ORIGINAL ARTICLE

Implementation of Inpatient Medical Records at dr. Reksodiwiryo Hospital: A Qualitative Study

Pelaksanaan Rekam Medis Rawat Inap di Rumah Sakit dr. Reksodiwiryo: Studi Kualitatif

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ABSTRACT

The objective of this study was to examine the implementation of medical records for hospitalized patients at dr. Reksodiwiryo Padang Hospital. The study employed a qualitative research methodology. Seven research informants were selected using the purposive sampling technique. Data were gathered through the utilization of in-depth interviews, on-site observations, and scrutiny of documents. The Miles and Huberman model was employed for data analysis, encompassing reduction, display, and conclusion operations. The data validity test employed both source triangulation and method triangulation. According to the research findings on the input element, the quantity of medical record personnel was adequate and there was an existing standard operating procedure (SOP). However, there was a lack of dedicated budget and insufficient facilities and infrastructure. The procedural element of patient documentation, particularly in regard to the recording of admission and discharge sheets, was not fully completed. There was a delay in the submission of medical records, resulting in suboptimal medical record processing. An error occurred during the medical record storage process, resulting in a misfile. The implementation of Medical Records for Inpatients at dr. Reksodiwiryo Padang Hospital was suboptimal and required enhancement. It is advisable for the hospital to provide training sessions to enhance the proficiency of medical record officers and familiarize them with the existing Standard Operating Procedures (SOPs).
***Keywords*: hospital, hospitalization, medical record**

ABSTRAK

Tujuan dari penelitian ini adalah untuk mengetahui pelaksanaan rekam medis pasien rawat inap di Rumah Sakit dr. Penelitian ini menggunakan metodologi penelitian kualitatif. Tujuh informan penelitian dipilih dengan menggunakan teknik purposive sampling. Data dikumpulkan melalui wawancara mendalam, observasi langsung, dan telaah dokumen. Model Miles dan Huberman digunakan untuk analisis data, yang meliputi reduksi, penyajian, dan penarikan kesimpulan. Uji validitas data menggunakan triangulasi sumber dan triangulasi metode. Berdasarkan hasil penelitian pada elemen input, jumlah tenaga rekam medis sudah memadai dan sudah ada standar operasional prosedur (SOP). Namun, kurangnya anggaran khusus dan sarana dan prasarana yang kurang memadai. Elemen prosedural dari dokumentasi pasien, terutama dalam hal pencatatan lembar masuk dan keluar, belum sepenuhnya dijalankan. Terjadi keterlambatan penyerahan rekam medis, sehingga proses pengolahan rekam medis tidak optimal. Terjadi kesalahan pada saat proses penyimpanan rekam medis, sehingga terjadi *misfile*. Pelaksanaan Rekam Medis Pasien Rawat Inap di Rumah Sakit dr. Reksodiwiryo Padang belum optimal dan perlu ditingkatkan. Disarankan kepada pihak rumah sakit untuk memberikan pelatihan untuk meningkatkan kemampuan petugas rekam medis dan membiasakan mereka dengan Standar Operasional Prosedur (SOP) yang ada.
Kata kunci: rawat inap, rekam medis, rumah sakit

INTRODUCTION

Hospitals are responsible for improving the quality of hospital services to patients. The quality of health services can be achieved from several aspects, one of which is the analysis of the completeness of inpatient medical record files[(1)]. The quality of health services that have a relationship with medical records comes from administrative, documentation, financial, educational, research, financial, and legal aspects[(2)]. Therefore, the medical record unit needs to be managed properly and professionally in order to produce quality information so that health services become excellent and valuable as management considerations in decision-making[(3)].

