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## Clinical Medical Record Audit Description For Quality Control And Cost Control In Healthcare Services At Dharma Yadnya General Hospital Denpasar: A Qualitative Study

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### Abstract

Clinical audit of medical records is an important effort to improve the quality of healthcare services and control costs in hospitals. However, inconsistent implementation and incomplete medical record documentation can affect its effectiveness. This study aimed to examine the implementation of clinical audits of medical records in supporting quality control and cost control at RSU Dharma Yadnya Denpasar. This study used a descriptive qualitative method, with data collection techniques including interviews and observations, and the data were analyzed using the Colaizzi 7-step method. The results showed that the implementation of clinical audits of medical records has followed a process in accordance with the Standard Operating Procedures (SOP), including sample selection, assessment, analysis, and the provision of recommendations. However, in practice, several discrepancies were found, such as audit implementation that was not consistently carried out according to schedule and incomplete medical record documentation. These conditions have resulted in the audit function not being optimal in supporting quality control and have caused obstacles in the claim process, thereby affecting cost control. Therefore, clinical audits of medical records play an important role in supporting quality and cost control; however, their implementation needs to be improved through consistent scheduling and increased compliance of healthcare personnel in completing medical records.

**Keywords:** Clinical Audit, Medical Records, Service Quality, Healthcare Service Costs.

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## INTRODUCTION

Healthcare services play a crucial role in improving public health. The quality of healthcare services is essential to ensure patient safety, proper treatment, and patient satisfaction. One of the key components in managing service quality in hospitals is medical record management. Medical records are documents that record the entire process of services provided to patients. In addition to administrative purposes, medical records are also used as a reference for medical decision-making, service evaluation, and effective cost management.

The ability of medical records to provide complete, accurate, and well-organized information greatly influences the quality of healthcare services delivered. Research conducted by Sugeng (2024) shows that medical record audits play an important role in ensuring that documentation processes comply with established standards. This contributes to improving service quality and patient safety. Furthermore, medical record audits help identify issues such as errors, delays, or discrepancies that may lead to decreased service quality or unnecessary costs.

Clinical audits of medical records are part of the hospital quality management system, aimed at ensuring that services and documentation comply with applicable procedures. These audits must be conducted continuously to support effective quality and cost management. In this way, hospitals can provide high-quality services while minimizing the risk of financial losses caused by discrepancies in medical record documentation and cost claims (Sugeng, 2024). Therefore, there are two fundamental aspects that healthcare institutions, especially hospitals, must consider in clinical medical record audits: quality control and cost control.

Quality control and cost control are two key indicators in assessing the success of healthcare services. Quality control focuses on improving services to meet medical standards and patient expectations, while cost control emphasizes the efficient use of resources without compromising service quality. Effective clinical medical record audits produce accurate data that serve as a basis for

improving service quality and optimizing cost management, strengthening hospital governance, and increasing patient satisfaction (Widya, 2025).

However, in practice, the implementation of clinical audits of medical records in various hospitals still faces several challenges that directly affect quality and cost control. Incomplete documentation, inaccurate clinical data, and discrepancies between diagnoses, procedures, and claim codes are frequently found in audit results. This situation indicates that medical records have not been fully utilized as a tool for controlling quality and costs, even though they are the primary source of data in service evaluation and healthcare financing.

This issue is further supported by findings from medical audits at Primary Healthcare Facilities (FKTP) in North Jakarta, which revealed a discrepancy of 32.8% between diagnoses recorded in medical records and those submitted in the BPJS Health claim system, as well as 35.75% of medical records that did not meet completeness standards. Inaccurate and incomplete data can lead to serious consequences, such as delays in claim processing, claim rejections, budget inefficiencies, and decreased quality of healthcare services. These findings indicate that weak implementation of clinical audits in medical records can hinder the effectiveness of quality and cost control in healthcare services (Wakhyuni et al., 2021).

