

Analysis Of The Completeness Of Filling In Inpatient Medical Records In Putri Hijau Hospitals Medan

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Abstract.

Basically the medical record is an important part of health care for patients in the hospital. Medical decisions taken by a doctor based on the diagnosis made will greatly affect the actions of patients in treatment. An accurate diagnosis is based on history, physical examination, supporting examination and written in the medical record file. The purpose of making a medical record to support the achievement of orderly administration in order to improve health services in the hospital. This study aims to analyze and determine the completeness of filling inpatient medical record files at the General Hospital Putri Hijau Medan . This type of research is descriptive with an approach Qualitative using the in-depth interview method from statements to six informants consisting of one pulmonary specialists, one nurse, three hospital management, chief medical records officer. The results of the study generally showed that from 40 medical record files by pulmonary specialists obtained the complete entry date (100%), the percentage of complete entry time (100%), the percentage of complete anamnesis recording (80%) completed by the doctor, complete physical examination (55%), complete diagnosis as much as (95%), treatment and complete action as much as (100%), consent and complete action as much as (100%), clinical observations as complete as much as (67.5%), the return summary is completely filled (50%), and the doctor's name and signature are completely filled (90%). The incompleteness of filling medical records is due to doctors feeling the time is limited because of the large number of patients, lack of communication between doctors and nurses in completeness of completing record files, medical lack of monitoring conducted by the hospital. It is expected that doctors, nurses improve communication for the completeness of the medical record, the doctor as the person in charge of the medical record to be more concerned with completing the medical record. Hopefully the hospital management will be more assertive to provide sanctions to the doctor to be able to increase the completeness of the medical record and further enhance monitoring.

Keywords: *Analysis, completeness of filling medical record files*

I. INTRODUCTION

A hospital is a complete individual health service institution that provides inpatient, outpatient and emergency care (Permenkes RI No. 3/MENKES/PER/2020). One of the parameters to determine the quality of health services in hospitals is data or information from good and complete medical records. Medical records are a very important tool in a health service because medical records function as a source of information and reference both regarding social data, medical data, to all treatment actions given to patients. Therefore, medical record files must be stored for a certain period of time. The medical record system that runs at Putri Hijau Hospital is already

computerized. The patient's medical record data is stored in a database that can be accessed from the registration area and each room. In the system that runs at Putri Hijau Hospital, there are several weaknesses, namely in the incomplete medical record data input process such as data on drugs that have been consumed by the patient, digital data such as ultrasound and X-rays that cannot be entered into the patient's medical record. The completeness of this data is very supportive of proper treatment of patients and affects hospital accreditation. Based on previous research by Simanjuntak & Napitupulu in his research entitled Analysis of Incomplete Medical Record Documents According to MKI Hospital Accreditation Standards 19.1 KARS Version 2012 At Imelda Hospital for Indonesian Workers (RSU IPI)

Medan in 2018 from the number of files carried out in the month June 2018 the number of population in the study, namely 81 medical record files of patients returning home with 66.67% completeness in the examination document form and 69.14% incompleteness in patient identification, while the incomplete medical record documents were caused by medical record officers and room nurses who were still less effective in monitoring nurses and doctors still often forget to fill out complete medical record files and the busyness of doctors and nurses in dealing with patients (Simanjuntak & Napitupulu, 2019). Based on the results of preliminary research conducted by conducting interviews with the head of the medical record, the researchers found that the coordination between the inpatient room staff and the medical record officer was still not going well. According to him, the patient's medical record data is often incomplete, so it needs to be corrected or re-examined. In addition, an initial interview with one of the head of the adult care room stated that decision making in the room was often sudden or without planning. In addition, programs are made more often based on existing programs.

II. METHODS

This type of research is a descriptive study with a qualitative approach which aims to find out clearly and more deeply about the analysis of the completeness of filling out medical record files at the Putri Hijau Hospital in Medan. The research was conducted at the Putri Hijau Hospital in Medan which is located on Jl. Green Princess No. 17, Kesawan, Medan City. The study was conducted to analyze the completeness of filling out the hospital's medical record file whether it was in accordance with the established standards. The time of the research was carried out in April – May 2022. The selection of research informants was carried out by purposive sampling, namely taking samples based on certain considerations from researchers with the following criteria: Research subjects have roles related to research objectives. Research subjects have time to participate in a series of research activities.