Based on literature studies, problems are still found in the management of medical records in hospitals. In the implementation of medical records at Pancaran Kasih General Hospital Manado, documents still need to be completed, and more precise writing is required in the assembly section. The coding section does not use the ICD-10 book as a guide for coding diseases, and there is no monitoring to review the accuracy of the data. There is a lack of human resources in the analysis section, and there is no officer training[(4)]. The results of Nuraini's research on medical records at X Hospital show that the medical record administration system needs to run optimally, resulting in a completeness of medical record files output of only 55.2%. In comparison, the timeliness of providing medical record files is only 31%(2). Likewise, filling inpatient medical records in March 2021 at Bina Sehat Bandung Hospital still did not reach 100%[(5)].

dr. Reksodiwiryo Padang Hospital is the only Army Hospital in Padang City. To achieve the expected level of service quality, the hospital has standard operating procedures (SOPs), including the SOP for inpatient medical records at dr. Reksodiwiryo Hospital. According to the fixed method for returning inpatient medical record files at dr. Reksodiwiryo Hospital, medical record files must be completed by a doctor or other health worker 1 x 24 hours after the inpatient is decided to go home and returned on time 2 x 24 hours after the patient is discharged from the hospital[(6)].

Based on an initial survey of the medical record installation at dr. Reksodiwiryo Hospital on June 25, 2021, 20 randomly taken inpatient medical records. The results was 15 medical records were found to be incomplete on the admission and discharge summary sheets, 11 medical records were vague on the INA CBGs verification form, seven medical records were undone on the inpatient medical summary, seven incomplete medical records on the nursing summary, six incomplete medical records on discharge planning, four incomplete medical records on the inpatient integrated patient development record, three incomplete medical records on the initial nursing assessment, and three incomplete medical records on the drug reconciliation form.

The return of medical record files for patients who have been discharged is also often delayed. Based on the results of a review of the status discharge book, about two inpatient medical record documents were returned with more than the expected standard of a maximum of 2 x 24 hours after the patient was discharged. This study aimed to analyze the implementation of medical records at dr. Reksodiwiryo Hospital, Padang City in 2021.

RESEARCH METHODS

This research uses a descriptive qualitative approach, carried out in June - July 2021 at dr. Reksodiwiryo Padang Hospital. Determination of informants in this study using a purposive sampling technique. The criteria for selecting informants is an in-depth understanding of the implementation of medical records at Reksodiwiryo Hospital. Informants who became the source of data in this study were the head of the Medical Records Room (1 person), Medical Records Officer (2 people), Head of the Inpatient Room (1 person), Nurse (1 person), and

Doctor (2 people). In-depth interviews used questions and probing organized as an in-depth interview guide. Observations were conducted using a checklist guide.

Data were collected through in-depth interviews, observation, and document review. All data that has been collected was analyzed using the Miles and Huberman model. This model includes three activities, namely data reduction, data display, and conclusions. Data analysis was done manually with the help of a matrix of data collection results. To ensure data validity, data validation was tested using source triangulation and method triangulation. Source triangulation using informants consisting of a Medical Records Officer, Nurse, and Doctor. Method triangulation utilizes in-depth interviews, observation, and document review.

This study was approved to be conducted based on a letter from dr. Reksodiwiryo Hospital with number B/370/VI/2021, dated June 24, 2021. The research institution does not require ethical clearance.

RESULT

The characteristics of the informants from the in-depth interviews are shown in Table 1 below. Based on Table 1, it is known that the research informants totaled seven people, consisting of 3 women and four men.

Table 1. Informant Characteristics

Informant Code	Age (Year)	Gender	Education	Position
Inf-1	34	F	Associate Degree (D3) of Medical Record	Head of Medical Record Unit
Inf-2	29	M	Associate Degree (D3) of Medical Record	Medical Record Staff
Inf-3	26	M	Associate Degree (D3) of Medical Record	Medical Record Staff
Inf-4	35	F	Associate Degree (D3) of Midwife	Head of InPatient Room
Inf-5	27	M	Bachelor (S1) of Medical Science	General Practitioner
Inf-6	35	M	Bachelor (S1) of Medical Science	General Practitioner
Inf-7	30	F	Associate Degree (D3) of Nursing	Nurse

Based on interviews with medical record officers, it was concluded that the number of medical record personnel needs to be increased. The increase in the number of patient visits is not proportional to the number of medical record staff, as the following interview excerpt shows:

> "...the availability of members is still very far. It used to be... 30 people. Now it has become 20 people." (Inf-2)
>
> "For the time being, it may not be sufficient because some members of the case-mix unit have resigned." (Inf-3)

Based on observation, there are 20 medical record staff: five in the registration department, nine at the registration counter, and 1 in the emergency room. In addition, five people in the status search section work in three shifts, namely the morning shift, afternoon shift, and night shift.

