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Article

Completeness of Medical Records Documents with Diagnosis of Bronchial Asthma in Outpatients at Pondok Kopi Islamic Hospital Jakarta

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Abstract: Completeness of medical record documents is the assessment or review of documents, and contents of medical records related to documentation, services and/or assessing the completeness of medical records. Medical records are written or recorded information or notes regarding identity, which contain 1). Notes, which include a description of the patient's identity, patient examination, diagnosis results, treatment, actions and other services carried out by doctors, dentists or other health workers according to their competence; 2). Documents, which are complete records, include x-ray photos, laboratory results and other information by scientific competence. Types of medical records consist of conventional medical records; and electronics. Medical Records can be stored alphabetically and numerically. The record management process is carried out by Medical Records officers at the Hospital at RSIJ Pondok Kopi Jakarta starting from the stage of preparing the Medical Record document (Assembling), the Indexing process (list of illnesses, actions, doctors and deaths), Quantitative analysis of medical records (Analysing) and finally storage of medical records according to the applicable alignment system (Filling). The factors that influence incomplete medical records are: 1). HR; 2). Tools/Machines; 3). Method/Method; 3). Material; and 4) Finance/Money.

Keywords: Completeness of Medical Record Documents, Diagnosis of Bronchial Asthma, Outpatients, at Pondok Kopi Islamic Hospital, Jakarta

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1. Introduction

Completeness of medical record documents is the assessment or review of documents, the contents of medical records relating to documentation, services and assessing the completeness of medical records. A completeness analysis is a review of specific areas of the medical record to identify deficiencies.

When establishing a diagnosis, the type of disease is determined by examining (testing) the symptoms. In short, diagnosis can be interpreted as an examination of something experienced by the patient. In the world of health, there is a term called diagnosis. In general, this word is used by doctors to determine the type of disease that attacks the patient's body. (detik.com, 2024/06/07)

Asthma is a chronic respiratory disease that is most commonly found in children (GINA, 2022). Asthma is characterized by shortness of breath, wheezing, coughing, and impaired expiratory flow, which occurs due to chronic inflammation, airway hyperresponsiveness (bronchospasm), mucus hypersecretion, and airway remodelling (smooth muscle

hypertrophy and hyperplasia, angiogenesis, and fibrosis) that occurs in the disease. untreated chronic asthma (WHO, 2023). The onset of symptoms usually first appears in childhood or toddlerhood and can continue into adulthood (GINA, 2022).

Asthma is a health problem throughout the world, both in developed and developing countries. Currently, asthma is no longer unknown in society. Asthma can be suffered by all levels of society from children to adults. Asthma was originally a genetic disease that was passed down from parents to their children. However, recently genetics has not been the main cause of asthma. Air pollution and lack of environmental cleanliness in big cities are the dominant factors in increasing asthma attacks (PDPI, 2019).

2. LITERATURE REVIEW

Diagnosis is determining the nature of a disease or distinguishing one disease from another. Asthma generally has symptoms such as cough (with or without mucus), dyspnea, and wheezing.

Bronchial asthma is a chronic inflammatory disease of the airways caused by a hyperresponsive reaction of the body's immune cells such as mast cells, eosinophils and T-lymphocytes to certain stimuli and causes symptoms of dyspnea, wheezing and coughing due to airway obstruction which is reversible and occurs episodically.

Asthma is a chronic inflammatory disease (inflammation) of the airways that causes increased airway hyperresponsiveness which causes recurrent episodic symptoms in the form of wheezing (sighing in the breath), shortness of breath, heavy chest feeling, and coughing, especially in the early hours of the morning (Hetti R A, 2009). Bronchial asthma is a disorder in the form of chronic inflammation of the airways which causes hyperactivity of the bronchi to various stimuli characterized by recurrent episodic symptoms in the form of wheezing, coughing, shortness of breath and a feeling of heaviness in the chest, especially at night and/or early in the morning, which is generally reversible. with or without treatment. Asthma fluctuates (comes and goes), meaning it can be calm without symptoms and does not interfere with activities, but can be exacerbated with mild to severe symptoms and can even cause death (Nugroho.T, 2016).

