ANALYSIS OF THE COMPLETENESS OF MEDICAL RECORDS OF PATIENTS IN TRAFFIC ACCIDENT CASES IN THE INPATIENT UNIT CLASS III ROOM BHAYANGKARA TK IV GORONTALO HOSPITAL

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ABSTRACT

This study aims to examine and analyze the completeness of medical records of patients in traffic accident cases treated in class III at Bhayangkara TK IV Gorontalo Hospital and find out how to identify the factors that influence the completeness of medical records. This research method uses a qualitative approach with the type of research used in this research being descriptive research. This research obtained information through in-depth interviews with 5 informants consisting of the Head of Medical Records, Medical Records Officer, Head of Class III Inpatient Room, Inpatient Nurse, Class III Inpatient Administrator. The results of the research show that recording patient identities at Bhayangkara TK IV Gorontalo Hospital has been carried out in accordance with detailed procedures, but there are still errors or incompleteness due to staff negligence. Important reports such as laboratory and radiology results run well with SIMRS support, but there is still manual recording which risks causing delays. The authentication process required re-verification due to suboptimal SIMRS integration and lack of staff training. Medical record documentation is generally complete, but challenges such as time, workload and technical issues still impact quality, requiring increased auditing and regular training to improve the system and ensure data accuracy.

Keywords : Record Medical, Accident Traffic, Hospitalization Inpatient

INTRODUCTION

A hospital is a health service institution that provides comprehensive individual health services and provides inpatient, outpatient and emergency services. Hospitals established by the Central or regional governments must be in the form of technical service units from agencies in charge of the health sector or certain agencies with management by public service agencies or regional public service agencies in accordance with statutory regulations (Permenkes, 2020). A medical record is a document that contains patient data regarding the patient's identity, examination, treatment, actions and other services that have been provided to the patient. Minimum Service Standards (SPM) are provisions regarding the Type and Quality of Basic Services which are Mandatory Government Affairs that every Citizen has the right to obtain at a minimum (Ministry of Law and Human Rights 2018).

Medical recorders play an important role as processors and presenters of data related to health information, one of which is morbidity data in traffic accident cases. Maintaining good and correct medical records is certainly one of the supporting factors for the success of efforts to improve the quality of health services, of course in this case it is the correctness of information about traffic accidents experienced by patients in order to facilitate all forms of procedures that will be carried out such as Jasa Raharja claims, determining action if injured. serious, or the need for a police

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report to investigate the crime scene. Medical recorders have a role in realizing patient safety in providing quality patient history (Samsudin, 2019).

A traffic accident is an undesirable event that occurs on the road unexpectedly and unintentionally. Of course involving one vehicle with another vehicle or even without a vehicle is also said to be an accident (single accident) (Siregar & Dewi, 2020). According to the World Health Organization (WHO, 2018) in its research Nugroho 2022, 1 person dies every 40 seconds and 1.3 million people die on the highway. Traffic accidents are the main cause of death for all ages, reaching 20-50 million injured victims and the main cause of death is children and teenagers aged 5-29 (Nugroho et al., 2021).

According to the Central Java Province Central Statistics Agency, it shows that in 2018-2020 the number of deaths was still high. In Central Java itself, the number of traffic accident victims (number of accidents) was recorded as 21,395 people (BPS, 2021). In Indonesia, based on data from the Indonesian National Police Traffic Corps (Korlantas Polri), in 2020 the number of traffic accidents (lakalantas) was 100,028 cases (Korlantas Polri, 2020). Traffic accident victims often suffer serious injuries that require fast and appropriate medical treatment. Therefore, complete medical records of traffic accident patients are very crucial to ensure that every treatment step is recorded properly and the patient receives appropriate treatment.

Based on initial studies by conducting interviews with Medical Records Officers, data on traffic accident patients who were hospitalized reached 30% of the total hospitalizations, while other diagnoses such as internal medicine only reached 15-20%. This comparison shows that traffic accident cases have a higher number each year compared to other diagnoses, such as internal diseases or infections. This makes traffic accidents one of the main focuses of this hospital's services because traffic accidents are one of the main causes of morbidity and mortality in the Gorontalo area.

Based on the results of observations in March 2024, it is known that data regarding the analysis of the completeness of medical record files for traffic accident patients in inpatient units is not 100% complete. Of the 10 medical record documents, it was found that 4 documents (40%) were complete and 6 documents (60%) were incomplete. Incomplete medical records are often found on traffic accident forms. This occurs because traffic accident patients often arrive in critical condition requiring immediate medical treatment, which results in important information related to patient identity data such as emergency contact numbers, addresses and insurance information being often missed or not recorded correctly.

Based on the description above, the researcher is interested in conducting research on Analysis of the Completeness of Medical Record Files for Patients in Traffic Accident Cases in Class III Inpatient Rooms at Bhayangkara TK IV Hospital, Gorontalo. From this analysis, we will find out what information is contained in the medical records of hospitalized traffic accident patients in accordance with the established standards and how to handle this.

