Idaho Department of Correction	**Standard Operating Procedure** **Operations Division** **Operational Services**	**Control Number:** 401.06.03.060	**Version:** 2.2	**Page Number:** 1 of 6 **Adopted:** 3-1-2001 **Reviewed:** 5-30-2012
		Title: Health Record		

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Open to the general public: ☒ Yes

BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY CONTROL NUMBER 401

Clinical Services and Treatment

DEFINITIONS

Standardized Terms and Definitions List

Contract Medical Provider: A private company or other entity that is under contract with the Idaho Department of Correction (IDOC) to provide comprehensive medical, dental, and/or mental health services to the IDOC's incarcerated offender population.

Facility Health Authority: The contract medical provider employee who is primarily responsible for overseeing the delivery of medical services in an Idaho Department of Correction (IDOC) facility.

Facility Medical Director: The highest ranking physician in an Idaho Department of Correction (IDOC) facility.

Health Authority: The Idaho Department of Correction (IDOC) employee who is primarily responsible for overseeing or managing the IDOC's medical services. (The health authority is commonly referred to as the health services director.)

PURPOSE

The purpose of this standard operating procedure (SOP) is to establish procedures to ensure that each offender has an integrated, problem-oriented healthcare record, which includes medical, dental, and mental health data initiated upon admission and maintained throughout the period of incarceration.

SCOPE

This SOP applies to all Idaho Department of Correction (IDOC) healthcare services staff, offenders, contract medical providers and subcontractors.

RESPONSIBILITY

Health Authority

The health authority is responsible for:

- Monitoring and overseeing all aspects of healthcare services, and
- The implementation and continued practice of the provisions provided in this SOP.

When healthcare services are privatized, the health authority will also be responsible for:

- Reviewing and approving (prior to implementation) all applicable contract medical provider policy, procedure, and forms; and
- Monitoring the contract medical provider's performance, to include but not limited to reviewing processes, procedures, forms, and protocols employed by the contract medical provider to ensure compliance with all healthcare-related requirements provided in respective contractual agreements, this SOP, **and** in *National Commission on Correctional Health Care (NCCHC) standard P-H-01, Health Record Format and Contents.* (See section 5 of this SOP.)

Contract Medical Provider

When healthcare services are privatized, the contract medical provider is responsible for:

- Implementing and practicing all provisions of this SOP, unless specifically exempted by written contractual agreements;
- Ensuring that all aspects of this SOP and *NCCHC standard P-H-01* are addressed by applicable contract medical provider policy and procedure;
- Ensuring facility health authorities utilize all applicable contract medical provider policy, procedure, forms, and educational information to fulfill all healthcare-related requirements provided in this SOP, *NCCHC standard P-H-01*, **or** as indicated in their respective contractual agreement(s); and
- Ensuring all applicable contract medical provider policy, procedure, and forms are submitted to the health authority for review and approval prior to implementation.

Note: Nothing in this SOP shall be construed to relieve the contract medical provider(s) of any obligation and/or responsibility stipulated in respective contractual agreements.

Facility Medical Director

The facility medical director **and** facility health authority (or designees) will be jointly responsible for ensuring the presence of an adequate number of appropriately trained staff and materials are available to meet the requirements of this SOP.

Facility Health Authority

The facility health authority will be responsible for establishing and monitoring applicable contract medical provider policy and procedure to ensure that all elements of this SOP **and** *NCCHC standard P-H-01* are accomplished as required.

In addition, to the above responsibilities, the facility health authority **and** the facility medical director (or designee) will be jointly responsible for ensuring the presence of an adequate number of appropriately trained staff and materials are available to meet the requirements of this SOP;

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GENERAL REQUIREMENTS

1. Introduction

The healthcare record is the primary tool used by healthcare services staff to manage the assessment, treatment, and care of patients. The IDOC uses the problem-oriented structure to organize the healthcare record. Standardizing the healthcare record enhances the quality of healthcare services, promotes continuity of patient care and treatment, and ensures consistent and accurate records throughout the IDOC.