Bronchial asthma is a chronic inflammatory disease of the airways caused by a hyperresponsive reaction of the body's immune cells such as mast cells, eosinophils and T-lymphocytes to certain stimuli and causes symptoms of dyspnea, wheezing and coughing due to airway obstruction which is reversible and occurs episodically. (Brunner and Suddarth, 2011). Bronchial asthma is a disease characterized by increased response of the trachea and bronchi to various stimuli with the manifestation of wide airway narrowing and the degree can change both spontaneously and as a result of treatment (Musliha, 2010). Bronchial asthma is a chronic inflammatory disorder of the respiratory tract, involving a complex interaction of inflammatory mediators, cells and tissues resulting in reduced airflow due to bronchoconstriction, edema, mucus secretion, and hyperresponsiveness (Irianto, K. 2014).

3. METHODS

The problem formulation in this research is to determine the completeness and accuracy of medical record documents for bronchial asthma in outpatients at Pondok Kopi Islamic Hospital, Jakarta.

The type of research used is quantitative observational analytic with a "cross sectional" research design.

4. RESULTS

This research uses secondary data obtained from the medical records unit staff at the Jakarta Islamic Hospital Pondok Kopi, then the medical record data is observed to see the completeness of medical information (anamnesis results, physical examination, supporting examinations, diagnosis and treatment) using a checklist sheet, and Does it match the diagnosis stated in the medical record with the coder's diagnosis code in the medical record?

5. DISCUSSION

Definition of Medical Records

Medical records are information or records, both written and recorded, regarding the patient's identity, condition and every action given, including the treatment received by the patient. In more depth, medical records have a broad meaning considering that all information about patients is reflected in medical records which are used as a basis for determining further actions in service efforts and other medical actions given to patients in health service facilities (Hendrik, 2013).

Fill in Medical Records

The contents of medical records are divided into six forms, namely medical records for outpatients, medical records for inpatients, medical records for emergency patients, medical records for disaster victims, medical records for the services of specialist doctors and specialist dentists and medical records for services provided during ambulance. (Rokhim, 2020).

There are several differences in the contents of medical records according to the type of patient. According to the Republic of Indonesia Minister of Health Regulation No.269/Menkes/Per/III/2008, the contents of medical records for inpatients and one-day treatment should contain at least several things, namely (Rokhim, 2020): (1). Patient identity; (2). Date and time; (3). Anamnesis results, including at least complaints and history of illness; (4). Results of physical examination and medical support; (5). Diagnosis; (6). Management plan; (7). Treatment and/or procedures; (8). Informed consent if necessary; (9). Records of clinical observations and treatment results; (10). Discharge summary; (11). Name and signature of the doctor, dentist, or certain health professional providing health services; (12). Other services provided by certain health workers; and (13). Dental case patients are equipped with a clinical odontogram.

Based on the medical record manual, the contents of the medical record contain (Indonesian Medical Council, 2006): (1). Notes, which contain a description of the patient's identity, patient examination, diagnosis results, treatment, actions and other services carried out by doctors and dentists or other health workers according to their competence;

(2). Documents, which are complete records, include x-ray photos, laboratory results and other information in accordance with scientific competence.

Types of Medical Records

a. Conventional Medical Records

Conventional Medical Records are defined as a collection of data containing patient records including patient identity, history, physical and supporting examinations, diagnoses written manually and in a structured manner describing all the patient's health information. (Hanafiah and Amir, 2016)

b. Electronic Medical Records

Electronic Medical Records, also called Electronic Health Records (RKE), are defined as a collection of electronic information data which contains patient health information. (Hanafiah and Amir, 2016)

Medical Records Management Process in Hospitals

The Medical Records management process is carried out by Medical Records officers starting from the stage of compiling Medical Record documents (Assembling), assigning disease codes based on ICD-10 (Coding), then carrying out the Indexing process (list of diseases, actions, doctors and deaths), Quantitative Analysis of Records Medical (Analysing) and finally storing medical records according to the applicable alignment system (Filling) (Widjaja & Dewi, 2017).

