

Factors Causing Incomplete Filling of Medical Records of Inpatients in Private Hospitals X Tangerang City

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Abstract. This research is aimed to identify the factors causing incompleteness in filling the medical record file of inpatients in private hospital X in the city of Tangerang, Banten. This research is a descriptive analysis study using quantitative and qualitative methods. The sample used was 100 files of inpatient medical records that returned to the medical record unit and indicated incomplete was taken by random sampling out of 100 incomplete medical record files, 156 were found to be incomplete. Factors causing incompleteness are due to the large number of patients treated by doctors, doctors have busy schedules, and short time doctor visits. Private hospital X must pay attention to this because the incompleteness of filling medical records affects the quality of medical record services and impacts on the continuity of service and patient safety.

Keywords: incomplete medical record, Inpatient.

1 Introduction

Medical records are written documents which contain identity, anamneses, physical examination, medical support examinations, diagnoses, clinical pathway, and all services provided to patients and treatment both performed in inpatients, outpatients as well as emergency services. Recording and filing of medical records can be done by general practitioners, specialists, subspecialists, dentists, dental specialists, residents who are practicing, nurses and non-nurses paramedics[1][2][5].

According to the regulation of Indonesian Health Minister number 269 in 2008 that the contents of a medical record in a hospital can be divided into the contents of the medical record for outpatient, inpatient, and emergency services. For the contents of medical services performed by specialist doctors and specialists, dentists can be developed as needed [2].

One of the efforts to improve the quality of hospital services is to improve the quality of medical record services, which include completeness, speed, and accuracy in providing information for better patient care needs. Management of a good medical record is a picture of the quality of medical services in the health care facility[6][11].

The medical record must contain complete information about the patient's past, present, and forecast processes that occur in the future. Records in a good, accurate, and complete medical record file are very useful for reminding physicians with the circumstances, examination results, and treatment that has been given to patients. This completeness is very useful for planning patient treatment strategies. Medical records must be made immediately and completed after the patient receives the service. All records in the medical record must be

accompanied by the name, time, and signature of the officer providing the service. It will be easily traced to each record recorded in the medical record file [2][5][10].

The incompleteness of the medical record file can be a problem because the medical record is the only record that can provide detailed information about what happens during a patient being hospitalized. It can have an impact on internal and external hospitals because the contents of the data contained in the medical record are the basis for making reports, both internal and external to the hospital. This report will be used for the preparation of various plans and evaluations of hospital activities. In addition, the incomplete medical record file also causes the health insurance claim process by the third party and BPJS Health to be hampered [1].

The inpatient unit is one of the health services that record their health service activities in the medical record. The Inpatient Unit is responsible for all clinical services provided by health workers to patients until after treatment. The patient's medical record that has used should be submitted to the medical record department within no later than 1x24 hours to see the complete contents of the data from the medical record file. The completeness of the medical record file is very important because it influences the service process carried out by medical staff in the inpatient unit, and it will affect the quality of its hospital services [7][8].

This research was conducted to identify the factors causing incompleteness of inpatient medical record file in a private hospital "X" in the Regency of Tangerang City, Banten.

2 Method

This research is a descriptive analysis study using quantitative and qualitative methods. The sample used was 100 files of inpatient medical records that returned to the medical record unit and indicated incomplete in a private hospital "X" in Tangerang City, Banten, on March 18-23, 2019. The sample was taken by random sampling. Incomplete data were grouped based on the types of inpatient sheets, such as a doctor's resume, initial inpatient assessment, perioperative assessment, entry and exit sheet, medical measures, emergency assessment, and Integrated Patient Development Record (IPDR). After being grouped, then a percentage of incompleteness is made.

In-depth interviews were conducted with 3 people, namely; 1 inpatient doctor, 1 inpatient nurse, and 1 medical records officer to explore the causes of incompleteness in filling out the medical record file.

3 Result

Inpatient medical record files generally consist of Medical Resumes, Initial Inpatient Assessments, Perioperative Assessments, Entry and Exit Sheets, Medical Measures, Emergency Measures, Integrated Patient Development Records (IPDR). The Emergency Evaluation Sheet is found in the medical record file if the patient receives the first treatment in the Emergency Installation Unit while the Perioperative Assessment sheet is in the medical record file if the patient undergoes an action such as surgery. From 100 samples of inpatient medical record files that trace their incompleteness on March 18-23, 2019. Several medical record files have more than one incompleteness. So that out of the 100 samples found 156 incomplete sheets.

Table 1. Incomplete Medical Records Sheet

No	Medical Records Sheet	Number	Percentage
1	Medical Resume	54	34,6%
2	Initial Inpatient Assessments	52	33,3%
3	Perioperative Assessments	23	14,7%
4	Entry and Exit Sheets	11	7,1%
5	Medical Measures	8	5,1%
6	Emergency Assessment	6	3,8%
7	Integrated Patient Development Records (IPDR)	2	1,3%
	TOTAL	156	100%

According to table 1, it can be seen that the medical resume sheet is the sheet with the most incompleteness. The percentage of incompleteness for this medical resume sheet is 34.6%. The sheet with the least completeness is IPDR, which is only 2 sheets with a percentage of 1.3%. The incompleteness in the medical resume sheet includes the patient's identity, the doctor's signature, the patient's signature, and examination actions.