Research subjects can provide as much information as possible according to research needs. The completeness of the medical record is a summary of the entire

period of care and treatment carried out by doctors to patients. completeness of medical records is a reflection of the quality of medical records and services provided by the hospital. Communication between nurses and doctors, doctor's workload, monitoring of doctors affect the completeness of medical records. The data collection method used in-depth interview techniques that were guided by interview guidelines that had been prepared in advance to complete the results of in-depth interviews, and the researchers also collected research documents such as completeness of medical records, hospital profiles, and regulations.

Qualitative data analysis consists of three streams of activities that occur simultaneously that is:

1. Data reduction.

Data reduction is a form of data analysis that summarizes, selects the main things, focuses on the important things, and looks for themes and patterns. Then the data that has been reduced will provide a clearer picture and make it easier for researchers to carry out further data and look for it when needed.

2. Data presentation

After the reduction, the next step is data presentation. Data presentation can be done in the form of brief descriptions, tables, charts, relationships between categories, flowcharts and the like. Presentation of data in qualitative research often uses narrative text.

3. Drawing conclusions and verification

The third step in qualitative data analysis is drawing conclusions and verification. Conclusions in qualitative research are new findings that have never existed before. Findings can be in the form of a description or description of an object that was previously still dark, so that after research it becomes clear, so that it can be a causal or interactive relationship, hypothesis or theory (Sugiyono, 2010).

III. RESULT AND DISCUSSION

Completeness of filling in date and time

Based on the results of observations made at the Putri Hijau Hospital in Medan, it was known that the completeness of filling in the date and entering the medical record was completely filled with 40 medical record files completely filled (100%) and the doctor stated that the time and date were filled in by the nurse. Financing can be calculated by the date the patient is admitted to the inpatient department. In general, filling in the date and time is filled in by the officer at the place of registration or reception of inpatients. So, the writing of the time of entry must be clear. This is different from the results of research by Ridho, et al (2012) at the Teaching Dental and Oral Hospital, University of Muhammadiyah Yogyakarta. The incompleteness of filling in the date and time is 1.65%. This shows that in filling out medical records it is still incomplete but in this component the incompleteness is small.

Completeness of filling in the anamnesis of the disease.

From the results of interviews with doctors stating that this item is important, usually if the item is not filled in completely the nurse will remind the doctor who is in charge it can be concluded that the nurse has a role in the completeness of the item. Complete anamnesis were disciplined in filling them out and felt the importance of the anamnesis. However, from the results of interviews with other doctors regarding the incomplete results of filling in the anamnesis in the medical record, it was stated that the report was not clear because the patient was in a difficult situation to ask so that this made it difficult for doctors to fill out anamnesis items. and it is not possible to answer the question apart from that there are also doctors who fill out the medical record but it is not clearly filled in with this, which causes an incomplete history item to be available.

Based on the results of observations in recording patient anamnesis, it is known that the completeness of the anamnesis there are 32 medical record files with a percentage (80%) of 40 medical record files and the incomplete filling of medical record files is not entirely the doctor's fault because each doctor of course has differences in taking anamnesis according to the patient's disease and The patients faced by doctors are also different. According to the doctor's explanation regarding the incompleteness of filling out the medical record file, it is not entirely the doctor's fault because when the doctor examines the patient's history, it is difficult to do because the patient is mute and cannot answer the doctor's questions. And sometimes difficulties can also occur when dealing with patients who because of low intellectual ability cannot understand the doctor's questions or explanations. This is not much different from the results of research by Nurul Safitri (2016) at RSU Haji Medan where an incomplete history (63.8%) is due to the anamnesis not being recorded completely due to patient reports, families being less clear in providing information and Due to the patient's condition, it was impossible to ask questions.

Completeness of filling in the physical examination.

Based on the results of the interview, the doctor knows that there are still some physical examination items that are not filled out completely, because sometimes there are many doctors' patients, so doctors have limited time and prioritize only the important ones. Based on other informants, the completeness of filling in the physical examination items is also important to know the patient's physical condition because this can affect the patient's recovery, therefore realize the importance of the completeness of the physical examination items and if there are items that are incomplete it is due to lack of supervision, so many doctors are negligent in their work. that matter. Based on the results of observations in the recording section of the patient's physical examination, it is known that as many as 22 files with a percentage (55%) of the 40 complete medical record files of all items, it can be seen that the percentage of incompleteness of these items is higher, this should be paid more attention to by the

management in order to evaluate the completeness of the medical record because this item is also important. The results of this study are not much different from the research conducted by Ratmanasuci (2008) at the Semarang City Hospital where the incomplete medical records of inpatient physical examinations amounted to 60% due to limited time to examine patients so that this item was missed by doctors and when viewed from its usefulness. Completing this report is important because this report is necessary to determine the course of the disease and to determine further diagnoses.

