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Analysis of Factors Inhibiting the Implementation of Patient Medical Record Retention and Destruction Activities at Waluyo Jati Hospital

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A B S T R A C T

Retention and destruction of medical record documents is a management aspect in health archives to reduce files that have been stored on the filling rack for a long time. This study aims to analyze the factors that hinder the implementation of retention and destruction of medical record documents at RSUD Waluyo Jati. Qualitative descriptive method was used to analyze these factors with data collection using the 5M approach. The results showed that the main obstacles were the lack of D3 Medical Record graduates and the lack of training related to document retention and destruction. RSUD Waluyo Jati does not have an SPO (Standard Operating Procedure) related to retention and planning document retention and destruction schedules and still uses the old ICU room to store inactive documents. Other problems include the lack of shredding and file transfer equipment, and the absence of a dedicated budget for these activities. The conclusion of this study emphasizes the importance of implementing retention and destruction of medical record documents in managing efficient archives. As a solution, efforts such as increased education and training for staff, the development of comprehensive SOPs, planning document retention schedules, improving infrastructure, collaboration with third parties, and proper budget allocation are needed to ensure the effectiveness of the medical record retention and destruction process.

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INTRODUCTION

As a comprehensive health care institution, hospitals include outpatient, inpatient, and emergency services. Hospitals are obliged to provide quality health facilities for the community with safe, quality and effective service standards, with the interests of patients as the top priority. Hospitals must maintain patient safety, provide quality care, and achieve desired outcomes in treatment and care, in accordance with the needs and expectations of patients and applicable health service standards. (Susi Dwi Yanti, Andika Mayansara & Venia Oktafiani, 2024).

A Regional General Hospital (RSUD) is a health care institution owned and operated by a local government, such as a district or city. RSUD aims to provide access to affordable and quality health services for all residents in the region, as well as actively participate in disease prevention efforts and public health education. By promoting professionalism and established service standards, RSUD not only focuses on the medical aspects but also supports the psychological and social aspects of patients, reflecting a commitment to provide holistic and comprehensive care that improves the quality of life of individuals and communities.(Vangoslava & Gunawan, 2017)

Patient care management is the cooperative activity of planning, evaluating, and providing patient care. It is utilized with available resources to improve patient safety, cost of care. Health care workers who assist in service management activities in hospitals, such as identifying patients, in nursing planning and quality management of services that are best for patients. (Siregar, 2024)

Medical record document storage must be done properly as all processes will involve files containing highly sensitive personal and medical information. Patient confidentiality must be maintained to protect privacy and prevent unauthorized access, in accordance with strict regulations. Good storage ensures the integrity and reliability of medical data, facilitates quick access for medical personnel, and prevents physical damage such as fire or flood. In addition, digital storage systems should be equipped with adequate tools to avoid data loss, support healthcare continuity, and maintain the availability of accurate and complete information for patient diagnosis and treatment. Good storage of medical record documents will positively affect the level of effectiveness of health services in various aspects. Organized and secure storage helps in minimizing medical errors that can occur due to missing or inaccurate data. In addition, the use of an efficient electronic medical record management system not only increases the productivity of medical personnel by reducing the time spent searching for files, but also facilitates better coordination between departments within the hospital. (Dyah et al., 2023)

And according to Fita Rusdian Ikawati, 2024 related to medical record storage space is that archive storage space, especially for medical records, plays a crucial role in maintaining the integrity and sustainability of important data.

Retention is a process that separates active and inactive medical record documents. Based on Minister of Health No. 269 of 2008, retention of medical record documents is carried out every 5 years. Active medical records are

documents that are still used for patients who are still visiting the hospital, while inactive medical records are documents that are no longer used because the patient has not visited for 5 years. Inactive medical record documents are stored for at least 5 years after the last date of treatment, then stored for at least 2 years in a separate room before being decided to be stored or destroyed. This is done to reduce the storage load on the filing shelves (BETRI, 2020).

Medical record document destruction is an effort to ensure that personal and sensitive patient information that is no longer needed is kept safe and not misused. This document destruction is done in a way that complies with applicable regulations and policies, such as using a paper shredder or a professional document destruction service, which ensures that patient data cannot be accessed or used again. All medical record document destruction processes must be done carefully and meet the standards set by the health institution and government regulations (Indriani, 2023).

Important medical record documents such as medical summaries, informed consent, operation records, death records, and infant identification will be archived and managed more strictly than other medical record documents. These documents are considered important because they contain critical information and have high legal, medical, and administrative value. Meanwhile, documents that no longer have any use value, or that have passed the prescribed retention period, must be managed and destroyed in an appropriate manner to ensure the confidentiality and security of patient information is maintained (Lesmana et al., 2021).

