STATE OF WASHINGTON DEPARTMENT OF CORRECTIONS	APPLICABILITY **PRISON** OFFENDER MANUAL		
	REVISION DATE 9/21/20	**PAGE NUMBER** 1 of 10	**NUMBER** **DOC 640.020**
POLICY	**TITLE** **HEALTH RECORDS MANAGEMENT**		

REVIEW/REVISION HISTORY:

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SUMMARY OF REVISION/REVIEW:

Major changes to include updating terminology, document control, and self-authentication procedures. Read carefully!

APPROVED:

Signature on file

8/21/20

SARA KARIKO, MD
Chief Medical Officer
Date Signed

Signature on file

8/24/20

JULIE A. MARTIN, MPA, CDE
Deputy Secretary
Date Signed

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8/25/20

STEPHEN SINCLAIR, Secretary
Department of Corrections
Date Signed

REFERENCES:

DOC 100.100 is hereby incorporated into this policy; RCW 9.95.170; RCW 40.14; RCW 70.02; RCW 74.09.555; WAC 137-08; WAC 137-100; DOC 210.115 Forms Management; DOC 280.500 Records Management of Official Offender Files; DOC 280.510 Public Disclosure of Records; DOC 610.040 Health Screenings and Assessments; DOC 610.600 Infirmary/Special Needs Unit Care; DOC 800.010 Ethics

POLICY:

I. A health record will be created and maintained per the Health Record Procedure (HRP) and state and federal regulations for each patient to include accurate, chronological documentation of medical, dental, and mental health care services provided to patients housed in a Prison.

II. The Department has established guidelines for disclosing protected health information and ensuring confidentiality per RCW 70.02.

A. Patients have the right to confidentiality of health information, personal access, grant access to others, request amendments, and review disclosures.

B. Patients will not be required to waive their rights as a condition of receiving treatment.

DIRECTIVE:

I. Responsibilities

A. The Health Services Forms and Records Analyst Supervisor will ensure the HRP is updated as necessary and maintained on the Health Services SharePoint site.

B. Each facility will:

1. Maintain a health record for each patient assigned to the facility.

2. Provide equipment, supplies, and sufficient space for health records, including overflow volumes.

3. Maintain health records in a secure location accessible only to authorized employees/contract staff.

a. Health records will be maintained separate from the central file, except as outlined per DOC 280.500 Records Management of Official Offender Files.

4. Establish a tracking process for health records to ensure they are returned and secured in the designated location by the end of the business day.

5. Establish a process to ensure errors (e.g., illegible, misfiled, duplicates, or incomplete documents) are corrected as soon as possible, but within 2 working days of discovery.

    a. The author's signature will be obtained on unsigned documents, or the Facility Medical Director may sign for document authors who are unavailable.

C. The facility Health Services Manager will ensure the health records system meets regulatory, Department policy, and HRP requirements, and appropriate coverage of employees/contract staff are available to:

1. Perform daily operational tasks (e.g., filing, thinning, preparing charts).

2. Ensure accurate retention and maintenance for documentation in the health record, including overflow.

3. Create/update health records during the screening and assessment process per DOC 610.040 Health Screenings and Assessments.

4. Conduct monthly formal audits per the HRP.

5. Comply with the facility process for ongoing chart review to identify and correct misfiled documents.

D. Anyone within the Department having access to health information will receive initial orientation, annual training, and sign DOC 14-003 Confidentiality Statement to ensure proper handling.

1. Use, access, or provision of access to information in a manner that violates Department policy may be subject to disciplinary action, up to and including dismissal and/or criminal prosecution per DOC 800.010 Ethics.

