ISBN: 978-623-92207-1-6

Quantitative Analysis Of Emergency Medical Record Documents Based On Mirm Standard 13.1.1 Snars Issue 1 In Rsjd Dr. Arif Zainudin Surakarta

1st Nabilatul Fanny
Faculty of Health Sciences, Duta Bangsa University
Surakarta, Indonesia
nabilatul@udb.ac.id

2nd Liss Dyah Dewi Arini
Faculty of Health Sciences, Duta Bangsa University
Surakarta, Indonesia
liss_dyah@udb.ac.id

3rd Oliva Virvizat Prasastin
Faculty of Health Sciences Kusuma Husada University
Surakarta, Indonesia
olivaprasastin@gmail.com

4th Yogheswaran Gopalan
Departement of Pharmacy Practive, UiTM
Selangor, Malaysia
yoghes@uitm.edu.my

5th Meita Dwi Purwanri
Faculty of Health Sciences, Duta Bangsa University
Surakarta, Indonesia

***Abstract*— SNARS 1st Edition is the latest accreditation standard made by KARS. SNARS Edition 1 has assessment standards, one of which is the MIRM 13.1.1 standard. Based on the initial survey at RSJD Dr. Arif Zainudin Surakarta already has regulations on emergency medical record documents. This study aims to provide input and evaluation in improving the quality of health services in completing medical record documents. The research method used is descriptive research with a retrospective approach. The sample consisted of 97 documents of emergency medical records with a systematic random sampling technique. Collecting data by means of observation, interviews and documentation. Data processing includes collecting, editing, tabulating, presenting data and descriptive data analysis. The results of the research on the regulation of emergency medical record documents are 100% compiled in accordance with the regulations. Time of arrival and exit, there were 88 complete medical record documents or 88.65% and 11 incomplete emergency medical record documents or 11, 34%. Summary of conditions when discharged from the emergency service unit, there are 81 complete emergency medical record documents or 78.57% and 16 emergency medical record documents are incomplete or 15.52%. Instructions for follow-up care were 100% complete. Conclusion of quantitative analysis of emergency medical record documents based on the standard MIRM 13.1.1 SNARS Edition 1 in RSJD Dr. Arif Zainudin Surakarta, there are still 16 incomplete medical record documents on items of arrival and exit times and a summary of the condition when the patient left the emergency service unit. It is better if there is a need for socialization to all caregivers regarding the accuracy in recording the filling of medical records.**

Keywords*— SNARS 1st Edition, MIRM 13.1.1, medical record documents

I. INTRODUCTION

One of the assessments of the quality of service in a hospital is accreditation. Hospital accreditation is an acknowledgment of the quality of hospital services, after an assessment has been made that the hospital has met the accreditation standards. Hospital accreditation is carried out by an independent body appointed by the minister, namely KARS (Hospital Accreditation Commission). In 2017 KARS issued a new accreditation standard that is functional, no-structural, and accountable to the minister which took effect on January 1, 2018 nationally throughout Indonesia called the National Standard for Hospital Accreditation Edition 1 which is abbreviated as SNARS Edition 1.

SNARS 1st Edition consists of 5 groups, namely patient safety goals, patient-focused service standards, hospital management standards, national programs and the integration of health education into hospital services. Standards relating to medical records in SNARS Edition 1 are in the sixth chapter of hospital management standards group, namely Management of Information and Medical Records (MIRM). MIRM is a standard covering organization and management, access and storage of medical records and supports medical record management which includes provision, content, filling of medical record documents, and review of medical records. MIRM has 15 standard sub-groups, one of which is the MIRM 13.1.1 standard, which contains the arrival and departure times of the emergency service unit. This information applies to all patients discharged from the hospital or transferred to another unit or inpatient unit.

Based on the preliminary survey, it is known that RSJD Dr. Arif Zainudin Surakata is a special type A (Plenary) hospital that has accredited KARS (Hospital Accreditation Commission) 2012 with a complete graduation in 2015 and has been accredited with SNARS Edition 1 which was held in June 2018. Based on 10 samples of medical record documents emergency department taken randomly and carried out quantitative analysis obtained 7 incomplete medical record documents with a percentage of 70% and 3 complete medical record documents with a percentage of 30%. So it can be said that the completeness of emergency medical record documents has not reached 100%. The incomplete medical record document occurred in the summary of the condition when he was discharged.

