INTERNAL MANAGEMENT POLICY & PROCEDURES

STATEMENT OF ANNUAL REVIEW

IMPP # 05-105

Title: INFORMATION TECHNOLOGY AND RECORDS: Health Record

The above referenced Internal Management Policy and Procedure (IMPP), issued effective 06-26-06, was reviewed during January 2009 by the KDOC Policy Review Panel per IMPP 01-101. At the time of this annual review the Policy Review Panel determined that: no substantive changes and/or modifications to this IMPP are necessary at this time, and the IMPP shall remain in effect as issued on the above stated date.

The next scheduled review for this IMPP is January 2010.

This statement of annual review shall be placed in front of the referenced IMPP in all manuals.

03/13/09

_____ _____

Policy and Procedure Coordinator Date

KANSAS DEPARTMENT OF CORRECTIONS

	INTERNAL MANAGEMENT POLICY AND PROCEDURE	**SECTION NUMBER** **05-105**	**PAGE NUMBER** **1 of 6**
		SUBJECT: **INFORMATION TECHNOLOGY AND RECORDS: Health Record**	
Approved By:  **Secretary of Corrections**		**Original Date Issued:**	**07-23-84**
		Current Amendment Effective:	**06-26-06**
		Replaces Amendment Issued:	**05-21-01**

POLICY

A health record shall be maintained, separately from the case management files, for each inmate under the custody of the Secretary of Corrections. This record shall contain accurate, cumulative documentation of all health care services and encounters provided throughout the period of incarceration. The inmate's health record shall accompany the inmate upon transfer to another KDOC facility. The health record may be removed from the facility and provided to outside health care providers only when the inmate requires offsite emergency care. When an inmate is released to post incarceration supervision, all medical and mental health records shall be forwarded, with case management records, to the respective records office for storage, retention and disposition.

DEFINITIONS

Active Health Record: Medical, dental and mental health records of all offenders housed within any KDOC facility.

Inactive Health Record: medical, dental and mental health records of all offenders discharged from sentence or released to post-incarceration supervision.

Contract Medical Consultant: The physician or the nurse hired under contract to the Department of Corrections to assist the Health Services Administrator

Departmental Health Authority: The medical director of the agency or organization responsible for the provision of health care for the Kansas Department of Corrections.

Facility Health Authority: The physician, or health administrator responsible for the provision of health care services at a facility. The facility health authority works under the direction of the Department's health authority.

Facility Records Office: The records storage area for the facility.

Health Record: Medical and mental health information maintained and secured by the health care provider and contained in the form of electronic or paper media.

Health Services Administrator: The Central Office position assigned to the Programs Division responsible for the coordination of medical and mental health service delivery to inmates.

Inactive Offender Records Repository: A centralized inactive records section for the Department of Corrections, located at the Topeka Correctional Facility-Central Unit (TCF-C).

Medical/Mental Health File: Reflects all medical, dental and mental health psychiatric orders and treatments provided, including consultations and X-ray films.

Mental Health File: Raw Psychological Testing Data File. Reflects all mental health and psychiatric testing material .

PROCEDURE

I. Establishment of the Health Record

A. The Departmental health authority shall ensure that the health record contains sufficient information to identify the inmate, support diagnoses or assessment, justify the treatment or care, and accurately document the results.

B. The facility health authority at the Topeka Correctional Facility - Reception and Diagnostic Unit (TCF-RDU) shall be responsible for initiating a health record at the time of the inmate's reception into KDOC custody.

1. The medical / mental health file folder shall be red in color.

2. The mental health psychological test data file folder shall be blue in color.

C. The TCF – and EDCF RDU health authority shall be responsible for maintaining a unit record system whereby all health records for each incarceration shall be brought forward and filed under the inmate's current assigned KDOC number. This requirement shall not restrict the facility health authority from filing inmate health records according to inmate name.

