COVID-19:
Journal of Health, Medical Records and Pharmacy
https://jurnal.devitara.or.id/index.php/sehat
E-ISSN: 3032-4033 Volume 1 Nomor 1 Tahun 2023

Overview of the Implementation of Incomplete Control of Medical Record Documents at Sentosa Baru Health Center in 2023

[1]Ali Sabela Hasibuan, [2]Siti Permata Sari Lubis, [3]Leli Nurmeida Gulo
[1,2,3] Study Program D-III Recorder and Health Information, Universitas Imelda Medan, Indonesia

ARTICLE INFO

Keywords:
Handling
Medical Records,
Incompleteness

ABSTRACT

One of the implementations of controlling medical record documents is by completing medical record documents properly in accordance with SOPs. This study was shown to determine the implementation of medical record document control at Sentosa Baru Health Center. This research is a Quantitative descriptive research. The method used in this study is by Observation. The research was conducted at Sentosa Baru Health Center. The study was conducted from June to August 2023. The population at Sentosa Baru Health Center is 780 medical record documents The sample size in this study was calculated based on the slovin formula so that 80 medical record documents were obtained as research subjects. For the completeness of medical record documents, in the section of writing patient identity, name, time, doctor's signature, there are 80 medical record documents completely (100%). The column of date, month, year, justification for writing medical records there are 40 complete medical record documents (50%) and in the writing section of Assessment, Planning, Screening-vital sign there are 60 complete medical record documents (75%). Thus, the author suggests to the medical record officer at Sentosa Baru Health Center, to re-socialize related to the SOP by filling out medical record documents and then evaluating the suitability between the SOP and the performance of the medical record officer.

Email :
alisabelahasibuan@gmail.com
sitipermata29@yahoo.co.id
leligulo27@gmail.com

INTRODUCTION

Based on the regulation of the Minister of Health of the Republic of Indonesia No. 55 of 2013 concerning the implementation of medical recorder work, a medical record is a file that contains records and documents about patient identity, examination, treatment, actions, and other services to patients at health care facilities [1]. The medical record contains all actions against outpatients at the puskesmas. The contents of medical record documents for outpatients in health care facilities are at least complaints from disease history , results of physical examination and medical support, diagnosis, management plan, treatment or action, other services that have been provided to patients [2].

The Community Health Center, hereinafter referred to as Puskesmas, is a first-level health facility responsible for public health in its work area. Minister of Health Regulation No. 75 of 2014 concerning Puskesmas or Community Health Centers states that puskesmas functions as an implementation of public health efforts and first-level individual health efforts[3]. Health, of course, requires that the patient's documents or files must be complete, the documents are also proof of service and can be accounted for and used as evidence if in the future there are legal problems.

Incomplete Control of incomplete medical record documents carried out by all medical record officers, Incomplete medical record files will be completed by medical record officers or incomplete medical records will be returned to the relevant section to complete medical records. except for incomplete medical record files that require authentication from medical personnel who fill in medical records when patients seek treatment [4]. A medical record is a record that contains the patient's identity, the results of examinations, medications, actions and other services provided to the patient and is a very important file for all health care installations [5].

Health services, especially in puskesmas at time, continue to experience changes and developments where this service is not only recommended for patient services but also includes complete documents. Completeness of documents is very necessary in supporting services because

document services are archives and become a reference in improving health services, this of course requires patient documents to be complete, documents are also proof of service and can be accounted for and used as evidence if in the future there are legal problems. The medical record contains all actions against outpatients at the puskesmas. The contents of medical record documents for outpatients at health care facilities are at least complaints and history of disease, results of physical examination and medical examination, diagnosis, treatment plan, treatment or action, other services that have been provided to patients at the time of treatment [2].