2. Elements of the Healthcare Record

At a minimum, the healthcare record shall contain the following elements:

- Identification information (e.g., inmate name, IDOC identification number, date of birth, and sex);
- A problem list containing medical and mental health diagnoses and treatments as well as known allergies;
- Intake and transfer screening forms;
- Health assessment forms;
- Progress notes of all significant findings, diagnoses, treatments, and dispositions;
- Provider orders for prescribed medication and medication administration records;

- Reports of laboratory, x-ray, and diagnostic studies;
- Flow sheets;
- Consent and refusal forms;
- Release of information forms;
- Results of specialty consultations and off-site referrals;
- Discharge summaries of hospitalizations and other in-patient stays;
- Special needs treatment plan, if applicable;
- Place, date, and time of each clinical encounter; and
- Printed name, title, and original signature of each documenter.

Note: Any and all changes made to the format and structure of the healthcare record, including the implementation of an electronic medical record (EMR), must be approved in writing in advance of the change being implemented. Such requests must be made in writing to the health authority.

3. Documentation Requirements

- Each health encounter shall be documented by a healthcare professional.
- Except for healthcare records that are generated by community providers or other correctional agencies, only IDOC-approved forms shall be used to document the healthcare record.
- An entry made in the healthcare record shall include a legibly printed **or** ink-stamped name and title placed in close proximity to the documenter's signature.

Infirmary

Infirmary charting shall be done in accordance with directive 401.06.03.052, *Infirmary Care*.

Non-infirmary

Documentation for non-infirmary encounters shall follow the problem-oriented or subjective, objective, assessment, and plan (SOAP) charting format.

4. Record Management

Storing

The healthcare record must:

- Not be deviated from the approved IDOC format (see appendix A to see where documents must be maintained in the healthcare record),
- Be maintained in a secure cabinet (located in a secure area),
- Separated from other records pertaining to offenders,
- Be maintained in chronological order within each section, and
- Not be readily available to non-healthcare services staff.

Transferring

The healthcare record must be transferred at the time an offender is transferred to another IDOC correctional facility. In no event shall an offender be transferred from one IDOC **or** contract-operated facility to another IDOC **or** contract-operated facility without the healthcare record.

Upon transfer of an offender from one facility to another, the sending facility shall log the file out **and** the receiving facility shall log the file in (both using the 'file transfer' function in the Corrections Integrated System [CIS]).

Reactivating

Offenders who are re-incarcerated must have their previous healthcare record reactivated upon each admission. Reactivation requires that the previous healthcare record be obtained and all current healthcare documentation placed within the previous healthcare record. The previous healthcare record can be requested by contacting the IDOC's Central Records Unit (located at Central Office).

Thinning

- When necessary, the healthcare record may be thinned (i.e., documents transferred to an 'extended file'). However, the healthcare record must always maintain at least one year of documentation. For healthcare records that remain too large even with one year of documentation left in them, an 'exemption' sticker may be requested from the IDOC's Medical Unit (located at Central Office). The 'exemption' sticker will allow less than one year of documentation to be maintained in the healthcare record.
- Extended files must be kept in an expanding file jacket and must be a different file type than the healthcare record.
- Problem lists, advanced directives, immunization records, history questionnaires, health assessments, lab tests, imaging, electrocardiograms (EKGs), electroencephalograms (EEGs), and any other diagnostic testing must never be removed from the healthcare record.
- When possible, all off-site consult reports will be left in the healthcare record. If not possible, maintain at least the most recent year in the healthcare record and transfer the remaining previous years to the extended file.

5. Compliance

Compliance with this SOP and all related IDOC-approved protocols will be monitored by the health authority (or designee) by using various sources to include: this SOP, clinical practice guidelines, routine reports, program reviews, and record reviews.

The health authority (or designee) must conduct two (2) audits per year, per facility (or more frequently as desired based on prior audit results). The audits must consist of monitoring applicable contract medical provider, IDOC policy and procedures, applicable NCCHC standards, and the review of a minimum of 15 individual records.

