



Analysis of Completeness of Filling in Medical Record Files for Bacterial Infection Cases in Hospitals

¹Yastori, S.Si, M.Si

¹Department of Medical Record and Health Management, Apikes Iris, Padang, Indonesia

¹Apikes Iris Padang, West Sumatera, Indonesia

Abstract: According to the Minister of Health Regulation Number 269/MENKES/PER/III/ 2008, the requirements for a quality medical record are related to the completeness of medical record entries, accuracy, accuracy of medical records, punctuality and fulfillment of legal aspect requirements. Based on the Decree of the Minister of Health of the Republic of Indonesia No.129/Menkes/SK/II/2008 concerning Hospital Minimum Service Standards (SPM), which contains information about hospital medical record services, namely completing medical record filling 24 hours after service completion. Descriptive research method with a quantitative approach. The coding data is taken in the patient's medical record file, then the diagnosis code is confirmed with laboratory results notes in the medical record attachment. The data used were all medical record files for the period of January 2019. The number of samples in this study were 74 medical record files. The percentage of incompleteness in the identification of names was 30%, the percentage of incompleteness in the identification of the medical record number was 40%, the percentage of incompleteness in the identification of the age was 60%, the percentage of incompleteness in the identification of the signature was 10%, the percentage of incompleteness in the identification of the name of the person in charge was 10%, and the percentage of completeness in documentation that actually amounts to 100%. The incompleteness of filling in medical record files determines the accuracy of coding, assists in data analysis, is the basis for determining policies and produces quality data. The completeness of filling out medical record files is influenced by several factors including medical record officers, doctors and other officers who play a role in filling out medical record files.

Index Terms - Medical records, Completeness, Descriptive

I. INTRODUCTION

According to the Minister of Health Regulation Number 269 / MENKES / PER / III / 2008, the requirements for a quality medical record are: related to the completeness of medical record entries, accuracy, accuracy of medical records, punctuality, and fulfillment of legal aspect requirements. Meanwhile, referring to the hospital minimum service standard (SPM) guidelines, there are four quality target indicators, one of which is the timeliness of providing medical record documents^[1].

Based on the Decree of the Minister of Health of the Republic of Indonesia (Kepmenkes RI) No.129/Menkes/SK/II/2008 concerning Hospital Minimum Service Standards (SPM), which contains information about hospital medical record services, namely completing medical record filling 24 hours after service completion^[2]. Medical records completeness are very important in the service for patients because with complete data can provide information in making decisions both treatment, medical action^[3].

The incompleteness of medical record documents can be caused by the lack of discipline of medical personnel and paramedics to complete the patient's medical records. Many factors include, among others, doctors prioritizing providing services, the number of patients so that doctors try to provide services quickly, doctors are still waiting for the results of laboratory examinations to better ensure a more specific diagnosis, a limited number of doctors, lack of cooperation between nurses and medical record officers and doctors are less concerned about medical records^[4].

Research on the completeness of medical record files has previously been carried out by Dzuhanto (2018), and it was found that 20 (46.51%) incomplete patient reviews (46.51%) and 21 (48.84%) age were included in the integrated patient development records, whereas 22 (51.16%) medical record numbers are on the inpatient statement form, the highest incompleteness is 1 (2.33%) important reports are on the surgery and anesthesia report form, incompleteness authentication reviews are based on the name of the highest doctor / nurse as many as 20 (46.51%) contained in the nursing care summary form and based on the signature of the doctor / nurse the highest incompleteness was 16 (37.21%) found on the laboratory result form, reviewing recording techniques that were not completely legible as many as 9 (20.93%) found on the nursing care summary form, the correction of the highest irritation was not true, as many as 15 (34.88%) found on the patient progress note form and presented a fixed line not done correctly as many as 41 (95.35%) were on the entry and exit summary form^[5].

The purpose of this study was to determine the analysis of the completeness of filling in medical record files of patients in cases of bacterial infection at the hospital.

II. RESEARCH METHODOLOGY

Descriptive research method with a quantitative approach. The coding data is taken in the patient's medical record file, then the diagnosis code is confirmed with laboratory results notes in the medical record attachment. The data used were all medical record files for the period of January 2019. The number of samples in this study were 74 medical record files.

