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ORIGINAL ARTICLE

Analysis of Medical Record Document Management Based on The Assessment Elements of MRMIK 3 LAM-KPRS at Mutiara Bunda Mother and Child Hospital

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ABSTRACT

Background: Accreditation is recognition given to hospitals for their efforts to continuously improve the quality of service. One of the accreditation institutions for hospital quality and patient safety is LAM-KPRS. The implementation of MRMIK 3 focuses on document management and hospital policies. RSIA Bunda Padang has specific needs in implementing this system, particularly in recording patient data related to pregnancy, childbirth, and neonatal care, thus requiring a system capable of supporting real-time data access. The aim of the study was to determine the results of the analysis of medical record document management based on the MRMIK 3 LAM-KPRS Assessment Elements at Mutiara Bunda Mother And Child Hospital. **Methods**: This study used a qualitative design and was conducted from March to April 2025. The sampling method used purposive sampling with a total of 3 people. The data collection technique used observation with research instruments, namely checklists based on the MRMIK3 LAM-KPRS accreditation assessment and conducted in-depth interviews with informants. Data analysis was carried out in three main steps: data reduction, data presentation, and drawing conclusions. **Results**: The results of the study showed that the hospital had implemented document management according to the criteria with a partially met assessment, had and implemented a uniform format for similar documents with a met assessment, and had documents with a partially met assessment. **Conclusion**: from the three assessment indicators, some were fulfilled and some were partially fulfilled.

Keywords: Accreditation, Document management, Medical records, Hospital

INTRODUCTION

Hospitals, as healthcare facilities, play a vital role in providing optimal care to patients. According to the World Health Organization (WHO), hospitals are an integral part of a social and health organization, with the function of providing comprehensive, curative, and preventive services to the community.

In practice, every hospital strives to provide the best healthcare services to patients. To achieve this, hospitals must continually improve the quality of service in accordance with the expectations of healthcare users. Quality service extends not only to medical services but also to supporting services such as medical records management (Kurnia, 2024).

Improving service quality can be achieved not only through improved facilities and medical personnel, but also through an efficient administrative system, particularly in the management of medical records. Medical records are a key element in supporting quality healthcare services because they contain comprehensive information about a patient's health history, which is used in clinical, administrative, and legal decision-making. If medical records are not managed properly, delays in service, errors in diagnosis, and even violations of patient privacy can occur. Therefore, the implementation of an

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effective Medical Records Management System (MSMS) is essential to ensure the accessibility, security, and integrity of medical record data in hospitals, thereby improving efficiency and accuracy in healthcare services (Aprilian et al., 2024).

Medical records are a crucial pillar in a hospital that cannot be underestimated. With the advancement of medical science, health law, and technology, coupled with patients and the public becoming more discerning and critical about their rights, medical records management must be managed by professionals. Producing good, correct, accurate, complete, and accountable medical records is highly dependent on strong collaboration between healthcare professionals. Management of medical records and health information services is an activity that plays a role in maintaining the confidentiality of medical records, maintaining and serving medical records both manually and electronically, and producing and presenting health information (Ministry of Health of the Republic of Indonesia, 2013).

Hospital accreditation is official government recognition of a hospital's compliance with established standards. This process aims to assess a hospital's efforts to continuously improve service quality. Based on Article 3 of Minister of Health Regulation No. 12 of 2020 concerning Hospital Accreditation, every hospital in Indonesia is required to undergo a routine accreditation process every four years. Hospital services focus on the best efforts to support patient recovery and provide an optimal care experience.

This recognition is granted by an independent institution tasked with accrediting hospitals in Indonesia, one of which is the Hospital Quality and Patient Safety Accreditation Institute. One of the evaluation components to improve service quality and ensure patient safety is Medical Records and Health Information Management (MRMIK). In implementing medical records management, hospitals must comply with one of the MRMIK standards, namely MRMIK 3, which serves as a guideline for document management and health information dissemination. MRMIK 3 focuses on the systematic management of hospital documents, including policies, procedures, and service guidelines to be applied uniformly across all clinical and non-clinical units. Internal hospital documents must have a regular review mechanism to ensure that all policies and procedures are always relevant and up-to-date.

RSIA Bunda Padang, as a hospital that focuses on maternal and child health services, has specific needs in implementing a medical records management system. The patient data managed at this hospital includes not only general medical records but also information related to pregnancy, childbirth, and neonatal care, which require more detailed and accurate recording. Therefore, this hospital needs to implement a document management system that can ensure that all policies and procedures used comply with standards. Furthermore, the information dissemination system must also be able to support medical personnel in obtaining patient data in real time, to accelerate appropriate and effective medical decision-making. Accurate information dissemination is a crucial factor in maternal and infant care, considering that the medical conditions of these patients can change rapidly and require an immediate response from healthcare professionals. Therefore, this research is expected to make a significant contribution to the development of a more modern, efficient, and nationally standardized medical records management system.

