

QUALITATIVE ANALYSIS OF MEDICAL RECORD DOCUMENTS IN INPATIENT PATIENTS IN THE PUBLIC HEALTH CENTER

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ABSTRACT

The community health center is one of the first level health service facilities that is required to maintain medical records. Medical record is a document that contains patient identity data, examinations, treatment, actions, and other services that have been given to patients. Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning medical records, Article 18 states that medical records are analyzed quantitatively and qualitatively. Qualitative analysis aims to ensure complete and accurate medical record data. Objective: The research objective was to determine the completeness and consistency of medical records based on six reviews. Method: This type of research is descriptive research with a retrospective approach. The population is 432 inpatient medical record documents, sample 81 inpatient medical record documents using simple random sampling technique. Collecting data using interviews and observation. Data processing, data presentation and data analysis were carried out on quantitative data and qualitative data in a non-statistical or descriptive manner in tabular and textular forms. Results: The results of the study: 1) review of the completeness and consistency of diagnosis by 71 (88%), 2) review of the consistency of recording diagnoses by 80 (99%), 3) review of things done during care and treatment by 81 (100%), 4) review of 8 forms of informed consent by 8 (100%), 5) review of recording techniques by 71 (88%), and 6) review of potential compensation matters by 66 (81%). Conclusions: The results of a qualitative analysis of medical record documents based on the six highest reviews were on the review of recording things that were done during care and treatment as well as the review of complete informed consent, namely 81 (100%), while the lowest review was on the review of things that had the potential for compensation, namely 66 (81 %). The researcher's suggestion to improve the completeness and consistency is to increase the commitment of Caring Professionals (doctors, midwives, nurses, medical recorders) regarding the importance of the completeness and consistency of medical records and the implementation of comprehensive and continuous quantitative and qualitative analyzes.

Keywords: compensation; completeness; consistency; diagnosis, informed consent; recording

INTRODUCTION

A community health center is a health service facility that organizes community health efforts and individual health efforts at the first level, by prioritizing promotive and preventive efforts in their working areas. Regulation of the Minister of Health of the Republic of Indonesia Number 43 of 2019 regarding community health centers article 7 states that public health centers are required to maintain medical records. Medical record is a document that contains patient identity data, examinations, treatment, actions, and other services that have been given to patients. Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning medical records Article 18, medical records are analyzed quantitatively and qualitatively. Qualitative analysis is a review of medical record filling related to inconsistency and incompleteness so as to show evidence that the medical record is inaccurate and incomplete. There are six components of qualitative analysis, namely a review of the completeness and consistency of diagnoses, a review of the consistency of recording diagnoses, a review of things that were done during care and treatment, a

review of informed consent, a review of recording techniques, and a review of potential compensation matters (Hatta, 2013).

Several studies related to the qualitative analysis of medical records include research (Khotimah & Imas, 2020) that completeness of filling close to 100% occurs in clarity of conditions or diagnosis, consistent input, reasons for service, informed consent, review of records and information on bearers of costs with the results being mostly shows a high average percentage but there are still incompleteness in some elements. Research by Nugraheni, et al., 2022 stated that a review of completeness and consistency of diagnoses, namely 92% of documents consistent, 8% inconsistent. Review the consistency of the diagnostic record 82% of the documents are consistent, 18% are inconsistent. Review of recording of things done during care and treatment 44% documents 56% inconsistent. The review of informed consent was not reviewed because there was no informed consent form in the DRM of the disease being examined. 73% document review method or practice is consistent, 27% is inconsistent. Review the things that have the potential to cause a claim for compensation 50% document is consistent, 50% is inconsistent. Based on this description, the researcher is interested in taking the title "Qualitative Analysis of Medical Record Documents for Inpatients at Public Health Centers".

METHOD

The type of research used is descriptive research with a retrospective approach. Research variables include: completeness and consistency of diagnosis, consistency of diagnosis recording, recording of things done during care and treatment, informed consent, recording techniques, and things that have the potential to cause claims for compensation. The study population was 432 inpatient medical record documents and the sample size was 81 inpatient medical record documents calculated using the Slovin formula. The sampling technique is simple random sampling. Collecting data using interviews, observation and checklist. Data processing includes editing, classification and tabulation. Presentation of data in a textular and tabular manner. Non-statistical data analysis or descriptive analysis.

