DIVISION OF ADULT INSTITUTIONS **POLICY AND PROCEDURES**	**DAI Policy #:** 500.50.02	**Page** 1 of 7
	Original Effective Date: 04/01/81	**New Effective Date:** 01/11/21
	Supersedes: 500.50.02	**Dated:** 01/05/15
	Administrator's Approval: Makda Fessahaye, Administrator	
	Required Posting or Restricted: [X] **Inmate** [X] **All Staff** [ ] **Restricted**	
Chapter: 500 Health Services		
Subject: Health Care Record Format, Content and Documentation		

POLICY

All Division of Adult Institution facilities shall ensure the Health Care Record is created and maintained as the designated legal record that documents health care provided to patients residing in correctional facilities and serves as communication tool for health care providers. The Director of the Department of Corrections Bureau of Health Services, Responsible Health Authority, shall approve the format, content and method of recording entries in the Health Care Record.

REFERENCES

Standards for Health Services in Prisons, National Commission on Correctional Health Care, 2018, P-H-01 Health Records
DAI Policy 500.30.11 – Daily Handling of Non-Emergency Requests for Health Care
DAI Policy 500.40.03 – Dental Record Keeping – Standard Format
DAI Policy 500.70.11 – Psychological Services Unit Record
Medical Acronyms, Eponyms & Abbreviations

DEFINITIONS, ACRONYMS AND FORMS

ACP- Advanced Care Provider – A provider with prescriptive authority

CCA – Corrections Corporation of America

CMR/IWMR – Central Medical Records/Inactive Women's Medical Records

DAI – Division of Adult Institutions

DJC – Division of Juvenile Corrections

DOB – Date of birth

DOC – Department of Corrections

DOC-0206 – Form Action Request

DPH – Division of Public Health

DSU – Dental Services Unit

ED – Emergency Department

EEG – Electroencephalogram

EKG – Electrocardiogram

EMR – Electronic Medical Record

Health Administrator – Individual who by virtue of education, experience, or certification is capable of assuming responsibility for arranging all levels of health care and ensuring quality and accessible health services for inmates.

Health Care Record (HCR) – Official confidential DOC record created and maintained for each patient consisting of all or some of the following components: Medical Chart, Dental Services Record, Psychological Records-Copies envelope, Medications Record envelope, Patient Request Folder, Psychological Services Unit Record, and other components as defined by the Bureau of Health Services.

HIM - Health Information Management

HIM Job Aid – A list of job aids to assist in EMR functionality

HIPAA – Health Insurance Portability and Accountability Act

HSU – Health Services Unit

MRI – Magnetic resonance imaging

PET – Positron emission tomography

PSU – Psychological Services Unit

Responsible Health Authority (RHA) – Individual responsible for a facility's health care services, arranging for all levels of health care, and assuring quality, accessible and timely health services who may be a physician, health administrator or agency.

WICS – Wisconsin Integrated Corrections System

PROCEDURES

I. Overview of Confidential DOC HCR

A. The method of recording entries in the healthcare record and the contents and format are approved by the responsible health authority (RHA) or designee.

B. Where mental health or dental records are separate from the medical record:
   1. A process ensures that pertinent information is shared.
   2. At a minimum, a listing of current problems, allergies and medications is common to all medical, dental, and mental health records of patients.

C. All patients sentenced to a DAI facility or committed to a DJC facility shall have a standard DOC HCR established in accordance with this policy and other policies referenced in this policy.

D. Documentation that healthcare staff received instruction in maintaining confidentiality.

II. Components of the Confidential DOC HCR

A. HCR shall contents include, at a minimum, the following elements when applicable:

1. Identifying information (e.g., patient name, identification number, date of birth, sex).
2. A problem list containing medical, dental and mental health diagnoses and treatments as well as known allergies.
3. Patient Care Plans: Includes standard care plans for specific medical special needs conditions such as diabetes and asthma.
4. Data Base: Documents are filed scanned in a specific order by type of document and by date within each type; includes screening forms and immunization records.
5. Receiving screening and health assessment forms.
6. Progress notes or flow sheets of all significant findings, diagnoses, treatments and dispositions.
7. Prescriber orders for prescribed medications, list of current medications and medication administration records.
8. Consultations: Includes the DOC-3001 – Off-Site Service Request and Report, results of specialty consultations and off-site referrals, documents from hospital EDs and inpatient hospitalizations, letters/reports written by off-site consulting practitioners, and Physical and Occupational therapy forms. Sets of documents from sent to the DOC by an ED or hospital ED and for an inpatient stay shall all be scanned together.
9. Psychiatric Services: Primarily consists of original reports by psychiatrists and Psychiatric Progress Notes.
10. Laboratory Results: Includes results of tests of blood, urine, stool or tissue. Results contained in a set of documents received from a hospital for an ED visit or inpatient stay shall be scanned in Consultations Section.
11. Medical Imaging: Includes reports relating to tests/procedures that show body parts or bodily functions such as x-rays, ultrasounds, MRIs, PET scans, nuclear scans, barium studies and EEGs/EKGs. Results contained in a set of documents received from a hospital for an ED visit or inpatient stay shall be scanned in Consultations Section.
12. Flow Sheets: Includes forms or documentation that track provision of certain medical procedures and ongoing assessments of medical conditions.
13. Medication Administration Record(MAR):
    a. Record of electronic delivery of medication.

b. External MARs shall be scanned into HCR.

