The Importance of Nurse Knowledge about Physical Examination and Inform on Medical Record Facility Inpatient Patient: Case Study in Sari Asih Hospital Karawaci Tangerang

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Keywords: medical records, knowledge, inpatients.

Abstract: Based on the results of the observation in Sari Asih Hospital Karawaci Tangerang obtained medical record of hospitalized records are still many empty is that in 2016 there are 296 (3.4%) patients and in 2017 there are 405 (3.9%) patients. The incompleteness of medical record data mostly occurred on the accuracy of patient identity (name, a medical record number, place of birth date, sex) that is 37 patients (9%); and physical examination of 44 patients (11%), informed consent 47 (12%). The nurse's function as one of the data inputs that make the documentation of nursing care actions will affect the quality of the patient's medical records. The incompleteness of DRM is because there are still many nurses who have poor knowledge (60%) about medical records.The purpose of this research is to determine the effect of knowledge of nurses in filling out medical records on the completeness of medical records file of inpatients (case study in Rs. Sari Asih Karawaci Tangerang). The design of this study is associative causal (causal) with a quantitative approach. The object of this research is nurses in hospital wards as much,and samples counted 25 people with purposive sampling technique. Data collection by using primary data in the form of questionnaire/questionnaire and secondary data based on RM 2017 data which then analyzed by binary logistic regression analysis.Based on the result of regression logistic binary statistical analysis, it is found that the nurses' knowledge variable in the filling of the medical record has a significant effect on the accuracy of the medical records file of the inpatients The better the nurse's knowledge,the more complete the patient's medical record. Advice for hospitals to socialize, regularly monitor and evaluatenurses, about the importance of completeness in filling the medical record.

1 BACKGROUND

Hospitals are health referrals that serve outpatients, emergency and inpatient care with various types of medical services and medical support in a hospital service system. Serving the patient is one of the hospital services, in accordance with the Regulation of Medical Record (RM) in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 269 / Menkes / PER / III / 2008 dated 02 March 2008 on Medical Record. Also described medical record is a file containing records and documents about the patient's identity, treatment examinations, actions and other services that have been given to the patient. Medical records should be in writing, complete and clear or electronically.

There is already a fixed procedure (attached) about the completeness of medical records data in inpatient turned out from the observations in "RS Sari Asih Tangerang" in the assembling in the implementation of his duties generated data medical records hospitalized records are still many empty. RS Data. Sari Asih Karawaci Tangerang in 2016 showed 8,793 (14.7%) of inpatients from 59,993 patients overall, from 8,793 inpatients there were 296 (3.4%) patients with incomplete medical record data. While in 2017 it showed an increase in hospitalized patients to 10,308 out of 85,947 patients as a whole, and from 10,308 inpatients there were 405 (3.9%) patients with incomplete medical record data. The incompleteness of medical record data mostly occurred in the patient accuracy of patient identity (name, a medical record number, place of birth date, sex) that is 37 patients (9%); and physical

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examination 44 patients (11%), informed consent 47 (12%)

The nurse's function as input data made from the nursing care actions performed will affect the poor quality of information in the patient's medical records. Better health data quality in the patient's medical record can be reviewed by and therefore requires a good knowledge of the nurse.

Knowledge of medical records, in this case, is the knowledge of what should be accomplished in the filling example of medical records other than that how to create a medical record correctly in accordance withPermenkes (2008) consisting of patient identification, treatment examinations, actions and other services that have been given to the patient

Initial survey conducted by the researchers resulted in data that there are still many nurses who have poor knowledge (60%) about the medical record.

The existence of this study is expected to contribute or its application, especially for nurses about the filling of medical records

This motivation is to improve the knowledge about the medical record so that the quality of medical record becomes better and better quality.

