



## **Analysis of Medical Record Evaluation Based on KARS Standards at RS TK II Moh. Ridwan Meuraksa Jakarta**

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### **ABSTRAK**

This study focuses on evaluating the medical records at RS TK II Moh. Ridwan Meuraksa, Jakarta, in line with the standards set by the Komite Akreditasi Rumah Sakit (KARS). The evaluation aims to measure the quality of the hospital's medical record system, a critical aspect of hospital operations that impacts patient care and administrative efficiency. The research employs both qualitative and quantitative methods to assess the medical records against KARS standards. Key findings indicate that while the hospital meets basic compliance requirements, there are significant areas for improvement, particularly in the completeness and accuracy of records. Recommendations include the implementation of enhanced training programs for staff, regular audits, and the adoption of advanced electronic medical record systems. The study highlights the importance of adhering to established standards to ensure high-quality healthcare delivery and suggests that continuous improvement in medical record management is essential for achieving accreditation and improving overall patient outcomes.

**Kata Kunci:** Relationship, Consumption, Cariogenic Food, Incidence of Dental Caries, In Grade 5 Children, SDN 10 Kampung Baru

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### **1. Introduction**

Medical records are the backbone of hospital operations, serving as a repository of patient information, including diagnoses, treatments, and outcomes. In Indonesia, the





Komite Akreditasi Rumah Sakit (KARS) sets the standards for medical record management, ensuring that hospitals maintain accurate and complete records to support clinical care and administrative processes. RS TK II Moh. Ridwan Meuraksa, a military hospital in Jakarta, underwent an evaluation of its medical record system to assess compliance with KARS standards. The purpose of this study is to analyze the quality of the hospital's medical records, identify gaps in compliance, and recommend strategies for improvement. This study is particularly relevant given the increasing emphasis on healthcare quality and the role of accreditation in ensuring that hospitals meet national and international standards. By examining the hospital's medical records, this research contributes to the broader effort to enhance healthcare delivery in Indonesia.

## 2. Research Methods

This study uses a mixed-methods approach, combining both qualitative and quantitative research methods to assess the medical records at RS TK II Moh. Ridwan Meuraksa. The qualitative component involves document analysis and interviews with hospital staff responsible for maintaining medical records. This helps to understand the processes, challenges, and perceptions related to medical record management at the hospital.

The quantitative component includes a thorough evaluation of the medical records using the KARS standards as benchmarks. Each record is assessed for completeness, accuracy, timeliness, and compliance with legal and regulatory requirements. The study also employs a SWOT analysis to identify the strengths, weaknesses, opportunities, and threats related to the hospital's medical record system. Data collection occurred over three months, from June to August 2012, and involved reviewing a representative sample of medical records from various departments within the hospital.

## 3. Results and Discussion

### a) Overview of Medical Record Management at RS TK II Moh. Ridwan Meuraksa

RS TK II Moh. Ridwan Meuraksa, as a military hospital, plays a critical role in providing healthcare services not only to military personnel but also to their families and the broader civilian population. The hospital's medical record system is





central to its operations, impacting everything from patient care to administrative efficiency and legal compliance. The hospital's current system relies heavily on manual processes, which, while effective in some respects, pose significant challenges in terms of scalability, accuracy, and timeliness. The hospital management has recognized the need to evaluate its medical record management practices to ensure they align with the standards set by KARS, which are essential for maintaining accreditation and ensuring the delivery of high-quality healthcare services.

#### b) **Compliance with KARS Standards**

The evaluation of the medical records at RS TK II Moh. Ridwan Meuraksa against KARS standards revealed several areas where the hospital's practices are falling short. According to KARS standards, medical records must be comprehensive, accurate, and updated in a timely manner. However, the study found that while the hospital meets the basic documentation requirements, there are significant inconsistencies in the quality of the records.

For instance, patient histories, which are critical for ongoing care and treatment planning, were often found to be incomplete. In many cases, important information such as previous diagnoses, treatments, and medication histories were missing or inadequately documented. This lack of completeness not only hampers the ability of healthcare providers to make informed decisions but also increases the risk of medical errors.

