J-Kesmas: Jurnal Fakultas Kesehatan Masyarakat
(The Indonesian Journal of Public Health)
p-ISSN: 2355-0643, e-ISSN: 2355-0988
Vol. 11, No. 01, April, 2024
Available at http://jurnal.utu.ac.id/jkesmas Open Access RESEARCH ARTICLE

Analysis of Completeness of Medical Records in Inpatient Patients at Dr. Pirngadi Hospital, Medan City

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Submitted:21/11/2023 **Revised:** 14/01/2024 **Accepted:** 06/03/2024 **Published online**: 30/04/2024

doi: https://doi.org/10.35308/j-kesmas.v7i2.7249. **How to cite this article**: Harahap, R.A., Ramadhanty, R.W., Lubis, E.M., Nurzannah, M., Oktaviani, R & Tampubolon, J. (2023). Analysis of Completeness of Medical Records in Inpatient Patients at Dr. Pirngadi Hospital, Medan City. *J-Kesmas: Jurnal Fakultas Kesehatan Masyarakat (The Indonesian Journal of Public Health)*. 11 (1): 17-21.

Abstract

Recording of medical record files must meet the minimum standards of hospital services. The purpose of this study was to analyze the completeness of medical record documents for inpatients at RSUD DR. Pirngadi, Medan City. This study used a quantitative method with a descriptive approach, the data analysis used was a univariate test. Of the 540 medical record files, there were 131 incomplete medical record files which were used as the population and used a sample of 99 medical record files. The research was conducted on January 9-February 17, 2023. The results showed that of the 99 medical record files on the patient's medical resume items, the majority 75 (75.8%) were complete, the minority 24 (24.2%) were incomplete, assessment initial medical majority 88 (88.9%) complete files, minority 11 (11.1%) incomplete, majority nursing assessment complete 99 (100%), cppt majority 83 (83.8%) complete files, minority 16 (16.2%) were incomplete, the majority of hand over forms were 99 (100%) complete, the majority of medical cards were 87 (87.9%) complete, the minority were 12 (12.1%) incomplete and the majority of nutritional care forms are complete 99 (100%). Based on the results of the study, it can be concluded that the incomplete inpatient medical record files at RSUD Dr. Pirngadi Medan City were affected by PPA's lack of compliance and discipline in filling out medical record files. It is expected that all PPAs can write down all examination actions in the patient's medical record file completely.

Keywords: Files; Medical Records; Hospital; Patients

Introduction

A hospital is a top-level health service institution that organizes plenary individual health services which include promotive, preventive, curative, and rehabilitative services by providing inpatient, outpatient, and emergency services. Besides that Hospitals also function as providers of treatment and health recovery Implement hospital administration standards. For that, the hospital must be able to improve quality medical procedures that are affordable and accessible to all levels community to achieve the highest degree of health (PP RI No. 47 of 2021).

Medical records are written data that are processed as reports and are useful in other matters associated with ALFRED in each patient. Medical record is one indicator of hospital performance in terms of completeness and return of inpatient medical record archives to track medical (Muhammad, 2018). According to the Regulation of the Minister of Health 269/MENKES/PER/III/2008 requirements for quality medical records are: related to completeness of the field of medical records; accuracy; accuracy of medical records; punctuality; And fulfillment of legal aspect requirements. Meanwhile, if referring to the service standard guidelines (SPM) for a hospital, there are four indicators of quality objectives, one of which is the accuracy of the time for providing medical record documents (Ministry of Health RI, 2008).

Medical record documents are documents that show continuity of care or treatment during the patient's hospitalization up to outpatient care, as a document Shows communication between the doctor in charge of the patient and the consultant doctor or staff other health. Medical record documents also provide authority to medical personnel or health to perform medical action. Medical record documentation is done as a second activity after providing patient care, so that documentation must always be complete, exactly as needed or desired. To get complete information, precise, accurate, and reliable, it is necessary to complete the contents of the medical record file.

Completeness of medical record files greatly affects the quality of health services, the quality of statistical data on diseases and health problems, as well as in the process of paying for medical expenses using INA CBG's software.

