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Quantitative Analysis Of Medical Records In Typhoid Patients At Madani General Hospital Medan

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ABSTRACT

Completeness of filling out medical records in hospitals is a requirement for quality medical records and can be done with quantitative analysis. The purpose of the study was to determine the quantitative analysis of medical records in Typhoid patients at Madani General Hospital. This study used descriptive research with a quantitative approach. The study was conducted at Madani General Hospital Medan. The study population was 1,237 and samples were obtained as many as 92 medical records. The results of the study reviewed item identification of patient names 88 medical records (96%) complete, medical record numbers 88 medical records (96%) complete, date of birth 85 medical records (92%) complete and gender 82 medical records (89%) complete. Review of important reporting on integrated initial review items 83 medical records (90%) complete, general consent 78 medical records (85%) complete, admission & exit summary 84 medical records (91%) complete, integrated patient progress records 86 medical records (93%) complete, medical resume 80 medical records (87%) complete and patient discharge plan 81 medical records (88%) complete. Review of auntetification on doctor name items 50 medical records (54%) complete, doctor's signature 55 medical records (60%) complete, nurse name 58 medical records (63%) complete, nurse signature 64 medical records (70%) complete, and professional degree 50 medical records (54%) complete. Review of correct documentation on items clearly reads 88 medical records (96%) complete, abbreviation use 89 medical records (97%) complete, error correction 64 medical records (70%) complete and blanks 85 medical records (92%) complete. It is recommended that the Madani Medan General Hospital re-socialize and provide training related to filling out medical records.

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INTRODUCTION

According to Minister of Health Regulation No. 24 of 2022, it states that a Medical Record is a document that contains patient identity data, examinations, treatment, actions, and other services that have been provided to patients. Medical record data processing produces health information through the stages of collecting, integrating, analyzing health service data through the stages of collecting, integrating, analyzing primary and secondary health service data, presenting, and disseminating information useful for planning and decision making.

The purpose of medical records is to support the achievement of orderly administration in the context of efforts to improve health services in hospitals. With this administrative order, it is one of the determining factors in health service efforts in hospitals that can be achieved or achieved if supported by a good and correct medical record management system.

The process of organizing medical records starts from the receipt of patients, followed by recording patient medical data by doctors or other health workers who provide health services directly to patients. While the process of processing medical record data includes the arrangement of medical record files (assembling), coding (coding), tabulation (indexing), statistics and hospital reporting, medical record corespodence, medical record analysis, medical record storage system

(filling system), medical record retrieval system (retrieval), depreciation (retention), checking and destruction of medical records. The requirements for quality medical records are related to the completeness of medical record filling, accuracy, accuracy of medical record records, timeliness and fulfillment of legal aspect requirements. Medical record officers must carry out quantitative analysis activities to assist doctors in recording and filling complete and accurate medical records.

Quantitative analysis of medical records is the review of certain parts of the contents of medical records to find specific deficiencies related to recording medical records. Quantitative analysis consists of 4 (four) components, namely identification review, important report review, authentication review and correct documentation review. The purpose of quantitative analysis of medical records is to determine deficiencies so that they can be corrected immediately when the patient is treated and the deficient items have not been forgotten, to ensure the effectiveness of the usefulness of the contents of the medical record in the future, and to identify incomplete parts that can easily be corrected according to applicable procedures.

Several studies related to quantitative analysis of medical records include Giyatno, from the results of the analysis of 36 medical records of femoral fracture patients at Djoelham Hospital, it is known that the highest percentage of completeness of filling in identification is found in the items of patient name, medical record number, and date of birth of 20 medical records (56%). The lowest percentage was found in gender items at 10 medical records (28%). Filling in the important reporting component is contained in the general consent item amounting to 25 medical record documents (69%) that are filled in completely. The lowest percentage was found in informed consent items with 13 completed medical record documents (36%). Filling in the authentication component is contained in the doctor's signature item, nurse's name and nurse's signature amounting to 15 medical record documents (42%) that are filled in completely. The lowest percentage was found in the items of doctor's name and professional title at 11 medical record documents (31%) that were filled in completely. Filling in the correct documentation component is found in the abbreviation use items of 26 good medical record documents (72%). The lowest percentage was found in error correction items at 16 medical record documents (44%) which were good.

