Indonesian Journal of Nutritional Epidemiology and Reproductive

ISSN: 2620-8261 (Online) DOI: 10.30994/ijner.v5i2.176 Vol. 5 No.2 May 2022, pp. 37 - 45

Analysis of Time for Providing Outpatient Medical Record Documents for General Old Patients at the Gondang Community Health Center, Tulungagung Regency

Dita Oisina Gusti Saputri¹, Ratna Wardani²

^{1,2}Institut Ilmu Kesehatan STRADA Indonesia *Corresponding Author : ditaoisinagustisaputri@gmail.com

ABSTRACT

The time to provide medical record documents quickly and accurately is one of the factors that can influence the quality of health services. The sooner the provision of medical record documents is found, the faster the service will be provided to the patient. The focus of this research is to determine the time needed to provide outpatient medical record documents for general old patients at the Gondang Tulungagung Community Health Center. This research uses a qualitative research method with a case study approach which aims to examine and establish validity by analyzing from various perspectives. The informants in this research were 3 people, namely the staff of the Community Health Center and 1 triangulator, namely the Head of the Gondang Community Health Center. The results of this research show that: the policy for providing medical records carried out by medical records officers has been implemented well in accordance with existing regulatory standards, standard operational procedures regarding the flow of providing medical record documents at the Gondang Community Health Center, Tulungagung Regency have been implemented well based on the SOP set by the head community health centers and the Ministry of Health, the time for providing outpatient medical record documents for general old patients at the Gondang Health Center, Tulungagung Regency has a time range between 2-5 minutes and less than 10 minutes, and the factors causing delays in the time for providing outpatient medical record documents for general old patients are in Gondang Community Health Center, Tulungagung Regency, where medical record documents were lost. It is hoped that medical record officers can maintain good service to patients and will be even more effective if the service provided can be improved by minimizing patient waiting time and providing friendlier service.

Keywords: Medical Record Documents, Provision Time

INTRODUCTION

The time to provide medical record documents quickly and accurately is one of the factors that can influence the quality of health services. The sooner the provision of medical record documents is found, the faster the service will be provided to the patient. Time to provide medical record documents is hampered due to the number of patient visits increasing every day while the number of service providers is limited (Sudrajat & Sugiarti, 2015). The time for providing medical record documents is calculated from when the patient registers until the medical record document is found (Ministry of Health, 2007). The Minimum Service Standards for Medical Records state that the time for providing medical record documents for outpatients is ≤ 10 minutes.

The Gondang Health Center UPTD is located on Jl Raya Gondang, Gondang District, Tulungagung Regency, with a working area of 12 villages supported by a network under it of 1 Pustu, 10 Ponkesdes, 1 Mobile Health Center, 1 Standby Ambulance and 39 Toddler

Posyandu, 16 Elderly Posyandu and 3 Posbindu PTM. The time for providing medical record documents for outpatients based on the Gondang Tulungagung Health Center SPO is <5 minutes. This is in accordance with the vision and mission of the Gondang Tulungagung Community Health Center, namely the creation of a basic health service center of choice for the community that is affordable, quality and professional. One aspect that needs to be achieved in implementing the vision and mission is medical record services, for example the time for providing outpatient medical record documents at the Gondang Tulungagung Community Health Center. The time to provide medical records is calculated using Response Time. Response Time calculation starts from calling the patient's queue number at the registration counter and when the medical record documents are found/provided (SPM Gondang Health Center Tulungagung, 2019).

General old patients are patients who have previously received treatment/come to the Puskesmas. so that you have received a medical card and have previous medical records. In relation to general old patients who already have previous medical records, the time for providing medical records should be faster compared to new patients who need to register data. This also influences patient satisfaction with the Gondang Tulungagung Health Center services.

Based on the conditions above, the researcher wants to review the time as well as the flow and procedures for providing outpatient medical record documents for general old patients at the Gondang Community Health Center, Tulungagung Regency by taking the title "Analysis of the Time for Providing Outpatient Medical Record Documents for General Old Patients at the Gondang Community Health Center, Tulungagung Regency"

METHODS

In this study, the informants were 3 medical records staff at the Gondang Tulungagung Community Health Center. This research uses a qualitative research method with a triangulation approach which aims to examine and establish validity by analyzing from various perspectives. Validity in quantitative research is seen based on the accuracy of a measuring tool, namely an instrument. Validity in qualitative research refers to whether the research findings accurately reflect the situation and are supported by evidence. Apart from that, this method examines the participant's perspective using in-depth interviews, documents, complementary techniques such as photos, recordings, and so on. (Sukmadinata, 2005).

