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Healthcare Record System	ACA Standards: 2-CO-1E-04, 2-CO-4E-01, 4-4281-8, 4-4382M, 4-4396M, 4-4413, 4-4414, 4-4415, 4-4446, 4-ACRS-4C-22, 4-ACRS-4C-23, 4-ACRS-4C-24		
Robert Patton, Director Oklahoma Department of Corrections	Signature on File		

Healthcare Record System

For the purpose of this procedure, the term “offender” will apply to anyone under the authority, custody or care of a prison or a community-based facility operated by or contracted with the Oklahoma Department of Corrections (DOC).

I. Healthcare Records (2-CO-4E-01)

A. Purpose and Overview

An individual healthcare record is initiated at reception and maintained on each offender throughout the period of incarceration.

1. This record will provide an accurate chronological account of all health care services provided and will include all in-patient and out-patient health care documents generated during incarceration. (4-4413, 4-ACRS-4C-22)
2. The healthcare record may include records maintained in an electronic healthcare record system (EHR) and/or WebExtender.

B. Physical Security

1. The healthcare record will be kept separately from the field record; (4-4396M, b# 1, 4-ACRS-4C-22);

2. Each EHR and WebExtender maintained will be kept in a secure environment and protected by appropriate electronic safeguards. Protected Health Information (PHI) stored electronically is to be password protected. Passwords are individual specific and are not to be shared by or accessible to more than one individual.
3. Electronic transmission device; including computers, fax machines, and other electronic equipment over which PHI may be received or transmitted, are to be maintained in secure sites and/or away from public access.
4. Computer screens containing PHI are to be inaccessible to public view. Computers that store PHI are to be secured before being left unattended.
5. PHI will be kept strictly confidential in accordance with OP-140108 entitled "Privacy of Protected Health Information." (4-4396, b# 2, 4-ACRS-4C-22)
6. Physical access to the EHR and user accounts that provide access to PHI are to be revoked upon the termination of an employee, student, or trainee or when others, such as contractors and vendors, no longer require access.

C. Healthcare Record Components/Content

The medical record content will meet all state and federal legal/regulatory and accreditation requirements. The medical record will include, at a minimum, the following:

1. Photo of offender;
2. Name of offender;
3. ODOC number;
4. Age;
5. Gender;
6. Race;
7. Institution;
8. Incarceration date;
9. Parole date;
10. Release date;

11. Alerts;
12. Problem List ([DOC 140106A](#));
13. Procedures;
14. Allergy record;
15. Medications;
16. Medication Administration Record ([DOC 140106C](#));
17. Medical Provider Orders ([DOC 140106E](#));
18. Clinical notes (providers, nursing, dental, mental health, optometry);
19. Immunization record;
20. Advance directives (if applicable);
21. Medical/mental health/dental history;
22. Screening test;
23. Optometric;
24. Surgical and past medical history;
25. Family history;
26. Consultation reports;
27. Laboratory;
28. Radiology reports;
29. Treatments;
30. Diet order;
31. Food Service Work Permission Slips ([DOC 140106E](#));
32. Vital signs;
33. Consent forms;
34. Authorization release of PHI;
35. Waivers;

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36. Infirmery record;
37. OB/GYN;
38. Inpatient/outpatient documentation; and
39. Request for health services

D. Documentation

1. All offender/clinical staff encounters will be documented/scanned in the EHR. A SOAP (Subjective, Objective, Assessment, Plan) note, "Progress Note" ([DOC 140106B](#)), or other appropriate note or medical/dental/mental health form will be used for documentation.
2. All documentation that requires an offenders signature will be completed and scanned into the offenders EHR.
3. Health record documentation will include, but not be limited to: information to describe the condition of the offender, justify diagnosis and treatment, document results of care or treatment, and describe specific orders for treatment, medications and recommendations.
4. Entries must be accurate, relevant, timely and complete.
5. Appropriate note titles must be matched to note content and the credentials of the author.
6. Notes must be reviewed and signed by the next working day.
7. EHR users must acknowledge notifications which require signatures.
8. An addendum to a note is made when deemed necessary to clarify information recorded in the original document or to add to the original document.
9. All applicable fields are to be completed. On fields that are not applicable to the offender, the field will have an entry of "N/A" (not applicable).
10. Handwritten documentation will be made in black ink. This is to ensure the quality of electronic scanning, photocopying and faxing of documents. All entries in the medical record must be legible to individuals other than the author.
11. All medical records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with Section I. item E. of this procedure.

E. Corrections, Amendments and Deletion of Records

When an error is made in the EHR, the original entry is not deleted, but will remain accessible. Reasons for the correction of an entry must be documented, signed and dated by the person making the revision. Erroneous entries documented will be corrected according to the following format:

1. Documents created in paper format are to be corrected in the following manner:
 - a. Draw a single line through the incorrect entry;
 - b. Date and authenticate the incorrect entry;
 - c. State the reason for the error;
 - d. Insert the correct information; and
 - e. If the document was originally created in a paper format and then scanned electronically, the electronic version must be corrected by printing the document, correcting as above steps 1 - 4, and then rescanning the document.
2. Documents that are created electronically must be corrected, amended or marked as deleted by one of the following formats:
 - a. Adding an addendum to the electronic document indicating the correct information, the identity of the person who created the addendum, the date created and the electronic signature of the person creating the addendum.
 - b. Editing/correcting the error by the author prior to signing the note.
 - c. Selecting "Mark as Deleted;" as well as stating the reason for the deletion, the identity of the person who marked note as deleted, the date created and the electronic signature of the person.
 - d. If the employee is no longer employed, the correctional health services administrator (CHSA) must submit a request in writing or via electronic mail to the chief medical officer (CMO)/designee to delete the erroneous record.
3. The following information must be included for the requested error to be processed and completed by the CMO/designee:
 - a. Offender name and ODOC number;

