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Completeness of Writing Patient Names in Hospitals

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Abstract. *Background: According to the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning Medical Records, they are documents that contain patient identity data, examinations, treatment, procedures and other services that have been provided to patients. Minimum Hospital Service Standards Completeness of filling in medical records 24 hours after completion must reach 100%. Objective: To determine the completeness factor in writing the patient's name in the patient's medical record at the hospital. Method: This research uses a literature review method. Results: The highest percentage of completeness in writing patient names was in research journals with a percentage of 98%, while the lowest percentage was 56%. Conclusion: From the results of a review of the completeness of writing patient names in hospital medical records, it was found that the completeness results were not 100% and not all hospitals had SOPs regarding procedures for writing patient names. Suggestion: Create an SPO for procedures for writing patient names that comply with standards so that officers can carry out these activities with guidelines. Background: In accordance with Republic of Indonesia Health Minister Regulation Number 24 of 2022, medical records are records that include information about a patient's identity, medical examinations, treatments, procedures, and other services rendered to them. Minimum Requirements for Hospital Services Within 24 hours of finishing, all medical records must be 100% complete. Goal: To ascertain the degree of completeness in entering the patient's name in the hospital's medical file. Method: A literature review approach is used in this study. Findings: Research journals had the highest percentage of complete patient names (98%) and the lowest percentage (56%) of complete patient names. Conclusion: A review of the completeness of writing patient names in hospital medical records revealed that not all hospitals have standard operating procedures (SOPs) pertaining to patient name writing, and the findings were not 100% complete. Recommendation: Establish a standard operating procedure (SPO) for writing patient names that adhere to standards so that officers can perform these tasks in accordance with protocols.*

Keywords: *Patient, Hospitals, Procedures*

Abstrak. Latar Belakang: Berdasarkan Peraturan Menteri Kesehatan Republik Indonesia Nomor 24 Tahun 2022 tentang Rekam Medis, rekam medis adalah dokumen yang berisi data identitas pasien, pemeriksaan, pengobatan, prosedur, dan layanan lainnya yang telah diberikan kepada pasien. Standar Pelayanan Minimum Rumah Sakit menyebutkan bahwa kelengkapan pengisian rekam medis 24 jam setelah selesai harus mencapai 100%.Tujuan: Untuk mengetahui faktor kelengkapan dalam penulisan nama pasien pada rekam medis pasien di rumah sakit.Metode: Penelitian ini menggunakan metode tinjauan pustaka.Hasil: Persentase kelengkapan tertinggi dalam penulisan nama pasien terdapat pada jurnal penelitian dengan persentase 98%, sedangkan persentase terendah adalah 56%. Kesimpulan: Dari hasil tinjauan kelengkapan penulisan nama pasien pada rekam medis rumah sakit, ditemukan bahwa hasil kelengkapannya belum mencapai 100% dan tidak semua rumah sakit memiliki SOP mengenai prosedur penulisan nama pasien. Saran: Membuat SOP untuk prosedur penulisan nama pasien yang sesuai dengan standar agar petugas dapat menjalankan kegiatan ini dengan pedoman yang jelas.

Kata Kunci: Pasien, Rumah sakit, Prosedur

1. INTRODUCTION

Health services are a right for every person guaranteed in the 1945 Constitution of the Republic of Indonesia which must be realized by efforts to improve the highest level of public health. Health Services are places used to provide health services both promotive, preventive, curative and rehabilitative (Undang-undang RI No. 44, 2009).

According to Law of the Republic of Indonesia Number 44 of 2009 concerning Hospitals which states, a Hospital is a health service institution for the community with its own characteristics which can be influenced by developments in health science, by prioritizing

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technological developments, as well as the socio-economic life of the community which must remain capable improve quality and affordable health services for the community to achieve the highest level of health. Hospitals are health service institutions that provide complete individual health services in the form of inpatient, outpatient and emergency services (Undang-undang RI No. 44, 2009).

According to the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning Medical Records, they are documents that contain patient identity data, examinations, treatment, procedures and other services that have been provided to patients (Permenkes Nomer 24, 2022)

According to Lily Widjaja in 2014, patient identification is the collection of data and recording all information related to a person's evidence. Patient identification is carried out by registration officers for new patients and ensuring that the existing data is valid when the patient returns to the hospital. This data identifies the patient by attaching the patient's identity in the form of a label or identity bracelet for identification. Regarding the correct way to write a name according to Lily Widjaja's book "Medical Record and Health Information System", writing the name must match the patient's name on a valid identity card such as KTP/Passport. There are 2 ways to write the patient's name, namely: Writing the name directly and Writing the family name.

The completeness of writing the patient's name in the medical record must reach 100% (Kepmenkes No 129 Tahun 2008, 2008). The impact of incompleteness in writing a patient's name is difficulty in processing the data, for example the data is scattered, if the patient's name is not filled in completely then the identification process will be difficult and the process of searching for medical record documents will become difficult if at any time the medical record form comes out of the folder. its parent (Ahmad Maliki, Saimi,Heru Purnama, 2018). The researcher's aim was to determine the completeness factor in writing the patient's name in the patient's medical record at the hospital.

