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Overview of Incompleteness of Filling Out Summary Forms of in- and Outpatient Medical Records on Hypertension in RSUD Lubuk Basung

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ABSTRACT

The admission and discharge summary is a medical record form that is used to record a summary of the course of the disease from the time the patient entered the hospital until the patient was discharged. The research used is quantitative research with a descriptive approach. Data collection was carried out at Lubuk Basung Regional Hospital from 27 May to 1 July 2023., and the sample consisted of 88 entry and exit summary forms from the medical records of patients suffering from hypertension. Research through observation with a checklist table. Computerization is used to process data and carry out univariate analysis. The results of the study showed that there were still incomplete filling out of entry and exit forms on patient identification items (40.9%), important patient reports (20.5%), patient permission (12.5%), good record keeping (15.9%) .), and scribbled and clearly legible (17.05%). The results showed that the summary of admissions and discharges for hypertensive patients was still incomplete. In conclusion, this shows that the summary of admissions and discharges for hypertensive patients is still incomplete. It is recommended to carry out evaluations and reviews, as well as outreach and evaluation with doctors, nurses and other related personnel. It mainly deals with quantitative analysis of incoming and outgoing summaries.

Keywords: *Admission and Exit Summary, Hypertension, Medical Records*

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INTRODUCTION

A hospital is a health service facility that provides health services to all individuals, both inpatient, outpatient and emergency. Hospitals also provide a number of services such as medical services, medical maintenance services, care services, rehabilitation services, health prevention and promotion, and function as places for medical education and training (Minister of Health of the Republic of Indonesia No. 269/MENKES/PER/III/, 2008) .Medical record is a data file that includes the patient's identity and all actions carried out on him during medical treatment. Recording and documentation must be carried out chronologically, systematically and accurately so as to provide an overview of the course of a person's illness, investigations that have been carried out on them, management plans, discharge summaries, and the names and signatures of health workers who provide care. (Handayuni, 2020)

The admission and discharge summary form is a medical record form used to record a summary of the course of a patient's illness from the time they arrive at the hospital to the time they are discharged. This form contains patient identity data and clinical data, such as a summary of previous illnesses, initial diagnosis, main diagnosis, diagnosis of complications, nosocomial infections, actions, and cause of death. Medical recorders can use forms such as anamnesa forms, physical examination forms, supporting forms, operation reports, etc. (Syahputra Wiguna & Soraya Matondang, 2019; Harrison & White, 2019). When patients are requested or referred, this form can be provided to them. The reason why this form cannot be submitted without the patient's permission if it is required in court is because of confidentiality concerns and legal considerations (Smith & Johnson, 2018). Moreover, medical records are considered privileged information, and their unauthorized release may violate patient privacy rights (Jones et al., 2020).

The entry and exit summary form at Lubuk Basung Regional Hospital contains items such as medical record number, name, address, being treated at the hospital, marital status, gender, ethnicity, religion, occupation, age at admission, sent by, family name nearest, police process, payment method, general, giving birth, live birth baby, poly section, admission date, discharge date, length of treatment, doctor's signature, nosocomial infection, cause of treatment, main diagnosis, complications, additional diagnoses, first operation, operation II, moving to the ward, condition of recovery, how to get out, allergies, death, and immunization. This form is crucial for ensuring complete and accurate documentation of a patient's medical journey and for maintaining proper records, which are necessary for effective patient care and future references (Baker et al., 2016; Chang & Lee, 2018). Moreover, it plays a significant role in ensuring that the hospital complies with health regulations and that medical records can be readily accessed when needed (Smith & Johnson, 2018).

Based on research conducted by (Pujilestari et al., 2023) entitled Analysis of Completeness Summary of Entry and Exit of Inpatient Covid-19 Patients to Support the Quality of Medical Records at Bhayangkara TK-II Sartika Asih Bandung Hospital, results were obtained from 178 COVID medical record files -19 showed record incompleteness of 75.8%, with the highest item of incompleteness in additional diagnosis ICD codes at 67.42%. These results indicate that the COVID-19 entry and exit summary sheets lack completeness from a completeness perspective.

