DEPARTMENT OF CORRECTIONS

Policy Number:	**500.045**
Title:	**Health Record Documentation**
Effective Date:	**8/21/18**

PURPOSE: To provide standards for documentation of offender medical and dental records.

APPLICABILITY: All staff who document in an offender's medical or dental record

DEFINITIONS:
Encounter - a contact between the offender and a health services staff with the responsibility for assessing and/or treating the patient.

Health record - the offender-specific medical or dental record that is compiled during the course of patient care (mental health record documentation is addressed in Division Directive 500.307, "Mental Health Records"). The health record is available to, and used by, all health care practitioners. Health records include such examples as:

A. Offender identification on each sheet;
B. Completed receiving screening form;
C. Health appraisal data forms;
D. Problem summary list;
E. Record of immunizations;
F. All findings, diagnoses, treatments, and dispositions;
G. Record of prescribed medications and administration records;
H. Laboratory, x-ray, and diagnostic studies;
I. Place, date, and time of health care encounters;
J. Health service reports (i.e., emergency department, dental, mental health, telemedicine, or other consultations);
K. An individual treatment plan, when applicable;
L. Progress reports;
M. A discharge summary of hospitalization and other termination summaries;
N. Informed consent and refusal forms; and
O. Release of information forms.

Kite – as defined in Division Directive 303.101, “Kites/Communication.”

Staff - health care employees of the State of Minnesota or health care professionals (e.g., physicians, physician’s assistant, dentists, licensed nurses, nurse practitioners, certified medical assistants, medical record personnel, and registered dietitians) under signed contract with the State of Minnesota to provide professional health care assessments, examination, and/or treatment to offenders.

PROCEDURES:

A. All health services staff must document in the offender's medical or dental record for each patient encounter, including staff responses regarding medical or dental actions taken or recommended due to receipt of offender kites. Entries include:

1. Subjective information;
2. Objective findings;
3. Assessment of the problem; and
4. Plan including education offered.

B. Staff documentation of kites must contain significant clinical information in the progress notes.
   1. Kites must be date stamped when received in health services.

   2. The health service administrator/designee determines whether it is important to retain a kite as a part of the medical record.

   3. Kites for medication refills, requests for record copying, requests for lab tests or sick call, repeat requests for resolved issues, requests for immunizations, or expressions of thanks do not need to be documented in the medical record unless directed by the health services administrator/designee.

C. Staff must enter all significant clinical information into the health record immediately or prior to completion of shift.

D. Nursing Assessment-Observation Form (attached) is available to document nursing assessments and pertinent medical data. An entry in the progress notes must be made referencing the form and the completed form must be filed in the medical record.

E. Staff must sign all entries after each document and include name or first initial, last name, and title.

F. Staff must not alter information entered in the medical record by another staff.

G. Staff must make corrections by drawing a single line through the entry, adding the date the correction is made, and initialing the entry. Staff must not obliterate chart entries. Staff must not use other notations. Staff must not write "error."

H. Staff must legibly document all encounters in black or blue ink. Staff must not use erasable pens, felt pens, markers, or correction fluid/tape.

I. Staff must not leave blank spaces between lines of charting.

J. Staff must date each health record entry with month, day, year, and time of entry (A.M., P.M., or military time).

K. Staff must not document offender name(s), offender identification number (OID), or identification of another offender. Staff must document reference to staff using name and title.

L. If making a late entry, staff must record the entry with the date and time of documentation, as well as the actual date and time of occurrence.

M. Practitioners must review, initial, and date all lab, radiology, test results, and reports from outside providers as soon as possible after receipt prior to filing in the health record.

N. Staff must check the health record for proper offender name and OID prior to making any entry.

O. Staff must use only approved abbreviations; see Approved Abbreviations List (attached).

P. Practitioners must, when documenting informed consent, include documentation that risks, benefits, and/or alternatives which may exist relative to the procedure were explained. The explanation must be in plain language.

Q. File dictated reports with the legend:
1. Date dictated;
2. Date transcribed; and
3. Initials of the transcriber.

R. The health services administrator maintains a current original Health Services Master Signature List (attached) compiled of all register nurse (RN), licensed practical nurse (LPN), certified medical assistant (CMA), certified athletic trainer, and practitioner staff working at his/her site. The Master Signature List allows practitioners to initial labs, etc. after review. The Master Signature List allows nursing staff to use only initials on the immunization record. Full names as noted above are required on all other documents in the medical record.
1. New employees are added at the time of hire, including transferring employees.
2. A new signature sheet is generated annually.
3. Central office health services maintains a copy of the Master Signature List.

S. The registered nurse supervisor or designee performs annual and periodic documentation audits. Audits are maintained in the registered nurse supervisor's files.

T. The health authority must approve the method of recording entries in the record, form and format of the record, and procedures for health record maintenance and safekeeping.

INTERNAL CONTROLS:

A. Health services staff performs annual documentation audits, which are maintained in the registered nurse supervisor's file.

ACA STANDARDS: 4-4366, 4-4397 and 4-4413

REFERENCES: AHIMA Practice Brief Document 409, September 1996
Policy 500.050, "Health Screenings and Full Health Appraisals"
Division Directive 500.190, "Health Care Data Practices"
Policy 106.210, "Providing Access to and Protecting Government Data"
Minn. Stat. §145.32, subd. 1
Policy 500.307, "Mental Health Records"
Division Directive 303.101, "Kites/Communication"
Prison Rape Elimination Act (PREA), 28 C.F.R. §115 (2012)

REPLACES: Policy 500.045, "Health Record Documentation," 4/3/18.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: Minnesota Department of Corrections Approved Medical Abbreviations and Symbols List (500.045A)
Authorization for Medical and/or Minor Surgery Procedures (500.045B)
Nursing Assessment-Observation Form (500.045C)

Health Services Master Signature List (500.045D)

APPROVALS:
Deputy Commissioner, Community Services
Deputy Commissioner, Facility Services
Assistant Commissioner, Facility Services
Assistant Commissioner, Operations Support