Department of Corrections

Staff Training

HEALTH SERVICES DIVISION

MEDICAL RECORD DOCUMENTATION

For Correctional

Health Care Professionals

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The contents of this document reflect the views of Ms. Joan Hayward. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

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Note : **This training module is fairly general in nature. However, other correctional agencies using it as a resource should make those changes necessary to ensure that it reflects the philosophy, policy and procedures of their system.**

MEDICAL RECORD DOCUMENTATION FOR CORRECTIONAL HEALTH CARE PROFESSIONALS

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PRE-INSTRUCTIONS:

1. Four hours (4) of in-classroom instruction have been allotted for this model training curriculum for Medical Record Documentation for Correctional Health Care Professionals. This curriculum module wi11 be used to orient new employees and to provide ongoing annual inservice training.

2. Review materials to insert jurisdiction specific information in appropriate areas and determine facility specific forms that will become handouts.

3. Distribute We-class Exercise form to trainees two weeks prior to training.

4. Arrange for the preparation of copies of "Lecture Guides:* for each unit for the trainees.

5. Guarantee that an overhead projector is ordered and delivered to the training site the day of the class.

PURPOSE:

As the medical record serves as a means of communication among the health care providers contributing to the care of the patient/inmate it is imperative that all appropriate information documented is a complete record for all providers to reference. The record provides for the continuity of care during the current illness as well as during follow-up or subsequent illness or injury.

The medical record system is essential to all the medical staff and health care providers to understand a patient's history, diagnosis and mode of treatment. The adaptation of the system to the needs of the facility is a measure of its effectiveness.

Problem oriented medical record documentation provides a logical way of documenting a prisoner's health care.

The maintenance of patient confidentiality has both an ethical and legal basis. Information provided by an inmate to health care professionals or information obtained by examination or test results must be regarded as confidential and the inmate must be assured that the information is confidential.

AUDIENCE: All new employees in the health care division of the correctional facility upon arrival in the department and subsequently on an annual or semi-annual basis as needed for in-service purposes.

TRAINING FORMAT:

The training format will include: pre-class exercise, lecture, discussion, role playing, application activities and a final test.

"Lecture Notes" and Overheads are provided for the Trainer for each the of following units. "Lecture Guides" are provided for the trainee for each of the following units.

1. Introduction
2. Overview
3. Technical documentation
4. Confidentiality
5. Transfer of Information

PERFORMANCE OBJECTIVES:

At the end of the training session, the trainee will be able to:

1. Give a definition of a medical/health record.
2. Discuss purposes and uses of medical records.
3. Briefly describe the source oriented format for medical records
4. Describe the components of the problem oriented medical record.
5. Document health information using problem oriented medical record, formats.
6. Demonstrate proper charting techniques.
7. Describe methods used in the maintenance of medical records for correctional facilities.
8. Delineate and apply principals of confidentiality to the innate's medical record.
9. Discuss procedural methods of transferring medical information for the inmate/patient in a variety of situations.

I N T R O D U C T I O N
L E C T U R E N O T E S

The task of documenting and maintaining medical information becomes immense when one considers the roughly one-quarter of a million adults housed in state and federal prisons.

As prisons offer a pre-paid type of health care with a variety of types of records kept and various practices employed in handling and managing records in prisons, this important task of documenting and maintaining the health information can become chaotic.

T H E R E C O R D

Defined as the "who, what, when, where, why and how of patient care", the medical or health record is a compilation of important facts of a patient's life and health history:

*past and present illnesses and treatments as written by the health professionals that contribute to the patient's care,

*data compiled in a timely manner

*containing sufficient data to identify the patient,

*support the diagnosis **or** the reason the patient is being seen, and

*justify the treatment

*and accurately document the results.

H E A L T H R E C O R D V S . M E D I C A L R E C O R D

The term "health record" serves a broader concept of health care and is often used interchangeably. There are differences in the terms, just like there are differences between the concept of "medical care" and "health care".

Health record: is, ideally, the single archive of all data on an individual.

*begin with birth records
*immunization records
*reports of all physical examinations
*records of illnesses and treatments regardless of where the patient has been seen and treated.
*efforts are being made to define standards for such a longitudinal record, but records today in most health care facilities are not as comprehensive as the ideal.

Medical Record: In most facilities, the records include only data gathered at that particular facility about episodes of care when the patient has been seen.

- *the term medical record accurately describes the content of present records
- *the term health record is used more in facilities that provide health care services other than short term, acute medical care. (ambulatory care)
- *the terms are used interchangeably at this point in time

P R I M A R Y P U R P O S E

The primary purpose of the medical record is to serve as a means of communication among the professional health care providers contributing to the care of the patient.

The record must accurately and adequately document a patient's life and health history, including past and present illnesses and treatments with emphasis on events affecting the patient during the current episode of care.

Many medical and ancillary personnel are utilized in providing health care for an illness or injury.

- *it is imperative that all appropriate information documented is a complete record for all providers to reference.
- *the record provides for continuity of care during the current illness or injury as well as during follow-up or. subsequent illness or injury.

P E R S O N A L / I M P E R S O N A L U S E S

The data assembled as the medical record contains a wealth of information and has a variety of uses. These uses can be personal or impersonal.

Personal Use: refers to usage in which the identity of the patient is retained and is necessary. EXAMPLE: Requests for copies of a patient's medical record

Impersonal use: refers to usage in which the identify of the patient is not retained and is not necessary. EXAMPLE: Data abstracted form 1,000 medical records for a research study

USES OF THE MEDICAL RECORD

PATIENT CARE MANAGEMENT:

*to document the course of the patient's illness and treatment during each episodes of care

*to communicate between the physician and other health professionals providing care to the patient

*to inform health professionals providing subsequent care

QUALITY REVIEW - to evaluate the adequacy and appropriateness of care

FINANCIAL REIMBURSEMENT - to substantiate insurance claims of the health care facility and patient

LEGAL AFFAIRS - to provide data to assist in protecting the legal interests of the patient, the physician and the health care facility

EDUCATION - to provide actual case studies for the education of health professionals

RESEARCH - to provide data to expand the body of medical knowledge

PUBLIC HEALTH - to identify disease incidence so plans can be formulated to improve the overall health of the nation and the world

PLANNING AND MARKETING - to identify data necessary for selecting and promoting facility services

M E D I C A L R E C O R D F O R M A T

There are a variety of types of records kept, various practices and procedures employed in handling and managing the records i prisons

EXAMPLE: some prisons maintain records on prisoners when one is moved to another prison.
*others keep all medical records on one prisoner in one folder (a unit record)
*others will keep several separate medical records on the same prisoners. (dental, mental, medical care separate)

Furthermore there are differences from the outside medical community--the way data are arranged in the charts and the basic format of the record. There are two common formats for medical records:

Source oriented where the records are arranged by the patient care departments which provide the care and the data.
*within each section the forms are arranged according to date
*usually arranged in reverse chronological order (with the most current information at the top) at the nurses' station in acute care situations
*rearranged upon discharge.

Advantages: the reports of each source are organized together making it easy to determine the assessment, treatments and observations a particular department has provided.

Disadvantages: critics, though, say it is not possible to quickly determine all of the patient's problems and treatment being provided for the patient at a given time since the data from the various departments are organized in sections and not according to the patient's problems nor integrated in time sequence.

Problem Oriented Medical Records: POMR provides a systematic method of documentation to reflect logical thinking on the part of the provider directing the care of the patient.

Each clinical problem is defined and followed individually and organized for solution.

There are four basic parts:
1) data base
2) problem list
3) initial plans
4) progress notes. (These will be looked at thoroughly in this training session.

Advantages: the physician is required to consider all the patient's problems in total context.

*the record clearly indicates the goals and methods of the physician in treating the patient

*medical education is facilitated by the documentation of logical thought processes

*the quality assurance process is easier because the data are organized

Disadvantages: The major disadvantage is that the format requires additional training and commitment from the medical and professional staffs. That explains why we are here today!!

Many standard setting agencies and organizations consider the problem oriented record to be the most suitable for prison health care for the following reasons:

*the problem oriented medical record displays a patient's treatment in a clear, logical format

*the POMR is a dynamic communication tool for the entire health team

*the abstracting of data for auditing the quality of care given and the utilization of services is easier for non-clinical personnel

*the POMR serves as an efficient basic information and data source for continuing education and research

*the record serves to assist in protecting the legal interest of the patient, the hospital and the responsible practitioner

MANAGING THE RECORD SYSTEM

To allow the medical record to become a useful and helpful tool for both clinical and managerial purposes, a few simple principles must be adhered to. This will make the work of the health care team more responsible and effective:

1. The record should be separate from the confinement file and should be stored near the center of clinical services.

2. If at all possible, all medical records for one patient should be kept in one file folder--that is, the in-patient record, the sick call or out patient record, and the mental health record should be kept together.

3. Medical records should be safeguarded so that confidentiality is protected and only authorized personnel will have access to them. **(Note:** in prison health care it is important to assure confidentiality which means denying access to records by other prisoners as well as other unauthorized persons.)

4. There should be documentation of every patient-practitioner encounter, regardless of the locale or time of service. That is, even if sick call is held in the cell blocks, there should be a structure record of each contact.

5. The medical record should be pulled and reviewed every time a patient is seen.

HEALTH RECORD SYSTEM OVERVIEW
LECTURE NOTES

The medical record system is essential to all the medical staff to understand a patient's history, diagnosis and mode of treatment.

The system should be designed and implemented to

- *first identify the patient
- *to then gather, store and retrieve the information about that specific patient

The degree to which the record system is adapted to the needs of the facility is a measure of how effectively the system functions.

The person responsible for the health care services of the facility should review and approve the form and format of the record system.

SYSTEM COMPONENTS

The Introduction presented six principles that must be adhered to manage the record system. These again become evident as we take an overview of the components of the health record system. (quick review of overhead)

UNIT RECORDS

- *a single health record where all data gathered on a patient is accumulated
- *it therefore reflects the health status of the patient
- *the record should be separate from the confinement file

(DISCUSS PRE-EXERCISE-QUESTION #1)

INMATE NUMBERING SYSTEM

Inmates are routinely assigned an identifying number.

- *in state correctional health facilities this number is more often referred to as an I.D. number
- *in the federal system, the number is a register number

In most states, a central office controls the assignment of the I.D. number. The assignment may be controlled by a computer registry, ledgers, files or log systems.

Typically, the inmate keeps the same number as long as s/he is in the prison System.

*if a prisoner is discharged or paroled, commits a crime and is returned to prison, they may be reassigned their previous number or a new number is assigned depending on the system

*in the federal system, the register number is assigned by a computer and the inmate keeps the register number throughout the confinement. The inmate will maintain the same number when transferred to a federal facility in another state.

(DISCUSS PRE-EXERCISE-QUESTION #2)

S Y S T E M F O R F I L I N G R E C O R D S

The identification or register number should be used to identify and file the inmate's health record, but records should **be** identified by both the inmate number and name.

*handwritten or typed on an adhesive label and attached to the folder. EXAMPLE: #123-45-6789 SMITH, Robert J.
*inmate patient records may then be filed by the identifying number, with the patient name available to verify accuracy
*the records may also be filed alphabetically, with the last name written first followed by the first or given name and the identifying number. EXAMPLE: SMITH, Robert J. #123-45-6789

(DISCUSS PRE-EXERCISE-QUESTION #3)

M A S T E R I N D E X

The cross-reference from a patient's name to his/her health record identification or registration number is the master index or master patient index.

*of particular importance if records are filed by number
*this cross reference may occur by computer
*if health care employees have access to the computer and identification numbers, no manual master index is necessary

Facilities without the computerized system to access numbers, should establish and maintain a master patient index.

*as simple as a card file for 3 x 5 index cards including the following information:

*inmate's name
*date of birth (can become important to identify patients with the same name)
*identification number
* health record number if it differs from the identification number

*the amount of basic information maintained in the master index is dictated by what is needed and what will be used

(DISCUSS PRE-EXERCISE-QUESTION #4)

F I L I N G

NUMERICAL FILING:

The identification number is used for filing in most health care setting.

*numerical filing results in fewer errors
*the progression of growth of files in more natural than alphabetical filing
*the filing by number can be faster and more efficient
*minimum training is required for the health care professionals

Furthermore, an individuals health care record is more confidential if access to the master index is necessary to locate the identification number to access the medical record.

ALPHABETICAL FILING:

Filing alphabetically has many inconsistencies including

*hyphenated surnames
*names with prefixes (D', Von, Mac, Le)
*names of cultures that use multiple names (Ng Ling Song) where it is difficult to know which is the surname
*religious titles (Sister Marie, Father Smith)

An additional problem in the correctional health setting is the use of one or more aliases by an inmate. It can be difficult to locate records filed alphabetically under several aliases, but if the master index uses cards for each alias, the record may be filed under one identification number.