2. LITERATURE REVIEW

Hospitals are health service institutions for the community with their own characteristics which can be influenced by developments in health science, by prioritizing technological developments, as well as the socio-economic life of the community which must continue to be able to improve quality and affordable health services for the community in order to achieve the highest possible level of health. its height. A hospital is a health service institution that provides complete individual health services in the form of inpatient, outpatient

and emergency services. The hospital implements Pancasila and is based on human, ethical and professional values, benefits, justice, equal rights and anti-discrimination, equity, patient protection and safety, and has a social function (Undang-undang RI No. 44, 2009)

According to the Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 concerning Medical Records, they are documents that contain patient identity data, examinations, treatment, procedures and other services that have been provided to patients (Permenkes Nomer 24, 2022). Purpose of Medical Records According to Regulation of the Minister of Health of the Republic of Indonesia Number 24 of 2022 (Permenkes Nomer 24, 2022) regarding the purpose of medical records to: Improve the quality of health services, provide legal certainty in the administration and management of medical records. Ensure security, confidentiality, integrity and availability of medical record data. Realizing the implementation and management of digital-based and integrated medical records.

According to Lily Widjaja's book about “Sistem Rekam Medis Dan Manajemen Informasi Kesehatan tahun 2014” Patient identification is the collection of data and recording all information related to a person's evidence. Patient identification is carried out by the registration officer for new patients and ensuring that the existing data is valid when the patient returns to the hospital. This data identifies the patient by attaching the patient's identity in the form of a label or identity bracelet for identification. Identification of patients at health service institutions in hospitals that require clear patient identity. Patients who come to the hospital for the first time are referred to as new patients at the start of collecting patient data. This data will be updated if there are changes in arrivals the following day. The aim is to obtain correct data, patient specifications to differentiate one patient from another, as well as for medical and financial purposes.

3. METHODS

The method used by this researcher is the literature review method, namely research collecting and identifying related searches for articles or journals in this research using the Google Scholar database using the keywords "completeness OR writing patient names AND in medical records at hospitals" using keywords that Correct.

4. RESULTS

Journal Discussing Standard Operational Procedures in Writing Patient Names in Hospitals. Based on the results of researchers reviewing related literature, there are 14 journals related to standard operational procedures obtained as follows.

No	Researcher Name and Researcher Year	Reference	1:yes/ 0:no There is	Fill in the SPO
1.	Ahmad Maliki, Saimi, Heru Purnama (2018)	(Ahmad Maliki, Saimi,Heru Purnama, 2018)	0	
2.	Erminia (2018)	(Erminia & Pratama, 2018)	0	
3.	Made Maha KarmaWirajaya, Ni MadeUmi Kartika Dewi (2019)	(Made Maha Karma Wirajaya, 2019)	0	
4.	Giyatno, Maysyarah Yolla Rizkika (2020)	(Giyatno & Rizkika, 2020)	0	
5.	Aditya Dwi Arimbi, Indah Muflihatin, Niyalatul Muna (2020)	(Arimbi et al.,2021)	0	
6.	Gebbrien Anggia Dianty, (2021)	(Gebbrien Anggia, 2021)	1	Completeness Writing Patient Names.
7.	Ni made ariska suryanti, madekarma wirajaya, made sudiari (2022)	(Suaryanti et al.,2022)	0	
8.	Sansy Dua LestariPutri Azah, (2022)	(Sansy Dua Lestari et al., 2022)	0	
9.	Nur fadilah (2022)	(Fadilah et al., 2022)	0	
10.	Indah Susilowati, Ratna Frenty Nurkhalim, Latifah Hasanah (2022)	(Indah Susilowati, Ratna Frenty Nurkhalim, 2022)	1	Examining the Truth in Writing Patient Identity Data.
11.	Budiana gustiara (2022)	(Gustiara et al.,2022)	1	Record Filling Completeness File Medical staff filled in by officers.
12.	Sarah khonsa (2022)	(Khonsa et al.,2022)	1	Completeness Medical Record File Review Form.
13.	Mekhtildis Suryati (2022)	(Mekhtildis Suryati, 2021)	1	Completeness analysis Medical Resume
14.	Nurrachma yulianti(2023)	(Nurrachma Yulianti, 2022)	1	Completeness of component filling Patient Identity.
	Amount		6	
	Persentase		40%	

Based on table 1, from the 14 journals reviewed by researchers, there were 6 journals (40%) that discussed Standard Operational Procedures regarding the completeness of filling in patient identity.

