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Qualitative Analysis of the Completeness of Medical Resume Documentation at Dr. Harjono S Regional Public Hospital, Ponorogo Regency

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Abstract. *A medical resume is a summary of patient care that plays a vital role in administrative, clinical, legal, and hospital accreditation aspects. This document serves as a crucial component in ensuring service quality and acts as legal medical evidence. This study aims to analyze the completeness of medical resume documentation at Dr. Harjono S Regional Public Hospital and identify the contributing factors to incomplete documentation. This research employed a qualitative descriptive method with a cross-sectional approach. Data were collected through observation of 15 inpatient medical resume documents from two departments (Pediatrics and Orthopedics) and interviews with medical record officers. The research instrument included an observation checklist assessing seven documentation components. Results showed that supporting examination results were the most complete component (100%), while patient identity data had the lowest completeness (67%). Contributing factors to incompleteness included high workload, lack of supervision, and low awareness among staff regarding the importance of complete documentation. Moreover, the absence of an internal quality control system was also identified as a challenge. This study recommends enhancing training, conducting regular supervision, and implementing electronic medical record systems to improve documentation quality.*

Keywords: *Document Completeness; Healthcare Service; Medical Records; Medical Resume; Qualitative Analysis.*

1. INTRODUCTION

Medical resumes are critical components of a patient's medical record, summarizing their treatment journey. They include clinical data such as patient identity, diagnoses, examination results, procedures, and admission-discharge dates. Beyond clinical purposes, they also serve administrative, legal, accreditation, and health insurance functions.

Preliminary observations at Dr. Harjono S Hospital indicated incomplete medical resumes, particularly in patient identity and legal sections. Out of 15 documents examined, only 5 were complete. Issues included missing discharge diagnoses, physician signatures, and discharge dates. These issues reflect poor supervision, lack of staff understanding of resume importance, and inadequate implementation of SOPs. Incomplete documentation can delay insurance claims, affect clinical decisions, and lead to legal vulnerabilities. This study aims to analyze the level of completeness and identify contributing factors, forming a basis for improving documentation quality in the hospital.

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2. THEORETICAL REVIEW

A medical resume is a concise report of services provided to a patient during hospitalization, containing clinical data like patient identity, diagnoses, examinations, procedures, and treatment timelines. It serves as a communication tool among healthcare providers, legal documentation, and accreditation material (Huffman, 1994).

According to Ministry of Health Regulation No. 24 of 2022, medical resumes must be complete and accurate, ensuring legal, objective, and integrated information. Sulistyowati (2019) states that factors affecting documentation completeness include medical staff workload, understanding of SOPs, time availability, and awareness of medical records as legal documents. Technical challenges such as limited recording facilities, shift variations, and inadequate supervision also play roles.

Previous studies (Sari, 2021; Rahman, 2022) reported that lack of supervision and low compliance contributed to documentation incompleteness. Swari et al. (2019) emphasized the importance of regular training and evaluation in improving record completeness.

3. RESEARCH METHOD

This study used a descriptive qualitative method with a cross-sectional approach. Data were collected through observations of 15 medical resumes and interviews with six informants (medical record officers, doctors, a nurse, and the head of the medical record unit). Stratified sampling was applied, and data were analyzed using content analysis to identify patterns and causative factors.

4. RESEARCH RESULTS

Factors Contributing to Incomplete Documentation

Based on interviews with six informants—consisting of two medical record officers, two doctors, one nurse, and the head of the medical records unit—this study identified several key factors contributing to the incompleteness of medical resume documentation at Dr. Harjono S Regional Public Hospital, Ponorogo Regency. One of the main contributing factors is the high workload faced by physicians in charge of patient care (DPJP), particularly those serving in outpatient and inpatient settings with a high volume of patients. The busy schedules and clinical demands often prevent doctors from having sufficient time to complete the medical resumes accurately and in a timely manner. As a result, documentation is frequently rushed, delayed, or missing important components, such as discharge diagnoses or physician

signatures. This condition is exacerbated by the lack of supervision and the absence of a structured internal quality control system within the hospital.

Another factor is the lack of proper socialization and understanding of the standard operating procedures (SOPs) related to medical resume documentation. Many medical personnel, especially newly assigned doctors, do not receive adequate orientation or technical guidance on how to complete medical resumes according to the established standards. This lack of knowledge leads to inconsistencies and variations in documentation practices, which ultimately affects the overall quality of the medical records. Furthermore, awareness among healthcare workers regarding the importance of documentation is still relatively low. Medical resumes are often perceived merely as administrative obligations, rather than as critical legal, clinical, and managerial tools for ensuring the quality of healthcare services and protecting both the institution and medical staff from legal risks. This mindset results in documentation being treated as a secondary task. These findings indicate that the incompleteness of medical resume documentation is not solely due to individual negligence, but rather stems from systemic issues involving human resources, organizational culture, and the hospital's management system. Therefore, improving documentation practices requires not only technical interventions such as training and supervision, but also behavioral and cultural changes that emphasize the significance of accurate and complete medical records in delivering quality healthcare.

Medical Resume Component Completeness

Based on observations of 15 documents from Pediatrics and Orthopedics clinics, completeness was measured across seven components::

T able 1. Completeness Level of Medical Resume Components.

No	Component	Complete	% Complete	Incomplete	% Incomplete
1.	Patient Identity	10	67%	5	33%
2.	Admission & Discharge Diagnoses	14	93%	1	7%
3.	Procedures	14	93%	1	7%
4.	Supporting Examinations	15	100%	0	7%
5.	Admission & Discharge Dates	14	93%	1	0%
6.	Physician Name, Signature, Date	14	93%	1	7%
7.	Consistency Across Forms	13	87%	2	13%

Based on the table above, the completeness of each component is described as follows:

Patient Identity

Out of the 15 documents reviewed, only 10 medical resumes contained complete patient identity information. This component includes the patient's name, date of birth, address, gender, marital status, and identification number. The completeness percentage for this component was 67%, making it the lowest among all components. This deficiency indicates that the entry of administrative data has not yet become a primary focus in the medical documentation process.

