

Analysis of Optimizing Achievement of Incompleteness Indicator of Manual Medical Record Files at the Gambiran Regional General Hospital, Kediri City

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ABSTRACT

The purpose of this research is to analyze optimizing achievement of incompleteness indicator of manual medical record files at the Gambiran Regional General Hospital, Kediri City. This type of research design is qualitative. The population in the study is 37 respondents. The sample collection technique is non-probability sampling. The non-probability sampling technique used is purposive sampling. The research sample used in this study is 15 respondents from medical records officers and head medical records triangulators. The focus of discussion in this research is influencer exposure, so data analysis techniques are carried out by means of data reduction, data presentation, and drawing conclusions. The results of the research show that the human resources at the Gambiran Regional General Hospital, Kediri City are sufficient in each unit. The availability of forms in the medical records section, doctors, and nurses at the Gambiran Regional General Hospital, Kediri City said that they are available. The Gambiran Regional General Hospital, Kediri City regarding standard operating procedure methods, medical record health workers said that the existing standard operating procedures are not clear. The head of medical records said that there are no sanctions given for making mistakes in filling out medical records.

Keywords: Optimizing Achievement, Incompleteness, Human Resources, Standard Operating Procedure

INTRODUCTION

A hospital is a health service institution that provides complete individual health services, providing inpatient, outpatient, and emergency services. Improving the quality of good health services is supported by maintaining good medical records for every health service in the hospital.

The maintenance of medical records begins when the patient is admitted to the hospital, followed by the recording the patient's medical data by a doctor dentist, or other health worker who provides direct health services to the patient. Whether a service is good or bad is described by whether or not the medical record files in a hospital are complete (Putri and Sonia, 2021).

Medical records in hospitals are divided into 2 types, namely outpatient medical records and inpatient medical records. Outpatient medical records are simpler than inpatient medical records. The contents of the inpatient medical record must at least include: patient identity, date and time, results of anamnesis, including at least complaints and history of illness, results of physical examination and medical support, diagnosis, management plan, treatment

and/or action, approval for action, if necessary, records of clinical observations and treatment results, discharge summaries, names and signatures of doctors, dentists or certain health workers who provide health services.

The inpatient unit (URI) is a part of clinical services that serves patients whose condition requires treatment for one day or more. The main task of URI is to record the results of all services provided to patients into the appropriate medical record form, which is then submitted to the medical records unit. Considering the importance of the use of medical record files and the impact of delays in returning medical record files, this will make the implementation of assembling officers difficult. Therefore, the patient's medical record files must be immediately returned to the medical records installation no later than 2x24 hours after the patient goes home completely and correctly.

Based on the results of a survey during residency, researchers found several problems related to the implementation of SIMRS in 2020 at the Gambiran Regional General Hospital, Kediri City, it is found that there is completeness in filling in manual medical record files 2x24 hours after inpatients went home, from the medical record files the denominator is 1,0429, only 52.92 percent achieved no in accordance with the target of 100 percent and there are still 6,183 numerator medical record files that are incomplete in terms of patient identity, date and time, results of anamnesis, complaints and history of illness, results of physical examination and medical support, diagnosis, management plan, treatment or action, the name and signature of the doctor, dentist or certain health worker who provides health services. The purpose of this research is to analyze optimizing achievement of incompleteness indicator of manual medical record files at the Gambiran Regional General Hospital, Kediri City.

LITERATURE REVIEW

Definition of Medical Record

Medical record has a very broad meaning, not just recording activities, but are understood as a system for administering medical record (Gunarti, 2019). Organizing medical record is an activity process that begins when the patient is received, the activity of recording patient medical data while the patient is receiving services, handling medical record files which includes storage, issuing files to serve requests for patient needs and other needs, as well as processing medical record for management purposes. and reporting.

Purpose of Medical Record

The purpose of medical record is to support the achievement of orderly administration in the context of efforts to improve health services (Notoatmodjo, 2018). Without the support of a good and correct medical record management system, it is impossible for orderly administration in health service settings to be successful as expected. Meanwhile, administrative order is one of the determining factors in health service efforts.