Based on the results of in-depth interviews, the skills possessed by officers at the Medical Records Installation of dr. Reksodiwiryo Padang Hospital is quite good, but the counter eight patient registration section (new, general, National Health Insurance (BPJS)) are D3 nursing graduates and high school graduates who have never received training on medical records. As the results of the following interview:

"For now, there is no training for medical records."(Inf-2,3)

"The form of skills that we have here... Helping each other, for example in distribution. If there are not many patients who register, we help each other with the distribution." (Inf-2)

"For skills for case-mix personnel, it is sufficient." (Inf-1,3)

Based on the results of in-depth interviews, it is known that the budget for the needs of the medical records unit are sufficient. Hospital budget for the medical records unit come from the center and patients. Budget have not been maximally realized due to the long process of requesting and procuring work equipment; the following are excerpts from interviews with several informants:

"If the budget is sufficient" (inf-1)

"The budget from the hospital is still far from the standard because there are still very few members here" (inf-2)

"The budget for the case-mix unit room is sufficient. If for the budget for one unit or several other units, there is no.... As for obstacles...we ask for an item or procurement for work completeness. Sometimes, there is also a rather slow process." (Inf-3)

The results of document review from the inventory list of the medical record room at dr. Reksodiwiryo Padang Hospital shows that the budget come from hospital procurement.

The results of in-depth interviews related to implementing inpatient medical records at dr. Reksodiwiryo Padang Hospital, namely the flow and SOPs already exist and have been socialized, can be seen from the following interview results:

"In medical records, we work based on the existing SOPs. So, our benchmark is based on the SOP.". (Inf-2)

"As for the SOP, there is one. For example ... like the medical record must be returned to the case-mix 1x24 hours after the patient is discharged." (Inf-3)

"It was socialized around 2020 often" (Inf-2)

"The flow is there...it has been determined, but for us, there are people who take it to the room to the medical records unit." (Inf-5)

Based on the document review results, Standard Operating Procedures (SPO) Medical Records No. SPO / MIRM / 2018 explains how the implementation of medical records as a whole, starting from the registration of inpatients/outpatients, new patients / old patients, emergency room patients, how the completeness and timeliness of filing by the relevant health professionals, and all medical record activities.

Based on the results of in-depth interviews, the facilities and infrastructure in the Medical Records Unit of dr. Reksodiwiryo Padang Hospital needs to be improved in terms of storage space. One room is used to store medical records from inpatient, outpatient, and emergency services. The room sizes and storage shelves cannot accommodate the increasing number of medical record documents. Meanwhile, the same thing happens in the case-mix room; the room capacity is limited for storing patient eligibility letters (SEP)s of discharged patients, following the interview excerpt:

"The storage space is now minimal...Because here automatically the number of patients every day is increasing and not decreasing" (inf-2)

"For now, the case-mix room may not be adequate because month by month the number of patients continues to increase, so it is necessary to add or improve the medical record room, namely this case-mix room."(inf-3)

"If the medical record room for status storage or medical record files is inadequate for now because the medical record files are already too many so, it is necessary to add storage shelves."(Inf-3)

Based on observations, the facilities and infrastructure at dr. Reksodiwiryo Padang Hospital is not optimal, including computers and printers at counter nine not functioning. Counter 9 is a place for inpatient registration, so inpatients must queue at counter 8, a place for new patient registration, general, and National Health Insurance (BPJS). In addition, the storage of outpatient and inpatient medical records is combined so that the 17 existing storage shelves become very crowded and even some medical record documents are placed in cardboard boxes.