2 RESEARCH METHODS

This research method using research method with a quantitative approach to know the significant relationship between variables studied. The technique used in this study is to determine the sample size of the population is a purposive sampling technique. Data analysis used binary logistic regression analysis. Sari Asih Karawaci Tangerang with one shot time horizon to study that is research done with the previous study, week, week, in order to answer the research question

OPERATIONAL DEFINITIONS VARIABLES

In this study the dependent variable (Y) is the completeness of the medical record is a file containing records and documents about the identity, examination, treatment, action, and other services that have been given to the patient in the form of physical examination data and informed consent with the instrument of the questionnaire based on medical records of RS Sari Asih Tangerang in 2017 with interval scale. While the independent variable (X) is the knowledge of the nurse that is knowledge about what should be completed in the filling of medical record file and Understanding the correct way of writing medical records file in accordance with Permenkes year 2008 with instrument is a questionnaire consisting of 15 items of questions with interval scale

2.1 Research Result

The result of research is shown in the frequency distribution of respondent characteristics as follows:

Table 1: Characteristics of Nurse RS Sari Asih Karawaci Tangerang

No	Characteristics of Respondents	Amount	%
1.	Age		
	20-26 years old	6	24
	27-40 years old	15	60
	41-61 years old	4	16
2.	Last education		
	SPK	0	0
	DIII	13	52
	S1	8	32
	S2	4	16
3.	Years Of Work		
	< 1 year	2	8
	< 5 year	5	20
	< 10 year	10	40
	> 10 year	8	32
4.	Gender		
	Man	7	28
	Woman	18	72

Source: data that has been processed (2018)

Based on Table 4.1 above, respondents are mostly aged 27-40 years, 60%, most respondents have recent education DIII (52%), work-based characteristics are mostly found <10 years (40%) and most of them are female (72%).

2.2 Variable Descriptive Satistics

Table 2: Results Descriptive Statistics Variable

Variabel	N	Minimum	Maximum	Mean	Std Deviation
Knowledge	25	6	15	11.40	2.90115
Complete Medical Record	25	32	37	36.12	1.56312
Vallid (N)	25				

Source: data that has been processed, SPSS 24

Output table 4.2 above shows the value of N or the amount of data to be studied amounted to 25 samples. The nurse's knowledge about the filling of medical record file has mean or a mean value of 11.40 which means that the average knowledge of the nurses is included in either category with a maximum value of 15 and a minimum value of 6 With a standard deviation of 2.90115 it can be said the average value of deviation of knowledge variables is 2.9%. Furthermore, for medical record completeness variable obtained mean or mean value of 36.12 which means the average completeness of medical records file included in the category either with a maximum value of 37 and a minimum value of 32. With the standard deviation 1.56312 can be said the average value of deviation variable the completeness of the medical record is 1.56%.

The descriptive results of each variable based on the number of presentations are as follows :

StatisticsTest

1. ValidityTest:The test results of instrument validity to 10 respondents are as follows:

Table 3: Validity Test Results

Question	r count	r table	conclusion
1.	0.694	0.6139	Valid
2.	0.863	0.6139	Valid
3.	0.863	0.6139	Valid
4.	0.835	0.6139	Valid
5.	0.863	0.6139	Valid
6.	0.694	0.6139	Valid
7.	0.863	0.6139	Valid
8.	0.835	0.6139	Valid
9.	0.811	0.6139	Valid
Question	**r count**	**r table**	**conclusion**
10.	0.863	0.6139	Valid
11.	0.726	0.6139	Valid
12.	0.863	0.6139	Valid
13.	0.835	0.6139	Valid
14.	0.863	0.6139	Valid
15.	0.835	0.6139	Valid

Source: data that has been processed, SPSS 24

The table above shows that all the question items in this study are valid. Where r table value with the number of respondents (N = 10 or df (N-2) = 8) and the significance level of 0.05 is 0.6139. The r valueof the whole question is greater than r table, which means the question items in the questionnaire have met the validity requirements

2. ReliabilityTest

Next is the reliability test of the questionnaire by taking 10 samples of Inpatient Patients BPJS Sari Asih Ciledug Hospital is processed using a computerized system with the softwareSPSS version 24 is:

Table 4: Reliability Test

Variable	Cronbach's Alpha	Conclusion
Nurse Knowledge About Medical Record	0.975	Reliable

Source: Primary data that is processed (2018)

In table 4.4 it can be seen that the knowledge variable of medical record file has Cronbach's Alpha (α) above 0.60 so it can be said that all the concepts of variable measuring of the questionnaire are reliable which means that the questionnaire used in this study is a reliable questionnaire to be analyzed Furthermore.

1. Wald Test

Table 5: Wald Test

		Wald	df	Sig.	conclusion
Step 1[a]	Medical Record Completeness	11.000	1	.006	Be accepted
	Constant	1.199	1	.000	

Source: Primary data that is processed (2018)

Based on table 4.5 above can be seen that the value of wald by 11,000 with the value of sig 0.000 <0.05 (5%), it can be concluded that the hypothesis accepted the knowledge variable significantly affect the completeness of the medical record file.