RESEARCH METHODS

This research uses a qualitative research approach with a type of descriptive research which is carried out to determine the value of variables, independently, either one or more variables (independent) without making comparisons, or connecting them with other variables.

RESEARCH RESULT

Table 4.1 Characteristics Informants

NO.	Informant's Initials	Gender	Last education	Informant Code

1.	H.D	Man	vocational school	1
2.	O.H	Woman	S1	2
3.	N.C.H	Woman	S1	3
4.	N.S.S	Woman	S1	4
5.	H.H	Man	S1	5

The description of table characteristics informants above is numbering five (5) people employees who consists of 1 person Head Record Medical (informants 1), one person Officer Record Medical (informants 2), one person

Head of class IV inpatient room (informant 3), one inpatient nurse (informant 4) and one class IV inpatient administrator (informant 5).

The description of results of interviews with 5 informants which consists of 4 components as following :

1. Identify Patient

Patient identification is an important process in medical records that aims to ensure that each medical record or medical action is associated with the correct patient. This process involves recording basic patient information, such as full name, date of birth, medical record number, and other identifying information.

In carrying out tasks which is carried out at section medical records at Bhayangkara Hospital TK IV Gorontalo identify patients in accordance with procedures , these things can be seen from statements the following informants :

I 1 : *" Yes, patient name name we follow patient on KTP, if name does not match with patient name , KTP, or gender sex it will repaired first side BJPS (H.D., 08/21/24)."*

"In the medical record, just wait for the patient's registration from the emergency room, the medical record will be recorded when the patient goes home and has been declared home by the doctor and the status is deposited into the medical record room. This will ensure that the patient's name and date match the patient's identity because of that status. We will carry out an FC/scan of the patient's ID card and hand it over and place it in the patient's status until the status is in the medical record room and we will check the patient's status. (H.D., 08/21/24)"

"We will definitely record the patient's gender accurately or without error because we record the gender based on the patient's status. If there is a mistake, the patient's gender does not match, it is possible that at the time of patient registration the gender was wrong at the time at BPJS, we will inform you. to the patient to change the data, the patient's gender (H.D., 08/21/24)."

"We record the patient's address until we get it from the patient's KTP because when registering we ask for the patient's KTP data, or if there is no physical proof of the KTP, we ask for the patient's scan/KK file to make sure that when recording the address and postal code correctly, the information is complete. patient (H.D., 08/21/24)."

"Our first steps are to take the data first, first check the patient's ID card, BPJS data or KK data. If there is a patient, we will do it. If it is inaccurate or incomplete, we will make sure we really ask the patient whether this is true patient data or whether there is a mistake. such as the gender, the patient's name is incomplete or the date of birth does not match (H.D., 08/21/24)."

I 2 : *" Yes has matches because if is input the , right must be there is with NIK , if there is name patient that is the same the will not automatically registered , means*

automatically read the patient has been registered at home sick Bhayangkara (O.H., 08/19/24).”

” Most in this hospital have patients whose names are the same but NIK are different , date of birth is different it will be checked again on the KTP (O.H., 08/19/24).”

“Gender also so , so far there has not been any mistake about gender patient ” (O.H., 08/19/24).”

“Well, for the address of the patient is also has on the KTP so has followed according ID card (O.H., 08/19/24).”

“The steps we take when errors information are discovered are incomplete usually we supplement with edit profile patient .... but must be filled in NIK, number telephone , name , type gender etc the can be changed to . (O.H., 08/19/24).”

I 3 : *“If from we indeed full name must be recorded appropriate documents document like KTP, can be also card BPJS or KK that we see from documents important patient , why ? Because it is very important to ensure patient patient in order to avoid errors and if is not appropriate then must immediately be corrected the medical patient information (N.C.H., 08/21/24).”*

"To ensure that we will record the patient's date of birth correctly, first we need to check official identity documents such as KTP or birth certificate, then we will also confirm with the patient's family and the data will be entered carefully into the medical record and checked again to avoid errors (N.C.H., 08/21/24).

“ Usually in us that that often occurs errors that when records official identity patient , well our way is minimizing errors , that is with verifying information type gender patient with official documents patient and ensure that team care inpatient performs records and performs double checks when necessary (N.C.H., 08/21/24).”

"We obtain the patient's address including the postal code by asking for information directly from the patient or his family or by asking for the patient's ID card directly, then we will record it carefully so that there are no errors and check again if there is any doubt or ambiguity so that the patient's address is recorded correctly and complete (N.C.H., 08/21/24).”

“So if from finally anyway , the first identify correct verify similar changes check documents patient with then perform updates data as changes by confirm repairs regularly complete in system record medical , after it confirm changes with patient to ensure the information that is updated is correct and finally we often carry out documentation process repairs periodically in order to prevent similar errors (N.C.H., 08/21/24).”

