

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 08/23/2016	NUMBER: H-60.1 Page 1 of 6
	Replaces: 03/17/2016	
	Formulated: 6/85	
	Reviewed: 07/16	
HEALTH RECORDS – ORGANIZATION AND MAINTENANCE		

PURPOSE: To provide guidelines for development, utilization and management of offender health records and to establish guidelines to ensure the integrity of documentation in the health record, including the correction of errors.

POLICY: Health records (paper and/or electronic) on each offender are maintained consistent with applicable laws in accordance with a national accrediting body.

- I. The health records shall contain the following information.
 1. Identification Data
 2. Problem List or Summary in electronic health record (including allergies, special needs, chronic clinics, monolingual Spanish speaking status, etc.)
 3. Receiving-screening and health assessment forms
 4. Prescribed medications and therapeutic orders
 5. Non-formulary approval or deferral forms
 6. Reports of laboratory, x-ray and diagnostic studies
 7. Clinic notes
 8. Special needs treatments plans, if any
 9. Immunization records
 10. All finding, diagnoses, treatments and dispositions
 11. Informed consent, refusal forms, and release of information forms
 12. All consultants and procedural results
 13. Discharge summaries of inpatient admissions and hospitalizations
 14. Place, date and time of each medical encounter
 15. Signature and title of each documenter (including electronic)
 16. Panorex and other dental x-rays
 17. Health records obtained from other sources with the patient's release of information
 18. Any other records pertaining to the health care of the patient.

- II. All existing paper health records must be filled in reverse chronological order as indicated on Attachment A. All Electronic Health Records (EHR) must be documented as indicated on the List of EHR Chart Section and Document Types available as indicated on Attachment A-B. Offender electronic health records may be sorted according to: Section Descending/Scan Date, Scan Date/Document Descending, Document Descending/Scan Date, Section Descending/Service Date, Service Date/Document Descending, and Document Descending/Service Date, Unsigned/Signed and Provider (Signer).

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 08/23/2016	NUMBER: H-60.1 Page 2 of 6
	Replaces: 03/17/2016	
	Formulated: 6/85	
	Reviewed: 07/16	
HEALTH RECORDS – ORGANIZATION AND MAINTENANCE		

Sick Call Requests and all other clinical documents must be scanned into the EHR within 3 business days.

- III. All services rendered by either hands-on or indirect care (e.g., radiological interpretations) must be documented in the patient’s health record on or about the time treatment is provided or observations are made by the appropriate health care provider. The offender’s health record will be made available to the healthcare provider during encounters. Entries made by clerical staff (i.e., scheduling clerks, dental clerks, etc.) shall be restricted to administrative matters only. Documentation in the record will be entered using black ink if a paper chart is being used and in black font if the EHR is used. Highlighting of entries in the health record in any color is not allowed.

Hand written entries in the health record must:

- Be legible
- In chronological order with no blank lines between entries
- Contain the date and time of the entry
- Have a legible signature and title, credentials, rubber stamp with authentication or electronic signature including credentials of the person making the entry.

Per Texas Medical Board recommendations, the health record should be contemporaneous and accurate. For this reason, previous chart entries that are copied and pasted into a current note should be clearly identified and this practice should be avoided. Pre population of non-biographic data fields that typically would change from visit to visit should not occur.

- IV. Corrections to the Health Record:

A. Paper Record

If the health record is on paper, white out or correction tape is never to be used. Entries should be written on the lines provided and not in the margins. If necessary, continuation of entry is permitted on the following page by documenting: “Continued from previous page, date, and time”. Corrections to documentation are to be made by drawing a single line through the entry, writing the word “error” and initialing. Highlighting of entries in the health record in any color is not allowed.

B. Electronic Health Record

1. Clinical Documents

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 08/23/2016	NUMBER: H-60.1 Page 3 of 6
	Replaces: 03/17/2016	
	Formulated: 6/85	
	Reviewed: 07/16	
HEALTH RECORDS – ORGANIZATION AND MAINTENANCE		

- a. Corrections can only be made by the originator of the document up to one week for medication-administration entries and indefinitely for other entries. The original document and the corrected document will be available in the offender EHR with the original document in a Discard Folder. Highlighting of entries in the health record in any color is not allowed.
- b. If a correction to a medication-administration entry is required in the EHR beyond one week, the request should be sent to the respective Information Technology (IT) Help Personnel, and if deemed appropriate they will place the entry in a discard file and the entry will be re-entered by the person who wrote the original entry. If that person is no longer available, that person’s supervisor or designee will be asked to rewrite the entry. If the corrected entry is to be in a table format that indicates medication or a vaccination has been delivered, it should be clear that this was given and is a historical event.

2. Patient Identification Errors

- a. If an entry in the EHR is made in the wrong chart, the respective IT Help Personnel should be contacted. They will remove the entry and place it in a discard folder. The entry should be rewritten by the same person, if available, in the correct chart with notation that it is a late entry. If the person that originally placed the entry in the wrong chart is no longer available, that person’s supervisor or designee will be asked to rewrite the entry.

