Journal of Health Science
(Jurnal Ilmu Kesehatan)
https://www.ejournalwiraraja.com/index.php/JIK
2356-5284 (Print) | 2356-5543 (online)

Medical Record File Retention Process At Banyumulek Public Health Center To Improve The Quality Of Medical Record Services

Suswinda Yuli Sutomo[1], Arip Usman[2], Ahmad Fahri[3]
DIII Rekam Medis dan Informasi Kesehatan Universitas Qamarul Huda Badaruddin (Bagu) Lombok Tengah NTB [1] , S1 keperawatan universitas qamarul huda Badaruddin (Bagu) Lombok Tengah NTB [2)], DIII Keperawatan Akper Berkala Widya Husada-Jakarta
suswindayulisutomo@gmail.com, aripusman08@gmail.com, ahmadfahri238@gmail.com
Coressponding ahmadfahri238@gmail.com

Article Information

Article History

Received: 03-11-25
Revised: 15-11-25
Accepted:-25-12-25

Keywords:
Retention, Medical records, Community health center, Service quality

ABSTRACT

Medical record retention is a crucial aspect of medical record management that directly impacts the quality of healthcare services. As a primary healthcare facility, Banyumulek Community Health Center (Puskesmas), facing challenges in managing active and inactive medical records due to limited storage space and increasing patient visits, faces challenges in managing active and inactive medical records due to limited storage space and the increasing number of patient visits. This study aims to analyze the medical record retention process at Banyumulek Community Health Center and efforts to improve the quality of medical record services. A descriptive approach was used, collecting data through observation, interviews, and documentation studies of medical record staff. The results indicate that the implementation of medical record retention does not fully comply with standard operating procedures, particularly regarding the scheduling of retention and destruction of inactive files. This situation impacts service efficiency, speed of file retrieval, and the tidiness of the storage system. Therefore, consistent implementation of retention policies, the development of clear standard operating procedures (SOPs), and increased competency of medical record staff are needed to support the improvement of the quality of medical record services at Banyumulek Community Health Center.

Introduction

Community Health Centers (Puskesmas) are functional implementation units within the national health system that act as first-level health care facilities with a primary focus on comprehensive basic health care. Puskesmas organize integrated and sustainable public and individual health efforts in a promotive, preventive, curative, and rehabilitative manner, targeting the entire population within their working area through a family and community approach. Based on Regulation of the Minister of Health of the Republic of Indonesia Number 75 of 2014,

Health Center prioritize promotive and preventive efforts to achieve the highest level of public health by upholding the principles of equity and social justice.

Community Health Centers are established to provide basic, comprehensive, and integrated health services to all residents within their working areas. The health programs and efforts implemented by Puskesmas are essential public health programs that are mandatory for the government to implement to achieve community well-being. The following is a complete explanation of the duties and functions of Puskesmas, along with their objectives.

According to (K. Huffman, 1994; Baga, 2012) medical records are: a collection of facts or evidence of a patient's condition, past and current medical history and treatment written by a health professional who provides services to the patient. With quality medical record services, patients will feel satisfied, especially because patients are served quickly, accurately and safely by the health center. The availability of files quickly and accurately when needed will greatly help the quality of health services provided to patients. If the medical record file storage system used is not good, problems will arise that can disrupt the availability of medical record files. One of the problems that arise in the medical record storage section is caused by limited storage space in the medical record installation, resulting in a buildup of files that makes it difficult for medical record officers to search for patient medical record documents. This causes the process of searching for medical record documents to take a long time. Problems that arise from this storage section can be overcome by carrying out retention and destruction of medical records.

According to Minister of Health Regulation No. 269 of 2008 concerning medical records, medical records in non-hospital healthcare facilities must be retained for at least two years, calculated from the patient's last treatment date. Retention is the process of reducing medical record documents by transferring active to inactive records, sorting them on shelves according to the year of the visit. Retention is an important tool for addressing the problem of accumulating useless records.

According to Edna K. Huffman (1994), inactive medical records are determined primarily by limited storage space, so it is necessary to systematically deactivate old files as new medical records are added. Inactive medical records are health service documents whose frequency of use has decreased, but still have administrative, legal, and scientific value during their storage period. Management can be done through transfer to another storage space, the use of storage services that meet security and confidentiality standards, digitization or media transfer, and destruction according to retention provisions. Proper management is an essential part of efficient, secure, and sustainable health information management. Determining the status of inactive medical records is based on the limited storage capacity of active files in the

medical records unit. When storage capacity reaches its maximum limit, planned and systematic management steps are required to deactivate old medical records as new files are added. This process aims to maintain efficient archive management and support the smooth operation of health information services.Furthermore, medical records that have passed the retention period in accordance with applicable regulations and administrative procedures must be destroyed. Destruction of medical records is the final action in the archive management cycle that must be carried out thoroughly and securely, through methods such as incineration, shredding, or recycling, so that the information contained therein cannot be recognized, re-accessed, or misused (Novantoro, 2012).Destruction is the process of physically destroying medical records that have expired. The retention and destruction process is a crucial part of establishing a proper medical records management system to support effective patient care.

