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ANALYSIS OF MEDICAL RECORD FILE RETENTION AT KANJURUHAN REGIONAL HOSPITAL, MALANG REGENCY

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ABSTRACT

Background: The implementation of medical record documentation is expected to follow the standard operating procedures (SOP) set by the Ministry of Health. However, many hospitals have not fully complied with this SOP, although an effective document storage system, especially medical records, is very important. This study aims to assess whether the practice of document retention at Kanjuruhan Regional Hospital, Malang Regency, is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia No. 269 of 2008 and the SNARS Accreditation standards.
Method: This study uses a qualitative descriptive approach, by observing and recording the medical record retention procedure. Data were collected through in-depth interviews, observation, and documentation. Data analysis was carried out by reducing data, presenting data, and drawing conclusions. The validity of the data was tested through data triangulation.
Results: The implementation of medical record file retention at Kanjuruhan Regional Hospital has not met the provisions of Regulation of the Minister of Health No. 269/Menkes/PER/III/2008 concerning the storage, destruction, and confidentiality of medical records. Medical records from 2014 were only retained in 2023 and 2024, exceeding the document age limit set by more than 5 years. Some of the problems faced include limited storage space, lack of trained workers, and complicated technology and procedures.
Conclusion: The practice of medical record file retention has not fully followed the existing SOP. A commitment from the hospital is needed to ensure that the retention process is carried out according to policy by improving facilities and infrastructure and human resources.

Keywords: Retention, Medical Records, Kanjuruhan Regional Hospital, Minister of Health Regulation 269

I. INTRODUCTION

Hospitals are vital institutions that provide health services to the community, with functions regulated by Law No. 44 of 2009. As an institution that plays a major role in maintaining public health, hospitals must continue to improve the quality of their services so that they can be accessed by all levels of society, with the aim of achieving optimal health and providing adequate health facilities (Ministry of Health of the Republic of Indonesia, 2009). The services provided by hospitals cover various aspects, such as outpatient care, inpatient care, and emergency care. To carry out this role effectively, hospitals need to ensure that all patients receive optimal services and in accordance with applicable health standards.

One important aspect in improving the quality of hospital services is the management of medical records. Medical records include various documents that record patient identity, examination results, treatment history, medical procedures, and other services received by patients at health facilities. Good management of medical records is essential to support the success of hospital services. In this case, hospitals must have an efficient and integrated health information system, which includes systematic document storage arrangements, especially for medical records (Ministry of Health of the Republic of Indonesia, 2008).

The process of managing medical records involves several stages, including storage, retention, and destruction of documents. The filing section or document storage unit plays a crucial role in this management. Medical record documents should not be stored permanently and must undergo a minimum retention of five years after the patient's last visit, in accordance with the Indonesian Minister of Health Regulation No. 269/Menkes/Per/III/2008 (Indonesian Ministry of Health, 2016). The retention process is carried out by sorting documents to separate files that are still active from those that are no longer active, with the aim of reducing the volume of files and preventing the accumulation of new documents every day (Latuconsina, et al., 2019). Important documents, such as medical resumes, written consent, operation sheets, and infant identification, are stored and scanned for archiving, while documents that have no further value are classified as inactive medical records and destroyed.

The Hospital Accreditation Standards (SNARS) managed by the Hospital Accreditation Committee (KARS) also set standards for the retention and storage of medical record documents, which are included in the Information and Medical Records Management (MIRM) 10 (KARS, 2018). By following these standards, hospitals can ensure that medical record documents are managed properly, thus facilitating the process of retrieving and returning documents by officers, as well as maintaining the order and completeness of medical record archives.

At the Kanjuruhan Regional Hospital, Malang Regency, the process of managing medical records, including retention, is carried out in accordance with applicable standard operating procedures. However, observations show that the medical record document storage room is often full and not equipped with special shelves. In addition, this hospital also faces challenges because it does not have special personnel to handle the process of managing medical records optimally (Lesmana, et al., 2021). This study aims to evaluate the implementation of medical record document retention at the Kanjuruhan Regional Hospital, by referring to applicable regulations and accreditation standards set by the government.

II. METHODS

This study uses a qualitative approach with a descriptive method, focusing on an in-depth understanding of the research variables through direct observation and recording of medical record retention procedures at Kanjuruhan Regional Hospital. Data collection was carried out through structured in-depth interviews, supported by tools such as tape recorders and cameras, as well as observation and documentation. The sampling technique used Purposive Sampling to ensure representation of the characteristics of the population being studied (Sugiyono, 2008). Data analysis was carried out interactively with the stages of reduction, data presentation, drawing conclusions, and verification, to ensure the validity and accuracy of the research results (Sugiyono, 2020). The validity of the data was tested through credibility, transferability, dependability, and confirmability tests (Notoatmodjo, 2012). This study also complies with research ethics, respects the privacy and dignity of subjects, and maintains the confidentiality of information.

