

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

SUBJECT: HEALTH RECORD FORMAT AND CONTENTS

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

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

PROCEDURE:

- A. The health care record will contain identifying information to include name, SID number and date of birth.
- B. The health care record shall include all the forms noted on **attachments 1 and 2**.
- C. Each health encounter will be documented by the health care professional.
- D. Documentation will be according to the problem oriented or SOAP method of charting. Infirmary charting will be done according to P&P #P-G-03, Infirmary Care.
- E. Each entry made in the health care record will include the date, time, signature, and title of the person making the entry.
- F. All off-site care shall be documented in the health care record either on the referral form, by letter, or clinical summary as agreed at the time of the referral.
- G. A copy of the most current electronic generated Health Status report shall be maintained in the health care record.
- H. Health care records are maintained separately from other records pertaining to the inmates. Information contained in the health care record may not be released except as outlined in ORS 179.495 through 179.505.

Health Record Format and Contents

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

The current health care record will contain the mental health information as noted on **attachment 2**. Mental health related inmate communication may be moved to overflow records after six months.

- J. Inmates who are re-incarcerated shall have their previous health care record reactivated upon each admission. Health care information for those re-entering the system after longer than five years will be contained in an overflow. A new health care record will be established at Intake.
- K. When an overflow chart is created, a label stating "OVERFLOW" will be placed on the front middle of the chart. The label will be 1" x 2-5/8" (Avery 5960) in size and the font style and size is Arial 30.
- L. Paroled records will place a year tab on the side of the record to indicate the year of most recent release.
- M. The health care record, all overflow charts, and x-rays are to be transferred at the time an inmate is transferred to another DOC facility.

