

ANALISA KUANTITATIF DAN KUALITATIF KETIDAKLENGKAPAN DOKUMEN REKAM MEDIS PADA PASIEN HIPERTENSI DI RS PANTI WILASA DR. CIPTO SEMARANG PERIODE TRIWULAN I TAHUN 2015

YULIANA LARASWATI

Program Studi Rekam Medis&Info. Kesehatan - D3, Fakultas Kesehatan, Universitas Dian Nuswantoro Semarang

URL : <http://dinus.ac.id/>

Email : 422201201190@mhs.dinus.ac.id

ABSTRAK

Dokumen rekam medis (DRM) dapat dijadikan sebagai tolak ukur mutu pelayanan suatu rumah sakit. Dimana mutu pelayanan ditentukan dengan analisa kuantitatif dan kualitatif menggunakan pendekatan Quality Assurance terhadap DRM tersebut. Penulis meneliti DRM kasus hipertensi (termasuk lima belas kasus terbanyak) di Rumah Sakit Panti Wilasa "Dr. Cipto" Semarang. Pada survey awal didapat bahwa 90% DRM hipertensi tidak lengkap. Tujuan untuk mengetahui gambaran umum analisa kuantitatif dan kualitatif ketidak lengkapan DRM kasus hipertensi periode triwulan I tahun 2015 di Rumah Sakit Panti Wilasa "Dr. Cipto" Semarang.

Jenis penelitian ini merupakan penelitian deskriptif dengan metode observasi, checklist, melakukan analisa terhadap dokumen rekam medis rawat inap pada pasien hipertensi yang telah diisi. Sampel penelitian adalah 65 dokumen rekam medis rawat inap.

Berdasarkan hasil penelitian terhadap 65 sampel didapatkan prosentase dari 9 review kuantitatif dan kualitatif menunjukkan bahwa review identifikasi 22% tidak lengkap, review pelaporan 100% tidak lengkap, review pencatatan 100% tidak lengkap, review autentifikasi 100% tidak lengkap, review ketidak lengkapan dan kekonsistenan diagnose 5% tidak lengkap, review kelengkapan dan kekonsistenan pencatatan diagnose 12% tidak lengkap, review pencatatan hal-hal yang dilakukan saat perawatan dan pengobatan 5% tidak lengkap, review adanya informed consent 0% tidak lengkap, review cara atau praktek pencatatan 9% tidak lengkap. Disimpulkan dengan presentase Delinquent Medical Record mencapai 100% tidak lengkap.

Melihat dari hasil Delinquent Medical Record 100% ketidaklengkapan maka penulis memberikan saran perlu adanya kesadaran dan kedisiplinan antara petugas dan dokter yang bertugas untuk lebih bertanggung jawab atas pengisian dokumen rawat inap.

Kata Kunci : Kata Kunci : Dokumen Rekam Medis, Quality Assurance, Hipertensi, Delinquent Medical Record
Kepustakaan :17 (1994 " 2015)

**QUANTITATIVE AND QUALITATIVE ANALYSIS OF THE IN-PATIENT
MEDICAL RECORD DOCUMENTS FOR PATIENTS WITH
HYPERTENSION AT THE PANTI WILASA DR.CIPTO HOSPITAL IN
SEMARANG IN FIRST QUARTER IN 2015**

YULIANA LARASWATI

*Program Studi Rekam Medis&Info. Kesehatan - D3, Fakultas
Kesehatan, Universitas Dian Nuswantoro Semarang*

URL : <http://dinus.ac.id/>

Email : 422201201190@mhs.dinus.ac.id

ABSTRACT

The medical record can be used as the measurement of the service quality in a hospital. The quality of services is determined by a quantitative and qualitative analysis used the quality assurance against the medical record document. The researcher conducted a research on medical record document for the cases of hypertension (considered as fifteen the most frequent cases) at the Panti Wilasa dr.Cipto hospital in Semarang. In the preliminary survey it is obtained that 90 % of hypertension is incomplete. The objective is to ascertain an overall picture of quantitative analysis and qualitative incompleteness medical record document for the cases of hypertension in the period of the first quarter in 2015 at the Panti Wilasa dr.Cipto hospital in Semarang.

This research is descriptive research. The data were taken by the method of observation , checklist , undertake analysis on key aspects of inpatient medical record Documents of the hypertension that have been filled .The study sample is 65 in-patient medical record document.

Based on the outcome of research on 65 samples, it can be found out that in 9 review of qualitative and quantitative shows that a review identification 22 % incomplete , review reporting 100 % incomplete , a review of the registration of 100 % incomplete , review authentication 100 % incomplete , review the incomplete and consistent diagnose 5 % incomplete , review the consistent recording diagnose 12 % incomplete , the registration of recording conducted at the care and medical treatment of 5 % incomplete , a review of the presence of informed consent 0 incomplete , review the manner or practice of recording 9 % incomplete .The percentage is inferred by delinquent medical of a record reached 100 % incomplete .

From the results of the delinquent medical record which is 100 % incompleteness, the researcher suggested that it is necessary to have a consciousness and discipline between the officials and the doctors working to be more responsible for the filling of in-patient document.

Keyword : Keywords: document medical record , quality assurance , hypertension , delinquent medical record
Bibliography: 17 (1994 – 2015)