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Analysis of Service Management in the Medical Records Unit of Montella Meulaboh Private General Hospital, West Aceh Regency

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ABSTRACT

Introduction: Medical records are files that contain notes and documents regarding patient identity, examinations, treatment, procedures and other services provided by health care facilities to patients. This study aims to look at the descriptive nature of service management in the medical records unit of the Montella Meulaboh Private General Hospital, West Aceh Regency. **Method**: This research was conducted qualitatively with a sampling technique using a total sampling method, namely 5 informants. **Results**: Medical records personnel are sufficient in number but in terms of quality they are not able to solve problems optimally. The implementation of medical records at RSUS Montella has not been running properly because there are still incomplete medical record records, the provision of medical record files still seems slow even though the SIMRS application has been used to store patient data, several problems are still found, which slows down the search for medical record files on the shelvesavailable.**Conclusion**: Increasing the number of medical records officers with educational backgrounds according to predetermined standards, providing the required training and education regarding medical records to existing officers, increasing the facilities and infrastructure to support medical records required according to predetermined standards.

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INTRODUCTION

According to Indonesian Minister of Health Regulation No. 269/MENKES/PER/III/2008, a medical record is a file containing notes and documents regarding patient identity, examinations, treatments, procedures, and other services provided to patients at healthcare facilities (Hakam, 2018). Medical records also include written and recorded information regarding the identity, history, physical examination,

laboratory tests, diagnoses, and medical procedures provided to patients, whether inpatients, outpatients, or those receiving emergency services (Hakam, 2018).

Medical records are part of the archives that describe all activities of an institution over a specific period of time. Hospitals must maintain medical records as a standard of healthcare service, useful for improving the quality of providing optimal care to all users (Pangesti et al., 2023). The existence of archives plays a significant role in determining policies and work guidelines to achieve an institution's vision and mission. Medical records play a crucial role in supporting orderly administration in efforts to improve healthcare services in hospitals and must be properly managed for the benefit of patients, doctors, and the hospital (Hakam, 2018).

A good medical record is one that contains all necessary information, including information obtained from patients, physicians' thoughts, examinations and actions, and communication between medical/healthcare personnel (Sanggamele et al., 2018). The purpose of creating medical records is to support orderly administration in order to improve healthcare services in hospitals or other healthcare facilities. Without a sound and proper medical records management system, orderly administration in healthcare facilities will not achieve the desired results. Administrative order is a crucial factor in achieving quality healthcare services. Medical records must be accurately documented, readily available, usable, easily retrievable, and comprehensive (Sanggamele et al., 2018).

Medical records services, which should support the patient care process in hospitals, often become a hindering factor. This situation is caused by the quality of services provided being lacking in terms of reliability, service time, attitude, facilities and infrastructure, and accuracy in recording and categorizing patient data when storing. This condition makes the process of retrieval of patient history difficult and slow, resulting in delays in nursing care (Hakam, 2018).

Achieving efficiency in medical records services requires a good and efficient recording system, adequate service instruments, and professional human resources. A good and efficient service system can be seen from the system's ability to receive input, store it, and process it to produce output that can be used as a reference for healthcare professionals when performing a specific action. Instruments are needed to store data, for example, if the system is computerized, the computer network and equipment used must meet the latest quality specifications. Human resources, on the other hand, refer to the quality and quantity of human resources involved in providing medical records services to healthcare professionals (Andriani et al., 2022).

The management of medical records must include a Standard Operating Procedure (SOP), one of which is the SOP for outpatient medical record borrowing, which is the process or flow that must be followed when borrowing outpatient medical records. According to Minister of Health Regulation 749a/Menkes/per/XII/1989 concerning the provisions for borrowing medical records, only the attending physician is authorized to borrow medical records. Generally, the provisions for borrowing medical records are divided into two categories: routine and non-routine borrowing. Routine borrowing is done by doctors for patient needs, and non-routine borrowing is done by doctors and other healthcare professionals for research purposes. Medical record borrowing is used for internal and external purposes, including clinic visits, readmissions, administration, medical, legal, financial, educational, and research on specific cases or court cases (Wiyati et al., 2021).

Problems with medical records may seem insignificant, but they significantly impact healthcare services. Failure to manage medical records according to procedures and guidelines can result in the loss of information. This problem can occur in healthcare

facilities that do not implement a proper medical records management system. Every healthcare facility requires management to ensure proper medical records management and the production of complete and accurate information to support the quality of care provided. Healthcare facilities are required to establish Standard Operating Procedures (SOPs) for medical records to ensure all activities are carried out in accordance with established SOP policies (Giyanafrenti, 2018).