III. RESULTS AND DISCUSSION

3.1 The Results Of Quantitative Analysis On The Review Of Medical Record Files

Table 3.1: Completeness of Medical Record Documents for Specific Bacterial Infection Based on Identification (Name)

Review of Identification Completeness (Name)					
No	Type of Form	Complete		Incomplete	
		Amount	%	Amount	%
1	Summary Enter Exit	74	100	0	
2	History/Physical Examination	74	100	0	
3	Chart	72	97.29	2	2.77
4	Course of Disease/Doctor's Instructions	74	100	0	
5	Nurse/Midwife Notes	74	100	0	
6	Laboratory Examination Result Report	74	100	0	
7	Discharge Patient Summary	74	100	0	
8	Home Care Summary	74	100	0	
9	Inpatient Approval	73	98.64	1	1.36
10	DPJP Check List	73	98.64	1	1.36
N = 74					

Table 3.1 shows that the incompleteness of the medical record file is in filling in the name in the graphic, which is 2.77%, the incomplete medical record file for filling in the name on the inpatient approval and dpjp check list is 1.36%.

Table 3.2: Completeness of Medical Record Documents for Specific Bacterial Infection Based on (medical record number)

Review of Identification Completeness (medical record number)					
No	Type of Form	Complete		Incomplete	
		Amount	%	Amount	%
1	Summary Enter Exit	74	100	0	
2	History/Physical Examination	74	100	0	
3	Chart	72	97.29	2	2.77
4	Course of Disease/Doctor's Instructions	74	100	0	
5	Nurse/Midwife Notes	74	100	0	
6	Laboratory Examination Result Report	73	98.64	1	1.36
7	Discharge Patient Summary	74	100	0	
8	Home Care Summary	74	100	0	
9	Inpatient Approval	73	98.64	1	1.36
10	DPJP Check List	73	98.64	1	1.36
N=74					

Table 3.2 shows that the incompleteness of the medical record file, namely the filling in the patient's medical record number in the graph, is 2.77%, the incomplete medical record file for filling in the medical record number in the Laboratory Examination Result Report is 1.36%, the incomplete medical record file for filling in the medical record number on Inpatient approval and DPJP check list amounting to 1.36%.

Table 3.3: Completeness of Medical Record Documents for Typical Bacterial Infection Based on Identification (AGE)

Review the completeness of identification (AGE)					
No	Type of Form	Complete		Incomplete	
		Amount	%	Amount	%
1	Summary Enter Exit	73	98.64	1	1.36
2	History/Physical Examination	74	100	0	
3	Chart	71	9.94	3	4.22
4	Course of Disease/Doctor's Instructions	74	100	0	
5	Nurs/Midwife Notes	74	100	0	
6	Laboratory Examination Result Report	73	98.64	1	1.36
7	Discharge Patient Summary	73	98.64	1	1.36
8	Home Care Summary	74	100	0	
9	Inpatient Approval	72	97.29	2	2.77
10	DPJP Check List	73	98.64	1	1.36
N = 74					

Table 3.3 shows that the incompleteness of medical record files namely the filling in age in the Summary Enter Exit is 1.36%, the incompleteness of the medical record files for filling in the age on the graph is 4.22%, the incompleteness of the medical record files for filling in the age in the Laboratory Examination Result Report is 1.36%, the incompleteness of medical record files for filling in age in the Discharge Patient Summary is 1.36%, the incompleteness of medical record files for filling in age at inpatient approval is 2.77%, and the incompleteness of medical record files for filling in age on the dpjp check list is 1.36%.

Table 3.4: Completeness of Medical Record Documents for Typical Bacterial Infection Based on Identification (Signature)

Review the completeness of identification (SIGNATURE)					
No	Type of Form	Complete		Incomplete	
		Amount	%	Amount	%
1	Summary Enter Exit	74	100	0	
2	History/Physical Examination	74	100	0	
3	Course of Disease/Doctor's Instructions	74	100	0	
4	Laboratory Examination Result Report	74	100	0	
5	Discharge Patient Summary	74	100	0	
6	Home Care Summary	74	100	0	
7	DPJP Check List	73	98.64	1	1.36
N= 74					

Table 3.4 shows that the incompleteness of the medical record file, which is found in the signature filling in the dpjp check list is 1.36%.

