

Research Article

Completeness of Medical Record Documents in Inpatient Surgery Cases at Tgk Chik Ditiro Regional Hospital

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Abstract: Completeness, suitability, and accuracy in filling medical record documents are essential for effective management of patient files, as well as for improving the overall quality of healthcare services. Medical records serve as a critical tool for documenting patient histories, treatments, and decisions made during their healthcare journey, thus impacting the quality of care provided. Incomplete or inaccurate documentation can lead to delays in treatment, miscommunication among healthcare providers, and legal issues related to patient care. Studies have shown that comprehensive medical records are linked to improved patient outcomes and enhanced operational efficiency in healthcare settings (Smith et al., 2019; Johnson & Patel, 2021). This study aimed to assess the completeness of patient medical record documents in the Medical Resume and Informed Consent forms for inpatients with surgical cases at Tgk. Chik Ditiro Sigli General Hospital. Using a descriptive quantitative approach, the research analyzed a random sample of 293 medical documents. The findings revealed that the completeness of medical record documentation was 69% for the Medical Resume sheet and 83% for the Informed Consent sheet. The study concluded that certain sections were either incomplete or omitted, primarily due to the assumption that certain fields were not applicable to the particular patient's case. This highlights the need for further training and awareness for healthcare staff regarding the importance of complete medical documentation. The hospital should implement stricter guidelines for filling out medical records and ensure that healthcare workers fully understand the significance of accurate and complete documentation. Future research could explore strategies for improving the consistency of medical record documentation and evaluate the impact of training programs on filling medical records (Williams et al., 2020).

Keywords: Documents; Hospital; Inpatient; Medical Records; Surgery

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1. Introduction

Global developments can lead to an increased need for information in various aspects, including health services. The use of health care facilities has also continued to increase over time as the public has become more aware of the importance of health care and services (Mawarni & Wulandari, 2013).

Medical records are a health service that encompasses completeness, accuracy, and speed in providing information to improve health care. Good quality medical records services reflect good health care practices for patients (Mawarni, 2013).

A complete medical record of surgical cases is crucial, particularly for its legal validity. According to Indonesian Minister of Health Regulation No. 290/MENKES/PER/III/2008, which discusses consent from doctors to patients in surgical and invasive procedures, as well as consent for sedation and anesthesia, (Dewi, 2017).

Problems with completing medical records include incomplete medical record files and doctors' lack of specificity in their diagnoses. This can have fatal consequences for patients. Medical records can also be used as material for medical evaluations and are crucial documents for hospitals and serve as a basis for evaluating the quality of healthcare provided to patients (Santosa, 2013) .

It is important to fill out the medical record document completely because this can affect the health service process provided to patients by medical personnel and can affect the quality of hospital services and the services of medical personnel in the hospital (Pamungkas, 2015)

The importance of filling out patient medical records completely for hospitals is as a measuring tool for the quality of hospital services. The quality in question is achieving the standards set for hospitals by the Ministry of Health regarding patient health services, one of which is through medical records (Kristianto, A., & Ernawati, D. (2015) .

medical records at Tgk. Chik Ditiro General Hospital were often incomplete, with gaps in information about disease coding . Similarly, informed consent was incomplete, particularly regarding the patient's admission and discharge dates.

Based on these problems, the researcher wants to examine the completeness of the Medical Record Documents for Inpatients in surgical cases at Tgk. Chik Ditiro Sigli General Hospital, which is reviewed from the Resume. Medical and completeness of filling out Medical Record Documents reviewed from Informed Consent .

The aim of this study is to determine the completeness of filling in the Inpatient Medical Record Documents for surgical cases reviewed from the Resume. Medical and Informed Consent .

2. Literature Review or Related Research

2.1 Medical Records

Medical records are files containing information related to patient identity, diagnosis, physical examination, laboratory, anamnesis, services and medical actions for patients as well as treatment for both inpatient, outpatient and emergency services (Ministry of Health, 2006).

According to the Minister of Health's regulations contained in Number 749a/Menkes/Per/XII/1989 concerning Medical Records, medical records are files containing notes and documents related to patient identity, medical procedures, treatment, examinations and other health services to patients.

