GEORGIA DEPARTMENT OF CORRECTIONS **Standard Operating Procedures**		
Policy Name: Patient Tracking Systems		
Policy Number: 507.04.04	**Effective Date:** 02/10/2022	
Authority: Commissioner	**Originating Division:** Executive Division (Physical Health)	**Access Listing:** Level I: All Access

I. Introduction and Summary:

Each facility will maintain logs of selected clinical activities for the purposes of scheduling, ensuring continuity of care, and data collection. This procedure is applicable to all facilities that house Georgia Department of Corrections (GDC) offenders to include private and county prisons.

II. Authority:

A. GDC Standard Operating Procedures (SOPS): 227.02 Statewide Grievance Procedure, 507.04.10 Consultations and Procedures, 507.04.28 Chronic Care, 507.04.27 Sick Call, 507.04.25 Health Screening- Offender Transfers, 507.04.37 Urgent and Emergent Care Services, 507.04.42 Infirmary Care, Observation, Accommodative Living Unit, 507.04.43 Medication Distribution System, and 507.04.54 Management of Offenders with Suspected or Active Tuberculosis.

III. Definitions: None.

IV. Statement of Policy and Applicable Procedure:

A. Patient Tracking Systems and Data Collection:

1. Each facility will maintain logs that are designated by the Office of Health Services as mandatory.

2. A computerized program may be used, provided the program can display and print forms which are entirely equivalent to official logs, including all columns and categories found in the approved logs. Additional columns are permitted.

B. Maintenance of Official or Approved Logs:

1. The following logs are currently mandatory:

a. Medical Database (Alpha Roster);

b. Diagnostic Intake Tracking Log (P-03-0005-01);

c. Intrasystem Transfer Tracking Log (P-03-0005-02);

d. Annual Physical Examination Log (P-03-0005-03);

e. Annual Physical Tracking Log for Females (P-03-0005-04);

f. Annual PPD Tracking Log (P-03-0005-05);

g. Chronic Illness Clinic (CIC) Tracking Log (P-03-0005-06);

h. Gynecological Clinic Tracking Log (P-03-0005-07);

i. Obstetrical Tracking Log (P-03-0005-08);

j. Urgent/Emergent Encounter Log (P-03-0005-09);

k. Sick Call Encounter Log for General Population (P-03-0005-10);

l. Sick Call Encounter Log for Restrictive Housing (P-03-0005-11);

m. Consultation Tracking Log (P-03-0005-12);

n. Health Care Concerns/Grievance Log (P-03-0005-14);

o. Infirmary Log (P-03-0005-15);

p. ACU/CSU Tracking Log (P-03-0005-16); and

q. Radiology Daily Services Log (P-03-0005-17).

2. Log pages should be numbered as required to ensure a chronological sequence.

3. Incorrect entries will be corrected by striking a single line through the entry, dating, and initialing the corrected entry. Deletions should be corrected in the same manner.

4. The log pages will not be recopied solely to alphabetize new arrivals. Computerized logs should be arranged in alphabetical order with respect to offender's last names.

5. Logs should be maintained in retrievable storage for a minimum of three (3) years in order to facilitate responding to grievances, gathering statistics, etc.

C. Defining the Specific Logs:

1. Medical Database (Alpha Roster):

   a. A current institutional alphabetical roster will be maintained so the staff can determine which offenders are currently in the facility.

   b. The roster should be printed twice a week. The most current roster should be maintained in the health care delivery area.

2. Diagnostic Intake Tracking Log:

   a. Each Diagnostic Center will maintain a Diagnostic Tracking Log for the purpose of ensuring the timely completion of all components of the medical diagnostic process.

   b. The log must be completely filled out to include the following:

      1) Date of arrival;

      2) Offender name;

3) State ID number;

4) Date laboratory studies are scheduled. (Including HIV and RPR);

5) Date laboratory studies are completed. (Including HIV and RPR);

6) Date of pending physical examination;

7) Date physical examination is completed;

8) Date of PPD; and

9) Date of Dental screening.

