DOCTOR BEHAVIOR IN FILLING THE MEDICAL RESUME SHEET IN BAGAS WARAS HOSPITAL, KLATEN

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Abstract

The hospital as one of the health service facilities, is part of the health resources that were needed in supporting the implementation of health efforts. The writing of patient diagnosis is the responsibility of the treating physician and should not be represented. The phenomenon found in the initial survey of Regional General Hospital Bagas Waras Klaten obtained many incomplete resume forms. The purpose of this research is to know the doctor's behavior on the filling of the in-patient resume sheet data at Bagas Waras HospitalKlaten. This research was a qualitative research with case study approach. Respondents in this study were DPJP Specialist Doctor, Medical Record Officer and Hospital Director. The data obtained from interviews, FGDs, observations and documentation and collected and grouped based on existing indicators, as well as based on existing facts and also on critical thoughts to obtain a weighted result. Based on the results of the doctor's observation through the medical resume sheet for 3 consecutive months which had been submitted to the medical record, it appeared that medical resume filled by the doctor after the patient finished treatment was still low, from 217 files, which was incomplete as much as 125 with a percentage of 41%. It was due to lack of cooperation between doctors and nurses in filling medical resume. In addition, the incomplete medical resume was due to the non-operation of the Standard Operational Procedure (SOP) which regulated the filling of medical resumes, the absence of regulations, sanctions for doctors who did not fill the medical resume so the doctors lazily fill medical resume. The doctor's behavior in completing the medical resume sheet is still low.

Keywords: Medical Resume, Behavior Physician

INTRODUCTION

Hospitals, as one of the health service facilities, are part of the health resources that are needed in supporting the implementation of health efforts. Every hospital health service is required to conduct medical records. The medical record service system is a system that organizes forms, records, and reports coordinated in such a way as to provide the required hospital management documents and is carried out for patients who are viewed as complete human beings. Detailed medical records, obtained information-information that can be used for various purposes. Such necessities are as evidence in lawsuits, research materials and education, and can be used as a tool for analysis and evaluation of the quality of services provided by the hospital. The writing of a patient's diagnosis is the responsibility of the treating physician and should not be represented. In the Regional General Hospital (RSUD) Bagas Waras Klaten already contained a protap related to the filling of medical record data, including the resume form and routinely has been analyzed the completeness of patient medical record data. The phenomenon found in the initial survey of Regional General Hospital Bagas Waras Klaten obtained many incomplete resume forms, the resume sheet has not been computerized and the filling is done manually by the doctor after the patient is declared allowed to go home. Based on the background that has been described above, the problems that will be studied further in this research is: How the doctor's behavior on the completeness of the writing of the resume medical record sheets of inpatients at the Bagas Waras, Regional General Hospital Klaten at 2017.

Medical record files are manuscripts or files containing records or documents on patient identities, examinations, treatments, actions, and other diseases to patients on

health care facilities.[1] Medical record files are facts relating to the state of the patient, past and current medical history and treatment written by the health profession that provides services to such patients.[2]

RESEARCH METHODS

1. Type of Research

This research was a qualitative research with case study approach. Data collection could be obtained from the qualitative data conducted to know the phenomenon of what was experienced by the research subject, such as behavior, perception, motivation, action and others holistically and in a way descriptive in forming words and language in a special context natural and by utilizing various natural methods[3]. Research that generally explained and provided understanding and interpretation of various human behaviors and experiences (Individuals) in various forms[4].

2. Research Design

The design of this study was a case study using an in-depth interview approach (in-depth interview). Interview was a rechecking tool or verification of information or information on information or information obtained previously. Interview techniques conducted in qualitative methods were in-depth interviews. According to Sutopo (2006), an in-depth interview was a process of obtaining information for the purpose of research by the means of frequently asked questions and face to face interviews with respondents or interviewees, where interviewers and respondents engaged in relatively long social life. Some things to consider a researcher when interviewing respondents were voice tone, speaking speed, question sensitivity, eye contact and nonverbal sensitivity.

