Incompleteness Analysis of Medical Record Data on Inpatient Discharge Summary

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Abstract : Hepatoma or hepatocellular carcinoma (KHS) is a primary malignant tumor of the liver originating from hepatocytes and the 3rd cause of death from cancer in the world. The history of a hepatoma patient can be seen based on the patient's medical record. The filling of medical record is done by doctors, nurses / midwives and medical record personel. However, in medical record filling, incompleteness is often found and cause inaccurate information. The study design used a retrospective analysis approach. Variable in the study were incompleteness; authentication and documentation on patient discharge summary form. Population in this study is inpatient medical records for Hepatoma cases in a Padang City Hospital from January to March 2019 were 75 medical record documents (discharge summary form) inpatients with hepatoma cases. The results indicated that there were incompletenesses on discharge data, date of birth, gender, name of the consular doctor, name of the doctor who sent, address, diagnosis, ICD code, procedure code, discharge status, follow-up, patient or family signature. The largest incompleteness filling out the discharge summary form is found in address data items as many as 46 medical records (61%).

Key word : Medical record, incompleteness, inpatient summary discharge.

I. INTRODUCTION

Hepatoma or hepatocellular carcinoma (KHS) is a primary malignant tumor of the liver originating from hepatocytes and the 3rd cause of death from cancer in the world. Approximately 500 new cases of hepatoma per 100,000 population occur each year with a male: female ratio = 2-6: 1.The incidence is highest in Sub-Saharan Africa and Asia, with an age range of 1 to 2 decades earlier the occurrence of hepatoma than in low prevalence areas like Europe and America [1-3]. History of hepatoma sufferers can be seen based on the patient's medical record documents. The medical record is a collection of facts about a patient's life and health history written by a health professional who is involved in caring for the patient[4]. The filling of medical record documents at the hospital is carried out by doctors, nurses / midwives and medical record personnel. However, in recording medical record documents, incompleteness in filling out medical record documents is often found, resulting in inaccurate information. Such as incomplete document filling by medical record officers on patient identities and patient discharge forms.

There are two types of analysis for the completeness of medical record documents, namely quantitative analysis and qualitative analysis. Quantitative analysis is used to evaluate the completeness of various types of forms and data / information, while qualitative analysis is used to examine the contents of medical records to look for inconsistencies and omissions that could cause the medical record to be considered incorrect or unnecessary[5]. The results of the analysis of the completeness of medical record documents can be used as an indicator of the quality of hospital services. The incompleteness of filling out the patient's medical record documents has a bad impact on the quality of the hospital itself and on the process of providing health services to patients. Incompleteness in the process of filling out medical record documents can cause a decrease in the quality of service in the hospital and will become a problem if the medical record documents are brought into legal problems because the incomplete medical record documents can cause inaccurate data when brought to the legal table. Based on the background, the writer is interested to analyze incompleteness of filling data in summary discharge medical record at the hospital "X" in Padang city.

Key word : Incompleteness, inpatient, summary discharge, medical record

II. RESEARCH METHODOLOGY

Type of research is quantitative descriptive, which is to determine the completeness of the document inpatient medical records for hepatoma cases using the criteria for document quantitative analysis. The study design used a retrospective analytical approach, namely the analysis of the completeness of the medical record documents used when the patient returned home or the documents returned to the

assembling department. The variables in the study were incompleteness; identification of authentication and documentation on patient's summary discharge form. The population in this study were inpatient medical record documents for Hepatoma cases in Padang City Hospital from January to March 2019, which were 75 medical record documents (discharge summary form) of hepatoma inpatients.

III. RESULTS AND DISCUSSION

3.1. Results of Descriptive Statics of Study Variables

Table 3.1: Review of Completting summary dscharge data of inpatient medical record

No	Data	Completeness	Percent (%)	Incompleteness	Percent (%)
1	Name	75	100	0	0
2	Number of Medical record	75	100	0	0
3	Date of admission	75	100	0	0
4	Date of disharge	74	99	1	1
5	Date of birth	65	87	10	13
6	Sex	72	96	3	4
7	Name of Consulent doctor	62	83	13	17
8	Name of doctor	64	87	11	13
9	Address	29	39	46	61
10	Indication of patient treated	75	100	0	0
11	History	75	100	0	0
12	Physical examination	75	100	0	0
13	Diagnose examination	75	100	0	0
14	Diagnosis	73	97	2	3
15	ICD code of diagnose	64	83	11	17
16	Procedure	75	100	0	0
17	Code of procedure	64	87	11	13
18	Medicine	75	100	0	0
19	Medicine is consumed at home	75	100	0	0
20	Disharge status	71	95	4	5
21	Future instruction	72	96	3	4
22	Authentication signature of patient or family	62	83	13	17
23	Authentication signature of PPBS Doctor	75	100	0	0
24	Authentication signature of DPJP Doctor	75	100	0	0

Table 3.1. shows the results of the analysis of the incompleteness of filling in data on the medical record documents of Hepatoma inpatient cases at Rumah X Padang City. The review of data filling on the discharge summary form shows that there are incompletenesses on the date of discharge, date of birth, gender, name of the consular doctor, name of the sending doctor, address, diagnosis, ICD code, procedure code, discharge status, follow-up instructions, patient signature or family. Of the 75 hepatoma patient medical record documents, filling in the item name, medical record number, date of admission, indication of the patient being treated, history, physical examination, diagnostic examination, procedures, medications given, medicines used at home, PPBS doctor's signature, DPJP doctor's hand is complete (100%) filled. Whereas the highest incompleteness of filling in items on the home summary form was found in the patient's address item, namely 61% (46 medical records) did not contain the patient's address on the discharge summary followed by 17% (13 medical record documents) did not contain the name of the consular doctor, ICD code and signature. patient / family and 13% (10 medical record documents) did not contain items on the date of birth, name of the doctor who sent them, and procedure code. The rest of the incompleteness of filling in items were date of discharge (1%), gender and follow-up instructions (4%), discharge status (5%) and diagnosis (3%). For items name, medical record number, date of admission, indication of patient being treated, history, physical examination, diagnostic examination, procedures, drugs given, medicines used at home and doctor's signature are 100% complete.

