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# Proceeding

STIKes BTH

## THE 1ST INTERNATIONAL SEMINAR OF HEALTH SCIENCES
## BAKTI TUNAS HUSADA HEALTH SCIENCE COLLEGE

"Strengthen Collaboration in Health Sciences for Supporting Sustainable Development Goals".

Saturday, April 22nd, 2017

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**Bakti Tunas Husada Health Science College**

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# FOREWORD

The 1st International Seminar of Health Science 2017 (ISHS 2017) is organized and hosted by Bakti Tunas Husada Health Science College and collaboration with another college and university.

The 1st ISHS 2017 theme this year is "Strengthen Collaboration in Health Sciences for Supporting Sustainable Development Goals". The seminar will cover a breath subjects including: Nursing, Pharmacy, Medical Laboratory Technology, Midwifery, Public Health and Other relevant sciences with Health. The objectives of this seminar are to disseminate the recent advancement in health sciences and to strengthen the network and collaboration among lecturers, researchers and institutions.

I would like to use this opportunity to express our sincere gratitude to keynote speaker (Dr. Parlis, Prof. Habibah, Prof. Hamidah, Dr. Ratana and Dr Ummy Mardiana) for coming and sharing their knowledge with us and all delegates for their contributed talks. My sincere gratitude also goes to Bakti Tunas Husada Health Science college and The Foundation of Bakti Tunas Husada in particularly. I would like to thank the collaboration organizing team from Madani Health Science College Yogyakarta, Buana Perjuangan University Karawang, Muhammadiyah University Tasikmalaya, Mitra Kencana Health Science College Tasikmalaya, Muhammadiyah University Tasikmalaya, Paguwarmas Health Science College Cilacap and Serulingmas Nursing Academy Cilacap as well as all members of the scientific committee, for their hard work.

The editorial team has made some editing and correction needed in some cases. Most of the editing correction are conducted and concentrated in the organization of the paper based on the guideline and the language. Some figures and tables were corrected, and placed accordingly. In addition, the language is the most time-consuming work; hence on behalf of the committee we apologize for the late publishing of this book and for any inconvenience as a result of the delay.

We give our gratitude to the reviewing and editing team for their hard work and for making the publication of this proceeding happen. We again thank all participants and presenters for the kindness to be part of the 1st ISHS 2017. We hope the readers of this book could gain new knowledge, information, and idea for a research and further research collaboration, particularly in the topics or subjects related to basic sciences.

Warms regards,

**Dr. Ruswanto, M.Si.**
Chairman of ISHS 2017

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# Evaluation of minimum service standards hospital of medical record service types in dr. Soekardjo General Hospital Tasikmalaya

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**Abstract.** The type of medical record service based on a minimum service standard hospital has four indicators such as completeness of medical records 24 hours after finishing of service is 100%, completeness of informed consent form after receiving clear information is 100%, time provision of medical records outpatient services with standard time ≤ 10 minutes and the provision of inpatient medical records to standard time ≤ 15 minutes. Results of a preliminary study on January 29 2016, the most cases surgery is biopsy/extirpation. The highest incompleteness is in the recording, 100% incomplete. The purpose of this study is to evaluate the implementation of the Minimum Service Standards Hospital medical record service types. This study uses a sequential mixed method. Samples were taken using total sampling technique number of 59 documents. Subjects selected by purposive sampling. The instruments used are as interview guides and observation sheet. The data collection is done by observation, in-depth interviews and Focus Group Discussion. The results showed a provision of time is ± 4 minutes, completeness of medical record documents 24 hours after the servicing consist of the completeness of patient identity (highest item name are57.63%), Review of the Important Report (the highest of action items are76.27%), Filling authentication (highest item signature of doctor/nurse are 62.71%) and a good documentation (highest item clearly readable recording are 30.51%). Filling informed consent form is not yet complete. The hospital already implementing evaluation of the minimum service standards but for completeness of medical record document has not been a priority.

**Keywords**: completeness, medical records, minimum service standards.

## INTRODUCTION

Minimum service standards are the provisions on the type and quality of basic services which are minimally entitled to be obtained by every citizen and this is also the obligatory affairs of the regions. Besides that, minimum service standards are also a technical specification of the benchmark of minimum service provided by the General Services Agency to the public. Minimum service standards for hospital refer to the Decree of Minister of Health of Indonesia Republic No. 129/ Menkes/SK/II/2008 about Minimum Service Standard of Hospital. There are 21 minimum services that must be provided by hospital, one of them is medical record service. Medical records document (MRD) has an important role in health care. Data in the form of information MRD health help doctors and other health professionals to determine the circumstances of the patients, the results of the examination and treatment before, and communication media for health workers who care for patients that will help further intervention. Records of care in MRD can be used to calculate the financing. In addition, the MRD can be used for education and research as well as having a legal function.

