ANALYSIS OF MEDICAL RECORD RECORDING OF MEDICAL INTENSIVE PATIENTS MIDWIFE HASRI AINUN HABIBIE HOSPITAL IN 2020

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ABSTRACT

The aims of this study were: 1) to analyze the medical records of inpatient obstetrics at Hasri Ainin Habibie Hospital; 2) find out what factors affect the recording of medical records at the Hasri Ainun Habibie Hospital.

This study uses a descriptive qualitative approach. Primary data obtained through interviews. Data processing techniques in this study are qualitative data analysis techniques, by doing data reduction, data presentation and conclusions and verification. Testing the validity of the data is done by triangulation of sources.

The results showed that: 1) the absence of medical physical examination items in the monthly report notes of midwifery inpatient medical records at the Hasri Ainun Habibie Hospital; 2) there are still medical record data that are not filled in on time according to the standards of the Minister of Health; 3) there are several medical record documents that are still often returned from the medical record installation to the midwifery inpatient medical record administration room; 4) medical record administration staff are still chasing doctors to fill in the completeness of medical records that have been returned from the medical record installation; 5) there are still medical record documents that have not been fully covered in the monthly report; 6) medical record coordinator is not qualified from medical record; 7) Of the 27 medical record personnel only 2 qualified from medical records; 8) there are still medical records personnel with educational qualifications from high school; 9) the absence of STR on medical record personnel; 10) medical record facilities and infrastructure at Hasri Ainun Habibie hospital are not yet complete; 11) Lack of socialization regarding the SOP for medical resumes.

Keywords: medical record recording, midwifery hospitalization

INTRODUCTION

Hospitals have an obligation to provide safe, quality, anti-discriminatory, and effective health services by prioritizing the interests of patients in accordance with hospital service standards [14].

A hospital is a professional health care institution whose services are provided by doctors, nurses and other health professionals. In hospital services, it involves various functions of service, education, and research and covers various levels and types of disciplines, so

that hospitals are able to carry out professional functions both in the medical technical field and in health administration. To carry out this task, it is necessary to support the existence of auxiliary units that have specific tasks, including the media recording unit [4].

Medical Record is a file that contains notes and documents regarding patient identity, date and discharge of patient, history, physical examination, diagnosis, treatment or action, approval of action, observation notes, summary of clinical discharge, doctor's name and signature [7]. Therefore, the medical record file is a record that reflects all important information concerning the patient, becoming the basis for determining further actions in medical service efforts [7].

The legal basis for medical recorders is in the regulation of the Minister of Health of the Republic of Indonesia number 55 of 2013 concerning the implementation of medical record work [10].

The purpose of making medical records is to support the achievement of administrative order in the context of efforts to improve health services in hospitals. Without the support of a good medical record management system, while orderly administration is one of the factors that determine health service efforts in hospitals [11].

Uses of Medical Record Documents

1. Facilitate the process of data collection,
2. Speed up the service process
3. Improve data accuracy,
4. Clarify data sharing (medical, financial, administrative, and operational data), and
5. Support the information processing process [1].

For inpatients, the medical record contains patient information, including:

1. Patient identity
2. Patient admission and discharge date and time
3. History
4. Physical examination
5. Diagnosis
6. Treatment/action
7. Action approval
8. Observation notes
9. Clinical discharge summary
10. Doctor's name and signature

and the percentage of doctor's name/signature is 485 medical record files (99%). This figure is still far from the 100% completeness target which is the standard for completing hospital medical records [7].

One of the efforts to improve the quality of health service facilities is to improve the quality of medical record services including completeness, speed and accuracy in providing information for health service needs. Based on these efforts, the quality of medical record services will describe the quality of medical services in health care facilities. A good medical record reflects good medical practice while also demonstrating the effectiveness and effectiveness of patient care. Unfortunately, the achievement of completing medical records at the Midwifery Inpatient Unit of the Hasri Ainun Habibie Regional General Hospital in March - December 2020 was still around 88.7%. This figure is still far from the 100% completeness target which is the standard for completing hospital medical records [7].

