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Analysis of Implementation the Medical Records System in Puskesmas UPT Medan Tuntungan

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Keywords

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Abstract. A medical records are one of the most important units in a health center. Medical records contain notes and documents regarding patient identity, examinations, treatment, procedures and other services provided to patients. One component of health services to determine the quality of health services is the availability of medical record data. The aim of this research is to find out the description/implementation of medical records in the medical records unit at the UPT Puskesmas Medan Tuntungan and to find out the system for implementing medical records starting from patient registration to file storage, with a descriptive research method with a qualitative approach with a sampling method using the snowball sampling technique. and with a qualitative research design.

1. INTRODUCTION

A Health development is essentially an effort carried out by all components of the Indonesian nation which aims to increase awareness, willingness and ability to live healthily for everyone in order to achieve the highest level of public health.

One of the efforts to provide health is the puskesmas. Puskesmas is the main milestone in the implementation of health in Indonesia and is a health service facility that organizes first-level public health efforts (UKM) and individual health efforts (UKP). Puskesmas prioritizes promotive and preventive efforts to achieve health status. highest level of community in its working area (Permenkes RI No. 43, 2019). To provide correct and accurate information, community health centers organize patient data processing information systems, namely through medical record units. Medical records are files containing notes and documents regarding identity patients, examinations, treatment, procedures and other services that have been provided to patients (Permenkes RI No. 269,2008).

The existence of the Republic of Indonesia Minister of Health Regulation no. 269 of 2008 concerning medical records, recording and patient data is a necessity and an obligation that has legal value. According to Setiadani (2016), one of the components of health services to determine the quality of health services is the availability of accurate medical record data or information. The quality of health services that are related to medical records comes from administrative, documentation, financial, educational, research and legal aspects (Suryanto, 2020). Therefore, the medical records unit needs to be managed well and professionally in order to produce information that is useful. quality, so that health services are excellent and useful as material for management consideration in decision making.

The impact of implementing medical records that do not comply with procedures will cause the patient's medical information in the family folder to become inaccurate and can cause delays in health services. According to Budi (2011), the medical record service system aims to provide information that facilitates management and service to patients and makes it easier for management to carry out planning, organizing, implementing, monitoring, assessing and controlling activities. The aim of this research is to review the implementation of medical records in the Medan Tuntungan Health Center UPT Medical Records Unit.

Based on the results of a preliminary study that the author found at the UPT Puskesmas Medan Tuntungan, the author found that medical record documents had the same medical record number with the names of different family heads and one family head had two family folders with different medical record numbers. Duplication of family folders occurs because each officer when registering a patient sometimes forgets to record the filling in of the registration book so that the number that has been given to the patient is used again by another officer. Apart from that, the author also found that the patient's medical record file did not match the name on the family card in the family folder.

2. METHOD

The research design used in this research is descriptive with a qualitative approach. The population used in this study was the head of medical records and all medical records officers in the menis records unit of the Medan Tuntungan Health Center UPT. The sample in this study was medical records officers in the medical records unit. The researcher chose the head of medical records, 1 registration officer, 1 officer in the coding section, 1 officer in the filling section Techniquesampling using snowball sampling.

3. RESULTS

Interview Result

Based on the results of in-depth interviews, information was obtained regarding the system for implementing medical records in the medical records unit of the UPT Medan Tuntungan Health Center which was carried out by 9 officers, the medical records officers had their own job descriptions and none of the medical records officers had a medical records background. The implementation of medical records is carried out computerized and has been carried out systematically and sequentially, however at the UPT Puskesmas Medan Tuntungan there is no SOP for a medical record processing system, only an SOP for confidentiality of medical record information and an SOP for access to medical records. Results of research that has been carried out.

The system for implementing medical records in the medical records unit of the UPT Medan Tuntungan Health Center starts from the information and registration unit. The patient registration flow activities at the UPT Medan Tuntungan Health Center medical records unit consist of screening, the officer asks the purpose of the patient's arrival and the BPJS/KIS/ASKES/E-KTP card. If the patient has never had treatment, the officer immediately makes a treatment card and creates a new patient's medical record. then enter the data into the register book, if the patient has visited before the officer will ask whether the patient brought a medical card, if not brought the officer will look for the name of the head of the patient's family in the registration card register book then look for the patient's medical record file then enter the data into the register book and if The patient brings a medical card, the officer will search for the medical record file then enter the data into the register book, register the patient (done online) and immediately take the patient and the medical record file to the destination poly service room. After completing the service, the medical record file is returned to the medical record room. by a polyclinic officer, then picar (primary care) is carried out and after that the medical record file is put back on the storage shelf. UPT Medan Tuntungan Health Center has a registration counter which is located to the right of the entrance.