Based on the results of in-depth interviews, it is known that there are still medical records that are not filled in completely, such as the doctor's signature, there is no doctor's visit time, the doctor's writing is not clear, the diagnosis on the INA CBGs sheet is often empty, and the patient's social data is not filled in completely. These results are illustrated by the informant's statement as follows:

"What is often not filled in is, for example, the doctor's signature or the doctor's diagnosis; sometimes there is nothing empty not filled in... about the NIK, it is often not filled in." (inf-2)

"If it is often not filled in, for example, the INACBGSs sheet is sometimes empty because doctors only make diagnoses or diagnoses of actions are only resumed, sometimes the INACBGs sheet is often empty..." (Inf-3)

"The part that is often not filled in is usually, for example, filling in the part of the visit sheet; yes, the Integrated patient progress notes (CPPT) is the patient's signature, and then it is usually just the time he visited, or the signature is not clear or the writing is not clear ..." (Inf-5)

From the observation, it was found that medical records filled in by doctors and nurses used pens with different ink colors. The doctor used a pen with black ink, while the nurse used blue ink. In addition, it was found that the patient's social data was incomplete before the patient entered the treatment room, the treatment room was not filled in, and the medical record officer did not always provide direction or explanation to the patient or the patient's family for filling out informed consent.

Based on the results of document review on 44 discharged patient medical record files, it was found that 63.63% of incompleteness was found on the entry and exit sheets and 18.18% of discrepancies between the billing treatment date and the Integrated patient progress notes (CPPT) date. Entry and exit sheets, often not filled in by doctors, are in the signature section. Meanwhile, medical record officers often do not fill in the diagnosis code section, and nurses incorrectly fill in between the billing treatment date and the Integrated patient progress notes (CPPT) date.

The results of in-depth interviews regarding the arrangement of inpatient medical records after completion of treatment and files that return to the medical records unit are incomplete. The files will be returned to the health workers concerned and can be seen from the following interviews.

"Normally, the doctor's signature is the same as the doctor's name. The signature is missing... The doctor is not there, it is returned to..the room" (Inf-3)

Based on observations, it is known that medical record files from the inpatient service unit are returned to the case-mix section for processing medical record files consisting of assembling, coding, indexing, and filling, such as the following interview results.

"There is filling here. After the medical record is returned from case-mix, it is immediately filled. Yes. The one who does the filling is a rolling mix." (Inf-1)

"Yes, before it is returned to the medical record, it has been completed, whether it is indexing or coding, everything has been completed." (Inf-2)

"Regarding both filling and assembling, it is running very smoothly now ... sometimes we are here, as you said earlier, filling assembling, every day there is a PJ, not so on." (Inf-2,3)

Based on observations, it is known that in the assembling process, medical record officers only check the completeness of medical record files, not reassembling them in the order of the patient's medical history, so the medical record forms become irregular. Based on the results of in-depth interviews, there are still officers who are late in returning medical record documents to medical record officers beyond the specified time, namely 2x24 hours. Based on a document review of 44 discharged patient medical records, it was found that 54.54% of patient files that had been discharged > 2x24 hours had yet to be returned to the case mix room. Based on in-depth interviews, this is because the medical record is incomplete and will be returned after the doctor and nurse complete the file.

Based on the results of in-depth interviews and observations, dr. Reksodiwiryo Padang Hospital uses a centralized storage system (centralization) with a medical record numbering system using straight numbers.

"For central storage, it is combined. Inpatient, outpatient, and emergency department are combined" (inf-2).

"Terminal" (inf-2).

"The storage numbering is straight centralized, so it is combined centrally."(inf-3)

Based on observation, dr. Reksodiwiryo Padang Hospital stores medical records centrally. Meanwhile, medical record numbering uses straight numbers. Based on the results of interviews and observations, inactive medical records will be transferred to the inactive archive storage room on the 2nd floor after a storage period of 3 years. Medical records appear to exceed the capacity of the shelves, disrupting the process of storing and retrieving medical records. Researchers also found files that needed to be organized according to the predetermined numbering.