Previous research conducted by Fadilah, in 2020.About the analysis of factors causing incomplete medical records of inpatients at the new city health center. It is known that 30 inpatient medical records in April and May 2019, which were identified based on patient identification, important reports and authentication, obtained an overall average of 720 incompleteness figures (53.08%). The results of the analysis found that the causative factor that greatly influenced the incompleteness of inpatient medical records at the Kotaanyar Health Center was the method factor, namely the absence of SOPs (Standard Operational Procedures), thus making officers carry out their work without any guidance, thus making officers ignore what should be filled in and completed in the patient's medical record [6]. Previous research conducted by Amelia, in 2021. About the review of the implementation of Assembling in controlling incompleteness of medical record documents at the Tanah Merah Health Center, sorting medical record files, checking the completeness of medical record files and controlling incomplete medical record files. The completeness of filling out inpatient medical record files at Tanah Merah Health Center is 62% from 100%. The results of assembling research at the Tanah Merah Health Center still have many incompleteness of inpatient medical record files up to 38% [7]. Previous research conducted by Sahira, in 2021. Regarding the quantitative analysis of outpatient medical record documents at the Gondanglegi Health Center, some outpatient medical record documents are still incomplete in the important reporting, authentication, and documentation sections. Completeness of documents based on quantitative analysis at Puskesmas Gondanglegi This research method is descriptive with a quantitative approach from 95 documents. The results showed that 99% of the identification was complete, the important report was 81% complete, the authentication was 54% complete and the documentation was 39% complete. In this study, researchers obtained results regarding the title of quantitative analysis, namely there were also incomplete medical record documents, which were the most in the review of medical record documentation, which was 61% [8]. Previous research conducted by Yuliastuti, in 2020. Regarding the review of the implementation of assembling in controlling incomplete medical record files at RSU Muslimat Ponorogo, this study uses qualitative research with a cross sectional approach. The results of research at Muslimat Ponorogo general hospital are known that the implementation of assembling in controlling medical record files is carried out by selecting medical record forms according to applicable regulations, checking incompleteness, taking incomplete medical record files to the relevant department for 2x24 hours [4].

The impact of incomplete Medical Record documents is that the contents of medical records are a source of patient information so that incomplete medical record documents can have an adverse impact on the process of health services to patients which can later have an impact on the quality of service and the quality of medical records is very important because it determines the quality of services in puskesmas or hospitals [9].

Based on the results of an interview in the initial survey with one of the officers at Sentosa Baru Health Center, there are still some incompleteness in outpatient medical record documents and complete and incomplete medical records from the observations of 10 outpatient medical record documents, it was found that there were 5 medical record documents filled in completely and it was found that there were 5 medical record documents that were not filled in completely, including starting from writing the date, month, year of assessment and planning, vital sign screening and justification of medical record writing.

COVID-19:
Journal of Health, Medical Records and Pharmacy
https://jurnal.devitara.or.id/index.php/sehat
E-ISSN: 3032-4033 Volume 1 Nomor 1 Tahun 2023

METHOD

The type of research used is quantitative descriptive research, which is research that only describes a variable in research as it is supported by data in the form of numbers produced from various circumstances. Thus it can be known that quantitative descriptive research is a study that only describes, studies, and explains a phenomenon obtained with data in the form of numbers contained in the study [10].

In this quantitative descriptive research, which will be used as a population at Sentosa Baru Health Center, there are 780 outpatient medical record documents. A sample is a portion of the total population that is expected to be used as part of the material for a study [11]. To be able to find out the number of samples that will be used as research analysis material using the slovin formula. So, the number of samples to be examined in this study is 80 outpatient medical record documents.

Sampling technique is a technique used in sampling in a study. Then the sample technique used in this study is to use Simple Random Sampling, which is where every member of the population has the same opportunity to be used as a sample without distinguishing strata in any form [11]. Research variables are everything in any form set by the researcher to be studied so that information is obtained about it, then conclusions are drawn [12]. There are 2 variables used in this study, namely: Incompleteness of medical record documents and SOPs.

