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ANALYSIS OF COMPLETENESS OF CASE STUDY PATIENT MEDICAL RECORDS IN THE MEDICAL RECORD LABORATORY OF STIKES RS BAPTIS KEDIRI IN 2024

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ABSTRACT

Medical Record Laboratory is a practicum area engaged in the service area; therefore, it is mandatory to organize medical records to achieve good administration. Registration, data entry, processing and analysis and documentation, these are the processes of organizing medical records. Filling out medical records is said to be good if each item on the medical record sheet is filled with complete data. Complete medical records are a quality image of a hospital. The purpose of this study was to determine a general description of analysis completeness of case study medical records on patient identity, anamnesis, informed consent, medical resumes in patients at Medical Record Laboratory of STIKES RS Baptis Kediri in 2024. The type of research used was descriptive research. The sample in this study was a case study medical record file of 42 medical records. The instrument used was a checklist sheet. Data analysis used univariate analysis. The results of the study obtained a percentage of completeness for patient identity medical records of 97.6%, anamnesis of 95.2%, informed consent of 100%, medical resume of 100%. It was expected that medical records officers need to have awareness and discipline in completing medical records through good cooperation between nurses and the doctors concerned.

Keywords: Medical Record Files, Completeness, Laboratory

INTRODUCTION

Hospital is a health service institution that provides comprehensive individual health services that provide inpatient, outpatient, and emergency services. Every hospital has an obligation to organize medical records. Hospitals are influenced by the development of health science, technological advances, and the socio-economic life of the community which must continue to be able to improve services that are of higher quality and affordable to the community to achieve the highest level of health. (Mahendra, 2018).

Hospital Management is the coordination between various resources through the process of planning, organizing, and having control capabilities to achieve the goal of recording and reporting health services in improving quality in hospitals. (Izzaty et al., 2019).

In this era of globalization, hospitals must prepare themselves to be ready to compete with others. Technological developments have led to demands and demands for hospitals to provide fast and professional health services for medical information needs. Serving patients is a form of hospital service, therefore hospitals have an obligation to carry out medical records properly. (Putu & Widana, 2019).

The quality of the completeness of filling in the identity on the medical record sheet is very important to determine who the sheet belongs to. The patient's identity sheet can be a tool for specific patient identification. Each sheet of patient social data in the medical record file contains at least data in the form of a medical record number, registration number, patient name, gender, place and date of birth, religion, complete address, marital status, and patient occupation. (Swari et al., 2019) Incomplete information in filling out medical records can be a problem, because medical records can provide detailed information about what has happened to the patient while in the hospital. This also has an impact on the quality of medical records and the services provided to the hospital. (Putu & Widana, 2019).

The results of the study (Putu & Widana, 2019) obtained 95 inpatient medical record files. The percentage of completeness for patient identity medical records was 100%. On the patient identity sheet at Ganesha Hospital, it was recorded at 100%. The results of the study (Wiranata & Chotimah, 2021) showed that 34 medical records were filled in (85%) at RSGMP UMY.

The results of the study (Oktavia, 2020) showed that the lowest Informed Consent sheet filling was in the risk alternative and patient address, namely 25.4% and 32.8% respectively. The completeness of filling in the Informed Consent sheet for inpatients at the Dr. Reksodiwiryo Class III Hospital is still incomplete because the percentage of completeness of filling in the Informed Consent sheet was only 66.3%. This means that the completeness of filling in the Informed Consent sheet for medical records has not reached the minimum service standard for medical records in hospitals, which is 100%.

According to the Regulation of the Minister of Health Number 269 / MENKES / PER / III / 2008, the requirements for quality medical records are: related to the completeness of filling in medical records; accuracy; accuracy of medical records; timeliness; and fulfillment of legal aspect requirements. Meanwhile, if referring to the guidelines for minimum service standards (SPM) for hospitals, there are four quality target indicators, one of which is the timeliness of providing medical record documents (Ministry of Health of the Republic of Indonesia, 2008).

