Studi kasus analisis review rekam medis berdasarkan akreditasi internasional di ruang rawat inap RSU Sanglah Denpasar tahun 2013 = Case study analysis of medical record review based on international accreditation in inpatient ward Sanglah Hospital Denpasar 2013

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Abstrak

Review rekam medis merupakan suatu proses yang penting dalam rangka peningkatan mutu layanan Rumah Sakit sesuai akreditasi Internasional. Review rekam medis yang dilakukan belum mencapai 100%. Penelitian ini merupakan penelitian deskriptif kualitatif. Pengumpulan data dengan wawancara dan penelusuran dokumen. Analisa data dengan content analysis.
Hasil penelitian menunjukkan standar pelaksanaan review rekam medis sudah dibuat sesuai rekomendasi tim akreditasi Internasional. Sosialisasi standar belum optimal, pemahaman tentang review rekam medis oleh dokter dan petugas gizi masih kurang, keterlibatan sumber daya manusia belum sesuai, belum adanya format laporan dan jadwal pelaporan dari instalasi rekam medis ke direksi dan belum berjalannya sistem evaluasi tindak lanjut sesuai PDCA (Plan Do Check Action).
Kesimpulan: review rekam medis belum berjalan sesuai standar yang dibuat.
Saran: pelaksanaan review rekam medis dimasukkan sebagai salah satu tugas pokok pejabat yang berwenang, supervisi dilakukan secara berkesinambungan, tingkatkan sosialisasi standar review rekam medis, review rekam dapat dilakukan secara rutin untuk semua rumah sakit sebagai siklus perbaikan kualitas rekam medis.
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Review of medical records is an important process in order to improve the quality of service correspond Hospital International accreditation. Review of medical records that do not reach 100%. This research is a qualitative descriptive study. Data collection with interviews and document searches. Data analysis with content analysis.
The results showed a standard implementation review of medical records has been made according to the International accreditation team's recommendations. Socialization of standards is not optimal, an understanding of the medical record review by physicians and nutrition workers are still lacking, the involvement of human resources is not appropriate, the lack of reporting formats and reporting schedules of the medical record installation to the directors and the evaluation system of follow-up not accordance to PDCA (Plan Do Check Action).
Conclusion: a review of medical records have not been going according to the standards set.
Suggestion: the implementation of medical record review included as one of the main tasks the competent authority, supervision is done on an ongoing basis, increase socialization standard medical record review, and medical record review can be performed routinely for all hospitals as medical record quality improvement cycle.