Moreover, the study found that the accuracy of the records was compromised by the use of outdated forms and templates. Many of the forms used for patient documentation had not been updated in several years, leading to inconsistencies in the way information was recorded. This was particularly evident in the documentation of patient diagnoses and treatment plans, where the use of outdated terminology and classifications often led to confusion and misinterpretation.

Timeliness was another significant issue identified in the evaluation. According to KARS standards, medical records should be updated promptly to reflect the most current information about a patient's condition and treatment. However, the





study found that there were frequent delays in updating the records, particularly in cases where patients were transferred between departments or discharged from the hospital. These delays often resulted in incomplete records being used for clinical decision-making, which could potentially compromise patient safety.

### c) Challenges in Medical Record Management

The interviews conducted with hospital staff provided valuable insights into the challenges they face in managing medical records. One of the primary challenges identified was the lack of training on KARS standards and the importance of maintaining high-quality medical records. Many staff members reported that they had not received formal training on medical record management, and as a result, they were not fully aware of the standards they were expected to meet.

Another challenge was the insufficient number of staff dedicated to medical record management. The hospital's medical records department was found to be understaffed, with a limited number of personnel responsible for maintaining and updating the records for the entire hospital. This not only placed a significant burden on the existing staff but also led to delays and errors in record-keeping.

The hospital's IT infrastructure was also identified as a major challenge. While electronic medical records (EMRs) are widely recognized as a solution for improving the accuracy and efficiency of medical record management, the hospital's current IT systems were found to be inadequate for supporting a fully electronic system. The lack of investment in modern IT infrastructure meant that the hospital continued to rely heavily on paper-based records, which are more prone to errors and delays.

Additionally, the coordination between departments was found to be lacking, which contributed to fragmented record-keeping. In many cases, different departments maintained their own records, which were not always integrated into the hospital's central system. This fragmentation made it difficult to track a patient's history across different departments, leading to incomplete or inconsistent records.

### d) SWOT Analysis





The SWOT analysis conducted as part of this study provided a comprehensive overview of the strengths, weaknesses, opportunities, and threats associated with the hospital's medical record management system.

**Strengths:** One of the key strengths identified was the commitment of the hospital staff to maintaining accurate records, despite the challenges they face. The staff's dedication to their work was evident in the interviews, where many expressed a strong sense of responsibility for ensuring that records were maintained to the best of their ability. Additionally, the hospital's strategic location in Jakarta provides it with a steady flow of patients, which supports the hospital's financial stability and its ability to invest in improvements.

**Weaknesses:** However, several weaknesses were also identified, including the reliance on outdated technology and manual record-keeping processes. The study found that the hospital's medical record management practices were hampered by the use of paper-based records, which are not only inefficient but also prone to errors and loss. The lack of standardized forms and templates further exacerbated these issues, leading to inconsistencies in the way information was recorded and stored.

**Opportunities:** The study identified several opportunities for improving the hospital's medical record management system. One of the most significant opportunities is the adoption of electronic medical records (EMRs), which have the potential to streamline record-keeping processes, reduce errors, and improve the accuracy and timeliness of records. Additionally, the hospital has the opportunity to implement continuous training programs for its staff, which would help to ensure that they are fully aware of KARS standards and the importance of maintaining high-quality records.

**Threats:** The primary threat identified was the potential loss of accreditation if the hospital's medical record management practices are not improved. Accreditation is essential for the hospital's continued operation and its ability to provide high-quality healthcare services. The study also identified the risk of legal





liability if the hospital's records are found to be incomplete or inaccurate, particularly in cases where medical errors occur as a result of poor record-keeping.

#### e) **Recommendations for Improvement**

Based on the findings of this study, several recommendations have been made to improve the medical record management practices at RS TK II Moh. Ridwan Meuraksa. These recommendations are designed to address the gaps identified in the evaluation and to ensure that the hospital's medical records comply with KARS standards.