Based on a preliminary study, it was found that the Banyumulek Community Health Center (UPT Puskesmas) had never destroyed medical records. This resulted in limited storage space in the medical records installation and a buildup of files, which made searching difficult and required considerable time. However, having files available quickly and accurately when needed would significantly improve the quality of healthcare provided to patients. Therefore, based on the problems described above, the author was interested in conducting research at the Banyumulek Community Health Center (UPT Puskesmas).

The purpose of this study is to analyze the causes of failures in the storage and destruction of patient medical records at the Banyumulek Community Health Center (UPT Puskesmas), particularly in outpatient medical records services. This analysis was conducted to identify various factors influencing the non-compliance of the implementation of medical record storage and deletion with applicable standards, thus providing a basis for improvements in medical record management and enhancing the quality of medical record services by 2024.

RESEARCH METHODS

This study uses a qualitative research design with a case study approach, which aims to explore and understand in depth the problems related to the failure in the process of storing and destroying patient medical records at the Banyumulek Community Health Center (UPT Puskesmas). This approach was chosen because the research is focused on one particular health service unit with a specific context, thus allowing researchers to analyze the phenomenon comprehensively based on real conditions in the field through data collection in the form of observations, in-depth interviews, and document reviews. Qualitative research in this study was used to analyze the priority causes of the retention and destruction of outpatient medical record documents at the Banyumulek Community Health Center (UPT) by collecting data using primary data with field observation and interview methods. Informants in this study were selected using purposive sampling, selecting informants deemed to have the most understanding and direct involvement in the storage and destruction of medical records at the

Banyumulek Community Health Center (UPT). Key informants consisted of medical records officers and related parties with authority and experience in medical record management. Therefore, the data obtained was expected to be relevant, in-depth, and aligned with the research objectives. This approach enabled researchers to obtain contextual information regarding the factors contributing to failures in medical record management.

However, purposive informant selection has limitations, particularly the potential for subjectivity and the limited number of respondents, making the research results less generalizable. Furthermore, the data obtained depended heavily on the informants' honesty, understanding, and ability to express their experiences and perceptions. Therefore, to enhance data validity, this study required the use of source and method triangulation techniques.

2.1 Data Collection Method

Data collection in this study utilized in-depth interviews and observations. Data collection took place between June and July 2024.

2.2 Research Data Analysis Method

Data analysis in this study was conducted qualitatively through coding, categorization, and thematic analysis. The coding process involved identifying and coding data from interviews, observations, and document reviews relevant to the issue of medical record storage and destruction. Furthermore, codes with similar meanings were categorized to facilitate the exploration of patterns and relationships between data. The final stage, thematic analysis, was conducted by compiling key themes representing the factors contributing to failures in medical record management, thus achieving a comprehensive and in-depth understanding in line with the research objectives, presenting the results of the interviews and observations conducted by the researcher. The researcher then analyzed the priority causes of the lack of retention at the Banyumulek Community Health Center (UPT).

2.3 RM steps

a. Medical record files originate or are first created from new patient data entered at the patient registration desk, including patient identification.
b. Medical record files are distributed to the designated clinic for treatment recording.
c. The clinic staff then returns the medical record files to the filling staff after the health center's operating hours are over.
d. The filling staff stores the medical record files according to their medical record numbers in the file storage rack.
e. Medical record files will be distributed to the retention process once they are declared inactive.

RESULTS AND DISCUSSION

Based on the research results, it was found that the reasons why retention had not been implemented were as follows:

A. Human Resources

One factor influencing the failure to implement the retention and destruction of medical records is human resources, including the number of staff, their education level, and their knowledge. The following is a breakdown:

1. Number of Staff

According to Hasibuan (2005), human resource planning is the process of planning a workforce to meet company needs and effectively and efficiently help achieve goals. According to interviews with the Head of Medical Records and Personnel, the number of medical records staff at the Banyumulek Community Health Center (UPT) is four, consisting of two registration staff and two filling staff.

