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In active filing management for preparation of use from legal aspects in general hospital Dr. H. Soewondo Kendal 2020

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Abstract

Management of inactive medical record document storage in accordance with the provisions of the Archival Law number 43 of 2009 Article 48 is an active archive that is stored for 2 years and the archive is inactive for 5 years, destruction of files outside of the procedure is an inappropriate act. Inactive medical record document sorting for general disease groups in Dr. H. Soewondo Kendal experienced a file loss of 4.41%, the default file was miss 0%. This study aims to analyze the management of inactive medical record documents for the preparation of legal use values. This type of research is qualitative research with a cross-sectional approach through observation and interviews. The results showed that the arrangement of inactive medical record documents was grouped by type of disease according to the archive retention schedule so that they could be easily and quickly tracked and retrieved. While the archive retention schedule per disease group is to determine the length of storage so that the standard procedure for organizing medical record documents that are not actively reviewed is legally useful. Management of inactive medical record documents needs to be supported by resources in the form of standard structuring procedures in addition to archive retention schedules. This procedure should be set forth in the input, process and output standards as a guideline for filing officers. Technical guidance is needed so that the archivist's understanding of inactive file management is uniform, so as to reduce the incidence of misfiles.

Keywords: Inactive filing management; Arrangement procedures; Document use value; Legal aspects

1. Introduction

The hospital is a public health service facility that provides comprehensive health services for a patient. For this reason, the hospital is obliged to conduct recording/ recording of identity data and the medical history of all patients it serves. This facility for recording the patient's identity data and medical history is called a medical record.[1]. Consequently, the hospital must have a medical record unit to manage patient medical record documents. (2). The sub-unit of hospital medical records is a filing that has an archiving function including managing medical record documents, both active and inactive.[2]

The paper base medical record documents that are still required because there is a need for approval or manual signature of medical personnel / patients required by patients for referral letters, inpatient approval letters, general approval, approval and operation reports (for surgical cases), birth identification reports , preoperative assessment, death report, discharge summary, death certificate, give birth report, external referral, and supporting examination results [3]

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Medical record documents consist of active documents and inactive documents. Active medical record documents are still used for health services for everyday patients. Meanwhile, inactive medical record documents are documents that within a certain period of time according to the archive retention schedule are no longer used for patient health service transactions. This inactive medical record document can still be reactivated if the patient comes for treatment again before the inactive medical record document retention period reaches a minimum period of 2 years. [4]. Therefore, the use-value of an inactive medical record document is as important as a patient's active medical record document. This causes the management of documentation to be orderly. The main priority of a filing officer in serving medical record documents of patients who come to the hospital for treatment on a daily basis causes inactive medical record document management to often not be carried out according to the expected quality standards [5]

Management of inactive medical record documents is important to be prepared for the smooth implementation of the use-value of inactive medical record documents at a later time. Management of the use-value of medical record documents is to restore the performance capacity of archival officers and storage space and shelves by shrinking documents. Use value activities are in the form of sorting useful medical record documents, at least as evidence and history of useless medical record documents. Medical record documents that are still of use-value will be preserved and medical record documents that have no use-value will be destroyed. [3]. The management of medical record documents that are not orderly will be an obstacle in the application of use-value. The length of time to keep medical records that vary between groups of diseases has medical and legal considerations.[6]

Based on the survey results in the inpatient room of the general hospital dr. H. Soewondo Kendal Hospital in August 2019 is an activity of Filing medical record documents per disease group based on the last date the patient was treated for the results of retention activities. [4] However, based on the results of sorting out the piles of inactive medical record documents for the group of 340 general illnesses, incorrect files were found, including 3 medical record documents for eye disease cases (0.88%), 1 case of Psychiatric illness (0.29%), 6 cases of skin disease (1.76%), 3 cases of heart disease (0.88%), and 2 cases. cases of drug dependence (0.59%), a total of 15 files (4.41%) experienced file loss. This number is quite high compared to the condition that the miss-files should be 0%.