The type of medical record service based on a minimum service standard hospital has four indicators such as completeness of medical records 24 hours after finishing of service are 100%, completeness of informed consent after receiving clear information are 100%, time provision of MRD outpatient services with standard time ≤ 10 minutes and the provision of inpatient medical records to standard time ≤ 15 minutes.

The implementation of medical records in a health care institution is one of the important indicator of regarding the quality of service at the institution. Medical record service quality has an impact on patients satisfaction or dissatisfaction with the services received (Nongki, 2011 in Sudrajat & Sugiarti, 2015).

Cancer is one of the main causes of death worldwide. One medical procedure that has been done for the management of cancer is surgical extirpation. Extirpation surgery is removal the entire tumor mass along with the capsule surgery. Data from Medical Records Unit of the Hospital Dr. Soekardjo Tasikmalaya showed higher rates of biopsy each month that shows the number of cases of cancer in various organs. Results of a preliminary study on January 29 2016, the most cases surgery is biopsy/extirpation. The number of cases in the period of January-December 2015 amounted to 521. The results of the analysis of the completeness of surgical cases in the fourth quarterly in 2015, the highest incompleteness is in the recording, 100% incomplete. While MRD inpatients in 2015, the highest numbers in the incompleteness of the informed consent form.

The purpose of this study was to evaluate the implementation of the Decree of the Minister of Health No. 129 of 2008 on the medical records of the type of service Minimum Standards of Hospital Services

## MATERIALS AND METHODS

### Study area

*Type and design research*

This research uses Mixed Method, a method that combines qualitative and quantitative approaches, and uses sequential strategy mix method with sequential explanatory strategy of collecting and analyzing quantitative data followed by collecting and analyzing qualitative data.

*Place and Time Research*

Research conducted at the Outpatient Registration Place (TPPRJ), Room Installation Medical Record, Filing Room, Operation Room, as well as meeting room of Sutsen Resto. Time of research is on August until October 2016.

*Population, Sample and Research Subjects*

Population of this study is MRD inpatient cases biopsy surgery on August until October 2016. Samples were taken by using total sampling technique amounted to 59 of biopsy/extirpation cases. The subject of research with a qualitative approach chosen by purposive sampling, that the head of the installation of the record and the attendant medical record registration section of hospitalization, a leadership element (physician / Head of Service), the head of the Room Operation, the head nurse operating room, the head of the installation of medical records clerk medical record registration section of hospitalization.

*Instruments and Data Collection Method*

Instruments that used are as interview guides and observation sheet. The data collection is done by observation and conduct in-depth interviews and Focus Group Discussion.

### Procedures

- Identify cases of biopsy / extirpation in the general surgery department
- Identify patients with biopsy / extirpation cases in the registration of inpatients (TPPRI)
- Observe inpatient service time for the case of biopsy / extirpation
- Observe the completeness of the entire MRD case Biopsy / extirpation August-October 2016
- Conducting in-depth interviews.
- FGD

### Data Analysis

Quantitative data analysis performed in this study to the sub variables include patient identification, important reports, authentication and registration. In-depth interviews and focus group discussions are intended to strengthen or clarify the quantitative data as well as to obtain additional important information. After analyzing the data with all data collected from in-depth interviews and focus group then conducted the categorization according to theme (thematic analysis).

## RESULTS AND DISCUSSION

**The average speed of ensuring provision of inpatient medical record**

Time provision ± 4 minutes / have fulfilled SPM inpatient (≤ 15 min).

**Completeness of filling the medical record 24 hours after services**

Review of the Patient Identity

**Table 1. The Analysis of Completeness Filing Identification**

| No. | Patient identification | Complete | | Incomplete | | Total |
|---|---|---|---|---|---|---|
| | | F | % | f | % | |
| 1. | Name | 34 | 57,63 | 25 | 42,37 | 59 |
| 2. | Age | 26 | 44,07 | 33 | 55,93 | 59 |
| 3. | Sex | 19 | 32,20 | 40 | 67,80 | 59 |

Review of the Important Report

**Table 2. The Analysis of Completeness Important Report**

| No. | patient identification | Complete | | Incomplete | | Total |
|---|---|---|---|---|---|---|
| | | F | % | F | % | |
| 1. | Act | 45 | 76,27 | 14 | 23,73 | 59 |
| 2. | Time | 29 | 49,15 | 30 | 50,85 | 59 |
| 3. | Date | 8 | 13,56 | 51 | 86,44 | 59 |
| 4. | Types and | 6 | 10,17 | 53 | 89,83 | 59 |
| 5. | Information | 2 | 3,39 | 57 | 96,61 | 59 |
| 6. | Signing √ | 1 | 1,69 | 58 | 98,31 | 59 |
| 7. | Giver Information Recipient Information | 30 | 50,85 | 29 | 49,15 | 59 |

