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Analysis of Completeness of Filling in Medical Record Files

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Abstract
The Minimum Service Standard (SPM) indicator is in the form of completing medical record documents for 24 hours. There are medical record files and informed consent that are incomplete and not in accordance with the SPM. The aim of the research is to identify and analyze the completeness of medical record files. The research was conducted at the Regional General Hospital (RSUD) in the Province of West Nusa Tenggara. The research objective was to determine the level of completeness of the contents of medical record documents. This research uses a quantitative type. The sample is 87 medical record files. Services in the medical record section are not in accordance with the SPM. With details of the completeness of the contents of the medical record documents for 24 hours after the service, it has not been filled in completely, such as the doctor's/nurse's initials (62%). The indicators for filling in informed consent were completeness after the patient was given incomplete information, such as providing information (76%), type of information (76%), doctor's signature (76%), and signatures of witnesses 1 and 2 (76%). The medical record document has not been filled in completely by the medical record officer.
Keywords: File analysis, Minimum Service Standards, Medical Records

Introduction

Hospitals are categorized as health service facilities (Pasyankes) providing services to patients that are plenary in nature, as well as providing services to inpatients, outpatients, polyclinics and emergency departments. Hospitals are expected to be able to apply Minimum Service Standards (SPM) to patients who come for treatment or check their health which has been implemented by the government. SPM has certain provisions regarding the type or form of basic services provided to patients.(Flavel et al., 2023)

Hospital SPM in this guide includes types of services, indicators and standards for achieving hospital service performance. The SPM indicator is a benchmark for quantitative and qualitative performance that is used to describe the amount of targets to be met in achieving a certain minimum service standard in the form of inputs, processes, results, and or service benefits. SPM has indicators that must be achieved which are part of the service indicators on medical records, in the form of completing filling in medical record documents for 24 hours after the service is carried out, completing patient consent sheets or informed consent after patients get optimal information from officers, time to provide medical record documents at outpatients, and inpatients.(Brunt, 2023)

The Hospital SPM indicator states that the standard time for providing outpatient service documents is 10 minutes, if the waiting time for providing outpatient documents is 10 minutes then it is said to be long or not in accordance with established standards. While the standard time for providing inpatient service documents is 15 minutes, if the waiting time for providing outpatient documents is 15 minutes then it is said to be long or not in accordance with established standards. A complete medical record is a medical record that has been completely filled out no later than 1x24 hours after the completion of outpatient services or after the inpatient has decided to go home with the standard filling of 100% filled out. A complete medical record includes patient identity, anamnesis, plan of care, implementation of care, follow-up, resume, and informed consent which must be signed by the doctor/other health worker in accordance with the authority and written name and date.(Zeedan et al., 2023)

Based on an initial study conducted by researchers on 10 medical record files at the Regional General Hospital (RSUD) in NTB Province, that there were still medical record files that had not been completely filled out within 1x24 hours, so the medical record files had to be returned to the previous polyclinic to be completed again. by a doctor or other health professional. Meanwhile, the completeness of the informed consent is still not in accordance with the SPM because there are still several doctors or health workers who do not complete the form contained in the informed consent, such as the full name or date of service. The purpose of this study was to determine the completeness of filling in medical record documents for 24 hours after the service was carried out and to determine the completeness of the availability of informed consent documents after being given information by officers at the NTB Provincial Hospital.

Literature Review

Informed consent is approval for medical action (Al-Kaabi & Abdullah, 2023) given by the patient or his closest family after receiving a complete explanation regarding the medical action to be performed on the patient. From this informed consent, a health agreement or agreement will be born, the existence of a health agreement is a determining factor and will foster a sense of security and comfort for a doctor or health worker to carry out their duties as health service providers. (Salim & Park, 2023)

Research methods

This is an observational study with a quantitative design, namely a study conducted to objectively describe a situation, in this study describing MSS for medical records. When this research was carried out from October 2020 to September 2021. The place chosen was the research location at the NTB Provincial Hospital. The variable of this study is the medical record SPM indicator which consists of the completeness of filling in the medical record 24 hours after the service and the completeness of the informed content after obtaining clear information.

The population in this study were medical record files on November 27, 2020, totaling 655 files at the NTB Provincial Hospital. The sampling technique in this study was a random sampling technique. The sample in this study were 87 medical record files which were calculated using the slovin formula. The instrument used in this study was made in the form of

an observation sheet that serves to observe and measure the level of success or achievement of goals and a stopwatch to measure the length of time required for an activity.

The primary data in this study are the completeness and incompleteness of medical record files. The data collection technique used is through observation. Secondary data in this study is the number of medical record files obtained from the problem under study. The data collection technique used is through observation. Data analysis is the process of systematically searching for and compiling data obtained from interviews so that they can be easily understood, and everything can be informed to others. In this study, the research variables were analyzed using the frequency distribution.