The implementation of inpatient medical records in hospitals must meet the expected Minimum Service Standards (SPM). The Minimum Service Standard for inpatient medical records is seen from the completeness of filling in medical records at least 1x24 hours after completion of service and the completeness of the informed consent is 100%, and the time for providing inpatient medical record documents is ≤15 minutes. (Mahendra, 2018).

Based on the research results (Swari et al., 2019) obtained data that the completeness of filling in medical records is seen from four aspects, namely Completeness Data with Patient Identity with the number of data filled in 86 medical record files and the number of files that are not filled in as many as 0 medical record files. Completeness Data Important Reports are filled in completely in 72 medical record files, while the remaining 14 medical record files are not filled in completely.

Medical Records

PERMENKES NO: 269/MENKES/PER/III/2008 defines medical records as files containing notes and documents including patient identity, examination results, treatment that has been given, and other actions and services that have been given to the patient. (Kholili, 2011). The purpose of medical records includes:1) Accurately and completely documenting the patient's life and health history including past and present illnesses, as well as their treatment with an emphasis on events that affect the patient during the episode of care; 2) Supporting the achievement of orderly administration in an effort to improve health services in hospitals; 3) Able to provide complete, accurate information and ready to be given when, where and to whom; 4) Providing maximum service to system users. (Mahendra, 2018).

The benefits of medical records based on Permenkes No.269/MENKES/PER/III/2008 concerning medical records are as follows: 1) Treatment medical records are useful as a basis and guide for planning and analyzing diseases and planning treatment, care and medical actions that must be given to patients; 2) Improving the quality of service by making medical records for the implementation of medical practice clearly and completely will improve the quality of service to protect medical personnel and to achieve optimal public health; 3) Education and research medical records which are information on the chronological development of diseases, medical services, treatment and medical actions, are useful as information material for the development of teaching and research in the fields of medical and dental professions. 4) Basis for financing Health medical records can be used as a guide and material for determining financing in health services at health facilities. These records can be used as evidence of financing patients; 5) Health statistics medical records can be used as health statistics material, especially to study the development of public health and to determine the number of sufferers of certain diseases. Proof of legal, disciplinary and ethical issues. Medical records are the main written evidence, so they are useful in resolving legal, disciplinary and ethical issues. (Mahendra, 2018).

Hospital medical records are an important component in the implementation of hospital management activities, hospital medical records must be able to present complete information about the medical and health service process in the hospital, both in the past, present and future estimates of what will happen. Filling in patient medical records by health workers who serve inpatients. The legal aspect of the Minister of Health's Regulation (Permenkes) on filling in medical records can provide legal sanctions for hospitals or health workers who neglect and make mistakes in filling in medical record sheets. (Nuraini, 2015).

Reorganizing medical records

1. Assembling

Reorganizing medical records according to their sequence and removing unnecessary medical record files. Incomplete medical records (no diagnosis and signature of the treating doctor or on-call doctor) then the medical records must be returned to the treatment room or to the ward, namely to the treating doctor no later than 1-3 days. The patient's medical record document after completing treatment is submitted to the assembling section within a maximum of 1x24 hours with the aim that the medical record can be examined for completeness of the data content of the medical record document. If

the medical record document is incomplete after the patient has completed the service or treatment with a time limit for completing the medical record document of 2x24 hours, it can be categorized as IMR (Incomplete Medical Record), while the medical record document that is incomplete after exceeding the completion period of each service unit with a time limit for completing the medical record document of more than 14 days, the medical record document is categorized as DMR (Delinquent Medical Record).

2. Coding

Coding is a medical record sheet that has been arranged in sequence, then giving a code to the medical record data according to ICD-10 according to the main diagnosis, additional diagnosis, complications, surgical procedures, causes of traffic accidents, and deaths of newborns.