3. Intrasystem Transfer Log:

   a. Each facility will maintain an Intrasystem Transfer Log.

   b. The log must be completely filled out to include the following:

      1) Name;

      2) State ID number;

      3) Date of birth and age;

      4) Date of last PPD;

      5) Date next PPD is due;

      6) Date of last Physical Examination;Date of the next Physical Examination;

7) Dates and type of any Chronic Illness Clinic due;

8) Date and type of pending Consultations;

9) In addition, for females:

- Date of last Pap Smear; and

- Date of last Mammogram.

c. The Daily Housing Assignment sheet may be used to ensure that all new arrivals are placed on the log. Health care personnel will be assigned the responsibility of reviewing the roster against the Intake Screening Log daily to ensure that the previous day's arrivals are all listed. At a minimum, the Director of Nursing or designee will review the log once a week to ensure that all new arrivals are being placed on the log.

4. Annual Physical Examination Log:

a. Each facility will maintain an Annual Physical Examination Log.

b. The log must be completely filled out to include the following:

1) Date of entry;

2) Name;

3) State ID number;

4) Date of birth/age;

5) Date of last Physical Examination;

6) Date for the next Physical Examination;

7) Checkmark indicating the physical exam has been performed as planned; and

8) Dates of performed exams are checked as done and future dates are shown.

5. Annual Physical Examination Log for Females:

1) Date of entry;

2) Name;

3) State ID number;

4) Date of birth/age;

5) Enrollment in Chronic Illness Clinic;

6) Date of last Physical Examination;

7) Date for the next Physical Examination;

8) Checkmark indicating the physical exam has been performed as planned;

9) Date of last PAP exam;

10) Date of next PAP exam;

11) Checkmark indicating the physical exam has been performed as planned;

12) Abnormal physical exam yes or no;

13) Date of last mammogram;

14) Date of next mammogram;

15) Abnormal mammogram yes or no; and

16) Dates of performed exams are checked as done and future dates are shown.

6. Annual PPD Tracking Log:

    a. Each facility will maintain an Annual PPD Tracking Log.

    b. The log must be completely filled out to include the following:

        1) Date of entry;

        2) Name;

        3) State ID number;

        4) Date of birth/age;

        5) Date of last PPD; and

        6) Date of next PPD.

7. Chronic Illness Clinic (CIC) Tracking Log:

    a. Each facility will maintain a CIC Tracking Log.

b. The log must be completely filled out to include the following:

1) Date of entry;

2) Name;

3) State ID number;

4) List of all Chronic Illness Clinics the patient is enrolled in;

5) Date of completion of Database;

6) Date of last CIC;

7) Date the next CIC is planned;

8) Laboratory studies are planned; and

9) Laboratory studies are done.

8. Gynecological Clinic Tracking Log:

a. Each female facility will maintain a Gynecological Clinic Tracking Log.

b. The log must be completely filled out to include the following:

1) Name;

2) State ID number;

3) Date of entry. (i.e., Date of physician order enrolling the patient into the clinic);

4) Date of appointment;

5) Diagnostic Procedure;

6) Procedure date;

7) Check mark indicating the procedure has been performed; and

8) Date of discharge from the clinic.

9. Obstetrical Tracking Log:

a. Each female facility will maintain an Obstetrical Tracking Log.

b. The log must be completely filled out to include the following:

1) Clinic Entry date (i.e., Date of physician order enrolling the patient into the clinic);

2) Name;

3) State ID number;

4) Last menstrual period;

5) Estimated date of confinement;

6) Date of ultrasound;

7) Initial OB appointment date;

8) Next visit:

- Tests;
- Appointment date;

9) Next visit:
   - Tests;
   - Appointment date;

10) Next visit:
    - Tests;
    - Appointment date;

11) Delivery date;

12) Type of delivery;

13) Six week follow up appointment date;

a. Discharge date from clinic; and

b. Dates of performed exams are checked as done and future dates are shown.

