IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

REVIEW OF QUANTITATIVE ANALYSIS OF MEDICAL RECORDS OF INPATIENTS IN SURGERY AT DR. REKSODIWIRYO HOSPITAL PADANG

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Abstract: Completeness of medical records is very useful for knowing in detail the patient's history, examination actions that have been carried out, and planning further actions. To achieve this, the medical record department is obliged to carry out quality monitoring by conducting quantitative, qualitative, and statistical analyses. Knowing the complete and incomplete of a medical record file needs to be analyzed quantitatively Medical records must be completed immediately after the patient receives service. Completeness of filling in inpatient medical records must be achieved within 24 hours. This is done on an ongoing basis so that the quality of the files is maintained and the quality of the hospital can be improved. Reksodiwiryo Padang City to know the incompleteness of inpatient medical record files, especially in surgical cases by looking at the four components. This research will be carried out in September-October 2021 by looking at the medical record file and looking for incompleteness in the former. This research method is descriptive qualitative, while the method used is the observation method, looking at objects directly with a retrospective approach, looking at existing data. The population of this study was all medical record files of inpatients at TK III Dr. Reksodiwiryo in surgical cases in the first quarter of 2020. The result is the highest percentage of the identification component is the birthdate item at 94.29%, and the highest percentage of incompleteness is found in the gender item, which is 77.14%. The highest percentage of the completeness of the important report components was obtained on the patient progress record form of 98.6%, only one form did not have a patient progress record. The highest percentage of incompleteness obtained on the informed consent form is 27.14%. The highest percentage of the completeness of the authentication component is obtained for the doctor's name item by 69% and the nurse's title item is 100% incomplete. The percentage of incompleteness in the components of the recording method is the highest in the abbreviated item of 91.4%. In the medical record file, there are almost no abbreviations for diagnosis on the form. The highest percentage of incompleteness is found in the blank section of 57.14%.

Keywords : Incompleteness, Review, Surgery, Quantitative, Qualitative, Components

I. INTRODUCTION

Implementation of medical records in a health service facility is one indicator to see the quality of service at the institution. A good quality medical record is a medical record that meets medical record quality indicators, including the completeness of the medical resume, accuracy, punctuality, compliance with legal requirements. Medical record forms are used and must be filled out by various hospitals. All forms must meet the standards. The medical record form itself does not guarantee proper and good medical data records if the doctors and medical staff do not carefully complete the required information on each medical record sheet properly and correctly (Huffman, 1999).

Completeness of medical records is very useful for knowing in detail the patient's history, examination actions that have been carried out and, planning further actions. To achieve this, the medical record department is obliged to carry out quality monitoring by conducting quantitative, qualitative, and statistical analyses. Knowing the complete and incomplete of a medical record file needs to be analyzed quantitatively. Namely, 4 reviews consisting of an identity review, a recording review, a reporting review, and an authentication review (Widjaya, 2018).

Medical records must be completed immediately after the patient receives services. Completeness of filling in inpatient medical records must be achieved within 24 hours (Hatta, 2008). This is done continuously so that the quality of the files is maintained and the quality of the hospital can be improved. Based on the results of a preliminary study with existing medical record officers, it was stated that every patient's medical record file received from an inpatient was always assessed for completeness but still not optimal and incomplete values were always obtained. One of the problems, among others, is in terms of input, namely the high workload of medical record officers, facilities, and infrastructure, especially storage rooms and technology that are not yet optimal, and implementation that is not by SOP. The output is often late and incomplete submission of medical record documents. Patients with surgical cases are also not spared from incompleteness because they must have informed consent and an operation report if there is an action in the case.

From the existing problems, the authors are interested in researching in a quantitative analysis review on surgical cases at RS.TK III Dr. Reksodiwiryo Padang City. The aim of knowing and analyzing the incompleteness of inpatient medical record files, especially in surgical cases by looking at four components.

AKNOWLEDGE

III. METHOD

Time and Place

This research was conducted in September 2021 at Dr. Reksodiwiryo Hospital and continued with data processing at the Academy of Recorders and Health Information IRIS Padang.

