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# Analysis of the Completeness of Medical Records in RSJ. Prof. Dr. Saanin Padang

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## ABSTRACT

Complete medical records are very useful for knowing in detail the patient's history, examinations that have been carried out, and planning further actions. To achieve this, the medical records department is obliged to carry out quality monitoring by carrying out quantitative, qualitative, and statistical analysis. To know whether a medical record file is complete or incomplete, it is necessary to carry out a quantitative analysis, namely four reviews consisting of an identity review, recording review, reporting review, and authentication review. Based on the results of a preliminary study with existing medical record officers, it was stated that every patient's medical record file received from inpatient care was always assessed for completeness but was still not optimal, and incomplete values were always obtained. One of the problems, among others, is in terms of input, namely the high workload of medical record officers, facilities, and infrastructure, especially storage space and technology, which are not yet optimal. It is important to discuss this problem so that researchers research to find out the completeness of medical record files in RSJ. Prof. HB. Saanin Padang City. This research was carried out in March 2024 at RSJ. Prof. HB. Sa'anin Padang. From the study, it was found that the highest percentage of completeness in filling out identification components was the name item at 97.98%, the highest percentage of completeness in important report components was found in the discharge summary form, CPPT and General consent each at 100%, the percentage of completeness in the recording method component was highest in You can use item type x at 100%. In the medical record file, no type-x was used. There is a need for policies regarding filling rules and periodic audits regarding the completeness of medical record files.

***Keywords:*** *Completeness, Medical record, files, hospital, analysis.*

## INTRODUCTION

Implementation of medical records in a health service facility is one indicator of the quality of service at the institution. A good quality medical record is a medical record that meets medical record quality indicators, including the completeness of the medical resume, accuracy, punctuality, compliance with legal requirements. Medical record forms are used and must be filled out by various hospitals. All forms must meet the standards. The medical record form itself does not guarantee proper and good medical data records if the doctors and medical staff do not carefully complete the required information on each medical record sheet properly and correctly (Huffman, 1999).

Medical record services are one of the medical support services in hospitals which are the basis for assessing the quality of hospital medical services. The patient's

medical record contains information, notes, and documents regarding the patient's identity, medical examinations, procedures, and other services provided to the patient (Ministry of Health, 2006). It is stated in the minimum service standards in hospitals, namely the time to provide medical record files for inpatients is ≤15 minutes, the time to provide medical record files for outpatients is ≤10 minutes, the completeness of filling in informed consent is 100% and the completeness of filling in medical records is 100%.

Completeness of medical records is very useful for knowing in detail the patient's history, examination actions that have been carried out and, planning further actions. To achieve this, the medical record department is obliged to carry out quality monitoring by conducting quantitative, qualitative, and statistical analyses. Knowing the complete and incomplete of a medical record file needs to be analyzed quantitatively. Namely, 4 reviews consisting of an identity review, a recording review, a reporting review, and an authentication review (Widjaya, 2018).

Medical records must be completed immediately after the patient receives services. Completeness of filling in inpatient medical records must be achieved within 24 hours (Hatta, 2008). This is done continuously so that the quality of the files is maintained and the quality of the hospital can be improved.

Based on the results of a preliminary study with existing medical record officers, it was stated that every patient's medical record file received from inpatient care was always assessed for completeness but was still not optimal, and incomplete values were always obtained. One of the problems, among others, is in terms of input, namely the high workload of medical record officers, facilities and infrastructure, especially storage space and technology that is not yet optimal, and administration that is not in accordance with SOP. Due to the frequent delays and incomplete submission of medical record documents, it is important to discuss this issue so that researchers carry out research with the aim of finding out the completeness of medical record files at RSJ. Prof. HB. Saanin Padang

## MATERIALS & METHODS

### Time and Place of Activities

This research was conducted in September 2024 at RSJ. Prof. HB. Saanin and continued with data processing at the Academy of Recorders and Health Information IRIS Padang.

### Research methods

This research method is descriptive qualitative, namely, research conducted to explain a variable without making comparisons or relationships. Meanwhile, the method used is the observation method, namely looking at objects directly with a retrospective approach, namely looking at existing data. The population of this study is all mental care medical record files in the first quarter of 2024. Meanwhile, the sample in this study is a portion of mental care medical records that will be selected randomly using the random sampling method. The observed completeness items include four components of quantitative analysis.

## RESULT

Research reviewing and analysis of the completeness of inpatient medical record documents have been carried out at RSJ. HB. Saanin Padang. The completeness of medical record files is reviewed for patients leaving for the first quarter of 2024, namely January to March. Quantitative analysis of medical record files is seen from four analysis components, namely identification components, important reports, authentication and recording methods. From the data collection that was carried out, 99 medical record files were obtained. A quantitative analysis of the identification components can be seen in Table 1.