Results and Discussion

Completeness Level of Medical Record File Contents for 24 Hours After Service

The following presents the level of completeness of the contents of medical record documents for 24 hours after the service is carried out by health workers. Based on the data, it shows that the medical record files related to patient identity and procedures and examination results are filled in completely (100%), however, there are 62% incomplete medical record files in the initial category of doctors/nurses and 38% which are complete. Level of Completeness of Informed Consent Documents After Being Provided with Information. Based on the data, it shows that the informed consent document is completely filled out (100%) for the patient's identity indicator. However, there are several other indicators that are not complete, namely the provision of information, the type of information, the doctor's signature and the signatures of witnesses 1 and 2 each at 76%.

Level of Completeness of Medical Record Document Contents for 24 Hours after Service is Provided

Some notes that must be contained in the medical record document related to the identity of patients who come to visit the hospital at least include the identity of the patient, the results of the examinations that have been carried out, administration of drugs, and elements of action or other basic services provided to patients. The medical record is called complete if every consultation action performed on the patient no later than 1x24 hours must be written on a medical record sheet, all records must be signed by a doctor/other health worker in accordance with clinical authority and written name and date.(Supri et al., 2019)

Based on the results of research conducted at the NTB Provincial Hospital in the filling room, it can be seen that in the patient identity form as a whole the medical record files fill out more complete medical record files, namely 100% compared to incomplete ones. Identity is a list of a person's personal history which usually resembles biographical data or personal data such as name, address, and date of birth, age, gender, religion and others. If these elements are not filled in completely, it will cause confusion when providing services due to the tendency for many patients to have the same name, but the elements of address, date of birth, age and others are different, therefore it is necessary to fill in the identity with complete to avoid unwanted things, and if the patient's identity form is filled in completely then the service will be fast and there will be no mistakes in providing services.(Jensen, 2007)

Likewise in the action form and examination results it is known that as a whole it has more complete medical record files, namely 100% compared to incomplete ones, where the

actions and examination results referred to here are as proof of travel or history of examinations and actions taken from the first time they came for treatment until the last treatment. If one of these forms is not filled in, it will cause confusion for the next service, because this form is the main key in providing further action or service to the patient, and if it is completely filled out, the action or service will run smoothly.(Marichamy & Natarajan, 2023)

As well as in the doctor/nurse initials form as a whole the medical record files fill in more incomplete medical record files (Bongongo et al., 2022), namely 62% because there are still many doctors/nurses who still ignore even the smallest of things even though things like this can affect SPM compared to complete medical record files, namely 38%, where the initials referred to here are proof that the medical records/documents were actually made by doctors/other health workers. Because if the action given is wrong and the patient gets a different doctor even though the polyclinic is the same, it will affect the next doctor who will provide services (Choy et al., 2020). The medical record is said to be complete if the patient's identity, actions and results of the examination, as well as the doctor's/nurse's initials are completely filled out with a standard filling of 100% filled out.

Respondents generally had sufficient knowledge to fill in incomplete medical records, namely 51.3 %, compared to those who filled out complete medical record files, namely 48.7%. Respondents who had less knowledge filled more incomplete medical record files, namely 93.8 %, compared to filling out completely, namely 6.2%. Based on this data, it can be seen that the comparison between those who filled out the medical record completely from those who had sufficient knowledge and those who had less knowledge was very significant (of the total who filled out the complete medical record 63.6%).

Completeness Level of Informed Consent Documents after being given information

Documents of consent action given by the officer to the patient or those who represent the patient, such as the patient's family or close relatives of the patient. Patients who come to the Pasyankes are given a sheet in the form of informed consent, which is giving consent freely and without coercion from anyone regarding the actions or services that will be received by the patient carried out by the doctor in charge of the patient. This is done after receiving sufficient information from the officer in good and polite language and can be understood by the patient.(Ali et al., 2023)

Patients can make the right decisions about everything related to the actions that will be carried out by the doctor. Information received by the patient regarding the aims and purposes of diagnostics, palliative care and treatment (Idriss et al., 2022), risks and other effects and complications that may occur at any time. In addition, it also explains the losses that will be obtained and the benefits given by the treatment performed, other alternatives available at the hospital, the estimated amount of costs to be incurred by the patient, the level of risk of failure of the action given, the patient's condition after being given treatment, and the experience level of a person. doctor.(Zhang et al., 2022)

Based on the results of research conducted at the NTB Provincial General Hospital in the filling room, it can be seen that overall the respondents can be seen the number of incomplete informed consent forms with an average incomplete filling of 76% and 24% complete with details on the form the information provider consists of the implementing doctor, information provider, and information recipient only filled in 1 or 2 forms, it will be said to be incomplete

and will be said to be complete if all the forms in the information provider are filled out in full (Garavatti et al., 2018). Whereas in the form the type of information consisting of diagnosis, risk, purpose of action, doctor's actions and others is not filled in at all or only a few are filled in, it will also be said to be incomplete and will be said to be complete if all the forms are in that type of information all filled in, as well as the doctor's signature, the signatures of witnesses 1 and 2 are only filled in with the full name or signature only, it will be said to be incomplete and will be said to be complete if the full name and signature are filled in completely .

