



Evaluation Of Triage Form Distribution And Its Implications For Patient Data Confidentiality At Hospital X In 2026

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Abstract

Patient data confidentiality may be compromised when the distribution of triage forms involves unauthorized individuals. A preliminary study at Hospital X found that triage forms and medical record files were still transported by patients' family members or relatives between the Emergency Department (ED) and the registration unit. This study aimed to evaluate the conformity of the triage-form distribution workflow with the hospital's Standard Operating Procedure (SOP) and to assess its implications for patient data confidentiality. A descriptive qualitative design was employed from June to July 2026 at the ED and registration/medical records unit. Nine informants who were directly involved in the distribution process were included using total sampling. Data were collected through interviews, direct observation, and review of the 2022 SOP for BPJS Emergency Patient Registration and were analyzed inductively through data reduction, display, and conclusion drawing. The findings showed that the SOP formally assigns medical record distribution to authorized staff; however, actual practice still involved patients' family members or relatives. Identified confidentiality risks included escorts who were not immediate family members, physical separation between the ED and registration area, temporary storage of forms in open areas, and the possibility of forms being lost or misplaced. The confidentiality risk was perceived to increase when the triage form became part of a complete medical record containing patient identity, diagnosis, and medical history. The study concludes that triage-form distribution at Hospital X in 2026 did not fully comply with the SOP and did not optimally safeguard patient data confidentiality. Implementation of Electronic Medical Records (EMR), stronger access control, and closer integration of registration and ED workflows are recommended.

Keywords: Triage Form Distribution, Patient Data Confidentiality, Medical Records, Standard Operating Procedure, Emergency Department

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1. Introduction

Hospitals provide comprehensive healthcare services encompassing promotive, preventive, curative, and rehabilitative activities. These services include outpatient, inpatient, emergency, laboratory, radiology, pharmacy, administrative, and medical record services. All service units are interconnected in supporting examination, treatment, care, and patient recovery, and their management should contribute to the quality of healthcare delivery in accordance with Law of the Republic of Indonesia Number 17 of 2023 concerning Health.

Triage in the Emergency Department (ED) begins with rapid assessment of airway, breathing, circulation, consciousness, and vital signs. Patients are then classified according to urgency, commonly using red for immediate emergency care, yellow for urgent conditions that can tolerate limited waiting, green for minor conditions, and black for deceased patients or those without signs compatible with survival. The results are documented in the medical record and patients are directed to the appropriate treatment area. Triage must be rapid, precise, and accurate to support patient safety and effective emergency care (Purnamasari Eka Putri et al., 2022).

Nawawi et al. (2024) reported that manual triage processes may encounter delayed reporting, incomplete patient data, and inefficient documentation, whereas a triage information system may improve service speed and reduce recording errors. Lestari et al. (2023) further showed that security and confidentiality practices in medical record units may not fully comply with standard operating procedures because of inadequate document supervision, limited access control, and inconsistent staff compliance. These findings are relevant because every movement or distribution of medical record documents should be controlled to protect patient information.

Patient data confidentiality is an obligation of healthcare personnel and forms part of the patient's right to privacy. Under Law Number 17 of 2023 and Minister of Health Regulation Number 24 of 2022 concerning Medical Records, medical records must be protected and accessed only for legitimate purposes. In an emergency-care setting, confidentiality may be threatened when medical record documents are carried by unauthorized persons, creating a risk of disclosure of identity and clinical information.

A preliminary study at Hospital X found that triage sheets were carried from the ED to registration by family members or relatives accompanying patients. After registration, medical record files containing the triage form, BPJS eligibility document (SEP), patient wristband, labels, and previous medical history for returning patients were also handed to family members or relatives to be returned to the ED. This practice may expose personal and clinical data to unauthorized access and highlights the importance of a distribution workflow that complies with the hospital SOP.





The study was therefore conducted in the ED and registration/medical records unit of Hospital X in 2026 because manual triage-document distribution was still used. This study aimed to evaluate whether the triage-form distribution workflow complied with the hospital SOP, whether the existing process adequately protected patient confidentiality, and how the distribution process affected the confidentiality of patient data.