a. Assembling

Structuring Medical Record documents for Inpatient patients (pediatric, surgical, obstetric and infant cases) (Ministry of Health, 2006), namely: (1). Summary (filled in by Medical Records Officer); (2). Entry restrictions; (3). Incoming and outgoing summary; (4). Introductory document letter; (5). Obstetric sheet (obstetric cases); (6). Birth records (obstetric cases); (7). Newborn baby sheet (obstetric cases); (8). Birth history (case of birth); (9). Doctor's instructions; (10). Pre/post surgical instructions (surgical cases); (11). Consultation sheet; (12). Nurse notes; (13). Anesthesia records (surgical cases); (14). Surgical report (surgical case); (15). Progress notes; (16). Temperature, pulse and respiration graphs; (17). Post pregnancy chart (chart of pregnant women in obstetric cases); (18). Infant charts (newborn cases); (19). Special supervision; (20). Laboratory examination results; (21). Radiodiagnostic examination results; (22). Copy of prescription; (23). Resume/death report.

b. Coding

Coding relies on ICD-10 diagnosis codes to generalize disease names and classes. Coding can use letters or numbers or combinations of letters in numbers that represent data components. Accuracy in coding diagnoses depends on the Medical Records officer (Ministry of Health, 2006).

c. Indexing

Indexing is a guide used to provide references to users in processing medical record document information which can be done manually or electronically. The type of index created is (Ministry of Health, 2006) (Widjaja & Dewi, 2017):

1) Patient index: a list containing the names of all patients who have received treatment at the hospital.
2) Disease and operation index: a list containing disease codes and operation codes for patients seeking treatment at the hospital.
3) Doctor index: contains the names of doctors who provide health services to patients
4) Death index: contains the reasons for certain deaths as a result of health services at the hospital.

d. Analyzing (Analysis of the quality of medical records)

Medical record documents that arrive at the medical record installation will be checked by RM officers to evaluate whether they are complete in quality and quantity.

1) Qualitative analysis: includes research on filling out medical record sheets carried out by medical staff and other health workers.
2) Quantitative analysis: based on the number of medical record sheets according to the length of treatment including completeness of medical, paramedic and medical support sheets according to established procedures.

What RM officers do in analyzing the quality of medical records include (Ministry of Health, 2006):

a) Medical Home that contains elements of inaccuracy or deletions that make the RM inaccurate and incomplete
b) RM officers must have received special education so that knowledge of medical terminology, anatomy, physiology, the basics of disease processes, the contents of medical records and the medical standards used are very necessary.

e. Filling

The medical record storage system is based on storage location, namely (Widjaja & Dewi, 2017):

1) Centralized: storage of all data about patients who receive Inpatient, Outpatient or emergency services is stored in one file, in one location and managed by the Medical Records Unit.
2) Decentralized: Storage of medical records for outpatient and inpatient patients is separate. The advantage of this system is time efficiency so that patients receive faster service and can lighten the workload of medical record keeping officers. However, a decentralized system allows duplication and requires a lot of costs.

Factors of Incompleteness in Medical Records

Several factors influence incomplete medical records, namely (Karma et al., 2019):

a) Human Resources/HR

The contributing factors are the lack of knowledge of medical records officers, low discipline and motivation of officers, quite high workload of officers and poor communication.

b) Tools/Machines
The contributing factors are the absence of a checklist to see if medical records are incomplete and there are still hospitals that do not have sufficient space to store medical records.

c) Method/Method
The causal factor is the absence of guidelines, policies and SOPs for work procedures in the medical records department. There is no evaluation or monitoring, the flow does not comply with standards and there is no reward and punishment.

d) Materials
The contributing factors are unsystematic medical record files and too many forms that have to be filled out.

e) Finance/Money
The causal factor is the limited funds to support the completeness of medical record documents.

Based on these two medical record storage systems, the most appropriate one to implement is the centralized system because it has the advantage of reducing the incidence of duplication in the maintenance and storage of Medical Record files and can save costs for equipment and space requirements and can increase the work effectiveness of storage officers (Widjaja & Dewi, 2017).

