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Overview of Completeness of Operation Report in Medical Records Surgical Patient Electronics

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Keywords

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ABSTRACT

The abstract must be informative and clear which provides a statement Efforts to improve the quality of hospital services in it must include patient medical records. One of the important components of the report is the operation report form. The purpose of this study was to determine the completeness of the operation report in the electronic medical records of surgical patients at the Klungkung District General Hospital. The method used in this study is quantitative analysis with a descriptive approach. The completeness of the operation report based on the identification review at the Klungkung District General Hospital is in the complete category of 282 (100%) and incomplete as many as 0 (0%), the authentication component contains 240 complete medical records with a percentage of 85.1% and 42 incomplete medical records

with a percentage of 14.9%, the important recording component contains 243 complete medical records with a percentage of 86.2% and 39 incomplete medical records with a percentage of 13.8% and the documentation component contains 249 complete medical records with a percentage of 88.3% and 33 incomplete medical records with a percentage of 11.7%. Based on the results of the study that has been carried out on the completeness of the operation report in the electronic medical records of surgical patients at the Klungkung District General Hospital, it can be concluded that there is still incompleteness in filling out the operation report and there are already components of the electronic medical record that are filled in completely. The suggestion from this study is to conduct socialization and training regarding the completeness and timeliness of filling out electronic medical records to all medical personnel who are responsible for filling out medical records, so that medical records can be filled in completely and can improve the quality of the hospital.

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1. INTRODUCTION

Efforts to improve the quality of hospital services must include patient medical records. Medical records are documents containing patient identity data, examinations, treatments, actions, and other services that have been provided to patients that must be stored as medical records (Yunisca et al., 2022). Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning electronic medical records, every health service facility is required to organize electronic medical records no later than December 31, 2023 (Ministry of Health of the Republic of Indonesia Number 24 of 2022). Electronic Medical Records are an information system that contains records and diseases that are made completely and in detail (Tasya, 2023). In accordance with the minimum service standards (SPM), the completeness of filling in medical records 1x24 hours after the completion of the service must be filled in 100%, so it must be equipped with patient identity on each sheet of medical records, authentic doctors at each designated place, filling in important reports on the file

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good medical records and documentation. One of the important components of the report is the surgical report form (Rahayu, 2022). The surgical report is one of the follow-up records of emergency treatment of a surgical procedure for a patient. The surgical report must be made immediately after surgery and included in the health record. If there is a delay in making the surgical report, information about the surgical procedure must be included in the progress notes, it should be noted that surgical records that are too short can result in unclear sequence of procedures and this can cause serious problems, especially if it goes to court (Tasya, 2023). The impact of incomplete filling in the Electronic Medical Record in the surgical report will have difficulty in evaluating medical services, and can cause problems, because the medical record document is the only record that provides detailed information about what happened when the patient was hospitalized (Yunisca et al., 2022).

This is supported by a study conducted by Alfiani (2020) entitled "Review of the Completeness of Medical Records on the Operation Report Form at Sumber Waras Hospital, Cirebon Regency" which found that the completeness of filling in the operation report data reached 70.08%, incompleteness reached 2.75% and incompleteness reached 27.17%. In line with the study conducted by Sukarsa & Masturoh (2023) which stated that the quantitative analysis of the 4 main components, namely completeness of identification 74.67%, authentication 90%, filling in important reports 70.46% and good documentation 57%. From these results, the highest and lowest results in the gender identification component were 96% and registration number 11%, the surgeon's signature/ full name authentication component 90%, the component for filling in important reports of surgical reports 100% and the nurse's name 34%, good documentation of the date of surgery 96% and the duration of surgery 13% (Sukarsa & Masturoh, 2023). This study is not free from limitations in its implementation, the limitations in this study are related to the system that accesses surgical reports in electronic medical records. This study also does not pay attention to the factors that influence and has not analyzed the workload at the research location which can affect the incompleteness of filling in the medical records of patients at the Klungkung Regency General Hospital.

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2. RESEARCH METHODS.