According to hospital guidelines, medical records management is divided into three categories: registration, filing, and data processing. The registration system includes a registration system, a numbering system, a naming system, and a KIUP (Main Patient Index Card) system. Furthermore, data processing involves various activities, including assembling (organizing and tidying up the order of medical record document forms), analysis (checking the completeness of medical record documents), coding (assigning codes), indexing (tabulation), retention and destruction), and reporting (Giyanafrenti, 2018).

Medical record completeness is the study or analysis of medical record content related to documentation, service delivery, and/or assessing the completeness of medical records (Asriati et al., 2022). Due to the busy schedules of doctors and nurses, medical record files are often incomplete and not returned on time, or even beyond the due date. As a result, medical records staff often feel hampered in the process of processing medical record files, even though data quality reflects the quality of the medical record. For this reason, analyzing medical record files is essential to ensure they can be processed and produce appropriate and more accurate health information (Asriati et al., 2022).

A preliminary survey conducted by researchers at Montella Private General Hospital (RSU Swasta Montella) found that the management of medical records unit services was running quite well. However, several obstacles remained: the number of medical records staff was only five, with none having graduated from medical records; patient data numbering and recording were conducted using two methods: SIMRS (Symristics Management System) and manual; incomplete medical resumes, which impacted the billing of National Health Insurance (JKN) fees; and disorganized storage. Based on the descriptions presented, the researchers were interested in conducting a study on "Descriptive Analysis of Medical Records Unit Service Management at Montella Private General Hospital, Meulaboh, West Aceh Regency." The aim was to examine and understand the descriptive management of services in the medical records unit at the healthcare facility at Montella Private General Hospital, Meulaboh, West Aceh Regency.

LITERATURE REVIEW

Medical records are a crucial component of hospital management activities. They provide accurate and comprehensive information about the medical and health care processes in the hospital, both past, present, and projected future (Rika Andriani et al., 2022). Medical record management begins upon admission, continues with recording patient data throughout the duration of the patient's stay, and continues with medical record file management, including storage and retrieval of files from storage to accommodate requests or borrowing for other purposes (Pratama & Mulyanti, 2023).

The high number of patient visits means staff need more time to prepare medical record documents. The smaller number of staff compared to the number of patients results in a high workload. This often leads medical records staff to perform multiple tasks (Pratiwi, 2021). Consistent with research conducted by Cahyaningrum et al. (2018), medical records staff often have multiple duties. For example, registration staff also serve as filing staff and distributing medical record documents to polyclinics, emergency room

registration staff also serve as inpatient registration staff, or coding staff who serve as assembly staff to sort medical record documents returned from the polyclinic. This results in a high workload and does not comply with established SOPs (Cahyaningrum et al., 2018).

Research by Sari & Masturoh (2017) found that the unavailability of medical record documents is caused by storage errors, resulting in them not being found when needed. Storage errors are also caused by unclear numbering on the front cover of medical records and damaged cover numbers that are difficult to read (Sari et al., 2017).

Manual systems can trigger patient registration queues. Furthermore, using a manual system can result in late delivery of information and daily patient data reports. Failure to return medical records on time also contributes to delays in providing outpatient medical records. If a patient returns to the outpatient clinic, medical records staff will have difficulty finding and tracing patient records that are not on the shelves, requiring more time to do so (Andi Ritonga & Maya Sari, 2019).

METHOD

This research is a qualitative descriptive study, describing and describing the management of medical records services at Montella Private General Hospital. The study was conducted in April 2023. The informants were all five healthcare workers in the medical records department. The study used semi-structured face-to-face interviews and observations. The research instrument used an interview guide with open-ended questions and an observation guide.

Data collection involved observation, interviews, and documentation. Furthermore, data analysis was conducted descriptively using content analysis. Data processing involved reviewing all data, transcribing interviews, identifying possible patterns, summarizing the data presented in a matrix, and interpreting the data (Oktarini & Pertiwi, 2023).

RESULTS AND DISCUSSION

The results showed that the key informants consisted of two individuals: the head of medical records and an assembly officer, both with bachelor's degrees and 2–3.5 years of service experience. The other three key informants were a coding officer, an analysis officer, and a filling officer, all with bachelor's degrees and diplomas, and 9–1.5 years of service experience.

