Research of Service Administration Health and Sains Healthys
Vol. 6 No. 1 Juni 2025
*p-ISSN:*2830-4748 e-ISSN: 2830-4772
DOI: *10.58258/rehat.v6i1.9052/ http://ejournal.mandalanursa.org/index.php/Rehat*

The Influence of Identification of Important Reports, Authentication and Documentation on Accuracy of Medical Records

Yoseph Lee[1], Dasrun Hidayat[2], Yuniati Lestari
Universitas Adhirajasa Reswara Sanjaya

Article Info
Article history:
Received: 24 June 2025
Publish: 30 June 2025

Keywords:
Identification;
Important Reports;
Authentication;
Documentation;
Medical Records.

Abstract
One of the key efforts undertaken by hospitals to provide high-quality healthcare services, both individually and comprehensively, including outpatient, inpatient, and emergency services is improving the quality of medical record management. Properly completed and well-organized medical records play a crucial role as a guideline in delivering healthcare services and serve as a source of information that supports medical research. Additionally, medical records function as a basis for assessing healthcare service performance and hold medico-legal significance. Medical records are considered to be of high quality when they meet several criteria, including completeness, accuracy, timeliness, and compliance with legal aspects. However, based on observations, several medical record documents in the Outpatient Emergency Department of RSIA Rinova Intan Bekasi were found to be incomplete, particularly in terms of identification, important reports, authentication, and documentation. This study employs the Mixed Method Explanatory approach, in which a quantitative analysis is followed by a qualitative examination to gain a deeper understanding of the findings. The quantitative approach involves 104 patient samples who sought treatment at the Outpatient Emergency Department of RSIA Rinova Intan Bekasi from February to March 2025, while the qualitative approach includes 7 informants, consisting of medical personnel and medical record officers. Data were collected through questionnaires, observations, and interviews. Thus, this study aims to analyze the influence of identification, important reports, authentication, and documentation on the accuracy of medical records in the Outpatient Emergency Department of RSIA Rinova Intan Bekasi. The findings of this research are expected to provide insights into the factors affecting the quality of medical records and serve as a foundation for enhancing the efficiency of medical record-keeping systems in hospitals.

Corresponding Author:
Yoseph Lee
Universitas Adhirajasa Reswara Sanjaya
Email: yoseph@gmai.com

1. INTRODUCTION

Service management in the health context is very important in relation to medical records for several reasons such as patient safety, decision making, continuity of service, and evaluation and improvement of the quality of health services.Health services include various facilities used to carry out efforts to improve health, prevent disease, treat and recover, which can be managed by the government, local government, reflecting the community.(Minister of Health Regulation No. 24 of 2022). The factor that is the benchmark for the quality of hospital services is the extent to which medical record files are filled in completely, because this contributes directly to improving overall health services. (Hikmah, 2018). To meet patient expectations, hospitals need to continuously

improve the quality of services, both in terms of health worker performance and through support systems such as medical record management. (Hidayat, 2024).

Health services are an effort carried out to maintain and improve the health of individuals and communities through the provision of comprehensive, effective and efficient health services. The provision of hospital services that prioritize professionalism and accountability is an important element in supporting the implementation of health programs towards the framework of improving the health service system that is broad and sustainable. (Minister of Health Regulation No. 3 of 2020). As a place for providing various forms of medical services, hospitals are required to provide services that...quality, precise, fast, and careful in order to create satisfaction for its patients. (Purwadhi, 2023).

