



Completeness of Inpatient Medical Record Files in Obstetric and Gynecology Cases During Pandemic Period

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ABSTRACT

The COVID-19 pandemic first appeared in Indonesia in March 2020, which created new problems for various public sectors. Hospitals as health care facilities are expected to provide optimal health services to patients. One of the services provided at the hospital is medical record service which is one of the determinants of the quality of health services. The incompleteness of the medical record file will cause patient documentation to become problematic and the patient's health information to be difficult to identify. Based on preliminary interviews conducted at the Taman Puring Muhammadiyah Hospital, it is known that the completeness of inpatient medical records is still low. Data obtained from the medical record unit in 2021 found that 64% of medical records were incomplete. This study uses a descriptive observational study design that identifies the percentage of completeness of medical record files where only 25.42% of inpatient medical records in obstetrics and gynecology cases are complete, this is influenced by several factors such as HR factors, supporting factors and driving factors studied. Qualitatively which concludes that policy factors and the availability of SOPs, supervision from medical record officers, and the willingness of doctors affect the completeness of the contents of medical records.



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Kata kunci:

Kelengkapan Isi
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ABSTRAK

Pandemi COVID-19 muncul pertama kali di Indonesia pada bulan Maret 2020 yang menimbulkan permasalahan baru bagi berbagai sektor publik. Rumah sakit sebagai sarana pelayanan kesehatan diharapkan dapat memberikan pelayanan kesehatan yang optimal kepada pasien. Salah satu pelayanan yang diberikan di rumah sakit adalah pelayanan rekam medis yang merupakan salah satu faktor penentu kualitas pelayanan kesehatan. Ketidaklengkapan berkas rekam medis akan mengakibatkan pendokumentasian pasien menjadi bermasalah serta informasi kesehatan pasien menjadi sulit diidentifikasi. Berdasarkan wawancara pendahuluan yang dilakukan di Rumah Sakit Muhammadiyah Taman Puring diketahui bahwa masih rendahnya kelengkapan rekam medis pasien rawat inap. Data yang diperoleh dari unit rekam medis pada tahun 2021 didapatkan 64% rekam medis yang belum terisi lengkap. Penelitian ini menggunakan desain studi deskriptif observasional yang mengidentifikasi persentase kelengkapan berkas rekam medis dimana didapatkan sebesar 25,42% saja rekam medis rawat inap pada kasus obstetri dan ginekologi yang lengkap hal ini dipengaruhi dari beberapa faktor seperti faktor SDM, faktor pendukung dan faktor pendorong yang ditelaah secara kualitatif yang menyimpulkan bahwa faktor kebijakan dan ketersediaan SOP, pengawasan dari petugas rekam medis, dan kemauan dokter mempengaruhi kelengkapan isi rekam medis.



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INTRODUCTION

Coronavirus is an infectious disease that was first discovered in Wuhan, China in December 2019. On February 11th, 2020 the World Health Organization (WHO) named this new virus SARS-Cov-2 and the disease caused by the virus was named Coronavirus Disease 2019 (COVID-19). The rapid and easy spread of the SARS-CoV-2 virus through human-to-human transmission resulted in the COVID-19 disease being designated a pandemic on March 11th, 2020 by WHO with an increasing number of cases and spread in many countries around the world (Burhan *et al.*, 2022). To date, 229 countries have reported cases of COVID-19 with a global total of 462,758,117 confirmed cases worldwide (WHO, 2022).

The first case in Indonesia occurred in March 2020 and continues to grow until in March 2022 there were around 5.9 million cases with a death rate of 153 thousand people. The pandemic that occurred has created new problems in various public sectors, one of which is health care institutions. The increasing number of patients and the high level of exposure of health workers have resulted in a decline in the quality of health services.

Hospitals as health care facilities have a role in efforts to realize the best public health status, therefore it is expected to provide optimal health services to patients. In addition, the hospital is also a service institution that provides complete individual health services consisting of inpatient, outpatient, and emergency services (UU RI No. 44 Tahun 2009). In providing services, hospitals are required to always make improvements in providing quality services by improving the quality of work to fulfill customer expectations (Ramadhana, 2018). The hospital functions to provide medical services, medical support services, and non-medical services. Medical record services were formed to realize orderly administration in hospitals and are one of the determining factors in efforts to improve health services (Rustiyanto, 2012).

A medical record is a file that contains notes and documents about patient identity, examination, treatment, action, and other services that have been provided to patients (Permenkes RI, 2008). Health workers such as doctors or dentists who provide medical services to patients are responsible for writing down all series of health service activities that have been provided to patients into the appropriate medical record form. The completeness of filling out a good medical record is very useful to make it easier for other health workers who will provide health services to view the patient's medical history so that the treatment plan or other treatment that will be given becomes more accurate and clear. In addition, medical records can be used as a basis for evaluating and developing health services, monitoring hospital performance and research data sources and policymaking in real-time data-based evaluations (Carpenter, 2007).

