INPATIENT MORTALITY REPORTING MANAGEMENT: A CASE STUDY OF THE MEDICAL RECORDS UNIT AT DAHA HUSADA REGIONAL PUBLIC HOSPITAL

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ABSTRACT

Background: Inpatient mortality reporting is a critical indicator of hospital service quality. Accurate data are essential for evaluating performance, identifying mortality risk factors, and planning healthcare improvements. **Objective:** This study aimed to analyze the management of inpatient mortality reporting at Daha Husada Regional General Hospital in terms of input, process, and output. **Methods:** A descriptive qualitative case study was conducted through in-depth interviews with medical record officers and direct observation of the reporting process. **Results:** The input consisted of medical record staff with a Diploma in Medical Records but without specific training, adequate facilities limited by technical issues in the Hospital Information System (SIRS), and the absence of a specific Standard Operating Procedure (SOP). The process involved data collection from inpatient wards and the Hospital Management Information System, processed using Excel, but without application of underlying cause-of-death coding or mortality reselection. The output included internal and external reports in the required format; however, diagnostic completeness remained insufficient. **Conclusion:** Inpatient mortality reporting at Daha Husada Regional General Hospital has been implemented, but strengthening policies, providing staff training, and applying standardized cause-of-death coding are required to improve reporting quality.

Keywords: Mortality, Inpatient, Medical records, Reporting, Service quality