STRATEGY TO REDUCE DELAYS IN RETURNING INPATIENT MEDICAL RECORD FILES AT SOUTH BUTON DISTRICT HOSPITAL

Sarniati [1] , Sri Wahyuni [2] Ahmad Amiruddin J [3]*

[1,2,3]Politeknik BauBau, Indonesia

ARTICLE INFORMATION

Received : 06 September 2024
Revised : 11 September 2024
Accepted : 25 October 2024
DOI :

KEYWORDS

Delay in Returning Files; Inpatient Medical Records; Hospital

CORESPONDING AUTHOR

Name : Sarniati
Address : Lohia Village, Lohia District
Email : samiatimuhra@gmail.com

A B S T R A C T

Medical records are documented information about a patient's identity, medical history, laboratory results, diagnosis, medical procedures, and treatments received, whether during inpatient, outpatient, or emergency care. The standard time frame for returning medical record files is 2x24 hours after the patient is discharged. Timely return of medical records is essential for maintaining a quality medical record management system. Between January and March 2024, 75 out of 394 files were returned late to the medical records unit. The purpose of this study is to analyze the factors contributing to delays in the return of inpatient medical records and to develop strategies to prevent delays in file returns at the South Buton Regency Regional General Hospital. This research is qualitative, using the action research method. Data collection methods included interviews, observations, and brainstorming sessions. The study was conducted at the South Buton District General Hospital between March and May. The findings revealed that the delays were primarily due to staff lacking knowledge about Standard Operating Procedures for properly completing documents, and the absence of tools, such as trolleys, that could facilitate the return process.

INTRODUCTION

Hospitals are institutions that provide complex health services that include various types of services to achieve optimal public health. Therefore, hospitals are required to provide professional services to ensure patient satisfaction. In addition to providing health services, hospitals must be able to produce timely and accurate data and information to support the implementation of these activities with a focus on service quality. One of the most important elements that every hospital must have is a medical records unit, because medical records play a very important role in providing patient data and information. (Arini, 2023). .

According to Permenkes No. 24 of 2022 , medical records are documents containing information about patient identity, examination results, treatment, behavior, services, and other information. Electronic records are records created and managed through an electronic system that supports the implementation of medical records.

A good medical record is one that is continuous from the beginning to the end of treatment or from the first registration until the patient's status becomes inactive. If the medical record management process is not managed properly, it can cause delays in returning medical records. Timely return of medical records, namely within 2x24 hours after treatment, is very important to ensure a high-quality medical record management system. Returning medical records is considered late if it exceeds this time limit. Patient medical records are intended to support organized hospital management in order to improve health services.

A study also showed that the person responsible for returning patient medical records did not have adequate skills when nurses performed this task. (Wahyuni, 2023)

Another study conducted by (Hikmah et al., 2019) at Kalisat Regional Hospital, found four factors that contributed to the delay in returning medical records, namely incomplete filling of medical records by doctors, lack of training in returning medical records, long distances between wards and medical records, and less than optimal use of communication tools. RSUD Buton

Selatan, a local government-owned hospital, also has problems with late delivery of medical records. According to a study (Shafieian, 2020a) , there were 75 medical records (20.9%) that were returned late to the storage room.A hospital is a medical institution that provides a variety of medical services, including inpatient, outpatient, and emergency care. (Mayang et al., 2024)The data collected in this study will then be managed using the content analysis method to obtain good research results that are in accordance with expectations.

METHODOLOGY

This study uses a qualitative descriptive approach to understand symptoms that do not need to be quantified. (Herman et al., 2020). states that the qualitative research method is a research method based on the philosophy of esotericism or interpretive which is used to research natural object conditions where the researcher is the main instrument and data collection techniques are carried out in a combined manner (triangulation), data analysis is inductive/qualitative, and the results of the study emphasize more on meaning than generalization. In the case study design, the research subjects are people who are present in the research setting and are used to provide information about the situation and environment where the researcher is located, ((Erlindai, 2019)). In this study, the research subjects were employees who returned medical records (Haqqi et al., 2019. This study was conducted at a public hospital in the Nambudong area. The research implementation process took place from March to May. The data collection methods in this study were observation, interviews, document examination and recording devices.

Hospital is a health care organization that organizes comprehensive health care and provides inpatient, outpatient, and emergency care. (Maya et al.) The data collected in this study will be processed using opportunity analysis to obtain good research results and in accordance with expectations.

RESULTS AND DISCUSSION

1. **Percentage of Medical Record File Returns**

Lack of timely return of medical records hampers staff data processing. Data delays also impact processing, so that information that should be submitted to hospital leadership cannot be submitted in a timely manner, hindering effective management assessments and delaying staff reporting. From a patient perspective, these delays can impact the care they receive and make critical information in their medical records inaccessible. (Hikmah et al., 2019) .

