Journal of SDGs
SUSTAINABLE DEVELOPMENT GOALS

FILLING OUT THE PATIENT MEDICAL RESUME SHEET AT HOSPITAL X

Agusianita [1]
Nofri Heltiani [2]

ABSTRACT

Problem: Analysis of medical record documentation is a review of certain parts of the contents of medical records with the aim of finding specific deficiencies related to recording medical records. Based on an initial survey of 10 sheets of medical resumes, it was found that 4 (40%) were complete (patient identification, important reporting and authentication) and 6 (60%) were incomplete. This is because medical record officers only assemble or sort one page to another without conducting a quantitative analysis of medical record files to check the completeness of the files supported by the absence of SOPs, and the absence of reporting on the completeness of filling in medical record files, which has an impact on the decline in the quality of hospital services. **Objective:** Knowing how to fill out a medical resume sheet at hospital X. **Method:** This type of research is observational research with a descriptive design. The population in this study was 438 medical resume sheets in 2024 and a sample of 209 with a simple random sampling technique. The research data used secondary data processed univariately using frequency distribution. **Results:** Of the 209 medical resume sheets, 23(15%) were incomplete patient identification, 132(64%) were incomplete important reporting, 113(54%) were incomplete authentication. It is expected that the hospital will compile an SOP on documentation analysis and socialize it to be a guideline for assembly officers to conduct medical record documentation analysis.

Keywords : Authentication Review; Critical Reporting Review; Medical Resume; Patient Identification Review.

Submission : 16 April 2025
Received : 27 April 2025
Accepted : 23 May 2025
DOI: https://doi.org/10.58222/sdgs.v1.i2.1214

1. INTRODUCTION

According to Government Regulation of the Republic of Indonesia Number 47 of 2021 concerning the Implementation of the Hospital Sector in Chapter 1 Article 1 states that a hospital is a health service institution that provides comprehensive individual health services that provide inpatient, outpatient and emergency services. Health services to the community need to be recorded or recorded as important confidential documents called medical records.

Medical records are written or recorded information about the identity, anamnesis, physical laboratory determination, diagnosis of all services and medical

[1] STIKes Sapta Bakti, Bengkulu, Indonesia. Email: agusianita2015@gmail.com
[2] STIKes Sapta Bakti, Bengkulu, Indonesia. Email: nofrihelti11@gmail.com

actions provided to patients and treatment for both inpatients, outpatients, and those receiving emergency services (Rustiyanto, 2011).

A medical resume is part of the medical record in the form of a very important and basic sheet in the inpatient form and is proof of the responsibility of health workers, especially doctors. The use of a medical resume is to briefly find out about the main complaints and current illness complaints (Pardede et al., 2020). The information contained in the medical resume that serves as a guideline for the accuracy of the diagnostic code consists of indications for the patient being treated, medical history (anamnesis), physical examination, diagnostic and laboratory examinations, diagnostic actions/therapeutic procedures and drugs given during the patient's hospitalization. The medical information contained in the medical resume will support coders in coding diagnoses accurately based on ICD-10 (Ministry of Health, 2014).

Filling out medical records is the responsibility of health workers. This is explained in the Medical Practice Law No. 29 of 2004, article 46 paragraph (1): "Every doctor or dentist in carrying out practice is required to make medical records." Furthermore, paragraph (2) states that "Medical records as referred to in paragraph (1) must be completed immediately after the patient has finished receiving health services. Paragraph (3) states that, "Every medical record must be marked with the name, time and signature of the officer who provided the service or action"

The completeness and accuracy of the contents of medical records are very useful, both for patient care and treatment, legal evidence for hospitals and doctors, and for medical and administrative research purposes (Hatta, 2013).

Hospital X is a type C hospital owned by the District Government and has been accredited by STARKES with a Full rating since 2022. Based on a preliminary survey conducted by researchers at Hospital Medical Records Unit in October 2024, it was found that the number of inpatient visits over the past 3 years has decreased and increased, this can be seen from the following data; the number of visits in 2022 was 6,701 patients, in 2023 it was 3,037 patients and in 2024 it was 4,018 patients.

