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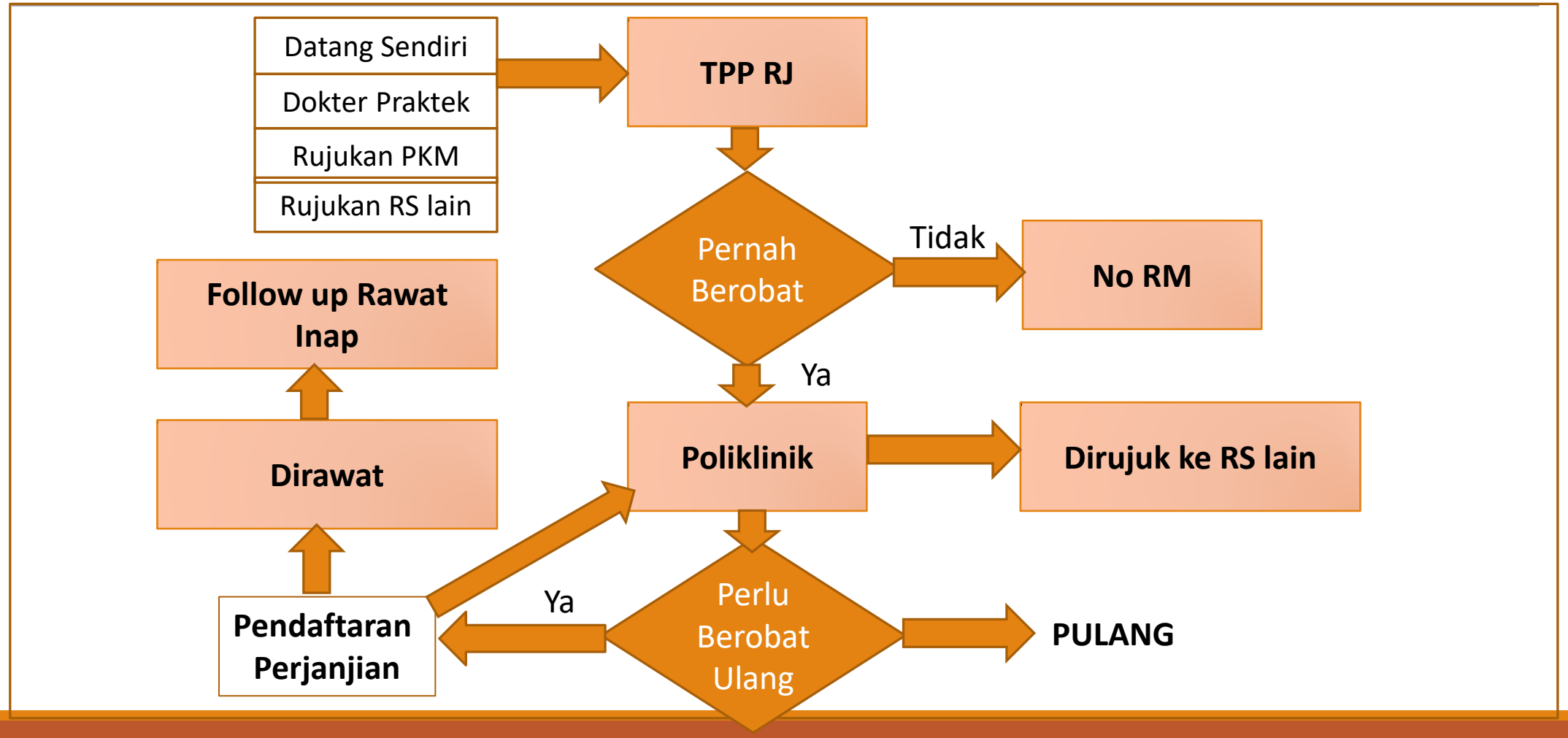

