted at the medical records department of Umar Wirahadikusumah Regional Hospital, it was found that patient care was provided by the Care Providers (PPA) in accordance with their duties and responsibilities. However, some services were still incompletely recorded in the medical records. This was indicated by the incompleteness of the medical record data during examination by the medical records staff. This situation resulted in incomplete information in the medical records, which could impact the quality of data used for services, reporting, evaluation, and measurement of hospital quality indicators.

Efforts Made by the Medical Records Installation to Complete Medical Records Filling in According to Indicators

Based on the results of research at the Medical Records Installation of Umar Wirahadikusumah Regional Hospital, it is known that efforts have been made to improve the completeness of filling in medical records according to hospital quality indicators, namely through Monitoring and Evaluation (Monev) activities for compliance with filling in complete medical records which are carried out every month.

This monitoring and evaluation activity is a form of medical record quality control, aimed at ensuring that all data and medical record forms are completed completely, accurately, and in accordance with hospital standards. Through this activity, the Medical Records Department can assess the level of compliance of Care Provider Professionals (PPA) with medical record completion and identify any areas that are incomplete.

Monitoring is carried out by examining samples of medical records that have been completed for use in patient care. Medical records officers assess the completeness of various components of the medical record, including patient identity, examination results, diagnoses, medical procedures, signatures and full names of healthcare professionals, and other elements that serve as indicators of completeness. The results of these inspections are then summarized to determine the level of compliance with completeness of medical records in each service unit.

The monitoring results are then discussed in a routine monthly evaluation. During the evaluation, medical records officers report the achievement of medical record completeness indicators to the relevant units and identify frequently missing items. Evaluation results can reveal the level of achievement of medical record quality indicators and the factors contributing to incomplete medical record entries.

Information obtained from monitoring and evaluation is then used to improve and take follow-up actions to enhance the quality of medical record completion in subsequent periods. In addition to serving as a means of quality control, monitoring and evaluation activities also serve as a training tool for healthcare workers, helping them better understand the importance of completing medical records completely, accurately, and timely, in accordance with applicable regulations.

Continuous monitoring and evaluation is expected to improve healthcare workers' compliance with medical record completion. This will result in more comprehensive and high-quality medical record data, which can support patient care needs, hospital quality reporting, accreditation processes, and management evaluation and decision-making.

IV. DISCUSSION

Based on research conducted at Umar Wirahadikusumah Regional General Hospital, it was discovered that the hospital has a comprehensive organizational structure and adequate service facilities. The Medical Records Department, a crucial component in supporting smooth service delivery, plays a strategic role in managing patient data and medical documents.

Based on the analysis results, electronic medical record data processing has been conducted routinely every month to support hospital quality reporting activities. Data processing involves sampling, data collection, data processing, and presentation of quality report output. Each stage plays a critical role in producing valid and accurate data as a basis for assessing hospital quality indicators.

During the sampling phase, medical records officers collect data from inpatients who have completed their treatment based on the hospital's quality indicators. Sampling facilitates the process of monitoring the completeness of electronic medical records. This activity allows officers to identify incomplete medical records early on, allowing for follow-up action before the data is used in quality reporting. This demonstrates that the sampling process serves not only as data collection but also as an initial step in medical record quality control.

Next, during the data collection phase, medical records officers collect various components that serve as indicators for assessing hospital quality, including medical record numbers, patient identification, admission and discharge dates, history taking results, physical and supporting examination results, diagnoses, procedures, clinical observation notes, discharge summaries, medications administered upon discharge, physician names, and signatures. The completeness of these components is crucial because all of this data serves as the primary source of information in reporting hospital quality. If any component is missing, the resulting information will be incomplete and can affect the accuracy of the reporting results.

During the data processing phase, medical records officers check the completeness of all medical record items, which serve as indicators of hospital quality. The study found several incomplete electronic medical records, including patient diagnoses that had not been entered, incomplete patient identities, and service forms that had not been completed by healthcare workers. This situation indicates that even though the hospital has implemented electronic medical records, the quality of the resulting data still depends heavily on healthcare workers' compliance in documenting patient care. Incomplete data requires medical records officers to identify the data, record it on an incompleteness monitoring form, and confirm it with the relevant unit before the data can be used in quality reporting.

The results of data processing on the completeness of filling in medical records indicate that of 128 inpatient medical records, 96 medical records (75%) were categorized as complete and 32 medical records (25%) were declared incomplete. The completeness percentage of 75% indicates that most health workers have completed medical records according to the standards set by the hospital. However, the remaining 25% of incomplete medical records indicate that the level of compliance with filling in medical records is not optimal. This result was obtained from observations using a checklist for the completeness of filling in inpatient

medical records with information 0 (incomplete) and 1 (complete). The results of the study on the completeness of filling in medical records indicate that some medical records are categorized as complete, and there are several medical records that do not meet completeness standards. This condition can affect the quality of information used in patient care, quality reporting, service evaluation, and hospital management decision-making.

In line with Widjaja's theory, (2018) medical records must be made as complete as possible by doctors or authorized health workers to view records of the patient's medical history from beginning to end continuously and this information must be in accordance with existing procedures.