(DISCUSS PRE-EXERCISE-QUESTION #3)

FILING SUPPLIES AND EQUIPMENT

All forms created for an inmate should be filed in a folder.
- *press board jackets are used in all federal correctional facilities and most states
- *others will use manila folders
- *often if both inpatient and outpatient care are provided by the facility, the jacket will have inpatient on one side of the folder and outpatient on the other.
- *other facilities may use a press board folder with inner dividers to separate forms into dental, mental health, inpatient, outpatient, administrative, medication, etc. records

Brackets may be used to secure the forms in the records.
- *usually two hole at the top of the form or two or three hole on the side
- *it is not recommended to have loose forms in the record because of potential loss

Each folder should have a label with the patient name and identification number.
- *location of the label depends on the type of filing equipment
  - *across the top of the folder for drawer files
  - *along the side for open shelf files

Filing equipment may be 4 or five drawer filing cabinets or open shelf files.
- *many prefer drawer files, however, the open shelf equipment is less expensive than cabinets
- *it is more efficient to file and retrieve records from open shelves
- *less floor space is required as an open shelf file can hold more records
- *cabinets must allot space for the opening of the drawers
- *open shelves may be less secure than cabinets

(DISCUSS PRE-EXERCISE-QUESTION #3)

STANDARDIZED FORMAT

The format of the record must be standardized to facilitate communication between members of the health staff according to the Standards for Health Services in Correctional Institutions. Format refers to how the various forms of the medical record are organized.

Format is based on the needs and requirements of the patients being treated. The person responsible for the health care services of the facility should review and approve the medical record form and format.

(DISCUSS PRE-EXERCISE-QUESTION #5)

RECORD ORDER OF ASSEMBLY

A prescribed order of filing should be used to allow all users to quickly locate information filed in any record.

- *prescribed order is dictated by the requirements of the facility
- *some facilities will have designated dividers with the printed order of assembly on each to facilitate the filing of forms behind each divider

(DISCUSS PRE-EXERCISE-QUESTION #5)

LOCATION OF RECORDS

Records should be maintained in an areas closest to those who use them--the health care providers in the clinic or dispensary.

OUTGUIDES

An outguide or chart locator system allows all providers of care to know where the medical records are at all times.

- *heavy weight forms can be used to give
  - *date
  - *inmate name
  - *identification number
  - *location where the record is being taken
  - *the person taking the record

The outguide takes the place of the record when it is removed from the files. When the record is returned, the outguide is removed.

(DISCUSS PRE-EXERCISE-QUESTION #6)

RETENTION AND DESTRUCTION

NCCHC standards require written policy and defined procedures so inactive medical record files are retained according to legal requirements of the jurisdiction and are re-activated if an inmate returns to the system. Inactive files should be marked in such a way that inmates can be identified as long-term-care patients if they re-enter the system.

- *when an inmate is discharged, paroled, or transferred (if the original medical record does not transfer with the patient)
- *the inactive medical record is retained as permanent records for the time provided by law and jurisdictional policy
- *this can vary from state to state from five years to indefinitely
- *the record may be maintained in its original form or it may be on microfilm
- *the record may be sent to a central archive area

In the federal prison system, "The medical records are retained in their original form after release of the inmate from the Federal Prison System. After one year, the inactive records are sent to the Regional Federal Record Storage Center along with the central record. Records will be retained for 30 years, then destroyed".

(SHARE FACILITY SPECIFIC RETENTION PROCEDURE)

ABBREVIATIONS

Health care providers use abbreviations as a common practice-when documenting in the medical record.

- *Abbreviations that may have several meanings become confusing and can lead to problems
- *a list of acceptable abbreviations should be developed and approved by the Director of Health Services
- *the only abbreviations that should be used in documentation are those included in the official list

Records that utilize abbreviations (medication records) can have a legend printed on the form to facilitate documentation and use.

(DISTRIBUTE ACCEPTABLE ABBREVIATION LIST)

P R O B L E M O R I E N T E D M E D I C A L R E C O R D T E C H N I Q U E S
L E C T U R E N O T E S

R E V I E W O F B A S I C S

The Problem-oriented medical record, commonly referred to as POMR was introduced by Lawrence L. Weed, MD in the late 1960's.

The POMR provides a systemic method of documentation to reflect logical thinking on the part of the physician or other health care provider directing the care of the patient. The health care provider defines and follows each clinical problem individually and organizes them for solution.

The POMR has four basic parts:

DATA BASE: a minimum set of data to be obtained on every patient

1. chief complaint
2. present illnesses
3. patient profile (the patient's typical day) and related social data
4. past history and review of systems
5. physical examinations of defined content
6. baseline laboratory data

PROBLEM LIST: a form placed in the front of the record. Problems are anything that require management or diagnostic workup

1. medical
2. social
3. economic
4. demographic problems, past or present

Problems are recorded at the level of the recorder's understanding of a particular problem. Problem lists may contain a statement of a symptom,
an abnormal finding,
a physiologic finding,
or a specific diagnosis.

*Conditions suspected or to be ruled out are not listed as problems but are noted in the initial plan.

*Additions or changes are made in the list as new problems are identified and active problems resolved.

*Problems are not erased; they are marked dropped or resolved and the date of the change recorded.

*Problems are titled and numbered and serve as the table of contents to the record.

INITIAL PLANS: describe what will be done to learn more about the patient's condition, treat the condition, and educate the patient about the condition.

Specific plans for each problem are delineated and fall into three categories:

1. more information for diagnosis (i.e. rule/out) and management
2. therapy (statements of drugs, procedures, goals and contingency plans)
3. patient education

Plans are numbered corresponding to the problem which they address.

PROGRESS NOTES: The follow-up for each problem.

*Each note is preceded by the number and title of the appropriate problem and may consist of any or all of the following elements:

1. subjective (symptomatic)
2. objective (measurable, observable)
3. assessment (interpretation or impression of current condition)
4. plan statements

*This becomes the acronym SOAP and writing progress notes in the POMR format is often called "soaping".

*The emphasis is on unresolved problems.

FLOW SHEETS may be used in situations in which there 'are several factors being monitored or when the patient's condition is changing rapidly. (These are in addition to the narrative notes to describe the patient's progress.)

DISCHARGE SUMMARY and TRANSFER NOTE are included in the progress note category. These should address all the problem numbers on a patient's list.

Dr. Weed recommended that other forms: physician's orders, consultants reports, nurses' notes, be in the problem oriented style with reference to titled and numbered problems.

TEN COMMANDMENTS OF HEALTH RECORD CONTENT

1. All entries, including dates and signatures, should be legibly written.

2. All entries should be signed with name and title. Do not sign the entry of another unless it is a countersignature.

3. All entries should be dated and timed with complete dates: month/day/year with time specified as a.m. or p.m. or in 24-hour notations (0900, 1115, 2300)

4. All entries should be made in ink (never in pencil) or typed. Black ink photocopies most legibly.

5. Do not leave blank space for another to fill in, particularly above a signature.

6. Never obliterate an entry by inking it out or by using a liquid erasure or correction fluid. To make a correction in a record, draw a single line through the error, write "ERROR" in the margin, date and sign.

7. Avoid using abbreviations unless they appear on an approved abbreviation list.

8. Document promptly, completely and accurately.

9. Avoid inconsistent and contradictory entries.

10 Refrain from including personal comments about the patient.

WHAT TO PUT IN THE CHART--AND WHAT TO LEAVE OUT

The following "Do's and Don'ts" will help make the patient's medical record a better legal document.

1. Do document patient behavior, especially non-compliant behavior. (The chart then reflects the patient's care as well as problems the patient bring on him or herself.)

2. Don't get personal. (Remember that the patient may be seeing a copy of this record--describe situations objectively.)

3. Do use quotes. (A patient's own words can be the most revealing information available.)

4. Don't advertise incident reports in the chart. (Incident reports left out of the medical record are protected by attorney-client privilege.)

5. Don't use the chart to settle disputes or assign blame. (Finger pointing and accusations have no place in the patient's record. Use other avenues for problem solving,.)

6. Do make neat, legible entries. (Your charting reflects your proficiency, competency, philosophy and values. Sloppy charting can also lead to poor communication and misunderstandings among staff members.)

7. Don't try to keep secrets. (Don't cover up embarrassing facts or soft-pedal the truth.)

CONTENT OF' THE OUTPATIENT RECORD

Three Basic Parts:

1) information obtained on reception into the prison system and/or at admission to a specific correctional facility

2) information documented during confinement

3) information collected for discharge or transfer

PART 1 (ON ADMISSION TO A SYSTEM OR FACILITY)

IDENTIFYING INFORMATION
- *inmate name
- *identification number
- *date of birth
- *sex

Others
- *social security number
- *marital status
- *race
- *name and address of next of kin
- *name and address of who to notify in case of emergency

MEDICAL HISTORY: used to evaluate the health status of the inmate on arrival and prior to housing him/her within the general prison population.

- *determine if the inmate has a communicable disease
- *injuries or conditions that may require immediate medical attention.

It routinely includes:
- *personal history of past and current medical, mental and dental conditions
- *hospitalizations
- *allergies
- *current medications
- *substance abuse history

The form must be signed and dated by the health care provider who completes the initial screening and medical history forms.

MEDICAL/PHYSICAL EXAMINATION: to document the findings of the medical or physical examination.

It routinely includes:
- *height, weight
- *temperature, pulse, respiration

*blood pressure
*general appearance of inmate
*results of tests for communicable diseases
*disabilities/work 'limitations
*identifying marks (scars, tatoos, deformities)
*assessments (medical, social, nutritional)

The physical examination form should be designed to meet the needs of the facility. The form must be signed and dated by the health care provider who performs the examination.

The identifying information, Medical History and Physical Examination along with any laboratory tests become the Initial Data Base. The objective of the initial data base is to build a foundation from which problems can be identified.

The data to be gathered is defined in advance and it becomes possible to obtain the same data on every resident entering your prison system. Data precisely defined by printed forms and guidelines can be collected by a variety of personnel. (example initial medical history and physical examination overhead)

When the Initial Data Base has been gathered and if any problems are identified, the physician will decide to take a specific course of action. These Initial Plans may include gathering more information, diagnostic workups, treatment, follow care and patient education. Each problem requires a separate plan except if the management is the same for several problems.

After the initial medical evaluations of a resident, more often there will be no need for an Initial Plan unless problems have been identified.

PHOTOGRAPH: While not routine, it is recommended.
*assures that the inmate who presents for treatment or medication is who s/he says s/he is.
*useful to escorting correctional officer or health care provider on transporting inmates to off-site treatment
*documents physical condition on arrival (mark on print inmate name, identification number, date)

There should be a written policy and procedures concerning photographing of inmates.

PART 2 (DURING CONFINEMENT IN THE CORRECTIONAL FACILITY)

PROBLEM LIST: a form containing numbered problems, diagnoses, or conditions affecting the patient's health status. Includes :
*past conditions that have been treated and date resolved
*chronic conditions
*new problems are added to the list as they develop

Format may vary from one facility to another, but basic components include

- *problem number
- *date problem or diagnosis was identified
- *name of the problem or diagnosis
- *date resolved

There may be acute or temporary problem sections as well as chronic problems. (overhead: blank form; working form)

It should be the top most form in the record to be accessible to all health care providers and printed on heavy paper to withstand frequent handling. The problem list serves as an index to the medical record.

Problems are identified by members of the health care team and listed at the level of his/her understanding. Recognizing a medical problem may be on one of four levels:

1. symptom or physical finding (back pain, wheezing, shortness of breath
2. abnormal laboratory findings (abnormal CBC, positive. VDRL)
3. physiologic findings (congestive heart failure)
4. diagnosis (diabetes mellitus)

"Rule outs" or questionable diagnoses do not belong on the problem list. They belong in the Initial Plan or in the Plan in the "P" of the progress note.

Psychiatric and social problems of the inmate should be entered on the list in a clearly stated manner (example: paranoid schizophrenia, triple bunked in house". If the mental health program of the prison is separate from the medical services, both the medical and mental health record should have the same Problem List attached to each.

When problems are further diagnosed or resolved, the problem list is amended with a dated arrow.

(Example: overhead Even though the problem is resolved, problem #1 is always congestive heart failure and the number is never used again. If a temporary problem becomes a major problem, the same technique is used, as shown in second example)

The problem list must be reviewed by the health care professional each time the medical record is opened.

PROGRESS NOTES/TREATMENT RECORD: a form designed to be used with the program list providing space for recording the date, time, problem number, problem title, and the S.O.A.P. of the inmate's problem.

Continuing problems use an existing number from the problem list while new conditions are assigned a new number on the problem list before the new condition is "soaped".

Soaping includes:

Subjective: the patient's symptoms and complaints are recorded as the information is provided by the patient, custody, friends and family

Objective: information gathered by the health care provider by examining the patient, recording vital signs and documenting physical findings, laboratory and x-ray results.

Assessment: after evaluation of the subjective and objective information, a diagnosis or medical impression is recorded. This explains the significance of the subjective and objective data and what the health professional thinks about problem management. It should lead to the formulation of the plan.

Plan: recordings of treatment, patient education and instructions for recommended follow-up. In this area, information is documented as to when the patient is to return and what symptoms to be aware of that require follow-up visits. (Example: return in three days for change of dressing, sooner if bleeding occurs) A further progress note can be made if the inmate does not return for treatment.

(Examples on Overhead)

Medical prescriptions must be carefully documented as to name of drug, dose or strength, time schedule, route of administration and amount prescribed. If medication will be administered one dose at a time in the "pill line" or equivalent, the record must indicate.