10. Urgent/Emergent Encounter Log:

a. Each facility will maintain an Urgent/Emergent Encounter Log listing all urgent or emergent needs including all walk-ins.

b. The log must be completely filled out to include the following:

1) Date;
2) Time notified;
3) Who notified by;
4) Name;
5) State ID number;
6) Patient location;
7) Nature of Problem;
8) Telephone triage yes or no;
9) Disposition;
10) Who responded;
11) Time of response;
12) If EMS is notified, list time of notification, arrival, and departure; and
13) Co-pay assessed yes or no.

11. Sick Call Encounter Log: General Population.

    a. Each facility will maintain a Sick Call Encounter Log for general population, reflecting availability of sick call access on a daily basis (Exceptions- weekends and holidays).

    b. The log must be completely filled out to include the following:

1) Date of encounter;
2) Name;
3) State ID number;
4) Nature of sick call complaints;
5) Qualified health care professional performing sick call;
6) No Shows;
7) Co-pay assessment; and
8) Disposition.

12. Sick Call Encounter Log: Restrictive Housing Unit:

a. Each facility will maintain a Sick Call Encounter Log for Restrictive Housing.

b. The log must be completely filled out to include the following:

1) Date of the visit;
2) Name;
3) State ID number;
4) Nature of complaint;
5) Qualified health care professional performing sick call;

6) Co-pay assessment; and

7) Disposition.

13. Consultations Tracking Log:

a. Each facility will maintain a Consultation Tracking Log.

b. The log must be completely filled out to include the following:

1) Monthly review by health authority;

2) Name;

3) State ID number;

4) Date consultation ordered;

5) Specialty service requested;

6) Request is designated as Local, ASMP, or Telemedicine;

7) Check mark for more information requested;

8) Date of denial;

9) Description of information requested or denial reason;

10) Date approved;

11) Date of appointment;

12) Date patient is seen;

13) Date consultation report received; and

14) Date of follow up appointment with MD/NP/PA.

14. Health Care Concerns/Grievance Log:

a. Each institution will keep an Offender Health Care Concerns/Grievance Log.

b. The log must be completely filled out to include the following:

1) Date of receipt;

2) Name;

3) State ID number;

4) File number;

5) Nature of the concern;

6) Resolution; and

7) Date resolved.

15. Observation Unit Log:

a. Each facility with an observation unit will maintain an Observation Unit Log.

b. The log must be completely filled out to include the following:

1) Date of placement;

2) Time of placement;

3) Name;

4) State ID number;

5) Reason/Diagnosis;

6) Disposition;

7) Date released;

8) Time released; and

9) Total hours in observation unit.

16. Infirmary Log:

a. Each facility with an infirmary will maintain an Infirmary Log.

b. The log must be completely filled out to include the following:

1) Date of admission;

2) Time of admission;

3) Name;

4) State ID number;

5) Reason for admission;

6) Status of admission;

7) Date of discharge; and

8) Disposition.

17. Radiology Daily Services Log:

a. Each facility will maintain a Radiology Daily Services Log.

b. The log must be completely filled out to include the following:

1) Date procedure is requested;

2) Name;

3) State ID number;

4) Whether invasive or non-invasive;

5) Date scheduled;

6) Date completed;

7) Date report is received; and

8) Signature of physician.

D. An Appointment Book will be maintained for scheduling necessary care, including but not limited to:

1. Physician, nurse practitioner and/or physician assistant appointments;

2. Chronic illness visits;

3. Laboratory procedures;
4. X-ray procedures;
5. Consultations/Follow-up;
6. Treatments;
7. Medication non-adherence counseling; and
8. Referral visits.

V. **<u>Attachments</u>:** None.

VI. **<u>Record Retention of Forms Relevant to this Policy</u>:** None.