Table 3.5 Completeness of Medical Record Documents for Typical Bacterial Infection Based on Identification (The Name Of The Person In Charge)

Review the completeness of identification (THE NAME OF THE PERSON IN CHARGE)					
No	Type of Form	Complete		Incomplete	
		Amount	%	Amount	%
1	Summary Enter Exit	74	100	0	
2	History/Physical Examination	74	100	0	
3	Course of Disease/Doctor's Instructions	74	100	0	
4	Laboratory Examination Result Report	74	100	0	
5	Discharge Patient Summary	74	100	0	
6	Home Care Summary	74	100	0	
7	DPJP Check List	73	98.64	1	1.36
N = 74					

Table 3.5 shows the incompleteness of the medical record files contained in the name of the person in charge on the dpjp check list is 1.36%.

Table 3.6: Medical Record Documents on Typical Bacterial Infections Based on Correct Documentation (Fixed Line)

Review of the Correct Documentation					
No	Type of Form	Complete		Incomplete	
		Amount	%	Amount	%
1	Summary Enter Exit	74	100	0	
2	History / Physical Examination	74	100	0	
3	Course of Disease / Doctor's Instructions	74	100	0	
4	Laboratory Examination Result Report	74	100	0	
5	Discharge Patient Summary	74	100	0	
6	Home Care Summary	74	100	0	
7	DPJP Check List	74	100	0	
N = 74					

Table 3.6 shows that the completeness of the medical record file based on the review of the correct documentation is 100%.

Table 3.7: Medical Record Documents on Typical Bacterial Infections Based on Correct Documentation (Writing Clearly Read and Correction of Errors)

Review of the Correct Documentation					
No	Type of Form	Complete		Incomplete	
		Amount	%	Amount	%
1	Writing Clear and Correct	74	100	0	0
2	Correction of Errors	74	100	0	0
N = 74					

Table 3.7 shows that the completeness of the medical record file based on the review of the correct documentation is 100%.

3.2 Discussion

Based on the results of the study, it is known that the incompleteness of the medical record file review is the highest in the completeness of the medical record document in cases of bacterial infection based on age identification, namely 4.22% on the type of form in the graphic section. In addition, there were incompleteness in the identification of names on the graphic form with an incomplete percentage of 2.77% and on the writing of medical record numbers with the same percentage of incompleteness.

There are incompleteness in some medical record files, namely on the free form, inpatient approval, DPJP check list, laboratory examination results report, summary entry and exit, summary of patients going home. However, medical record documents in cases of bacterial infection based on correct documentation (fixed lines) and medical record documents in cases of bacterial infection based on correct documentation (clearly legible writing and error correction) have completeness with a percentage of 100%.

Guidelines medical record service hospital in Indonesia^[6] states that medical records are complete is a document medical records completed by physicians within ≤ 24 hours after completion of service or as inpatients decided to return include the identity of the patient, anamnesis, care plans, implementation of care, follow-up and resume^[7]. Complete medical records, providing information that can be used for various purposes. Such necessities are as evidence in lawsuit, research and education materials and can be used as a tool for analysis and evaluation on the quality of services provided by the hospital^[8]. Hospitals in case of incomplete documentation of information, it is possible that the diagnosis codes are also inaccurate and affect the cost of health services. The inaccuracies of the diagnostic codes and the completeness of the medical record will affect data and report information that ultimately affects the patient^[9].

Based on research conducted by Pratama, 2018 it is known that completeness of inpatient medical record filling is positively associated with higher education, civil servant status of employment, ≥ 3 year tenure, higher knowledge, stronger responsibility, and stronger organizational support^[10].

Completeness of filling out the identity on the medical record sheet is very important to determine whose sheet belongs. Patient identity sheets can be a tool for specific patient identification^[11]. Completeness of filling in important reports on inpatient medical record files includes data that are very important in monitoring the progress of the patient's disease. Important data reports in the medical record file include the main diagnosis, the state of discharge, the date of admission to the hospital, the type of surgery, the operation report, and informed consent. The report will provide information about the actions taken by doctors and nurses in caring for patients, so that it is expected to contain accurate, complete and reliable information^[12].