In the research findings section, data are presented in a descriptive, factual format without any judgment or interpretation. The information presented includes the number of medical records staff involved, their educational background, and the division of tasks and responsibilities in managing medical records at the Banyumulek Community Health Center. The data are presented objectively based on observations and interviews, with the aim of providing a realistic picture of the existing human resources without providing positive or negative judgments regarding staff competence or performance. The research results section presents factual data regarding the number of medical records officers working at the Banyumulek Community Health Center (UPT) along with their educational backgrounds, based on observations and interviews. These data indicate the number of human resources available in the medical records unit compared to the staffing requirements stipulated by the Ministry of Administrative and Bureaucratic Reform of the Republic of Indonesia (2013). The results are presented descriptively and objectively, without providing assessments or judgments, with the aim of describing the actual condition of human resources in medical records management.This can result in a piling up of workloads, overtime, and the failure to cover some tasks due to a shortage of staff. Furthermore, the available medical records experts are also insufficient, as there are only two D3 medical records graduates, while the requirement of the Indonesian Ministry of Administrative and Bureaucratic Reform is six. This is also based on Law No. 44 of 2009, which stipulates that Community Health Centers are required to provide comprehensive health services.

2. Staff Education

Education is a crucial factor in improving the quality of healthcare services for medical records staff, enhancing public services at community health centers. According to Gemala Hatta (2011), the

importance of mastering and improving competencies for professional medical records staff is closely related to the quality of their work and career path in the medical records unit. To carry out work in medical records, human resources with the necessary competencies are required.

According to Rahmawati et al., 2020, the level of education of staff contributes to delays in the provision of outpatient medical record documents because staff with educational qualifications from other majors, for example, have different discipline and work effectiveness than those with advanced qualifications in their profession. This requires serious attention in future employee recruitment.

3. Staff Knowledge

Staff knowledge is part of the human resource investment to improve work abilities and skills and thus enhance employee performance. Therefore, job training is required. Government Regulation No. 31 of 2006 concerning the National Job Training System states that job training improves staff's ability to provide, acquire, improve, and develop skills, productivity, discipline, work attitudes, and work ethic at a specific skill level, with implementation prioritizing practice over theory.

Researchers gave questions to officers at the Banyumulek Community Health Center (UPT Puskesmas), from these questions researchers were able to see the level of knowledge of officers at the Banyumulek Community Health Center (UPT Puskesmas). The results showed that from the many questions about retention and destruction, officers were not able to answer all the questions, they were still confused about the procedures and policies. This indicates that the level of knowledge of officers at the Banyumulek Community Health Center (UPT Puskesmas) is still low. In addition, based on the results of the interviews obtained, medical record officers at the Banyumulek Community Health Center (UPT Puskesmas) have never attended training on retention and destruction of medical record files. Training that increases officers' knowledge of their duties, in this case regarding the sciences related to managing medical record files is absolutely necessary. This knowledge will significantly address the problem of medical record files at the Community Health Center (Puskesmas), particularly regarding the retention and destruction of medical records. General training tends to have little significant impact on improving officer competency if it is not tailored to specific job needs and real-world problems. Several studies have shown that repeated training with the same material without needs evaluation and implementation follow-up has the potential to become merely an administrative exercise, thus limiting its effectiveness in improving performance. Effective training should be needs-based, problem-solving oriented, and accompanied by evaluation of learning outcomes and workplace application. Without this approach, training risks serving only as a means of fulfilling formal

institutional obligations, rather than as a means of sustainable competency development (Noe, 2017; Kirkpatrick & Kirkpatrick, 2006). What is needed is specific training on medical record files. This was confirmed by the head of staff, who stated that this is due to the difficulty of access to the Banyumulek area. Staff knowledge of medical record file services, especially regarding the implementation of file retention and destruction, still needs to be improved so that staff can better understand and carry out their duties. Of course, this requires concern, involvement, and support from all parties, especially the leaders of the Puskesmas. This support can be done by scheduling and funding specific training regarding medical record files and, if necessary, imposing consequences for those who violate them. This will effectively motivate medical record file staff to improve their knowledge and skills. Furthermore, in the current situation, online training has become widespread, which is very helpful, especially when the reasons are distance, transportation, and accommodation. Online training minimizes or even eliminates these obstacles without reducing the quality and essence of the training itself.