The impact of inhibiting factors on the implementation of retention at RSUD Waluyo Jati is that the storage shelves are full, so many documents accumulate on the shelves. This accumulation causes officers to have difficulty finding medical record documents and many documents are damaged (Agustin et al., 2020).

From the observations that the researchers got, the new General Hospital changed its name to Waluyo Jati Kraksaan General Hospital which was established by the Governor of East Java on January 6, 1982, and is located on Jl. dr. Soetomo No.1, Kandang Jati Kulon Village, Probolinggo District. This RSUD is a type B regional hospital with full accreditation. and the storage room for inactive medical record documents is stored in the old ICU room, and the room is distinguished from the filling room because the filling room looks full, the filling shelves are also full and not neatly arranged, because retention activities have not been carried out again so that many document folders are damaged and not suitable for reuse.

Based on the description above, the researcher is interested in making research on "Analysis of factors inhibiting the implementation of Retention and Destruction of Medical Record Documents at Waluyo Jati Hospital" with 5M research instruments (Man, Method, Material, Machine, and money) (IVANA SITA DEWI et al., 2022).

LITERATURE REVIEW

According to Minister of Health number 24 of 2022 concerning medical records are records and documents about patient identification, treatment, examination, actions and other services that have been provided to patients. Medical records are a support for orderly administration in a hospital. From this understanding, information can be taken that medical records are a tool to record the history of all services received in medical matters.

While Electronic Medical Records (RME) can make it easier for healthcare professionals to access patient data quickly and easily, and reduce health risks and data loss. Therefore, it is important to understand how the use of an electronic medical record (RME) system can help in organizing more effective and efficient health information management (Sylvia Anjani, 2022).

According to Fita Rusdian Ikawati,2024 regarding electronic medical records, one of the most suitable developments is as a transition from manual medical records to electronic medical records. It may be the storage and processing of patient health information in digital that can be accessed electronically (Fita Rusdian Ikawati, 2024).

Medical records aim to support administration in improving health services. However, to achieve this, an effective medical record management system is necessary. As such, proper and accurate management will ensure patient health information is available in a timely and accurate manner (Ritonga & Rusanti, 2018).

Proper management of medical records is essential to improve the quality of medical record services. Medical records must be stored in the filing room safely to protect them from physical, chemical and biological damage. Medical record storage has a certain period of time (retention period) that has been determined, because the number of medical records will continue to grow along with the increase in patient visits. Therefore, a system called retention or shrinkage is needed. According to the Indonesian Ministry of Health (2006), retention is the process of reducing medical record files from storage shelves by moving inactive medical record files from active file shelves to inactive file shelves through sorting by year of visit. Retention is carried out to prevent the accumulation of medical records on storage shelves and ensure a smooth work process (Zein & Alvionita, 2024).

METHODOLOGY

This study was conducted at RSUD Waluyo Jati in May 2024. The research approach used was descriptive qualitative with the main objective to provide an in-depth understanding of the factors that hinder the implementation of retention and destruction of medical record documents. In collecting data, a 5M approach was used which includes five key aspects. Man, Method, Material, Machine, Money (Fita Rusdian Ikawati, 2023).

To obtain accurate and comprehensive data, the data collection techniques used involved in-depth interviews with one key informant, the head of the medical records installation. In addition, observation was also conducted to observe the processes and obstacles that occur in the implementation of retention and destruction of medical record documents.

RESEARCH RESULT

Factors that Influence the Implementation of Retention and Destruction

1. Aspects Man

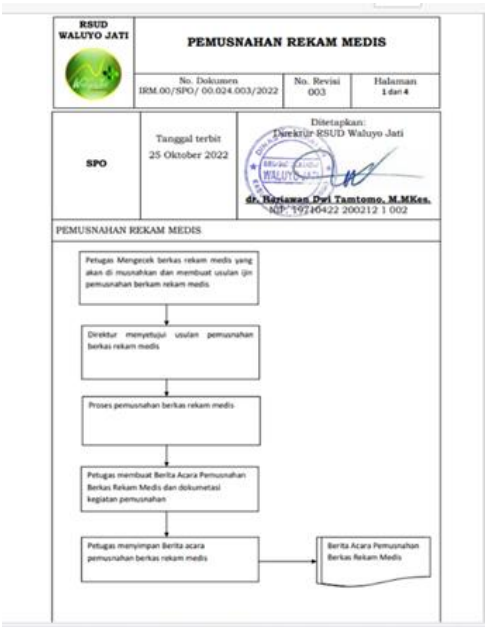
From the results of interviews with informants, it is known that in the medical record installation there are five filing employees with various last education. The first officer has a junior high school educational background, three others have a high school background, and one officer is a Bachelor of Computer Science graduate. Each officer is tasked with finding patient files and returning them to the storage rack according to the rack number. In addition, there is one person who serves as the head of the installation with a D4 Medical Records education.