The incompleteness of the medical record file will result in problematic patient documentation and the patient's history of health information being difficult to identify (Permenkes RI, 2008). The results of the analysis of the completeness of the medical record file will determine the ranking of a health facility and can affect the quality of health services provided in an institution. Quality medical record files are always filled with complete, clear, and can be processed into useful information as evidence in legal cases, and administrative and financial orders (Swari *et al.*, 2019).

According to Riyantika (2018), there are several factors that cause incomplete medical records, namely human

resource factors, supporting factors, and driving factors. Human resources are one of the factors causing the incompleteness of patient medical records due to busy doctors, too much workload, and awareness of doctors or nurses as medical record filling officers. The supporting factors such as the availability and maintenance of supporting facilities can also be one of the causes of incomplete medical records, and this is also related to the availability of procedural standards and policies regarding filling out medical records as a driving factor for the completeness of medical records in hospitals.

The obstetrics and gynecology department is an integrated department in inpatient and outpatient services at Muhammadiyah Taman Puring Hospital. In addition, obstetrics and gynecology services are one of the superior services at this hospital, where maternal and child health services are a manifestation of the hospital's vision as a quality and trusted health institution in Jakarta with superior reproductive health and child development (Profil Rumah Sakit Muhammadiyah Taman Puring, 2020).

Inpatient services are one part of clinical services that serve patients because of some circumstances that require patients to be hospitalized for one day or more. The main task of the inpatient unit is to record all the results of services provided to patients into the appropriate medical record file, to then be submitted to the medical record unit for completeness analysis and stored by the assembly subunit (Murtafia, 2016).

Based on preliminary interviews conducted with medical record officers at the Muhammadiyah Taman Puring Hospital, it is known that the percentage of completeness of inpatient medical records filled in by the doctor in charge of the patient, this is due to the increased workload, especially during the pandemic where the number of patients increased sharply, limited time, and ignorance of the importance of filling out complete medical record files. In some conditions, the medical record has been filled in but the filling items in it have not been completely filled in, and illegible notes or writing are other problems that make it difficult to identify and recapture the medical records officer. Based on data obtained from the medical record unit, which was seen from the completeness of inpatient medical records for the period of August 2021, it was found that 36% of medical records were completely filled out and 64% of the files were not completely filled out. This is in line with the results of research from Deloitte (2020), that the pandemic brings new challenges because health facilities experience a surge in patients, causing problems when treating and documenting patients, considering that the Taman Puring Muhammadiyah Hospital also serves several COVID-19 patients, including obstetrics and gynecology cases.

Based on the description above, it has been explained that the completeness of the medical record file is very important as a measure of the quality of medical support services in hospitals. However, the reality on the ground is that there are still medical record files for inpatient obstetrics and gynecology cases at the Taman Puring Muhammadiyah Hospital that have not been filled out completely by medical record filling officers such as doctors/specialists who provide services to patients, especially during the COVID-19 pandemic. Therefore, the researcher wanted to identify the completeness of inpatient medical record files in obstetrics and gynecology cases during the pandemic at the Muhammadiyah Taman Puring Hospital, South Jakarta. The purpose of this study was to determine the percentage of completeness of medical records of inpatients in obstetrics and gynecology cases

during the pandemic and also to determine the factors associated with these completeness.

METHOD

This research design uses a descriptive observational study with a qualitative approach. In descriptive research method, research is directed to describe or describe a situation in a community or society (Notoatmodjo, 2010). Qualitative research is a research method used to explore various phenomena, where the researcher is the key instrument, the analysis is inductive and the research results emphasize meaning rather than generalization (Sugiyono, 2013). In this study, the type of research is a case study on the completeness of medical record documents by starting with a quantitative approach by examining and calculating the percentage of completeness of medical records as the output of this study using a checklist, then the results of the data are developed qualitatively which is also the focus of this research by conducted in-depth interviews with informants involved in filling out inpatient medical record files in obstetrics and gynecology cases at the Muhammadiyah Taman Puring Hospital, South Jakarta.

In this study, quantitative methods play a role in obtaining descriptive data related to items of completeness of inpatient medical record files in obstetrics and gynecology cases for the period May 2021 - February 2022 which were analyzed univariately so that the percentage of complete and incomplete medical record files can be presented and then draw conclusions. Then the researcher continued to use qualitative research methods which aimed to determine the factors related to the completeness of the medical records of inpatients in obstetrics and gynecology cases at the Muhammadiyah Taman Puring Hospital. This qualitative data is used to explain and enrich the information obtained from quantitative data so as to produce more comprehensive information

This research takes the time of March 2022 at the MuhammadiyahTaman Puring Hospital, South Jakarta. The type of data used is primary data and secondary data, primary data collection was carried out by in-depth interviews with informants. Secondary Data: secondary data collection is done by reviewing medical record documents. The document review process is assisted by using a checklist. The informants in this study were the doctor in charge of the patient, the head of the medical record unit, and the medical record officer. Several informants were selected to fulfill the validity of the data by using source triangulation. Triangulation of sources carried out by researchers is by cross-checking data with facts from sources in the form of different informants.

