

**PROGRAM STUDI SARJANA TERAPAN MANAJEMEN INFORMASI KESEHATAN  
UNIVERSITAS IMELDA MEDAN**

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**ABSTRAK**

Rekam medis merupakan dokumen penting yang mendukung kualitas pelayanan kesehatan, terutama pada pasien bedah yang memerlukan dokumentasi lengkap, akurat, dan konsisten. Penelitian ini bertujuan untuk mengevaluasi kualitas pengisian rekam medis pasien bedah di Rumah Sakit Umum Bandung Tahun 2025. Evaluasi dilakukan berdasarkan enam komponen analisis kualitatif, yaitu: kelengkapan dan kekonsistenan diagnosis, konsistensi pencatatan diagnosis, pencatatan perawatan dan pengobatan, keberadaan informed consent, praktik pencatatan, serta potensi tuntutan hukum. Jenis penelitian ini adalah deskriptif kuantitatif. Sampel sebanyak 60 berkas rekam medis pasien bedah dipilih menggunakan teknik purposive sampling, dan dinilai menggunakan instrumen lembar checklist. Data dianalisis secara deskriptif dengan menghitung persentase kelengkapan, akurasi, dan konsistensi dari setiap komponen. Hasil penelitian menunjukkan bahwa secara umum kualitas pengisian rekam medis pasien bedah tergolong baik. Sebagian besar indikator menunjukkan nilai 100% dalam aspek kelengkapan, akurasi, dan konsistensi. Namun, masih ditemukan beberapa ketidakkonsistenan pada diagnosis akhir dan pencatatan informed consent yang belum sepenuhnya akurat. Selain itu, keterbatasan teknis seperti gangguan jaringan pada sistem rekam medis elektronik (RME) juga menjadi kendala pencatatan yang optimal. Kesimpulan dari penelitian ini bahwa kualitas pengisian rekam medis telah memenuhi standar, namun perlu peningkatan pada beberapa aspek. Disarankan untuk dilakukan pelatihan rutin, supervisi, dan audit dokumentasi secara berkala guna menjaga mutu rekam medis yang berkelanjutan.

**Kata Kunci:** *Rekam Medis, Kualitas Pengisian, Pasien Bedah, Konsistensi*  
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**BACHELOR OF APPLIED HEALTH INFORMATION MANAGEMENT STUDY PROGRAM**  
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**ABSTRACT**

*Medical records are essential documents that support the quality of healthcare services, particularly for surgical patients who require complete, accurate, and consistent documentation. This study aimed to evaluate the quality of medical record documentation for surgical patients at Bandung General Hospital in 2025. The evaluation was based on six components of qualitative analysis: completeness and consistency of diagnosis, consistency in recording diagnoses, documentation of care and treatment, presence of informed consent, recording practices, and potential legal liability. This research employed a quantitative descriptive design. A total of 60 medical record files of surgical patients were selected using purposive sampling and assessed using a checklist instrument. Data were analyzed descriptively by calculating the percentage of completeness, accuracy, and consistency for each component. The results indicated that, overall, the quality of medical record documentation for surgical patients is considered good. Most indicators showed 100% in terms of completeness, accuracy, and consistency. However, some inconsistencies were observed in the final diagnosis and the recording of informed consent, which were not entirely accurate. In addition, technical limitations, such as network disruptions in the electronic medical record (EMR) system, also posed challenges to optimal documentation. In conclusion, the quality of medical record documentation met the required standards but requires improvement in certain areas. It was recommended to implement regular training, supervision, and documentation audits to maintain sustainable medical record quality.*

**Keywords** : *Medical Records, Documentation Quality, Surgical Patients, Consistency*

**Reference**: 37 (2006-2024)

