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Analysis of The Completeness of The Contents of Inpatient Medical Record Documents for Kidney Failure Cases at Ny.R.A Habibie Kidney Specialty Hospital

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ABSTRACT

Background. This study aims to determine the completeness of medical record documents for inpatient cases of kidney failure because there are incompleteness in filling out the completeness of medical record documents for inpatient cases of kidney failure at the Ny.R.A Habibie

Purpose. Medical records are files that contain information about patient identity, anamnese, physical laboratory determinations, diagnoses for all medical services and actions provided to patients and treatment for both inpatients, outpatients and those who get emergency services

Method. Research methodology is a systematic framework or approach used by researchers use to plan, conduct, and analyze research

Results. Based on the results of research that has been conducted at the Medical Records Installation at the Ny.R.A Habibie Kidney Special Hospital Bandung

Conclusion. Medical record documents, in analyzing medical record files should be carried out by medical record officersThe tax system does not have a partially significant effect on taxpayers' perceptions of tax evasion because whether the tax system is good or not is not the only thing that affects the perception of taxpayers.

KEYWORDS
Completeness, Hospitalization, Renal Failure

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INTRODUCTION

Medical records are files that contain information about patient identity, anamnese, physical laboratory determinations, diagnoses for all medical services and actions provided to patients and treatment for both inpatients, outpatients and those who get emergency services(Dola Ramalinda). Medical records are used as a reference for future patients, especially when patients return to treatment, patient medical records must be ready when patients return to treatment. Health workers will find it difficult to perform actions or therapies before knowing the history of the disease, actions or therapies that have been given to patients contained in medical record files. The important thing in a medical record file is its availability when needed and the completeness of its filling.

According to Permenkes No. 24 of 2022 article 31 paragraphs 1 and 2, filling in clinical information is in the form of recording and documenting the results of examinations, treatment, actions, and other health services that have been and will be provided to patients(Rahayu et al., 2024). Recording and documentation must be complete, clear, and carried out after the patient receives health services by including the name, time, and signature of health workers who provide health services.

Medical record documents in patients with kidney failure must be complete because it will make it easier for doctors to treat patients with kidney failure. In addition, medical record documents are also a source of data in the medical records section in data processing which will then become useful information for management in determining strategic steps for the development of health services(Maulinnisaa Tiur R.N, 2024). Incomplete medical record documents for Kidney Failure disease can cause inaccuracies in the action information provided to patients(Muchsam et al., 2023). Social data information includes patient identity and medical data includes examination results and anamnesis must be complete. Every action that will be given to a patient with Renal Failure is one of them through a signed doctor's assessment, as an act of medical accountability both from the examination until the patient is discharged from the hospital.

Medical records are important documents that contain information about the patient's identity, anamnesis, physical and laboratory examination results, diagnosis, and all medical actions given to patients both in inpatient care, outpatient care, and emergency services (Dola Ramalinda). Medical records not only function as a record of the patient's medical history, but also become an important reference for health workers in providing follow-up actions or therapy when patients return to treatment. In the context of kidney disease, the completeness of medical record documents is very important to ensure that the medical treatment provided is appropriate and in accordance with the patient's treatment history.

Facts on the ground show that there are still many medical record documents that are not filled in completely, especially in patients with kidney failure. This has the potential to cause difficulties for medical personnel in making clinical decisions and can have an impact on the quality of health services received by patients. Based on the provisions of Permenkes No. 24 of 2022 Article 31 paragraphs 1 and 2, filling in clinical information in medical records must be carried out completely, clearly, and documented after the patient receives health services, by including the name, time, and signature of the health worker who provides the service (Rahayu et al., 2024). However, in reality, in the field, there are still shortcomings in filling out this document, which has an impact on data processing for decision-making for hospital management and health service development.

The research gap lies in the lack of studies that specifically examine the completeness of filling in the medical records of patients with kidney failure, especially in hospitals that specialize in the treatment of kidney disease. This study seeks to fill this gap by providing an in-depth analysis of the level of completeness of filling medical records in patients with kidney failure.

The purpose of this study is to evaluate the completeness of medical record documents of patients with kidney failure, as well as identify the factors that cause the incompleteness of filling out these documents. The results of this study are expected to contribute to improving the quality of medical record documentation in hospitals, as well as supporting better decision-making in the health management of kidney failure patients.

RESEARCH METHODOLOGY

Research methodology is a systematic framework or approach used by researchers use to plan, conduct, and analyze research(Sutisna et al., 2024). This type of research uses descriptive research methods, namely research conducted only up to the conclusion, presentation, and analysis of data in the form of narratives, tabulations or diagrams as well as calculations of percentages and sample data without forecasting and proving broader data or analyzing a research result but not used to make broader conclusions(Raharja et al., 2024)

The research approach used is quantitative, because the research data is in the form of numbers and analysis using statistics(Hariyanti et al., 2024). This study aims to determine the percentage of completeness of filling out inpatient medical record documents for kidney failure cases at the Ny.R.A Habibie Kidney Specialized Hospital.