In quantitative research, the population in this study is the entire unit in the study in the form of all medical record documents of inpatients who were recorded as being treated by obstetrics and gynecology specialists in the period May 2021 - February 2022 at Muhammadiyah Taman Puring Hospital, South Jakarta. The total population in this study amounted to 532 inpatient medical records. Calculation of the sample size used in this study is to use the sample formula Leme show (1997). Medical record file sample:

$$n = \frac{Z^2_{1-\alpha/2} p (1-p) N}{d^2(N-1) + Z^2_{1-\alpha/2} p (1-p)}$$

P

$$n = \frac{1,96 \times 1,96 \times 0,6 \times 0,4 \times 532}{(0,05 \times 0,05) \times 531 + 1,96 \times 1,96 \times 0,6 \times 0,4}$$

$$n = \frac{490,495488}{1,3275 + 0,921984}$$

$$n = \frac{490,495488}{2,249484} = 219 \text{ medical records}$$

Based on the calculation of the sample size, the number of samples obtained is 219 medical records with an additional sample of 10% to anticipate the possibility of drop out so that the number of samples obtained is 240 inpatient medical record files. Sampling was carried out using a non-probability sampling technique, namely consecutive sampling, which means that the samples taken were all observed subjects and met the sample selection criteria which were then included in the sample until the required sample size was met (Sastroasmoro, 2008). Samples were taken by means of the entire population that met the inclusion criteria and excluded samples that included the exclusion criteria. All samples that meet the criteria are taken data within the research period until the desired sample size is met.

The inclusion criteria in this study were medical record files that were registered as inpatients at the Taman Puring Muhammadiyah Hospital, registered medical record files treated by obstetrics and gynecology specialists, medical records registered in the period May 2021 - February 2022 and have been returned to medical record unit assembly officer. While the exclusion criteria are medical record files registered by the doctor in charge of other departments and medical record documents that are lost or have not been returned to the assembling officer of the medical record unit.

In data analysis, the qualitative approach uses content analysis, which is a technique to draw conclusions through an effort to find the characteristics of messages that are carried out objectively and systematically in the form of narratives and interview matrices. Meanwhile, in the review of medical record documents, the analysis was carried out univariately by looking at the percentage of completeness of the medical record files and presented in tabular form. In conducting the analysis, the researcher was assisted by a checklist of elements of the completeness of medical records based on the Minister of Health of the Republic of Indonesia No. 269 Year 2008.

RESULTS AND DISCUSSION

Analysis of Completeness Patient Identity Form

Completeness of filling in patient identity or social data on the patient identity form is very important to determine ownership of the form. Identity data is contained on a green sheet located at the front of the medical record file behind the medical resume sheet. This data was obtained since the patient registered the patient for inpatient assisted by the hospital admission officer. Patient identity or patient social data can be used as a specific patient identification tool (L. Wijaya and D. Rosmala Dewi, 2017). The completeness of the patient's identity at least contains data related to the medical record number, patient name, date of birth, gender and also the date and time of the patient's admission.

Table 1 shows the number of fillings for the 5 components contained in the inpatient identity sheet. In the

data above, it is found that all files are filled in completely. The number of unfilled files is 0. The conclusion is that the

completeness data to identify inpatients has a percentage of 100%.

Table 1.
Completeness Patient Identification Data

No	Component Analysis	Amount		Percentage Completeness
		Exist	No Exist	
1	Registry Number of Medical Record	240		100%
2	Patient's Name	240		100%
3	Date of Birth	240		100%
4	Gender	240		100%
5	Entry Date and Time	240		100%

Table 1 shows the number of fillings for the 5 components contained in the inpatient identity sheet. In the data above, it is found that all files are filled in completely. The number of unfilled files is 0. The conclusion is that the completeness data to identify inpatients has a percentage of 100%.