3. Qualitative Analysis

The analysis done by the researcher was presented in the table forms, there were:

a) Data reduction was to summarize and select the main points, focusing the important things from the data obtained.
b) Presentation of data was the presentation of data compiled as narrative text.
c) Conclusion and verification.
d) Withdrawal conclusions by rethinking during writing. Reviewing the notes, reviewed and exchanged ideas and placed a snapshot of the findings in another set of data.

4. Research Procedures

The steps that had done in this study, generally included several stages, which were:

a) Preparation phase stages of this study would conduct observation of research sites and literature studies on research first. Then the next stage of preparing the thesis proposal with the research instrument (questionnaire / interview guide and recorder).
b) Data Collection Stage 1) Primary Data Primary data was data obtained directly from the source of research object that was specialist doctor, head of ward, head of RM and Director of Hospital. 2) Secondary Data Secondary data was additional data obtained from other side, this data was not directly obtained by researcher from research subject. Where the data obtained from the medical record data information.
c) Data Processing Stage
After the data was collected, then the data would be analyzed qualitatively.
d) Settlement Stage.
The data that had been collected was presented in the form of a description, then arranged to be a packed report. Technical Data Analysis: This study used qualitative data analysis techniques, i.e data obtained from interviews, FGDs, observations and documentation and collected and grouped based on existing indicators, as well as based on existing facts and also on critical thoughts to get a result. Therefore, in analyzing the data analysis, it was used discrete analysis

techniques. This technique was done by describing the data in the field, the data was analyzed and concluded. Data analysis was performed at the time of data collection took place after the selection of data collection within a certain period. At the time of the interview, the researcher had analyzed the answers. The data obtained consisted of primary data and secondary data. After finishing the editing, grouped according to the problem of research and it was analyzed of disctitive data in the form of narration. To ensure the validity of data, in this study triangulation technique was to test the validity of data by comparing the state and perspective of a person with a variety of opinions and views of people from specialist doctors, RM officers who were not in the input into the study respondents.

5. Data Collection
   a) In-depth Interviews The technique used was in-depth interviews to informants for exploring the implementation / completion of medical resume by DPJP *Rawat Inap*, RM Officer and Director at Bagas Waras HospitalKlaten District. Interviews were conducted in an unstructured or open manner in which the researcher did not use a systematic and complete set of interview guidelines to collect the data.
   b) Documentation Study View the existence and completeness of the document in the form: A. Medical Resume Filling Accuracy Policy B. SPO Accuracy of Medical Resume Filling.
   c) Observation The observational technique used was passive participation, where the research was involved with the day-to-day activities of the person being observed or being used as a source of research data.
   d) Study Documentation View the existence and completeness of the document in the form: 1) Accuracy of Medical Resume Filling Policy 2) SPO Accuracy of Medical Resume Filling

RESULTS

After observing the filling of medical resume sheets by specialist doctors DPJP Bagas Waras HospitalKlaten, there were several pieces of medical resume incomplete. For 3 consecutive months, the average non-recycle medical sheet reached 42.73%. The incomplete medical resume data for 3 months were July, August and September 2016 as follows:

Tabel 1. Incompleteness Medical Resume in Bagas Waras Hospital Klaten

		Complete		Not Complete	
Month	Total hRM	Total	%	Total	%
Juli	76	45	59.21	31	40.79
Ags	64	33	51.56	31	48.44
Sep	77	47	61.04	30	38.96

Tabel 2 Incompleteness Medical Resume in Bagas Waras Hospital Klaten

Month	Incompleteness Medical Resume													
	name	age	sex	Address	signing	Dr names	DX in	DX final	operation	Med record	Pem physic	facility	compilation	Healing
JULY	1	2	1				14			19	19	34		
AGST		1					8			19	19	28	1	
SEPT							16			19	19	28		1