And from the results of initial observations, it is known that of the 28 medical record personnel at the Hasri Ainun Habibie Hospital, there are only 2 medical record personnel who have educational qualifications from D3 Medical Records. And the doctor in charge of midwifery inpatient at RSUD Hasri Ainun Habibie only amounted to 2 people, this is not proportional to the large

number of patients in RSUD Hasri Ainun Habibie. This could be the cause of the incomplete recording of medical records in the midwifery inpatient room at the Hasri Ainun Habibie Regional General Hospital in 2020.

Basically, medical records are an important part of health services in hospitals. A doctor is required to work professionally so that he is able to provide good health services and in accordance with doctor competency standards. One of the obligations that must be carried out by a doctor is to make a patient's medical record which functions as a record or documentation tool and a means to guarantee health services and has a very important role in health information to be used in making a decision. In fact, in the daily practice of medicine, the main problems and obstacles faced in the administration of medical records are doctors, and other health workers underestimate the matter of medical records because they have not been in a legal case and reasoned that they do not have enough time to fill out medical records. As a result, many of them make incomplete medical records. It will have a bad impact because it causes problems in the future when the doctor or health worker is caught in a legal case due to negligence and procedural errors that harm the patient. A doctor is required to work professionally so that he is able to provide good health services and in accordance with the competency standards of doctors.

RESEARCH METHODS

This study uses a qualitative approach with a qualitative descriptive type of research. Primary data were obtained through notes from interviews, results from field observations and documents regarding informants. Data collection techniques are through interviews, observations, and documentation to the hospital director, medical record coordinator, medical record staff, person in charge of midwifery inpatient medical records, and midwifery inpatient administration staff at Hasri Ainun Habibie Hospital. Data processing techniques in this study are qualitative data analysis techniques, by performing data reduction, data presentation, conclusions and verification. Testing the validity of the data is done by triangulation of sources.

RESULTS AND DISCUSSION

The completeness of the recording of the record file cannot be separated from the support of the management in order to create a complete medical record in accordance with the Regulation of the Minister of Health of the Republic of Indonesia No: 269/Per/Menkes/III/2008. Doctors are required to fill out a medical record immediately after completion of the action at least containing the identity, date and time of admission, history taking, physical examination, diagnosis, management plan, treatment/action, approval of action, observation notes, discharge summary as well as the name and signature of the doctor providing health services[7]. Based on this, the treatment/action item is an item that must be filled in the medical record file so that the doctor must fill in the item completely. Every doctor in carrying out medical practice is required to make a medical record so that it can avoid or minimize the risk of malpractice on the actions and administration of treatment therapy in the future by the patient, the doctor has prioritized the recording of medical records as complete and accurate written evidence[13]. While the target for completeness of filling out medical records must be 100% complete, this is a standard for completeness of filling out hospital medical records [6]. Therefore, the medical record becomes a very

important part to be filled in and is very useful for the hospital documentation section This is a standard for completing hospital medical records [6]. Therefore, the medical record becomes a very important part to be filled in and is very useful for the hospital documentation section This is a standard for completing hospital medical records[6]. Therefore, the medical record becomes a very important part to be filled in and is very useful for the hospital documentation section

Based on the results of the study, the average percentage was 88.7% completely filled and 21.3% incompletely filled with the percentage of identity records that were completed as many as 488 medical record files (100%) the percentage of incoming time that was completed was 482 medical record files (98.8%) Percentage of completeness of Anamnesis recording as many as 485 medical record files (99.3%) which were completed by a doctor, physical examination column which was not recorded, the percentage of Diagnosis 488 complete medical record files (100%), Treatment/Action 484 complete medical record files as many as (99.2%), Completely completed action approval as many as 473 medical record files (96.9%), observation notes 449 medical record files (92%), discharge summary there is no data column for filling in the discharge summary,and the percentage of doctor's name/signature is 485 medical record files (99%).

