

## **COMPLETENESS OF MEDICAL RECORD DOCUMENTS FOR INPATIENT KIDNEY FAILURE AT THE HOSPITAL**

**Tasya Aisyah Adinda Raekha<sup>1</sup>, Sri Wahyuningsih<sup>1</sup>, Nor Akmar Bt Mohd Yahya<sup>2\*</sup>**

<sup>1</sup>Universitas Duta Bangsa Surakarta, Jl. K.H Samanhudi No.93, Sondakan, Laweyan, Kota Surakarta, Jawa Tengah 57147, Indonesia

<sup>2</sup>University Malaysia of Computer Science & Engineering, Block 12, Star Central, Lingkaran Cyber Point Timur, 63000 Cyberjaya, Selangor, Malaysia

\*[akmar.yahya@unimy.edu.my](mailto:akmar.yahya@unimy.edu.my)

### **ABSTRACT**

Health service providers are required to record all services provided to patients in the form of a complete medical record file. Incomplete filling of medical records can lead to misinformation used by health professionals in providing services or treatment plans. This study aims to determine the completeness of medical record documents and the factors that cause incomplete medical record documents for kidney failure. This research is a literature study. The sample in this study were 5 journals related to the completeness of medical record documents for inpatient cases of kidney failure using purposive sampling technique. The instrument in this study used the google application. Processing of data by searching on the site, collecting overall journals, journal screening and extracting data based on inclusion criteria using the Systematic Literature Review (SLR) method. The analysis was carried out using data analysis techniques, namely quantitatively. The results of the study on the completeness of medical record documents for inpatient kidney failure based on a review of patient identification, the entire journal was incomplete, 100% incomplete, mostly on the name and age items. Review reporting there is 1 journal is 100% complete, 4 journals are not complete 100% incomplete mostly on date and time items, authentication review the entire journal is not complete. 100% of the incompleteness is found in the items of the doctor's name and the doctor's signature. The review of the recording of the entire journal is not complete. 100% of the incompleteness is on the item using the fixed line on the blank form. The factor of the incompleteness of the medical resume on the inpatient document is due to the lack of accuracy of the officers infilling, lack of discipline of officers, and the absence of a clear SOP. The conclusion of this study is that from 5 journals regarding the completeness of medical record documents in terms of reviews of identification, reporting, authentication and recording, it shows that medical record documents are 100% incomplete. This is due to the lack of accuracy of officers in filling it out, lack of discipline of officers, and the absence of clear SOPs.

Keywords: analysis quantitative kidney failure; completeness of inpatient; medical record documents

### **INTRODUCTION**

Health care facilities that are currently needed by the community are hospitals. In Law No. 44 of 2009, it is explained that hospitals have an important role in providing individual health services in a complete manner including the provision of inpatient, outpatient, and emergency services that are obliged to record all services provided to patients in the form of medical records files. Medical records can be created in writing or electronically containing records of the patient's identity, examination, treatment, actions and other services that have been provided to the patient. Medical record data is used as a means of communication between professions so that the data must be complete and accurate.

Incomplete filling in medical records can lead to misinformation used by the health profession in providing services or treatment plans. In Law No. 29 of 2004 it is explained that every medical record must be spiked with the name, time and signature of the officer who provides the

service or action. Medical records must be completed as soon as the patient gets services from the hospital. The time used to complete the inpatient medical record is 2 x 24 hours, while the outpatient medical record is 1 x 24 hours. Efforts to maintain the quality of service (Quality Assurance) of hospitals can be done by improving the quality of medical records that are fast, precise, useful and accountable. Quality Assurance (QA) is carried out to maintain the completeness of medical record documents seen from quantitative analysis and qualitative analysis. Quantitative analysis is used to find out the completeness by using 4 reviews, namely identification reviews, reporting reviews, authentication reviews and record keeping reviews.

Until now the completeness of medical records documents in the hospital has not been fully completed. Based on research conducted by Miftachul Ulum (2019) it is known that the highest completeness is found in the authentication review which is 79% and the highest incompleteness is found in the identification review which is 75%. Then based on research conducted by Fitriyani Lubis and Khairina Rizki (2018) it was known that the incompleteness of medical records files amounted to 27.2% and the completeness of medical records files by 72.8%. While the research conducted by Septi Nur Rayahu, Sri Sugiarsi and M. Arief TQ (2013) with the title Quantitative Analysis of Inpatient Medical Record Documents in Chronic Kidney Disease Cases is known that of the four reviews, the highest incompleteness occurs in the recording review, namely correction of errors on the form (71.43%) clear and readable writing (10.71%), while the highest completeness occurs in the identification review which is 100%. The impact that occurs if the medical record file is incomplete is the lack of orderly administration in an effort to improve the quality of service, the decline in the quality of medical records, the vagueness of information in the medical record file so that it can cause errors in the patient's action and treatment plan and inaccuracies in decision-making by hospital leaders report resulting from incomplete medical records files.