Based on a preliminary study conducted by the researcher with the Head of the Medical Record Unit at Dharma Yadnya General Hospital, Denpasar, on December 4, 2025, similar problems were identified in the implementation of clinical medical record audits. These include incomplete medical record documentation, discrepancies between clinical data and billing, and delays in claim processing that may result in financial losses for the hospital. In addition, the follow-up mechanism for audit results has not been functioning optimally, so audit findings have not been fully utilized as a basis for improving service quality and sustainable cost control.

These issues reflect a gap between the ideal standards of clinical medical record audit implementation and actual practice in the field. If these problems are not addressed systematically, improving service quality and cost efficiency in hospitals will be difficult to achieve. Therefore, a comprehensive study is needed to provide an in-depth understanding of how clinical medical record audits are conducted, particularly in supporting quality and cost control at Dharma Yadnya General Hospital, Denpasar.

## **RESEARCH METHODS**

This study was conducted using a descriptive qualitative method to provide a comprehensive and in-depth description of the clinical medical record audit implementation for quality and cost control at Dharma Yadnya General Hospital (RSU), Denpasar. The research was centered at the Medical Record Unit and Hospital Management, with data collection initiated following a preliminary study in December 2025. The informants were selected through a purposive sampling technique, involving seven key stakeholders including the management team, medical committee (doctors/DPJP), nursing staff, medical record officers, and the finance/claims department. These informants were chosen based on their expertise, work experience, and direct involvement in the clinical audit process, ensuring that the data collected was both relevant and credible.

Data collection was carried out through triangulation methods, combining in-depth interviews, direct observations, and documentation reviews. During the interviews, the researcher utilized an interview guide to explore the structure, frequency, and challenges of the audit process. Observations were conducted to assess the actual practice of medical record documentation and audit flow, while documentation reviews focused on Standard Operating Procedures (SOPs), hospital policies, and audit reports. To analyze the gathered information, the study employed Colaizzi's seven-step method, which includes transcribing results, extracting significant statements, formulating meanings, clustering themes into categories, and validating the findings to provide a fundamental structure of the clinical audit phenomenon.

To ensure the trustworthiness and validity of the data, the researcher applied source and method triangulation by cross-referencing information obtained from different units and comparing interview results with observed documentation. The primary research instrument was the researcher themselves, supported by interview guides and recording devices. This methodological framework was designed to bridge the gap between ideal standards and field practices, ultimately identifying how clinical audits serve as a critical tool for maintaining healthcare service quality and preventing financial loss due to claim discrepancies at RSU Dharma Yadnya Denpasar.

## RESULTS AND DISCUSSION

### **Implementation of Clinical Medical Record Audits in Supporting Healthcare Service Quality Control**

The results of this study were obtained through in-depth interviews conducted with seven informants working in the medical record unit and hospital management. Informants were selected purposively based on criteria such as work experience, knowledge of medical records, and involvement in clinical audit processes within the hospital. The selected informants were considered to have relevant understanding and experience, enabling them to provide in-depth information regarding the implementation of clinical medical record audits. The data obtained were then used to describe the implementation process of clinical medical record audits in supporting healthcare service quality control.

Based on interviews regarding clinical medical record audits in healthcare quality (Question 1: *Can you explain how clinical medical record audits are implemented at Dharma Yadnya General Hospital, Denpasar?*), it was found that clinical audits are conducted in a structured, planned, and continuous manner as part of efforts to improve service quality and control costs. The audit process includes assessing the completeness, accuracy, and consistency of medical record documentation based on service standards, clinical guidelines, and applicable regulations. The process begins with selecting medical record samples, followed by evaluation using audit instruments, and concludes with discussion of results and recommendations for improvement. Audits are conducted periodically, typically every three months, involving healthcare professionals such as attending physicians (DPJP), nurses, and other medical staff to ensure proper and complete documentation.