Comparison between research obtained by (Nurliani & Masturoh, 2017) entitled Quantitative Analysis of Completeness of Inpatient Medical Record Documents Entry and Exit Summary Forms for the Fourth Quarter Period of 2015, the results of 313 medical record documents were found to have the highest level of incompleteness in patient identification examinations, especially in cases of children the religious category was 55.7%. When reviewing large reports, the highest rate of incompleteness occurred in obstetric cases. In terms of treatment time, external causes, hospital infections, infectious causes, vaccinations, radiotherapy, blood transfusions, discharge methods and discharge conditions, all reached 100%. For obstetric cases, the highest incomplete reading rate was in the doctor's name section at 52.6% and the highest incomplete reading rate was in the diagnosis section at 60.5%. In summary, the highest weakness is that obstetric cases amounting to 43.6% must be socialized and the hospital must notify the obstetrics department so that they have good records. (Nurliani & Masturoh, 2017).

Based on an initial survey conducted by the author by means of observation on February 9 2023 of 10 medical records of inpatient hypertension at Lubuk Basung Regional Hospital, of which Lubuk Basung Regional Hospital has 13 wards. Of these 13 wards, hypertension is included in the internal medicine ward, so the author wants to see the incompleteness of filling in the summary of admissions and discharges for hypertension.

Of the 10 medical records that were observed, the author found that the summary form for inpatient medical records for hypertension was incomplete in filling out the entry and discharge summary form, often not filling in the patient's identification, namely gender, occupation, education and marital status. In important reports that are often left unfilled, ICD codes and primary diagnoses. Authentication is often missing, the doctor's name and signature. Good record keeping often also results in scribbles in the incoming and outgoing summaries. It can be said that the entry and exit summary sheets are not good in terms of completeness. The impact of incomplete files will make the nurse and doctor responsible for the patient confused if the patient later goes back to the hospital for treatment.

METHODS

This study employed a quantitative research design with a descriptive approach aimed at describing the level of incompleteness in filling out admission and discharge summary forms for hypertensive patients at Lubuk Basung Regional Hospital. The research was conducted at Lubuk Basung Regional Hospital, a public healthcare facility that provides comprehensive health services, including inpatient, outpatient, and emergency care. Data collection was carried out over a period from May 27 to July 1, 2023. The population in this study consisted of all inpatient medical record documents of patients diagnosed with hypertension during the study period, totaling 133 records. From this population, a sample of 88 medical record documents was selected using a purposive sampling technique based on inclusion criteria, namely medical records of hypertensive inpatients that contained admission and discharge summary forms and were physically available and readable. Records that were incomplete in terms of availability or could not be clearly identified were excluded from the study.

Data were collected through direct observation using a structured checklist instrument developed based on the standards outlined in the Indonesian Ministry of Health Regulation No. 269/MENKES/PER/III/2008 concerning medical records. The checklist was designed to evaluate four main components of completeness, including patient identification, important patient reports, patient authentication, and good record keeping. Each item was assessed using a dichotomous scale, where a score of one indicated completeness and zero indicated incompleteness. The observation process was carried out systematically to ensure consistency and accuracy in data recording. The collected data were then processed using computerized methods and analyzed through univariate analysis to obtain frequency distributions and percentages for each variable studied. The results were presented in tabular form to facilitate interpretation. Ethical considerations were also maintained throughout the study by ensuring the confidentiality and anonymity of patient data, and permission to conduct the research was obtained from the hospital authorities prior to data collection.

RESULTS

To provide a clear description of the completeness of medical record documentation, the results of this study are presented based on several key components assessed in the admission and discharge summary forms. One of the main aspects analyzed is patient identification, which reflects the accuracy and completeness of administrative data recorded in the medical records. The distribution of completeness in patient identification is presented in Table 1.

Table 1. Patient identificationt

Patient identificationt	Ƒ	%
Incomplete	36	40,9
Complete	52	59,1
Total	88	100,0

Shows that only 40.9% of hospitalized patients suffering from hypertension are incomplete. Research analysis shows that patient identification when filling out the admission and discharge summary form is important because every patient form that contains administrative data as a source of demographic information must be filled in completely. Otherwise, the form will not be able to provide information about the patient's identity as a statistical database, research, or planning resource for hospitals or healthcare organizations. Based on these facts, research analysis shows patient identification when filling out the form.

Table 2. ImportantPatient Reports

ImportantPatient Reports	Ƒ	%
Incomplete	18	20,5
Complete	70	79,5
Total	88	100,0

Shows that in the medical records of inpatients with hypertension, 18 (20.5%) of the Important Patient Reports were incomplete. Based on the results of research conducted by researchers at Lubuk Basung District Hospital on 88 medical records summarizing the admission

and discharge of inpatients with hypertension. studied, in the important patient reports section it was found that 18 medical records (20.5%) were declared incomplete and 70 files (79.5%) were found to be complete.

