OPTIMIZATION STRATEGY FOR REDUCING MEDICAL RECORD DOCUMENTS AT REGIONAL PUBLIC HOSPITAL

Nadhirah Saffanah [1], Sri Wahyuni [2], Mariyanto Nurshamsul [3]*
[1,2,3]Politeknik Baubau, Baubau, Indonesia

ARTICLE INFORMATION

Received: 20 Januari 2025
Revised : 28 Januari 2025
Accepted: 27 Februari 2025
DOI

KEYWORDS

Keywords : Inactive Medical Record Files, Depreciation

CORRESPONDING AUTHOR

Name : Sri Wahyuni
Address: Jl. Gatot Subroto RT 003 RW 003 Kel. Bukit Wolio Indah, Kota Baubau
E-mail : srimars1@gmail.com

A B S T R A C T

Reduction of inactive medical record files has not been carried out by Buton Tengah Regional Hospital. Reduction of inactive medical record files is carried out five years after the last patient was treated in the hospital or five years after the patient died. This study aims to determine the optimization strategy for reducing medical record files. This study uses a qualitative descriptive research design. The subjects of the study were one submission officer and the head of the medical record department. The object of the study was the active medical record files belonging to Buton Tengah Regional Hospital. The results of this study were a decrease in human resources (HR) in the medical record unit by 16 people. The means to reduce the number of medical record files that were reduced were scanners and computers, but the infrastructure for storing inactive files. Meanwhile, the SOP for reducing medical record files and strategies for maximizing the reduction of inactive BRM are not yet available. In addition, Buton Tengah District Hospital has prepared a work plan for reducing medical record files which will be implemented in 2024, but the reduction of inactive files at Buton Tengah Hospital has not been implemented. So it is necessary to create a reduction SOP at Buton Tengah Hospital because currently there is only an SOP for retention and destruction. At Buton Tengah Hospital, there is no special place for inactive files. Therefore, it is necessary to create a special room for inactive files at Buton Tengah Regional Hospital.

INTRODUCTION

Medical records are documents that contain patient identity, test results, diagnoses, treatment procedures, and other information. Public health, administration, law, finance, research, education, and documentation are all areas that require professional oversight (Damanik, 2023). Regulation of the Minister of Health of the Republic of Indonesia No. 24 of 2022 concerning Management of Medical Records as a Source of Information states this. Health information is generated through the processing of medical record data that goes through the stages of analysis of collection, integration, and primary and secondary health data services. Therefore, competent and authorized nurses must be able to provide medical record and health information services in accordance with applicable laws and regulations (Ministry of Health of the Republic of Indonesia, 2022).

Active and inactive medical records are two categories that differentiate them (Ulfa et al., 2021). Inactive medical records are medical records whose value has decreased or been lost altogether and have reached a certain age, namely five years, at which point they will never be used again because the patient no longer visits the health facility (Marsum et al., 2018). Active medical records are files that still have utility value (Basyarudin, 2022).

Medical records can be kept for more than a few years, but if there are no more shelves available to store them, records that are no longer useful will be destroyed by burning, shredding, or crushing; overcrowding of shelves will cause files to become torn, damaged, or wrinkled (Tanjung et al., 2022).

Medical record files are destroyed in stages. Research, transfer, assessment, and destruction are carried out first (Ministry of Health of the Republic of Indonesia, 2006). Based on previous studies conducted by (Jayanti & Herman, 2020), as many as 6200 DRMs have been stored since the establishment of the health center in 2020, and the RM staff are very short of filing cabinets, lack of document storage space. As a result, the authorities have difficulty collecting and returning medical records because active medical records that are still stored in the archive room are not downgraded to inactive (Farida & Muhadi, 2019). As a result, the archive becomes full because the files remain mixed between active and inactive.

The release of patient medical information to other parties, especially to insurance companies, must have a clear flow and procedures, because the patient's medical information is confidential and health care facilities are responsible for protecting patient medical information provided to other parties (Wahyuni, 2023).