RESULTS AND DISCUSSION

Qualitative Analysis of Inpatient Medical Record Documents in the Completeness and Consistency Review

In the review of the completeness and consistency of the diagnoses, there are items of incoming diagnoses, main diagnoses, additional diagnoses and final diagnoses. Reviews are carried out on hospitalization card forms, registration forms and resume forms. The research sample was 81 inpatient medical record documents consisting of diagnoses of typhoid fever, parturition, gastro enteritis, acute diarrhea, hypertension, and measles.

Table 1.

Results of Review of Completeness and Consistency of Diagnoses in Medical Record Documents of Inpatient Care at Public Health Centers

Num	Items	Consistent		Inconsistent	
		Amount	%	Amount	%
1	Admission Diagnosis	71	88	10	12
2	Main Diagnosis	79	98	2	2
3	Additional Diagnostics	-	-	-	-
4	Final Diagnosis	79	98	2	2

Table 1, it shows the highest consistency results in the main diagnostic items and the final diagnosis with a percentage of 98% meaning that of the 81 inpatient medical record documents studied there were 98% consistent documents and 2% inconsistent documents. The highest inconsistency was found in the incoming diagnostic items with a percentage of 12%, meaning that of the 81 inpatient medical record documents studied, 12% were inconsistent documents and 88% were consistent documents.

Qualitative Analysis of Inpatient Medical Record Documents in Diagnostic Recording Consistency Review

Review the consistency of recording diagnoses on the items of progress notes, doctor's instructions, and drug records filled out by doctors, nurses, midwives and pharmacists on the register form.

Table 2.

Results of Consistency Review of Diagnostic Recording in Medical Record Documents of Inpatient Care at Public Health Centers

Num	Items	Consistent		Inconsistent	
		Amount	%	Amount	%
1	Progress Note	80	99	1	1
2	Doctor's Instructions	81	100	0	0
3	Drug Records	81	100	0	0

Table 2, it shows the highest consistency results, namely in the doctor's instruction items and drug records with a percentage of 100%, meaning that of the 81 inpatient medical record documents studied there were 100% consistent documents and 0% inconsistent documents. The highest inconsistency was found in the progress notes item with a percentage of 1%, meaning that of the 81 inpatient medical record documents studied, 1% were inconsistent documents and 99% were consistent documents.

Qualitative Analysis of Inpatient Medical Record Documents in the Review of Recording Things Done During Care and Treatment

In the review of the recording of things done during care and treatment, there are items of supporting examination test results and the patient's condition. The forms used in the review of records of things done during care and treatment include examination results forms, registration forms and resume forms.

Table 3.

Results of the Review of the Recording of Things to Do During Care and Treatment at the Community Health Center

Num	Items	Consistent		Inconsistent	
		Amount	%	Amount	%
1	Supporting Examination Test Results	81	100	0	0
2	Patient Condition	81	100	0	0

Table 3, a review of the recording of things done during care and treatment includes the contents of the results of supporting examination tests and the patient's condition. The results of the 81 medical record documents examined were 100% consistent, meaning that out of the 81 inpatient medical record documents studied, 100% were consistent documents and 0% were inconsistent

documents because the examination results form, register form and resume form were filled in completely, continuously and consistent in each form.

Qualitative Analysis of Inpatient Medical Record Documents in a Review of Informed Consent

In the review of the informed consent form, there were several items including: patient's name, age, gender, explanation to the patient, date and time, and signature.