The obstacles faced in the filling process are missing files, meaning the wrong placement of medical record documents and documents that have not been placed on the storage rack. The following is an interview about dealing with existing obstacles.

"Sometimes there is a status that has not been returned; sometimes there is also a status that is misplaced. So inevitably, we have to look for it because the doctor must see the previous diagnosis."(inf-2)

"...we will make a temporary status that still uses a folder, but we will
print o.. previous diagnosis" (inf-2)

Based on the results of the interview, misfiles resulted in additional work for officers because they had to print medical record forms containing the patient's medical history as reference material for doctors.

Based on the results of in-depth interviews, it is known that the obstacles faced at this time are insufficient medical record personnel, resulting in constraints in status searches, filling out medical records, and National Health Insurance (BPJS) claims. The following is information obtained from the results of in-depth interviews:

"There are no obstacles."(Inf-1)

"As for the problem ... that is ... about finding the status of patients who control to the polyclinic that often happens that we often o...face at this time by finding the status" (Inf- 2)

"As for obstacles because it may include a lack of manpower, it needs to be added because ... claiming in case-mix has a limited time, for example ... a service month like July, the maximum increase is on the 5th, but due to constraints ... the case-mix staff is reduced so it is postponed to the 7th ..." (Inf-3)

"For the submission, there are no obstacles for us because people come every day. Mostly, if there are problematic statuses that are pending, then when they are finished, we will deliver them." (Inf-4)

The results of observations showed that the implementation of medical records had not gone well because the number of officers was not optimal. Document review conducted on 29 randomly taken inpatient medical record files found that the most incompleteness was Discharge planning as much as 58.62%, admission and discharge summary sheets as much as 51.72%, and inpatient medical summaries as much as 27.58%. Based on data obtained from medical record documents of patients discharged in the case mix room, as many as 44 files, it is known that the most incompleteness is found in the admission and discharge sheet, with as much as 63.63% and the discrepancy between the billing treatment date and the Integrated patient progress notes (CPPT)date as much as 18.18%. Most of these records were not filled in by medical record officers, doctors, and nurses.

The return of medical record files for discharged patients is also often delayed. Based on the SOP that applies at dr. Reksodiwiryo Padang Hospital, nurses must return the status of medical records within 2x24 hours after the patient is discharged. Still, based on a document review of 44 medical records of patients discharged in the case mix room, 24 medical records were returned more than 2x24 hours.

DISCUSSION

Based on the study's results, the number of medical record staff owned by dr. Reksodiwiryo Padang Hospital has 20 people. Educational qualifications consist of eight employees who graduated from D3 medical records, one who graduated from D3 Nursing, two who graduated from Public Health, and nine who graduated from high school. According to Regulation of Minister of Health of The Republic of Indonesia No. 30 of 2019 concerning hospital classification and licensing, medical record personnel for type C hospitals are at least two D3 Medical Records[(7)], so that the quantity of medical record personnel at dr. Reksodiwiryo Hospital has met the existing standards. When viewed in terms of quality, medical record personnel still need a D3 medical record and Health Information education background.

This is in line with various studies that conclude that there are medical record officers who do not have a medical record background, even high school graduates [(2)(3)(4)]. According to the Regulation of Minister of Health of The Republic of Indonesia number 24 of 2022, a Medical Recorder is a person who has graduated from Medical Record education. Support from the hospital is needed to support medical record officers who graduated from high school to continue their education with a medical record background.

Based on the research results, it is known that the budget for the needs of the medical record unit are sufficient. Hospital budget for medical record units come from the center and patients. Budget have yet to be realized optimally because receiving and procuring work equipment takes a long time. Based on the results of the study, it is known that the budget for the needs of the medical records unit are sufficient. Hospital budget for the medical records unit come from the center and patients. Budget have not been maximally realized due to the long process of procuring work equipment.