Table 1. Informant Characteristics

Informant	Education	Length of Service	Jabatan/Tenaga Fungsional
IK1	Bachelor's Degree	2 Years	Head of Medical Records
IK2	Bachelor's Degree	3,5 Years	Administration and *Assembling*
IU3	Bachelor's Degree	9 Months	Coding
IU4	Diploma	1,5 Years	Analysis
IU5	Diploma	1 Year	*Filling*

Human Resources

Healthcare services are required to provide sophisticated, efficient, and satisfactory services. Therefore, efforts are being made to increase the number and quality of healthcare workers and enhance knowledge in the health sector. Interviews with informants revealed that the available human resources are adequate, but not yet adequate in terms of professionalism and quantity at Montella General Hospital. The following informant stated:

"*...hmm, currently there aren't any because BPJS Kesehatan only re-established its partnership in early January, so patients are still in the low-income category, so medical records duties can still be covered if there are any shortcomings*" *(IK 1).*

"*The current availability of medical records personnel is adequate, but not yet optimally sufficient, and in terms of professional staff for the hospital's needs. Although the existing human resources can address this, the current human resources do not align with the required education. Currently, there are only four medical records personnel with educational backgrounds in midwifery, economics, public health, and IT*" *(IK 2).*

"*It would be more productive if there were two or three medical records professionals available so that the existing tasks would be more focused*" *(IU 3).*

"*It is not sufficient in terms of the hospital's capabilities and needs*" *(IU4).*

"*The current human resources are insufficient, so it would be better if there were medical records officers to manage outpatient and inpatient files*" *(IU5).*

Assembling

Assembling involves sorting and checking the completeness of medical record files. This involves assigning checklist numbers to medical record files and sorting them according to the checklist numbers, ensuring the completeness of each medical record file. Research findings indicate that the assembling process carried out by the Medical Records Department at Montella General Hospital has not been running smoothly, with many medical record forms remaining incomplete. Consequently, many forms are returned during the re-sorting process. The following informant stated:

"*The current assembling process only involves incoming files needed for claims. These are then compiled, selected, and submitted to the coding department for claim submission. There is no standard operating procedure (SOP) for this process*" *(IU 1).*

"*In my opinion, this process is quite time-consuming because it requires meticulous attention to detail in the order of patient numbers and double-checking the files for missing numbers. Sometimes, there are files without a medical record number, a nurse's signature, or a doctor's name, resulting in incomplete files being mixed in.*" *(IU 1).*

"*Files are often incomplete, so they're returned to the nursing department to be filled out again, making us do double the work.*" *(IU1).*

Coding

Coding is the assignment of codes using letters, numbers, or a combination of letters and numbers to represent data components. Coding is a disease and procedure classification activity that groups diseases and procedures based on specific, agreed-upon criteria. Research has identified challenges during the coding process, including the large number of incomplete patient diagnoses, which can lead to delays in coding, resulting in a backlog of documents and impact on claims submissions. The following informant's statement is as follows:

"*Currently, coding is performed by a doctor who understands coding. However, sometimes, when coding is performed, many medical record files remain incomplete, such as lab results, EKG results, and patient discharge summaries. This sometimes affects claim submissions.*" *(IK 1)*

"*At Montella, when a patient enters the ER, their personal data is recorded, then sent to their respective inpatient rooms. This is where the treatment and procedures, including surgery, lab tests, and all other treatments, take place until they are discharged. The ward nurse completes the information and contacts the doctor to create the medical summary. Once the medical summary is complete, everything in the status is sent to the medical record for coding. After coding, we enter the data.*" *(IU 3)*

"*Incomplete files and unclear doctor's handwriting are sometimes difficult to read. If the*

doctor writes it unclearly, we can't input or interpret the diagnosis. If the diagnosis is complete and clear, it's easy to find it in ICD-10 or ICD-9 for further action. Sometimes, if it's unclear, I ask the doctor directly by phone. Sometimes, if it's incomplete, we have to call them." "We are responsible for returning the patient to the room where they were treated so they know that they made a mistake and it must be corrected immediately" (IU 3)

Analysing

Analyzing is the Medical Records Unit (URM)'s function as an analyst and reporter within the medical records service system. It analyzes all medical record data received by the Medical Records Unit (URM) to be processed into information presented in reports for management decision-making at the hospital. Based on research findings, the analysis process in the medical records department at Montella General Hospital is not being conducted. The following informant stated:

"*Analysis involves report creation. We only create reports for incoming patient data. Reporting is done through the Hospital Management Information System (SIMRS), so report creation is no longer done manually. However, because there are no staff to prepare reports and no one understands the process, medical record files are currently only stored" (IK 2).*

"*Analysis is currently not being conducted because medical records staff only prepare raw data, and then the surveillance team processes it, while there is no surveillance team" (IU 4)*

Filing (Storage)

Storage of medical records involves returning medical records to their shelves based on their medical record numbers. The medical records department at Montella General Hospital does not yet have a specific storage method; they are simply stored in cabinets and are not separated into inpatient and outpatient medical records. The following informant's statement:

"*The filling process involves storing files neatly arranged to make them easier to find when patients return for treatment. Some files sometimes take a long time to find because staff are eager to leave quickly. As a result, files are often misplaced or simply filed away." (IK 2)*

"*Once files are assembled, coding is usually given directly to the filling department unless there are any issues." (IU 4)*

"*It's inadequate because many medical record files are located on the first floor and others on the third floor. Coding is done there. Once files are stored in cabinets, they are sometimes difficult to find. Although there is a hospital information management system (SIM RS) for storing patient information, it is still not as comprehensive as medical records." (IU 4)*

"*Files that have been coded by staff are then stored on storage shelves. Because there are not enough cabinets, files are stored in stacks, as seen" (IU 4).*

Descriptive Analysis of Human Resources at Montella Private Hospital

Health Human Resources (HR) is a system that integrates various integrated and mutually supportive planning, education, and training efforts to ensure the highest level of public health. Health HR can also be defined as all individuals who actively and professionally work in the health sector, whether they have formal health education or not, to achieve health care needs (Nazhifah et al., 2021).

According to Regulation of the Minister of Health of the Republic of Indonesia Number 340 of 2010 concerning Hospital Classification, medical records services are clinical support services. There are no specific provisions regarding the number of medical records personnel required in a Class D hospital (Pohan & Karaeng, 2022). However, based on Regulation of the Minister of Administrative and Bureaucratic Reform of the Republic of Indonesia Number 30 of 2013 concerning Medical Recorder Functional Positions and Their

Credit Points, the functional position of medical recorders for Class D hospitals has been set at 15 skilled personnel and 4 expert personnel. The regulation also states that skilled medical recorders must have a minimum diploma III in health information medical records, and expert medical recorders must have a minimum of a bachelor's or diploma IV degree (KEMENPAN RI, 2013). Based on this, it is certain that Montella Private Hospital is in dire need of other human resources.

According to Law No. 36 of 2014, medical recorders and health information officers are among the healthcare professionals included in the medical technical staff group. Their job is to manage patient data into useful health information for decision-making. Good medical record management requires competent personnel in the field of medical records, both in terms of quality and quantity (Gultom & Sihotang, 2019).

Based on information obtained from in-depth interviews with key informants and primary informants regarding Human Resources (HR) for Medical Records at Montella General Hospital, all informants stated that there were no professional medical record personnel. There were only three individuals with a Diploma Three in Midwifery, a Bachelor's Degree in Economics, and a Bachelor's Degree in Public Health. They only performed medical record functions on a rotating basis, according to the current shift allocation. There was no specific task organization for medical records. Meanwhile, the other staff, acting as primary informants, mostly had educational backgrounds in midwifery. The informants in this study worked at the Outpatient Registration Center (TP2RJ) and the Emergency Inpatient Registration Center (TP2RID).

Human resources are a crucial factor in ensuring the smooth operation of medical records in hospitals, not only in terms of quantity but also in terms of the quality and performance of medical records staff. The educational background of staff should be a Diploma III in Medical Records, but the primary informants in this study generally only had a midwifery degree, leading to errors in file storage by medical records staff. Furthermore, human resource knowledge and competency can be improved by providing routine and ongoing training to all staff to ensure that educational background does not influence the implementation of hospital medical records (Nazhifah et al., 2021).

Other factors contributing to the lack of compliance with medical record completion include incomplete patient data, medical records staff who have not updated their STRs, and medical record facilities and infrastructure, often mixed up and missing. Furthermore, the existing facilities are incomplete, with only desks, chairs, and computers. Furthermore, the infrastructure consists of a building that combines medical record storage with staff workspaces. There is no dedicated meeting room for medical records staff. There are SOPs available for medical records, but they are still not implemented properly when completing medical records. The time required to provide medical record documents often exceeds the specified time, with the time allotted for services exceeding 10 minutes, resulting in long patient waits (Rosita et al., 2022).

