

ANALYSIS OF MEDICAL RECORD FILE COMPLETENESS AT KAMPEONAHO PUBLIC HEALTH CENTER

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A B S T R A C T

Background: completeness of medical record documentation is a crucial aspect to ensure service quality, legal certainty, and the availability of accurate health data in primary healthcare centers. Objective: this study aimed to analyze the completeness of outpatient medical record files at Kampeonaho Health Center in 2025. Method: a quantitative descriptive method was employed, with a sample of 77 files out of a total of 327 records selected using a simple random sampling technique. Four components were assessed, namely patient identification, essential reports, authentication, and proper documentation. The results indicated that patient identification components—including name, medical record number, address, and date of birth—were fully completed (100%), whereas the age field showed 2.59% incompleteness. In the essential reports, general consent and visit date were fully documented (100%), while complaint and diagnosis fields had an incompleteness rate of 5.19% each. Authentication by doctors and nurses was 97.40% complete. In terms of documentation, legibility was high (93.50%), but correction entries were relatively low (55.84%). Conclusion: Overall, the completeness of medical records at Kampeonaho Health Center has shown satisfactory results, yet deficiencies remain in authentication and correction documentation. Therefore, enhanced discipline and training for healthcare personnel are necessary to improve the accuracy of medical records and strengthen the quality of healthcare services..

INTRODUCTION

Quality healthcare is highly dependent on the availability of complete, accurate, and accountable medical records. Medical records serve not only as administrative records, but also as legal documents, sources of medical information, bases for financing claims, and references for research and education (Permenkes RI No 24 Tahun 2022) At the primary care level, such as community health centers, the existence of good medical records is crucial because it concerns the continuity of public health services with a promotive and preventive orientation.

However, an issue that is still commonly encountered is incomplete medical records, whether in terms of patient identity, important reports, authentication, or documentation. This incompleteness has serious implications, such as difficulties for healthcare workers in making diagnoses, suboptimal service, and obstacles in claiming insurance coverage (Suaryanti et al., 2022) Preliminary studies conducted at the Kampeonaho Community Health Center in 2025 found that there were still medical records that were not fully completed, including names, signatures of medical personnel, and diagnosis codes on the CPPT sheet, indicating weak documentation discipline.

A number of previous studies have also shown similar problems. Research (Mahyuni et al., 2023) reported that the level of patient identification completeness only reached 61%, while complete important reports only reached 45% (Suaryanti et al., 2022) found that the completeness of important reports was even lower, at 25.35%. These findings confirm that the issue of medical record completeness is not only local in nature, but also a national issue in various health facilities. However, there is still limited research that specifically examines the condition of outpatient medical record completeness at the Kampeonaho Community Health Center, resulting in a research gap that needs to be filled.

The urgency of this research lies in efforts to improve the quality of medical record management in primary health care facilities. Quantitative analysis of medical records can be used to objectively

assess the completeness of files, as well as to identify aspects that still need improvement (Winarso, Pasalle, & Rande, 2020). Thus, this study is expected to not only contribute academically, but also serve as a practical basis for health centers in improving the quality of medical documentation and strengthening the quality of health services.

The purpose of this study is to analyze the completeness of outpatient medical record files at the Kampeonaho Community Health Center in 2025, focusing on four main components, namely patient identification, important reports, authentication, and proper documentation.

METHOD

This study used a quantitative approach with a descriptive design that aimed to describe the completeness of outpatient medical record files at the Kampeonaho Community Health Center in 2025. The data used was secondary data in the form of outpatient medical records. The research population included all outpatient medical records for the period January–February 2025, totaling 327 documents, with a research sample of 77 documents determined using the Slovin formula at a 10% error rate through simple random sampling.

This research was conducted at the Kampeonaho Community Health Center, Baubau City, in April–May 2025. Data were collected using a documentation study method and direct observation of medical records, which included four components of quantitative analysis, namely patient identification, important reports, authentication, and proper documentation. A checklist was used as a research instrument to assess the completeness of each item, supported by a calculator and writing instruments to help record the analysis results.