Based on the inventory list of the medical record room of dr Reksodiwiryo Padang Hospital, the origin of procurement was obtained from the hospital. Based on theory, the allocation of budget to replace damaged supporting equipment does not exist but can be

procured by the hospital if needed [8]. It is recommended that hospitals allocate special budget to support the smooth implementation of medical records and speed up the process of disbursing budget.

Based on the research results, the Standard Operating Procedure (SOP) related to the implementation of medical records is contained in SOP No. SPO/MIRM/2018 with a publication date of November 5, 2018. Based on the SOP, medical records must be filled in clearly, completely, and on time by the professional officer concerned. Officers are required to make the SOP a guideline in working to complete routine work processes, in this case, filling out inpatient medical record documents so that they can run well [9].

Based on the results of the study, it is known that the medical record SOP has been socialized, but only sometimes. SOPs are process documents that explain in detail how employees perform specific jobs[10]. The socialization of SOPs affects nurses' behavior, so routine monthly socialization is needed to maintain nurses' work behavior(11). In X hospital, the socialization of SOPs in medical records was carried out in various ways, including during work orientation, when officers were asked to read the SOPs through more senior colleagues, and pasting work procedures in the medical record room. The socialization was carried out infrequently and planned [2].

Facilities and infrastructure in the Medical Records Unit of dr. Reksodiwiryo Padang Hospital needs to be improved, namely in terms of storage space. One room stores inpatient, outpatient, and emergency room medical records. The size of the room and storage shelves need to be improved for the increasing number of medical record documents. Meanwhile, the same thing happens in the case mix room; the room capacity is limited for storing the patient eligibility letter (SEP) of patients who are discharged.

This is in line with the management of Medical Records at Pancaran Kasih General Hospital Manado. The facilities and infrastructure in the subfield of medical records already exist but are not complete, so they cannot support employees work [4]. The availability of facilities and infrastructure has a positive influence on the quality of service. Therefore, it is necessary to prepare adequate facilities and infrastructure[12].

The hospital marks medical records by filling through differences in pen ink color. Doctors record medical records using black ink, while nurses use blue ink. This is in line with the implementation of medical records on tuberculosis patients at the Tk IV DKT Madiun Hospital, which uses differences in ink between doctors and nurses in the SOP for recording medical records[13].

There are still problems in recording medical records at dr. Reksodiwiryo Hospital, including no doctor signature, no doctor's visit time, unclear doctor's writing, diagnoses on INA CBGs sheets are often empty, and patient social data needs to be filled in completely. The treatment room was not filled in, and the medical record officer sometimes provided directions or explanations to the patient or the patient's family for filling out informed consent.

Based on the results of the study, of the 44 medical record files, the most incompleteness was found in the admission and discharge sheets, as much as 63.63%. This is followed by the mismatch between the billing treatment date and the Integrated patient progress notes (CPPT) date by 18.18%. Entry and exit sheets are often not filled in by doctors in the signature section, and medical record officers often need to fill in the diagnosis code section. Meanwhile, nurses need to correctly fill in the difference between the billing treatment date and the CPPT date. This is in line with the implementation of inpatient medical records at Bina Sehat General Hospital Bandung, that there is the incomplete filling of medical record documents. The study's results found completeness of identification at 100%, completeness of important reports at 62.96%, fullness of authentication at 16.05%, and completeness of correct recording at 72.84%[5].

Completeness of medical record recording is one of the critical indicators that need to be considered in the completeness of medical records. A good recording will facilitate ongoing patient care. Good records must be easy to read and understand by health workers so as to avoid causing miss perceptions in reading patient medical records[(2)].

The arrangement of medical records of inpatients, after completion of treatment and files that return to the medical record unit, are incomplete, the files will be returned to the health worker concerned. Medical record files from the inpatient service unit are returned to the case mix section for processing medical record files, which consists of assembling, coding, indexing, and filling. However, based on the results of observations, it is known that in the process of assembling medical records, officers only check the completeness of medical record files, not reassembling them in the order of the patient's medical history so that the medical record forms become irregular.