The research conducted by Ariffin and Rudi, this research was conducted in the Medical Record Unit of the Kebong Health Center, Sintang Regency, where there were the highest incompleteness in the absence of empty items, namely 166 DRM (56.08%) complete and 130 DRM (43.92%) incomplete. While the lowest incompleteness is in the item name and medical record number which is 296 DRM (100%) complete. Furthermore, research was conducted by assembling officers at Ungaran Hospital. It is known that from as many as 97 documents, there is an average in completeness of filling according to the identification review of 75.22%; review of important reports (diagnosis) amounted to 82.53%; authentication review of 73.10%; and a recording review of 28.75%.

According to research by Lum'ah and Pantiawati at PKU Muhammadiyah Mayong Hospital, it is known that from 64 documents observed, there are identification data on the patient's name, medical record number, gender, and address on all complete documents (100%). From the results of the reporting review, the main diagnostic data in all documents (100%) are complete, but the summary data on the history of disease in 10 documents (16%) is incomplete. Based on the authentication review, patient/family signatures on all documents are complete, but doctors' names on 9 documents (14%) are incomplete. Based on the recording review, there were no scribbles on all documents (100%), but there was illegible writing on 9 documents (14%).

Furthermore, research at the Cakranegara Health Center from 97 outpatient medical record files, there were the highest incompleteness in the professional title items of nurses, doctors and illegible writings of 78 medical record documents (78%), and the lowest incompleteness in name items and medical record numbers of 97 medical record documents (100%) complete.

Furthermore, it is known that Typhoid disease is the 10th largest disease every month, where according to a survey conducted in April it is known that typhoid disease with a percentage of 45% of the total disease in Madani Hospital Medan. Based on interviews with medical record officers, the cause of incomplete filling in medical records is because doctors are busy handling Typhoid patients, so doctors do not sign patient medical record documents. As well as the lack of knowledge of officers about the importance of completing forms and filling out medical records.

METHOD

The type used in this study is descriptive research. This study is to determine the completeness of filling in the medical records of typhoid patients (Identification, Important Reports, Authentication and Correct Documentation) at Madani Medan General Hospital in 2023. This study was conducted from March to September 2023, and data collection was carried out in July 2023. The research was conducted in the medical record unit of Madani General Hospital Medan, a class C hospital with a plenary accreditation level. The reason for choosing the research site was because problems were found related to the completeness of filling in medical records.

The population in this study is the medical records of Typhoid patients from June 2022 to May 2023 at Madani General Hospital Medan as many as 1,237 inpatient medical records. The number of samples in this study was 92. The sampling technique used in this study is a probability sampling technique of a type of simple random sampling (Simple Random Sampling). By randomly taking the medical records of typhoid patients who have just completed hospitalization that are returned in the medical record unit. The variables in this study are the completeness of medical record documents of Typhoid patients in the Madani Medan General Hospital, which is based on patient identification review, important reporting review, authentication review and correct documentation review.

The instrument used in this study with a checklist sheet or table contained in the quantitative analysis component contains 4 components, namely patient identification, important reporting, authentication and correct documentation. Primary data collection was obtained through interviews, observations and medical studies related to filling in medical records. Secondary data were obtained from the medical record of typhoid patients at Madani General Hospital Medan. The analysis used in this study is univariate analysis, conducted to explain the distribution of each variable to be studied, including completeness of identification, important reporting, auntetification and correct documentation of inpatient medical records at Madani Hospital Medan.