One of the diseases that should be recorded in the medical record is kidney failure. Kidney failure is the biggest cause of death in Indonesia, a disease caused by progressive and irreversible damage to kidney function where the body's ability to fail to maintain metabolism and balance of fluids and electrolytes causes uremia in the form of ureum retention and other nitrogen waste in the blood. Medical records documents of kidney failure must be complete, this is to make it easier for doctors to monitor treatment because patients have to undergo a series of treatments, actions and therapies on a regular basis. Based on the facts above, researchers are interested in reviewing and describing the literature review study of the completeness of medical records documents for hospitalization of kidney failure in hospitals, using four reviews, namely identification reviews, authentication reviews, reporting reviews and recording reviews.

## **METHOD**

The type of research used is literature studies. Literature study method is a series of activities related to the method of collecting library data, reading and recording, and processing research materials (Zed, 2008: 3). This study describes the completeness of medical records documents for hospitalization of kidney failure in hospitals. According to Notoatmodjo (2018: 103) variables are measures or characteristics owned by members of a group that are with those owned by other groups. The variables associated in this study are completeness of medical records documents for hospitalization of kidney failure disease based on identification review, completeness of medical records documents for hospitalization of kidney failure disease based on reporting review, completeness of medical records documents hospitalized kidney failure disease based on

authentication review, completeness of medical records documents hospitalized kidney failure disease based on record review and factors affecting the cause of incompleteness of medical records documents hospitalized kidney failure

The data obtained from this study is secondary data obtained by bukam from direct observation. however, from the results of research that has been done by previous researchers. Research data sources are primary data in the form of relevant article or journal literature. Search the literature using the google scholar database. The keyword used in this study is "completeness of medical records documents for hospitalization of kidney failure in hospitals". Data screening is done by applying stories of inclusion and exclusion. Inclusion criteria are criteria that if met can cause prospective objects to become research objects. While the exclusion criteria are criteria that if found to cause objects cannot be used in research. In this study after passing the screening stage up to data extraction, the analysis can be done by combining all data that meets the requirements of inclusion using techniques either quantitatively, qualitatively or both. In this study, researchers will use data analysis techniques, namely quantitatively. Data that has been processed properly processed manually or using the help of a computer, will have no meaning without being analyzed. Analyzing data is not just describing and interpreting the data that has been processed. Final output of data analysis must obtain the meaning or meaning of the research (Notoatmodjo, 2018)

## RESULTS

### Overview of Research Subjects

The completeness of medical records documents for hospitalization of kidney failure is very important, because the data written in the medical record document will be used by medical personnel including doctors to monitor patient treatment so that the data written must also be complete and continuous. In the process of preparing a literature study aimed at knowing the completeness of the medical records documents of hospitalization in kidney failure in hospitals and knowing the factors causing the incompleteness of hospitalized medical records documents, researchers used 5 journals as a reference. Based on 5 journals on the completeness of medical record documents used by researchers as a reference for literature studies, researchers can present a picture of the research subject as follows:

Table 1.

Overview of Research Subjects

No	Researcher's Name	Year	Types of Research	Research Instruments	Population	Sample
1.	Septi Nur Rahayu, et al	2013	Descriptive	Observation and checklist guidelines	112 medical record documents	56 medical record documents
2.	Miftachul Ulum	2019	Descriptive	Observation, interview and checklist guidelines	40 medical record documents	40 medical record documents
3.	Susanti, et al	2013	Descriptive	Observation and checklist guidelines	72 medical record documents	72 medical record documents
4.	Venny Ryana Wati, et al	2016	Descriptive	Observation, interview and checklist guidelines	46 medical record documents	46 medical record documents

No	Researcher's Name	Year	Types of Research	Research Instruments	Population	Sample
5.	Bima Yunus Dzulhanto	2018	Descriptive	Observation, interview and checklist guidelines	217 medical record documents	43 medical record documents

Research conducted by Septi Nur Rahayu, et al (2013) using the type of descriptive research and research instruments, namely by using observation guidelines and checklist for a population of 112 medical record documents and samples of 56 medical record documents. Research conducted by Miftachul Ulum (2019) using descriptive research types and research instruments, namely by using observation guidelines, interviews and checklist for populations and samples of 40 medical record documents. Susanti's research, et al (2013) used descriptive research types and research instruments, namely using observation guidelines and checklist with a population and a sample of 72 medical record documents. While the study by Venny Ryana Wati, et al (2016) used descriptive research types and research instruments, namely using observation guidelines, interviews and checklist with populations and samples of 46 medical record documents. In addition, research conducted by Bima Yunus Dzulhanto (2018) used descriptive research types and research instruments, namely by using observation guidelines, interviews and checklist for the population.