1. **Adoption of Electronic Medical Records (EMRs):** The adoption of electronic medical records (EMRs) is one of the most significant steps the hospital can take to improve its medical record management practices. EMRs have been shown to reduce errors, improve the accuracy and completeness of records, and streamline the process of updating and maintaining records. The hospital should invest in modern IT infrastructure to support the implementation of EMRs, and staff should be trained on how to use the new system effectively.
2. **Regular Audits and Continuous Improvement:** The hospital should implement a system of regular audits to monitor compliance with KARS standards and to identify areas for improvement. These audits should be conducted by a dedicated team with expertise in medical record management, and the findings should be used to inform continuous improvement efforts. By regularly reviewing and updating its practices, the hospital can ensure that it remains in compliance with accreditation standards and provides high-quality care to its patients.
3. **Staff Training and Development:** Continuous training and development programs should be implemented to ensure that all staff members are fully aware of the importance of maintaining high-quality medical records and are equipped with the skills and knowledge to do so. This training should cover both the technical aspects of medical record management, such as how to use EMRs, and the legal and ethical considerations involved in record-keeping.





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4. **Standardization of Forms and Templates:** To address the inconsistencies identified in the evaluation, the hospital should standardize the forms and templates used for medical record-keeping. This will help to ensure that all records are complete and accurate and that the information is recorded in a consistent manner. Standardization will also make it easier to integrate records from different departments and to maintain a comprehensive and up-to-date record for each patient.
5. **Enhancing IT Infrastructure:** Investing in modern IT infrastructure is critical for the successful implementation of EMRs and for improving the overall efficiency of the hospital's medical record management system. The hospital should ensure that its IT systems are capable of supporting a fully electronic record-keeping system and that adequate support is available for staff who may need assistance with the new technology.
6. **Improving Inter-Departmental Coordination:** Improving coordination between departments is essential for ensuring that all relevant information is captured in the medical records. The hospital should implement protocols for sharing information between departments and for integrating records into the central system. This will help to reduce fragmentation and ensure that all records are complete and accurate.

#### 4. Conclusion

##### 1) Summary of Key Findings

The evaluation of medical record management at RS TK II Moh. Ridwan Meuraksa against KARS standards has provided a comprehensive understanding of both the strengths and weaknesses of the current system. The findings of this study highlight several critical issues that need to be addressed to ensure that the hospital's medical records meet the high standards required for accreditation and, more importantly, contribute to the delivery of high-quality healthcare services.

The study revealed that while the hospital meets basic documentation requirements, significant challenges remain in terms of the completeness, accuracy,





and timeliness of records. These challenges are primarily attributed to the reliance on outdated, manual record-keeping systems, insufficient training for staff, and inadequate IT infrastructure. The implications of these findings are far-reaching, as poor medical record management can lead to medical errors, compromised patient care, and potential legal liabilities.

Despite these challenges, the hospital has a number of strengths that can be leveraged to improve its medical record management system. These include a committed and dedicated staff, a strong institutional reputation, and a strategic location that supports a steady flow of patients. By building on these strengths and addressing the identified weaknesses, RS TK II Moh. Ridwan Meuraksa has the potential to significantly enhance its medical record management practices, thereby improving both patient outcomes and operational efficiency.

## 2) Broader Implications for Healthcare Management

The findings of this study have broader implications for healthcare management, particularly in the context of hospital administration and quality improvement. Medical records are not merely administrative tools; they are integral to the delivery of safe, effective, and patient-centered care. As such, the management of medical records must be prioritized as a critical aspect of healthcare administration.

One of the key lessons from this study is the importance of investing in modern technology to support medical record management. The transition from paper-based records to electronic medical records (EMRs) is no longer a luxury but a necessity for any hospital that aims to provide high-quality care. EMRs offer numerous benefits, including improved accuracy, better accessibility of information, and enhanced coordination of care. Hospitals that fail to make this transition risk falling behind in terms of both operational efficiency and quality of care.