Medical record recording

1. **Patient identity**

   After conducting interviews regarding the results of incomplete recording of patient identities. Through interviews with informants, it can be seen that doctors, midwives, and midwifery inpatient administration staff fill in the patient's identity, because patient identity is a very important document, and can be used to distinguish patient 1 from another. other patients, so as to facilitate or facilitate the provision of health services. And from observations it was found that it was true that the patient identity column of the medical record was completely filled, and the most frequent filling in the patient identity column was the midwife or nurse in the administration section. This statement is in accordance with the statements given by key informants and additional informants.

2. **Patient Admission Date and time**

   Through interviews conducted at the Hasri Ainun Habibie Hospital, the complete entry date for inpatients is because nurses and officers at the inpatient registration section always enter the date column correctly so that the date of admission can be filled in. And from observations it was found that it was true that the patient identity column of the medical record was completely filled, and the most frequent filling in the patient identity column was the midwife or nurse in the administration section. This statement is in accordance with the statement given by the informant. And this is in accordance with the existing medical record in 2020 which shows the time and date of entry/exit of the patient is 100% complete.

3. **History**

   After conducting interviews and observations regarding the incomplete results of the history taking in the medical record, it was stated that the doctor always filled out the patient's anamnesis record and was assisted by the midwife, unless the patient was an emergency, the doctor might forget to fill it in, or by asking his family directly. And for anamnesis records that are not completely filled in in the monthly medical record report in 2020,

it is caused by staff who forget or are not careful in filling out anamnesis records. In this case, it is in accordance with the anamnesis data which shows that there is a column in the anamnase file of hospitalized patients that is completely filled in as much as 99.3%. History of inpatients must be done, because patient history is health information needed to carry out health service actions provided to patients. The main purpose of anamnase data is to provide complementary materials for doctors to obtain a diagnosis that forms the basis for treatment of a patient. Anamnesis is useful when a laboratory or x-ray examination is needed to be performed on the patient so that the correct diagnosis can be established. With a complete history of inpatients, it makes it easier for doctors to provide treatment and care [3].

4. **Physical examination**

After conducting interviews and observations related to the incomplete results of filling out the physical examination, it was concluded that doctors always filled out physical examination records but only in important parts, this was due to the limited time of doctors and high workload. This shows that the physical examination was carried out by a doctor, but only in the important parts, only in the monthly reporting of the medical records of Ainun Habibie Hospital which did not input the monthly report. This is due to the lack of knowledge of medical record personnel in filling out the completeness of medical record recording items and inputting is done based on the previously existing format. physical examination data on patients and the inaccuracy of medical record personnel in filling out physical examination items. If this report is not filled out completely then there will be no treatment and further action. This objective physical examination information must be available in the patient's medical record within 24 hours of being registered as a patient. Without a physical examination, no action can be taken. It is important that this report is filled in completely because this report is necessary to determine the course of the disease and to determine further diagnoses.

5. **Diagnosis**

After interviews and observations related to the results of incomplete filling of diagnostic items in the medical record file, it was found that doctors and midwives always filled out the diagnosis column in the patient's medical record, this was in accordance with the results of the monthly report in the medical record of inpatients which stated the percentage of diagnoses was complete. 100%. The completeness of filling in the patient's diagnosis recording by the doctor is a must because it relates to the treatment action to be given by the patient, if the treatment given by the doctor to the patient is wrong due to an unclear or incomplete diagnosis filled in by the doctor, there will be medication errors or malpractice by the doctor. towards the patient. The completeness of this item can be useful for inputting in the ICD x for SIM (Management Information System) purposes. For example, if the diagnostic item is filled in completely, it will further facilitate services in presenting information to support health research and functions and billing if the patient is a participant in health insurance[3]. The usefulness of the diagnosis is to study previous cases of a disease, test theories, compare data about the disease in order to present scientific writings, present service data needed in a hospital capability survey, find patient medical

records where doctors only remember the diagnosis while the patient's name is forgotten, providing educational materials for medical students [2].

