

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

**Nama** : Sri Falya Rifqah  
**NIM** : 2113363027  
**Judul** : **Evaluasi Pelaksanaan Audit Rekam Medis Melalui Analisis Kualitatif Berdasarkan 6 Komponen Review Rekam Medis Pasien Dengan Diagnosa *Chronic Kidney Disease* Di RSUD Imelda Pekerja Indonesia Tahun 2025**

**ABSTRAK**

Audit rekam medis bertujuan untuk memastikan bahwa proses pengelolaan informasi medis pasien dilakukan dengan standar tertinggi dalam hal kekonsistensian, akurasi, dan keamanan data. Proses analisis kualitatif dalam dokumen rekam medis mencakup enam aspek penting, yaitu: review kelengkapan dan kekonsistensian diagnosa, review kekonsistensian pencatatan diagnosa, review pencatatan hal-hal yang harus dilakukan saat perawatan dan pengobatan, review terhadap informed consent, review cara atau teknik pencatatan, review hal-hal yang berpotensi menyebabkan tuntutan ganti rugi yang mendukung keakuratan dan kelengkapan catatan medis. Tujuan penelitian ini untuk mengetahui pelaksanaan audit rekam medis melalui analisis kualitatif berdasarkan 6 komponen review rekam medis pasien dengan diagnosa *Chronic Kidney Disease* di RSUD Imelda Pekerja Indonesia Tahun 2025. Penelitian ini menggunakan metode kualitatif dengan pendekatan deskriptif terhadap 5 rekam medis pasien dengan diagnosa *Chronic Kidney Disease* serta wawancara kepada 5 informan Profesional Pemberi Asuhan (PPA). Hasil penelitian menunjukkan bahwa kekonsistensian pada komponen diagnosa dan tindakan, pencatatan klinis, pendokumentasian waktu telah mencapai tingkat persentase 100% serta tidak adanya hal yang menunjukkan potensi ganti rugi. Namun, pada komponen penghentian/pelaksanaan obat dan persetujuan/penolakan tindakan masih belum konsisten dengan persentase 40% dan 80% serta keterbacaan pada *informed consent* belum dinyatakan konsisten (0%). Penelitian ini merekomendasikan rumah sakit untuk melakukan review rekam medis melalui pendekatan analisis kualitatif bertujuan mempertahankan nilai kualitas pencatatan rekam medis berdasarkan kekonsistensian, kelengkapan dan keakuratan sesuai standar.

**Kata Kunci** : **Audit rekam medis, Kualitatif, *Chronic Kidney Disease*, Kekonsistensian**  
**Daftar Pustaka** : **28 (2008-2024)**

**APPLIED BACHELOR'S DEGREE PROGRAM IN HEALTH  
INFORMATIONMANAGEMENT IMELDA UNIVERSITY OF MEDAN**

**Name** : Sri Falya Rifqah  
**NIM** : 2113363027  
**Title** : *Evaluation of Medical Record Audit Implementation Through Qualitative Analysis Based on 6 Components of Medical Record Review Patients with Chronic Kidney Disease Diagnosis at Imelda Indonesian Workers Hospital in 2025*

**ABSTRACT**

*Medical record audits aim to ensure that the process of managing patient medical information is carried out to the highest standards in terms of consistency, accuracy, and data security. The qualitative analysis process in medical record documents covers six important aspects, namely: review of the completeness and consistency of diagnoses, review of the consistency of diagnosis recording, review of the recording of things that must be done during care and treatment, review of informed consent, review of recording methods or techniques, review of matters that have the potential to cause compensation claims that support the accuracy and completeness of medical records. The purpose of this study is to determine the implementation of medical record audits through qualitative analysis based on 6 components of medical record reviews of patients with a diagnosis of Chronic Kidney Disease at Imelda Indonesian Workers Hospital in 2025. This study used a qualitative method with a descriptive approach to five medical records of patients diagnosed with Chronic Kidney Disease and interviews with five Professional Care Providers (PPA) informants. The results of the study showed that consistency in the components of diagnosis and treatment, clinical recording, and time documentation had reached a percentage of 100% and there was no indication of potential compensation. However, the components of drug discontinuation/administration and consent/refusal of treatment were still inconsistent with percentages of 40% and 80%, respectively, and the legibility of informed consent was not declared consistent (0%). This study recommends that hospitals review medical records through a qualitative analysis approach aimed at maintaining the quality of medical record documentation based on consistency, completeness, and accuracy in accordance with standards.*

**Keywords** : *Medical record audit, Qualitative, Chronic Kidney Disease, Consistency*

**References** : 28 (2008-2024)