Filling of completeness authentication

**Table 3. The Analysis of Filling completeness authentication**

| No. | Authentication | Complete | | Incomplete | | Total |
|---|---|---|---|---|---|---|
| | | F | % | F | % | |
| 1. | Name of doctor/nurse | 12 | 20,34 | 47 | 79,66 | 59 |
| 2. | Sign of doctor/nurse | 37 | 62,71 | 22 | 37,29 | 59 |
| 3. | Patient Name | 32 | 54,24 | 27 | 45,76 | 59 |
| 4. | Sign of Patient | 5 | 8,47 | 54 | 91,53 | 59 |
| 5. | Witness Name | 20 | 33,90 | 39 | 66,10 | 59 |
| 6. | Sign of Witness | 22 | 37,29 | 37 | 62,71 | 59 |
| 7. | Hospital's Witness Name | 6 | 10,17 | 53 | 89,83 | 59 |
| 8. | Sign of Hospital's Witness Name | 8 | 13,56 | 51 | 86,44 | 59 |

Filling of completeness of the Good Documentation

**Table 4. The Analysis of Filling of completeness of the Good Documentation**

| No. | Good Documentation | Complete | | Incomplete | | Total |
|---|---|---|---|---|---|---|
| | | F | % | f | % | |
| 1. | Date | - | - | 59 | 100 | 59 |
| 2. | Recording Clearly Legible | 18 | 30,51 | 41 | 69,49 | 59 |
| 3. | The use of fixed lines | 5 | 8,47 | 54 | 91,53 | 59 |

**Completeness of the Informed Consent Form Filling in the District General Hospital dr. Soekardjo Tasikmalaya**

Review of the Patient Identity

**Table 5. Completeness of Filling Patient Identity**

| No. | Patients Identity | Complete | | Incomplete | |
|---|---|---|---|---|---|
| | | F | % | f | % |
| 1. | Name | 59 | 100 | 0 | 0 |
| 2. | Age | 56 | 95 | 3 | 5 |
| 3. | Sex | 53 | 90 | 6 | 10 |

Review of the Important Report

**Table 6. Completeness of Filling Important Report**

| No. | Important Report | Complete | | Incomplete | |
|---|---|---|---|---|---|
| | | F | % | f | % |
| 1. | Act | 59 | 100 | 0 | 0 |
| 2. | Time | 59 | 100 | 0 | 0 |
| 3. | Date | 46 | 78 | 13 | 22 |
| 4. | Types and Information | 58 | 98 | 1 | 2 |
| 5. | Signing √ | 57 | 97 | 2 | 3 |

| | | | | | |
|---|---|---|---|---|---|
| 6. | Information provider | 58 | 98 | 1 | 2 |
| 7. | Recipient Information | 59 | 100 | 0 | 0 |

Review authentication

**Table 7. Filling completeness authentication**

| No. | Authentication | Complete | | Incomplete | |
|---|---|---|---|---|---|
| | | F | % | f | % |
| 1. | Name of doctor/nurse | 54 | 92 | 5 | 8 |
| 2. | Sign of doctor/nurse | 59 | 100 | 0 | 0 |
| 3. | Patient Name | 57 | 97 | 2 | 3 |
| 4. | Sign of Patient | 28 | 47 | 31 | 53 |
| 5. | Witness Name | 53 | 90 | 6 | 10 |
| 6. | Sign of Witness | 55 | 93 | 4 | 7 |
| 7. | Hospital's Witness Name | 27 | 46 | 32 | 54 |
| | Sign of Hospital's Witness Name | 25 | 42 | 34 | 58 |

The Good Documentation

**Table 8. Filling Completeness of the Documentation**

| No. | Good Documentation | Complete | | Incomplete | |
|---|---|---|---|---|---|
| | | F | % | f | % |
| 1. | Date | 46 | 78 | 13 | 22 |
| 2. | Recording Clearly Legible | 59 | 100 | 0 | 0 |
| 3. | Fixed line usage | 59 | 100 | 0 | 0 |

**Result of In depth Interview and Focus Group Discussion**

*Theme 1 : Inpatient registration services*

- The Groove of Inpatient Registration. Registration inpatients done at the registration window inpatients. Originally a patient from the clinic if the patient's condition is healthy / not in an emergency.
- The obstacles of registration Inpatient Surgery Cases. Does not carry requirements, such as family card, the number of patient visits are not comparable with the only one officer handling. job description of the officer has not specific yet.

