ANALYSIS OF OUTPATIENT MEDICAL RECORD FILES BASED ON ACCREDITATION STANDARDS AT THE KAROBENGKE COMMUNITY HEALTH CENTER

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A B S T R A C T

File Analysis is a review of specific areas of the medical record to identify specific deficiencies. The designated areas are usually written in a procedure developed jointly by the health information manager and the health care provider in accordance with the medical staff rules and policies of the administration and the facility in question and the standards of licensing, accreditation and certification materials. This study aims to determine the analysis of medical record files for outpatients at the Katobengke Health Center in 2024. The method used is using a descriptive type of approach with a quantitative approach and the method of data collection techniques using interview methods, and observation. The population in this study amounted to 2,752 BRM. Sampling using random sampling technique and compressed using a formula which amounted to 96 BRM. The highest level of completeness in the identification component is the name subcomponent with a total of 95 with a percentage value of 99%. The highest level of completeness in the important report component is in the Complaints, Diagnosis, and Visit Date subcomponents with a total of 96 medical record files with a completeness percentage value of 100% The highest level of completeness in the authentication component is in the doctor's name subcomponent with a total of 86 medical record files with a completeness percentage value of 89%. The highest level of completeness in the correct documentation component is in the Legible Writing subcomponent with a total of 36 medical record files with a completeness percentage value of 37%. The suggestion for this study is that the hospital should conduct socialization or counseling to doctors, nurses and / or midwives to complete each available sheet to be completed.

INTRODUCTION

Puskesmas acts as the spearhead in providing health services to the community in Indonesia, tasked with organizing public health efforts and providing basic care for individuals. With a focus on promotive and preventive approaches, Puskesmas are committed to improving the overall and optimal health status of the community. This health initiative is designed to serve the community as a whole, aiming to achieve an excellent degree of health, without compromising the quality of individual care. Every service provided by the health center is meticulously recorded in the medical record file, ensuring that every patient receives the attention they deserve.

Puskesmas is a Health Service Facility (Faskes). Health Service Facility is a place used to organize health service efforts, both promotive, preventive, curative and rehabilitative carried out by the government, local government and / or the community. Puskesmas has the task of implementing health policies to achieve health development goals in its working area (Sinta, 2023).

Puskesmas serves as a pioneer in first-level health services, playing an important role in realizing optimal health and efficient medical record management. To ensure high service quality, reliable medical record performance is key. Medical records not only record the patient's identity, but also document the results of examination, treatment, and various other actions and services. With this accurate and comprehensive information, puskesmas can continue to innovate and improve the quality of services for the community (Sitti Budiaty & Latumbu, 2022).

A medical record is a collection of documents that includes important information about a patient, including identity, examination results, treatment, medical measures, and other services received. The main purpose of medical records is to ensure smooth administration and improve the quality of health services in hospitals. Every interaction and action towards the patient must be

carefully recorded, while maintaining the confidentiality of the information so that it is not accessed by unauthorized parties (Wahyuni, 2023).

Medical records are archives that store various important records about patients, ranging from identity to the results of examinations and medical actions that have been given. This document serves as a complete guide in maintaining the optimal quality of health care and other services that patients have received.Medical records are considered quality if they meet the following criteria: Accurate, complete, reliable, valid, and timely. High quality medical records ensure that the recorded health information is an appropriate and comprehensive representation of the patient's condition and treatment, and is available at the time required to support effective medical decisions. According to (Siswati & Dea Ayu Dindasari, 2019), Medical records are valuable archives that document who the patient is, the type of care provided, the reasons behind it, the time of service, and the way it is carried out. With this information, medical records become an important guide in the patient's healing journey and health management.

