

MEDICAL RECORD STORAGE SYSTEM BASED ON ACCREDITATION CRITERIA 3.8.4 IN PUBLIC HEALTH CENTERS

Sri Wahyuningsih Nugraheni^{1*}, Muhammad Amin bin Sahari², Beta Setiawati¹, Kufita Alya Salsabila¹

¹Universitas Duta Bangsa Surakarta, Jl. K.H Samanhudi No.93, Sondakan, Laweyan, Kota Surakarta, Jawa Tengah
57147, Indonesia

²University Malaysia of Computer Science & Engineering, Block 12, Star Central, Lingkaran Cyber Point Timur,
63000 Cyberjaya, Selangor, Malaysia

*sri_wahyuning@udb.ac.id

ABSTRACT

The Sawit Boyolali Community Health Center was accredited in 2017. Retention of medical record documents has been carried out in the last three years, namely 2020, 2021 and 2022. The obstacle in implementing retention is that there are no standard operating procedures regarding retention, storage systems and identification of medical records. This type of research is descriptive qualitative with a cross sectional research design. The research variable consists of three assessment elements on criteria 3.8.4. Collecting research data using interviews, observation and documentation. Processing, analysis and presentation of data is done descriptively. The results of the study are: the decree of the head of the public health center becomes the basis for the policy of implementing medical record retention without standard operating procedures, namely the decree of the head of the community health center Sawit Boyolali number 440 of 2017 concerning the storage of medical records. The implementation of medical record identification is regulated through standard operating procedures number 005/SOP/VII/UKP/2017 regarding patient registration. Medical record coding provides a medical record number code of eight digits, the first two digits are the village/kelurahan code, the second two digits are the medical record number, and the third two digits are the family card code/family status. The medical record storage system is centralized, that is, outpatient and inpatient medical records are stored in one folder/folder. Documentation of the results of examinations, treatment, actions, and other services that have been provided to patients by doctors, dentists and or health workers made immediately and after the patient receives services. The conclusions of the research based on accreditation criteria 3.8.4 are: (1) there is a retention policy in the form of a decree from the head of the public health center without standard operating procedures. Patient identification in medical records is regulated in standard operating procedures regarding patient registration. Medical record coding uses eight digits with a centralized storage system. Recording and documentation of medical records is carried out by the doctor in charge of the patient.

Keywords: coding; documentation; identification; retention; storage

INTRODUCTION

A community health center is a health service facility that organizes first-level individual health efforts, by prioritizing promotive and preventive efforts, to achieve the highest degree of public health in its working area. The policy of the Ministry of Health of the Republic of Indonesia in an effort to improve the quality of services in First Level Health Facilities (FKTP), especially public health centers, namely the Regulation of the Minister of Health of the Republic of Indonesia Number 46 of 2015 and Number 27 of 2019 concerning Accreditation of Community Health Centers, Primary Clinics, Independent Practice Places Doctor, and Dentist's Independent Practice. The policy aims to ensure quality improvement, performance improvement and the implementation of risk management on an ongoing basis in public health centers. Therefore, it is necessary to carry out an assessment by an external party using the standards set through the accreditation mechanism.

One of the most important parts of a health service agency is the implementation of good medical record services. Medical record is a file that contains records and documents about patient identity, examination, treatment, actions and other services to patients. The medical record file storage system is very important to do in a health care institution, because the storage system can make it easier for medical record files to be stored in storage shelves, speed up finding or returning medical record files stored in storage shelves, easy to return, and protect files. medical records from the danger of theft, the danger of physical, chemical, and biological damage. The storage system aims to make it easier and faster to find medical record files stored on filing shelves.

Minister of Health Regulation Number 46 of 2015 article 3 paragraph 2 states that the accreditation of public health centers is carried out every 3 years. Boyolali Regency has basic health facilities as the first service facility as many as 25 community health centers with details of the types of public health center services with a total of 14 inpatient public health centers and 11 non-inpatient public health centers. The Sawit Boyolali community health center has both inpatient and outpatient services. The Sawit Boyolali community health center was accredited in 2017. Retention of medical record documents has been carried out in the last three years, namely 2020, 2021 and 2022. The obstacle in implementing retention is that there are no standard operating procedures regarding retention, storage systems and identification of medical records.