The results of initial observations conducted on 10 sheets of medical resumes showed that 4(40%) were complete (patient identification, important reporting and authentication) and 6(60%) were incomplete. Based on the results of interviews with medical record officers, it was found that the incompleteness of patient identification items, important reporting and authentication was caused by medical record officers only assembling or sorting one page to another without conducting a quantitative analysis of medical record files to check the completeness of the files supported by the absence of SOPs, and the absence of reporting on the completeness of filling in medical record files. According to Hatta (2013), medical record documents are said to be complete if all data in them is filled in completely and correctly according to the provisions set by the hospital. The contents of the identification review on each sheet of medical record documents including administrative data as demographic information must be filled in completely because if not filled in, it will result in not being able to inform the patient's identity as a statistical database, research and planning source for hospitals or health service organizations.

Based on research by Namiah (2012) at RSI Amal Sehat, the impact of not filling in patient identity is that if the patient's name and medical record number are not

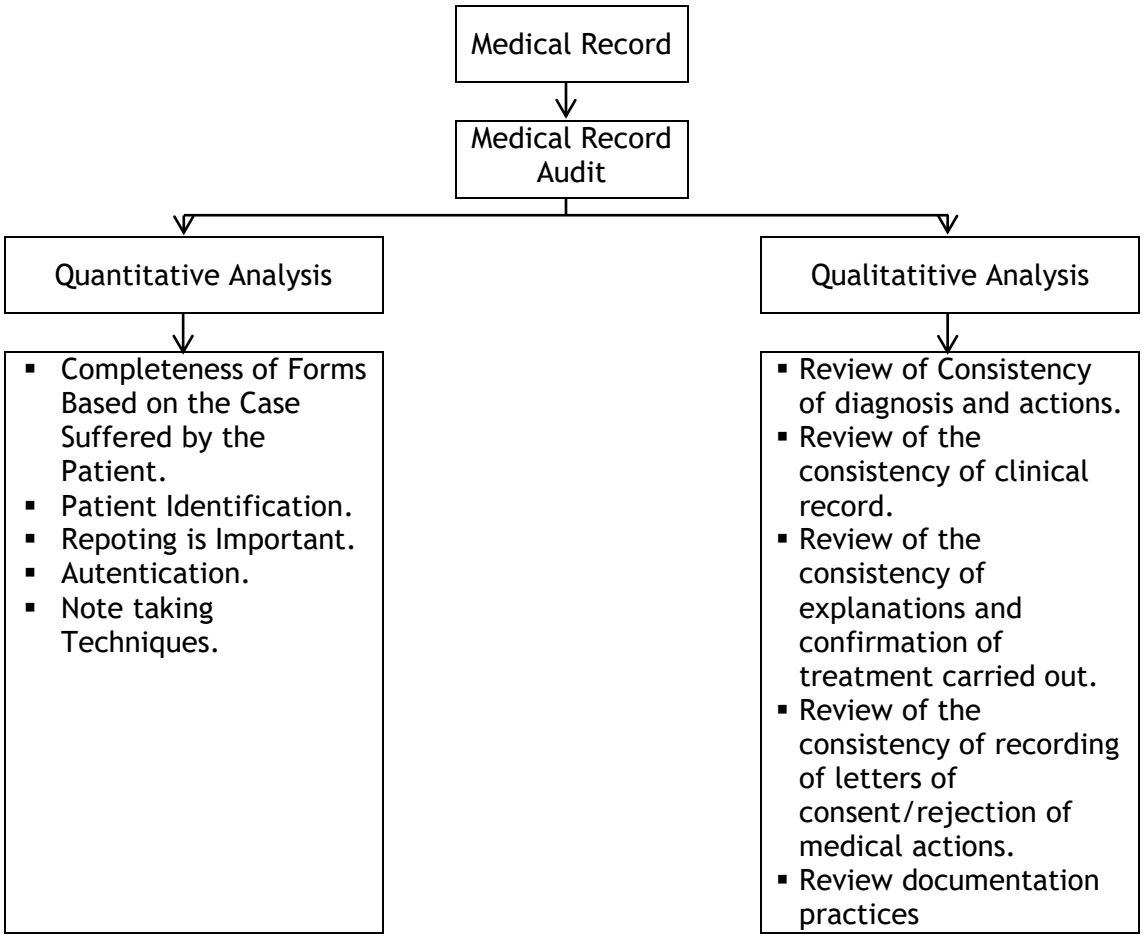
filled in, it will be difficult for officers to determine ownership of the medical record form if one of the forms is detached from the medical record document. The impact of not filling in gender makes it difficult for officers to distinguish the patient's gender. The impact of not filling in age on the patient's medical record file can affect the type of medicine that will be given to the patient.

