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Overview of Completeness of Filling Out Inpatient Discharge Summary Form at General Ahmad Yani General Hospital Metro in 2021

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A B S T R A C T

Medical records are the property of hospitals that must be maintained because they are useful for patients, doctors, and hospitals. Medical record documents are very important in carrying out the quality of medical services provided by hospitals and their medical as well as accurate evidence in court, doctors, nurses, and other health workers who treat patients are required to complete medical records following applicable regulations. This study aims to describe the completeness of filling out inpatient discharge summary form at General Ahmad Yani General Hospital Metro in 2021. This study used a descriptive research method. The research location is the Medical Record Unit of General Ahmad Yani General Hospital Metro Lampung. This research was conducted in October 2021. Of the 100 samples of medical records, the completeness of the inpatient discharge summary form was completed. There are 80% complete and 20% incomplete, where the completeness value of 100% is found in the patient identity filling item, and there are no scribbles. Meanwhile, 20% incompleteness is found in important note items (5%) and authentication (15%). In conclusion, standard operating procedures for completeness of medical records already exist and the implementation of completeness of medical record files has been carried out according to applicable standards, but it can be seen that the steps in the SOP are not detailed and less thorough.

1. Introduction

Hospital is a health service institution that provides complete individual health services that provide inpatient, outpatient, and emergency services. Hospital accreditation is the acknowledgment of the quality of hospital services after an assessment has been made that the hospital has met accreditation standards. Hospital classification is the grouping of hospital classes based on service capabilities, health facilities, supporting facilities, and human resources. [1]

According to the Decree of the Minister of Health of the Republic of Indonesia No. 269/MENKES/PER/III/2008, the definition of a medical record is a file containing notes and documents regarding patient identity, examination, treatment, actions, and other services that have been provided to patients. Medical records are an important part of all services to patients, from the first visit to subsequent visits.[2-4] As written information about health care, it is also used for medical research for statistical activities of health services. This is further exacerbated by the problem of limited funds so that there is a lack of effort in increasing the capacity of resources which in the end it is difficult to achieve effective and efficient medical record services.

One indicator of the success of health services is patient satisfaction. The concept of service quality

related to patient satisfaction is determined by five elements of service quality, namely, tangible, reliability, responsiveness, assurance, and empathy. The quality of health services shows the level of perfection of health services in creating a sense of satisfaction in each patient. The more perfect the satisfaction, the better the quality of health services.[5-6]

An inpatient discharge summary form is a form in the form of a brief explanation or summarizing all important information regarding the disease, the examination carried out, and its treatment. The discharge summary form has been used such as guarantee medical services, as an assessment material for medical staff, and fulfilling requests from official bodies, one of which is insurance, as information for referral patients.[7] The discharge summary form must be filled out completely by the responsible health worker to optimize the use of the discharge summary form. Given the importance of discharge summary forms for hospitals, hospitals need to exercise control over filling out discharge summaries.[8] This study aims to describe the completeness of filling out the summary form for inpatient discharge at General Ahmad Yani General Hospital Metro in 2021.

2. Methods

This study used a descriptive research method. The research location is the medical record unit of General Ahmad Yani General Hospital Metro Lampung. This research was conducted in October 2021. The sample used in this study was obtained by using a simple random sampling technique. Data collection techniques were carried out by document observation, medical record staff interviews, and literature study. The data that has been collected is then analyzed manually by checking and correcting the results of the checklist so that it can be read, then the data is processed in tabular form to make it easier to calculate the percentage. The data in the form of interviews were recorded in the form of transcripts, while the observation data on the completeness of the inpatient discharge summary were recorded in the follow-up datasheets/checklist sheets and tables.

3. Results and Discussion

Table 1 shows the completeness of filling out the summary form for inpatient discharge at General Ahmad Yani Hospital Hospital Metro. Of the 100 samples of medical records, the completeness of the inpatient discharge summary form was completed. There are 80% complete and 20% incomplete, where the completeness value of 100% is found in the patient identity filling item, and there are no scribbles. Meanwhile, incompleteness is found in important note items (5%) and authentication (15%) (Table 2).

Table 1. Completeness of filling out a summary form for inpatient discharge

Completeness of filling out the form	**Total**	**Percentage**
Complete	80	80%
Incomplete	20	20%
Total	**100**	**100%**

Table 2. Recapitulation of completeness of filling out inpatient discharge summary form

Component Analysis	Complete	Percentage	Incomplete	Percentage	Information
Identification	**100**	**100%**	**0**	**0%**	**Filled in**
1. RM number	100	100%	0	0	
2. Name	100	100%	0	0	
3. Gender	100	100%	0	0	
4. Age	100	100%	0	0	
Important reports	**95**	**95%**	**5**	**5%**	**Final diagnosis incomplete**
1. Incoming diagnosis	100	100%	0	0%	
2. Main diagnosis/final diagnosis	95	95%	5	5%	
3. History	100	100%	0	0%	
4. Examination	100	100%	0	0%	
5. Diagnosis of complications	100	100%	0	0%	
6. Treatment/procedure	100	100%	0	0%	
7. Condition of discharge	100	100%	0	0%	
8. Recommendations	100	100%	0	0%	
Authentication	**85**	**85%**	**15**	**15%**	**No signature and doctor's full name**
1. Doctor's signature	85	85%	15	15%	
2. Doctor's name	85	85%	15	15%	
Correct record/no streak	**100**	**100%**	**0**	**0%**	**Complete**
1 Writing a diagnosis	100	100%	0	0%	
2. Information	100	100%	0	0%	
Total	**80**	**80%**	**20**	**20%**	

Based on the results of interviews with medical record staff and field observations, the inhibiting factors that affect the implementation of the complete discharge summary form for inpatients at General Ahmad Yani Hospital Hospital Metro consist of human factors, costs, materials, methods, and machines. The results of interviews with data processing officers stated that there was still a lack of knowledge about the meaning of the quality of medical records so medical records were considered not too important, which resulted in incompleteness and clarity of writing on the summary form of inpatients discharged from inpatients. A computerized system is also needed to minimize errors and ensure the completeness of filling out medical.[9-11]

Based on the results of the study, the completeness of filling out the summary form for inpatient discharge at General Ahmad Yani General Hospital Metro Lampung in 2021, results obtained are 80% complete and 20% incomplete. Where the number of incompleteness in the authentication items is the highest at 15% and the lowest is the important note items as much as 5%. The selection of each page or sheet of medical record documents in terms of patient identification must at least contain the medical record number and patient name. If there is a sheet without the patient's identity, a review must be carried out to determine the ownership of the medical record form.

Resource management is a way of working that is used to organize and control everything efficiently to achieve and meet the desired results. Resource management can be factors that can influence the arrangement and execution of tasks in the medical record and health information unit, namely man, money, methods, machines, and materials (facilities).[5]

4. Conclusion

Standard operating procedures for completeness of medical records already exist and the implementation of completeness of medical record files has been

carried out according to applicable standards, however, the steps in the SOP are not detailed. Most of the medical records have been filled in with the completeness value contained in the patient identity filling item and without scribbles.

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