Missfiled medical record documents have the potential to cause malpractice incidents and demands from patients against medical personnel or hospitals who handle them. Correct medical record documents can ensure patient safety from the mall and serve as a means of communication between medical personnel who treat patients. [7]. The incidence of miss files on medical record documents can result in administrative losses, that is, if the patient comes for treatment again, there is a risk of a miss-file event. As a result, the patient's previous medical history cannot be used as a basis for further treatment and can potentially lead to malpractice. In addition, the legality aspect of the use-value of medical record documents for each disease group based on the shelf life of each document for each disease group was not achieved. [8]

This study has a general objective to analyze the management of inactive medical record documents for the compilation of utility values from the legal aspect. The specific objectives of this study are to (1) describe the procedures for structuring inactive medical record documents in preparation for use-value activities; (2) describing the retention schedule for inactive medical record archives according to legal aspects.

2. Material and methods

This type of research is a qualitative study with a cross-sectional approach. [9]. Data collection methods include observation and interviews. the data source used is primary data and secondary data. Primary data is to obtain data regarding the procedure for structuring inactive medical record documents and archive retention schedules according to the results of interviews with filing officers. [10]. Secondary data for data storage about how to manage inactive medical record documents and archive retention schedules. The data objects are 1,532 inactive medical record documents in the Inactive Archives Room of dr. H. Soewondo Kendal 2019. This medical record document is divided into 4 piles of files per disease group. The pile of files includes 235 documents from the orthopedic disease group, 324 documents from the Psychiatric illness group, 333 documents from the heart disease group, 312 documents from the leprosy group, and 328 documents from the eye disease group. The subjects of this study were 4 filing officers as key informants and 1 head of the medical record unit as triangulation informants. [5]. Data processed by tabulation and editing. Furthermore, it will be analyzed qualitatively.

3. Results and discussion

Policies to regulate the implementation of medical record activities, both policies made internally by the hospital and policies or regulations from the government, there are several policies and guidelines that become the rules for implementing hospital-based medical record archive depreciation. Medical record installation service policy. Archives retention schedule at dr. H. Soewondo Kendal based on the decision of the medical committee which set a retention schedule based on specific diagnosis and utility considerations.

3.1. Result

3.1.1. Procedure for organizing inactive medical record documents Archive Retention Schedule

Table 1 Interview Results with Filing Officers Concerning Inactive Medical Record Documents Arrangement

What are the steps for implementing inactive medical record structuring?
KI1, KI2, KI3, KI4: The conclusions of the answers to the four key informants are almost the same, namely: (1) sorting the detained medical record documents, (2) entering inactive medical record document data into the transfer list by entering the medical record number, patient name, and year, (3) separating the medical record document of inactive patients who died from the medical record documents of patients who are still alive, (4) grouping the medical record documents according to the type of disease. (5) Accumulation of inactive medical record documents based on the year of treatment, sorted by oldest year document at the bottom, and at the top is the most recent document data

Results of Interview with Triangulation Informants regarding the procedures for structuring inactive medical record documents: (1) taking inactive medical record documents from retention results, (2) separation between inactive medical record documents of deceased patients and living patient medical record documents (3) data entering medical record documents are not active in the transfer list in the Hospital Management Information System (SIM RS), (3) sorting and classifying inactive medical record documents

Table 2 Interview results about filing officer obstacles in inactive medical record documents arrangement

Are there any restrictions when arranging inactive medical record documents?
KI1, KI2, KI3, KI4: The conclusion from the answers of the four key informants is almost the same: (1) the problem often experienced by filing officers when arranging files is the Hospital Management Information System (SIM RS) which is often interrupted when inputting data on the list of inactive medical record document transfers, (2) it takes time to reopen the inactive medical record document to find a diagnosis of the disease because the label of the type of disease in the folder is detached.
Meanwhile, according to the Triangulation Informant, the problem that often occurs when inputting inactive medical record document data is the RS SIM which often experiences interference. when inputting the MRD transfer list.