The system in Medical Record Services aims to provide information to make it easier to manage medical services to patients and also easier to make managerial decisions which include planning, implementation, supervision, organization, assessment and control through providing clinical and administrative service information at health service facilities (Nuraini, 2015) .

In the Regulation of the Minister of Health of the Republic of Indonesia Number 269/Menkes/Per/III/2008, it is explained that the use of medical records can be used as a communication tool between doctors and other medical personnel in providing health care services, patient care and patient treatment, as evidence of medical and dental law, presenting clinical data, for education and research, can be the basis for financing health services and health statistics data.

2.2 Medical Record Documents

According to reference 269/MENKES/PER/III/2008 Regarding Medical Records and the quality of medical records must refer to the stipulated articles as in Article 5 paragraph 4: namely every recording in the medical record must be filled in the name, time, and signature of the doctor, dentist or other health workers who have provided medical services to the patient directly. Then in Article 5 paragraphs 5 and 6 it is stated that if there is an error in recording the medical record, it can be corrected. The correction as referred to in paragraph 5 can only be done by crossing out without removing the previous record that was corrected and affixed with the doctor's initials (Wilda, 2017) .

Documents are the completeness of a record, namely x-rays, information or laboratory results according to their scientific competence (Kholili, 2011) . There are several medical record documents that must be in accordance with the Regulation of the Minister of Health of the Republic of Indonesia (PERMENKES) on inpatient care, namely: Patient identity; medical support: Physical examination results; Date and time; Anamnesis; Diagnosis; Treatment; actions; Management plan; Medical observation notes and treatment results; Approval for action if necessary; Name and signature of the doctor or health worker; Discharge summary ; Other services that have been provided by health workers (Kholili, 2011) .

2.3 Inpatient Care

Inpatient care is a service in a hospital, in inpatient care important records contain the patient's identity, diagnosis, examination, consent to medical treatment (if any), treatment and other health services provided to the patient (Hidayat, 2008) .

Documentation is part of the evidence of a service process that has been provided by health workers or hospitals, as part of the health information system, because it contains patient clinical data (Hidayat, 2008) .

2.4 Surgical Cases

Surgical cases are a public health problem, where cases involve specialist doctors in carrying out and handling surgical cases, an example of a surgical case is heart surgery (Takaendengan, 2016) .

2.5 Contents of Medical Records

The contents of the medical record are descriptions related to patient identity, treatment, diagnosis, examination, actions and other services that have been carried out by health workers or by doctors in accordance with their competence (Kholili, 2011) .

The contents of medical records must be kept confidential. Only the treating physician and the patient's written permission may be disclosed to the patient. If a medical record is damaged due to poor maintenance or incomplete documentation, resulting in the contents becoming unclear or unclear, medical law may apply to the doctor in question (Hetty, 2015) .

The most important thing in organizing medical records is that the medical record file must be filled out completely, without delay (on time), and done immediately. If it is delayed, it can cause the doctor to forget the patient's condition and illness, thus also impacting the quality of hospital services (Hetty, 2015) .

The data entered in the Medical Record File is different for each patient who has received outpatient, emergency, or inpatient health services. Each health service, whether outpatient, emergency, or inpatient, can create a medical record with its own data (Minister of Health Regulation 269/PER/MENKES/PER/III/2008).

3. Proposed Method

This research is a quantitative research, namely to find out about the Completeness of Medical Record Documents for Inpatients in Surgical Cases at Tgk. Chik Ditiro Sigli General Hospital. Quantitative Research Methodology is a method based on Quantity or Numerical Information and is usually associated with statistical analyses . Quantitative is often and simplified by experts as a type of research that is more centered on numbers (Stokes, 2003) .

The population in this study was all medical record documents for inpatient surgical cases, totaling 1,025 medical record documents for surgical cases over a three-month period from January to March. Sampling used the Slovin formula, amounting to 293 medical record documents.

4. Results and Discussion

Data collection will be carried out by obtaining primary data through a checklist observation sheet to determine the completeness of the Inpatient Medical Record Documents for Surgical Cases at Tgk Chik Ditiro General Hospital.

4.1 Document Demographics

Research results regarding the completeness of patient documents based on the number of months and the number of patient respondents.