The plan indicates the need for more information such as additional lab tests.

A problem list and "soaped" progress notes allow the tracking of problems through the documentation. (Example: a diabetic inmate whose diabetes is assigned problem number "3" can have all diabetic documentation referenced by reviewing the progress notes labeled with a "3".

It is essential that all SOAP notes be legibly written, dated, timed and signed.

MEDICATION RECORD: Medications can be provided by one of two methods:

*medications are prescribed and a supply provided the inmate patient
*controlled or restricted medications are distributed one dose at a time. Inmate patients may also be placed on the "pill line" to ensure medications are taken and at the appropriate time.

The medication entry on the progress note/treatment record should indicate that the inmate was provided with the medication or that it is a "pill line** medication.

Pill line medication records can vary, but all contain space for recording month and year
-name of medication
-dosage
-frequency
-time to be given
-name of health care provider who prescribed the medication
-31 pre-numbered columns to correspond with days of the month
-space initials of those who dispense medication and space for signatures to correspond with the initials
-other: space for allergies; legend as required for absence of inmate (A) or refusal of medication (R), or medication withheld (W)

LABORATORY/X-RAY/DIAGNOSTIC STUDIES: Forms used for ordering tests and studies should be dated with the date ordered and then dated and signed by the person who performed the test or interpreted the x-ray and reported the results. Half size or smaller order forms can be affixed to a standard size sheet.

Studies done outside the correctional facility should be reviewed and countersigned by the correction&l health staff prior to filing the reports to assure that the result have been reviewed.

FLOW SHEET: Data on a particular diagnosis, treatment or laboratory test results can be tracked on a flow sheet. It allows easier comparison of data and save time in searching a medical record to find items recorded on separate forms. (Example: An inmate being followed for hypertension can have a flow sheet in the record to monitor daily, weekly or monthly blood pressures. Flow sheets can be used for diabetic patients to monitor weight and fasting blood sugars.) Intervals of observation can be documented using a flow sheet. Flow sheets can track dental exams, chest x-rays, pre-natal care etc. (Examples: Overheads)

Any significant information in the flow chart should be indicated in the objective part of the Progress Notes nor any problem they effect either by copying the finding in the note or simply by

"see flow chart".

Flow sheets require a legend if abbreviations are used. Entries should be dated, legible and if initials are used, a place for signatures provided.

IMMUNIZATION RECORD: This may be a separate form or combined with the initial treatment. Some facilities print the immunization form on heavier weight paper and it serves as a divider in the record.

It is easier to track a long term inmate on a separate form. Dates of immunization must be written legibly and the staff member who immunized the inmate must sign or initial the entry. If initials are used, there must be a signature to correlate with the initials on the form.

CONSULTATIONS/OFF SITE REFERRALS: a form is needed to advise off site health care providers of the reason an inmate is referred. The form should provide space at the top for the on-site health care provider to document the inmate's current symptoms, current medications, treatment, reason for referral. The bottom half of the form should allow for documentation such as the physical findings, results of laboratory tests/x-rays if done and treatment made by the off-site consultant and recommendations for further treatment. The information is needed to provide continued care when the inmate returns to confinement.

The referral form can also be used for non-acute needs such as eye, hearing or dental examinations.

The consultation form should be completed, dated and signed by the correctional health care provider and completed and signed by the off site consultant provider as well. A copy of the form should be filed in the inmate's health record at the correctional facility.

DENTAL RECORDS: Dental records should be filed as part of the unit health record. Each entry should be legibly written, dated and signed. Dental records routinely include a chart of the teeth and may also include an envelope for filing all dental documentation.

EYE/HEARING EXAMINATIONS: Special forms are routinely used for eye examinations, prescriptions for eyeglasses and for hearing tests. Entries should be legible, dated and signed by the health professional examining the eyes or hearing. These forms should be filed as part of the unit record. If these examinations are done off site, pertinent information should be available to include in the inmate's health record.

SURGICAL AND PATHOLOGY REPORTS: when outpatient surgery is done,

document:
- type of local anesthesia used
- description of the procedure
- required follow up

Tissue removed should be referred for pathological examination and the report should be filed in with the unit record.

All entries must be legibly written, dated and signed.

MISCELLANEOUS: additional forms may be included in the health record (Example: mental health, restriction, special treatment, special diet)

PART 3 (DISCHARGE OR TRANSFER SUMMARY)

Several forms can be used to document an inmate's health condition on leaving confinement after serving a sentence or on transfer to another correctional facility. Basic information include:
- chronic illness or handicap
- allergies
- restrictions
- current medications
- need and reason for on-going treatment

Further information will be given when we discuss transfer of the inmate/patient.

A SUMMARY OF THE TECHNICAL PROCESS

As an offender enters a prison, a paper trail is created which attempts to record the important, and sometimes, not so important, events which occur during his incarceration. There are elements in that trail which can be identified with the four basic components of the POMR as shown:

CORRECTIONAL DATA BASE

Admission and Intake

-gathers information to assess the offender's background, education, employment history and attitudes
-may be collected by general staff under supervision of trained correctional staff
-includes a mental assessment

Placement and Work Classification

-developing additional information by extending testing and screening
-decision making process for development of correctional program for offender

Assignment to Prison Program

-developing a program for each offender
-shared written and oral presentations by staff teams for educational, vocational and work assignments
-developed by correctional professionals

MEDICAL DATA BASE

Initial Data Base

-collects standardized health information on each prisoner

-includes history, physical examination, laboratory tests, etc.

-collected by members of the health care team

Problem List

-lists of prisoner's health problems
-indexes the medical record by titling, numbering, and dating identified problems
-provides perspective on past, present, and possible future problems
-developed by all health care team members
-clarifies communication among the health care team

Initial Plan

-developing a plan for resolving identified problems

-includes problem number, and course of action for the problem

CORRECTIONAL

Review and Assessment for Release

-continuous evaluation of offender's progress in program
-developing liaison with community resources to devise release program
-assessment of the capability of the offender and the community to accept his return to society

MEDICAL

Progress Notes

-details the follow-up of the problem
-always identified by the number or letter originally assigned
-includes four parts:
Subjective--data obtained from the patient, friends, custody
Objective--clinical and laboratory findings
Assessment--appraisal based on subjective and objective data
Plan of Management--treatment, patient education, and if indicated, further development of information

This shows how the POMR is much more structured than record developed for the correctional program.

PRACTICE EXAMPLES

I. Problem List and Initial Plan.

Using the following case history, develop a Problem List and Initial Plan from your own level of understanding. After completing all practice examples, see suggested solutions.

Case History:

A newly arrived resident is a 24-year old black male complaining of "skin problems" for 4 - 5 years and not feeling well for three weeks.

He had the usual childhood diseases with no complications, but had always been a "different" boy. He was hospitalized for six months when he was 18 for a "nervous breakdown". There have been no emotional problems since then, but he has often felt people "bugged" him and he preferred his own company. Three weeks ago he spent 5 days in bed because of an attack of weakness, muscle pains, fever, and discomfort in the upper abdomen. He had no appetite and ate practically nothing during that period. At present he does not feel entirely well, but his appetite is better.

He is one of five siblings. His father disappeared when he was three and his mother works sporadically as a domestic. He speaks of her only as a large woman with white hair. Two brothers are in prison, one sister is in a mental hospital, and one sister is reported as well and happily married.

On physical examination he appeared withdrawn and smiled briefly several times for no apparent reason. There was no evidence of recent weight loss. Temperature was 98.8, pulse was 74, regular, BP 165/94, respirations 12. He is 170 inches tall and weighs 155 pounds. Sclerae were slightly yellow. Many teeth had cavities and the gums were spongy and friable. Tonsils were enlarged but did not appear infected. Skin examination revealed irregular, rounded areas, elevated, red and covered with white scales which easily flaked. These areas were on extensor surfaces of forearms and across the upper abdomen. Examination of the abdomen revealed a tender liver edge extending 1 1/2 finger breadths below the costal margin. The rest of the physical exam revealed no abnormalities.

Mental Status Assessment: Resident was moderately withdrawn, oriented as to person, time, and place. Smiled inappropriately several times and did not speak spontaneously.

Positive Lab Findings: Serum bilirubin 6 mg/dl
SGPT 70 units

2. S.O.A.P. and the Problem List

Using the following case histories, construct a Problem List for each case. Since both of these-patients were originally seen on sick call, you must S.O.A.P. the encounters, identify problems, and list them. (Remember, there is more than one encounter in each case.)

Case A:

June 1, 1977. A 25-year o1d white male appearing well nourished and in generally good health complains of a sudden onset of severe frontal headache of four hours duration. The headache is described as "bursting" and "intolerable." There is no history of previous headaches. At the onset of the headache, his side vision became impaired. It was as though "horse-blinders" had been put on him.

Positive finding on physical examination: loss of bi-temporal vision on confrontation by moving fingers.

Initial Impression:

1. Ruptured cerebral aneurysm, near optic chiasm. Plan: Emergency consult with neurosurgeon. Spinal tap.

Progress Notes: 6/2/78

Spinal tap yielded moderately bloody fluid at 250 mn H_20 pressure.

Spinal tap repeated four hours later by a neurosurgeon showed grossly bloody fluid. A cerebral angiogram revealed several "berry aneurysms" with evidence of leakage in area of optic chiasm. Initial diagnostic impression was confirmed.

Emergency craniotomy discovered a ruptured aneurysm of the anterior communicating cerebral artery. This vessel was tied off, and the operative wound closed. Patient recovered uneventfully.

Case B:

June 1, 1977. A 40-year old male complains of chills, fever, muscle aches, general weakness, and shortness of breath for four days duration. Significant findings on physical examination: ill-appearing male, profusely perspiring, with no evidence of recent weight loss. Temperature 102.8, pulse 124, regular. There is a blowing grade IV diastolic murmur which extends throughout diastole. There are slightly increased crepitations throughout lung fields and splinter hemorrhages in several fingernail beds. Several recent needle marks are seen in the skin in the antecubital fossa.

Initial Impression:

1. Bacteremia, caused by self-administered intravenous introduction of an unknown substance.
2. Mycotic involvement of pulmonary valves
3. Bacterial pneumonitis, diffuse.

Plan:

1. Blood culture with sensitivities to antibiotics.
2. Chest film.
3. ECG.

Initial Lab Reports:

1. Blood culture: many colonies of short chain gram positive cocci, sensitive to Ampicillen.
2. Chest film: fullness of right cardiac border, diffuse areas of infiltration of lung fields.
3. ECG: right heart strain.

Diagnosis:

1. Bacteremia, caused by contamination, self-administered injection of unknown substance.
2. Mycotic involvement of pulmonary valves.
3. Pneumonitis, patchy, bacterial.
4. Mild/moderate rightsided congestive failure.

Treatment:

1. Admit to infirmary, close observation (possible rupture of a pulmonary valve).

2. Ampicillen, 500 mg, q.i.d.

3. Thiazide diuretics.

Excerpts of Progress Notes:

July 1, 1977. Shortness of breath on exertion. Bacteremia and pneumonitis definitely cleared. Heart murmur unchanged. Cardiac silhouette by x-ray shows prominence of right heart border. Hilar congestion.

Venous pressure 80 mn H_20.

ECG shows definite right ventricular hypertrophy.

Treatment: Digitalize. Change thiazide to mercurial diuretics. Low salt diet.

January 2, 1978. Shortness of breath climbing flight of stairs. Evaluation by cardiac function study group at University of Washington Medical Center yields recommendation for open heart surgery and transplant of porcine heterograph.

March 1, 1978. Open heart surgery as recommended by Cardiac Study Group.

May 25, 1978. Clinically well. ECG continues to show evidence of right ventricular hypertrophy.

Plan: See prison physician once a month. No medication. No restrictive activities. Check back in six months.

1. **CASE SOLUTION:**

SAMPLE PROBLEM LIST

MAJOR PROBLEMS: (require follow-up as may significantly affect health.)

6. DATE LISTED	7. NO.	8. PROBLEM	9. PROVIDER (NAME AND CODE)	10. PROBLEM CODE	11. INACTIVE DATE
June 1, 1978	1	Hypertension; moderate	M.A. Negretti, M.D.		
June 1, 1978	2	Psoriasis	M.A. Negretti, M.D.		
June 1, 1978	3	Hepatitis, infectious	M.A. Negretti, M.D.		
June 1, 1978	4	Dental caries, chronic gingivitis	M.A. Negretti, M.D.		

INITIAL PLAN

Problem #1 - Hypertension

Check blood pressure weekly

Problem #2 - Psoriasis

5% coal tar ointment with ultra violet radiation

Problem #3 - Hepatitis

Admit to infirmary for observation

Problem #4 - Dental caries, chronic gingivitis

Refer to Dr. Brown (dentist)

Problem - Schizophrenia, latent?

