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Review Of Completeness in Filling Out the General Consent Form for Oncological Surgery Polyclinic Patients at Prof. Dr. I.G.N.G. Ngoerah Hospital

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Abstract

General consent is a general agreement given by a patient or their family to receive health services, which plays an important role in ensuring the validity of informed consent and legal protection for the hospital. Completeness of this form is crucial so that the information can be clearly understood by the patient and their family, and supports the accountability of health services. This study uses a quantitative method with a descriptive approach. The population used is the general consent documents of outpatients at the Oncology Surgery Clinic of Prof. Dr. I.G.N.G. Ngoerah General Hospital in October - December 2024, totaling 251 documents. The results showed that in the identification aspect, 245 documents (97.6%) were completely filled out. In the authentication aspect, 240 documents (95.6%) were completely filled out, but many still did not include the name of the registration officer. In the recording aspect, only 181 documents (72.1%) were completely filled out, especially the relationship variable with the patient which was often not filled out. Meanwhile, the reporting aspect showed 147 documents (68.6%) were complete, but the recording of the date variable was incomplete. The completeness of the general consent form for outpatients at the Surgical Oncology Clinic of Prof. Dr. I.G.N.G. Ngoerah General Hospital varies. The identification and authentication aspects have been completed well, but recording and reporting aspects require more attention to improve documentation quality and legal protection for the hospital.

Keywords: General Consent, Completeness of Form Completion, Medical Records

INTRODUCTION

Healthcare service facilities are tools and/or places used to provide healthcare services, whether promotive, preventive, curative, or rehabilitative, carried out by the government, local governments, and/or the community (Regulation of the Minister of the Republic of Indonesia, 2022). One of the healthcare service facilities that plays a crucial role in maintaining public health is the hospital. A hospital is a healthcare institution that provides comprehensive individual health services, offering inpatient, outpatient, and emergency services (Ministry of Health RI, 2020). Hospitals not only play an important role in maintaining public health but also hold a great responsibility in delivering professional and safe services. One of the important aspects of healthcare services is medical record management.

According to Ministerial Regulation No. 24 of 2022, a medical record is a document containing patient identity data, examinations, treatments, procedures, and other services provided to the patient. A medical record not only contains demographic data and medical history but also includes information regarding patient consent for medical procedures, as documented in the general consent form. General consent is a general agreement provided by the patient or their family to receive healthcare services. The process of granting general consent usually occurs when the patient registers for the first time, also known as a new patient, to receive healthcare services from administrative officers. The form contains information about the rights

and obligations of the patient and their family. If the patient is unable to make decisions regarding care, a family member may act as their representative (Purnomo, 2017). Therefore, the general consent form is an important document in patient registration.

General consent must be completed to support accreditation and should be known and understood by patients and/or their families. General consent must be documented in written or recorded form to ensure accountability and avoid disputes in the future (Law No. 27 PDP, 2022). It should be noted that although general consent provides a legal foundation for healthcare workers to perform medical procedures, patients still have the right to withdraw their consent at any time.

The completeness of filling out the general consent form is very important to ensure that the informed consent given by the patient is valid and legally binding, as well as to protect the hospital from potential legal claims. Complete and accurate data in the general consent form helps build trust between patients and healthcare workers and facilitates tracking and evaluation processes. However, incomplete filling of the general consent form is a common problem in many hospitals. This can be seen in findings such as incomplete date and time data, incomplete responsible party information, and unsigned forms by either registration officers or patients. Such incompleteness may weaken the validity of patient consent, complicate tracking and evaluation processes, and reduce the quality of services provided. Incomplete forms can be interpreted as a lack of transparency and communication between healthcare providers and patients, thereby weakening the legal standing of healthcare workers in case of disputes. Furthermore, incomplete forms can also complicate auditing and quality control processes in healthcare services (Yadav, 2021).