I 4 : *” Yes, it must comply with document (N.S.S.,19/08/24).”*

“ Now is already system online, so all actions are through system so automatically all recorded recorded medical (N.S.S.,08/19/24).”

“Yes always recorded with accuracy (N.S.S., 08/19/24).”

"We obtain the patient's address including the postal code by asking for information directly from the patient or his family or by asking for the patient's ID card directly, then we will record it carefully so that there are no errors and check again if there is any doubt or ambiguity so that the patient's address is recorded correctly and complete (N.C.H., 08/21/24).”

“ Oh, that's normal if there is a identity that is different we will direct to service social (N.S.S.,19/08/24).”

I 5 : *" Recording patient all complete , for identity patient such as name patient , number telephone , guarantee what , date admission patient status etc. so less more must be completed (H.H., 08/21/24)."*

"The first need admission ER, why .. because besides for take care of administration patients can register patients especially patients that are emergency that require extra treatment so passed first or escorted to room later for administration family that completed and admission must record in its entirety for completeness recording status it usual administration care overnight that complements (H.H., 08/21/24)."

"Must, that not be allowed, we for make such guarantees that we only register name, number telephone same guarantee, if before still use BPJS now already use KTP, so for recording type gender I feel not will tone error (H.H., 21 /08/24)."

"Well, like that I explained earlier , right there are administration IGD, now it's BPJS has do not use cards because has use KTP so it's on KTP that complete and for postal post that has asked directly to patient , there are also those who do not use postal codes like domicile (H.H., 08/21/24)."

"The the first coordination we between administration with the nursing who the first coordination ER to admission care inpatient continue we continue that to doctor / nurse for changes that we confirm with our we who will answer if an error occurs or differences name, address date of birth that quickly we finish so that doesn't hinder process assurance patient (H.H., 08/21/24)."

2. Report Important

Important reports in medical records are part of medical documentation that include information related to the patient's condition, examination results, diagnosis, and medical actions that have been carried out.

Process completeness record medical in component report important in section record medical at Home Bhayangkara Hospital Precession Gorontalo in accordance with the results of interviews with informants can be stated as as follows :

I1: *"Yes, of course, we always record all important patient data reports from the radiology laboratory or patient CPPT or patient resumes, and now we record them via electronic medical records. "So, thank God, we have used electronic medical records* (H.D., 08/21/24)."

"From the medical record, the report must first be checked and verified, then record the report carefully in the medical record and ensure all important information is included, after that do a double check to ensure there are no errors, and we will also keep a copy of the original report along with medical records for reference and audit purposes (H.D., 08/21/24)."

" The that we must confirm with the registration party us make sure is correct for data patients that are do not miss , reports reports that directly we check first in parts of the room reports do not match or are different in parts units per units (H.D., 08/21/24)."

" Now reports that we often do pull data that based from results system management website, so we can take data from there (H.D., 08/21/24). "

"Yes there system , if there errors reports that does not correspond or is wrong carry out recording reports and errors occur must be immediately reviewed by from staff medical sometimes often go down in

the field to each unit to check reports that should be updated again (H.D., 08/21/24)."

I 2 : *" Already , results laboratory and radiology also already automatically there on the RS SIM. (O.H., 08/19/24)."*

" At SIMRS it klw we make reports now already good, it's already no manual automatically from SIMRS so for data visits, which there are diagnosis , address , number phone etc. it can be exported from SIMRS so already corresponds with that is registered and already corresponds with the final diagnosis because we took data all from SIMRS. If there are discrepancies , we communicate again with third parties for clarification before recording final. (O.H., 08/19/24)."

"*So usually if you're in outpatient care you don't miss it because if you're in outpatient care you already use SIMRS completely so all the data is in SIMRS and it's appropriate except for inpatient care, some inpatients still use sheets but the rest already use SIMRS. "Well, and for inpatient reporting, use the date of discharge, but in SIMRS the data is from the date of admission, so you still need to cross-check it again"* (O.H., 19/08/24)."

"Well, the good thing at SIMRS is is already can be sorted where treat which way where treat inpatient can also be sorted all doctors, so is already not from us for grouped manually, if for reporting whatever is requested it directly in SIMRS, except if there are additional types of patients members of police , society general or civil servants police it does include SIMRS but is still manual(O.H., 08/19/24)."

" There are, for example CPPT it must be verified by a doctor right , it will there been warning if will discharge the patient , has there been verification from DPJP? so the nurse or midwife will confirm or confirm again to DPJP (O.H., 19/08 /24)."