2. Research Methods

This study used a descriptive qualitative design to obtain an in-depth understanding of triage-form distribution and its relationship with patient data confidentiality at Hospital X in 2026. Qualitative research emphasizes open communication, observation, and in-depth interviews to understand behavior, perceptions, and meanings within their natural context (Hasibuan et al., 2022).

The study was conducted from June to July 2026 in the Emergency Department and the Registration/Medical Records Unit of Hospital X. The location was selected because triage-form distribution remained manual and patients' family members or relatives were involved in moving documents. Total sampling was applied to nine individuals directly involved in the distribution process, including registration officers, the head of the medical records installation, nurses, and physicians.

Research instruments consisted of an interview guide, an observation sheet, and a document-review guide. The document reviewed was the 2022 Standard Operating Procedure for BPJS Emergency Patient Registration. Primary data were obtained through interviews, while supporting data were obtained from field observations and SOP review.

Data processing consisted of editing, verbatim transcription, data organization, coding, and categorization according to the study focus. Data were analyzed descriptively and inductively through three stages: data reduction, presentation in narrative and tabular form, and conclusion drawing based on patterns and relationships identified across the data.

The study considered ethical principles including respect, beneficence, justice, honesty, accuracy, completeness of information and informed consent, privacy, anonymity, and respondent confidentiality (Hansen, 2022). Respondent identities were protected throughout data collection and reporting.

3. Results and Discussion

a. Results

Distribution Workflow and Compliance with the Hospital SOP

Interviews with ED registration officers indicated that patient registration itself was perceived to comply with the applicable SOP. One registration officer explained that failure to follow the SOP could lead to disclosure of confidential patient information. However, this perceived compliance primarily concerned the registration





stage. During movement of triage forms and medical record files between the ED and registration area, family members or relatives were still involved.

Review of the 2022 SOP for BPJS Emergency Patient Registration showed that the workflow for new emergency patients comprises eight steps, from greeting and escorting the patient to the ED, interviewing and validating BPJS membership, creating a medical record, to sending the medical record file to the ED. The SOP specifies that registration staff send the medical record file to the medical record distribution section for delivery to the ED. For returning emergency patients, registration staff validate and register the patient in SIMRS and print a medical-record loan slip that is connected to the distribution section. Thus, for both new and returning patients, the SOP explicitly assigns distribution of the medical record file, including an attached triage form, to authorized registration and medical record distribution staff rather than to patients or their accompanying family members.

Most informants stated that medical record files should not be distributed by family members or relatives because the files contain private patient information. One registration officer nevertheless distinguished the initial triage sheet from a complete medical record file, indicating that family members might carry a single triage form during registration, whereas a complete medical record file should preferably be transported by staff. Direct observation showed that both staff distribution and family/relative distribution occurred in practice.

Table 1. Observation of Parties Distributing Medical Record Files

Observed Aspect	Present	Not present
Medical record files distributed by authorized staff	✓	
Medical record files distributed by patients' family members or relatives	✓	

Patient Data Confidentiality During Triage-Form Distribution

Informants identified several circumstances that could threaten confidentiality during distribution: discussing form contents in public areas, temporarily placing forms in open locations, delivering forms to the wrong unit or patient, using unauthorized intermediaries, allowing a non-family escort to carry documents, and the physical separation of the ED registration room from the triage area.

These findings were grouped into four principal risk factors: (1) the person accompanying the patient may not be an immediate family member; (2) the ED registration area is physically separated from the triage area, requiring documents to be transported between locations; (3) forms may be temporarily stored in open areas or their contents discussed in public; and (4) forms may be lost or misplaced during





transfer. The continued involvement of family members or relatives therefore creates opportunities for unauthorized access to personal and clinical information.

Implications of the Distribution Process for Patient Data Confidentiality

Most informants considered a distribution process that did not comply with the SOP to have implications for patient confidentiality. The head of the medical records installation emphasized that the person carrying the triage document might not be an immediate family member. A physician similarly noted that a triage form may contain suspected diagnoses or other confidential information that could be read by unintended persons.