3.2. Discussion

The same research was conducted by Rahayu et al. [6], obtained the results of completing filling in patient identification (Patient's Name) with the highest percentage of incompleteness found on the home care summary form, namely 35.72% as many as 20 medical record documents. It is not in accordance with Huffman[4] that the medical record sheet must at least contain the patient's name and the patient's medical record number. Judging from its function, the patient's name must always be on every form to prevent if one of the forms is separated from the medical record document, it will be easier for officers to recombine. Based on procedure number 33 / PROTAP / IV / 2011, it is stated that writing names aims to avoid confusing medical record documents between one patient and another and writing names must be done correctly. This is in accordance with regular procedure number 71 / PROTAP / IV / 2011 concerning identification of medical record documents which state that the name and number of the patient's medical record must be included on the medical record sheet available at outpatient and inpatient installations. Filling in the medical record number on each sheet of the medical record form for hepatoma patients aims to prevent if one of the forms is separated from the medical record document, the officer will have no difficulty in recombining the separated forms on the patient's medical record document.

According to Hatta[7], if there is no signature of the person in charge, the medical record document does not have the validity of the records from health workers or other personnel involved in providing services to patients so that information cannot be legally accounted for. This research is 83% in accordance with standard procedure number 49 / PROTAP / IV / 2011 concerning completeness of document filling medical records stating that all records are signed with a signature, full name, time and date.

Based on the results of the completeness of the authentication (name of the person in charge), it can be seen that the highest percentage of incompleteness is found on the summary form of the patient coming home, namely 17% (13 documents). The name of the person in charge that is not listed will make it difficult for the officer to determine who is the party responsible for the services provided to patients [8].

The person in charge's signature has been completely filled in on all documents. According to Hatta [7], if there is no signature of the person in charge, the medical record document does not have the validity of the records from health workers or other personnel involved in providing services to patients so that information cannot be legally accounted for. This is in accordance with the standard procedure number 49 / PROTAP / IV / 2011 concerning the completeness of filling out medical record documents which state that all records are signed with a signature, full name, time and date.

In assembling inpatient medical record files, you must pay attention to the following sequence: First stage: patient identity + power of attorney + letter / cover document. The second stage of medical examination records includes doctor's group notes followed by nurse's group notes. Third stage: three types of results of medical investigation (laboratory, radiology, copy of prescription) closed with patient resume / death report [9].

IV. Conclusion

The largest incompleteness filling out the discharge summary form is found in address data items as many as 46 medical records (61%).

References

[1] Isselbacher KJ, Dienstag JL. Tumors of the liver and billiary tract. In : FauciAS, Braunwald E, Isselbacher KJ, Wilson JD, Martin JB, Kasper DL, et al.Harrison's principles in internal medicine. 16th ed. New York : Mc GrawHill; 2005. p. 533-36.

[2] Engstrom PF, Sigurdson E, Evans AA. Primary neoplasms of the liver. In :Frei E, Holland JF, editors. Cancer medicine. 5th ed. London : B.C.Deckerinc; 2000. p. 1391-401.

[3] Budihusodo U. Karsinoma Hati. Dalam : Sudoyo AW, Setiyohadi B, Alwi I,Simadibrata M, Setiati S, editor. Buku Ajar Ilmu Penyakit Dalam. Ed 4.Jakarta : Pusat Penerbitan Departemen Ilmu Penyakit Dalam FKUI; 2006.hal. 457-62.

[4] Huffman EK. 1994. Health Information Management. Berwyn: Physician Record Company.

[5] Hatta, G. 2013. Pedoman Manajemen Informasi Kesehatan di Sarana Pelayanan Kesehatan.Jakarta: UI-Press

[6] Septi Nur Rahayu, Sri Sugiarsi, M. Arief TQ. 2013. Analisis Kuantitatif Dokumen Rekam Medis Pasien Rawat Inap pada Kasus Chronic Kidney Disease Triwulan IV Di RSUD Pandan Arang Boyolali. Jurnal Rekam Medis, ISSN 1979-9551, VOL.VII.NO.2, OKTOBER 2013, Hal 49-60.

[7] Hatta, G. R. 2010. Pedoman Manajemen Informasi Kesehatan di Sarana Pelayanan Kesehatan. Revisi 2. Jakarta: Universitas Indonesia.

[8] DepKes RI. 2006. Pedoman Pengelolaan Rekam Medis Rumah Sakit Di Indonesia. Revisi II. Jakarta: Direktorat Jenderal Bina Pelayanan Medis.

[9] Hatta.G.1993. Perumusan Rekam Medis Dalam Tanggung Jawab Praktek Profesional Tenaga Kesehatan, Dalam Laporan Hasil Rakernas I dan Kumpulan Makalah Seminar Nasional I dan Rakernas I 7-8 Agustus 1993,Pormilis, Jakarta