2.1 Types of Research

The type of research used is quantitative descriptive research. Descriptive is a research method carried out on a group of objects which usually aims to see a picture of the phenomenon (including health) that occurs in a certain population (Sugiyono, 2022). Quantitative is research data in the form of numbers that will be measured using statistics as a calculation test tool, related to the problem being studied to produce a conclusion (Nursalam, 2017). This research method is used to determine the completeness of the surgical report in the electronic medical records of surgical patients at the Klungkung Regency General Hospital.

Research Location The location of this research was carried out at the Medical Records Installation of the Klungkung District General Hospital. This research was conducted in January - March 2024. Population The population in this study was the number of surgical report forms from October to December 2023 as many as 960. Sample The sample is a collection of individuals or objects that are obtained and measured to represent the population. In this study, the sample taken should be a sample that can represent the population (Swarjana, 2023). The sample used in this study was the medical record documents of surgical patients at the Klungkung Regional Hospital. The sample from the study was selected from a portion of the population, the minimum sample size with the calculation of the Slovin Formula, namely as follows:

$$= \frac{}{1 + \quad 2}$$

Note:

n : Number of Samples

N : Population Size

e : tolerable error limit (5%)

then the formula calculation is obtained

$$= \frac{960}{1 + 960\ (0.05)_2}$$

$$= \frac{960}{3.4}$$

$$= 282$$

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2.2 Data Collection Techniques

The data collection technique uses the observation method, which is the result of the soul's active and attentive actions to realize the presence of stimuli, where the researcher makes observations and records directly by looking at the surgical patient data on the computer.

2.3 Data processing techniques

a. Editing

In this editing process, efforts are made to re-check the accuracy of the data obtained or collected.

b. Coding

Coding is the process of classifying data according to its classification by giving a certain code. Data classification is done based on the researcher's consideration. All data is given a code to facilitate the data processing process. The code is given according to the provisions, namely coding regarding the score from the checklist. The coding on the checklist for the completeness of filling out the Operations Report is as follows: Code 0 = Incomplete Code 1 = Complete

c. Entry

Data entry is the activity of entering data that has been collected into a computer table or database, then creating a simple distribution..

d. Cleaning

Cleaning is done to recheck the data that has been entered, whether there are any errors before data processing is carried out. Before processing the data, the researcher rechecks the data that has been entered, whether there is any data that is not correctly entered into the computer program. Cleaning aims to avoid missing data so that it can be done accurately. If there is no missing data, then continue with data analysis. After cleaning is done, and no missing data is found, the researcher continues with data analysis (Swarjana, 2016).

e. Data Analysis

The data analysis used in this study is descriptive. Data analysis is a process of systematically searching and compiling data that has been obtained from the results of the study so that conclusions can be drawn with field notes and documentation by compiling data into categories, describing them into

RESULTS AND DISCUSSION

3.1 Results

Table 1 Results of Analysis of Completeness of Operation Reports Based on Patient Characteristics in General Hospitals Klungkung Regency Area:

Patient Characteristics	Frequency	Percentage
Old Visit	158	56%
New Visit	124	44%
Total	282	100%

Based on the results of table 1, the results obtained based on patient characteristics from 282 electronic medical records were 158 (56%) in the old visit category, while patients in the new visit category were 124 (44%).

Table 4.2 Results of the Analysis of Completeness of Operational Reports based on Identification Review at the Klungkung District General Hospital:

Identification Review	Complete	Incomplete
Medical Record Number	282 (100%)	0 (0%)
Patient Name	282 (100%)	0 (0%)
Age	282 (100%)	0 (0%)
Gender	282 (100%)	0 (0%)

Based on the results of table 4.2, it was obtained from 282 electronic medical records that the majority of the frequency of completeness of surgical reports based on identification review at the Klungkung Regency Regional General Hospital was in the complete category of 282 (100%) and incomplete of 0 (0%).