Table 4.
Review of Informed Consent on Inpatient Medical Record Documents at Community Health Centers

Num	Items	Consistent		Inconsistent	
		Amount	%	Amount	%
1	Patient's name	8	100	0	0
2	Age	8	100	0	0
3	Gender	8	100	0	0
4	Explanation to the Patient	8	100	0	0
5	Date and Time	8	100	0	0
6	Signature	8	100	0	0

Table 4, it shows the results of the consistency of the item patient name, age, gender, explanation to the patient, date and time, and signature with a percentage of 100%, meaning that out of 8 inpatient medical record documents on the informed consent form studied, it shows 100% document consistent and 0% inconsistent documents.

Qualitative Analysis of Inpatient Medical Record Documents in Review of Recording Techniques

In the review of the recording technique, there were items that contained no eraser fluid, no abbreviations, no scribbles without initials. Review of recording techniques is carried out on statement forms, inpatient cards, inpatient register forms, information giving forms, medical resumes, results of supporting examinations.

Table 5.
Review of Recording Techniques in Inpatient Medical Record Documents at Public Health Centers

Num	Items	Consistent		Inconsistent	
		Amount	%	Amount	%
1	No Wiping Liquid	81	100	0	0
2	No Abbreviations	81	100	0	0
3	No Scribbles Without initials	71	88	10	12

Table 5 items with no liquid wipes and no abbreviations with a percentage of 100%, meaning that of the 81 inpatient medical record documents studied, there were 100% consistent documents without eraser fluid and without abbreviations and 0% inconsistent. The inconsistency of items with no strokes without initials was found on the register form and resume form, namely as many as 10 forms with a percentage of 12%, this was because the register form and resume form had

many strokes without initials and there was writing crossed out several times making it difficult to read.

Qualitative Analysis of Inpatient Medical Record Documents in Review of Matters with Potential Compensation

In the review of matters that have the potential for compensation there are patient identification items, time series, progress recording, completeness inclusion of the doctor in charge of the patient, and clarity of writing.

Table 6.
Review of Potential Compensation Items in Medical Record Documents for Hospitalization at Public Health Centers

Num	Items	Consistent		Inconsistent	
		Amount	%	Amount	%
1	Patient Identification	78	96	3	4
2	Time series, date and time	73	90	8	10
3	Progress Recording	80	99	1	1
4	Completeness Inclusion of the Doctor in Charge of the Patient	68	84	13	16
5	Clarity of Writing	80	99	1	1

Table 6, the results of a review of matters that have the potential for compensation show that in the items for recording developments, the highest consistency was found in the register form, namely 81 documents with a percentage of 100%, meaning that out of the 81 documents studied, there were 81 consistent forms. While the inconsistency is found in the resume form, namely 1 document with a percentage of 1%, this is because the patient's condition is not filled. In the item clarity of writing, the highest consistency was found in the statement form, inpatient card form, register form, information giving form, namely 81 documents with a percentage of 100%, meaning that out of the 81 documents studied, there were 81 consistent forms. While the inconsistency is found in the resume form, namely 1 document with a percentage of 1%, this is because the writing cannot be read clearly.

In the patient identification item, the highest consistency was found in the inpatient card form, namely 81 documents with a percentage of 100%, meaning that out of the 81 documents studied, there were 81 consistent forms. While inconsistencies were found in the register form and resume form, namely as many as 3 documents with a percentage of 4%, this was due to the absence of patient identity on the second sheet of the register form and the absence of patient identity in the form of age, doctor, index number, ward on the resume form. In the patient time series, the highest consistency was found in the register form, namely 73 documents with a percentage of 90%, meaning that of the 81 documents studied, there were 73 forms that were consistent and 8 documents with a percentage of 10%, which were inconsistent, meaning that out of the 81 documents studied, there were 8 inconsistent forms. this is due to the absence of patient identification on the second sheet of the register form and the absence of hours on the first sheet. In the completeness item for the inclusion of the Doctor in Charge of the Patient, the highest consistency was found in the resume form, namely 75 documents with a percentage of 92%, meaning that out of the 81 documents studied, there were 75 consistent forms. While the inconsistency is found in the register form, namely as many as 10 documents with a percentage

of 12%, this is because there is no doctor's name on the resume form, there is no doctor's name and initials on the register form.