The medical record document storage room is located separately from the registration room, namely behind the registration room. Outpatient registration activities at UPT Medan Tuntungan Health Center are carried out at the registration counter. Registration is carried out in order to obtain information about the patient and the purpose of the patient's arrival. Activities in the patient registration system include the naming system and numbering system.

The system for naming patients in the medical records unit at the UPT Puskesmas Medan Tuntungan does not have an SOP. The naming system used at the UPT Puskesmas Medan Tuntungan is a direct naming system, namely naming according to the patient's original identity as stated on the KTP (residential identification card) and KK (family card). The name of the head of the family is included in the medical record file and if the head of the family is no longer there (died) the name that will be included in the medical record file is the mother's name. An example of naming a patient at the UPT Puskesmas Medan Tuntungan is as follows.

The numbering system at the UPT Puskesmas Medan Tuntungan is not implemented in accordance with the attachment to the decision of the head of the Puskesmas Tuntungan Number: 445/148/SK/PKM-TTG/III//2018 concerning medical record processing. According to the attachment to the decision of the head of the Tuntungan Community Health Center Number: 445/148/SK/PKM-TTG/III//2018 concerning the processing of numbering medical records at the Medan Tuntungan Community Health Center UPT, it begins with sub-district coding. However, the numbering system applied does not use the sub-district coding system. Medan Tuntungan applies a numbering system

that continues with the numbers already available. The numbering system used at the UPT Puskesmas Medan Tuntungan is UNS (Unit Numbering System) where each patient who visits is given a family medical record folder number which will be used for the next visit and can be used for one family. An example of numbering at the UPT Puskesmas Medan Tuntungan is as follows.

Table 1. Patient numbering system in the medical records unit of Medan Tuntungan Health Center UPT

No	No Family Folder	Family Member	Medical Record No
1	00 – 01 – 27	Father :	00 – 01 – 27
		Mother :	00 – 01 – 27
		Child :	00 – 01 – 27
2	00 – 20 – 01	Father :	00 – 20 - 01
		Mother :	00 – 20 - 01
		Child :	00 – 20 – 01

Assembling activities carried out in the medical records unit of the Medan Tuntungan Health Center UPT are:

1. Provide a medical record form.
2. Provide medical record number and family folder.
3. Receive return of medical record files from the poly.

Disease coding in the Medan Tuntungan Health Center UPT medical records unit is not carried out by medical records officers, but is carried out by doctors at each polyclinic. Medical records officers only carry out pcare by entering the registration code in the pcare application on the computer and then inputting the diagnosis code that has been given by the doctor from the poly department. The medical record file storage system used in the Medan Tuntungan Health Center UPT medical records unit uses a family folder, namely records about the health condition of one family are stored in one folder. The file storage system in the storage rack uses Straight Numbering Filing (SNF), namely the storage of medical record files is stored in shelves sequentially according to their numbered sequence.

Medical Records Management System

The naming system in medical record services is a procedure for writing a person's name which aims to differentiate one patient from another patient and to make indexing easier (Patient Main Index Card/ KIUP). For this reason, writing the patient's name on the medical record form is very important so that there are no errors in service, such as mixing one patient's medical record file with another.

The patient's name is written in full according to the identity card (not a nickname) and the name on the cover of the medical record file is written in capital letters. According to Savitri (2011). The naming system used at the UPT Puskesmas Medan Tuntungan is a direct naming system, namely naming according to the patient's original identity as stated on the KTP (residential identification card) and KK (family card). The name of the head of the family is included in the medical record file and if the head of the family is no longer there (died), the name that will be included in the medical record file is the mother's name.

The numbering system in medical record services is the procedure for writing numbers given to patients who come for treatment as part of the patient's personal identity. The system for assigning patient numbers is divided into 3, namely: (1) assigning serial numbers (serial numbering system) (2) assigning unit numbers (unit numbering system) (3) assigning unit serial numbers (serial unit numbering system) According to Savitri (2019). The numbering system applied in the Medan Tuntungan Health Center UPT medical records unit is UNS (Unit Numbering System). The duplication of medical record numbers that occurred in the medical records unit of the Medan Tuntungan Health Center UPT was due to an error/negligence by the medical records officer in marking in the register book that the medical record number had been used.

The activities for assembling medical records at the UPT Puskesmas Medan Tuntungan include providing medical record forms, providing medical record numbers and family folders and receiving returns of medical record files from the clinic. Providing ICD-10 diagnosis codes at UPT Puskesmas Medan Tuntungan is not carried out by medical records officers but is carried out by doctors who provide health services to patients in each polyclinic. Medical records officers only carry out pcare by

entering the registration code in the pcare application on the computer and then inputting the diagnosis code that has been given by the doctor from the poly department.

