Pengembangan sistem informasi monitoring dokumen rekam medis rawat inap di RSUP Fatmawati tahun 2020 = Development of an inpatient medical record document monitoring information system in RSUP Fatmawati 2020.

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Abstrak

Latar Belakang: Informasi yang tidak efektif disebabkan oleh adanya keterlambatan pengembalian dan ketidaklengkapan pengisian data rekam medis. Kepmenkes Nomor 129 Tahun 2008 tentang Standar Pelayanan Minimal Rumah Sakit menetapkan waktu pengembalian dokumen rekam medis yaitu 1x24 jam dan kelengkapan dokumen rekam medis harus 100%. Di RSUP Fatmawati Jakarta terdapat peningkatan prosentase keterlambatan pengembalian dan ketidaklengkapan dokumen rekam medis rawat inap.
Tujuan: Penelitian ini bertujuan untuk mengetahui dan mengidentifikasi alur, kebutuhan sistem informasi yang akan dikembangkan, serta merancang sistem informasi monitoring dokumen rekam medis rawat inap di RSUP Fatmawati.
Metode: Penelitian ini menggunakan metode kualitatif dan dilakukan secara bertahap sesuai tahapan SDLC, serta menggunakan pendekatan metode prototype.
Hasil: Adanya masalah-masalah pada sistem informasi rumah sakit saat ini yang membuat petugas masih harus melaksanakan pekerjaannya secara manual. Sistem informasi monitoring dokumen rekam medis rawat inap dirancang melalui penyusunan alur sistem, perancangan basis data, tampilan antarmuka (userinterface), SPO, dan manualbook.
Kesimpulan dan Saran: Sistem informasi yang baru dapat mengatasi permasalahan yang terjadi, mempercepat dan mempermudah pekerjaan petugas, serta menghasilkan laporan yang bermutu. Sehingga capaian SPM rumah sakit dan indikator mutu IRMIK meningkat. Sebaiknya ada dukungan penyediaan sarana dan prasarana dari rumah sakit untuk pengembangan sistem informasi monitoring dokumen rekam medis rawat inap, perlu adanya sosialisasi SPO dan manualbook, proses uji coba sistem kepada user, serta sebaiknya dilakukan upaya perawatan basis data secara berkala.
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Background: In the hospital, ineffective information is caused by late referral and incomplete medical records. Decree of the Minister of Health No. 129/2008 of Hospital Minimum Service Standards explained this case. The standard said that medical record documents must be returned in 1x24hours and its completeness must be 100%. Nevertheless, Fatmawati Jakarta Hospital underwent an increase of late returns and incomplete inpatient medical record documents percentages.
Objectives: Aims of this study are determining and identifying flow and needs of the development of an information system. Also, this study aims to design an information system for monitoring inpatient medical record documents.
Methods: This study used a qualitative method, SDLC stages, and a prototype method approach.
Results: There are problems in the current hospital information system. Also, it makes employees still need to do their works manually. Therefore, an inpatient medical record document monitoring information system was designed through some stages. Those are the system flow, database, user interface, OPS, and

manualbook formings.
Conclusions and Recommendations: The new information system provides some improvements in the hospital. Those are particularly in achievement and enhancement of quality indicators and standards. This is because it can overcome problems and produce quality reports. Also, it makes employees do their works efficiently. For recommendations, the hospital should support this development by facilities and infrastructure provision. They also need to socialize the operational procedure standard and manualbook. Then, they should do the process of testing the system to users and database maintenance efforts regularly.