6. **Treatment/Action**

After interviews and observations related to the results of incomplete medical records, it is known that doctors always fill in treatment/action items immediately after giving treatment, and midwives always remind and make sure to fill in the notes/action column given. However, in the 2020 medical record monthly report, there are still incomplete entries due to the carelessness of the officers in inputting. This is in accordance with the results of existing research on treatment data/action recording of inpatient obstetric medical records. The incompleteness of filling out treatment/actions in inpatient medical records affects decision-making about therapy, action and determination of patient diagnoses.

7. **Action approval**

After conducting interviews and observing the approval of the action, it is known that the approval of the action is often done by the doctor before taking the action so that the doctor can be protected from the patient's demands if something happens in the future, but the key informant stated that there was an agreement sheet in the medical record that was not filled in because it was there is no risky action given by the doctor. This shows that there is a match between the medical record report for inpatient obstetrics and the reality at the research site. This consent sheet is an important item because the approval of this action has a medico-legal meaning and is a mandatory prerequisite in the process of giving treatment to the patient so that there are no future demands. Approval of action by the patient's family to facilitate the doctor in the treatment carried out for the patient. The importance of filling in the completeness of the action approval so that the doctor avoids legal demands if the patient experiences death, disability or other undesirable things. When viewed from its usefulness, namely ALFRED in terms of law (Legal value) which can be a proof in court if there is a claim by the patient's family against the hospital, especially for the doctor concerned.

8. **Observation notes**

After conducting interviews and observations related to the results of observation notes, it was found that doctors always filled in observation notes and were often assisted by midwives during visits, and the incompleteness of observation notes in the monthly medical record report was caused by the inaccuracy of medical record personnel in inputting monthly reports. Filling out clinical observations can be a doctor's tool for patients who are hospitalized if one day the patient returns to the hospital. The importance of filling out clinical observation records continuously so that doctors can determine whether the patient is really healthy or the patient should be hospitalized until the patient's illness begins to improve. In this case, it is necessary to have the accuracy of medical record personnel in inputting into monthly reports so that all observations can be recorded in the medical record file. Therefore, it can be concluded that clinical observation items are in line with observations made by researchers on clinical observation items that have not been filled out completely due to the inaccuracy of medical record officers in inputting data. Clinical observations of patients must be carried out

routinely while the patient is still hospitalized and all records must be signed by the doctor [2].

9. Clinical discharge summary

After conducting interviews and observations related to the incomplete results of the discharge summary notes in the monthly medical record report, it was concluded that doctors often filled out medical records returning home, but there were also certain patients who did not have time for doctors to record their return summary reports because patients were forced to return home at the time of discharge. the doctor is not in the hospital or home on Sundays or at night. The purpose of this discharge summary is to ensure continuity of high quality medical services and as a useful reference material for doctors who receive, if the patient is hospitalized, assessment materials for hospital medical staff, to meet requests from official bodies or individuals regarding treatment. a patient [2]. Discharge summary/resume should be brief and only explain important information about the disease, examinations performed and treatment, resume should be written as soon as the patient is discharged. In the medical record, the resume sheet is placed on the front to make it easier for the doctor to see if needed. The resume must be signed by the treating doctor, for patients who died, a resume was not made but a cause of death report was made. For this discharge summary, there needs to be supervision from the hospital management so that the discharge summary is filled out by the doctor on the day after the patient goes home or leaves the hospital. If this part of the return summary is not filled in,

10. Doctor's name and signature

After interviews and observations were made regarding the incomplete results of the doctor's name and signature due to the doctor's busy schedule, so that he forgot to fill it out, sometimes he just signed it while the midwife filled in the name. patient, therefore the doctor must complete the name and affix a signature in accordance with the Law on Medical Practice. The doctor's name and signature must be included in every medical record, because the doctor's name and signature are responsible for all services provided to inpatients. By clearly filling in the name and signature, it is easier for the patient to know the history of his illness. With the name and signature filled in by the doctor, it will make it easier for the hospital to respond quickly to patients if there are cases of the same disease as other patients. The name and signature section is also important to fill in because the name and signature section is useful for seeing which doctor fills out and is responsible for the patient whose medical record file is being filled out at that time and to adjust the doctor's fees to match the duties carried out by the doctor.