Analysis of Completeness of Initial Inpatient Assessment

Completeness of filling out the initial assessment sheet contained in the Permenkes No. 269 Tahun 2008 includes several data that are important to be filled in by the doctor in charge of the patient because it is useful for initial assessment when the patient is in the inpatient room and also as a benchmark in monitoring the progress of the patient during treatment. The data assessed in the patient's initial assessment sheet include:

Table 2.
Completeness Data Initial on Inpatient Assessment Sheet

No	Component Analysis	Amount		Percentage Completeness
		Exist	No Exist	
1	Main complaint	226	14	94,16%
2	History of Current Illness	140	100	58,33%
3	Physical Examination	173	67	72,08%
4	Supportive Examination	92	148	38,33%
5	Diagnosis	227	13	94,58%
6	Management Plans	227	13	94,58%
7	Signature and Full Name of The Doctor Who in Charge of The Patient	229	11	95,42%

Based on Table 2, it shows that none of the above components are filled out completely from all the medical record files that have been reviewed. Components that have a good percentage are found in the main complaint, which is 94.16%, the file is completely filled, the patient's diagnosis is 94.58%, the file is completely filled, the management plan is 94.58%, and the signature is accompanied by the full name of the doctor in charge of the patient. This signature and name are very important as a form of authentication on the medical record form whose purpose is to ensure the completeness and validity of the filled data. Meanwhile, of the seven components above, the percentage of completeness of filling items in the initial assessment is a history of current illness (58.33%) and supporting examination records accompanied by supporting results that are relevant and meaning ful to the patient's disease condition, which is only 38.33% or approximately 92 completely filled files.

Analysis of Completeness in Other Files Data

Several other forms are also included in the minimal component of the completeness of the contents of the inpatient medical record, including the informed consent form which is a sheet containing approval for medical

actions made by the patient or family after receiving information related to the action to be taken. Filling out this sheet is very crucial because it is related to ethics in patient care, so that doctors and patients are legally protected. All components of information related to medical procedures must be conveyed and written clearly and correctly then the consent form is signed by the doctor, the patient and the two witnesses.

In addition, there is an integrated patient development record sheet (CPPT) which is a documentation of the progress of the patient's condition carried out by integrated health workers. If the CPPT data is incomplete and accurate, it will affect the quality of care provided to the patient, which will also affect the outcome of therapy when the patient is treated. On the other hand, if the recording is done correctly and accurately, it will affect the performance of health workers in making decisions and providing optimal results for patients. This form is briefly used to document the patient's condition, which makes each professional care provider communicate with each other and convey information about the patient in writing, including treatment and or actions that are being or have been taken.

In addition, there is a medical resume sheet which is a form in the form of a brief explanation or summarizing all important information regarding the disease, examinations

carried out and treatment of patients after being treated (S. Sugiyanto et al., 2015). Some of the functions of the medical resume form are, among others, as a guarantor of medical services, as an assessment material for medical personnel, as written evidence to fulfill requests from official state bodies,

one of which is the high court and as information for patients when referred. The medical resume form must be filled in completely by the responsible health worker in order to optimize the usefulness of the medical resume itself (Ramadhani, 2008).

Table 3.
Completeness of Other Files Data

No	Component Analysis	Amount		Percentage Completeness
		Exist	No Exist	
1	Informed Consent	206	34	85,83%
2	Medical and/or Surgical Treatment	239	1	99,58%
3	Integrated Process Patient Record	236	4	98,33%
4	Discharge Summary	229	11	95,25%

Based on Table 3, it was found that the completeness of the contents of the four components above was classified as good. The highest completeness of the contents of the entire inpatient medical record file is treatment and/or medical action records (99.58%) performed, both those recorded in the CPPT sheet and the operation report that has been filled out properly. Meanwhile, even though the informed consent sheet has reached 85.83%, there are 14.17% of medical record

files in obstetrics and gynecology cases that are not accompanied by filling out the informed consent properly and completely.

Based on the overall components of the completeness of the inpatient medical record file based on the Minister of Health of the Republic of Indonesia No. 269 of 2008, then the percentage of completeness of the contents of the medical record is obtained as follows.

Table 4.
Completeness of Inpatient Medical Record Contents

No	Component Analysis	Amount		Percentage Completeness
		Complete	Incomplete	
1	Completeness of inpatient medical records for obstetrics and gynecology cases	61	179	25,42%

Table 4 shows as many as 240 samples of inpatient medical records of obstetrics and gynecology cases during the pandemic at Muhammadiyah Taman Puring Hospital, the number of medical records that are classified as complete is 61 medical records (25.42%). This shows that most of the inpatient medical record files at the Muhammadiyah Taman Puring Hospital in obstetrics and gynecology cases are still incomplete according to existing regulations.

This phenomenon was then explored further by conducting in-depth interviews with 4 obstetrics and gynecology specialists related to problems in filling out inpatient medical record documents, especially during the COVID-19 pandemic. This condition is also related to the adequacy of filling time, workload, motivation, and knowledge of medical record filling officers as well as the availability of facilities and infrastructure, policies and standard operating procedures related to filling out inpatient medical record files in hospitals.