Hospitals organize various forms of health service processes that cover various medical and administrative aspects. One of them isAn important part of the overall health care process is the medical records section which has the potential to improve services. (Agustiany et al., 2024). All aspects of hospital services must meet standards, especially in the medical records section, which can be used as a basis for determining treatment procedures. Patients in helping the efficiency of implementing health actions in the hospital environment (Agustiany et al., 2024). According to (Minister of Health Regulation 24 of 2022), Medical records include files that include the patient's personal information, anamnesis results, physical examinations, laboratory results, diagnoses, and medical actions taken. This document is a complete record of the medical report regarding the examination process and patient care during treatment at a health facility. All forms of recording by doctors or dentists in connection with the medical treatment given to the patient for the purposes of pseudo-health services is stored in the medical record (Minister of Health Regulation No. 24 of 2022). The contents of medical records include various information, both documented in writing and through recordings, regarding identity, other medical support actions, diagnosis and therapy both in Emergency room, outpatient and inpatient care must be provided by health service providers so that they have a positive impact on the competitiveness of health services. (Purwadhi, 2023). Medical action in emergency services is needed immediately for patients with life-threatening conditions, with the main goal of saving lives and preventing disability (Minister of Health Regulation No. 47 of 2018).

Well-organized medical records in a hospital environment can support improvements in the quality of health services, so that their existence is considered a crucial element. (Riyantika, 2018). Assessment of the completeness and accuracy of medical records is carried out by reviewing the contents listed on the sheets that have been set as standards. Completely and validly documented medical record information reflects the quality of medical services and is the basis for evaluating the quality of health services in hospitals (Nuraini, 2015).

Medical records are closely related to various important aspects in the health service system, such as patient identification, recording important reports, authentication of medical actions, and documentation of the entire service process. These four aspects support each other to ensure accuracy. Data, legality of medical actions, and continuity of information between health workers in providing quality services. In the study (Widowati, 2023) at the Sleman health center using 98 medical record files of patients with independent financing, it was found that the integrity of the information for the identity recording aspect was 96%, the medical document aspect was 58%, the authentication aspect was 91%, and the data recording aspect was 82%. These findings are not in line with (Minister of Health Regulation No. 24 of 2022) which requires that medical records be compiled comprehensively and immediately completed after the patient receives services (Widwati, 2023).

Patient identification is included in the accreditation indicators designed to reduce the risk of events that pose a risk or harm to patients in the context of safety and hospitals (Murtiningtyas and Dhamanti, 2022). According to patient data in December 2024, variable occupancy was found identification 94%, means it has not reached 100%, which will affect accuracy of medical records. Completeness of patient identification aspects in medical records as well as administrative data and a source for home planning. Illness, which is determined by the accuracy of medical records. The results of a study that is in line with that were presented by Elvisa (2017), where the highest percentage of completeness of medical records in the identification aspect was found in the patient's name section, which was filled in as much as 92% in its entirety. Meanwhile, the data shows that the gender section has the lowest percentage of completion, with a completeness level of only 51%.

Important aspects of the report serve as a source of information regarding medical and nursing actions carried out by doctors and nurses during the patient care process, which will relate to the accuracy of medical records. For important reports on patient data in December 2024, the occupancy was 88%, this is still below the minimum service standard, so it has an impact on accuracy of medical records. Therefore, this report is expected to be compiled accurately, completely, and accountability (Yusuf Setiawan, 2020). Research on 2,651 medical record documents of patients undergoing inpatient care showed that 81.30% had been completely filled in, while 18.70% were still found to be incomplete, including data that monitored the development of the disease. patient. for patient's disease progress record,

The authentication aspect is the process of verifying the identity of health workers, such as doctors or nurses, who have the authority to fill out medical record documents, in order to ensure the validity and responsibility for the information included (Lesmana and Suciana, 2022).From the December 2024 data, the filling of the authentication variable was 93%, this has not reached 100%, so it has an impact accuracy of medical records. Research (Gustiara et al, 2022) of 97 inpatient medical record files stay found 48,75% completely filled and found 34% on signature items Doctor In the authentication process, each entry must be accompanied by an identity in the form of name, time of implementation, and signature of the doctor, dentist, or health worker involved in providing the service (Minister of Health Regulation No. 24 of 2022).

