Analisa kuantitatif dan kualitatif dokumen rekam medis rawat inap pada pasien obstetri terkait dengan risiko kehamilan post sectio caesarea triwulan I di RSIA Hermina Pandanaran Semarang tahun 2016

ANING AYU ARDIANA
(Pembimbing : Dyah Ernawati, S.Kep., Ns, M.K)
Rekam Medis&Info. Kesehatan - D3, FKes, Universitas Dian Nuswantoro
www.dinus.ac.id
Email : 422201301398@mhs.dinus.ac.id

ABSTRAK

Berkas rekam medis rawat inap digunakan untuk meningkatkan mutu pelayanan kesehatan maka harus diisi lengkap dan dapat digunakan sebagai alat bukti hukum bila diperlukan. Berdasarkan survey awal,peneliti melakukan observasi terhadap 10 dokumen rekam medis pasien obstetridi RSIA Hermina Pandanaran Semarang. Hasil ketidaklengkapan pada review identifikasi (40%), review pelaporan (50%), review autentifikasi (60%), review kelengkapan dan kekonsistenan diagnosa (50%), review kelengkapan pencatatan (40%), review pencatatan hal yang dilakukan saat perawatan dan pengobatan (60%).Tujuan penelitian yaitumengetahui tingkat kelengkapan pengisian Dokumen Rekam Medis Rawat Inap Pada Pasien Obstetri Terkait Dengan Risiko Kehamilan Sectio Caesarea Triwulan I di RSIA Hermina Pandanaran Semarang Pada Tahun 2016.

Jenis penelitian yang digunakan adalah deskriptif dengan metode observasi dan pendekatan retrospektif. Pencatatan data menggunakan tabel ceklist. Populasi adalah dokumen rekam medis pasien obstetri terkait risiko kehamilan post sectio caesarea dengan jumlah sampel 40 dokumen rekam medis, sedangkan pengambilan sampel dilakukan secara acak.

Berdasarkan 4 review analisa kuantitatifmenunjukan hasil persentase review identifikasi 30% pada formulir resume pasien keluar, review pelaporan 63% pada formulir ringkasan masuk dan keluar, review pencatatan 28% pada formulir asuhan keperawatan, review autentifikasi 67% pada formulir ringkasan masuk dan keluar. Hasil analisa kualitatif,ketidakkonsistenan review kelengkapan dan kekonsistenan diagnosa 45%, review kelengkapan pencatatan diagnosa 38%, review kekonsistenan pencatatan saat perawatan dan pengobatan 30%,review ada tidaknya informed consent 10%, review hal yang menyebabkan tuntutan ganti rugi 100% konsisten, review cara praktik pencatatan 25% dan IMR (Incomplete Medical Record) sebesar 70%.

Disarankan untuk memberikan sosialisasi atau himbauan terhadap kelengkapan pengisian dokumen rekam medis terhadap petugas pencatatan data. Memaksimalkan fungsi asembling untuk memonitoring kelengkapan dokumen rekam medis pada masing-masing bangsal. Pemberian protap tentang kelengkapan dokumen rekam medis.

Kata kunci : Dokumen Rekam Medis, Kuantiatif, Kualitatif, Pasien Obstetri

Kata Kunci : Kata kunci : Dokumen Rekam Medis, Kuantitatif, Kualitatif, Pasien Obstetri

Generated by SiAdin Systems ï¿½ PSI UDINUS 2016

Quantitative and qualitative analysis of inpatient medical record documents on obstetric patient associated with risk of pregnancy post sectio caesarea in first quarter in Hermina Pandanaran Hospital Semarang Year 2016

ANING AYU ARDIANA
(Lecturer : Dyah Ernawati, S.Kep., Ns, M.K)
Diploma of Medical Record - D3, Faculty of Health Science,
DINUS University
www.dinus.ac.id
Email : 422201301398@mhs.dinus.ac.id

ABSTRACT

Inpatient medical record document used to improve the quality of health services therefore must be complete and can be used as legal evidence when necessary. Based on the initial survey, researchers conducted observations of 10 medical records document of patients in obstetrics at RSIA Hermina Pandanaran Semarang. The results of incompleteness on the review of identification (40%), review of reporting (50%), review authentication (60%), review the completeness and consistency of diagnosis (50%), review the completeness of record (40%), review the recording of the things done when patient care and treatment (60%). The purpose of research known the level of completeness of Inpatient Medical Records Document on Obstetric Patients Associated With Pregnancy post Sectio Caesarea in first Quarter In RSIA Hermina Pandanaran Semarang 2016.
This type of research was descriptive, observational methods and retrospective approaches. Data collected by checklist table. Population were medical record documents of patient related obstetric risk pregnancies post sectio caesarea with a sample of 40 documents, while the sampling done randomly.
Based on 4 review of quantitative analysis showed percentage review of identified 30% in resume patient discharge, review of reporting 63% on entry and exit summary form, review of recording 28% in the form of nursing care, review of authentication 67% on entry and exit summary form. The results of qualitative analysis, inconsistencies review the completeness and consistency of diagnosis was 45%, review the completeness of diagnosis recording 38%, review the consistency of recording the time of treatment and the treatment 30%, review whether there was informed consent 10%, review the things that caused a demand for compensation 100% consistent, reviews how practice of recording 25% and IMR (Incomplete Medical Record) by 70%.
Researcher advised to provide socialization or appeal the completeness of medical record documents to officer of data recording. Maximizing assembling functions for monitoring the completeness of medical record documents on each ward. Provision the procedures of medical record documents.
Keywords : Medical Record Document, Quantitative, Qualitative, Obstetric Patients

Keyword : Keywords : Medical Record Document, Quantitative, Qualitative, Obstetric Patients

Generated by SiAdin Systems ï¿½ PSI UDINUS 2016