Quality Completeness of identity filling on the medical record sheet is very important for determining whose it is. Patient identity sheets can be a tool for specific patient identification. Each patient's social data sheet in the medical record file at least contains data in the form of medical record number, registration number, patient name, type gender, place, and date of birth, religion, complete address, marital status, and occupation of the patient (Swari et al., 2019).

A medical record is a file that contains notes and documents about patient identity, examination, treatment, actions, and other services that have been given to patients. The medical record is called complete if the medical record contains everything information about the patient including medical resume, nursing, patient identity, anatomic pathology results, and all results of supporting examinations, and has been initialed by the doctor responsible, the maximum time to enter the medical record department for inpatients is 2x24 hours, with the standard for completing medical records (Permenkes No.269, 2008).

Analysis of the completeness of filling out medical record documents is very necessary, to find out how much the number of completeness of filling in medical record documents exceeds the time limit that has been given, given the importance of medical record documents to produce information continuously. Analysis of the completeness of filling out medical record documents is wrong one way to assess how the quality of service at the hospital is concerned. The higher the completeness number, the better the quality of service.

Based on research conducted by Nesri Helmi and Alfauzain (2022) there are still obstacles in the implementation of assembling, such as ward staff who have not filled out the medical record files completely, as a result, the files must be returned to the ward to be completed. This resulted in double jobs for assembling officers and there were still found returning inpatient medical records that did not comply with the SOP. Another problem is the lack of PPA (Professional Caregiving) responsibility in filling out the complete medical record file.

Based on the composition of the completeness of the patient status files at Pirngadi General Hospital, the medical record form consists of General Consent, Summary of patient entry and entry history, ER patient screening form, initial emergency patient assessment, evaluation and management, ER nursing assessment, screening patient nutrition, transfer of patients from the ER between rooms, evidence of explanation and education to patients and families, ER fall risk intervention assessment, DPJP, patient discharge planning, initial medical assessment of illness, educational forms for inpatient patients and families, integrated patient progress notes, discharge summaries, initial inpatient nursing assessment, nursing care, hand over forms, laboratory attachment sheets, medication cards, record tables of medication administration and nutritional care. Of the several forms above, researchers will only examine 7 forms, namely Patient Resume, CPPT, Patient Initial Medical Assessment, Nursing Assessment, Hand Over, Drug Card, and nutritional care. Based on the results of the analysis that has been done the 4 forms are incomplete or there are wrong documents.

Incomplete medical records can affect services at the related hospital. For this reason, researchers are interested in taking the title "Analysis of Completeness of Medical Record Files Inpatients at RSUD Dr. Pirngadi Medan City".

Methods

This research methodology uses quantitative research with a descriptive approach. Sampling was done by random sampling. Determination of the number of samples using the Slovin formula. Where in one month there were 540 incoming medical record files with 131 incomplete files. So the population in this study was 131 medical record files and the samples were 99 inpatient medical record files. Determination of this sample using the Slovin formula. The data analysis used is a univariate test. The research was conducted at the Regional General Hospital Dr. Pirngadi on 9 January and 17 February 2023

Results

Variables	Complete		Not Complete	
	f	%	f	%
Analysis of Patient Identity Completeness				
Patient name	99	100	0	0
Medical Record Number	99	100	0	0
NIK	99	100	0	0
Gender	99	100	0	0
Date of Birth	99	100	0	0
Patient Report Completeness Analysis				
Patient Medical Resume	75	75,8	24	24,2
Initial Medical Assessment	88	88,9	11	11,1
Initial Nursing Assessment	99	100	0	0
Cppt	83	83,8	16	16,2
Hand Over	99	100	0	0
Medicinal Card	87	87,9	12	12,1
Nutrition Care	99	100	0	0

Component Filling in Inpatients				
Doctor Name	97	98	2	2
Doctor Signature	97	98	2	2
Nurse Name	99	100	0	0
Nurse Signature	99	100	0	0

Discussion

Incomplete files are incompleteness made by health workers in hospitals that provide services to patients. An incomplete medical resume file is a very important problem because it can affect the service process carried out by medical officers and affect the quality of a hospital's service quality. Research conducted by Siti Agus Kartini and Haliza Liddini (2019) stated that most of the filling in medical resume files at the Mitra Medika Medan General Hospital were complete, and a small number of fillings were incomplete. Incomplete medical resume files can be affected by inadequate Human Resources (HR) and Standard Operating Procedures (SOP).