Table 3 Interview results on filing officer efforts in overcoming constraints on inactive medical record document arrangement

KI1, KI2, KI3, KI4: The conclusion of the answers of the four key informants is that (1) if there is a problem in the system when data input to the list of inactive medical record documents is transferred, the data is recorded manually. Data is recorded manually into the inactive medical record document transfer list, (2) reading the document to look for the patient's history in order to determine the type of disease.

The triangulation informant stated that the solution used if there is a problem with the system when inputting data is by manually recording the inactive medical record document transfer list, after which the system can be used again. According to observations, the following is the archive retention schedule (table 4)

Table 4 Archive retention schedule in the filing section of dr. H. Soewondo Kendal

Number	Disease Group	In active	
		Outpatient	Inpatient
1	General	2 Year	2 Year
2	Eyes	2 Year	2 Year
3	Psychiatric	5 Year	5 Year
4	Orthopedic	2 Year	2 Year
5	Leprosy	2 Year	2 Year
6	Drug Addiction	2 Year	2 Year
7	Heart	2 Year	2 Year
8	Pulmonary	2 Year	2 Year

The general provisions for storage time are for: (1) research and education; (2) a criminal case (23 years of active medical record documents); (3) sexual harassment; (4) HIV / AIDS; (5) organ transplants. Meanwhile, the following are the results of interviews with key informants (KI) and triangulation informants (TI):

Table 5 Interview results regarding the retention period of inactive medical records documents according to the archives retention schedule

How many years will inactive medical record documents be retained according to the archive retention schedule?
<p>KI 1: Outpatient / inpatient medical record documents have a storage period of at least 5 years.</p> <p>KI 2: Inactive medical record documents for cases of non-Psychiatric illness are kept for 2 years. As for other general provisions, for example medical record documents used for research purposes or for legal cases, such as murder and rape, will be kept for longer, up to 23 years.</p> <p>KI 3: Inactive medical record documents are kept for approximately 5 years. There are also disease case documents that reach a storage period of 23 years for the purposes of legal cases and educational research purposes.</p> <p>KI 4: Inactive documents are usually stored for about 2 years, except for psychiatric case documents that will be kept for 5 years.</p>
<p>Conclusion: Two KI opinion is that inactive medical record documents will be kept for at least 2 years. Meanwhile, two other people argued that the length of time to keep inactive medical record documents was 5 years. Two KI staff stated that medical record documents for legal, research, and educational purposes have a shelf life of at least 23 years. One IK person said that the medical record document for psychiatric cases will be kept for 5 years.</p>

Note: (KI) is Key Informants

The interview results with Triangulation Informants (IT) regarding the shelf life of inactive medical record documents according to the Archive Retention Schedule are that Inactive outpatient and inpatient medical record documents have the same time, namely 2 years after the active period of 5 years. There are exceptions to medical records of cases of childhood illness, Psychiatric health, drug dependence, rape, HIV, criminal cases, and various cases for research purposes. Such medical records will be stored for a longer period of time, which can take up to 20 years of storage.

Table 6 Interview results regarding the agreement if the medical record document storage rack is full of inactive

If inactive medical records have piled up on the storage shelf, is there an agreement on how many years for their storage period?
KI1, KI2, KI3, KI4: We can conclude from the answers of the four key informants is almost the same, namely there is an agreement from the management regarding the length of time to keep inactive when the storage rack for inactive medical records documents is full. The procedure is that the filling officer will report to the head of medical records first about the accumulation of medical record documents that occurred in the inactive storage shelf. Then the head of medical records will report it to the hospital management. The management will hold a meeting by making minutes.

Triangulation informants also answered the same, namely there was an agreement on the results of the management meeting about the length of time to store inactive when the inactive storage rack was full. The procedure begins with a filling officer report to the head of the medical record. The report is submitted by the head of the medical record to the management to find a solution in monthly meetings and produce minutes.