Note: Healthcare records shall be available at all times for audit and inspection.

REFERENCES

Appendix A, *Healthcare Record Format*

National Commission on Correctional Health Care (NCCHC), *Standards for Health Services in Prisons*, Standard P-H-01, Health Record Format and Contents

Directive 401.06.03.052, *Infirmary Care*

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IDAHO DEPARTMENT OF CORRECTION
Healthcare Record Format

The healthcare record consists of a six-part folder, and the individual documents must be filed in the applicable part of the folder, as indicated.

Part A	Part B
Problem List (All together in chronological order)	Physician Order Sheet
Advance Directive	***Progress Notes***
Immunization Record (All together in chronological order)	Interdisciplinary Progress Notes (**Not** nursing protocols)
TB Annual Screenings, HIV Screenings, Etc.	
Cautions/IMITS/Alerts	
History & Physicals	***MARS***
History Questionnaire	Medication Administration Records
Health Assessments and Physicals	Non-formulary Pharmacy Request
Lab	***Treatments***
All Laboratory and Pathology Reports	Treatment Records
Imaging	BS/WT/BP Flow Sheet, Intake or Output
	Consults
X-ray, Ultrasound, CT & MRI Reports, including Off-site Radiology Reports.	Consult Notes
	Emergency Service Utilization Reports
Wet Reading Reports	Off-site Authorization Request
Diagnostics	ER Reports
EKG, EEG, & Audiology Reports (All together)	
Ophthalmology (All together)	
Receipt of Eyeglasses/Eyeglass Replacement Form	
Part C	**Part D**
Health Service Requests (Kites)(**Except** dental)	Intra-system Transfer Forms
All Nursing Protocols	Release to Community Forms/Discharge Release Forms
Disposition Response Forms	Medical Diet Authorization
	Receipt for Medical Products (**Except** eyeglasses)
	Food Service Worker Clearance
Segregation/Detention Forms (Under colored paper under kites)	Offender Healthcare Orientation
Grievances and Offender Concern Forms do not go in the Healthcare Record	Medical Status Report
	Chronic Care
Part E	**Part F**
Release of Healthcare Information	***OB/GYN***
Release of Liability	OB/GYN Records, Including Post Partum Orders (File OB/GYN labs in 'lab' section)
All Refusals Including Refusals for Physicals	*(Ultrasound Reports are Filed in 'Imaging' Section)*
Release of Responsibility	***Dental***
Reimbursements	Dental Health Service Requests (Kites)
Power of Attorney	Dental X-rays
Waiver of Childproof Container	Dental Supplementary Notes
Consent Tab	Dental History Forms
All Consent Forms Including Dental Consents, Physical Consents, Mental Health Consents, Etc.	Dental Treatment Record
Mental Health	***Infirmary***
Evaluations & Assessments	Infirmary Admission Record
Mental Health Evaluation	Infirmary Discharge Record
Level of Care (LOC)	Nursing Assessment
Psychiatric Evaluation, AIMS, Etc.	Admission Orders
Suicide Risk Assessment	***History***
Treatment Plans/Multidisciplinary	Outside Hospital Records
All Treatment Plans from the Interdisciplinary Treatment Team	Old Records Requested with Copy of Records Releases.
Progress Notes/Clinical Contact Notes	County Jail Records and Transfer Forms from County Jails.
Psychiatry Progress Notes/Clinical Contact Notes (Provider orders go in the 'physician order' section)	
Clinical Progress Notes	
Tele-psych Notes	**Note:** Infirmary Dr.'s orders, diagnostic tests, and progress notes are to be filed in their proper place within the chart.
Miscellaneous	
Mental Health Observation Forms	**Note:** Old healthcare records, from prior incarcerations, are **not** filed in the 'history' section.
Mental Health Referral Forms	

Appendix A
401.06.03.060
(Appendix last updated 5/30/12)