The collected data was then managed through the stages of editing, classification, and tabulation. The analysis was conducted univariately to calculate the frequency distribution and percentage of each research variable. The analysis results were then presented in the form of tables and descriptive narratives to illustrate the level of completeness of outpatient medical record filling at the Kampeonaho Community Health Center.

RESULTS & DISCUSSION

1. Completeness of Medical Record Documentation at the Kampeonaho Community Health Center
The results of the analysis of medical records at the Kampeonaho Community Health Center are as follows:

- a. Identification Review

The following is Table 4.5, which shows the patient identification review in the medical records at the Kampeonaho Community Health Center:

Table 1 Review of Patient Identification

NO	Identity	Indicator					
		Number of Complete Fillings			Number of Incomplete Fillings		
		N	n	%	N	n	%
1	MR Number	77	77	100,00%	77	0	0,00%
2	Patient name	77	77	100,00%	77	0	0,00%
3	Full address	77	77	100,00%	77	0	0,00%
4	Age	77	75	97,40%	77	2	2,59%
5	Place & date of birth	77	77	100,00%	77	0	0,00%

Based on Table 1, it can be seen that the highest percentage of completeness is for the components of RM number, name, and complete address, with 77 files (100%). Meanwhile, the incompleteness of medical records based on identification has a percentage of 2.59%. The following is a diagram of patient identification at the Kmpeonaho Community Health Center:

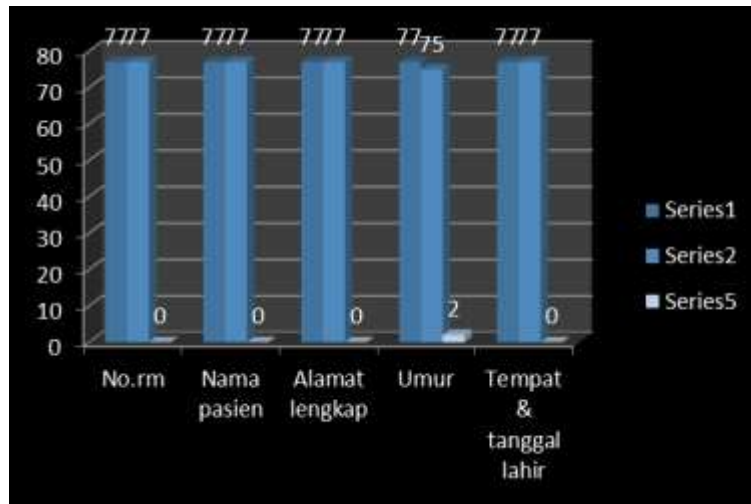


Figure 1 Diagram of Patient Identification Review at Kampeonaho Community Health Center

2. Review of Important Reports

The following is a table reviewing important reports in the medical records at the Kampeonaho Community Health Center:

NO	Important Report	Indicator					
		Number of Complete Fillings			Number of Incomplete Fillings		
		N	n	%	N	n	%
1	Complaints	77	73	94,80%	77	4	5,19%
2	Diagnosis	77	73	94,80%	77	4	5,19%
3	Date of Visit	77	77	100,00%	77	0	0,00%
4	General Consent	77	77	100,00%	77	0	0,00%

Based on Table 2, it can be seen that the highest percentage of completeness in patient medical records is the date of visit and general consent components, with 77 medical records (100%). Meanwhile, the incompleteness of medical records based on important reports is complaints at 5.19% and diagnoses at 5.19%. The following is a diagram of important reports in medical records at the Kampeonaho Community Health Center:

