

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 05/12/2014	NUMBER: H-60.2  Page 1 of 3
	Replaces: 10/30/2013	
	Formulated: 7/85	
	Reviewed: 04/16	
<b>INPATIENT HEALTH RECORDS</b>		

**PURPOSE:** To establish guidelines for the initiation and maintenance of inpatient records.

**POLICY:**

- I. Care provided to offenders admitted to medical inpatient beds for observation or treatment must be documented in an inpatient health record.
  
- II. An inpatient record must be initiated by the nursing staff on all offenders admitted to a medical inpatient bed. The admitting provider will write admission orders or cosign his or her voice/telephone orders. The admission orders must be documented on the Inpatient (IP) Admission Physician Order form. The admission orders should specify 1) the admitting or provisional diagnosis, 2) the level of care / type of patient, 3) the correct inpatient PULHES (4PT or 4PP), and 4) the correct mode of transportation to be recorded on the HSM18. All subsequent orders must be documented on an IP Provider Orders form.
  
- III. A provider must document a patient assessment including a physical examination and a treatment plan for all infirmary admissions on the appropriate form within 24 hours or the first work day after admission.
  - A. Infirmary admissions other than intra-system transfers and Short Stay Admits require completion of a full history and physical (H&P). The IP Facility History & Physical form should be used. The H&P must minimally include the following:
    1. patient's name, TDCJ number, facility of assignment and date of admission
    2. allergies
    3. patient type/level of care
    4. chief complaint and history of present illness
    5. physical examination
    6. admitting impression/diagnoses
    7. treatment plan
  
  - B. If a patient is transferred *to the same or a lower level of care* from one infirmary to another within the same university system, the receiving provider may complete *either* a new IP Facility History & Physical form *or* a transfer IP Facility Progress Note. A transfer Progress Note must minimally include the following:
    1. patient's name, TDCJ number, sending infirmary, and date of arrival
    2. allergies
    3. patient type/level of care,
    4. documentation of any new problems occurring during transfer
    5. physical examination documenting condition of the patient upon receipt from the transferring facility.
    6. treatment plan
  
  - C. In treatment and diagnostic cases of a minor nature which require 72 hours or less of

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 05/12/2014	NUMBER: H-60.2  Page 2 of 3
	Replaces: 10/30/2013	
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infirmiry care, the IP Facility Short Stay form may be used. The IP Facility Short Stay form may also be used for Short Stay Progress Notes, if progress notes are clinically indicated, and Discharge Note. Completion of a full Discharge Summary is not required for Short Stays.

- IV. Progress notes by licensed clinical staff must give a pertinent chronological report of the patient's course in the infirmiry and reflect any change in condition or new complaints and results of treatment. Frequency of provider progress notes is based on the level of care for the patient and whether the patient is a Permanent or Non-Permanent infirmiry system resident. Frequency will depend upon patient specific and not facility specific requirements. Minimum provider progress note requirements are twice weekly for sub-acute and skilled nursing care patients, weekly for Non-Permanent convalescent care and assisted living patients, and monthly for Permanent convalescent care and assisted living patients. All hospice patients will be designated as Permanent and have progress notes written at least monthly. Progress notes will be more frequent if indicated by changes in the patient's condition and/or treatment.
- V. Nursing staff must complete 24 hour chart checks of the orders. Documentation of condition and care provided is completed each shift.
- VI. The attending provider must complete an IP Discharge Data form on all discharged patients. A discharge summary is also required for all discharged patients excluding Short Stay admits.
  - A. The IP Discharge Data form will be completed and submitted to TDCJ Health Services Liaison (HSL) *prior to* or at the time of discharge
  - B. A full discharge summary will be completed on the IP Discharge Summary form at the time of discharge or an IP Discharge Note form may be completed with the full discharge summary to follow within 7 days. A Discharge Summary must minimally include the following:
    1. patient's name, TDCJ number, and facility of assignment
    2. Brief summary of admission history and physical exam (an H&P for the current admission in the health record will meet this requirement)
    3. Admission diagnosis
    4. Inpatient course including results of diagnostic tests, medications and treatments provided and changes in signs and symptoms, operative procedures, pathology, clinical laboratory examinations, etc.
    5. Discharge diagnosis
    6. Discharge treatment plan including discharge medications, special diet, activity or assignment limitations, recommendations regarding referrals, and facility level follow up.
- VII. Guidelines for inpatient mental health documentation:

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 05/12/2014	NUMBER: H-60.2  Page 3 of 3
	Replaces: 10/30/2013	
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- A. The following documentation must occur upon admission:
  - 1. Complete psychiatric evaluation, including pertinent physical finding within 3 work days of admission.
  - 2. Psychosocial evaluation within 10 work days of admission
  - 3. Nursing will complete the Mental Health Inpatient Nursing Assessment within 8 hours of admission. If the offender is being admitted to inpatient care from Crisis Management where a nursing assessment was completed, nursing may substitute a nursing clinic note indicating admission/transfer, current status/observations, and vital signs.
- B. A current inpatient individualized treatment plan (ITP) will be documented in the inpatient chart. The ITP will be reviewed as necessary or at least every 180 days and will indicate any significant changes in patient status or treatment.
- C. Documentation will be made in the record upon each clinical intervention.
- D. Discharge documentation will include:
  - 1. Identifying data
  - 2. Date and reason for admission, including the admit diagnosis.
  - 3. Clinical course and reason for discharge
  - 4. Discharge diagnosis
  - 5. Recommendations
  - 6. Dated signature of discharging psychiatrist
  - 7. The HSM-18 will be updated to reflect the current diagnosis and restrictions.
- E. Mental health patients being considered for court ordered temporary mental health services upon release from TDCJ will be referred to the Skyview Psychiatric facility 30 days prior to their anticipated release date in order to complete all necessary documentation required.

Reference: ACA Standard 4-4352 (Ref. 3-4354), Infirmity Care (Non-Mandatory)