Mental status assessment

M.A. Negretti, M.D.
6/1/78

ADULT CORRECTIONS DIVISION

SAMPLE

3. FACILITY

2. CASE A SOLUTION:

6/l/78 C.C. "headache"

S. Intolerable, bursting, frontal headache for four hours. Vision impaired as if horse blinders had been put on.

O. "LOSS of bitemporal vision on confrontation by moving fingers. Elevated spinal fluid pressure. Bloody spinal fluid.

A. Ruptured cerebral aneurysm, near optic chiasm.

P. Admit to hospital. Spinal tap. Emergency consult with neurosurgeon.

L. P. JONES, M.D.

6/2/78 Problem #l, ruptured cerebral aneurysm

S. Intolerable, bursting frontal headache for four hours. Vision impaired as if horse blinders had been put on.

0. Spinal tap yielded moderately bloody fluid. Spinal fluid pressure 250 mm H_20. Neurosurgeon confirmed diagnostic impression on repeat spinal tap four hours followinq admission which showed grossly bloody fluid. Cerebral anqioqram revealed several "berry aneurysms" with evidence of leakage in area of optic chiasm.

A. Ruptured aneurysm of the anterior communicating artery.

P. Emergency craniotomy.

L. P. JONES, M.D.

In the first Progress Note, the patient is beinq seen on a referral from sick call. He is still an outpatient. The second Progress Note by the same physician, L. P. Jones, is written after admission to the hospital and consultation with the neurosurgeon. The operative report of a neurosurgeon would be much longer and more complete.

PROBLEM LIST:

The "headache" could have been placed on the Temporary Problem List if there had been a history of previous headaches. It is placed on the Major Problem Listbecause it is an initial severe headache associated with bloody spinal fluid.

SAMPLE PROBLEM LIST

MAJOR PROBLEMS: (require follow-up as significantly affect health.)

6. DATE LISTED	7. NO.	8. PROBLEM	[redacted]		
6/2/78	1	Ruptured aneurysm	L. P. Jones M.D.		

ADULT CORRECTIONS DIVISION

PROGRESS NOTES

SAMPLE

1. RESIDENT NAME | 2. RESIDENT NUMBER

3. FACILITY

2. CASE B SOLUTION:

6/1/78 (patient seen on sick call)
c.c. "feels like I have the flu"

S. Chills, fever, muscle aches, general weakness and shortness of breath for four days, no recent weight loss

O. Profusely perspiring, T 102.8°, P 124 regular. Blowing grade IV diastolic murmur throughout diastole. Slightly increased crepitations throughout lung fields and splinter hemorrhages in several fingernail beds. Recent needle marks in skin of anticubital fossa.

A. Bacteremia caused by self-administered I.V. introduction of unknown substance. Mycotic involvement of pulmonary valves. Bacterial pneumonitis, diffuse.

P. Admit to hospital, close observation. Blood culture with sensitivities to antibiotics.
Chest film.
ECG.
Ampicillen 500 mg qid.
Thiazide diuretics.

L. P. JONES, M.D.

The Problem List is as follows:

SAMPLE PROBLEM LIST

MAJOR PROBLEMS: (require follow-up as may significantly affect health)

6. DATE LISTED	7. NO..	8. PROBLEM	9. PROVIDER (NAME AND CODE)	10. PROBLEM CODE	11. INACTIVE DATE
6/3/78	1	Bacteremia	L.P. Jones MD		7/1/78
6/3/78	2	Bacterial Endocarditis	L.P. Jones MD		
6/3/78	3	Pneumonitis	L.P. Jones MD		7/1/78
6/3/78	4.	Congestive Heart Failure	L P Jones MD		

DEPARTMENT OF SOCIAL & HEALTH SERVICES
ADULT CORRECTIONS DIVISION

SAMPLE

PROGRESS NOTES

1. RESIDENT NAME	2. RESIDENT NUMBER
	I
3. FACILITY	

2. (CASE B continued)

Excerpts OF Progress Notes:

7/l/77 Problem #2 Bacterial Endocarditis
Problem #4 Congestive Heart Failure

S. Shortness of breath on exertion.

0. Diastolic murmur, essentially unchanged. Venous pressure 80 mm H_20. ECG: right ventricular hypertrophy.

A. CHF, insufficiency of pulmonary valves.

P. Digitalize on Digoxin. Start mecurial diuretics. Instruct patient in low salt diet.

R. SMITH, P.A.

1/2/78 Problem #2 Bacterial Endocarditis
Problem #4 Congestive Heart Failure

S. Shortness of breath on climbing one flight of stairs.

0. See extensive report of findings and recommendations of cardiac study group.

A. Gradually increasing tricuspid insufficiency.

P. Open heart surgery and transplant tricuspid prosthesis..

P. S. GRAL, M.D.

2. (CASE B continued)

3/l/78 Problem #2 Bacterial Endocarditis
Problem #4 Congestive Heart Failure

P. Transfer to U of W for open heart surgery.

M. GREEN, M.D.
Medical Director

5/25/78 Problem #2 Bacterial Endocarditis
Problem #4 Congestive Heart Failure

S. Feeling well. No complaint. No **shortness of breath.**

O. P 74 regular, BP 125/86. No murmurs.
ECG shows evidence of right ventricular preponderance.
Cardiac silhouette smaller.

A. Satisfactory post-surgical course. No complications.

P. No medication. No restrictive activities. Return visit in 2 weeks. Reevaluate at U of W August 8, 1978.

P. s. GRAL, M.D.

CONFIDENTIALITY OF MEDICAL RECORDS LECTURE NOTES

The maintenance of patient confidentiality has both an ethical and legal basis. Information provided by an inmate to health care professionals or information obtained by examination or test results must be regarded as confidential and the inmate must be assured that the information is confidential.

The courts acknowledge that there are some exceptions to confidentiality

- *the disclosure is required by law or
- *it becomes necessary to protect the welfare of the individual or the community.

The patient may waive their right to confidentiality by filing a claim for insurance benefits, etc.

NCCHC Standards require that medical records be stored in the prison

- *under secure conditions
- *separate from confinement records
- *and that access to medical records is controlled by the health authority

Patients should be protected from disclosure of certain confidences entrusted to a practitioner during a course of treatment. The confidential relationship that exists between doctor and patient extends to inmate-patient and their clinicians.

A current file on the rules and regulations covering the confidentiality of medical records and the types of information that may and may not be shared should be maintained.

In addition, information gathered and recorded about alcohol and drug abuse and psychiatric conditions may have special restrictions on disclosure under state or federal regulations.

(DISCUSS FACILITY SPECIFIC POLICY AND PROCEDURES THROUGHOUT THIS UNIT)

CONFIDENTIAL VERSUS NON-CONFIDENTIAL, HEALTH INFORMATION

CONFIDENTIAL: when the patient is identified. A signed authorization from the patient is required to release the information outside the health care delivery system.

NON-CONFIDENTIAL: patient information may, however, be used without identification of the individual patient without any authorization. Numbers may be used to identify patients in committee minutes, reports and the documents may be distributed.

O W N E R S H I P

Medical records developed in the hospital or clinic are considered to be the physical property of that facility. Original medical records should not be removed from a facility except in accordance with institutional or jurisdictional policies.

While the forms that make up the health record belong to the facility, the confidential information documented on these forms belong to the patient and the inmate/patient has the right to authorize the release of information.

A U T H O R I Z A T I O N F O R R E L E A S E O F C O N F I D E N T I A L I N F O R M A T I O N

The request for copies of health records include health care providers, other health care facilities, third party payers, attorneys and the courts.

The inmate/patient shall authorized in writing the release of medical records and information for the transfer outside the correctional system unless otherwise provided by law or administrative regulation.

- *have the inmate patient sign a specific authorization for the release of confidential medical information at the time the information is being requested by an off-site person or agency
- *general authorizations generated at the time of inmate arrival that cover information not yet generated are discouraged (Obtaining authorization prior to the collection of information does not allow for intelligent decision making on the part of the patient.)

E X C E P T I O N S F O R A U T H O R I Z A T I O N S

There are exceptions to the requirement for a signed authorization.

- *a health care provider may release confidential information without a signed authorization if s/he is required to do so by law or in order to protect the welfare of the individual or of the community
- *court orders, subpoenas or statutes may require that the original or a photocopy be provided for legal procedures upon receipt of an appropriate request (court order or subpoena).

When a patient is referred to another health care facility or health care provider for continued health care, confidential

information may be forwarded without the signed authorization of the patient.

*it is understood that confidentiality will be maintained and that the medical information is needed to provide continued treatment for the patient
*the original health record should not be removed from the correctional health setting

Specific release of information is not required from the inmate/patient if the information in his health record is used collectively in research, education or quality assurance activities that do not identify the patient.

PATIENT ACCESS TO HEALTH RECORDS

Procedures vary from state to state on how and when a patient can see or obtain copies of the health record.

*some state procedures require that the inmate review the health record in the presence of a medical staff member. *some state departments of corrections have a policy to not provide inmate/patient access while statutes in those states provide for the general community to have access to their medical records, to obtain copies or to inspect

ACCESS TO THE HEALTH RECORD BY CORRECTIONAL PERSONNEL

William Paul Isele, J.D., author of Health Care In Jails:... writes that it should make no difference that the patient is confined. The principles of open and honest communication with one's physician apply equally to all patients and it is conceivable that the physician may have to protect his patient's confidentiality from disclosure to confinement personnel if they have no legitimate reason to see the patient's records.

Exceptions to the above include

*situations of communicable disease that could endanger the welfare of the community
*a medical condition or conditions that could endanger the welfare of the inmate
*statutory directive to report medical conditions of inmates to correctional authorities

Regular reports could be made to responsible authorities indicating which inmates need hospitalization, which should be isolated due to infections disease and which need special diets or cannot participate in heavy work details. These reports do not include the entire medical record.

INMATE AS EMPLOYEE

Only carefully selected inmates shall be utilized to work in the hospital and then only in assignments of minimal responsibility subject to close supervision according to Health Services Manual of the Federal Bureau of Prisons.

- *this is to preclude the inmate from gaining access to sensitive information
- *or from being subjected to the threat of violence or similar pressures from other inmates to achieve their own ends

Inmates may not be assigned where they will have access to medical records, including copies of medical records and documents which will becomes part of the medical record.

NCCHC standards state the use of inmates in health care delivery

- *frequently violates state laws
- *invites litigation
- *brings discredit to the correctional health care field
- *gives the inmates unwarranted power over their peers

Inmates should not be employed in areas where they may have access to confidential health information.

(IF TIME PERMITS, USE THE CONFIDENTIALITY EXERCISES FOR DISCUSSION OR ROLE PLAYING APPLICATION ACTIVITIES. EXERCISES MAY ALSO BE USED AS POST-TRAINING PROBLEMS TO BE HANDED IN AT A LATER DATE.)

CONFIDENTIALITY EXERCISES

1. Your institution's Hearings Officer contacts you stating that during a drug urinalysis, Inmate Jones could not urinate within the two hour time limit. According to the Hearings Officer, Inmate Jones reported to the Correctional Officer that "I have a urinary tract problem, and just can't go on command." The Hearings Officer wants to know if this is true, and if so would you please provide the documentation. The Hearings Officer would like this by the end of the day. How do you proceed?

2. A woman telephone called identified herself as Mrs. A. J. Smith, she goes on to say that he daughter was dating a current prisoner. Yesterday her daughter received a letter from this man stating he had just received his AIDS test results and it was positive. Mrs. Smith would like to confirm the test results. How would you proceed?

3. Inmate Brown's mother telephones stating her son is getting out of prison next week and he has an appointment to go to his regular doctor the day following release. Mrs. Brown would like a full copy of her son's medical record transferred to Dr. Johnson's, officer before his appointment. How would you proceed?

POLICIES AND PROCEDURES

CONFIDENTIALITY OF PATIENT HEALTH INFORMATION: A POSITION STATEMENT OF THE AMERICAN MEDICAL RECORD ASSOCIATION, published 1985.

MODEL POLICY OF THE AMERICAN MEDICAL RECORD ASSOCIATION

*All requests for health records of health information including requests for information on patients currently under treatment shall be directed to the health record department.

*Release of information from the health record shall be carried out in accordance with all applicable legal, accrediting, and regulatory agency requirements, and in accordance with written institutional policy.

* All information contained in the health record is confidential and the release of information will be closely controlled. A properly completed and signed authorization is required for release of all health information except:

-as required by law'
-release to another health care provider currently involved in the care of the patient'
-medical care evaluation; or
-research and education in accordance with conditions specified below

* In keeping with the tenet of informed consent, a properly completed and signed authorization to release patient information shall include at least the following data:

-name of institution that is to release the information;
-name of individual or institution that is to receive the information
-patient's full name, address and date of birth;
-purpose or need for information;
-extent or nature of information to be release, with inclusive dates of treatment
(NOTE: An authorization specifying "any and all information...." shall not be honored);
-specific date, event or condition upon which the authorization will expire unless revoked earlier;
-statement that authorization can be revoked but not retroactive to the release of information made in good faith;
-date that consent is signed;
(NOTE: Date of signature must be later than the date of information to be released)
-signature of patient or legal representative
(NOTE: in the case of treatment given a minor without parental knowledge, the institution shall refrain from releasing the portion of the record relevant to this

episode of care when responding to a request for information for which the signed authorizations i that of the parent or guardian. an authorization by the minor shall be required in this instance.)

*Information released to authorized individuals/agencies shall be strictly limited to that information required to fulfill the purpose stated on the authorization. Authorizations specifying *any and all information..." or other such broadly inclusive statements shall not be honored. Release of information that is not essential to the stated purpose of the request is specifically prohibited.