Population, Sample, and Sampling Technique

Population

Population is the whole object of research (Noor J, 2017). The population in this study were all medical record documents of inpatients with kidney failure cases at the Ny.R.A Habibie Kidney Special Hospital in February 2023, totaling 92 medical record documents.

Sample

The sample is the object under study and is considered representative of the entire population (Notoatmodjo, 2018). According to Arikunto in 2010 if the population is less than 100, then the sample is taken as a whole, but if the population is greater than 100, then 10-15% or 20-25% of the population can be taken.

Data Collection Techniques and Instruments

Data Collection Technique

The data collection technique used in this study is an observation technique, which is to collect data by directly observing the object to be studied, namely directly taking samples of inpatient medical record documents for renal failure patients to observe incompleteness on each form and using a retrospective approach, namely looking at existing data.

Research Instruments

Observation sheet, in the form of a check list to determine the percentage of completeness of filling out inpatient medical record documents based on accurate clinical documentation criteria.

Stationery, used to record data needed during research

Calculator, used to calculate the percentage of completeness of filling out inpatient medical record documents based on accurate clinical documentation criteria.

Data Processing and Analysis Technique

The data obtained through the above methods are then processed in the following way:

Checking (Editing)

Rechecking or examining the data that has been collected and has been processed into a checklist so that there is no illegible or incorrectly written data.(Maulinnisaa, Agung, 2024)

Tabulation

Making tables to enter data into tables to facilitate data calculation and analysis.

Data Presentation

Presenting data in tabular form.

Calculation

Provide a percentage of incompleteness of inpatient medical record documents.

While the data analysis used in this research is descriptive analysis, namely describing the results of research and comparing with existing theories and based on the results of the research conclusions can be drawn.

RESULT AND DISCUSSION

Based on the results of research that has been conducted at the Medical Records Installation at the Ny.R.A Habibie Kidney Special Hospital Bandung, the authors can suggest the following;

Completeness of Patient Identification

According to Hatta (2013), the selection of each page or sheet of medical record documents in terms of patient identification must at least contain the medical record number and patient name. If there is a sheet without identity, a review must be carried out to determine the ownership of the medical record form. Completeness of patient identification review is useful as patient safety care, which prevents injury due to errors in patient identification. Review of identification in medical record files in the inpatient room for kidney failure cases at the Ny.R.A Habibie Bandung Kidney Specialized Hospital in accordance with (Hatta, 2013). The patient's identity record form must be filled in completely, such as the name and medical record number items must be filled in on each medical record form, this is intended to avoid errors in service delivery and continuity in assembling medical record files. Filling in gender to find out whether the patient is male or female, date of birth to find out the identity of when the patient was born, if information is still needed from the hospital. By filling in all items in the identification section, it will make it easier to determine the patient's file if there are forms that have not been assembled, it will make it easier to complete patient data, this is important for the continuity of patient information and ownership of the contents of the medical record file. Based on the research results in table 4.2 regarding patient identification review, the completeness value is filled with a percentage of 67% and the incompleteness value is filled with 32%.

Discussion of the completeness of patient identification in medical record documents is very important to ensure patient safety and avoid mistakes in the provision of health services. As revealed by Hatta (2013), each sheet of medical record documents must be equipped with a medical record number and the patient's name to ensure ownership of the document. This is in line with patient safety practices, which aim to prevent injuries or mistakes due to improper patient identification. In this study, the completeness of patient identification at Mrs. R.A Habibie Bandung Kidney Special Hospital reached 67%, showing that there is still room for improvement, especially related to the importance of completing all patient identity data on each sheet of medical record documents.

Filling out complete patient identification, such as gender and date of birth, is also important to support the accuracy of medical information. This data makes it easier for medical personnel to access the right information about patients, as well as reduce the risk of errors in the treatment process. Patient identification completeness helps in integrating and assembling different medical record documents so that patient information can be managed properly and no part is left behind. Therefore, incompleteness of filling, which in this study reached 32%, could hinder the optimal documentation and clinical decision-making process.

In addition, the completeness of identification plays an important role in maintaining the continuity of patient information, especially in situations where documents have not been fully assembled. With complete identification data, hospital staff can easily find and reorganize documents that may not have been properly organized, so that all medical records remain intact and can be accessed quickly. This is not only important for maintaining patient safety, but also to ensure that medical records can be used effectively in the evaluation and follow-up of patient care.

Completeness of Important Reports

In Hatta (2013), it is explained that important reports are evidence of records that can be accounted for in full, namely the existence of visit data / information containing reasons, patient complaints (if any), examination history, additional data (lab), ultrasound, ECG, ECG, diagnosis or condition, referral (if done). Based on the research results in table 4.3 above, it can be seen that the number of important general medical record reports with a higher incomplete presentation is the Integrated Patient Progress Note (CPPT) with a percentage of 18%, Treatment and or action 15%, Approval of action when needed 10%. Incompleteness in filling out these important reports can cause difficulties in evaluating the medical services provided and ultimately cannot be used as evidence in court. In the event of malpractice claims from patients, medical records can help doctors or other health workers as evidence of services provided.