Based on Table 2, the level of obedience of specialist doctors DPJP Bagas Waras Hospital Klaten regency in compliance with the provisions to record medical resume was still low. That was probably because the doctors were too busy in serving patients. While the points of incompleteness in medical resume included: 1. Investigation 2. Physical Examination 3. Health History 4. DX Sign In Age 6. Name 7. Sex 8. Compile 9. Treatment. Based on the interview results, it obtained level of understanding of medical specialists about medical resume was very good. Filling medical resume within 1 x 24 hours was also considered sufficient by a specialist, this was because before the patient came home, medical resume must be filled. In addition, the awareness to fill the medical resume sheet was quite good, it was proved by the Director's Regulation about the maximum limit of medical resume completeness 1x24 hours, but based on deeper searches medical resume data was still a lot of repetition. Based on Government Regulation no. 32/1996 explained that doctors, nurses, and resume medical personnel were obliged to write medical resume documents. Meanwhile, according to *Permenkes* No. 749a year 1989 sheets resume immediately completed within 2x24 and maximum 14 days after the patient returned. A person's knowledge was derived from education or experience derived from a variety of sources, such as books, people (friends, relatives, officers) and from various media that could form certain beliefs so that one would behave accordingly. Knowledge was also a resultant result of the sensing process (sight and hearing) of an object.

This was in accordance with the opinion of WHO (1984) cited by Notoatmojo[5] mentioned that a positive knowledge of health values would be realized in action. The above opinion was supported by Green's theory cited by Notoatmojo who said that knowledge was part of predisposing factors that were very decisive in shaping one's behavior. A behavior had not been automatically manifested in practice, the realization of behavior into a real action (practice) required supporting factors or conditions that allowed. Another opinion stated that the activities which had been done was called behavior, while according to WHO team work results determined by the knowledge, perceptions, attitudes, beliefs and assessments of a person to the object of health. Besides caused by the doctor's laziness, the high percentage of incompleteness was due to the hasty charging, so there were still some items missed in filling the resume and the doctor's busy schedule was high enough to have

limited time in filling medical resume. This incomplete filling would reduce information about the patient's journey during hospitalization. The incompleteness of the items on the date of entry and exit date would affect the claim process as proof of financing calculation because it did not get complete information about how long the patient was doing the treatment in the hospital. This was because there was no meeting among doctor, nurse, medical record officer and health worker related to evaluate the number of incompleteness occurring on the medical resume filling, so that the number of incompleteness was increased. If the incomplete number of medical resumes was allowed and increased, it would affect the quality of hospital services. Research conducted in several hospitals in French mentioned that the completeness of medical records was closely related to the quality of inpatient services, so the good and continuous monitoring was needed. In addition, through monitoring activities especially in filling medical resume could be known obstacles or difficulties faced by the officer during the process of filling the medical resume took place. The components that became the most important element in the evaluation implementation had also been fulfilled. Moreover, it was supported by the reporting of evaluation result of medical resume filling done by resume medical part of Bagas Waras Hospital which had been arranged regularly and systematically and reported regularly every month for following up. In this research, there were some weaknesses that could not do the evaluation on the implementation of policy (SOP, job description, reward and punishment of medical resume), and medical resume filling procedure at Bagas Waras Hospital inpatient installation, so it could know the suitability between policy and implementation. This was due to the limitations of researchers (Dang et al, 2013). The completeness of medical resume at Bagas Waras Hospital Klaten hospital ward was different in each treatment room. In the SOP filling medical resume Bagas Waras Hospital has covered the procedures in the medical resume implementation included medical service resume flow, the provision of medical resume filling, medical resume filling procedures and technical manual medical resume sheet. The flow of medical resume service at Bagas Waras Hospital had been classified based on patient type including outpatient, inpatient and emergency department as contained in the guidance of medical resume implementation also divided into 3 types. In addition, the arrangement of grooves starting from the patient came to the hospital to get out of the hospital was not much different from the medical resume flow contained in the guidelines of the Directorate General of Medical Services. Filling provisions along with medical resume filling procedures prepared by the medical resume section of Bagas Waras Hospital in accordance with the filling provisions contained in the guidelines for the administration of medical resume. The use of medical resume sheets at Bagas Waras Hospital was modified in accordance with the needs of the hospital but still in accordance with the guidelines. The job description of the medical resume filling officer at Bagas Waras Hospital had been clearly regulated, otherwise it had been established in a hospital policy so that the job description had a fairly strong legal standing in the hospital. As for the job description, it had involved all the medical resume officers who not only come from health workers including doctors, doctors specialists, nurses, nutritionists but medical support service personnel and medical resume officers were also included.