Apart from location, medical records can be stored alphabetically and numerically:

a. Alphabetic
This is the easiest method for collecting RM because it only uses the patient's name to identify RM, so there is no need to cross-reference the patient's name to the RM number on the KIUP. Storing RM alphabetically can be done by:

1) Direct naming: writing the name by the order of the names listed on the RM
Example: Putra, M.Bintang Alamakky in group H

2) Family name: naming starts with the family name followed by the first and second names.
Example: Princess, Adeeva Afsheen in group P

b. Numerical

1) Serial Numbering System

2) Every visit to the hospital the patient gets a new RM. If you visit 3 times, the patient will get a different RM Number and this number must be recorded in the KIUP. Meanwhile, the RM is stored in a different place, separately according to the number given.

3) Unit Numbering System

4) Each patient who visits is only given one RM number which is always used for subsequent visits, both outpatient and inpatient visits. Patient medical records are only stored in one

document and one number so that every time a patient visits the medical record must be taken to the storage shelf for use during treatment.

5) Serial-Unit Numbering System
6) This system is a combination of serial and unit numbering systems. Every patient who comes is given a new number, but the old Medical Records are combined and stored in the Medical Records with the newest number after the patient receives service so that the Medical Records remain in one file (Widjaja & Dewi, 2017)

Diagnosis

Diagnosis is determining the nature of a disease or distinguishing one disease from another. (Dorland, 2015)

Bronchial Asthma

a. Bronchial asthma is a serious global health problem. 5% to 10% of people of all ages suffer from this chronic airway disorder. This review article presents important diagnostic and treatment considerations based on current national and international asthma guidelines.

Bronchial asthma is a chronic inflammatory disorder of the airways. Asthma was responsible for 21.6 million DALYs (Disability-Adjusted Life Years) in 2019, which was 20.8% of the total DALYs from chronic respiratory diseases. Based on the results of the 2017 Household Health Survey (SKRT), asthma is the fourth cause of death (mortality) in Indonesia or 5.6%.

Bronchial asthma is a chronic inflammatory disease of the airways characterized by bronchial hyperreactivity and varying degrees of airway obstruction. The disease is diagnosed based on clinical history, physical examination, and pulmonary function tests, including reversibility tests and measurements of bronchial reactivity.

The death rate due to bronchial asthma is highest in countries with low and medium SDI (Socio-Demographic Index), while the prevalence is highest in countries with high SDI (1). It was reported that North America had the highest age-based prevalence of asthma in 2019 (10,399.3 per 100,000) and East Asia had the lowest (2,025.5 per 100,000). From 1990 to 2019, the number of prevalence cases of asthma increased from 226.9 million to 262.4 million, with the highest number of cases in South Asia and North America (2). In Indonesia, nineteen provinces have a prevalence of asthma that exceeds the national figure and one of them includes Aceh (3).

The symptoms that are characteristic of asthma are:

1) more than one symptom (wheezing, shortness of breath, cough and chest tightness) especially in adults
2) symptoms are generally worse at night or early in the morning
3) symptoms vary with time and intensity
4) symptoms are triggered by viral infections (flu), physical activity, exposure to allergens, weather, emotions, and irritants such as cigarette smoke or strong odours.

The characteristics of cough in asthma range from non-productive to productive due to the large amount of sputum which is mucoid and often very strong. The risk of

developing asthma is an interaction between host factors and environmental factors. Host factors include genetic predispositions that influence the development of asthma, namely genetic asthma, allergies (atopy), bronchial hyperactivity, gender and race. Environmental factors predispose individuals with a predisposition to asthma to develop persistent asthma symptoms. The World Health Organization (WHO) states that the prevalence of asthma is 3-5% in adults. Based on the results of Riskesdas (2013), the prevalence of asthma in the 35-44 year age group is 5.6% and in the 45-year and over age group is 3.4% (13).