METHOD

This type of research is descriptive qualitative with a cross sectional research design. The research variable consisted of three assessment elements on criteria 3.8.4, namely: (1) policies and procedures for retention of medical record files, (2) identification of patient medical records, and (3) coding, storage, and documentation of medical records. The research subjects were medical records officers at the Sawit Boyolali community health center, while the objects of research were retention policies and procedures, the implementation of patient medical record identification, and the coding, storage, and documentation of medical records. The primary data of this study include the results of interviews, observations and documentation. While the secondary data of this study were the profile of the Sawit Boyolali community health center, Standard Operating Procedures regarding retention, identification of patient medical records, and coding, storage, and documentation of medical records and patient medical record documents. Collecting research data using interviews, observation and documentation. Data processing consists of collecting and editing. Data analysis is done by describing and interpreting the data. Presentation of data is presented in the form of descriptive analysis.

RESULTS

Policies and Procedures for Retention of Medical Record Files with Clarity of Retention Period at the Sawit Boyolali Community Health Center

The policy for storing medical record files with clarity on the retention period at the Sawit Boyolali community health center is regulated in the decree of the head of the public health center number 440 of 2017 concerning the storage of medical records. The standard operating procedure regarding the storage of medical record files with clarity on the retention period has not been ratified so that the implementation of storing medical record files at the Sawit Boyolali community health center refers to the Decree of the Head of the Public Health Center.

The medical record file storage system is centralized with a family folder. Storage of medical record files on storage racks with a straight numerical filing system. The implementation of storing medical record files at the Sawit Boyolali community health center, namely:

1. Medical records at non-hospital health care facilities (community health centers) must be kept for at least two years from the last date the patient was treated.
2. After the specified time limit is exceeded, medical records can be destroyed.
3. Medical record retention procedures, namely: (a) Viewing the date of the last visit, (b) After two years from the last visit the patient did not visit the community health center, the medical record file is taken from an active medical record, then reviewed in an excel application , (c) Retention is carried out every two years for outpatient medical records and 5 years for inpatient medical records.

In the results of interviews with medical record officers, it was found that the Sawit Boyolali community health center in carrying out the task of retaining active to inactive outpatient medical record files was in accordance with the decree of the head of the public health center number 440 of 2017 concerning the storage of medical records. The legal basis for storing medical record files with a clear retention period at the Sawit Boyolali community health center is the Regulation of the Minister of Health of the Republic of Indonesia number 269 of 2008 concerning medical records article 9 paragraph 1. The activity of transferring medical record files from active to inactive is carried out by selecting one by one record document. medical records to find out which forms have use value and do not have use value with the aim of being a reference for implementing steps for officers to shrink medical record files.

Identification Method According to the Policy and Procedure of Medical Record Files at the Sawit Boyolali Community Health Center

Patient identification is the collection of data and recording of all information about patient evidence, so that one can recognize one patient by distinguishing it from other patients. The reference for registration officers to identify patients at the Sawit Boyolali community health center is the standard operating procedure Number 005/SOP/VII/UKP/2017 regarding registration. The operational standard regulates the main things that must be done by medical recorders in identifying patients.

The procedure for carrying out patient identification at the Sawit Boyolali community health center is:

1. The officer asks for patient data, which includes personal identification data consisting of an identity card or family card and health insurance membership data in the form of BPJS, KIS Access, or Jamkesda.
2. The officer asks the patient's personal data, such as name, address, religion, place/date of birth, name of parents/husband/wife and so on.
3. The officer checks the similarity of the patient's personal data with the data on the identity card or family card and health insurance.
4. Officers fill in patient data on the patient registration sheet, and enter patient data into the computer.
5. The officer takes the patient's medical record status sheet and family folder according to the patient's family card registration number.
6. The officer compiles the patient registration sheet and the patient's medical record status sheet in the family folder.

7. The officer rechecks the patient's identity with the data contained in the family folder.
8. The officer asks the patient's complaint.
9. The officer determines the service poly in accordance with the patient's complaint.
10. The officer submits the medical record status that has been identified to the appropriate polyclinic according to the patient's complaint.

Based on the results of interviews with officers stated that the identification method was used in the registration section as a reference for registration officers to identify patients who visited the Sawit Boyolali community health center.