3.1.2. Filing management for preparation of use-value from legal aspects

Based on the results of the observation as follows:

Table 7 Arrangement of inactive medical record documents per 4 disease groups

No	Observation date	Medical documents /disease group	Missfile medical record documents
1	Tuesday, December 3, 2019	235 documents (Orthopedic disease)	9 documents /3.83%(7 General, 1 Eye, 1 Leprosy)
2	Wednesday, December 4, 2019	324 documents (Psychiatric illness)	14 documents/4.32% (4 Pulmonary, 3 Orthopedic, 1 Eye, 1 Leprosy, 5 General, 1 Heart)
3	Thursday, December 5, 2019	333 documents (Heart Disease)	18 documents /5.41% (9 General, 3 Eye, 4 Pulmonary, 1 Psychiatric Illness, 1 Leprosy)
4	Friday, December 6, 2019	312 documents (Leprosy)	12 documents /3.85% (2 Heart Disease, 2 Pulmonary, 1 Drug Addiction, 5 General, 1 Orthopedic)
5	Monday, December, 9 2019	328 documents (Eye Disease)	11 documents/3.35%
	Total	1.532 documents	64 documents <i>miss-file</i> /4.18%

There were 64 cases of miss-file (4.18%) among the 1,532 inactive medical record documents. The highest incidence of miss-files is in the pile of inactive medical record documents for the heart disease group. Namely as much as 5.41% which were found on the 3rd day of observation.

According to the results of the interview, it was found:

Table 8 Interview results on how to group inactive medical record documents based on the archive retention schedule

KI1, KI2, KI3, KI4: How do I group Inactive Medical Record Documents based on the Archive Retention Schedule?
The conclusion of the answers of the four informants is the same. Namely, inactive medical record documents are grouped according to the type of disease, month, and year. The officers also separated the inactive medical record documents for dead patients and those who were still alive. Inactive medical records were inserted into the folder. Folders stacked by month and year.

The triangulation informant replied that the sorting of inactive medical record documents was carried out periodically which refers to the month, year, and diagnosis of the patient's disease. Inactive medical record document sorting which refers to disease groups that are not included in the archive retention schedule has not been carried out. For example, cases of children, law, life, drug addiction, rape, and. HIV. Medical record document is stacked as a whole by being put in the inactive MRD folder. Then do the separation of inactive medical record documents of dead patients from inactive medical record documents of living patients.

3.2. Discussion

Quantitative and qualitative complete medical record documents are legal evidence that can protect all parties, including patients (party 1), medical personnel / health service facilities (party 2), and health insurance (party 3). (11). Complete documentation can prove that a patient has received medical services from a doctor according to the Indonesian Doctors Association (IDI) procedure. Likewise, a complete doctor's service can be proven by the presence of records / notes in a patient's medical record document, meanwhile, a third party, namely health insurance, also utilizes medical record documents to accurately determine the cost of health services [12]

3.2.1. Organizing Inactive Medical Record Documents Procedure

Procedure for Organizing Inactive Medical Record Documents

The stages of arranging medical record documents organized by filing officers are complete. The stage of sorting out retention results documents, inputting inactive medical record document data into the document transfer list, classifying them based on patients who died and are still alive, and according to the type of disease, then finally piling up medical record documents in activities based on the year of treatment including the theory of record document management medically inactive. [13]. Based on the research of Diploma of Medical Records and Health Information Study Program Students, Dian Nuswantoro University, Semarang in the filing of various hospitals in Central Java in the last three years (2017-2020), not many hospitals have organized inactive medical record documents with complete retention results. conducted by the filing officer of Soewondo Kendal Hospital.

However, there are several steps in the filing officer performance in inactive medical record documents that can assess the results more efficiently and effectively. First, at the stage of inactivated medical record document retention in active filing, a patient's document is directly based on the longest-stored disease case. So, entering the inactive filing just needs to be stacked per disease group.