14. Reports of laboratory and other diagnostic studies.
15. Consent/refusals: Includes forms that require a signature indicating consent, approval, or acceptance or refusal, disapproval, or non-acceptance of treatment, a procedure or rules and authorizations for disclosure of health information.
16. Correspondence: Includes written communications between patients and DOC providers, between providers, and between non-health staff and health services staff.
17. Release of information forms.
18. Discharge summaries of hospitalization and other inpatient stays.
19. Special needs treatment plan.
20. Immunization records.
21. Optical: Records documenting delivery of optometric services.
22. Patient Request Folder. Includes: HSRs, Medical Supply/Medication Refill Requests, but may include Interview/Information Requests and some Psychological Services Requests triaged by HSU. Does not include written communications from health staff to patients.
23. Place, date and time of each clinical encounter.
24. Name and title of each documenter.

III. Scanning in the HCR

A. All healthcare staff shall use great care when scanning all documents to ensure scanning in the correct patient's HCR.
   1. Compare name on the document being filed scanned to the name in the HCR.
   2. Scanning to the incorrect patient's medical HCR may result in a failure to deliver health care to the appropriate patient and may constitute a reportable breach under HIPAA federal regulations.

B. Scan all documents created by the DOC and received by the DOC as soon as possible, but in no more than one week of date of creation of the document or receipt of a document from outside of DOC.

C. Scan DOC forms as described in the distribution on the bottom of each form. If a DOC form does not include a distribution on the bottom, see Section D below.
   1. Use DOC forms only for the purposes for which they were developed.
   2. Do not alter/modify official DOC forms in any manner.

D. Consult EMR HIM Job Aid 04 of this policy if distribution is unclear or missing at the bottom of a DOC form and for scanning non-DOC documents.

E. EMR HIM Job Aid 03: This attachment directs the scanning of documents in all components of the Electronic HCR.
   1. Lists number of DOC forms is in numerical order followed by non-DOC forms such as CCA, used by out-of-state prisons, and DPH forms.

2. Includes columns that direct the scanning location in by section within the HCR.

F. Email the Health Information Supervisor if a DOC form or non-DOC document is not listed in the attachments. The Health Information Supervisor will ask you to provide a copy of the document.

G. An employee wishing to revise an existing form or develop a new form shall submit a draft to his or her supervisor along with a completed DOC-0206 – Form Action Request.

IV. General Documentation Standards

A. ACPs shall record their review of all laboratory, radiology, other test results, and other documents received from off-site health providers by initialing, and inserting date and time as soon as possible after being received.

V. Progress Notes

A. Document all patient encounters, including telephone contacts regarding patient care.

B. All entries into the HCR are automatically signed and dated by clicking sign after completion.

C. Late entry documentation shall use the following:
   1. Record the words “Late Entry” and include date and time of actual visit in body of the Progress Note.
   2. Electronically sign and date the late entry.

VI. Correcting Errors in Entries

A. See HIM Job Aid Resolving Errors in Documentation for instructions on correcting documentation errors in the HCR.

B. Correcting errors in medication orders by deletion of order, EMR draws line through single order and correct order is entered.

VII. Abbreviations

A. Use only approved abbreviations in the HCR. Refer to the current edition of Medical Acronyms, Eponyms & Abbreviations, for approved medical abbreviations.

B. See DAI Policy 500.40.03 for approved dental abbreviations.

C. Prohibited Abbreviations
   Abbreviations with the potential of being misunderstood shall not be used and recommend using preferred terms.

Abbreviation	Potential Problem	Preferred Term
U (for Unit)	Mistaken as zero, four, or cc.	Write “unit”.
IU (for international unit)	Mistaken as IV (intravenous or 10 (ten)	Write “international unit”
Q.D.; Q.O.D. Latin abbreviation for once a day or once every other day.	Mistaken for each other or QID.	Write “daily” or “every other day”.
Trailing zero (X.0 mg). Lack of leading zero (.Xmg).	Decimal point is missed.	Never write a zero after a decimal point (X mg.). Always write a zero before a decimal point (0.X mg).
MS, MSO4, MgSO4	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write “morphine sulfate” or “magnesium” or “magnesium sulfate”.
A.S., A.D., A.U. Latin abbreviation for left, right or both ears. O.S., O.D., O.U. Latin abbreviation for left, right or both eyes.	Mistaken for each other (e.g. AS for OS, AD for OD, AU for OU, etc.)	Write “left ear”, “right ear”, “both ears”, “left eye”, “right eye”, or “both eyes”.
υg Greek letters for microgram.	Mistaken for “mg” (milligram)	Write “microgram”.

Bureau of Health Services: _____Date Signed: _____
Michael Rivers, Director of Healthcare Administration

_____Date Signed: _____
Vacant, Medical Director

_____Date Signed: _____
Mary Muse, Nursing Director

Administrator’s Approval: _____Date Signed: _____
Makda Fessahaye, Administrator

.DIVISION OF ADULT INSTITUTIONS FACILITY IMPLEMENTATION PROCEDURES

Facility:		
Original Effective Date:	**DAI Policy Number:** 500.50.02	**Page** 7 of 7
New Effective Date:	**Supersedes Number:**	**Dated:**
Chapter: 500 Health Services		
Subject: Health Care Record Format, Content and Documentation		
Will Implement ☐ As written ☐ With below procedures for facility implementation		
Warden's/Center Superintendent's Approval:		

REFERENCES

DEFINITIONS, ACRONYMS AND FORMS

FACILITY PROCEDURE

I.

A.

1.

a.

B.

C.

II.

A.

B.

C.