Good documentation aspects will make it easier to handle patients continuously, documentation that is written clearly and is easy to read is very important because it has a direct impact on the accuracy of the information contained therein.For the documentation variable occupancy, only 87% was filled according to patient data for December 2024, which greatly affected accuracy. hospital medical records. Documentation is made easy to read and understand by health workers. In other words, this can prevent misunderstandings in reading it, which can cause losses to patients and hospitals. sick. Incomplete medical record documentation has the potential to interfere with administrative regularity, thus hampering the service improvement process health in the hospital environment. (Hikmah, 2018). In the study (Sawondari et al., 2021) at RUMKITAL Dr Ramelan Surabaya for the documentation aspect found 80% for clear and legible recording, while error correction100% not filled. If the four aspects are not filled in completely, this can cause obstacles in providing detailed information about the medical procedures that have been carried out on patients during medical treatment at health service institutions. In addition, this condition also affects the quality of medical records and the quality of services provided. (Devhy & Widana, 2019).

Based on several findings in the field, specifically at the Rinova Intan Bekasi Women and Children's Hospital, researchers found that medical record services were carried out manually and there were still incomplete data entries, resulting in losses to

patients and hospitals. The manual medical record system is considered less effective because it takes a long time to search for information. Digitizing all documents will facilitate access, speed up data processing, and increase the accuracy of information (Handiwidjojo, 2015). The relevance of filling in medical records at the Emergency Room of Rinova Intan Bekasi Hospital for December 2024 can be seen in table 1.1

Table 1.1 Primary Data of Emergency Room Medical Records of Rinova Intan Hospital for the Period of December 2024

No	Aspect	Sample (N)	L	%	TL	%
1	Identification	120	113	94%	7	6%
2	Important Report	120	105	88%	15	12%
3	Authentication	120	112	93%	8	7%
4	Documentation	120	104	87%	16	13%
Rate-Rata			**108,5**	**91%**	**11,5**	**9%**

Ket ; L (Complete)
TL (Incomplete)

Based on table 1.1, the process of recording medical records in the outpatient services of the Emergency Room of RSIA Rnova Intan Bekasi using 120 samples, it was found thatThe most frequent medical record filing was in the identification aspect, 113 samples (94%) and the most frequent incomplete filling was 16 samples (13%) in the documentation aspect. From the results of table 1.1, it can be concluded that the process of recording medical records in the outpatient services of the Emergency Room of Rinova Intan Hospital, Bekasi, is not 100% in accordance with standards. minimum service (Minister of Health Regulation No. 6 of 2024).

To overcome this problem, researchers try to take several theories to overcome it, the identification aspect that has not been filled in 100% needs to use electronic medical records (EMR) according to government regulations in supporting health services in improving health services (Yanti, 2024). According to (Handiwidjojo, 2015) it is necessary to think about the use of computerization which will facilitate the process of managing data quickly and accurately. For the important report aspect, it is found that the date of treatment is filled in, informed consent which have not been filled in or are incomplete. The solution is to provide an explanation to the doctors on duty so that they will fill it in, because important reports can present data on medical interventions that have been carried out by doctors in the patient care process. (Yusuf Setiawan, 2020). The authentication aspect is still incomplete in filling in the service date and the doctor's signature, how to overcome this according to(Ministry of Health, 2006) can use personal identity number or Personal Identification Number (PIN). While the documentation aspect includes writing that is incomplete, cannot be read and there are empty columns that are not marked. The way to overcome it is to give input to the doctors on duty by saying that good and true documentation includes crucial notes that cannot be ignored (Wahyu Pamungkas et al., 2010) So it can be said that filling in medical records safely, correctly and completely is included in the category of medical support services which determine the quality standards of medical services in hospitals (Nuraini, 2015).

There is research that reveals the relationship between aspects of identification, important reports, authentication and documentation on the level of completeness of filling out medical records, as seen in the study.(Raisarais G & Leni H, 2021)The study conducted by Raisa Rais G and Leni H (2021) entitled "Analysis of Completeness of Inpatient Medical Records at RSU Bina Sehat Bandung", using a descriptive quantitative method, 81 medical records were used as research samples. The results of the study showed that the identification aspect was filled in completely by 100%, the important report aspect was 62.96% (51 samples), the authentication aspect was only 16.05% (13 samples), while the

