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Quantitative analysis of the completeness of medical records documents for inpatient general surgery patients at X Padang Hospital

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ABSTRACT

The quality of medical records is an indicator of the quality of hospital services which can be seen from the completeness of filling out medical record documents. Incompleteness in filling out medical record documents will disrupt administrative order which will affect the patient treatment process, where officers will have difficulty identifying the patient, officers will have difficulty determining the next treatment or therapy action that will be carried out on the patient. Based on the results of the initial survey at Hospital X Padang, it was found that a quantitative review of medical record documents had never been carried out. The aim of this study was to determine the results of a quantitative review of the completeness of medical records for general surgery inpatients. This research method is descriptive with a quantitative approach. The population and sample in this study were documents from inpatients specifically for general surgery in the fourth quarter of 2021, with a total sample of 38 documents. The research location is at Hospital the doctor's hand was 94.7%, the method of recording abbreviated items was 73.7%. From the results of the quantitative analysis research, it was concluded that it still does not meet the Minimum Service Standards, namely 100%. To increase the completeness of filling out medical records, it is hoped that hospitals can create reward and punishment policies, implement rules or SOP guidelines for filling out medical record documents.

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INTRODUCTION

According to Law Number 44 of 2009, a hospital is a health facility that provides individual health services which include promotive, preventive, curative and rehabilitative services(Nomor, 44 C.E.). So that hospitals can carry out their functions well, hospitals are required to provide quality services in accordance with established standards(Anggraeni & Herlina, 2022). Based on the

Indonesian Ministry of Health Number 129 of 2008 concerning Minimum Hospital Service Standards, it is explained that one of the services that must be provided by hospitals is medical records(Citra, 2015). The quality of medical records is an indicator of the quality of hospital services which can be seen from the completeness of filling out medical record documents(Rizkika, 2020). Incomplete medical record files such as the absence of the doctor's signature and clear name, the diagnosis and diagnosis code have not been filled in or have not been written, and the history of the disease has not been filled in completely, then this has an impact on the usefulness of the medical record, namely from the administrative and medical aspects. , law, finance, research, education, and documentation(Luhukay, 2021).

Incompleteness in filling out medical record documents will disrupt administrative order and thus affect the patient's treatment process, where officers will have difficulty in identifying the patient, difficulty in determining the next treatment or therapy action that will be carried out on the patient. Medical records are useful from a legal aspect as evidence to uphold justice(Yanti & Yulianti, 2023).

One of the analyzes that can be carried out on medical records is through quantitative analysis(Nisa, 2021). According to (Hatta, 2008) quantitative analysis is intended to assess the completeness and accuracy of inpatient and outpatient health records held by health service facilities with the aim of creating medical record content that avoids inconsistent (consistent) input or violations of recorded records. Resulting in inaccurate and incomplete results. Medical records can be said to be complete if they contain four main components of quantitative analysis, namely patient identification review, important reporting review, authentication review, and correct documentation review(Wijaya, 2022). Based on the results of the initial survey at Hospital X Padang, it was found that a quantitative review of medical record documents had never been carried out. The aim of this research is to obtain the results of a quantitative review of the completeness of medical records regarding the filling out of medical record documents. The research location is Hospital X Padang.

RESEARCH METHOD

The research design used in this research is a descriptive quantitative approach. The aim is to find out the results of a quantitative review of the completeness of medical records regarding filling in medical record documents, especially for general surgery patients at Hospital X Padang. Implementation time starts from August to November 2022. According to (Sumargo, 2020)if the population is less than 100 people, then the sample should be taken as a whole (use population), but if the population is greater than 100 people, then a sample of 10-15% or 20-25% can be taken. of its population. The research sample uses all members of the population or is called the total sample. This usage is used because the population members are relatively small (Hardani et al., 2020). The population of inpatients specifically for general surgery in the fourth quarter of 2021 was 38 people. So the sample in this research is 38 documents. The data collection process in this research was carried out through the following stages: preparation by arranging permits, data collection/implementation process, researchers used participant observation to collect data(NABELA, 2018). (Budiyasa, 2020)The instrument used in this research was a checklist sheet or table which contained a quantitative analysis component.

RESULTS AND DISCUSSIONS

Research on quantitative analysis of the completeness of inpatient medical record documents for general surgery patients was carried out at Hospital X Padang. Quantitative analysis was carried out on medical record documents specifically for general surgery cases for patients leaving the fourth quarter period, namely October, November and December 2021. Quantitative analysis of medical record documents was seen from four analysis components, namely the identification

component, important reports, authentication and how to record. From the data collection that was carried out, 38 medical record documents for general surgical cases were obtained during that period. The quantitative analysis of the identification components can be seen in table 1.