Qualitative Analysis of Inpatient Medical Record Documents in Six Reviews

The results of calculations based on 6 qualitative analysis reviews on inpatient medical record documents at community health centers are as follows:

Table 7.
Qualitative Analysis of Inpatient Medical Record Documents in Six Reviews

Num	Review	Consistent		Inconsistent	
		Amount	%	Amount	%
1	Completeness and Consistency of Diagnosis	71	88%	10	12%
2	Diagnostic Record Consistency	80	99%	1	1%
3	Recording of things to do during treatment and medication	81	100%	0	0%
4	Informed Consent	8	100%	0	0%
5	Recording Techniques	71	88%	10	12%
6	Matters with Potential Compensation	66	81%	15	19%

Table 7 The results of a qualitative analysis of medical record documents based on the six highest reviews were on the review of recording things that were done during care and treatment as well as the complete informed consent review, namely 81 (100%), while the lowest review was on the review of things that had the potential for compensation, namely 66 (81 %).

Qualitative Analysis of Inpatient Medical Record Documents in the Completeness and Consistency Review

The highest consistency was found in the main diagnostic items and the final diagnosis of 79 medical record documents or with a percentage of 98%. Meanwhile, the highest inconsistency was found in the incoming diagnostic items of 10 medical record documents or with a percentage of 12%. The cause of the inconsistency in the incoming diagnostic items was due to the inaccuracy of the medical staff and the large number of patients who were in a hurry to complete the documents. The results of a review of the completeness and consistency of the diagnosis are not in accordance with Sudra (2020), that the contents in the medical record should be able to show a guiding mindset from the start of accepting the patient until he is discharged. It is necessary to analyze the quality of records carried out by doctors. This activity was carried out to evaluate the quality of medical services provided by treating doctors (Ministry of Health of the Republic of Indonesia, 2006). Based on Hatta (2013) the completeness of medical record information is based on chronological order according to the stages of visiting and providing health services so that medical information is clear and easy to understand. Incompleteness and inconsistency of diagnoses occurred in Nugraheni's study, et al., 2022, namely a review of the completeness and consistency of diagnoses, namely 77 inpatient medical record documents (92%) were consistent and 7 inpatient medical record documents (8%) were inconsistent.

Qualitative Analysis of Inpatient Medical Record Documents in Diagnostic Recording Consistency Review

The highest consistency was found in items of doctor's instructions and drug records of 81 medical record documents or with a percentage of 100%. Meanwhile, the highest inconsistency was found in the developmental record item of 1 medical record document or with a percentage of 1%. The reasons for not filling in progress notes were the busy activities of the health workers and the perceptions of the health workers that these items were not important and could be left blank. The results of a review of the consistency of recording diagnoses are not in accordance with Sudra (2020), that consistency means that it can show a sequential mindset from the start of accepting a patient to sending him home. So, in this case, it is not only between one diagnosis and another that must show consistency, but also between the diagnosis and other supporting parts in the medical record, for example progress notes, doctor's instructions and medication records. Data analysis was carried out on inpatient medical records at the Aceh Tamiang District Hospital, there were incomplete filling in the inpatient medical record on the item evidence of implementation of the treatment plan, instructions and medication changes, as well as the actions taken which were filled in by the nurse. This is because nurses lack communication with other health workers in caring for patients. This is also due to the fact that the evidence of the action taken on the patient has not yet been printed, the nurses are busy serving the patient so that the form for proof of action is not attached or combined into the medical record file as it should be (Ritonga, et al., 2023).

Qualitative Analysis of Inpatient Medical Record Documents in the Review of Recording Things Done During Care and Treatment

The highest consistency was found in the supporting examination test results and the patient's condition in the amount of 81 medical record documents or with a percentage of 100%. This means that the 81 samples studied showed consistency and 0 documents were inconsistent. The results of the review of recording things that were done during care and treatment were in accordance with Sudra (2020), namely, in general, good quality medical records are expected to be AC21R4A1, namely Accurate, Complete, Consistent, Informative, Rational, Relevance, Reassurance, Responsible, and Accessible. Identification of aspects of supporting examinations, namely as many as 19 medical record documents where there were no X-ray examination results from 19 patients who had X-ray examinations (Nuraini, et al., 2020). The implementation of treatment and care based on medical science or nursing science can only be carried out by health workers who have the expertise and authority to do so (Republic of Indonesia, 2009). Diagnosis of typhoid fever is carried out by recording complaints, checking pulses, checking body temperature, blood tests and widal examinations. The examination is adjusted according to the symptoms felt by the patient (Khotimah & Imas, 2020).

