OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-H-01

SUBJECT: HEALTH RECORD FORMAT AND CONTENTS

POLICY: Each inmate will have an integrated health care record, which includes medical, dental and mental health, initiated upon admission and maintained throughout the period of incarceration. The health care record is the chief tool used by health care professionals to manage the assessment, treatment and care of patients with health problems. The Health Services Section uses the problem-oriented structure for the organization of the health care record. The organization and method of documentation in the health care record is the same at all institution health service units. The individual inmate's health care record is transferred when an inmate is transferred from one DOC facility to another. Standardization of the health care record enhances the quality of health services provided and promotes continuity of patient care and treatment.

REFERENCE: NCCHC Standard P-H-01
OAR 291-124-075
HIPAA 164.512 (5) (ii)

PROCEDURE:

A. The health care record will contain identifying information to include name, SID number and date of birth.

B. The health care record shall include all the forms noted on Attachments 1 and 2.

C. Each health encounter will be documented by the health care professional.

D. Documentation will be according to the problem oriented or SOAP method of charting. Infirmary charting will be done according to P&P #P-G-03, Infirmary Care.

E. Each entry made in the health care record will include the date, time, signature, and title of the person making the entry.

F. All off-site care shall be documented in the health care record either on the referral form, by letter, or clinical summary as agreed at the time of the referral.

G. A copy of the most current electronic generated Health Status report shall be maintained in the health care record.

H. Health care records are maintained separately from other records pertaining to the inmates. Information contained in the health care record may not be released except as outlined in ORS 179.495 through 179.505.

I. The current health care record will contain the past two years of most medical information. See attachment 1 for details. Overflow charts will be made to include information thinned from the current health care record and will maintain the same order as the original chart. In the event the current record exceeds three inches, contents may be reduced as needed. Kytes and MARs may be moved to overflow records after three months.

J. Inmates who are re-incarcerated shall have their previous health care record reactivated upon each admission. Health care information for those re-entering the system after longer than five years will be contained in an overflow. A new health care record will be established at Intake.

K. When an overflow chart is created, a label stating "OVERFLOW" will be placed on the front middle of the chart. The label will be 1" x 2-5/8" (Avery 5960) in size and the font style and size is Arial 30.

L. Paroled records will place a year tab on the side of the record to indicate the year of most recent release.

M. The health care record, all overflow charts, and x-rays are to be transferred at the time an inmate is transferred to another DOC facility.

Effective Date: ______________
Revision date: November 2006
Supersedes P&P dated: April 2005

OREGON DEPARTMENT OF CORRECTIONS HEALTH SERVICES
ORDER AND SEQUENCE FOR FILING HEALTH CARE INFORMATION

Attachment 1 – P&P P-H-01

Left Side		Right Side	
LABEL SHEET DENTAL X-RAYS CD's for MRI's and CT Scans from PACS system, place in dental x-ray envelope.		Health Status Report	Current only
		DENTAL RECORDS	
		Medical/Dental History Oral Examination Dental Treatment **MISCELLANEOUS:** Consent/Refusal Dental Procedure Dental Necessary/Optional Forms Dental Outside Referral Forms	1 Year
PROBLEM List	PERM	**DOCTORS ORDERS:**	2 Years
Medical History	Semi-Perm	*With allergy label: patient label: Advanced directives &*	
Physical Examination	Semi-Perm	*Primary practitioner if designated written on divider tab.*	
ODOC Receiving Screening	Semi-Perm	Physician Orders	2 Years
FLOW SHEETS		**PROGRESS NOTES:**	
All Parameter Flow Sheets	2 Years	Progress Notes	2 Years
Parenteral Flow Sheets	2 Years	Infirmary Notes	2 Years
Body Mark Identification Sheets	2 Years	Infirmary Admission Assessment	2 Years
Neurological Flow Sheets	2 Years	Integrated OCIC progress notes	
SPECIAL NEEDS:		Integrated OYA progress notes	
All Special Needs Forms	INC		
Hepatitis C Worksheet	INC		
LABORATORY:		MEDICATION ADMINISTRATION RECORDS	3 Months
All Laboratory and pathology reports	2 Years	**OPTICAL RECORDS**	INC
Lab and path results from outside visit for that purpose	2 Years	*All forms related to vision problems*	
HIV test results	INC	Optical Necessary/Optional forms	INC
X-RAYS:		Optical outside referral forms	INC
All X-ray Reports	INC	**OLD RECORDS:**	
All x-ray imaging reports from outside referrals	INC	County Jail records (except Clackamas/OCIC)	
All Imaging Reports (MRI, CT, etc.)	INC	Any non-ODOC Health Care Records while not incarcerated.	
Tuberculosis/PPD:		**CONSULTS:**	
PPD flow sheets	INC	Medical Outside Referral Sheets	INC
Oregon State Health Division forms r/t/Tuberculosis		Letters from Outside consultants	INC
Food Services Screening forms	1 Year	Medical Therapeutic Level of Care Form	INC
MISCELLANEOUS TESTS:		ODOC Referred hospital records	INC
EKG	INC	**CONSENTS:**	
Audiograms	2 Years	Medical Informed Consent/Refusal forms	2 Years
Stress Test	INC	HIV Consents	2 Years
Others that do not fit elsewhere		Emergency Notification Forms	INC
Note: For an outside hospital visit or ER visit, the entire packet of records received back goes under consults along with the pink sheet. If the visit is specifically for a path, lab or imaging exam, the pink sheet and any dictated summary goes under the consults tab. The path, lab or imaging results themselves go under the appropriate lab or x-ray tab.		**MISCELLANEOUS:**	
		Medical Necessary/Optional Forms	2 Years
		Personal Property Forms	
		Miscellaneous Correspondence	2 Years
		Request for outside records forms	2 Years
		Smart Start forms	2 Years