Although Mutiara Bunda Mother and Child Hospital has implemented accreditation in 2023 using the LAM-KPRS instrument, it is necessary to evaluate the improvements provided by the accreditation surveyor, especially in MRMIK 3 at the hospital RMIK unit level. The LAM-KPRS accreditation standard, specifically the MRMIK 3 assessment element, is implemented as an effort to improve the quality of medical records management, but the evaluation of its implementation generally still focuses on achieving accreditation at the hospital level. Studies that specifically assess the implementation of MRMIK 3 at the work unit level after accreditation are still limited, even though the unit level is the main implementer of policies and procedures for

managing medical record documents. Therefore, research is needed that evaluates the implementation of MRMIK 3 at the unit level to assess the conformity between accreditation standards and operational practices in the field so that medical record document management meets the criteria comprehensively and consistently, and carries out routine document updates.

Based on this, a systematic analysis of medical record document management according to the MRMIK 3 assessment elements is essential. This analysis not only assesses administrative compliance with accreditation instruments but also identifies implementation barriers, policy-procedure gaps, and recommended best practices to improve document management quality and accreditation readiness. Therefore, this study is expected to provide empirical evidence for improving internal hospital policies and contextual recommendations for MRMIK 3 implementation

METHODS

The type of research used is descriptive research with a qualitative approach, namely a study conducted to describe or depict a phenomenon that occurs in society (Notoatmodjo, 2012). The object of this study describes the management of medical record documents based on LAM-KPRS Edition 1 of 2022 in the MRMIK 3 section. The assessment elements are related to the layout of regulatory document manuscripts, the hospital has and applies a uniform format for all similar documents in accordance with hospital regulations, and has internal documents at both the owner/corporate level, hospital level and unit level (clinical and non-clinical). The location of this study is at RSIA Mutiara Bunda Padang in the medical record unit. The research period is from March to April 2025. The number of informants from this study involved three key informants, namely the human resource manager, the head of the medical record unit, and the medical record officer, who were selected purposively because each represented the policy level, unit management, and operational implementation, thus being able to provide a comprehensive picture of the implementation of MRMIK 3 at the unit level. Data were collected through interviews and documentation. Data analysis was carried out using a qualitative approach consisting of three main steps, namely data reduction, data presentation, and drawing conclusions.

RESULTS AND DISCUSSION

During the data collection process, researchers interviewed several informants at Mutiara Bunda Padang Maternity and Child Hospital. The following are the characteristics of the respondents in the study:

Table 1. Respondent characteristics

No	Informant	Age (years)	Last Education	Position
1	Informant 1	35	S-2 Public Health	Human Resources Manager
2	Informant 2	24	D3 medical records and health information	Head Of Medical Records
3	Informant 3	21	D3 medical records and health information	Medical Records Officer

From the table above, it is known that the number of informants for this research is 3 people consisting of the HR Manager, Head of Medical Records, and Medical Records Officer. The following are the results of the research conducted using the qualitative research method regarding the analysis of medical record document management based on the MRMIK 3 LAM-KPRS assessment elements at Mutiara Bunda Hospital can be seen in Table 2 below:

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Table 2. Triangulation matrix of assessment elements based on MRMIK 3