### **Completeness of Medical Records Documents for Hospitalization of Kidney Failure Disease Based on Quantitative Analysis**

#### **Completeness and Incompleteness Based on Identification Review**

Each medical record form must include the identity of the patient at least consisting of the name of the patient and his medical record number. This is to avoid the loss of the medical record form if there is a form scattered without the name of the owner of the form. In the evaluation of the identification of the items studied are the medical record number, name and age of the patient that must be written on all medical record forms. Based on 5 journals on the completeness of medical record documents used by researchers as the basis of literature studies, the results of the completeness of medical record documents are obtained based on the following identification review:

Table 2.  
 Completeness Based on Identification Review

No	Researcher's Name	Year	Results of Completeness in The Identification Review Medical Record Document
1.	Septi Nur Rahayu, et al	2013	Of the 56 medical record documents obtained the highest completeness results of 100% on the item name, medical record number, age and contained in the entry and exit summary form and laboratory examination results report. The lowest completeness on the item name, medical record number, age is found on the chart form and the nurse or midwife record by 50%. So it can be concluded that the document is not 100% complete
2.	Miftachul Ulum	2019	Of the 40 medical record documents obtained the highest completeness result of 25% of all medical record forms and the

No	Researcher's Name	Year	Results of Completeness in The Identification Review Medical Record Document
			lowest completeness of 75% of all medical records form. So it can be concluded that the document is not 100% complete.
3.	Susanti, et al	2013	The highest completeness result of 100% on the item name, medical record number, age is found on the entry and exit summary form and laboratory results while the lowest completeness on the item of medical record number, name and age is contained on the ECG form at 58.33%. So it can be concluded that the document is not 100% complete.
4.	Venny Ryana Wati, et al	2016	Of the 46 medical record documents obtained the highest completeness of 100% on the age item contained on the entry and exit summary form, laboratory results. The lowest completeness in the name and age items is contained in the integrated development record form of 34.78%. So it can be concluded that the document is not 100% complete.
5.	Bima Yunus Dzilhanto	2018	Of the 43 medical record documents obtained the highest completeness results 100% on the name item, medical record number, age on all medical record documents and the lowest completeness on the name item contained in the integrated patient development record form of 46.51%. So it can be concluded that the document is not 100% complete.

Based on the research results of Septi Nur Rahayu, et al (2013) it is known that from 56 medical record documents, the highest completeness result was obtained by 100% on the item name, medical record number, age and found on the entry and exit summary form and inspection report laboratory. The lowest completeness on the item name, medical record number, the age is on the chart form and the nurse or midwife record is 50%, so it can be concluded that the document is not 100% complete. While the research of Ulum Miftachul Ulum (2019) is known from 40 medical record documents obtained results of completeness 25% of all medical record form. Lowest equipment 75% of all medical record form, so it can be concluded that the document does not 100% complete, so it can be concluded that the document is not complete 100%.

Then the results of research conducted by Susanti., et al (2013) It is known that from 72 medical record documents the results obtained are: the highest completeness of 100% on the item name, medical record number, age is on the entry and exit summary form and laboratory results while the lowest completeness is on the items of medical record number, name and the age on the ECG form is 58.33%, so it can be concluded that the document is not 100% complete. While research by Venny Ryana Wati, et al (2016) that of 46 medical record documents the highest completeness result obtained is 100% on the age item contained in the summary form of entry and exit, laboratory results. The lowest completeness of the name and age item is on the form integrated progress record of 34.78%, so it can concluded that the document is not 100% complete. Bima Yunus Dzilhanto's research (2018) found that 43 medical record documents obtained the highest completeness results 100% in item name, medical record number, age on all medical record documents and the lowest completeness of the name item is on the note form integrated patient development by 46.51% so that it can concluded that the document is not 100% complete.