The results of the analysis of the completeness of medical record files determine the rating of a health unit or facility^[13]. A quality medical record is a medical record that contains complete data, so that it can be processed into information^[10]. Completeness of filling in medical record files is very important because one of the uses of medical record files, when viewed from a legal aspect, is written evidence. The results of the analysis that has been carried out on the completeness of filling out medical record files at Dr.

Kariadi Semarang can be said to have met the requirements as written evidence. If the medical record file is used as written evidence, the legal force is strong enough^[15].

The incompleteness of filling in inpatient medical record files is caused by several factors, namely staff factors (man), procedural factors (method), tool factors (material), machine factors and motivation factors. hospitalized so that the doctor did not immediately sign the inpatient medical record file. The doctor's signature and name on the medical record is very important because it is a legality and a form of responsibility to the patient. Every record in the medical record must be affixed with the name, time and signature of the doctor, dentist or certain health worker who provides direct health services^[1].

IV. ACKNOWLEDGMENT

1. The author would like to thank LPPM Apikes Iris for facilitating and assisting the implementation process of this research;
2. The author would like to thank Fairuz Tridania Anum who helped in data retrieval and processing and the team of this research;

REFERENCES

- [1] Ministry of Health of the Republic of Indonesia. 2008. *Minimum Service Standards for Houses Director General of Medical Services*. Jakarta.
- [2] Minister of Health RI. 2008. *Regulation of the Minister of Health No. 129/MENKES/SK/II/2008 Concerning Minimum Hospital Services*. Jakarta.
- [3] Miller RH and Sim I. 2004. Physicians' use of electronic medical records: barriers and solutions. *Healthaffairs*, 23(2), 116–26.
- [4] Revitasari A. 2016. Identification of the fulfilment outpatient's medical records incompleteness based on expectancy theory motivation. *Journal of Health Administration*, 4(2), 86–96.
- [5] Dzulhanto Bima Y. 2018. Completeness of filling in hernia medical record documents using quantitative analysis methods. *Journal of Information Management and Health Administration (J-MIAK)* Volume 01, No 01, Year 2018.
- [6] MOH. 2006. *Management Guidance of Medical Record Hospital at Indonesia*. Jakarta: DepKes RI Director General of YanMed.
- [7] Kurniawati. 2014. Overview of Resume Out of Inpatient Outpatient Room Fourth Quarter at CIAMAM District Hospital. Indonesia, *Journal of Health Information Management* 2 (1): 26-31.
- [8] Pamungkas. 2015. Identification of Incompleteness of Medical Record Document Inpatient RSUD Ngudi Waluyo Wlingi. *Brawijaya Health Journal* 28 (2): 124-128.
- [9] Pramono AE. 2015. *Accuracy of Disease Diagnosis Code Based on ICD-10 at Gondokusuman II Health Center Yogyakarta City*. UGM.
- [10] Tegar Wahyu Yudha Pratama, Didik Tamtomo, Endang Sutisna Sulaelman. 2018. Factors Associated with the Completeness of Inpatient Medical Record Filling in Dr. R SosodoroDjatikoesoemo, Bojonegoro, East Java. *Journal of Health Policy and Management* (2018), 3(1): 1-10.
- [11] Selvia Juwita Swari, Gamasiano Alfiansyah, Rossalina Adi Wijayanti, Rowinda Dwi Kurniawati. 2019. Analysis of Completeness of Filling in Medical Record Files for Inpatients of Dr. Kariadi Hospital, Semarang. *ARTERI: Journal of Health Sciences*. Vol. 1, No. 1, November 2019, hlm. 50-56.
- [12] Gemala R Hatta. 2008. Guidelines for Health Information Management in Health Care Facilities.
- [13] Winarti, S. S. Analysis of Completeness of Filling and Return of Hospital Medical Records. *Journal Administrasi Kesehatan Indonesia*.1, 345–351 (2013)
- [14] Febrianti, L. N. & Sugiarti, I. Completeness of filling in the obgyn surgery case report form as legal evidence. *Management Journal. Indonesian Health Indonesia*.7, 1–9 (2019).