Second, there is no difference between the medical record documents of patients who have died and those who are still alive, so there is no need for intermediate stages. By law, the old treatment, based on the use value, all medical record documents have the same status. [14]

Third, additional data from interviews with triangulation informants, that specifically for inactive medical record documents for psychiatric cases will be separated and stacked on different shelves because their storage periods are different and need to be adjusted according to theory. That the grouping of inactive medical record documents is based on a minimum of eight groups according to the archive retention schedule, namely according to cases of general illness, eye, psychiatric disease itself, orthopedics, leprosy, drug dependence, heart and lungs. [14], In fact, to facilitate tracking documents, for example, to be activated if a patient comes for treatment before the two years of inactivity expires or for the use value stage, it is necessary to separate each disease code (according to the disease diagnosis) for each group of diseases.

Finally, piling up inactive medical record documents according to the year, namely the lowest year for the longest, while the newest year at the top will have an impact on document tracking difficulties. According to theory, the accumulation

of medical record documents is only a pile per year. So, the oldest date is the lowest. The latest date is at the top. Because it will make it easier to record it in the list of inactive medical record document transfers. In addition, previously it had been recorded in an orderly manner in the Coding and Indexing section of the hospital, namely the Disease Index document. The Disease Index recapitulates a disease diagnosis per accurate disease code per a given year period. So, it can be a tool to track medical record documents for various purposes [15]

The tools in the form of a list of moving inactive medical record documents and Disease Index Cards (paper or electronic) can also overcome the obstacles in managing existing inactive medical record documents. According to the results of interviews with key informants and triangulation informants, hospital SIM is often interrupted when inputting data on the transfer list of inactive medical record documents. As a result, it takes time to reopen inactive medical record documents in order to look for a diagnosis of the disease because the label of the type of disease is also on the folder.

3.2.2. Archive Retention Schedule

According to the results of observations, that the schedule for retention of inactive medical record archives, both for outpatient and inpatient cases, at Filing RSUD dr. H. Soewondo Kendal is in accordance with the theory. All have an inactive shelf life of at least two years, except for psychiatric cases. The medical record document of Psychiatric health cases is considered to be kept in inactive filing for longer than cases of other diseases.

Meanwhile, the active period of medical record documents for psychiatric cases is shorter (minimum outpatient 10 years and minimum hospitalization for 5 years) than cases of other diseases, such as eyes (hospitalization for 10 years), orthopedics (hospitalization for 10 years), leprosy. and Drug Dependence (outpatient and hospitalized 15 years), Heart and Pulmonary (hospitalized 10 years). This is of course not only based on medical considerations but also from a legal aspect.

Likewise, the general provisions regarding the storage time for medical record documents whose cases are of use value: (1) research and education; (2) criminal cases; (3) sexual harassment; (4) HIV / AIDS; (5) organ transplants, then at least it will be active for 23. Furthermore, for the inactivity period, the inactive archive retention schedule should be determined. Meanwhile, the use value of inactive medical record documents will be determined by the Use Value Team.

Two key informants (KI) are of the opinion that inactive medical record documents will be kept for at least 2 years. Meanwhile, two other people argued that the length of time to keep inactive medical record documents was 5 years. This difference indicates the need for a standard operating procedure that is equipped with an inactive record retention schedule, thus guiding the uniform performance stages of officers because of the same understanding of uniform inactive storage time. Namely, the period of inactivity of disease group medical record documents other than cases of Psychiatric illness, both outpatient and inpatient, will be kept for a minimum of five years. Meanwhile, inactive medical record documents for psychiatric cases (outpatient and inpatient) will be kept for a minimum of 5 years. Medical records of cases of children, as well as for research and education purposes, rape, HIV / AIDS, sexual adjustment, foreign patients, adoption cases, IVF, organ transplants, and plastic surgery/ reconstruction can be determined by the Hospital Use Value Team. Medical record documents for children and HIV / AIDS, can be determined for a longer active and inactive shelf life with medical considerations, at any time the patient comes for treatment at the Outpatient Unit / Inpatient Unit / Emergency Unit at Soewondo Kendal Hospital, then the document can be traced back to be activated as a basis for further treatment of the patient. Medical record documents for research and educational purposes, such as the Covid 19 (Corona Virus Disease) case medical record documents, can also be considered by the Value Team to be kept active and inactive for longer according to the needs of the hospital, especially the Education hospital. Meanwhile, documents for cases of rape, sex adjustment, foreign patients, cases of adoption, IVF, organ transplants, and plastic surgery/ reconstruction can be determined by the hospital use value team because they can be valid legal evidence. [16]