3. Indexing

Indexing is making tabulations according to the codes that have been made into indexes (can be done with index cards or computerized). The index card must not include the patient's name. There are three indexes in the hospital, namely disease, surgery and death indexes. (Giyana, 2012).

Analysis of medical record content

1. Quantitative Analysis

Analysis aimed at the number of medical record sheets according to the length of treatment includes the completeness of medical, paramedic and supporting sheets according to established procedures. Officers will analyze each file received whether the medical record sheets that should be in a patient's medical record are there or not. Quantitative Analysis can be in the form of the percentage (%) of incomplete medical records (Incomplete Medical Record/IMR). Incomplete patient files from certain sheets should immediately contact the inpatient room staff where the patient is being treated. Quantitative Analysis Components, namely:

a) Correcting patient identification on each form
b) Checking each page of the medical record at least the name and medical record number
c) Presence of all required reports
d) There are certain reports that are generally found in the medical records of all facilities, such as medical history reports, physical examinations, progress notes and resumes.
e) Authentication required for all entries f. authentication can be in the form of a signature, stamp held only by the owner.

2. Qualitative Analysis

Examination of medical record entries to find inconsistencies and content that usually cause the record to be incomplete or inaccurate. Components of qualitative analysis, namely:

a) Complete and consistent recording of diagnostic statements made in almost all parts of the medical record, each indicating the level of understanding of the patient's medical condition at that time, for example at the time of admission (treated).
b) The conformity of one part to another and to the whole, for example the diagnostic statement, must be consistent from admission to discharge.
c) Description and justification of patient care in the hospital, medical records must describe and be the reason that justifies the direction of the patient's hospitalization. So medical records must document the results of diagnostic examinations, treatment, patient education and patient allocation in full.
d) Recording all things that are required for "informed consent". Information regarding the patient's consent to treatment must be written carefully. The doctor must record the information that has been given to the patient to provide consent or refusal of the actions that will be received by the patient.
e) Implementation of good documentation methods. Medical records should not have a "time gap" (the time gap between the action and the recording is too long) that cannot

be explained. Medical records must have legibility, namely legible writing, use of permanent ink, complete filling of forms and medical records should not contain derogatory or critical comments.

f) The potential for a "compensable event" Compensable events are conditions that are detrimental to patients and can force facilities or service providers to face criminal or civil lawsuits. (Mahendra, 2018).

RESEARCH METHOD

The type of research used was descriptive research. This study was to determine a general description of analysis completeness of case study medical records on patient identity, anamnesis, informed consent, medical resumes in patients at Medical Record Laboratory of STIKES RS Baptis Kediri in 2024. The sample in this study was a case study medical record file of 42 medical records using total sampling. The instrument used was a checklist sheet. Data analysis using univariate analysis.

RESEARCH RESULT

Characteristics Analysis of the completeness of medical record at Medical Record Laboratory of STIKES RS Baptis Kediri in 2024

From the research conducted by the researcher, the results of the study were obtained regarding the characteristics of respondents which can be seen in the following table:

Table 1. Frequency Distribution and Percentage Analysis of the completeness of medical record files at Medical Record Laboratory of STIKES RS Baptis Kediri in 2024.

No.	Characteristics	Frequency	Percentage (%)
1	**Patient Identity**		
	Complete	41	97.6
	Incomplete	1	2.4
	Total	42	100
2	**Anamnesis**		
	Complete	40	95.2
	Incomplete	2	4.8
	Total	42	100
3	**Informed consent**		
	Complete	42	100
	Incomplete	0	0
	Total	42	100
4	**Medical Resume**		
	Complete	42	100
	Incomplete	0	0
	Total	42	100

Based on table 1, it was obtained that the completeness of patient identity in medical records was generally (97.6%) complete, although 2.4% were found to be incomplete. The completeness of the anamnesis in medical was mostly 95.2% complete, although 4.8% were found to be incomplete, in contrast to the completeness of the informed consent in medical records, which was all 100% complete. The completeness of the medical resume in medical records was all 100% complete.