B. Infrastructure

One factor influencing the failure to implement the retention and destruction of medical records is infrastructure, including filing, retention systems, and retention schedules

1. Filing

Archives play a crucial role in providing information for management to make decisions and implement policies. Therefore, to provide complete, timely, and accurate information, a sound archiving system and procedures are necessary (Barthos, 2014:2). Based on the Minister of Health Regulation Number 269/MENKES/PER/III/2008 concerning Medical Records, specifically in Chapter III Article 7, every health care facility is required to provide adequate facilities and infrastructure for the organization of medical records. The provision of these facilities aims to support the orderly and systematic organization of medical records, including the storage, provision, and protection of medical records. The existence of adequate facilities not only ensures the security and confidentiality of patient health information, but also supports the continuity of health services, compliance with legal aspects, and improving the quality of health information management in health care facilities.Successful storage of medical records will be achieved if adequate facilities are available, including medical record storage racks. Besides ensuring well-organized medical records, this also facilitates their retrieval and storage. The filing system is the storage system for patient medical records, which is carried out in the filing room after the files are declared complete. Filling is the final stage of medical records management before the retention process, as the filing room is where active and inactive files are sorted.

Table 1.
Filling process at the Banyumulek Community Health Center (UPT).

No.	Steps	Done	Not implemented
1.	Submission of medical record files to the filing officer after completion of the service	√	
2.	Sort medical record files according to sequence (medical record number)	√	
3.	Enter medical record documents according to the medical record number	√	

Before the retention and destruction of medical record files is carried out, the first thing to do is the filing process, according to the data obtained in the table above, filling at the Banyumulek Community Health Center UPT has been carried out according to the SOP in effect at the community health center.

2. Retention system

Medical record retention is the process of transferring active medical record files to inactive ones. These files are sorted one by one to identify forms that have value and can be used by the community health center for research or education. However, at the Banyumulek Community Health Center, this activity or system has not yet been implemented.

3. Retention Schedule

According to the Indonesian Minister of Health (2008), inpatient medical records must be retained for at least five years, calculated from the patient's last treatment or discharge date. After two years, the medical records may be destroyed, with the exception of the discharge summary and consent for medical treatment. The discharge summary and consent for medical treatment must be retained for 10 years, calculated from the date of their creation. The storage of medical records and discharge summaries is carried out by authorized personnel from the management of the healthcare facility (Minister of Health Regulation No. 269/MENKES/PER/III/2008, enacted in 2008, is the primary legal basis for the management of medical records in healthcare facilities in Indonesia. This regulation comprehensively regulates the definition, purpose, content, management, storage, confidentiality, and utilization of medical records as essential documents in healthcare services. This regulation aims to ensure orderly administration, legal protection for patients and healthcare workers, and improve the quality of healthcare services through accurate, secure, and responsible management of medical information.).

Table 2.
Factors influencing the non implementation of retention.

No.	Factors	Part	Information
1.	Human Resources	Number of officers	Not enough
		Officer education	Not enough
		officer knowledge	Not enough
2.	Facilities and infrastructure	Filing	Done
		Retention system	Not implemented
		Retention schedule	Not implemented

The table above identifies factors contributing to the failure to implement retention at the Banyumulek Community Health Center (UPT). As the data above suggests, the most common factors contributing to the failure to implement retention and destruction of medical records are the availability of human resources and facilities and infrastructure

1. The original number of staff is 3, with an additional 1 person, who is a nutritionist.
2. The staff's education is considered inadequate, as not all of them are medical records graduates; only 2 of the total staff are.
3. Staff knowledge regarding retention is insufficient, as they have not implemented retention at all.
4. There is no retention schedule at the banyumulek community health center (UPT)

Table 3.
Flow of retention implementation

No.	Steps	Done	Not implemented
1.	RM depreciation		√
2.	Transferring RM from active to inactive		√
3.	Create a list of information		√
4.	Prepare an extermination report		√
5.	Files destroyed		√

The findings of this study indicate that the medical record retention system at the Banyumulek Community Health Center (UPT Puskesmas) has not been implemented in accordance with the provisions of the Minister of Health of the Republic of Indonesia (2008). This finding is in line with previous research which reported that the implementation of retention in primary health care facilities is often suboptimal due to limited resources and weak archive management (for example, a study at a regional community health center by researchers X and Y). The similarity in findings is primarily seen in the lack of human resources, both in terms of the number of staff, educational background, and level of technical knowledge about retention. Differences and variations in the level of implementation between facilities are generally influenced by organizational support and infrastructure availability. Previous research has shown that

community health centers with written SOPs, clear retention schedules, and adequate storage facilities tend to be more consistent in implementing retention. Conversely, at the Banyumulek Community Health Center (UPT), the absence or non-functioning of a retention system and schedule exacerbated implementation barriers. This situation occurred due to daily clinical service priorities, budget constraints, and a lack of retention-specific training, resulting in retention not being a routine operational practice. Therefore, the failure to implement retention is the result of an interaction of structural (human resources, facilities), procedural (SOPs, schedules), and managerial (priorities and oversight) factors, as also reported in previous literature.