Moreover, this study underscores the need for continuous training and professional development for hospital staff. The management of medical records is a complex task that requires a deep understanding of both clinical and administrative processes. Without adequate training, staff may not fully appreciate the importance of





maintaining high-quality records or may lack the skills necessary to do so. Continuous education and training programs are therefore essential to ensure that all staff members are equipped with the knowledge and skills required to maintain accurate, complete, and up-to-date medical records.

Another significant implication of this study is the role of leadership in driving quality improvement initiatives. Effective leadership is crucial for setting the vision, mobilizing resources, and fostering a culture of quality within the organization. Hospital leaders must take an active role in overseeing the management of medical records, ensuring that the necessary investments in technology and training are made, and that staff are held accountable for maintaining high standards of record-keeping.

The study also highlights the importance of regular audits and reviews in maintaining compliance with accreditation standards. Accreditation is not a one-time event but an ongoing process that requires continuous monitoring and improvement. Regular audits of medical records can help identify gaps in compliance and provide valuable insights into areas where improvements are needed. These audits should be conducted by a dedicated team with expertise in medical record management, and the findings should be used to inform ongoing quality improvement efforts.

### 3) Recommendations for Policy and Practice

Based on the findings of this study, several recommendations can be made for both policy and practice. These recommendations are intended to guide hospital administrators, policymakers, and healthcare providers in improving medical record management practices and ensuring compliance with accreditation standards.

- a. **Implementation of Electronic Medical Records (EMRs):** The adoption of EMRs should be a top priority for RS TK II Moh. Ridwan Meuraksa. EMRs offer numerous advantages over paper-based records, including improved accuracy, easier access to patient information, and enhanced coordination of care. The hospital should invest in modern IT infrastructure to support the implementation of EMRs and ensure that staff are adequately trained to use the new system. Policymakers should also consider providing financial incentives or support to





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hospitals to facilitate the transition to EMRs, particularly for smaller or resource-limited institutions.

- b. Continuous Training and Professional Development:** The hospital should implement continuous training and professional development programs for all staff involved in medical record management. These programs should cover both the technical aspects of record-keeping, such as how to use EMRs, as well as the legal and ethical considerations involved in maintaining patient records. Training should be mandatory for all relevant staff and should be regularly updated to reflect changes in standards, regulations, and best practices.
- c. Regular Audits and Quality Assurance:** Regular audits of medical records should be conducted to ensure compliance with KARS standards and to identify areas for improvement. These audits should be part of a broader quality assurance program that includes regular reviews of hospital policies, procedures, and practices related to medical record management. The findings from these audits should be used to inform continuous improvement efforts and to ensure that the hospital remains in compliance with accreditation standards.
- d. Standardization of Forms and Documentation Processes:** The hospital should standardize the forms and templates used for medical record-keeping to ensure consistency and accuracy across all departments. Standardization will help to reduce errors, improve the completeness of records, and make it easier to integrate information from different sources. Policymakers should consider developing national or regional guidelines for the standardization of medical records to ensure consistency across healthcare institutions.
- e. Enhancing IT Infrastructure:** Investment in IT infrastructure is critical for the successful implementation of EMRs and for improving the overall efficiency of medical record management. The hospital should ensure that its IT systems are capable of supporting a fully electronic record-keeping system and that adequate support is available for staff who may need assistance with the new technology.





Policymakers should consider providing funding or technical assistance to hospitals to help them upgrade their IT infrastructure.

- f. Strengthening Inter-Departmental Coordination:** Improving coordination between departments is essential for ensuring that all relevant information is captured in the medical records. The hospital should implement protocols for sharing information between departments and for integrating records into the central system. This will help to reduce fragmentation and ensure that all records are complete and accurate. Policymakers should consider developing guidelines or best practices for inter-departmental coordination in hospitals to improve the quality of care and patient outcomes.
- g. Leadership and Accountability:** Hospital leaders must take an active role in overseeing the management of medical records and ensuring that the necessary resources are allocated to this critical function. Leadership should set the vision for quality improvement, mobilize resources, and foster a culture of accountability within the organization. Policymakers should consider developing leadership training programs for hospital administrators to equip them with the skills and knowledge needed to lead quality improvement initiatives effectively.

