DIVISION OF ADULT INSTITUTIONS **POLICY AND PROCEDURES**	**DAI Policy #:** 500.50.02	**Page** 1 of 11
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	Supersedes: 500.50.02	**Dated:** 12/05/12
	Administrator's Approval: Cathy A. Jess, 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 inmate 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, 2014, P-H-01 Health Record Format and Contents
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 500.50.20 – Infirmary Record
DAI Policy 500.50.23 – Short Term Inmate Patient Admission Health Care Record
DAI Policy 500.50.24 – Dialysis Record
DAI Policy 500.70.11 – Psychological Services Unit Record
Medical Acronyms, Eponyms & Abbreviations
Attachment A – Filing in Health Care Record (HCR)
Attachment AA – Filing in Health Care Record (HCR) – Grid
Attachment B – Health Care Records Supply List
Attachment C – Labels for Forms
Attachment D – Moving Contents of PRF to Naviant

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

DOC-3001 – Off-Site Service Request and Report

DOC-3020 – Problem List

DOC-3021 – Progress Notes

DOC-3023 – Prescriber's Orders

DOC-3034 – Patient Medication Profile

DOC-3415 – Physician's Telephone Consultation

DOC-3437 – Nurse's Telephone Consultation

DPH – Division of Public Health

DSU – Dental Services Unit

ED – Emergency Department

EEG – Electroencephalogram

EKG – Electrocardiogram

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.

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.

SOAP – Method of documentation that includes subjective, objective, assessment and plan components.

STIA – Short term inmate admission

WICS – Wisconsin Integrated Corrections System

PROCEDURES

I. Overview of Confidential DOC HCR

A. All inmate patients shall have a standard DOC HCR established in accordance with this policy and other policies referenced in this policy.
   1. A DOC HCR shall include, at a minimum, a Medical Chart.
   2. Except for an inmate patient with a short-term inmate admission only (see DAI Policy 500.50.23), all inmate patients shall have:
      a. Dental Services Record.
      b. PSU Record.
      c. Patient Request Folder.
      d. Psychological Records-(Copies) envelope.
      e. All inmate patients for whom medications are prescribed shall have a Medications Record envelope.

B. Each inmate patient's HCR shall include his/her name, DOC number and date of birth.

C. HSUs (including psychiatrists), DSUs and PSUs shall make available to each other pertinent information regarding each inmate patient's current problems and medication in order to provide overall coordinated care.

D. Transfers between facilities shall be documented in WICS.

II. Components of the Confidential DOC HCR

A. Facilities shall create and maintain all components of the HCR in accordance with this policy. See Attachment B for information for obtaining all HCR supplies.

B. Medical Chart
   1. Gray/green chart: All individuals sentenced to a DAI facility or committed to a DJC facility have a Medical Chart with standard gray/green covers and a set of approved chart dividers.
   2. STIA/Orange chart: Individuals placed at a facility for a short-term admission have a Medical Chart with standard orange/off-white covers and a set of standard Chart dividers, unless the facility has obtained the

gray/green Medical Chart from a previous stay. See DAI Policy 500.50.23. Sections of a Medical Chart include:

a. Problem List: Primarily includes the DOC-3020 – Problem List which identifies medical special needs and mental health diagnoses and treatments as well as known allergies.
b. Patient Care Plans: Includes standard care plans for specific medical special needs conditions such as diabetes and asthma.
c. Data Base: Documents are filed in a specific order by type of document and by date within each type; includes screening forms and immunization records.
d. Progress Notes: Primarily consists of the DOC-3021 – Progress Notes plus assessments, encounters and on-call consultations, including place, date and time of encounters. Documents identify significant findings, diagnoses, treatments and dispositions.
e. Prescribers Orders: Primarily consists of the DOC-3023 – Prescriber's Orders signed by prescribing practitioners that identify prescribed medication and medication administration.
f. 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 sent to the DOC by an ED or hospital for an inpatient stay shall all be filed together.
g. Psychiatric Services: Primarily consists of original reports by psychiatrists and Psychiatric Progress Notes.
h. 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 filed in Consultations Section.
i. 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 filed in Consultations Section.
j. Flow Sheets: Includes forms that track provision of certain medical procedures and ongoing assessments of medical conditions.
k. Medications: Documents must be filed in a specific order by type of document and by date within each type of document.
l. Miscellaneous: Primarily includes retrieval information from off-site health care providers from prior to a period of incarceration and outdated legal documents.
m. Consents/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.

n. Correspondence: Includes written communications between inmate patients and DOC providers, between providers, and between non-health staff and health services staff.
o. Optical: Records documenting delivery of optometric services; Optical Sleeve (sheet protector): for documents smaller than 8 ½ by 11 inches.

