# ABSTRAK

**Judul** : Identifikasi Kelengkapan Pengisian Rekam Medis Elektronik Pasien Rawat Inap di RSKD Duren Sawit Jakarta
**Nama** : Munazhifah
**Program Studi** : Rekam Medis dan Informasi Kesehatan

Rekam medis harus dibuat secara tertulis, lengkap, dan jelas atau secara elektronik. Rekam kesehatan elektronik merupakan Rekam Medis Elektronik suatu akses dalam pengaturan informasi kesehatan pasien yang dihasilkan setiap kali pasien mengakses perawatan medis. Rekam medis harus dilengkapi dalam waktu 24 jam dengan persentase kelengkapan 100%. Penelitian ini bertujuan untuk mengetahui persentase kelengkapan pengisian Rekam Medis Elektronik pasien rawat inap di Rumah Sakit Duren Sawit Jakarta. Metode penelitian menggunakan metode deskriptif dengan pendekatan analisis kuantitatif. Sampel 77 rekam medis elektronik pasien rawat inap menggunakan *purposive sample* (sampel pertimbangan). Hasil penelitian: belum ada Standar Prosedur Operasional Rekam Medis Elektronik yang menjadi pedoman dalam bekerja. Dari analisis diperoleh kelengkapan pengisian sebesar 84% dan ketidaklengkapan sebesar 16%, Belum mencapai standar minimal yang telah ditetapkan Kemenkes yakni 100%. (Komponen terlengkap adalah komponen identitas pasien dengan persentase 100%, sedangkan kelengkapan yang terendah adalah komponen laporan yang penting 65%). Beberapa faktor yang menyebabkan rekam medis tidak lengkap yaitu: Banyaknya jumlah pasien, dokter senior yang tidak mengerti teknologi, dan sistem dan jaringan komputer yang terkadang *error/down*. Saran dibuatkan Standar Prosedur Operasional tata laksana pengisian Rekam Medis Elektronik, pendampingan dan sosialisasi kepada dokter senior dan petugas menghubungi pihak terkait agar dapat melengkapi rekam medis segara (< 24 jam).

**Kata kunci** : Isi RME Pasien Rawat Inap

## *ABSTRACT*

***Title*** ***:*** *Identification of Completeness of Filling out Electronic Medical Records of Inpatients at RSKD Duren Sawit Jakarta*
***Name*** ***:*** *Munazhifah*
***Study Program*** ***:*** *Medical Records and Health Information*

*Medical records must be made in writing, complete, and clear or electronically. Electronic health record is an electronic medical record which is an access in managing patient health information that is generated every time a patient accesses medical care. Medical records must be completed within 24 hours with a 100% completeness percentage. This study aims to determine the percentage of completeness of electronic medical records of inpatients at Duren Sawit Hospital, Jakarta. The research method uses a descriptive method with a quantitative analysis approach. A sample of 77 electronic medical records of inpatients uses a purposive sample (consideration sample). The results of the study: there is no Standard Operating Procedure for Electronic Medical Records that serves as a guide in working. From the analysis, it was found that the completeness of filling was 84% and the incompleteness was 16%. It has not reached the minimum standard that has been set by the Ministry of Health, which is 100%. (The most complete component is the patient identity component with a percentage of 100%, while the lowest completeness is an important report component 65%). Several factors cause incomplete medical records, namely: The large number of patients, senior doctors who do not understand technology, and computer systems and networks that sometimes error/down. Suggestions are made for Standard Operating Procedures for filling out Electronic Medical Records, mentoring and socializing to senior doctors and officers contacting related parties so that they can complete medical records immediately (< 24 hours).*



***Key words*** ***:*** *Contents of inpatient Electronic Medical Record*