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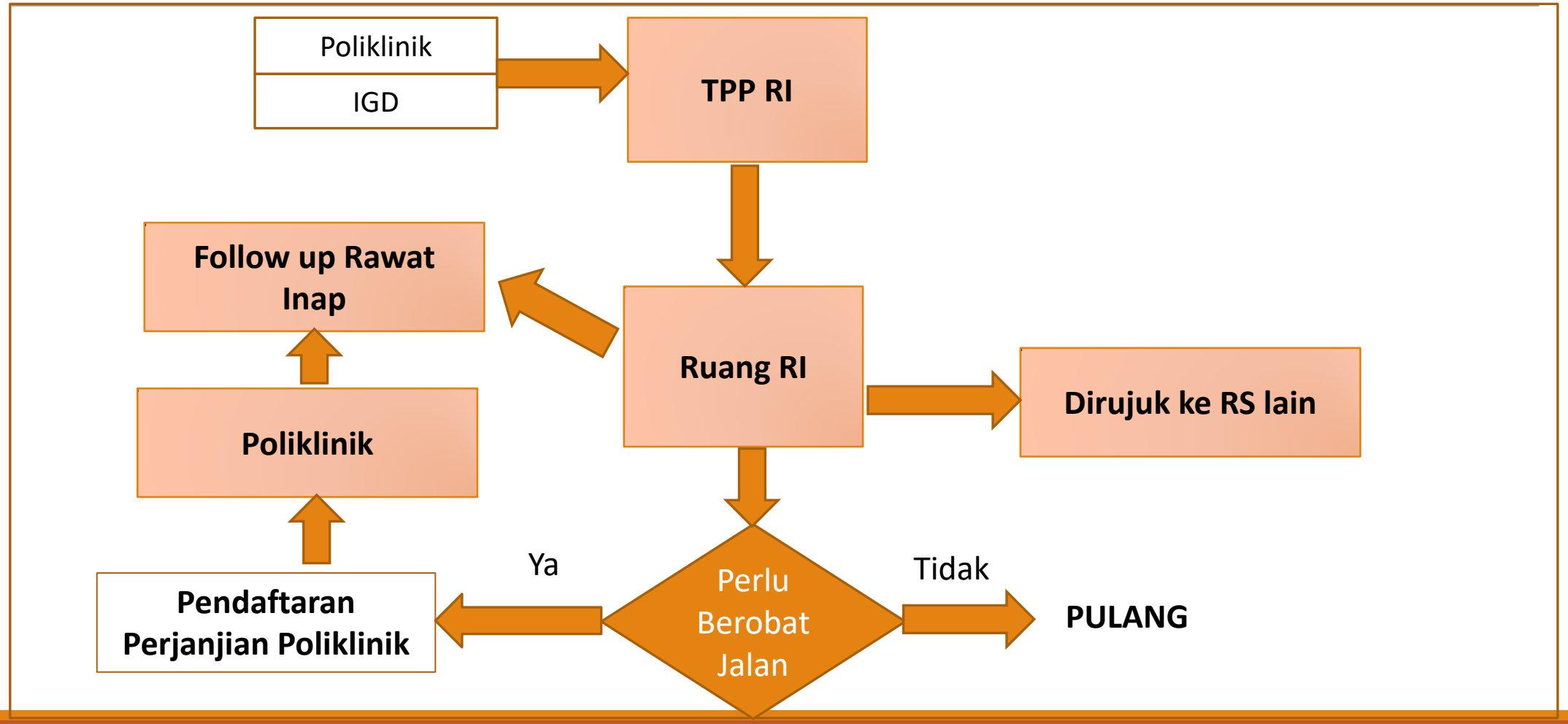