1. Completeness and Incompleteness Based on Reporting Review

Everything obtained from the patient must be reported in the record medical history, as well as the results of examinations and consultations. Important to note that in every recording of this report must be include the date and time. It is closely tied to the rules filling out medical records and very important when tracking is needed an event. In the reporting review, the items studied are hours and hours the date of the examination or action as well as the results of the inspection report the patient's laboratory which must be written on all medical record forms. Based on 5 journals regarding the completeness of medical record documents which is used by researchers as the basis for the study of literature, it is obtained the results of the completeness of the medical record document based on the reporting review as follows :

Table 3.  
 Completeness Based on Reporting Review

No	Researcher's Name	Year	Results of Completeness in The Identification Review Medical Record Document
1.	Septi Nur Rahayu, et al	2013	From 56 medical record documents, the highest completeness result was 100%. the date and time items are contained in the entry and exit summary form, history taking, physical examination, nurseofntohteesd,istheeaseouaree contained in the entry and exit summary form and anamnesis or physical examination while the lowest percentage is on the discharge summary form.
2.	Miftachul Ulum	2019	Of the 40 medical record documents, thehighest completeness result was 45%. on the hour item of all medical record forms. The lowest completeness is 55% on the date item of all medical record forms. So it can be concluded that the document is not 100%
3.	Susanti, et al	2013	Of 72 medical record documents, the highest completeness result was 100% on the date and time items contained in the entry and exit summary form, physical examination, laboratory results while the lowest completeness is 0%. So it can be concluded that the complete document is 100%
4.	Venny Ryana Wati, et al	2016	Of the 46 medical record documents, the highest completeness results were 100% on the date and time items contained in the entry and exit summary form, nutritional care, initial examination examination, assessment, careplans, integrated records and nursing rewcohrildes the lowest completeness on the time and date items contained on the medical management plan form by 13.04%. So it can be concluded that the document is not 100% complete.
5.	Bima Yunus Dzulhanto	2018	From 43 medical record documents, the highest completeness result was 100% on the date and time items of all medical record forms. The lowest completeness of 2.33% on the date and time items is found in the operation report form and the anesthesia report. So it can be concluded that the document is not 100% complete.

Research by Septi Nur Rahayu, et al (2013) that of 56 medical record documents obtained 100% completeness results on items the date and time are listed on the entry and exit summary form, history taking, physical examination, nurse's notes, disease course are found in entry and exit summary form and history or physical examination while the lowest percentage on the discharge summary form by 87.5%, so it can be concluded that the document is incomplete 100%. Miftachul Ulum's research (2019) that out of 40 recorded documents, medical results obtained the highest completeness of 45% on the hour item of all medical record forms. The lowest completeness is 55% on date items from all medical record forms, so that it can be concluded that the document is not 100% complete.

While research by Susanti., et al (2013) that out of 72 medical record documents obtained results of 100% completeness are found in entry and exit summary form, physical examination, laboratory results on date and time items. The lowest 0% completeness is on the form summary of entry and exit, physical examination, laboratory results on items date and time, so it can be concluded that the complete document 100%. While research by Venny Ryana Wati, et al (2016) that From 46 medical record documents, the highest completeness result was obtained 100% on the date and time items are on the summary form entry and exit, nutritional care, initial examination, assessment, planning care, integrated records and nursing records while the lowest completeness on the item time and date is on the form medical management plan by 13.04% so it can be concluded that the document is not 100% complete. Bima Yunus Dzulhanto's research shows that from 43 recorded documents, medical equipment obtained the highest completeness result of 100% on items date and time of all medical record forms. Lowest equipment of 2.33% on the date and time items contained in the report form surgery and anesthesia reports, so it can be concluded that the incomplete 100%.

## 2. Completeness and Incompleteness Based on Authentication Review

Completing medical records applies the principle that every entry must be clear responsibility. The clarity of the person in charge is realized with the inclusion of the full name and signature, which What is meant by the full name (full name) is the full name accompanied by the title complete. This is done so that, if one day it happens wrong action can be known who is the responsible doctor over the patient. In the authentication review, the items under study are: signature and full name of the doctor in charge of the patient who must written on all medical record forms. Based on 5 journals regarding the completeness of medical record documents which is used by researchers as the basis for the study of literature, it is obtained the results of the completeness of the medical record document based on the authentication review as follows :

Table 3.  
 Completeness Based on Authentication Review

No	Researcher's Name	Year	Results of Completeness in The Identification Review Medical Record Document
1.	Septi Nur Rahayu, et al	2013	From 56 medical record documents, the highest completeness result was 100% on the item in charge of the name of the person in charge and the signature of the person in charge is on the form summary in and out, while the lowest completeness is found in the summary form for discharge patients, which is 50% on the item in charge of the name of the person in charge and the signature of the