III. RESULT

A. Overview of the Research Location : Kanjuruhan Regional Hospital is a regional hospital owned by the Malang Regency Government located on an area of 32,140 m² with an operational area of 11,550 m². This hospital is located in the southern part of Malang and has 280 beds serving the area up to the border of Blitar and Lumajang Regencies. Since the end of 2006, Kanjuruhan Regional Hospital has officially had the status of a Class B Non-Educational Hospital, has met the ISO 9001:2015 SMM standard, and has received full-level accreditation which is valid until 2022. The history of Kanjuruhan Regional Hospital began from 1958 to 1966, when it operated as a Health Center led by Dr. Han Wi Sing, with 40 staff and 41 beds. In 1966, this hospital changed into Basic Health Center 7 which was inaugurated by the Regent of Malang and led by Dr. Hartono Wijaya, with 45 staff and still providing 41 beds.

In 1971, Kanjuruhan Regional Hospital transformed into Puskesmas Pembina Basic 12 under the leadership of dr. Ibnu Fadjar, with the number of employees increasing to 69 people and 46 beds. In 1978, this hospital changed into a Puskesmas with Care and proposed the status as a class D hospital, led by dr. Tuti Hariyanto with 51 beds and 75 employees. The transition process from Puskesmas Perawatan to a Class D Hospital took place from 1983 to 1984 under the leadership of dr. Tuti Hariyanto, with an increase in capacity to 61 beds and 80 employees. In 1984, this hospital was upgraded to a Type C Hospital, had 130 beds and 180 employees, and a Health Nursing School was established in 1985.

In 1996, RSUD Kanjuruhan became a Self-Help General Hospital Unit with 155 beds and 334 employees under the leadership of dr. Tuti Haryanto, MARS. Furthermore, in 2001, this hospital changed its name to the Regional Hospital Agency of Malang Regency, led by dr. Setyo Darmono with 156 beds and 327 employees. In 2003, this hospital changed its name to the Regional General Hospital of Malang Regency under the leadership of dr. April Mustiko R, Sp.A, with 169 beds and 339 employees. In 2004, RSUD Kanjuruhan was upgraded to a Public Service Agency with a Class B Non-Educational Hospital Type under the leadership of dr. Agus Wahyu Arifin, MM, with 201 beds and 424 employees.

In 2008, this hospital officially changed its name to the Regional General Hospital of Kanjuruhan, Malang Regency based on the Regent's Decree No. 180/37/Kep/421.013/2008. This name change is in line with the change in organizational structure regulated in Malang Regent Regulation Number 37 of 2008. Based on Malang Regent Decree No. 180/232/KEP/421.013/2009, Kanjuruhan Hospital was designated as a SKPD with full PPK BLUD status. Until 2010, under the leadership of dr. Lina Julianty P., Sp.M, MM, the number of employees in this hospital increased to 564 people with a bed capacity increased to 221. Then, the Human Resources available at Kanjuruhan Hospital are presented in Table 4 below

Table 4. Human Resources at Kanjuruhan Regional Hospital

Kategori	SDM	Ket.
Tenaga Medis		
1. Pelayanan Medik Dasar		
a. Dokter	15	Struktural
b. Dokter Gigi	1	
2. Pelayanan Medik Dasar		
a. Peny. Dalam	5	
b. Kesehatan Anak	4	
c. Bedah	3	Struktural
d. Obstetri dan Ginekologi	3	

3.	**Pelayanan Medik Sub Spesialistik Dasar**		
a.	Bedah	1	Sub Spesialis
b.	Obstetri dan Ginekologi	1	Sub Spesialis
4.	**Pelayanan Spesialis Penunjang**		
a.	Anestesi	3	
b.	Patologi Klinik	2	
c.	Radiologi	1	
5.	**Pelayanan Spesialis Lain**		
a.	Mata	2	
b.	THT	2	
c.	Saraf	2	
d.	Jantung dan Pembuluh Darah	2	
e.	Kulit dan Kelamin	1	
f.	Patologi Anatomi	1	
g.	Paru	2	
h.	Urologi	1	
i.	Ortopedi	4	Struktural
j.	Bedah Saraf	1	
k.	Bedah Plastik	1	
6.	**Pelayanan Dokter Gigi Spesialis**		
1.	Konservasi gigi	1	
2.	Prostodonti	1	

Sumber: Data Primer, 2024

In accordance with Malang Regent Regulation Number 33 of 2014, the organizational structure of Kanjuruhan Hospital, Malang Regency consists of a Director and Deputy Director of Services. The Deputy Director of Services oversees three main areas: Medical Services, Nursing Services, and Supporting Facilities and Services. Each area has a section that is responsible for the implementation of services and monitoring and evaluation. The establishment of installations at Kanjuruhan Hospital is regulated based on the Regulation of the Director of Kanjuruhan Hospital Number 31.C of 2020, which is a revision of the previous regulation, Number 291 of 2018.