Buton Tengah Regional General Hospital, which was established in 2019, is the only health facility in the district. The problem is that there are many inactive medical record files, which shows that the hospital has never reduced the number of files, based on the initial data collection results. Another problem at the Buton Tengah District Hospital regarding medical record files is that the archive room is too small, causing high humidity levels and will make medical record files easily torn and damaged.

METHODOLOGY

This study uses descriptive methodology to explain how Buton Tengah Regional Hospital implements medical record file reduction. Interviews and observations will be the basis of this study. The variables used are interview lists as instruments for calculating, observing, and making case studies.(Djollong, 2014).The implementation of this research will start from May-June 2024. This research will be conducted at the medical records unit at the Buton Tengah District Hospital, Southeast Sulawesi.

The study participants included the head of the medical records unit and four other medical records officers who worked to reduce the number of medical record files at the Buton Tengah Regional Hospital. Medical record documents are still in the research process.

In this study, the data collection methods used are documentation studies, interviews, and observations. Triangulation is a strategy used by qualitative methodology to ensure the truth and accuracy of research findings (Hasanah, 2017). Data triangulation refers to the use of different types of data, different theories, different methods of analysis, and a large number of researchers.(Azhari et al., 2023).

RESULTS AND DISCUSSION

Evaluating HR competency (PMIK) related to reduction in Buton Tengah District Hospital.

From the results of intensive observations and interviews with informants, it is known that this medical records unit has 16 employees consisting of 2 civil servants, 8 interns who work in the registration section, 4 DIII medical records graduates who work in the filing and casemix sections.1 DIII nursing graduate who was placed in the casemix section.

Medical Recorders and Health Information Officers are defined as individuals who have completed Medical Records and Health Information (RMIK) education in accordance with PermenKes No. 55 of 2013 concerning the Implementation of Medical Record Work. Decree of the Minister of Health Number: HK.01.07/MENKES/312/2020 concerning Professional Standards for Medical Recorders and Health Information, as well as Competency Standards and Professional Code of Ethics, states that competency standards are divided into several areas of competency. One of these areas of competency is Management of Medical and Health Information Service Providers, which includes the collection, processing, and presentation of health service and program data manually and electronically. Manual and computerized analysis of health program and care data using health program and service data as knowledge or input for decision making (Hade et al., 2019). Administration of RMIK services in medical institutions, Management of RMIK services in all health facilities Control over the quality of RMIK services. According to Shofari in (Silitonga et al., 2021) further states that the main responsibility, duties and functions of HR are the organization of medical records units.

Table 1. Human Resources (HR) Observation Results

NO	Observed Aspects	Observation Results		
		Yes	No	Information
A.	**HR**			
1	Medical records officers know the procedures for separating active and inactive medical record files.	√		
2	Medical records officers know the files that are separated according to the criteria of inactive files.	√		

Source: Processed Data, 2024

Evaluating the facilities and infrastructure related to the reduction of medical record documents at the Buton Tengah District Hospital

Scanners and computers are facilities used to store reduced medical record files in this study, based on observations and in-depth interviews with informants. Inactive files are still mixed with active files because the storage infrastructure is not yet available.

According to research by Rustiyanto and Rahayu in (Sidjabat et al., 2022) found that inactive medical record files can be moved from active file shelves to inactive file shelves by placing the files on the file storage shelves according to the year of the visit. Hospitals must provide a special room for storing unused medical record files. This is done so that active medical record files are maintained, the filling room is more organized and comfortable, and officers are more motivated to provide services there effectively and efficiently (Wasiyah et al., 2021).