The type of research design in this research is a case study, where research is directed at collecting data, extracting meaning, gaining understanding from the case. Cases are in no way representative of the population and are not intended to draw conclusions from the population. Case study conclusions apply only to that case. Each case is unique or has its own characteristics that are different from other cases (Sukmadinata, 2005).

RESULTS

A. General description of the research location

History of the Gondang Community Health Center UPTD UPTD Gondang Health Center was founded in 1970 as an Outpatient Health Center, then in 2008 it was upgraded to an Inpatient Health Center and in 2012 Gondang Health Center diversified its services in the form of Basic Emergency Neonatal Obstetry Services (PONED). In 2013, Gondang Community Health Center received an award as Outstanding Community Health Center at Tulungagung Regency Level. Over time, the UPTD Gondang Community Health Center has experienced several improvements, both regarding the physical building, facilities and infrastructure of the Community Health Center, as well as an increase in the number of human resources.

The Gondang Health Center UPTD is located on Jl Raya Gondang, Gondang District, Tulungagung Regency, with a working area of 12 villages supported by a network under it of 1 Pustu, 10 Ponkesdes, 1 Mobile Health Center, 1 Standby Ambulance and 39 Toddler Posyandu, 16 Elderly Posyandu and 3 Posbindu PTM

B. Description of Informant Characteristics

1. Informant 1

Informant 1 is a 57 year old man, married for 34 years, has 2 children aged 33 years and 22 years. The informant has a job as a civil servant at the UPTD Gondang Tulungagung Health Center while the informant's wife has a job as a housewife. Description of the informant's response during the interview: the informant's expression looked normal, occasionally smiling, very responsive, while sitting in a chair, the informant's gaze was directed at the researcher and sometimes directed in another direction as if imagining something, the voice sounded clear.

2. Informant 2

Informant 2 is a 41 year old woman. Married for 11 years and has one child aged 9 years. The informant has a job as a staff employee at the Gondang Community Health Center UPTD, while her husband has a job as a contractor. Description of the informant's response during the interview: the informant's expression looked normal, occasionally smiling, responsive, while sitting in a work chair and leaning against the wall, both hands were placed on the floor and sometimes moved to his thighs, the informant's gaze was sometimes directed at the researcher and sometimes towards the researcher. in the other direction as if he was imagining something. The sound is clear.

3. Informant 3

Informant 3 is a 42 year old woman, unmarried. The informant has a job as astaff employee at the Gondang Community Health Center UPTD. Description of the informant's response during the interview: the informant's expression looked normal, occasionally smiling shyly, responsive, while sitting in a work chair, the informant's gaze was directed at the researcher and sometimes directed in another direction as if imagining something, the voice sounded clear.

4. Triangulator

Triangulator is a 50 year old woman, married for 24 years, has 3 children aged 23 years and 20 years. The informant has a job as a civil servant at the UPTD Gondang Tulungagung Community Health Center and serves as Head of the Community Health Center and her husband is a civil servant. Description of the triangulator's response when the interview and data checking were in progress: the triangularor's expression looked firm, occasionally smiling, very responsive, while sitting in a chair, the informant's gaze was directed at the researcher and sometimes directed at the document as if reading and understanding something, the voice sounded clear.

DISCUSSION

A. Policy for Providing Outpatient Medical Record Documents for General Old Patients at the Gondang Community Health Center, Tulungagung Regency

The results of interviews conducted by researchers with informants revealed that the policy for providing medical record documents for each patient was different, starting from old general patients or old JKN patients. The policies applied by officers to long-term general outpatients at the Gondang Community Health Center, Tulungagung Regency are in accordance with applicable standards, namely starting from the patient registering at the registration section to show the treatment card or identification data until the medical record documents are delivered by the distribution officer to the destination

polyclinic. Gondang Community Health Center implements a centralization of medical records policy. This policy manages the storage of inpatient and outpatient medical records in one storage room so that the process of searching and storing medical records becomes more effective.

This is in accordance with researchAbdullah (2013)that speed in providing medical record files to polyclinics is an indicator of the quality of service in medical records. The faster the medical records arrive at the polyclinic, the faster the service will be provided to the patient.