B. Research Results : Interviews with three informants from Kanjuruhan Hospital—Head of Medical Records Unit, Filling Officer, and Medical Records Staff—revealed various aspects related to the implementation, procedural flow, obstacles, and recommendations in the retention of medical records at the hospital.

1. Implementation of Medical Record Retention

Medical record retention at Kanjuruhan Regional Hospital follows the guidelines of the Indonesian Ministry of Health, where inpatient medical records are stored for 5-10 years, and outpatient medical records are stored for 2-5 years. Retention procedures include identification, sorting, and destruction of inactive files according to regulations. The medical records unit plays an important role in ensuring compliance with these standards.

2. Medical Record Retention Procedure Flow

The retention procedure involves several stages, namely identification, classification, marking, and grouping of files. The file recording and labeling system includes unique numbering, use of color codes, and electronic databases to facilitate the management of inactive files.

Figure 4. Medical record document storage space at Kanjuruhan Regional Hospital

3. Obstacles to Implementing Medical Record Retention
Some of the obstacles faced include limited storage space, lack of trained human resources, inadequate technology, and complex procedures.
4. Recommendations for Medical Record Retention
To overcome these obstacles, several recommendations are proposed, such as implementing an electronic medical record (EHR) system, increasing staff training, adding human resources, improving infrastructure, and routine evaluation of existing procedures.

IV. DISCUSSION

A. Implementation of Medical Record Retention Process : Medical record retention at Kanjuruhan Regional Hospital is carried out based on the last date of the patient's visit, where document sorting is done manually by checking one by one to assess the value of the document. Documents that still have value, such as admission and discharge summaries, disease condition summaries, surgery documents, newborn identification, and death documents, are stored in folders which are then placed on active archive shelves. On the other hand, documents that are no longer valuable are prepared to be destroyed.
However, the implementation of retention at Kanjuruhan Regional Hospital is not entirely in accordance with the provisions contained in Permenkes No. 269/Menkes/Per/III/2008 and Circular Letter of the Director General of Yanmed No. HK.00.06.1.5.01160 of 1995. According to these regulations, medical record archives must be stored for at least five years from the last date of service or death of the patient. At Kanjuruhan Hospital, medical records from 2014 were only retained in 2023 and 2024, which exceeded the document storage age limit.

B. Medical Record Retention Policy : The retention procedure at Kanjuruhan Hospital is stated in the SOP for destruction and reduction which is still combined in one document, without a separate SOP for each process. Although there is an Archive Retention Schedule (JRA), its implementation is not fully in accordance with applicable provisions. The existing SOP is very important to ensure that the retention process is carried out correctly, reduce the risk of procedural errors, and maintain work productivity.

C. Implementation of Medical Record Sorting : The sorting process is carried out by moving medical record documents that are more than five years old from active to inactive status. At Kanjuruhan Hospital, this sorting involves manual examination of each document one by one to determine whether the document is still active or inactive. Documents that are

still considered active are stored back on the active storage rack, while documents that are no longer valuable are stored in the corner of the room, due to limited special storage space.

D. Implementation of Medical Record Sorting : The medical record retention procedure at Kanjuruhan Hospital includes three main stages:
1. Moving documents from active to inactive status.
2. Reducing the number of forms on active storage shelves.
3. Assessing and selecting documents based on their utility value.
Kanjuruhan Hospital has provided the necessary facilities and infrastructure, such as computers, scanners, printers, inactive rooms, and inactive storage shelves, to support the implementation of retention.

E. Implementation of Medical Record Sorting : Evaluation of medical records at Kanjuruhan Hospital is carried out to assess whether documents are still needed or can be destroyed. This assessment is based on the relevance of the document and is carried out after the document is selected for retention. However, its implementation has not been fully in accordance with the retention schedule set by the regulations.

F. Implementation of Medical Record Sorting : Kanjuruhan Hospital faces several obstacles in implementing medical record retention, including limited storage space, lack of trained workers, inadequate technology, and complicated procedures. To overcome these obstacles, several recommendations that can be considered include:
1. Digitization of Medical Records: Implement an electronic medical record system to reduce the need for physical storage and improve accessibility of medical record data.
2. Staff Training: Provide regular training for staff related to medical record management and the use of the latest technology to improve skills and efficiency.
These recommendations are expected to help Kanjuruhan Hospital manage medical record retention more effectively, in accordance with applicable regulations, and improve the quality of health services.

V. CONCLUSION

This study concludes that the implementation of medical record retention at Kanjuruhan Regional Hospital refers to the guidelines of the Indonesian Ministry of Health, but there are delays, such as files from 2014 which were only retained in 2023-2024. The retention process includes identification, classification, and marking of files, with the main obstacles being limited space, lack of trained personnel, and inadequate technology. It is recommended to digitize medical records, train staff, improve infrastructure, and audit and evaluate periodically to improve the efficiency of retention management.

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