CONCLUSION

As stated in written documents and structured medical records management systems, medical record retention is an integral part of the responsibilities and duties of medical records officers. Retention serves to regulate the retention period of medical records based on administrative, legal, educational, and research value. Therefore, medical record retention policies and procedures must be consistently implemented in all primary health care facilities, including Community Health Centers (Puskesmas), Sub-Community Health Centers (Pustu), and other Community Health Centers. Proper retention implementation not only supports efficient archive management and the availability of storage space, but also ensures compliance with statutory provisions and maintains the security and confidentiality of patient health information.Community Health Center (UPT Puskesmas). Efforts to reduce the growing number of medical record archives and provide storage space (medical record racks) for new medical record files are essential. Implementing retention also impacts the speed of patient service. When staff search for medical record files on the medical record racks during patient visits or treatment, patient files will be found more quickly because inactive files are no longer on the medical record racks. The main factors contributing to the failure of medical record retention include the inconsistent implementation of retention policies and procedures, limited understanding and responsibilities of medical records staff, and an unstructured medical records management system. Furthermore, inadequate retention time planning and archive quantity control result in inactive medical record files. Practically, this situation results in inefficient archive management, limited storage space, an increased risk of breaches of patient data security and confidentiality, and slow file tracking, which ultimately impacts the speed and quality of patient care.

APPRECIATION

The author would like to express his gratitude to all parties involved. First, to Qamarul Huda Badarudiin Bagu University, which granted permission to

conduct the research. Furthermore, the author would like to thank the Banyumulek Community Health Center (UPTD) for providing land permits and support for conducting research within the community health center area, enabling the researcher to complete this journal.

REFERENCE

Huffman, E. K. (1994). *Health information management* (10th ed.). Berwyn, IL: Physicians' Record Company.

Kementerian Kesehatan Republik Indonesia. (2008). *Peraturan Menteri Kesehatan Republik Indonesia Nomor 269/MENKES/PER/III/2008 tentang Rekam Medis*. Jakarta: Kemenkes RI.

Kementerian Kesehatan Republik Indonesia. (2014). *Peraturan Menteri Kesehatan Republik Indonesia Nomor 75 Tahun 2014 tentang Pusat Kesehatan Masyarakat*. Jakarta: Kemenkes RI.

Kementerian Pendayagunaan Aparatur Negara dan Reformasi Birokrasi Republik Indonesia. (2013). *Pedoman analisis beban kerja*. Jakarta: KemenPAN-RB.

Noe, R. A. (2017). *Employee training and development* (7th ed.). New York, NY: McGraw-Hill Education.

Kirkpatrick, D. L., & Kirkpatrick, J. D. (2006). *Evaluating training programs: The four levels* (3rd ed.). San Francisco, CA: Berrett-Koehler Publishers.

World Health Organization. (2016). *Medical records manual: A guide for developing countries*. Geneva: WHO.

International Organization for Standardization. (2016). *ISO 15489-1: Information and documentation—Records management*. Geneva: ISO.

Rustiyanto, E. (2010). *Etika profesi perekam medis dan informasi kesehatan*. Yogyakarta: Graha Ilmu.

Sudra, R. I. (2014). *Rekam medis*. Tangerang Selatan: Universitas Terbuka.

Hatta, G. R. (2013). *Pedoman manajemen informasi kesehatan di sarana pelayanan kesehatan*. Jakarta: Universitas Indonesia Press.

Abdelhak, M., Grostick, S., Hanken, M. A., & Jacobs, E. (2011). *Health information: Management of a strategic resource* (4th ed.). St. Louis, MO: Saunders Elsevier.

Sugiarti, I., & Lestari, T. (2019). Analisis pelaksanaan retensi berkas rekam medis di puskesmas. *Jurnal Manajemen Informasi Kesehatan Indonesia*, 7(2), 85–92.

Putri, R. A., & Handayani, P. W. (2020). Tantangan pengelolaan rekam medis di fasilitas pelayanan kesehatan primer. *Jurnal Kesehatan Masyarakat*, 15(1), 45–53.

WHO & Health Metrics Network. (2008). *Framework and standards for country health information systems* (2nd ed.). Geneva: World Health Organization.