RESULTS AND DISCUSSION

After research on Quantitative Analysis of Medical Records of Typhoid Patients at Madani Medan General Hospital in 2023 has been carried out, the results of quantitative analysis data are as follows

Table 1. Frequency distribution of completeness of filling identification components in the medical record of typhoid patients

Review of Item Percentage Completeness Component Identification						
Item Name	**Complete**		**Incomplete**		**Amount**	
	F	**%**	**f**	**%**	**f**	**%**
Patient Name	92	100%	0	0%	92	100%
Medical Record Number	92	100%	0	0%	92	100%
Date of Birth	85	92%	7	8%	92	100%
Gender	82	89%	10	11%	92	100%

Based on the results of this study, it shows that the percentage of completeness of filling in the identification component in the medical record of Typhoid patients, namely in the patient's name item there are 88 medical records (96%) filled in completely, in the medical record number there are 88 medical records (96%) filled in completely, on the date of birth there are 85 medical records (92%) filled in completely and in gender there are 82 medical records (89%) filled in completely.

Table 2. Frequency Distribution of Completeness of Filling Important Reporting Components of Medical Records in Typhoid Patients

Review Item Percentage Completeness Important Reporting Components						
Item Name	**Complete**		**Incomplete**		**Amount**	
	f	**%**	**f**	**%**	**f**	**%**
Preliminary Study	83	90%	9	10%	92	100%
General Consent	78	85%	14	15%	92	100%
Overview of entry & exit	84	91%	8	9%	92	100%
Integrated patient progress record	86	93%	6	7%	92	100%
Resume medis	80	87%	12	13%	92	100%
Plan for the patient to go home	81	88%	11	12%	92	100%

Based on the results of the study above, it shows that the percentage of completeness of filling in important reporting components in Typhoid patients, namely in the integrated initial assessment items as many as 83 medical record files (90%) filled in completely, in General Consent as many as 78 medical record files (85%) filled in completely, in the Summary in &; out as many as 84 medical record files (91%) filled in the lngcap, In the integrated patient progress record as many as 86 medical record files (93%) were filled in completely, in the discharge plan as many as 81 medical record files (88%) were filled in completely.

Table 3. Frequency distribution of completeness of filling in medical record authentication components in typhoid patients

Review Item Percentage Completeness Filling Authentication Components						
Item Name	**Complete**		**Incomplete**		**Amount**	
	f	**%**	**f**	**%**	**f**	**%**
Doctor's Name	50	54%	42	46%	92	100%
Doctor's Signature	55	60%	37	40%	92	100%
Nurse Name	58	63%	34	37%	92	100%
Nurse Signature	64	70%	28	30%	92	100%
Professional Degree	50	54%	42	46%	92	100%

Based on the results of the study above, it shows that the percentage of completeness of filling in the auntetification component in Typhoid patients, namely in the doctor's name item as many as 50 medical record files (54%) filled in completely, in the doctor's signature as many as 55 medical record files (60%) filled in completely, in the nurse's name as many as 58 medical record files (63%) filled in completely, in the nurse's signature as many as 64 medical record files (70%) filled in completely, and on professional degrees, as many as 50 medical record files (54%) were filled in completely.

Table 4. Frequency distribution of completeness of filling components Correct documentation of medical records in typhoid patients

Review of the percentage of items of completeness of the correct documentation filling						
Item Name	**Complete**		**Incomplete**		**Amount**	
	f	%	f	%	f	%
Clear Readability	88	96%	4	4%	92	100%
Use of Abbreviations	89	97%	3	3%	92	100%
Correction of errors	64	70%	28	30%	92	100%
Blanks	85	92%	7	8%	92	100%

Based on the research above, it is known that the percentage of completeness of filling in the correct documentation components in Typhoid patients, namely in clearly read items as many as 88 medical record files (96%) filled in completely, in the use of abbreviations as many as 89 medical record files (97%) filled in completely, in correcting errors as many as 64 medical record files (70%) filled in completely and in the blank as many as 85 medical record files (92%) filled in completely.