Table 1. Number of Patient Documents Based on Gender

No	Month	Man	Woman	Amount
1.	January	186	172	358
2.	February	167	144	311
3.	March	203	153	356
4.	Total	556	469	1025

Based on the table above, the number of documents from patients at Tgk Chik Ditiro Sigli General Hospital is 1025 patient medical record documents.

4.2 Completeness of Medical Record Documents

The documents examined by the author are in two aspects, namely the Medical Resume and Informed Consent.

4.2.1 Medical Resume

A total of 293 respondents had 14 points that had to be filled in and completed by officers from the Medical Resume Document and the average point completion per respondent was 10 of the 14 points on the Medical Resume sheet.

Table 2. Average completion of Medical Resumes

No.	Variables	Complete Questionnaire Items	%	Incomplete Questionnaire Items	%	Amount
1.	Medical Resume	2848	69.42	1254	30.68	4102

The Medical Resume contains 14 items. After careful examination and data from the hospital documents, 2,848 questionnaire items were completed, representing 69.42% of the total. Furthermore, 1,254 items were incomplete, representing 30.68% of the total. The total number of items in the Medical Resume Variable is 4,102.

In the table below, the author discusses information on filling out each point of the Medical Resume

Table 3. Explain each point about Medical Resume

No.	Points/Items	Explanation
1.	Patient Identity	The author found that out of the 293 documents, 100% were completely filled in.
2.	Anamnesis	The points in the Anamnesis were also filled in 100% of the total points, namely 293 points from the Medical Resume and Informed Consent sheets.
3.	Past Medical History	Only 36.9% were completed. In this case, not all patients had a clear medical history at a specific hospital and various other causes of the case. Therefore, this completion percentage is not a perfect total.
4.	Examination During MRS	This MRS check point is obtained 100% for each patient file that is completely filled out.
5.	Diagnosis	Diagnosis is a disease code or disease name, of which 293 patient documents contain a percentage of 98.30%. This means there is a shortage of filling which is a big question

		why at this point the hospital staff emptied it even though it was only minus 1.70%.
6.	Problems faced	The author calculated that approximately 76.80% of patient data was filled in at this point. The remainder was incomplete. This gap was attributed to medical staff not asking patients about their complaints.
7.	Consultation	Only 37.20% of consultations were filled, referring to medical consultations at the hospital. The remaining patients who didn't receive consultations were those who arrived unexpectedly, such as due to accidents, or those who weren't regular patients at the hospital.
8.	Treatment/Action (ICD-9-CM)	This point is 68.60% filled. This is the code that requires medical action on the patient. The remaining unfilled codes are for patients who no longer require special treatment or no longer require specific medical treatment.
9.	Disease Course	Of the 293 patient document files, 46.40% were filled. The remaining fields were for patients who had not previously been treated at the hospital, so the hospital lacked complete documentation of their medical histories. Therefore, these fields were left blank.
10.	Condition at the time of discharge from the hospital	The patient's condition was recorded at the time of discharge after inpatient care at the hospital, and the rate was 93.90%. The remaining cases included cases where medical staff failed to record the information, cases where patients absconded, requested early discharge, and various other situations.
11.	Prognosis	The effects experienced by patients after undergoing surgical procedures at the hospital. The medical team at the hospital recorded 6.48% of patients experiencing post-surgical effects. The remaining 6.48% of patients were fine after their surgical procedures.
12.	Cause of Death	Only 8.87% of this point was filled in. Because not all patients died during the post-treatment period, this point was not filled in.
13.	Follow-up	Follow-up on patients by medical personnel is recorded on each sheet of the Medical Resume that the author found to be 100% complete.
14.	Doctor's Signature	100% of all Medical Resume documents are signed by the doctor as the person performing the medical action on the surgical patient.

In the Medical Resume Variable, there are 14 Points or Items listed on the Medical Resume sheet. A total of 293 Respondents did not all fill in completely, meaning some were filled in and some were not filled in for various reasons. The author has explained one by one each Point or Item on the Medical Resume sheet that the author took from 293 Respondents. The conclusion that the author can give from the 14 Points is that not all of them were filled in completely because there were several cases that caused each particular point to not need to be filled in, such as the Point on Cause of Death, not all respondents were required to fill in because not necessarily all patients hospitalized at Tgk. Chik Ditiro Sigli General Hospital died after surgery. Then there were also several cases of medical personnel not filling in Points that should be filled in and this could have been done consciously or intentionally.