Effective Date: _____

Review date: October 2008

Supersedes P&P dated: August 2008

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

**Attachment 1
P&P P-H-01**

MEDICAL/DENTAL SECTION OF THE CHART

Left Side		Right Side		
<p>LABEL SHEET DENTAL X-RAYS CD's for MRI's and CT Scans from PACS system, place in dental x-ray envelope.</p>		<p>HEALTH STATUS REPORT</p> <p>DENTAL: Medical/Dental History (pink) Oral Examination (yellow) Recall Examination Periodontal Examination Dental Treatment</p> <p>CONSENTS: Consent/Refusal Dental Procedure</p> <p>CONSULTS: Dental TLC Dental Outside Referral Forms Lab Rx Dental Necessary/Optional Forms Inmate Correspondence Letters</p> <p>OLD RECORDS: Medical/Dental History (pink) Oral Examination (yellow)</p> <p>MISCELLANEOUS: Dental Interview requests Other miscellaneous dental information</p>		<p>Current only</p> <p>5 Years</p>
<p>PROBLEM List Medical History Physical Examination ODOC Receiving Screening</p> <p>FLOW SHEETS All Parameter Flow Sheets Parenteral Flow Sheets Body Mark Identification Sheets Neurological Flow Sheets</p> <p>SPECIAL NEEDS: All Special Needs Forms Hepatitis C Worksheet</p>	<p>PERM Semi-Perm Semi-Perm Semi-Perm</p> <p>2 Years 2 Years 2 Years 2 Years</p> <p>INC INC</p>	<p>DOCTORS ORDERS: <i>With allergy label: patient label: Advanced directives & Primary practitioner if designated written on divider tab.</i> Physician Orders</p> <p>PROGRESS NOTES: Progress Notes Infirmary Notes Infirmary Admission Assessment Integrated OCIC progress notes Integrated OYA progress notes</p> <p>HOSPICE</p>	<p>2 Years</p> <p>2 Years</p> <p>2 Years 2 Years 2 Years</p>	
<p>LABORATORY: All Laboratory and pathology reports Lab and path results from outside visit for that purpose HIV test results</p> <p>X-RAYS: All X-ray Reports All x-ray imaging reports from outside referrals All Imaging Reports (MRI, CT, etc.)</p> <p>Tuberculosis/PPD: PPD flow sheets Oregon State Health Division forms r/t/Tuberculosis Food Services Screening forms</p> <p>MISCELLANEOUS TESTS: EKG Audiograms Stress Test Others that do not fit elsewhere</p> <p>Note: For an outside hospital visit or ER visit, the entire packet of records received back goes under consults along with the pink sheet. If the visit is specifically for a path, lab or imaging exam, the pink sheet and any dictated summary goes under the consults tab. The path, lab or imaging results themselves go under the appropriate lab or x-ray tab.</p>	<p>2 Years 2 Years INC</p> <p>INC INC INC</p> <p>INC</p> <p>1 Year</p> <p>INC 2 Years INC</p>	<p>MEDICATION ADMINISTRATION RECORDS</p> <p>OPTICAL RECORDS <i>All forms related to vision problems</i> Optical Necessary/Optional forms Optical outside referral forms</p> <p>OLD RECORDS: County Jail records (except Clackamas/OCIC) Any non-ODOC Health Care Records while not incarcerated.</p> <p>CONSULTS: Medical Outside Referral Sheets Letters from Outside consultants Medical Therapeutic Level of Care Form ODOC Referred hospital records Autopsy Reports</p> <p>CONSENTS: Medical Informed Consent/Refusal forms HIV Consents Emergency Notification Forms Advance Directives</p> <p>MISCELLANEOUS: Medical Necessary/Optional Forms Personal Property Forms Miscellaneous Correspondence Request for outside records forms Smart Start forms</p>	<p>3 Months INC</p> <p>INC INC</p> <p>INC INC INC INC</p> <p>2 Years 2 Years INC</p> <p>2 Years</p> <p>2 Years 2 Years 2 Years</p>	
<p>Thinning of medical portion of the chart: After 1 year: progress notes, MARs, medication consents, release-of-information consents. All forms will be grouped in the respective groupings within each of the major categories: i.e., All Medication sheets will be grouped together. All forms will be ascending Chronological Order. Inmate Communication must be retained in main chart for three months for medical. After that, they may be moved to overflow. Perm means current and all previous incarcerations. Semi-Perm means the current and most previous incarceration. INC means current incarceration only.</p>				

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**Attachment 2
P&P P-H-01**

MENTAL HEALTH SECTION OF THE CHART

<u>MENTAL HEALTH (when inmate not on active case load)</u>	
<p><u>LEFT SIDE</u></p> <p>EMPTY</p>	<p><u>RIGHT SIDE</u></p> <p>MENTAL HEALTH</p> <p>Intake Assessment Reports</p> <ul style="list-style-type: none"> • Oregon Corrections Intake Center Intake Assessment Report • Oregon Correctional Institution Treatment Services Drug and Alcohol History • PAI Results
<u>MENTAL HEALTH* (when inmate is on active case load)</u>	
<p><u>LEFT SIDE</u></p> <p>MENTAL HEALTH FLOW SHEET SUICIDE MH MISCELLANEOUS MH CONSENT MH SPECIAL PROCEDURES MH LEGAL MENTAL HEALTH MH COLLATERAL</p>	<p><u>RIGHT SIDE</u></p> <p>CO-OCCURRING DISORDER MH PROGRESS NOTES MH TREATMENT PLAN MHI MH ASSESSMENT</p>
<p><i>When thinning to overflow from the mental health section of the chart, maintain the last three years from the Assessment (but include the initial assessment from Intake even if older than three years), MH Legal, MH Collateral, and SUICIDE sections. Maintain the most current MH Consents. Thinned material is placed under the Mental Health tab until placed in the overflow chart.</i></p> <p><i>Also, do not remove the last three MH evaluations, latest involuntary medication hearing forms, progress notes from last 12 months, the latest treatment plan, and inmate communication related to BHS from past six months.</i></p>	

Kytes must be retained in main chart for three months for medical and six months for BHS. After that they may be moved to overflow.

Perm means current and all previous incarcerations.

Semi-Perm means the current and most previous incarceration.