Completeness about filling out the diagnosis

Based on the observations, it is known that in the recording section of the patient's diagnosis there are 38 medical record files with a percentage (95%) which are completely filled out of the 40 medical record files examined by the researchers are almost complete. in accordance with the terminology used. All diagnoses must be written correctly on the entry and exit sheets, but in reality there are still incomplete diagnoses. Based on the results of interviews with doctors, they stated that there were still incomplete diagnoses due to the large number of patients so doctors tried to provide fast service, and doctors were still waiting for the results of laboratory tests or X-rays to further confirm a more specific diagnosis. diagnostic items. Not much different from Meigian's (2013) research at Mulia Hati Hospital, Wonogiri, which also showed that there were 58% incomplete filling in the entry diagnosis and final diagnosis items. The incompleteness of the diagnostic items is not filled in, namely because there are many patients, APS patients (On Own Request), medical record files have been distributed to other sections, it takes a lot of time.

Completeness of filling out treatment/action records.

Based on the results of observations made, it is known that in the treatment/action recording section all specialist doctors with a percentage of completeness (100%) the percentage of completeness items is very good. Based on the results of interviews with all doctors regarding the completeness of filling out treatment/action items, doctors said they knew the benefits and uses of medication/action record items so that they made medication record items complete. Based on the Law on Medical Practice No. 29 of 2004 article 46 paragraph 1 states, every doctor or dentist in carrying out medical practice is obliged to make medical records so that in order to avoid or minimize the risk of malpractice claims for actions and providing medical therapy in the future by patients, doctors/health workers have prioritized recording records. medical evidence as complete and accurate written evidence.

Completeness of filling out informed consent/approval of action.

Based on the results of interviews that doctors obey and are responsible for inpatients. Because to carry out a treatment and action requires approval of action against inpatients from sick families. The doctor's knowledge of the approval of the action was good so that in accordance with the results of the observations, the

researchers found a high completeness rate. After interviewing the doctor or health worker regarding the complete filling of the consent column for action, the reason is that if there is no approval for action from the patient's family, then medical action cannot be carried out. In addition, doctors also already know the benefits of filling out an action agreement. According to the results of the interview, the informant filled out the agreement for this action so that there would be no future demands so that unwanted cases would not occur. If a doctor performs a medical action without the consent of the patient or his family, he may be subject to administrative sanctions in the form of revocation of his practice license. With the consent of the patient or his family, the patient or family already knows the risks that can arise from the medical actions taken and also the actions that are given legality.

Completeness of filling out clinical observation notes

Based on the results of interviews, the incompleteness in filling out medical records due to insufficient time to fill them out and the number of things that must be filled in, the lack of cooperation between nurses and doctors in completing clinical observation items and doctors being missed to fill them out. Therefore, it can be concluded that clinical observation items are in line with observations made by researchers on clinical observation items that have not been filled out completely. Based on the results of observations made, it is known that in the recording section of clinical observation notes 27 completely filled medical records from 40 medical records examined with a percentage (67.5%) of these items are also almost the same as physical examination items where these items have a sufficient number of incompleteness. high. Observation means observing with the aim of obtaining data about a problem so that an understanding is obtained, or as a means of rechecking or proving, the information/information obtained previously. Observation in clinical psychology aims to obtain data about clinical problems. The importance of filling out clinical observation records continuously so that doctors can determine whether the patient is really healthy or should be hospitalized until the patient's illness begins to improve.

Completeness of filling out a discharge summary/medical resume.

Based on the results of the interview, the incomplete completion of the discharge summary was because the patient who returned home when the doctor did not have a visit and was also not in the hospital. and the busyness of doctors who also work in private hospitals so that the medical record file is not filled out completely but there are still doctors who try to fill it completely because knowing the summary items for going home is also important. Based on the results of observations made, it is known that in the discharge summary recording section as many as 20 complete medical records with a percentage (50%) of 40 medical record files while the results of interviews asked to doctors about incomplete completion of inpatient discharge summaries, stated that the patient went home at the time of discharge. the doctor is not

there or goes home when the doctor doesn't visit the hospital the patient comes home that's where the weakness is and the doctor still thinks this item is not too important but the doctor is trying to fill in this item. According to the Ministry of Health of the Republic of Indonesia Year (2006), Summary of inpatient discharge, the summary can be written at the end of the progress notes or a separate sheet. The discharge summary should be brief and include only important information about the disease, examinations performed and treatment. This summary should be written as soon as the patient is discharged and answer all questions that address the services the patient received from admission to discharge. And the purpose of making this discharge summary is to ensure continuity of high quality medical services and useful reference materials for doctors who receive them, if the patient is re-treated to fulfill requests from official bodies or individuals.