#### 4) Future Research Directions

While this study provides valuable insights into the management of medical records at RS TK II Moh. Ridwan Meuraksa, further research is needed to explore several areas in more detail. Future research could focus on the following areas:

- 1. Impact of EMRs on Healthcare Quality:** Research is needed to assess the impact of EMRs on healthcare quality, including their effect on patient outcomes, efficiency, and satisfaction. Studies could compare hospitals that have implemented EMRs with those that have not, to determine the benefits and challenges of this technology.
- 2. Barriers to EMR Adoption:** Further research is needed to identify the barriers to the adoption of EMRs, particularly in resource-limited settings. Understanding





these barriers can help policymakers and healthcare providers develop strategies to overcome them and facilitate the transition to electronic records.

3. **Best Practices in Medical Record Management:** There is a need for more research on best practices in medical record management, particularly in the context of accreditation and quality improvement. Studies could explore the practices of high-performing hospitals and identify the key factors that contribute to their success in maintaining high-quality records.
4. **Role of Leadership in Quality Improvement:** Research is needed to explore the role of leadership in driving quality improvement initiatives in hospitals. Studies could examine the impact of different leadership styles and approaches on the success of quality improvement efforts, including the management of medical records.
5. **Patient Perceptions of Medical Records:** Research could also explore patient perceptions of medical records and their role in healthcare delivery. Understanding patient attitudes towards medical records, including issues of privacy, access, and accuracy, can help healthcare providers improve their practices and better meet patient needs.

## 5. Compliance with ethical standards

### 1. Ethical Framework in Healthcare

Healthcare is a field deeply rooted in ethical principles, given its direct impact on human lives. The management of medical records is an area where ethical considerations are particularly important, as these records contain sensitive personal information about patients. Ethical compliance in medical record management is not just about adhering to legal requirements but also about upholding the trust that patients place in healthcare providers to protect their privacy and ensure the accuracy of their medical history.

RS TK II Moh. Ridwan Meuraksa operates within the ethical framework established by the Indonesian Ministry of Health, which mandates strict adherence to patient rights, confidentiality, and data protection standards. The ethical principles





guiding the hospital's operations include respect for patient autonomy, beneficence, non-maleficence, and justice. These principles form the foundation of the hospital's approach to managing medical records, ensuring that all actions taken are in the best interest of the patients while maintaining the highest standards of professionalism and integrity.

## 2. Patient Confidentiality and Data Protection

Patient confidentiality is a cornerstone of medical ethics and is enshrined in both national and international regulations. The confidentiality of medical records is crucial because it protects patients from potential harm that could arise from unauthorized access to their personal health information. At RS TK II Moh. Ridwan Meuraksa, maintaining the confidentiality of medical records is a top priority. The hospital has implemented various measures to safeguard patient information, including secure storage systems, restricted access to records, and strict protocols for the handling and sharing of information.

One of the key challenges in maintaining patient confidentiality is the transition from paper-based to electronic medical records (EMRs). While EMRs offer numerous benefits, such as improved accessibility and accuracy of information, they also pose new risks in terms of data security. To mitigate these risks, the hospital is in the process of upgrading its IT infrastructure to ensure that all electronic records are protected by robust cybersecurity measures. This includes encryption of sensitive data, regular security audits, and training for staff on best practices for data protection.

Additionally, access to medical records at RS TK II Moh. Ridwan Meuraksa is strictly controlled. Only authorized personnel have access to patient records, and any access to these records is logged and monitored to prevent unauthorized use. The hospital has also established clear guidelines for the sharing of patient information, ensuring that it is only shared with those who have a legitimate need to know, and only with the patient's consent.

## 3. Informed Consent





Informed consent is another critical aspect of ethical compliance in healthcare. Patients have the right to be informed about how their medical records will be used, who will have access to them, and how their privacy will be protected. At RS TK II Moh. Ridwan Meuraksa, obtaining informed consent is a fundamental practice that is integrated into all aspects of patient care and record management.