I3: *"This process usually involves receiving a report from a laboratory or radiology and then verifying and ensuring that the report is recorded correctly in medical records. As the head of a special inpatient room for a class III room, I always emphasize the importance of accuracy in this process to ensure that all medical information is available for proper treatment and the medical records staff themselves always remind me if there are reports that have not been submitted (N.C.H., 21/08/ 24)."*

"To ensure that reports from third parties, such as laboratories or radiology, are recorded correctly in medical records, we always implement a layered checking system. So every report received is checked first by a nurse before being submitted to the medical records officer and it is documented. In addition, there is strict coordination with the laboratory and radiology teams to ensure that examination results are received and recorded promptly. And I also monitor this process regularly and use a notification system to alert if there are reports that have not been recorded (N.C.H., 08/21/24)."

"If there are important reports that have not been recorded or have been missed, we from the inpatient team have strict follow-up procedures. The first is to re-check the medical records by a nurse or medical records officer to ensure the completeness of the documents. If we find a report that has not been recorded, we immediately contact the party concerned, such as the laboratory or radiology, to obtain a copy of the report and immediately record it. Additionally, I conduct regular audits to ensure no important reports are missed, as well as provide warnings or additional training if errors are discovered in the record-keeping process (N.C.H., 08/21/24)."

" Important reports in medical record system are grouped and indexed by type examination , such as laboratory and radiology , and are arranged chronologically . The medical record system also allows quick searches , so that we can with easily access and review information that requires (N.C.H., 08/21/24)."

"There is, a system that ensures important reports are regularly updated and reviewed by . Incoming reports are automatically communicated to the team through a notification system, and there is a regular schedule for review of reports by physicians and nurses, to ensure that all current information is recorded and used in patient care (N.C.H., 08/21/24)."

I 4 : " *Yes, all must be recorded medically, must be placed in the patient status (N.S.S.,19 /08/24)."*

" By by seeing identity from KTP or KK (N.S.S., 19/08/24)."

"Yes always recorded with accurately (N.S.S.,08/19/24)."

"Reports are important if you are hospitalized, you need a police report so that it is clear whether it is actually a single or multiple accident (N.S.S., 19/08/24)."

" Viewed from number medical record (N.S.S.,08/19/24)."

I 5 : *" So the data data that we take of information patient see of resume resume review , identity patient automatically will be moved in SIMRS, so we will see of medical resume review (H.H., 08/21/24)."*

"If for data collection case I think case has been discussed that data collection case not will we do miss unless there is that that happened and how party home hospital resolve that case we need family patient or education with family (H.H., 08/21/24)."

"Yes, here every time we will be report , in the administration care stay This report in front of on the screen that are actually who has authority for charge we administration care stay so we communicate to the nurse anyone who will be in the room later that are we will fill according to with each class so that is there recorded in front of of the screen can be seen so that the term updated updated and the public general in front of can see condition house sick especially for rooms that are updated or not (H.H., 08/21/24)."

"The first numbering medical records it very important , if in RS we must permission if is not in RS it occurs outside the scope of RS then we do not need permission because is concerns the life of the patient . So to recording I feel less is is good but we need to innovation which is new more so that is better more besides the service we have at administration (H.H., 08/21/24)."

"Yes, it an important change one of right leave entry patient , patient enter patient leave it if in administration care inpatient always before send report it has been updated and sent (H.H., 08/21/24)."

3. Authentication

Authentication is the process of verification or proving the authenticity and validity of a document or action in medical reports . At the Bhayangkara Polda Gorontalo Hospital, authentication is carried out by by giving a hand sign , initials , or stamp by medical reports who is authorized , such as doctor or nurse , on records or medical reports.

Process completeness record medical in component Authentication in section record medical at Bhayangkara Hospital The precession of Gorontalo corresponds with the results of interviews with informants can be stated as as follows :

I 1 : *" Yes, in every entries home sick medical records equipped with sign hand , so means does registration must the officer have does signing and then also in the SIMRS section also there is treaking about who does process entries data medical records patient (H.D., 08/21/24)."*

"If for the verification process we each ask the patients or families patients about data information patients or families patients at home sick we must check that is correct recorded and to ensure that is with that is correct and valid (H.D., 08/21/24)."

"Steps steps at when changes this record team definitely we find based on results first , the first we will ascertain whether this patient data is happening error at when does entry we from medical record team will ask to the administration section registration and registration IGD we even does check whether is correct or incorrect at when does entry this then if if is correct we will ask again to the patient's patient at when does again in the hospital we will check correct this patient data is correct or wrong (H.D., 21 /08/24)."

"When carrying out authentication, the electronic system, especially the entry, is always verified. When recording, there must be someone who checks it in stages, the verification is like the patient's CPPT, the patient's medication, of course it must be verified by a doctor whether it has been read or whether it is properly verified. by DPJP as well as the patient's medication (H.D., 08/21/24)."

"Yes, we from the medical record team have several times carried out special training such as seminar (H.D., 08/21/24)."