Completeness of filling in the name and signature of the treating doctor on the inpatient medical record at the Putri Hijau Medan Hospital

Based on the results of the interview, the completeness of this item, the informant stated that the doctor only signed the name of the nurse who filled it in and there were also doctors who realized that the name and signature were important to know who the doctor was in charge and in accordance with the applicable SOP, but it might not be implemented because every doctor different and there is no strict sanction. Filling in the name and signature must be filled in according to the applicable SOP, the incomplete filling of the name and signature is due to the lack of implementation of the SOP and every doctor is different, there are those who obey it according to the SOP action and there are also no sanctions firm. Not different from the research by Meliala and Sunartini (2004) at IRNA II, RSUP Dr. Sardjito Yogyakarta, obtained 94.6% filling in the doctor's name and signature on the complete medical record. Even though there was an increase in the completeness of filling in the doctor's name and signature items before and after training for health workers, there were still items that were not filled out completely. This means that doctors still lack awareness to be able to complete this item.

Completeness related to interpersonal communication between doctors and nurses

It can be concluded that interpersonal communication between doctors and nurses has been categorized as good because it was explained during interviews with doctors and nurses that there was communication between nurses and doctors in reminding the medical record file if it was found to be incomplete, although it still did not have a big effect on doctors in reminding them because doctors always in a hurry so they don't have time to complete the medical record file that has been given by the nurse to the doctor and also because of each other's busyness. This can be related to the importance of Communication which is the process of delivering a message by one person to another to inform or change attitudes, opinions, or behavior either directly

orally, or indirectly through the media. Communication is needed to realize effective collaboration, This need to be supported by means of communication that can unify patient health data comprehensively so that it becomes a source of information for all team members in decision making (Rahaminta, 2012).

Completeness related to the limited time of doctors in filling out medical records for the number of patients

Based on the results of interviews, the number of patients affects the doctor's workload so that the doctor's time is limited because there are quite a lot of lung patients in the hospital and doctors also visit polyclinics and visiting hours outside the hospital so that the doctor's time is limited. Not different from the research of Ridho, et al. (2012) which states that the number of patients treated by doctors per day affects the time required to fill out medical records. The more the number of patients served by a doctor, of course, the more medical record sheets that must be filled in, so there is not enough time to complete everything, especially patients with many cases.

Completeness related to monitoring in the administration of medical records at the Putri Hijau Medan General Hospital

Based on the results of interviews, in organizing medical records, the hospital only asked the doctor to fill out the complete medical record of the patient. If an incomplete medical record is found, it is reported at a weekly meeting attended by all division heads and directors, after which the Head of the Medical Record Unit is asked to remind the doctor to immediately complete his medical record. Based on the research of Mawarni and Wulandari (2013) regarding the identification of incomplete medical records of inpatients at Muhammadiyah Lamongan Hospital, it shows that the cause of incomplete filling of medical records in the inpatient installation of Muhammadiyah Lamongan Hospital is the absence of monitoring so that the process of filling out complete medical records cannot be controlled. So far, Lamongan Muhammadiyah Hospital has not carried out the monitoring process for filling out medical records.

IV. CONCLUSION

The incomplete medical record files for the four lung specialist doctors still contained incomplete items, while the incomplete items were anamnesis, physical examination, diagnosis, clinical observation notes, discharge summary and doctor's name & signature. The completeness of the medical records of inpatients from four specialist doctors at the Putri Hijau Hospital in Medan was influenced by the doctor feeling that his time was limited, due to his busy schedule with the large number of patients. It is still not optimal communication between doctors and nurses properly in being responsible for the completeness of filling out medical record files. Hospitals do not carry out control or guidance and provide strict sanctions to doctors/health workers who are related and who do not fill out complete medical records.

V. ACKNOWLEDGMENTS

The authors are grateful to Mrs. Dr.dr. Sri Wahyuni Nasution, M.K.T. M.K.M as Examiner who has taken the time to test me. Secretary of the Master of Public Health Study Program at Universita Prima Indonesia Medan Mrs. dr. Sri Lestari Ramadhani Nasution, MKM as well as Advisor II who has provided direction and guidance in the preparation of the thesis. And thank to the Putri Hijau Hospital Medan that provide information.

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