Based on the opinion of specialist doctors, they stated that basically their time in filling out medical record files was very sufficient, but they only said that time constraints occurred when there were some urgent or emergency actions so that doctors focused on surgery and pursued time with polyclinic hours, so there are some files that are not filled in or are late to fill in other days.

"... tapi kalau pasien rawat inap dari Poliklinik, kadang tidak cukup kalau pasiennya banyak, terutama ketika mengisi rekam medis yang buat rawat inap atau buat yang tindakan terutama, karena kan kalau buat yang tindakan kan banyak yahh ... yang harus diisinya. Nah

biasanya itu nanti dilengkapi di saat rawat inap gitu atau kalau misalnya operasinya cito, jadi ada tindakan atau operasi cito, eee ... apalagi kalau operasinya itu bersamaan dengan jam poli, misalnya saya lagi di Poliklinik tiba-tiba ada yang lahiran begitu, biasanya itu juga menghambat untuk pengisian rekam medis secara lengkap, tapi biasanya nanti kalau saya visite tu kan, itu sih nanti biasanya dilengkapi" (11).

"...cukup.. waktunya cukup, selama ada kemauan sebenarnya waktu nya cukup kok dok" (12).

They also said that during the pandemic and before the pandemic there was no significant difference, the time required to fill out inpatient medical records was sufficient. The obstacle is more to the longer time due to the large number of files that need to be filled out so that it affects the lack of willingness to fill out the complete medical record file on all the components of the existing form.

"hmm ... ya sebetulnya sih kalau kita liat waktu ya semua kalo waktu lebih cenderung bahwa itu terlalu banyak yang dikerjain. Jadi ngisi nama satu-satu ngisi nama semua segala macam itu kan ... ya gitu ya lengkapin semua itu lebih cenderung adalah kita ngisi yang penting-penting ajalah gitu, jadi lebih prefer untuk ngisi yang dianggap penting gitu. Jadi nggak, bukan karena waktu praktek nggak. Kalau waktu sih sebenarnya kalau mau ngisi ya ngisi aja, tapi kan waktunya jadi lebih panjang kan ya waktunya. Jadi waktunya lebih banyak aja dibuat untuk kegiatan itu gitu ya" (14).

Workload is a mismatch between the expected role, the amount of time, and the resources available to fulfill the requirements. The workload is related to the number of tasks that must be carried out, the availability of time (Michael et al., 2009). Based on the results of interviews with informants regarding the workload of doctors in hospitals during the pandemic, it is as follows:

"sebetulnya selama pandemi malah beban kerjanya menurun, karena pasiennya kan juga turun, tapi sih sebenarnya mau pasiennya banyak atau pasien sedikit buat saya pribadi sih tidak mempengaruhi motivasi saya untuk mengisi lengkap ya..." (11).

"beban kerjanya berkuranglah orang pasien lebih sedikit kok, jadi malasnya bertambah hehehe, intinya kalau kayak gitu sih harus disosialisasikan terus ya, karena kan itu masalah kesadarannya yang kurang" (14).

During the pandemic, they argue that the workload in hospitals has decreased because the number of obstetrics and gynecology patients has also decreased. This is influenced by the factor that patients who require procedures, such as caesarean sections or other procedures, must pass the COVID-19 screening first because the Muhammadiyah Taman Puring Hospital is basically not a COVID-19 referral hospital that has limited isolation rooms for inpatients. Post operatively, so that the number of patients tends to decrease in mid-2020 until the end of 2021. However, for several specialist doctors who work in other hospitals that serve COVID-19 patients, the fatigue factor is one of the things that affects the motivation of specialists to fill in the completeness medical records.

"hmmm... tergantung, kalau misalnya habis ada tindakan COVID-19 di rumah sakit yang lain, untuk mengisi kelengkapan rekam medis biasanya diiii... apa namanya dii... apa istilahnya, ditunda, dan tergantung faktor kelelahan juga sih, jadi kalau masih bisa dilengkapi di hari setelahnya, misalnya saat ini visit terutama kayak pengkajian awal biasanya saya lengkapi hari setelahnya atau saat pasien mau pulang" (14).

One of the solutions offered to reduce the workload of doctors is the need for a team from medical records and also nurses who complete administrative deficiencies so that filling in for doctors in charge of patients is more concise. Another obstacle is that sometimes patients go home at times when the doctor in charge of the patient is not practicing, such as on a weekend, so that forms such as discharge summaries or patient discharge sheets are not filled out.

"jadi untuk mengurangi beban dokter, harus ada tim yang melengkapi kekurangan kekurangan yang sifatnya administratif banget ya, di luar terapi, yaa jadi itu yang harus dilengkapi oleh tim itu, apakah itu dari tim rekam medis, apakah dari perawat, gitu ya seperti itu, biar rekam medisnya lebih sempurna" (14).