II. METHOD

This type of research is descriptive research, which is a study conducted to describe a phenomenon that occurs in society [1]. This study describes a quantitative analysis of emergency medical record documents based on the standard MIRM 13.1.1 SNARS Edition 1 at RSJD Dr. Arif Zainudin

 ISBN: 978-623-92207-1-6

Surakarta. The approach in this study is cross sectional. The population of this study was the medical record documents of emergency patients in 2018, totaling 2760 medical record documents, the total sample was 97 documents with a systematic random sampling technique. Data collection is done by reviewing medical record documents and interviewing medical record officers. The results of this study were analyzed descriptively, which describes the results of the quantitative analysis of emergency medical record documents based on the standard MIRM 13.1.1 SNARS Edition 1 in RSJD Dr. Arif Zainudin Surakarta is then compared with the relevant theories.

III. RESULT

The form used in the emergency medical record document at RSJD Dr. Arif Zainudin Surakarta in 9 forms, namely:

1. Emergency Nursing Assessment
2. Emergency Medical Assessment
3. Crisis Triage Rating Scale
4. Mechanical Fixation Measures
5. Provision of Information Injection Actions
6. Electro Convulsive Therapy (ECT) Actions Provision of Information
7. General Anesthesia Actions Provision of Information
8. Internal Transfer Patient Records
9. PANSS-EC (Positive And Negative Syndrome Scale) Assessment Sheet

From these forms an analysis will be carried out based on the patient's arrival time, the patient's discharge time, a summary of the condition at discharge, the follow-up instructions for care in accordance with the MIRM 13.1.1 SNARS Standard Edition 1 [4].

Emergency patient medical records contain the arrival and departure times of the emergency service unit. This information applies to all patients who have been discharged from the hospital or who have been transferred to another unit or an inpatient unit. When discharged from the emergency department, it means that the patient physically leaves the emergency room, can go home or be transferred to another unit or inpatient unit or referred to another hospital. The medical record also contains conclusions on the completion of patient care, the patient's condition when moving or discharged, and instructions given as follow-up services [4].

Regulation

RSJD Dr. Arif Zainudin Surakarta has several regulations related to emergency medical record documents as follows:

1. Regulations on emergency patient medical records containing the time of arrival and discharge of the patient, a summary of the patient's condition upon discharge from the emergency department, and instructions for follow-up care.
2. SPO Number 03.02.61 concerning Analysis of Completeness of Medical Record Documents.
3. SPO Number 03.02.18 concerning Completion of Incomplete Patient Medical Record Documents.
4. SPO Number 03.02.31 concerning Filling in Emergency Medical Records.
5. SPO Number 03.02.25 concerning Reporting of Emergency Medical Records.

Regulations regarding medical record documents have been implemented properly. The assembling officer performs the assembly/preparation of medical record documents, analyzes the completeness of medical record documents and medical actions both in quality and quantity. Doctors, nurses, and other health workers have also filled out documents in a disciplined manner and in accordance with their respective authorities.

Based on minister of health regulations (Permenkes) 269 / MENKES / PER / III / 2008 it states that every doctor and dentist in carrying out medical practice is obliged to make medical records. Thus, doctors and other health professionals such as midwives, nutritionists, physiotherapists and others have a direct obligation to the process of loading patient medical records and are required to always complete medical record documents [2].

Time of Arrival and Exit of the Emergency Services Unit

Table 1. Completeness of Filling in Time of Arrival and Exit of the Emergency Service Unit

No	Form Name	Time of Arrival and Exit			
		Complete		Incomplete	
		∑	%	∑	%
1.	Emergency Nursing Assessment	97	100	0	0
2.	Emergency Medical Assessment	88	88,65	11	11, 34
3.	Crisis Triage Rating Scale	97	100	0	0
4.	Mechanical Fixation Measures	97	100	0	0
5.	Provision of Information Injection Actions	97	100	0	0
6.	Electro Convulsive Therapy (ECT) Actions Provision of Information	97	100	0	0
7.	General Anesthesia Actions Provision of Information	97	100	0	0
8.	Internal Transfer Patient Records	97	100	0	0
9.	PANSS-EC (Positive And Negative Syndrome Scale) Assessment Sheet	97	100	0	0

Based on table 1, it is known that the information filling time of arrival and exit of the service unit at RSJD Dr. Arif Zainudin Surakarta, 88.65% complete and 11.34% incomplete.

Based on the results of interviews with emergency room nurses (UGD), the incompleteness of filling in medical record documents was due to negligence and lack of accuracy of officers in filling out forms, especially writing hours of arrival and hours of discharge when performing services or examining patients.

