<table>
<tr><td colspan="3">GEORGIA DEPARTMENT OF CORRECTIONS

Standard Operating Procedures</td></tr>
<tr><td colspan="3">Policy Name: Health Record Management, Format and Contents</td></tr>
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Commissioner</td><td>Originating Division:
Health Services Division (Physical Health)</td><td>Access Listing:
Level I: All Access</td></tr>
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I. Introduction and Summary:

A permanent health record will be developed and maintained for each offender to document health care services and facilitate continuity of care. 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): 507.04.13 Continuity of Care for Ambulatory Services, 507.04.18 Discharge Planning, 508.38 Involuntary Psychotropic Medication, 507.04.48 Physical Restraints, 507.04.52 Patient Transport, and 507.04.86 Right to Refuse Treatment;

B. NCCHC 2018 Adult Standard: P-H-03; and

C. ACA Standards: 5-ACI-6D-08 (ref. 4-4413), 5-ACI-7A-04 (ref. 4-4352), 4-ACRS-4C-22, 4-ACRS-4C-23, and 4-ALDF-4D-26.

III. Definitions: None.

IV. Statement of Policy and Applicable Procedures:

A. Records Maintained:

1. A health record will be established for each offender upon entry to the Georgia Department of Corrections (GDC) system.

2. Further detail on the required assembly order for the health record is provided in the Medical Records Manual; Ancillary Forms.

3. Health records will be maintained in a confidential and secure manner in physically secure areas under the immediate control of health services personnel.

4. Authorized information to be placed on the outside of the record will be:
   a. Name and State I.D. number.

   b. Name Alert, if indicated.

   c. Known allergies.

   d. No disease/condition, including TB, HIV related information will be placed on the outside of the chart (This includes any stickers for color-coding or TB control flags).

B. Filing:

1. Filing equipment and space will be adequate to maintain the records, provide security, and facilitate retrieval.

2. A uniform identification system approved by the Office of Health Services will be maintained for filing to ensure the prompt location of an offender's health record.

3. All records and reports will be completed, and loose sheets will be filed within a period consistent with good medical, dental, and mental health practice.

4. Copies of all reports will be filed in the health record.

5. All documents in each record section will be filed in reverse chronological order.

6. All lab and diagnostic reports will be reviewed, initialed, and dated by the responsible advanced clinical provider before filing in the health record.

7. Loose sheets belonging to offenders who have left the facility (e.g., transfer) will be forwarded to the correct facility within ten (10) days.

C. Chart Organization and Content:

1. The health record is organized into six distinct sections with tabs separating the respective sections and assembled as follows:

a. SECTION I:

i. Physician Orders; and

ii. History/Physical Profile (Tab):

1) Physical Profile Form/Health Activity Form:

2) Physical Exam;

3) Health History; and

4) Receiving Screening Form.

b. SECTION II:

i. Plastic ID Plate;

ii. Pending Consultation;

iii. Problem List (Tab); and

iv. Progress Notes (Tab):

1) SOAPE Format;

2) Black ink is required; and

3) Includes Intra-System Transfer Health Screening Form and the Use of Force Initial Exam(s).

c. SECTION III:

i. Immunization Record; and

ii. Lab/X-ray (Tab):

1) Laboratory reports;

2) X-ray reports;

3) EKG reports;

4) Other procedures, (i.e., EMG, CT Scan, ECHO, EEG); and

5) Audio examinations.

iii. Eye Chart (Tab):

1) Eye Examinations;

2) Completed Eyeglass Order forms; and

3) Completed Eye Consults.

iv. Consents/Education (Tab):

1) Consent Forms: Refusal of Treatment and Waiver of Refusal of Treatment for Medical Treatment only;

2) Release of Information Requests; and

3) Education forms (i.e., HIV, TB).

v. Miscellaneous (Tab)

1) Health information from facilities prior to incarceration.

d. SECTION IV:

i. Flow Sheets (Tab):

1) Chronic Care Clinic Flow Sheets; and

2) PPD Flow Sheets/Database/CIC Database.

ii. Completed Consultation Sheets; and

iii. Medication Administration Record (MAR).

e. SECTION V:

i. Dental (Tab):

1) Progress Notes;

2) Intake Examination;

3) Consents: Refusal of Dental Treatment/Waiver of Refusal of Dental Treatment;

4) Dental Consults; and

5) Dental and Panoramic X-rays.

ii. Psychiatric/Mental Health (Tab):

1) Evaluations;

2) Progress Notes;

3) Refusals: Waiver of Refusal of Mental Health Treatment;

4) Completed Mental Health Consultations; and

5) Mental Capacity Evaluation.

f. SECTION VI:

i. Infirmary (Tab):

1) Infirmary Record/Hospital Admission;

2) Reference Assembly Order for Health Records for Infirmary Chart Assembly to arrange in chronological order; and

3) Community Hospital Admission Records.

D. General Requirements for Documentation:

1. Date and Time.

a. For every entry in the progress note, a date and time will be noted. All entries will be dated with month/day/year (i.e., 1/1/2022).

b. Military time will be used.

2. Format.

   a. All entries will be made legibly and in black ink.

   b. For every entry in the progress note, the type of encounter (e.g., sick call, chronic care, walk-in, etc.) will be indicated.

   c. Problem Oriented Health Record (POMR) format will be used.

   d. Only abbreviations approved by the GDC Statewide Medical Director will be used in the health record. Stedman's Abbreviations will serve as the guide (Stedman's Abbreviations/Acronyms & Symbols, Williams & Wilkens, Baltimore).

   e. All forms in the health record will be identified clearly with the offender’s name, State ID number, date of birth, race, and sex.

3. Corrections.

   a. When errors occur, a single line will be drawn through the error. The error line will be initialed and dated.

   b. The error will not be obliterated by ink. At no time will there be erasures and at no time will white out be used.

   c. Late entry documentation will include:

      1) Use the current date to identify when the late entry is done.

      2) Clearly mark the entry "Late Entry".

      3) State the date when the entry should have been documented.

4. Signatures.

    a. All entries will be signed by the provider with first initial, last name and professional title.

    b. Signature stamps will not be used except in combination with a signature and never in lieu of a signature.

    c. The Responsible Health Authority will maintain an up-to-date signature file in the medical unit for all health care staff.

5. Forms.

    a. Approved Health Service forms for facilities will be provided in the Medical Records Manual.

    b. Any new health record forms not contained in the Reference Forms Manual will require the approval of the Office of Health Services.

    c. Facilities will refrain from the design and use of other new health services forms without the approval of the Office of Health Services.

E. Deficiencies in Documentation: Deficiencies in documentation, including lack of signature, will be identified through review by the responsible health authority or designee for proper completion as soon as possible.

F. Legal Issues:

1. Reference to or inclusion of audits, CQI activities or incident reports will not be documented in the health record.

2. All documentation will be objective. Providers will refrain from the use of argumentative or adversarial statements regarding offenders or other health care providers.

3. References to offender grievances will not be entered in the health record.

G. Record/Offender Roster Cross-check Verification: An alphabetical roster of all resident offenders (updated weekly at a minimum) will be available in the medical section. This list will contain, at least, the full name of the offender, State ID number, sex, and race.

H. Reactivation of Old Records: When a released offender returns to the GDC system, the record of the previous incarceration will be reactivated, for reference purposes and will be clearly marked "Previous Incarceration" inside the record.

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

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