"... tergantung harinya juga, kalau misalnya hari weekend yang saya tidak ada jadwal praktek, jadi sebenarnya bisa tidak lengkap kalau misalnya pasien pulang disaat bukan pas saya ada jadwal praktek disini, atau lagi hari weekend" (13).

Most of the specialist doctors who take care of inpatients are aware of the importance of filling out complete medical records, both for their impact on patients and on health workers. Medical records are related to patient management carried out by health workers, which if the quality is good then the quality of patient care will also be good. In addition, medical records also serve as written evidence, legal aspects for personal protection of medical personnel, and also as a description of the patient's medical history as conveyed by the informant below:

"... ya sebetulnya kalau menurut pendapat saya itu sangat penting yah, karena kan itu berkaitan dengan tata kelola pasien yah, bagaimana pasien bisa dikelola dengan baik sesuai dengan instruksi kita kan, oleh misalnya perawat, dokter jaga dan sebagainya..." (11).

"yang berikutnya penting karena berkaitan dengan aspek legal sih, kan buat perlindungan diri saya sendiri kan, kalau saya melengkapi rekam medis dengan benar" (11).

"rekam medis kan sebagai alat bukti tertulis kita ya, kalau misalkan suatu saat ... ya semoga sih tidak terjadi ya, tapi kalau seandainya ada komplain dari pasien yaa kita bisa membuktikan dengan menunjukkan rekam medis, disana kan tertulis apa yang sudah kita lakukan gitu, seperti yang saya bilang tadi tuliskan apa yang kamu lakukan dan lakukan apa yang kamu tulis" (12).

"kalau dari saya untuk rekam medis pentingnya terutama di pengkajian awal pasien yang menurut saya penting..." (13).

The motivation that underlies specialist doctors in filling out the completeness of the contents of medical records is self-awareness to write considering the urgency and importance of quality medical record contents for patients and health workers.

"kesadaran aja... kesadaran untuk menulis, dan juga diingatkan nah itu juga perlu kadang-kadang diingatkan juga tuh, yah diingetin untuk eee apa, untuk di kerjain. Kadang kadang kalau gak diingetin ini sih jadi bisa lewat ya" (14).

Other human resource factors related to the completeness of the contents of the medical record are the knowledge of health workers related to the medical record itself, based on the informant's explanation, in general knowledge regarding the definition, purpose and benefits of the medical record is sufficient for them to know, that the medical record is evidence. written containing patient data filled in by health personnel containing the patient's social and medical history.

"...pastinya dong kalau misalnya suatu saat pasien berobat kembali ke kita kemudian pasien menanyakan riwayat penyakitnya, yaa kita bisa tuh lihat riwayat perjalanan penyakitnya, dioperasi karena apa dan lain sebagainya semua lengkap di rekam medis, maka dari itu pentingnya pengisian berkas rekam medis mulai dari riwayat sosial, pekerjaan, usia dan lainnya semua ada di dalam rekam medis..." (12).

"rekam medis adalah bukti tertulis kita... bukti tertulis eee dari riwayat penyakit pasien... engg bukti tertulis apa yang sudah dilakukan kepada pasien dan yang saya

ketahui tentang rekam medis kan ada dua ya, rekam medis elektronik dan rekam medis paper based terus kemudian... dan seminimal minimalnya rekam medis terisi yaa paling apa yaa... hmmm riwayat sosial pasti harus ada ya, pekerjaan, usia, sama data pasien, riwayat penyakit... perjalanan penyakitnya dok, sama kalau misalnya dilakukan tindakan jangan lupa laporan operasi... apalagi ya kayaknya harus lengkap ya gak ada minimal ya..." (12)

"hmmm apa ya... rekam medis itu berkas yang berisi data-data pasien yang diisi oleh tenaga kesehatan yang bertujuan untuk eeee mengarsipkan lah atau mendatakan semua apa namanya data data penting pasien yang perlu dicatat untuk terkait pengobatan dan evaluasi pengobatan pasien" (13).

In the implementation of filling out medical records, of course, there will be various obstacles that arise, especially during the pandemic for the doctor in charge of the patient in the inpatient room. The obstacles that arise according to the informant are not in the direction of technical implementation or supporting facilities and infrastructure, but are related to the working period of the doctor himself, that some obstetrics and gynecology specialists who are senior or who have worked for a long time tend to be unfamiliar with filling out complete medical records because habit factors, besides the role of mentoring and supervision of the medical record unit is also an obstacle, because of the lack of socialization related to the completeness of this medical record which ultimately causes limitations in filling out by doctors.

This is supported by research conducted by Ramadhana (2018) which states that there is no effect of a doctor's working period with the completeness of filling out inpatient medical record files. Previous research conducted by Afdhal (2015) that a person's tenure does not affect the completeness of inpatient medical records. This is because the willingness to fill out medical record documents has become a personal condition for each, although basically it has become a job responsibility that must be fulfilled and is included in the routine work of a doctor.