> *"Because the officers are in a hurry in writing because they are assigned to the emergency service unit (UGD) which is trying to take action quickly so they often forget to write" Respondent 1*

Each report must include the date and time given to the patient. From this theory, the date and time must be included at the time the patient performs treatment because to know when and at what time the patient gets services and

ISBN: 978-623-92207-1-6

must include a report because to get history information according to the patient's case needs [3].

The date of filling in, the doctor's signature, the doctor's name on the medical record document is clinical data which is interpreted as data on the results of examinations, treatment, care performed by health practitioners and medical support for inpatients, outpatients and emergencies. Therefore it is necessary to fill in the date of filling in order to find out and record when the patient is discharged from the hospital, the doctor's signature to strengthen the responsibility of a doctor in administering medical action, the name of the doctor to be responsible for the implementation of medical services to patients, so that this can support medical services [5].

Summary of conditions when discharged from the emergency service unit

Table 2. Completeness of Filling in Summary of Conditions When Exit the Emergency Service Unit

No	Form Name	Summary of Exit Conditions			
		Complete		Incomplete	
		∑	%	∑	%
1.	Emergency Nursing Assessment	97	100	0	0
2.	Emergency Medical Assessment	81	78,57	16	15,52
3.	Crisis Triage Rating Scale	97	100	0	0
4.	Mechanical Fixation Measures	97	100	0	0
5.	Provision of Information Injection Actions	97	100	0	0
6.	Electro Convulsive Therapy (ECT) Actions Provision of Information	97	100	0	0
7.	General Anesthesia Actions Provision of Information	97	100	0	0
8.	Internal Transfer Patient Records	97	100	0	0
9.	PANSS-EC (Positive And Negative Syndrome Scale) Assessment Sheet	97	100	0	0

Based on table 2, it is known that filling in summary information on conditions when they left the emergency service unit at RSJD Dr. Arif Zainudin Surakarta is 78.57% complete, while 15.52% is incomplete.

The incomplete filling in the summary of conditions when leaving the emergency service unit is due to a lack of communication with the Caregivers Professional (PPA) and the lack of awareness of the doctor who is in charge of the patient (DPJP) and other medical officers. The following is an excerpt from the interview with the head of medical records:

> *"The causes are many, one of which is due to a lack of communication with professional caregivers and a lack of awareness of doctors who are in charge of patients and related medical officers in filling out emergency medical record forms" Respondent 2*

The importance of recording a summary of conditions when leaving the service unit to ensure high quality medical services and as a useful material for the receiving doctor if the patient is hospitalized again and maintaining continuity of patient care in the future, and as a copy to the patient's primary doctor and consultants who need.

The medical resume must be complete and written briefly with the name and signature of the doctor who treats the patient and can explain important information about the patient, especially the disease, the examination performed, and the treatment received for the patient. Doctors as health service providers are responsible for filling out medical record documents, especially complete medical resumes [6].

The incompleteness of medical resumes is a problem because medical resumes can provide detailed information about what has happened during the patient's hospitalization, which has an impact on the quality of medical records and services provided by the hospital [7].

Instructions for follow-up care

Table 3. Completeness of Filling in Instructions for Follow up Care

No	Form Name	Instructions for follow-up care			
		Complete		Incomplete	
		∑	%	∑	%
1.	Emergency Nursing Assessment	97	100	0	0
2.	Emergency Medical Assessment	97	100	0	0
3.	Crisis Triage Rating Scale	97	100	0	0
4.	Mechanical Fixation Measures	97	100	0	0
5.	Provision of Information Injection Actions	97	100	0	0
6.	Electro Convulsive Therapy (ECT) Actions Provision of Information	97	100	0	0
7.	General Anesthesia Actions Provision of Information	97	100	0	0
8.	Internal Transfer Patient Records	97	100	0	0
9.	PANSS-EC (Positive And Negative Syndrome Scale) Assessment Sheet	97	100	0	0

Based on table 3, it is known that the filling of follow-up instructions for care at RSJD Dr. Arif Zainudin Surakarta is 100% complete.