2. Coefficient of Determination Test Nagelkerke R Square

Table 6: Nagelkerke R Square Test

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	8.376[a]	.486	.769

Source: Primary data that is processed (2018)

Based on the results of Nagelkerke R square test obtained value of 0.769 which means then the proportion of completeness of the medical record file that can be explained by 76.9%. while the remaining 23.1% can be explained by other variables outside the research model such as attitudes, beliefs, beliefs of values, physical environment (facilities or health facilities), attitudes and behavior of health workers or other officers.

3 DISCUSSION

3.1 Univariate Analysis

3.1.1 Nurse Knowledge in Charging Medical Record Files

The knowledge that is discussed in this research that is about a medical record that is knowing what must be completed in filling out medical record file and understand how to write medical record file correctly in accordance with Permenkes year 2008 consisting of writing name, contact person address, record number medical and patient age etc. (Shofari, 2006). According to Permenkes No. 269 In 2008, the medical record is a file containing records and documents such as patient identity, examination results, a medication that has been given, and other actions and services that have been given to the patient. The purpose of the medical record is to support the achievement of orderly administration in order to improve health services. Without the support of a proper medical record management system, then the administrative order will not succeed (Gondodiputro, 2007). The scale assessment of knowledge categories based on Budiman and Riyanto (2013) are grouped into two groups:

1) Knowledge level category Good value> 50%
2) Knowledge level category Less good value ≤ 50%

In this research obtained most of the knowledge of nurses included in the good category as many as 20 people (80%). While as many as 5 people with less good knowledge (20%) as for the score answer each question item on the questionnaire knowledge sheet as follows.

Table 7: Respondents answer Score

No	Question	Score	(%)
1.	At least the things that should be included in the medical record are identity, anamnesis, physical examination, and diagnosis	15	60
2.	Medical Records on the patient's physical examination include information such as inspection, palpation, percussion and auscultation	21	84
3.	Medical Record regarding the physical examination of the patient contains the patient's nursing history	23	92
4.	Medical Record regarding the physical examination of the patient at least contains the height of the body (TB), weight (BB), temperature, and pulse/pulse frequency.	23	92
5.	Medical Record results have to be complete within 24 hours after the patient is treated and before the surgery	22	88
6.	Medical Record physical examination contains the history and the course of the patient's illness	23	92
7.	Medical Record physical examination contains diagnosis and patient laboratory results	22	88
8.	In the Medical Record form of Informed consent contains the consent of the medical treatment signed by the patient/family of the patient concerned beforecertainactions/therapies	9	36
9.	In the Medical Record form of Informed consent contains the consent obtained by a physician before any medical examination, treatment, and medical action to be performed for the patient's healing	16	64
10.	The Medical Record form informed consent contains the patient's identity (Name, date of birth, Gender, address, ID / ID / SIM, no phone)	23	92
11.	The Medical Record form informed consent form must be signed by the patient/patient's family 24 hours before any medical action is taken	22	88
12.	The Medical Record form informed consent form is known and signed by both witnesses, the nurse acting as one of the witnesses	21	84
13.	The Medical Record form informed consent form must be stamped	14	56
14.	The Medical Record form informed consent form is not required for emergency patients who are not accompanied by the patient's family	7	28
15.	The Medical Record form informed consent form must be signed by the physician as the person in charge of the written information	24	96

Source: Primary data that is processed (2018)

Fromdata can be seen for the medical record physical examination of the lowest score on the item question 1 with a score of 15 (60%) ie at least things that should be included in the medical record is identity, anamnesis, physical examination and diagnosis when for file recording especially in inpatients must contain at least about the identity of

the data, date and time, the results of the history, the results of physical examination, investigation, diagnosis, management plan, treatment, observation record, home summary, name and sign of doctor / dentist for dental cases equipped with odontogram. Further scores on item no. 2 of 21 (84%) with RM note notes regarding physical examination of the patient include information in the form of inspection, palpation, percussion and auscultation. Though it should be information of RM physical examination not only that but also include an examination of the head to toe which contains the result of the check of vital signs (temperature, blood pressure, pulse, respiratory rate) and basicbiometric (TB, BB, Pain).