Informed consent that is filled in completely 100% is required when a patient is going to be operated on or is going to undergo certain surgical procedures, where the giving of approval or refusal of the treatment to be taken is valid evidence regarding the medical action given if there is a medical action error in the form of diagnostic or therapeutic.

Conclusion

The level of completeness of the contents of medical record documents for 24 hours after being given service at the NTB Provincial Hospital has been carried out with the level of completeness related to patient identity having fulfilled 100%, the actions and examination results have fulfilled 100%. However, in elements related to initials or doctor/nurse signatures, there are several medical record documents with an incomplete status of 64% which are not in accordance with the SPM. The completeness of the contents of the patient consent document in the form of informed consent after the patient has been given information, it has been filled out properly with the level of completeness of patient identity 100%, providing information 76%, type of information 76%, doctor's signature and signatures of witnesses 1 and 2 76% who have not yet in accordance with the existing SPM that is 100%.

References

Al-Kaabi, R. A., & Abdullah, A. A. (2023). A survey: medical health record data security based on interplanetary file system and blockchain technologies. *Indonesian Journal of Electrical Engineering and Computer Science*, *30*(1). https://doi.org/10.11591/ijeecs.v30.i1.pp586-597

Ali, N., Khan, N., Mustahsan, S., Ali, S., Waheed, S., & Khan, U. (2023). Chlorine gas hazardous material incident in Karachi, Pakistan: A clinical experience from an emergency department of a tertiary care hospital. *Journal of the Pakistan Medical Association*, *73*(4). https://doi.org/10.47391/JPMA.6935

Bongongo, T., Govender, I., Nzaumvila, D. K., & Maphasha, O. M. (2022). Preparedness level of frontline healthcare professionals in Tshwane regarding the COVID-19 pandemic. *South African Family Practice*, *64*(1). https://doi.org/10.4102/safp.v64i1.5341

Brunt, C. S. (2023). Assessing the impact of enforcement and compliance with minimum staffing standards on the quality of care in nursing homes: Evidence from the Centers for Medicare and Medicaid Services' staff star rating downgrade policy. *Health Economics (United Kingdom)*, *32*(2). https://doi.org/10.1002/hec.4619

Choy, M. A., Sturgiss, E., Goodyear-Smith, F., & Smith, G. J. D. (2020). Digital health tools and patients with drug use disorders: Qualitative patient experience study of the electronic case-finding and help assessment tool (eCHAT). *Journal of Medical Internet Research*, *22*(9). https://doi.org/10.2196/19256

Flavel, M. J., Holmes, A., Ellen, S., & Khanna, R. (2023). Evaluation of consultation liaison

psychiatry in Australian public hospitals (AU-CLS-1). *Australasian Psychiatry*, *31*(1). https://doi.org/10.1177/10398562221143930

Garavatti, E., Tucker, J., & Pabian, P. (2018). Utilization of an interprofessional integrated clinical education experience to improve medical and physical therapy student comfort in treating patients with disabilities. *Education for Health: Change in Learning and Practice*, *31*(3). https://doi.org/10.4103/efh.EfH_177_17

Idriss, S., Aldhuhayyan, A., Alanazi, A. A., Alasaadi, W., Alharbi, R., Alshahwan, G., Baitalmal, M., & Alonazi, W. (2022). Physicians' Perceptions of Telemedicine Use During the COVID-19 Pandemic in Riyadh, Saudi Arabia: Cross-sectional Study. *JMIR Formative Research*, *6*(7). https://doi.org/10.2196/36029

Jensen, U. J. (2007). The Struggle for Clinical Authority: Shifting Ontologies and the Politics of Evidence. *BioSocieties*, *2*(1). https://doi.org/10.1017/s174585520700508x

Marichamy, V. S., & Natarajan, V. (2023). Blockchain based Securing Medical Records in Big Data Analytics. *Data and Knowledge Engineering*, *144*. https://doi.org/10.1016/j.datak.2022.102122

Salim, M. M., & Park, J. H. (2023). Federated Learning-Based Secure Electronic Health Record Sharing Scheme in Medical Informatics. *IEEE Journal of Biomedical and Health Informatics*, *27*(2). https://doi.org/10.1109/JBHI.2022.3174823

Supri, A., Rachmawaty, R., & Syahrul, S. (2019). Nurses' Performance Assessment Based On Nursing Clinical Authority: A Qualitative Descriptive Study. *Journal of Nursing Practice*, *2*(2). https://doi.org/10.30994/jnp.v2i2.48

Zeedan, M., Attiya, G., & El-Fishawy, N. (2023). Enhanced hybrid multi-objective workflow scheduling approach based artificial bee colony in cloud computing. *Computing*, *105*(1). https://doi.org/10.1007/s00607-022-01116-y

Zhang, C., Fiscella, K., Przybylek, S., Chang, W., & Liu, Y. (2022). Telemedicine Experience for PrEP Care among PrEP-Eligible Women and Their Primary Care Providers during the First Year of the COVID-19 Pandemic in the United States. *Tropical Medicine and Infectious Disease*, *7*(10). https://doi.org/10.3390/tropicalmed7100280