Table 3 Results of Analysis of Completeness of Operation Reports Based on Authentication Review at General Hospitals Klungkung Regency Area:

Authentication Review	Complete	Incomplete
Doctor's Name	268 (95%)	14(5%)
Doctor's Signature	267(94.7%)	15(5.3%)
Nurse Name	269(95.4%)	13(4.6%)

Based on the results of table 3 obtained from 282 electronic medical records, the majority of the frequency of completeness of the operation report based on the authentication review at the Klungkung District General Hospital, namely the doctor's name category is in the complete category as many as 268 (95%) and incomplete as many as 14 (5%), the signature category is in the complete category as many as 267 (94.7%) and incomplete as many as 15 (5.3%), the nurse's name category is in the complete category as many as 269 (95.4%) and incomplete 13 (4.6%). So that the results obtained from 282 medical records of the completeness of the Operation Report in the authentication component, there are 240 medical records filled in completely with a percentage of 85.1% and 42 medical records are incomplete with a percentage of 14.9%.

Table 4 Results of Completeness of Operation Reports based on the Review of Important Records at Regional General Hospitals Klungkung Regency:

*Reviews*Recording	Complete	Incomplete
Type of Operation	282 (100%)	0 (0%)
Operation Date	282 (100%)	0 (0%)
Operating Hours Start	277 (98.2%)	5 (1.8%)
Operation Hours Completed	275 (97.5%)	7 (2.5%)
Anesthesia Hours	275 (97.5%)	7(2.5%)
Duration of Anesthesia	267 (94.7%)	15(5.3%)
Complications	269 (95.4%)	13 (4.6%)

Bleeding	264 (93.6%)	18 (6.4%)
Excised tissue	252 (89.4%)	30 (10.6%)

Based on the results of table 4 from 282 electronic medical records, the frequency of completeness of surgical reports based on a review of important records at the Klungkung District General Hospital was obtained, namely the type of surgery in the complete category was 282 (100%) and incomplete was 0 (0%), the date of surgery in the complete category was 282 (100%) and incomplete was 0 (0%), the operating date was in the complete category was 277 (98.2%) and incomplete was 5 (1.8%), the operating hours finished in the complete category were 275 (97.5%) and incomplete was 7 (2.5%), the hours of anesthesia in the complete category were 275 (97.5%) and incomplete were 7 (2.5%), the duration of anesthesia in the complete category was 267 (94.7%) and incomplete was 15 (5.3%), complications in the complete category were 269 (95.4%) and incomplete were 13 (4.6%), bleeding in the complete category was 264 (93.6%) and incomplete was 18 (6.4%), the excised tissue in the complete category was 252 (89.4%) and incomplete was 30 (10.6%). So that the results obtained from 282 medical records of the completeness of the Operation Report on the important recording component, there were 243 complete medical records with a percentage of 86.2% and 39 incomplete medical records with a percentage of 13.8%.

Table 5 Results of Completeness of Operation Reports Based on Correct Documentation in General Hospitals Klungkung Regency Area:

Documentation	**Complete**	**Incomplete**
Correct Recording Clear and Legible	273 (96.8)	9 (3.2%)
Blank Sections Are Marked	258(91.5%)	24 (8.5%)

Based on the results of table 4.5 from 282 electronic medical records, the majority of the frequency of completeness of surgical reports based on correct documentation at the Klungkung District General Hospital, namely correct, clear and legible recording, is in the complete category of 273 (96.8) and incomplete 9 (3.2%), the blank section is marked in the complete category of 258 (91.5%) and incomplete as many as 24 (8.5%). So that the results obtained from 282 medical records of the completeness of the surgical report on the correct documentation component, there are 249 complete medical records with a percentage of 88.3% and 33 incomplete medical records with a percentage of 11.7%.