Based on the results of the study, it was found that 99 (100%) patient identities were complete, such as the patient's name, medical record number, NIK, gender, and date of birth of the patient. Nurses or officers do not need to write down the patient's name because the patient's name is available in the form of a barcode. Officers only need to paste the barcode on the medical record form. Patient identity is very important to ensure the accuracy of the patient receiving the service or action, as well as to align the service or action needed by the patient. With the patient's name, the medical record number can be used to identify who the medical record belongs to. If one day there is a form that is separated from the document, and there is no patient name or medical record number, how can you find out who the form belongs to, that is the importance of writing the patient's name and medical record number. This accreditation is supported by patient safety goals. In addition, having the patient's name and medical record number will make it easier for officers to find medical record files on the file shelf if the patient comes to the hospital to return for treatment. It is the same as the research conducted by Ali Sabela Hasibuan and Giobani Malau that for patient identification each sheet of the medical record form is filled in 100% completely. Because nurses don't need to bother writing the patient's identity, they can simply attach the patient identification barcode that was prepared when the patient registered at the inpatient registration section.

The highest percentage of incomplete filling was found in patient medical resume items (24.2%). This is because there are still incomplete medical resume forms and factors causing incomplete medical resume filling, namely the lack of socialization about filling out medical resumes and the level of doctor compliance. The results of this study have similarities with research conducted by M. Reza Trianda Saputra and Adi Setiawan (2019) that the completeness of filling out medical resumes is not 100% complete because there are still medical resume forms that are not filled out. Factors causing incomplete medical resume filling were PPA's busyness, and lack of PPA compliance, even though there was an SPO made by the hospital.

Based on (Ministry of Health of the Republic of Indonesia, 2008) regarding Hospital Minimum Service Standards, namely the completeness of filling out a medical resume 24 hours after completion of 100% service. Completion of a medical resume aims to:

1. To ensure continuity of care and to provide a useful reference for visiting physicians upon re-admission.
2. As research material for hospital medical personnel.
3. To fulfill requests from official bodies or individuals regarding the treatment of a patient, for example from an Insurance Company (with the approval of the Management).
4. To provide a copy to the expert system, the system needs a record of the patients they have treated.

Based on research that has been conducted at RSUD Dr. Pirngadi City of Medan the incompleteness of the CPPT was 16.2%. Integrated patient progress notes (CPPT) are documentation records carried out by health workers to coordinate or collaborate between health workers in documenting health services to patients. The form of implementation of integrated care is documentation carried out by PPA (Professional Care Giver). Documentation carried out in integrated notes is in the form of progress notes written based on subjective data (S), objective data (O), Data Analysis (A) and Planning/planning (P).

Integrated documentation can be used as written evidence of activities carried out by multidisciplinary health workers who are in the inpatient room. The documentation says omplete if the records carried out by doctors, nurses, pharmacists and nutritionists comply with the standards set by the hospital, so as to protect health workers on legal issues. Research conducted by Nopan Saputra, et al (2021) found that the completeness of integrated patient development record documentation (CPPT) at RS X Padang was incomplete. This is due to several factors including a lack of understanding of the benefits of filling in CPPT, besides that health workers also lack support from superiors in completing CPPT and the lack of hospitals facilitating CPPT filling.

The patient's initial medical assessment is the stage of the process in which doctors and nurses evaluate patient data both subjectively and objectively for decisions regarding the patient's health status, treatment needs, interventions and evaluation. At least the patient's medical assessment form contains the patient's medical history, chief complaint, medical

history, physical examination, diagnosis, problems and plan of care. Based on the research results the percentage of incompleteness the initial medical assessment item was 11.1%. This shows that filling out the patient's initial medical assessment form is close to complete. Errors that occur in filling out the initial assessment are usually caused by discrepancies in the physical examination contained in the initial assessment form with the CPPT.

