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Health Retention: Health Regulations and Archive Management

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ABSTRACT

Medical records are documents containing patient identification data, examinations, treatments, actions, and other services provided to patients. The storage of medical records, which includes the creation and archiving of medical information, is considered crucial for improving service quality. In managing medical records, the destruction of medical records becomes one of the most important elements. Conventional medical record files are no longer efficient to use; therefore, the destruction of these medical record files is necessary. This study aims to analyze the legal aspects of destroying conventional medical record files in accordance with applicable regulations. The method used is descriptive qualitative with a normative legal research type, referring to the applicable regulatory approach. Results: Retention implementation according to health regulations and archive management still needs to be carried out to prevent accumulation and improve the quality of health services in hospitals. Conclusion: In the health ministerial regulations, laws, and archive regulations, there is an emphasis on the storage of medical records up to the retention activities. However, regulations regarding the retention of conventional medical record files are still limited or not detailed in the current regulations. Therefore, a clearer and more explicit regulation related to the retention or destruction of conventional medical records and their legal protection is needed.

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INTRODUCTION

The hospital is one of the healthcare institutions that provide health facilities such as emergency installations, outpatient care, and inpatient care, with services provided by doctors, nurses, and other healthcare professionals (Khoirul ihsan, 2023). According to Law Number 29 of 2004, it is stated that every medical practice, whether by a doctor or dentist, in the provision of healthcare services, is required to maintain medical records (Presiden Republik Indonesia, 2004). With the advancement of time, hospitals are required to further improve the performance of healthcare services to achieve high-quality healthcare services.

The retention period of medical records is divided into two types: active medical records, which are still in use when patients visit, and inactive medical records, which are those that have reached five years since the patient's last visit (Dewi Kisaputri et al., 2023).

Medical records are not permanently stored in active storage racks. Medical records are stored in accordance with established regulations. Therefore, retention activities are necessary to reduce the number of medical record files. Retention is an activity of reducing files or sheets of records that no longer have any useful value by separating them from the storage space (김진곤, 2004).

The storage of medical records, which includes the creation and archiving of medical information, is considered very important to improve the quality of services (Ikawati et al., 2021). Well-organized and tidy archives can provide consistent service. Similarly, the storage of archives must be balanced with the destruction process to prevent the accumulation of archives that can interfere with service delivery(Nuraini & Rohmiyati, 2014). The management of medical record archives can be used for various operational purposes (Ikawati et al., 2021). Retention schedules are made with a list that at least includes the retention period, type of archive, and notes containing information on whether the archive is to be re-evaluated, destroyed, or permanently kept (Indonesia, 2018).

In the management of medical records, the destruction of medical records is one of the most important elements. In the current digitalization era, conventional medical records are no longer efficient to use, thus it is necessary to destroy medical record files and subsequently store patient health histories in an application (Ikawati et al., 2022). The destruction of medical records aims to reduce the fullness of storage space and maintain the neatness of medical record organization. This activity must be carried out by a destruction team according to guidelines and witnessed by several authorized parties (Maghfira et al., 2022). Based on the above background and the various impacts that can affect the quality of healthcare services due to the failure to destroy medical record files, this research aims to analyze the legality of the destruction of conventional medical record files in accordance with applicable regulations and procedures.

LITERATURE REVIEW

Medical Records

Medical records are documents that contain patient identification data, examinations, treatments, actions, and other services provided to the patient(Peraturan Menteri Kesehatan RI No 24 tahun, 2022). The purpose of medical records is to improve the quality of healthcare services, provide legal certainty, ensure confidentiality, security, and availability of medical record data.

The functions of medical records include maintaining and providing patient information to determine treatment, making medical decisions, serving as evidence in legal matters, and as material for research and other medical actions(Cahayati & Jepisah, 2022).

Retention or Destruction

Retention is an activity to reduce the number of medical record files or sheets that no longer have useful value by separating them from their storage place. The aim is to reduce the number of files so that the thickness of the files can be reduced and to save on the use of storage racks, as well as to preserve valuable medical record files (archives) as sources for educational and research activities (BPPRM Revisi VI 18).