Qualitative Analysis of Inpatient Medical Record Documents in a Review of Informed Consent

The highest consistency was found in the patient's name, age, gender, explanation to the patient, date and time of 8 medical record documents or with a percentage of 100%. This means that of the 8 samples studied, they were consistent and 0 documents were inconsistent. The results of the qualitative analysis of the review of informed consent are in accordance with Sudra (2020), that informed consent is not just asking for the patient's signature on the consent form for a medical action plan, but must begin by providing an explanation of the plan so that the patient has sufficient

capital to consider his decision. must be conveyed including the purpose of the action, the advantages and disadvantages. It needs to be read carefully to ensure that the patient's name, age, gender, condition, date and signature comply with applicable regulations. Data analysis was carried out on inpatient medical records at the Aceh Tamiang District Hospital, there were incomplete filling in the inpatient medical record on the item completeness of the contents of the informed consent filled in by the nurse. This is because the information sheet on the patient's status is not attached to the informed consent sheet. Informed consent was not attached due to the negligence of the nurse who had not written informed consent (Ritonga, et al., 2023). Identification of the informed consent aspect is most prevalent in the aspect of identity information, there are 30 medical record documents (100%) which are due to being incomplete and not writing the address and telephone number (Nuraini, et al., 2020).

Qualitative Analysis of Inpatient Medical Record Documents in Review of Recording Techniques

The highest consistency was found in the item that there were no erasers and no abbreviations for 81 medical record documents or with a percentage of 100%. Meanwhile, the highest inconsistency was found in the item without initials of 10 medical record documents or with a percentage of 12%. The cause of the highest inconsistency in items without initials is due to a lack of human resources and the large number of patients so that filling is in a hurry. The results of a review of recording techniques are not in accordance with Sudra (2020), that documentation in the medical record may not eliminate the contents of the documentation in any way. So, there is no use of eraser fluid (correction fluid), eraser rubber, thick streaks, patches, perforations, and so on. Inconsistency in recording techniques occurred in the study of Nugraheni, et al., 2022 where a review of recording techniques 61 inpatient medical record documents (73%) were consistent, 23 inpatient medical record documents (27%) were inconsistent.

Qualitative Analysis of Inpatient Medical Record Documents in Review of Matters with Potential Compensation

The highest consistency was found in the item of recording progress and writing clarity of 80 medical record documents or with a percentage of 99%. While the highest inconsistency was found in the completeness item for including DPJP of 13 medical record documents or with a percentage of 16%. The highest cause of inconsistency in the completeness item for the inclusion of the DPJP is due to the negligence of the medical staff, the lack of understanding from the officers of the importance of consistency in filling out the form. This is not in accordance with Sudra's theory (2020), that the principle stating "record what is done and do what is recorded" must really be implemented. So the officer/team carrying out the qualitative analysis of medical records must really pay close attention to the balance of entries in all medical record sheets, especially for things that generally have the potential to become the door to problems:

1. Patient identification
2. Approval of a medical action plan
3. Medical action report
4. Identification of newborns
5. Time series (date and time)
6. Completeness and existence of an inspection/action plan with a report on the results
7. Complete inclusion of the person in charge of service (name and signature)

8. Recording of all patient developments from time to time, both positive and negative developments

9. Clarity of writing (can be read again and does not cause understanding)

Analysis of data on inpatient medical records at the Aceh Tamiang District General Hospital, there were incomplete filling in inpatient medical records on the date and time items, signatures/ initials were easy to read filled in by doctors. This can happen because doctors are busy serving patients so that the medical records are not filled out correctly also because there are so many forms to be filled in that the filling out of the forms is inconsistent (Ritonga, et al., 2023). The results of the analysis carried out were not found in the documents according to the claim or did not match the claim that the patient had typhoid as a result of his work, so the percentage of "no" information was obtained 100% because there was no information on compensation (Khotimah & Imas, 2020).