Medical records play a crucial role as they serve as important records or documents that must be protected and kept confidential (Nugroho, 2020). A quality medical record contains sufficient information about the patient and the services received, including the knowledge needed to identify the patient, confirm the diagnosis and treatment, and record the outcome. The existence and security of medical records are key to ensuring that important health information remains accurate, complete and confidential. File analysis is the process of reviewing medical records in specific areas to identify specific deficiencies. The areas to be analyzed are usually specified in procedures jointly developed between the health information manager and the healthcare provider, in accordance with medical staff regulations, administrative policies, and standards from relevant licensing, accreditation, and certification agencies.

Medical records are documents that contain records regarding patient identity, examination results, treatment, actions, and other services received at health facilities. One of the main objectives of medical records is to support optimal service for patients (Wahyudi et al., 2022). The impact of not using medical record file analysis is that each patient does not know what diseases they suffer from, what types of drugs are given and cannot find out their health history or diseases that have been suffered.

Completeness of medical record filling is an important issue, considering that this document stores crucial information about the patient's condition (Ahmad Maulana & Herfiyanti, 2021). This incompleteness can occur due to several factors, one of which is the lack of sanctions from the puskesmas for doctors or nurses who do not complete medical records (Uyang et al., 2023).

Medical record incompleteness is a condition where medical records contain deficiencies, errors, or ambiguities that may affect the outcome of a diagnosis, medical action, or important reports. This can interfere with the quality of care and decisions made (Lestari & Muflihatin, 2020).

Based on research conducted by (Halimatusaadah & Hidayati, 2022), the completeness of filling out outpatient medical records at the General Poly UPTD Puskesmas Haurwangi, namely, the results of the analysis of the completeness of patient identification there were 64 complete medical record documents 92% and there were 7 incomplete, representing 10% of the total. However, of the 65 documents reviewed, 92% have been filled in properly, with only 6 documents still having deficiencies (8%). In terms of authentication, 63 documents were found to be complete, giving a result of 89%, while 8 documents remained incomplete (11%). Interestingly, in the record review, all 71 documents were filled in perfectly, achieving a 100% completeness rate. This signifies impressive progress in medical record management, creating a strong foundation for better healthcare.

From the results of preliminary research at the Katobengke Health Center, it was found that medical record files had not been filled in completely from the first quarter, namely January to March 2024, and based on the results of preliminary confirmation to the medical records officer stated that after the service was completed, sometimes no inspection was carried out again regarding the filling of medical record files and the files were immediately returned to the storage rack.

METHODOLOGY

This type of research is quantitative research, namely quantitative research is a type of research used to answer a research problem related to data in the form of numbers (Putra et al., 2023). This research design uses a descriptive design, which aims primarily to describe the characteristics of a phenomenon in detail and systematically Scientific Writing will be about an objective situation (Putra et al., 2023).

Cross-sectional studies are a type of observational research that collects and analyzes data from variables at a single point in time, covering the entire sample population or a defined subset. This approach, also known as cross-sectional analysis, transversal study, or prevalence study, provides a comprehensive picture of the phenomenon under study. With this approach, data is collected at one specific moment to get a comprehensive picture of the distribution or prevalence of a phenomenon in the population. This approach allows researchers to capture a picture of the situation at a single point in time, providing valuable insights into existing patterns, relationships, and characteristics.

This research was conducted at the Katobengke Health Center, and this research was conducted from March to April 2024. The population studied included all outpatient medical record files in the first quarter of January to March 2024 at the Katobengke Health Center. The sample in this study were outpatient medical record files from the Katobengke Health Center in Baubau City with a population of 2,752 medical record files. Sampling was conducted using simple random sampling technique, where sample members were randomly selected from the population without regard to strata. This method gives each individual an equal chance of being selected, resulting in a pure and representative sample for more accurate analysis (Bella et al., 2019). And the technique for calculating the sample size uses the Slovin formula.

Variables in this study refer to measures or characteristics that distinguish members of a group from others. In the quantitative analysis of medical record files, there are several key components that are evaluated, namely Identification Review, Significant Report Review, Authentication Review, and Recording Review. Each of these components contributes to providing a clearer and more detailed picture of the quality of medical data.