I 2 : *" Yes, if is in status, for example we use hand marks and stamps, if there is hand marks but is not there is our stamp is not accept so there must be there is hand marks and there must be there is stamp but if only status usually , if in SIMRS there must be there is backrode, so later will say the nurse which is or the doctor treats but if is not there is barckrode means is not verified by the nurse or the doctor said (O.H., 08/19/24)."*

" Yes, there are we see directly from medical resumes which has not exist date discharge that means the patient has not finished been discharged (O.H., 08/19/24)."

" Usually there is patient already be sent but the doctor there are still wants to check again patient so if according to the doctor there are still there is action that added to SIMRS then patient canceled later already added new be be sent again but from SIMRS, that's why action every patient will be checked again whether there is an error or cannot because if already claimed it already cannot be changed (O.H., 08/19/24)."

"If from us officers record staff authentication in system record staff electronic is carried out by requiring each medical staff to use an access code or personal ID, before can enters data. To ensure that the information is truly valid. Every action is also recorded in an activity is records who is accessing or changes data, so that makes it easier to search if is needed (O.H., 08/19/24)."

"Yes, we have training SIMRS so every partner or employee here already knows how to use SIMRS" (O.H., 08/19/24)."

I 3 : *" Yes, Each entry in the record medical is equipped with a a physical or digital from nurse . This process is carried out to ensure the completeness of the which recorded*

. The physical or digital sign can be a physical hand on record medical print or digital authentication on system record medical electronic , depends on system which is used in home sick (N.C.H., 08/21/24).”

"From me, the verification process to ensure the data in the medical record is correct and valid is carried out through several steps. First, the nurse or medical officer checks the recorded data before entering it into the medical record. Then, there is a double check by the supervisor or unit head to verify the accuracy of the information. In addition, data is also checked periodically through medical record audits to ensure that all records comply with applicable standards and procedures (N.C.H., 08/21/24).”

“Yes, there are specific procedures to ensure that changes in medical records are authenticated in an appropriate manner. Each change must be accompanied by a signature or digital authentication of the medical staff making the change. These procedures include recording the reason for the change and the time the change was made, so that any modification can be clearly traced and verified (N.C.H., 08/21/24).”

"In an electronic medical record system, the authentication process is carried out through the use of digital identification, such as a username and password or fingerprint, which can only be accessed by authorized medical staff. Each important entry, such as a diagnosis or test result, must be authenticated with a digital signature that records the name and time of authentication. The system also maintains an audit trail that allows tracking of any changes or additions in the medical record, ensuring that only authorized individuals can make or change critical entries (N.C.H., 08/21/24).”

"In the inpatient department, we receive special training regarding the importance of authentication in medical records, namely training explaining authentication procedures, how to use the electronic medical record system correctly, and the importance of maintaining the security of patient data (N.C.H., 08/21/24)."

I4: "Everyone has used SIMRS because everything is complete there, so how many times have you visited? What is the diagnosis every time you visit? When is the treatment date? It's all in SIMRS” (N.S.S., 19/08/24).”

“ Need verification from DPJP (N.S.S.,19/08/24).”

"For us nurses, it is almost the same as the head of the room in that changes in medical records must be authenticated through clear procedures, where each change is accompanied by a signature or digital access code from the nurse or medical staff who made the change (N.S.S., 19/08/ 24).”

"From us, authentication in the electronic medical record system involves special steps to maintain the security of important entries. Each nurse uses personalized access, such as an electronic ID card or pin code, which is required before they can enter data into the system. The system typically requires additional confirmation, such as re-entering a password or using two-factor authentication, before the entry is saved. The system also tracks each change, recording details of who made the entry and when, so that the entire process is transparent and accountable (N.S.S.,19/08/24).”

“Yes, we nurses do receive special training about the importance of authentication in medical records. This training focuses on the proper use of electronic medical record systems, including how to properly authenticate each entry (N.S.S.,08/19/24).”

I 5 : *" So now sign hand sign in the form of barcrode , already no there is anymore except on the manual, so must there is sign hand if no there is sign hand will be sent home no want claimed same BPJS (H.H., 08/21/24)."*

"Okay, it would be better if I asked the nursing department, they are the ones who enter every nursing action, for the verification issue, we actually administer inpatient care and the first verification method is to determine the correctness of the name, patient's medical record number, patient's telephone number and most importantly. That identity covers everything, it must really be adjusted so that there are no mistakes. If it is appropriate, it will be transferred to the medical record. If it is not complete, the medical record will be returned to inpatient care before entering the claims section (H.H., 08/21/24)."

" The the first data numbering medical record must be follow the first continue procedures for removal of data from ER or from poly has according to procedures must be registered first in the emergency room and before data is transferred has recorded and has printed number SPM like sutar introduction treated inpatient so data not be admitted treated inpatient if not there is a letter because it will state that patient data complete (H.H., 08/21/24)."

