Study of Incompleteness Medical Records of Inpatient in Appendicitis Cases at Dr. Reksodiwiryo Hospital Padang

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ABSTRACT

Background: Incomplete filling of medical record files for inpatients at Dr. Reksodiwiryo hospital medical records will describe health services and the quality of medical record services. Medical record quality services include the completeness of medical record files, accuracy in providing diagnosis and diagnosis codes, as well as speed in providing service information. The requirements for quality medical records must be accurate, complete, reliable, valid, timely, usable, common, comparable, guaranteed, and easy.

Methods: This research method is a descriptive with a retrospective approach or looking at existing data. This study was carried out in September 2021. The population was 70 files cases of inpatient digestive surgery. Samples were taken from 27 files of inpatients with appendicitis cases.

Results: From the research that has been done, the highest percentage of incomplete identification components is found on the gender item about 81.48%, the highest percentage of incomplete important report components is obtained on the medical resume and informed consent items about 11.1%. The highest percentage of incomplete authentication components was obtained in the nursing degree about 96.3%. The highest percentage of the components of the recording method was obtained by 59.3%, there are several blank sections about 16 files. The percentage of incomplete diagnostic codes and procedures is 100%

Conclusions: the researcher suggested that the hospital can have an Operational Standard on filling out the completeness of medical records files

Keywords: Incompleteness, Review, Appendicitis, Quantitative Components

INTRODUCTION

Nowadays, the increasing of information is needed, one of which is in the health sector, is urgently needed at this time. The citizen who already understand and realize the importance of health care make health services in every facilities begin to be improved, both in terms of quality and facilities and infrastructure. One of them is improving the quality of medical record services (Mawarni, 2013).

Medical record quality services include the completeness of medical record files, accuracy in providing diagnosis and diagnosis codes, as well as speed in providing service information. The requirements for quality medical records must be accurate, complete, reliable, valid, timely, usable, common, comparable, guaranteed, and easy. In a complete and correct medical record, information is obtained that is used for various purposes. One of the evidence to the court, education, and training, and can be used for analysis and evaluation of the quality of hospital services. Given the many uses of medical records, it is necessary to control the filling of medical record files (Winarti, 2013).

In the process of controlling the current medical record file, it is found that several parts do not fully consider this medical record important so that incomplete filling is still found. In
fact, according to the Minister of Health of the Republic of Indonesia (2008), the standard for completing medical records must be 100%. This problem must be found a solution, one of which is to see or analyze the incompleteness of medical records. Analysis of the incompleteness of filling out medical record documents is necessary, to find out how much the number of incomplete filling of medical record documents exceeds the time limit that has been given, given the importance of medical record documents to produce continuous information. Analysis of the incompleteness of filling out medical record documents is one way to assess the quality of service at the hospital concerned. The less the number of incompleteness, better the quality of service (Oktaviani, 2017)

The data that shows the incompleteness of the medical record file can be seen from filling outpatient data, anamnesis sheets, resume sheets, diagnosis sheets, and filling out procedures report and informed consent sheets. The problem of incomplete filling of medical record files also occurs in the surgical ward at Dr. Reksodiwiryo Hospital. At the time of the preliminary study by looking at the completeness of the filling, it was still not 100% complete, some forms were still found to be incomplete such as identification items, and some important reports. This was due to several factors, both external and internal, such as staff medical records who were not disciplined in their work. Based on the background and problems that occur, the author is interested in conducting a study entitled "Study of incomplete medical record files of inpatients in cases of appendicitis at Dr. Reksodiwiryo Hospital"

The purpose of this study was to determine the incomplete filling of medical records in cases of appendicitis in hospitalized patients Dr. Reksodiwiryo Padang

METHODS

This research method is a descriptive with a retrospective approach or looking at existing data. This study was carried out in September 2021. The population was 70 files cases of inpatient digestive surgery. Samples were taken from 27 files of inpatients with appendicitis cases. The instrument used in this research is to use a checklist table instrument. The data collection used is using the observation method and using the completeness checklist table.