Policies for managing medical record documents at each community health center will be different. Although there are standards that have been set by the Ministry of Health Decree regarding the time for providing medical record files, several health centers have a policy of using internal standards for providing medical record files. According to the Indonesian Ministry of Health 2007, the time for providing medical record documents starts from the patient registering until the medical record is found/provided by the officer. Patient registration here is defined as starting when the patient is interviewed by the registration officer. Then the documents are found or made available by officers, not to the polyclinic. Gondang Community Health Center has its own policy in accordance with the Community Health Center's SPO. This is because you know there is a patient, namely after there is a medical record number. The patient's medical record number appears after the patient's data for treatment has been saved at the time of registration. If the patient's medical record number is available, the officer will provide the medical record document to the designated polyclinic. However, the steps in the flow of providing medical record documents are not always carried out, such as the officer looking at the medical record number on the patient's KIB. This happens because not all patients carry the KIB for a long time, there are some patients who admit that their KIB was left at home or lost, so the registration officer will search for the patient's data based on the appropriate name and address, once the data is found, the patient's medical record document is printed and delivered to the destination clinic.

This is in accordance with what is stated in the SOP (Standard Operating Procedure) for old patient admissions which states that files that have been found by the medical records officer will be immediately delivered to the designated polyclinic. Distribution carried out by medical records officers can help provide medical record documents more quickly compared to the patients themselves, because usually there are some patients who do not know the location of the polyclinic they are going to, in contrast to officers who usually have memorized the locations or polyclinics so that they can get there, it doesn't take long there. Because the faster the medical record documents arrive at the polyclinic, the faster the medical services will be provided to the patient. According to the Ministry of Health (2006), distribution of medical record documents to polyclinics must be carried out by officers who are authorized to carry patient medical record documents. This is to minimize information leaks and the release of medical record documents from the scope of the health center. Based on the results of observations, the policy of providing medical records carried out by medical records officers at the Gondang Community Health Center is in accordance with existing regulatory standards. This is proven by the officers carrying out their duties well where the officers provide services such as short time for providing documents, policies in registration, and in taking patients and their documents to the destination clinic so that they can immediately receive care and treatment. This policy applies to old and new patients, JKN patients and general patients in accordance with the SPO from the Ministry of Health and Community Health Centers.

B. Standard Operational Procedures Regarding the Flow of Providing Medical Record Documents at the Gondang Community Health Center, Tulungagung Regency

The results of interviews conducted by researchers with informants revealed that standard operational procedures regarding the flow of providing medical record documents at the Gondang Community Health Center, Tulungagung Regency are in accordance with applicable regulations. The flow of providing medical record documents for existing patients must show a medical card as well as a personal data card to show that the patient already has a medical record book stored in the health center's medical records section. Then after that the officer will ask the patient to wait a moment to find a medical record document that matches the patient's personal data in the medical records room. This process does not take too long, however, if an error occurs where the medical record document is slipped or lost, the patient will have to wait longer than usual because the officer has to create a new medical record document. Then, once the medical record book is available, the officer will take the patient's medical record documents to the designated polyclinic and immediately hand them over to the doctor in the treatment room to get in line for treatment. Until later, it will be filled in by doctors and related health workers according to the patient's condition and complaints as well as the doctor's advice. After the examination process is complete, the medical record documents will be left in the examination room to be given back to the medical records officer and the patient will be given a prescription to redeem the medicine at the pharmacy.

This SOP is in accordance with Helmi (2013) that the scope of the medical records unit starts from patient reception, distribution, assembling, coding, indexing, storing medical record files and reporting. If we look at the medical records unit as an organization with its own system, the medical records unit has several systems and subsystems that support activities in the medical records unit so that the function of the medical records unit as a provider of health information can be carried out well and produce information that is accurate, fast, and up to date. The system implemented at the Gondang health center is also in accordance with the SOP implemented according toBudi (2011) that the system in the medical records unit includes a patient reception system, a medical records management system, and a statistical system. The patient reception system consists of several subsystems, namely outpatient reception, emergency patient reception, and inpatient reception. The medical record file processing system consists of several subsystems, namely assembling, coding, indexing, filing, and retention. The next system, namely the statistical system, consists of several subsystems, namely daily census, reporting, and the medical certificate section. Standard operational procedures carried out by medical records officers at the Gondang Community Health Center have been carried out in accordance with existing steps and regulations according to the letter from the director of specialist medical services No. YM.00.02.2.2.837 which was implemented in 2002. Instructions for filling in standard operational procedures consist of a heading box and the contents of standard operational procedures. The heading box contains the boxes RS, SPO Title, No. document, no. Revision, Fixed Procedure Page, Date of publication, determined by the director.

Standard operational procedures (SPO) are a set of instructions or steps that are standardized to complete certain routine work processes. Standard operational procedures regarding patient admission flow state that starting from the patient registering until the files have been found by the medical records officer, they are immediately delivered to the destination polyclinic. Distribution carried out by medical record officers can help provide medical record documents more quickly compared to the patients themselves, because usually there are some patients who do not know the location of the polyclinic they are going to, in contrast to officers who usually have memorized the locations or polyclinics

so that they can get there. it doesn't take long there. Because the faster the medical record documents reach the clinic, the faster the medical services will be provided to the patient.