Naimah (2012) also said in her research that the impact if every important reporting form has not been filled in completely will result in the patient's medical history from the beginning to the end being discontinuous so that in providing medical services and treatment to patients it is not optimal.

The impact on the completeness of authentication if the doctor's name and signature are not filled in, it will make it difficult for medical record officers to determine the doctor responsible for the care given to the patient, which will affect the quality of patient care (Namiah, 2012).

Based on the background description above, seeing the importance of medical records in creating continuous medical information, the research question formulated is how is the description of filling out the patient's medical resume sheet at Hospital X.

2. THEORETICAL FRAMEWORK



3. METHODOLOGY

This type of research is observational research with a descriptive design. The population in this study was 438 medical resume sheets in 2022 and a sample of 209 with a simple random sampling technique. The research data used secondary data processed univariately using frequency distribution.

4. RESULTS AND DISCUSSIONS

a. Completing the Medical Resume Sheet in Patient Identification Review

Tabel 1. Completing the Medical Resume Sheet in Patien Identification Review

Patient Identificaton Items	Frequency (n)			Presentase (%)		
	Complete	In complete	Amount	Complete	In Complete	Amount
Medical Record Number	199	10	209	95	5	100
Patient Name	205	4	209	98	12	100
Date of Birth	194	15	209	93	7	100
Nursing Class	177	32	209	85	15	100
Treatment Room	193	16	209	92	8	100

Source : Processed Secondary Data, 2024

Based on table.1 regarding the filling of the medical resume sheet in the patient identification review at Rejang Lebong Regional Hospital, it is known that the filling of the patient's medical resume sheet in the patient identification review, the majority of each item is filled in completely, but there are still 32 (15%) incomplete nursing class items.

In accordance with the Decree of the Minister of Health of the Republic of Indonesia No. 129 / Menkes / Per / 2008 concerning the Minimum Service Standards for Completeness of Filling in Medical Records is 100%, meaning that filling in each identity variable, namely consisting of name, medical record number, date of birth or age must be filled in in its entirety, but in reality the filling of these variables is not yet standard because it has not reached 100%.

According to Indradi (2014) each medical record file must include the patient's identity, at least consisting of the patient's name and medical record number or can also be supplemented with: name, medical record number, date of birth / age, gender and complete address. This completeness is adjusted to the policies and needs of each health service facility.

The incompleteness of filling out the medical resume sheet at hospital X was caused because after the medical record files returned to the filing room, the medical record officer only assembled or sorted one page to another without conducting a quantitative analysis of the medical record files to check the completeness of the files supported by the absence of SOPs, and the absence of reporting on the completeness of filling out the medical record files.

According to Hatta (2013), the selection of each page or sheet of medical record documents in terms of patient identification, at least must include a medical record number and patient name if there are sheets without an identity, a review must be carried out to determine the ownership of the medical record form.

Incomplete filling out of patient identification, especially the name and medical record number, will result in the medical record document not being able to be identified as its owner, when viewed from its function, patient identification is used to differentiate between one patient and another. So if the patient's identification is exchanged, it will have an impact on the process of providing services to patients such as giving the wrong medicine or taking the wrong action.