documentation aspect reached 72.85% (59 samples). The conclusion of the data obtained from the study revealed that the integrity of the data in the medical record form at RSU Bina Sehat Bandung has not reached 100%. This situation is influenced by the limited duration of work. Doctors to complete the form, as well as delays in distributing the form which resulted in some sections not being filled in. Furthermore, research (Sawondari et al., 2021) which used descriptive qualitative approach conducted in the research at Rumkital DR Ramelan Surabaya using 20 sample sheets of medical resumes, the results obtained were 82.5% for the average completeness of filling in medical records, while the average incompleteness was 17.5%, incompleteness of the research for the identification aspect was 20% (4 samples), important report aspect 15% (3 samples), authentication aspect 15% (3 samples) and documentation aspect 20% (4 samples).

The difference between this research and previous research starts fromsampling technique, where researchers combine quantitative and qualitative research approaches for the accuracy of medical records. Through this research, the scope of aspects that researchers make is also broader where in this study there are aspects of identification, important reports, authentication and documentation. While previous studies only examined the scope of medical records in general without looking further into other supporting aspects of medical records.

To support improving the quality of health services, the presence ofMedical records play an important role in the world of health in increasing patient satisfaction (Aldio Putra et al., 2024). Medical records play an important role in supporting the creation of orderly administration. If medical records management is not carried out regularly and correctly, efforts to realize integrated administration will not be able to run optimally (Silvia, 2024).Medical records in hospitals serve as the main reference in compiling health information, both for patients undergoing types of services that include short visits and follow-up care in hospital.. (Basyarudin, 2022).

Medical records contribute to the provision of quality and comprehensive services for patients and hospitals, by optimizing resource utilization, increasing distribution efficiency, and supporting research activities in hospital service management (Silvia, 2024).Medical records specifically refer to the written history of each patient's hospital care. More comprehensively, medical records include all records or data arising from the relationship directly or indirectly with various activities in the hospital related to patient treatment efforts as an important tool in support services health effectively and accurately (AD Harikatang et al., 2024). Incomplete data in medical records can impact the quality of health services and hospital performance, because these documents serve as important references in making further clinical decisions related to patient care. (AD Harikatang et al., 2024). When medical records do not contain all the information in its entirety, the patient's treatment process can be disrupted and not continue continuously. To ensure the quality of health services, indicators are needed such as an evaluation of the completeness of medical record documents. (Purba, 2016).

In order to process data properly and accurately in health services, medical records are required, where these medical records can help the process and search for data and process it quickly and efficiently.(AD Harikatang et al., 2024). The quality of health services can be seen from whether the contents of the medical records are complete or not.(Alif, 2019). Medical records not only function as documentary evidence, but also as a source of expert information recorded in medical records (Sudjana, 2017).

The urgency of this study lies in the importance of accuracy when filling out medical records, incomplete medical record data in the Emergency Room of Rinova Intan Hospital, Bekasi, which is caused by the medical record system which is still manual, thus creating challenges in the efficiency of management and searching to evaluate patient data,

where this study is very relevant because the results of this study are expected to be able to measure how much influence the components that include identification, crucial reports, data validation (authentication), and medical recording have on the accuracy of medical records in the Emergency Room of Rinova Intan Hospital, Bekasi through an approach Mixed Method. This study is aimed at examining the validity of the identification process of Important Authentication and Documentation Reports on the Accuracy of Medical Records in the Emergency Installation of Rinova Intan Hospital, Bekasi.

3. RESEARCH METHOD

A research method is a scientific approach used to systematically analyze data to achieve the objectives set in a study. This research uses the *mixed methods*, which is an approach that combines quantitative and qualitative methods in an integrated manner to achieve a more comprehensive understanding of the phenomenon under study. (Cresswell, 2024), which aims to provide a more comprehensive analysis related to the influence of the aspects of identification, important reports, authentication, and documentation on the level of accuracy of records of medical records installed in the Innovative Medical Installation (IGD). Diamond Bekasi.