Based on the results of research at the South Buton District Hospital, the rate of delay in returning medical record files was recorded at 20.6% in January, 25.7% in February, and 11% in March.

This delay is related to the processing of EHR by the entity or agency responsible for EHR. One of the main users of EHR is inpatient care, where EHR is used to record all services provided to patients. Given that EHR is very important to support the functional activities of the hospital, it is important to reduce the number of late EHR returns for EHR units and inpatient units.

The findings of this study are consistent with findings from (Haqqi et al., 2020) , The delay in returning medical record files of inpatients is still quite serious, and the return time is more than 2x24 hours. In 63 cases, 72.41% of the return of medical record files was delayed. The reasons for the delay include the completion of files too quickly by doctors.

2. Causes of Delays in Returning Medical Record Files

a. Safe

In this study, 'people' refers to human resources, namely people who have a direct role in returning medical records. The delay in returning medical records of inpatients is related to the responsibility of the nurse on duty. Human resources involved in returning medical records include medical record officers, where education, training, and work experience have a significant impact on the process.

The results of the study conducted at the South Buton District Hospital showed that there were still nurses who were late in returning patient medical records. This was because the medical records were incomplete, for example they had not been filled out completely by the nurse or had not been signed by the doctor.

study is consistent with the following research findings . (Wirajaya & Rettobjaan, 2021) It was found that the delay in returning medical records of inpatients at Pasirian Lumajang Regional Hospital was caused by nurses who did not complete the medical records and doctors who did not sign them.

b. Method

Standard Operating Procedures (SOP) are guidelines used as a reference in providing services. Regarding the return of patient medical records, the SOP requires that medical records must be returned to the EHR unit within 2x24 hours after the patient is discharged from the hospital. The main reason for this is because some nurses do not fully understand the existence and importance of the SOP.

This study supports the following findings (R ohmawati et al, 2021) . It was found that the cause of the delay in returning patient medical records was the lack of accuracy and standardization in filling out medical records by nurses, which was caused by a lack of knowledge of the SOPs applied in the ward.

c. Machine

Standard Operating Procedures (SOP) are guidelines that you must follow when providing services. Regarding the return of patient medical records, the SOP stipulates that medical records must be returned within 2x24 hours after the patient is discharged from the hospital. However, the return of patient medical records at the South Buton District Hospital has been delayed from month to month because some nurses have not fully understood the existence and importance of the SOP.

3. Strategy to Reduce Delays in Returning Inpatient Medical Record Files

The process of identifying the causes of delays in returning patient medical records at the South Buton District Hospital was carried out using the 5M method (Man, Method, Machine, Machine, Material, Money). The results of the study identified various factors causing delays in returning medical records as follows:

a. Safe

Regarding the Man element, the delay in returning the files was caused by nurses and doctors who had not completed filling in the medical record files, such as the doctor's signature not being included. This study supports the findings of (Rohmawati et al., 2021) which stated that the delay in returning medical record files at Pasirian Lumajang Regional Hospital was caused by nurses who had not completed filling in the medical record files and doctors who had not signed the files.

b. Method

In the Method aspect, there is still a delay in returning medical record files of more than 2x24 hours. This is caused by several nurses who are not yet aware of the SOP regarding the return of medical record files. This study is in line with the findings (Dewi et al., 2021) , which states that delays are caused by the lack of accuracy and discipline of nurses in filling out medical record files, as well as their lack of understanding of the applicable SOPs.

c. Machine

In the 'mechanical' component, the lack of aids such as trolleys to facilitate the return of medical record files is one of the factors of delay. This finding is supported by several studies, such as who also (Dewi et al., 2021) stated that the delay in returning medical record files to the hospital was caused by the lack of adequate facilities and infrastructure.

Based on the results of the analysis and discussion with medical record officers, the main causes of delays include the lack of SOPs regarding the completeness of medical records, the lack of nurse knowledge about the SOP for returning files, and the lack of medical record files due to the unavailability of aids such as bogies. This study is in line with the findings Sudarta. (2022) , which shows that at Pasir Ruzajang Hospital, the failure of nurses to fill out and doctors to sign medical records was the cause of late returns.

To overcome delays in the process of returning inpatient medical record files, the South Buton District Hospital conducted brainstorming and agreed on a strategic step in the form of compiling a more complete SOP to improve the medical record documentation process.