Research methods

This research method is descriptive qualitative, namely research conducted to explain a variable without making comparisons or relationships. While the method used is the observation method, which looks at objects directly with a retrospective approach, namely looking at existing data. The population of this study was all medical record files of inpatients at TK III Dr. Reksodiwiryo in surgical cases in the first quarter of 2020. Completeness items observed include four components of quantitative analysis

V. RESULTS

Research review quantitative analysis of medical record documents of inpatients has been carried out in hospitals. Dr. Reksodiwiryo Hospital. Quantitative analysis was carried out on medical record files specifically for surgical cases in patients discharged from the first quarter of 2020, namely January to March. Quantitative analysis of medical record files is seen from the four components of the analysis, namely identification components, important reports, authentication, and recording methods. From the data collection

that has been done, 70 medical record files of digestive surgery cases have been obtained. Quantitative analysis of the identification components can be seen in table 1.

Table 1. The frequency distribution of incompleteness of the components of Identification of Medical Record Files specifically for Digestive Surgery at Dr. Reksodiwiryo Hospital in the First Quarter of 2020

No	Quantitative Component	Complete		Incomplete	
		n	%	n	%
1	Name	58	82,86	12	17,14
2	No RM	61	87,14	9	12,86
3	Date Of Birth	66	94,29	4	5,71
4	Gender	16	22,86	54	77, 14

Based on table 1, it can be seen that the highest percentage of completeness of filling in the identification component is the date of a birth item at 94.29% and the highest percentage of incompleteness is found in the gender item, which is 77.14 %. On each medical record form, the patient identification that is printed and made in the form of a sticker is only the patient's name, date of birth, and medical record number, so the gender item is not filled out completely. Some of the patients' names were not written completely and clearly on the forms that were not affixed to the patient identification sticker. To see the distribution of filling out the important report components, see table 2.

Table 2. The frequency distribution of incompleteness of the components of important report of Medical Record Files specifically for Digestive Surgery at Dr. Reksodiwiryo Hospital in the First Quarter of 2020

No	Quantitative Component	Complete		Incomplete	
		n	%	n	%
1	General Consent	63	90,0	7	10,00
2	Informed Consent	51	72,9	19	27,14
3	Anasthesia Report	55	78,6	15	21,43
4	Progress Note	69	98,6	1	1,43
5	Operation Report	56	80,0	14	20,00
6	Medical Resume	61	87,1	9	12,86

From table 2, it can be seen that the quantitative analysis of the important report components consists of the general consent form, informed consent, anesthesia report form, progress note form, operation report, and medical resume. The highest percentage of the completeness of the important report components was obtained on the patient progress record form of 98.6%, only one form did not have a patient progress record. The highest percentage of incompleteness obtained in the informed consent form was 27.14%. This is because the diagnosis obtained in the medical record file does not have an operation/procedure. A total of 70 medical record files have been processed, nine mild diagnoses were found that did not have procedures.

Table 3. The frequency distribution of incompleteness of the components of Authentication of Medical Record Files specifically for Digestive Surgery at Dr. Reksodiwiryo Hospital in the First Quarter of 2020

No	Quantitative Component	Lengkap		Tidak Lengkap	
		n	%	n	%
1	Doctor's Name	69	98,6	1	1,43
2	Doctor's Signature	68	97,1	2	2,86
3	Doctor's Degree	66	94,3	4	5,71
4	Nurse Name	24	34,3	46	65,71
5	Nurse's Signature	60	85,7	10	14,29
6	Nurse's Degree	0	0,0	70	100,00

Based on table 3, the highest percentage of the completeness of the authentication component was obtained on the doctor's name item by 69% and only one medical record file was incomplete in writing the doctor's name. In the medical record file, each form has the doctor's full name stamp along with the title. The percentage of incomplete authentication components in the nurse's degree is 100%. All medical record files in surgical cases do not include the title of the nurse's name. In each form it was also found that the nurse's name was not written completely, the percentage of incompleteness in the nurse's name item was also quite large as much as 65.71%. 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. The frequency distribution of incompleteness of the components of Recording Method of Medical Record Files specifically for Digestive Surgery at Dr. Reksodiwiryo Hospital in the First Quarter of 2020

No	Quantitative Component	Lengkap		Tidak Lengkap	
		n	%	n	%
1	clear	42	60,0	28	40,00
2	Abbreviation	64	91,4	6	8,57
3	Correction	63	90,0	7	10,00
4	Empty Section	30	42,9	40	57,14

From table 4, it can be seen that the percentage of incompleteness in the components of the recording method was the highest in the abbreviated item of 91.4%. In the medical record file, there are almost no abbreviations for diagnosis on the form. The highest percentage of incompleteness is found in the blank section of 57.14%. This blank is found in many forms. Furthermore, the item with the highest percentage of incompleteness is the item of writing clarity of 40%. An illegible diagnosis is a diagnosis of Acute Appendicitis.