II. Documentation Requirements

A. Health record documentation will comply with required statutes and regulatory standards. Documentation should be completed as soon as possible, but no later than 2 business days after an encounter, and will include:

1. Healthcare history (e.g., family/social history, allergies, surgeries, illness)
2. History of current illness and related physical examination
3. Assessments and plan

4. Healthcare needs and clinical priorities
5. Documentation of health services provided
6. Explanation of treatment risks and benefits, including any education provided
7. Filing in the correct section of the record by the author, or delivered upon completion to the secured health records area for filing

B. Only current Department forms will be used per DOC 210.115 Forms Management.

C. Documentation will:

1. Include patient name, DOC number, and date of birth on each page, including documents received from external sources. Embossing cards and pre-printed labels are allowed.

2. Include the date (i.e., month/day/year) and time (i.e., 24-hour).

3. Be typed or legibly written in black/blue ink that does not erase/smudge.

4. Use standard language and minimize abbreviations.

5. Be entered consecutively with no blank spaces between entries.

6. Be limited to comments/notations specific to the document. Additional notes should be documented separately.

7. Include any discipline-specific directives.

8. Have all required fields completed.

9. Be self-authenticated.

   a. Self-authentication will be original and include:

      1) Printed name stamp consisting of first initial, last name, and professional title with hand-written initials,

         a) Pre-made signature stamps will not be used in lieu of wet signatures for health record documentation.

         b) Signature stamps may be used with permission when needed for disability accommodation.

2) Typed/pre-printed name and professional title with hand-written initials,

3) Legibly printed name and professional title with hand-written initials, or

4) Electronic signature to include computer-generated name stamps when those cannot be altered.

b. For multiple-page documents, self-authentication and the word "continued" will be written on the bottom of each page.

D. When documentation authored by the patient is received by health services employees/contract staff and determined to be critical to patient care:

1. The employee/contract staff will write a note on DOC 13-435 Primary Encounter Report, DOC 13-047 Dental Treatment Record, or DOC 13-538 Mental Health Encounter to include:

   a. The date it was received, and
   b. How the document is critically relevant to patient care,

2. The document received must be date-stamped and authenticated by the healthcare provider and filed in the General Correspondence section of the patient's health record.

E. The health record, including copies, will not be removed from Department premises unless for official duties. Copies are only allowed:

1. For reproduction of lost/damaged records.

2. When the original is printed on thermal paper. The copy will be considered the original document.

3. When the author is off-site and documentation is authenticated and scanned.

   a. Once printed, the scanned image will be considered the original. Any nurse notes will be recorded on this document.

4. When required for treatment. These documents will be immediately destroyed upon treatment completion or patient transfer.

a. Copies will be maintained in a secured location in the Health Services area, and will not be considered part of the official health record.

F. Electronic documents will be immediately destroyed once added to the health record.

G. Amendments to correct information can only be made per the HRP and RCW 70.02.

H. Information to revise/update previous notes/encounters will be documented as appropriate, reference the original document, and be filed by the date of the new document and not the original.

1. Documentation occurring more than 2 business days from the date of the original document requires approval from the Facility Medical Director and clinical director supervising the author.

a. Documents scanned to the Facility Medical Director for stand-alone Level 2 facilities to be signed and scanned back will be considered originals.

III. Filing and Thinning

A. Health record documents will be filed in the appropriate section of the health record as soon as possible, but not to exceed 5 business days from creation. Documents removed for any reason must be immediately refiled to ensure documentation is not lost or misfiled.

B. Health records will be filed and thinned per Health Record Procedure HR101 Filing and Thinning located on the Health Services SharePoint site.

1. Consultation dividers are not required if a patient has not received a consult.

2. Designated dividers will be used for discipline-specific sections.

3. Overflow envelopes will be used for thinning health records, as needed. Records requiring repeated thinning will be added to existing overflow envelopes.

a. Records for active infirmary admissions will only be thinned when directed by the treatment team per DOC 610.600 Infirmary/Special Needs Unit Care.

C. Exceptions to thinning procedures may only be approved by the primary care provider/therapist or dentist to meet treatment needs. Facilities will develop a process to handle exceptions.

1. Any non-standard thinning will be returned to standardized format prior to transferring a record from the facility.

IV. Transfer, Release, or Death

A. When a patient is transferred, the health record will be handled per DOC 280.500 Records Management of Official Offender Files and the HRP.