*Following authorized release of patient information, the signed authorization will be retained in the health record with notation of the specific information released, the date of the release and the signature of the individual who released the information.

*Health records shall be available for use within the facility for direct patient care by all authorized personnel as specified by the chief executive officer and documented in a policy manual.

*Direct access to health records for routine administrative functions, including billing, shall not be permitted except where the employees are instructed in policies on confidentiality and subject to penalties arising from violations.

*Health records shall be available, in the health record department, to authorized students enrolled in educational programs affiliated with the institution. Students must present proper identification and written permission of the instructor with their request. Data compiled in educational studies may not include patient identity or other information which could identify the patient.

*Health records shall be made available for research to individuals who have obtained approval for their research projects from an institutional review board, or other appropriate medical staff committee, administrator, or other designated authority. Research projects which involve use of health records shall be conducted in accordance with institutional policies on the use of health records for research. Any research project which involves contact of the patient by the researcher must have written permission of the patient's attending physician, and/or by the chief executive officer of the facility or his designee, prior to contact. An institutional policy on use of medical records in research should guide these activities.

*If facsimiles of health records are provided to authorized internal users, the same controls will be applied for return of

these facsimiles as for the return of the original health record. Wherever possible, internal users will be encouraged to use the original health record rather than to obtain a facsimile.

*The names, addresses, dates of admission or discharge of patients shall not be released to the new media or commercial organizations without the express written consent of the patient or his authorized agent.

*Requests for health information received via telephone will require proper identification and verification to assure that the requesting party is entitled to receive such information. A record a the request and information released will be kept.

TRANSFER OF THE' INMATE/PATIENT LECTURE NOTES

(FACILITY SPECIFIC FORMS AND POLICIES MAY BE USED THROUGHOUT THIS UNIT.)

TRANSFER FOR ACUTE HOSPITAL CARE

INTRODUCTION: As most correctional facilities provide only infirmary care, inmate patients with a serious illness requiring medical or surgical treatment may have to be transferred out of the correctional facility for treatment.

NCCHC STANDARDS: "require that summaries or copies of the health record be routinely sent to the receiving agency either before or at the same time as the inmate".

"Written authorization by the inmate is required for the transfer outside the correctional system of medical records and information, unless otherwise provided by law or administrative regulation."

WHAT TO SEND: Portions of the medical record that relate to the needed off-site treatment should be copied and transferred with the inmate patient.

*history,
*the most recent physical examination,
*pertinent lab and x-ray test results,
*a list of current medications,
*any relevant consultation reports.

METHODS: copies should be:
*placed in a sealed envelope
*addressed to the appropriate health care facility or provider to assure confidentiality
*correctional officer accompanying the inmate should NOT have access to these records
*signed authorization from the inmate for release of this confidential medical information may not be required since the records are being provided for continued medical care

IN RETURN: The off-site hospital where the inmate patient receives medical or surgical care must be held responsible for providing information concerning its health care services.

*information must be forwarded to the correctional facility health care team so that appropriate follow-up care can be given
*copies of relevant portions of the hospital medical records, including a discharge summary should be returned to the correctional facility with the inmate.

*if this does not occur, the correctional health officer should contact the medical record department at the off-site facility and request that treatment information be forwarded.

TRANSFER FOR OTHER OFF-SITE CARE

INTRODUCTION: Other examinations such as hearing tests, eye examinations, dental care, physical therapy, etc. nay not be provided on site at the correctional facility or the correctional health care providers will need consultation with an off-site medical specialist.

WHAT TO SEND: when inmates are transported off site

*copy of RELEVANT portions of the health record should be sent to the off-site provider
*the copy should be placed in a sealed envelope
*addressed to the off-site provider to assure confidentiality
*the correctional officer accompanying the inmate patient should not have access to the health record
*signed authorization from the inmate for release of this confidential medical information is usually not required as the records will be used for providing continued health care

CONSULTATION FORM: The use of a consultation form for off-site care is recommended.

*providing such a form usually assures that some type of documentation concerning the off site treatment will be available to the correctional health care staff on the return of the inmate patients
*the top of the consultation form can be used to briefly outline the current health problem requiring off site treatment
*the bottom portion can be used by the consultant to document treatment and recommendation for follow-up

TRANSFER TO ANOTHER CORRECTIONAL FACILITY

Federal

Within the federal prison system, the entire original medical record is transferred with the inmate when s/he is sent to another federal institution.

*the original medical record along with other pertinent documentation is transported by a federal correctional officer.
*a signed authorization form the inmate is not required as the record is being sent from one federal health care jurisdiction to another.

State

In virtually all state departments of correction, the policies and procedures provide for the entire original health record to be sent with the inmate when s/he is transferred to another facility within the state's system.

*the original health record is transported by a correctional officer.
*a signed authorization is not required as the record is being sent from one state health care jurisdiction to another.

City/County

The entire health record is NOT copied nor is the original record transferred with the inmate on transfer from a city or county jail to a federal or state prison.

*a summary of relevant portions of the record should be made or relevant portions of the record copied and forwarded to the prison receiving the inmate.
*the summary should include:
    *medical history
    *date of and pertinent findings from the latest physical examination
    *date of and copies of pertinent laboratory and x-ray results
    *immunization record
    *current health status
    *current level of activity
    *list of medical problems
    *current medications
    *anticipated future health care needs
*photocopies of relevant portions of the record should be sent rather than a summary
*authorization by the inmate is dependent of jurisdictional rules and regulations.

NEED FOR IMMEDIATE CARE

An inmate may be in need of immediate follow-up care upon arrival at a receiving facility.

- *long standing, chronic problems (example: hypertension, insulin dependent diabetes)
- *acute, short term problems (example: cast removal, sutures, prescription refill)

FORM: attached to the medical record saves time and guess work on the part of the receiving personnel.

- *marked: INMATE REQUIRES IMMEDIATE HEALTH CARE
- *includes:
  - *patient name
  - *date of birth
  - *date of transfer
  - *medical condition requiring immediate attention
  - *summary information on the medical condition
  - *time frame within which immediate attention must be given
  - *signature of health care provider

CONFIDENTIALITY DURING TRANSPORT

The record MUST be transported in a confidential manner. It does not matter if transfer of the health record occurs at the time of, or before, or after inmate transfer.

- *transported in a sealed envelope or container
- *addressed to the health services unit
- *transporting officer should not have access to the record
- *transporting officer may need to be aware of an existing health condition of the patient by information contained on a simple form

FAX MACHINES AND THE TRANSFER OF INFORMATION

The FAX machine is one of the most dramatic innovations in office technology and has rapidly changed our way of doing business. FAX machines have developed a regular role in the medical record department. The main concern in sending medical information by FAX machine is security. There are three security problems:

- *interception over the telephones lines and made to appear on a separate FAX machine (unlikely and much medical information is shared by telephone today with no concern that a third party might intercept)

*information may be misdirected to a wrong telephone number disclosing it inappropriately to third parties (this could occur when information is sent through the mail and verification of the phone number prior to FAXing the information will provide “due care”.)

*problems with confidentiality once it is received on the FAX machine of the recipient. (It is recommended that one telephone prior to sending the FAX to assure an authorized individual will retrieve the information.)

A cover sheet should be developed by the facility for the faxing of documents to include:

-date and time of fax transmission
-sending facility’s name and address
-sending facility’s telephone and facsimile number
-sender’s name
-receiving facility’s name and address
-receiving facility’s telephone and facsimile number
-authorized receiver’s name
-number of copies sent
-statement regarding redisclosure
-statement regarding destruction
-instructions for authorized receiver to verify receipt of information
-instructions for unintended receiver (call collect, please don’t read, destroy or return record)

POLICIES AND PROCEDURES

Written policies and procedures governing the release of records and information at the time of inmate transfer or discharge is essential.

*policies should indicate when an authorization for release of information is required
*policies and procedures should be reviewed by legal counsel prior to implementation

(DISCUSSION PRE-CLASS EXERCISES)

MEDICAL RECORD DOCUMENTATION IN CORRECTIONAL FACILITIES

TEST

CIRCLE THE APPROPRIATE WORD:

1. Records should be (SEPARATED FROM/MERGED WITH) the confinement file.

2. All medical records on one patient should be filed (SEPARATELY/TOGETHER).

3. Access to records by authorized personnel is allowed but access by other inmates is (DENIED/ENCOURAGED).

4. Documentation should be made of (MOST/EVERY) encounters by health care practitioners.

5. The medical record should be reviewed (EVERY TIME/AS NECESSARY) when a patient is seen.

MULTIPLE CHOIDE/BEST ANSWER

6. When you must correct an entry, you should

    1. Obliterate the entry and write the new entry in its place

    2. Obliterate the entry and write the new entry near by

    3. Draw a single straight line through the entry so it remains legible and write "disregard" nearby.

    4. Make a wavy line across the entire entry and write "error: in large capital letters next to it. Sign and date it.

7. SAMPLE PROGRESS NOTE: "Hgb of 10; x-ray showed osteoporosis; cellulose acetate electrophoretic analysis of serumproteins showed dysproteinemia." What part of a SOAP progress note is this?

    1. Subjective

    2. Objective

    3. Assessment

    4. Plans

8. SAMPLE PROGRESS NOTE: "The patient has possible rheumatoid arthritis." What part of a SOAP progress note is this?

    1. Subjective
    2. Objective
    3. Assessment
    4. Plans

9. The primary purpose of the medical record:

    1. communication between health care professionals
    2. education of student nurses
    3. quality review of patient follow up
    4. research on a treatment

10. An example of personal use of the medical record

    1. audit to review compliance of charting POMR
    2. quality review study for signature completion
    3. records sent to inmate's personal physician
    4. study by medical school of abstracted records

11. Not one of the four basic components of POMR

    1. data base
    2. operative report
    3. problem list
    4. initial plan

12. SAMPLE PROGRESS NOTE: "The patient complains of pain in his joints and his color is ashen." What part of a SOAP progress not is this?

    1. Subjective
    2. Objective
    3. Assessment
    4. Plans

13. Recommended file order for problem list
    1. after initial plan
    2. after history and physical
    3. first sheet in the record
    4. prior to progress notes
14. NOT a NCCHC standard for medical record storage
    1. controlled access to records
    2. locked drawer files
    3. separate from confinement records
    4. stored under secure conditions
15. Exception to maintenance of confidentiality occurs when
    1. disclosure is required by law
    2. inmate is discharged from prison
    3. inmate’s request is by next of kin
    4. transfer to another facility
16. During transfer for off-site care, the record must be
    1. carried by the inmate
    2. copied in its entirety
    3. faxed earlier to the off-site facility
    4. transported in a confidential manner
17. A description of source oriented medical records:
    1. by data base
    2. by patient care departments
    3. by problem list
    4. by treatment

18. The definition for medical records:

    1. collection of progress notes
    2. immunization records
    3. patient's past history and physical examination
    4. who, what, when, where, why, how of patient care

19. Which of the following does not belong a problem list

    1. CHF
    2. Diabetes
    3. Elevated blood pressure
    4. R/O asthma

20. Application of a flow sheet

    1. discharge note
    2. identification information
    3. rapid changes in patient's condition
    4. surgical note

21. SAMPLE PROGRESS NOTE: "Repeat fasting blood sugar. Dietician will begin patient education." What part of a SOAP note is this?

    1. Subjective
    2. Objective
    3. Assessment
    4. Plans

22. through 25. Write a problem oriented progress note on this test sheet based on the following information:

The nurse sees a patient in the infirmary who reports he has been spitting up blood and blood has been going down his throat for two days. The patient has been using ice bags on the back of the head and nose at all times prior to reporting to the infirmary.

Review of the medical record shows the patient to have thrombocytopenia noted as Problem #4 (the final problem) on the problem list. Further review shows the patient is on heparin. On examination, the nurse notes that there is bright red blood oozing continuously and notes vital signs. Blood pressure: 142/116 Pulse: 88

The nurse decides to inform the physician about the bleeding and question the next heparin dosage. She recommends the patient to continue the ice bags and gives emotional support to the patient. She also decides to continue to follow the blood pressure and pulse of the patient.

ANSWER:

PROBLEM #5 EPISTAXIS

SUBJECTIVE: "I have been spitting up blood and blood has been going down my throat for two days now".

OBJECTIVE: Patient is swallowing blood that is oozing continuously; blood is bright red in color; keeps ice bags to back of head and nose at all time. BP: 142/116 Pulse: 88

ASSESSMENT: Bleeding may be due to heparin therapy or problem No. 4 thrombocytopenia

PLANS: Keep physician informed about bleeding. Question next dose of heparin; continue to apply ice bags; continue to monitor vital signs; give the patient continued emotional support.

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PRE-CLASS EXERCISE

IN A FEW WEEKS YOU WILL BE ATTENDING A TRAINING SESSION ON MEDICAL RECORD DOCUMENTATION IN CORRECTIONAL FACILITIES. TO HELP YOU APPLY THE KNOWLEDGES AND TECHNIQUES YOU WILL GAIN FROM THE CLASS, RESEARCH THE FOLLOWING INFORMATION THAT WILL BE UNIQUE TO YOUR CORRECTIONAL FACILITY.

