	<b>DEPARTMENT OF CORRECTIONS AND REHABILITATION</b> <b>CORRECTIONS ADMINISTRATION</b> <b>POLICY AND PROCEDURES</b>	<b>EFFECTIVE DATE:</b> <b>January 01, 2024</b>	<b>POLICY NO.:</b> <b>COR.10.H.01</b>
		<b>SUPERSEDES (Policy No. &amp; Date):</b> <b>COR.10.1H.01 of September 19, 2009</b>	
	<b>SUBJECT:</b> <b>MEDICAL RECORDS FORMAT AND CONTENTS</b>		<b>Page 1 of 8</b>

## 1.0 PURPOSE

To standardize the format, content, and charting process for Department of Corrections and Rehabilitation (DCR) medical records.

## 2.0 SCOPE

This policy and procedure apply to all branch facilities and their assigned personnel.

## 3.0 REFERENCES, DEFINITIONS & FORMS

### .1 References

- a. Hawaii Revised Statutes, Section 26-14.6, Department of Corrections and Rehabilitation; Section 353-A, Director of Corrections and Rehabilitation, Powers and Duties.
- b. Hawaii Revised Statues, Titles 16-19 Section 334-5.
- c. Hawaii Revised Statues, Titles 19 Section 323C (1999 Cumulative Supplement); Titles 32-36, Sections 622-58, (1991 Supplement); Title 6-9, Section 94/3, (1985 Replacement).
- d. Standards for Health Services in Prisons. National Commission on Correctional Health Care, (2018).
- e. Standards for Health Services in Jails. National Commission on Correctional Health Care, (2018).

### .2 Definitions:

- a. Active Records: The status of a medical record of an incarcerated individual in custody.
- b. Archive: A secure area designated for the storage of inactive medical records. Currently located at the OCCC.
- c. Archived Record: A medical record that has been inactive for more than three (3) years that is placed in storage and preserved for its continuing value for twenty-five (25) years.

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- d. Archive: A secure area designated for the storage of inactive medical records. Currently located at the OCCC.
- e. Custodian of Medical Records: The facility Health Record Librarian or in their absence the facility Clinical Section Administrator.
- f. Health Record: A indexed data set containing a patient’s medical and psychiatric history, diagnosis and treatments generated by all levels of health professionals from the moment of incarceration until the patient is released from custody.
- g. Inactive Records: The status of a medical record of an offender released from custody until the period of inactivity within the record exceeded three (3) years.

.3 Forms

- a. DCR 0478, Health Maintenance Summary (attached)

**4.0 POLICY**

- .1 A medical record shall be assembled after intake for each incarcerated individual remaining in the system for greater than fourteen (14) days unless the incarcerated individual has established hardcopy archived record.
- .2 The medical record shall be maintained during the entire period of incarceration.
- .3 The information in the record shall be authentic, confidential, legible support diagnoses document clinical encounters, and contain sufficient identifying data as to make the record unique to an individual.
- .4 Medical records shall be secured and stored separately from institutional files.
- .5 Except for established rules, laws and policies that require or allow access to health information, access to the health record is restricted.

**5.0 PROCEDURES**

- .1 MEDICAL RECORD CONTENT

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The minimal contents of the designated record set shall include:

- a. Identifying information that includes, at a minimum, the incarcerated individual's name, date of birth and prison number (SID),
- b. Receiving screening and all documents associated with the health assessment,
- c. A problem list or face sheet that records immunizations, vaccinations, allergy alerts, significant medical and mental health diagnoses,
- d. Multidisciplinary progress notes documenting clinical and psychiatric encounters, significant findings, diagnoses, dispositions and medication orders,
- e. Chronic care and special needs treatment plans,
- f. Medication Administration Records,
- g. Emergency room visits, hospital discharge summaries, and specialty consultations including nutritional screenings, evaluations and diets,
- h. Clinical treatment logs,
- i. Laboratory, X-Ray and diagnostic studies,
- j. Psychiatric screenings, evaluations, examinations and diagnoses,
- k. Medical Needs Memorandum,
- l. Injury Reports,
- m. All consents, authorizations, and refusals,
- n. Discharge summaries.

All other information stored in the medical record for efficient retrieval and to verify compliance with accreditation standards such as health status classification report, transfer sheet, incarcerated individual requests, correspondences, legal documents, compliance or tracking logs and copies of original documents generated and maintained by another agency or institution

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shall not be considered part of the health record data set when responding to request for copies of the medical record. Documents that are not part of the health record data set can be requested through the normal process used to obtain copies of government records.

**.2 MEDICAL RECORD FORMAT:**

**For paper health records:**

- a. The medical record shall be a letter size folder with a 1/3" end tab.
- b. Color-coded alphabetical tabs that are the first three letters of the patient's last name shall be placed to the left of the end tab of the folder.
- c. The minimal the patient's name, date of birth, and SID number shall be typed on both sides of a 3 1/2" x 1/2" label. The identifying label shall be placed to the right of the end tab of the folder. The label shall be protected by peel and seal, transparent tape.
- d. Aliases and social security numbers shall be recorded on the inside back cover above the identifying label.
- e. The current indexes are:
  - 1. Progress Notes
  - 2. Chronic Care
  - 3. Medication Record
  - 4. Consults/Hospital Summary
  - 5. Diagnostic
  - 6. Mental Health
  - 7. Consent/Miscellaneous

**.3 CHARTING PROCEDURES**

- a. The S.O.A.P. method of charting is the preferred charting format for singular complaints.

