THE DESIGN OF INFORMATION SYSTEMS FILING OUTPATIENT MEDICAL RECORDS

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Abstract: The system information section filing in UPT Puskesmas Rahayu to submit a medical record file to any of the poly, assembling medical records, store medical records, retention medical records are already inactive. This research aims to design and create a system of information filing outpatient medical records in UPT Puskesmas Rahayu in terms of borrowing and return the medical record file as well as facilitate the retention of medical records with the use of qualitative methods. The Data used in the study in UPT Puskesmas Rahayu, namely interviews, observation, and FGD (Focus Group Discussion). This study shows the input data of the patients is in accordance with UPT Puskesmas Rahayu. Input patient data include No RM, the Name of the KK, the Patient's Name, Gender, Address, and Villages. This research resulted in the information system of medical record filing outpatient procedures that can facilitate the officer in the management of the filing of medical records.

Keywords: borrowing and return; medical record filing; puskesmas

Abstrak: Sistem informasi bagian filing di UPT Puskesmas Rahayu untuk mengirimkan berkas rekam medis ke setiap poli, assembling rekam medis, menyimpan rekam medis, meretensi rekam medis yang sudah in aktif. Penelitian ini bertujuan untuk merancang dan membuat sistem informasi filing rekam medis rawat jalan di UPT Puskesmas Rahayu dalam hal peminjaman dan pengembalian berkas rekam medis serta mempermudah dalam retensi rekam medis dengan menggunakan metode kualitatif. Data yang digunakan dalam penelitian di UPT Puskesmas Rahayu yaitu wawancara, observasi dan FGD (Focus Group Discussion). Penelitian ini menunjukkan input data pasien sudah sesuai dengan yang ada di UPT Puskesmas Rahayu. Input data pasien meliputi No RM, Nama KK, Nama Pasien, Jenis Kelamin, Alamat, dan Kelurahan. Penelitian ini menghasilkan sistem informasi rekam medis filing rawat jalan yang dapat mempermudah petugas dalam pengelolaan filing rekam medis.

Kata kunci: peminjaman dan pengembalian; puskesmas; rekam medis filing

INTRODUCTION

The health center is the first unit of reference for the surrounding community in the service of the health examination and also health care services funded by the government [1]. In-unit medical record documents in the filing system are one of the quality management systems of the services [2]. The identity of the patient, examination, treatment, action, and other services that have been given to patients is a medical record file that stores records and documents [3]. After the patient completed treatment, the medical records are returned to the filing with the duties and obligations in the provision of the service medical records and health information within 1x24 hours. The completeness of the medical records of patients who have already been filled by the doctor must be returned no later than 1 x 24 hours. Recorder medical received the medical record to be processed and put it back into the storage rack of the medical record.

One unit of the medical record that a filing that has been accredited by the Ministry of health which has the function of being a place set up and save a document by using the arrangement of a particular system in a systematic way, then if the medical record is required to be present it quickly and precisely.[4]. The process and how to file the storage of medical records in place is away in the system of medical record filing. It is in order for the readiness of the medical record has be made available in the storage space if used when needed by the patient. [5]. Misfile is a problem that is making a delay in seeking medical record files. This is caused by some aspect, which is that there is one patient who had two medical record numbers and the number that is present in the medical record is not clear. These problems often occur in the filing [6]. The book of the expedition is used in the activities of lending and return by officers of the medical record, as a hint to determine and monitor the medical record that are still borrowed or which have been restored [7]. Retrieval of the medical record files is an activity that there is a problem that is often encountered here, that is not found back the medical record by the officer filing. It inhibits the activities of health services, due to the attendant difficulties in search of medical records at the time needed. Control with the control on borrowing and returning the medical record can reduce the doubling of the number of medical records and delays in medical record documents. [8].

The field of technology is growing rapidly and almost touch all levels of society is as information technology[9]. The health service has many uses of information technology to facilitate in performing the service, for example, information systems electronic medical records. Medical record systems are computerized greatly facilitate and reduce human error, so they can improve the quality of patient care. The application of Information Technology-based computer for data processing activities, so that it can help and can I speed up the data processing system at an agency all fields, especially the field of health [10]. Based on the results of the interview on June 21, 2021, in UPT Puskesmas Rahayu shows the results of the data obtained. That is the implementation of the return of the medical record sometimes happens inaccuracies caused by human negligence. It is difficult for recording medical at the time of taking the medical

record whether the medical record is misplaced luggage or has not yet been returned to the filing. Then the discovery of some of the obstacles in the return of the medical record documents from the poly to the medical records room. At the time of medical record documents in the back of the poly, there is no record that the medical record has returned and the unavailability of the register book as a place to record it. Then the electronic system that has been available in SIMPUS Puskesmas Online as a replacement for the book of the register can not be used.

The formulation of the problem obtained from the discussion above is as follows: First, namely, how to reduce human error in returning medical records? Second, whether holding a register book can help reduce human error problems? Third, what was obtained after implementing the outpatient filing information system and the impact on outpatient services at the UPT Puskesmas Rahayu. In the description of the problem formulation, this research is used to evaluate and as a learning material how the electronic health system is very helpful in providing effective and efficient service.

