SECTION: **COMPLIANCE**	**Approved 1/05/99**	**Effective Date 2/01/99**	**Revised 1/04/00**
Chapter: **PATIENT RECORDS**	**Retired:**		
Policy: **MAINTENANCE AND RETENTION**	PAGE 1 OF 4		

I. PURPOSE

This policy is designed to make Creighton employees, faculty, residents, students and agents (collectively referred to herein as "health care providers") within any of the Health Sciences Schools (Medicine, Nursing, Dentistry, and Pharmacy and Allied Health) aware of the appropriate methods for maintaining and retaining patient medical, dental, nursing, pharmacy, physical therapy and occupational therapy records (hereinafter referred to as "patient records"). This policy is based on state and federal laws, as well as provider contractual obligations and liability insurance requirements. This policy does not address documentation of patient care for reimbursement purposes.

II. POLICY

It is important that a patient's record contain the necessary information to assist health care providers in providing appropriate care. The patient record also supports the services billed to private and public payers. Patient record content is also governed by liability insurer requirements and is used as a risk management tool.

III. SCOPE

This policy applies to all University employees, faculty, residents, students and agents who have access to and/or make entries in patient records.

IV. PROCEDURES

A. The Patient Record

1. Contents: The Nebraska Department of Health Regulations, Title 175, Ch. 9, .003.04 requires that a confidential record be maintained for each patient. The patient's record must contain sufficient information to justify the diagnosis and support the treatment and end results.

The following information, as applicable, should be included in the patient's record:

1. Identification data
2. Allergies/Adverse Reactions
3. Chief complaint
4. Present illness/problem
5. Medications
6. Vital Signs
7. History & physical exam
8. Clinical pathology lab reports
8. Radiology reports/dental X-rays
9. Provisional diagnosis
10. Consultations
11. Treatment, medical, dental, PT, OT and/or surgical
12. Tissue report
13. Progress notes
14. Discharge summary
15. Autopsy findings

Informed consent, when required, should be documented in the patient's record. All documents should be secured in the patient's record (i.e. no post-it notes). After hours calls should be appropriately documented in the patient's record.

. **2. Entries:** Each page of the patient's record should contain the patient's name, the licensed health care provider's name and patient account number. All entries into the patient's record should be dated and written in ink or computer printout and signed or initialed by the person making the entry, along with that person's credentials. All dictation must be signed or initialed by the person who dictated the report. Verbal or phone orders must be added to the record within a reasonable time with the attending or ordering health care provider's signature.

Entries into the patient's record should be legible, complete and accurate. Any abbreviations used in the patient's record should be from an approved list of abbreviations.

Any corrections to the patient's record should be initialed and made in such a way so that any incorrect information is crossed out, but still legible. Late addenda to the medical record shall be dated as of the date of entry into the patient's record.

3. Re-creation of Lost Patient Records: Although it is rare, any lost patient record should be recreated to the best extent possible. The record should reflect that it is recreated, noting the dates covered in the recreated patient record. Recreated entries should be dated as of the date they are entered into the medical record. Any entries which cannot be recreated should be identified by date and type of service (i.e. office visits, phone calls, etc.). The recreated patient record should identify the last known location of (or person having possession of) the original patient record.

4. Patient Records Obtained from Other Health Care Providers: The patient's record at Creighton may contain information obtained from other health care providers who have treated or who are currently treating the patient. This information may be released or disclosed pursuant to any valid written consent to release, subpoena or court order.

B. Retention of Patient Records

1. Patient Records. The length of time a patient's records must be retained is dependent upon the type of patient treated. Patient records, including pathology slides, diagnostic images and tracings should be retained as follows:

a. **Competent Adults:** Ten (10) years from the last date of service. However, a mother's records related to pregnancy and live birth should be retained until the minor reaches the age of majority or ten (10) years from the delivery date, whichever is longer.

b. **Minors:** Three (3) years after the patient reaches the age of majority (19 years in Nebraska, 18 years in Iowa) or ten (10) years after the last date of service, whichever is longer.

c. **Mentally Incompetent Patient:** Ten (10) years after the point they either become competent or have a guardian appointed or power of attorney responsible for health care decisions designated.

d. **Employee Patient Records:** Thirty (30) years after the date of termination of employment.

V. ADMINISTRATION AND INTERPRETATIONS

Questions regarding this policy may be addressed to General Counsel, the Compliance Officer, the Health Sciences Vice President, Dean and/or their staff.

VI. AMENDMENTS OR TERMINATION OF THIS POLICY

This policy may be amended or terminated at any time.

VII. REFERENCES

Nebraska Department of Health Regulations, Title 175, ch. 9; Neb. Rev. Stat. 25-222; Neb. Rev. Stat. 25-213; Metro Omaha Medical Society Physician-Attorney Guidelines (1995); TriCare Administrative Guide, pg. 2.4 (7/97)