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Research Article

Implementation of Completeness and Accuracy of Surgical Medical Record in Regional Hospital Kendari Based on Regulation of the Minister of Health Number 269 of 2008

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Abstract: One indicator to assess the quality of a health service in a hospital is the availability of a complete and accurate medical record. This study aims to determine the level of completeness and accuracy of the contents and filling of the Surgical Inpatient Medical Record at Kendari City Hospital based on Regulation of The Minister of Health of The Republic of Indonesia number 269 of 2008. The design of this research is quantitative with a descriptive approach. This study uses a sampling technique that is simple random sampling. The results of this study are in terms of the completeness of the contents of the medical record in the good category that is 100% complete. While in terms of accuracy of filling medical records is in the category of not good, namely less than 100%, namely 93.93% where this shows the weak functioning of the medical record as legal evidence. So that the Hospital needs to hold more routine socialization about SOPs, Director Decrees and medical record legal regulations to medical officers.
Keywords: Medical Records, Hospitals, Inpatients, Surgical Patients.

INTRODUCTION

The development of globalization requires all elements, especially health elements to continue to maintain and improve the quality and quality of service. One of the health institutions is the Hospital, where the Hospital is a health care institution that organizes health services. One of the obligations of the hospital is to hold a medical record (Juhari, 2019). According to Law Number 29 of 2004 concerning Medical Practices, the organization of medical records in health services is also the duty of every doctor.

One indicator to assess the quality of a health service in a hospital is the availability of a complete and accurate medical record (Zegers, *et al.,* 2011). Without the completeness and accuracy of the medical record, it gives the impression that health services are not taking place properly and it is difficult to imagine the actual facts that are happening (Zozus, *et al.,* 2015). This is because medical records are clumps of all health practitioners' activities that are written and described as their activities towards patients (Indar, 2017).

The use of medical records in terms of legal aspects is stated in Article 13 Regulation of The Minister of Health of The Republic of Indonesia No. 269 of 2008, which is as evidence in the process of law enforcement, medical and dental disciplines as well as enforcement of medical ethics and dentistry ethics. Medical records made based on applicable procedures and then strengthened by oaths can be used as evidence of letters, especially in cases of suspected medical malpractice (Hatta, 2008).

Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 269 of 2008 concerning Medical Records Medical records held by patients with medical actions that contain high risks must be completed with a medical action approval form signed by the party entitled to give consent. Medical actions that carry a high risk are medical actions that, based on a certain degree of probability, can result in death or disability. The Indonesian Medical Council cites examples of high-risk medical procedures, namely surgical and certain invasive measures (KKI, 2006).

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Based on preliminary studies conducted by researchers at the Kendari City Regional General Hospital which is also one of the Hospitals as a referral center in Southeast Sulawesi. Where the number of inpatients from 2014 to 2018 continues to show an increase, namely 6,516, 7,417, 8,674, 9,196 and 10,006 with the highest number of inpatient visits, namely surgical patients. Where researchers also get incomplete data filling the Medical Action Approval Form based on the surgical operator doctor.

Given the importance of implementing medical records in accordance with legal requirements, researchers are interested in examining the Implementation and Completeness of the Accuracy of Inpatient Surgical Medical Records at Kendari City General Hospital.

METHODOLOGY

Research Design

This research was conducted using a quantitative method with a descriptive approach that analyzes the Medical Record file using a Checklist. The study was conducted at the Kendari City General Hospital in the province of Southeast Sulawesi, in August-September 2019.

Research Object and Samples

The object of this research was the contents and filling of the Surgical Inpatient Medical Record at Kendari City Hospital, which consisted of 89 samples of the surgical inpatient medical Record file, from May to July 2019.

Data Collection

Data collection method used in this study is observation. Observation was carried out by observing and recording directly at the study site for everything related to the object under study, so researchers tried to obtain data about the level of completeness and accuracy of the Surgical Inpatient Medical Record file in Kendari City Hospital based on Regulation of The Minister of Health of The Republic of Indonesia number 269 of 2008. In this observation, researchers used research instruments in the form of checklist sheets and notebooks.

Data Analysis

The first step in processing quantitative data in this study is to analyze the level of completeness and accuracy of the contents and filling of the Inpatient Surgery Medical Record at the Kendari City Hospital in May to July 2019 based on Regulation of The Minister of Health of The Republic of Indonesia number 269 of 2008 using a checklist. The second step is to process data analysis results in the form of percentages.