OVERVIEW

1. IS THE MEDICAL INFORMATION ON AN INDIVIDUAL INMATE/PATIENT KEPT IN A SINGLE FILE OR IN MULTIPLE FILES? IF THERE ARE MULTIPLE FILES, LIST THE TYPES OF INFORMATION CONTAINED IN EACH.

2. WHAT KIND OF NUMBER IS ASSIGNED THE INMATE? WHAT IS IT CALLED IN YOUR FACILITY? WHEN THE INMATE/PATIENT WHO IS DISCHARGED OR PAROLED COMMITS A CRIME AND IS RETURNED TO THE CORRECTIONAL FACILITY, WHAT HAPPENS TO THE NUMBER?

3. ARE INMATE'S HEALTH OR MEDICAL RECORDS FILED BY NAME OR NUMBER? WHAT KIND OF FILING EQUIPMENT IS USED FOR STORAGE OF THE RECORDS? DESCRIBE THE FOLDER THAT CONTAINS AN INPATIENT RECORD.

4. LOCATE THE MASTER INDEX OR THE MASTER PATIENT INDEX. HOW IS IT KEPT (COMPUTER, CARD FILE, ETC.)? WHAT INFORMATION IS CONTAINED ON EACH INMATE/PATIENT?

5. DETERMINE THE FORMAT (HOW THE VARIOUS FORMS IN THE RECORD ARE ORGANIZED) FOR MEDICAL RECORDS IN YOUR FACILITY. FIND THE PROCEDURE THAT LISTS THE REQUIRED ORDER FOR THE VARIOUS FORMS.

6. **LOCATE A SAMPLE** OF THE OUTGUIDES USED IN YOUR CORRECTIONAL FACILITY. NOTE WHAT INFORMATION MUST BE COMPLETED BEFORE A RECORD IS REMOVED FROM THE FILES.

PROBLEM ORIENTED MEDICAL RECORDS TECHNIQUES

7. OBTAIN SAMPLE COPIES OF THE VARIOUS FORMS USED IN THE DOCUMENTATION OF HEALTH CARE IN YOUR FACILITY.

CONFIDENTIALITY

8. OBTAIN A COPY OF YOUR FACILITY POLICY AND PROCEDURE CONCERNING CONFIDENTIALITY AND TRANSFER OF INFORMATION.

TRANSFER OF INFORMATION

9. OBTAIN COPIES OF FORMS USED IN TRANSFERRING MEDICAL INFORMATION ON INMATES.

LECTURE GUIDE: INTRODUCTION

INTRODUCTION

THE RECORD

"who, what, when, where, why and how of patient care"

*

*

*

*

*

HEALTH RECORD VS. MEDICAL, RECORD

Health record:

Medical Record:

PRIMARY PURPOSE

Primary Purpose:

U S E S

Personal Use:

Impersonal use:

H O W R E C O R D S A R E U S E D

PATIENT CARE MANAGEMENT:

*

*

*

QUALITY REVIEW

FINANCIAL REIMBURSEMENT

LEGAL AFFAIRS

EDUCATION

RESEARCH

PUBLIC HEALTH

PLANNING AND MARKETING

MEDICAL RECORD FORMAT

Source oriented

Advantages:

Disadvantages:

Problem Oriented Medical Records:

Advantages:

Disadvantages:

More suitable for prison health care for the following reasons:

*clear, logical format

*communication tool

*easier abstracting of data

*continuing education and research

*protecting the legal interest

MANAGING THE RECORD SYSTEM

Simple principles:

1.

2.

3.

4.

5.

6.

LECTURE GUIDE: HEALTH RECORD SYSTEM OVERVIEW

INTRODUCTION

The medical record system is essential to all the medical staff to understand a patient's history, diagnosis and mode of treatment.

The system should be designed and implemented to

*

*

UNIT RECORDS

*a single health record

*reflects health status

*separate from confinement file

INMATE NUMBERING SYSTEM

Inmates are routinely assigned an identifying number.

*in state correctional health facilities:

*in the federal system:

Number assignment/reassignment:

S Y S T E M F O R F I L I N G R E C O R D S

M A S T E R I N D E X

cross-reference:

- *important if records filed by number
- *may be computerized
- *depends on access to computer

Card file:

- *inmate's name
- *date of birth
- *identification number
- *health record number

F I L I N G

NUMERICAL FILING:

The identification number is used for filing in most health care setting.

- *fewer errors
- *growth **of files**
- *filing faster, more efficient
- *minimal training for staff

ALPHABETICAL FILING:

Filing alphabetically has many inconsistencies including

*hyphenated surnames

*prefixes

*cultures with multiple names

*religious titles

Aliases:

F I L I N G S U P P L I E S A N D E Q U I P M E N T

All forms created for an inmate should be filed in a folder.

*pressboard or manila

*inpatient/outpatient

*inner dividers to separate forms

Brackets:

*location of brackets

*loose forms not recommended

Labels:

*location depends on equipment

*across top **or** on side

Filing equipment:

*drawers vs. shelves

*shelves more efficient

*shelves take less space

*cabinets must allow space for drawers

*open shelves may be less secure

STANDARDIZED FORMAT

The format of the record must be standardized to facilitate communication between members of the health staff according to the Standards for Health Services in Correctional Institutions. Format refers to how the various forms of the medical record are organized.

Based on the needs and requirements

RECORD ORDER OF ASSEMBLY

LOCATION OF RECORDS

OUTGUIDES

An outguide or chart locator system allows all providers of care to know where the medical records are at all times.

*date
*inmate name
*identification number
*location where the record is being taken
*the person taking the record

Use :

RETENTION AND DESTRUCTION

*when an inmate is discharged, paroled, or transferred

*the inactive medical record is retained

*this can vary **from** state to state

*original form or microfilm

*central archive area

A B B R E V I A T I O N S

Health care providers use abbreviations as a common practice when documenting in the medical record.

*can become confusing

*list of acceptable abbreviation for facility

LECTURE GUIDE: PROBLEM ORIENTED MEDICAL RECORD TECHNIQUES

REVIEW OF BASICS

The Problem-oriented medical record, commonly referred to as POMR was introduced by Lawrence L. Weed, MD in the late 1960's.

*provides a systemic method of documentation to reflect logical thinking on the part of the physician or other health care provider directing the care of the patient

*the physician/provider defines and follows each clinical problem individually and organizes them for solution.

The POMR has four basic parts:

DATA BASE: a minimum set of data to be obtained on every patient

1. chief complaint
2. present illnesses
3. patient profile (the patient's typical day) and related social data
4. past history and review of systems
5. physical examinations of defined content
6. baseline laboratory data

PROBLEM LIST: a form placed in the front of the record. Problems are anything that require management or diagnostic workup

1. medical
2. social
3. economic
4. demographic problems, past or present

Problems are recorded at the level of the recorder's understanding of a particular problem. Problem lists may contain a statement of a symptom,
an abnormal finding,
a physiologic finding,
or a specific diagnosis.

*Conditions suspected ***or*** to be ruled out are not listed as problems but are noted in the initial plan.

*Additions or changes are made in the list as new problems are identified and active problems resolved.

*Problems are not erased; they are marked dropped or resolved and the date of the change recorded.

*Problems are titled and numbered and **serve** as the table of contents to the record.

INITIAL PLANS: describe what will be done to learn more about the patient's condition, treat the condition, and educate the patient about the condition.

Specific plans for each problem are delineated and fall into three categories:

1. more information for diagnosis (i.e. rule/out) and management
2. therapy (statements of drugs, procedures, goals and contingency plans)
3. patient education

Plans are numbered corresponding to the problem which they address.

PROGRESS NOTES: The follow-up for each problem.

*Each note is preceded by the number and title of the appropriate problem and may consist of any or all of the following elements:

1. subjective (symptomatic)
2. objective (measurable, observable)
3. assessment (interpretation or impression of current condition)
4. plan statements

*This becomes the acronym SOAP and writing progress notes in the POMR format is often called "soaping".

*The emphasis is on unresolved problems.

FLOW SHEETS may be used in situations in which there are several factors being monitored or when the patient's condition is changing rapidly. (These are in addition to the narrative notes to describe the patient's progress.)

DISCHARGE SUMMARY and TRANSFER NOTE are included in the progress note category. These should address all the problem numbers on a patient's list.

Dr. Weed recommended that other forms: physician's orders, consultants reports, nurses' notes, be in the problem oriented style with reference to titled and numbered problems.

TEN COMMANDMENTS OF HEALTH RECORD CONTENT

1. All entries, including dates and signatures, should be legibly written.

2. All entries should be signed with name and title. Do not sign the entry of another unless it is a countersignature.

3. All entries should be dated and timed with complete dates: month/day/year with time specified as a.m. or p.m. or in 24-hour notations (0900, 1115, 2300)

4. All entries should be made in ink (never in pencil) or typed. Black ink photocopies most legibly.

5. Do not leave blank space for another to fill in, particularly above a signature.

6. Never obliterate an entry by inking it out or by using a liquid erasure or correction fluid. To make a correction in a record, draw a single line through the error, write "ERROR" in the margin, date and sign.

7. Avoid using abbreviations unless they appear on an approved abbreviation list.

8. Document promptly, completely and accurately.

9. Avoid inconsistent and contradictory entries.

10. Refrain from including personal comments about the patient.

WHAT TO PUT IN THE CHART--AND WHAT TO LEAVE OUT

The following "Do" and Don'ts" will help make the patient's medical record a better legal document.

1. Do document patient behavior, especially non-compliant behavior.
2. Don't get personal.
3. Do use quotes.
4. Don't advertise incident reports in the chart.
5. Don't use the chart to settle disputes **or** assign blame.
6. Do make neat, legible entries.
7. Don't try to keep secrets.

CONTENT OF THE OUTPATIENT RECORD

Three Basic Parts:

1) information obtained on reception into the prison system and/or at admission to a specific correctional facility

2) information documented during confinement

3) information collected for discharge or transfer

PART 1 (ON ADMISSION TO A SYSTEM OR FACILITY)

IDENTIFYING INFORMATION
- *inmate name
- *identification number
- *date of birth
- *sex

Others
- *social security number
- *marital status
- *race
- *name and address of next of kin
- *name and address of who to notify in case of emergency

MEDICAL HISTORY: used to evaluate the health status of the inmate on arrival and prior to housing him/her within the general prison population.

- *determine if the inmate has a communicable disease
- *injuries or conditions that may require immediate medical attention.

It routinely includes:
- *personal history of past and current medical, mental and dental conditions
- *hospitalizations
- *allergies
- *current medications
- *substance abuse history

The form must be signed and dated by the health care provider who completes the initial screening and medical history forms.

MEDICAL/PHYSICAL EXAMINATION: to document the findings of the medical or physical examination.

It routinely includes:
- *height, weight
- *temperature, pulse, respiration

*blood pressure
*general appearance of inmate
*results of tests for communicable diseases
*disabilities/work limitations
*identifying marks (scars, tatoos, deformities)
*assessments (medical, social, nutritional)

The physical examination form should be designed to meet the needs of the facility. The form must be signed and dated by the health care provider who performs the examination.

The identifying information, Medical History and Physical Examination along with any laboratory tests become the Initial Data Base. The objective of the initial data base is to build a foundation from which problems can be identified.

The data to be gathered is defined in advance and it becomes possible to obtain the same data on every resident entering your prison system. Data precisely defined by printed forms and guidelines can be collected by a variety of personnel.

Initial Plans may include gathering more information, diagnostic workups, treatment, follow care and patient education. Each problem requires a separate plan except if the management is the same for several problems.

PHOTOGRAPH: While not routine, it is recommended.
*assures that the inmate who presents for treatment or medication is who s/he says s/he is.
*useful to escorting correctional officer or health care provider on transporting inmates to off-site treatment
*documents physical condition on arrival (mark on print inmate name, identification number, date)

There should be a written policy and procedures concerning photographing of inmates.

PART 2 (DURING CONFINEMENT IN THE CORRECTIONAL FACILITY)

PROBLEM LIST: a form containing numbered problems, diagnoses, or conditions affecting the patient's health status. Includes:
*past conditions that have been treated and date resolved
*chronic conditions
*new problems are added to the list as they develop
Format may vary from one facility to another, but basic components include
*problem number
*date problem or diagnosis was identified
*name of the problem or diagnosis
*date resolved

There may be acute or temporary problem sections as well as chronic problems.

It should be the top most form in the record to be accessible to all health care providers and printed on heavy paper to withstand frequent handling. The problem list serves as an index to the medical record.

Problems are identified by members of the health care team and listed at the level of his/her understanding. Recognizing a medical problem may be on one of four levels:

1. symptom or physical finding (back pain, wheezing, shortness of breath
2. abnormal laboratory findings (abnormal CBC, positive VDRL)
3. physiologic findings (congestive heart failure)
4. diagnosis (diabetes mellitus)

"Rule outs" or questionable diagnoses do not belong on the problem list. They belong in the Initial Plan or in the Plan in the "P" of the progress note.

Psychiatric and social problems of the inmate should be entered on the list in a clearly stated manner. If the mental health program of the prison is separate from the medical ***services,*** both the medical and mental health record should have the same Problem List attached to each.

When problems are further diagnosed or resolved, the problem list is amended with a dated arrow.