In the initial stage, a descriptive quantitative approach was used with the aim of providing an objective picture of the phenomenon under study through numerical data collection techniques and statistical analysis. This approach is based on the paradigm of positivism$ which emphasizes hypothesis testing and numerical data analysis (Sugiyono, 2017). Quantitative data were collected through a structured questionnaire instrument containing closed-ended questions with a Likert scale of 1–5 to measure the variables related to the accuracy of medical records. Data analysis in this research was conducted using descriptive and inferential statistical methods, which aimed at identifying patterns of relationships between the studied variables.

After presenting the results of the quantitative analysis, the research continued with a qualitative approach through interviews and observations of medical officers and documentation of patients in the intensive care unit of RSIA Rinova Intan Be$kasi in order to better understand the influencing factors in incompleteness of medical records (Nugrahe$ni, Kumar and Azizah, 2023).

This research design uses the approach *explanatory sequential mixed methods*, which is an approach that utilizes quantitative results as a basis for further exploration with qualitative methods (Ivankova, Cresswell and Stick, 2006). This approach allows researchers to provide more detailed explanations of statistical findings and reveal aspects that cannot be explained numerically (Rachmad e$t al., 2024). Thus, the combination of these methods is expected to provide a more comprehensive and in-depth analysis of the factors affecting the accuracy of medical records in the Emergency Facility (ICU) of RSIA Rinova Intan Bekasi.

4. RESEARCH RESULTS AND DISCUSSION

Based on the results of the validity test using correlation analysis*Pe$arson Product Moment Against* 5 combined indicators (X1,2,3,4 and 5.1 to X1,2,3,4 and 5.5) against the variables TOTAL_X1 to TOTAL_Y, it is known that all values *Pearson Correlation* shows a very high and significant number. The correlation value ranges from 0.319 to 0.928, all of which exceed the r table value of 0.1927 (with N = 104 and a significance level of 5%). This shows that all items or indicators in the questionnaire have a strong and positive relationship to the measured variable construct, and meet the validity criteria statistically.

The level of significance (Sig. 2-tailed) of all correlations appearing in the table is 0.000 or less than 0.05, which means that the detected relationships are statistically significant and do not occur by chance. For example, in the combined indicators X1,2,3,4 and 5.3 which have a correlation to TOTAL_Y of 0.928**, it shows that the items in this group are very valid in representing the construct of the Y variable. Likewise, high correlations in other indicators such as X1,2,3,4 and 5.4 (0.876**) or X1,2,3,4 and 5.5 (0.881**) strengthen that the instrument has been well developed and consistently measures the intended concept.

These results indicate that all items on the research questionnaire can be declared valid, as they satisfy two main conditions, namely the value of the correlation coefficient above r table and the significance level below 0.05. Thus, the researcher can proceed to the next stage of analysis with the confidence that the measurement tool used has been able to accurately the variable. High validity also strengthens data integrity, which is important for obtaining authentic and reliable research results. These findings can be seen in detail in the following table.

Table 4.1 Validity Test

Correlations

		TOTAL_X1	TOTAL_X2	TOTAL_X3	TOTAL_X4	TOTAL_Y
X1,2,3,4, and 5.1	Pearson Correlation	.763**	.409**	.319**	.595**	.731**
	Sig. (2-floor $d)	.000	.000	.001	.000	.000
	N	104	104	104	104	104
X1,2,3,4, and 5.2	Pearsons Correlation	.763**	.761**	.883**	.892**	.775**
	Sig. (2-floor $d)	.000	.000	.000	.000	.000
	N	104	104	104	104	104
X1,2,3,4, and 5.3	Pearsons Correlation	.850**	.799**	.841**	.887**	.928**
	Sig. (2-floor $d)	.000	.000	.000	.000	.000
	N	104	104	104	104	104
X1,2,3,4, and 5.4	Pearsons Correlation	.841**	.770**	.840**	.882**	.876**
	Sig. (2-floor $d)	.000	.000	.000	.000	.000

	N	104	104	104	104	104
X1,2,3,4, and 5.5	Pe$arson Correlation	.786**	.769**	.860**	.839**	.881**
	Sig. (2-floor $d)	.000	.000	.000	.000	.000
	N	104	104	104	104	104

Source: SPSS Test Data (2025)

Reliability Test Results

Based on the results of the reliability test displayed in the Reliability Statistics table, it is known that the value *Cronbach's Alpha* as large as 0.934 with the number of items as large as 25**.** This value indicates a very high level of reliability. In general interpretation, the instrument is said to be reliable. if the Cronbach's Alpha value is more than 0.70. With a value of 0.934, this instrument is not only reliable, but is included in the very reliable category or *excellent reliability*.