Table 2. Observation Results of Facilities and Infrastructure

NO	Observed aspects	Observation Results		
		Yes	No	Information
B.	**Facilities and infrastructure**			
1.	There is a special place for separating medical record files.		√	
2.	There are tools for separating medical record files.	√		
3.	There is a list of descriptions	√		

Source: Processed Data, 2024

The limitations of the study identified in this journal include several important aspects. First, although there are 16 people in the medical records unit, not all members have adequate training to carry out the reduction of inactive medical record files effectively. In addition, the Central Buton District Hospital does not yet have a specific Standard Operating Procedure (SOP) for the reduction of inactive medical record files, which can hinder the implementation of the process systematically. Inadequate infrastructure is also an obstacle, especially the absence of a special room for storing inactive files, which causes the files to be stored together with active files, potentially disrupting management.

Evaluating Policies And Sops Related To The Reduction Of Medical Record Documents At The Buton Tengah District Hospital

According to the results of observations and interviews with informants, Central Buton Regional Hospital does not have a standard operating procedure (SOP) for the destruction of inactive medical records. The existing SOP regulates the procedures for storing and destroying unused medical records.

Standard Operating Procedures (SOP) are guidelines that include standard operating procedures used by an organization to ensure that every choice made, action taken, and processing facility used by individuals in the organization has been carried out in an efficient, reliable, standard, and methodical manner (Jayanti & Herman, 2020). Medical records serve as a tool to achieve administrative orders, which improve hospital health services (Ministry of Health of the Republic of Indonesia, 2022). Several factors, including those related to administrative, medical, legal, financial, scientific, educational, and documentation, make medical records valuable. The patient admission system, medical record processing system, and statistical system are all part of the medical record unit system. Retention or reduction and destruction are two subsystems that form one of the medical record file processing systems (Ulfa et al., 2021).

The findings of this study require SOPs for destruction and reduction so that medical records remain useful. To support the achievement of orders in order to improve health services in hospitals, guidelines are needed that contain standard operating procedures in the organization and medical record file processing system consisting of several subsystems, including storage or reduction and destruction of medical records. This is because medical records are useful for various purposes, including administrative, medical, legal, financial, research, educational, and documentation purposes.

Table 3. Policy and SOP Observation Results

NO	Observed aspects	Observation Results		
		Yes	No	Information
C.	Policies and SOPs			
1.	There is an SOP for separating active and inactive medical record files.	√		
2.	To set aside or separate			
	a. RMK Sheet			
	b. Operation Sheet			
	c. Resume Sheet	√		
	d. Consent Sheet			
	e. Baby Identification Sheet			
	f. Death Sheet			
3.	Patient medical record files/sheets that have been separated and still have value are stored in one folder.	√		
4.	The separated inactive files are placed in a box and labeled.		√	
5.	Files that have been placed in the box are placed in the inactive file storage room.		√	

Source: Processed data, 2024

Developing an optimization strategy related to the reduction of medical record documents at the Buton Tengah District Hospital

In this study, based on the results of in-depth interviews and observations of informants, it was obtained that the optimization strategy for the reduction of inactive medical records is still in preparation, where the implementation of the reduction needs to prepare a room for inactive files and it is necessary to create a reduction SOP so that the implementation of the reduction runs well and it is necessary to carry out the reduction because the Buton Tengah District Hospital has not carried out the reduction of inactive files for 5 years.

One way to reduce the number of inactive medical records is the transfer or sorting of medical record files. This process organizes inactive medical records from previous patient visits and moves active medical records to inactive storage in accordance with applicable hospital regulations or provisions. Furthermore, the utility of medical records is an assessment activity related to medical record forms that must or can be completed. According to previous research by (Amran et al., 2022), there are various methods for the reduction of inactive medical records, such as sorting and transmission, assessment, scanning, and destruction. The researcher conducted observations to identify standard operating procedures (SOP) for the implementation of the destruction of inactive medical records; identification of the assessment of inactive medical records; identification of inactive medical record media using a scanner to measure changes; and identification of procedures for the destruction of inactive medical records (Hasibuan, 2017). There is no special storage space required for medical records when inactive medical records are shipped. In addition, utility evaluation is the process used to determine whether or not medical records should be retained. According to previous research by (Setiatin & Syahidin, 2017), to reduce the number of inactive medical records, no special storage space is required; in addition, the evaluation of utility is a process used to determine whether medical records can be destroyed or should be retained. Previous research by (Wiguna & Safitri, 2019) shows that reducing the number of inactive medical records requires many steps. These steps include sorting and sending, assessing, scanning, and destroying.