Assessment Elements	Data and Evidence Tracing	Interview Results	Observation Results	Documentation	Conclusions	LAM-KPRS Assessment Scores
The hospital implements document management in accordance with points a) - h)	- Regulatory Documents: A set of rules to guide the preparation and control of documents: a) Review and approval of all documents by authorized parties before issuance. b) The process and frequency of document review and ongoing approval. c) Controls to ensure that only the most recent and relevant versions of documents are available. d) How to identify changes in documents. e) Maintaining the identity and legibility of documents. f) The process for managing documents originating from outside the hospital. g) Retention of obsolete documents for at least the period specified by legislation, while ensuring	The review and approval of medical record documents prior to publication has been carried out in accordance with applicable regulations, but has not been consistently applied to all documents. The process is routinely carried out in stages and tiers. The hospital has implemented a document control system. However, document control is not yet fully optimal, due to the following: There are no routine internal audits specifically for document version control. Every change to a policy or SOP must be submitted by the relevant unit. The hospital has established provisions for maintaining document identity and legibility through policies and	All documents are reviewed and approved by authorized parties before they are issued. The hospital has implemented a document control system that includes the preparation, review, approval, and storage of medical record documents. Policy documents and SOPs are stored in hard and soft copies, but are only stored in the Human Resources Management department, not in the medical records unit. Observations indicate that: The latest versions of documents are available in the active document rack and/or official electronic folder of the medical records unit. Older documents are stamped or marked "Not Applicable" and	**There are policies and SOPs that regulate the review and approval of documents that have been signed by authorized officials. Some SOPs do not include the last revision date. Director's Decree on Manuscript Management and Document Control Contains provisions for the process of compiling, reviewing, approving, revising and controlling documents, the existence of SOPs** Control of Medical Record Documents, the existence of Minutes of Evaluation/Revision Meetings Documenting the review process Documents are reviewed periodically. Director's Decree on Document Control, Standard Operating Procedures for Controlling and Revision of Medical Record Documents, and Invalid Medical	the hospital has implemente d ongoing document reviews and approvals, but these have not been implemente d comprehens ively and consistently. controls to ensure only the most recent versions of documents are used and relevant available have been implemente d, However, it is not yet comprehens ive and consistent across all service units. The hospital has a mechanism to identify changes to documents, document identity and legibility	Partially Fulfilled.

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Assessment Elements	Data and Evidence Tracing	Interview Results	Observation Results	Documentation	Conclusions	LAM-KPRS Assessment Scores
	that they are not misused. h) Identification and tracking of all documents in circulation (e.g., identified by title, publication date, edition and/or most recent revision date, number of pages, and the name of the person who authorized the publication and revision and/or reviewed the document). - Observation and Interview of the implementation of manuscript layout. - Documentation of evidence of RS manuscripts in accordance with regulations.	SOPs for managing medical record documents. The hospital has a mechanism for managing documents originating from outside the hospital. However, not all external documents are recorded in a special register. The hospital has a policy and SOP regarding the management of obsolete documents. Obsolete documents are withdrawn from the service area. The hospital has a mechanism for identifying and tracking documents in circulation through a document numbering and control system. Changes or revisions to documents can be traced. However, records are not routinely updated.	stored as archives. The latest versions of documents can be identified by the revision markings on the front page or approval sheet. Most active documents meet identity and legibility requirements. External documents have not been officially stamped or marked. Not all documents are recorded in the external document receipt book/log. Obsolete documents have been separated from the active document rack. Some documents have been marked "not applicable." There is no dedicated inventory list of obsolete documents. Most documents in circulation have clear identification on the front page or approval sheet.	Record Documents (Archives) Documents Reviewed: SOP for Document Control and Revision, Document Management and Control Policy, Document Revision History Sheet, Master List of Medical Record Documents, Old Documents and Documents revision. There are regulations governing the identity and readability of documents. Recent documents generally have Complete and clearly legible identity Policies and SOPs are available that regulate the management of documents from outside the hospital. External documents reviewed are generally relevant and integrated into the medical record. The external document receipt book/log has not been filled out consistently. There are regulations	maintenance has been regulated and largely implemented, the process for managing documents originating from outside the hospital has been implemented, However Not yet fully consistent and standardized across all service units. Storage of obsolete documents has been implemented in accordance with regulations, but there is still not yet full consistency in tagging and control. Identification and tracking of all	

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Assessment Elements	Data and Evidence Tracing	Interview Results	Observation Results	Documentation	Conclusions	LAM-KPRS Assessment Scores
				governing the storage of old documents in accordance with statutory regulations. There is no archive retention schedule. Obsolete document marking is not yet uniform. There are regulations governing the identification and tracking of documents. The latest documents generally include the full identity and certifying officer. The master list of documents is not always updated after revisions.	documents in circulation have been implemented.	
The hospital maintains and implements a uniform format for all similar documents in accordance with hospital regulations.	Evidence Documents: with a uniform format	The hospital has established uniform document format provisions through document management policies and document control SOPs, each document must use the standard format determined by the hospital.	Most of the documents have used a uniform format according to hospital regulations.	Official regulations and templates for document formats are available. The latest documents generally conform to the standard format, while older documents have not yet fully adapted to the latest format.	The hospital has and applies a uniform format for similar documents.	Fulfilled
The hospital has internal documents	Internal documents: a) owner/corporat	a) have internal documents at the owner/corporate	a) Internal owner/corporate-level documents are available in	Internal documents at the owner/corporate level are available.	a) The hospital has internal documents	Partially fulfilled

