ANALISA KUANTITATIF DAN KUALITATIF KETIDAKLENGKAPAN DOKUMEN REKAM MEDIS RAWAT INAP TINDAKAN CESAREAN SECTION DI RSUD KOTA SALATIGA PERIODE TRIWULAN PERTAMA TAHUN 2014

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ABSTRAK

Dokumen rekam medis sangat penting mengingat kegunaan rekam medis adalah administrasi, hukum, keuangan, penelitian, pendidikan serta dokumentasi. Dokumen rekam medis dapat digunakan untuk menilai mutu pelayanan rumah sakit. Untuk menjaga mutu pelayanan rumah sakit perlu dilakukan analisa kuantitatif dan kualitatif pada dokumen rekam medis. Berdasarkan survei awal di RSUD Kota Salatiga peneliti menemukan tingkat kebandelan dalam pengisian dokumen rekam medis khususnya pada tindakan cesarean section. Tujuan dari penelitian ini adalah mengetahui analisa kuantitatif dan kualitatif ketidaklengkapan pada dokumen rekam medis rawat inap tindakan cesarean section di RSUD Kota Salatiga periode triwulan pertama tahun 2014.

Jenis penelitian yang digunakan adalah deskriptif dengan pendekatan cross sectional dengan menggunakan data retrospektif melalui metode observasi. Populasi yang digunakan adalah seluruh dokumen rekam medis rawat inap tindakan sectio caesarea periode triwulan pertama tahun 2014 yang berada di filing. Teknik pengambilan data menggunakan checklist. Pengolahan data dengan cara editing, tabulating, klasifikasi, dan penyajian data.

Hasil penelitian dari 88 dokumen rekam medis rawat inap tindakan cesarean section di RSUD Kota Salatiga tahun 2014 pada review identifikasi 7 (7,95%) lengkap dan 81 (92,05%) tidak lengkap, review pelaporan 7 (7,95%) lengkap dan 81 (92,05%) tidak lengkap, review pencatatan 9 (10,23%) baik, 79 (89,77%) tidak baik, review autentifikasi 6 (6,82%) lengkap dan 82 (93,18%) tidak lengkap, review kelengkapan dan kekonsistenan diagnosa 61 (69,32%) konsisten dan 27 (30,68%) tidak konsisten, review kekonsistensian pencatatan diagnosa 88 (100%) konsisten, review hal-hal yang dilakukan selama perawatan dan pengobatan 59 (67,05%) konsisten dan 29 (32,95%) tidak konsisten, review adanya informed consent 58 (65,91%) lengkap dan 30 (34,09%) tidak lengkap, review cara/praktek pencatatan 62 (70,45%) baik dan 26 (29,55%) tidak baik, review hal-hal yang berpotensi menyebabkan tuntutan ganti rugi 59 (67,05%) lengkap dan 29 (32,95%) tidak lengkap, dan diperoleh perhitungan DMR (Deliquent Medical Record) sebesar 97,73%.

Saran yang diberikan peneliti untuk meningkatkan mutu pelayanan rekam medis khususnya kelengkapan isi dokumen rekam medis adalah memberikan sosialisasi dan pengarahan kepada dokter, perawat, dan tenaga medis mengenai isi prosedur tetap dan arti penting dokumen rekam medis.

Kata Kunci : Kata kunci : DRM rawat inap tindakan cesarean section, Analisa kuantitatif kualitatif
Kepustakaan : 15 buah (1994 - 2014)

THE ANALYSIS QUANTITATIVE AND QUALITATIVE OF INCOMPLETNESS INPATIENT MEDICAL RECORD DOCUMENTS OF CAESAREAN SECTION IN RSUD SALATIGA IN THE FIRST QUARTER OF 2014

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ABSTRACT

The document of medical record is very important because of its uses are administration, law, finances, research, education and documentation. The document of medical record can be used to access the quality of hospital service. Keeping the quality of hospital service becomes a reason to do quantitative and qualitative analysis to the document of medical record. Based on a beginning survey in RSUD Salatiga, the researcher found that there is obstinate of medical record document. Especially in the level of caesarean section. The purpose of this research is to know the analysis quantitative and qualitatif of incompletness inpatient medical record documents of caesarean section in RSUD Salatiga in the first quarter of 2014.

This research uses descriptive with cross sectional approach by using retrospective data trough an observation. The population of this research is all inpatient medical record document of caesarean section in the first quarter of 2014 that can be found in filing. Thecnique removal data use checklist. The data analysis is editing, tabulating, classification and data serves.

The result of this research from 88 inpatient medical record documents of caesarean section in RSUD Salatiga on first quarter 2014. The researcher found that in identification review, 7 (7,95%) of documents are complete and 81 (92,05) are incomplete, then in reporting review 7 (7,95%) of documents are complete and 81 (92,05) are incomplete, then in recording review 9 (10,23%) are good 79 (89,77%) are not good, authentication review 6 (6,82%) are complete and 82 (93,18%) are incomplete, then in diagnosis of completeness and consistency review 60 (69,32%) are consistent and 27 (30,68%) are inconsistent, in diagnosis of recording consistency review 88 (100%) are consistent, the review of all things to do during the cure and treatment review 59 (67,05%) are consistent and 29 (32,95%) are inconsistent, then the existence of informed consent review 58 (65,91%) are complete and 30 (34,09%) are incomplete, then in recording practice review 62 (70,45%) are good and 26 (29,55%) are not good, then in all things that may cause compensation claim review 59 (60,05%) are complete and 29 (32,95%) are incomplete, and the calculation of DMR (Deliquent Medical Record) is 97,73%.

The researcher suggest to improve the quality of medical record service especially the completeness of medical record document contents is to conduct a socialization and briefing to the doctor, nurses, medical worker about the content of permanent procedure and the significance of medical record document.

Keyword : Keywords : Inpatient medical record document cesarean section, Quantitative and Qualitative analysis
Literature : 15(1994-2014)