The instrument in this study, which was used to collect the data was the observation guideline. This study contains what things will be observed to be researched. Inside there are several statements filled with *checklist marks.* The goal is to get information about what parts have not been filled in completely on the outpatient medical record documents at Puseksmas Sentosa Baru.

Data collection is done by observation. Observation is an activity that uses the five senses, can be vision, smell, hearing, to obtain the information needed to answer research problems. Researchers conduct direct observations to collect primary and secondary data from related medical record officers. Primary data was obtained through direct observation at Sentosa Baru Health Center. Secondary data is obtained from SOPs obtained from research sites as reference material.

After the required data has been collected, the next step is to process the data. The data processing techniques used in this study are:

1. Make observations by making observations using *checklist* sheets to get a more detailed picture of the implementation of controlling incomplete medical record documents at Sentosa Baru Health Center.
2. Is a collection of information arranged with the possibility of leading to conclusions and data collection, the presentation of data is presented in the form of a narrative that describes the results of the study. With the presentation of data, it can be easier to understand the events that occur and plan the next steps based on what has been understood [13]
3. This stage the researcher will draw conclusions from the findings. The conclusions in quantitative research are new findings that have never existed before. Findings can be in the form of descriptions or images of an object that were previously still unclear so that after examination it becomes clear[14].

In this study, data analysis used in this study is to describe data that has been collected by direct observation methods to the field. Then it is processed as a whole into the results of the analysis to see the picture of the implementation of controlling the incompleteness of medical record documents at the Sentosa Baru Health Center.

RESULTS AND DISCUSSION

SOP Observation Results for Medical Record Filling

Observations made at Sentosa Baru Health Center found that the Puskesmas already has SOPs (Standard Operating Procedures) related to filling in medical records. SOPs at Sentosa Baru Health Center are useful for encouraging or mobilizing officers in filling out medical records. At Sentosa Baru

COVID-19:
Journal of Health, Medical Records and Pharmacy
https://jurnal.devitara.or.id/index.php/sehat
E-ISSN: 3032-4033 Volume 1 Nomor 1 Tahun 2023

Health Center, the filling of medical records has not been carried out according to the procedure because there are still incomplete medical record documents.

Results of Observation of Frequency Distribution of Medical Record Documents

The observations made by the researcher about the description of the implementation of control of incomplete medical record documents at Sentosa Baru Health Center on medical record documents obtained the number of frequency distributions of incomplete medical record documents as follows:

Table 1. Frequency Distribution of Incomplete Medical Record Documents at Sentosa Baru Health Center

No	Completeness of Medical Records	Complete		Incomplete		Total
		Frequency	%	Frequency	%	
1.	Patient Identity	80	100%	0	0%	**80**
2.	Date, month, year columns	40	50%	40	50%	**80**
3	*Assesment* dan *planning*	60	75%	20	25%	**80**
4	Name, time and signature of the doctor	80	100%	0	0%	**80**
5	*Skrining – Vital Sign*	60	75%	20	25%	**80**
6	Justification for Medical Record Writing	40	50%	40	50%	**80**

Based on the table above, it is stated that the frequency distribution of incomplete medical record documents is mostly complete in the patient identity section and the name, time and signature sections of doctors are completely filled in as many as 80 medical record documents with a percentage (100%). The frequency in the *assessment, planning and screening section of vital-sign* obtained 60 complete medical record documents with a percentage (75%) and 20 incomplete medical record documents with a percentage (25%). The lowest frequency is in the date, month, year column and justification for writing medical records as many as 40 medical record documents with a percentage (50%) and 40 incomplete medical record documents with a percentage (50%).