Table 1. SOP draft for the completeness of filling out medical record files

SOUTH BUTON DISTRICT HOSPITAL SOUP	No Documentation	Page
	Orderly Date	Determined, Director
Understanding	The authority to fill out patient medical record files refers to the arrangement of duties and responsibilities of related officers to fill out medical record documents completely, accurately and on time.	
Objective	Arrange the duties and responsibilities of officers in charge of filling out medical records.	
Policy	Medical records must be filled out completely, correctly, and on time by authorized officers.	
Procedure	A. Doctor a) The results of the patient's physical examination, diagnosis, and treatment are recorded in the medical record immediately after the examination or no later than 24 hours after the examination. b) All medical procedures must be reported on the same day and recorded in the medical record. c) Ensure that the patient's name and medical record number are listed on all documents for which he/she is responsible . d) Double check the medical data, sign and date it clearly. e) After the patient is discharged, the doctor must record and write a summary of the patient and his/her illness within 24 hours. f) If a patient dies, the doctor must record the cause of death on the death form and medical record. g) The principal diagnosis should be written in capital letters. h) The doctor is responsible for the completeness of medical data, 1. Patient summary, diary and doctor's notes, disease summary. ➢ This should be written by the patient's treating physician. ➢ If the treating physician has not been notified of the patient's death or PLP, he or she will complete this form. ➢ If the patient has died or is PLP but is not being treated by a general practitioner, the ward doctor on duty at that time will complete the form. ➢ If the patient is treated by several doctors, this form is filled out by the doctor who approves the patient's discharge. 2. General condition/admission/delivery/birth: filled in by the doctor who first saw the patient. 3. The application form must contain, at least, a request for consultation and a response to that request. 4. Death certificate: Filled out by the doctor treating the patient at the time of death. B. Nurse Filling out patient condition development notes. a) Write the date, time, signature, and clear name of the nurse who performed the service. b) Write the patient's name and chart number on each document for which you are responsible. c) Ensure that the patient and illness summary has been completed, and if not, ask the doctor to complete it. d) Responsible for the completeness of medical record documents. e) After the patient is declared allowed to go home, return the complete medical record files to the medical records unit within 2x24 hours, no later than 09.00 WIB C. MEDICAL SERVICE SUPPORT OFFICERS a) You must include proof of your medical records.	

	b) Complete the medical record form with clear, accurate, and easy-to-read information. c) Include the date, name, and signature of the officer who provided the service. d) You are responsible for the accuracy of the evidence submitted. D. MEDICAL RECORD OFFICER a) Complete patient identification and social data on relevant documents. b) Make sure the medical record number is listed on the folder and related documents. c) Your identity and social data must be written clearly and easily read. d) Responsible for evaluating the completeness of medical record documentation. e) Responsible for maintaining the confidentiality of medical record documents.
Work unit	1. Medical records 2. Outpatient 3. Inpatient 4. Medical Support

Source: South Buton District Hospital

.

CONCLUSION

A study conducted by Rijksuniversiteit Groningen on the reasons for delays in returning medical records of inpatients in hospitals identified the following reasons.

The following factors contribute to the delay in returning medical records. In the 'people' factor, the nurse did not complete the inpatient medical records. In addition, the doctor did not sign the patient's medical records. In the "Method" element, there is no standard operating procedure (SOP) that determines the completeness of the inpatient medical records. In the "Machine" element, there is no tool such as a trolley to help return medical records.

Strategy to Reduce Delays in Returning Inpatient Medical Record Documentation Using Action Research Method: The diagnostic action step identifies the causes of delays in returning medical records by focusing on three factors, namely human, method, and machine. The Planning Action stage includes the preparation of SOPs related to the completeness of filling in inpatient medical record documents. However, the Taking Action and Evaluating Action stages were not implemented due to limited research time.

Based on the researcher's direct experience during this research process, there were several obstacles that caused the Taking Action and Evaluating Action methods to not be implemented due to time constraints. This needs to be a concern for future researchers to further improve their research, considering that this research has limitations that need to be improved in the future.

ACKNOWLEDGEMENT

I would like to express my deepest gratitude to supervisor 1 and supervisor 2 for their guidance, direction, and valuable suggestions during the process of creating this journal.

The author would also like to thank Baubau Polytechnic for providing the facilities and data needed for this research.

Thanks also to the family, friends who have provided support, assistance during the process of compiling and researching this. Without the support and encouragement of all parties this research cannot be completed properly.

REFERENCES

Arini, L. D. D. (2023). Tinjauan Faktor-Faktor Penyebab Keterlambatan Pengembalian Berkas Rekam Medis Pasien Rawat Inap ke Unit Kerja Rekam Medis di Rumah Sakit Maguan Husada. *Jurnal Osadhawedyah, 1*(1), 10–16.