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S= Subjective comments made by the patient or witness describing why health care is being sought.

O= Objective finding made through direct observations, measurements, and diagnostics performed by a health care professional;

A= Assessment or diagnosis based on the professional interpretation of the subjective comments and objective findings;

P= Plan of action based on the assessment to address the findings. This may include further testing, a course of treatment, medications, a follow-up visit or no action.

- b. The Problem Oriented form of charting may be used for charting multiple complaints.
1. Complaint number one
  2. Complaint number two
  3. Complaint number three

Subjective and objective observations, measurements, and diagnostics are numbered to correspond with appropriate complaint.

Assessment, diagnoses, rule out diagnostics, course of treatment or medications are numbered to correspond with the appropriate complaint.

- c. A narrative documentation format shall be permitted when performing admissions, discharges, transfers, and record other medical information such as completed movements, medication renewal, transfer clearances, or other occasions when the S.O.A.P. format is not useable.
- d. Each patient encounter shall be written or typed with indelible black or blue ink on the multidisciplinary progress notes. The date and time of each encounter must be recorded in the appropriate call them. Each entry shall be signed by the appropriate health professional and shall include their title.
- e. Identification of entries may be by written signature, initials, rubberstamp, signature, or electronic signature. The use of initials is permitted only on documents, with a space specifically designated for initial use. Initials are not acceptable when a document does not indicate initials, or when a signature is designated. Rubberstamp signatures are permitted only when a handwritten signature is placed next to the stamp.

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- f. Nursing staff shall note the transcription of provider orders in red ink, by signing their first initial and full last name, and the date and the time of the order transcription.
- g. Verbal or telephone provider orders can be taken only by a registered nurse and shall be transcribed by the same registered nurse on the multiple disciplinary progress notes. The initials VO designating a verbal order or TO designating a telephone order, followed by name of the provider shall proceed the actual order. The order shall be legibly, written, and designate the provider's prescribed course of action. Medication orders must contain the complete drug name (no abbreviations) dose including units, route, and unabbreviated frequency and duration.
- h. Verbal or telephone provider orders taken by a registered nurse and recorded on the multidisciplinary progress notes shall be signed by the originating provider within 48 hours. On-call provider orders may be signed by the originating provider or the next scheduled physician visiting the facility.
- i. Physicians assigned to a facility may sign verbal or telephone orders given by another State physician.
- j. All incoming documents that display or detail, normal or abnormal values ordered by a particular provider or the physician-on-call maybe noted by another provider. Any provider, noting an abnormality is responsible for the follow up care of the patient or notification to the ordering provider.
- k. All incoming documents, ordered by a particular physician or the physician-on-call regardless, if the results are normal or abnormal, maybe noted by the NP if the order is in the normal scope of practice for a nurse practitioner. The provider who notes the abnormality is responsible for the follow up care of the patient or notification to the ordering provider of the abnormality.
- l. Stamps and peel and stick labels structuring a clinical assessment are permitted providing information required as a component of normal charting, such as the date time and handwritten signature are included.

.4 ARCHIVED RECORDS

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- a. The Oahu Health Information Unit (HIU) Record Librarian shall act as the Department's Archivist and retain inactive medical records for a minimum of three (3) years from the date the incarcerated individual is released from custody and dental records for a minimum of seven (7) years from the date of release. Inactive medical records after the third (3) year of retention shall be expunged and scanned into the electronic data archive system. Inactive medical records dated prior to 2003 are stored in the State Records Center. After twenty-five (25) years, the medical record shall be destroyed in accordance with guideline set forth by the State of Hawaii Records Center.
- b. Inactive dental records, shall be stored immediately behind the inactive medical record by the Oahu HIU such time as the medical record is scanned into the electronic data archive system. The dental record shall be retained in the archive for up to four (4) additional years until reaching seven (7) years of inactive status, for which the dental x-rays shall be destroyed and the dental record shall be scanned into an electronic data archive system.
- c. The Archivist shall be given daily notice of any new facility intakes without an onsite medical record. The Archivist shall conduct a search for any prior health records, stored in the Department's Archive or State archives (records archive prior to 2003). Any existing inactive hardcopy record shall be re-activated or records filed at the States Record Center shall be retrieved and forwarded to the intaking facility.
- d. The record-tracking database shall be updated when incarcerated individuals are transferred from one facility to another to show location of the medical record.
- e. In the event that in incarcerated individuals, archived record has been scanned, the intaking facility record custodian shall create a new medical record outside the cover and shall be stamped or tagged for "PRIOR EXISTING ELECTRONIC RECORD". A copy of the Health Maintenance Summary [DCR 0478] printed from the scanned record shall be placed in the new record.

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APPROVAL RECOMMENDED:


JAN 0 1 2024  


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Deputy Director for Corrections Date

APPROVED:


JAN 0 1 2024  


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DIRECTOR Date

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