Destruction is an activity carried out by hospitals to reduce the volume of medical records in the storage room. Destruction is an effort to destroy or eliminate archives that have expired in terms of time and function and are no longer useful. This activity applies to all hospitals, including the hospital where the research was conducted(Keterlambatan & Dan, 2023).

METHODOLOGY

This research employs a qualitative descriptive method. The type of research is normative legal research, using an approach based on applicable laws and regulations by analyzing the rules and regulations concerning the implementation of medical record destruction.

The data sources in this research are secondary data, which are already available and collected for examination, including laws, Minister of Health regulations, archival regulations, journals, books, and other information related to the research.

RESULT AND DISCUSSION

The influence of applicable health regulations on conventional file retention policies

Medical Records have established regulations in implementing applicable policies. The advancement of technology driving progress in the field of medical records requires policymakers to continuously update medical records policies, especially concerning the retention of medical records. Retention, or weeding, is certainly important and very beneficial to improve the quality of healthcare services. The retention of medical record files is also carried out in accordance with the applicable regulations, both at the government level and within healthcare facilities. According to (Presiden Republik Indonesia, 2004) No. 29 Article 46 paragraph 1, it is stated that every doctor, dentist, or other health worker must carry out medical records in the practice of medicine. The medical records referred to in paragraph (1) must be fully completed immediately after the patient has finished receiving healthcare services. Medical records are defined as a file containing notes of examination results, treatments, actions, and other services, as well as patient identity data. Meanwhile, electronic medical records are referred to in Article 1 paragraph 2, "electronic medical records are medical records created using an electronic system intended for the

administration of medical records" (Peraturan Menteri Kesehatan RI No 24 tahun, 2022).

The processing and storage of medical records are also very important because they facilitate the retrieval of medical record files when needed. According to (Peraturan Menteri Kesehatan RI No 24 tahun, 2022) Article 39 paragraph 1, "the storage of electronic medical record data in healthcare facilities is carried out for at least 25 years from the patient's last visit." In paragraph 2, "after the time limit referred to in paragraph (1), electronic medical record data is exempt from destruction if the data will still be used or utilized." According to research(Keterlambatan & Dan, 2023) at hospital X, there are still delays in retention and destruction due to a lack of facilities and infrastructure and the absence of a retention schedule. Furthermore, research by(Khasanah et al., 2022) at hospital X in Cirebon revealed that retention has not been implemented due to a lack of human resources, causing staff to work double jobs.

According to BPPRM Revision VI 18, retention or weeding of medical record files is an activity of reducing sheets or files of medical records that no longer have value by separating their storage location. Medical record files of value can be stored by scanning, which can save storage space. The purpose of retention activities is to reduce the number of medical record files that no longer have value, thus reducing the thickness of medical record files, preserving valuable medical records as sources for research and education for students and health researchers, and saving the use of shelves or storage space.

According to (*Pedoman_Penyelenggaraan_Rekam_Medis_RS_2.Pdf*, 2004) in the Ministry of Health of the Republic of Indonesia, weeding is the activity of reducing files from storage racks by moving inactive medical record files to inactive racks after sorting them according to the year of the visit, microfilming inactive files according to regulations, destroying microfilmed files according to regulations, and then scanning medical record files. After this activity, the destruction of medical record files is carried out. Destruction is the process of physically destroying medical record archives whose active period, function, and value have ended. Destruction must be done thoroughly by burning, shredding, or recycling so that the contents and form are no longer recognizable.

With the numerous regulations governing retention and destruction, retention in hospitals should have been well implemented. However, in practice, there are still several hospitals that have not yet implemented it due to constraints in human resources, facilities, and infrastructure, and the lack of a retention schedule. This is consistent with the findings of (Marsum et al., 2018) which stated that retention has not been implemented due to the absence of a retention schedule, causing staff confusion about when to carry out retention.