Coding, Storage and Documentation System in accordance with Policies and Procedures at the Sawit Boyolali Community Health Center

At the Sawit Boyolali community health center, the coding system is the coding of medical record numbers based on the village/region where the patient lives. The list of patient medical record number codes at the Sawit Boyolali community health center is described in table 1 as follows:

Table 1
List of Medical Record Number Codes at the Sawit Boyolali community health center

No	Name of Village/Territory	Area code
1	Within the region/village	
	Kemasan	01
	Tlawong	02
	Jenangan	03
	Cepoko sawit	04
	Guwo kajen	05
	Tegalrejo	06
	Manjung	07
	Gombang	08
	Kateguhan	09
	Bendosari	10
	Jatirejo	11
	Karang duren	12
2	Out of area	90
3	outside the district	99

The medical record coding system consists of 8 digit numbers:

00 000 00
 1 2 3

Information:

- The first two digits : village code
- Second four digits : Medical record number
- The third two digits : family card code / family status

- Code 00 indicates the relationship of the head of the family
- Code 01 signifies the wife's relationship
- Code 02 indicates the relationship of the 1st child
- Code 03 indicates the relationship of the 2nd child and so on

The mechanisms for coding patient medical records at the Sawit Boyolali community health center include:

1. Every patient who visits the Sawit Boyolali community health center with the address Desa Packaging the first two-digit code 01, Tlawong Village the first two-digit code 02, Jenengan Village the first two-digit code 03, Desa Cepoko Sawit the first two-digit code 04, Desa Guwo Kajen first two-digit front code 05, Tegal rejo Village first two-digit front code 06, Manjung Village first two-digit front code 07, Gombang Village first two-digit front code 08, Kateguhan Village first two-digit front code 09, Bendosari Village front code first two digits 10, Jatirejo Village first two-digit front code 11 and Karang Duren Village first two-digit front code 12. Patients with addresses other than Sawit Boyolali region/village are given the first two-digit front code 90 and patients with addresses other than Boyolali district are given a front code the first two digits of 99.
2. Every new patient who has never been examined at the Sawit Community Health Center will get a medical record number in the middle 4 digits as a medical record serial number through a medical record number help book consisting of 3 numbering help books within the region, a numbering help book outside the region and help books outside the district and adapted to each region.
3. Numbering at the Sawit Boyolali community health center uses a personal system, this can be known by separating the status of family members in the last two digits, namely code 00 for the head of the family, code 01 for the wife, code 02 for the first child, code 03 for the second child etc.

The medical record storage system at the Sawit Boyolali community health center is centralized, namely outpatient medical records and inpatient medical records stored in one folder/folder, with the following conditions:

1. Medical records are kept by the medical record officer in accordance with the area code where each patient lives
2. Medical records are stored in the family folder
3. The family folder is stored on a storage rack in the medical record room.

At the Sawit Boyolali community health center, recording and documenting the results of examinations, treatment, actions, and other services that have been provided to patients by doctors, dentists and/or health workers are made immediately after the patient receives service. The provisions for recording and documenting medical records are as follows:

1. Accurate: writing notes always begins by writing the date, time and factual data
2. Concise: using standardized abbreviations
3. Recording: includes present and past conditions
4. If an error occurs at the time of recording, it can be corrected by deleting it without removing the corrected and initialed note, followed by correct information and not erasing. Data validation will be broken if data is deleted
5. Write your name and initials on each activity that has been done
6. If the recording continues on a new page, sign and rewrite the time and date on that part of the page.

DISCUSSION

Policies and Procedures for Retention of Medical Record Files with Clarity of Retention Period at the Sawit Boyolali Community Health Center

The policy for storing medical record files with clarity on the retention period at the Sawit Boyolali community health center is regulated in the decree of the head of the public health center number 440 of 2017 concerning the storage of medical records. In its implementation, it is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia number 269 of 2008 concerning medical records, article 9 paragraph 1, that medical records in non-hospital health service facilities must be kept for at least two years from the last date the patient was treated. After the two-year time limit is exceeded, the medical record is called an inactive medical record. If a patient with an inactive medical record returns for treatment, the medical record becomes active again. If the inactive period exceeds 5 years except for medical records for certain cases (related to the law at least 23 years, HIV, adoption, IVF, organ transplant, plastic surgery, rape, sex adjustment, research/education) medical records can be scheduled to be destroyed. Based on the Regulation of the Minister of Health of the Republic of Indonesia number 269 of 2008 concerning medical records, Article 8 paragraph 3 states that a summary of discharge and approval of medical treatment must be kept within 10 years from the date the summary was made. Article 8 paragraph 4 emphasizes that the storage of medical records and summary returns is carried out by officers appointed by the head of health service facilities.

