EVALUATION OF DOCUMENTATION SEQUENCE CAUSES PERINATAL

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ABSTRACT

The Underlying cause of death is an event or condition without which the patient would not have died. The aim of the research is to determine the accuracy of writing the sequence of causes of perinatal death based on mortality rules

The research method used in this research is descriptive research, with a retrospective approach. Data collection using observation and interviews. The research population was 50 medical record documents of patients who died perinatally in 2018-2022 using a saturated sampling technique.

The percentage of accuracy in writing the sequence of perinatal deaths at PKU Muhammadiyah Hospital Surakarta shows 100% inaccurate. The writing inaccuracy is due to the writing not being in accordance with the existing standart Operating Procedure, the order of perinatal death is still written on the medical certificate for the cause of adult death.

The accuracy of writing the order of perinatal deaths is still relatively low. It would be better if the hospital further increases its outreach activities so that medical personnel can write the order of death on the certificate correctly in accordance with the rules or standards that apply in the hospital.

KEYWORDS *Accuracy Code, Perinatal Rules, Perinatal Deaths*

INTRODUCTION

Perinatal mortality is an indicator in assessing the success of health services and health development. In 2000, more than 6,300,000 perinatal deaths occurred worldwide, 73% of these perinatal deaths occurred in developing countries. Of this number, 3,000,000

deaths occurred in the early neonatal period and 3,300,000 deaths were stillbirths (WHO, 2006:5). The maternal mortality rate (MMR) and infant mortality rate (IMR) in Indonesia, especially the perinatal mortality rate, are still quite high, therefore efforts are needed to improve the quality of obstetric services, especially in referral health service facilities. Improving the quality of obstetric services includes maternal and perinatal services which must be carried out by following developments in science and technology, especially in the health sector. (Minister of Health of the Republic of Indonesia, 2008)

In determining the code for the cause of death of a patient, especially in perinatal deaths, a medical recorder is guided by the MMDS which contains items regarding the cause of death or Underlying Cause of Death. Underlying Cause of Death is the cause of death as all diseases, illnesses or injuries that cause or contribute to death if not suffered by the patient. Recording the causes of perinatal death in a country provides input for decision makers in determining important health policies and programs to determine one cause of death for coding and reporting purposes. Information regarding the basic causes of death is very useful as a basis for developing primary preventive programs, so that it can improve the public health status (Health Research and Development Agency, 2006)

Based on research conducted by Rosmala (2018) at RSUD K.R.M.T. Wongsonegoro Semarang 2017". The results of this research showed that 10 samples of perinatal death certificates did not have a special form for perinatal death certificates so that 100% of perinatal death certificates did not include a code. The format of perinatal death certificates in hospitals does not match those in ICD 10. Filling out perinatal death certificates by doctors and determining the cause code for perinatal death in hospitals does not match those in ICD 10. Research conducted by Ardhi (2022) shows that the results research on the accuracy of diagnosis codes

Based on ICD-10, in cases of patients who died at Panti Waluyo Hospital in 2019-2021, the number of inaccuracies was 20 documents with a percentage of 23.52%. Based on research conducted by Rahmawati and Lestari (2018) at RSUP dr. Soeradji Tirtonegoro Klaten showed that the patient's death certificate was 100% complete. Meanwhile, the accuracy of determining the basic cause of death code on the death certificate is based on the MMDS table at RSUP dr. Soeradji Tirtonegoro Klaten is 90% inaccurate and 10% accurate. Based on the journals that the researchers reviewed, it is explained that the core problems that are often found in the inaccuracy of codifying the basic causes of death are starting from the absence of a special form for perinatal death certificates, the format of perinatal death certificates in hospitals not matching those in ICD 10, Completing Perinatal Death Certificates. by the doctor and the determination of the code for the cause of perinatal death in the hospital does not match that in ICD 10 and there is also no description or failure to carry out duties in accordance with the SPO that has been issued by the hospital.

Based on the results of a preliminary survey conducted by the author at the PKU Muhammadiyah Surakarta Hospital which is located at Jl Yosodipuro No. 59, Timuran, Banjarsari District, Surakarta City, Central Java. The Preliminary Survey begins by opening the medical records of patients who died in perinatal cases. Researchers took 10 medical record documents from patients who died in perinatal cases to be used as samples

The Purpose of this research are Know the procedure for writing the order of causes of perinatal death, the percentage of accuracy and inaccuracy in writing the order of causes of perinatal death based on mortality rules and factors causing inaccurate writing of the sequence of perinatal death events at the PKU Muhammadiyah Hospital in Surakarta

RESEARCH METHOD

The research method used in this research is descriptive research, with a retrospective approach. Data collection using observation and interviews. The research population was 50 medical record documents of patients who died perinatally in 2018-2022 using a saturated sampling technique. Data processing with editing, tabulation, classification, data presentation.