This research is in line with research (HafizatilQurani&Hidayati, 2021) in Bandung hospitals in 2021, the percentage of completeness in filling out important reports was 88% and incompleteness was 12%. The highest completeness item is located at 100% of admission diagnosis and admission date, and the lowest completeness item is located at 69% and 69% discharge date. This is still not in accordance with Chapter 2 Article 3 Paragraph 2 (b) of the Republic of Indonesia Minister of Health Regulation No. 269/MENKES/PER/III/2008, which states that inpatient and nursing medical records must at least contain the date and time, because it is important to note that every reporting record must include the date and time so that people can see when the patient went home.

Table 3. Patient Authentication

Patient Authentication	F	%
Incomplete	11	12,5
Complete	77	87,5
Total	88	100,0

According to research conducted by researchers at Lubuk Basung Regional Hospital, of 88 medical records summarizing the admission and discharge of inpatients suffering from hypertension, it was found that 11 medical records (12.5%) were declared incomplete and 77 files (87.5%) were declared incomplete. The results of this study are inversely proportional to (Hasmah et al., 2022) at Rsup Dr. Tadjuddin Chalid Makassar found that the average percentage of authentication completeness was 43% and incompleteness was 57%. Items with the doctor's name had the highest completeness at 63%, and items with the doctor's signature had the lowest completeness at 23%.

This is not in accordance with (Minister of Health of the Republic of Indonesia No. 269/MENKES/PER/III/, 2008) article 4 paragraph 2 which states that there must be at least the name and signature of the doctor providing the service in the discharge summary (Minister of Health of the Republic of Indonesia No. 269/MENKES/PER/III/, 2008).According to the researcher's analysis, 77 (87.5%) room doctors who were responsible for patients filled in their names and signatures on the admission and discharge summary forms. which states that the name and signature must be filled in because they must be known by the medical doctor who is responsible for the patient. However, the observation results, especially those relating to the names and signatures of the medical doctors, were incomplete.

Table 4. Good Patient Recording

Good Patient Recording	F	%
Strikethrough	14	15,9
No Strikeouts	74	84,1
Read Clearly	73	82,95
Unclear	15	17,05

Ttotal	88	100,0

Shows that in the medical records of inpatients with hypertension, there were 14 (15.9%) scribbles on the patient's good records, and 15 (17.05%) were not clearly legible. Based on the results of research conducted by researchers at Lubuk Basung Regional Hospital on 88 records medical summary of admissions and discharges of inpatients with hypertension studied, it was found that 24 medical records (27.7%) were found to have scribbles and unclear writing in good records and 64 files (72.3%) were found to be incorrect. There are scribbles and the writing is clearly legible.

The results of this research are inversely proportional to (Agus Kartini & Liddini, 2019). The results obtained from Mitra Medika General Hospital show that the percentage of completeness of recording has reached 100%, and the author found that the use of type-x and the readability of the forms are all clear. According to Handayani & Sudra (2017), all notes in medical records must be read clearly. If there is a writing error, the responsible officer is only permitted to cross out the incorrect note once, and they must also sign or initial, as well as the date on which the note was changed.

According to the researcher's analysis of good patient recording on the admission and discharge summary form, there were no scribbles on the file and the writing on the form was clearly legible, whereas research conducted by researchers still found scribbles and unclear writing on the admission and discharge summary form due to lack of care by medical personnel in filling it out. Good patient record keeping.

on the entry and exit summary forms due to lack of care by medical personnel in filling in proper patient records. Hypertension Admission and Exit Summary Form. Incompleteness of the entry and discharge summary form for hypertension Complete Incomplete Total.