One registration officer perceived the confidentiality risk as lower when the triage form remained a single sheet used only for registration, but considered uncontrolled distribution unacceptable once it had become part of a complete medical record file. Overall, the findings indicate that confidentiality risk increases as the document accumulates more patient identity, diagnosis, and medical-history information.

b. Discussion

The SOP of Hospital X normatively assigns medical record distribution to authorized staff, and this is consistent with the views of most informants. Nevertheless, observation demonstrated a gap between the written procedure and actual practice because patients' family members or relatives were still involved in carrying triage forms and medical record files. This gap is important in the context of Law Number 17 of 2023 concerning Health, which requires healthcare and medical record management to be delivered comprehensively and with appropriate quality. Purnamasari Eka Putri et al. (2022) also emphasized that ED triage must be performed rapidly, accurately, and appropriately, which requires orderly management of its documentation.

The observation that both authorized staff and family members distributed records indicates that confidentiality controls were not consistently implemented. This finding is consistent with Lestari et al. (2023), who reported incomplete implementation of medical-record security and confidentiality standards associated with limited access control and inconsistent compliance. In contrast, Daeli et al. (2024) described stricter control at Pasar Minggu Regional General Hospital, where fingerprint-based access restricted medical-record distribution and storage to authorized personnel. The comparison suggests that a written SOP alone is insufficient when physical access control and enforcement are inconsistent.

Minister of Health Regulation Number 24 of 2022 requires medical records to be securely maintained and accessed only for legitimate purposes. This principle implies that physical control should be maintained throughout every stage of document





movement. At Hospital X, confidentiality currently depends substantially on individual compliance and the behavior of accompanying persons rather than on a structured access-control mechanism. As long as manual distribution involving family members continues, the possibility of unauthorized disclosure remains.

The findings further suggest that confidentiality risk is not static. It increases as a triage document becomes part of a complete medical record containing identity, diagnosis, and medical history. Even a single triage form, however, may contain sensitive clinical information and should therefore be treated as confidential. The distinction made by one informant between a single triage sheet and a complete file reflects perceived differences in risk, but it does not eliminate the need for controlled handling of the initial form.

Staff competence may also affect the duration and quality of triage and documentation processes. Fadila (2025) reported a significant relationship between nurses' triage knowledge and response time. In the context of this study, longer triage and registration processes may increase the duration for which documents remain outside direct medical-record control, thereby extending opportunities for unauthorized access or loss.

From a system perspective, the observed risks support the development of a more preventive approach. Electronic Medical Records could allow triage information to be transmitted electronically from the ED to registration without requiring family members to transport physical documents. In addition, integrating the physical layout of ED registration with the emergency service area could shorten document movement, strengthen staff supervision, and reduce opportunities for unauthorized handling. These changes should be accompanied by clear access rights, audit trails, staff training, and periodic compliance monitoring.

4. Conclusion

The ED registration process at Hospital X was generally perceived to comply with the applicable BPJS Emergency Patient Registration SOP, including the requirement that distribution of medical record files from registration to the ED is the responsibility of registration and medical record distribution staff. However, field practice still involved patients' family members or relatives in transporting triage forms and medical record files between the ED and registration area. Therefore, the distribution process did not fully comply with the SOP.

The existing triage-form distribution process did not optimally guarantee patient data confidentiality. Involvement of unauthorized persons may expose patient identity, diagnosis, and medical-history information. Identified risks included non-immediate-family escorts, physical separation between registration and the ED, temporary storage in





open areas, and the possibility of forms being lost or misplaced.

Hospital X is advised to consider implementation of Electronic Medical Records for triage documentation and transmission, together with stronger access control and a more integrated registration-ED layout. These measures may reduce physical document movement, minimize involvement of unauthorized intermediaries, and strengthen the security and confidentiality of patient information.

5. Compliance with ethical standards

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Disclosure of conflict of interest

The source manuscript does not report a conflict-of-interest declaration. The authors should confirm the appropriate statement before submission.

Statement of informed consent

The study states that informed consent, privacy, anonymity, and respondent confidentiality were considered as research ethics principles. The final wording should be confirmed by the authors according to the approval and consent procedures actually used.

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