TINJAUAN PELAKSANAAN PELAPORAN DATA MORTALITAS PASIEN RAWAT INAP DI RSUD WATES TAHUN 2016

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INTISARI

Latar Belakang: Rumah sakit merupakan sarana yang menyelenggarakan sistem pelayanan kesehatan untuk memelihara dan meningkatkan kesehatan demi mewujudkan derajat kesehatan yang optimal bagi masyarakat. Indikator utama dalam sistem pelayanan kesehatan adalah tersedianya tenaga pelayanan medis yang berkualitas, salah satunya petugas rekam medis. Karena, pemberkasan rekam medis dikatakan bermutu apabila memuat informasi yang akurat, lengkap, dapat dipercaya, valid, dan tepat waktu. Didalam rekam medis, data mortalitas merupakan informasi kesehatan yang terpenting, karena dapat mengukur keberhasilan pembangunan bidang kesehatan.
Tujuan Penelitian: Diketahuinya Pelaksanaan dan pembuatan pelaporan data mortalitas pasien rawat inap berdasarkan UCoD (*Underlying Cause of Death*) di RSUD Wates Tahun 2016.
Metode Penelitian: Jenis penelitian yang digunakan adalah penelitian deskriptif dengan menggunakan pendekatan kualitatif serta rancangan *cross-sectional*. Teknik pengumpulan data menggunakan teknik wawancara kepada 2 orang dokter rawat inap, 1 orang petugas *coding* rawat inap, 1 orang kepala rekam medis, observasi, dan studi dokumentasi.
Hasil: Pelaporan mortalitas yang telah dilaksanakan oleh RSUD Wates adalah pelaporan data morbiditas dan mortalitas pasien rawat inap (RL 4a) yang pengolahan datanya menggunakan sistem komputerisasi, pelaporan angka kematian berupa NDR berjumlah 15,87 permil dan GDR berjumal 26,48 permil, dan data pelaporan mortalitas berupa penyebab kematian/*Underlying Cause of Death* (UCoD) yang dilaporkan kepada dinas kesehatan. Pelaksanaan penentuan diagnosis penyebab kematian sudah dilakukan oleh dokter penanggungjawab (DPJP) di formulir sebab kematian, akan tetapi dokter DPJP masih menuliskan diagnosis berupa kondisi *symptoms* dan kondisi yang tidak jelas (gagal nafas, henti nafas, henti jantung, gagal jantung) ke dalam formulir surat keterangann kematian, sehingga pendokumentasian belum sesuai dengan aturan yang ada di dalam ICD 10. Sedangkan, petugas *coding* rawat inap sendiri belum melakukan proses reseleksi penentuan penyebab dasar kematian (UCoD) karena banyaknya *job description* yang dibebankan kepada petugas *coding* rawat inap tersebut. Persentase kesesuaian penentuan penyebab kematian (UCoD) di RSUD Wates dari 83 sampel berkas rekam medis adalah sebesar 33 berkas (40%), sedangkan ketidaksesuaian penentuan penyebab kematian/*Underlying Cause of Death* (UCoD) di RSUD Wates dari 83 sampel berkas rekam medis sebesar 50 berkas (60%).

Kata Kunci: UCoD, Data Mortalitas, Pasien Rawat Inap, Pelaporan Data Mortalitas.

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The Observation on Data Reporting of Inpatients' Mortalities in General Hospital of Wates Region in 2016

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ABSTRACT

Background: Hospital is a facility to provide health service system to sustain and enhance health quality toward its optimal level for society. The main indicator of health service system is the presence of quality health workers such as medical record staff. Medical record documentation can be regarded qualified when accomodating accurate, complete, trustable, valid, and punctual information. In medical record, mortality data is the most essential health information as it can assess the progress of health development.
Objective: To identify the implementation of in-patients' mortalities data reporting process according to UCoD (Underlying Cause of Death) in general hospital of Wates in 2016.
Method: This was a descriptive study by using qualitative approach and cross sectional design. Data compilation technique applied interview to 2 inpatient doctors, 1 coding staff for inpatient, 1 head of medical record unit, observation, and documentation study.
Result: Mortalities reporting in general hospital of Wates was reporting on morbidities and mortalities of inpatients (RL 4a) by using computerized system for data administration, reporting on mortality rate figured out NDR of 15.87 per mil and GDR of 26.48 per mil, reporting on mortality rate was in the format of Underlying Cause of Death (UCoD) reported to the Health Agency. The implementation of diagnosis on causes of death had been conducted by the on-duty doctor in the form of cause of death. Nevertheless, the doctor still wrote diagnosis such as symptomps and unidentified conditions (breathing failure, breathing stop, cardiac stop, cardiac failure) in the form of death information letter. This made documentation unsuitable with the standard of ICD 10. In the meanwhile, coding staff for inpatient had not conducted reselection on underlying cause of death (UCoD) due to overwhelming workload. The conformity percentage of determination of UCoD in general hospital of Wates was 33 files (40%) out of 83 medical record files and the unconformity percentage of determination of UCoD in general hospital of Wates was 50 files (60%) out of 83 medical record files.

Keyword : UCoD, Mortality Data, Inpatient, Mortality Data Reporting.

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