b. Epidemiology

WHO and the Global Asthma Network (GAN), which is an asthma organization in the world, predict that by 2025 there will be an increase in the asthma population of 400 million and there will be 250 thousand due to this disease (WHO, 2023). Based on data from the Ministry of Health for 2020, asthma is one of the most common types of disease suffered by Indonesian people until the end of 2020. The number of asthma sufferers in Indonesia is around 4.5 per cent of the total population of Indonesia or around 12 million more. Based on asthma prevalence data, according to the World Health Organization (WHO) in 2019, there were around 235 million asthma sufferers or 1% - 18% of the world population (Ministry of Health of the Republic of Indonesia, 2020). Basic health research (Riskesdas) carried out by the health research and development agency to determine the prevalence of various diseases in 2018 found that the highest prevalence of asthma recurrence in Indonesia was in Aceh, namely 68.9% and the lowest was in Jogjakarta. Meanwhile, the prevalence of bronchial asthma recurrence in Lampung province is 68% in adults (Ministry of Health of the Republic of Indonesia, 2018).

c. Etiology

Asthma is not a contagious disease. Asthma cannot be transmitted to other people. Asthma is not caused by just one factor. There are different types of asthma. In some types of asthma, several family members may suffer from asthma, but this is not seen in some other types of asthma (Global Initiative for Asthma (GINA), 2021).

The fundamental cause and strongest factor in the occurrence of asthma is a combination of genetic predisposition with environmental exposure to inhaled substances and particles that can trigger allergic reactions or disrupt the airways such as (1). Indoor allergens (e.g. house dust in bedding, carpets and furniture, dolls, pollution and pet dander); (2). Outdoor allergens (such as pollen and mould); (3). Tobacco smoke; (4). Chemical irritants in the workplace; (5). Air pollution (Puspasari, 2019).

Until now, the aetiology of Bronchial Asthma is not known with certainty. However, something that often occurs in all asthma sufferers is the phenomenon of bronchial hyperactivity. The bronchi of asthma sufferers are very sensitive to immunological and non-immunological stimuli. Because of these properties, asthma attacks easily occur due to various stimuli, both physical, metabolic, chemical, allergens, infections and so on. The causal factors that often cause asthma need to be known and avoided as much as possible. These factors are (Ghofur, A. 2012): (a). Main allergens: (b). house dust, mould spores, and grass pollen; (c). Irritant with smoke, odours and pollutants; (d). Respiratory tract infections, especially those caused by viruses; (e). Extreme weather

changes; (f). Excessive physical activity; (g). Work environment; (h). Drugs; (i).Emotion; Others: such as gastroesophageal reflux.

d. Pathophysiology of Bronchial Asthma

Asthma is chronic inflammation in the airways with various cells and cellular elements playing a role. Chronic inflammation is associated with airway hyperresponsiveness resulting in recurrent episodes of wheezing, chest tightness, shortness of breath and coughing, especially at night or early in the morning. Asthma symptoms are variable, multifactorial and potentially related to bronchial inflammation.

According to Afghani & Hendriani, (2020) (Mustopa, 2022) In allergic respiratory reactions, IgE antibodies bind to the allergen and cause mast cell degranulation. This degranulation releases histamine. Histamine narrows bronchial smooth muscle. An excessive histamine response can cause asthmatic seizures. Histamine stimulates mucus formation and increases capillary permeability, resulting in congestion and swelling in the spaces between the lungs. People with asthma may have a hypersensitive IgE response to allergens and may be more susceptible to mast cell degranulation. Whenever the inflammatory response is hypersensitive, the result is bronchospasm, mucus formation, oedema, and airway obstruction.

e. Causative factors such as viruses, bacteria, fungi, parasites, allergies, irritants, weather, and physical and psychological activities will stimulate bronchial hyperreactivity reactions in the respiratory tract, thereby stimulating plasma cells to produce immunoglobulin E (IgE). IgE will then attach to the mast cell wall receptor, then the mast cells are sensitized. Sensitive mast cells will experience degranulation, and mast cells that experience degranulation will release several mediators such as histamine and bradykinin. This mediator causes an increase in capillary permeability resulting in mucosal edema, increased mucus production and contraction of bronchiolar smooth muscle. This will cause proliferation due to blockages and condensation forces in the airway so that the process of O2 and CO2 exchange is hampered resulting in ventilation problems. Low O2 intake into the lungs, especially in the alveoli, causes an increase in CO2 pressure in the alveoli or what is called hyperventilation, which will cause respiratory alkalosis and a decrease in CO2 in the capillaries (hypoventilation) which will cause respiratory acidosis. This can cause the lungs to be unable to fulfil their primary function in gas exchange, namely removing carbon dioxide, causing the O2 concentration in the alveoli to decrease and diffusion disorders to occur, and this will continue to lead to perfusion disorders where oxygenation to the tissues is inadequate, resulting in hypoxemia and hypoxia which will cause various clinical manifestations (Nugroho, T. 2016).