"hambatannya sih ya ngg mungkin ada beberapa DPJP ada hambatan, mungkin karena nggg udah senior mungkin jadi malas nulis atau apa, tapi kalau menurut saya sendiri gak ada hambatan sih dok dalam menulis rekam medis..." (12)

"Cuma masalah ketidakterbiasaan aja sih, hehehe kan ada kalau dokter sejak PPDS udah disuruh ngelengkapin status di RS X, sudah tau tuh ... Cuma kalau dokter dokter senior kan belum terbiasa yaa jadi biasanya itu hambatannya sih dari kebiasaannya saja" (13)

"feedback nya kurang itu feedbacknya dari rekam medis" (14)

Based on the percentage of completeness of inpatient medical record files that have been reviewed, it is known that there are several medical record items that have a low percentage such as history of current illness (58.33%), results of investigations (38.33%), and physical examination records (72.08%).

"hmmm, yaa mungkin saya sih setuju sih dengan hasil ini...gitu, karena yaa mungkin itu karena nggg waktu ya,

jadi biasanya kita gak bisa nanya detil ya, jadi yang ditanya itu yang terkait dengan keluhannya, dan poinnya kesitu aja, jadi kebanyakan hanya di keluhan utamanya saja, kalau misalnya riwayat penyakit secara utuh gitu, yaa emang bener sih, saya terutama yaa karena waktu yah, jadi juga gak bisa eee, biasanya sih kalau saya merujuk kepada hasil anamnesa perawat atau hasil anamnesa bidan, dan lebih kalau dokter isinya gak saya ulangi kecuali berkaitan banget dengan keluhan utama" (11)

"yaa setuju sih karena dalam mengisi riwayat penyakit seperti riwayat penyakit sekarang, riwayat penyakit dahulu, kadang ringkas ya kalau saya sih biasanya cuma nulis 'mulas-mulas, atau terdapat gerakan janin' atau apa gitu, yaa biasa memang malas sih, tap ikan biasanya keluhannya sudah ditulis ya di asesmen awal yang ditulis sama bidan, jadi biasanya sudah kita gak tulis lagi sih, sama halnya di bagian pemeriksaan fisik" (12)

"hasilnya sesuai sih ... harusnya riwayat penyakit .. ngg ini gak sih harusnya riwayat penyakit kan yang dia kan rata-rata kalau pasien obstetri kan usia kehamilan, pergerakan janin, ada mules-mules, itu sih harusnya diisi ya, paling yang gak diisi itu seringnya di riwayat penyakit dahulu dan riwayat alergi karena suka lupa, tapi harusnya kalau riwayat penyakit sekarang harus diisi ya"kalau pemeriksaan fisik ini, hmm dimengerti karena memang gak ada khusus untuk obgynnya, paling cuma abdomen aja sih, paling saya nulisnya abdomen sesuai usia kehamilan, tapi yang lain-lain kalau ada pasien pasien abortus atau keguguran, status ginekologi kan gak ada disana, meskipun ada sih digenitalia, tapi mungkin pada nggak ngeh ya" (13).

"...kolom pemeriksaan penunjang ini saya rasa udah cukup diwakilkan dengan lembaran lab, hasil USG dan lain-lain, ngg ternyata perlu diisi juga ya? Baru tau saya..." (14).

Facilities and infrastructure are supporting factors provided by hospitals in supporting inpatient medical record filling activities. According to the informants related to the availability of facilities and infrastructure at the Taman Puring Muhammadiyah Hospital such as stationery, work stations, documents, forms and others, it is sufficient with good maintenance.

"Oh itu sih menurut saya sudah cukup lengkap sih, yang mungkin justru masih kurang adalah alat untuk pemeriksaan fisik yah, di sin ikan juga gak ada stetoskop, jadi gimana kita mau ngisi pemeriksaan dari atas ke bawah yaa, misalnya jantung, paru, tenggorokan, gak ada sarananya disini, jadi paling yang kita isi itu yang berkaitan dengan obstetri dan ginekologinya..." (11)

"sarananya ... sudah cukup sih" (12)

"...kalau alat tulis ada, hmmm apa ya, formulirnya juga sudah cukup kok, perawatannya dan ketersediaannya juga sudah baik saya rasa, jadi gak ada masalah sih cukup untuk memfasilitasi kegiatan kita buat ngisi" (13)

"sebagian besar sudah cukup sih ... sebagian besar sudah oke" (14)

Facilities are all physical objects that can be visualized by our eyes or palpable by our five senses so that they can be easily recognized by patients and are generally part of a building or building itself, while infrastructure is an object or network or installation that makes an existing facility. can function as intended. The availability of facilities and infrastructure prepared by the Taman Puring Muhammadiyah hospital includes medical record forms, stationery, computers, printers, and a room to fill out medical records. The condition of the facilities and infrastructure is sufficient so that the activities of filling out medical records can run well from the supporting aspects (Murthi, 2016). Activities to complete the contents of medical records are also influenced by driving factors, namely hospital policies regarding filling out medical records, standard operating procedures, and whether or not there are sanctions for medical record filling officers who are negligent in carrying out medical record filling activities.

