STATE of MAINE
DEPARTMENT OF CORRECTIONS

Approved by Commissioner:

EFFECTIVE DATE: December 1, 2003
LATEST REVISION: May 28, 2013
CHECK ONLY IF APA [ ]

I. AUTHORITY

The Commissioner of Corrections adopts this policy pursuant to the authority contained in 34-A M.R.S.A. Section 1403.

II. APPLICABILITY

All Departmental Juvenile Facilities

III. POLICY

It is the policy of the Department of Corrections to maintain health care records for all residents to enable health care providers to accurately assess a resident’s health care status and document diagnoses, treatment and plan of care. The method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping shall be approved by the facility’s Health Services Administrator.

IV. CONTENTS

Procedure A: Health Care Records Management
Procedure B: Transfer of Health Care Records
Procedure C: Retention of Resident Health Care Records

V. ATTACHMENTS

None

VI. PROCEDURES

Procedure A: Health Care Records Management
1. The health care records for each resident shall be maintained in an electronic format and shall include the resident’s name, date of birth and MDOC number.

2. All progress notes entered into a resident’s health care records shall follow a problem oriented charting style (Subjective, Objective, Assessment, Plan -- SOAP note).

3. Each resident’s health care record (paper and/or electronic) shall contain, at a minimum, the following items filed in a uniform manner:
   a. Resident’s name and MDOC number on each printed sheet,
   b. Problem list, including allergies,
   c. Admission health screening form,
   d. Health assessment forms,
   e. All significant findings, diagnoses, treatments and dispositions,
   f. Progress notes,
   g. Health care practitioners’ orders,
   h. Laboratory reports,
   i. X-ray reports, diagnostic studies, operative reports, pathology reports, and examination and consultation reports, and telemedicine reports, if applicable,
   j. Consent to treat and/or refusal of treatment forms,
   k. Release of information forms,
   l. Flow sheets and chronic care clinics and wellness clinics (annual examinations), and special needs treatment plan, if any,
   m. Physical activity limitation sheets,
   n. Food Service Medical Clearance Form,
   o. Immunization records,
   p. Medication Administration Record (MAR),
   q. Sick Call Slips, if applicable,
   r. Hospital, nursing home records, if applicable,
   s. Advance Directives
   t. Correspondence,
   u. Mental health records,
   v. Dental records,
   w. Optometric records,
   x. Physical therapy records,
   y. Individualized treatment plan,
   z. Place, date and time of health encounters
   aa. Hospital discharge summaries and termination summaries for outpatient treatments and special services, as applicable,
   bb. Information received as a result of release of information requests, if applicable,
   cc. Transfer and/or discharge health care summary forms, and
   dd. Documentation of resident death, if applicable.
4. Information related to HIV testing, treatment and follow-up may only be released to a staff member whom the Chief Administrative Officer of the facility deems has a legitimate need to know this information. This information may only be released to other agencies or individuals who, by law, have a right to view this information or by virtue of a release form signed by the resident or the resident’s parent/guardian specific to information relating to HIV.

5. Each entry into a resident’s health care record shall include signature, title, date and time of entry. Each entry shall be made immediately following the event, unless impractical. A late entry shall be made as soon as possible and shall reflect the delay in making the entry.

Procedure B: Transfer of Health Care Records

1. The Classification Officer, Records Officer, or designee, shall be responsible to notify the health care staff of transfers in a timely manner to facilitate the preparation of medications and health care records, as applicable. (See Policy 13.4, Health Screening and Assessments, Procedure C)

2. Once health care staff are notified of a transfer or impending transfer to another Department facility, the health care staff shall prepare a Medical Transfer form (See Policy 13.4, Attachment F).

3. When a resident is transferred to a facility in another jurisdiction, a Medical Transfer form shall be forwarded to the receiving facility with the resident, along with a printed version of the resident’s MAR, immunization record, and a Health Care Discharge Summary (see Policy 13.5, Attachment F). Additional health care information shall be provided upon request.

4. Designated health care staff shall evaluate the resident’s medical suitability for travel, with attention to communicable disease issues, and shall provide written instructions for the transport officers, if necessary, regarding medication or health interventions required en route, as well as any specific precautions to be taken by transport officers.

5. Upon release from a facility, a Health Care Discharge Summary (Policy 13.5, Attachment F) shall be prepared and a copy given to a resident who has attained the age of 18, or to the resident’s legal guardian.

6. Upon release of the resident from the custody of the Department, health care record information shall be provided to specific and designated health care practitioners or community hospitals, only with the written request or authorization of a former resident who has attained the age of 18 and who has no legal guardian or if the former resident has not attained the age of 18 or has a
legal guardian, only with the written request or authorization of the resident’s parent or legal guardian.

Procedure C: Retention of Resident Health Care Records

1. Inactive resident health care records shall be forwarded to the facility’s Classification or Records Officer, or designee, within sixty (60) days of the resident’s release and shall be kept at the facility as set out in the Department’s record retention schedules.

VII. PROFESSIONAL STANDARDS

ACA:

4-JCF-4C-09  A written medical summary is required for all intrasystem transfers to maintain continuity of care. When a juvenile is transferred, the following is required:

1. The health record and medical summary shall be forwarded to the receiving facility prior to or provided at arrival.
2. Confidentiality of the health record is maintained.
3. Medically sensitive conditions and/or specific precautions to be taken by transportation officer(s) are addressed and documented prior to transport.
4. Written instructions regarding medication or health interventions required en route should be provided to transporting officers and be separate from the medical record.

4-JCF-4C-31 (MANDATORY) The principle of confidentiality applies to juvenile health records and information about juvenile health status. The active health record is maintained separately from the confinement case record. The health authority, in accordance with state and federal law, controls access to the health-record.

4-JCF-4C-32 A juvenile’s health records (paper and/or electronic) contain the following items filed in a uniform manner:

1. Patient Identification on each sheet
2. Receiving-screening form
3. Health-appraisal data and examination forms
4. Record of immunizations
5. Diagnoses, treatments, and dispositions
6. Individualized treatment plan, when appropriate
7. Progress reports
8. Place, date and time of health encounters
9. Record of prescribed medications and their administration, if applicable
10. Laboratory, x-ray and diagnostic studies
11. Release-of-information forms
12. Consent and refusal forms
13. Health service reports (for example, emergency department, dental, mental health, telemedicine, or other consultations
14. Discharge summary of hospitalization and other termination summaries, (outpatient treatments and special services not requiring hospitalization but which have a documented endpoint)
15. Legible signatures and the titles of providers (may use ink, type, or stamp under the signature

The health authority approves the method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping. The health record is made available to and used for documentation by all qualified health-care professionals and health-care practitioners.

4-JCF-4C-33 Inactive health-record files are retained as permanent records, in accordance with state and federal law. Health-record information is provided to specific and designated health-care practitioners or medical facilities in the community only on the written request or authorization of the juvenile’s parent, guardian, or legal custodian.