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Assessment Elements	Data and Evidence Tracing	Interview Results	Observation Results	Documentation	Conclusions	LAM-KPRS Assessment Scores
covering points a) - c.)	e-level documents b) hospital-level documents; and c) unit-level documents (clinical and non-clinical), including: (1) Unit-level policies (clinical and non-clinical) (2) Organizational guidelines (3) Service/implementation guidelines (4) Standard Operating Procedures (SOPs) (5) Unit work programs (annual)	level. Hospital, documents issued by the owner or management body, However, access to corporate level documents is still limited, and not all officers understand the contents of the documents thoroughly, The hospital has had complete hospital level documents, these documents are compiled by each unit, reviewed by the relevant management, However, not all units have carried out routine document updates, each unit in the hospital has had unit level documents reviewed and approved by the authorized leader. These documents are used as a daily work reference in each unit.	hardcopy and/or softcopy. These documents are stored in the management unit. However, corporate documents have not been widely distributed across all units. b) Hospital-level documents are available and used as work guidelines. Policy documents, guidelines, and SOPs are generally stored in hardcopy and/or softcopy in the management department, not in individual units. c) Unit-level documents are available and used as work guidelines. These are available in hardcopy and/or softcopy in the management department. Annual work programs are available, but they are not always updated year-to-date.	Revision control and dissemination of corporate documents are not optimal. Hospital-level documents are available. Documents have been established and used as work references. Some documents have not been updated according to the review period. Unit work programs have not been fully approved on time. Unit-level documents are available. Documents are used as work references in the unit.	that include owner/corporate-level documents, but their management, control, and utilization are not fully integrated and equitable across all units. b) Hospital-level documents are in place, but not all documents are consistently managed and updated.c) Unit-level documents (clinical and non-clinical) are used as daily work references in each unit but are not available in the medical records unit.	

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The hospital implements document management according to: a). Review and approval of all documents by authorized parties before issuance. b) Process and frequency of document review and ongoing approval. c) Controls to ensure that only the latest/current and relevant versions of documents are available. d) How to identify changes in documents. e) Maintaining document identity and legibility. f) Process for managing documents originating from outside the hospital. g) Storage of old, obsolete documents for at least the period specified by law, while ensuring that they will not be misused. h) Identification and tracking of all documents in circulation (LAM-KPRS, 2022).

Based on the results of interviews with informants, information was obtained that the hospital has carried out continuous document reviews and approvals, but has not been implemented comprehensively and consistently, controls to ensure only the latest and most relevant versions of documents are available have been implemented in all service units. The hospital has a mechanism to identify changes in documents. Maintenance of document identity and legibility has been regulated and has been largely implemented, but has not been evenly distributed and not yet consistent across all medical record documents. The process of managing documents originating from outside the hospital has been implemented, but has not been fully consistent and standardized across all service units. Storage of old (obsolete) documents has been implemented according to regulations, identification and tracking of all circulating documents has been implemented, but has not been fully consistent and has not covered all medical record documents.

According to the research findings of Sharifi et al. (2021) entitled "Medical Record Documentation Quality in Hospital Accreditation," to evaluate the quality of medical record documentation in hospitals within the context of accreditation, identifying factors that influence documentation (including organizational structure, management support, and documentation practices), accreditation encourages improvements in documentation quality and a better document management system. Good document management is important, demonstrating the relationship between accreditation and documentation quality.

Based on the results of interviews with informants: "The document control system aims to ensure that only the latest version of documents is used in services. Each revised document will be given a revision number and an effective date, and will be re-approved by an authorized official before being distributed. (Inf1)." The informant also explained that the latest version of the document is stored in a special place and/or on electronic media in the medical records unit, while older versions of documents are withdrawn from circulation and marked "not valid" or "archived". Distribution of documents is limited to related units to prevent inappropriate use of documents. However, the results of the interviews also revealed that document control is not yet fully optimal, because there is no routine internal audit specifically for document version control.

Based on observations at the Medical Records Installation and related service units, it was discovered that the hospital has implemented document control by separating active documents (latest versions) from expired documents. Medical record documents used in services are generally documents with the latest effective date and revision number. The latest version of the document is available in the active document rack and/or official electronic folder of the medical records unit. However, in some units, the following were still found: Documents without clear version markings; Mismatches between hardcopy and softcopy documents. This indicates that document control is in place but not yet fully consistent.

Based on interviews with informants, it was discovered that the hospital has established provisions for maintaining document identity and legibility through policies and SOPs for medical record document management. Informants stated that each document must include the following identification details: document title, document number, effective date, revision number, and person responsible for the document. Document legibility is maintained by using a standard format, a uniform font, and clear, easy-to-read writing

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throughout all sections. For electronic documents, file format settings and a centralized storage system are implemented.