MENTAL HEALTH (when inmate not on active case load)

MENTAL HEALTH:
Computerized Intake Screening Form

MENTAL HEALTH* (when inmate on active case load)

Left Side	Right Side
Mental Health Flow Sheet **MH SPECIAL PROCEDURES:** **MH CONSENT:** **MH LEGAL:** **MH MISCELLANEOUS** **MENTAL HEALTH** **MH COLLATERAL (not to be released by ODOC)** When thinning to overflow from the mental health tab, do not move: Intake evaluations, last three SMU evaluations, latest involuntary medication hearing, summaries of outside consults or communication hospitalizations (except for progress notes from those records).	**MH PROGRESS NOTES** **MH TREATMENT PLAN:** **SMU: (yellow tab)** **MH ASSESSMENT:** *A separate document is available describing when records are moved to the mental health tab. After moving to the mental health tab, documents may be thinned to overflow. After 3 months: nursing flow sheets, treatment plan updates (if more than 3) After 1 year: progress notes, MARs, medication consents, release-of-information consents.

All forms will be grouped in the respective groupings within each of the major categories: i.e., All Medication sheets will be grouped together. All forms will be ascending Chronological Order.

Kytes must be retained in main chart for three months for medical and six months for CTS. After that they may be moved to overflow.
Perm means current and all previous incarcerations.
Semi-Perm means the current and most previous incarceration.
INC means current incarceration only.

Filing sequence 8/23/06

MH ASSESSMENT – filed in chronological order, most recent on top

Bridgepoint Discharge Summary
- Typed report

COPE Program Referral Form
COPE Program Termination Summary
COPE Program Transfer Summary to SMU
Intake Assessment Report
- 2 printed pages
- Oregon Corrections Intake Center Intake Assessment Report
- Full Scale Profile (from PAI)

Mental Health Evaluation
Mental Health Screening Report
- Pink
- Remove and shred NCR half-pages (if attached) before filing

Mental Status Screening
Psychosocial History Summary
- Blue
- When back of page is used, page flips to put 2nd side on top

SMU Admission Data Sheet
SMU Admission Psychiatric Evaluation
- Yellow
- Typed report

SMU Referral Information
Special Management Unit Discharge Summary
- Lime green
- Typed report

Suicide Risk Screening
Turning Point Discharge Summary
- Typed report

PURGING TO MH SECTION
Must contain all assessments done in the past 5 years
Remove older assessments except for one good comprehensive assessment
When i/m leaves SMU, move **SMU Admission Data Sheet** to Mental Health tab

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MH TREATMENT PLAN – ***filed in chronological order, most recent on top***

Mental Health Behavior Management Plan
- Typed Report

Crisis Management Contract
Mental Health Treatment Plan
- When back of page is used, page flips to put 2nd side on top