II. Contents of the Medical File

A. The medical/mental health file shall be established and maintained in the electronic and paper format which includes:

1. Identification data (name, KDOC number, age, date of birth, and sex);

2. A defined database (past health care history, initial physical exam, and list of problems);

3. Patient Notes/Physician Orders (documentation of all occasions of health care provided, both on-site and off-site); and,

4. Supportive ancillary services (all laboratory, x-ray, EKG, other diagnostic work, dental, optometric, pharmacy, therapies, consultations, and hospitalizations).

B. Medical files shall include any medical or dental information, but at a minimum shall include:

1. Screening and health appraisal/assessment forms;

2. History and physical forms;

3. Findings, diagnoses, treatments, dispositions, and prognoses;

4. Specials needs treatment plan;

5. Immunization records;

6. Medications and medication administration records;

7. Laboratory, X-ray, and other diagnostic studies and reports;

8. Consent and refusal forms;

9. Release of information forms;

10. Records of place, date, and time of encounters;

11. Specialists consultation reports;

12. Treatment plans, including nursing care plans;

13. Progress notes/reports;

14. Hospital discharge, infirmary discharge, and other service termination summaries;

15. Physical examination records/summaries;

16. Psychiatric and mental health professionals shall utilize the medical/mental health record as a source of information, particularly when the inmate is on psychotropic medication or requires psychiatric/medical management. The mental health record shall contain:

    a. Reception & Diagnostic Unit evaluation reports;

    b. Psychological testing results;

    c. Clinical Service Reports;

    d. Psychiatric evaluation summaries;

    e. Mental health treatment plans;

    f. Chronological notes from counseling sessions; and,

    g. Any documentation of treatment in mental health treatment facilities.

17. Other written or graphic data on health care services rendered in a:

    a. Hospital;

    b. Infirmary;

    c. Chronic care clinic;

    d. Emergency room;

    e. Outpatient clinic;

    f. Rehabilitation facility;

    g. Dental clinic;

    h. Psychiatric/psychological treatment setting;

    I. Private physician's office or clinic;

    j. Routine sick call encounter; and/or,

    k. Routine segregation rounds.

18. Contents of the mental Health File: The mental health psychological raw test data file shall contain raw psychological test data from all administered psychological tests.

A. Health care personnel shall have input, when appropriate, into the medical file. These shall include: Physicians, registered nurses, licensed practical nurses, dentists, psychiatrists, physician assistants, and treatment specialists.

B. Each document contained within the health record shall be titled and signed.

III. Health Record Maintenance and Review

A. The health authority of the facility in which the inmate is housed shall ensure that each health record is maintained in a manner consistent with statutory requirements and accepted standards of care and security for the following purposes:

1. To serve as a basis for planning individual care;

2. To facilitate and document continuity of evaluation, treatment, care, and any changes in condition;

3. To facilitate evaluation of quality of care;

4. To protect the legal interests of the KDOC, facility, inmate, and the health-care providers;

5. To serve as a basis for statistical analysis and clinical data for use in program planning, education and approved research; and,

6. To document communication between the responsible physician and other health-care providers contributing to the inmate's total health care system.

B The health authority shall approve the methods of recording entries in the health records, the form and format of the health records, and the procedures for their maintenance and safekeeping.

C. The Health Information Technology Administrator, employed by the Department's health care provider, shall conduct an annual audit of health records at each facility.

1. This audit shall be for the purpose of ensuring accuracy and completeness of information, organizational conformity, and storage security.

D. The KDOC Health Services Administrator shall conduct random spot audits of health care records in conjunction with onsite visits and shall conduct audits of particular records whenever questions or problems dictate.

IV. Transfer of Health Records

A. Health records shall be brought up-to-date prior to the inmate's to transfer another KDOC facility.

1. Facility personnel responsible for inmate transfers shall notify health care personnel at least 24 hours prior to a routine transfer, whenever feasible, to ensure that the health record is appropriately prepared for transfer.

