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GAMBARAN KELENGKAPAN INFORMASI KLINIS PASIEN KASUS KECELAKAAN PADA DOKUMEN REKAM MEDIS (DRM) DI UGD RS TPT TK. III DR. R. SOEHARSONO BANJARMASIN.

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Kelengkapan Informasi Klinis diartikan sebagai kelengkapan data hasil pemeriksaan, pengobatan, perawatan yang dilakukan oleh praktisi kesehatan penunjang medis terhadap pasien rawat inap maupun rawat jalan (termasuk gawat darurat). Rekam medis pasien memuat seluruh informasi klinis dan nonklinis yang bersinggungan dengan pelayanan yang diterima pasien selama di rumah sakit. Informasi klinis pasien salah satunya terdapat didalam dokumen rekam medis. Kelengkapan pengisian informasi klinis pada dokumen rekam medis sangat penting karena dokumen rekam medis yang lengkap adalah cermin mutu rekam medis serta layanan yang diberikan oleh rumah sakit dengan standar kelengkapan 100%. Penelitian ini bertujuan untuk mengetahui gambaran kelengkapan informasi klinis pasien kasus kecelakaan pada dokumen rekam medis (DRM) di UGD RS TPT Tk. III Dr. R. Soeharsono Banjarmasin dilihatdari: Riwayat Medis (anamnesis), Diagnosa Utama dan Sekunder, Tindakan, Pemeriksaan Fisik dan Penunjang. Metode penelitian yang digunakan adalah deskriptif. Objek penelitiannya adalah 38 sampel dokumen rekam medis pasien kasus kecelakaan di UGD RS TPT Tk. III Dr. R. Soeharsono Banjarmasin. Pengambilan sampel dilakukan dengan metode *quota sampling.* Berdasarkan hasil penelitian kelengkapan informasi klinis berupa Riwayat Medis (Anamnesis) 89% lengkap, Diagnosa Utama dan Sekunder 68% lengkap, Tindakan 98% lengkap, Pemeriksaan fisik dan penunjang 92% lengkap. Disimpulkan bahwa gambaran kelengkapan informasi klinis pasien kasus kecelakaan pada dokumen rekam medis (DRM) di UGD RS TPT Tk. III Dr. R. Soeharsono Banjarmasin belum 100% lengkap.

Kata Kunci: Informasi Klinis, Kecelakaan, Dokumen Rekam Medis

ABSTRACT

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DESCRIPTION OF CLINICAL INFORMATION COMPLETENCY OF ACCIDENT CASE PATIENTS ON MEDICAL RECORDING DOCUMENTS (DRM) IN UGD RS TPT TK. III DR. R. SOEHARSONO BANJARMASIN.

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Completeness of Clinical Information is defined as the completeness of data on the results of examinations, treatment, care performed by medical supporting health practitioners for both inpatients and outpatients (including emergency departments). The patient's medical record contains all clinical and non-clinical information that pertains to the services received by patients while in the hospital. One of the patient's clinical information is contained in the medical record document. Completeness of filling in clinical information on medical record documents is very important because a complete medical record document is a reflection of the quality of medical records and services provided by the hospital with 100% completeness standards. This study aims to describe the completeness of clinical information on accident patients in medical record documents (DRM) in the emergency room of RS TPT Tk. III Dr. R. Soeharsono Banjarmasin seen from: Medical History (anamnesis), Primary and Secondary Diagnosis, Actions, Physical Examination and Support. The research method used is descriptive. The object of the research was 38 samples of medical record documents of accident patients at the emergency room at TPT Tk. III Dr. R. Soeharsono Banjarmasin. The sample was taken by using quota sampling method. Based on the results of the study, the completeness of clinical information in the form of medical history (history) was 89% complete, Primary and Secondary Diagnosis was 68% complete, Actions were 98% complete, Physical examination and support were 92% complete. It was concluded that the description of the completeness of clinical information on accident patients on medical record documents (DRM) in the ER at TPT Tk. III Dr. R. Soeharsono Banjarmasin is not 100% complete.

Keywords: Clinical Information, Accident, Medical Record Document