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Management of Inpatient Medical Records at Dr. Tajuddin Chalid Hospital Makassar

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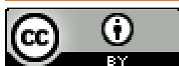
Abstract. Hospitals are health care institutions that organize comprehensive individual health services that provide inpatient, outpatient, and emergency services. Therefore, hospitals are expected to be able to carry out good medical recording activities. Since pre-independence Indonesia has carried out medical recording activities, it's just that it has not been implemented properly, in terms of structuring and processing or following the correct information system. One of the supports for improving the quality of the hospital is in its Medical Record activities. Medical records are related to recording, processing data, and reporting information needed for hospital activities. Medical records as patient health records are useful for providing information from various data on activities carried out to patients while patients are undergoing treatment at the hospital. This study aims to determine how the processing of inpatient medical record files at Ujung Pandang Dr. Tajuddin Chalik Hospital. The research conducted used qualitative research methods with a descriptive approach, namely research that describes and describes the inpatient medical record management system at Dr. Tajuddin Chalik General Hospital. The results of this study are the process of processing medical record files consisting of the process of Completeness (Assembling), Coding (Coding), and Storage (Filling). Conclusion Based on the results of research on the Inpatient Medical Record Management System at Dr Tajuddin Chalid Hospital Makassar that for the input component, namely the medical record personnel of Dr Tajuddin Chalid Hospital Makassar still lacks officers so that it is no longer in accordance with the workload. For facilities and infrastructure, there is a shortage of storage shelves and expansion is needed for medical record storage rooms.

Keywords: Management, Inpatient Medical, Hospital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1. Introduction

Medical records can also be interpreted as information both written and recorded about identity, anamneses, physical examinations, laboratories, diagnoses as well as all medical services and actions provided to patients and treatment both inpatients, outpatients and those who get emergency services. If studied more deeply, medical records do not only contain ordinary medical records, because these records have reflected all information regarding a patient which will be used as a basis for determining further actions in service efforts and other medical actions given to a patient. Medical records have a very broad meaning not only as a recording activity but also as a system of organizing an installation / unit of activity. While the recording activity itself is only one form of activity listed in the job description in the medical record unit/installation (Ministry of Health, 2006).

2. Research Method

The research conducted used qualitative research methods with a descriptive approach, namely research that describes and describes the inpatient medical record management system of Dr. Tajuddin Chalid Ujung Pandang Hospital. Data collection techniques. This research uses two sources, namely: Primary data: The data collection method uses in-depth interviews guided by instruments that have been prepared in advance to find out the inpatient medical record management system. Secondary Data: to complement the data from in-depth interviews, researchers also collect data and documents that are already available and can be obtained through literature, viewing, and listening.

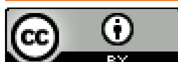
3. Results And Discussions

a. Result

The result of this study is that the medical record file processing process consists of the Completeness process: (Assembling, Coding, and Filling.

b. Discussion

1) File arrangement (Assembling). The Assembling section is part of the medical record processing process that first receives medical record files from nurses, whose job is to ensure that all data on the medical record file has been filled in completely and then give the medical record file to the Coding section for the next medical record process.
2) Coding. The Coding section is part of the medical record file processing process that receives complete medical record files from the Asseembling section, to be given Coding from diagnoses made by doctors. The function of the code can be used as a cost claim from the care and treatment received by the patient and facilitates service in the presentation of information to support the functions of planning, management, and research in the health sector.



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3) Storage (Filling). The Coding section is part of the medical record file processing process in charge of taking medical record files when patients arrive and receiving complete medical record files from the Coding section and are ready to be stored. Then manage the medical record storage room so that the medical record files remain arranged according to serial numbers and neatly organized.
4) Human Resources to the Medical Record Processing Process. Taking an important role related to the processing of medical record files. The continuity of the medical record processing process depends on the medical record officer so that it will produce complete, accurate and timely medical records.

4. Conclusion

a) For the input component, namely Hospital medical record personnel are still short of officers so that they are no longer in accordance with their workload. For facilities and infrastructure, there is a shortage of storage shelves and an expansion is needed for the medical record storage room. For the flow of hospital inpatient medical record files, it is not in accordance with the flow of inpatient medical record files made by the Ministry of Health and in the processing process there is a process that is not carried out systematically according to the flow made.
b) For the process component, namely in the medical record processing process in the File Arrangement section (Assembling) the officer is less careful in checking the completeness of the medical record file as a result when the medical record file is submitted to the Coding section there are still incomplete files.
c) For the medical record processing process in the Coding section, officers have difficulty in providing patient diagnosis codes due to the unclear diagnosis written by the doctor so they have to contact the doctor again, then returning incomplete medical record files is not done in a systematic way.
d) For the medical record processing process, the Storage (Filling) section in implementing the medical record storage system has used centralization, meaning that the hospital has followed the Guidelines for the Implementation of Hospital Medical Records issued by the Ministry of Health.

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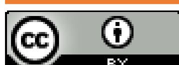
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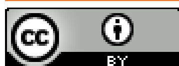
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