**REVIEW OF MEDICAL RECORDS MANAGEMENT SYSTEM AND HEALTH INFORMATION AT KULATI HEALTH CENTER**

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| **ARTICLE INFORMATION** |  | **ABSTRACT** |
| Received: Revised : Accepted: DOI:  | *Medical records are files containing notes and documents about patient identity, examinations, treatments, actions and other services that have been provided to patients. Medical records are an important part of health services for patients now and in the future. Medical records aim to help achieve normal organization in the health management improvement graph in clinics or health centers or other health management places. The purpose of this study was to analyze the medical records and health information management system at the Kulati Health Center. The subjects in this study were 1 person in charge of medical records and 1 medical records officer at the Kulati Health Center. While the object of this study was the medical records and health information management system at the Kulati Health Center. The type of research used in this study is descriptive qualitative. The Kulati Health Center is in the good category in the medical records and health information management system. The results of this study indicate that: First, officers have good coding skills because they have attended training on coding medical records. Second, medical records are stored at the Kulati Health Center centrally, by combining outpatient and emergency medical record files. Third, Kulati Health Center has never reduced medical records, only separating active and inactive medical record files because there have been no direct medical record graduates. This makes its implementation less than optimal.* |
| **KEYWORDS** |
| *Medical Records Management System, Medical Records* |
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**INTRODUCTION**

The Health Center is a technical implementing unit of the District/City Health Office that is responsible for organizing health development in a health area. The Health Center is an organizational unit that operates in the field of health services that is at the forefront and has a mission as a center for developing health services, which carries out comprehensive and integrated health development and services for the community in a certain work area that has been determined independently in determining service activities but does not include financing aspects (Ministry of Health of the Republic of Indonesia, 2004 inSanah, Ridho, and Trihono (2017).

Medical records are an essential part of health care for current and future patients. Medical research, statistics on health care, and the management and programming of facilities and services for health care all use medical records (WHO, 2006 inSanggamele, Kolibu, and Maramis (2018).

Medical records are files containing notes and documents about patient identity, examinations, treatments, actions and other services that have been given to patients. The use of medical records can be used as health maintenance and patient treatment, evidence in medical records can be used as health maintenance and patient treatment, evidence in the law enforcement process, education and research needs, the basis for payment of health service costs and health statistics data (H, Linda Fitri Loli 2020).

The purpose of creating medical records is to help achieve normal organization in the health management improvement graph in clinics or health centers or other health management places. The regular implementation of health service facilities will not be successful as expected without the help of a reliable medical record management system. On the other hand, regular business is one of the perspectives that guarantees good health management business. Good medical record management in accordance with methods and principles is needed to produce good medical record services (Latarisa, 2020 in Nasution 2023).

The purpose of implementing medical record management is to support the achievement of orderly administration in order to improve health services. Therefore, without the support of a good and correct medical record management system, there will be no orderly administration as expected. Medical records have benefits that can be seen from various aspects, namely medical aspects, administrative aspects, legal aspects, financial aspects, research aspects, educational aspects and documentation aspects (Ministry of Health of the Republic of Indonesia 2006).

Based on initial observations conducted at Kulati Health Center, it was found that there had been no reduction (retention) to reduce the storage shelf capacity of the many former medical records. At Kulati Health Center, only active and inactive files were separated and then stored in another storage room. Then it was also found that coding was still carried out by non-medical record officers and storage at Kulati Health Center used the name of each head of family, not using the existing numbers or alphabets.

Seeing these problems, researchers are interested in conducting research on "Review of the Medical Records Management System and Health Information at Kulati Health Center".

**METHODOLOGY**

The type of research used in this study is descriptive qualitative, which is analyzing, describing, and summarizing various conditions, situations from various data collected in the form of interview results or observations regarding the problems studied that occur in the field. The methods used are documentation, observation and interview methods. The subjects in this study were 1 person in charge of medical records and 1 medical records officer at Kulati Health Center. While the object of this study was the medical records management system and health information at Kulati Health Center.

The study was conducted in the medical record room of Kulati Health Center. The study was conducted from June to July 2024. The data collection techniques used in this study are Observation, Interview Guidelines and Documentation. The data analysis technique in this study is descriptive, namely the method of medical record management system and health information by describing and describing the conditions in the field in order to compare theories and research results.

**RESULTS AND DISCUSSION**

## **Medical Record File Coding**

Based on the results of interviews conducted by researchers with informants related to coding of medical record files, it was obtained information that for those on duty, the person will do the coding, while for entry it is done by one person. Information was also obtained that there were no medical record officers who were direct medical record graduates and had undergone training related to medical records but not as a whole, however, there were still officers who had difficulty finding coding.

Medical record management aims to create administrative order that supports the achievement of hospital goals, namely improving the quality of health services.(Khairussari & Rudi 2018). In this case, each hospital is required to follow the guidelines or technical instructions that have been prepared. Based on research conducted at the Kulati Health Center, it is known that the process of coding medical record files is carried out using the Primary Care application. This application makes it easier for officers to input data and code. Officers only need to enter the code according to the ICD standard, then the application will display the relevant options automatically.

Regarding the division of tasks, there is a clear system at the Kulati Health Center, where officers on duty on the day of duty are responsible for coding, while data entry tasks are carried out by other officers. Thus, both processes are not handled by the same person, which can improve the accuracy and efficiency of medical record data processing. However, limited educational background is a challenge in itself, because the majority of officers do not come from medical records majors, but from nursing or midwifery professions. Nevertheless, they have undergone training to increase their knowledge and skills in coding and data entry, although this training has not provided a deep understanding.