RESULTS AND DISCUSSION

Identification

Based on the results of the study of the completeness of filling out outpatient medical record files at the Katobengke Health Center in the first quarter of data, namely January to March that the completeness of filling out the patient identification component with a sample of 96 outpatient medical record files, that the lowest percentage value of completeness in the Address subcomponent with a total of 38 BRM (40%), and the highest completeness in the name subcomponent with a total of 95 BRM (99%).

Based on the results of research from (Valentina & Melayu, 2020), it shows that the number of correct filling of the nine components of identity data is 86 medical record files. The number of files with nine unfilled components was 0, indicating that all medical record files in the sample contained complete and accurate patient social data, in accordance with the patient's identity card. In conclusion, all medical record files in the sample were filled with correct and comprehensive information.

Medical record files like patient files must have a medical record number, name and date of birth, which ensures that the medical record file really belongs to the patient concerned and marks the sheets if the sheets are scattered into the file or elsewhere. Analysis of the completeness of filling in the identification component was carried out by examining each sheet in the patient's medical record file. Medical records are said to be complete if all the data in them are filled in properly and in accordance with the provisions set by the hospital. One important aspect is the completeness of identification, which aims to ensure the owner of the document. Each sheet of medical record documents must include administrative data and demographic information that is filled in completely. Failure to do so may result in failure to confirm identity (Karma et al., 2019). Patients serve as a major source of statistical data, research, and strategic planning for hospitals or health care institutions. Information obtained from patients helps in the process of decision-making, service development, and improving the quality of health care more effectively. Data collected from patients is used for statistical analysis, research development, and strategic planning to improve the quality of healthcare services. Well-integrated patient data helps in statistical analysis, research development, and strategic decision-making to improve the quality of healthcare and healthcare planning.

Based on (Kemenkes RI, 2023) concerning Puskesmas Accreditation Standards, medical records are prepared in accordance with applicable laws and regulations, becoming a vital component in the world of health. This document contains a comprehensive record of the patient's identity, examination results, treatment, actions, and other services that have been provided. Medical records must be carefully organized, both in clear and complete written form, as well as electronically, to ensure the security and ease of access to this important information.

Based on the results of the research that has been conducted, it is not in accordance with the theory that the contents of the identification review on each sheet of medical record documents, including administrative data and demographic information, must be filled in completely. If not, this can result in difficulties in confirming the patient's identity, which is an important basis for data management. statistics, the identification filling is still not completely and fully filled in (Karma et al., 2019).

This study is not in line with the results of research from (Bella et al., 2019), The medical record files used as samples fully contain patient social data that is filled in completely and accurately, in accordance with the information contained in the patient's identity card.

Important Report

Based on the results of the analysis of the completeness of filling out outpatient medical record files that have been carried out at the Katobengke Health Center, the data for the first quarter, namely January to March, that the completeness of filling out the important report component files with a total sample of 96 outpatient medical record files, the lowest level of completeness of filling is in the Informed Consent subcomponent with a total of 27 record files (28%). The highest level of completeness in the important report component is in the Complaints, Diagnosis, and Date of Visit subcomponents with a total completeness of 96 medical record files (100%).

Based on research from (Gumilar & Herfiyanti, 2021), it shows that the lowest percentage of completeness was recorded in 0 files (0%). Meanwhile, the highest percentage of completeness was found in the important report components, namely diagnosis and date of admission, with 81 files (100%) completely filled. In contrast, the lowest percentage of completeness was found in the operation report, where 51 files (62.92%) were properly filled.

Completeness of medical records is very important as it has a direct impact on the care provided by medical staff and affects the overall quality of care received by patients. Complete documentation ensures that all relevant information is available to support appropriate medical decisions and effective treatment. Complete medical record documents serve to maintain the quality of health services, while incomplete filling is an indicator of service quality known as the incomplete filling rate of medical records (NEVITA, 2021).