Regarding Question 2 (*Who is involved in the clinical audit process?*), the findings indicate that clinical audits involve multiple stakeholders across hospital units, including hospital management, quality committees, physicians (DPJP), nurses, medical record staff, as well as claim/finance units and supporting medical personnel. This multidisciplinary involvement ensures that audits evaluate not only documentation completeness but also service processes and their financial implications.

For Question 3 (*How often are clinical audits conducted and what is the workflow?*), audits are conducted periodically, generally every three to six months depending on hospital policy, although some audits may be triggered by specific cases. The workflow includes audit planning, determining indicators, collecting and evaluating data, analyzing results, and providing feedback along with follow-up improvements.

Regarding supporting factors (Question 4), the implementation of clinical audits is facilitated by management policies, leadership commitment, availability of SOPs, competent human resources, hospital information systems, and awareness among healthcare staff regarding the importance of complete medical records.

For Question 5 (*How are clinical audit policies established?*), policies are set by hospital management through director decisions aligned with healthcare regulations and accreditation standards. These policies are then disseminated to all service units to ensure consistent implementation.

Regarding the audit workflow (Question 6), the process includes planning, determining indicators and samples, collecting and assessing data, analyzing results, and conducting evaluation meetings to determine recommendations and corrective actions.

For Question 7 (*How are audits used for quality control?*), clinical audits are used to assess whether services comply with medical standards. Audit results help identify strengths and weaknesses in service delivery and documentation, serving as a basis for improving procedures and enhancing discipline among healthcare workers.

Regarding challenges (Question 8), common obstacles include limited time due to high patient loads, incomplete medical record documentation, and varying levels of understanding among staff regarding clinical audit processes.

For Question 9 (*What supports smooth audit implementation?*), key factors include management support, adequate resources, clear SOPs, and strong inter-unit collaboration.

For Question 10 (*What aspects are assessed in audits?*), audits evaluate patient identity, anamnesis, diagnosis, medical procedures, supporting examination results, and healthcare provider authentication.

Regarding Question 11 (*How do audits improve documentation quality?*), audits provide feedback that encourages healthcare workers to be more careful, disciplined, and consistent in completing medical records.

For Question 12 (*Do audits impact staff performance?*), audit results positively influence work practices by improving document management systems, strengthening coordination, and increasing attention to completeness.

For Question 13 (*What supports medical record staff?*), supporting factors include infrastructure, training, management support, SOPs, and effective communication across units.

For Question 14 (*Management perspective*), hospital management views clinical audits as essential for evaluating service quality and ensuring compliance with medical standards.

For Question 15 (*Use of audit results*), audit findings are used as a basis for decision-making, including policy formulation, service evaluation, and quality improvement planning.

For Question 16 (*Management support*), management supports audit sustainability through policy development, resource provision, and requiring all units to participate in audit activities.

### **Implementation of Clinical Medical Record Audits in Supporting Healthcare Cost Control**

The findings also describe the role of clinical audits in cost control. Based on Question 1 (*How do clinical audits contribute to cost control?*), audits ensure that medical procedures align with proper medical indications, preventing unnecessary actions and reducing cost inefficiencies.

For Question 2 (*Relationship between medical records and claims*), medical records serve as the primary source of information for diagnosis, procedures, and services, forming the basis for coding and claim submissions.

Regarding Question 3 (*Do audits reduce coding errors?*), clinical audits help minimize coding and claim errors by verifying the consistency between medical record data and assigned codes.

For Question 4 (*How audits assess cost efficiency*), audits evaluate whether services provided are appropriate relative to costs incurred, ensuring efficient use of resources.

Regarding Question 5 (*Common issues*), problems include discrepancies between diagnoses and claim codes, incomplete medical records, and inconsistencies between performed procedures and documentation, which complicate coding and claims.

For Question 6 (*Follow-up actions*), errors are addressed through clarification with attending physicians, document correction, and coordination with relevant units to revise necessary documentation.