DISCUSSION

Analysis of the completeness of patient identity in the medical record files

The results of the study in table 1 showed that most of the patient's identities are in the complete category, namely 97.6% of medical record files and a small portion was still found to be incomplete (2.4%) of medical record files. The characteristics of patient identity in medical record files from all patients are in the patient's name file, patient introduction, medical record number, discharge diagnosis, and the name of the treating doctor. Meanwhile, the identities that are not filled in by all patients are the sub-district point, occupation and how the patient entered. The human factor is the registration officer causing the incomplete filling of the medical record file, namely the lack of awareness and discipline, the material factor causing the incomplete filling of the inpatient medical record file 24 hours after the completion of the service is the absence of recapitulation data for the incomplete filling of the inpatient medical record file in each inpatient room. This is slightly different from the research results. (Putu & Widana, 2019) obtained 95 inpatient medical files. The percentage of completeness for patient identity medical records is 100%. On the patient identity sheet at Ganesha Hospital, it is recorded that 100% is complete so that medical record officers in inputting, processing data and making reports in the form of health service activity information are on time.

Completeness of filling in the identity on the medical record sheet is very important for According to the Regulation of the Minister of Health Number 269 / MENKES / PER / III / 2008, the requirements for quality medical records are: related to the completeness of filling in medical records; accuracy; accuracy of medical record records; timeliness; and fulfillment of legal requirements. Meanwhile, if referring to the guidelines for minimum service standards (SPM) for hospitals, there are four quality target indicators, one of which is the timeliness of providing medical record documents (Ministry of Health of the Republic of Indonesia, 2008).

Analysis of the completeness of the anamnesis medical record files

The results of the study table 1 in general (95.2%) of the anamnesis sheets were complete and a small portion (4.8%) of the medical record files were incomplete. The characteristics of the anamnesis that are almost all filled in are the patient's name, anamnesis, history of previous illnesses, pain scale, physical examination of consciousness, physical examination of limbs, differential diagnosis, working diagnosis, treatment, plan, signature and name of the doctor, date and time. Meanwhile, the completeness of the anamnesis that is often not filled in is the history of allergies and history of drug use. This happens because the doctor in charge of the patient often has not completed the medical record form, so that incomplete medical records are returned to the nurse to be completed. This is in line with research (Wiranata & Chotimah, 2021) it was found that 34 medical records were filled in (85%). At RSGMP UMY, this happened because incomplete medical records were a problem, because medical records are sometimes the only records that can provide information about things related to patients and diseases as well as examinations and administration of drugs.

According to Redhono, et al. (2012) anamnesis is an interview activity between a patient/patient's family and a doctor or other authorized health worker to obtain information about complaints and medical history suffered by the patient. The purpose of the anamnesis activity is to obtain information about the problems experienced by the patient. If the anamnesis is carried out in detail, the information that is really needed in the health service will be obtained. Therefore, medical personnel or doctors treating patients must write a complete anamnesis to obtain accurate information in establishing a diagnosis.

Analysis of the completeness of the Informed Consent medical record

The results of the study in table 1 on the informed consent sheet were generally 100% complete. The characteristics of the informed consent are all filled in properly, including the patient's name, treatment consent action, date and signature of the patient/patient's family and the signature of the hospital. On the informed consent sheet. The completeness of the informed consent sheet can be used for various purposes. These needs include as evidence in legal cases, research and education materials and can be used as a tool for analysis and evaluation of the quality of services provided by the hospital. This informed consent will provide legal protection not only for patients but also protect health workers/doctors from disproportionate demands from the patient.