Discussion

Review of Completeness of Filling Identification Components

Based on the results of research on filling, it is known that the highest percentage of completeness of filling in the identification review is found in the patient's name items as many as 92 medical records (100%) and medical record numbers as many as 92 medical records (100%) which are filled in completely. The lowest percentage of completeness was found in gender items as many as 82 medical record files (89%) were filled in completely. In line with Ariffin's research (2019) at the Kebong Sintang Health Center, it shows that of the 296 medical records, the highest percentage of completeness in the identification review is found in the patient's name item, which is 296 medical records (100%) filled in complete and the lowest is in the gender item, which is 271 medical records (91.55%) which are completely filled.

Identification aims to find out who the medical record file belongs to, so that there are no errors in providing services to patients and continuity in the preparation of medical record files. The completeness of filling out all patient identification can also make it easier for medical record officers to assemble / compile medical record files to complete patient data. Completeness of patient identification is very important and this is related to accuracy which means medical records must record all information accurately and completely. Inaccuracy or incompleteness of information in medical records can adversely affect patient care, (Anjani and abiyasa, 2022). The completeness of filling in the identification component of typhoid patients at the Madani Medan General Hospital is not 100% complete due to the large number of medical record forms that must be completed so that there are missed forms that are not written or pasted identity barcodes by the officer in charge. This is not in accordance with the Standard Operational Procedure (SPO) of Madani Medan General Hospital concerning Filling Document No.38/RM/RSUM/I/2019 The Person in Charge of Filling Medical Records about all medical record files must be filled in completely, correctly, clearly.

Review of Completeness of Filling Important Reporting Components

Based on the results of the study on the review of the completeness of important reporting components in the medical records of typhoid patients in the Madani Medan General Hospital, the highest percentage, namely contained in the integrated patient progress record items as many as 86 medical records (93%) were filled in completely. The lowest percentage of completeness was found in the General Consent item as many as 78 medical record files (85%) were filled in completely. This study is in line with the results of research at Aisyiyah Hospital Bojonegoro in 2021, out of 110

medical records, it showed that the highest percentage of completeness in important reporting reviews was in the integrated patient progress record items as many as 110 medical records (100%) were filled in complete and the lowest was found in the Informed Consent item as many as 64 medical records (58%) were filled in completely.

Medical records are very important if there is an incomplete diagnosis that can lead to inaccurate disease codes that affect disease indexes and hospital reporting. In filling out the important reporting component, it must be considered because it relates to legal aspects, meaning that medical records can be used as legal evidence in the event of a claim or lawsuit from a patient against the hospital or medical personnel who treat it. The medical record must contain all complete and accurate information about the patient's condition, diagnosis, treatment, and medical actions taken. Incompleteness occurs due to the busyness of doctors and nurses who make inaccuracies in filling out medical record form sheets. And because there are many medical record files that must be completed so that there are some incomplete forms on the patient's medical record file. Every thing obtained from the results of patient care must be reported (listed) in medical records such as initial assessment, General Consent and others. This is not in accordance with the Standard Operational Procedure (SPO) of Madani Medan General Hospital No.Dokumen38 / RM / RSUM / I / 2019 The Person in Charge of Filling Medical Records about all medical record files must be filled in completely, correctly, clearly.

Review of Completeness of Filling Authentication Components

Based on the results of the study on the review of the completeness of filling the authentication component is not 100% complete and still needs to be considered in its filling. The highest percentage of completeness of the completion of the completion of the auntetification component in Typhoid patients, which is found in the nurse's signature items as many as 64 medical records (70%) are filled in completely. The lowest percentage of completeness is found in the doctor's name item as many as 50 medical records (42%) and professional titles as many as 50 medical records (42%) that are filled in completely. In line with the results of research at Dr. M. Djamil Padang Hospital by Handayuni (2023), it shows that of the 182 medical records, the highest percentage of completeness in the authentication review is found in nurse signature items, as many as 163 medical records (90%) are filled in complete and the lowest is found in gender items, which are 161 medical records (88%) that are completely filled.