Each officer had a job description for filling out different medical resume files in accordance with the services provided to the patient to avoid overlapping the filling task on the same medical resume file. The division of tasks was distinguished by the type of medical resume file that was the Medical Document of Nursing (DMK). Reward and punishment became one of the policies set by Bagas Waras Hospital which was used as a frame of reference in order to reduce the incompleteness of the medical resume filling that occurred. However, the policy had not been fully supported by all parties related to the filling of medical resume at Bagas Waras Hospital. The majority of medical resume returns had been made in a timely manner but the timeliness was 2x24 hours after completion of providing services to patients or after the

patient was declared when the deadline for the return of medical resume based on health minister's decree number 129 / MENKES / SK / II / 2008[7] on Standard Minimum Hospital Service was ≤24 hours. Based on the minimum service standards, then the entire return of medical resume inpatient installation Bagas Waras Hospital could be said as not complete. This further reinforced that lazy doctors' behavior needed an immediate follow-up.

The limit provisions were stipulated to provide an opportunity for officers to fill out medical resumes to supplement the medical records of patients who had been treated so that the medical resume could return to the medical resume in complete condition. In addition, the improvement method of writing in the filling of the majority medical resume was not in accordance with the procedures as set out in the guidelines of the administration and hospital medical revision procedure II revision in 2006, where every improvement of writing must include the signatures' officers who made improvements to the writing, so the data about patients could be accounted for. The medical resume section of Bagas Waras Hospital did not carry out monitoring of medical resume filling. Therefore, there was no supervision on the process of filling the patient's medical resume in each treatment room. According to the handbook on monitoring and evaluating for results (2002), monitoring aimed to carry out measurements or assessments of process performance to achieve the expected output. In support of the success of the National Health Insurance (JKN) program, BPJS Health used a new financing method at certain health facilities, especially hospitals. The method of financing applied in the JKN era was a prospective payment method and it was expected to realize the expectations as mentioned above. One of the prospective payment methods currently adopted in Indonesia was casemix (case based payment) and it had been implemented since 2008 in the Public Health Insurance (Jamkesmas) program. Since the implementation of casemix system in Indonesia had been made the tariff change three times; INA-DRG tariff in 2008, INA-CBGs tariff in 2013, and INA-CBGs tariff in 2014. Grouping of diagnostic codes and procedures was done by using UNU grouper (UNU grouper). Research conducted by the University of Washington Institutional Review Board for three years mentioned that the data was prepared to be included into the claims data was not complete, so the coder could only infer from the existing information. The lack of claims data was about the severity and duration of the disease before the patient was diagnosed. This led to an inaccuracy in coding the diagnosis in order to supplement the healthcare claims, the coder could not equate the diagnostic information made, with the diagnostic codes were already available in ICD codes where the ICD code was generally accurate one of the ICD functions was to evaluate A large number of patients with similar conditions and not in evaluating individual outcomes. So that the completeness of medical resume data was needed to determine the amount of claims that would be given by the insurance company.

RSUD section of sane must prepared patient data and improved the documentaries capability for prospective payment mechanism which had been set by BPJS. The data entered into the grouper, which would be the output of INA-CBG'S, it must be quality data. The importance of this quality data could not be ruled out, as it provided a means of communication for physicians and health teams, providing a basis for evaluating the adequacy and suitability of services, providing a basis for strengthening repayment claims, and protecting the legal interests of patients, facilities, and doctors. Completeness of data on medical resume was very important, because if the available data was incomplete, then the hospital coder would not be able to perform the maximum diagnosis coding. It also depended on the completeness of information from patients and physicians (clinical data and patient administration), so that the data should be accurate, timely and based on optimal positive communication between physician and coder[8].

