TINJAUAN KELENGKAPAN PENGISIAN DOKUMEN REKAM MEDIS PASIEN RAWAT INAP PADA KASUS *DENGUE FEVER* DI RUMAH SAKIT PKU MUHAMMADIYAH BANTUL

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INTISARI

Latar Belakang: Rekam medis harus diisi lengkap, kelengkapan rekam medis dapat dilakukan menggunakan cara analisis kuantitatif yang menilai 4 komponen yaitu *review* identifikasi, laporan penting, autentifikasi dan pendokumentasian yang benar. Terdapat SOP kelengkapan pengisian rekam medis di rumah sakit yaitu 100%. Dari hasil studi pendahulua di Rumah Sakit PKU Muhammadiyah Bantul Kelengkapan terendah *review* laporan penting pada formulir ringkasan masuk keluar pada item diagnosa utama sebanyak 4 dokumen (20%). Pada formulir Resume medis kelengkapan dalam *review* laporan penting pada item jam keluar sebanyak 6 dokumen (30%).
Tujuan: Tujuan penelitian ini adalah mengetahui persentase kelengkapan pengisian dokumen rekam medis rawat inap.
Metode: Jenis penelitian ini adalah deskriptif pendekatan kuantitatif. Teknik pengambilan data dengan observasi, dan studi dokumentasi. Teknik pengambilan sampel dengan cara rendom, sampel dalam penelitian ini sebanyak 76 dokumen rekam medis rawat inap kasus *dengue fever*.
Hasil: Persentase rata-rata kelengkapan hasil analisis kuantitatif mengenai review identifikasi pada formulir ringkasan masuk keluar mencapai 86%, sedangkan formulir resume medis mencapai 81%. Review laporan penting pada formulir ringkasan masuk keluar mencapai 73%, sedangkan formulir resmue medis mencapi 60%. Review autentifikasi pada formulir ringkasan masuk keluar mencapai 62%, sedangkan formulir resume medis mencapai 83%. Review pendokumentasian yang benar pada formulir ringkasan masuk keluar mencapai 41%, sedangkan formulir resume medis mencapai 97%.

Kata Kunci: Kelengkapan, Formulir *Dengue Fever*, Rumah Sakit

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REVIEW OF THE COMPLETION OF FILLING THE MEDICAL RECORD DOCUMENT OF HOSPITAL PATIENT IN DENGUE FEVER FEVER CASE PKU MUHAMMADIYAH HOSPITAL BANTUL

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ABSTRACT

***Background**: Medical records must be filled in completely, completeness of medical records can be done by means of quantitative analysis that assesses 4 components, namely identification review, important reports, correct authentication and documentation. There is a standard operating procedure for filling out medical records at the hospital, which is 100%. From the results of a preliminary study at PKU Muhammadiyah Bantul Hospital. The lowest completeness of review of important reports on the summary entry form on the main diagnostic item is 4 documents (20%). In the complete medical resume form in review of important reports on 6 hours out items (30%).*

***Objective**: The purpose of this study was to determine the percentage of completeness of filling in inpatient medical record documents.*

***Method**: This type of research is descriptive quantitative approach. Data collection techniques with observation and documentation study. The sampling technique was rendom, the sample in this study were 76 inpatient medical record documents for dongue faver cases.*

***Results**: The average percentage of completeness of the quantitative analysis results regarding the identification review on the exit entry summary form reached 86%, while the medical resume form reached 81%. Review of important reports on the summary entry form comes out to 73%, while the medical response form reaches 60%. Review of authentication on the summary entry form came out to 62%, while medical resume forms reached 83%. The correct documentation review on the outgoing summary form reached 41%. while medical resume forms reach 97%.*

***Keywords:** completeness of medical record documents*

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