Assembling activities also include checking the completeness of filling in medical record files and forms that must be present in medical record files[(14)]. Another opinion of assembling is the organization of forms that describe who, what, when, and how in terms of patient health services, which are written evidence of official hospital documents chronologically[(13)].

Based on the study results, there are still officers who still need to be on time in returning medical record documents to the medical records officer beyond the specified time of 2x24 hours. The medical record is incomplete and will be returned after the health professional completes the file.

Analyzing the completeness of medical record files is needed to obtain the percentage of completeness of the files, which is then divided by the number of patients or the number of files available. If the file is incomplete, it is returned to the room; if it is complete, it is immediately stored in the storage room [(4)].

Medical record storage activities aim to protect the medical record and its contents from physical damage. Medical records must be protected and cared for because they are precious objects for the hospital; there are two ways to store medical records: centralization or decentralization. Based on the results of the study, dr. Reksodiwiryo Padang Hospital uses a centralized storage system (centralization) with a medical record numbering system using straight numbers.

This is in line with the management of medical records at the Muhammad Kendal Islamic Hospital, which uses a centralized system, and its alignment uses straight middle filling[(15)]. This centralized storage system has several advantages, such as the ease of training officers who must carry out storage work. In addition to having advantages, this system also has several disadvantages. When aligning medical records, officers must pay attention to all numbers so that it is easy to make mistakes [(16)].

Based on the results of the study, missing files were found, namely medical record documents not on the appropriate shelf or located on another shelf. This aligns with the completeness of medical records at Bengkulu City Hospital, where 44% of medical record documents experienced missing files[(16)]. Missed files at dr. Reksodiwiryo Hospital resulted in additional work for officers because they had to print medical record forms containing the patient's medical history as doctor's reference material. Based on observations, this was due to the need for more accuracy of medical record officers despite using tracers to minimize the occurrence of missed files.

The results of the study found that of the 29 medical record files of inpatients taken randomly, it was found that the most incomplete was discharge planning as much as 58.62%, admission and discharge summary sheets as much as 51.72%, and inpatient medical summaries as much as 27.58%. Based on data obtained from medical record documents of patients discharged in the case mix room, as many as 44 files, it is known that the most incompleteness is in the admission and discharge sheet, with as much as 63.63% and the

discrepancy between the billing treatment date and the Integrated patient progress notes (CPPT)date as much as 18.18%. Based on 44 medical records of patients discharged in the case mix room, 24 medical records were returned more than 2x24 hours.

An excellent medical record is a medical record in which all patient data, examinations, actions, supporting examinations, and patient diagnoses are recorded entirely, and the accuracy of its return must also be by the SOPs in the hospital. Medical record management in hospitals supports the achievement of orderly administration to achieve hospital goals, namely improving the quality of health services in hospitals[16].

Based on Giyana's research in 2012, one of the essential things regulated in the management of inpatient medical records at Semarang City Hospital is the time to return medical record files related to the completeness of filling in medical record files[17]. Several parameters can be seen to determine the quality of medical records in hospitals: Completeness of return time, completeness of forms in medical record files, and completeness of filling in medical record files[14].

CONCLUSION

The utilization of inpatient medical records at dr. Reksodiwiryo Padang Hospital was suboptimal. This is evident via the necessity for further training for medical record officers, regular dissemination of standard operating procedures, and insufficient facilities for the storage of medical records. A comprehensive documentation of medical record forms and documents is necessary. The process of medical record file processing is currently underway, however, the medical record officers do not engage in file sorting tasks. Medical record files still require placement.

SUGGESTION

It is advisable for Dr. Reksodiwiryo Padang Hospital to provide specialized training for medical record officers, implement Standard Operating Procedures (SOPs) in the medical record room, enhance monitoring and assessment efforts, and strategize the implementation of electronic medical records.

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