Factors that affect the recording of medical records

Based on the results of interviews, observations, and documentation in May-June 2021. So that the resulting factors that affect the completeness of the medical records of inpatient obstetrics at Hasri Ainun Hospital in 2020 are produced, namely:

Human Resources

1. medical record coordinator is not a medical record qualification
2. Of the 27 medical record personnel, only 2 are qualified from medical records
3. Most of the medical record personnel who are placed in the medical record are only qualifications of the Bachelor of Public Health (SKM)

4. There are still medical record personnel with educational qualifications from high school
5. There is no STR for medical record personnel, so if there is a problem in the future it is difficult to provide protection for the medical record personnel, and the hospital.
6. There are only 2 doctors in charge in the midwifery inpatient room
7. Time to complete medical records is not enough due to the busyness of doctors in providing services to patients, because inpatient obstetrics doctors also practice in polyclinics

It is recommended that medical record personnel employed at Hasri Ainun Habibie Hospital follow the Regulation of the Minister of Health of the Republic of Indonesia Number 55 of 2013 concerning the implementation of medical recorder work. namely Diploma Three graduation standards as an Associate Expert in Medical Records and Health Information, Diploma four graduation standards as a Bachelor in Applied Medical Record and Health Information, Bachelor graduation standards as a Bachelor in Medical Record and Health Information, Master graduation standards as a Master in Medical Record and Health Information. And also Medical Recorders and Health Information who have competence, as evidenced by a valid registration certificate (STR) and a Work Permit (SIK) for Medical Recorders and Health Information. So that it can create good quality medical record services and according to standards.

The time to complete medical records is not enough due to the busyness of doctors in providing services to patients, because inpatient obstetrics doctors also practice in polyclinics. This must still be reminded by the medical record officer on duty in the midwifery inpatient room, in this case the Person in Charge of Medical Records (PJRM).

The types of resources needed in the medical record and health information unit include: Medical Recorders and Health Information who have competence, as evidenced by a valid registration certificate (STR) and a Work Permit (SIK) for Medical Recorders and Health Information [12]. As for Medical recorder qualifications;

1. Diploma three graduation standards as an Associate Expert in Medical Records and Health Information
2. Graduate standard of Diploma Four as Bachelor of Applied Medical Record and Health Information
3. Graduate standard of Bachelor as Bachelor of Medical Record and Health Information
4. Master's graduation standard as a Master of Medical Records and Health Information [10].

Facilities and infrastructure

1. The medical record facilities and infrastructure at Hasri Ainun Habibie Hospital are still incomplete.
2. There is still a lack of room for medical records because the head room of the medical record installation is still integrated with the active medical record storage room, and the medical record management room.
3. Lack of medical record document storage cabinet
4. There is no meeting table in the room of the head of the medical record installation
5. A work table that is still used for two in 1 work desk.
6. Computers are also still in use for two people in 1 computer.
7. The medical record installation room that is not arranged quickly and is still messy.
8. The archive rack is still lacking

Means are anything that can be used as a tool in achieving a goal or goal. Meanwhile, infrastructure is everything that is the main support for the implementation of a process (business, development, project). These two needs cannot be separated from each other [6]. The medical record and health information unit will not produce the expected output without the support of facilities and infrastructure that meet the standards. The main functions of facilities and infrastructure basically have a goal: Creating comfort, Creating satisfaction, Speeding up work processes, Facilitating work processes, Increasing productivity, Higher quality results.