Based on a preliminary study conducted using samples from July to September 2024 at the Oncology Surgery Polyclinic of Prof. Dr. I.G.N.G. Ngoerah Hospital with a total of 176 files, it was found that the completeness rate was 30 files (17.05%), while the incompleteness rate reached 146 files (82.95%). The incompleteness included missing date and time, missing contact person or family information, unsigned forms by patients and staff, and even incomplete identity information.

Since the percentage of incomplete general consent forms found is still high, the researcher is interested in conducting a more in-depth study of general consent, particularly at the Oncology Surgery Polyclinic. This is because the Oncology Surgery Polyclinic has the highest number of visits at Prof. Dr. I.G.N.G. Ngoerah Hospital. Therefore, the researcher is interested in carrying out a scientific study entitled "A Review of the Completeness of General Consent Form Completion for Patients at the Oncology Surgery Polyclinic of Prof. Dr. I.G.N.G. Ngoerah Hospital."

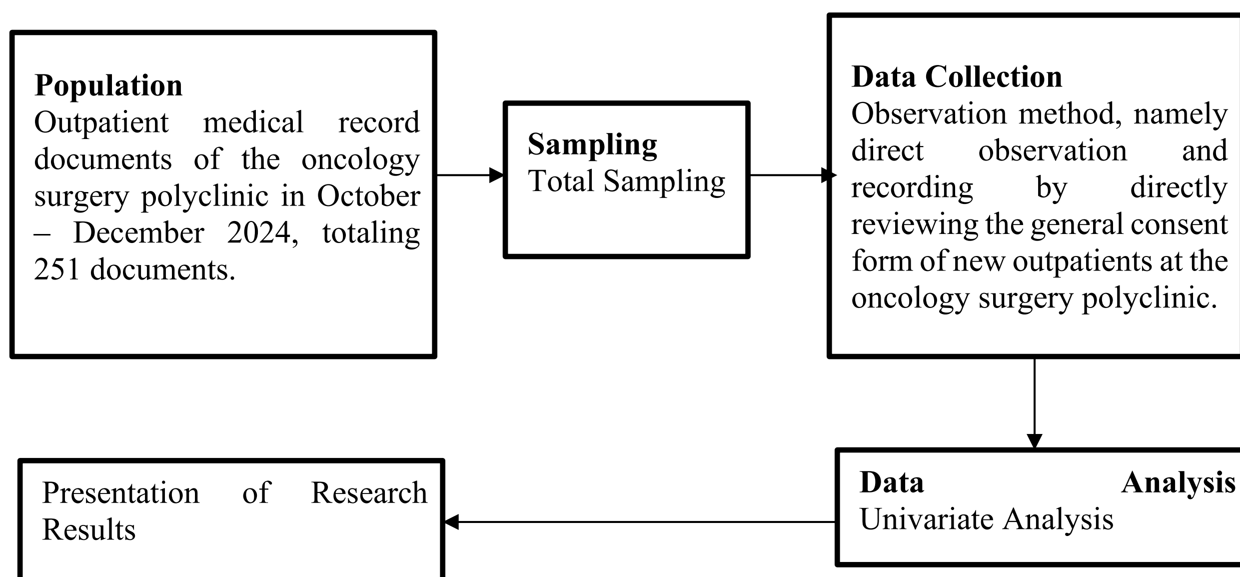
RESEARCH METHOD

2.1 Type of Research

In this study, to review the completeness of general consent for oncology surgery patients at Prof. Dr. I.G.N.G. Ngoerah Hospital, the researcher used a quantitative research type with a descriptive approach. The descriptive research method is a method for studying the status of a group of people, an object, a set of conditions, a system of thought, or a class of events in the present. The purpose of descriptive research is to create a description, picture, or illustration systematically, factually, and accurately regarding the facts, characteristics, and relationships between the phenomena being investigated.

Quantitative research is a research approach that assumes human behavior can be predicted and social reality can be measured objectively. In quantitative research, valid and reliable measurement tools are used, and accurate analysis is carried out, so that the research results obtained reflect the actual conditions without deviation.

