TINJAUAN PROSEDUR PENGENDALIAN KETIDAKLENGKAPAN DOKUMEN REKAM MEDIS (DRM) RAWAT INAP TRI WULAN PERTAMA DI ASSEMBLING RSUD TUGUREJO SEMARANG TAHUN 2016

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ABSTRAK

Berdasarkan Peraturan Menteri Kesehatan Nomor 269/MENKES/PER/III/2008, rekam medis harus tercatat dengan lengkap. Berdasarkan survei awal, terdapat dokumen rekam medis yang tidak lengkap sebanyak 60% (12/20 dokumen rekam medis), hal ini dapat berdampak pada bagian yang lain dalam unit rekam medis.Tujuan penelitian adalah untuk mendeskripsikan prosedur pengendalian ketidaklengkapan dokumen rekam medis rawat inap di Assembling RSUD Tugurejo Semarang Tahun 2016.

Penelitian yang digunakan adalah deskriptif dengan metode observasi dan wawancara. Subjek penelitian adalah koordinator assembling 1 orang dan 3 orang petugas assembling bagian pengendalian ketidaklengkapan dokumen rekam medis. Objek penelitian adalah sejumlah 99 dokumen rekam medis rawat inap.

Hasil penelitian menunjukkan bahwa tugas pokok dan fungsi sudah mendukung dan dilaksanakan dengan baik oleh petugas akan tetapi prosedur dan kebijakan belum dilaksanakan secara keseluruhan. 72,7% dokumen tidak lengkap pada analisa kuantitatif dokumen rekam medis rawat inap (Formulir RM 1, RM 13.3, RM 14.2, RM 20 dan RM 26 A), dimana 91,9% dokumen lengkap pada review Identifikasi. 76,8% dokumen tidak lengkap pada Review pelaporan. 68,7% dokumen lengkap pada Review pencatatan. 75,8% dokumen tidak lengkap pada Review otentifikasi.

Saran penelitian ini, pemberian sosialisasi secara mendalam oleh komite medis tentang arti penting kelengkapan isi data rekam medis kepada petugas kesehatan agar lebih bertanggung jawab dalam pengisiannya

Kata Kunci : Pengendalian DRM, ketidaklengkapan DRM, analisa kuantitatif dan kualitatif

REVIEW OF CONTROL PROCEDURES ON INPATIENT MEDICAL RECORDS INCOMPLETENESS IN THE 1st QUARTER OF 2016 IN TUGUREJO REGIONAL PUBLIC HOSPITAL SEMARANG

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ABSTRACT

Based on Minister of Health Regulation No. 269 / Menkes / Per / III / 2008, medical records must be recorded completely. Based on the preliminary survey, there were incomplete medical records as much as 60% (12 of 20 medical records), this may affects the other section of medical record. The purpose of study were to describe the control procedures on incompleteness of inpatient medical records in assembling Tugurejo Regional Public Hospital Semarang 2016.

The research was descriptive with observation and interviews method. Subjects were 1 coordinators of assembling and 3 assembling officers on incompleteness control section of medical records. Research object was 99 inpatient medical records.

The results showed that the duties and functions of officers already supported and implemented but standard procedures and policies were not fully implemented. There were 72.7% incomplete documents based on quantitative analysis of inpatient medical record (Form RM 1, RM 13.3, 14.2 RM, RM 20 and RM 26 A), 91.9% document were complete by Identify review. 76.8% documents were incomplete on reporting Review. 68.7% document were complete by Register Review. 75.8% documents by incomplete by authentication Review.

We recommend that, in depth socialization by the medical committee about the importance completeness of content on medical records to health officers to be more responsible in the filling.

Keyword : Control, incompleteness, quantitative and qualitative analysis