Since the government is implementing PPKM, the Community Health Center is also implementing it according to the protocol, this does not affect the implementation time for providing medical record documents. Every patient who comes is required to wear a mask, keep their distance and wash their hands, especially for patients who are suspected of having an outbreak, a separate examination is carried out with stricter protocols. Flow is a form of written communication to support maximum service. Every service provided must be accompanied by a flow so that patients are not confused and speed up the provision of medical records. The flow of providing medical record documents at the Gondang Community Health Center, Tulungagung Regency has been implemented based on the SOPs determined by the Head of the Community Health Center and the Ministry of Health. Standards are set starting from the patient registering, being taken to the clinic until the file is stored again, this is done according to the flow in the SPO, so that by implementing the appropriate SOP it can reduce the patient's waiting time to receive medical services. Because following the service flow is one of the supporting facilities in the service of providing medical record documents and a mismatch in the flow can have an impact on the service of providing medical record documents being late.

C. Time for Providing Outpatient Medical Record Documents for General Old Patients at the Gondang Community Health Center, Tulungagung Regency

As a result of interviews conducted by researchers with informants, it is known that the time for providing medical record documents for general outpatients at the Gondang Community Health Center, Tulungagung Regency is very varied but generally has almost the same time span. The time it takes for patients to wait to get their medical record book varies depending on how many patients come. If the patient is very busy, the patient has to wait a maximum of 15 minutes and if the medical record documents are slipped or lost, then the officer has to recreate the patient's medical record so that the time needed by the patient is quite longer. However, in practice, every 2-5 minutes the medical records officer will collect medical record documents for one patient. So if there are quite a lot of patients coming, it will take close to 15 minutes to wait for their medical records to be given and if it is quite quiet then it will take around 5 minutes for the patient to get their medical records.

The results of this research are supported by research conducted Sudrajat & Sugiarti (2015) that the time to provide medical record documents quickly and accurately is one of the factors that can influence the quality of health services. The sooner the provision of medical record documents is found, the faster the service will be provided to patients. Time to provide medical record documents is hampered due to the number of patient visits increasing every day while the number of service providers is limited. The results of this study are also in accordance with Health Department regulations (2013) that the time for providing medical record documents from the time the patient registers until the medical record is provided/found by the medical records officer with an average time standard of ≤ 10 minutes (Ministry of Health, 2013).

The activity of providing medical record files is the process of providing medical record files starting from the patient registering until the medical record is provided/found by the officer (Kepmenkes RI, 2008). The timeliness of providing medical records is very important in maintaining the quality of health services. If the provision of medical records is late, then the services that will be provided to patients will also be late. The time for distributing medical record documents at the Gondang Community Health Center is calculated from the time the patient registers at the counter, the distribution officer takes the medical record documents from the shelf until the

patient and the medical record documents are delivered to the destination clinic. The total time from searching for medical record documents until the medical record documents are delivered to the destination polyclinic results in an average of 2-5 minutes.

The results of research at the Gondang Community Health Center, medical records officers were able to provide medical record documents with an average time to obtain results of 2-5 minutes. This is in accordance with Minister of Health Decree no. 129 of 2008 concerning Minimum Service Standards, namely: The length of time for officers to provide outpatient medical record documents is less than 10 minutes. Since the government is implementing PPKM, the Community Health Center is also implementing it according to the protocol, this does not affect the implementation time for providing medical record documents. Every patient who comes is required to wear a mask, keep their distance and wash their hands, especially for patients who are suspected of having an outbreak, a separate examination is carried out with stricter protocols.

D. Factors Causing Delays in Providing Outpatient Medical Record Documents for Old Patients in General at the Gondang Community Health Center, Tulungagung Regency

As a result of interviews conducted by researchers with informants, it is known that there are many things that can cause delays in providing medical record documents for long-term general outpatients at the Gondang Community Health Center, Tulungagung Regency. Some of these factors are the layout of medical records which are sometimes not well organized, where several times it happens that medical record documents are slipped because the patient has not been checked at the health center for a long time, causing the medical records officer to have to search carefully. And if the medical record cannot be found, the officer has to re-create a new medical record document, which takes even longer. Another cause of delays is that there is only one person in the medical records department and three people in the registration department, causing the process of searching for medical record documents to take longer. If there are more officers, it is likely that the medical record search process will be faster.