DISCUSSION

Quantitative analysis is carried out on four components, namely identification, important reports, authentication, and recording methods. The first component is identification, consisting of name, medical record number, date of birth, and gender. Birthdate items have the highest percentage. Each sheet of the form contains the date of the birth item which can determine the age of the patient. The completeness of this identification component is the highest component compared to other components.

The identification component is administrative data that is very important to start a service. In addition, it is also demographic information that must be filled in completely to process hospital statistics, without an identification component we will not know whose medical records we manage at the service facility. As stated by Widjaya (2018), every medical record form must at least have a patient identity such as the patient's name,

medical record number, date of birth, and gender. If there is an unidentified sheet, it must be reviewed to determine who it belongs to.

The quantitative analysis begins by examining each medical record sheet, according to Huffman (1999) that the patient's identity at least has a name and medical record number. Because if you don't know who the sheet belongs to, it makes the ownership of the form difficult to know and the possibility of misdiagnosing or administering medication so that it must be reviewed to make sure who the form belongs to. Gender items get the highest percentage of incompleteness. This item is rarely found on medical record sheets. The hospital only provides and prints many items of names, dates of birth, and medical record numbers. It is important to include gender on the identification sheet to know how the service is provided according to gender.

The second component is an important report component. This component also determines the incompleteness of a medical record document. This important report review aims to analyze forms such as medical history, physical examination, clinical observations, and conclusions at the end of treatment. If this report is complete it can be used for diagnostic testing, consultation, or surgery (Rani, 2015). From the observations on the reporting analysis, it shows that the most incompleteness in the informed consent reporting review. Because some of the diagnoses found did not have an operative action/procedure.

According to Huffman (1999), reporting review is a quantitative analysis procedure that must confirm which reports will be carried out, when and under what circumstances because if at any time there are patients who feel they have experienced malpractice in service, they can show medical record documents as legal evidence. Hatta's statement (2010) that report items such as summary entry and exit, operation reports, medical resumes, progress notes must be filled in completely because they are subjective descriptions to emphasize the reasons for medical treatment and services to be provided to patients.

The patient progress report item received the highest percentage of completeness. Every hospitalized patient will be observed and monitored for health by nurses and doctors every day. All patient progress will be recorded in a detailed progress note form.

The third component is the authentication component. Authentication is a process that is an act of proof (validation) of a person's identity, in this case, a doctor or nurse who has the authority to fill in the patient's medical record file. Authentication can be in the form of full name, signature, stamp, and initials that can be identified in medical records or a person's code for computerization. Authentication in terms of filling in the medical record file is related to the doctor in charge of the patient and the nurse who handles the patient during inpatient care (Hatta, 2008).

The fourth component is the recording method. In recording or writing medical records, errors in writing or abbreviations that are not by the provisions and procedures for correcting errors must be carried out properly so that the contents are easy to read and clear. If the needs and writings are not clear, there will be errors in reading them, it can also harm the hospital, especially doctors and nurses in dealing with these patients if used in legal force. In the justification of writing, it is forbidden to use corrective and cross out more than twice (Rani, 2015). The unit responsible for reviewing incomplete records is the nurse. The incompleteness in the recording is caused by nurses being less thorough and having to know more about how to fill out the correct medical record form.

A quality medical record is a medical record that contains complete data so that it can be processed into information. The completeness of filling out medical record files is very important because one of the uses of medical record files, when viewed from a legal aspect, is written evidence.

CONCLUSION

Based on the results of a review of quantitative analysis of medical record files of inpatients in surgical cases in the first quarter of 2021 at the hospital. Dr. Reksodiwiryo Hospital can
concluded that:

1. The highest percentage of the identification component is the birthdate item at 94.29%, and the highest percentage of incompleteness is found in the gender item, which is 77.14%.
2. The highest percentage of the completeness of the important report components was obtained on the patient progress record form of 98.6%, only one form did not have a patient progress record. The highest percentage of incompleteness obtained on the informed consent form is 27.14%.
3. The highest percentage of the completeness of the authentication component is obtained for the doctor's name item by 69% and the nurse's title item is 100% incomplete
4. The percentage of incompleteness in the components of the recording method is the highest in the abbreviated item of 91.4%. In the medical record file, there are almost no abbreviations for diagnosis on the form. The highest percentage of incompleteness is found in the blank section of 57.14%.

ACKNOWLEDGMENT

The author would like to thank Apikes Iris for funding this research. This research was funded by LPPM Apikes Iris (Apikes Iris Research and Community Engagement Agency).

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