The problem list must be reviewed by the health care professional each time the medical record is opened.

PROGRESS NOTES/TREATMENT RECORD: a form designed to be used with the problem list providing space for recording the date, time, problem number, problem title, and the S.O.A.P. of the inmate's problem.

Continuing problems use an existing number from the problem list while new conditions are assigned a new number on the problem list before the new condition is "soaped".

Soaping includes:

Subjective: the patient's symptoms and complaints are recorded as the information is provided by the patient, custody, friends and family

Objective: information gathered by the health care provider by examining the patient, recording vital signs and documenting physical findings, laboratory and x-ray results.

Assessment: after evaluation of the subjective and objective information, a diagnosis or medical impression is recorded. This explains the significance of the subjective and objective data and what the health professional thinks about problem management. It should lead to the formulation of the plan.

Plan: recordings of treatment, patient education and instructions for recommended follow-up. In this area, information is documented as to when the patient is to return and what symptoms to be aware of that require follow-up visits. A further progress note can be made if the inmate does not return for treatment.

Medical prescriptions must be carefully documented as to name of drug, dose or strength, time schedule, route of administration and amount prescribed. If medication will be administered one dose at a time in the "pill line" or equivalent, the record must indicate.

The plan indicates the need for more information such as additional lab tests.

A problem list and "soaped" progress notes allow the tracking of problems through the documentation.

It is essential that all SOAP notes be legibly written, dated, timed and signed.

MEDICATION RECORD: Medications can be provided by one of two methods:

*medications are prescribed and a supply provided the inmate patient
*controlled or restricted medications are distributed one dose at a time.

The medication entry on the progress note/treatment record should indicate that the inmate was provided with the medication or that it is a "pill line" medication.

Pill line medication records can vary, but all contain space for recording month and year

name of medication
dosage
frequency
time to be given
name of health care provider who prescribed the medication
31 pre-numbered columns to correspond with days of the month
space initials of those who dispense medication and
space for signatures to correspond with the initials
other: space for allergies, legend as required

LABORATORY/X-RAY/DIAGNOSTIC STUDIES: Forms used for ordering tests and studies should be dated with the date ordered and then dated and signed by the person who performed the test or interpreted the x-ray and reported the results. Half size or smaller order forms can be affixed to a standard size sheet.

Studies done outside the correctional facility should be reviewed and countersigned by the correctional health staff prior to filing the reports to assure that the results have been reviewed.

FLOW SHEET: Data on a particular diagnosis, treatment or laboratory test results can be tracked on a flow sheet. It allows easier comparison of data and save time in searching a medical record to find items recorded on separate forms. Intervals of observation can be documented using a flow sheet. Flow sheets can track dental exams, chest x-rays, pre-natal care etc.

Any significant information in the flow chart should be indicated in the objective part of the Progress Notes nor any problem they effect either by copying the finding in the note or simply by "see flow chart".

Flow sheets require a legend if abbreviations are used. Entries should be dated, legible and if initials are used, a place for signatures provided.

IMMUNIZATION RECORD: This may be a separate form or combined with the initial treatment. Some facilities print the immunization form on heavier weight paper and it serves as a divider in the record.

It is easier to track a long term inmate on a separate form. Dates of immunization must be written legibly and the staff member who immunized the inmate must sign or initial the entry. If initials are used, there must be a signature to correlate with the initials on the form.

CONSULTATIONS/OFF SITE REFERRALS: a form is needed to advise off site health care providers of the reason an inmate is referred. The form should provide space at the top for the on-site health care provider to document the inmate's current symptoms, current medications, treatment, reason for referral. The bottom half of the form should allow for documentation such as the [physical findings, results of laboratory tests/x-rays if done and treatment made by the off-site consultant and recommendations for further treatment. The information is needed to provide continued care when the inmate returns to confinement.

The referral form can also be used for non-acute needs such as eye, hearing or dental examinations.

The consultation form should be completed, dated and signed by the correctional health care provider and completed and signed by the off site consultant provider as well. A copy of the form should be filed in the inmate's health record at the correctional facility.

DENTAL RECORDS: Dental records should be filed as part of the unit health record. Each entry should be legibly written, 'dated and signed. Dental records routinely include a chart of the teeth and may also include an envelope for filing all dental documentation.

EYE/HEARING EXAMINATIONS: Special forms are routinely used for eye examinations, prescriptions for eyeglasses and for hearing tests. Entries should be legible, dated and signed by the health professional examining the eyes or hearing. These forms should be filed as part of the unit record. If these examinations are done off site, pertinent information should be available to include in the inmate's health record.

SURGICAL AND PATHOLOGY REPORTS: when outpatient surgery is done, document:

- type of local anesthesia used
- description of the procedure
- required follow up

Tissue removed should be referred for pathological examination and the report should be filed in with the unit record.

All entries must be legibly written, dated and signed.

MISCELLANEOUS: additional forms may be included in the health-record (Example: mental health, restriction, special treatment, special diet)

PART 3 (DISCHARGE OR TRANSFER SUMMARY)

Several forms can be used to document an inmate's health condition on leaving confinement after serving a sentence or on transfer to another correctional facility. Basic information include:

- chronic illness or handicap
- allergies
- restrictions
- current medications
- need and reason for on-going treatment

Further information will be given when we discuss transfer of the inmate/patient.

A SUMMARY OF THE TECHNICAL PROCESS

As an offender enters a prison, a paper trail is created which attempts to record the important, and sometimes, not so important, events which occur during his incarceration. There are elements in that trail which can be identified with the four basic components of the POMR as shown:

CORRECTIONAL DATA BASE

Admission and Intake

-gathers information to assess the offender's background, education, employment history and attitudes
-may be collected by general staff under supervision of trained correctional staff
-includes a mental assessment

Placement and Work Classification

-developing additional information by extending testing and screening
-decision making process for development of correctional program for offender

Assignment to Prison Program

-developing a program for each offender
-shared written and oral presentations by staff teams for educational, vocational and work assignments
-developed by correctional professionals

MEDICAL DATA BASE

Initial Data Base

-collects standardized health information on each prisoner

-includes history, physical examination, laboratory tests, etc.

-collected by members of the health care team

Problem

-lists of prisoner's health problems
-indexes the medical record by titling, numbering, and dating identified problems
-provides perspective on past, present, and possible future problems
-developed by all health care team members
-clarifies communication among the health care team

Initial Plan

-developing a plan for resolving identified problems

-includes problem number, and course of action for the problem

CORRECTIONAL

Review and Assessment for Release

-continuous evaluation of offender's progress in program
-developing liaison with community resources to devise release program
-assessment of the capability of the offender and the community to accept his return to society

MEDICAL

Progress Notes

-details the follow-up of the problem
-always identified by the number or letter originally assigned
-includes four parts:
Subjective--data obtained from the patient, friends, custody'
Objective--clinical and laboratory findings
Assessment--appraisal based on subjective and objective data
Plan of Management--treatment, patient eduction, and if indicated, further development of information

PRACTICE EXAMPLES

I. Problem List and Initial Plan.

Using the following case history, develop a Problem List and Initial Plan from your own level of understanding. After completing all practice examples, see suggested solutions.

Case History:

A newly arrived resident is a 24-year old black male complaining of "skin problems" for 4 - 5 years and not feeling well for three weeks.

He had the usual childhood diseases with no complications, but had always been a "'different" boy. He was hospitalized for six months when he was 18 for a "nervous breakdown". There have been no emotional problems since then, but he has often felt people "bugged" him and he preferred his own company. Three weeks ago he spent 5 days in bed because of an attack of weakness, muscle pains, fever, and discomfort in the upper abdomen. He had no appetite and ate practically nothing during that period. At present he does not feel entirely well, but his appetite is better.

He is one of five siblings. His father disappeared-when he was three and his mother works sporadically as a domestic. He speaks of her only as a large woman with white hair. Two brothers are in prison, one sister is in a mental hospital, and one sister is reported as well and happily married.

On physical examination he appeared withdrawn and smiled briefly several times for no apparent reason. There was no evidence of recent weight loss. Temperature was 98.8, pulse was 74, regular, BP 165/94, respirations 12. He is 170 inches tall and weighs 155 pounds. Sclerae were slightly yellow. Many teeth had cavities and the gums were spongy and friable. Tonsils were enlarged but did not appear infected. Skin examination revealed irregular, rounded areas, elevated, red and covered with white scales which easily flaked. These areas were on extensor surfaces of forearms and across the upper abdomen. Examination of the abdomen revealed a tender liver edge extending 1 1/2 finger breadths below the costal margin. The rest of the physical exam revealed no abnormalities.

Mental Status Assessment: Resident was moderately withdrawn, oriented as to person, time, and place. Smiled inappropriately several times and did not speak spontaneously.

Positive Lab Findings: Serum bilirubin 6 mg/dl
SGPT 70 units

2. **S.O.A.P. and the Problem List**

Using the following case histories, construct a Problem List for each case. Since both of these patients were originally seen on sick call, you must S.O.A.P. the encounters, identify problems, and list them. (Remember, there is more than one encounter in each case.)

Case A:

June 1, 1977. A 25-year old white male appearing well nourished and in generally good health complains of a sudden onset of severe frontal headache of four hours duration. The headache is described as "bursting" and "intolerable." There is no history of previous headaches. At the onset of the headache, his side vision became impaired. It was as though "horse-blinders" had been put on him.

Positive finding on physical examination: loss of bi-temporal vision on confrontation by moving fingers.

Initial Impression:

1. Ruptured cerebral aneurysm, near optic chiasm. Plan: Emergency consult with neurosurgeon. Spinal tap.

Progress Notes: 6/2/78

Spinal tap yielded moderately bloody fluid at 250 mm H_20 pressure.

Spinal tap repeated four hours later by a neurosurgeon showed grossly bloody fluid. A cerebral angiogram revealed several "berry aneurysms" with evidence of leakage in area of optic chiasm. Initial diagnostic impression was confirmed.

Emergency craniotomy discovered a ruptured aneurysm of the anterior communicating cerebral artery. This vessel was tied off, and the operative wound closed. Patient recovered uneventfully.

Case B:

June 1, 1977. A 40-year old male complains of chills, fever, muscle aches, general weakness, and shortness of breath for four days duration. Significant findings on physical examination: ill-appearing male, profusely perspiring, with no evidence of recent weight loss. Temperature 102.8, pulse 124, regular. There is a blowing grade IV diastolic murmur which extends throughout diastole. There are slightly increase crepitations throughout lung fields and splinter hemorrhages in several fingernail beds. Several recent needle marks are seen in the skin in the antecubital fossa.

Initial Impression:

1. Bacteremia, caused by self-administered intravenous introduction of an unknown substance.
2. Mycotic involvement of pulmonary valves
3. Bacterial pneumonitis, diffuse.

Plan:

1. Blood culture with sensitivities to antibiotics.
2. Chest film.
3. ECG.

Initial Lab Reports:

1. Blood culture: many colonies of short chain gram positive cocci, sensitive to Ampicillen.
2. Chest film: fullness of right cardiac border, diffuse areas of infiltration of lung fields.
3. ECG: right heart strain.

Diagnosis:

1. Bacteremia, caused by contamination, self-administered injection of unknown substance.
2. Mycotic involvement of pulmonary valves.
3. Pneumonitis, patchy, bacterial.
4. Mild/moderate rightsided congestive failure.

Treatment:

1. Admit to infirmary, close observation (possible rupture of a pulmonary valve).

2. Ampicillen, 500 mg, q.i.d.

3. Thiazide diuretics.

Excerpts of Progress Notes:

July 1, 1977. Shortness of breath on exertion. Bacteremia and pneumonitis definitely cleared. Heart murmur unchanged. Cardiac silhouette by x-ray shows prominence of right heart border. Hilar congestion.

Venous pressure 80 mm H_2O.

ECG shows definite right ventricular hypertrophy.

Treatment: Digitalize. Change thiazide to mercurial diuretics. Low salt diet.

January 2, 1978. Shortness of breath climbing flight of stairs. Evaluation by cardiac function study group at University of Washington Medical Center yields recommendation for open heart surgery and transplant of porcine heterograph.

March 1, 1978. Open heart surgery as recommended by Cardiac Study Group.

May 25, 1978. Clinically well. ECG continues to show evidence of right ventricular hypertrophy.

Plan: See prison physician once a month. No medication. No restrictive activities. Check back in six months.

LECTURE GUIDE: CONFIDENTIALITY OF MEDICAL RECORDS

INTRODUCTION

The maintenance of patient confidentiality has both an ethical and legal basis. Information provided by an inmate to health care professionals or information obtained by examination or test results must be regarded as confidential and the inmate must be assured that the information is confidential.

The courts acknowledge that there are some exceptions to confidentiality

*required by law

*necessary to protect welfare

NCCHC Standards require that medical records be stored in 'the prison

*under secure conditions

*separate from confinement records

*controlled access

Patients should be protected from disclosure of certain confidences entrusted to a practitioner during a course of treatment. The confidential relationship that exists between doctor and patient extends to inmate-patient and their clinicians.

CONFIDENTIAL VERSUS NON-CONFIDENTIAL, HEALTH INFORMATION

CONFIDENTIAL:

NON-CONFIDENTIAL:

OWNERSHIP

Physical property of the facility

Medical records should not be removed from a facility except in accordance with institutional or jurisdictional policies.