1. For transfers between Department Prisons, the transporting officer will ensure the health record is transferred with the patient.

2. While stored at the regional records office, records employees may only open the health record to incorporate loose filing. All other access must be authorized by the Health Services Forms and Records Analyst Supervisor.

B. At no time should the health record be provided to patients upon transfer/release or to attend off-site/outpatient medical appointments.

C. If a death occurs, the patient's health record will be sent to Headquarters Health Services per the HRP.

V. Health Information Disclosure

A. Information contained in the health record, including information shared with health care professionals, is confidential and will only be disclosed/photocopied as authorized by statute. Requests will be processed per the HRP.

B. Patients may request, in writing, to examine or obtain a copy of all or part of their health information. A response will be made within 15 business days upon receipt of the written request.

1. Requests for copies will be submitted per DOC 280.510 Public Disclosure of Records.

2. Facilities will develop a process for patients to examine electronic health information. Information must be pre-screened to ensure patient health/ safety and confidentiality (e.g., group encounter with multiple patient names).

C. Authorization by a patient for voluntary disclosure of the health record, including copies, must be made in writing and maintained in the health record.

1. Verbal disclosures must be documented on DOC 13-203 Health Information Disclosure and verified using the code word provided on DOC 13-035 Authorization for Disclosure of Health Information.

a. A list of verbal disclosure authorizations will be maintained on the Health Services SharePoint site under Authorizations for Verbal Communications. Entries will be deleted from the Health Services SharePoint site when the authorization is expired/revoked.

D. Information may be disclosed without the patient's authorization as follows:

1. In the course of official duties, access to the health record is granted to:

a. Health services employees/contract staff (e.g., direct care, administrative, oversight).

b. The Americans with Disabilities Act (ADA) Compliance Manager and facility ADA Coordinators.

c. Employees/contract staff authorized by the Assistant Secretary for Health Services or per policy.

d. The following case management employees designated by the Secretary, who may document and access limited health information contained in a patient's electronic file while under the Department's jurisdiction:

1) Prison, Work/Training Release, and Field case managers
2) Correctional Program Managers
3) Correctional Unit Supervisors
4) Work/Training Release and Community Corrections Supervisors
5) Field Administrators
6) Work/Training Release Administrator

2. Non-health services employees/contract staff with a need to know patient health information will complete DOC 13-159 Request for Health Information for each request and submit separate emails as follows:

a. In Prison, to the Registered Health Information Administrator (RHIA)/Registered Health Information Technician (RHIT)/designee at the facility where the patient is housed.

b. In Work/Training Release or on community supervision, to dochealthinformation@doc1.wa.gov.

3. Information may be disclosed and/or exchanged with:

a. Health care providers in the community to ensure continuity of care per RCW 70.02.050(1)(a) and RCW 74.09.555

b. Coroners/medical examiners

c. Bill payers/payees

d. Attorneys General (AAG) representing the Department involved with current litigation (i.e., lawsuit or other legal action)

e. Representatives of other state agencies, public health authorities, or law enforcement personnel as authorized per statute/policy

f. Office of Corrections Ombuds (OCO)

1) Mental health and sexually transmitted infections require authorization.

E. Access to the health record, except health services employees/contract staff who have been granted access, will be documented on DOC 13-235 Health Record Access Log and maintained as a permanent document in the legal section of the health record.

F. Employees and contract staff receiving copies from health records will ensure confidentiality, and will not provide any information to anyone except as allowed under RCW 70.02.

DEFINITIONS:

Words/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

ATTACHMENTS:

None

DOC FORMS:

DOC 13-035 Authorization for Disclosure of Health Information
DOC 13-047 Dental Treatment Record
DOC 13-159 Request for Health Information
DOC 13-203 Health Information Disclosure
DOC 13-235 Health Record Access Log
DOC 13-435 Primary Encounter Report
DOC 13-538 Mental Health Encounter
DOC 14-003 Confidentiality Statement