C. Dental Services Record: Documents filed in this envelope/chart identify dental services. See Attachment A under Dental Services Record for list of documents. See DAI Policy 500.40.03 for guidance in setting up and documenting in this record.

D. Medications Record – Medical Chart (blue envelope): Contents of blue envelope document delivery of medications to an inmate patient.

E. Psychological Records (Copies) – Medical Chart (white envelope): Includes copies of designated documents created by the PSU. No original documents shall be filed in this envelope.

F. PSU Record (yellow envelope or multi-section hard cover chart): Primarily includes original documents created by psychologists and copies of reports written by psychiatrists. See DAI Policy 500.70.11 for additional information.

G. Patient Request Folder: Primarily includes HSRs, Medical Supply/Medication Refill Requests, but may include Interview/Information Requests and some Psychological Services Requests triaged by HSU staff all filed with most recent on top. Does not include written communications from health staff to inmate patients. See Attachment D for instructions for thinning the contents of the Folder and forwarding to the scanning vendor for saving in Electronic Content Management (E-Client).

H. Infirmary Chart: Discontinued blue cover chart used for documents created during an Infirmary stay. See DAI Policy 500.50.20.

I. Hemodialysis Chart: Documents related to hemodialysis treatment. Maintained in Hemodialysis units only and then stored in CMR/IWMR. See DAI Policy 500.50.24.

J. Records from a DJC stay : DJC documents are separated from DAI documents in the Medical Chart, Dental Record and PSU Record due to confidentiality protections provided to records related to a delinquency adjudication.
1. DJC documents shall not be interfiled with DAI documents and shall remain as a separate set of documents.
2. Documents in the Medical Chart are filed behind a yellow indexing tab with admission and release dates of the commitment in a DJC facility.
3. Documents in the Dental Record are filed between a cover sheet and an end of records sheet.

4. The documents in the PSU Records are filed between a cover sheet and an end of records sheet.

III. Filing in the HCR

A. All health staff shall use great care when filing all documents in the HCR to ensure filing in the correct inmate patient's HCR.
   1. Compare name on the document being filed with name label on the part of the HCR in which filing is being done, especially common names and for HCRs with same name alert label.
   2. Misfiling may result in a failure to deliver health care to the appropriate inmate patient and may constitute a reportable breach under HIPAA federal regulations.

B. File 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. File 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.
   3. Affix an approved label that includes the inmate patient's name, DOC number and date of birth at the top of all forms. See Attachment C.

D. Consult Attachment A or AA of this policy if distribution is unclear or missing at the bottom of a DOC form and for filing of non-DOC documents.
   1. Attachment A: This Attachment directs the filing of documents in all components of the HCR.
      a. For most chart sections and other parts of the HCR, Attachment A lists documents in alphabetical order to enable the reader to easily determine whether a document is filed in that location. This does not mean that documents should be filed in alphabetical order.
      b. Documents are generally filed in date order in a section with the most recent on top.
   2. Attachment AA: This attachment is an Excel grid that lists all documents included in Attachment A in addition to historical and non-DOC forms.
      a. Lists number DOC forms in numerical order followed by non-DOC forms such as CCA, used by out-of-state prisons, DPH forms and F-2#, used at Wisconsin Resource Center.
      b. Lists non-numbered forms in alphabetical order.
      c. Includes columns that direct the filing location in a section of the Medical Chart, PSU Record or other component of the HCR.
      d. Indicates prior filing locations of a document by showing former location in parentheses.

E. Email CMR at DOC DAI DCI Central Medical Records if a DOC form or non-DOC document is not listed in the attachments. CMR will ask you to provide a copy of the document.

F. 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. All off-site health encounters shall be documented in the HCR including, at a minimum, documentation of diagnostic findings and treatment recommendations.

B. All documentation shall be made in black ink, except as described below:
   1. Red ink may be used for indicating allergies.
   2. Red ink shall be used to identify controlled medications on the DOC-3034 – Patient Medication Profile.
   3. See DAI Policy 500.40.03 for approved uses of red ink in the Dental Record.

C. All entries in the HCR shall be legible.

D. Every document shall include the inmate patient's name and DOC number, preferably on a printed label. See Attachment C of this policy.

E. ACPs, Physicians, nurse practitioners and dentists 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.

F. Dental staff shall follow DAI Policy 500.40.03 and 500.40.31 for maintaining the Dental Services Record.

G. PSU staff shall follow DAI Policy 500.70.11 for maintaining the PSU Record.

V. Progress Notes

A. Document all inmate patient encounters, including telephone contacts regarding an inmate patient in the Progress Notes section of the Chart on DOC-3021 – Progress Notes, or other appropriate form in other parts of the HCR.