f. Clinical Manifestations of Bronchial Asthma

1) Asthma generally has symptoms such as cough (with or without mucus), dyspnea, and wheezing.
2) Asthma usually attacks at night.
3) Exacerbations are often preceded by increasing symptoms over days, but can also occur suddenly.
4) Heavy breathing and wheezing.

5) Airway obstruction that worsens dyspnea.
6) Dry cough at first: followed by a stronger cough with excessive sputum production. (Puspasari, 2019)

Meanwhile, clinical manifestations that can be found in asthma patients according to Halim Danokusumo (2000) in (Padila, 2013) include:

1) Early Stage

The hypersecretory factor is more prominent

a) Coughing with sticky phlegm that is difficult to expel, accompanied by a cold or not
b) Fine wet rhonchi in the second or third attack, they come and go
c) Wheezing
d) There are no thoracic deformities yet
e) There is an increase in blood eosinophils and IgE

2) BGA is not yet pathological

The predominant factors of bronchial spasm and edema:

a) Shortness of breath occurs with or without sputum
b) Wheezing
c) Wet rhonchi if there is hypersecretion
d) Decreased partial pressure of O2

3) Advanced/chronic stage

a) Cough, rhonchi
b) Severe shortness of breath and as if the chest is being squeezed
c) Phlegm is sticky and difficult to expel
d) Breath sounds are weak or even inaudible (silent chest)
e) The thorax is like a barrel chest
f) There is visible tension in the stenorcleidomastoid muscle
g) Cyanosis
h) BGA Pa O2 less than 80%
i) There is an increase in the left and right bronchovascular features on lung X-ray
j) Hypocapnea and alkalosis and even respiratory acidosis.

f) Diagnostic Examination

1. Sputum test

The sputum test found:

1) Eosinophil crystals Charcot-Leiden crystals which are degranulated spines.
2) There are Curshmann's coils, which are cylinders of cells in the bronchial tree.
3) The presence of creoles, fragments of bronchial epithelium.
4) The presence of neutrophils and eosinophils. B. Blood test

2. Blood gas analysis

Blood flow fluctuates, but the prognosis is poor if there is low PaCO2 or PH, increased blood SGOT and LDTI, examination of allergic factors, there is IgE which increases during seizures and decreases when there are no seizures

3. X-ray photo

On x-rays, the results of asthma patients are generally normal. During an asthma attack, this photo shows lung hyperinflation in the form of increased radiation permeability, enlarged intercostal spaces, and reduced size of the diaphragm.

Vital capacity measurement (lung function evaluation). Lung function measurements are used as an indirect assessment of airway hyperresponsiveness to assess airway obstruction, reversibility of lung dysfunction, and variability of lung function (Mustopa, 2022).

g) Complications

Asthma complications are:

a. Pneumothorax

Pneumothorax is an important condition that occurs when air enters the pleural cavity and the pressure inside the pleura rises to atmospheric pressure.

b. Atelectasis

Atelectasis is an airless lung disease and can be caused by various factors.

c. Breathing failure

Respiratory failure is a condition where the lungs cannot function to exchange oxygen and carbon dioxide.

d. Bronchitis

Bronchitis is an infectious disease that occurs in the bronchi (Afgani & Hendriani, 2020).

h) Classification

The following is a classification of the degree of bronchial asthma based on the general clinical picture in adults.

i) Management of Bronchial Asthma

The main goal of asthma management is to improve and maintain the quality of life so that asthma patients can live normally without obstacles in carrying out daily activities according to the Global Initiative for Asthma (2017) in (Lorensia, Suryadinata, & Ratnasari, 2019).