"eee... sepanjang pengetahuan saya sih, sudah banyak himbuan kan kaitannya dengan akreditasi yaa, seringkali kan memang sudah ada baik disampaikan dalam rapat komite medis atau disurati gitu, kalau mengenai sanksi sendiri sih, kalau yang sekarang sih saya lihat belum ada, tapi biasanya mekanismenya kita diingatkan oleh petugas rekam medis gitu.." (11).

"sebenarnya gak ada sanksi khusus sih, paling teguran atau mengingatkan kembali ya, mengingatkan kembali terkait pengisian rekam medis terkait kelengkapan yang harus diisi, karena ini terkait dengan akreditasi juga ya, ya gak ada sanksi sih, paling teguran untuk mengingatkan kembali oleh perawatnya atau saat rapat komite medik kita ingatkan kembali, kalau kebijakan sih harusnya sudah ada atau diadopsi Cuma belum disampaikan secara luas aja kali ya" (12).

Based on the informant's statement, it is known that the policy related to filling out medical record files does not yet exist at the Taman Puring Muhammadiyah hospital, only an appeal. Meanwhile, regarding the form of sanctions and reprimands, there are no special sanctions related to health workers who are not disciplined in filling out medical record files, but warnings and reminders from nurses on duty.

Regarding the availability of the procedure for filling in inpatient medical records, the informants admitted that they did not know or had not received socialization related to the existence of standard operating procedures (SOP), as well as internal training related to the introduction of medical records to health workers.

"nah, ee saya kira sih secara resmi belum ada ya, yang saya tau kan, sebenarnya di akreditasi kan sudah ada ya, cuma mungkin belum dikeluarkan, dan belum disampaikan ke dokter DPJP secara resmi dari direksi gitu belum ada" (11)

"SOP kayaknya sih gak pernah ada ya, paling karena dari pengalaman aja ya, kalau di sini statusnya ... hmmm saya belum pernah melihat diurutin secara apa namanya langsung sih, yang ini yang mana yang mana, cuma kalau disini gimana aku kurang tau gimana berurut atau acak-acakan..." (13)

"SOP pengisian juga gak disosialisasikan, jadi gak tau mana yang harus diisi, jadi mungkin ada tapi belum pernah disosialisasikan gitu ya, jadi mungkin ada tapi gak

pernah disosialisasikan bahwa ini harus di buat gitu, pelatihan pun saya rasa gak ada" (14)

Standard Operating Procedures (SOP) is a document that describes in detail various standard operating procedures that exist within an organization, used to ensure all decisions and actions, as well as the use of facilities run effectively, efficiently, consistently, standardized, and systematic. The purpose of SOPs is to ensure that all employees do their jobs the same way. Based on research conducted by Murthi (2016) states that hospitals need to make a flow of each medical record form that is in one medical record form, and how to fill it out and the maximum filling time that all medical record filling officers, namely doctors, nurses, and doctors must know. and other health workers involved in the development of patient care in the inpatient room.

CONCLUSIONS AND SUGGESTIONS

Based on the description of the results and discussion of the research on the completeness of inpatient medical record files in obstetrics and gynecology cases at the Taman Puring Muhammadiyah Hospital, South Jakarta, it can be seen that of the eleven dependent variables in accordance with the Minister of Health Regulation No. 269 of 2008, there are several items of completeness that are still low, such as medical history (58.33%), results of investigations (38.33%), and physical examination records (72.08%). Meanwhile, after interviewing the informants, it can be concluded that the doctor's workload and working time do not really affect the filling of inpatient medical record files, because during the pandemic, the number of patients tends to decrease and the available time is still sufficient, but the problem lies in the willingness or motivation to fill out medical record files, especially on some items that are rarely filled by the doctor in charge of the patient. Then regarding the facilities and infrastructure at the hospital, it is deemed sufficient and well-maintained so that it can support the activities of filling out medical records, but there are no policies and SOPs that are well socialized to medical record filling officers so that there are still many doctors who do not fill out or do not know the urgency of some the form in the medical record to be filled out completely. In addition, the supervision factor of the medical record officer and nurse also influences the completeness of the contents of the medical record. Suggestions for hospitals in the future based on this study are to make written policies related to medical record filling activities and also to socialize the procedural flow in each medical record form as a reference for doctors and nurses in completing the contents of medical records, especially inpatients.

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