No	Researcher's Name	Year	Results of Completeness in The Identification Review Medical Record Document
			person in charge. So it can be concluded that the document is not 100% complete.
2.	Miftachul Ulum	2019	Of the 40 medical record documents, the highest completeness result was 79% on the name of the person in charge of all medical record forms. The lowest completeness is 21% on the signature item in charge of all medical record forms. So it can be concluded that the document is not 100% complete.
3.	Susanti, et al	2013	From 72 medical record documents, the highest completeness result was 100% on the item the name of the person in charge and the signature of the person in charge are found on the entry and exit summary forms. Meanwhile, the lowest percentage of completeness on the item in charge of the name and signature of the person in charge is found on the disease course form or doctor's instructions, which is 50%. So it can be concluded that the document is not 100% complete.
4.	Venny Ryana Wati, et al	2016	From 46 medical record documents, the highest completeness result was 100% on the item in charge of the bright name contained in the entry and exit summary forms, general assessments, plans medical management, records integrated development. While the lowest completeness of 13.04% on the item in charge of the name of the person in charge is found on the initial nutritional care form and the summary of discharge. So it can be concluded that the document is not 100% complete.
5.	Bima Yunus Dzulhanto	2018	From 43 medical record documents, the highest completeness result was 46.51% on the name of the person in charge. on the nursing care summary form. The lowest completeness of 37.21% on the item in charge of the signature is found in the laboratory results. So it can be concluded that the document is not 100% complete

Research by Septi Nur Rahayu, et al (2013) that out of 56 documents medical records obtained the highest completeness results 100% on the item name person in charge and the signature of the person in charge is on summary form in and out, while the lowest completeness is on the discharge patient summary form, which is 50% on the name item person in charge and the signature of the person in charge, so that concluded that the document is not 100% complete. Research by Miftachul Ulum (2019) that from 40 medical record documents obtained results the highest completeness of 79% on the item name of the person in charge of all medical record forms. Lowest completeness of 21% on items the signature of the person in charge of all medical record forms, so that it can be concluded that the document is not 100% complete.

Susanti et al (2013) research that out of 72 recorded documents, medical results obtained 100% completeness on the item name person in charge and the signature of the person in charge is on entry and exit summary forms. While the percentage of completeness lowest on the item

responsible for the name and signature the person in charge is on the disease course form or instructions doctor, which is 50%, so it can be concluded that the incomplete 100%. Research by Venny Ryana Wati, et al (2016) that From 46 medical record documents, the highest completeness result was obtained of 100% on the item the bright name of the person in charge there is on entry and exit summary forms, general assessments, plans medical management, integrated progress records, while the lowest completeness is 13.04% on the item in charge of the name of the person in charge contained in the initial nutritional care form and discharge summary, so that it can be concluded that the document is not 100% complete.

Based on research by Bima Yunus Dzulhanto (2018) that of 43 medical record documents obtained results of completeness 46.51% found on the nursing care summary form in the item name person responsible. The lowest completeness of 37.21% is in laboratory results on the item in the signature of the person in charge, so that it can be concluded that the document is not 100% complete.

### 3. Completeness and Incompleteness Based on Recording Review

Recording reviews are principally used to assess whether medical records have met these aspects and to maintain quality as well as the completeness of the medical record documents. On record review The items studied were the use of lines in empty lines, clarity of writing, and initialing the wrong words that must be written on all medical record forms. Based on 5 journals regarding the completeness of medical record documents which is used by researchers as the basis for the study of literature, it is obtained the results of the completeness of the medical record document based on a record review as follows : Research by Septi Nur Rahayu, et al (2013) from 56 recorded documents medical examination, the highest completeness result was 39.29% on the item the use of clearly legible lines is found on the disease course form, Doctor's instructions The lowest completeness is 28.57% on items the use of clearly legible lines is found on the return summary form, so it can be concluded that the document is not 100% complete. Study conducted by Miftachul Ulum (2019) that out of 40 recorded documents, medical records obtained results of completeness of 56% of all medical record forms on items use clearly legible lines and error correction. The lowest completeness is 44% of all medical record forms in the use of line items is clearly legible, so it can be concluded that Documents are not 100% complete.

Susanti et al (2013) research from 72 medical record documents The highest completeness result obtained is 100% found on the form summary of entry and exit, physical examination on writing items clearly legible. he lowest completeness of 15.28% is on the travel form disease or the instructions on the writing item are clearly legible, so it can be concluded that the document is not 100% complete. While research by Venny Ryana Wati, et al (2016) of 46 medical record documents the highest completeness result was 89.13% on the item the use of fixed lines is found on the initial examination assessment form lowest completeness of 19.56% on the fixed line usage items found on the nursing assessment form, discharge summary, so that it can be concluded that the document is not 100% complete. Based on Bima Yunus Dzulhanto (2018) from 43 recorded documents medical equipment obtained the highest completeness result of 100% on items use of fixed lines in hernia disease forms. Whereas the lowest completeness of 95.35% on the fixed line usage items contained in the entry and exit summary forms, so that concluded that the document is not 100% complete.