Dewi, A., Sulrieni, I. N., Rahmatiqa, C., & Yuniko, F. (2021). Literature Review: Analisis Faktor Penyebab Keterlambatan Pengembalian Rekam Medis di Rumah Sakit. *Indonesian of Health Information Management Journal (INOHIM)*, *9*(1), 21–29.

https://doi.org/10.47007/inohim.v9i1.234

Dilla, R. F., Mudiono, D. R. P., & Alfiansyah, G. (2020). Analisis Faktor Penyebab Keterlambatan Pengembalian Berkas Rekam Medis Rawat Jalan di RSUPN Dr. Cipto Mangunkusumo. *J-REMI : Jurnal Rekam Medik Dan Informasi Kesehatan*, *1*(4), 447–455. https://doi.org/10.25047/j-remi.v1i4.2085

Erlindai. (2019). 695Fa4a331803Ab2E6972Ab4E9Cbf0B1 (Faktor Man). *Faktor Penyebab Keterlambatan Pengembalian Berkas Rekam Medis Rawat Inap Di RS Esthomihi Medan Tahun 2019*, *4(2)*(2).

Farid, Z. M., Fernando, N. R., & Sonia, D. (2021). Efektivitas Penggunaan Rekam Medis Elektronik Terhadap Pelayanan Pasien Rawat Jalan di Klinik Darul Arqam Garut. *Cerdika: Jurnal Ilmiah Indonesia*, *1*(9), 1247–1254. https://doi.org/10.36418/cerdika.v1i9.178

Haqqi, A., Aini, N. N., & Wicaksono, A. P. (2020). Analisis Faktor Penyebab Keterlambatan Pengembalian Berkas Rekam Medis Rawat Inap di RS Universitas Airlangga. *J-REMI : Jurnal Rekam Medik Dan Informasi Kesehatan*, *1*(4), 492–501. https://doi.org/10.25047/j-remi.v1i4.2158

Herman, L. N., Farlinda, S., Ardianto, E. T., & Abdurachman, A. S. (2020). Tinjauan Keterlambatan Klaim Berkas BPJS Rawat Inap di RSUP dr. Hasan Sadikin. *J-REMI : Jurnal Rekam Medik Dan Informasi Kesehatan*, *1*(4), 575–581. https://doi.org/10.25047/j-remi.v1i4.2030

Hikmah, F., Wijayantin, R. A., & Rahmadtullah, Y. P. (2019). Penentu Prioritas Dan Perbaikan Masalah Keterlambatan Pengembalian Berkas Rekam Medis Rawat Inap DI RSD Kalisat. *Jurnal Manajemen Informasi Kesehatan Indonesia*, *7*(1), 58. https://doi.org/10.33560/jmiki.v7i1.214

Mayang, S., Amirudin, A., & Lestari, S. L. (2024). Perancangan Sistem Informasi Retensi dan Penyusutan Berkas Rekam Medis di Rumah Sakit. *Jurnal Sains Dan Kesehatan*, *3*(1), 35–43. https://doi.org/10.57151/jsika.v3i1.370

Permenkes No. 24. (2022). Peraturan Menteri Kesehatan RI No 24 tahun 2022 tentang Rekam Medis. *Peraturan Menteri Kesehatan Republik Indonesia Nomor 24 Tahun 2022*, *151*(2), 1–19.

Presiden RI. (2023). Undang-Undang Republik Indonesia Nomor 17 Tahun 2023 Tentang Kesehatan. *Undang-Undang*, *187315*, 1–300.

Rohmawati, A. L., Erawantini, F., & Roziqin, M. C. (2021). Analisis Faktor Penyebab Keterlambatan Pengembalian Berkas Rekam Medis Rawat Inap Rumah Sakit Pusat Pertamina. *J-REMI : Jurnal Rekam Medik Dan Informasi Kesehatan*, *2*(2), 264–270. https://doi.org/10.25047/j-remi.v2i2.2013

Shafieian, R. (2020a). Keterlambatan Pengembalian Berkas Rekam Medis Rawat Inap. *Literature Review*, *27*(8), 22–39.

Shafieian, R. (2020b). Literature Review Literature Review متون بررسي متون بررسي متون بررسي .39–22), 8(Literature Review. *Literature Review*, *27*

Sudarta. (2022). *済無No Title No Title No Title*. *16*(1), 1–23.

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.

Wirajaya, M. K. M., & Rettobjaan, V. F. C. (2021). Faktor yang Memengaruhi Keterlambatan Pengembalian Rekam Medis Pasien Rawat Inap di Rumah Sakit: Kajian Literatur. *Jurnal Kesehatan Vokasional*, *6*(3), 147. https://doi.org/10.22146/jkesvo.66282