Based on research by Naimah (2012), the impact of not filling in the medical record number on the patient's medical record document is that it will make it difficult for officers to determine ownership of the patient's medical record form if one of the forms is detached from the patient's medical record document because the medical record number is a special patient identification. Therefore, in order for the completeness of patient identification to be 100% on the medical resume sheet, Rejang Lebong Regional Hospital should prepare an SOP on patient identification review, then socialize it so that it becomes a guideline for assembling officers to conduct medical record documentation analysis.

b. Completing the Medical Resume Sheet in Important Repoting Review

Tabel 2. Completing the Medical Resume Sheet in Important Repoting Review

Important Repoting Items	Frequency (n)		Amount	Presentase (%)		Amount
	Complete	In complete		Complete	In Complete	
Anamnesis	202	7	209	97	3	100
Physical Examinatior	197	12	209	94	6	100
Clinical Findings	93	116	209	44	56	100
Diagnosis	207	2	209	99	1	100
Treatment During HOspitalization	196	13	209	94	6	100
Action	116	98	209	55	45	100
Reason for Returning	96	112	209	46	54	100
Patient Discharge Date	164	45	209	78	22	100
Patient Discharge Time	147	62	209	70	30	100
Condition When Returning Home	105	104	209	50	50	100
Advanced Treatment	76	132	209	36	64	100
Plan	88	121	209	42	58	100
Recommendations						
Patient Room Stamp	201	8	209	96	4	100

Source : Processed Secondary Data, 2024

Based on table.2 regarding the filling of the medical resume sheet in the patient identification review at hospital X, it is known that the filling of the patient's medical resume sheet in the important reporting review is mostly filled in completely, but there are still some advanced treatment items that are not filled in completely as many as 132 (64%).

In accordance with the decree of the Indonesian Minister of Health Number 129/Menkes/Per/2008 concerning the minimum service standard for the completeness of filling in medical records is 100%, meaning that the filling of each reporting variable consists of pre-operative and post-operative diagnoses.

According to Indradi (2014) quantitative reporting review aims to check the completeness of all forms of reports according to the needs of each patient's case.

Everything obtained from the patient must be reported (listed) in their medical records.

In filling out the reporting components, completeness must be considered, because it is written evidence to support the legal aspects of medical records, this is to protect patients for every action taken not categorized as malpractice. If not filled in completely, it can result in losses for patients, both material and non-material, and will be subject to administrative sanctions (Regulation of the Minister of Health of the Republic of Indonesia, 2008). Therefore, in order for the completeness of important reporting to be 100% on the medical resume sheet, Rejang Lebong Regional Hospital should prepare an SOP on reviewing important reporting, then socialize it so that it becomes a guideline for assembling officers to conduct analysis of medical record documentation.

c. Completing the Medical Resume Sheet at the Authentication Review

Tabel 3. Completing the Medical Resume Sheet at the Autentication review

Autentication Items	Frequency (n)		Amount	Presentase (%)		Amount
	Complete	In complete		Complete	In complete	
DPJP Signature	194	15	209	93	7	100
DPJP Full Name	169	40	209	81	19	100
NIP DPJP	96	113	209	46	54	100

Source : Processed Secondary Data, 2024

Based on table.3 regarding filling out the medical resume sheet in the patient identification review at hospital X, it is known that filling out the patient's medical resume sheet in the authentication review, the majority of each item is filled in completely, but there are still some DPJP NIP items that are not filled in completely as many as 113 (54%).

In accordance with the Decree of the Minister of Health of the Republic of Indonesia No. 129 / Menkes / Per / 2008 concerning the minimum service standards for the completeness of filling out medical records is 100%, meaning that filling in each reporting variable, namely the doctor's full name, doctor's signature and assistant's name must be filled in in its entirety, but in reality the filling of these variables is not yet standard because it has not reached 100%.

According to Indrandi (2014) in filling out medical records, the principle applies that each entry must have a clear person in charge. The clarity of the person in charge is realized by including a full name and signature, where what is meant by a full name is the full name accompanied by a full title.

Incomplete filling of authentication variables can be detrimental to various parties, not only patients but doctors and hospitals can also be harmed if there are errors in providing actions and drugs, and determining the quality of data on the informed consent sheet, also being written evidence by the hospital that the doctor has provided medical action, medical action and care to the patient with prior approval from the patient or the patient's family (Hatta, 2013). According to the Regulation of the Minister of Health of the Republic of Indonesia Number 129/Menkes/Per/III/2008 concerning approval of medical actions, article 9 paragraph 2, that the explanation must be recorded and documented in the medical record file by the doctor who provides the explanation by including the date, time, name and signature of the giver and recipient of the explanation.