Based on an interview with the head of medical records, it was stated that the filling out of follow-up care instructions was often filled in completely as quoted from the

ISBN: 978-623-92207-1-6

interview with the head of medical records:

> *"Yes, for the completeness of filling out follow-up care instructions, it is often filled completely because considering the importance of what instructions will be given to patients and their families, including names and locations for further treatment, when to go to the hospital, and when urgent services must be obtained" Respondent 2*

Percentage of completeness and incompleteness of emergency medical record documents

Table 4. Results of Quantitative Analysis of Emergency Medical Record Documents

No	Emergency Medical Record Documents	Total	%
1	Complete	75	77, 32
2	Incomplete	22	21, 34

Emergency Unit (IGD) is one of the hospital clinical services that provides 24-hour service in cases of emergency or non-emergency, or non-emergency or emergency and emergency cases. Determination of the type of case depends on the patient's condition as determined by the doctor in charge of the ER. Emergency services prioritized patient care first because of the case, then administrative services. In terms of clinical recording into the medical record form for these cases is the same, the only difference is the way of clinical service [3].

Overall, the factors that cause and result in incomplete emergency form filling include:

1. Lack of control in filling and completing emergency medical record documents.
2. Lack of socialization about existing fixed procedures.
3. There is a lack of good cooperation between the authorities and those responsible for completing the filling of emergency forms.

Incomplete medical record documents are a problem because medical records are often records that can provide detailed information about the patient's disease history during the patient's visit to the hospital, both outpatient and inpatient.

Complete and accurate medical records can be used as a reference for basic legal health services (medico legal), supporting information to improve medical quality, medical research and used as a basis for assessing hospital performance. In a complete medical record, information can be obtained that can be used for various purposes. These needs include, among other things, as evidence in legal cases, research and educational materials, and can be used as a tool for analysis and evaluation of the quality of services provided by hospitals [8].

Based on research conducted by Indar, states that incomplete medical record documents can be caused by employment status, knowledge, and years of service with complete medical record filling. Meanwhile, the doctor's motivation and type of expertise and completeness of filling in medical records did not have a significant relationship. Therefore, efforts should be made to develop human resources through education and training as well as courses related to filling out medical records. It is recommended that doctors provide guidance in filling out medical record documents and provide internal training on determining the main diagnosis in accordance with the provisions of the ICD-10, so that doctors can increase their knowledge of completeness of filling in medical records. Increase the motivation of doctors in filling medical records through career development, promotion and giving feedback by providing rewards and punishments [8].

IV. CONCLUSION

Based on the results of quantitative analysis of emergency medical record documents based on the standard elements of the MIRM 13.1.1 SNARS assessment, Edition I at RSJD Dr. Arif Zainudin Surakarta, there are already regulations governing the challenge of completing medical record documents, filling in when arrival and exit are still 88.65% complete, 3. Summary of conditions when leaving the emergency service unit 78.57% complete, follow-up instructions 100% filled in completely. Efforts should be made to develop human resources through education and training (education and training) as well as courses related to filling out medical records in order to be more thorough and disciplined in checking the completeness of medical record documents. There should be guidance for doctors in filling out medical record documents and providing internal training on determining the main diagnosis in accordance. with the provisions of the ICD-10, so that doctors can increase their knowledge about completeness of filling in medical records. Increase the motivation of doctors in filling medical records through career development, promotion and giving feedback by providing rewards and punishments.

REFERENCES

[1] Notoatmodjo, Soekidjo. 2012. Metodologi Penelitian Kesehatan. Jakarta : Rineka Cipta

[2] Menteri Kesehatan Republik Indonesia. 2008. Peraturan Menteri Kesehatan Republik Indonesia Nomor. 269/MENKES/PER/III/2008 tentang Rekam Medis. Jakarta.

[3] Sudra, Rano Indradi. 2014. Rekam Medis Ed.2. Tanggerang Selatan : Universitas Terbuka.

[4] Komisi Akreditasi Rumah Sakit. 2017. Standar Nasional Akreditasi Rumah Sakit Edisi 1. Jakarta.

[5] Hatta, Gemala. 2010. Pedoman Manajemen Informasi Kesehatan di Sarana Pelayanan Kesehatan. Jakarta: UI-Press.

[6] Departemen Kesehatan Republik Indonesia. 2006. Pedoman Penyelenggaraan dan Prosedur Rekam Medis Rumah Sakit di Indonesia Revisi II.Jakarta.: Direktorat Jenderal Bina Pelayanan Medik.

[7] Konsil Kedokteran Indonesia. 2006. Standar Pendidikan Profesi Dokter. Jakarta: Konsil Kedokteran Indonesia.

[8] Indar, Irmawaty, dkk. 2013. Faktor yang Berhubungan dengan Kelengkapan Rekam Medis Di RSUD H. Padjonga DG. Ngalle Takalar