**Table 1. The frequency distribution of completeness of the components of Identification of Medical Record Files RSJ. HB. Saanin Padang in the First Quarter of 2024**

| No | Quantitative Components | Complete | | Incomplete | |
|---|---|---|---|---|---|
| | | n | % | n | % |
| 1 | Name | 97 | 97.98 | 2 | 2.02 |
| 2 | No MR | 95 | 95.96 | 4 | 4.04 |
| 3 | Date Of Birth | 87 | 87.88 | 12 | 12,12 |
| 4 | Gender | 87 | 87.88 | 12 | 12,12 |

Based on Table 1, it can be seen that the highest percentage of completeness in filling in the identification component is the name item at 97.98% the highest rate of incompleteness is found in the date of birth and gender items, namely 12.12% each. On each medical record form, the patient identification is printed and made in the form of a sticker. However, it was found that several forms did not have stickers attached and only had names and medical record numbers written on them. Important report components are filled in in Table 2.

**Table 2. The frequency distribution of completeness of the components of important report of Medical Record Files RSJ. HB. Saanin Padang in the First Quarter of 2024**

| No | Quantitative Components | Complete | | Incomplete | |
|---|---|---|---|---|---|
| | | n | % | n | % |
| 1 | Discharge Form (RP) | 99 | 100 | 0 | 0 |
| 2 | CPPT | 99 | 100 | 0 | 0 |
| 3 | General Consent (GC) | 99 | 100 | 0 | 0 |
| 4 | Initial Medical Assessment of Psychiatry (PM) | 84 | 84.8 | 15 | 15.15 |
| 5 | Initial nurse assessment (PKP) | 93 | 93.9 | 6 | 6.06 |
| 6 | Monitoring Form 48 hours (FM) | 91 | 91.9 | 8 | 8.08 |
| 7 | Progress Note (CPK) | 64 | 64.6 | 35 | 35.35 |
| 8 | Mental Nursing Assessment of Specialist Nurses (PKS) | 56 | 56.6 | 43 | 43.43 |

From Table 2. it can be seen that the quantitative analysis of the important report components consists of the general consent form, informed consent, anesthesia report form, progress note form, operation report, and medical resume. The highest percentage of completeness of important report components was obtained in the discharge summary, CPPT, and General consent forms, each at 100%. The highest percentage of incompleteness was found on the Specialist Nurse Mental Nursing Assessment (PKS) form at 56%. This is because the form was not included and was also incompletely filled in by the nurse. The frequency of authentication components can be seen in Table 3.

**Table 3. The frequency distribution of completeness of the components of Authentication of Medical Record Files RSJ. HB. Saanin Padang in the First Quarter of 2024**

| No | Quantitative Components | Complete | | Incomplete | |
|---|---|---|---|---|---|
| | | n | % | n | % |
| 1 | Doctor’s Name | 84 | 84.8 | 15 | 15.15 |
| 2 | Doctor’s Signature | 92 | 92.9 | 7 | 7.07 |
| 3 | Doctor’s Degree | 75 | 75.8 | 24 | 24.24 |
| 4 | Nurse Name | 94 | 94.9 | 5 | 5.05 |
| 5 | Nurse’s signature | 41 | 41.4 | 58 | 58.59 |
| 6 | Nurse’s Degree | 52 | 52.5 | 47 | 47.47 |

Based on Table 3, the highest percentage of completeness of the authentication component was found in the doctor's signature item at 92%, only seven medical record files were incomplete in the doctor's signature. In the medical record file, each

form has the doctor's full name and title stamped. The percentage of incomplete authentication components found in the nurse's signature was 41%. On each form it was also found that the nurse's name was not written completely, the percentage of incompleteness in the nurse title item was also quite large at 52.5%. The frequency of completeness of the recording method components can be seen in Table 4.

**Table 4. The frequency distribution of completeness of the components of Recording Method of Medical Record Files RSJ. HB. Saanin Padang in the First Quarter of 2024**

| No | Quantitative Components | Complete | | Incomplete | |
|---|---|---|---|---|---|
| | | n | % | n | % |
| 1 | Clear | 44 | 44.4 | 55 | 55.56 |
| 2 | Type-X use | 99 | 100.0 | 0 | 0.00 |
| 3 | Correction | 54 | 54.5 | 45 | 45.45 |
| 4 | Empty Section | 8 | 8.1 | 91 | 91.92 |

From Table 4, it can be seen that the percentage of completeness in the recording method component is highest for items using type x at 100%. In the medical record file, no type-x was used. The highest percentage of incompleteness was found in empty items at 8.1%. This blank section is often found on several forms. Furthermore, the item with the highest percentage of incompleteness is the item for clarity of writing at 44.4%.

