References:

Related ACA Standards — **4th Edition Standards for Adult Correctional Institutions 4-4413, 4-4350**

PURPOSE

The medical record serves many purposes including the plan for patient care, continuity of information about the patient's medical needs and treatment thereof. It is a permanent legal document that informs health care professionals within the Division of Prisons Health Services, outside providers in hospitals and consultants about the patient's medical history and care received.

POLICY

All medical record documentation will be in accordance with the approved plan and procedure developed by the Division of Prisons Health Services.

DEFINITIONS

Provider – MD (includes Psychiatrist), DO, PA, FNP, Dentist, or Psychologist.
Attending physician- Physician is responsible for care to the patient at the facility or in an impatient setting; provides backup to the Physician Extender.
Physician Extender- designates Physician Assistant (PA) or the Family Nurse Practitioner (FNP) which also provides care.
Health Care Professional- NCDPS Nurse, Social Worker, Respiratory Therapist, Physical Therapist, Pharmacist, Occupational Therapist, or other member of the patient's treatment team that have obtained advanced degrees.
Health Care Staff – includes other team members that have provided services such as the CHA I, CHAII, Medical Records Assistants.
Consultant- A physician specialist, that provides consultation and makes recommendations to the attending physician related to specialty care of the patient.

PROCEDURE

A. The Medical Record should be a chronological document that:
1. Records pertinent facts about patient's health and wellness
2. Enables the treating provider to plan, evaluate, and prescribe treatments and interventions
3. Enhances communication between professionals in order to provide continuity of care.
4. Assists in the Utilization Review process
5. Allows for development and use in the Performance Improvement Program
6. Provides a legal source document to verify delivery of care
7. Provides a source of clinical data for research and education
8. Provides an element in preventing and minimizing the potential adverse consequences of malpractice litigation.
9. Provides a date and time of all services rendered, communications, and assessments.

B. It is the intent of the Health Services Section to follow the medical records documentation recommendations of the NC Medical Board for all assessments using the **SOAP** format.

1. "**S**"= Subjective information (history, or testimony of feelings verbatim in patient's own words.
2. "**O**"= Objective material including measurable data such as height, weight, temp, and includes all examination findings by the writer.
3. "**A**"= Assessment of both subjective and objective findings leading to an impression, or diagnosis formed by the provider.
4. "**P**" = Plan of treatment written such that any other provider or health care professional can follow to completion; also includes the schedule for follow-up and/or continuity of care; includes documentation of informed consent or refusal of treatment; explanation of education about treatment and other instructions.

C. The following forms will be written in **SOAP** format whenever a patient assessment is done.
DC 752 Provider Progress Notes
DC 602 Sick Call Appointment Request
DC 387 Chronological Record of Health Care

D. The DC 834 Provider Order Series should include:

1. Instructions given to other health care professionals in the form of orders, including non prescription items, patient care instructions.
2. Drug orders which should include:
   a. Name of drug
   b. Dosage instructions
   c. Mode/route of administration (by mouth etc)
   d. Frequency of administration, and/or time of administration
   e. Length of treatment (x 1 week)
   f. Number of refills
   g. Date, time, and legible signature **(first name, last name, title)** of person writing order.
3. Diagnostic testing
4. Therapeutic treatments/interventions

5. Methods of obtaining orders:

a. Orders may be written by a Division of Prisons Provider and directly implemented.

b. The consultant may offer recommendations to be reviewed by Division of Prisons providers and orders written by the DOP Provider after review. Dental and Oral Surgery consultants' orders, including Oral Surgery fracture repair, will be reviewed and written by a DOP Dental Provider. Orders will be implemented after written by a DOP Provider.

c. The following consultant providers may write orders that do not require review by a DOP Provider. Orders from these consultant providers may be directly implemented:

   1. Infectious Disease Clinic for HIV treatment,
   2. Hepatology Clinic for Hepatitis B and C treatment,
   3. Nephrology Clinic for dialysis,
   4. and preoperative and postoperative orders for surgery done at Central Prison.

d. Telephone orders should be written as: t.o. per… provider name/writer's name and title, and should be co-signed as soon as possible after initiation.

e. Standing orders from Chronic Disease Guidelines or Nursing Protocols should be written as:

   1. s.o. per… provider name/writer's name and title.

2. Standing orders do not have to be signed by the facility provider, as these orders are approved by the current Medical Director.

f. Verbal orders should be written as: v.o per… provider's name/writer's name and title, and should be co-signed as soon as possible after initiation.

General Guidelines

The following general guidelines should be observed when completing a medical record:

1. Chronic Disease Flow sheets should be reviewed, signed, and dated by the provider.
2. Be certain entries in all medical records are clear, readable, and in black ink, with the exception of allergies in red.
3. If notes are dictated, the transcriptions should be carefully reviewed and signed within a reasonable time.
4. Do not squeeze words into a line or leave blank spaces of any sort. Draw diagonal lines through all blank spaces after an entry and initial.
5. Entries should be in reverse chronological order.
6. Do not erase, write over, "white-out", or try to ink out an entry.
7. In case of error, draw a single line through the incorrect entry, with the date, time, and your initials in the margin. Enter correction above or near original entry. Don't write ERROR.
8. Additional comments added after completion of an entry should be done as a separate entry, entered, dated/timed and signed.
9. No alteration after the fact will be allowed. The medical record is a legal document.
10. Indicate the date and time of each entry.
11. Each entry must be signed or initialed as required, using first and last name and title, or first and last initials as applicable.
12. Each page should bear the patient's name, facility name and number, and patient's identification number (OPUS).
13. Entries to the medical record should be made as close to the time of assessment or occurrence as possible.
14. Use only standard and accepted medical abbreviations, found on the Health Services approved abbreviations list.
15. The medical record should only contain entries pertinent to the care of the patient.
16. The medical record should not contain comments or criticisms about other providers, policies, procedures, utilization review, and /or reviewers.

17. Avoid the use of generalizations, and subjective comments with the exception of the Subjective section in SOAP format.

18. Confidential communications should only be recorded with the permission of the patient. (Example: Patient gave permission for writer to divulge he had been physically abused by his teacher in school.)

19. Use precise language and objective statements.

20. When faxed copies of medical record forms are received for use in the medical record (i.e., tele-psychiatry, Telephone Triage, etc.), the faxed copy and original copy (when received) will be attached together and both placed in the medical record. Indicate on the received original copy "see attached faxed copy" or on the faxed copy "original to follow".

21. Medical records staff should keep a record of when and by whom the medical record is photocopied.

22. Medical Records Assistants MAY document the following:
    a. When acting as a witness to the signing of a document by signing their name and date of signature on the document.
    b. When release of information is processed by the Medical Records Assistant by documenting the type of information released, number of pages released, date of the release and their name on the DE-436, "Release of Information" form or request for information if no authorization is required.
    c. When an offender appointment has been set up, i.e. appointment date and time, or cancellation of the appointment on the DC-767, "Consultation/Referral Form".
    d. The offender's name and OPUS number on all forms and the medical records jacket.
    e. Transcription of orders, after completion of transcription of orders class if acting as ward clerk.

6/5/2014

Paula Y. Smith, MD, Chief of Health Services Date

SOR: Risk Manager

Addendum:

Form DC 834 Provider Order
Form DC 752 Provider Progress Notes
Form DC 602 Sick Call Appointment Request
Form DC 387 Chronological Record of Health Care
Form DC-767 Consultation/Referral