RESULTS

Based on the results of research on the study of incomplete medical record files of inpatients with appendicitis cases in January - March 2020 through an assessment of identification, reporting, recording, and authentication reviews and the completeness of the diagnosis and procedure codes, the final results obtained are follows:

Table 1. Frequency distribution of incomplete components Identification of medical record files in cases of appendicitis at Dr. Reksodiwiryo Hospital Padang

| No | Item          | Incompleteness | n  | %    |
|----|---------------|----------------|----|------|
| 1  | Name          |                | 6  | 22.22|
| 2  | MR Number     |                | 6  | 22.22|
| 3  | Date of Birth |                | 2  | 7.41 |
| 4  | Gender        |                | 22 | 81.48|

From table 1, it can be seen that the identification review component consists of name, medical record number, date of birth, and gender. From the table, it can be seen from 27 medical record files that have been seen, the highest percentage of incompleteness is obtained on the gender item about 81.48% or 22 files. The identification component listed on the inpatient medical record file that is printed in the form of a sticker is only the patient's name, medical record number, and date of birth, which is attached to each medical record form
Table 2. Frequency distribution of incomplete components Important Report of medical record files in cases of appendicitis at Dr. Reksodiwiryo Hospital Padang

| No | Item               | Incomplete |
|----|--------------------|------------|
|    |                    | N   | %     |
| 1  | Medical Resume     | 3   | 11,11 |
| 2  | Progress Note      | 2   | 7,41  |
| 3  | Informed Consent   | 3   | 11,11 |
| 4  | Anesthesia Report  | 2   | 7,41  |
| 5  | Operation Report   | 2   | 7,41  |
| 6  | General consent    | 2   | 7,41  |

From table 2, it can be seen that the distribution of incomplete components of the review of important reports, namely medical resumes, progress notes, informed consent, anesthesia reports, operating reports, general consent. This form is a very important report to support the service information received by the patient. The highest percentage of incompleteness was obtained in the medical resume and informed consent of 11.1% or 3 files, respectively.

Table 3. Frequency distribution of incomplete components authentication of medical record files in cases of appendicitis at Dr. Reksodiwiryo Hospital Padang

| No | Item                | Incomplete |
|----|---------------------|------------|
|    |                     | n   | %     |
| 1  | Doctor's Name       | 1   | 3,7   |
| 2  | Doctor's Signature  | 1   | 3,7   |
| 3  | Nurse’s Name        | 13  | 48,1  |
| 4  | Nurse’s Signature   | 6   | 22,2  |
| 5  | Doctor’s Degree     | 3   | 11,1  |
| 6  | Nurse’s Degree      | 26  | 96,3  |

From table 3, it can be seen that the distribution of the incomplete authentication review components is the doctor's name, doctor's signature, nurse's name, nurse's signature, doctor's title, and nurse's title. The highest percentage of incomplete authentication components was obtained in the nurse's degree about 96.3%, or 26 files. Almost all medical record files do not have a nurse's title in the medical record file, because nurses only write their short names and signatures.

Table 4. Frequency distribution of incomplete components Recording Method of medical record files in cases of appendicitis at Dr. Reksodiwiryo Hospital Padang

| No | Item       | Incomplete |
|----|------------|------------|
|    |            | n   | %     |
| 1  | Clear      | 13  | 48,1  |
| 2  | abbreviation| 3   | 11,1  |
| 3  | Correction | 4   | 14,8  |
| 4  | Empty Section | 16 | 59,3  |

From table 4, it can be seen that the components of the review of the recording method
consist of clear recording, no abbreviations, no corrections or writings that are typed-x or crossed out many times, and empty parts that can be filled in by other service providers. From table 4 it can be seen that the highest percentage of the components of the recording method is obtained by 59.3% blank sections or as many as 16 files

Table 5. Frequency distribution of incomplete components Diagnose and Procedures Code of medical record files in cases of appendicitis at Dr. Reksodiwiryo Hospital Padang

| No | Item                   | Incomplete | n   | %  |
|----|------------------------|------------|-----|----|
| 1  | Diagnose Code          |            | 27  | 100|
| 2  | Procedures Code        |            | 27  | 100|

From table 5 it can be seen that the items of incomplete diagnosis and procedure codes in the medical record file are 100%. Diagnostic codes are not included on the patient admission and discharge forms and also on the medical resume

DISCUSSION

From the research that has been done and the data that has been collected and processed, it is obtained that several medical record files are incomplete. The study of the incompleteness of the medical record file is seen from a quantitative and qualitative review. Quantitative reviews can be seen from the components of identification, important reports, authentication, and recording methods. The qualitative review is seen from the legibility of the writing, the completeness of the informed consent, and the consistency of the diagnosis and progress notes.