The initial nursing assessment is data that shows the actions of the nurse in caring for the next patient. contains reasons for hospitalization, medical history and medication, psychosocial history, physical examination and nutritional screening. The goal of effective patient assessment can result in decisions regarding care needs, patient treatment that must be carried out immediately and continuing treatment for emergencies, planned services, even when the patient's condition changes (SNARS, 2018). Based on the research conducted, the majority of the initial nursing assessments were complete with 99 medical record files (100%).

The drug card is a form of medical record file that is no less important to attach because patient care at the hospital is highly dependent on the effectiveness of the drug card user. So if the drug card is incomplete, there will be an error in patient care in the next treatment. There is a drug incompatibility listed in the CPPT but not listed in the drug card and vice versa. Then you can too causing an error in the cost details claim. This is one of the reasons for the large number of errors cost breakdown.

Filling in the Authentication Component in Inpatients such as the doctor's name is 98% completely filled in, the doctor's signature is 98% completely filled out. While the nurse's name and signature are filled in completely 100% completely filled out. The contents of the doctor's signature and the doctor's name on the entry and exit summary form are clinical data which is interpreted as data on the results of examinations, treatment, care performed by health practitioners and medical support for inpatients and outpatients, therefore it is necessary to fill in the signature items the hand and name of the treating doctor in order to strengthen the responsibility of a doctor in administering medical procedures and implementing medical services to patients. If the doctor's name and signature are not filled in, the examination, treatment or treatment that has been carried out cannot be accounted for by the doctor and can be considered ethically malpractice.

Research conducted by Sela Rika Khoirun Nisa, et al (2021) that based on calculating the completeness of filling in the documentation review in the medical record documents for outpatients at the Gondanglegi Health Center, the percentage of incompleteness includes 9% complete doctor's name, and 91% incomplete, sign 99% complete doctor's hands and 1% incomplete. In this case the Gondanglegi Health Center has not met the standard that should be 100%.

The doctor's signature is very important to find out who the doctor is carrying out the examination and the doctor's responsibilities. If the doctor's name and signature are not filled in, it can result in not knowing who the doctor is doing the examination and being unable to hold the doctor accountable. The incompleteness mentioned above can make it difficult for officers to determine which doctor is responsible for the care given to the patient and if there are medical record documents that must be completed by the doctor. This is explained in the Law of the Republic of Indonesia number 29 of 2004 concerning Medical Practice article 46 paragraph (3) which states that each medical record must be affixed with the name of the time and the signature of the officer providing the service or action.

There are several causes of incomplete medical record files for inpatients at RSUD Dr. Pirngadi namely the lack of PPA compliance regarding medical resume filling and documentation in the medical record, there are still discrepancies in the physical examination contained in the initial assessment form with the CPPT and discrepancies with the drug card.

In Permenkes Number 269 of 2008 concerning Medical Records, in article 2 it is said that a good medical record must be made in writing, complete and clear or electronically. A complete medical record is very useful. For patients who receive health services, a complete medical record is useful as a complex record of the types of services that have been obtained. Because it lists all services received, medical records can also be used as evidence of services. The patient's health condition can be seen properly by health workers so that it allows health workers to assess and treat risk conditions. As for the health service provider, this medical record has many benefits in providing supporting services. And can help continuity (means of communication) between fellow health workers.

Conclusion

The research at RSUD Dr. Pirngadi Medan City reveals that although medical record files are mostly complete, inconsistencies exist primarily in the documentation of medical resumes and CPPTs. These shortcomings are linked to insufficient adherence to PPA guidelines. To improve the completeness and accuracy of medical records, it is crucial to enforce documentation standards and enhance staff training.

Acknowledgment

This research can run well thanks to the presence of various parties. thanks to the supervising lecturer who has provided direction and guidance in research. as well as all workers in the medical records section of RSUD Dr. Pirngadi Medan City who participated in this study.

Author Contribution and Competing Interest

The author's contribution to this study was to collect data through the analysis of inpatient medical record files, conduct in-depth observations and interviews, analyze the results, and compile manuscripts.

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