In general, asthma treatment is divided into non-pharmacological treatment and pharmacological treatment, including:

a. Non-pharmacological treatment

1. Health Education

The aim of this consultation is to help clients expand knowledge about asthma, consciously avoid triggers, take medication correctly and consult with the health team.

2. Avoid trigger factors. Clients need to help identify triggers for asthma attacks in their environment and teach them how to avoid and reduce trigger factors, including appropriate fluid intake for clients.

3. Chest physiotherapy Physical therapy can be used to increase mucus secretion. This can be achieved with postural drainage, percussion, and chest vibration.

b. Pharmacological Treatment of Bronchial Asthma

1. Beta agonist

The aerosol works very quickly with 3-4 sprays, with a 10 minute interval between the first and second spray. This medicine contains Metaproterenol (Alupent, Metrapel).

2. Methyl Xanthine

Methylxanthines are aminophylline and theophylline, and these drugs are given when beta agonists do not provide satisfactory results. For adults, give 125-200 mg 4 times daily. Corticosteroids.

If beta agonists do not respond well to methylxanthine, corticosteroids should be administered. Aerosol form of steroid (beclomethasone dipropinate) at a dose of 800 four times a day. Long-term steroids have side effects, so long-term steroid side effects should be monitored carefully.

3. Ketotifen The effect is the same as a daily dose of 2 x 1 mg chromolin. The effect can be administered orally.
4. Ipletropium bromide (Atroben) Atroven is an anticholinergic drug that is given in aerosol form and has bronchodilator properties. (Mustopa, 2022)

Hospital

A hospital is a health service facility that provides comprehensive individual health services by providing inpatient, outpatient and emergency services. The Central Government, Regional Government or private sector can establish hospitals in the form of technical implementation units from agencies tasked with health or regional public service agencies in accordance with statutory provisions (Permenkes RI, 2020).

Based on the type of service, hospitals are categorized based on. (Permenkes RI, 2020):

1. General Hospital

Hospitals that provide health services in all fields and types of diseases where the health services provided at least consist of:

a. Medical services and medical support (general medical services, specialist medical services, and subspecialist medical services)
b. Nursing and midwifery services include generalist nursing care and/or specialist nursing care and midwifery care
c. Non-medical services consist of pharmaceutical services, laundry services, food management, maintenance of infrastructure and medical equipment, information and communication, post-mortem and other non-medical services.

2. Special Hospital

Specialized hospitals provide primary services in one particular field or type of disease depending on the discipline, age group, organ, type of disease, or other specialty.

6. Conclusions

Completeness of medical record documents is the assessment or review of documents, the contents of medical records relating to documentation, services and/or assessing the completeness of medical records. A completeness analysis is a review of specific areas of the medical record to identify deficiencies.

Medical records are information or records, both written and recorded, regarding the patient's identity, condition and every action given, including the treatment received by the patient. one of the contents of a medical record is an outpatient medical record. The contents of the medical record contain 1). Notes, which contain a description of the patient's identity, patient examination, diagnosis results, treatment, actions and other services carried out by doctors, dentists or other health workers according to their competence; 2). Documents, which are complete records, include x-ray photos, laboratory results and other information in accordance with scientific competence. Types of medical records consist of: 1). Conventional Medical Records; 2). Electronic Medical Records;

There are several factors that influence incomplete medical records, namely: 1). Human Resources; 2). Tools/Machines; 3).Method/Method; 3). Material; and 4) Finance/Money.

The process of managing Medical Records in Hospitals is carried out by Medical Records officers starting from the stage of preparing Medical Record documents (Assembling), then carrying out the Indexing process (list of diseases, actions, doctors and deaths), Quantitative Analysis of Medical Records (Analysing) and finally storage medical records according to the applicable alignment system (Filling). Medical Records can be stored alphabetically and numerically.

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A hospital is a health service facility that provides comprehensive individual health services by providing inpatient, outpatient and emergency services. Central Government, Regional Government or private sector.

Based on the type of service, hospitals are categorized based on: 1). General Hospital which provides health services in all fields and types of diseases where the health services provided consist of at least; 2). Specialized Hospitals that provide primary services in one field or one particular type of disease depending on the discipline, age group, organ, type of disease, or other specialty.

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