Table 1. Filling Section Human Resources

No	Name	Duty	Graduates
1.	Endang Fitriyani, S. ST	Head of medical records	D4 Medical Records
2.	Khairul Anwar	Filling	Senior High School
3.	Moh. Ali	Filling	Junior High School
4.	Andika Yudi Prasetyo	Filling	S1 Computer
5.	Smarno	Filling	Senior High School
6.	Moh. As'ad Imam Masruri	Filling	Senior High School

2. Method Aspect

From interviews with informants at RSUD Waluyo Jati, it is known that this hospital already has an SOP (Standard Operating Procedure) for the Destruction of Medical Record Documents issued in 2022. However, RSUD Waluyo Jati does not yet have a specific schedule that regulates the retention and destruction of medical record documents. In addition, this hospital also does not have an SOP (Standard Operating Procedure) relating to the document retention process.



RSUD WALUYO JATI

PEMUSNAHAN REKAM MEDIS

No. Dokumen	No. Revisi	Halaman
IRM.00/SPO/ 00.024.003/2022	003	1 dari 4

	Tanggal terbit	Ditetapkan: Direktur RSUD Waluyo Jati
SPO	25 Oktober 2022	dr. Ruriawan Dwi Tamtomo, M.MKes. NIP. 19740422 200212 1 002

PEMUSNAHAN REKAM MEDIS

Petugas Mengecek berkas rekam medis yang akan di musnahkan dan membuat usulan ijin pemusnahan berkam rekam medis

Direktur menyetujui usulan pemusnahan berkas rekam medis

Proses pemusnahan berkas rekam medis

Petugas membuat Berita Acara Pemusnahan Berkas Rekam Medis dan dokumetasi kegiatan pemusnahan

Petugas menyimpan Berita acara pemusnahan berkas rekam medis

Berita Acara Pemusnahan Berkas Rekam Medis

Figure 1. SOP Extermination

3. *Aspect Material*

According to information from RSUD Waluyo Jati, the storage room for inactive documents is in the old ICU room. The availability of shelves and space for medical records for a smooth storage system in the hospital. By having adequate and standardized shelves and space for medical records, the storage process can be carried out properly according to the applicable procedures.

Figure 2. Inactive Document Space

4. *Aspect Machine*

Based on interviews with informants at Waluyo Jati Hospital, the Medical Records Installation section already has a tool but the tool is not large enough but can be used to process medical record document destruction activities. Namely a paper shredder and transfer tool as a tool into one digital file.

5. Aspect Money

Based on interviews with informants, Waluyo Jati Hospital in the Medical Records Installation has not made a budget for retention and destruction of inactive medical record documents. The budget itself is a projection that estimates the expected performance over a certain period of time.

DISCUSSION

In the Man, it shows that the educational background of medical record officers greatly affects the quality of services provided to the community. At the very least, medical record officers must have a minimum educational background of D3 Medical Records in order to properly understand the process of retention and destruction of medical record documents. Adequate education allows them to carry out their duties more effectively and efficiently, while maintaining high standards of health services.

To improve service quality, one of the steps that can be taken is through training. This training includes in-depth learning about the storage and destruction of medical record documents. With proper training, it is expected that medical record officers can improve their technical skills and performance. Training can be conducted both internally and externally, such as through in-hospital programs or training institutions outside the hospital. Internal training can be tailored to the specific needs of the hospital and is more accessible to all staff. Meanwhile, external training can provide new perspectives and up-to-date knowledge from experts in the field of medical records. Both types of training are equally important to ensure that medical record officers are up-to-date on best practices in medical record document management.

In the Methode element, explaining the retention and destruction of medical record documents at RSUD Waluyo Jati, it is important to have a regular schedule and a comprehensive Standard Operating Procedure (SOP) regarding retention. This schedule will ensure that the retention and destruction process is carried out consistently and on time, while the SOP will provide clear guidance for each step in the process. With SOPs in place, all retention and destruction activities can be carried out in accordance with established standards, thereby reducing the risk of errors and ensuring compliance with applicable regulations.

From the results of the interview, it was concluded that Waluyo Jati Hospital currently only has an SOP for the destruction of medical record documents issued in 2022. However, this hospital does not have a specific schedule for document retention and destruction, and does not have an SOP that regulates document retention. This condition causes difficulties in organizing the retention and destruction process effectively.