RESULTS

Table 1. Contents of Surgical Inpatient Medical Records between Regulation of The Minister of Health Number 269 of 2008 with Contents of Inpatient Surgical Medical Records at Kendari City Hospital

Fill in the Medical Record Form according to Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008	Fill in the form in the Medical Record Hospital of Kendari City	Completeness
Patient identity	a. Social identity can be found on the inpatient sheet b. Patient's identity can be found on each form in the form of RM No., Name and Age	Complete
Date and Time	Entry dates and times are on each form	Complete
Anamnesis results	Patient complaints or history are on the form: a. Doctor's note b. Medical resume	Complete
Physical examination results and supporting medic	The results of physical examination and medical support are on the form: a. Preoperative Notes b. Operation Note c. Doctor's Note d. Medical Resume e. Pulse Temperature Record f. Laboratory Examination Results g. Surgical Medical Nursing	Complete
Diagnosis	The diagnosis is on the form: a. Inpatient Sheet b. Provision of Medical Action Information c. Preoperative Notes d. Operation Note	Complete
Management Plan	The management plan is on the Problem-solving plan form	Complete
Action	Medical measures are on the form: a. Inpatient Sheet	Complete

	b. Provision of Medical Action Information c. Approval of Medical Action d. Preoperative Notes e. Operation Note f. Doctor's Note g. Medical Resume	
Approval for Action	Approval for action is on the Informed Consent sheet	Complete
Notes Clinical observations and treatment results	Clinical observation notes are on the form: a. Preoperative Notes b. Medical Resume Notes c. Pulse Temperature Record d. Surgical Medical Nursing The treatment results are on the Drug Use Record Form (RM 23e)	Complete
Return summary (discharge summary), contains: a. Patient identity b. Diagnostic entry and indication of the patient being treated c. Summary of results of physical and supportive examinations, final diagnosis, treatment and follow-up d. Names and signatures of doctors who provide health services	Return summary can be found on the Medical Resume Form that contains: a. Patient identity / social data b. Incoming Diagnosis c. Lab Checks / other, Main Diagnosis, Therapy and Treatment d. Names and Signature of the Caring Doctor	Complete
Names and signatures of doctors who provide health services	The name and signature of the doctor who provided the service is on each form	Complete
Other services performed by certain health workers	Other services are on the Surgical Medical Nursing Care Form	Complete

Table 1. shows that from 89 samples of Surgical Inpatient Medical Records, all the requirements listed in Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008 were 100% fulfilled. It can be concluded that the completeness of the contents of the medical record based on Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008 concerning Medical Records is good, because it has met 100% of all the requirements listed in Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008.

Table 2. Results of Analysis of Accuracy in Filling Inpatient Surgery Medical Records at Kendari City Hospital in terms of Regulation of The Minister of Health Number 269 of 2008

Fill in medical records	Patient Identity Information (%)	Proof of Record (%)	Validity of Records (%)	Procedure for recording (%)	Average	Information
Inpatient Form	89,88	92,13	89,88	88,76	90,16	Not good
Laboratory examination results	97,75	100	100	89,88	96,90	Not good
Doctor's Note	89,88	98,87	96,62	88,76	93,53	Not good
Preoperative notes	92,13	91,01	95,50	89,88	92,13	Not good
Operation Note	95,50	98,87	100	89,88	96,06	Not good
Pulse temperature recording	89,88	92,13	92,13	89,88	91,00	Not good
Medication usage notes	100	88,76	98,87	97,75	96,34	Not good
Resume medis	89,88	89,88	89,88	89,88	89,88	Not good
Surgical medical nursing care	100	100	100	97,75	99,43	Not good
Average	**93,87**	**94,62**	**95,87**	**91,38**	**93,93**	**Not good**
Conclusion	**Filling completeness less than 100%**					**Not good**

Table 2. shows that the researcher conducted a complete analysis of 9 (nine) medical record forms with 4 (four) criteria ranging from patient identity information, proof of records, validity of records, and procedures for recording medical records. From these four criteria, the average value of completeness of the overall filling with a value of 93.93% is accurate with the category of not good. Judging from the type of form, the percentage of accuracy of filling from the highest to the lowest is the Form of surgical medical nursing care (99.43%), Laboratory Examination Results (96.90%), Records of drug use (96.34%), Operating Records (96 , 06%), doctor's notes (93.53%), preoperative notes (92.13%), pulse temperatures (91.00%), preoperative notes (90.16%), hospitalization forms (89.88) %). Judging from the quantitative analysis, the percentage of accuracy of filling from the highest to the lowest is the validity of the recording (95.87%) with the category not good, Evidence of recording (94.62%) with the category of not good,

patient identity information (93.87%) with the category is not good and the procedure for recording (91.38%) with the category is not good. It can be concluded that filling the Surgical Inpatient Medical Record at Kendari City Hospital in terms of Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008 is inaccurate because it does not meet the Minimum Service Standards of the Hospital, namely filling medical records 24 hours after completing the service and getting clear information must be 100% complete.