The results of this study still have components that are not completely filled in so that they are not in accordance with theory (NEVITA, 2021) In line with research (Gumilar & Herfiyanti, 2021), the highest in the important report component is in the Complaints, Diagnosis, and Date of Visit subcomponents with a total completeness of 50 medical record files with a completeness percentage value of 100%, but in the informed consent component there is still no correct and precise sheet with a completeness rate of 100%.

Authentication

Based on the results of the research on the analysis of the completeness of filling in medical record files that have been carried out at the Katobengke Health Center in the first quarter month data, namely January to March, that the authentication component, with a total sample of 96 outpatient medical record files, has the lowest level of completeness in filling in the Nurse's Name with a total of 36 medical record files (37%). The highest level of completeness in the Authentication component is in the doctor's name subcomponent with a total completeness of 86 medical record files (89%).

Based on research (Fahrunisa et al., 2023), the level of completeness of patient identity and examination results has reached 100%, reflecting good quality. However, in the aspect of the doctor's/nurse's signature, there were still 64% of incomplete medical record documents, which did not meet the SPM standards. On the other hand, the informed consent document showed good results: the patient's identity was 100% complete, but the provision of information, the type of information, and the signatures of the doctor and witnesses 1 and 2 only reached 76%. This indicates that there is still room for improvement for all elements to meet the SPM standards.

In research (Swari et al., 2019), that the components of nursing diagnoses, discharge plans, education sheets, consent / refusal of action, and informed consent contain authentication in all 86 medical record files sampled. Meanwhile, the discharge checklist component showed correct authentication in 63 medical record files. Research on proper authentication showed the following results:

In the outgoing patient resume component, there are 82 medical record files ready for processing.
The initial assessment component recorded 69 identified files.

In the integrated sheet component, we found 72 complete medical record files.
In the nursing care component, there were 67 files registered.
The radiology and/or laboratory results component included 75 significant files.
he operation report shows 83 processed medical record files.

This result indicates the number of medical record files that have been properly authenticated in each of the important components of the medical record. Doctors, nurses/midwives and all other providers of nursing actions are very important to fill in signatures and clear names to clearly know who the provider of nursing actions is and who is responsible for a patient In the Law of the Republic of Indonesia No. 29 of 2004 concerning Medical Practice, Article 46 Paragraph (3) emphasizes that every medical record record must include the name, time, and signature of the officer who provided the service or action. This provision ensures accountability and transparency, and provides protection for patients and medical personnel in every health service process. Based on the Minister of Health Regulation on Puskesmas Accreditation Standards (2023) that, Every record in the medical record must be compiled completely and clearly, include the name, time, and signature of the doctor, dentist, and / or health worker who provides services must record information sequentially according to the time of service provided, to ensure a clear sequence of care and facilitate proper coordination in patient handling.

The results of this study are not in accordance with the Regulation (Kemenkes RI, 2023), concerning Puskesmas Accreditation Standards, because there are still many sheets that are not filled in with signatures and clear names, which makes it less certain about who the doctor in charge of the patient is. In line with research conducted by (Fahrunisa et al., 2023), that in the paraf element or signature of doctors and nurses, it was found that 64% of medical record documents were still in incomplete status and did not meet SPM standards. This indicates the need for more attention to improve the accuracy of documentation, in order to ensure compliance with procedures and optimal service quality.

Correct Documentation

Based on the results of the research on the analysis of the completeness of filling in medical record files that have been carried out at the Katobengke Health Center in the first quarter month data, namely January to March, that the documentation component with a total sample of 96 correct outpatient medical record files, the lowest level of completeness of filling is in the error correction subcomponent with a total of 3 medical record files (3%). The highest level of completeness in the correct documentation component is in the Legible Writing subcomponent with a total completeness of 36 medical record files (37%).