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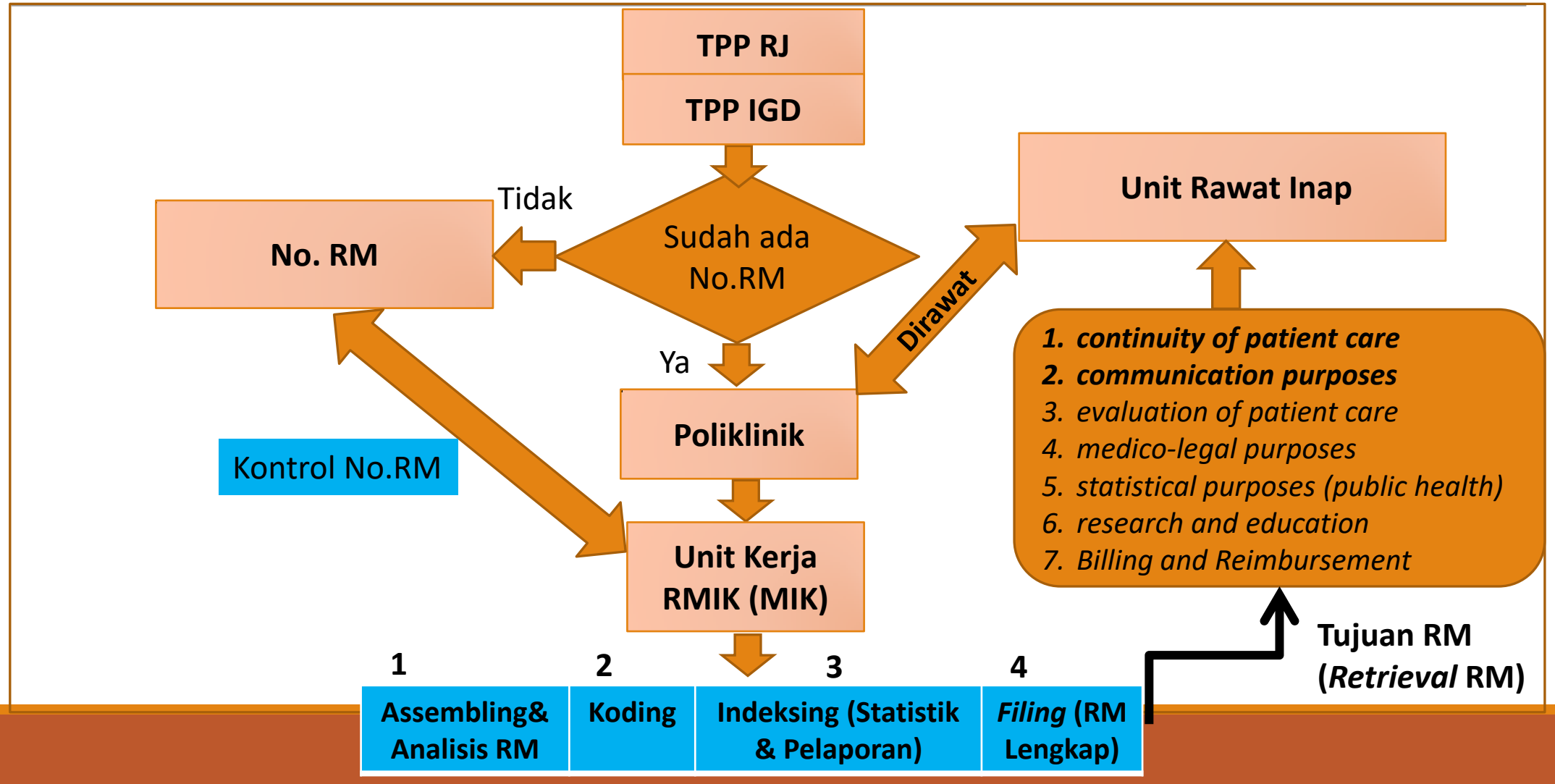