## DISCUSSION

Quantitative analysis is carried out on four components, namely identification, important reports, authentication, and recording methods. The first component is identification, consisting of name, medical record number, date of birth, and gender. Birthdate items have the highest percentage. Each sheet of the form contains the date of the birth item which can determine the age of the patient. The completeness of this identification component is the highest component compared to other components.

The identification component is administrative data that is very important to start a service. In addition, it is also demographic information that must be filled in completely to process hospital statistics, without an identification component we will not know whose medical records we manage at the service facility. As stated by Widjaya (2018), every medical record form must at least have a patient identity such as the patient's name, medical record number, date of birth, and gender. If there is an unidentified sheet, it must be reviewed to determine who it belongs to.

The quantitative analysis begins by examining each medical record sheet, according to Huffman (1999) that the patient's identity at least has a name and medical record number. Because if you don't know who the sheet belongs to, it makes the ownership of the form difficult to know and the possibility of misdiagnosing or administering medication so that it must be reviewed to make sure who the form belongs to. Gender items get the highest percentage of incompleteness. This item is rarely found on medical record sheets. The hospital only provides and prints many items of names, dates of birth, and medical record numbers. It is important to include gender on the identification sheet to know how the service is provided according to gender.

The second component is an important report component. This component also determines the incompleteness of a medical record document. This important report review aims to analyze forms such as medical history, physical examination, clinical observations, and conclusions at the end of treatment. If this report is complete, it can be used for diagnostic testing, consultation, or surgery (Rani, 2015). From the observations on the reporting analysis, it shows that the most incompleteness in the informed consent reporting review. Because

some of the diagnoses found did not have an operative action/procedure.

According to Huffman (1999), reporting review is a quantitative analysis procedure that must confirm which reports will be carried out, when and under what circumstances because if at any time there are patients who feel they have experienced malpractice in service, they can show medical record documents as legal evidence. Hatta's statement (2010) that report items such as summary entry and exit, operation reports, medical resumes, progress notes must be filled in completely because they are subjective descriptions to emphasize the reasons for medical treatment and services to be provided to patients.

The patient progress report item received the highest percentage of completeness. Every hospitalized patient will be observed and monitored for health by nurses and doctors every day. All patient progress will be recorded in a detailed progress note form.

The third component is the authentication component. Authentication is a process that is an act of proof (validation) of a person's identity, in this case, a doctor or nurse who has the authority to fill in the patient's medical record file. Authentication can be in the form of full name, signature, stamp, and initials that can be identified in medical records or a person's code for computerization. Authentication in terms of filling in the medical record file is related to the doctor in charge of the patient and the nurse who handles the patient during inpatient care (Hatta, 2008).

The fourth component is the recording method. In recording or writing medical records, errors in writing or abbreviations that are not by the provisions and procedures for correcting errors must be carried out properly so that the contents are easy to read and clear. If the needs and writings are not clear, there will be errors in reading them, it can also harm the hospital, especially doctors and nurses in dealing with these patients if used in legal force. In the justification of writing, it is forbidden to use corrective and cross out more than twice (Rani, 2015). The unit responsible for reviewing incomplete records is the nurse. The incompleteness in the recording is caused by nurses being less thorough and having to know more about how to fill out the correct medical record form. A quality medical record is a medical record that contains complete data so that it can be processed into information. The completeness of filling out medical record files is very important because one of the uses of medical record files, when viewed from a legal aspect, is written evidence.

## CONCLUSION

Based on quantitative analysis research on medical record files for surgical cases at RSJ. HB. Saanin Padang City can be concluded that:

1. The highest percentage of completeness in filling out the identification component was the name item at 97.98%. The highest rate of incompleteness was found in the date of birth and gender items, namely 12.12% each.
2. The highest percentage of completeness of important report components was obtained in the discharge summary, CPPT, and General consent forms, each at 100%. The highest percentage of incompleteness was found on the Specialist Nurse Mental Nursing Assessment (PKS) form at 56%.
3. The percentage of completeness authentication components found in the nurse's signature was 41%. On each form it was also found that the nurse's name was not written completely, the percentage of incompleteness in the nurse title item was also quite large at 52.5%.
4. The highest percentage of completeness was found in empty items at 8.1%. This blank section is often found on several forms. Furthermore, the item with the highest percentage of incompleteness is the item for clarity of writing at 44.4%.

***Declaration by Authors***

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**Conflict of Interest:** The authors declare no conflict of interest.

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