Determining the main diagnosis was quite difficult. It was defined as the condition of the diagnosis at the end of the treatment episode, which caused the patient to obtain the required service or

examination. The condition was closely related to the use of resources during the patient being treated and determining the length of the day of care. Determination of the secondary diagnosis included all the diagnoses other than the main diagnosis in an episode of treatment that arose during the patient being treated. There were two types of secondary diagnoses that arose from a patient. Co-morbidity (occured with the main diagnosis at the time of admission), e.g hypertension, diabetes mellitus at admission, complications arising from the episode of treatment, or the consequences of the illness or treatment of the patient during treatment. These included nosocomial infections, decubitus infections, pnemothorax, septicemia, kidney failure, etc. Medical resume was an important part of patient management. It was very important for doctors and hospitals to properly maintain patient records for two important reasons. The first was that it would assist physicians in the scientific evaluation of their patient profiles, assisted in analyzing treatment outcomes, and to plan treatment protocols. It also helped in planning the government's strategy for future medical care. But equally important in this arrangement was in the issue of alleged medical negligence. The legal system relied primarily on documentary evidence in situations where medical negligence was suspected by patients or relatives. In allegations of negligence, this was very useful as the most important evidence in deciding on a doctor's sentence or release. The problems that often arose in Bagas Waras Hospital would result in an inaccurate data that led to coding error and the results of those CBG's broken.

The following issues were viewed in the financing effect of inadequate and inappropriate coding documentation. A patient's final diagnosis, which might not be fully or precisely coded, it might result in an incorrect coding in determining how long the patient should be hospitalized. This would lead to the payment of inappropriate claims from the BPJS, and the difference in the amount of disposable income. A sick rickshaw would have a deficit in BPJS claims that could lead to weak financial management of the hospital and refunds. Conditions experienced by Bagas Waras Hospital Klaten also experienced in most hospitals in India. Most of the hospitals in India, they still experienced some obstacles in performing medical records, both small hospitals and large hospitals. It was very important for physicians who handled patients to perform documented care of patients undergoing diagnosis. This would be the only way for doctors to prove that the treatment was done correctly. In addition, it would also be helpful in scientific evaluation and reviews of patient management issues. With the increasing use of health insurance for treatment, insurance companies also needed proper records to prove the patient's demand for medical expenses. Improper recording might result in a decrease of health claims.

The contents of medical records included a variety of patient chronological documentation, clinical findings, diagnostic test results, preoperative care, surgical records, post-operative care, and patient progress notes and medications. Properly written surgery records might protect a surgeon in cases of alleged omissions from surgical complications. In prescribing medicines must be readable with patient's name, date, and signature.

According to some theories, leadership had been described as individual behavior when directing group activities toward common goals. An important aspect of leadership roles was that it could influence group activities and cope with change. The difficulty when considering the leadership of health professionals was that most theories were not developed in a health context but they were usually developed for business arrangements and then applied to health. Several studies provided evidence that leadership initiatives were linked to the improvements in attendance to hospital problems. The behavioral theories developed between 1940 and 1980 illustrated general leadership styles such as authoritarian, democratic and laissez-fair. Situational and contingent theories between 1950 and 1980 recognized the importance of considering the needs of the worker, the task to be performed, and the situation or environment. Interactional leadership theory (1970 to present) focused on influences within a particular organizational environment and the interactive

relationships of 'leaders' with 'followers'. An emerging theory involved supportive leadership, stated that supporting and building relationships with employees would increase the likelihood that they would be positively influenced and motivated to work toward the same goals. This theory was developed in the study of organizational behavior that showed people were happier and more satisfied in their work when they had a supportive leader who empathized at the personal level.

In large organizations such as health systems, many groups with associated subcultures might support or contradict each other. Leadership needed to leverage diversity within the organization as a whole and efficiently utilize resources while designing management processes, while encouraging personnel to work toward common goals.

CONCLUSIONS AND RESEARCH SUGGESTIONS

1. Conclusion

a. The incompleteness of writing the patient's medical records on the resume sheet was due to the lack of knowledge of the physician in relation to the applicable regulation of medical resume sheet.

b. The incompleteness of writing the patient's medical records on the resume sheet was due to some lazy doctors' behavior.

2. Suggestions

a. Establishing a Medical Record Team / Committee to monitor and evaluate the completion of medical sheets at regular intervals.

b. Fixing internal rules related to the completeness of the patient's medical resume writing.

c. It is necessary to socialize the applicability of medical record writing regulation in Bagas Waras HospitalKlaten regularly. There should be regular training of filling sheet of medical resume

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