The primary factor contributing to incomplete medical record data stems from the Professional Care Provider (PPA). Although patient care has been carried out in accordance with their respective duties and responsibilities, several components of the medical record are still found to be incomplete, such as patient assessments, diagnoses, Integrated Patient Progress Notes (CPPT), medical instructions, nursing care forms, and authentication in the form of the name and signature of the healthcare professional. This finding indicates that the problem lies not in the patient care process, but rather in incomplete documentation of services. Medical records are written evidence of all services provided to patients. If documentation is incomplete, patient care information will be incomplete and potentially reduce the quality of data used in hospital quality reporting.

Incomplete diagnoses, patient identification, and service forms found during the study also have the potential to impact the validity of hospital quality indicators. Uninputted diagnoses can lead to errors in case classification and disease reporting. Incomplete patient identification can pose a risk of misidentification, while incomplete service forms can result in poorly documented service information. Therefore, complete medical records are a crucial aspect in supporting service quality and patient safety.

To address this issue, the Medical Records Department at Umar Wirahadikusumah Regional Hospital has implemented a monitoring and evaluation (Monev) process for compliance with medical record completion. The monitoring process involves examining samples of completed medical records used in patient care. The review focuses on components that serve as indicators of completeness, such as patient identity, examination results, diagnosis, medical procedures, healthcare provider names, and staff signatures. The monitoring results are then summarized to determine the level of compliance with medical record completion in each service unit.

The monitoring results are then discussed in a monthly evaluation involving relevant units. Through this evaluation, medical records officers can identify the most frequently missing items and identify factors contributing to incomplete medical records. The information obtained is then used as a basis for further improvements in the following period. This monitoring and evaluation activity is crucial because it not only serves as quality control for medical records but also serves as a means of coaching healthcare workers to be more compliant in documenting services according to hospital standards.

Thus, the study results indicate that the electronic medical record data processing process at the Medical Records Installation of Umar Wirahadikusumah Regional Hospital has been carried out systematically and has produced a hospital quality report. However, incomplete medical records were still found at 25%, largely due to suboptimal documentation by the PPA. Therefore, ongoing monitoring and evaluation need to be maintained and improved to improve compliance with the completeness of medical records, thereby ensuring the quality of electronic medical record data can support accurate, valid, and sustainable hospital quality reporting.

V. CONCLUSION

This study shows that the processing of Electronic Medical Records data at the Medical Records Installation of Umar Wirahadikusumah Regional General Hospital has been carried out systematically in accordance with Standard Operating Procedures (SOP) through the stages of sampling, data collection, data processing, and presentation of quality reports. The results of the study indicate that of the 128 inpatient medical records studied, 96 medical records (75%) have met the complete criteria, while 32 medical records (25%) are still incomplete. Incompleteness is mainly found in filling in diagnoses, patient identity, service

forms, and authentication which are the responsibility of the Professional Care Provider (PPA). To address this condition, the hospital has carried out routine monitoring and evaluation activities as an effort to improve compliance with filling in medical records and support accurate and continuous quality reporting.

This study still has limitations because it was only conducted in one hospital, used inpatient medical record data for the period December 2025, and focused on the completeness of medical record filling, so the results cannot reflect conditions in different periods or health care facilities. Future research is recommended to involve more hospitals, a longer observation period, and examine other factors that influence the quality of Electronic Medical Records. Practically, the results of this study can be used as evaluation material for hospital management in strengthening monitoring and evaluation, increasing Professional Care Provider compliance with the completeness of medical record documentation, and optimizing the quality of Electronic Medical Record data as a basis for quality reporting and improving the quality of health care.

REFERENCES

- [1]. Efektivitas, M., Di, K., Arif, R., Andriani, R., & Pertiwi, J. (2025). Analisis implementasi rekam medis elektronik terhadap kelengkapan dokumentasi rekam medis. *Jurnal ARSI: Administrasi Rumah Sakit Indonesia*, 11(3), 57–67.
- [2]. Kementerian Kesehatan Republik Indonesia. (2020). Peraturan Menteri Kesehatan Republik Indonesia Nomor 3 Tahun 2020 tentang klasifikasi dan perizinan rumah sakit. Kementerian Kesehatan Republik Indonesia.
- [3]. Notoatmodjo, S. (2018). Metodologi penelitian kesehatan. Rineka Cipta.
- [4]. Nurmiana, S. (2025). Volume 3 Nomor 2 2025. 3, 155–166.
- [5]. Priadana, M. S., & Sunarsi, D. (2021). Metode penelitian kuantitatif. Pascal Books.
- [6]. Sari, L., Erpidawati, E., & Adri, R. F. (2024). Kelengkapan indikator mutu rekam medis pasien rawat inap di Rumah Sakit Umum Daerah Arosuka Kabupaten Solok Tahun 2024. *MARAS: Jurnal Penelitian Multidisiplin*, 2(4), 1848–1854.
- [7]. Sugiyono. (2017). Metode penelitian kuantitatif, kualitatif, dan R&D. Alfabeta.
- [8]. Widjaja, L., Indawati, L., Rumana, N. A., & Muniroh. (2018). The Role of Leadership Improves the Doctor's Performance in Completing Medical Records. Proceedings of the International Conference on Health Informatics.