Discussion

SOP (*Standard Operating Procedure*) filling out medical records

The new Sentosa Health Center already has SOPs in filling out medical records, but when researchers make direct observations at the new Sentosa Health Center, there are still incomplete medical record documents that are not in accordance with the SOPs. Standard Operating Service Procedure is the flow of providing medical record services provided by health workers to retrieve patient data that has been stored in the medical record installation. Standard Operating Procedures (SOPs) are very important and very helpful for medical record officers to achieve a goal, especially in filling out medical record documents. [15]. Based on observations that have been made at the Sentosa Health Center, it is known that medical record officers filling out medical record documents are still not in accordance with existing Standard Operating Procedures (SOPs), because medical record officers do not understand and obey the SOPs for filling out medical record documents that have been set by the puskesmas. Therefore, it is necessary to re-socialize related to the SOP for filling out medical records and then evaluating the suitability between the SOP and the performance of medical record officers.

Frequency Distribution of Medical Record Documents

Frequency distribution on patient identity

Based on the results of research conducted on outpatient medical record documents at the Sentosa Baru Health Center, it is known that the percentage for the completeness of medical record

COVID-19:
Journal of Health, Medical Records and Pharmacy
https://jurnal.devitara.or.id/index.php/sehat
E-ISSN: 3032-4033 Volume 1 Nomor 1 Tahun 2023

documents in the patient identity writing section is 80 medical record documents with a percentage (100%). Based on the results on the patient's identity, the frequency has been filled in completely and in accordance with the SOP.

Frequency Distribution of Date, Month and Year Columns

Based on the results of research conducted on outpatient medical record documents at the sentosa baru health center, it is known that the percentage for the completeness of medical record documents in the writing section of the date, month and year column there are 40 complete medical record documents with a percentage (50%) and there are 40 incomplete medical record documents with a percentage (50%). The incompleteness of medical record documents in the date, month and year columns is caused by officers not being careful in filling in so that they are not in accordance with existing SOPs.

Frequency Distribution *of Assessment* and *Planning*

Based on the results of research conducted on outpatient medical record documents at the sentosa baru health center, it is known that the percentage for the completeness of medical recording documents in the Assessment and *Planning writing section* there are 60 complete medical record documents with a percentage (75%) and 20 incomplete medical record documents with a percentage (25%). In the results of the outpatient medical record document study, the completeness of medical record documents is good, because at this frequency the completeness is greater than the frequency of incompleteness.

Frequency Distribution of Doctor's Name, Time and Signature

Based on the results of research conducted on outpatient medical record documents at the Sentosa Baru Health Center, it is known that the percentage for the completeness of medical record documents in the name, time and signature of doctors there are 80 medical record documents with a percentage (100%). Based on the results on the patient's identity, the frequency has been filled in completely and in accordance with the SOP.

Frequency Distribution *of Screening-Vital Sign*

Based on the results of research conducted on outpatient medical record documents at the sentosa baru health center, it is known that the percentage for the completeness of medical recording documents in the Screening Vital Sign writing section *there are 60 complete medical record documents with a percentage (75%) and 20 incomplete medical record documents with a percentage (25%). In the results of the outpatient medical record document research, the completeness of medical record documents is good, because at this frequency the completeness is greater than the frequency of incompleteness.*

Frequency Distribution of Medical Record Writing Justification

Based on the results of research conducted on outpatient medical record documents at the sentosa baru health center, it is known that the percentage for the completeness of medical record documents in the justification section for writing medical records there are 40 complete medical record documents with a percentage (50%) and there are 40 incomplete medical record documents with a percentage (50%). Incomplete medical record documents in the date, month and year columns are caused by medical record officers not being careful in filling in dates, months and years. The officer was not careful in making the filling so that it was not in accordance with existing SOPs.

