

ABSTRAK

Latar Belakang: Puskesmas Bambanglipuro Bantul berencana mengubah sistem penyimpanan dari *personal folder* menjadi *family folder* serta mengubah penomoran rekam medis dari penomoran individu menjadi penomoran keluarga. Perubahan tersebut berdasarkan Permenkes No. 39 Tahun 2016 tentang Pedoman Penyelenggaraan Program Indonesia Sehat dengan Pendekatan Keluarga (PIS-PK) berdasarkan data dan informasi dari Profil Kesehatan Keluarga berupa *family folder*. Namun Puskesmas Bambanglipuro Bantul belum memiliki standar operasional prosedur (SOP) penomoran dan penyimpanan rekam medis *family folder*. Sehingga diperlukan SOP penomoran dan penyimpanan rekam medis *family folder*.

Tujuan: Merancang SOP penomoran rekam medis dan SOP penyimpanan rekam medis *family folder* di Puskesmas Bambanglipuro Bantul.

Metode: Cara pengambilan data menggunakan wawancara, observasi, studi dokumentasi dan *focussed group discussion*. Alat yang digunakan adalah pedoman wawancara, *check list* observasi, *check list* studi dokumentasi, dan pedoman *focussed group discussion*. Perancangan SOP menggunakan *Microsoft Word* 2010.

Hasil: Format SOP menggunakan teori Ditjen Yankes (2017). Puskesmas membutuhkan mekanisme penomoran individu menjadi penomoran keluarga, sehingga dihasilkan SOP Penomoran Rekam Medis Pasien Baru dan SOP Penomoran Rekam Medis Pasien Lama. SOP Penyimpanan Rekam Medis disusun berdasarkan kebutuhan puskesmas dan teori terkait *family folder* dan *terminal digit filing*. Format penomoran rekam medis dan mekanisme perubahan dari *Straight Numerical Filing* menjadi *Terminal Digit Filing* dijelaskan dalam usulan pedoman penyelenggaraan rekam medis.

Kesimpulan: Telah dihasilkan SOP Penomoran Rekam Medis Pasien Baru, SOP Penomoran Rekam Medis Pasien Lama, dan SOP Penyimpanan Rekam Medis yang mengacu pada Ditjen Yankes (2017).

Kata Kunci: *Family folder*, Penomoran, Penyimpanan, Perancangan, SOP

ABSTRACT

Background: Puskesmas Bambanglipuro Bantul plans to change the storage system from personal folders to family folders and change the numbering of medical records from individual numbering to family numbering. These changes are based on Permenkes No. 39 of 2016 concerning PIS-PK based on data and information from the Family Health Profile in the form of a family folder. However, Puskesmas Bambanglipuro Bantul does not have a SOP for numbering and storing a family record medical record. So that the required SOP numbering and storage of medical records are family folders.

Objective: Designing Standard Operating Procedures (SOP) of numbering and storing medical records of family folders at Puskesmas Bambanglipuro Bantul.

Method: The way to retrieve data using interviews, observation, documentation studies and focussed group discussions. The tools used are interview guides, observation check lists, check list documentation studies, and guidelines for focussed group discussions. SOP design using Microsoft Word 2010.

Results: The SOP format uses the theory of Ditjen Yankes (2017). Puskesmas need an individual numbering mechanism to become a family numbering, so that the SOP Numbering of New Patient Medical Records and Old Patient is produced. The SOP for Medical Record Storage is compiled based on the needs of the health center and the theories related to family folders and TDF.

Conclusions: The New Patient Medical Records Numbering SOP, Old Patient Medical Record Numbering SOP, and Medical Record Storage SOP is produced referring to Ditjen Yankes (2017).

Keywords: Design, Family folder, numbering, storage, SOP