Component Identification

The identification component is the process of collecting patient personal data which usually consists of the patient's name, number, medical record, date of birth, address, gender, address, and so on. This identity is the main evidence that the patient has received examination and treatment at the health care facility. So that each identification item in each medical record form must be filled out completely and accurately. According to Hatta (2010) identification of medical records is one of the administrative data as demographic information of patients who visit the hospital. This demographic data must be filled in completely. The incompleteness of this demographic data will result in the provision of incomplete information regarding the patient's identity, which is one of the statistical databases, research, and planning sources for hospitals or health care organizations. In the medical record file for the appendicitis case, the identification items that are printed in the form of a sticker are only the name, medical record number, and date of birth. This identification sticker is printed in large quantities according to the form in the inpatient file. Other identification items such as gender, address, and so on are written manually. So this item is prone to not being filled in completely.

Authentication Component

Authentication components such as name, signature, and title are very important to provide the legality of a form. Forms affixed with clear names and signatures can be legally accounted for. Therefore, this component is one of the important components that should not be ignored and not filled in completely. Of each authentication item, the nurse's clear name and the nurse's title have the highest percentage of incompleteness, the name of the nurse listed on each form, especially the progress notes, is only with a short name and initials. According to Hatta (2008), doctors, nurses, or medical personnel must affix their signatures and full names every time they record the results of examinations on patients after receiving services at the hospital by existing authorities and function as authentic evidence that can be legally accounted for.
Important Report Components

Completeness of important reports is a component that must be filled in completely. In Hatta's statement (2010) that the items for admission diagnosis, final diagnosis, surgery, a summary of the history, physical examination, results of supporting examinations, and progress notes in medical record documents must be filled in because these are subjective descriptions that emphasize the reason for the need for medical treatment that can be treated. impact on patient care. For example, if a diagnosis item is not filled in, it affects the provision of a diagnostic code in the medical record which is then indexed to facilitate services in presenting information to support the functions of planning, management, and health research.

Components of Recording Method

The recording method component is an important component to facilitate patient handling and also information that will be needed in the future. This record must be done properly and legibly. Good record keeping will facilitate continuous patient handling. Good records must be easy to read and understand by health workers so as not to cause misperceptions in reading patient medical records. Empty items are also not allowed to be in the form, because it can make the health worker responsible for refilling the blanks again.

Completeness of diagnostic codes and procedures

One of the obligations of the medical recorder is to provide diagnostic codes and procedures. The quality of coded data is important for health information management personnel, health care facilities, and health information management professionals. The accuracy of diagnostic data is very important in the field of clinical data management, cost collection, along with other matters related to health care and services (Puspitasari, 2017). The quality of this code is very necessary for health information management personnel, one of which is for reimbursement of costs. Therefore, this code must be precise and written on the medical record form.

CONCLUSION

Based on the results of the study of incomplete medical record files of inpatients with appendicitis cases at Dr. Reksodiwiryo Hospital can be concluded that:

1. The highest incompleteness of identification components was found in gender item about 81.48% or 22 files
2. The highest incompleteness of important report components was obtained on medical resumes and informed consent items, each of 11.1% or 3 files.
3. The highest percentage of incomplete authentication components is obtained in nurses' degrees about 96.3%, or 26 files.
4. The highest percentage of the components recording method is blank sections about 59.3% or 16 files.
5. The percentage of incomplete diagnostic codes and procedures is 100%

SUGGESTION

1. Suggested to carry out quantitative and qualitative reviews regularly
2. the researcher suggested that the hospital can have an Operational Standard on filling out the completeness of medical records files
3. The medical record officer is expected to be able to fill in the diagnostic and procedure code items in the entry and exit summary as well as the medical resume
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