As for the informed consent, the lowest score on item no 14 (7%) is the RM informed consent form not required for emergency patients who are not accompanied by the patient's family. In this question, many nurses who assume in emergency conditions must continue to fill in informed consent. Whereas according to Permenkes No 209 / Menkes / Per / III / 2008 in Article 4 paragraph (1) that no informed consent needed in emergencies. However, if an action has been taken to rescue the emergency, the physician is obliged after that to explain to the patient or immediate family.

The next lowest score on item 8 with a score of 9 (36%) with the question on the RM form of Informed consent contains the consent of the medical treatment signed by the patient/family of the patient before any specific action/therapyis performed. Many nurses consider informed consent only for certain therapies. Whereas informed consent is written and oral consent which is done for all medical actions in normal circumstances and emergency situations.

Overall nurse knowledge about RM physical examination and informed consent included in good category, this can be seen from the mean value of 11.40.

The results of this study in line with research conducted by Agus Siswanto in 2012 obtained the results of nurse knowledge about the regulation of medical record in the category very good 43.6%, both 25.5%, quite 23.6%, and less 7.3% . Another study conducted by Ardika (2012) found that 11 people (73.3%) who know medical records in either category.

The low score on statement item # 1 concerning the inclusion of minimal data on medical record documents is very fatal because most respondents answered wrongly (60%). Similarly, question no 2 is about RM records on physical examination of the patient. This proves that there are still many nurses who do not know about the procedure of filling the medical record correctly. According to the medical record document, researchers should be given sufficiently detailed data, as this relates to treatment and care to the patient and the implementation of further examination to the patient. As for the informed consent the lowest score on item No. 8 and 14. This indicates that many nurses who do not understand the use of informed consent.

The nurse as one of the medical record personnel has the responsibility to evaluate the quality of the medical record itself to ensure consistency and completeness of the content. Therefore, the RM report, in this case, the physical examination and informed consent is in full condition and contains all positive and negative discovery data.

According to the researcher the good level of knowledge by the nurse this is caused by 60% age of respondents are in the range of 27-40 years it shows the nurse at productive age to produce good performance besides the highest nurse education level is DIII (52%) and work experience <10 years (40%) this is also a good input for nurse knowledge because education influences the learning process, the higher the education of a person the easier it is for the person to receive the information. With higher education then one will tend to get information both from others and from the mass media. The more information that goes in,the more knowledge gained about health. Knowledge is closely related to education where it is expected that someone with higher education then the person will be more knowledgeable. Further experience or high work can increase the knowledge of nurses because experience as a source of knowledge is a way to obtain the truth of knowledge by repeating the knowledge gained in solving problems faced in the past so that with long service can develop a person's ability to increase knowledge.

Also, nurses who have a good knowledge of medical records (80%) are nurses who are always active to find out about SOP filling the medical record. While 20% of nurses with knowledge of filling the medical record is not good, this is according to the researcher because the nurses are not active to seek information about medical records either ask through RM officers, doctors, midwives, verifieretc. and never participate in training and workshop about medical record. Nurses who do not yet have a good knowledge of medical records are usually new nurses who have not been input from long-standing nurses with good experience in filling out medical record data. According to Notoatmodjo

(2010), the source of certain knowledge possessed and controlled by a person is obtained through experience, both individually and in society.

3.1.2 Medical Record Completeness

Medical records according to the Indonesian Minister of Health Regulation 269 / MENKES / PER / III / 2008 are files containing records and documents on identities, checks, medications, actions and other services that have been provided to patients. The completeness of medical records is of great importance because the complete medical resume in addition to maintaining the quality of medical records is also used for the administration of insurance claims (Anggraini, 2013)

Referred to the completeness of medical records in this study is the completeness of medical records documents viewed regarding clinical examination and informed consent.

Based on this research, the researcher get the result of the contents of the medical record document of inpatient patient of BPJS in Asari Karawaci Hospital of Tangerang in 2017, is as follows: from 25 samples of medical record document there are 18 medical record documents complete with percentage 72%, while medical record which is incomplete there are 7 with a percentage of 28%.

The result of this research is in line with the research conducted by Ardika (2012) which is 10 documents RM (66,7%) that fulfill the complete category.