2.2 Framework



2.3 Population

The population is the entirety of the research objects that become the focus of attention and the source of research data. The population used in this study consists of the medical record documents of new outpatients at the Oncology Surgery Polyclinic of Prof. Dr. I.G.N.G. Ngoerah Hospital during October – December 2024, totaling 251 documents.

2.4 Sample

A sample is a representation of the total population to be studied. This study uses the total sampling method, amounting to 251 medical record documents, where total sampling is a sampling technique in which all members of the population are taken as the sample (Sugiyono, 2019). This method was chosen because the population size is relatively small, making it possible for the researcher to include the entire population in the study.

2.5 Data Collection Method

The data collection method used in this study is the observation method. The researcher collected data through direct observation of the objects under study, namely by directly reviewing the medical record documents of new outpatients at the oncology surgery polyclinic to examine the completeness of the general consent form, as well as using a descriptive approach by analyzing existing data.

2.6 Data Analysis

The data analysis technique applied in this study is univariate analysis. Univariate analysis is used to report each variable from the research results. After data collection, the data were analyzed using descriptive statistics to be presented in the form of tabulation, minimum, maximum, and mean values by processing all data statistically to report the results in the form of the distribution of each variable (Sugiyono, 2019).

RESULTS AND DISCUSSION

Based on the results of the study conducted by taking samples from October to December 2024 regarding the General Consent of outpatients at the Oncology Surgery Polyclinic of Prof. Dr. I.G.N.G. Ngoerah Hospital, it was found that there were incompletions. The quantitative analysis of the completeness of the outpatient General Consent form is as follows:

Table 3.1 Analysis Results

No	Analysis Components	Completeness				Total	
		Complete		Incomplete			
		f	%	f	%	f	%
1	Patient Identity	245	97,6	6	2,4	251	100
2	Patient/Family Signature	240	95,6	11	4,4	251	100
3	Officer Name	68	27,1	183	72,9	251	100
4	Officer Signature	247	98,4	4	1,6	251	100
5	Name of Person in Charge	251	100	0	0	251	100
6	Relationship to Patient	181	72,1	70	27,9	251	100
7	Phone Number/Email Address	249	99,2	2	0,8	251	100
8	Address	203	98,0	48	2,0	251	100
9	Date	147	58,6	104	41,4	251	100
10	Time	230	91,6	21	8,4	251	100

Based on the table above, it can be seen that from the 251 documents used as samples in this study, the identification section was completely filled out in 245 (97.6%) documents. For the authentication aspect, it was found that from 251 documents, the patient or family signature variable was complete in 240 (95.6%) documents. However, the officer's name variable was incomplete in 183 (72.9%) documents, while the officer's signature variable was complete in 247 (98.4%) documents. Regarding the recording aspect, it was found that from 251 documents, the person-in-charge variable was fully complete with a 100% rate, while the relationship with the patient variable was complete in 181 (72.1%) documents. For the phone number or email variable, completeness was very high at 249 (99.2%) documents, while the address component showed completeness in 203 (80.9%) documents. In terms of reporting completeness, it was found that from 251 documents, the date variable was complete in 147 (58.6%) documents, while the time variable reached 230 (91.6%) documents.

3.1 Completeness of Filling in the Identification Section of the Outpatient General Consent Form

Based on the study of 251 outpatient general consent documents at the Oncology Surgery Polyclinic of Prof. Dr. I.G.N.G. Ngoerah Hospital, it was found that 245 documents (97.6%) were complete in terms of patient identity, while 6 documents (2.4%) were incomplete. Patient identity variables in this study included full name, date of birth, gender, and medical record number. These four elements are fundamental to healthcare documentation, ensuring the validity of patient consent and preventing identity errors in medical services.