Admission and Discharge Diagnoses

Diagnosis information is crucial as it describes the patient's condition upon admission and discharge. A total of 14 out of 15 documents listed both admission and discharge diagnoses completely, with a completeness rate of 93%. One document failed to include the discharge diagnosis, which may lead to ambiguity regarding the patient's final medical condition.

Medical Procedures/Interventions

This component covers the medical procedures administered during the patient's treatment. Observation results showed that 14 documents (93%) recorded the procedures completely, while 1 document did not include this information. The absence of procedural data can hinder medical service evaluations and claims administration processes.

Supporting Examination Results

All 15 documents (100%) included complete supporting examination results. This demonstrates that the ancillary services, such as laboratory and radiology departments, have been functioning according to standard procedures and are well-documented within the medical resume.

Admission and Discharge Dates

This component provides information on the duration of patient care. Fourteen documents recorded the admission and discharge dates completely (93%), while one document did not list the discharge date, which compromises the administrative clarity of the document.

Attending Physician's Name and Signature (DPJP)

The name and signature of the attending physician serve as proof of the document's legality and authorization. Fourteen documents included this information completely (93%), while one document lacked either the name or signature, potentially reducing the document's validity.

Consistency Between Forms

Consistency between forms refers to the alignment of content between medical resume forms RM.RI 01 and RM.RI 02. Based on the analysis, 13 documents (87%) were consistent, while 2 documents contained inconsistencies, such as differing diagnoses or procedures listed across the forms.

Discussion

Contributing Factors

This study demonstrates that the incompleteness of medical resume documentation is not solely due to individual negligence but rather a combination of various systemic factors. Attending physicians (DPJP) face a high workload, particularly in outpatient and inpatient services with a large number of patients. This situation often results in the medical documentation process being rushed or delayed, which affects the completeness of the records. This condition is supported by the theory proposed by Sulistyowati (2019), who stated that a heavy workload negatively impacts compliance and the quality of medical documentation. When time is limited and greater priority is given to clinical procedures, documentation often becomes a neglected aspect.

In addition, a lack of understanding of Standard Operating Procedures (SOPs) also contributes significantly. New doctors and staff members often do not receive proper orientation or training on how to correctly fill out medical resumes. This leads to variations and inconsistencies in documentation across different personnel. The study by Swari et al. (2019) also concluded that training and understanding of SOPs have a strong correlation with the quality of documentation. Another contributing factor is the weakness of supervision and the absence of evaluation systems or checklists, which results in incomplete documents being archived. This indicates a lack of internal quality culture within the hospital, particularly in the unit responsible for managing medical records. Finally, awareness regarding the importance of medical resumes as legal and clinical documents remains low. These documents are often perceived merely as administrative requirements rather than as an integral part of comprehensive healthcare services.

Level of Completeness in Medical Resume Documentation

This study was conducted to assess the level of completeness in medical resume documentation across 15 patient records from the Pediatric and Orthopedic clinics at Dr. Harjono S Regional Public Hospital, Ponorogo Regency. Observation results showed that only 5 documents (33%) were fully completed in all components. This indicates that the majority of medical resume documents still do not meet the established standards of completeness.

From the analysis, it was found that the component with the highest level of completeness was the supporting examination results, which reached 100%. This demonstrates that laboratory and radiology data have been well integrated and properly documented. On the other hand, the component with the lowest completeness was patient identity, with only 67%. Some documents were found to be missing information such as address, occupation, marital status, or patient identification number. Completeness levels for diagnosis, medical procedures, admission and discharge dates, as well as the attending physician's signature, each reached 93%. This suggests that although most documents were relatively well-filled, there were still instances of negligence in completing several critical components. Meanwhile, consistency between medical resume forms RM.RI 01 and RM.RI 02 reached only 87%, indicating discrepancies in information across different sections of the resume.

These findings reflect that medical resume documentation at Dr. Harjono S Hospital has not yet fully complied with Ministry of Health Regulation No. 24 of 2022 on Medical Records, which mandates complete data entry prior to document archiving. While technical aspects such as supporting examinations are well-documented, administrative components and final verification prior to storage still require improvement. This study aligns with research by Sari (2021) and Rahman (2022), which reported that many hospitals have yet to implement comprehensive document validation or checklist systems. Therefore, it is essential for Dr. Harjono S Hospital to strengthen its internal monitoring system and conduct regular training for medical personnel to enhance the quality of medical resume documentation.

5. CONCLUSION AND RECOMMENDATIONS

Based on the research findings and discussions presented, it can be concluded that the completeness of medical resume documentation at Dr. Harjono S Regional Public Hospital, Ponorogo Regency, is not yet fully optimal. The component with the highest level of completeness was the supporting examination results (100%), while patient identity had the lowest completeness rate (67%). Inconsistencies and deficiencies were also found in the diagnosis, medical procedures, physician legal authorization (DPJP), and cross-form consistency. The factors contributing to these deficiencies include high workload, lack of training and SOP socialization, and low staff awareness regarding the importance of medical documentation. These issues are not only technical in nature but also managerial and behavioral.

To improve the completeness of medical resume documentation, it is recommended that the hospital conduct regular training and periodic evaluations for healthcare staff regarding the importance of medical documentation. Furthermore, a consistent internal monitoring system and a completeness checklist should be implemented before archiving documents. The adoption of an electronic medical record system also serves as a strategic solution to ensure the accuracy and completeness of medical resume documentation.

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