From the observation, this study shows that without a clear retention and destruction schedule, the document filing shelves become crowded and untidy. This results in difficulties in finding and managing medical record documents. RSUD Waluyo Jati should immediately develop a document retention and destruction schedule and develop a comprehensive SOP on retention. These

steps will help improve efficiency and orderliness in the management of medical record documents, thus supporting better health services.

Based on the element of Material, with the results of interviews at RSUD Waluyo Jati, it can be concluded that this hospital already has a special room for storing inactive medical record documents. This room is located in the former old ICU area. However, the storage room does not have a permanent employee who is specifically tasked with handling the document retention and destruction process.

As a result, the filing shelves in this room look overcrowded and disorganized. This condition shows that although physical space for inactive document storage is available, without staff specifically tasked with managing retention and destruction, this process cannot run properly. Documents are piled up without any structured management, making it difficult to find and manage inactive medical records. To overcome this problem, the RSUD needs to assign a permanent employee who is responsible for handling inactive medical record documents, including the retention and destruction process.

From the Machine element, it can be concluded that the scanner is an important device used to convert physical medical record forms into digital files. The main function of this scanner is to assist in storing and maintaining medical record forms in digital form. Thus, files that have use value will be stored safely and organized in one digital file, facilitating access and data management.

However, documents that have no use value, a shredder is used to destroy these files. The shredder available at RSUD Waluyo Jati is currently only one unit and is small in size, so it cannot accommodate many files that must be destroyed. This condition causes the document shredding process cannot be done efficiently and in large quantities. Therefore, the hospital needs to collaborate with those who provide medical record destruction services to overcome the limited capacity of its shredder. In addition, to improve efficiency, RSUD Waluyo Jati needs to consider procuring a shredder with a larger capacity. In addition, training for staff on the use of scanners and shredders is also important to ensure that all processes are carried out correctly and safely.

Based on the element of money (budget), it can be that RSUD Waluyo Jati currently does not have an adequate budget to carry out file retention and destruction activities. Although there is an urgent need to add paper shredders and scanners, the hospital has not provided special funds for this purpose. This condition causes the process of retention and destruction of documents cannot be carried out optimally.

This budget limitation has a direct impact on the efficiency and effectiveness of medical record document management. Without an adequate shredder, unnecessary files continue to accumulate and hinder access to active and important documents. In addition, the lack of sufficient scanners also hindered the process of document digitization, which is crucial to ensure the security and easy access of medical record data. To address these issues, RSUD Waluyo Jati needs to allocate a dedicated budget that covers the cost of

purchasing the necessary equipment as well as operational costs for document retention and destruction. In addition, investment in adequate technology and equipment can provide long-term benefits for RSUD Waluyo Jati.

CONCLUSIONS AND RECOMMENDATIONS

The findings of this study indicate that retention and destruction of medical record documents are crucial in long-term health records management in health care facilities. This study aims to identify factors that hinder the implementation of retention and destruction of medical record documents at RSUD Waluyo Jati Kraksaan Probolinggo.

First, in terms of human resources (HR), it was found that personnel involved in this process must have at least a D3 medical record education. However, they have not received specialized training on medical record retention and destruction procedures. This leads to a lack of knowledge and skills needed to carry out this task effectively.

Second, from the method aspect, the research revealed that although there is a Standard Operating Procedure (SOP) policy governing document retention and destruction, there is no structured planning schedule for the implementation of these activities. The absence of a planning schedule causes retention and destruction activities not to be carried out consistently and on time.

Third, in terms of materials, RSUD Waluyo Jati Kraksaan has a special room for storing inactive medical record documents placed in the old ICU room, but documents that should be managed properly are neglected.

Fourth, in terms of equipment, the hospital has a paper shredder and scanner that should be used to destroy documents and digitize files. However, due to the lack of trained and skilled employees, these tools are not used optimally, so the process of destruction and digitization does not run effectively. The shredder is not large enough and is not capable of destroying a large number of files.

Finally, from a budgetary aspect, although there was previously an allocation of funds for the purchase of a shredder, there is currently no new budget provided to support document retention and destruction activities. As a result, even though the equipment is available, document destruction activities cannot be carried out optimally due to budget constraints. Therefore, there needs to be an effort to involve cooperation.

ADVANCED RESEARCH

The suggestion given from this research is to carry out retention so that document destruction can be carried out immediately. There is a need for additional human resources for medical record officers so that the implementation of work in the filing unit is more optimal without increasing the burden on existing officers. Organize or include officers in training activities and seminars related to retention and destruction of medical record documents. The head of medical records must immediately make a retention schedule. Adding budget planning funds for the addition of inactive medical record

document shelves and proposing the transfer of inactive medical record document rooms. In addition, it is necessary to submit a budget for the purchase of a scanner.

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