For Question 7 (*Supporting factors for cost control*), these include complete medical record data, integrated information systems, coder training, and clear SOPs.

Regarding Question 8 (*Impact on policy*), clinical audits influence policies related to service quality and cost efficiency by providing evidence for decision-making.

For Question 9 (*Management support*), management supports audit implementation through policies, budgeting, human resources, and infrastructure, ensuring effective and systematic audit processes across all units.

Overall, the findings from this study indicate that the implementation of clinical medical record audits plays a significant role in supporting both quality control and cost control in healthcare services. From the quality perspective, clinical audits function as a systematic evaluation tool to assess whether healthcare services and documentation comply with established medical standards, clinical guidelines, and hospital policies. Through regular and structured audits, hospitals are able to identify gaps in service delivery, such as incomplete documentation, inconsistencies in medical records, and deviations from standard procedures. These findings then become the basis for continuous improvement, ensuring that healthcare services are delivered safely, effectively, and in accordance with professional standards.

Furthermore, the involvement of multiple stakeholders—such as hospital management, physicians, nurses, medical record staff, and financial or claims units—demonstrates that clinical audits are conducted in a collaborative and multidisciplinary manner. This collaboration is essential in ensuring that audit results reflect not only the completeness of documentation but also the overall service process and its impact on patient outcomes and administrative processes. The presence of strong management support, clear policies, standard operating procedures (SOPs), and adequate resources further strengthens the implementation of clinical audits, making them more structured, consistent, and effective.

From the cost control perspective, clinical medical record audits contribute significantly to improving efficiency in healthcare financing. By ensuring that medical actions and procedures are aligned with appropriate medical indications, audits help prevent unnecessary services and reduce the risk of overutilization of resources. In addition, audits play an important role in ensuring the accuracy of coding and claim submissions. Since medical records serve as the primary basis for determining diagnosis and procedure codes, complete and accurate documentation is essential to avoid claim discrepancies, delays, or rejections. Therefore, clinical audits not only support service quality but also enhance financial accountability within the hospital.

However, this study also highlights several challenges that may hinder the optimal implementation of clinical audits. These include limited time availability of healthcare workers due to high patient workloads, incomplete medical record documentation, and variations in staff understanding of audit procedures. Technical and administrative constraints, such as limited training and coordination issues, also contribute to inefficiencies in the audit process. If not properly addressed, these challenges may reduce the effectiveness of clinical audits in achieving their intended goals.

To overcome these challenges, several improvement efforts are necessary. These include strengthening training programs for healthcare staff, improving coordination among units, enhancing the role of hospital information systems, and ensuring consistent management support in terms of policies, supervision, and resource allocation. Regular evaluation and follow-up of audit findings are also crucial to ensure that identified problems are addressed promptly and systematically.

In conclusion, clinical medical record audits serve as a strategic instrument in enhancing healthcare service quality and controlling costs. When implemented effectively, audits can improve documentation accuracy, strengthen service delivery processes, support evidence-based decision-making, and promote efficient use of healthcare resources. Therefore, the sustainability and continuous improvement of clinical audit practices are essential for achieving high-quality, efficient, and accountable healthcare services.

## **Discussion**

The results of this study indicate that the implementation of clinical medical record audits plays an important role in supporting both quality control and cost control in healthcare services. From the perspective of service quality, clinical audits are carried out in a structured, planned, and continuous manner. This shows that hospitals have made systematic efforts to ensure that healthcare services provided to patients are in accordance with established standards. Through the audit process, which includes assessing the completeness, accuracy, and consistency of medical record documentation, hospitals are able to evaluate whether the services delivered meet clinical guidelines and applicable regulations. This finding reflects that clinical audits function not only as an administrative activity but also as an essential tool in maintaining and improving healthcare service quality.

