

ABSTRAK

Latar Belakang: Ketidaktepatan pemilihan diagnosis dan kode diagnosis harus diperhatikan karena dapat menyebabkan pelaporan menjadi tidak akurat. Berdasarkan studi pendahuluan, dari sepuluh sampel terdapat ketidaktepatan pemilihan diagnosis sebesar 30% pada BRM, 60% pada SIMPUS, serta 60% pada P-Care. Salah satu upaya untuk memastikan diagnosis pasien akurat yaitu dengan melakukan audit informasi klinis.

Tujuan: Melakukan audit informasi klinis menggunakan aturan morbiditas untuk menganalisis ketepatan diagnosis utama dan kode diagnosis utama. Mengetahui perbedaan tingkat ketepatan kode diagnosis utama berkas rekam medis dan aplikasi elektronik rekam medis.

Metode: Kuantitatif analitik cross sectional. Populasi penelitian adalah 10 besar kasus pada pasien rawat jalan dalam BRM, SIMPUS, dan P-Care di 18 puskesmas dengan sampel 30 rekam medis setiap puskesmas. Pengambilan sampel dengan *purposive sampling*. Pengumpulan data dengan studi dokumentasi. Analisis data dengan uji *mann withney*.

Hasil: Audit informasi klinis dari pemilihan diagnosis utama menghasilkan diagnosis utama tepat sebesar 74%, aturan morbiditas paling banyak digunakan yaitu MB2, ketepatan tertinggi pada MB5. Audit informasi klinis dari kode diagnosis utama menghasilkan kode diagnosis utama tertepat pada SIMPUS sebesar 52%, kategori ketepatan kode diagnosis utama terbanyak pada Kategori A. Nilai sig. < 0,05 pada BRM dibandingkan SIMPUS, BRM dibandingkan P-Care, SIMPUS dibandingkan P-Care, dan BRM dibandingkan aplikasi ERM.

Kesimpulan: Audit informasi klinis menghasilkan perbandingan ketepatan kode diagnosis utama BRM < SIMPUS. Ketepatan kode diagnosis utama BRM < P-Care. Ketepatan kode diagnosis utama SIMPUS < P-Care. Ketepatan kode diagnosis utama BRM < aplikasi ERM.

Kata kunci: Audit informasi klinis, ketepatan diagnosis utama, aturan morbiditas, ketepatan kode, BRM, SIMPUS, P-Care.

ABSTRACT

Background: Inaccuracy in selecting diagnose and diagnose code must be considered because it can cause inaccurate reporting. Based on the preliminary study, from 10 samples there were 30% inaccuracy in the choice of diagnosis in Medical Record, 60% in SIMPUS, and 60% in P-Care. One of the efforts to ensure an accurate patient diagnosis is to conduct an audit of clinical information.

Objective: To conduct an audit of clinical information using morbidity rules to analyze accuracy of the primary diagnosis and the main diagnostic code. Knowing the difference in the level of accuracy of the main diagnosis code of medical record files and medical record electronic applications.

Methods: Quantitative analytic cross sectional. Population research is the top 10 cases in outpatients in Medical Record, SIMPUS, and P-Care at 18 primary health care. The total sample 30 medical record each primary health care. The sample collection with purposive sampling. Data collection with study documentation. Data analysis by mann withney test.

Results: Audit of clinical information from the main diagnosis selection resulted in the main diagnosis being correct by 74%, the most widely used morbidity rule was MB2, the highest accuracy was MB5. The audit of clinical information from the main diagnostic code resulted in the correct main diagnosis code in SIMPUS by 52%, the category of accuracy of the main diagnosis code was mostly in Category A. Sig value. < 0.05 on BRM versus SIMPUS, BRM versus P-Care, SIMPUS versus P-Care, and BRM versus ERM application.

Conclusion: Clinical information audit produce comparison accuracy level BRM $<$ SIMPUS. Accuracy level BRM $<$ P-Care. Accuracy level SIMPUS $<$ P-Care. Accuracy level BRM $<$ electronic medical record (SIMPUS and P-Care).

Keywords: Clinical informations audit, accuracy of main diagnose, rule of morbidity, accuracy of diagnose code, BRM, SIMPUS, P-Care