#### 4. Factors Causing Incomplete Medical Record Documents

##### a. Factors causing incompleteness based on identification review

Based on 5 journals regarding the completeness of medical record documents which is used by researchers as the basis for the study of literature, after conducting a review on each journal, it is known the causal factors incomplete medical record documents based on identification review as follows:

Research by Septi Nur Rahayu, et al (2013) from 56 recorded documents medical examination, the highest completeness result was 39.29% on the item the use of clearly legible lines is found on the disease course form, Doctor's instructions The lowest completeness is 28.57% on items the use of clearly legible lines is found on the return summary form, so it can be concluded that the document is not 100% complete. Study conducted by Miftachul Ulum (2019) that out of 40 recorded documents, medical records obtained results of completeness of 56% of all medical record forms on items use clearly legible lines and error correction. The lowest completeness is 44% of all medical record forms in the use of line items is clearly legible, so it can be concluded that Documents are not 100% complete. Susanti et al (2013) research from 72 medical record documents The highest completeness result obtained is 100% found on the form summary of entry and exit, physical examination on writing items clearly legible.

The lowest completeness of 15.28% is on the travel form disease or the instructions on the writing item are clearly legible, so it can be concluded that the document is not 100% complete. While research by Venny Ryana Wati, et al (2016) of 46 medical record documents the highest completeness result was 89.13% on the item the use of fixed lines is found on the initial examination assessment form lowest completeness of 19.56% on the fixed line usage items found on the nursing assessment form, discharge summary, so that it can be concluded that the document is not 100% complete. Based on Bima Yunus Dzulhanto (2018) from 43 recorded documents medical equipment obtained the highest completeness result of 100% on items use of fixed lines in hernia disease forms. Whereas the lowest completeness of 95.35% on the fixed line usage items contained in the entry and exit summary forms, so that concluded that the document is not 100% complete.

#### **Factors Causing Incomplete Medical Record Documents**

##### 1. Factors causing incompleteness based on identification review

Based on 5 journals regarding the completeness of medical record documents which is used by researchers as the basis for the study of literature, after conducting a review on each journal, it is known the causal factors incomplete medical record documents based on identification review as follows:

Based on research by Septi Nur Rahayu, et al (2013) it is known that factors that cause incompleteness in the identification review lack of discipline of officers who have been given the authority to filling out medical record documents. Research from Miftachul Ulum (2019) the contributing factor is because they often run out of labels inpatient registration that should exist and is less thorough in staff filling. Research by Susanti, et al (2013) the causative factors namely the indiscipline and negligence of the medical record officer or nurse ward in charge of filling out the form. Research from Venny Ryana Wati, et al (2016) contributing factors namely the large number of patient visits so that officers often forgot and did not immediately complete the patient data. While research from Bima Yunus Dzulhanto (2018) the causative factor is the lack of the

accuracy of the medical record officer who is responsible for filling out medical record documents and lack of inpatient registration labels.

## 2. Factors causing incompleteness based on reporting review

Based on 5 journals regarding the completeness of medical record documents which is used by researchers as the basis for the study of literature, after conducting a review on each journal, it is known the causal factors incomplete medical record documents based on reporting reviews as follows:

Based on research by Septi Nur Rahayu, et al (2013) it is known that factors that cause incompleteness in the reporting review due to lack of discipline of officers in filling out forms and can This is because since the beginning of the examination of the supporting forms for Completeness of filling out the patient summary form is not filled in complete. Research from Miftachul Ulum (2019) the contributing factors that is because of the indiscipline of the responsible ward nurse in filling out the form. Research Susanti, et al (2013) factors The cause is indiscipline and negligence of the medical record officer or the ward nurse in charge of filling out the forms. Research from Venny Ryana Wati, et al (2016) contributing factors namely the lack of awareness or thoroughness of medical staff to Include the date and time of service for each inspection to the patient so that there are still incomplete. Whereas research from Bima Yunus Dzulhanto (2018) the causative factors are lack of accuracy of medical record officers who are responsible for fill out medical record documents and lack of care registration labels stay.