Table 1. Frequency distribution of incompleteness of the medical record document identification component for general surgery patients at Hospital X Padang in Quarter IV 2021

Number	Quantitative Components	Complete		Incomplete	
		n	%	n	%
1	Name	31	81,58	7	18,42
2	RM number	33	86,84	5	13,16
3	Date of birth	31	81,58	7	18,42
4	Gender	32	84,21	6	15,79

Based on table 1, it can be seen that the highest percentage of completeness in filling out the identification component is the medical record number item at 86.84% and the highest percentage of incompleteness is found in the name and date of birth items, namely 18.42%. On each medical record form, patient identification is made in the form of a sticker containing the patient's name, date of birth and medical record number. On forms that did not have patient identification stickers attached, some patient names were not written completely and clearly. To see the distribution of filling in important report components, see table 2.

Table 2. Frequency distribution of incomplete components of the important report of medical record files for general surgery patients at Hospital X Padang in the fourth quarter of 2021

Number	Quantitative Components	Complete		Incomplete	
		n	%	n	%
1	Medical Resume	15	39,47	23	60,53
2	Progress Notes	26	68,42	12	31,58
3	Informed Consent	2	5	36	95
4	Anesthesia Report	1	2,6	37	97,4
5	Operations Report	18	47,4	20	52,6

From table 2 above, it can be seen that the results of the quantitative analysis of the important report components consist of the medical resume, progress note form, informed consent form, anesthesia report form, and operation report. The highest percentage of completeness of important report components was found on the patient progress record form at 68.42%. The highest percentage of incompleteness was found on the anesthesia report form at 97.4%.

Table 3. Frequency distribution of incompleteness of components of medical record file authentication for general surgery patients in Hospitals X Quarter IV 2021

No	Komponen Kuantitatif	Lengkap		Tidak Lengkap	
		n	%	n	%
1	Doctor's Name	21	55,3	17	44,7
2	TTD Doctor	36	94,7	2	5,3
3	Doctor's Degree	18	47,4	20	52,6
4	Nurse Name	1	2,6	37	97,4
5	TTD Nurse	29	76,3	9	23,7
6	Nursing degree	0	0,0	38	100,00

Based on table 3, the highest percentage of completeness of authentication components was found in the doctor's signature item at 94.7%. In the medical record file, each form has the doctor's full name and title stamped. The highest percentage of incompleteness was found in the nurse's name component at 97.4%. Almost all medical record files for general surgery cases do not include the title in the nurse's name. The nurse's name form only includes a short name, such as on the progress note form, anesthesia report form, informed consent and other forms.

Table 4. Frequency distribution of incomplete components of the method for recording medical record files for general surgery patients at Hospital X in the fourth quarter of 2021

No	Komponen Kuantitatif	Lengkap		Tidak Lengkap	
		n	%	n	%
1	Clear	6	15,8	32	84,2
2	Abbreviation	28	73,7	10	26,3
3	Correct	15	39,5	23	60,5
4	Blank Section	19	50	19	50

From table 4, it can be seen that the percentage of completeness in the recording method component is highest for abbreviated items at 73.7%. The highest percentage of incompleteness was found in clear items at 84.2%. This incomplete writing clarity section is often found on forms.

Quantitative analysis of the completeness of medical record documents can be carried out on four components, namely identification, important reports, authentication and recording methods(Lily & Deasy, 2017). The first component, namely identification, consists of the items name, medical record number, date of birth and gender. The highest percentage of completeness in filling out the identification component was the medical record number item at 86.84% and the highest percentage of incompleteness was found in the name and date of birth items, namely 18.42%.

On each medical record form, patient identification is made in the form of a sticker containing the patient's name, date of birth and medical record number. However, not all medical record forms have patient identification stickers attached, but some do not and it can be found that some patient names are not written completely and clearly. In contrast to the results of research on calculating the completeness of filling in (Nisa, 2021), a review of identification on outpatient medical record documents at the Gondanglegi Community Health Center, it was found that the percentage of incompleteness including filling in medical record numbers was only 1%, this incompleteness was because there were still several empty medical record number columns. on the medical record document because the officer only writes the medical record number in the medical record document folder. This happened because the officer forgot due to being in a rush due to the large number of patients and did not write the medical record number on the new document and the medical record number in the column in the document was not filled in because the folder already had the patient's medical record number.

According to Wijaya (2018) every medical record form must at least have the patient's identity such as the patient's name, medical record number, date of birth and gender. If there are sheets without identification, they must be reviewed to determine who the sheet belongs to.

