ABSTRACT

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Study program: Medical Record and Health Information

The most important health information in the medical record is the death data. Death data is an important indicator in measuring the success of health sector development, the purpose of collecting and processing mortality data is to find out the cause of death according to the International Statistical Classification of Diseases and Related Health Problems 10th revision of the ICD-10. The most popular problem occurs is infant death. Infant deaths are deaths that occur between the time after the baby is born until the baby is not exactly one year old which is stated in 1,000 live births in the same year. Many factors are associated with infant mortality. Broadly speaking, in terms of causes, infant mortality is of two kinds namely endogenous or commonly referred to as neonatal death: infant death that occurs in the first month after birth, and is generally caused by factors brought about by the child from birth, which is obtained from her parents during pregnancy. Based on a survey at the Ade Mohammad Djoen Sintang Regional Hospital it is known that for the determination of the basic cause of death according to WHO procedures / policies in ICD-10 volume 2 in the Ade Mohammad Djoen Regional Hospital, especially the perinatology room has not been implemented. For this reason, the researchers conducted a study of mortality data reports with the title "Completion Review of the Perinatology Death Form at the Ade Mohammad Djoen Sintang Regional Hospital". The conclusion obtained from this study is the results of the study found 120 cases of medical records in the past one year in which 80% of the files collected have the same lack of completeness where the file is not marked by the physician responsible for the patient at the Ade Mohammad Djoen Regional Hospital Sintang, limited time to meet with the doctor responsible for filling in the autopsy questionnaire for perinatal patient deaths, most of the files in the scope of the study have the same problem, namely the lack of signatures of the doctors responsible, the death questionnaire for perinatal patients within one year used researchers are often invalid with the amounts recorded in administrative data in the scope of research.

Keywords:

Hospital, Medical Records, Perinatology, Infant Death

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