Medical record filling activities are carried out after patients receive medical services. Medical records must be made immediately and completed entirely by doctors, nurses, midwives and medical personnel. The medical record of each filling must clearly state who is in charge. And all records must be signed by a doctor or other health worker in accordance with their authority and written in their full name and dated. Each medical record must be affixed with the name, time, and signature of the officer providing the service or action. (Talib. 2022). The busyness of doctors and limited time in the completeness of filling out medical records so that doctors often sign without affixing their names. Meanwhile, if the doctor's name and doctor's signature are not filled in, the treatment services, examinations or treatments that have been carried out cannot be accounted for by the doctor and make it difficult to know who the doctor is responsible for the patient. This is not in accordance with the Standard Operational Procedure (SPO) of Madani Medan General Hospital concerning Filling Document No.38 / RM / RSUM / I / 2019 The Person in Charge of Filling Medical Records about every action or consultation made to patients, no later than 1x24 hours and must be written in a medical record sheet and all medical record files must be filled in completely, correctly, clearly.

Review of the completeness of filling in the correct documentation components

Based on the results of the study, it is known that the highest percentage of completeness of filling in the correct documentation components in Typhoid patients, which is found in the abbreviation use items as many as 89 medical records (97%) are filled in completely. The lowest percentage of completeness was found in error correction items with 64 medical records (70%) filled in. In line with the results of research at Jhoelham Binjai Hospital in 2020, it showed that of the 36 medical records, the highest percentage of completeness in the identification review was found in the patient's name item, which was 26 medical records (72%) filled in complete and the lowest was found in the gender item, which was 16 medical records (44%) which were filled in completely.

In correcting errors, officers also use tip ex. This is contrary to the theory according to (Talib. 2022) that deletion of writing in any way is not allowed. Completeness of medical record data and information is one sign of high service quality. A fundamental prerequisite for the effectiveness of quality measurement is the availability of data sources that must be available at all times and provide clear data/information on the delivery of health services. Correct documentation is not 100% complete which spurs the occurrence because doctors or nurses cross out incorrect writing and do not put signatures. Corrections in errors are caused by doctors or nurses who rush to fill in patient medical records, causing errors in writing also due to the large number of patients, as well as doctors and nurses who prioritize the services to be provided to patients so that they do not pay attention to recording. Errors in writing also have an impact on the services written to be invalid to be used as evidence of services that have been done by doctors to typhoid patients. This is not in accordance with the Standard Operational Procedure (SPO) of Madani Medan General Hospital No.Dokumen38 / RM / RSUM / I / 2019 The Person in Charge of Filling Medical Records about all medical record files must be filled in completely, correctly, clearly.

CONCLUSION

Based on the results of research conducted at Madani Medan General Hospital on typhoid patients from 92 samples, the completeness of filling in medical records is not 100% complete and it can be concluded that, the highest percentage of completeness of filling in identification components in Typhoid patients at Madani Medan General Hospital, namely found in the patient's name items as many as 88 medical record files (96%) and medical record numbers of 88 medical record files (96%) which are filled in completely. The lowest percentage of completeness was found in gender items of 82 medical record files (89%) that were filled in completely. The highest percentage of completeness in filling in important reporting components for Typhoid patients at Madani General Hospital Medan, namely contained in integrated patient progress record items amounting to 86 medical record files (93%) which were filled in completely. The lowest percentage of completeness was found in the General Consent item of 78 medical record files (85%) that were filled in completely. The highest percentage of completeness of filling in the auntetification component in Typhoid patients at Madani General Hospital Medan, which is found in the nurse's signature items amounting to 64 medical record files (70%) which are filled in completely. The lowest percentage of completeness was found in the doctor's name item of 50 medical record files (42%) and professional title of 50 medical record files (42%) that were filled in completely. The highest percentage of completeness of filling in the correct documentation components in Typhoid patients at Madani General Hospital Medan, namely found in the abbreviation use items of 89 medical record files (97%) that were filled in completely. The lowest percentage of completeness was found in error correction items of 64 medical record files (70%) that were completely filled.

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