Archival management practices considered effective in complying with health regulations related to conventional file retention

Archiving is created in conjunction with actions taken by institutions. Archives are considered important as a source of information for an institution; thus, the government enforces (Indonesia, 2018) Number 47 of 2015 concerning Archiving Article 1 paragraph 4, which states, "archives are a record of events or activities in various forms and media in accordance with the development of information and communication technology created and received by state

institutions, educational institutions, community organizations, local governments, political organizations, companies, and individuals in carrying out social, national, and state life."

One of the institutions in the field of health that performs archiving is hospitals. The archives held by hospitals must be organized to serve the community effectively. One of the archives generated by hospitals is medical records. Therefore, its management must follow the archival principles issued by the national archives, including archive reduction (Haryanti, 2022).

Archive management is also important for organizations to maintain the authenticity of records once they are created. Archive management involves systematically overseeing archives from creation, receipt, use, storage, to destruction to ensure the smooth operation of an organization.

Archive reduction is an action taken in line with the expiration of the retention period of archives as determined by legislation, regulations, and procedures. In (TVERSK, 2009) Law No. 43 of 1999 concerning Archiving, archive reduction refers to reducing the number of archives by transferring inactive archives from processing units to archival units, destroying archives that have no utility value, and transferring static archives to archival institutions.

efore conducting archive reduction, assessment is necessary to identify archives that no longer have utility value and are suitable for destruction. This requires guidelines commonly referred to as archive retention schedules. According to (Indonesia, 2018) Number 47 Article 1 paragraph (1), "Archive Retention Schedule (JRA) is a list containing at least the storage or retention period, type of archive, and information recommending the destruction, reassessment, and permanence of a type of archive in accordance with the guidelines for archive reduction and preservation." The purpose is to correctly destroy archives whose retention periods have expired, temporarily store archives that have not been used for a long time, and preserve archives with long-term value. Meanwhile, in(Grainne Walshe, 2012) Government Regulation No. 28 Article 56, archive reduction includes transferring inactive archives from processing units to archival units, destroying archives that have expired retention periods and no longer have utility value according to the provisions of regulations, and transferring static archives from creators to archival institutions.

Based on (Menkes Jakarta, 1995) on Circular Letter of the Director General of Medical Services No. HK.00.06.1.5.01160 regarding Technical Instructions for Procurement of Medical Record Forms and Destruction of Medical Record Archives, the procedure for destroying medical record archives is as follows: forming a destruction team and procedure with a hospital director's decree, the team creates a list of archives to be destroyed, the destruction is carried out by burning, shredding, or witnessed by a third party as per the destruction team, the destruction team creates a destruction report signed by the chairman and secretary and acknowledged by the hospital director, the original destruction report is kept in the hospital and the second copy is sent to the hospital owner. Specifically, medical records that are damaged/unreadable can be destroyed directly after the hospital director makes a statement on sealed paper. Based on the research(Susilowati et al., 2022) at X Public Hospital in Tulungagung, there are 3 regulations used, but their implementation has not been maximized due to

the limited number of medical record staff in the storage room and inadequate facilities.

CONCLUSSION AND RECOMMENDATION

Medical records are the most important part of healthcare services, thus requiring a strong legal foundation in its implementation. In ministerial regulations, laws, and archive regulations provide clarification on conducting the storage of medical records up to retention activities or destruction of medical record files. Upon closer examination, regulations regarding the retention of conventional medical record files are still limited or not yet detailed enough from the current applicable regulations. Therefore, there is a need for clearer and more definitive regulations regarding the retention or destruction of conventional medical records as well as their legal protection. These regulations should also govern how storage is carried out and the procedures for destruction. Whether the files should be scanned or other activities should be carried out. It is hoped that in the future, all forms of medical record activities can be made into standard procedures to ensure consistency in the right and proper steps.

ADVANCED RESEARCH

The limitation of this study lies in the lack of information and knowledge obtained or sought from journals and books. It would be advisable for the next researcher to seek and acquire as much information as possible, thus ensuring that the research results are maximized and detailed.

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