The involvement of various stakeholders, such as hospital management, physicians (DPJP), nurses, medical record staff, and claim or finance units, indicates that clinical audits are conducted collaboratively across different units. This multidisciplinary approach strengthens the effectiveness of the audit process because it allows for a more comprehensive evaluation—not only of documentation but also of service processes and their impact on patient care. Good collaboration between units also supports better communication and coordination, which ultimately contributes to improving the completeness and accuracy of medical record documentation.

However, despite the structured implementation, several challenges were identified. Limited time availability of healthcare workers due to high patient loads often becomes a barrier to conducting audits optimally. In addition, incomplete medical record documentation and differences in understanding among staff regarding audit procedures may affect the quality of audit implementation. These findings indicate that although the system is already in place, there is still a need to strengthen human resource capacity, improve discipline in documentation, and enhance awareness among healthcare workers regarding the importance of clinical audits.

From the cost control perspective, clinical medical record audits contribute significantly to improving efficiency in healthcare services. By ensuring that medical actions are aligned with appropriate medical indications, audits help prevent unnecessary procedures that may lead to increased healthcare costs. In addition, audits also play a role in ensuring the accuracy of coding and claim submissions. Since medical records serve as the primary basis for determining diagnosis and procedure codes, any inaccuracies or incompleteness in documentation may lead to claim discrepancies, delays, or even rejection of claims. Therefore, the implementation of clinical audits supports not only service quality but also financial management within the hospital.

The study also found that clinical audits help identify common problems related to discrepancies between diagnoses and claim codes, incomplete medical records, and inconsistencies between performed procedures and documented information. These issues can directly affect the claim process and lead to inefficiencies in healthcare financing. Through the audit process, such problems can be detected early and corrected through clarification, document revision, and coordination with relevant units. This demonstrates that clinical audits function as a preventive and corrective mechanism in managing healthcare costs.

Furthermore, management support plays a crucial role in ensuring the sustainability of clinical audit implementation. Policies established by hospital management, along with the provision of resources such as human resources, infrastructure, and budget, contribute to the smooth execution of audit activities. The existence of standard operating procedures (SOPs) and clear audit instruments also helps ensure that audits are conducted in a consistent and systematic manner. In addition, training for staff, particularly coders and medical record officers, is essential to improve their competence and ensure accurate documentation and coding practices.

Overall, the findings of this study are consistent with the concept that clinical medical record audits are an integral part of hospital quality management systems. Clinical audits provide valuable information that can be used as a basis for decision-making, policy formulation, and continuous improvement of healthcare services. However, to achieve optimal results, hospitals need to address

existing challenges by strengthening human resource capacity, improving coordination among units, and enhancing the use of information systems.

In conclusion, clinical medical record audits have a significant impact on improving healthcare service quality and controlling costs. Their effective implementation requires strong management support, active involvement of all stakeholders, and continuous evaluation and improvement. By optimizing the implementation of clinical audits, hospitals can enhance service quality, ensure financial efficiency, and ultimately improve patient satisfaction.

## CONCLUSION

The implementation of clinical medical record audits for quality control at Dharma Yadnya General Hospital, Denpasar, has followed procedural steps, including assessment, analysis, and the provision of recommendations. However, its implementation has not been consistent according to the schedule, and incomplete medical record documentation is still frequently found. This indicates a gap between standard operating procedures (SOPs) and actual practice, meaning that the audit function as a tool for monitoring and evaluating quality has not yet been fully optimized.

The implementation of clinical medical record audits for cost control at Dharma Yadnya General Hospital plays a role in supporting cost management, particularly in ensuring the alignment between healthcare services and the claims process. However, irregular audit implementation, incomplete medical records, and errors in diagnosis coding remain significant challenges, leading to delays and potential discrepancies in claims. This indicates that the audit function in cost control has not been maximized. Therefore, it is necessary to implement audits in a scheduled and consistent manner, supported by compliance in medical record documentation, to achieve optimal cost efficiency.

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