Table 6 Results of the Analysis of the Percentage of Total Completeness of Completing Operation Reports at Regional General Hospitals Klungkung Regency:

No	**Component Analysis**	**Percentage of Completeness of Operational Report Electronic Medical Records**		
		Complete	**Incomplete**	**Amount**
1	Identification	282 (100%)	0 (0%).	282 (100%)
2	Authentication	240 (85.1%)	42 (14.9%)	282 (100%)
3	Recording Important	243 (86.2%)	39 (13.8%)	282 (100%)
4	Documentation	249 (88.3%)	33 (11.7%)	282 (100%)

Based on the results of table 6, it was obtained from 282 electronic medical records that the majority of the frequency of completeness of the operation report based on the identification review at the Klungkung District General Hospital was in the complete category of 282 (100%) and incomplete of 0 (0%), the authentication component contained 240 complete medical records with a percentage of 85.1% and 42 incomplete medical records with a percentage of 14.9%, the important recording component contained 243 complete medical records with a percentage of 85.1% and 42 incomplete medical records with a percentage of 14.9%.

percentage of 86.2% and 39 incomplete medical records with a percentage of 13.8% and the documentation component contains 249 complete medical records with a percentage of 88.3% and 33 incomplete medical records with a percentage of 11.7%. So that the results of the total percentage of completeness of the Operation Report from 282 medical records contain 203 complete medical records with a percentage of 72.0% and 79 incomplete medical records with a percentage of 28.0%.

2. DISCUSSION

Based on the research results obtained from 282 electronic medical records, the majority of the frequency of completeness of surgical reports based on identification review at the Klungkung District General Hospital was in the complete category of 282 (100%) and incomplete of 0 (0%), the authentication component contained 240 complete medical records with a percentage of 85.1% and 42 incomplete medical records with a percentage of 14.9%, the important recording component contained 243 complete medical records with a percentage of 86.2% and 39 incomplete medical records with a percentage of 13.8% and the documentation component contained 249 complete medical records with a percentage of 88.3% and 33 incomplete medical records with a percentage of 11.7%.

This is in line with the research conducted by Dewi and Setiyarini (2016) which obtained the results of the completeness of filling in the operational report data reaching 70.08%, incompleteness reaching 2.75% and incompleteness reaching 27.17%. Quantitative analysis of the 4 main components, namely completeness of identification 74.67%, authentication 90%, filling in important reports 70.46% and good documentation 57%.

Every patient who receives surgery, the results of the surgery must be filled in immediately on the surgery report sheet. The surgery report is filled in completely and signed by the doctor who performed the surgery. The doctor did not complete the surgery report because the doctor was too busy and many other things influenced it, for example the doctor was in a hurry so he did not have time to fill in the complete surgery report.

Medical records must be created and completed after the patient receives health services (Ministry of Health of the Republic of Indonesia, 2022). This is also in accordance with hospital service standards which require the completeness of filling in electronic medical records <24 hours after completion of service must reach 100% [1]. Researchers argue that the percentage of filling in the completeness of the surgical report is higher than the percentage of incompleteness. This is also used to measure the quality of services provided by the hospital, measure the quality of medical records, and for good documentation.

CONCLUSION

Based on the results of the research that has been carried out on the completeness of filling out the operation report in the electronic medical records of surgical patients at the Klungkung District General Hospital, it can be concluded that the results of the study indicate that the characteristics of patients with the old visit category are 158 (56%) while patients with the new visit category are 124 (44%), Completeness of identification filling is 282 (100%) and incompleteness is 0 with a percentage (0%), Completeness of authentication components is 240 Complete operation reports with a percentage of 85.1% and 42 Incomplete operation reports with a percentage of 14.9%, the highest incompleteness is in the doctor's signature component, which is 15 (5.3%), Completeness of important recording components is 243 Complete operation reports with a percentage of 86.2% and 39 Incomplete operation reports with a percentage of 13.8%, the highest incompleteness is in the excised tissue component as much as 30 (10.6%), Completeness of documentation components is 265 Complete operation reports with a percentage of 94% and 17 Incomplete surgical reports with a percentage of 6%, the highest incompleteness is in the blank section component marked as many as 24 (8.5%), Analysis of the total percentage of completeness of surgical reports based on 4 components of the majority frequency of 282 medical records of completeness in surgical reports, namely complete as many as 203 (72.0) and incomplete as many as 79 (28.0).

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