Uses of Medical Record

The general uses of medical record is as follows (Notoatmodjo, 2003):

1. As a communication tool between doctors and other experts who take part in providing services, treatment and care to patients.
2. As a basis for planning the treatment/care that must be given to the patient.
3. As a basis for calculating the cost of paying for patient medical services.
4. As useful material for analysis, research and evaluation of the quality of services provided to patients.
5. Protect the legal interests of patients, hospitals and doctors and other health workers.
6. As written proof of all service actions, disease development and treatment

during the patient's visit or treatment at the hospital.

7. Become a source of memories that must be documented as well as material for accountability and reports.
8. Provides special data that is very useful for research and educational purposes.

Medical Record Archiving System

There are two ways of managing storage in administering medical record, namely (Soekidjo, 2003):

1. Centralization means storing a patient's medical record in one unit, both outpatient and inpatient medical record.
2. Decentralization means storing medical record by separating outpatient and inpatient medical record.

RESEARCH METHODS

This type of research design is qualitative. Qualitative design is a research process to understand human or social phenomena by creating a comprehensive and complex picture that can be presented in words, reporting detailed views obtained from informant sources (Hidayat, 2007). The aim of qualitative research is to understand the conditions of a context by leading to a detailed and in-depth description of a portrait of conditions in a natural context, regarding what actually happens according to what is in the field of study (Arikunto, 2010).

The population in the study is 37 respondents. The sample is part of the population which is part or representative of the population studied (Notoatmodjo, 2005). The research sample is a portion of the population taken as a data source and can represent the entire population. The sample collection technique is non-probability sampling. The non-probability sampling technique used is purposive sampling. Purposive sampling technique is a sampling technique used by researchers if the researcher has certain considerations in taking samples or determining samples for certain purposes (Riyanto, 2009). The research sample used in this study is 15

respondents from medical records officers and head medical records triangulators.

Data analysis is the process of systematically searching and compiling data obtained from interviews, field notes, and documentation, by organizing the data into patterns, choosing what is important and what will be studied, and making conclusions so that it is easy for oneself and others to understand. other (Syahrums, 2012). The focus of discussion in this research is influencer exposure, so data analysis techniques are carried out by means of data reduction, data presentation, and drawing conclusions.

RESULT AND DISCUSSION

General Description

The Gambiran Regional General Hospital is one of the type B hospitals belonging to the Kediri City Regional Government which has the most complete diagnostic equipment facilities with sophisticated technology in Kediri City. The Gambiran Regional General Hospital was built in 1875 and operates on Jalan Captain Piere Tendean, Kediri City and uses SIMRS integrated with the medical records installation section.

The vision of the Gambiran Regional General Hospital, Kediri City is to be a quality, professional and competitive hospital in health services. Meanwhile, the mission of the Gambiran Regional General Hospital, Kediri City is:

- a. Providing satisfactory health services to all customers.
- b. Increasing the quantity, quality of human resources and standardized infrastructure.
- c. Making the hospital a referral center for health services for the Kediri area and surrounding areas.

RESULT AND DISCUSSION

Human resources are the utilization, development, assessment, provision of services, and management of individual members of an organization or group of workers. In this study, the human resources at the Gambiran Regional General Hospital,

Kediri City are sufficient in each unit. In this study, the interview results that are obtained are related to the importance of the medical record itself. Statements from the head of medical records and health workers in the medical records department said that the medical record itself is a lifeline for the patient which is very important, because the medical record is a record of the patient's own diagnosis, at any time the patient's diagnosis is wrong. Doctors, nurses, and other medical records personnel can double-check patient medical records that have been filled in previously. Medical records are records and documents regarding patient identity, examinations, treatment, actions, and other services that have been provided to patients. They are also very important in helping someone in certain conditions. Comprehensive information before carrying out clinical interventions can improve health service outcomes. Minister of Health of the Republic of Indonesia Number 268 of 2008, also said that medical records are files containing notes and documents regarding patient identity, examinations, treatment, procedures and other services that have been provided to patients. Human resources, which have the largest proportion of other health workers, of course have the responsibility to provide optimal and quality nursing services to patients on an ongoing basis. Therefore, the discipline of nursing staff needs to be considered to improve the quality of service. According to the head of medical records when interviewed, the informant said that when compared the discipline of nurses and doctors is quite different, doctors are still between 60 to 80 percent while nurses can be said to be 90 to 100 percent. This is because doctors are difficult to regulate because their union is strong.

