ABSTRAK

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TINJAUAN KELENGKAPAN PENGISIAN FORMULIR *DISCHARGE PLANNING* PADA BERKAS REKAM MEDIS RAWAT INAP DI RUMAH SAKIT JIWA SAMBANG LIHUM KABUPATEN BANJAR

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Discharge planning merupakan suatu proses yang dinamis dan sistematis dari penilaian, persiapan, serta koordinasi yang dilakukan untuk memberikan kemudahan pengawasan pelayanan kesehatan di Rumah Sakit. Berdasarkan hasil studi pendahuluan yang dilakukan di Rumah Sakit Jiwa Sambang Lihum didapatkan bahwa ketidaklengkapan pengisian formulir *discharge planning* dilihat dari 10 berkas rekam medis terdapat 7 (70%) berkas yang tidak terisi secara lengkap pada bagian tanda tangan kepala ruangan dan tanda tangan perawat. Tujuan penelitian ini adalah mengetahui kelengkapan pengisian formulir *discharge planning* pada berkas rekam medis rawat inap di Rumah Sakit Jiwa Sambang Lihum. Metode penelitian dalam penelitian ini adalah deskriptif dengan pendekatan *Mix Method* (kuantitatif dan kualitatif), alat pengumpulan data menggunakan observasi berupa check List dan wawancara. Sampel berjumlah 94 berkas rekam medis yang dihitung menggunakan rumus slovin. Hasil penelitian ini yaitu kelengkapan pengisian formulir *discharge planning* dilihat dari pengisian data identitas pasien dan data laporan penting sudah terisi lengkap 100%, akan tetapi di lihat dari pengisian data autentifikasi masih belum sesuai dengan Standar Pelayanan Minimal yang mengharuskan terisi lengkap 100%, pada indikator nama perawat, tanda tangan perawat, gelar perawat, nama kepala ruangan, tanda tangan kepala ruangan, gelar kepala ruangan tidak terisi lengkap yaitu hanya 71%. Faktor penyebab ketidaklengkapan pengisian formulir *discharge planning* yaitu disebabkan oleh Sumber Daya Manusia, petugas sering terlupa mengisi formulir rekam medis dikarenakan banyaknya bagian yang harus di lengkapi dan dikonfirmasi kembali dengan Dokter Penanggung Jawab, sehingga mengakibatkan terdapatnya bagian dari formulir *discharge planning* yang terlupa dan tidak terisi dengan lengkap.

Kata Kunci : Formulir *Disharge Planning*, Rekam Medis, Standar Pelayanan Minimal

ABSTRACT

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REVIEW OF THE COMPLETENESS OF FILLING IN THE DISCHARGE PLANNING FORM IN THE INPATIENT MEDICAL RECORDS AT THE SAMBANG LIHUM PSYCHIATRIC HOSPITAL BANJAR DISTRICT

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Discharge planning is a dynamic and systematic process of assessment, preparation, and coordination that is carried out to facilitate the supervision of health services in hospitals. Based on the results of a preliminary study conducted at the Sambang Lihum Mental Hospital, it was found that the incompleteness of filling out the discharge planning form was seen from the 10 medical record files, there were 7 (70%) files that were not filled in completely on the signature of the head of the room and the signature of the nurse. The purpose of this study was to determine the completeness of filling out the discharge planning form in the inpatient medical record file at the Sambang Lihum Mental Hospital. The research method in this research is descriptive with a Mix Methods approach (quantitative and qualitative), the data collection tool uses observation in the form of check lists and interviews. The sample is 94 medical record files which are calculated using the slovin formula. The results of this study are that the completeness of filling out the discharge planning form can be seen from the filling in of patient identity data and important report data that has been completely filled in 100%, but in terms of filling out the authentication data it is still not in accordance with the Minimum Service Standards which require that 100% be completely filled in, on the name indicator nurse, nurse's signature, nurse's title, name of head of room, signature of head of room, title of head of room is incomplete, namely only 71%. Factors causing incomplete filling of the discharge planning form are caused by Human Resources, officers often forget to fill out medical record forms due to the large number of sections that must be completed and reconfirmed with the doctor in charge, resulting in parts of the discharge planning form being forgotten and not filled in completely.

Keywords : Discharge Form Planning, Medical Records, Minimum Service Standards