## 3. Factors causing incompleteness based on authentication review

Based on 5 journals regarding the completeness of medical record documents which is used by researchers as the basis for the study of literature, after conducting a review on each journal, it is known the causal factors incomplete medical record documents based on authentication review as follows:

Based on research by Septi Nur Rahayu, et al (2013) in know the factors that cause the lack of nurse discipline and nurses do not understand the importance of the signature of the person in charge. Miftachul Ulum's research (2019) The causative factor is because : indiscipline of the ward nurse in charge of form filling. Research from Susanti, et al (2013) factor The reason is that the nurse did not provide a name on the form disease course or doctor's instructions because there are no items the name for the nurse so sometimes the nurse doesn't include it his name. While research from Venny Ryana Wati, et al (2016) factors The cause is the lack of awareness or thoroughness of the officers medical for the name of the person in charge. While Bima's research Yunus Dzulhanto (2018) the causative factor is incompleteness filling in the signature of a doctor or nurse is less thorough in Filling it in, this will result in difficulties for the medical record officer in determining the doctor or nurse who is responsible for medical treatment given to the patient.

## 4. Factors causing incompleteness based on record review

Based on 5 journals regarding the completeness of medical record documents which is used by researchers as the basis for the study of literature, after conducting a review on each journal, it is known the causal factors incomplete medical record documents based on record review as follows:

Based on research by Septi Nur Rahayu, et al (2013) in know the factors causing the occurrence There is no SOP that regulates regarding the use of fixed lines on blank sheets. Study Miftachul Ulum (2019) The causative factor is because : lack of understanding of officers regarding the

correct recording technique. Research Susanti, et al (2013) the factors that cause untruth recording because nurses or midwives do not know the benefits use of fixed lines on blank sheets of medical record forms. While research from Venny Ryana Wati, et al (2016) factors The cause is a lack of understanding of the procedures for justification said in the medical record. Meanwhile, Bima Yunus Dzuhanto's research (2018) the causative factor is the absence of SOPs that regulate about assigning a fixed line to an empty area.

## **DISCUSSION**

The discussion in principle is the interpretation of research results based on the literature review discussed by discussing and review everything with previous research or facts bibliography, presented honestly and fairly , is not excessive.

### **Completeness Based on Identification Review**

Based on five journals regarding the completeness of record documents medical inpatients for kidney failure in the hospital, the whole journal still shows the level of incompleteness of medical record documents hospitalization for kidney failure . This is caused by In the medical record form, there are still many incomplete patient name, medical record number, age, address, religion. The incompleteness is caused by the officers being less careful and negligent in complete medical record documents. So, this is not in accordance with Sudra's theory (2017), where the patient 's identity on the record form sheet medical records can also be completed with name, medical record number , date of birth, age, gender , and complete address . This equipment must be adjusted to the policies and needs of each each health service .

### **Completeness Based on Reporting Review**

Based on five journals regarding the completeness of record documents medical inpatient kidney failure in the hospital overall journal still shows the level of incompleteness of medical record documents Hospitalization for kidney failure is still high. This is because on the date and time items as well as the reports that should be included, but there are still many incomplete filling in the item. Incompleteness caused by officers lack of discipline of officers in filling items. It is not suitable with the Sudra theory (2017), where every report or action intreat, treat must be reported in patient documents as well as given the date and time this is closely related to the rules filling out medical records and very important when needed event tracking .

### **Completeness Based on Authentication Review**

Based on five journals on quantitative analysis completeness of inpatient medical record documents for kidney failure the overall hospital journal still shows the level of incomplete medical record document for failed illness kidney is still high. This is caused because the item 's name is bright and signatures are still found to be incomplete on the item bright name and signature of doctor, nurse , insurerresponsibility and other medical personnel, due to insufficient staff thorough and disciplined in understanding the filling of item orders. It is not yet in accordance with the theory of Sudra (2017), where filling in the medical record must be clear The person in charge is realized by including the clear name (complete) and signature

### **Completeness Based on Recording Review**

Based on five journals regarding document completeness inpatient medical records for kidney failure in the overall hospital the journal still shows the level of incompleteness of the recording

document Hospitalization for kidney failure is still high. This, due to because in error correction , the use of standard abbreviations ,the provision of fixed lines is still a lot of incompleteness in determination of writing on the form. The incompleteness is due to because the officers do not understand in filling items and there is no SOP that regulates the provision of fixed lines. Things don't match Sudra's theory (2017), where the completeness of the recording review includes, The ink used should be dark and contrasting with the paper color to make it clear and easy to duplicate when needed. Writing must be readable again properly and not \_lead to perceptual difficulties or biases . If there is a typo then to fix it must not remove the wrong writing. In general , it is recommended to cross out once on a piece of writing the one who wrote the correction above the wrong writing and include the date and signature correct the text .

### **Factors Causing Incomplete Medical Record Documents**

Based on 5 journals on quantitative analysis of completeness inpatient medical record documents in hospitals, entire journals shows that the level of incompleteness of medical record documents Hospitalization for kidney failure in the hospital is still high, this is due to because the officers are less thorough, the officers are less disciplined, the lack of knowledge of officers and there is no SOP that regulates medical records , especially in managing the filling of medical record documentsand.

