GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

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TITLE: RETENTION OF RECORDS

Policy

The medical records of all patients of the Guam Memorial Hospital Authority shall be retained in the Medical Records Department in storage forms that are in line with the hospital and Government of Guam requirements.

Purpose

Medical Records contain all the information regarding a patient's visit to the hospital and are the basis of all medico-legal actions taken on behalf of the patient and the hospital.

Activity

1. "Active" patient records are defined as those who have been seen at the hospital within five (5) years of the current date. These are to be maintained in their original form (hard copy) in the PERMANENT FILE section of the department.

2. After five (5) years, these records are microfiched in their entirety, after which time the hard copies of patient records shall be destroyed by shredding only after certification by the Medical Records Administrator of designee.

Exceptions:

a. The hard patient copies of minors shall be maintained through their age of majority PLUS ten (10) years, after which time the copies shall be disposed in accordance with the established departmental procedures;

b. The hard copies of the following newborn birth documents shall be maintained indefinitely:

(1) Face sheet

(2) Admission/Assessment OB Nursery form with the newborn's footprints; and

(3) Newborn physical examination form.

c. The hard patient copies of the mentally incompetent, whether adult or minor, shall be maintained throughout that person's life, or until the mentally incompetent state is resolved.

3. Hard copies of patient records shall be destroyed by shredding only after required information has been microfiched and after certification by the Medical Records Administrator or designee.

4. Microfiche jackets are to be maintained physically secure in designated area within the medical records department.

5. On all expired patients, the microfiche jackets shall be kept indefinitely. As to all other patients who were discharged alive and whose status not known whether dead or alive, the microfiche jackets shall also be maintained indefinitely.

6. Shredded patient records may be disposed of in the most appropriate manner, preferably one in which reconstruction will be impossible (i.e, burning).

7. Access to the information contained in the microfiche material shall be in accordance with the established hospital and departmental policies and procedures.

A. <u>EKG TRACINGS:</u>

All reports and representative samplings of the EKG tracings are submitted to the Medical Records Department by the servicing department, and are made part of the patient medical chart. Reports and tracings are microfiched and retained in accordance with the established retention schedule.

Copies of the reports and representative samplings of the EKG tracings are maintained by the servicing department for comparative reading for three (3) years, after which time they should be destroyed in accordance with appropriate disposal measures.

B. <u>EEG TRACINGS:</u>

Since representative samplings of the EEG tracings cannot be effectively made, reports of the EEG tracings are provided by the servicing department and are made part of the medical chart, which are microfiched and retained in accordance with the established retention schedule.

EEG tracings in its original form shall be retained by the servicing department for a minimum period of ten (10) years, except for minors, for whom a twenty-eight (28) year retention period is observed.

C. ECHOCARDIOGRAMS:

All original echocardiogram reports are part of the patient's medical chart, and shall be microfiched and retained in accordance to the established retention schedule.

Copies of the reports and the ORIGINAL video tapes are to be maintained by the servicing department for comparative readings for a minimum of ten (10) years. For minors, the ORIGINAL video tapes shall be maintained for twenty-eight (28) years, after which time they should be destroyed in accordance with the appropriate measures.

D. FETAL MONITOR TRACINGS:

Fetal monitor tracings are to be maintained in their original form up to twenty-eight (28) years after birth. They shall be identified and stored separately from the patient's medical chart in Medical Records Department. They shall be destroyed in accordance with appropriate disposal measures after retention schedule completion.

E. PATHOLOGY SLIDES AND SPECIMENS

All Slides, specimens and blocks are to be retained in their original manner, and are to be stored and maintained by the involved departments.

1. SPECIMENS: retention period shall be left to the pathologist's discretion.

2. PARAFFIN BLOCKS: retention period shall be at least five (5) years.

3. PATHOLOGY SLIDES:

   a. ADULT: retention period shall be at least ten (10) years.

   b. CHILDREN: retention period shall be at least twenty-eight (28) years.

4. AUTOPSY SLIDES: retention period shall be at least ten (10) years after the autopsy.

F. X-RAYS and ULTRASOUND FILMS:

X-ray reports are made part of the patient's medical charts, and shall be microfiched and retained in accordance with the established retention schedule.

All films, tracings and video tapes are to be retained and maintained in their Original form in the Radiology Department. Longer retention period is encouraged for all films, as older x-rays can be important for comparison purposes, including dating the time that a patient developed a problem.

1. ADULTS: original films storage period shall be at least five (5) years after which time they shall be microfiched.

2. CHILDREN: storage period shall be up to twenty-eight (28) years, after which time they shall be microfiched.

G. LOGS:

All logs and/or log books are to be retained in their ORIGINAL form and shall be maintained by the involved departments.

1. MATERNITY: logs shall be kept for at least twenty-eight (28) years to allow for a belated claims for birth injury.

2. EMERGENCY ROOM: logs shall be kept for at least ten (10) years.

3. SURGICAL: logs shall be kept for at least ten (10) years.

NOTE: Ten (10) years retention period for the emergency and surgical logs is based on the assumption that neither the emergency room nor the surgical log include matters related to children's births. If they do, twenty-eight (28) years retention period must be maintained.

II. OTHER RECORDS:

POLICY:

The following guidelines shall govern the storage time of all administrative documents.

PURPOSE

To provide guidelines which dictate the amount of time certain documents must be kept.

PROCEDURE:

1. Appropriate and/or pertinent departments or sections shall maintain file as per guidelines.

2. Storage of excess records and/or documents related to medical records shall be coordinated with Medical Records Department.

3. Storage of excess records related to Medical Staff, Quality Assurance, Risk Management, Utilization Review and other administrative functions shall be coordinated with the Administrator's Office.

4. An organized filing system of stored records shall be maintained in accordance with the established policies, procedures and the Library repository guidelines.

		RECOMMENDED RETENTION
A.	MEDICAL STAFF RECORDS	
	Medical Staff committee records including minutes, reports and other records.	Permanent
	Physician files	Permanent
	Physician applications, rejected.	Permanent
	Physician continuing education records.	Permanent
	Physician agreements	Permanent
	Allied health professionals files, including physician assistants, nurse practitioners and other non-employee health professionals.	Permanent
B.	TUMOR REGISTRY FILES	Permanent
C.	GENERAL RECORDS	
	Accident/incident subject to civil action.	6 years

Administrative files	6 years
Annual reports to State Department of Health Services	Permanent
Birth records to local government	Permanent
Census (daily)	6 years
Communicable disease report to state and local health departments.	3 years
Corporate records, including: Medical Staff Bylaws	Permanent
Meeting minutes of:	
Board of Trustees Executive Committee Medical Staff	
Correspondence	2 years (Further retention is contingent upon continued interest and need.)
Death records to local government	Permanent
Inspection reports by local state or federal agents	3 years
Memoranda sent	2 years
Memoranda received	Discretionary
Minutes and reports of hospital Infection Control Committee	Permanent
Department reports:	
non-annual	6 years
annual	Permanent
statistics	6 years
minutes	3 years
outdated policy/ procedure manuals	6 years
Statistics on admission and	

Services	Permanent
Survey results	Six years

Reviewed: EMC, 7/92

Revised