*Theme 2 : Provisioning of Status MRD Patients*

- As a minimum service standards, maximum time of provision new patient MRD is 10 minutes
- Provision of MRD Inpatient old patient status, the providing activities MRD to be submitted to the poly can be more than 15 minutes

*Theme 3 : The Groove of Clinical Services Patient.*

The groove of clinical service inpatient cases of B/E is patients get doctor service in the polyclinic, with medical support covering letter patients are advised doing the medical examination. Test results which is obtained by the patient should be consulted to the doctor back in the polyclinic. If patients require surgery, physicians and patients and the witness must make an inpatient approval to acquire operation schedule. Before the first operation carried out as an act of pre-operative assessment

*Theme 4 : MRD restoration delay.*

The delay in the restoration of MRD is influenced by several factors; completeness record in servicing status, the obstacles in the room because the first stacked, culture / traditions of the local hospital.

*Theme 5 : Completeness of filling MRD is still preferred for a particular form*

*Theme 6 : Filling Informed Consent Form is not according to the rules yet*

Filling internal policy informed consent has not been asserted yet

Awareness of health workers are still lack

*Theme 7 : The utilization of medical record form is not in accordance with the standard form of MRD Inpatient.*

There are different diagnoses when entered the clinic and after surgery. This indicates a discrepancy with the flow of incoming patient procedure. Patients of surgical clinic sign up to do the surgery. After getting the surgery schedule, MRD will be obtained immediately before the actual operation. MRD provision of inpatient has been done before but it gets Bed Occupancy Rate (BOR) lengthen so that the current policy has been changed, but has not poured into the Standard Operating Procedure

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done before but it gets Bed Occupancy Rate (BOR) lengthen so that the current policy has been changed, but has not poured into the Standard Operating Procedure.

As for the achievement of the highest completeness, on the review of item name identification is as much as 57.63%, but not 100%. Identity is important to prevent patient identification errors in the implementation of health care delivery. Actual issues today are related to the identity of the patient in which is an important thing relating to patient safety are the focus and accreditation requirements.

While the data completeness are the lowest in the item sex as much as 69.49% incomplete. MRD is the main evidence which is capable of justifying their patients with a clear identity (Hatta, 2013).

The results of the reviews of the important reports, note that the acquisition of completeness of the highest critical report on the action items as much as 76.27%, while on the items date, type and incompleteness of the information providers reached 100%. Huffman (1999) asserts that the report important is a thing that should be exist in the medical record results considering the detail implementation of the service is a priority report documenting reasons. In the assessment of completeness filling an important report, which has not reached the full level other than the date is the type of information, and information providers. Information providers become important thing to show that the one who do the action is the one whose in charge. According to Law No.36 of 2014 on Health Workers Article 29 Paragraph 1 states that medical personals whose placed in health care facilities shall carry out duties in accordance with the competence and authority.

Review the authentication indicates that the highest of filling completeness is in the signature item doctor / nurse as much as 62.71% while the lowest achievement of the filling completeness is in the signature of patient items as much as 91.53% incomplete. Authentication is as a form of executive health services should at least be filled completely. Minister of Health of the Republic of Indonesia No. 269/Menkes/PER/III/2008 concerning the Medical Record in Article 5 confirms that every recording into the medical record must be affixed with the name, time and signature of the doctor, dentist or certain health workers who provide services directly.

Documentation can describe the quality of service visits of three items, namely Filling date, recording clearly legible and fixed line usage / utilization of the appropriate fields on the form of medical records. The highest percentage completeness of filling in this review on the recording item is clearly read as much as 30.51% and the lowest filling completeness on date items, 100% incomplete. According to Huffman (1999) entries should always be done by means of a good record because error correction is a very important aspect in the documentation. Known that form the design of the medical record contains the rules of the order of the data items logically according to the order of placement was made to simplify the user's recording and presenting clear information can be captured readers (Huffman, 1999). If the item was achieved incompleteness with a high percentage, it is necessary to consider the effectiveness of the form.

In order to maintain quality, Regional General Hospital dr. Soekardjo has been carried out evaluation of the Minimum Service Standards. The activities performed by medical records at each year end include evaluation of patient visits during the first year with the time and personnel available. Evaluation of completeness of MRD had already attempted implemented. It's just still focused on the completeness of the informed consent which is commonly implemented in the period each year for 3 consecutive months. The assessment results are reported and discussed at the meeting of the ethics committee. However, the problems related to the incompleteness is still considered unimportant. The hospital will carry out accreditation KARS, momentum is expected to be a reference commencement accreditation system improvements including documentation of the medical record.

## CONCLUSION

The average speed of ensuring provision of inpatient medical record is 4 minutes ($\leq$ 15 minutes). Completeness of medical records 24 hours after finishing service has not been reached. Completeness the informed consent after receiving information that clearly has not been achieved.

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