### **CONCLUSION**

Based on the results of quantitative analysis of 5 document journals inpatient medical records for kidney failure at the hospital the authors conclude as follows : Based on 5 journals resulting from quantitative analysis of completeness of record documents medical review from a review of identification, reporting, authentication and recording shows that the medical record document is 100% not complete. Based on 5 journals about the factors causing the incomplete documents medical records due to the lack of accuracy of officers in filling them out, lack of officer discipline, and the absence of clear SOPs. This matter can affect the incompleteness of medical record documents where the medical record document must be filled in completely because it is considered important as a summary of the patient's disease course from the beginning to the endend.

### **REFERENCES**

- Budi, S.C. (2011). *Manajemen Unit Kerja Rekam Medis*. Yogyakarta: Quantum Sinergis Media.
- Departemen Kesehatan RI. (2006). *Pedoman Penyelenggaraan & Prosedur Rekam Medis Rumah Sakit*. Revisi II. Jakarta: Direktorat Jendral Pelayanan Medik Departemen Kesehatan Republik Indonesia.
- Dzulhanto, B.Y., (2018). *Kelengkapan Pengisian Dokumen Rekam Medis Penyakit Hernia Dengan Metode Analisis Kuantitatif*. Jurnal Manajemen Informasi dan Administrasi Kesehatan (J-MIAK). Vol 1 (1). Hal. 1- 10. <http://journal.univetbantara.ac.id/index.php/jmiakrekammedis/article/view/121/109>
- Doenges, Marilyn E.dkk. (2000). *Rencana Asuhan Keperawatan & Pedoman Untuk Perencanaan dan Pendokumentasian Perawatan Pasien*. Edisi III. Alih Bahasa: I Made Kriasa. EGC. Jakarta
- Kemenkes RI. (2008). *Peraturan Menteri Kesehatan RI NO269/MENKES/PER/III/2008. Tentang Rekam Medis*. Jakarta: Menteri Kesehatan Republik Indonesia.

- Lubis, Fitriyani., dkk. (2018). *Tinjauan Ketidaklengkapan Pengisian Catatan Medis Pada Berkas Rekam Medis Rawat Inap Pasien Penderita Diabetes Melitus Terhadap Klaim BPJS di Rumah Sakit Umum IPI Medan Tahun 2018*. Jurnal Ilmiah Perkam dan Informasi Kesehatan Imelda, Vol 3.
- Peraturan Pemerintah. (2004). Undang-undang No. 29 Tahun 2004. *Tentang Praktik Kedokteran*. Jakarta: Presiden RI.
- Peraturan Pemerintah. (2009). Undang-undang No. 44 Tahun 2009. *Tentang Rumah Sakit*. Jakarta: Presiden RI.
- Rahayu, S.N, dkk. (2013). *Analisis Kuantitatif Dokumen Rekam Medis Pasien Rawat Inap Pada Kasus Chronic Kidney Disease Triwulan IV di RSUD Pandan Arang Boyolali*. Jurnal Rekam Medis, Vol. 2 (7); Hal. 49-60.
- Sabarguna. (2008). *Tentang Quality Assurance Pelayanan Rumah Sakit*. Yogyakarta: Sagung Seto.
- Sudra, R. I. (2017). *Rekam Medis*. Tangerang Selatan: Universitas Terbuka.
- Susanti., dkk, (2013). *Analisis Kuantitatif Dokumen Rekam Medis Pasien Rawat Inap Kasus Chronic Heart Failure Triwulan IV Tahun 2012 Dirumah Sakit Umum Daerah Pandan Arang Boyolali*. Jurnal Rekam Medis,2(7).
- Ulum, M. (2019). *Analisis Kuantitatif Dokumen Rekam Medis Pasien Rawat Inap Kasus Bedah di RSUD Kanjuruhan Kepanjen : Program Studi D3 Rekam Medik dan Informasi Kesehatan STIKes Widya Cipta Husada Malang*. Vol. 3 No. 6; Hal. 10-18. ISSN : 2089-4228.
- Wati, V.R., Harjanti. (2016). *Analisis Kuantitatif Dokumen Rekam Medis Pasien Rawat Inap Diagnosis Hematemesis Melena*.
- Wirajaya Maha. (2019). *Faktor-Faktor yang Mempengaruhi Ketidaklengkapan Rekam Medis Pasien pada Rumah Sakit di Indonesia*. Jurnal Manajemen Informasi Kesehatan Indonesia. Vol.7 (2).
- Zed, Mestika. (2008). *Metode Penelitian Keperustakaan : Yayasan Obor Indonesia*.