OSP SMU Initial Treatment Care Plan
SMU Treatment Care Plan
SMU Treatment Care Plan Problem List– 3 pages
- Problem List
- Problem/goal sheet with typed entries on plan
- Problem/goal sheet all handwritten

SRCI SMU Initial Treatment Care Plan

PURGING TO MENTAL HEALTH SECTION
Move all treatment plans not currently in use to Mental Health Section

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<u>MH PROGRESS NOTES</u> <u>– filed in chronological order, most recent on top</u>

Mental Health Progress Notes
- When back of page is used, page flips to put 2nd side on top

Monthly Mental Health Group Progress Note
- Green

Mental Health Medication Management Progress Note
- Yellow

SMU Treatment Team Review Note
- Pumpkin
- Typed report

Progress notes from on-call MH professionals re crisis interventions
- Email

Do <u>not</u> include other material, such as correspondence from inmates, test results, crisis response plans or other contracts with inmates – they should be filed in other sections. Progress notes can refer to them, indicating where they are filed.

PURGING TO MENTAL HEALTH SECTION

Move progress notes older than 1 year to Mental Health Section

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<u>MH CONSENT</u>

Application for Voluntary Admission to the Special Management Unit

Authorization for Release of Information
- Another agency's form

Authorizations for release of information
- ***Not on our forms***

Inmate's written request for a copy of his medical record
- Kyte or letter

Medication Inmate Informed Consent/Refusal
- Each prescribed medication must have a consent form

Mental Health Services Confidentiality Policy/Consent to Treatment
- Remove & shred yellow NCR copy (if attached) before filing

PURGING TO MENTAL HEALTH TAB

MENTAL HEALTH SERVICES CONFIDENTIALITY/CONSENT TO TREATMENT FORM IS NOT MOVED
- **CAN BE MOVED IF INMATE IS REMOVED FROM ALL SERVICE – VERY UNLIKELY**

MEDICATION CONSENTS CAN BE MOVED WHEN THE MEDICATION IS NO LONGER PRESCRIBED

Application for Voluntary Admission to the Special Management Unit
- Can be moved when inmate leaves SMU
- Should be moved when inmate changes to involuntary status

Other consents can be moved when 1 year old

MH SPECIAL PROCEDURES – chronological order except most recent AIMS

Abnormal Involuntary Movement Scale (AIMS)

- Most recent is always on top in this section
- When back of page is used, page flips to put 2nd side on top

SMU Clozaril Blood Draw Log – SMU Clozaril Checklist (on back
SMU Clozaril Prescription – Directions for Standard Titration
Special Management Unit Restraint/Suicide Watch Log
Emergency Seclusion and Restraint Entry Note/Flowsheet

PURGING TO MENTAL HEALTH TAB

Old AIMS can be moved when a new one is started
Clozaril forms can be moved if Clozaril prescription is stopped or form is full
SMU Restraint/Suicide Watch Log can be moved when restraint/watch stops
Emergency S & R Entry Note can be moved when seclusion/restraint stops
Flowsheet can be moved when seclusion/restraint stops

MH MISC

Clinically important correspondence and other non-legal papers that do not fit elsewhere

- Suicide notes, grievances, other correspondence from inmates
- Correspondence with family
- Mood rating scales
- Other papers that have clinical significance

DO NOT KEEP ALL KYTES, REFERRALS, AND SUCH – JUST WHAT HAS CLINICAL SIGNIFICANCE – when in doubt, ask case manager

PURGING TO MENTAL HEALTH TAB

All material more than 1 year old can be purged

MH LEGAL – filed in chronological order, most recent on top

30-day Involuntary Medication Progress Report
Administration of Emergency Medication
Administration of Involuntary Medication Appeal Decision of CMO
Attorney correspondence

- All other legal forms, papers, documents, correspondence

Court commitment paperwork
Court orders re mental health, subpoenas, other court material
Emergency Medications 24-hour Discontinuation Request
Inmate Capacity to Consent to Treatment
Involuntary Medication Hearing - Inmate Rights Checklist
Involuntary Medication Hearing Request
Involuntary Medication Notification ***(to Chief Medical Officer)***
Notice of Appeal of Independent Examining Physician Decision to medicate w/o Informed Consent
Notice of Emergency Assignment to the Special Management Unit
Notice of Independent Examining Physician Decision and right to appeal
Notice of Involuntary Medication Hearing
Report of Independent Examining Physician -- 2-3 pages