METHOD

This research was conducted using the method of qualitative because in the research data collection use the techniques of observation, interview, and documentation. So the qualitative research methods it is appropriate to use.

The research uses a qualitative method intends to master the object under study in-depth, to elaborate the concept of sensitivity to the problems faced, explain the validity of which is associated through the search theory from the bottom, and lays out an understanding of one or more of the facts found [11].

Observational research conducted data collection by observing several active medical records. After that, it is collected and used as data. Interview research was conducted by interviewing the head of the medical records regarding the problems that often occur in filing outpatient medical records.

The results of the interviews were processed into data.

Documentation research is carried out by documenting the flow of activities around filing to get a direct description of the outpatient medical record filing activities.

RESULT AND DISCUSSION

The Analysis Of The Needs Of The System Software. The results obtained from the observation of interview and FGD (Focus Group Discussion) against the officer filing that amounts to 1 person in UPT Puskesmas Rahayu that is, in the filing system of medical record file using the centralized system and using the method of numbering Unit Numbering System. The problem most often arises in the activities of the filing that is wrong in the file storage of medical records, and the officer is less scrupulous when storing medical records to the rack (human error). From the results of these interviews, it is expected that the system to record the medical record, name, poly purposes (medical record entry and exit) so it can find traces of the medical records that have not been returned.

Image 1. Login Form Officers

Based on image 1. Login officers are the first step to go to the next section. Here only officers who have registered can access, i.e. by entering a username and password before login.

Image 2. Form Menu

Based on image 2. Form menu, after logging in appears to form the menu. In the menu there are some items buttons to connect directly to the form that will be addressed, namely, the keys form the patient data, a form button distribution, form the refund button, and the form out.
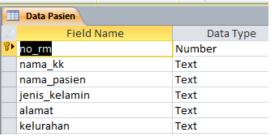

Image 3. A Database of Patient Data

Image 4. Form of Patient Data

Based on image 4.Form of Patient Data. Inpatient data, there are goods that must be filled, namely regarding the identity of the patient. Consisting of noRM, the name of the KK, the Patient's Name, Gender, Address, and Villages. Then there is also the save button if new data will be stored, and then the button changes if there is existing data to change, then the Delete button to remove the data that has been stored and will be removed, which is the exit button lastly, namely to get out of the page.
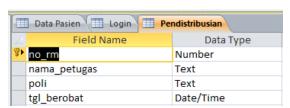

Image 5. Database Distribution

256

Image 6. Form of Distribution

Based on image 6. Form of Distribution. Page of the distribution, i.e. the page to record the medical record coming out or that will be distributed. The recording consists of NoRM, the Name of the Officer, Polly, Date of Treatment. There is also a button that is stored if the data will be stored, the change button if there is data to be changed, the delete button if there is data to be deleted, and the exit button when you're done.

Image 7. The Database Returns

Image 8. Return Form

Based on image 8. Return Form, Return which is a page to record the status of the medical record that has returned or not been returned to the place of storage of medical records. The recording consists of NoRM, Action, Diagnosis, and last file status. There is also the save button to save the data will be stored, the delete button for the data to be deleted and the exit button when you're done.

Image 9. Patient Data Report

Based on image 9. Patient Data Report. Report patient data is, the data of the patient or the identity of the patient self-contained in the medical record. Report patient data is a sample of patient data that has been registered. The report of this data is the result of a recap of the overall patients who have visited and already have a medical record. In the report, the items worth noting include the patient medical record number, the name of the head of the family, the patient's name, address, and villages.

Image 10. Report Distribution

Based on image 10. Report Distribution. Report on the distribution of an entire medical record data are distributed per day. In the activities of the health service medical record that will be distributed will be recorded and the results in the form of a report on the distribution of like the picture above.

This report data recorded include patient medical record number, name of the officer filing a responsible, poly the purpose of distribution, and the date of treatment per patient days of such treatment. It is as the description later in the day that the patient is the last treatment is based on the date of the distribution shown. This is because this system is for outpatient services, then the date comes and the home is on the same day.

Image 11. Report of the Return

Based on image 11. Report of the Return. The image above is a sample of reports returns data in the medical record of the daily outpatient. This report is displayed on a daily basis which shows the large number of patients who visit. In the return form, there is a button the report will display the report data return outpatient medical records.

This report consists of some of the items that patient medical record number, the action is given by the doctor the time of treatment if there is, the patient's diagnosis after examination given by the doctor, and the status of the medical record file. Status of the file this is the position of the medical record file after the patient's home has returned to the in-place storage of medical records or not. This report is the end result of the system information filing outpatient medical record.

258

CONCLUSION

Health information systems provide many benefits in the world of health, one of which is for health services, because this can make work very efficient and effective. Electronic medical records is one of the health information systems that have developed in Indonesia. Therefore, this study obtained an outpatient filing information system, which is one part of the electronic medical record system to be applied to the UPT Puskesmas Rahayu.

It is hoped that electronic medical records will also begin to be developed at first-level health facilities such as puskesmas. It is also hoped that this research can be used as learning and research material in the development of electronic medical records.

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