Physical examination is a physical examination in the whole body of the client's examination,or only a certain part is deemed necessary, to obtain systematic and comprehensive data to ensure/prove the results of anamnesis, determine the problem and plan appropriate nursing actions for the client (Dewi Sartika, 2010)

In this research for Medical Record Form of Physical Examination there are 5 RM files of patient with incomplete field that is on:

(1) High Body Examination (TB)

Height is a measure of the size of a human body in height measured in pure state of height from heel to head without any other object being measured (Setyapranomo 2017).

In this research data Medical record TB incomplete according to the researchers, this is because there are still nurses who are not disciplined in the filling fil records RM record

(2) Mental Status

The mental status examination includes mental status assessment, awareness assessment, psychomotor activity assessment, orientation assessment, perceptual assessment, form and thought content assessment, mood and affective assessment, impulse control assessment, reality valuation assessment, insight assessment, functional ability assessment (MOH, 2010)

In this research medical record data mental status incomplete according to the researchers this is because there are still nurses who are not disciplined in the filling completelyMedical record.

(3) Genital Devices

Genitalia Physical Examination is to find out whether the client has a problem with genitalia (vital tool) both internally and externally.

According to researchers physical examination of the patient's genitals can make the client feel ashamed,sonurses should take a quiet approach. The gynecological examination is a difficult experience for the patient. Also, there are cultural restrictions.Therefore there are still nurses who do not perform a physical examination of the genitals in patients.

Next, on the Informed Consent form,6 RM patient files are incomplete which include:

(1) No identity (KTP/SIM) of the patient
(2) TTL family members (* authorized)
(3) No identity (KTP/SIM) of family member (* authorized)
(4) Signature of the witness of the patient

Informed consent is incomplete according to the researcher because the patient/family of the patient did not complete the form at the time of consultation. Therefore the nurse should be careful and careful inquiries and should ensure that questions asked on the form are clear and understandable by the patient

3.1.3 Nurse Knowledge in Charging Medical Record on Medical Files Record Completeness

Based on the results of research that has been described previously it is obtained data that there is a significant influence between nurse knowledge variables in the filling of medical records to the completeness of medical records file it can be seen in table 4.3 that is obtained wald value of 11,000 with the value of sig 0.000 <0.05 (5%), then the influence of knowledge variable with the

completeness of medical record is 76.9% this is proven by the test of nagelkerke R square (Table 4.5). While the remaining 23.1% affect the completeness of medical records by other variables that are not examined such as attitudes, beliefs, beliefs values, physical environment (facilities or health facilities), attitudes and behavior of health workers or other officers.

The results of this study are in line with research conducted by Utami (2016) which states that there is a meaningful relationship between nurse knowledge about the medical record with the completeness of nursing note at the inpatient installation at Al AT-Turots Al-Islamy Sleman General Hospital (p = 0.006). Another study conducted by Agung Personal (2011) suggests that low-knowledge nurses risk 6.280 times greater for incomplete documentation.

According to the Minister of Health Number 269 of 2008, the documentation of medical record file is started when the patient is admitted to the inpatient ward, the receiving nurse must fill out the recording form starting from the identity (name and patient RM number), the report should include data assessment, diagnosis, nursing actions, and the execution and evaluation of actions when carrying them out, then continued with authentication (affixing doctor's name and signature). The medical record resume is completed by the nurse as soon as the patient is declared allowed to go home by the doctor, or go home at his request, or dies. From this, it can be concluded the completeness of medical records file is very important to support the performance of health practice. Ardika (2012) states the completeness of documenting the medical record is influenced by various factors such as educational background, length of service, knowledge, skills, motivation, psychological and so forth.

Of the 7 incomplete medical record documents, were analyzed further without the use of statistical tests and obtained results that nurses filled the document with an uneven distribution of age from 22 to 33 years old and they were mostly graduates from nursing school (SPK). The data obtained on the educational background of the research samples showed 48% were graduates of undergraduate nursing (S1) and S2 they have knowledge about the good medical record and complete the documentation of nursing care completely.

While the other 52% who are graduates from the SPK, nursing academy (DIII) and perform the process of documentation with different levels of completeness. This difference in completeness may be due to the lack of knowledge, awareness and motivation of the nurse to complete the documentation process. Also, SPK education and academy is a beginner profession education so that in the implementation of its work requires experience and training enough to be able to do the job well.

