ABSTRACT

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Title *: Analysis of Write Errors Medical Record Documents Hospitalized at RSUD Kanjurhan*

Each hospital must have a medical record unit with the aim of supporting the achievement of administrative order in order to improve the quality of health services in the hospital. The quality of the medical record can be seen from the completeness of the content of each item on the sheet of medical record documents in terms of completency, suitability, accuracy of its content, as well as can be viewed from protected or not confidentiality of information. Write errors are one of the causes of incompleteness of medical record documents due to the inclusion of items on quantitative analysis. The research is aimed at analyzing DRM writing errors, identifying the number of writing mistakes, identification of causal factors, as well as corrective efforts. The method used is descriptive, which is to show the results of observations with the method of observation and interview. As for the results of the research, the number of errors in the writing of medical records in RSUD Kanjuruhan is still high as 54 documents (57%), while the result was obtained in nurses the highest level of error in writing is 29 documents. Factors that cause writing errors are work experience, lack of understanding of officers, there are PPA officers who are less compliant with the policy, and the evaluation and monitoring system is not fully implemented. Enhancement efforts with the planning table of action (POA) is by performing socialization intensively related to the correction of errors and maximizing the open review of medical records.

Keywords: Write Errors, Incompleteness, Documents of Medical Records