Confidential information belongs to the patient.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

The inmate/patient shall authorize in writing the release of medical records and information for the transfer outside the correctional system unless otherwise provided by law or administrative regulation.

- *authorization for release of information when information is being requested by an off site person **or** agency
- *general authorizations are discouraged

EXCEPTIONS FOR AUTHORIZATIONS

- *required by law or to protect welfare of individual or community
- *court orders, subpoenas, statutes

When a patient is referred to another health care facility or health care provider for continued health care. . .

- *understood that confidentiality will be maintained
- *continuity of patient care and treatment
- *original records <u>should not</u> be removed

Specific release of information is not required for research, education and quality assurance activities when patient is not identified.

PATIENT ACCESS TO HEALTH RECORDS

Procedures vary from state to state on how and when a patient can see or obtain copies of the health record.

ACCESS TO THE HEALTH RECORD BY CORRECTIONAL PERSONNEL

William Paul Isele, J.D., author of Health Care In Jails:... writes that it should make no difference that the patient is confined. The principles of open and honest communication with one's physician apply equally to all patients and it is conceivable that the physician may have to protect his patient's confidentiality from disclosure to confinement personnel if they have no legitimate reason to see the patient's records.

Exceptions to the above include

*communicable disease

*condition could endanger the welfare of inmate

*statutory directive to report

INMATE AS EMPLOYEE

Only carefully selected inmates shall be utilized to work in the hospital and then only in assignments of minimal responsibility subject to close supervision.

*preclude inmate from gaining access to information

*protect inmate from being subjected to threat

Inmates may not be assigned where they will have access to medical records, including copies of medical records and documents which will becomes part of the medical record.

NCCHC standards state the use of inmates in health care delivery

*frequently violates state laws

*invites litigation

*brings discredit to the correctional health care field

*gives the inmates unwarranted power over their peers

Inmates should not be employed in areas where they may have access to confidential health information.

P O L I C I E S A N D P R O C E D U R E S

CONFIDENTIALITY OF PATIENT HEALTH INFORMATION: A POSITION STATEMENT OF THE AMERICAN MEDICAL RECORD ASSOCIATION, published 1985.

MODEL POLICY OF THE AMERICAN MEDICAL RECORD ASSOCIATION

*A11 requests for health records of health information including requests for information on patients currently under treatment shall be directed to the health record department.

*Release of information from the health record shall be carried out in accordance with all applicable legal, accrediting, and regulatory agency requirements, and in accordance with written institutional policy.

* All information contained in the health record is confidential and the release of information will be closely controlled. A properly completed and signed authorization is required for release of all health information except:

-as required by law'
-release to another health care provider currently involved in the care of the patient'
-medical care evaluation; or
-research and education in accordance with conditions specified below

*In keeping with the tenet of informed consent, a properly completed and signed authorization to release patient information shall include at least the following data:

-name of institution that is to release the information;
-name of individual or institution that is to receive the information
-patient's full name, address and date of birth;
-purpose or need for information;
-extent or nature of information to be release, with inclusive dates of treatment
(NOTE: An authorization specifying "any and all information...." shall not be honored);
-specific date, event or condition upon which the authorization will expire unless revoked earlier;
-statement that authorization can be revoked but not retroactive to the release of information made in good faith;
-date that consent is signed;
(NOTE: Date of signature must be later than the date of information to be released)
-signature of patient or legal representative
(NOTE: in the case of treatment given a minor without parental knowledge, the institution shall refrain from releasing the portion of the record relevant to this

episode of care when responding to a request for information for which the signed authorizations i that of the parent or guardian. an authorization by the minor shall be required in this instance.)

*Information released to authorized individuals/agencies shall be strictly limited to that information required to fulfill the purpose stated on the authorization. Authorizations specifying "any and all information..." or other such broadly inclusive statements shall not be honored. Release of information that is not essential to the stated purpose of the request is specifically prohibited.

*Following authorized release of patient information, the signed authorization will be retained in the health record with notation of the specific information released, the date of the release and the signature of the individual who released the information.

*Health records shall be available for use within the facility for direct patient care by all authorized personnel as specified by the chief executive officer and documented in a policy manual.

*Direct access to health records for routine administrative functions, including billing, shall not be permitted except where the employees are instructed in policies on confidentiality and subject to penalties arising from violations.

*Health records shall be available, in the health record department, to authorized students enrolled in educational programs affiliated with the institution. Students must present proper identification and written permission of the instructor with their request. Data compiled in educational studies may not include patient identity or other information which could identify the patient.

*Health records shall be made available for research to individuals who have obtained approval for their research projects from an institutional review board, or other appropriate medical staff committee, administrator, or other designated authority. Research projects which involve use of health records shall be conducted in accordance with institutional policies on the use of health records for research. Any research project which involves contact of the patient by the researcher must have written permission of the patient’s attending physician, and/or by the chief executive officer of the facility or his designee, prior to contact. An institutional policy on use of medical records in research should guide these activities.

*If facsimiles of health records are provided to authorized internal users, the same controls will be-applied for return of these facsimiles as for the return of the original health record. Wherever possible, internal users wi11 be encouraged to use the original health record rather than to obtain a facsimile.

*The names, addresses, dates of admission or discharge of patients shall not be released to the new media or commercial organizations without the express written consent of the patient or his authorized agent.

*Requests for health information received via telephone will require proper identification and verification to assure that the requesting party is entitled to receive such information. A record a the request and information released will be kept.

LECTURE GUIDE: TRANSFER OF' THE INMATE/PATIENT

TRANSFER FOR ACUTE HOSPITAL CARE

NCCHC STANDARDS: "require that summaries or copies of the health record be routinely sent to the receiving agency either before or at the same time as the inmate".

"Written authorization by the inmate is required for the transfer outside the correctional system of medical records and information, unless othervise provided by law or administrative regulation."

WHAT TO SEND: Portions of the medical record that relate to the needed off site treatment should be copied and transferred with the inmate patient.

*history

*physical

*lab and x-ray

*current medications

*consultation reports

METHODS: copies should be:

*sealed envelope

*addressed to facility

*accompanying officer not to have access

*inmate's authorization may or may not be required

IN RETURN: The off-site hospital where the inmate patient receives medical or surgical care must be held responsible for providing information concerning its health care services.

*information forwarded to correctional facility

*relevant copies of hospital record

*if copies not provided, correctional health officer contacts medical record department off-site

TRANSFER FOR OTHER OFF--SITE CARE

INTRO: Other examinations such as hearing tests, eye examinations, dental care, physical therapy, etc. may not be provided on site at the correctional facility or the correctional health care providers will need consultation with an off-site medical specialist.

WHAT TO SEND: when inmates are transported off site
*relevant portions of health record

*sealed envelope

*addressed to off-site provider

*accompanying officer not to have access

*inmate's authorization may or may not be required

CONSULTATION FORM: The use of a consultation form for off-site care is recommended.

*form assures documentation available on return of inmate

*top of form can outline current problem

*bottom can be used by consultant for documentation

TRANSFER TO ANOTHER CORRECTIONAL FACILITY

Federal

Within the federal prison system, the entire original medical record is transferred with the inmate when s/he is sent to another federal institution.

*original record is transported by a federal correctional officer

*signed authorization is not required

State

In virtually all state departments of correction, the policies and procedures provide for the entire original health record to be sent with the inmate when s/he is transferred to another facility within the state's system.

*original record is transported by a correctional officer
*signed authorization is not required

City/County

The entire health record is NOT copied nor-is the original record transferred with the inmate on transfer from a city or county jail to a federal or state prison.

*summary of relevant portions

*the summary should include:

*medical history

*latest physical exam findings

*pertinent laboratory and x-ray results

*immunization record

*current health status

*current level of activity

*list of medical problems

*current medications

*anticipated future health care needs

*photocopies

*authorization

N E E D F O R I M M E D I A T E C A R E

An inmate may be in need of immediate follow-up care upon arrival at a receiving facility.

*long standing, chronic problems

*acute, short term problems

FORM: INMATE REQUIRES IMMEDIATE HEALTH CARE
*includes:

*patient name

***date of birth**

***date of transfer**

*medical condition requiring immediate attention

*summary information

*time frame

*signature of health care provider

C O N F I D E N T I A L I T Y D U R I N G T R A N S P O R T

The record MUST be transported in a confidential manner. It does not matter if transfer of the health record occurs at the time of, or before, or after inmate transfer.

*sealed envelope

*addressed to health services unit

*transporting officer should not have access

*transporting officer may need t be aware of existing health condition by information on a simple form

FAX MACHINES AND THE TRANSFER OF' INFORMATION

Security Problems:

*interception over phone lines

*information may be misdirected to a wrong telephone number

*confidentiality after FAX is received

Cover Sheet provides protection of information.

POLICIES AND PROCEDURES

Written policies and procedures governing the release of records and information at the time of inmate transfer or discharge is essential.

*authorization for release of information

*reviewed by legal counsel

MEDICAL RECORD DOCUMENTATION IN CORRECTIONAL FACILITIES

TEST *NAME*_____

CIRCLE THE APPROPRIATE WORD:

1. Records should be (SEPARATED FROM/MERGED WITH) the confinement file.

2. All medical records on one patient should be filed (SEPARATELY/TOGETHER).

3. Access to records by authorized personnel is allowed but access by other inmates is (DENIED/ENCOURAGED).

4. Documentation should be made of (MOST/EVERY) encounters by health care practitioners.

5. The medical record should be reviewed (EVERY TIME/AS NECESSARY) when a patient is seen.

MULTIPLE CHOICE/BEST ANSWER

6. When you must **correct** an entry, you should

    1. Obliterate the entry and write the new entry in its place

    2. Obliterate the entry and write the new entry near by

    3. Draw a single straight line through the entry so it remains legible and write "disregard" nearby.

    4. Hake a wavy line across the entire entry and write "error: in large capital letters next to it. Sign and date it.

7. SAMPLE PROGRESS NOTE: "Hgb of 10; x-ray shoved osteoporosis; cellulose acetate electrophoretic analysis of serumproteins shoved dysproteinemia." What part of a SOAP progress note is this?

    1. Subjective

    2. Objective

    3. Assessment

    4. Plans

8. SAMPLE PROGRESS NOTE: "The patient has possible rheumatoid arthritis." What part of a SOAP progress note is this?

    1. Subjective
    2. Objective
    3. Assessment
    4. Plans

9. The primary purpose of the medical record:

    1. communication between health care professionals
    2. education of student nurses
    3. quality review of patient follow up
    4. research on a treatment

10. An example of personal use of the medical record

    1. audit to review compliance of charting POMR
    2. quality review study for signature completion
    3. records sent to innate's personal physician
    4. study by medical school of abstracted records

11. Not one of the four basic components of POMR

    1. data base
    2. operative report
    3. problem list
    4. initial plan

12. SAMPLE PROGRESS NOTE: "The patient complains of pain in his joints and his color is ashen." What part of a SOAP progress not is this?

    1. Subjective
    2. Objective
    3. Assessment
    4. Plans

13. Recommended file order for problem list
    1. after initial plan
    2. after history and physical
    3. first sheet in the record
    4. prior to progress notes
14. Not a NCCHC standard for medical record storage
    1. controlled access to records
    2. locked drawer files
    3. separate from confinement records
    4. stored under secure conditions
15. Exception to maintenance of confidentiality occurs when
    1. disclosure is required by law
    2. inmate is discharged from prison
    3. inmate's request is by next of kin
    4. transfer to another facility
16. During transfer for off-site care, the record must be
    1. carried by the inmate
    2. copied in its entirety
    3. faxed earlier to the off-site facility
    4. transported in a confidential manner
17. A description of source oriented medical records:
    1. by data base
    2. by patient care departments
    3. by problem list
    4. by treatment

18. The definition for medical records:

    1. collection of progress notes
    2. immunization records
    3. patient's past history and physical examination
    4. who, what, when, where, why, how of patient care

19. Which of the following does not belong a problem list

    1. CHF
    2. Diabetes
    3. Elevated blood pressure
    4. R/O asthma

20. Application of a flow sheet

    1. discharge note
    2. identification information
    3. rapid changes in patient's condition
    4. surgical note

21. SAMPLE PROGRESS NOTE: "Repeat fasting blood sugar. Dietician will begin patient education." What part of a SOAP note is this?

    1. Subjective
    2. Objective
    3. Assessment
    4. Plans

22. through 25. Write a problem oriented progress note on this test sheet based on the following information:

The nurse sees a patient in the infirmary who reports he has been spitting up blood and blood has been going down his throat for two days. The patient has been using ice bags on the back of the head and nose at all times prior to reporting to the infirmary.

Review of the medical record shows the patient to have thrombocytopenia noted-as Problem #4 (the final problem) on the problem list. Further review shows the patient is on heparin. On examination, the nurse notes that there is bright red blood oozing continuously and notes vital signs. Blood pressure: 142/116
Pulse: 88

The nurse decides to inform the physician about the bleeding and question the next heparin dosage. She recommends the patient to continue the ice bags and gives emotional support to the patient. She also decides to continue to follow the blood pressure and pulse of the patient.