When compared with other studies, significant variations were found. A study by Giyatno & Rizkika, M. Y. (2020) titled *Quantitative Analysis of the Completeness of Medical Record Documents of Inpatients Diagnosed with Femur Fracture at Dr. R.M. Djoelham Binjai Hospital* on 36 inpatient records showed an identification completeness rate of 56%. Patient name, medical record number, and date of birth were the most complete elements, while gender was only recorded in 28% of documents, showing a similar imbalance in filling out basic identity elements. Meanwhile, much better results were found in a study by Apriliani, L., & Gunawan, E. (2024) titled *Analysis of the Completeness of Outpatient Medical Records at Nagrak Public Health Center*, which found that out of 1,906 outpatient records, identification completeness was 94%, indicating a more disciplined and consistent recording system. Conversely, a study by Wirajaya, Made Karma Maha and Dewi, Ni Made Umi Kartika (2019) at Dharma Kerti Tabanan Hospital showed incompleteness in 99.14% of 232 inpatient medical records.

From this comparison, it can be concluded that the identification completeness in this study is moderate: better than Dharma Kerti Tabanan Hospital but still far behind the ideal standard achieved at Nagrak Public Health Center. This highlights the need for system improvements and greater compliance from officers in filling in basic patient identities to meet optimal documentation quality standards. Incomplete patient identity data can lead to ambiguity regarding the validity of the consent form, and in certain cases, may affect the validity of medical services provided. It can also become a finding in both internal and external audits and impact hospital accreditation assessments.

3.2 Completeness of Filling in the Authentication Section of the Outpatient General Consent Form

Based on the findings from 251 outpatient general consent documents at the Oncology Surgery Polyclinic of Prof. Dr. I.G.N.G. Ngoerah Hospital, the completeness of authentication varied across the variables studied. The first variable, patient or family signature, was fairly high, with 240 documents (95.6%) complete and 11 documents (4.4%) incomplete. The second variable, officer's name, showed the lowest completeness, with only 68 documents (27.1%) filled in and 183 documents (72.9%) incomplete. The third variable, officer's signature, had very high completeness, with 247 documents (98.4%) complete and only 4 documents (1.6%) incomplete.

This shows that most patients or their families provided signatures as a form of general consent for medical actions, indicating awareness and compliance in signing consent documents. Similarly, the high completeness of officer signatures reflects that officers generally understood and implemented SOPs in patient registration. However, the officer's name variable showed relatively low completeness, indicating a lack of compliance with documentation procedures. The absence of officer names can create accountability gaps, making it difficult to trace who obtained patient consent in the event of legal or audit processes.

When compared with other studies, these findings are very low. At Dr. R.M. Djoelham Binjai Hospital, Giyatno & Rizkika, M. Y. (2020) reported slightly better completeness, with doctor's signature, nurse's name, and nurse's signature present in 42% of documents, while doctor's name and professional title were recorded in 31% of documents. Much better results were observed in Apriliani & Gunawan (2024) at Nagrak Public Health Center, where authentication completeness reached 97%, showing high staff awareness and discipline. Similarly, Wirajaya & Dewi (2019) at Dharma Kerti Tabanan Hospital reported 74.14% authentication completeness. From these comparisons, it can be concluded that authentication quality in this study is still very low and requires systematic intervention.

According to the researcher, this emphasizes the need to improve staff knowledge, attitudes, and practices in authentication, which is crucial not only administratively but also legally for protecting patients and healthcare workers.

3.3 Completeness of Filling in the Recording Section of the Outpatient General Consent Form

The study of 251 outpatient general consent documents found that all forms included the person-in-charge variable completely, showing excellent compliance. For the relationship with the patient variable, 181 documents (72.1%) were complete, while 70 (27.9%) were incomplete. For phone number or email, 249 documents (99.2%) were complete, while only 2 (0.8%) were incomplete. For the address variable, 203 documents (80.9%) were complete, while 48 (19.1%) were incomplete.

This indicates that most recording variables were filled out properly, particularly for name, contact, and address information, which are vital for communication, documentation, and legal accountability. However, the incomplete "relationship with the patient" variable in 70 documents is significant, as it legitimizes the authority of the person providing consent. Missing

this data raises doubts about consent validity, especially when the patient did not sign the form themselves.

