Vol. 01, No. 2, May 2024, 22-30
e-ISSN: **3047-8839**

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

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Article Information
Received: May 23, 2024
Revised: May 27, 2024
Online: June 29, 2024

Keywords
Admission and Exit Summary, Hypertension, Medical Records

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.

Keyword: *Admission and Exit Summary, Hypertension, Medical Records.*

http://doi.org/10.69855/mgj.v1i2.37
https://gpijournal.com/index.php/miracle

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 research is a type of quantitative research and uses descriptive research methods with checklist tables. The aim of the descriptive research design is to describe incompleteness in filling out the Summary of Entry and Exit Medical Record Inpatient Medical Record form for Hypertension at Lubuk Basung District Hospital in 2023.

RESULTS

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 reveals the incompleteness in filling out the admission and discharge summary forms for hypertensive patients at Lubuk Basung Regional Hospital, particularly in the areas of patient identification, important patient reports, patient authentication, and good record keeping. These findings align with previous studies indicating that incomplete medical records can hinder the quality of documentation and hospital services (Pujilestari et al., 2023; Nurliani & Masturoh, 2017). Specifically, the incompleteness in patient identification and important reports can negatively impact the management of patient data. Additionally, the lack of proper authentication, such as missing doctor's signatures, and unclear or crossed-out writing suggests that there is still a need for increased awareness among medical staff regarding the importance of accurate form completion.

The study showed that 40.9% of hypertensive patients had incomplete identification, while 20.5% of important patient reports were not filled out properly. This indicates there is room for improvement in the form-filling procedures. In line with regulations from the Indonesian Ministry of Health, complete medical records are crucial not only for effective medical services but also for compliance with legal and ethical standards (Minister of Health of the Republic of Indonesia, 2008). Therefore, further evaluation and outreach to medical staff, including doctors and nurses, are necessary to address these deficiencies. Improving the completeness of medical records will likely expedite service delivery and enhance the accuracy of patient data, ultimately leading to better healthcare service quality at Lubuk Basung Regional Hospital.

CONCLUSIONS

In this study, which used 88 samples from 133 populations, it was found that the existing data was generally incomplete, starting from the entry and exit summary form in the patient identification section, the entry and exit summary form in the patient's important report section, the entry and exit summary form in the patient authentication section and the scribbles on Incoming and outgoing summary form, good recording section and lack of clarity in writing.

ACKNOWLEDGMENT

On this occasion the researcher would like to thank STIKES Dharma Landbouw Padang, the staff of Lubuk Basung Regional Hospital who have given the author the opportunity to conduct research at the hospital, and the parties who have provided input and assistance to the researcher.

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