TINJAUAN PELAKSANAAN RETENSI DRM NON AKTIF DI FILING RUMAH SAKIT PERMATA BUNDA PURWODADI TAHUN 2015

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ABSTRAK

TINJAUAN PELAKSANAAN RETENSI DRM NON AKTIF DI FILING RUMAH SAKIT PERMATA BUNDA PURWODADI TAHUN 2015

Frekuensi keluar masuknya rekam medis sangat tinggi bagi rumah sakit swasta. Dalam waktu penyimpanan yang lama, rak dokumen akan penuh dan tidak mencukupi lagi untuk DRM yang baru. Dari hasil survey wawancara dan observasi kepada 4(empat) petugas, di dapat petugas A 25% mengeluh tidak terdapat jadwal retensi arsip di Rumah Sakit Permata Bunda Purwodadi. PetugasB 25% mengeluh rak dokumen sudah penuh. Petugas C 25% mengeluh tidak adanya pengoptimalan pelaksanaan retensi dalam kelompok penyakit berdasarkan JRA dan petugas D 25% mengeluh tidak adanya daftar pemindahan dokumen rekam medis inaktif. Sehingga petugas kebingungan bagaimana cara melakukan retensi yang baik. Maka dari itu peneliti ingin meninjau pelaksanaan retensi DRM non aktif di filing Rumah Sakit Permata Bunda Purwodadi.

Penelitian ini termasuk penelitian deskriptif dengan pendekatan cross sectional. Subjek dalam penelitian ini ada 2 (dua), dengan objek adalah pelaksanaan sistem retensi dokumen rekam medis non aktif. Metode yang digunakan yaitu observasi dengan mengetahui prosedur tetap tentang pelaksannan retensi dokumen rekam medis dan wawancara kepada 4 (empat) petugas filing di RS.Permata Bunda Purwodadi sebagai pedoman pelaksanaan retensi DRM non aktif.

Hasil penelitian pada wawancara petugas filing disimpulkan bahwa petugas tidak mengetahui tentang tata cara pelaksanaan retensi, sehingga petugas harus bertanya terlebih dahulu kepada kepala rekam medis. Petugas tidak mengetahui penataan DRM inaktif dan jadwal retensi arsip belum terdapat di rumah sakit. Di dalam protap belum terdapat langkah â€“ langkah tentang retensi. Sudah terdapat kebijakan retensi di rumah sakit.

Untuk mengatasi permasalahan tersebut maka peneliti menyarankan agar memperbaiki prosedur tetap dan menjelaskan tentang tata cara pelaksanaan retensi sehingga kegiatan tersebut dapat lebih terjadwal. Mengadakan pelatihan tentang pengelolaan DRM / kearsipan agar pelaksanaan retensi berjalan dengan lancar.

Kata Kunci : Kata Kunci : retensi, protap, kearsipan, kebijakan
Kepustakaan : 13 (1988-2015)

THE REVIEW ON THE NON ACTIVE DRM RETENTION IN FILING UNIT OF PERMATA BUNDA HOSPITAL IN PURWODADI IN 2015

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ABSTRACT

THE REVIEW ON THE NON ACTIVE DRM RETENTION IN FILING UNIT OF PERMATA BUNDA HOSPITAL IN PURWODADI IN 2015

Frequency of out going and in coming medical records is very high for a private owned hospital. In the long run of storage time, shelf document will be full and no longer adequate for the new DRM. The records officer who was part of filing in Permata Bunda hospital in Purwodadi do not have a reference in carrying out the functions namely retention, because there is no standard procedure in grain explains, so the attendant confusion how to do good retention and true. Thus the resear chers would like to review the implementation of the review of non active DRM retention at the filing unit of Permata Bunda hospital in Purwodadi. From the results of the interview and observation to four 4 officers, it can be found that 25% of A officers complained that there are no records on retention schedules at Permata Bunda hospital in Purwodadi. 25 % of B officers complained that document shelfs are full. 25% of C officers complained of the lack of optimization on implementation of retention in the disease group based JRA and 25% D officers complained on the absence of medical records documents which are transfer red to in active list. There is confusion among the filing attendant on how to do good retention.

This study includes a descriptive study with cross sectional approach. The method used is observation by knowing the true procedures of medical records retention and interview 4 document filing clerks in Permata Bunda hospital Purwodadi as guidance of non â€“ active DRM retention.

The result from the interview are the filing officer did not know about the procedures of retention, so the officer must ask in advance to the head of the medical record. There is no retention schedule at the hospital. Although there is a retention policy at the hospital but there are no action procedure to do it. Know ledge filing officer is due to several factors, such as lack of training, education and work experience.

To over come these problems, the researchers suggested that the hospital improve the fix procedure and explain the procedures of retention so that these activities can be scheduled. The hospital hold a training on the management of DRM / archival retention so that implementation runs smoothly.

Keyword : Keywords : retention, fixed procedure, filing

Bibliography : 13 (1988-2015)