" For entry I clearly from ER into care inpatient , example from poly throw data into care inpatient we do registration after that action namely TTV and carrying out taking blood and checking active or not patient data and last action (H.H., 08/21/24)."

"Here we have a special program from the leadership, we have a program every 6 months apart from renewing dead STRs, there is also special training but it still uses our own money, the training comes from outside so some of it is with the hospital, at least for the sake of his career he does the training independently. to deepen knowledge (H.H., 08/21/24)."

4. Correct documentation

Correct documentation is the process of recording medical information accurately, completely, and in accordance with applicable standards, so that every medical action and decision can be traced and accounted for. At the Bhayangkara Precession Polda Gorontalo Hospital, correct documentation includes several aspects, such as recording patient information clearly and completely, using standard medical terms, recording the time and date of each action or observation, and ensuring that all records are signed or initialed by the officer who performed them. action.

The process of completing medical records in the correct documentation component in the medical records section at Bhayangkara Presessi Hospital, Gorontalo, according to the results of interviews with informants, can be stated as follows:

I 1 : *" Yes, clear and definitely we must be detail when do recording diagnoses patient in records treatment patient that must be complete and clear if if is not complete us will do repetition status to do completion status that and to time from us here 1x24 hours to do completeness status patient if at when is deposited is not complete (H.D., 08/21/24)."*

"How ensure is we always at when emergency definitely always documented reported in group RS or at when reports or emergency actions will carried out in group group, changes the condition of the patient is definitely documented with how to write on WA with DPJP or nurse carried out in group (H.D., 08/21/24)".

"Our data formats include the patient's name, patient's gender, address, date of birth, and the patient's ethics always comply with a standard format by recording medical data to maintain consistency (H.D., 08/21/24)."

" During this documents was recorded medical Thank God let now it has not ever are missing , because we keep and checked properly don't let have documents record medical patients who are missing or are discharged from hospitals without knowledge from medical medical or officer record medical (H.D., 08/21/24)."

"In terms of procedures, we have conducted medical documentation audits twice, but now there has been a lot of activity in the past few months, but we are still trying to carry out medical record documentation procedures regularly (H.D., 08/21/24)."

I 2 : *" Yes, if for diagnosis and treatment if we have clear and complete (O.H., 08/19/24)."*

"We are responsible for entering data accurately and ensuring that each entry is recorded in accordance with existing guidelines and we also double-check to avoid errors (O.H., 08/19/24)."

"Yes there is, it is seen from resume dispansi all , there is diagnosis diagnosis diagnosis end there is the name of the doctor are treats, what medicines are under (O.H., 08/19/24)."

"Well, every month, we definitely check the patient's status, whether the status is there and if the status is not there, we will look for which room, but it has been lost in the hospital, but if it is recorded medically, it has never been lost, and there are also those who have been admitted but forgot to give them home. that's why we created a loan book with status O.H., 08/19/24)."

"There we have SOP, every status entered recorded medical must be checked especially first and must , if is not complete must be given home , after status we see on SIMRS if is not verified will be confirmed (O.H., 08/19/24)"

I3*: "Well, the detailed recording of diagnosis and treatment in the medical record is done carefully to ensure that no important information is missed. Every aspect of patient care is clearly recorded, including changes in diagnosis or medical procedures, to ensure all necessary data is available to the medical team. They believe that complete and timely documentation is critical to supporting clinical decision making and ensuring optimal quality of care for patients (N.C.H., 08/21/24)."*

"By supervising the entire documentation process and ensuring that nurses and doctors follow established procedures. We also routinely monitor and conduct audits to ensure that all medical procedures and changes in patient conditions are properly recorded (N.C.H., 08/21/24)."

"Yes, there is a standard format used to record medical data which aims to maintain consistency and clarity. The Head of the Room ensures that all staff follow the established format and guidelines, which include categories such as diagnosis, medical procedures, and changes in the patient's condition, and monitors to ensure compliance with the format (N.C.H., 08/21/24)."

"Lost or incomplete documents are handled promptly through reporting and recovery procedures. I always ensure that staff report deficiencies or missing documents, and then take steps to complete them, such as requesting copies from the relevant parties or contacting other departments to obtain the required data. This process also involves noting deficiencies in the system for audit and monitoring (N.C.H., 08/21/24)."

"Yes, there are procedures to check and audit medical documentation periodically. The Head of Room ensures

that regular audits are carried out to check compliance with documentation standards. This process involves a random review of medical records and verification that documentation meets established guidelines. Audit results are used to provide feedback and make improvements if necessary (N.C.H., 08/21/24)."