CONCLUSION

The conclusion of this study shows that Buton Tengah District Hospital has human resources assigned to reduce inactive medical record files, but the implementation is not optimal because it has not been equipped with adequate training. In addition, this hospital only has a Standard Operating Procedure (SOP) for storage and destruction; currently there is no SOP for the destruction of inactive medical record files. Lack of infrastructure and facilities is another obstacle; In particular, there is no special area for storing inactive medical record files, so the data is moved to a room that also stores active files. As a result, the plan to minimize the number of inactive medical record files is currently being prepared and is not fully ready to be implemented. Although there are 16 members of the medical record unit, not all of them have the necessary training to efficiently reduce the number of inactive medical record files, which is one of the weaknesses of this study. In addition, the absence of a clear Standard Operating Procedure (SOP) for reducing inactive medical record files at Buton

Tengah Hospital can complicate the implementation of the procedure methodically. Another obstacle is inadequate infrastructure, especially the lack of a special place to store inactive data, so that the data is stored among active files and complicates administration.

ACKNOWLEDGMENT

The author humbly thanks Supervisor I and Supervisor II for the guidance, advice, and suggestions they provided during the process of writing this diary. The author also thanks Politeknik Baubau, which has provided the facilities and data needed for this research. He also thanks his family and friends who have helped and supported me during the process of collecting and studying this diary. Without the support and encouragement of all parties involved, this research would not have been fully completed.

REFERENCES

Amran, R., Apriyani, A., & Dewi, N. P. (2022). Peran Penting Kelengkapan Rekam Medik di Rumah Sakit. *Baiturrahmah Medical Journal*, *1*(2), 69–76.

Azhari, D. S., Afif, Z., Kustati, M., & Sepriyanti, N. (2023). Penelitian Mixed Method Research untuk Disertasi. *INNOVATIVE: Journal Social Science Research*, *3*(2), 8010–8025.

Basyarudin, B. (2022). Aspek Yuridis Rekam Medis Elektronik Dijadikan Alat Bukti Apabila Terjadi Kesalahan Pelayanan Kesehatan. *Jurnal Cakrawala Ilmiah*, *1*(12), 3495–3510. https://doi.org/10.53625/jcijurnalcakrawalailmiah.v1i12.3212

Damanik, B. N. (2023). Determinan Kelengkapan Berkas Rekam Medis Rawat Inap Di Rumah Sakit Umum Daerah Tanjungpura Kabupaten Langkat Tahun 2023. *Jurnal Kesehatan Deli Sumatera*, *1*(2), 1–9.

Djollong, A. F. (2014). Teknik Pelaksanaan Penelitian Kuantitatif. *Istiqra'*, *2*(1), 86–100.

Farida, E. W., & Muhadi. (2019). Dasar Organisasi dan Manajemen Unit Kerja Rekam Medis. In *Indomedia Pustaka* (Edisi Revisi).

Hade, S., Djalla, A., & Rusman, A. D. P. (2019). Analisis Penerapan Sistem Informasi Manajemen Rumah Sakit Dalam Upaya Peningkatan Pelayanan Kesehatan Di Rsud Andi Makkasau Parepare. *Jurnal Ilmiah Manusia Dan Kesehatan*, *2*(2), 293–305. https://doi.org/10.31850/makes.v2i2.152

Hasanah, H. (2017). Teknik-Teknik Observasi (Sebuah Alternatif Metode Pengumpulan Data Kualitatif Ilmu-ilmu Sosial). *At-Taqaddum*, *8*(1), 21. https://doi.org/10.21580/at.v8i1.1163

Hasibuan, A. S. (2017). Tinjauan Pelaksanaan Penyusutan Berkas Rekam Medis Inaktif Dirumah Sakit Umum Imelda Pekerja Indonesia (IPI) Medan Tahun 2016. *Jurnal Ilmiah Perekam Dan Informasi Kesehatan Imelda*, *2*(1), 192–199.