INC means current incarceration only.

FILING SEQUENCE FOR BHS FORMS

RIGHT SIDE

CO-OCCURRING DISORDERS (when applicable) – filed in chronological order, most recent on top:

- Progress Notes
- Treatment Plan
- ASAM Assessment

MH PROGRESS NOTES – filed in chronological order, most recent on top:

All Mental Health Progress Notes including:

- Individual Contacts
- Mental Health Group Progress Notes
- Mental Health Medication Management Progress Note (including COD program prescriber notes)
- MHI Progress Notes
- COPE Progress Notes
- Electronic Correspondence

Do not include other material. Progress notes can refer to them, indicating where they are filed.

**OREGON DEPARTMENT OF CORRECTIONS HEALTH SERVICES
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**Attachment 2
P&P P-H-01**

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

Comprehensive Treatment Plan
MH Support Plan
DD Support Plan
Behavioral Management Plan
Risk Management Plan

MHI (when applicable) – filed in chronological order, most recent on top:

MHI Referral Form
Admission Data Sheet
MHI Treatment Care Plan
MHI Psychiatric Evaluation
MHI Discharge Summary
MHI Treatment Team Review Notes

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

COPE Program Referral Form
COPE Program Discharge Summary
Intake Assessment Reports

- Oregon Corrections Intake Center Intake Assessment Report
- Oregon Correctional Institution Treatment Services Drug and Alcohol History

Mental Health Evaluation Summary
Psychosocial History Summary
Mental Status Screening
PAI Testing
DD Testing and reports
Other Psychological testing and reports

LEFT SIDE

MENTAL HEALTH FLOW SHEET

SUICIDE – filed in chronological order, most recent on top

Suicide Screening
Mental Status Screening
Mental Health Special Status
Suicide notes

MH MISC – filed in chronological order, most recent on top:

Clinically important correspondence and other non-legal papers that do not fit elsewhere
Copy of inmate grievances and other inmate correspondence
Correspondence with family
Mood rating scales
Other miscellaneous papers that have clinical significance
DO NOT KEEP ALL INMATE COMMUNICATION – JUST WHAT HAS CLINICAL SIGNIFICANCE
(Clinical significance will be decided by the Mental Health Provider or Institutional BHS Manager)

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**Attachment 2
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MH CONSENT – filed in chronological order, most recent on top

Application for Voluntary Admission to the Mental Health Infirmary
Authorization to Use and Disclose Health Information (ROI)
Medication Inmate Informed Consent/Refusal
Behavioral Health Services Informed Consent to Treatment
Request for Mental Health Information
MHI Voluntary Admission Form

MH SPECIAL PROCEDURES – chronological order except most recent AIMS

Abnormal Involuntary Movement Scale (AIMS) - Most recent is always on top in this section
MHI Restraint/Suicide Watch Log
MHI Clozaril Blood Draw Log – MHI Clozaril Checklist (on back)
MHI Clozaril Prescription – Directions for Standard Titration
Emergency Seclusion and Restraint Entry Note/Flowsheet
Crisis Prevention Plan

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

30-day Involuntary Medication Progress Report
Administration of Emergency Medication
Administration of Involuntary Medication Appeal Decision of CMO
Emergency Medications 24-hour Discontinuation Request
Inmate Capacity to Consent to Treatment
Involuntary Medication Hearing - Inmate Rights Checklist
Involuntary Medication Hearing Request
Involuntary Medication Notification (to Chief Medical Officer)
Notice of Appeal of Independent Examining Physician Decision to medicate w/o Informed Consent
Notice of Emergency Assignment to the Mental Health Infirmary
Notice of Independent Examining Physician Decision and right to appeal
Notice of Involuntary Medication Hearing
Report of Independent Examining Physician
Notice of Mental Illness regarding civil commitment

MENTAL HEALTH – filed in chronological order, most recent on top

Thinned material until placed in the overflow chart

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

All records and information received from other sources. This information should not be re-released except to the client when expressly requested on the signed ROI.