I 4 : " *Yes there is , each detail regarding diagnosis and patient is recorded with complete and clear in medical record . They ensure that each step patient , includes changes in diagnosis or plan patient , documented in detail . This is done to ensure completeness information and guarantee quality patient care (N.S.S. ,08/19/24)."*

"Yes, we ensure that every medical action and change in the patient's condition is recorded directly and in detail in the medical record. We also report and document any changes that occur during patient care (N.S.S.,08/19/24)."

"There is, clear use of standard formats in day-to-day record-keeping to ensure that all data is recorded in a uniform and clear manner. This includes details such as date , time , and description medical team or change conditions , which facilitate understanding and accessibility information by the entire medical team (N.S.S. ,08/19/24)."

"Well, If finds such that are missing or is not complete , the nurse immediately reports the documents to superior or head room . We then work together with team to get such that are missing or fill data is not complete . All attempts to correct or complete such documents are recorded with details in medical records to ensure accuracy and transparency information that has (N.S.S.,08/19/24) ."

"Nurses engage in this process by adhering to established documentation procedures and excelling in audits when necessary. They follow applicable guidelines and are ready to provide clarification or complete documentation when an audit is conducted. This process helps ensure that all medical records remain in compliance with applicable standards (N.S.S., 08/19/24)"

I 5 : *" Obviously once , diagnosis that the first here there 3x change diagnosed why sometimes error because often canceled or status the patient respectively appears even though the patient has been discharged so must be replaced diagnosed (H.H., 08/21/24)."*

"Here, our official rule is that the first duty is morning, noon and evening, so any medical procedures for documentation that are carried out will be documented correctly in every department (H.H., 08/21/24)."

" Yes, that standard is clear , if standard here standard specifically that discipline time is point don't let make is is missed if is missed later confirmed with karu if not can go directly to the underwriter answer and forward to above and don't let make mistakes (H.H., 08/21/24)."

"Here there have been 2 incidents where patients were accidentally deleted for recording and went through a long process and had to go to IT to return the patient and had to report it to BPJS (H.H., 21/08/24)."

" Here to standards procedures actually there , but here more we to pawas direct which ensures every action whether it record meds or also work always in supervision always come to check continue problems standards recording already done already as per maybe forgot maybe there but

if missed maybe already as per (H.H., 08/21/24).”

DISCUSSION

1. Identify Patient

Identification of the in section medical records in Bhayangkara Hospital TK IV Gorontalo is stage beginning in management medical records , which begins to process collecting data identity the patient includes name complete , number identity , and information contact . So that information patient collects becomes the basis for ensuring that medical records patient issued and administered are appropriate and correspond to the patient concerned .

This identification process requires filling out a registration form which includes the patient's personal data as well as verification via official identity documents such as KTP or SIM. This data is entered into the hospital's medical record system, both in digital and physical form. The accuracy of identification data is very important, especially in cases of traffic accidents, where the patient may not be able to provide information directly or in an emergency.

The above activities can be supported by the theory in previous research that a comprehensive identification process, including collecting identity data and verification through official documents, is very important to ensure the accuracy of medical data, avoid errors, and improve the quality of care, especially in emergency situations such as traffic accidents. This research supports the importance of systematic steps in patient identification to maintain the integrity and consistency of managed medical information. Smith et al. (2021)

Jones et al. (2018) emphasized that comprehensive patient identity verification helps avoid medical errors caused by erroneous or incomplete data. Accurate identity data also minimizes the risk of mistreatment in the emergency department.

A study by Patel and Hughes (2020) observed that integration of digital medical record systems made the patient identification process easier. However, they note that reliance on digital systems alone can be risky in the event of technology failure, requiring supporting protocols.

From a regulatory perspective, O'Brien (2021) emphasizes that official document requirements for patient identification are key in ensuring the validity of patient data. However, in emergency situations, flexibility in verification methods is also needed so as not to hamper the handling process.

Larson et al. (2019) examine the importance of correct identification as part of a patient's right to receive appropriate care. They stated that errors in identification could harm patients legally and ethically, and impact patient trust in hospitals.

2. Report Important

Important reports in medical records for traffic accident cases include physical examination results, initial diagnosis, radiology reports, and treatment notes. At Bhayangkara TK IV Gorontalo Hospital, documentation of this report must be carried out carefully to ensure that all medical aspects of the patient are recorded properly. The steps taken include:

a. Recording Results Physical Examination
   1) Once the patient is admitted, a thorough physical examination must be carried out by a doctor or trained medical personnel. This includes examining the injured area as well as body systems that may have been affected by the accident.
   2) Data from the physical examination is entered into a medical form that includes findings such as external (wounds, bruises) and internal (swelling, pain) injuries.

b. Preparation of Initial diagnosis

1) Based on the results of the physical examination and other clinical data, the doctor makes an initial diagnosis which includes the medical conditions suspected to be experienced by the traffic accident patient.
2) The initial diagnosis must be recorded in the medical record by including the diagnosis code according to the international classification system (eg ICD-10). An explanation of possible complications and follow-up plans should also be included.

c. Filing Reports Radiology
1) Examinations such as x-rays , CT scans, or MRI are performed according to clinical indications to evaluate injury more more.
2) Radiological examination results should be prepared and included in the medical record, with details of findings such as fracture location, tumor size, or presence of hematoma. This report should include the radiologist's interpretation and treatment recommendations

d. Notes Treatment and Medical Actions
1) Any medical procedure , including of administration of drug , installing infusion , or procedure surgery , should be recorded with details . This information includes name of drug , dose , time of administration , and response patient to treatment.
2) Daily or as needed updates on the patient's progress and possible side effects should be included in the treatment record to monitor response to treatment.