DISCUSSION

This study analyzes the completeness and accuracy of 89 samples of Surgical Inpatient Medical Record at the General Hospital of Kendari City conducted in August to September 2019. Where this study uses the guidelines of the Minister of health regulations, namely Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008 concerning Medical Records.

According to Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008, a medical record is a file containing records and documents about the patient's identity, examination, treatment, actions and other treatments that have been given to the patient. The contents of the medical record for inpatients and one-day care includes at least: 1) Patient's identity; 2) Date and time; 3) Results of history taking, including at least complaints and history of disease; 4) Results of physical examination and medical support; 5) Diagnosis; 6) Management plan; 7) Treatment and / or actions; 8) Approval of actions if needed; 9) Records of clinical observations and treatment results; 10) discharge summary; 11) The names and signatures of certain doctors, dentists, or health workers who provide health services; 12) Other services performed by certain health workers; and 13) For dental patients with clinical odontograms.

Without the support of a good and accurate medical record management system, it is impossible for an orderly hospital administration to succeed as expected. While administrative order is one of the determining factors in the efforts of health services in hospitals (Department of Health, 2006).

In the medical record at the Kendari City Hospital, all items that must be in the medical record are listed in certain forms. These forms are Inpatient Form, Laboratory Examination Form, Doctor Records Form, Preoperative Record Form, Operation Note Form, Pulse Temperature Record Form, Drug Use Record Form, Medical Resume Form, Medical Surgical Nursing Form, Action Approval Form Medical, Medical Action Information Form and Patient Safety Checklist Form (WHO, 2009). Orderly hospital administration can be realized through systematic medical record management. Complete, and orderly (Reiser, 1991). Indonesia needs to develop a strategy in terms of hospital services, especially for the management of medical records aimed at improving health services (Handayani *et al.,* 2015).

The contents of the medical record at Kendari City Hospital are in accordance with Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008 concerning Medical Records in Article 3 and Article 4. However, from the results of the analysis of the completeness of filling medical records at the Kendari City Hospital it does not meet the Minimum Service Standards of the Hospital referring to the Minister of Health Number 129 of 2008, which requires 100% complete medical records. In this case, the doctor also has not fulfilled Law Number 29 Year 2004 concerning Medical Practice Article 46, especially in terms of the validity of the recording and the procedure for recording. It is explained in article 46 paragraph (3) that each medical record must be given the name, time, and signature of the officer who provided the service or action, while the results of the analysis of the completeness of the validity item of the record are 95.87% and the completeness of the procedure for the record is 91.38%. The purpose of the medical record is to support the achievement of standardized administration in the context of efforts to improve health services in hospitals (Mann & Williams, 2003; Carpenter *et al.,* 2007).

Completion of incomplete medical records is also not in accordance with Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008 Article 5 Paragraph (2) which explains that: Medical records as referred to in paragraph (1) must be made immediately and completed after the patient receives services; Paragraph (3): Making medical records as referred to in paragraph (2) shall be carried out through recording and documenting the results of examinations, treatments, actions and other services that have been provided to patients; and paragraph (4): Every record in the medical record must be accompanied by the name, time and signature of the doctor, dentist or certain health worker who provides direct health services.

CONCLUSION

Judging from the completeness of the contents of the inpatient surgery Medical Record unit based on Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008 concerning Medical Records, the contents of the Surgical Inpatient Medical Record in the City Hospital of Kendari are included in the good category which is 100% complete. Whereas in terms of accuracy of filling in medical records for inpatient surgery units based on Regulation of The Minister of Health of The Republic of Indonesia Number 269 of 2008 concerning Medical Records, filling in medical records for inpatient surgery in Kendari City Hospital is included in the bad category

with a percentage of less than 100%, namely (93.93%). As for the suggestions, the Hospital organizes regular socialization about SOPs, Director Decrees and medical record legal regulations to medical officers. It is recommended to continue further research to explore further the suitability of legal requirements in the medical record.

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