Although incompleteness in contacts and addresses was minimal, these remain critical since such data supports follow-up care, communication, and emergency contact. Thus, completeness should not focus solely on signatures but also on all supporting information.
When compared with other studies, Giyatno & Rizkika, M. Y. (2020) at Dr. R.M. Djoelham Binjai Hospital found 72% completeness in the use of medical abbreviations but only 44% correction of documentation errors, showing low compliance. Apriliani & Gunawan (2024) at Nagrak Public Health Center reported excellent recording completeness at 94%. In contrast, Wirajaya & Dewi (2019) at Dharma Kerti Tabanan Hospital found poor recording completeness, with 59.48% incompleteness.

This shows that although recording has received attention, improved monitoring, training, and SOP reinforcement are still needed to ensure consistency and accuracy.

3.4 Completeness of Filling in the Reporting Section of the Outpatient General Consent Form

From 251 outpatient general consent documents, data on reporting (date and time) showed varied completeness. A total of 147 documents (58.6%) recorded the date completely, while 104 (41.4%) did not. Meanwhile, the time variable was much better, with 230 documents (91.6%) complete and 21 (8.4%) incomplete.

This indicates that date and time reporting in the general consent forms was not yet optimal. Many forms lacked complete dates, either leaving them blank or only partially filling them in (e.g., only day and month without year). This makes the timing ambiguous and reduces the administrative validity of the document.
The absence of dates in over 100 forms is concerning since dates are legally binding in medical documentation, marking when consent was given and crucial for legal and audit purposes. Meanwhile, the high completeness of time recording is commendable, showing staff awareness of the importance of precise time documentation.

Compared with other studies, Wirajaya & Dewi (2019) at Dharma Kerti Tabanan Hospital reported 61.64% completeness in reporting. Giyatno & Rizkika, M. Y. (2020) at Dr. R.M. Djoelham Binjai Hospital found general consent reporting completeness at 69% and informed consent at only 36%. In contrast, Apriliani & Gunawan (2024) at Nagrak Public Health Center reported 97% completeness, almost perfectly aligned with SOP standards. These differences indicate that reporting quality heavily depends on staff compliance with SOPs and documentation monitoring.

Therefore, according to the researcher, continuous improvements are needed in the reporting system at Prof. Dr. I.G.N.G. Ngoerah Hospital, particularly in complete date recording, to ensure legally accountable documentation.

CONCLUSION

4.1 Conclusion

Based on the findings regarding the completeness of outpatient general consent forms at the Oncology Surgery Polyclinic of Prof. Dr. I.G.N.G. Ngoerah Hospital, the following conclusions were drawn:

1. In the identification aspect, 245 documents (97.6%) recorded complete patient identities, while 6 documents (2.4%) were incomplete.
2. In the authentication aspect, 240 documents (95.6%) contained patient/family signatures and 247 (98.4%) contained officer signatures. However, only 68 documents (27.1%) recorded officer names, while 183 (72.9%) did not.

3. In the recording aspect, the person-in-charge variable was recorded in all documents (100%), relationship with the patient in 181 documents (72.1%), and contact information in 249 documents (99.2%). However, full addresses were only recorded in 203 documents (80.9%).
4. In the reporting aspect, the date was recorded in 147 documents (58.6%) and the time in 230 documents (91.6%).

4.2 Suggestions

Based on the study results, the researcher proposes the following suggestions:

1. The hospital should routinely conduct socialization of the Standard Operating Procedures (SOPs) for filling in general consent forms to outpatient registration officers to ensure full understanding and compliance.
2. The hospital should carry out periodic monitoring and evaluation of general consent form completion as part of quality improvement and accountability in patient documentation.
3. The hospital should implement digital general consent forms to facilitate easier data entry and automatic validation, as well as reduce the risk of lost or damaged forms.

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