ANALISIS KELENGKAPAN FORMULIR *INFORMED CONSENT* PADA BERKAS REKAM MEDIS RAWAT INAP KASUS BEDAH DI RST.TK.II.DR.SOEDJONO.MAGELANG

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INTISARI

Latar Belakang: Pelayanan kesehatan dapat berjalan dengan baik yaitu dengan menjaga mutu pelayanan khususnya mutu rekam medis. Terdapat berbagai lembaran dalam berkas rekam medis salah satu nya formulir *informed consent* adalah persetujuan yang diberikan oleh pasien atau keluarga pasien setelah mendapat penjelasan secara lengkap mengenai tindakan kedokteran atau kedokteran gigi yang akan dilakukan terhadap pasien.

Tujuan: penelitian ini bertujuan untuk mengetahui kelengkapan data sosial pasien,bukti rekaman, bukti keabsahan,tata cara mencatat dan proses pelaksanaan formulir *informed consent* di RST.TK.II.dr.Soedjono.Magelang.

Metode:penelitian ini menggunakan metode deskriptif untuk mendeskripsikan prosentase kelengkapan formulir *informed consent* pada rekam medis rawat inap kasus bedah triwulan I dengan pendekatan kualitatif untuk menggambarkan data yang didapatkan dari hasil observasi, wawancara dan digunakan untuk mengetahui proses pelaksanaan formulir *informed consent* pada rekam medis rawat inap kasus bedah.

Hasil : Berdasarkan hasil observasi dan wawancara masih di temukan kelengkapan kurang dari 100%, dan masih ada perawat yang mengisi formulir *informed consent*, masih banyak informasi yang tidak di sampaikan oleh dokter karena keterbatasan waktu dari dokter.

Kesimpulan : kelengkapan data sosial pasien sebanyak 80% sudah baik, kelengkapan bukti rekaman sebanyak 55% sudah cukup baik, kelengkapan bukti keabsahan sebanyak 74% sudah baik, dan kelengkapan tata cara mencatat sebanyak 63% sudah baik. Proses pelaksanaan formulir *informed consent* masih ada informasi yang belum disampaikan karena keterbatasan waktu dokter dan masih ada perawat yang ikut mengisi formulir *informed consent.*

Kata Kunci: *Informed Consent*, Kelengkapan, Bedah

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ANALYSIS OF COMPLETENESS OF INFORMED CONSENT FORM ON MEDICAL RECORDING IN THE INVENTORY OF SURGICAL CASE IN RST.TK. II.DR. SOEDJONO. MAGELANG

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ABSTRACT

Background: Health services can run well by maintaining the quality of services, especially the quality of medical records. There are various sheets in the medical record file one of the informed consent forms is the agreement given by the patient or family of the patient after obtaining a complete explanation of the medical or dental actions that will be performed on the patient.

Objective: This study aims to determine the completeness of the patient's social data, recording evidence, proof of validity, procedures for recording and the process of implementing informed consent forms at RST.TK.II.dr.Soedjono.Magelang.

Methods: This study used descriptive method to describe the percentage of completeness of informed consent forms in inpatient medical records of quarter I surgical cases with a qualitative approach to describe the data obtained from the observation, interviews and used to determine the process of informed consent forms in inpatient medical records surgical case.

Results: Based on observations and interviews, it was found that the completeness was less than 100%, and there were still nurses who filled out informed consent forms, there was still a lot of information that was not conveyed by the doctor because of the doctor's limited time.

Conclusion: Completeness of the patient's social data as much as 80% has been good, completeness of record evidence as much as 55% is good enough, completeness of proof of validity as much as 74% is good, and completeness of procedures for recording as much as 63% is good. The process of implementing informed consent forms still has information that has not been delivered due to the limited time of the doctor and there are still nurses who participated in filling out informed consent forms.

Keywords: Informed Consent, Completeness, Surgery

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