Identification Method According to the Policy and Procedure of Medical Record Files at the Sawit Boyolali Community Health Center

The reference for registration officers to identify patients at the Sawit Boyolali community health center is the standard operating procedure Number 005/SOP/VII/UKP/2017 regarding registration. The operational standard regulates the main things that must be done by medical recorders in identifying patients. According to Budi (2011: 44), the identification method is the process of collecting data and recording all information about the evidence of a person so that we can determine and equate the information with an individual person, in other words that with identification we can find out a person's identity and with identity. We can get to know someone by distinguishing them from others. Identification is carried out for the purposes of:

1. Recognizing physically by looking at someone's face/physical in general and comparing someone with pictures/photos.
2. Obtain personal information including name, parents name, husband/wife name, occupation, address, religion, place/date of birth, blood type, and education and can also add specific personal information.
3. Combining physical identification with personal information, combining the two things can be more trusted because it is carried out by an institution that has the authority to make and issue a person's identity in the form of: identity cards, student cards, passports, driving licenses, and so on.

Coding, Storage and Documentation System in accordance with Policies and Procedures at the Sawit Boyolali Community Health Center

At the Sawit Boyolali community health center, the coding system is a medical record number code based on the village/region where the patient lives using an eight-digit number. The medical record storage system at the Sawit Boyolali community health center is centralized, namely outpatient medical records and inpatient medical records stored in one folder/folder. Recording and documenting the results of examinations, treatment, actions, and other services that have been

provided to patients by doctors, dentists and or health workers are made immediately after the patient receives services.

According to Budi (2011: 82-83) coding activity is the provision of coding by using letters and numbers or a combination of letters and numbers that represent data components. The purpose is as a reference for the steps in organizing medical records so that they can be easily retrieved when needed. The coding procedure is that the registration officer receives the patient's patient queue number and makes a medical record if the patient is a new patient, the officer makes a medical record coding system using a combination of numbers, the officer uses the regional or village coding number, the officer uses the medical record serial number with numbers, the officer asks for a card patient visits (for old patients), officers look for medical records according to the medical record number on the visit card.

According to Budi (2011: 93-94) the procedure for storing medical record files contains individual data that is confidential, then each sheet of the medical record file form must be protected by inserting it into a folder or folder so that each folder contains data and information on the results of services obtained by the patient. individually (not in groups or families). Storage of medical record files is different from storage of folders or office folders. The medical record file has the "tongue" protruded out so that the color coded medical record number will appear among several medical record files. Storage of medical record files aims to make it easier and faster to find medical record files stored in filing racks, easy to retrieve from storage, easy to return, protect medical record files from theft, dangers of physical, chemical and biological damage. A centralized medical record file storage system is a storage system by combining outpatient, emergency, inpatient medical record files into one storage folder. According to the Regulation of the Minister of Health of the Republic of Indonesia number 269 of 2008 concerning medical records, documents are records of doctors, dentists, and/or certain health workers, reports on the results of supporting examinations, daily observation and treatment records and all recordings, both in the form of radiology photos, imaging images, and electro-diagnostic recordings.

CONCLUSION

Storage of medical record files with a clear retention period at the Sawit Boyolali community health center is regulated in the decree of the head of the public health center number 440 of 2017 concerning the storage of medical records. In its implementation, it is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia number 269 of 2008 concerning medical records, article 9 paragraph 1, that medical records in non-hospital health service facilities must be kept for at least two years from the last date the patient was treated. Identification of patients at the Sawit Boyolali community health center refers to standard operating procedures Number 005/SOP/VII/UKP/2017 regarding registration. The operational standard regulates the main things that must be done by medical recorders in identifying patients. The coding system at the Sawit Boyolali community health center is the provision of a medical record number code based on the village/region where the patient lives using an eight-digit number. The medical record storage system at the Sawit Boyolali community health center is centralized, namely outpatient medical records and inpatient medical records stored in one folder/folder. Recording and documenting the results of examinations, treatment, actions, and other services that have been provided to patients by doctors, dentists and or health workers are made immediately after the patient receives services.

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