Knowledge is very important in forming one's behavior, hence from the result of this research indicate that the better the nurse'knowledge about filling of medical record file hence more complete data of patient medical record. Therefore, for RS Sari Asih Karawaci Tangerang to maintain and even improve the knowledge of medical record officer for the implementation of hospital management system by conducting training or seminar related to the medical record.

3 CONCLUSION

Based on the results of research on the Influence of Nurses' Knowledge in Filling Medical Records Against Completeness of Medical Record Files Inpatient Patients at RS. Sari Asih Karawaci Tangerang Year 2017, it can be concluded as the most of the knowledge of nurses in the filling of medical records file included in good category (80%), then most of the completeness of medical records file of inpatients included in complete category (72%). The result of the statistical test showed that there was significant influence between the nurse knowledge variable in filling the medical record to the completeness of the medical record file. This was proved by the wald test value of 11,000 and the sig value 0.000 <0.05

The nurse's knowledge about charging RM will affect the quality of the medical record which ultimately also affect the hospital administration. Because as the main objective of the medical record is to support the achievement of the administrative order to improve health service in the hospital, without support by a system of medical record management good and correct, orderly hospital administration will not succeed as expected. Also, incomplete medical record data resulted in delays from Claim payments submitted by the Hospital which will also affect the hospital operations is the obstruction of Hospital cash flow (cashflow).

4 IMPLICATIONS

1. There should be an education, workshop training, and seminar related to medical record to improve the knowledge of the nurse

2. The nursing perception among nursing staff about filling the completeness of medical records file so that all nurses can perform their duty well according to SOP.
3. Nurses should be careful and careful inquiries and should ensure that questions asked on the informed consent form are clear and understood by the patient
4. Preferably for newly employed nurses from the beginning of the orientation given the knowledge and advance about the importance of the completeness of the inpatient medical record file
5. To the management of RS to activate the function of medical record committee in charge of planning, implementation, supervision, controlling, audit and assessment of medical service quality according to the guideline of the medical record of MOHRI so as to improve the quality of hospital service.

5 SUGGESTION

1. Need to do further research to find other factors that influence the completeness of the patient's medical record
2. Nurses are expected to carry out a fixed procedure or SOP on filling in the completeness of the existing medical records file
3. For the management of Sari Asih Hospital Karawaci Tangerang to socialize, regularlymonitor and evaluate to health workers, especially nurses, about the importance of completeness in filling medical records.
4. For the hospital to provide work motivation to the nurses in the treatment room about the importance of the completeness of medical record files
5. For further researcher need to dig further information related to medical record completeness by taking all indicator in filling in the medical record of inpatient (for example identity, anamnesis, investigation etc) so that can get good analysis result

REFERENCES

Great, Private. *Analysis of Influence Factor Knowledge, Motivation, and Perception Nurses About Room Head Supervision Against the Implementation of Nursing Care Documentation in Inpatient Room of Kelet Hospital.* Central Java Province in Jepara. Semarang: Faculty of Public Health. UNDIP; 2009

Ardika. *Relationship between Nurses' Knowledge of Medical Records with Completeness of Nursing Records*. Semarang: Diponegoro University Semarang. 2012

Dewi, Sartika. *Physical examination. http://nursingbegin.com/tag/pemeriksaan-phisik/(online) accessed 07 February*. 2018. Jakarta. 2010

Gondodiputro. *Medical Records And Health Information System In Primary Health Care Facilities Puskesmas*. E-Journal of Public Health Sciences Faculty of Medicine, Padjadjaran University of Bandung. 2007

Notoatmodjo. *Health Research Methodology. Jakarta: Rineka Cipta*. 2010

Permenkes No. 269 / Menkes / Per / III / 2008. *About Medical Record*. Jakarta: 2008

Shofari B. *Management of Medical Record Service System at the Hospital*. Jakarta: Rineka Cipta.2006

Utami, Sri. *Knowledge Level Relationships About Medical Records With Completed Filling Of Nursing Notes On Inpatient Installations At At-Turots Hospital Al Islamy Sleman. Yogyakarta*. E-journal. Retrieved on February 2, 2018. http://www.permataindonesia.ac.id/wp-content/uploads/2016/08/06. -Journal-PI_Utami-Amalina-Fahmi.pdf. Journal of Permata Indonesia. Volume 7, Number 1, May 2016. 2016.