Descriptive Analysis of Assembling

Assembling is part of the medical record processing process, which first receives completed medical record files and then forwards them to the Coding department for further processing. However, in the processing process at Montella General Hospital, medical records processing for the assembly section is carried out after coding (Pratiwi, 2021).

Based on observations at Montella General Hospital regarding the assembly process, it was found that when sorting patient documents, documents often lacked sequential numbers. Incomplete documents were returned to the assembly staff for

completion. This process also sorted empty files by placing them at the back so they could be reused if they were still usable.

Descriptive Coding Analysis

The Coding section is part of the medical record processing process that receives completed medical records from the Assembly section and assigns codes to diagnoses made by physicians. These codes can be used to claim costs for patient care and treatment and facilitate the presentation of information to support planning, management, and research in the health sector (Wardani & Suyanto, 2022).

Based on information obtained from in-depth interviews with key informants and observations regarding the coding and indexing process, obstacles were identified, including staff shortages, unclear writing, non-standard abbreviations, and inaccurate data. In practice, there was no monitoring to review data accuracy. Staff needed to reconfirm with physicians before assigning codes to diagnoses, requiring additional time to complete the work. Coding was performed while staff were indexing the diagnosis into the computer using existing applications. Staff coded using ICD-10 software references for primary and secondary diagnosis codes or using a summary coding list and did not communicate to physicians if the diagnosis was unclear.

In the Coding section, officers assign codes according to disease codes, operations, and procedures according to the ICD-10 book. If incomplete medical record documents are found, they are returned to the relevant person, such as the nurse/nurse assistant or doctor. After coding is complete, they are entered into the computer index and grouped alphabetically. The coding is then sent to the Verifier for BPJS claims, before being sent to the medical record storage. In this room, the analysis or completeness of medical record documents is carried out simultaneously with Assembling to sort the files, only after which they are stored in the storage rack or Filling (Pratiwi, 2021). As a medical records officer, the most frequent obstacles encountered in the Coding section are regarding the writing of doctors and new abbreviations that are sometimes not understood by officers, requiring officers to cross-check with the relevant doctors, which takes more time.

Descriptive Analysis

Based on information obtained through interviews with key informants, the available facilities and infrastructure can support report preparation. Reports generated through the Hospital Management Information System (SIMRS) are quite easy to operate on a computer, but they cannot be operated properly after observing the report creation procedure.

Report creation involves collecting data from various hospital units that have gone through a process of compilation, coding, and storage. Medical record files can be retrieved when the patient or physician requests a review of the medical record file form and for report creation. There is only one person performing the analysis, and sometimes other colleagues assist to ensure report submission is timely.

Descriptive Analysis of Filling

Filling. After Coding, the medical record file processing section is responsible for retrieving the medical record files upon patient arrival and receiving the completed medical record files from the Coding department, ready for storage. Then, manage the medical records storage space to ensure that the files remain sequentially numbered and neatly organized (Wardani & Suyanto, 2022).

The medical records storage process must be carried out properly because this process involves files containing information about the patient during the patient's medical care at the hospital. These records can be reused for follow-up treatment, insurance application data, and doctor research. The medical records activity that is highlighted in maintaining patient medical record information is medical records storage management. Proper medical records storage management will impact the effectiveness of medical records services in hospitals (Dyah et al., 2023).

Medical records are stored in a centralized system to prevent duplication of records. However, the informant mentioned above stated that duplicate records sometimes occur for a single patient. This occurs when a lengthy search fails to find a specific file. A new file is created for the patient, and once the file is found, it is consolidated into a single file.

Observations indicate that inadequate storage space and cabinets are still a challenge in the filing process. Many stacks of patient records are found on the first floor and some on the third floor. The shelving is limited, allowing only one staff member to pass through at a time, which requires significant storage time. This is especially true when the number of files to be stored exceeds the limited number of cabinets.

CONCLUSION

The conclusion obtained in this study is that the management of Montella Hospital is still lacking in terms of medical record unit services. This can be seen from the human resources of medical record experts who are not yet available so that in terms of understanding and skills do not meet the required quality, difficulty in searching for medical record files and completeness of files that are often incomplete. So, this requires additional officers, especially those with a medical record educational background and also training or education regarding medical record management to existing officers. Recommendations that can be given are to increase the number of medical record officers with educational backgrounds according to predetermined standards, provide the necessary training and education regarding medical records to existing officers as a support for the medical record unit that meets the specified standards.

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