Based on research by Naimah (2012) that the impact if the doctor's full name is not filled in on the patient's medical record form will make it difficult for officers to find out who the doctor is responsible for the patient's care and if the authentication is not filled in completely if there is a legal claim in the future then the doctor's full name will be a problem because there is no name of the doctor in charge who handled the patient.

According to the Indonesian Ministry of Health (2016) that the full name must be included in accordance with the provisions for the completeness of medical record documents where each recording must be signed and accompanied by the full name of the person in charge along with his/her title.

Therefore, in order for the completeness of authentication to be 100% on the medical resume sheet, Rejang Lebong Regional Hospital should compile an SOP on authentication review, then socialize it so that it becomes a guideline for assembling officers to conduct analysis of medical record documentation.

5. CONCLUSION

Medical record documentation analysis is a review of certain parts of the contents of medical records with the aim of finding specific deficiencies related to recording medical records. In accordance with the Decree of the Minister of Health of the Republic of Indonesia Number 129/Menkes/Per/2008 concerning the Minimum Service Standards for Completeness of Filling in Medical Records is 100%, but at Rejang Lebong Regional Hospital, the completeness of medical records seen on the medical resume sheet is mostly incomplete. This is because the medical record files that are returned to the filing room are not subject to documentation analysis to check the completeness of the files supported by the absence of SOPs, as well as the absence of reporting on the completeness of filling in medical record files.

ACKNOWLEDGEMENTS

Thank you to the Chair and Head of the Research and Community Service Unit of STIKes Sapta Bakti who have given permission to the author so that he can complete the research. The author also expresses his thanks to the Director of RS.X who has given permission for researchers to carry out research.

REFERENCES

Budi, S. 2011. *Manajemen Unit Kerja Rekam Medis*. Yogyakarta: Quatum Sinergis Media.

Departemen Kesehatan Republik Indonesia. 2006. *Pedoman Pengelolahan Rekam Medis Rumah Sakit di Indonesia Revisi II*. Jakarta: Dirjen Yanmed.

Hatta, Gemala R. 2013. *Indikator Untuk Meningkatkan Pelayanan Kesehatan di Rumah Sakit*. Jakarta: Universitas Indonesia.

Indradi, R. 2014. *Rekam Medis Edisi II*. Tangerang Selatan: Universitas Terbuka.

Naimah, Lani. 2012. *Analisis Kuantitatif Dokumen Rekam Medis Rawat Inap dengan Diagnosis Vertigo di RSI Amal Sehat Periode Triwulan IV pada Tahun 2012*. Jurnal Penelitian APIKES Mitra Husada Karang Anyar.

Pardede, dkk. 2020. *Kelengkapan Resume Medis dan Keakuratan Kode Diagnosis BPJS Rawat Inap di RSUP DR.M.Djamil Padang Indonesia*. Jurnal Kesehatan medika Saintika Vol.11 No.2, Desember 2020.

Peraturan Menteri Kesehatan Republik Indonesia Nomor 512/Menkes/PER/IV/2007 Tentang Izin Praktik dan Pelaksanaan Praktik Kedokteran.

Keputusan Menteri Kesehatan Republik Indonesia No.129/Menkes/Per/2008 tentang Standar Pelayanan Minimal Kelengkapan Pengisian Rekam Medis

Peraturan Menteri Kesehatan Republik Indonesia Nomor 269/Menkes/Per/III/2008 Tentang Rekam Medis.

Peraturan Pemerintah Republik Indonesia Nomor 47 Tahun 2021 Tentang Penyelenggaraan Bidang perumahsakitan pada Bab 1 Pasal 1. Jakarta: Pemerintah Republik Indonesia.

Rustiyanto, E. 2011. *Manajemen Filing Dokumen Rekam Medis dan Informasi Kesehatan*. Yogyakarta: Politeknik Kesehatan Permata Indonesia.

Undang-Undang Republik Indonesia No.29 Tahun 2004. *Tentang Izin Praktik Kedokteran*. Jakarta: Menkes RI.