2. The records shall be transferred with the inmate in accordance with IMPP 12-110.

B. When transferring an inmate to offsite emergency care, requested copies of pertinent information from the inmate's health record shall be faxed by health care staff, or, delivered by KDOC personnel, to the emergency provider in accordance with provisions of IMPP 05-107.

1. In the event health care personnel are not on site, the health record shall be checked out of the health records storage area by authorized KDOC personnel and delivered to the emergency provider for copying of pertinent information.

2. Once the emergency health care provider has copied the necessary information, the health record shall be returned to the health record storage area by the authorized KDOC staff member.

V. Storage of Health Records

A. The warden shall provide adequate space within the clinic and/or mental health area(s) of the facility for the secure storage of health records.

B. The health authority at each facility shall ensure that all active health records are stored in a locked and secure area accessible only to authorized personnel.

1. The clinic shall be the preferred area for storage of health records.

2. The health authority, in consultation with the warden, shall identify those persons authorized to access health records.

3. The health authority shall maintain a current list, by name, of all persons granted health record access.

C. The Department's health care contractor shall establish a policy and procedure that ensures accountability of each health record at all times.

1. At a minimum, the record of accountability shall provide for written documentation any time a medical or mental health file is transferred or transmitted from one facility to another facility. Such documentation shall include the name of the facility to which the documentation is being transferred.

VI. Retention of Health Records

A. When an inmate is released from custody to post incarceration supervision or dies when incarcerated, all medical and mental health records shall be forwarded to the facility records office per provisions of IMPP 05-103.

1. Forwarding of health records to the facility records office after an inmate's death shall not occur until after photocopying of the medical file, per the requirements of IMPP 01-114, has occurred. A copy of the entire medical file shall be forwarded to the Director of Investigations via the Central Office Health Services Unit.

a. Any additional health documents received after the initial copy of the medical file was provided to the Central Office shall also be copied and routed in the same manner.

2. All available medical and/or mental health information shall be included in the health record and provided to the facility records office staff for packaging with other records and files related to the inmate prior to shipment to the repository.

VII Release of Health Records

A. Any request for release of health information is to be forwarded to either the KDOC Records Custodian or his/her designated Medical Request Administrator (MRA) within one working day of receiving the request.

B. The KDOC Records Custodian or designated MRA shall log and monitor the release of all requests for medical, dental, and mental health information as they occur throughout the Department.

C. After a request is received by the KDOC Records Custodian or designated MRA, the receiving staff shall inform staff within the records office holding the affected files of the types of information to be copied and the method to be employed in transmitting the information back to the KDOC Records Custodian or designated MRA.

1. The transmittal of this information shall occur within three [3] working days.

D. Requests for information on offenders whose records are in the custody of the Health Authority (PHS) will be handled by the local records office, subsequent to the receipt of the information request from the KDOC Records Custodian or designated MRA.

1. The local records officer shall coordinate with PHS to provide the required information.

NOTE: The policy and procedures set forth herein are intended to establish directives and guidelines for staff and offenders and those entities who are contractually bound to adhere to them. They are not intended to establish State created liberty interests for employees or offenders, or an independent duty owed by the Department of Corrections to either employees, offenders, or third parties. Similarly, those references to the standards of various accrediting entities as may be contained within this document are included solely to manifest the commonality of purpose and direction as shared by the content of the document and the content of the referenced standards. Any such references within this document neither imply accredited status by a Departmental facility or organizational unit, nor indicate compliance with the standards so cited. This policy and procedure is not intended to establish or create new constitutional rights or to enlarge or expand upon existing constitutional rights or duties.

REPORTS REQUIRED

None.

REFERENCES

IMPP 05-103, 05-107, 12-110
ACO 2-4E-01
ACI 3-4376, 3-4377, 3-4378, 3-4379
NCCHC P-59, P-60, P-61, P-62, P-63

ATTACHMENTS

None.