This is slightly different from the results of the study (Oktavia, 2020) Padang, the lowest filling of the Informed Consent sheet was in the risk alternative and patient address, namely 25.4% and 32.8% respectively. The completeness of the Informed Consent form for inpatients at the dr. Reksodiwiryo Class III Hospital is still incomplete because the percentage of completeness of the Informed Consent form was only 66.3%. This means that the completeness of the Informed Consent form for medical records has not reached the minimum service standard for medical records in hospitals, which is 100%. This is because 1. Medical record officers (Man) are still lacking in quantity, human resource/staff development in the form of training has never been carried out, and there is no reward and punishment system. 2. The SOP for organizing medical records is available at the medical record installation but has not been socialized to all medical record officers and existing medical personnel so that its implementation is not fully in accordance with the SOP. 3. Obstacles in the recording process often occur in forgetting to fill out the informed consent form. 4. Analysis of the contents of medical records in the implementation of the medical record service system at the dr. Reksodiwiryo Class III Hospital is not optimal. Based on Law of the Republic of Indonesia No. 29 of 2004 concerning medical practices as stated in Article 45 paragraph (1) states that "every medical or dental action to be performed by a doctor or dentist on a patient must obtain approval. According to Regulation of the Minister of Health of the Republic of Indonesia No. 585 of 1989, the parties who provide approval are: a) Adult patients who are conscious and mentally healthy; b) Parents or guardians for patients who are not yet adults; c) Guardians or curators for adult patients who are under guardianship; d) Parents or guardians or curators for adult patients who suffer from mental disorders; e) The closest family for patients who are not yet adults and do not have parents or guardians and or parents or guardians are unable to attend.

Analysis of medical resumes of medical record files

The results of the study table 1 most of the medical resume sheets were 100% complete. Characteristics of complete medical resumes from all files in the patient's name, medical history, main diagnosis and additional diagnosis and doctor's signature.

This is in line with the results of the study (Putu & Widana, 2019) obtained 95 inpatient medical record files. The percentage of completeness for medical record medical resumes is 100%. Because one of the purposes of medical records is the administrative aspect, which means that a medical record file concerns actions based on authority, responsibility as medical and paramedical personnel in achieving service goals.

Permenkes No.269/MENKES/PER/III/2008, a discharge summary (resume) must be made by a doctor or dentist who treats the patient. The contents of the discharge summary must at least include patient identity; admission diagnosis and indications for patient care; summary of physical and supporting examination results, final diagnosis, treatment and follow-up; and the name and signature of the doctor or dentist providing health services. The diagnosis contained in the medical record is filled completely and clearly in accordance with the directions in ICD-10.

CONCLUSION

Based on the results of the study on the analysis of the completeness of medical records at Medical Record Laboratory of STIKES RS Baptis Kediri in 2024. Based on the characteristics of the patient identity sheet (RM 1) the patient's identity category was complete, namely 97.6% of medical record files The complete category of all patients was mostly in the patient's name, patient introduction, medical record number, discharge diagnosis, and the name of the treating doctor, while the incomplete category of all patients is the work section and how the patient entered. Based on the characteristics of the anamnesis sheet, the complete category was 96.2% of medical record. The complete category of all files is in the point of patient name, anamnesis, previous medical history, pain scale, physical examination of consciousness, physical examination of limbs, differential diagnosis, work diagnosis, treatment, plan, signature and doctor's name, date and time. While the incomplete category of the entire file on the history of allergies and history of drug use. Based on the characteristics of the informed consent sheet complete category 100% of medical record files. Complete category of the entire file majority on the patient's name, treatment consent action, date and signature of the patient/patient's family and the signature of the hospital. Based on the characteristics of the medical resume sheet complete category 100% completeness of medical records characteristics of the medical resume complete category of the entire file majority on the point of the patient's name, history of the disease, main diagnosis and additional diagnosis and the doctor's signature.

RECOMMENDATIONS

It was expected that medical records officers need to have awareness and discipline in completing medical records through good cooperation between nurses and the doctors concerned.

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