According to the Minister of Health Regulation on Standards (Kemenkes RI, 2023), If an error occurs in recording medical records, doctors, dentists, and other health workers can make corrections by crossing out one line, without deleting the wrong record, then giving the initials and date on the correction. If additional words or sentences are needed, they must also be accompanied by initials and dates. From research conducted by (NEVITA, 2021), the highest percentage of completeness lies in the item of clear recording, which recorded a perfect score of 100%. On the other hand, the most significant incompleteness occurred in the legible diagnosis item for obstetric cases, reaching 60.5%. This reflects that a lack of attention from staff in recording can affect the quality of important information, often focusing on speed of service, especially when dealing with many patients, thus paying less attention to the quality of writing in medical records.

Based on the results of research conducted at the Katobengke Health Center, there are still patient names that have not been filled in completely and error corrections that sometimes do not have a signature and cannot be read, so that they do not meet the contents of the Minister of Health Regulation Regarding (Kemenkes RI, 2023), in line with research conducted by (NEVITA, 2021), that there are still items that have not reached the correct level of documentation reaching 100%.

CONCLUSION

Based on the results of research and discussion that the completeness of filling out outpatient medical record files at the Katobengke Health Center in Baubau City has been carried out, the following conclusions are obtained:

Completeness of filling in the patient identification component with a sample of 96 hospitalized medical record files, that the lowest percentage value of completeness in the Address

subcomponent with a total of 38 BRM (40%), and the highest completeness in the name subcomponent with a total of 95 BRM (99%).

Completeness of filling in important report components with a sample number of 96 outpatient medical record files, the lowest level of completeness was in the Informed Consent subcomponent with 27 record files (28%). The highest level of completeness in the important report component is in the Complaints, Diagnosis, and Visit Date subcomponent with a total of 96 medical record files (100%).

Completeness of filling in the Authentication component, with a total sample of 96 outpatient medical record files, the lowest level of completeness was in the Nurse's Name with a total of 36 medical record files (37%). The highest level of completeness in the Authentication component is in the doctor's name subcomponent with a total completeness of 86 medical record files (89%).

Completeness of filling in the correct documentation component with a total sample of 96 correct outpatient medical record files, the lowest level of completeness was in the error correction subcomponent with a total of 3 medical record files (3%).

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REFERENCES

Ahmad Maulana, D., & Herfiyanti, L. (2021). Analisis Kelengkapan Rekam Medis Rawat Inap Di RSUD Bayu Asih Purwakarta. *Cerdika: Jurnal Ilmiah Indonesia, 1*(8), 933–938. https://doi.org/10.36418/cerdika.v1i8.147

Bella, Y., Suhendri, H., & Ningsih, R. (2019). Peranan Metode Pembelajaran The Power Of Two Terhadap Kemampuan Pemecahan Masalah Matematika. *Jurnal Mercumatika : Jurnal Penelitian Matematika Dan Pendidikan Matematika*, *3*(2), 129. https://doi.org/10.26486/jm.v3i2.821

Fahrunisa, F., Halid, M., & Ikhwan, I. (2023). Analisis Kelengkapan Pengisian Berkas Rekam Medis. *J-REMI : Jurnal Rekam Medik Dan Informasi Kesehatan*, *4*(2), 52–56. https://doi.org/10.25047/j-remi.v4i2.3373

Gumilar, R. A., & Herfiyanti, L. (2021). Analisis Kelengkapan Rekam Medis Rawat Inap di Rumah Sakit Umum Bina Sehat Bandung. *Cerdika: Jurnal Ilmiah Indonesia*, *1*(9), 1192–1199. https://doi.org/10.36418/cerdika.v1i9.163

Halimatusaadah, H. I., & Hidayati, M. (2022). Analisis Kelengkapan Pengisian Rekam Medis Pasien Rj Poli Umum Guna Menunjang Mutu Rekam Medis. *J-REMI : Jurnal Rekam Medik Dan Informasi Kesehatan*, *3*(2), 159–168. https://doi.org/10.25047/j-remi.v3i2.2737

Karma, M., Wirajaya, M., Made, N., & Kartika, U. (2019). Analisis Ketidaklengkapan Rekam Medis Pasien Rawat Inap di Rumah Sakit Dharma Kerti Tabanan. *Jurnal Administrasi Rumah Sakit Indonesia*, *6*(1), 10–20. https://doi.org/10.7454/arsi.v6i1.3553

Kemenkes RI. (2023). *Kepmenkes Nomor 165 Tahun 2023 Tentang Standar Akreditasi Puskesmas (Pusat Kesehatan Masyarakat)*. 1–195.