3. Late Note and Addendum

- a. A late note is defined as documentation added to the offender’s health record after the care giver completed the shift in which the documentation was required. All late notes must be designated “Late Note” along with the correct date of activity, and time, prior to the late documentation.
- b. Clinical entries will be made during the shift that the writer is working. If a completed note requires additional information and it is still within the writer’s shift an addendum to the entry should be documented. Addendums to an entry in an offender’s EHR must be documented on a

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 08/23/2016	NUMBER: H-60.1 Page 4 of 6
	Replaces: 03/17/2016	
	Formulated: 6/85	
	Reviewed: 07/16	
HEALTH RECORDS – ORGANIZATION AND MAINTENANCE		

separate clinic note. (See SOP in attachment F).

4. Patient-related emailed documents

- a. If patient-related emailed documents are entered in the wrong record, the respective Help Personnel should be contacted. They will remove the emailed document and place it in a discard folder. The entry should be rewritten by the same person, if available, in the correct chart with notation that it is a late entry. If the person that originally placed the emailed document in the wrong chart is no longer available, that person’s supervisor or designee will be asked to rewrite the emailed document.
- b. If patient-related emailed documents are emailed to the wrong person, the SOP titled “Change Sign User” should be referred to and followed. This SOP is available in Attachment D and also available under “Guidelines” while in EHR.
- c. If the person receiving the patient-related emailed document deems a clarification is required, the user should attach the Pearl document titled “ADD Document Clarification” to the emailed document being clarified and outline the clarifications being made. If new orders are required, the user making the clarification should enter these at this time. The SOP for attaching a document through the email is available in Attachment E.
- d. Patient-related emails should not be sent to email groups (except referrals to mental health special programs, per policy, or for referrals in the Texas Tech sector, Office of Public Health), nor to other people from whom a response is not expected or required.
- e. Documents should not be sent for notification purposes only unless sent as administrative email.

V. Management of Patient-Related emails

- a. All EHR users are responsible for signing all patient related email in a timely manner.

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 08/23/2016	NUMBER: H-60.1 Page 5 of 6
	Replaces: 03/17/2016	
	Formulated: 6/85	
	Reviewed: 07/16	
HEALTH RECORDS – ORGANIZATION AND MAINTENANCE		

- b. If an employee who routinely receives and may need to act on clinical information is expected to be out for more than 5 business days and is aware of this prior to the absence and will not be predictably looking at their Pearl email, cross-coverage should be set up by the employee for the period of absence.
- c. When a unit administrator or designee learns that any employee who routinely receives and may need to act on clinical information is expected to be unavailable for more than 5 business days and has not arranged for Pearl email cross-coverage, that administrator should immediately contact their respective IT help personnel to report this information. The help personnel will assure that a cross-cover of email can be set up. The cross-coverage will go to the supervisor on record unless they have specified another receiver of the emails. It is expected that the forwarded emails will be handled by the new receiver as if they were originally meant for them in order to ensure a seamless continuity of care.

VI. Chart Completion in the event of death, resignation, termination or incapacitation

- a. In the event a record is incomplete due to death, resignation, termination, or incapacitation of an employee, the record should be given to their supervisor for completion. If the affected employee is a healthcare provider, the record should be given to the unit health authority (TTUHSC)/facility medical director (UTMB-CMC) or, if he/she is the person who is no longer available, the next level medical director will determine if some other provider on the staff can accurately and appropriately complete the record.
- b. If the record cannot be completed by another provider on staff, the “filed incomplete” form is to be locally produced, completed and signed by the unit health authority/facility medical director and the health records supervisor or designee and scanned into the offender’s electronic health record or filed in the paper record.

VII. All mid-level practitioner orders requiring physician co signature will be cosigned within 3 business days.

VIII. Only approved Health Services forms or electronic documents are authorized for permanent inclusion in the health record. Use of unapproved forms or electronic

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 08/23/2016	NUMBER: H-60.1 Page 6 of 6
	Replaces: 03/17/2016	
	Formulated: 6/85	
	Reviewed: 07/16	
HEALTH RECORDS – ORGANIZATION AND MAINTENANCE		

documents or modifications to approved forms is not authorized for permanent inclusion in the health record. Use of unapproved forms or electronic documents or modifications to approved forms is not authorized for permanent inclusion in the health record. To avoid misinterpretations, only symbols and abbreviations on the approved list found on Attachment C are permitted. (This does not pertain to the filing of appropriate clinical information).

- IX. All existing Standard Operating Procedures related to the Electronic Health Record may be found on the Correctional Managed Care (CMC) Web.

References: ACA Standard 4-4366
ACA Standard 4-4413 (Ref. 3-4376) Health Records