B. Use SOAP format for Progress Notes that document inmate patient assessment encounters.

C. SOAP format is not necessary for informational Progress Notes.

D. Include the date and military time at the beginning of each note.

E. At the end of a page when a note will be continued, enter the date, write "continued" and sign. Write "continued" on the top of the next page.

F. Write on the lines of documents. Do not write in the margins.

G. Sign all entries.
   1. Two staff with the same name shall use their first initial, middle initial and last name at a minimum.
   2. Initials only are acceptable on flow sheets and medication records as directed on the form.

H. If a Progress Note is dictated and needs to be interfiled, the person who completed the dictation shall enter on DOC-3021 "Note Dictated."

I. To file a DOC form designated for filing in the Progress Notes section, cross out and initial the blank lines on the DOC-3020 – Problem List preceding the form.
   1. In some cases, blank lines remaining on a partially completed page and an entire side of a DOC-3021 may need to be crossed out.
   2. Note that the filing of the DOC-3437 – Nurse's Telephone Consultation and DOC-3415 – Physician's Telephone Consultation may be out of order because the forms may not be filed in the Chart on the same day as they are completed because they are completed off-site by the on-call nurse or on-call Physician.

J. Late entries in Progress Notes. Enter late entries as follows:
   1. Place the words "Late Entry" in the time and date column.
   2. Document the current date and time.
   3. In the body of the Progress Note, document the time and date of the encounter.
   4. Sign and date the late entry.

VI. Correcting Errors in Entries

A. Correcting errors except for medication orders.
   1. Draw a single line through the incorrect information.
   2. Write "ERROR" above the entry.
   3. Initial and date the correction above the entry.
   4. Do not use white-out correction fluid, correction tape, or similar method that obliterates any portion of the entry.

B. Correcting errors in medication orders.
   1. Draw a single line through the entire order.
   2. Rewrite the medication order in its entirety. Do not correct portions of the order.

VII. Abbreviations

A. Use only approved abbreviations in the HCR.

B. Refer to the current edition of Medical Acronyms, Eponyms & Abbreviations, for approved medical abbreviations. The following are additional abbreviations that may be used:
   1. APAP – Acetaminophen.
   2. 5FU – Fluorouracil.
   3. DF – Dialysate flow (DeLong defines this abbreviation differently).
   4. DFR – Dialysis Flow Rate.
   5. URR – Urea Reduction Ratio.
   6. TMP – Transmembrane Pressure (DeLong defines this abbreviation differently).

C. See DAI Policy 500.40.03 for approved dental abbreviations.

D. 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”.

VIII. Use Of Approved Stickers/Labels

A. Affix the approved name/DOC number/DOB labels on the top of DOC forms so that no printed information is covered. See Attachment C of this policy.

B. Use only approved stickers available from Central Medical Records. See Attachment B of this policy.

C. Affix approved stickers to the outside of the front Chart cover, including Medical Alert, Same Name Alert, Limited English Proficiency stickers, and

stickers about legal documents such as Power of Attorney for Health Care Guardianships.

D. Affix stickers with protected health information (medical condition) to the inside of the front Chart cover upon diagnosis of the condition.

E. Use only stickers approved by the Pharmacy and Therapeutics Committee on the DOC-3023 – Prescribers Orders and DOC-3034 – Patient Medication Profile.

IX. Use of Name Stamps

A. Stamps that include a printed version of a staff member's name may be used for legibility purposes, but a stamp does not replace the need to sign or initial an entry in the HCR or a document filed in the HCR.

B. The health staff member assigned a stamp shall keep the stamp in a secure location at all times and not permit any other individual to use the stamp.

Bureau of Health Services: _____Date Signed: _____
James Greer, Director

_____Date Signed: _____
Ryan Holzmacher, MD, Medical Director

_____Date Signed: _____
Mary Muse, Nursing Director

Administrator's Approval: _____Date Signed:_____
Cathy A. Jess, Administrator

DIVISION OF ADULT INSTITUTIONS FACILITY IMPLEMENTATION PROCEDURES

Facility: Dodge Correctional Institution		
Original Effective Date: 12/05/12	**DAI Policy Number:** 500.50.02	**Page** 11 of 11
New Effective Date: 01/05/15	**Supersedes Number:** 500.50.02	**Dated:** 12/05/12
Chapter: 500 Health Services		
Subject: Health Care Record Format, Content and Documentation		
Will Implement [X] As written [ ] With below procedures for facility implementation		
Warden's/Center Superintendent's Approval:		