4.2.2 Informed Consent

The Informed Consent questionnaire contained 1,758 items. Of the 1,465 items, or 83.33%, the questionnaire was completely filled in. Of the 1,758 items, 293 were incomplete, or 16.67%.

Table 4. Average completion of Informed Consent

No.	Variables	Complete Questionnaire Items	%	Incomplete Questionnaire Items	%	Amount
2.	Informed Consent	1465	83, 33	293	16, 67	1758

In the table below, the author will explain each point one by one.

Table 5. Explain each point about informed consent

No	Point	Explanation
1.	Patient Identity	The Patient's Identity on the Informed Consent sheet is filled in completely, 100%, and nothing is missing.
2.	Identity of Parents/Guardians/Husband/Wife/Child	The identity of the patient's parents/guardians/husband/wife/children is also filled in completely 100%.
3.	Action Statement (Agree/Disagree)	At this point, the author found absolutely no written consent to the procedure. The point in question was left blank in all the documents the author encountered. This meant only identification and some written consent were included in the letter, and the signature of the parent/guardian/husband/wife/child was immediately addressed to confirm consent for the patient's medical treatment.
4.	Adverb of time	100% of documents found with time information on the Informed Consent sheet.
5.	Signature of Parent/Guardian/Husband/Wife/Child	100% Complete on all documents the author encountered.
6.	Officer's Signature (Doctor/Midwife)	Also 100% filled in completely in all Informed Consent documents of patients who will undergo medical procedures.

Informed Consent sheet has 6 points or items that the author observed on the Informed Consent sheet at Tgk. Chik Ditiro Sigli General Hospital and there are a total of 293 Respondent Documents that the author collected. The completeness of the consent sheet or Informed Consent prepared by the Hospital has been completely and fully filled. However, there is one point that is no longer filled in completely, namely the AGREE/DISAGREE point for surgical procedures by medical personnel. However, this does not mean that the patient's family does not agree, because after filling in the data, the family immediately carries out the signature process. This can be said to be wrong because all the Respondent samples that the author collected were not filled in at this point. Perhaps this is an error on the part of the officer who did not inform the patient's family to fill it in.

4.2.3 Total of both variables

From the two variables (Medical Resume and Informed Consent) the total number of items owned is 8,919 items in total, including 4,102 from Medical Resume and 1,758 Informed Consent . Then the medical record files that were completely filled in were 7,161 (73.60%), namely 2,848 (69.42%) from Medical Resume and 1,465 (83.33%) from Informed Consent

Table 6. Average filling of both variables

No.	Variables	Complete Questionnaire Items	%	Incomplete Questionnaire Items	%	Amount
3.	Total	7161	73, 60	1547	26.4	8919

5. Comparison

Research contribution This can become material consideration For compile related policies filling document record medical patient care stay case surgery , quality and quality service House Sick as well as material reference For repair system service record medical House Sick in the future and can made into as material reference in develop as well as references to research continued .

6. Conclusion

The conclusion from the results of this study is that:

There are a number of points on the Medical Resume and Informed Consent sheets that are filled in completely or 100% and some that are not filled in at all or 0%.

There are several important points that were not filled in correctly and were deliberately left blank by the officer.

There was one point that was missing or not filled in at all by the officer, namely on the Informed Consent form , where the Agree/Disagree section was for the medical procedure. Instead, it went straight to the patient's family's signature section.

There are two points on the medical resume that have a low percentage because they refer to the patient's past medical history. This is because patients undergoing medical procedures at the hospital are not previously hospitalized or are sudden patients, for example, accident patients.

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and Dedy Firdaus Ridwan ; Resources: Sartika Maulida Putri ; Data Curation: Sartika Maulida Putri ; Writing original draft: Sartika Maulida Putri and Dedy Firdaus Ridwan; Writing review and editing: Sartika Maulida Putri; Visualization: Nurpida ; Supervision: Yenni Fitri Velayati; Project administration: Iriani ; Funding: Sartika Maulida Putri, Dedy Firdaus Ridwan , Iriani, Nurpida and Yenni Fitri Velayati ."

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