ANALISA REVIEW KUANTITATIF DAN KUALITATIF DOKUMEN REKAM MEDIS KASUS BEDAH ORTHOPEDI PADA PERIODE TRIWULAN IV DI RUMAH SAKIT MARDI RAHAYU KUDUS TAHUN 2015

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ABSTRAK

Mengingat pentingnya peranan dokumen rekam medis dalam menciptakan informasi medis yang berkesinambungan dan menurut aspek hukum kesehatan maka perlu dijaga kelengkapannya. Dokumen rekam medis rawat inap kasus bedah orthopedi masih sering ditemukan tidak lengkap di RS Mardi Rahayu Kudus, sehingga dokumen rekam medis sering menumpuk di bagian assembling dan menghambat pelayanan ketika pasien kontrol. Survei 10 dokumen rekam medis ditemukan 60% tidak lengkap.Tujuan penelitian ini adalah menganalisis tentang analisa kelengkapan dokumen rekam medis kasus bedah Orthopedi di Rumah Sakit Mardi Rahayu Kudus.
Jenis penelitian adalah penelitian deskriptif. Metode penelitian adalah observasi, pendekatan cross sectional dan pengambilan data secara retrospektif. Dengan menggunakan teknik random sampling diperoleh sampel sebanyak 58 DRM dari total populasi sebanyak 133 dokumen rekam medis kasus bedah orthopedi pada triwulan IV tahun 2015.
Hasil penelitian untuk review identifikasi dokumen rekam medis yang lengkap 74,13% dan tidak lengkap 25,87%, review pencatatan 63,79% baik dan 36,21% pencatatannya belum baik, review autentifikasi 67,24% lengkap dan 32,76% tidak lengkap, review pelaporan pada RM.RI 03 100% lengkap dan pada RM.RI 06.1 22,41% tidak lengkap, review kekonsistensian diagnosa 79,31% konsisten dan 20,69% tidak konsisten, review kekonsistensian pencatatan diagnosa 89,65% konsisten dan 10,35% tidak konsisten, review pencatatan saat perawatan 87,93% lengkap dan 12,07% tidak lengkap, review pencatatan informed consent 74,13% lengkap dan 25,87% tidak lengkap, review cara pencatatan 84,48% lengkap dan 15,52% tidak lengkap. Hal-hal yang menyebabkan tuntutan ganti rugi 74,13% tidak berpotensi dan 25,87% berpotensi. Berdasarkan hasil analisa kuantitatif dan kualitatif terdapat 37 dokumen lengkap dan 21 dokumen belum lengkap sehingga dihasilkan tingkat kebandelan dokumen sebesar 56,75%.
Disimpulkan masih banyak dokumen yang tidak lengkap. Dengan demikian peneliti menyarankan agar setiap formulir rekam medis diberi stiker label, pencatatan yang lengkap dan terbaca, adanya petugas rekam medis di setiap ruangan, pemberian sanksi yang tegas oleh komite medik kepada dokter dan perawat serta pertemuan secara periodik dengan dokter dan petugas kesehatan lain untuk sosialisasi cara pencatatan yang baik dan lengkap serta penggunaan terminologi medis sesuai ICD 10.
Kata kunci : Dokumen Rekam Medis, Quality assurance, analisa kuantitatif dan kualitatif

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ANALYSIS THE REVIEW OF QUANTITATIVE AND QUALITATIVE MEDICAL RECORD DOCUMENT CASE OF ORTHOPAEDIC SURGERY IN FOURTH QUARTER AT MARDI RAHAYU HOSPITAL KUDUS IN 2015

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ABSTRACT

Considering the importance of medical record documents in creating a sustainable medical information and according to the medico legal aspects therefore document should be maintained its completeness. Inpatient medical records document of orthopedic surgery cases often found incomplete in Mardi Rahayu Hospital, so that medical records documents often accumulate in the assembling and hamper the service when the patient treated again. Survey of 10 document medical records found 60% did not complete. This study analyzed completeness medical record documents cases of Orthopaedic surgery at Mardi Rahayu Hospital.
This was a descriptive study. The research was observational, cross-sectional approach and retrospective data collection. By using random sampling techniques obtained sample of 58 document of the total population 133 cases of orthopedic surgery in fourth quarter 2015.
The results of the study showed that review of identification 74.13% was complete and 25.87% was incomplete, review the recording of 63.79% good and 36.21% not good, review the authentication 67.24% was complete and 32.76% was incomplete, review of reporting on RM.RI 03 100% was complete and on RM.RI 06.1 22.41% was incomplete, review the diagnosis consistency 79.31% was consistent and 20.69%was inconsistent, review consistency of recording of diagnoses 89.65% was consistent and 10.35% was inconsistent, review the recording time of treatment 87.93% was complete and 12.07% was incomplete, review the recording of informed consent 74.13% was complete and 25.87% was incomplete, review ways of recording 84.48% was complete and 15.52%was incomplete. Things that lead to claims for compensation 74.13% did not trigger potentially and 25.87% was trigger potentially. Based on the results of quantitative and qualitative analysis of the document contained 37 was complete and 21 was incomplete so that the resulting rate of 56.75% obstinacy document.
Concluded there were many incomplete documents. Thus researcher suggest that any form of medical records given a sticker label, complete and legible recording of document, assign medical records officers in every room, providing strict sanctions by the medical committee to doctors and nurses also meetings periodically with doctors and other health workers in order to socialize good recording and completeness of medical record and appropriate the use of medical terminology according to ICD 10.

Keywords : Medical Record Document, Quality assurance, quantitative and qualitative analysis

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