The results of interviews with Triangulation Informants (TI) regarding the shelf life of inactive medical record documents according to the Archive Retention Schedule are that

Inactive outpatient and inpatient medical record documents have the same time, namely 2 years after the active period of 5 years. Medical record documents for common disease cases (outpatient and inpatient) will be kept inactive for 2 years. Meanwhile, there is an exception for medical record documents of psychiatric cases (outpatient and inpatient) which will be kept in inactive filing for at least 5 years. [17]

Meanwhile, the results of interviews with other KI, stated that the medical record documents of cases of childhood illness, Psychiatric illness, drug dependence, rape, HIV/ AIDS (Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome), criminal cases, and various cases for research purposes will be kept until 20 years. Differences

in understanding of the length of time to keep medical record documents of various cases also need to be uniformed with the existence of standard operating procedures and their socialization. Namely, the minimum aspect of legal medical record documents will be stored actively for 23 years after a legal provision. Furthermore, it is necessary to involve the hospital's use value team to determine its inactive shelf life. [18]

Medical records of cases of children, as well as for research and education purposes, rape, HIV/ AIDS, sexual adjustment, foreign patients, adoption cases, IVF, organ transplants, and plastic surgery/ reconstruction can be determined by the Hospital Use Value Team. Medical record documents for children and HIV / AIDS, can be determined for a longer active and inactive shelf life with medical considerations, at any time the patient comes for treatment at the Outpatient Unit / Inpatient Unit / Emergency Unit at Soewondo Kendal Hospital, then the document can be traced back to be activated as a basis for further treatment of the patient. Medical record documents for research and educational purposes, such as the Covid 19 (Corona Virus Disease) case medical record documents, can also be considered by the Value Team to be kept active and inactive for longer according to the needs of the hospital, especially the Education hospital. Meanwhile, documents for cases of rape, sex adjustment, foreign patients, cases of adoption, IVF, organ transplants, and plastic surgery/ reconstruction can be determined by the hospital use value team because they can be valid legal evidence. [19]

The constraint faced by the filing subunit is the limited storage shelf for inactive medical record documents. According to KI and TI who have the same understanding of the procedure for handling the problem, that the solution is with a filling officer report to the head of medical record Department. The report is submitted by the head of MRD Department to find a solution in monthly meetings and produce minutes. Of course, this kind of solution is ineffective and inefficient since the same problem will be repeated in inactive fillings. So, if there is already a stipulation on the length of time to keep inactive medical record documents, either based on the provision of archive retention schedules or those that have been set by the Hospital Use Value Team, then it is only necessary to make a minimum service standard which contains provisions for the value activities of inactive medical record documents to be carried out regularly, routine and orderly.

By implementing value activities regularly and in orderly manner, it will be a solution in restoring rack capacity, filing space, and other inactive filing resources. There is no need for a long bureaucracy since the reporting procedure of the management to find solutions in monthly meetings, the results of which will be determined by an official report. While the solution in theory is the implementation of use value of inactive medical record documents that are no longer valuable (to be destroyed) and which are still useful (to be perpetuated) consists of the Medical Committee/ Medical Records Committee as chairman, senior medical record officer as the secretary, as well as senior nurses, administrative elements and other related persone; (for example legal experts) as members. This Hospital Use Value Team is often referred to Medical Record Extermination Team. According to Dehnavi and Baghini's, that federal law determine the generalities of the retention of medical records and the details of the law may vary according to the needs and circumstances of each state. [20]

3.2.3. Filing Management for Preparation of Use-Value from Legal Aspects

The use value of perpetual medical record documents set by the Value-for-Use Team must have started with a determination of the length and short duration of keeping active and inactive medical record documents according to the hospital file retention schedule. Meanwhile, the duration of keeping active and inactive medical record documents itself is considered for its useful value from the aspects of administration, legal, financial, research, education, and documentation.