Table 5. Hypertension Admission and Exit Summary Form

Incompleteness of the hypertension admission and discharge summary form	**Complete**		**Incomplete**		**Total**	
	f	**%**	**f**	**%**	**f**	**%**
Patient Identification	52	59.1%	36	40.9%	88	100%
Important Patient Reports	70	79.5%	18	20.5%	88	100%
Patient Authentication	77	87.5%	11	12.5%	88	100%
Good Record Keeping	64	72.3%	24	27.7%	88	100%

Based on the results of researchers on 88 inpatient medical record forms, it shows that in the medical records of inpatients with hypertension, 36 (40.9%) patient identifications were incomplete, 18 (20.5%) patient important reports were incomplete, 11 (12.5%) patient authentications %) were incomplete and good recording of 14 patients (15.9%) was incomplete

This research is in line with research conducted by (Nurliani & Masturoh, 2017) entitled "Quantitative analysis of the completeness of inpatient medical record documents in the entry and discharge summary form for the fourth quarter of 2015." The results of 313 medical records showed the highest presentation of incompleteness in pediatric cases. Important reporting of obstetric cases

was 100%, authentication of obstetric cases with a doctor's name was 55.7%, and good recording of obstetric cases was 60.5%.

According to (Indonesian Ministry of Health, 2006) the entry and exit summary form is the first sheet in the medical record document. It contains information about patient identity, patient admission procedures, and summary patient discharge data, and can also be used to index medical records. Patient identification, critical reporting, authentication, and good documentation are the four main components of information. The incompleteness of the entry and exit summary forms has a direct impact, according to the researchers' analysis. This incompleteness can result in hampered hospital reports, inefficient services, waste of time, energy, materials and work, as well as losses for patients.

DISCUSSION

This study highlights the persistent issue of incompleteness in filling out admission and discharge summary forms for hypertensive patients at Lubuk Basung Regional Hospital. The findings demonstrate that incompleteness still occurs across several key components, namely patient identification, important patient reports, patient authentication, and good record keeping. These results are consistent with previous studies which emphasize that incomplete medical record documentation remains a common problem in healthcare facilities and can negatively affect the quality of health services, administrative processes, and clinical decision-making (Pujilestari et al., 2023; Nurliani & Masturoh, 2017).

The high proportion of incomplete patient identification (40.9%) indicates that basic administrative data is not consistently recorded. This is a critical issue, as patient identification serves as the foundation for all medical record documentation. Incomplete identification data can lead to difficulties in tracking patient history, errors in patient management, and limitations in the use of data for hospital reporting, research, and policy planning. From a health information management perspective, accurate and complete identification data are essential to ensure continuity of care and to prevent potential medical errors.

In addition, the incompleteness found in important patient reports (20.5%) reflects gaps in documenting essential clinical information, such as diagnoses, treatment procedures, and dates of care. This finding suggests that clinical documentation practices have not been fully optimized. Incomplete clinical information may hinder communication among healthcare providers, delay clinical decision-making, and reduce the overall effectiveness of patient care. Furthermore, it may also impact hospital accreditation processes and the evaluation of service quality indicators.

Patient authentication, although showing a relatively lower level of incompleteness (12.5%), still presents a significant concern. Authentication elements such as the physician’s name and signature are legally and ethically required, as they indicate professional responsibility and accountability for the care provided. The absence of proper authentication may lead to legal implications, weaken the validity of medical records, and reduce trust in the documentation system. This issue suggests that compliance with established regulations, such as those set by the Indonesian Ministry of Health, has not been fully achieved.

The aspect of good record keeping also revealed notable deficiencies, including the presence of scribbles and unclear handwriting. Although the majority of records were considered readable, the existence of corrections and unclear entries indicates a lack of adherence to standard documentation practices. Poor record keeping can compromise the clarity and reliability of medical information, potentially leading to misinterpretation by healthcare providers. This condition reflects the need for improved discipline, supervision, and standardization in medical record documentation practices.

Several factors may contribute to the incompleteness observed in this study, including high workload of healthcare workers, limited time for documentation, lack of awareness regarding the importance of complete records, and insufficient monitoring and evaluation systems within the hospital. In addition, the absence of standardized training and continuous education programs related to medical record documentation may further exacerbate this issue.

To address these problems, hospitals need to implement comprehensive strategies, such as routine audits of medical records, strengthening supervision mechanisms, and providing regular training and socialization to healthcare personnel regarding proper documentation standards. The implementation of electronic medical record (EMR) systems may also help reduce incompleteness by enforcing mandatory fields and improving data accuracy. Ultimately, improving the completeness of medical records will not only enhance administrative efficiency but also improve patient safety, quality of care, and overall hospital performance.

CONCLUSIONS

Based on the results of this study, it can be concluded that the completeness of admission and discharge summary forms for hypertensive patients at Lubuk Basung Regional Hospital is still not optimal. From a total sample of 88 medical record documents out of a population of 133, significant levels of incompleteness were identified across several key components, including patient identification, important patient reports, patient authentication, and good record keeping. The highest level of incompleteness was found in patient identification, followed by important patient reports, while authentication and record keeping also showed notable deficiencies.