The main obstacle faced by officers is the difficulty in finding the right diagnosis code due to a lack of in-depth understanding of coding, so they often ask for help from doctors when they have difficulties. This shows that, even though there has been training, there is still a need to deepen the knowledge of officers about medical record coding so that the data entry process can run more efficiently and accurately.

## **Medical Record File Storage**

Based on the results of interviews conducted by researchers with informants related to the SOP for storing medical records, information was obtained that there is an SOP for storing medical records and using a centralized storage system that contains all medical record documents, both outpatient and emergency rooms. Information was also obtained that based on the alignment system, the name of the head of the family is used and arranged based on each village and wooden shelves are provided for storing medical records, but medical record folders are sometimes misplaced so that they somewhat hinder the service process.

Based on research on the storage of medical record files at the Kulati Health Center, it appears that there are several important aspects. The health center has an SOP related to the storage of medical records, but the understanding of officers regarding the SOP is still limited.The Last Supper (2019) reminds that if file storage is not carried out in accordance with SOP, this can result in the loss of files and complicate the process of tracking or rediscovering documents.

The process of storing files at the Kulati Health Center is carried out by grouping files based on the name of the head of the family and arranging them according to the village of residence. This method is expected to facilitate the search and management of files. However, the implementation of a centralized system to store all medical record files from the emergency unit (UGD) and outpatients in one location can cause several problems. Based on research byApriliani, et al. (2020) This centralized system unifies the storage of outpatient, inpatient, and emergency installation files in one location with upper and lower file divisions. Files related to death and those that are useless are stored in the retention room, while inactive medical record files are placed in the corner of the active file storage rack, which risks causing congestion.

The main obstacle faced by Kulati Health Center is that files are often misplaced or not stored in the right place, which results in obstacles in the patient registration process. Inaccuracy in storing these files slows down access to medical information and has the potential to affect the efficiency of patient services. Therefore, it is necessary to have a management plan for inactive files so that there is always space for new files, by separating inactive storage shelves from active shelves to facilitate searching when needed (Ministry of Health, 2010 in Apriliani, et al., 2020).

The supporting facilities used are wooden shelves for the storage process, although the shelves are relatively simple. Although wooden shelves function as storage, the quality and durability of the material can limit the effectiveness of storage. Thus, there is an urgent need to improve the understanding of officers regarding SOPs, improve storage methods, and consider the use of better storage facilities to improve the efficiency and security of medical record files at the Kulati Health Center.

## **Destruction (Retention) of Medical Record Files**

Based on the results of interviews conducted by researchers with informants related to destruction (retention), information was obtained that the retention period is 5 years, however, destruction has never been carried out, only separated between active and inactive medical record files. Information was also obtained that the person responsible for the destruction of medical record files is the head of the health center and the head of medical records.

Based on the results of research on the destruction (retention) of medical record files at the Kulati Health Center, it was found that although officers understand the importance of the destruction process, its implementation is still not optimal. Retention itself is defined as the process of transferring patient medical record files from active storage to inactive storage (Apriliani, Muflihatin, and Muna 2020). Researchers noted that until now, the destruction of medical record files has never been carried out. The existing process is limited to separating the files of patients who are not actively receiving treatment, have moved, or have died. This shows the lack of clear policies or procedures in managing the destruction of files, so that unnecessary files continue to pile up.

The results of this study are in line with the findingsHilmansyah, (2021) which states that one of the causes of the failure to implement retention and destruction of medical record files is the absence of a retention schedule at the relevant agency. Previous research also found that the failure to implement the destruction process was caused by limited understanding and knowledge of officers, as well as the lack of adequate facilities to implement the retention of these files (Tuwardi, 2016 in Hilmansyah, 2021). The retention period for medical record files set at five years is acknowledged by officers, but in practice, this retention has not been implemented effectively.

This finding is also supported by research results fromThe story of the ..., which shows that the process of retaining medical record files has not been carried out effectively. The assessment process that should be carried out after five years for inactive medical record files has not been implemented properly. General medical record files should be kept for five years, while files for certain diseases such as mental illness, drug addiction, and leprosy, need to be kept for up to 15 years before being destroyed. However, the selection and destruction procedures for these files have not been optimized.

The absence of a responsible person and lack of experience in the process of destroying files are challenges in managing medical record information efficiently. The uncertainty about who is responsible for destroying files indicates that the existing system still needs improvement. Improvement efforts are needed to ensure that medical record file management is carried out properly, in order to reduce storage space density and maintain the security and confidentiality of patient information. Evaluation and implementation of more effective destruction procedures are essential to handle files that are no longer needed and avoid potential risks related to patient information management.

**CONCLUSION**

Based on the results of the research that has been conducted, it is concluded that Kulati Health Center is in the category of quite good in the medical record management system and health information. The conclusions contained in the scientific paper on the medical record management system and health information include: First, Officers have good coding skills because they have been trained in coding medical records. The drawback is due to the absence of medical record graduates at Kulati Health Center so that there are often errors related to coding medical records. Second, Storage of medical records at Kulati Health Center uses a centralized storage system, by combining outpatient medical record files and emergency room medical record files. The drawback is that sometimes medical record files get stuck so that it hinders the service process because the alignment system directly uses the name of each head of the family and uses a small font so that it is quite difficult for officers to read. Third, The reduction of medical records at Kulati Health Center has never been done, only separated between active and inactive medical record files because there are no direct medical record graduates so that the implementation is not optimal.

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