The completeness of important reports in medical record documents plays a crucial role in ensuring the quality and accountability of the health services provided. Hatta (2013) emphasized that important reports, such as patient complaint records, examination results, supporting data (e.g. laboratory, ultrasound, ECG), diagnosis, and referrals, are evidence that must be recorded completely and can be accounted for. In this study, there are several important reports that have not been filled in completely, with the CPPT (Integrated Patient Development Record) form being the most incomplete, which is 18%. This shows that although most of the important reports are filled, there are shortcomings that need to be corrected urgently to improve the quality of medical documentation.

Incompleteness in filling out important reports can have a serious impact on the evaluation process of medical services provided to patients. Reports such as CPPT, approval of action, and medical action records are important documents for evaluating the effectiveness and appropriateness of the actions taken during treatment. If these reports are incomplete, the medical team may face difficulties in conducting retrospective evaluations of the treatments that have been given, which can ultimately influence future clinical decisions. In addition, the completeness of important reports also serves as necessary documentation for the purpose of internal audit of the hospital and improving the quality of service.

In addition to medical evaluation, a complete medical record also serves as legal evidence in the case of malpractice claims. Incompleteness of important reports can weaken the legal position of hospitals and medical personnel in their defense in court. In the event of a malpractice claim from the patient, a complete medical record can be used as valid evidence that the medical procedure has been carried out in accordance with applicable standards. Therefore, efforts to improve the completeness of filling out important reports must be a priority for every health institution, not only for administrative purposes but also to protect medical personnel from unfounded lawsuits.

Completeness of Authentication

Hatta (2013) explains that all entries in medical records must have authorization from the health worker who wrote them. Include the name and position (doctor, nurse, other health workers) and the date it was made. If the authentication review only contains the doctor's signature and does not include the name of the treating doctor, it is difficult to know who the responsible doctor is. It is difficult to know who the responsible doctor is, because the doctor's name and signature indicate the legality aspect, namely as proof of responsibility if at any time used as evidence in a legal case. Especially in risky cases or actions, authentication must be filled in completely and signed by the doctor or the authorizer. Incomplete authentication is part of the doctor's indiscipline and responsibility. Based on the research results in table 4.4 above, it can be seen that the percentage of completeness of authentication containing the doctor's name and doctor's signature is 75% and incompleteness is 25%.

The completeness of authentication in medical records is essential to ensure that every action and information recorded can be accounted for legally and ethically. Hatta (2013) emphasizes that every entry in a medical record must be accompanied by authorization by the health worker who wrote it, including the name, position, and date of making the record. Incompleteness of authentication, such as simply listing a signature without including the name of the doctor in charge, poses a major problem in terms of accountability. Without a clear name, it can be difficult to know who is responsible for the actions taken, which can complicate medical evaluation as well as legal proceedings in the event of a lawsuit.

In the context of high-risk medical cases, complete authentication, including the signature and name of the doctor, is essential to guarantee the legality of the actions taken. This is not only useful as evidence in legal situations, but also provides assurance to patients that the actions they have received have been carried out by legitimate and competent medical personnel. Incomplete authentication can indicate a lack of discipline among doctors or medical personnel in maintaining standard documentation procedures. In this study, the authentication completeness rate reached 75%, which means that there are still 25% of incomplete documents, and this needs to be improved so that optimal documentation standards can be achieved.

In addition to the legal aspect, complete authentication also plays an important role in ensuring the continuity of patient care. In care that involves a lot of medical personnel, clear authentication helps identify who is responsible for every aspect of patient care. In the event of a problem or change in a patient's condition, complete authentication makes it easier for the medical team to refer to the right doctor for follow-up. Therefore, it is important for every healthcare institution to ensure that authentication in medical records is carried out in a disciplined manner and in accordance with established standards.

CONCLUSION

Based on the conclusions stated above, the authors propose the following suggestions:

It is hoped that the hospital needs to socialize to all officers regarding the completeness of filling out medical record documents, follow Standard Operating Procedures (SPO) related to quantitative analysis of the completeness of medical record documents, in analyzing medical record files should be carried out by medical record officers, and give a warning to doctors and officers if there are still incomplete medical record documents. There can be a certain reward and punishment program for the performance that has been done by all parties involved in the hospital, related to the completeness of filling out medical records. Make a graph regarding the orderliness of doctors in filling out inpatient medical record files. For further researchers, it is hoped that further research can be carried out regarding quantitative analysis of the completeness of medical record documents.

AUTHORS' CONTRIBUTION

Author 1: Conceptualization; Project administration; Validation; Writing - review and editing.
Author 2: Conceptualization; Data curation; In-vestigation.

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