PURGING TO MENTAL HEALTH TAB

Can be moved if more than 5 years old or not currently in force

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MENTAL HEALTH
Material purged from other sections

When this section is also too full, the oldest material can be moved to an overflow chart – in the overflow chart, it is put behind a Mental Health tab, which is under all medical papers (so the mental health information is kept separate and there is no need to move it to file medical information)

MH COLLATERAL – not to be released
Records of treatment & other confidential information from other agencies & providers – this information can**not** be released by us to any other agency, lawyer, court, or provider – people who want copies must request them from the original provider – when inmate is released, this material should be shredded.

MATERIAL IS **NOT** MOVED FROM THIS SECTION, except to be shredded at release.

FORMS

30-day Involuntary Medication Progress Report – MH Legal
Abnormal Involuntary Movement Scale (AIMS)-MH Special Procedures
Administration of Emergency Medication - MH Legal
Administration of Involuntary Medication Appeal Decision of CMO – MH Legal
Application for Voluntary Admission to the Special Management Unit- MH Consent
Attorney correspondence – MH Legal
Authorization for Release of Information – MH Consent
Authorization for release of information not on our forms – MH Consent
Bridgepoint Discharge Summary –MH Assessment
COPE Program Referral Form – MH Assessment
COPE Program Termination Summary –MH Assessment
COPE Program Transfer Summary to SMU – MH Assessment
Court commitment paperwork –MH Legal
Court orders re mental health, subpoenas, other court material – MH Legal
Crisis Management Contract – MH Treatment Plan
Emergency Medications 24-hour Discontinuation Request - MH Legal
Emergency Seclusion and Restraint Entry Note/Flowsheet-MH Special Procedures
Inmate Capacity to Consent to Treatment/ Ability to Weigh Risks/Benefits of Medication-MH Legal
Inmate's written request for copy of his/her chart- MH Consent
Intake Assessment Report – MH Assessment
Involuntary Medication Hearing Inmate Rights Checklist – MH Legal
Involuntary Medication Notification (to CMO) – MH Legal
Involuntary Medication Hearing Request –MH Legal
Medication Inmate Informed Consent/Refusal – MH Consent
Mental Health Behavior Management Plan – MH Treatment Plan
Mental Health Evaluation – MH Assessment
Mental Health Flow Sheet-Top of Chart-Left Side-Pink
Mental Health Medication Management Progress Note – MH Progress Notes
Mental Health Progress Notes – MH Progress Notes
Mental Health Screening Report – MH Assessment
Mental Health Services Confidentiality Policy/Consent to Treatment – MH Consent
Mental Health Treatment Plan – MH Treatment Plan
Mental Status Screening – MH Assessment
Monthly Mental Health Group Progress Note – MH Progress Notes
Notice of Appeal of Independent Examining Physician Decision to medicate w/o informed consent – MH Legal
Notice of Emergency Assignment to the Special Management Unit – MH Legal

Notice of Independent Examining Physician Decision and right to appeal – MH Legal
Notice of Involuntary Medication Hearing – MH Legal
OSP SMU Initial Treatment Care Plan – MH Treatment Plan
Progress notes from on-call MH professionals re crisis interventions-MH Progress Notes
Psychosocial History Summary – MH Assessment
Report of Independent Examining Physician – MH Legal
Request for Transfer to Oregon State Hospital – MH Legal
SMU Admission Data Sheet – MH Assessment
SMU Admission Psychiatric Evaluation – MH Assessment
SMU Clozaril Blood Draw Log – SMU Clozaril Checklist (on back) - MH Special Procedures
SMU Clozaril Prescription – Directions for Standard Titration –MH Special Procedures
SMU Referral Information – MH Assessment
SMU Treatment Care Plan – MH Treatment Plan
SMU Treatment Care Plan Problem List – 3 pages – MH Treatment Plan
SMU Treatment Team Review Note – MH Progress Notes
Special Management Unit Discharge Summary – MH Assessment
Special management Unit Restraint/Suicide Watch Log – MH Special Procedures
SRCI SMU Initial Treatment Care Plan – MH Treatment Plan
Suicide Risk Screening – MH Assessment
Turning Point Discharge Summary – MH Assessment