In addition, the value *Cronbach's Alpha Based on Standardized Items* also shows the same figure, namely 0.934, which indicates that both in its raw form and after being standardized, the internal consistency between items remains very strong. This shows that the items in the questionnaire work consistently in measuring the variables or constructs under study, without any items disturbing the overall stability.

The researcher can conclude that the entire instrument or question details in the questionnaire have met the reliability requirements and can be used for further analysis. This result strengthens the validity of research findings, because the data collected comes from an instrument that is statistically proven to be consistent and reliable in measurement**.** These findings can be seen in detail in the following table.

Table 4.*2*Reliability Test

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.934	.934	25

Source: SPSS Test Data (2025)

Description of Respondent Characteristics

In this study, the researcher used three main data collection techniques to obtain comprehensive primary data. The first technique is the online distribution of the questionnaire using the platform *Google$ Form*, which facilitates large-scale data collection and increases the efficiency of data distribution and processing processes. The second technique is the distribution of the questionnaire in printed form (*print out*) that is given directly to the respondent, in order to reach people who may not have internet access or be more comfortable with traditional methods. These two methods aim to obtain information related to the influence of important report identification, authentication, and documentation on the accuracy of medical records in the Emergency Department (IGD) of RSIA Intan Rinova Bekasi.

In addition, to deepen the understanding and strengthen the results of the quantitative data obtained through the questionnaire, the researcher also applied the interview method. This interview was conducted with a number of previously identified

respondents and aimed to gather more in-depth information regarding their experiences, views, as well as challenges faced in the practice of identifying important reports, authentication, and documentation of medical records in the IGD. The data elicited from these interviews served as a supplement to enrich the analysis of the questionnaire, provided a qualitative perspective that complemented the quantitative results, and provided confirmation on the existing findings. The results of the collected questionnaires will be presented in the following table, which describes the characteristics of the respondents in this study, as listed in Table 4.3.

Table 4.3 Research Results

CHARACTERISTICS	AMOUNT	PERCENTAGE (%)
GENDER		
Gender (Male)	43	41%
Gender (Female)	61	59%
AGE		
Under 25 years	48	46%
25-30 years	25	24%
31-45 years	25	24%
Above 46 Years	6	6%
EDUCATION LEVEL		
No formal education	1	1%
SD s/d SMA	44	42%
D1 s/d D4	35	34%
S1 to S3	24	23%
PEKERJAAN		
ASN/PPK	23	22%
Private sector employee	28	27%
Businessman	35	34%
Daily Casual Laborer (*Freelance*) /	18	17%
LONG BE$USER OF THE SERVICE		
Less than 1 year	32	31%
1-3 years	43	41%
3-4 years	17	16%
Above 5 years	12	12%
FRE$QUENCY OF MEDICAL RE$ECAM SERVICE USE		
1 time	32	31%
2 s/d 3 kali	41	40%
4 s/d 5 kali	15	14%
Above 5 times	16	15%

Source : Data Primer (2025)

Table 4.3 above depicts the characteristics of the respondents involved in this research, which include information on gender, age, education level, occupation, length of service users, and frequency of service users in the IGD hospital. Rinova Intan Bekasi. Based on gender, the respondents were almost evenly distributed, with 43 male respondents (41%) and 61 female respondents (59%). This suggests that the study involved a fairly representative population of both genders.