Document changes are identified through a document revision system. Any changes to policies or SOPs must be submitted by the relevant unit and reviewed by the Head of the Medical Records Unit before being approved by authorized officials. However, several informants stated that not all documents have a complete revision history, especially for older documents. External document storage is not yet uniform across units. This indicates that external document management is implemented but not yet fully standardized.

Based on the results of interviews with informants, information was obtained that the hospital has policies and SOPs regarding the management of old (obsolete) documents. Obsolete documents are withdrawn from the service area, then stored as archives according to the retention period stipulated in the law. Old documents that are no longer used are stored separately from active documents. However, there are still: Old documents without clear markings, Old documents that are still stored in the service unit, There is no special inventory list for obsolete documents.

Based on the results of interviews with informants, information was obtained that the hospital has established uniform document format provisions through document management policies and document control SOPs. In accordance with previous research that standardized documentation has a positive effect on the quality of medical documentation, a uniform format is needed in hospital document management (Ebbers et al., 2022). Health services emphasize that the quality system should continuously monitor, evaluate, and improve processes (including documentation and work procedures), and that periodic reviews are part of quality improvement efforts Endalamaw et al. (2024).

Hospitals already have internal documents, including owner/corporate-level documents. These documents include the hospital's articles of association, corporate strategic policies, governance guidelines, and master policies that serve as a reference for developing hospital operational policies. Informants reported that owner/corporate-level documents are issued by the owner or management body, then disseminated and implemented by hospital management. These documents serve as the basis for developing internal policies, including medical records management policies.

However, access to corporate-level documents remains limited, and not all staff fully understand their contents. Internal owner/corporate-level documents are available in hard and/or soft copy. These documents are stored in the hospital management unit.

The hospital maintains comprehensive hospital-level documents, including clinical and non-clinical unit policies, organizational guidelines, service guidelines, standard operating procedures (SOPs), and annual unit work programs. Informants reported that these documents are prepared by each unit, reviewed by relevant management, and approved by authorized officials. Hospital-level documents are used as a reference for service delivery and management, including medical records management. However, several informants stated that not all units routinely update documents, particularly annual work programs and outdated SOPs. Policy documents, guidelines, and SOPs are generally stored in hardcopy and/or softcopy in the relevant units. Annual work programs are available, but not fully updated, and document formatting and labeling are not yet fully uniform across units. This indicates that document availability is good, but control and updating still need to be improved.

Each unit in the hospital has unit-level documents that serve as guidelines for the implementation of tasks and services. These documents include unit policies, organizational guidelines, service/implementation guidelines, standard operating procedures (SOPs), and the unit's annual work program. Informants reported that unit-level documents are prepared by each unit, referring to hospital policies, then reviewed and approved by authorized leaders. These documents serve as a reference for daily work in their respective units.

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However, not all units regularly evaluate and update these documents, particularly for annual work programs and outdated SOPs. Based on observations, policy documents and SOPs are not available in this medical records unit.

Standard operating procedures (SOPs) provide the correct and best steps in medical records based on mutual consensus to carry out various activities and service functions created by health care facilities based on professional standards (Swari et al., 2019). Sandika and Ernianita (2019) stated that a factor that can cause less than optimal implementation of medical record maintenance is the lack of SOPs regarding medical record maintenance itself. The implementation of medical record document maintenance also requires a clear SOP to support systematic medical record maintenance. This can reduce the occurrence of work confusion, so that the implementation of medical record document maintenance becomes more orderly and carried out optimally. It was found that although SOPs are important guidelines, not all units have complete SOPs, and SOPs are part of the hospital's internal documents that support clinical and administrative functions (Taufiq, 2019). Standardization of internal documents (including policies, guidelines and SOPs) improves the consistency and efficiency of services in the hospital system. Wollitz, et al. (2023).

CONCLUSION

In general, medical record document management based on the MRMIK 3 LAM-KPRS assessment elements at Mutiara Bunda Hospital has been implemented, but it is not yet fully optimal because its implementation is not comprehensive and consistent across all units. The availability of a uniform document format and the existence of internal documents at various levels demonstrate a commitment to accreditation standards, but document integration, control, and utilization still need to be strengthened, especially in the medical records unit. Therefore, the hospital needs to implement integrated and sustainable document management, ensure regular document updates, and ensure the availability of all policies, regulations, and medical record SOPs in the medical records unit as the main reference in carrying out daily work.

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