Facilities and infrastructure are needed to support operational activities, such as the availability of forms in the medical records section. From the results of observations and interviews that have been conducted regarding the availability of forms in the medical records section, doctors, and nurses

at the Gambiran Regional General Hospital, Kediri City said that they are available, but sometimes the medical records section in the front room is sometimes slow so filling in is also late, but the head medical records say that forms are always available and are never missing when they are needed. The head of medical records also said that checking the filling in of medical records is always done before going home so that the data stored is not wrong. To achieve the goals specified in the medical record, a form is really needed. The form itself is a form and the form is an important tool for running an organization because it is useful for determining responsibility for activities that occur, recording service data to reduce the possibility of errors by stating all events in the form. written form and as a means of communication.

Completeness in filling out medical records is very important in order to produce quality medical records and have useful value for medical records, including as a means of communication, quality evaluation, payment, and legal protection. Incomplete medical records will affect the information submitted, and payment for health services that have been provided and cannot be used as evidence of legal protection if at any time needed. From the results of interviews conducted at the Gambiran Regional General Hospital, Kediri City regarding standard operating procedure methods, medical record health workers said that the existing standard operating procedures are not clear, and nurses said that they did not pay attention to standard operating procedures, they just worked as usual and then returned home and also said that standard operating procedures are in place and should have been carried out according to procedures. However, the head of medical records said that standard operating procedures had been posted in each room unit and are very clear. For further clarity, those of us who conducted the interviews are given time to double-check the truth. Standard operating procedures have not been implemented optimally, and there has

been no form of evaluation by doctors, nurses or midwives regarding the completeness of filling out medical record documents. Factors that cause incomplete filling in of patient medical record sheets include limited time for service providers when there are a lot of patients visiting, and a lack of awareness among service providers of the importance of completeness in filling outpatient medical record sheets. Checking the refill is always carried out before the patient goes home so that errors do not occur in the future.

In Law of the Republic of Indonesia Number 29 of 2004, it is explained that sanctions will be given if medical records are not completed. However, during an interview at Gambiran Regional General Hospital, Kediri City, the head of medical records said that there are no sanctions given for making mistakes in filling out medical records, this should be considered important and must be carried out so that incompleteness does not happen again.

CONCLUSION AND SUGGESTION

The results of the research show that the human resources at the Gambiran Regional General Hospital, Kediri City are sufficient in each unit. The availability of forms in the medical records section, doctors, and nurses at the Gambiran Regional General Hospital, Kediri City said that they are available. The Gambiran Regional General Hospital, Kediri City regarding standard operating procedure methods, medical record health workers said that the existing standard operating procedures are not clear. The head of medical records said that there are no sanctions given for making mistakes in filling out medical records.

Based on the research results, the suggestions are as follows:

1. For the Gambiran Regional General Hospital, Kediri City
 - a. Re-tighten the discipline of doctors and nurses.
 - b. Always provide information about filling out medical records.

- c. Implement or impose sanctions on health workers or doctors who do not fill in complete medical records.

2. For Health Workers

In this research, the advice for health workers at the Gambiran Regional General Hospital, Kediri City is to pay more attention to standard operating procedures and follow the socialization of filling out medical records, so that errors no longer occur.

3. For Further Researchers

This research certainly has limitations which are suggestions for future researchers, namely being able to analyze and dig up information from health workers regarding the completeness of medical record files.

Declaration by Authors

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