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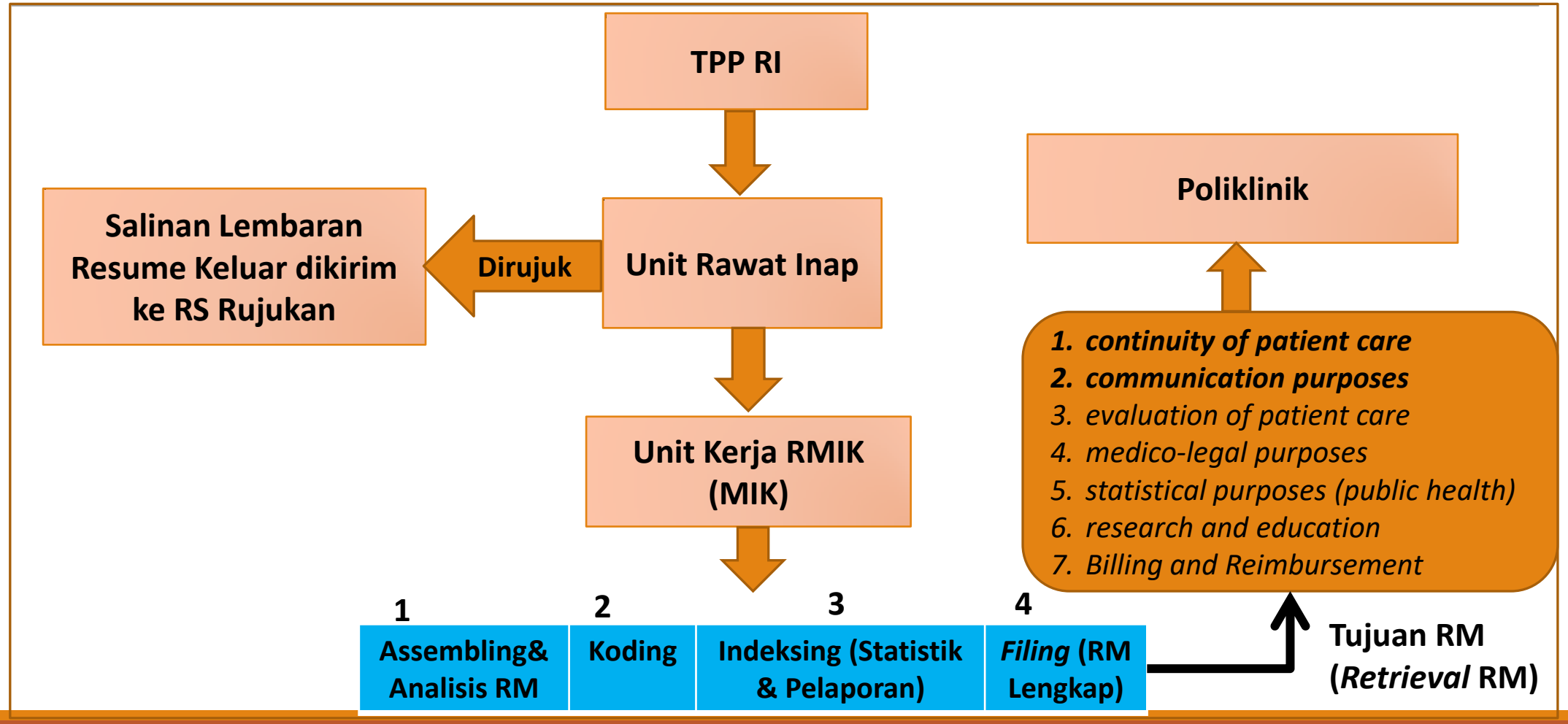

REKAM MEDIS ATAU REKAM KESEHATAN

The health record usually begins at :

- the registration counter of the clinic, or
- the admission office of the hospital, or
- the emergency room office

the first time a patient presents or is brought in for care/treatment or is seen for the first time

REKAM MEDIS ATAU REKAM KESEHATAN

- The collection of essential and accurate **identification information** is the first step in the development of the medical record
- The essential identification data includes the patient's:
  1. **full name (family name, given, and middle name or initial)**
  2. **health record or hospital file number**
  3. **date of birth**
  4. **address**
  5. **gender**

REKAM MEDIS ATAU REKAM KESEHATAN

If the patient is being admitted to hospital, **the provisional or admitting diagnosis must also be included at this time, that is, the reason the patient is being admitted for care/treatment should be recorded on the front sheet of the health record**.

The patient is then sent, with the health record, to the clinic, emergency room or unit, whichever is applicable.

In the clinic - the nurses and doctors record the information collected at this time onto the forms provided, remembering to write the **name and hospital file number** on the top of every new form used. The person who provides the service should sign each entry.

In the emergency room - the same procedure as for clinic.

REKAM MEDIS ATAU REKAM KESEHATAN

In the unit (Rawat Inap) - the nurse adds data relating to nursing care plan and doctors record their notes on a patient's:

1. **past medical history**
2. **family medical history**
3. **history of present illness**
4. **physical examination**
5. **plan for treatment and**
6. **requests for laboratory/X-ray tests.**

The doctor continues to record, on a daily basis, writing notes on the patient's progress, medical findings, treatment (including prescriptions for medication), test results, and the general condition of the patient.

Nurses record all observations, medications administered, treatment and other services rendered by them to the patient.

Other health professionals record their findings and treatment as required during the patient's hospitalization.