The results of this research are in accordance with the research conducted Desmarika (2018) which states that the factors that influence the delay in providing medical record documents at the Wates Community Health Center include material factors, namely the accumulation of doctor's prescription paper from the registration section to the filing section, thereby slowing down the process of providing medical record documents. The results of this study are also in accordance with researchHakam (2018)that the obstacles to the implementation of providing medical record files based on the SOP at the Minggir Community Health Center are errors in the location of the medical record file storage rack, medical record files are still in the service clinic and a lack of human resources at registration.

The factors causing delays in each community health center are different, such as medical records being misfiled. Misplaced files can affect the provision of medical record documents. Because officers have to search for the document until they find it, so it can hinder other work. The occurrence of misfiling of medical record documents can occur due to lack of accuracy by officers in storing patient medical record documents. Another cause of delays is that there is only one person in the medical records department and three people in the registration department, causing the process of searching for medical record documents to take longer.

The policy implemented by Gondang Community Health Center officers to reduce these obstacles is by using color coding on patient medical records in the medical record folder. The color coding of medical record numbers has been regulated in the SPO based on the director's decision letter with document number 05/SPO/00/A-44. Where each

medical record number has its own color code to make it easier to find documents that are misfiled, improving the quality of human resources with various seminars and training, neatly arranging documents, and grouping documents according to their groups. It is hoped that the existence of this policy can help reduce the factors causing delays in providing medical record documents for outpatient general patients at the Gondang Community Health Center, Tulungagung Regency.

CONCLUSION

Based on the research results, it can be concluded that:

- 1. The policy of providing medical records carried out by medical records officers has been running well according to existing regulatory standards.
- 2. Standard operational procedures regarding the flow of providing medical record documents at the Gondang Community Health Center, Tulungagung Regency have been implemented well based on the SOPs established by the head of the community health center and the Ministry of Health.
- 3. The time for providing outpatient medical record documents for general old patients at the Gondang Community Health Center, Tulungagung Regency ranges between 2-5 minutes and less than 10 minutes.
- 4. The factor causing the delay in providing outpatient medical record documents for general old patients at the Gondang Community Health Center, Tulungagung Regency is that medical record documents are lost and lost.

REFERENCE

- Abdullah, H. (2013). Analisis Kegiatan Pengelolaan Rekam Medis Rawat Inap Pasien Kanker Payudara Program Jamkesmas Untuk mendukung pengelolaan pembiayaan. Jurnal Kesehatan masyarakat Universitas Diponegoro
- Alaydrus, S. (2011). Comparison of Completeness in Filling Out Medical Records Between Specialist Doctors at the Garuda Pavilion and Residents in the Internal Medicine Ward of RUSP dr. Kariadi Semarang Period August 2010. UNDIP Semarang.
- Budi, SC (2011). Medical Records Work Unit Management. Quantum Synergistic Media.
- Desmarika, D. (2018). Analisis Waktu Penyediaan Dokumen Rekam Medis Rawat Jalan di Puskesmas Wates Bulan Agustus tahun 2018. Universitas Jendral Ahmad Yani : Yogyakarta
- Hakam, F. (2018). Analisis Penyediaan Rekam Medis Pasien Rawat Jalan Berdasarkan Standar Operasional Prosedur (SOP) di Puskesmas X. Vol. 1. No. 1. 2018. Jurnal Manajemen Informasi dan Administrasi Kesehatan. Universitas Veteran Bangun Nusantara.
- Hanafiah, J., & Amir, A. (2012). Medical Ethics & Health Law. EGC.
- Hatta, GR (2016). Guidelines for Health Information Management in Health Service Facilities. University of Indonesia.
- Helmi, NZ (2013). Trigger Finger. Textbook of Musculoskeletal Disorders. Salemba Medika.
- Kementerian Kesehatan Republik Indonesia. (2008). PERMENKES RI 269/MENKES/III/2008
- Kementerian Kesehatan Republik Indonesia. (2012). Permenkes no. 40 tahun 2012
- Sally, T. (2008). Analysis of Incompleteness of Medical Records. University of Indonesia.
- Sudrajat, I., & Sugiarti, I. (2015). The Relationship between the Speed of Providing

- Outpatient Medical Record Documents and the Level of Patient Satisfaction. Indonesian Journal of Health Information Management (JMIKI), 3(1).
- Sugiarti. (2015). Tinjauan Penyediaan Dokumen Rekam Medis di RSUD Dr. Soekardjo Kota Tasikmalaya. Jurnal Manajemen Informasi Kesehatan Indonesia. Vol. 3 No. 2 2015. Poltekkes Kemenkes Tasikmalaya

Sukmadinata, NS (2005). Educational Research Methods. Rosda Karya Teenager.