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Program Pascasarjana
Program Magister Ilmu Kesehatan Masyarakat
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ABSTRAK

Muh. Erwin Rosyadi Suatrimin

Pengembangan Ssistem Informasi Rekam Medis untuk Mendukung Evaluasi Data Morbiditas Pasien Rawat Inap di Bagian Rekam Medis RS ”Ibnu Sina” YW-UMI Makassar
xiii +142 halaman + 22 tabel + 49 gambar + 14 lampiran

Bagian rekam medis RS ”Ibnu Sina” YW-UMI Makassar saat ini telah di fasilitasi dengan sistem informasi rekam medis yang meliputi input, proses serta output yang tentunya diharapkan dapat mengefisienkan tugas pokok dan fungsi (tupoksi) di bagian rekam medis. Sistem informasi rekam medis diharapkan dapat memenuhi kebutuhan pelaporan baik berupa laporan internal maupun berupa laporan eksternal RS.

Berdasarkan studi pendahuluan yang dilakukan dalam rangka pengembangan sistem informasi rekam medis RS yang berjalan masih terdapat beberapa permasalahan pada kelengkapan penginputan data, keakuratan, ketepatan waktu proses penyajian laporan, aksesibilitas, serta kesesuaian dengan kebutuhan evaluasi data morbiditas pasien rawat inap. Tujuan pengembangan sistem yaitu menghasilkan sistem informasii rekam medis untuk mendukung evaluasi data morbiditas pasien rawat inap di bagian rekam medis RS

Pengembangan sistem informasi dilakukan berdasarkan tahapan kerja FAST (*Framework for the Application of System Techniques*). Subyek penelitian terdiri 8 responden. Variabel penelitian meliputi kelengkapan, keakuratan, ketepatan waktu, aksesibilitas dan kesesuaian. Hasil observasi dan wawancara dilakukan dengan metode analisis isi. Hasil analisis deskriptik yang dilakukan diketahui bahwa tidak ada perbedaan kelengkapan baik sebelum dan setelah pengembangan, dengan jawaban Ya (8=100%), ada perbedaan keakuratan sebelum pengembangan yang menjawab Tidak (8=0%) dan setelah pengembangan yang menjawab Ya(8=100%), ada perbedaan ketepatan waktu proses pelaporan yang menjawab Tidak (8=0%) dan setelah pengembangan yang menjawab Ya (8=100%), tidak ada perbedaan aksesibilitas berupa kegiatan input dan edit sebelum yang menjawab Ya (8=100%) dan setelah pengembangan yang menjawab Ya (8=100%) namun ada perbedaan aksesibilitas pelaporan baik sebelum dengan jawaban Tidak (8=0%) dan setelah pengembangan (8=100%) serta ada perbedaan kesesuaian baik sebelum dengan jawaban Tidak (8=0%) dan setelah pengembangan jawaban Ya (8=100%).

Pengembangan sistem informasi rekam medis dapat mendukung evaluasi data morbiditas pasien rawat inap di bagian rekam medis RS berupa laporan RL2a, laporan RL2a1, registrasi pasien, kunjungan rawat inap, diagnosa pasien, laporan jenis pembiayaan, pelayanan rawat inap dan laporan kelompok 10 besar penyakit

Perlu mengevaluasi kembali struktur DBMS yang digunakan serta melakukan pengembangan sistem untuk pengolahan data morbiditas pasien rawat jalan di bagian rekam medis RS

Kata Kunci : Sistem Informasi, Rekam Medis, Evaluasi Data Morbiditas
Kepustakaan : 28 buah (1997-2010)

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ABSTRACT

Muh. Erwin Rosyadi Suatrimin

Development of Medical Record Information System to Support Evaluation on Inpatients Morbidity Data at Medical Record Unit of Ibnu Sina Hospital of YW-UMI Makassar

xiii +142 pages + 22 tables + 49 figures + 14 enclosures

Medical record unit of Ibnu Sina hospital of YW-UMI Makassar had been equipped with medical record information system. It included input, process and output and it was expected to make the implementation of main tasks and functions (tupoksi) more efficient. Medical record information system was expected to be able to fulfill the need for reporting in the form of hospital internal reports or external reports.

Based on the preliminary study done in developing the existing hospital medical record information system there were several problems found in the data entry completeness, accuracy, time precision in processing report presentation, accessibility and suitability with the need of inpatient morbidity data evaluation. The purpose of system development was to build medical information system to support evaluation on inpatient morbidity data in the hospital medical record unit.

The development of information system was done based on Framework for the Application of System Techniques (FAST) working steps. Study subjects consisted of 8 respondents. Study variables were completeness, accuracy, time precision, accessibility and suitability. Content analysis was done in analysing the results of observations and interviews. Results of descriptive analysis: There was no difference in the completeness before and after the development with 8 respondents answering yes (100%), there was an accuracy difference before the development with 8 respondents answering no (100%) and after the development with 8 respondents answering yes (100%), there was a difference in time precision of reporting process with 8 respondents answering no (100%) before the development and 8 respondents answering yes (100%) after the development, no difference in accessibility on the input activities and editing before the development with 8 respondents answering yes (100%) and 8 respondents answering yes (100%) after the development but there was a difference in the good report accessibility before the development with 8 respondents answering no (0%) and 8 respondents answering yes after the development (100%), and there was a difference on good suitability before the development with 8 respondents answering no (0%) and 8 respondents answering yes (100%) after the development.

The development of medical record information system is able to support inpatient morbidity data evaluation in the hospital medical record unit. It is in the form of RL2a report, RL2a1 report, patient registration, inpatient visit, patient diagnosis, type of expenditure report, inpatient service and the top ten disease pattern report.

It is important to re-evaluate DBMS structure used and to develop the system for analysing outpatient morbidity data in the hospital medical record unit.

Keywords : Information system, medical record, morbidity data evaluation
Bibliography : 28 (1997-2010)