RESULT AND DISCUSSION

Documentation the Sequence of Causes of Perinatal Death Based on Mortality Rules at PKU Muhammadiyah Hospital Surakarta

The death certificate contains a series of events that led to death. The written diagnosis must be complete and consistent to make it easier for the coder to code the diagnosis of the basic cause of death. The basic causes of death are the causes of death as all diseases, illnesses or injuries that cause or contribute to death (Hatta, 2013). Based on the results of observations and interviews at the PKU Muhammadiyah Surakarta Hospital, there is a procedure for writing the order of causes of death, however for writing the order of causes of perinatal death at the PKU Muhammadiyah Surakarta Hospital the writing is not in accordance with the existing Standart Operating Procedure. The implementation of Standart Operating Procedure. needs to be monitored to serve as evaluation material for decision making. This is supported by the opinion of Kusumastuti (2014: 10) that the implementation of SOPs can be monitored internally and externally and Standart Operating Procedure can be evaluated periodically at least once a year with evaluation material covering aspects of efficiency and effectiveness in using Standart Operating Procedure. Errors in writing sequences and procedures medical care will have an impact on coding and also on the perinatal death reporting system.

Percentage of Accuracy and Inaccuracy in Writing the Sequence of Causes of Perinatal Death Based on Mortality Rules at PKU Muhammadiyah Hospital Surakarta

Accuracy is the accuracy of assigning disease codes based on the diagnosis and action given by a doctor or nurse using medical terminology based on ICD-10 and ICD-9 CM (Ministry of Health of the Republic of Indonesia, 2006). Criteria for the accuracy of the diagnosis can be seen from the course of the disease, history and physical examination carried out by the doctor.

Based on the results of research on the accuracy and inaccuracy of writing the sequence of causes of perinatal death in 2018-2022, the medical record documents examined by researchers were 50 documents. This inaccuracy was due to the writing on aspects of the document that were not appropriate, doctors still wrote down the sequence of perinatal causes of death in the medical certificate for adult causes of death and it was found that several doctors had not filled in the order of diagnosis of the basic causes of death in accordance with ICD-10. This is not in line with the theory of Sarimawar and Suhardi (2008). Health officers or certificate makers must record the sequence of disease events leading to death and the original cause of that sequence.

The inaccuracy in writing the sequence of causes of perinatal death at the PKU Muhammadiyah Surakarta Hospital is still relatively high, for this reason it is necessary to carry out an evaluation by the PKU Muhammadiyah Surakarta Hospital and immediately realize the socialization that has been carried out. In order to provide the provision of health services and the ability to measure the results of clinical and financial examinations

appropriately which can be used as information needed to improve service quality, strategic planning, output analysis, research, statistical and financial analysis as well as in the decision making process (Nuryati and Hidayat, 2014).

The order of writing diagnoses that is in accordance with ICD-10 rules will make it easier for coding parties to code and determine accurate basic cause of death codes. This is supported by the theory of Nuryati and Hidayat (2014). If the diagnosis of the basic cause of death has been determined by a doctor and is in accordance with the rules for determining the diagnosis of the cause of death in ICD-10, then the cause of death coding staff will also correctly code the diagnosis of the basic cause of death.

Factors Associated with Inaccuracy in Writing the Sequence of Causes of Perinatal Death at PKU Muhammadiyah Hospital, Surakarta.

Factors that cause inaccuracies in writing the sequence of causes of perinatal death can be seen through management elements, According to Emerson in Arifin (2012), management has five elements (5M), namely Man, Money, Material, Machine, Method. Based on this management theory, the inaccuracy in writing the sequence of causes of perinatal death is influenced by Man, Machine and Method.

(1) Medical Personnel (Doctor) Factor. Medical personnel, especially doctors, are the determiners of the diagnosis who have the rights and responsibilities in determining the diagnosis. In writing the sequence of causes of death, the DPJP doctor (Patient Responsible Doctor) has the right to write the sequence of events that caused the death. There are several doctors who have not written a diagnosis according to the order of causes of death according to ICD 10. This is not in line with the theory of the Indonesian Ministry of Health (2006:59) Determining a patient's diagnosis is the obligation, right and responsibility of the doctor (medical personnel) involved, not can be changed. Therefore, the diagnosis in the medical record is filled in completely and clearly in accordance with the directions in the ICD-10 book.
(2) Facilities related to implementing cause of death codes are not yet complete. At the Medical Records Installation of the Muhammadiyah Hospital in Surakarta, the MMDS table has not yet been implemented. The coding staff only codes the diagnosis written by the doctor without checking the causal relationship based on the MMDS table and has not applied the rules according to ICD-10.
(3) Not all doctors fill in the diagnosis leading to death. Filling in the diagnosis of the basic cause of death at PKU Muhammadiyah Surakarta Hospital is appropriate because the person who fills in the diagnosis is a doctor, but not all doctors have written down the diagnosis of the cause of death, or the order in writing the diagnosis of the cause of death is not in accordance with ICD-10

CONCLUSION

Based on the results of research conducted at the PKU Muhammadiyah Hospital in Surakarta, it can be concluded that:

(1) The implementation of writing the sequence of events causing perinatal deaths at the PKU Muhammadiyah Hospital in Surakarta already has Standard Operating Procedures, but writing the sequence of causes of perinatal deaths is still not implemented well.
(2) Accuracy and Inaccuracy in writing the sequence of causes of perinatal death in 2018-2022 for 50 medical record documents with 100% incorrect/inaccurate results.
(3) Inaccuracy in writing the sequence of causes of perinatal death is that the SOP for writing the cause of perinatal death has not been implemented, the order of writing the

diagnosis by medical personnel (doctors) is not in accordance with ICD-10 and also cultural factors from the past because cases of perinatal death are relatively small so writing is still not in accordance with aspects of the document.

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