INTISARI

Latar Belakang: Pencatatan angka kematian baik di Rumah Sakit maupun di fasilitas pelayanan kesehatan lain sangat penting dilakukan. Pencatatan kematian belum tertata dalam sistem yang terpadu baik oleh Kementerian Kesehatan maupun oleh Kementerian Dalam Negeri sehingga dikembangkan Proyek Peningkatan Sistem Registrasi Kematian di 15 kabupaten/kota di Indonesia. Dalam pencatatan kematian, dokter dan petugas *coding* memiliki peranan penting dalam penentuan sebab kematian. Dokter berperan menuliskan diagnosis penyebab kematian di dalam formulir kematian, yang kemudian diagnosis tersebut menjadi acuan untuk penentuan sebab dasar kematian (*underlying cause of death*). Sedangkan petugas *coding* memiliki peran untuk menentukan kode *underlying cause of death (UCOD)* berdasarkan diagnosis yang dituliskan oleh dokter di dalam formulir kematian.
Tujuan: Mengetahui pelaksanaan pendokumentasian diagnosis penyebab kematian di RSUD dr. Soedirman Kebumen, mengetahui pelaksanaan pengodean diagnosis penyebab kematian di RSUD dr. Soedirman Kebumen, mengetahui kesesuaian penentuan kode *Underlying Cause of Death* (UCoD) di RSUD dr. Soedirman Kebumen dan mengetahui faktor-faktor yang menghambat pelaksanaan penentuan penyebab kematian serta upaya yang dilakukan.
Metode: Jenis penelitian yang digunakan adalah penelitian deskriptif dengan menggunakan pendekatan kualitatif serta dengan rancangan *cross-sectional*. Teknik pengumpulan data menggunakan teknik wawancara kepada 3 orang dokter dan 3 orang petugas *coding*, observasi dan studi dokumentasi.
Hasil: Pelaksanaan penentuan penyebab kematian belum sesuai dengan ketentuan karena masih mencantumkan kondisi seperti *symptoms* dan *mode of dying* serta proses pendokumentasian diagnosis kedalam formulir penyebab kematian belum sesuai dengan aturan yang ada di dalam ICD-10. Pelaksanaan penentuan diagnosis *underlying cause of death* belum sepenuhnya menerapkan aturan *rule* seleksi yang ada di dalam ICD-10. Penentuan UCOD seringkali didasarkan pada pemahaman masing-masing petugas dengan mempertimbangkan diagnosis yang tertulis di *resume* medis pasien. Persentase kesesuaian penentuan kode diagnosis penyebab dasar kematian (*underlying cause of death*) di RSUD dr. Soedirman Kebumen dari 166 sampel berkas rekam medis adalah sebesar 115 berkas atau 69,28%. Sedangkan ketidaksesuaian penentuan kode diagnosis penyebab dasar kematian adalah sebesar 51 berkas atau 30,72%. Faktor-faktor yang menghambat pelaksanaan penentuan penyebab kematian adalah berasal dari *man* dan *methode.*

Kata Kunci/Keyword: penyebab kematian, pendokumentasian penyebab kematian, kode penyebab dasar kematian.

ABSTRACT

Background: It is important to do the recording of mortality both in hospitals and other health care facilities. The Ministry of Health and the Ministry of Home Affairs has not arranged Registration of death in an integrated system, which is why The Project of Death Registration System Improvement is developed in 15 districts / cities in Indonesia. In the recording of death, doctor and coder has an important role in determining the cause of death. Doctor writes the diagnosis of the cause of death in the form of death, and the diagnosis becomes reference for underlying the cause of death. While coder has a role to determine the *underlying cause of death* code (UCOD) based on the diagnosis written by the doctor in the form of death.

Objective:Knowing the implementation of the cause of death diagnosis documentation at RSUD dr. Sudirman Kebumen, knowing the implementation of causes of death diagnosis coding at RSUD dr. Sudirman Kebumen, knowing the suitability of code determination of the *underlying cause of death* (UCOD) at RSUD dr. Sudirman Kebumen, and knowing the factors that hinder the implementation of the cause of death determination as well as the efforts made.

Method: The type of the research is descriptive study by using qualitative approach and the cross-sectional design. Data collection techniques were interviews with 3 doctors and 3 coders, observation and documentation.

Results: Implementation of the cause of death determination has not been in accordance with the provisions because not only they are still includes conditions such as *symptoms* and *modes of dying* but also the process of diagnosis documentation of form into the cause of death has not been in accordance with the existing rules in the ICD-10. Implementation of the underlying cause of death diagnosis determination is not fully implementing the rule of selection rules that exist in the ICD-10 yet. The determination of UCOD often based on the understanding of each officer to consider a diagnosis that is written in the patient's medical resume. The percentage of suitability in basic cause of death code diagnosis determination (underlying cause of death) at RSUD dr. Sudirman Kebumen of 166 medical record sample file is 115 files or 69.28%. While the discrepancy of the basic cause of death code diagnosis determination is by 51 file or 30.72%. The factors that hinder the implementation of the cause of death determination are derived from man and method.

Keyword: cause of death, cause of death documentation, the basic cause of death code.