The medical record file storage system at UPT Puskesmas Medan Tuntungan implements a centralized storage system, namely where outpatient medical record documents are stored in the same folder/document, namely using a family folder and the alignment system used is straight numbering filling or a direct number system, namely the file storage system. medical records by lining up medical record files based on the order of their medical record numbers directly on the storage shelf. This system has several advantages, such as making it easy to train officers who carry out storage. Apart from having advantages, this system also has several disadvantages, such as when lining up medical record files, officers must pay attention to all the numbers so mistakes can easily occur.

The implementation of retrieving medical record files at the UPT Puskesmas Medan Tuntungan does not use a tracer, so misfiles often occur and result in additional work for officers because they have to create new medical records for old patients, so the registration process tends to take longer and there is duplication of medical records on storage shelves. In the implementation of returning medical record files, there are still medical record files that are stored incorrectly in their place. The implementation of storage at the UPT Puskesmas Medan Tuntungan does not use SOPs and will have an impact on increasing the number of misfiles. According to Suhartina (2019), storage implementation that does not comply with the SOP will result in files being lost and difficult to find. UPT Medan Tuntungan Community Health Center sorts active and inactive medical record files. Storage of medical record files in the storage rack is only used for active medical record files and in-active medical record files will be immediately destroyed. Outpatient medical record files are kept at least for a period of 5 years starting from the last date the patient received treatment, however at the UPT Puskesmas Medan Tuntungan the storage limit for medical records is 3 years. The storage limit for Medan Tuntungan Health Center UPT medical records is 3 years, after the time limit has passed the medical records can be destroyed unless the action approval is kept for 10 years. This is in accordance with the Republic of Indonesia Minister of Health Regulation No. 269 of 2008 concerning medical records which states that non-home health services ill carry out retention for at least 2 years.

Competency Results

The competency of medical record officers/recorders in managing medical record files is very important, because medical record officers' knowledge of medical record management will have an impact on the health services that patients will receive. The results of interviews with Medical Records Officers regarding education as medical recorders show that Medical Records Officers have not studied as medical recorders. There are Medical Records Officers who have studied as nurses and environmental health education. Medical record files aim to make it easier and faster to find medical record files.

The results of interviews with Medical Records Officers regarding the management of medical record files in the storage room show that there are Medical Records Officers who manage medical record files in the storage room every day. There are Medical Records Officers who do not manage medical record files in the storage room because they are not storage officers. Some medical record officers manage medical record files after the files return from the poly department, there are officers who manage medical record files in the storage room after carrying out activities through the pcare application. There are Medical Record Officers who manage medical record files in the storage room when the patient arrives. , and there is a Medical Records Officer who manages medical record files when patients seek treatment.

If the medical record files in the storage room are not handled properly, problems will often be encountered. The problems faced certainly hinder the services that patients will receive when seeking treatment. The results of interviews regarding the problems often faced by each Medical Records Officer in the storage room showed that incorrect numbering of medical record files was found, duplicate medical record numbers, wrong storage places, late arrival of files from the poly room, accumulation of files that were returned late. from the poly room, medical record files are often not visible, and it is wrong to return medical record files to the storage shelf. Problems that often occur in

the storage room have certain times when medical record officers work, namely every day, when patients come for treatment, when patients visit and every Monday & Saturday. Every problem faced has an explanation as to why it happened. The results of interviews regarding explanations of problems experienced by medical records officers can occur, namely lack of officer training, officer inadvertence, technical errors, lack of training, lack of employee cooperation, and lack of Medical Records Officers.

4. CONCLUSION

The implementation of medical records in the UPT Medan Tuntungan Health Center medical records unit is carried out computerized and has been carried out systematically and sequentially, however the implementation of medical records does not have an SOP. The assignment of ICD-10 diagnosis codes at the UPT Puskesmas Medan Tuntungan is not carried out by medical record officers but is carried out by doctors who provide health services to patients at each polyclinic. Medical records officers only carry out pcare by entering the registration code in the pcare application on the computer and then inputting the diagnosis code that has been given by the doctor from the poly department. The implementation of retrieving medical record files at the UPT Puskesmas Medan Tuntungan does not use a tracer, so misfiles often occur and result in additional work for officers because they have to create new medical records for old patients, so the registration process tends to take longer and there is duplication of medical records on storage shelves. In the implementation of returning medical record files, there are still medical record files that are stored incorrectly in their place. The medical record file storage system at the UPT Puskesmas Medan Tuntungan implements a centralized storage system, namely where outpatient medical record documents are stored in the same folder/document, namely using a family folder and the alignment system used is straight numbering filling or a direct number system.

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