Jayanti, F. A., & Herman, J. (2020). Pelaksanaan Penyusutan Dalam Pengelolaan Arsip Rekam Medis di Puskesmas Mensiku Sintang. *Jurnal Perekam Medis Dan Informasi Kesehatan*, *3*(1), 53–56.

Peraturan Menteri Kesehatan Republik Indonesia Nomor 24 Tahun 2022 Tentang Rekam Medis, 24 Kementerian Kesehatan Republik IndonesiaRepublik Indonesia 1 (2022).

Marsum, M., Windari, A., Subinarto, S., & Candra, N. F. (2018). Tinjauan Keterlambatan Retensi Dokumen Rekam Medis Di RSUD DR. Soediran Mangun Sumarso Kabupaten Wonogiri. *Jurnal Rekam Medis Dan Informasi Kesehatan*, *1*(1), 21. https://doi.org/10.31983/jrmik.v1i1.3576

Setiatin, S., & Syahidin, Y. (2017). Perancangan Sistem Informasi Penyimpanan Rekam Medis Rawat Inap Berbasis Elektronik. *Jurnal Manajemen Informasi Kesehatan Indonesia*, *5*(2), 81–88.

Sidjabat, F. N., Ardila, C. N., Setiawan, I., Anastaria, D. V., & Pratama, I. K. (2022). Gambaran Pelaksanaan Keamanan Dokumen Rekam Medis Pada Ruang Filing Di Rumah Sakit Baptis Kediri. *KOLONI : Jurnal Multidisiplin Ilmu*, *1*(1), 43–56.

Silitonga, T. D., Ulfa, H. M., Ramadani, D. R., & Stikes Hang Tuah Pekanbaru. (2021). Analisis Indeks Rekam Medis di Rumah Sakit Pekanbaru Mdical Center (PMC) Tahun 2020. *Journal of Hospital Management and Health Sciences (JHMHS)*, *2*(1), 110–115.

Tanjung, L. A., Karo-Karo, S., & Hartanti, I. F. (2022). Tinjauan dan Pelaksanaan Penyusutan Rekam Medis Di RSU Madani Medan. *Jurnal Ilmiah Perekam Dan Informasi Kesehatan Imelda (JIPIKI)*, *7*(2), 185–192.

Ulfa, H. M., Silitonga, T. D., & Gustia, T. (2021). Analisis Penyusutan dan Pemusnahan Dalam Menjaga Nilai Guna Rekam Medis Di Rumah Sakit Pekanbaru Medical Center Tahun 2020. *JHMHS: Journal of Hospital Management and Health Science*, *2*(1), 73–81.

Wahyuni, S. (2023). Tinjauan Pelepasan Informasi Medis Kepada Pihak Bpjs Di Rumah Sakit Umum Daerah Kabupaten Buton Tahun 2019. *Jurnal Kesehatan Tambusai*, *4*, 2303–2317.

Wasiyah, W., Tri Purnama Sari, & Indra Bayu Kusuma. (2021). Gambaran Pelaksanaan Penyusutan Dan Pemusnahan Berkas Rekam Medis Inaktif Di Rumah Sakit Umum Daerah Rokan Hulu Tahun 2020. *Jurnal Rekam Medis (Medical Record Journal)*, *1*(2), 183–199. https://doi.org/10.25311/jrm.vol1.iss2.405

Wiguna, A. S., & Safitri, D. R. (2019). Tinjauan Sistem Penyimpanan Dokumen Rekam Medis Di Rsu Sinar Husni Tahun 2019. *Jurnal Ilmiah Perekam Dan Informasi Kesehatan Imelda*, *4*(2), 648–654. https://doi.org/10.52943/jipiki.v4i2.88