Finally, in treatment and medical action records, detailed recording of medical actions supports real-time evaluation of patient progress (Gonzalez and Roberts, 2021). The study by Patel et al. (2022) also emphasize the importance of daily records in assessing the effectiveness of treatment, allowing for adaptation according to the patient's response. Simultaneous manual and digital archiving was considered beneficial by Nakamura et al. (2023) because it supports fast access and flexibility, but cross-verification is needed to avoid data inconsistencies. The legal aspect is also important here, according to Young and Kim (2021), because accurate documentation helps hospitals in compliance with legal standards.

3. Authentication

Authentication is very useful to ensure that every note in a patient's medical record, especially in cases of traffic accidents, has been verified and authenticated by authorized medical personnel. Authentication in the medical records section at Bhayangkara TK 4 Gorontalo Hospital can ensure that every medical record, including the results of physical examinations, initial diagnoses, and medical actions in cases of traffic accidents, has been verified and authorized by the doctor or nurse in charge.

This authentication process allows the hospital to guarantee that the information recorded is accurate, valid, and comes from a reliable source. This is especially important in emergency situations such as traffic accidents, where medical decisions are rapid.

Apart from that, authentication has a role in legal protection for medical personnel and hospitals. According to Brown et al. (2022), the authentication process functions as proof that medical procedures are carried out according to standards. Digital authentication, such as electronic signatures, is also recognized by Patel et al. (2023) as a solution to maintain security and reduce the risk of data manipulation, so that medical information can be fully trusted.

Authentication not only ensures the validity of records, but also supports collaboration between medical personnel.

Wilson and Garcia (2020) stated that authentication allows medical teams to work with validated data, increasing efficiency and consistency in patient care. Moreover, authentication ensures that data follows applicable medical standards, as mentioned by Adams and Carter (2023), thereby helping to maintain the quality and integrity of information.

4. Correct documentation

Correct documentation in medical records is essential to ensure the accuracy and reliability of information, especially in emergency cases such as traffic accidents. First, completeness of records, including examination results, diagnoses, and medical procedures, supports continuity and quality of care (Johnson et al., 2019; Brown & Lee, 2021). Second, proper correction of incorrect entries avoids misunderstandings and maintains data integrity (Adams & Roberts, 2021; Thomas et al., 2023). Third, daily or periodic records consistently monitor patient progress, ensuring a more precise and comprehensive treatment plan (Wilson & Smith, 2022; Garcia & Brown, 2020).

CONCLUSION

Based on the results of research and discussions obtained from observations, in-depth interviews, and documentation, researchers can identify deficiencies in the completeness of medical records for traffic accident patients in the medical records section of Bhayangkara TK IV Hospital, Gorontalo, which are still incomplete and still have deficiencies or need improvement. in terms of completeness of medical records, especially in certain aspects such as identification of patient data, important reports, authentication and correct documentation. These deficiencies can include incomplete data on the medical record form, absence of a medical officer's signature, or lack of documentation in accordance with established standards from which the following conclusions can be drawn:

1. Identification Patient Data

   Recording patient identity , including full name , date of birth , type gender , and address , done with thorough and in accordance with official documents such as KTP or BPJS.

2. Report Important

   While recording important reports such as laboratory and radiology results generally goes well with the help of SIMRS, there are several shortcomings encountered, one of the shortcomings is that there are reports that still have to be recorded manually, especially for patients who are members of the National Police, which can result in delays and the risk of errors. Additionally, multi-layered verification processes often burden staff, while slow communication with third parties can cause delays in record-keeping.

3. Authentication

   Every entry in a medical record requires a signature or authentication, either physical or digital. Even though there are strict procedures, several challenges remain, such as errors in initial data entry that require re-verification, and problems in SIMRS system integration that are not yet fully optimal.

4. Correct documentation

   Documentation of medical records at the Bhayangkara TK IV Gorontalo Hospital has been carried out completely and according to procedures, even though there are challenges related to time constraints, busy schedules and technical incidents. However, there are shortcomings in terms of inconsistent audit frequency and the risk of technical errors, so it is recommended to increase audit frequency, regular training, and improve IT systems to minimize errors and ensure all patient data is recorded correctly.

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