Qualitative Analysis of Inpatient Medical Record Documents in Six Reviews

The results of a qualitative analysis of medical record documents based on the six highest reviews were on the review of recording things that were done during care and treatment as well as the complete informed consent review, namely 81 (100%), while the lowest review was on the review of things that had the potential for compensation, namely 66 (81 %). Respondents generally had sufficient knowledge to fill in incomplete medical records, namely 51.3%, compared to those who filled out complete medical record files, namely 48.7%. Respondents who had less knowledge filled out more incomplete medical record files, namely 93.8%, compared to filling out completely, namely 6.2%. Based on this data, it can be seen that the comparison between those who filled out the medical record completely from those who had sufficient knowledge and those who had less knowledge was very significant (of the total who filled out the complete medical record 63.6%) (Fahrnisa, et al., 2023).

The results of the research on the review of completeness and consistency of diagnoses were 92% consistent documents, 8% inconsistent. Review the consistency of the diagnostic record 82% of the documents are consistent, 18% are inconsistent. Review of recording of things done during care and treatment 44% documents 56% inconsistent. The review of informed consent was not reviewed because there was no informed consent form in the medical record document of the disease being studied. 73% document review method or practice is consistent, 27% is inconsistent. Review the things that have the potential to cause a claim for compensation 50% document is consistent, 50% is inconsistent. Factors that influence incompleteness in the qualitative analysis at PKU Muhammadiyah Selogiri Hospital are man or human factors (Nugraheni, et al., 2022). Factors that influence the incomplete filling of medical record documents at PKU Muhammadiyah Surakarta Hospital are the Human factor (Man), the busyness of the doctor who handles the patient waiting for him in the poly room or has been awaited at another hospital and the lack of accuracy of nurses in filling out medical record documents (Nugraheni, et al. al., 2022). The medical record unit has never conducted an analysis of medical record documents, because the treatment and care of patients is the authority of health workers who have medical or nursing knowledge (Hikmah, et al., 2018).

The results of a review of the completeness and consistency of the diagnoses of the Integrated Patient Progress Note sheet yielded 10.7% complete and inconsistent (Lestari, et al., 2022). Filling in the service data that has been provided to patients in the medical record documents of patients

with incomplete abortion cases has been recorded, but based on the results of a qualitative medical analysis of medical record documents, the use of follow-up data or information as a conclusion, especially the recording in the patient's integrated record is still incomplete, and there is a void in the operation report forms and anesthesia forms (Kardila & Diana, 2018). The causative factor in terms of human resources that causes limitations in the completeness of medical record filling is the low level of awareness and understanding of the doctor in charge of the service of the importance of medical records in hospital services so that it requires increased socialization regarding Standard Operating Procedures and policies related to medical records to each unit. services in an integrated and comprehensive manner. Training or outreach activities can be carried out in the form of seminars or workshops from the hospital management by involving special sources from the medical record unit. The doctor in charge of the patient believes that if there is an incomplete form, you can rely on the nurse to remind you to complete the medical record. This shows that the role of nurses is quite important in the completeness of medical records so that good coordination is needed between Professional Caring Providers (Saputra & Arifal, 2022).

CONCLUSION

The results of a qualitative analysis of medical record documents based on the six highest reviews were on the review of recording things that were done during care and treatment as well as the complete informed consent review, namely 81 (100%), while the lowest review was on the review of things that had the potential for compensation, namely 66 (81 %). The researcher's suggestion to improve the completeness and consistency is to increase the commitment of Caring Professionals (doctors, midwives, nurses, medical recorders) regarding the importance of the completeness and consistency of medical records and the implementation of comprehensive and continuous quantitative and qualitative analyzes.

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