In the age category, the majority of Russian respondents are under 25 years old, with 48 people (46%) included in this group. The age groups of 25-30 years and 31-45 years each have 25 people (24%), while the group over 46 years only consists of 6 respondents (6%). This shows that a large part of the respondents are individuals who are still in productive age, who have the potential to more often use medical record services at IGD. In terms of education level, most respondents have a relatively high level of formal education, with 42% of them having an education equivalent to elementary school to high school, 34% having a D1 to D4 education, and 23% having a S1 to S3 education.

For the employment category, the majority of the respondents were self-employed (34%), followed by self-employed (27%) and civil servants/PPK (22%). A total of 17% of the respondents worked as freelance day laborers or pensioners, which shows a variation in the employment background of the respondents. Regarding the length of service users, the majority of respondents (41%) had used the medical record service in the intensive care unit for 1 to 3 years, followed by 31% who had used the service for less than 1 year. Only a few respondents have been users for more than 5 years (12%) or between 3 and 4 years (16%). Finally, in terms of frequency of use of the medical record service, the majority of respondents (40%) used it 2 to 3 times, followed by 31% who used the service only once. A total of 14% of respondents used the service 4 to 5 times, while 15% of respondents used it more than 5 times.

4. CONCLUSION

1. Identification variables have been shown to have an important influence on the accuracy of medical record results in the Emergency Room of Rinova Intan Hospital, Bekasi. The process of recording complete patient identity, including name, date of birth, and address, can prevent data input errors that can impact medical treatment. Proper identification is the initial basis for the validity of all patient medical records.
2. Important reports as research variables show a significant role in ensuring the accuracy of medical record results. The existence of documents such as examination results, consent forms, and the identity of the examining physician are important references in the continuity of medical services and subsequent therapy referrals. The regularity and completeness of these reports also determine the quality of data in the medical record system.
3. Authentication variables have a significant impact on the accuracy of medical record results in the ER. Recording the time, signature, and name of the medical personnel conducting the examination are indicators of accountability and validity of each medical action. The absence of authentication elements can cause administrative disruptions, including in insurance claims and medical validity.
4. Documentation variables play an important role in maintaining the accuracy of medical record results. Accuracy in recording patient information, including writing complete and correct names, is very influential in the medical treatment process. Documentation errors, even small ones, can pose a risk of therapeutic errors and reduce the quality of service and patient safety.
5. Integration of the Four Variables Has a Significant Influence on the Accuracy of Medical Record Results

   The results of the study show that the four variables, namely identification, important reports, authentication, and documentation, together contribute significantly to the accuracy of medical record results in the Emergency Room of RSIA Rinova Intan Bekasi. Systemic integration of these four aspects encourages the creation of safe,

reliable services, and is able to increase the efficiency and effectiveness of the medical documentation system in the hospital.

5. BIBLIOGRAPHY

Abdurrohman, R. *et al.* (2024) 'Tanggung Jawab Hukum Rumah Sakit Berdasarkan Doktrin Corporate Liability Menurut Pasal 193 Undang-Undang Nomor 17 Tahun 2023 Tentang Kesehatan', *Jurnal Cahaya Mandalika ISSN 2721- 4796 (online)*, pp. 2635–2647. doi: 10.36312/jcm.v3i3.3659.

Adeniyi, et al. (2024) 'The Role of Electronic Health Records in Enhancing Patient Care and Clinical Outcomes: A Review of Recent Advances and Challenges', *World Journal of Advanced Research and Reviews*, 21(1), pp. 165–171. Available at: https://wjarr.com/sites/default/files/WJARR-2024- 0592.pdf.

Al., A. et (2023) 'Evaluasi E-Medrec pada Bagian Analisis Rekam Medis Kuantitatif Rawat Inap di Rumah Sakit TK II Dustira Cimahi', *Jurnal Ilmiah Perekam dan Informasi Kesehatan Imelda (JIPIKI)*, 8(2), pp. 231– 241. doi: 10.52943/jipiki.v8i2.1379.

Al., W. et (2024) 'Pengaruh Identifikasi Pasien terhadap Keakuratan Rekam Medis di IGD RSIA Rinova Intan Bekasi', *Jurnal Manajemen Informasi Kesehatan*, 12(1), pp. 45–52.