The procedure for evaluating inactive medical record documents is a medical record file which is assessed as a medical record file that has been inactive for 2 years (according to the decision of the hospital). The indicators used to assess inactive medical record documents are (a) the frequency of their use for educational and research purposes (b) they are still of primary use value (administration, legal, financial, research and education) (c) at least they are of secondary use value (proof and history). Medical record documents that have been assessed are then made a list of archive reviews. [21]

For this reason, there is a need for order in the management of inactive medical record documents and documentation in order to prepare routine use values (on time). There were 64 cases of misfile (4.18%) among the 1,532 inactive medical record documents. The highest incidence of misfiles is in the pile of inactive medical record documents for the heart disease group. Namely as much as 5.41% which were found on the 3rd day of observation. Of course, the incidence of this misfile is the cause of routine use value activities after the inactivity period for medical record documents is disrupted. Tracking misfile medical record documents requires time and filing officers who have priority main tasks and main functions of serving active medical record documents for service transactions to patients. So, further use value activities will be delayed if the cause of this misfile problem is not immediately resolved.

Meanwhile, from the legal aspect, inactive medical record documents also still have medical uses as a basis for treatment for patients who come back for treatment at Soewondo Kendal Hospital. So, inactive medical record documents must also be managed in an administrative order such as active medical record documents in order to achieve the retrievable principle for the purposes of patient treatment transactions. Given that medical record documents are a source of memory (documentation) of a patient's medical history for medical personnel and a means of communication between medical personnel in conducting medication, therapy or medical action for a patient. [22]

Medical records have an important role and function in health service activities or in medical practice. The Canadian Council on Hospital Accreditation states that: Medical records are an important tool in the practice of medicine. They serve as a basis for planning patient care; they provide a means of communication between the attending physicians and other physicians and with nurses and other professional groups contributing to the patient's care; they furnish documentary evidence of the course of the patient's illness, treatment and response to treatment. [20; 22]

In a contractual relationship, the doctor agrees to strive for the patient's recovery carefully and sincerely. Meanwhile, the patient agrees to do medication, therapy, or certain medical actions by the doctor for him with (or without) a certain amount of money in return. So, the relationship between the doctor and the patient is a relationship based on an agreement (contract), then the legal terms of the agreement as stipulated in article 1320 of the Civil Code or Burgerlijk Wetboek (BW) apply in that relationship. Because the legal relationship between the doctor and the patient is born because of the agreement, so if the patient feels aggrieved due to certain medical actions that are not in accordance with the contents of the agreement, then he can file a suit for default under Article 1243 of the Civil Code. Conversely, if the patient feels aggrieved due to the error or negligence of a doctor who was born due to an illegal act (onrechtmatige daad), for example due to the negligence of a doctor in carrying out medical actions (malpractice), then the patient or his/ her family can sue him under Article 1365 of the Civil Code.[23]

This is related to the problem of proving the element of error and the means of evidence that can be used to prove the element of error. In the field of health (medicine), there are four kinds of documentary evidence that can help prove the presence or absence of errors or negligence of doctors in carrying out their professional duties, namely: (1) medical card; (2) informed consent; (3) medical records; (4) a doctor's prescription (medical prescription).

