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ABSTRACT

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INFORMATION SYSTEM OF TAKE CARE IN-PATIENT MORBIDITAS IN MEDICAL RECORD UNIT OF RS. BANYUMANIK SEMARANG YEAR 2006

After the Hospital of Banyumanik got an operational permission and formal confession from Department of Center Health to serve public. For that all produced information from all activity shall be continual and up to date, including its management of morbidities information in Medical Record Unit of RS. Banyumanik Semarang. Produced Information from medical record unit in concern of coding / indexing, analyzing / reporting is very importance in producing information about report of patient morbidities. Therefore though management of data morbidities in RS Banyumanik has been done by using application of Ms. Excel but in fact that the management of electronic data not yet earned to produce information concerning report of morbidities. Based on mentioned above the researcher wish to develop Information System of Morbidities Take care In-patient in Medical Record Unit of RS. Banyumanik Semarang Year 2006.

Research type, which is used in this research, is a qualitative research. The research device used is cross sectional. Researched Object that is Information System of Take Care In-patient in Morbidities in RS. Banyumanik Semarang. Research Subject that is perpetrator of information system in concerned in execution of information system of take care In-patient morbidities.

From result of interview and observation can be known the information system of morbidities in RS. Banyumanik Semarang that is: there is no policy – the policy arranging information system of take care In-patient morbidities, there are no organization chart in information system of take care In-patient morbidities, perpetrator - perpetrator in concerned that is TPPRI, URI, URM, medical record Manager and hospital director, data input stems from sheet of RM 01 (sheet in and out), information process is started from registration process of patient in TPPRI producing patient and room data, in URI producing treatment data, in URM producing disease and action data. Information to be produced from information system of morbidities that is index (disease, action / operation, doctor, death cases) and report of morbidities.

Base on the context diagram and flow diagram data, system is operated by multiuser. The Programming Language used is Visual Foxpro 8.0. Network topology used if this system is developed to become multi user is star topology or star work.

Keyword : Morbidities Information System, Medical Record Unit
Bibliography : 26 books, 1980 - 2004

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ABSTRAK

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SISTEM INFOMASI MORBIDITAS RAWAT INAP di UNIT REKAM MEDIS RS. BANYUMANIK SEMARANG TAHUN 2006

Setelah Rumah Sakit Banyumanik mendapatkan ijin operasional dan pengakuan yang resmi dari Departemen Kesehatan Pusat untuk melayani masyarakat. Untuk itu semua informasi yang dihasilkan dari semua kegiatan haruslah berkesinambungan dan up to date, termasuk didalammya pengelolaan informasi morbiditas di Unit Rekam Medis RS. Banyumanik Semarang. Informasi yang dihasilkan dari unit rekam medis urusan koding/indeksing, analising/reporting sangatlah penting dalam menghasilkan informasi tentang laporan morbiditas pasien. Oleh karena itu meskipun pengelolaan data morbiditas di RS Banyumanik telah dilakukan dengan menggunakan aplikasi ms. excel tapi kenyataan pengelolaan data elektronik belum dapat menghasilkan informasi mengenai laporan morbiditas. Berdasar hal tersebut peneliti ingin mengembangkan Sistem Informasi Morbiditas Rawat Inap di Unit Rekam Medis RS. Banyumanik Semarang Tahun 2006.

Jenis penelitian yang digunakan dalam penelitian ini adalah penelitian kualitatif. Rancangan penelitian yang digunakan adalah *cross sectional*. Obyek yang diteliti yaitu Sistem Informasi Morbiditas Rawat Inap di Rumah Sakit Banyumanik Semarang. Subyek penelitian yaitu pelaku sistem informasi yang terlibat dalam pelaksanaan sistem informasi morbiditas rawat inap.

Dari hasil observasi dan wawancara dapat diketahui sistem informasi morbiditas di RS. Banyumanik Semarang yaitu: belum adanya kebijakan – kebijakan yang mengatur sistem informasi morbiditas rawat inap, belum terdapat struktur organisasi dalam sistem informasi morbiditas rawat inap, pelaku – pelaku yang terlibat yaitu TPPRI, URI, URM, kepala rekam medis dan direktur rumah sakit, input data bersumber dari lembar RM 01 (lembar keluar-masuk), proses informasi dimulai dari proses pendaftaran pasien di TPPRI yang menghasilkan data pasien dan data kamar, di URI menghasilkan data perawatan, di URM menghasilkan data penyakit dan data tindakan. Informasi yang akan dihasilkan dari sistem informasi morbiditas yaitu indeks (penyakit, tindakan / operasi, dokter, sebab kematian) dan laporan morbiditas.

Berdasarkan diagram konteks dan data flow diagram, sistem dioperasikan oleh *multiuser*. Bahasa pemrograman yang digunakan adalah Visual Foxpro 8.0. Topologi jaringan yang digunakan jika sistem ini dikembangkan menjadi multi user adalah topologi bintang atau star work.

Kata kunci : Sistem Informasi Morbiditas, Unit Rekam Medis
Kepustakaan : 26 buah, 1980 - 2004