

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 8/23/18	NUMBER: H-60.1 Page 1 of 6
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	Formulated: 8/88 Reviewed: 07/18	
HEALTH RECORDS – ORGANIZATION, MAINTENANCE AND GOVERNANCE		

PURPOSE: To provide guidelines for the development, utilization, management, accuracy and integrity of offender health records in either paper or electronic format.

POLICY: Health records (paper and/or electronic) on each offender are maintained in a manner 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 record
10. All findings, 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. Panoramic radiograph and other dental x-rays
17. Health records obtained from other sources with the patient's release of information, excluding radiologic images, photographs or video content.

II. All existing paper health records must be filed 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 Sections 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).

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

- III. A.** 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 unless unforeseen circumstances prevent this (e.g. power outage, network outage). Entries made by clerical staff (e.g. 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 including the credentials of the person making the entry.

Electronic Health Record entries must:

- Have an electronic signature, including the credentials of the person making the entry.

B. Per Texas Medical Board rules, the health record should be “legible, contemporaneous and accurate”. For this reason,

1. Previous chart entries that are copies and pasted into a current note, should be clearly identified as copied text with the original date and time of the entry at the beginning and end of the copies portion of text, however, this practice should be avoided.
2. Forwarding text (“Copy Forward” or “Cloning”) from a previous note on which that text did not originate is not allowed.

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3. Pre-population of non-biographic fields that would typically change from visit to visit should not occur.

C. Administrative or controversial communication about patient care should not be part of the Medical Record.

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

- 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 EHR. Highlighting of entries in the health record in any color is not allowed. Corrections should be done by addendum.
- b. If a correction to a medication-administration entry is required in the EHR beyond one week, a corrected paper medication administration record must be completed by the person who wrote the original entry and scanned in to the EHR. If that person is no longer available, his/her supervisor or designee will be asked to enter the corrected

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medication administration record. 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. Note Builder or Automated documents: If an entry in the EHR is made in the wrong chart, the respective IT Help Desk should be contacted to initiate removal from the chart. The entry should be rewritten by the person who wrote the original entry, 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, his/her supervisor or designee will be asked to rewrite the entry.
- b. Scanned document: Documents scanned to the wrong chart may be moved to the correct chart.

3. Late Note and Addendum

- a. Clinical entries will be made during the shift that the writer is working.
- b. 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.
- c. An addendum is defined as documentation added to the health record that is used to addend one's own work

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during his/her shift. Addendums to an entry must be documented on a separate clinic note.

- d. An addendum may also be used to correct an error User’s corrected entry must be designated “CORRECTION:”
- e. Document Clarification notes will be used to explain an entry by another user.

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

1. 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.
2. 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.

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

VII. All records from outside of CMC pertaining to a patient (outside records) will be directed to a CMC provider for review and signature. If records are received on paper,

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they will be scanned in and directed to the provider at that time. Records received electronically will be forwarded to a provider for review and signature. This includes specialty clinic documentation for telemedicine encounters with non-CMC practitioners.

VIII. Only approved Health Services forms or electronic documents are 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. 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). Approval for the addition of new types of content in the EHR should be obtained by requesting it from the IT/IS department of UTMB, represented by the CMIO for CMC.

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