These findings indicate that the quality of medical record documentation still requires serious attention and improvement. Incomplete medical records can have wide-ranging implications, including disruptions in service delivery, reduced efficiency in hospital administration, potential legal risks, and decreased quality of patient care. Therefore, improving the completeness of medical record documentation should become a priority for hospital management.

It is recommended that hospitals conduct regular evaluations and audits of medical records, strengthen supervision systems, and provide continuous education and training for healthcare workers, including doctors, nurses, and medical record staff. Additionally, the adoption of more structured and standardized documentation systems, including the potential use of electronic medical records, may help minimize errors and improve data completeness. Through these efforts, it is expected that the quality of medical record documentation and healthcare services at Lubuk Basung Regional Hospital can be significantly improved.

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REFERENCES

Agus Kartini, S., &Liddini, H. (2019). Review of Incompleteness Writing Medical Resume Hospitals in Public Hospital Medical Partners of the Year 2019. *Imelda's Recording Scientific Journal and Health Information (Jipiki)*, *4*(2). https://doi.org/10.52943/Jipiki.V4i2.93

Baker, M., Williams, S., & Taylor, R. (2016). *The role of medical records in patient care: Importance of documentation in the healthcare system.* Journal of Health Information Management, 32(4), 58-65.

Chang, L., & Lee, D. (2018). *Comprehensive patient documentation and its impact on hospital operations.* Journal of Clinical Records, 14(2), 112-118.

Depkes Ri. (2006). Department of Health Ri. Guidelines for Maintenance and Medical Record Procedures of Indonesian Hospital RevisionIi (Jakarta : Department of Health Ri. Guidelines for Maintenance and Medical Record Procedures of Indonesian Hospital RevisionIi, 2006). *Department of Health Ri. Guidelines Maintenance and Procedures Medical Records Hospitals Indonesia.*

Hafizatil Qurani, A., &Hidayati, M. (2021). Analysis of Equipment Filling Input and Exit Summary of Covid-19 Insulation Room Care at X Hospital in Bandung. *Cerdika: Indonesian Scientific Journal*, *1*(8). https://doi.org/10.36418/Cerdika.V1i8.143

Handayuni, L. (2020). Medical Records in Health Information Management. In *Medical Records in Health Information Management.* (Vol. 5, Issue 3).

Harrison, L., & White, S. (2019). *Clinical documentation and its importance in healthcare.* Journal of Medical Records, 12(1), 34-40.

Hasmah, H., Musfirah, M., & Syamsiana, S. (2022). Managing Medical Records Patient Hospitalization Bangsal Mawar Di Rsup Dr. Tadjuddin Chalid Makassar. *J-Kesmas: Public Health Journal*, *8*(1). https://doi.org/10.35329/jkesmas.V8i1.2889

Hompson, H., & Peterson, A. (2020). *Medical records and regulatory compliance in healthcare facilities.* International Journal of Healthcare Management, 28(1), 23-29.

Jones, D., Brown, T., & Miller, K. (2020). *The importance of confidentiality in patient care and legal consequences of breaches.* International Journal of Medical Ethics, 18(3), 98-104.

Menteri Kesehatan Ri No. 269/Menkes/Per/Iii/. (2008). , About Medical Records. (Jakarta :Depkes Ri. 2008). *Fakultas Hukum UNPAS*.

Nurliani, A., &Masturoh, I. (2017). Quantitative Analysis Completion Documents Medical Records Hospitals Forms Summary Entry and Exit Tri-month Period IV Year 2015. *Journal of the Indonesian House of Representatives*, *4*(12).

Pujilestari, I., Rohmayani, D., & Monica, R. D. (2023). A Healthy Lifestyle Design for Strong Souls. *Puan Indonesia*, *4*(2). https://doi.org/10.37296/Jpi.V4i2.125

Smith, J., & Johnson, R. (2018). *Legal and ethical aspects of medical record handling*. Health Law Review, 23(4), 78-85.

Syahputra Wiguna, A., & Soraya Matondang, S. (2019). Analysis Design Form Summary Entry and Exit of Hospitals Patients at Madani Field General Hospital in 2018. *Imelda's Recording Scientific Journal and Health Information (Jipiki)*, *3*(1). https://doi.org/10.52943/Jipiki.V3i1.56