Interviews were conducted to find out the cause of the incompleteness of the inpatient medical record file. The interviews involved 3 resource persons, namely 1 inpatient doctor, 1 inpatient nurse, and 1 medical records officer. Based on the results of the interview, researchers obtained information about the incompleteness of the inpatient medical record file. The following are the results of interviews 3 causes of incomplete inpatient medical record file, namely:

1. The doctor has a busy schedule.
The tight schedule of visits or medical procedures such as surgery can cause doctors sometimes forget to complete the medical record file that has not been completely filled.
2. A lot of patients to be treated.
Doctors feel they must provide maximum service to patients, but if the number of patients is large enough so that doctors prioritize service to patients rather than filling out the complete medical record file, so there are several sheets in the medical record file that are forgotten when filled.
3. The doctor does not write the medical record file
Filling the medical record sheet takes 1x24 hours to complete the inpatient medical record file. Sometimes the doctor is in a hurry to visit another treatment room, so some sheets are not filled.

4 Discussion

There are some studies on the completeness of the medical record file that still found that the medical record file was not filled out completely, which occurred in several hospitals. Some researchers, among others, Pujihastuti (2014), from 100 medical record files taken, there were 30 incomplete medical record files. Pamungkas (2015) found that incomplete medical record documents occurred in the Perinatology room of Ngudi Waluyo Wlingi Regional Hospital, which was 34.79%. Meanwhile, Winarti (2013) found incompleteness in inpatient installation at RS X Surabaya by 66%. Rahmadhani (2008), in a preliminary survey at RSUD

Dr. Mowardi Surakarta, found a medical record file with the category of IMR (Incomplete Medical Record) of 70%.

More detailed studies have also been carried out, where this study not only looks for the percentage of incomplete medical record files but also searches for incompleteness that occurs on various sheets in the medical record file. Nurhaidah (2016) reported from 40 incomplete inpatient medical records files the highest percentage of incompleteness on the medical resume sheet. Winarti (2013) reported in her research at X hospital in Surabaya found the highest incompleteness on the history sheet of the disease, 18% of the sample. The incompleteness of the exit summary sheet was found in Nugraheni's (2013) study, 84.7% of 149 medical records of inpatients with typhoid fever in Banyudono Boyolali District Hospital. From the various studies above it turns out that the incompleteness of filling in the medical record file fillings varies greatly, including the medical resume, history of illness, summary of the patient's exit, and others.

Pujihastuti's research (2014) states that one of the factors causing the incompleteness of filling medical record document information including less time for doctors visits, a large number of patients, busy doctors, and doctors in a hurry. The same result in Nuraidah's research (2016) found that the factors that cause diagnosis main are not filled, including doctors busy, the number of patients is large; doctors only concerned with service.

In this study, 100 incomplete inpatient medical record files obtained medical resume sheets with the percentage of the incompleteness of 34.6%. The incompleteness in the medical resume sheet includes the patient's identity, the doctor's signature, the patient's signature, and examination actions. Republic of Indonesia Minister of Health Regulation No. 269 of 2008 states that data such as patient identity, the signature of fillers, and medical examination are completeness that should be filled in the medical record. Completeness of the medical record is very useful to know in detail the patient's disease history, examination actions that have been carried out, and plan further actions. Diagnosis of the disease determined by a doctor will greatly affect the actions of patients both in treatment or even the actions to be taken. An accurate diagnosis is based on history, physical examination, supporting examination, and written in the medical record file.

The treating doctor, medical record officer, the hospital director, and medical staff have the responsibility for the medical record. The main responsibility for the completeness of the medical record lies with the doctor who treats the patient. The incomplete medical records will make the classification and codification of the disease more difficult. It is also difficult for the hospital to make a report and will slow the insurance claims. The incompleteness of filling medical records also affects the quality of medical record services [2][9].

A complete medical record can be obtained information that can be used for various purposes. The use of medical records contains several aspects, namely administration, law, finance, research, education, and documentation. In the administrative aspect of the medical record is a health service administration record. By the law, the medical record can be used as evidence in court. In addition, medical records can also be used as a basis for detailing the cost of health services to be paid by patients. In the aspect of research, medical records can be used as material for research in the fields of medicine, care, and health. The data in the medical record can be used as material or teaching references in the field of the health education profession. The medical record file has a documentation value because its contents concern the source of the memory, which must be documented and used as material for accountability and hospital reports [7].

5 Conclusion

Out of 100 incomplete medical record files, 156 were found to be incomplete. It is because several medical record files have incomplete more than 1 type for 1 medical record file. The most type of incompleteness is the incomplete medical resume that is as much as 54%. Factors causing incompleteness are due to the doctor's busy schedule, the large number of patients that must be treated by a doctor, and the short doctor's visit time. It results in doctors often not completing resumes. The incompleteness of medical records will make the process of classification and coding of diseases, obstructs the process of making hospital reporting, and impedes the process of filing insurance claims. The incompleteness of filling medical records will also affect the quality of medical record services and have an impact on the continuity of service and patient safety. Hospitals should have strict policies and SOP to complete the medical record file and provide sanctions for those who do not complete the medical record file. It is to reduce the number of incomplete medical records.

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