Quantitative analysis begins by examining each RM sheet, according to (Huffman & Edna, 1994) that the patient's identity must at least have the name and medical record number. If the page no longer has an identity then it must be reviewed to ensure whether the sheet belongs to the patient whose medical record is being analyzed or not. Because if you don't know who the sheet belongs to, it will make it difficult to know the ownership of the form and there may be errors in diagnosis or administration of medication, so it must be reviewed to ensure whose form it belongs to. The gender item received the highest percentage of incompleteness. This item is rarely found on medical record sheets. The hospital only provides and prints many items of name, date of birth and medical record number. It is important to include gender on the identification sheet so you can know how services are provided according to gender.

The second component is an important report component. This component also determines the incompleteness of a medical record document(Swari et al., 2019). When reviewing important reports such as admission and discharge summaries, operation reports, medical resumes, progress notes must be filled in completely because they are subjective descriptions to emphasize the reasons for medical treatment and the services that will be provided to the patient(ALLPANDIANTO, 2021). From the research results, it was found that the highest

percentage of completeness of important report components was obtained on the patient progress record form at 68.42%. The highest percentage of incompleteness was found in the anesthesia report form at 97.4%(Suaryanti et al., 2022). The patient progress note report item received the highest percentage of completeness.

Every patient who is hospitalized will be observed and monitored by nurses and doctors every day. All patient progress will be recorded in a detailed progress note form. When filling in the reporting component, it is important to pay attention to its completeness, because written evidence supports the legal aspects of medical records, this is to protect the patient because every action taken is not categorized as malpractice. If it is not filled in completely, it can result in harm to the patient, both material and non-material, then administrative sanctions will be imposed(RI, 2008).

The third component is the authentication component. Authentication is a process which is an act of proving (validating) a person's identity, in this case a doctor or nurse who has the authority to fill in the patient's medical record file. (Purwanti et al., 2020)Referring to Minister of Health Regulation Number 269 / MENKES / PER / III/2008 in article 5 paragraph 4, every entry in the medical record must include the name, time and signature of the doctor, dentist or certain health worker who provides direct health services. When filling out a medical record, the person responsible for each entry must be clear. Authentication review can be in the form of a name or stamp, signature, professional title (Widjaya, 2018).

From the research results, the highest percentage of completeness of the authentication components was obtained from the doctor's signature item at 94.7%. The highest percentage of incompleteness was found in the nurse's name component at 97.4%. Generally, nurses do not write their names and titles. This is due to busyness(Agustri et al., 2021).

Nurses to write authentication, so doctors more often just sign. This can result in the examination, care or treatment that has been carried out being irresponsible and can make it difficult for officers to determine the doctor who is responsible for the patient. The completeness of filling out the authentication components is very important for the hospital. Doctors and other health workers should work together so that the authentication of medical record documents is filled in completely. This is in line with the results of(Oktavia, 2020) research on completeness of authentication components for inpatients diagnosed with femur fracture at RSUD Dr. R.M Djoelham Binjai is not 100% complete. This is not in accordance with Standard Operating Procedures (SPO).

The fourth component is the method of recording. From the results of research on the recording method component, the highest rate was obtained for abbreviated items at 73.7%(Nugraha & Ningsih, 2022). The highest percentage of incompleteness was found in clear items at 84.2%. This incomplete writing clarity section is often found on forms. In correcting errors, officers also use tips ex(Bete & Nurvita, 2023). Errors in writing corrections can make the written data invalid or correct to be used as evidence of the action the doctor has taken on the patient. According to Minister of Health Regulation Number 269/MENKES/PER/III/2008 in article 5, paragraph 5, in the event that an error occurs in recording a medical record, corrections can be made by crossing out without removing the corrected note and initialing the doctor, dentist or health worker. the particular person concerned.

From the results of (Rehatta et al., 2022), the completeness of recording does not meet the minimum service standard of 100%. However, if the medical record has not been filled in completely, then the medical record file is marked with a sticky note label according to the name of the doctor in charge of the patient (DPJP) who does not fill out the RM completely, then the incomplete RM document is returned to each polyclinic.

CONCLUSION

The results of the study showed that the highest percentage of completeness in filling out the identification components was the medical record number item 86.84%, the patient progress record form 68.42%, the authentication component in the doctor's signature item 94.7%, the method for recording the abbreviation item 73.7% . From the results of this quantitative analysis research, it can be concluded that it still does not meet the Minimum Service Standards, namely 100%. To increase the completeness of filling out medical records, it is hoped that hospitals can create reward and punishment policies and implement SOP rules or guidelines for filling out medical record documents.

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