Before any information is recorded or shared, patients are provided with clear and comprehensive information about the purpose of the data collection, how their information will be used, and their rights regarding their medical records. This includes the right to access their own records, the right to request corrections to any inaccurate information, and the right to refuse the sharing of their information with third parties, except where legally required.

Informed consent is particularly important in the context of research or audits involving medical records. When medical records are used for research purposes, patients are fully informed about the nature of the research, the potential risks and benefits, and the measures in place to protect their privacy. Patients must voluntarily agree to participate, and their consent is documented in their medical records. The hospital also ensures that any research conducted using patient records is reviewed and approved by an ethics committee to ensure that it meets all ethical standards.

#### **4. Ethical Challenges in Medical Record Management**

Managing medical records in a way that complies with ethical standards presents several challenges, particularly in a complex and dynamic environment like a hospital. One of the primary challenges is balancing the need for comprehensive and accurate record-keeping with the need to protect patient privacy. This is especially challenging in cases where patients have complex medical histories that require detailed documentation.

Another challenge is ensuring that all staff members are aware of and adhere to ethical standards in their daily work. The hospital addresses this challenge through regular training and education programs that emphasize the importance of ethics in medical record management. These programs cover topics such as patient





confidentiality, informed consent, and the ethical use of medical information. By fostering a culture of ethics, the hospital ensures that all staff members understand their responsibilities and are equipped to handle ethical dilemmas when they arise.

The hospital also faces challenges related to the ethical use of technology in medical record management. As the hospital transitions to electronic medical records, it must navigate the ethical implications of digital data storage and sharing. This includes ensuring that the technology used is secure, that patient data is protected from unauthorized access, and that the digital records are as accurate and reliable as their paper counterparts. The hospital's IT department plays a critical role in addressing these challenges by implementing state-of-the-art security measures and providing ongoing support and training to staff.

## 5. Accountability and Transparency

Ethical compliance in medical record management also requires a commitment to accountability and transparency. At RS TK II Moh. Ridwan Meuraksa, this commitment is reflected in the hospital's policies and procedures, which are designed to ensure that all actions related to medical records are documented and that there is a clear chain of responsibility for maintaining the integrity of these records.

The hospital has established protocols for auditing and reviewing medical records to ensure that they meet ethical standards. These audits are conducted regularly and involve a review of both the content of the records and the processes used to maintain them. Any discrepancies or areas of concern identified during the audits are addressed promptly, with corrective actions taken to prevent future occurrences.

Transparency is also a key component of the hospital's approach to ethical compliance. The hospital is committed to being open and honest with patients about how their information is used and protected. This includes providing patients with access to their own medical records and responding promptly to any requests for





information or corrections. By maintaining transparency, the hospital builds trust with its patients and ensures that they feel confident in the care they receive.

## 6. Ethical Standards and Continuous Improvement

Finally, compliance with ethical standards in medical record management is an ongoing process that requires continuous improvement. RS TK II Moh. Ridwan Meuraksa is committed to regularly reviewing and updating its policies and practices to ensure that they remain aligned with the latest ethical guidelines and best practices in healthcare.

The hospital's ethics committee plays a central role in this process, providing guidance on ethical issues and reviewing new policies and procedures before they are implemented. The committee also oversees training programs and ensures that all staff members are kept up-to-date with the latest developments in medical ethics.

Continuous improvement also involves staying informed about new technologies and trends in medical record management and assessing their ethical implications. The hospital actively participates in professional organizations and conferences to stay abreast of the latest developments and to ensure that its practices are aligned with industry standards.

In conclusion, RS TK II Moh. Ridwan Meuraksa is deeply committed to maintaining high ethical standards in all aspects of its medical record management. By prioritizing patient confidentiality, obtaining informed consent, addressing ethical challenges, and fostering a culture of accountability and transparency, the hospital ensures that its medical records are managed in a way that respects the rights and dignity of its patients. Continuous improvement is at the heart of the hospital's approach, ensuring that it remains compliant with ethical standards and continues to provide high-quality care.

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