Medical Resume SOP

Hasri Ainun Habibie Hospital already has a Medical Resume SOP for inpatients, but there is no socialization regarding the SOP. The last socialization was carried out at the time of last year's accreditation. Until now, socialization of filling out medical records has not been carried out again. The socialization was carried out in a way, all related units were gathered in the meeting room to attend the SOP presentation and then the SOP was distributed to all related units. lack of socialization regarding the completeness of filling in inpatient medical records, causing the level of completeness to decrease. Based on the results and the theory, it means that the lack of socialization can affect the completeness of medical records because the last socialization was carried out last year. And if there are new doctors and nurses working after that time, it will make the doctors and nurses not know the SOP for filling out medical records, so it needs to be routine in order to reduce the number of incomplete medical records. Therefore, it is better to socialize the SOP for filling out medical records intensively to doctors and nurses, so that it can cover all doctors and nurses, both old and new workers.

Implementation of Medical Record Filling is Still Not In Accordance with SOPs. The implementation of filling out medical records by doctors/nurses is not in accordance with SOPs. In filling out medical records, it is still found the use of tip-ex and scribbles that are not affixed with initials and the date when changing them. Whereas in the SOP for filling out medical records at Hasri Ainun Hospital there is already a statement, namely, If there is a writing error, then the officer providing medical services to the patient as mentioned above is not justified in deleting in any way, but by crossing out and affixing the initials and date at the time. to change it, if there is a writing error, then the correction can only be done by crossing out without removing the corrected notes and affixed with the doctor's initials, dentist or certain health personnel concerned [7]. Based on the results of the research and theory, it was found that there was a discrepancy in the implementation of the recording with the applicable SOPs and theories. Therefore, it is better to socialize the SOP for filling out medical records to doctors and nurses intensively.

Leadership Policy

At Hasri Ainun Hospital, there are already SOPs related to filling out medical records, but there are no sanctions for health workers who do not complete medical records.

It is better to have a punishment and reward system, in order to provide motivation for related parties so that it is hoped that the filling of inpatient medical records will increase.

CONCLUSION

1. Conclusions are made on the recording of medical records which include patient identity, time and date of patient entry/exit, history taking, physical examination, diagnosis, treatment/action, approval of action,

observation notes, summary of clinical discharge, and writing of name and signature on medical resume. Midwifery inpatient hospital Hasri Ainun Habibie is said to have been good in filling out the completeness of recording medical records. However, it is better for the approval of the action if there is no risky action given, it should be filled in or given a statement that no action has been given, and for the physical examination, it should be filled in as a whole, not only the important ones, and for filling out the name and signature, it should be filled in on the same day so that no medical record is returned from the medical record installation to the midwifery inpatient administration room, and also so that the administrative personnel who are responsible for the midwifery inpatient administration are not always chasing after the doctor to complete the name and signature of the doctor in charge. And for the collection of monthly report data on the recording of medical records, it is better to add a physical examination item. And it is also better for medical record personnel who input the monthly medical record report to be more thorough in filling it out so that no medical records are accidentally left unfilled or accidentally missed. and also so that the administrative personnel who are responsible for the administration of midwifery inpatients do not always chase after the doctor to complete the name and signature of the doctor in charge. And for the collection of monthly report data on the recording of medical records, it is better to add a physical examination item. And it is also better for medical record personnel who input the monthly medical record report to be more thorough in filling it out so that no medical records are accidentally left unfilled or accidentally missed. and also so that the administrative personnel who are responsible for the administration of midwifery inpatients do not always chase after the doctor to complete the name and signature of the doctor in charge. And for the collection of monthly report data on the recording of medical records, it is better to add a physical examination item. And it is also better for medical record personnel who input the monthly medical record report to be more thorough in filling it out so that no medical records are accidentally left unfilled or accidentally missed.