REKAM MEDIS ATAU REKAM KESEHATAN

At discharge - when the patient is **discharged**, **the doctor records**,

- at the end of the progress notes,
- the condition of the patient at discharge,
- the prognosis,
- treatment and whether the patient has to return for follow up.

In addition, **the doctor should also write a discharge summary**, and write, on the front sheet of the record,

- the principal diagnosis,
- other diagnoses and
- operative procedures performed, and
- sign the front sheet to indicate responsibility for the information recorded under his signature

TUJUAN DOKUMEN RM/RK (lihat hlm 26)

Purpose and Value of Documentation

Federal and state statutes, licensing requirements, and accreditation standards provide minimum guidelines to ensure accurate and complete documentation. Such documentation facilitates effective communication among caregivers to provide continuity of patient care.

The **health record** is the document healthcare providers use to collect and store clinical data for individual patients. In the context of the overall healthcare delivery system, health records serve several important purposes, including the following:

- Ensuring continuity of patient care among providers and along the continuum of care
- Providing a means for evaluating outcomes, quality, and peer review
- Providing documentation to substantiate reimbursement, claim submissions, and medical necessity of care
- Protecting the legal interests of customers, caregivers, and healthcare organizations
- Providing clinical data for biomedical research
- Supporting professional education and training for physicians, nurses, and allied health professionals
- Supporting operational management of healthcare organizations
- Providing health-services data for public health planning and governmental policymaking

PENGGUNA RM/RK: Individu (lihat hlm 29)

FIGURE 2.1. Representative users of the health record: Individuals*

Patient Care Delivery—Providers

- Physicians
- Residents
- Nurse practitioners
- Dental hygienists
- Dentists
- Dietitians
- Laboratory technologists
- Chaplains
- Nurses
- Pharmacists
- Physical therapists
- Behavioral health providers
- Social workers

Patient Care Delivery—Consumers

- Patients
- Families
- Patients' legal representatives

Providers of Patient Care Management and Support

- Health information management professionals
- Administrators
- Financial managers and accountants
- Quality managers
- Allied health professionals
- Risk managers
- Unit clerks
- Utilization review managers

Patient Care Reimbursement

- Benefit managers
- Insurers (federal, state, and private)

Other

- Accreditors
- Government policy makers and legislators
- Lawyers
- Healthcare researchers and clinical investigators

*This is a representative (not exhaustive) list of users

PENGGUNA RM/RK: Institusi (lihat hlm 30)

FIGURE 2.2. Representative users of the health record: Institutions*

Healthcare Delivery (Inpatient and Outpatient)

- Alliances, associations, networks, and systems of providers
- Ambulatory surgery centers
- Donor banks (blood, tissue, organs)
- Health maintenance organizations
- Home care agencies
- Hospices
- Hospitals (general and specialty)
- Nursing homes
- Preferred provider organizations
- Physician offices (large and small group practices, individual practitioners)
- Psychiatric facilities
- Public health departments
- Substance abuse programs

Management and Review of Care

- Medicare peer review organizations
- Quality management companies
- Risk management companies
- Utilization review and utilization management companies

Reimbursement of Care

- Business healthcare coalitions
- Employers
- Insurers (federal, state, and private)

CLINICAL CREDENTIAL OF HEALTHCARE PROFESSIONALS WHO WRITE HEALTH RECORD DOCUMENTATION (hlm. 213)

TABLE 5.3. Clinical credentials of healthcare professionals who write health record documentation

Credential	Abbreviation	Health Record Documentation
Registered nurse	RN	Nursing assessments, progress notes, medication records, vital signs, care plans, transfer records, flowcharts
Licensed practical nurse or licensed vocational nurse	LPN or LVN	Nursing assessments, progress notes, medication records, vital signs, transfer records, flowcharts
Nurse-anesthetist	CRNA	Anesthesia records
Nurse-midwife	CRNM	Obstetrical records
Nurse-practitioner	NP	Records associated with specialized nursing practice (pediatric, geriatric, obstetric, and others)
Clinical social worker	LSW	Psychosocial assessments, progress notes
Respiratory therapist	CRT	Records of respiratory therapy, progress notes
Occupational therapist	OT	Records of occupational therapy, progress notes

ISI REKAM MEDIS DI INDONESIA

1. PMK 269/2008
2. Standar Akreditasi RS (KARS)
3. Hospital Bylaw