Medical records that contain medical service data, starting from the stage of anamneses, diagnosis, informed consent, to therapy performed by doctors to patients, legally can function as evidence in court proceedings, especially in cases of malpractice. Medical (medical malpractice). As soon as the importance of the function of medical records for doctors is viewed from a legal aspect, then medical records made by doctors according to standards must be kept in an orderly manner by doctors or the hospital, legally as evidence in his defense in court That his medical actions have met professional standards. [24]

On the other hand, for the Public Prosecutor, if it turns out that in the medical service relationship there are no medical records made by doctors or made not in accordance with the standards stipulated in the regulations, then this could be detrimental to the doctor or hospital. Even with evidence that medical records are not made or made but not in accordance with standards, doctors can be prosecuted for unprofessional conduct or violating professional standards. [25]

For this reason, the research team provided a solution in the form of inactive medical record management that had been prepared to facilitate the implementation of use value activities regularly and on time. Meanwhile, according to the Regulation of the Minister of Health Number 269/ Menkes/ PER/ III / 2008 concerning medical records in article 8 paragraph 2, medical records can be destroyed after the inactivity period, except for discharge resumes and informed consent. Furthermore, in the third paragraph it is stated that the discharge resume and informed consent must be kept for a minimum period of 10 years from the time the summary is made (immortalized). At least two of these documents were produced in use value activities. [26]

Management of inactive medical record documents includes the following stages: (1) inactive medical record documents resulting from retention are documented in the inactive medical record document transfer list (manually or electronically); (2) stacked in certain disease code groups (according to a certain disease index per year); (3) stacked according to the last date the patients were treated per month per the same year; (4) a disease diagnosis code marker is given and the patient's last date for treatment. Point number 4 is important to be the basis for the timeline for implementing use values, given the large number of inactive medical record documents that exist. For example, Arizona state law has detailed patient record based on family plans, forensics, vaccinations, Psychiatric health, laboratory evidence, mammography, medication prescription, and drug documents, dental, and nutrition record. (23)

The general disease diagnosis codes to divide groups of inactive medical record documents on inactive filing shelves are : A and B (Certain Infectious and Parasitic Diseases); C & D (Neoplasm and Diseases of the Blood); E (Endocrine, Nutritional and Metabolic Diseases); F (Psychiatric and Behavioural Disorder); G (Diseases Nervous System); H (Eye, Adnexa, Ear and Mastoid Diseases); I (Diseases Circulatory System); J (Diseases Respiratory System); K (Diseases of The Digestive System); L (Diseases of The Skin and Subcutaneous Tissue); M (Diseases of the Musculoskeletal System and Connective Tissue); N (Diseases of The Genitourinary System); O (Pregnancy, Chldbirth and the Puerperum); P (Conditions in Originating in The Perinatal Period); Q (Congenital Malformation, Deformations and Chromosomal Abnormalities); R (Symptoms, Sign and Abnormal Clinical and Laboratory Findings); S and T (Injury, Poisoning and Certain Other Consequenses of External Cause); V and Y (External Cause Morbidity and Mortality); Z (Factor of Influencing Health Status and Contact with Health Services) [27]. If there are too many inactive medical records that are managed and complex, this problem is faced by many types A hospitals, then the accumulated documents can be grouped according to a more specific disease code per code. This aims to achieve the retrievable principle, at any time documents are needed for various purposes, it will be easy and quick to find them again. Included as legal evidence.

This procedure must be stated in the input, process and output standards as a guide for filing officers. Another suggestion is that it is necessary to provide technical guidance so that the understanding of filing officers on inactive filing management becomes uniform, so that it can reduce the incidence of inactive medical record document missfiles.

4. Conclusion

Based on the research results, it can be concluded as follows:

The procedure for arranging medical record documents based on disease groups is in the archive retention schedule and there is no need for a sorting stage between living patient medical record documents and patients who have died;

Utilization of an archive retention schedule in addition to determining the shelf life of inactive medical record documents, also as a basis for document grouping. Regulations in the form of policies and standard operating procedures must be established to ensure compliance of officers in carrying out the performance of inactive filing management;

Management of inactive medical record documents must be orderly in order to achieve the retrievable principle, including the availability of medical record documents as legal evidence that can protect the interests of the patient and the doctor (other medical personnel)/ the hospital.

Compliance with ethical standards

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Disclosure of conflict of interest

All authors have stated that this study is of no competing interest

Statement of informed consent

This study was in accordance with international research standards and informed consent was obtained from all individual participants included in the study.

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