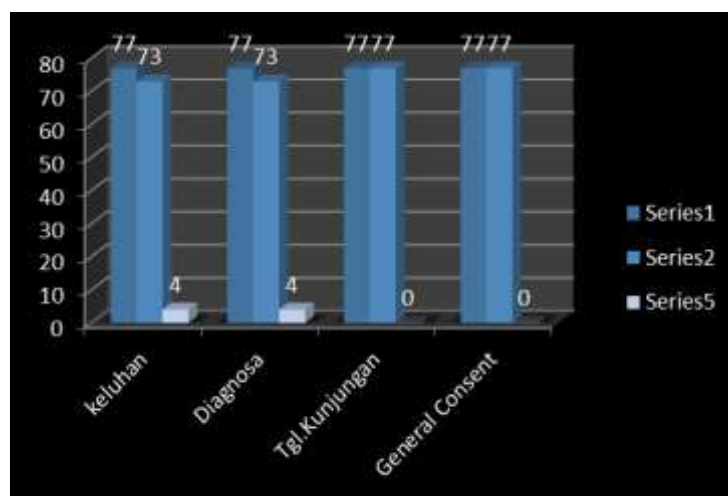


Figure 2 Diagram of Important Patient Reports at the Kampeonaho Community Health Center

3. Authentication Review

The following is a table of authentication reviews on medical records at the Kampeonaho Community Health Center.

Table 3 Authentication Review							
NO	Authentication	Indicator			Indicator		
		Number of Complete Fillings			Number of Incomplete Fillings		
		N	n	%	N	n	%
1	Name of Doctor/Nurse	77	75	97,40%	77	2	2,59%
2	Signature of Doctor/Nurse	77	75	97,40%	77	2	2,59%

Based on Table 3, it can be seen that the completeness of medical records in terms of the name and signature of the doctor/nurse was 75 complete medical records out of 77 records analyzed (97.40%). Meanwhile, the incompleteness of medical records based on authentication shows an incompleteness rate of 2.59% for the name of the doctor/nurse and 2.59% for the signature of the doctor/nurse. The following is a diagram of the authentication review of medical records at the Kampeonaho Community Health Center:

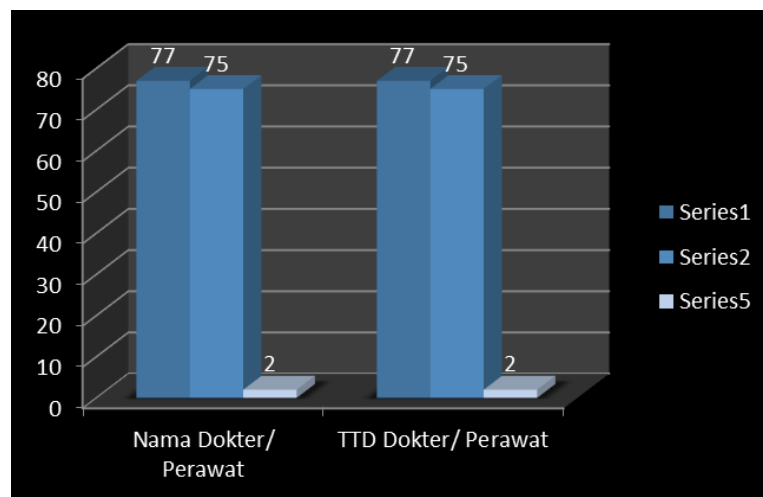


Figure 3 Kampeonaho Community Health Center Patient Authentication Review Diagram

4. Review of Proper Documentation

The following is a table reviewing the proper authentication of medical records at the Kampeonaho Community Health Center.

Table 4 Review of proper documentation

NO	Proper Documentation	Indicator			Indicator		
		Number of Complete Fillings			Number of Incomplete Fillings		
		N	n	%	N	n	%
1	Readability of Writing	77	72	93,50%	77	6	7,79%
2	Improvements in Writing	77	43	55,84%	77	34	44,15%

Based on Table 4, it can be seen that the percentage of completeness in medical records at the Kampeonaho Community Health Center is legible writing (93.50%) and writing corrections (55.54%). The incompleteness of medical records is legible writing (7.79%) and writing corrections (44.15%). The following is a diagram of the correct documentation review of medical records at the Kampeonaho Community Health Center:

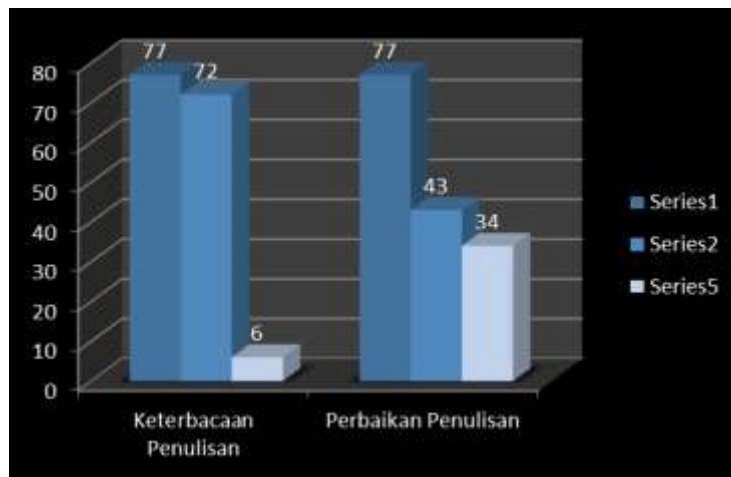


Figure 4 Diagram Review of documentation of patients at the Kampeonaho Community Health Center

The results of the study show that the completeness of outpatient medical records at the Kampeonaho Community Health Center in 2025 is generally in the good category, although there are several aspects that are still not optimal. Patient identification components, including name, medical record number, address, and date of birth, were recorded completely in all samples (100%). However, there was a 2.59% incompleteness in the age section. Important reports, including general consent and date of visit, were also recorded as complete (100%), while the completeness of filling in the main complaint and diagnosis had a deficiency of 5.19% each. In terms of authentication, the completeness of doctor and nurse signatures was 97.40%. The documentation aspect showed that the legibility of writing reached 93.50%, but the completeness of writing corrections was still low at only 55.84%.

These findings show that most medical record completeness indicators have been met, especially in the aspects of patient identification and important reports. These results are in line with research (Mahyuni et al., 2023) which confirms that patient identity is the most consistently filled component, as it is directly related to legal and administrative aspects. The high level of completeness in the general consent component also supports the provisions of Minister of Health Regulation No. 24 of 2022, which emphasizes the importance of informed consent in every health service.

However, the low level of completeness in writing corrections indicates that the implementation of standard operating procedures in terms of record correction is still weak. This is relevant to the findings. (Suaryanti et al., 2022) which reports that the discipline of officers in making corrections is still a common obstacle in primary care facilities. The low completeness of chief complaints and diagnoses can have an impact on the quality of clinical data used in medical and administrative decision-making processes. This emphasizes the importance of improving the accuracy of health workers in documenting substantive clinical data.

Academically, this study contributes by confirming that although the completeness of outpatient medical records at the Kampeonaho Community Health Center is relatively good, there is still a need to strengthen aspects of proper documentation, particularly in terms of writing corrections and recording diagnoses. From a practical standpoint, the implications of this study are the need for routine supervision, ongoing training, and the implementation of a reward and punishment system for medical record officers and medical personnel. These steps are important to ensure the quality of health information, support service accountability, and strengthen the medical record management system in accordance with national standards.

CLOSING

Research on the completeness of outpatient medical record files at the Kampeonaho Community Health Center in 2025 shows that, in general, the documents are fairly complete, but there are still several aspects that need to be improved. In terms of patient identification, the completeness of medical record numbers, names, addresses, and places and dates of birth reached 100%, while the age item still showed an incompleteness rate of 2.59%. In terms of important reports, the date of visit and general consent were 100% complete, but complaints and diagnoses still had incompleteness rates of 5.19% each. Authentication by doctors and nurses showed a completeness rate of 97.40%, with an incompleteness rate of 2.59%. The aspect of proper documentation shows a fairly high legibility of writing (93.50%), but the completeness of writing corrections only reaches 55.84%. These findings confirm that the quality of medical records needs to be continuously improved, especially in terms of authentication and writing corrections.

This study focused on only one location, namely the Kampeonaho Community Health Center, with a sample size of 77 files, so the results cannot be generalized to all primary health facilities. Furthermore, this study uses a quantitative descriptive design, so it is not yet able to analyze the factors causing incompleteness in depth. Therefore, further research is recommended to expand the scope of the location, use a mixed method, and add variables of human resources and institutional policy to obtain a more comprehensive picture.

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