2. Factors that affect the recording of medical records
   a. HR Factor
      1) The medical record coordinator is not a medical record qualification, this is not in accordance with the regulation of the Minister of Health of the Republic of Indonesia number 55 of 2013 concerning the implementation of medical record work.
      2) Of the 27 medical record personnel, only 2 qualified from medical records, this is not in accordance with the general provisions of Article 1 of the regulation of the Minister of Health of the Republic of Indonesia number 55 of 2013 concerning the implementation of medical record work.
      3) Most medical record personnel who are placed in medical records are only qualifications of Bachelor of Public Health (SKM).
      4) There are still medical record personnel whose educational qualifications are from high

school, this is not in accordance with the general provisions of Article 3 of the Regulation of the Minister of Health of the Republic of Indonesia Number 55 of 2013 concerning the Implementation of Medical Recording Jobs.

5) There is no STR for medical record personnel, so if there is a problem in the future it is difficult to provide protection for the medical record personnel, and the hospital. this is not in accordance with the regulation of the minister of health of the republic of Indonesia number 55 of 2013 regarding the implementation of medical recorder work in article 4 licensing regarding the STR of medical recorders.
6) Time to complete medical records is not enough due to the busyness of doctors in providing services to patients, because inpatient obstetrics doctors also practice in polyclinics
7) There are still medical record data that are not filled in on time according to the standards of the Minister of Health at the time the researchers conducted this study.
8) There are several medical record documents that are still often returned from the medical record installation to the midwifery inpatient medical record administration room regarding the completeness of filling out medical record documents.
9) Medical record administrative personnel are still chasing doctors to fill in the completeness of medical records that have been returned by the medical record installation.
10) there are still medical record documents that are not fully covered in the monthly report.
11) Doctors feel that time is very limited to complete medical records and doctors are busy with a large number of patients.

b. Facilities and infrastructure
   1) The medical record facilities and infrastructure at the Hasri Ainun Habibie hospital are not yet complete.
   2) There is still a lack of room for medical records because the head room of the medical record installation is still integrated with the active medical record storage room, and the medical record management room
   3) lack of medical record document storage cabinet
   4) There is no meeting table in the room of the head of the medical record installation
   5) A work table that is still used for two in 1 work desk.
   6) Computers are also still in use for two people in 1 computer.
   7) The medical record installation room that is not arranged quickly and is still messy.
   8) The archive rack is still lacking

c. Medical Resume SOP

   Hasri Ainun Habibie Hospital has a standard SOP for admitting inpatients in 2018

   1) Lack of socialization regarding medical resume SOPs
   2) Medical official SOPs are only displayed in the medical record installation room and registration room only and are not reproduced and displayed in each inpatient room.
   3) There are still many medical record staff who do not know the flow of the existing medical resume SOP.

d. Leadership Policy
   1) There has not been a sanction for administrative staff who do not fill out a medical resume in a timely manner
   2) Still employing medical record personnel who are not qualified from the medical record

The recording of the medical record should be on the item of approval of the action if there is no risky action given, it should be filled in or given a statement that no action has been given, and for the physical examination, it should be filled in as a whole, not just the important ones, and for filling in the name and signature, it should be filled in on the same day so that no medical record is returned from the medical record installation to the midwifery inpatient administration room, and also so that the administrative staff responsible for the midwifery inpatient administration does not always pursue – Chasing the doctor to complete the name and signature of the doctor in charge. And for the collection of monthly report data on the recording of medical records, it is better to add a physical examination item.

We recommend that the medical record personnel who are placed in the medical record section are qualified people from medical record education to comply with the regulations of the Minister of Health of the Republic of Indonesia number 55 of 2013 concerning the implementation of medical record work. And it is expected to complete medical record facilities and infrastructure in the form of additional room for the Head of the Medical Record Installation which includes a work desk, meeting table, chairs, computers, printers, filing cabinets, air conditioning (AC/fan), office stationery, tools communication, and also in active and inactive medical record storage rooms in which there are mobile/static medical record storage racks, work desks, chairs, computers, printers, air conditioning (AC/fan/exhaust fan), office stationery, tools communication, fire extinguisher, PPE (mask, handrub), Outguide/tracer

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