CONCLUSION

Sentosa Baru Health Center already has SOPs in filling out medical record documents, but it is still not in accordance with the standards that have been made based on SOPs. The cause of incomplete

medical record documents is the lack of accuracy of medical record officers in filling out medical record documents or lack of understanding of health workers in filling out medical record documents, the cause of incompleteness is that the implementation of SOPs has not been in full accordance with running well at Sentosa Baru Health Center. Based on the results of research conducted by researchers on outpatient medical record documents at Sentosa Baru Health Center. For the completeness of medical record documents, in the section of writing patient identity, name, time, doctor's signature, there are 80 medical record documents completely (100%). The column of date, month, year, justification for writing medical records there are 40 complete medical record documents (50%) and in the writing section *of Assessment, Planning, Screening-vital sign* there are 60 complete medical record documents (75%). Researchers can suggest to the Puskesmas, namely: We recommend that the implementation of procedures and policies must be carried out properly so that the filling of completeness of medical record documents can be 100% complete. Medical record officers should pay more attention to the contents of medical records and coordinate with doctors or nurses to continue to fill in complete outpatient medical records and the head of the puskesmas should carry out training for medical record officers to increase knowledge and skills in filling out medical record documents according to SOPs that have been made previously.

REFERENCES

R. Kemenkes, *Peraturan Menteri Kesehatan Nomor 55 Tahun 2013 tentang Penyelenggaraan Pekerjaan Perekam Medis*. 2009.

Rini, "Rekam medis berisi tentang semua tindakan terhadap pasien rawat jalan di puskesmas," 2019.

2014 Depkes, "Departemen kesehtan peraturan menteri kesehtan republik indonesia," 2014.

H. Yuliastuti, "Tinjauan Pelaksanaan Assembling Dalam Pengendalian Ketidaklengkapan Berkas Rekam Medis Di Rsu Muslimat Ponorogo," *J. Delima Harapan*, vol. 7, no. 1, pp. 39–47, 2020, doi: 10.31935/delima.v7i1.94.

Maimun and I. Sari, "Analisis Deskriptif Kelengkapan Dokumen Rekam Medis Di Poli Rawat Jalan Kia Rsupn Dr. Cipto Mangunkusumo," *J. Kesehat.*, vol. 10, no. 1, pp. 13–24, 2022, doi: 10.35913/jk.v10i1.244.

D. Fadilah, "Analisis faktor penyebab ketidaklengkapan rekam medis pasien rawat inap di puskesmas kotaanyar kabupaten probolinggo," 2020.

S. Amelia, "Tinjauan Pelaksanaan Assembling Dalam Pengendalian Ketidaklengkapan Berkas Rekam Medis Rawat Inap Di Puskesmas Tanah Merah," *Naskah Publ.*, 2021.

A. Sahira, "tinjauan pelaksanaan assembling dalam pengendalian ketidak lengkapan berkas rekam medis rawat inap di puskesmas tanah merah tahun 2021," 2021.

Dr ms Muhammad thabran talib skm mars, *manajemen rekam medis si jantung rumah sakit*. 2022.

W. Wahyudi, "Analisis Motivasi Belajar Siswa Dengan Menggunakan Model Pembelajaran Blended Learning Saat Pandemi Covid-19 (Deskriptif Kuantitatif Di Sman 1 Babadan Ponorogo)," *KadikmA*, vol. 13, no. 1, p. 68, 2022, doi: 10.19184/kdma.v13i1.31327.

Notoatmodjo, "METODOLOGI PENELITIAN," *2018*, 2018.

2015 Sugiyono, "Defenisi Operasional variabel penelitian," 2015.

A. Abdul, "Teknik Analisis Data Analisis Data," *Tek. Anal. Data Anal. Data*, pp. 1–15, 2020.

Sugiono, "Analisis Perubahan Hemodinamik," *Skripsi STT Kedirgant. Yogyakarta*, pp. 34–50, 2021.

E. A. Agustina, "Faktor Penyebab Ketidaklengkapan Pengisian Dokumen Rekam Medis Rawat Inap di Rumah Sakit: Literature Review," *J. Manaj. Inf. Kesehat. Indones.*, vol. 10, no. 1, p. 104, 2022, doi: 10.33560/jmiki.v10i1.403.