Allpandianto, S. (2021) *Tinjauan Kelengkapan Rekam Medis Pada Pasien Tuberkulosis Di Rumah Sakit Tk. IV DKT Madiun*. STIKES Bhakti Husada Mulia.

Ambarani, P. Y., & Yuliani, R. D. (2023) 'Analisis Kuantitatif Dokumen Rekam Medis Rawat Inap di Rumah Sakit Ibnu Sina Kabupaten Gresik', *Jurnal Informasi Kesehatan Indonesia*, 9(2), pp. 141–150. Available at: https://ojs.poltekkes-malang.ac.id/index.php/JIKI/article/download/4184/643/.

Amran, et al. (2022) 'Peran Penting Kelengkapan Rekam Medik Di Rumah Sakit', *Baiturrahmah Medical Journal*, 1(2), pp. 69–76.

Apriliyani, S. (2021) 'Penggunaan Rekam Medis Elektronik Guna Menunjang Efektivitas Pendaftaran Pasien Rawat Jalan Di Klinik Dr. Ranny', *Cerdika: Jurnal Ilmiah Indonesia*, 1(10), pp. 1399–1410.

Arimbi, et al. (2021) 'Analisis Kuantitatif Kelengkapan Formulir Informed Consent Rumkital Dr. Ramelan Surabaya', *J-REMI: Jurnal Rekam Medik dan Informasi Kesehatan*, 2(2), pp. 221–230.

Azizah, F. N. (2023) *Pengaruh Sleep Deprivation terhadap Response Time Tenaga Perawat di IGD RSU Cut Meutia Aceh Utara*. Universitas Malikussaleh.

Azwar, S. (2012) *Reliabilitas dan Validitas*. Edisi ke-4. Pustaka Pelajar.

Basyarudin, B. (2022) 'Aspek Yuridis Rekam Medis Elektronik Dijadikan Alat Bukti Apabila Terjadi Kesalahan Pelayanan Kesehatan', *Jurnal Cakrawala Ilmiah*, 1(12), pp. 3495–3510.

Berutu, et al. (2020) 'Kekuatan Hukum Pembuktian Rekam Medis Konvensional Dan Elektronik Berdasarkan Hukum Positif Indonesia', *Jurnal Hukum Samudra Keadilan*, 15(2), pp. 305–317.

Bete, M. A. and Nurvita, S. (2023) 'Analisis Kuantitatif Kelengkapan Pengisian Catatan Perkembangan Pasien Terintegrasi Dokumen Rekam Medis Rawat Jalan Di Rumah Sakit Jiwa Daerah Abepura Periode Februari Tahun 2022', *Jurnal Rekam Medis & Manajemen Infomasi Kesehatan*, 3(1), pp. 46–59. doi: 10.53416/jurmik.v3i1.152.

BINUS University (2021) *Memahami Koefisien Determinasi dalam Regresi Linear*. Available at: https://accounting.binus.ac.id/2021/08/12/memahami- koefisien-

determinasi-dalam-regresi-linear/.

Buckland, M. K. (1997) 'What is a ?document??', *Journal of the American Society for Information Science*, 48(9), pp. 804–809. doi: 10.1002/(SICI)1097-4571(199709)48:9<804::AID-ASI5>3.0.CO;2-V.

Creswell, J. W. (2024) 'My 35 Years in Mixed Methods Research', *Journal of Mixed Methods Research*, 18(3), pp. 203–215. doi: 10.1177/15586898241253892.

Damayanti, V. and Suhenda, A. (2023) 'Analisis Kelengkapan Pengisian Rekam Medis Pasien Diabetes Melitus Di Puskesmas Cijeungjing Kabupaten Ciamis Tahun 2020', *Media Informasi*, 19(1), pp. 80–88.

Denis, J.-L. (2014) 'Accountability in Healthcare Organizations and Systems', *Healthcare Policy | Politiques de Santé*, 10(SP), pp. 8–11. doi: 10.12927/hcpol.2014.23933.