5. DISCUSSION

Standard Operating Procedures (SPO) are a set of instructions/steps that can be standardized in completing a work process, where SPO provides good and correct steps for carrying out various activities and service functions created by health service facilities according to professional standards (Kemenkes RI, 2007)

Based on the results of the researchers' literature review of 14 journals, there were 6 journals (40%) which discussed standard operational procedures and had been implemented but had not yet been thoroughly socialized, while the other 9 journals did not discuss standard operational procedures regarding the completeness of writing patient names, which resulted in the writing of names Not all patients have reached 100%.

Based on the results obtained in the journal, some of them still do not comply with Standard Operational Procedures (SPO), there are some whose name writing is incomplete, therefore if the patient's name is not complete, it can cause the patient to be mistaken, because the wrong identity does not match the instructions. fatal, errors can occur when administering the drug. medical procedures, taking blood samples, exchanging urine test results, wrong blood transfusions which will definitely have a fatal impact on the patient's health.

Writing the patient's name in the medical record must reach 100% because a complete medical record will make it easier for officers to find patient data, which includes the patient's identity with a standard of 100% completeness. The naming system in medical services is a procedure for writing patient names which aims to differentiate one patient from another patient and to make it easier to index the patient's main index card (KIUP). Therefore, if the patient's name is not filled in, the identification process will be difficult and the process Searching for medical record documents will become difficult if at any time the medical record form comes out of the main folder (Ahmad Maliki, Saimi,Heru Purnama, 2018)

Based on the results of researchers from 14 journals regarding the completeness of writing patient names in hospital medical records, it can be concluded that there is 1 journal that does not discuss complete or incomplete samples in writing patient names, the percentage obtained for the completeness of writing patient names is on average (85 .9%) in the complete category and, (14.1%) in the incomplete category. Incompleteness in filling in patient identification greatly affects medical records in hospitals. Health workers are anyone who dedicates themselves to the health sector and has knowledge or skills through education in the health sector.

Naming in medical record services is a procedure for writing a name with one person's identity which aims to differentiate one patient from another patient. In western countries,

writing a patient's name is very easy because patients already have a standard family name or surname or first name. Then in Indonesia itself there are many ethnic groups and heterogeneous cultures. Therefore, naming must be done correctly (Lily Widjaja, 2014)

Factors that cause incomplete writing of patient names in medical records in hospitals from the perspective of health workers are: first, there is a lack of responsibility in writing patient names found in (Erminia & Pratama, 2018), (Ahmad Maliki, Saimi, Heru Purnama, 2018) and (Fadilah et al., 2022), secondly there is a lack of human resources (HR) found in (Arimbi et al., 2021), thirdly there is a lack of discipline in in (Suaryanti et al., 2022), fourthly there are inaccuracies in writing patient names found in (Ahmad Maliki, Saimi, Heru Purnama, 2018), (Made Maha Karma Wirajaya, 2019), (Giyatno & Rizkika, 2020), (Fadilah et al., 2022), (Indah Susilowati, Ratna Frenty Nurkhalim, 2022), (Gustiara et al., 2022) and (Khonsa et al., 2022) fifthly there is a lack of knowledge in (Nurrachma Yulianti, 2022). The main factor causing incompleteness by human resources is the factor of not being thorough on the part of officers, found in 7 journals (54%). Human resources greatly influence the writing of a patient's name. If the name is written incorrectly, it will have a very fatal effect, so officers must be more careful in completing the patient's identity.

Standard Operating Procedures (SPO) are a set of instructions/steps that can be standardized in completing a work process, where SPO provides good and correct steps for carrying out various activities and service functions created by health service facilities according to professional standards. Method factors that were obstacles to incomplete writing of patient identification discussed in 5 journals were: lack of socialization (40%) from health workers, inappropriate SOPs (40%) and no SOPs (20%). From the results obtained in the journal, there are still some writings of patient names that do not comply with Standard Operating Procedures. This results in there being no reference for officers to fill in medical records, resulting in differences in writing patient names.

6. CONCLUSION

Based on the results of research regarding the completeness of writing patient names in hospital medical records, it can be concluded that not all journals studied have 100% complete writing of patient names in medical records. The causes of incompleteness that the researchers summarized could possibly be caused by: 1. Not all hospitals have the completeness of writing patient names according to Standard Operating Procedures for writing patient names. 2. Average percentage of incomplete writing of patient names. Based on the results of the 14

journals studied, the average completeness of writing patient names was 85.9% complete and the average of incomplete journals was 14.1%. 3. The constraint factor that influences the incompleteness of writing the patient's name is found in Man and Method, that is, what causes the incompleteness carried out by Man (human resources) is the officer's careless factor found in 7 journals (54%), the method constraint factor has not been the existence of standard operational procedures.

Based on the results of the researchers above, the author suggests that hospitals should create standard operational procedures regarding writing patient names that comply with standards so that staff can carry out these activities with guidelines and conduct outreach regarding the importance of completeness in writing patient names. Conduct an audit of the performance of registration officers, especially when writing patient name identification. There needs to be special training for staff regarding the completeness of writing patient names.

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