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- b. Name of assessment/form/treatment plan/progress note;
 - c. Date of assessment/form/treatment plan/progress note;
 - d. The time the form was signed by the clinician who completed it; and
 - e. The reason for the request.
4. When a pertinent entry is missed or not written in a timely manner, the late entry will be entered in the following format;
- a. Identify the new entry as a “late entry;”
 - b. Late entry note will reflect the current date and time; and
 - c. Identify or refer to the date and circumstance for which the late entry is written.
5. Offenders may request a medical record amendment and/or medical record addendum in accordance with [OP-140107](#) entitled “Medical Services Management System.”

F. Downtime Documentation

1. In the event that the EHR is not operational, a paper format system will be used. Healthcare record forms for services normally documented in the EHR will be available at each facility for staff use.
- a. The start and stop times of the downtime should be documented in the health record to ensure accuracy of the legal record.
 - b. Upon notification that the EHR system is again operational, the information documented on paper will be entered manually or scanned into the EHR.
2. Critical data to be manually entered into the EHR post-downtime include the following:
- a. Medication orders;
 - b. Text orders; and
 - c. Vital signs.

G. Grievances/Request to Staff

Grievances and “Request to Staff” are not included in the EHR. Such forms will be maintained in accordance with [OP-090124](#) entitled “Offender

Grievance Process.”

H. Healthcare Record Transfers (2-CO-1E-04, 4-ACRS-4C-24)

1. A sealed Medical Transfer Summary ([DOC 140113A](#)), and dental x-rays will accompany the offender when transferred to another ODOC facility or private prison. (4-4414, b# 2)
2. The healthcare record will be transported in a manner to maintain confidentiality. (4-4414, b# 1)
3. Upon arrival to a receiving facility, the offender's EHR will be transferred electronically to that facility's clinic by that facility's medical staff.
4. Offenders released to specialized supervision programs will have their medical record(s) transferred to the closed record unit.

I. Escape Status

1. Offenders who have escaped and those reinstated from escape will have documentation addressing their escape status entered in the EHR by a qualified healthcare professional (QHCP) when such information has been conveyed to them. The date and time of the escape or return and any other pertinent information will be noted.
2. The healthcare record (hardcopy) will be stored and maintained by the health services unit responsible for the offender's health care during the interim escape period.
3. Central classification requests to transfer an escaped offender's medical record to a location other than its assigned location will require documentation concerning the request to be entered in the EHR prior to record transfer.

J. Discharge Note (4-4446, b# 7)

1. A "Discharge Health Summary" ([DOC 140106D](#)) will be completed by a QHCP prior to an offender's parole or discharge from ODOC. A copy of the "Discharge Health Summary" and the offender's immunization record will be offered to the offender upon discharge.
2. Any offender who is discharged by death will have pertinent information documented in the EHR in accordance with [OP-140111](#) entitled "Offender Deaths, Injury and Illness Notification and Procedures."

K. Closed Record Storage and Maintenance (4-4415)

Inactive healthcare records will be retained in compliance with the legal requirements for the jurisdiction.

1. Closing of Healthcare Records

- a. An offender discharged by death will have their healthcare record closed in accordance with [OP-140111](#) entitled "Offender Death, Injury and Illness Notification and Procedures."
- b. Dental films and x-ray films will be forwarded to the Closed Records Unit through the use of a sealed envelope or box within ten working days when an offender is paroled or released from custody.
- c. The offender's EHR will be transferred to "Inactive" status through the Offender Management System (OMS).

2. Disposition of Closed Records

The healthcare record will be retained in accordance with [OP-020202](#) entitled "Management of Office Records" and the Agency Record Disposition Schedule, 89-04: 7-25: as approved by the Oklahoma Department of Libraries Archives and Records Commission. (4-4281-8)

II. Healthcare Forms (electronic and hardcopy)

Forms available electronically or hardcopy are in accordance with MSRM 140106-01 entitled "Healthcare Records – Table of Content."

III. References

Policy Statement No. P-140100 entitled "Offender Medical, Mental Health and Dental Care"

OP-020202 entitled "Management of Office Records"

OP-090124 entitled "Offender Grievance Process"

OP-140107 entitled "Medical Services Management System"

OP-140111 entitled "Offender Death, Injury and Illness Notification and Procedures"

"Agency Disposition Schedule" 89-04: 7-25, as approved by Archives and Records Commission

IV. Action

The chief medical officer is responsible for compliance with this procedure.

The division manager of Health Services is responsible for the annual review and revisions.

Any exceptions to this procedure will require prior written approval from the director.

This procedure is effective as indicated.

Replaced: Operations Memorandum No.OP-140106 entitled "Healthcare Record System" dated July 8, 2014

Distribution: Policy and Operations Manual
Agency Website

<u>Referenced Forms</u>	<u>Title</u>	<u>Location</u>
DOC 140106A	"Problem List"	Attached
DOC 140106B	"Progress Note"	Attached
DOC 140106C	"Medication Administration Record"	Attached
DOC 140106D	"Discharge Health Summary"	Attached
DOC 140106E	"Food Service Work Permission Slip"	Attached
DOC 140106F	"Medical Provider Order Sheet"	Attached
DOC 140113A	"Medical Transfer Summary"	OP-140113