Lestari, D. F. A., & Muflihatin, I. (2020). Analisis Faktor Penyebab Ketidaklengkapan Rekam Medis Pasien Rawat Inap di Puskesmas Kotaanyar. *J-REMI : Jurnal Rekam Medik Dan Informasi Kesehatan*, *2*(1), 134–142. https://doi.org/10.25047/j-remi.v2i1.2217

NEVITA, N. R. (2021). Analisis Ketidaklengkapan Rekam Medis Rawat Inap Di Rumah Sakit. *Indonesian Journal of Health Information Management*, *1*(2), 11–20. https://doi.org/10.54877/ijhim.v1i2.14

Nugroho, E. A. (2020). Implementasi Undang-Undang Negara Republik Indonesia Nomor 11 Tahun 2008 Tentang Informasi & Transaksi Elektronik (Uu Ite) Terhadap Rekam Medis Elektronik (Emr). *Jurnal JURISTIC*, *1*(03), 276. https://doi.org/10.35973/jrs.v1i03.1863

Putra, W. A., Norhayati, S. L., & Wijaya, P. R. (2023). Pengaruh Menggunting Pola Transportasi Terhadap Kemampuan Motorik Halus Anak KB Al Karomah Tahun Ajaran 2022-2023. *Tematik: Jurnal Penelitian Pendidikan Dasar*, *2*(1), 60–67. https://doi.org/10.57251/tem.v2i1.985

Sinta. (2023). Pelayanan Rekam Medis. *Jurnal Kesehatan*, *4*(43), 2289–2296.

Siswati, S., & Dea Ayu Dindasari. (2019). Tinjauan Aspek Keamanan Dan Kerahasiaan Rekam Medis Di Rumah Sakit Setia Mitra Jakarta Selatan. *MEDICORDHIF Jurnal Rekam Medis*, *6*(2), 91–99. https://doi.org/10.59300/mjrm.v6i0.49

Sitti Budiaty, W. O., & Latumbu, S. (2022). Perancangan Tracer/Out Guide Berkas Rekam Medis Di Puskesmas Wolio Kota Baubau. *Jurnal Sains Dan Kesehatan*, *1*(1), 16–26. https://doi.org/10.57151/jsika.v1i1.28

Swari, S. J., Alfiansyah, G., Wijayanti, R. A., & Kurniawati, R. D. (2019). Analisis Kelengkapan Pengisian Berkas Rekam Medis Pasien Rawat Inap RSUP Dr. Kariadi Semarang. *ARTERI : Jurnal Ilmu Kesehatan*, *1*(1), 50–56. https://doi.org/10.37148/arteri.v1i1.20

Uyang, I. T., Ardan, M., & Umar, Z. (2023). Analisis Kelengkapan Rekam Medis Pasien Rawat Jalan Di Puskesmas Sungai Siring Samarinda. *Jurnal Sains Dan Teknologi*, *5*(1), 284–288.

Valentina, & Melayu, S. M. (2020). *Gambaran ketidaklengkapan pengisian formulir laporan anestesi*. *5*(2), 149–155.

Wahyudi, K., Wahab, S., & Ganesha, P. P. (2022). *Di Uptd Puskesmas Kaliwedi*. *1*, 69–77.

Wahyuni, S. (2023). Tinjauan Pelepasan Informasi Medis Kepada Pihak Bpjs Di Rumah Sakit Umum Daerah Kabupaten Buton Tahun 2019. *Jurnal Kesehatan Tambusai*, *4*, 2303–2317. http://journal.universitaspahlawan.ac.id/index.php/jkt/article/view/15711