Saint Louis COUNTY PUBLIC HEALTH	**CORRECTIONS MEDICINE** **Health Record Format and Content** **ACA Standard: 4 ALDF – 4C – 01**	
	Effective: January 1994 Revised: August 2001, April 2016, August 2019 Reviewed: Aug 2001, May 2013, Aug 2014, Apr 2016, Apr 2017, Apr 2018, April 2019	Policy Number: CM – 58

I. **PURPOSE:** To provide documentation of all health care services rendered to patients; to provide a means of communications to assure continuity of care; to serve as a basis for planning individual care, to protect the medical-legal interests of the patient, institution and care providers; and to serve as a basis for statistical analysis and clinical data for use in program planning and education.

II. **POLICY:** An electronic medical record (EMR) shall be maintained on all patients and will be maintained as a confidential document, to the extent required by law.

III. **RESPONSIBILITY:** All staff working in the Corrections Medicine program are responsible for the content of this policy and procedure as well as adherence to the policy.

IV. **PROCEDURE:**

1. A medical record shall be initiated at the time of the first health care encounter and screening. If a patient is readmitted to the facility, the prior medical record will be reactivated.

2. The health record shall be organized in a unit modified, problem oriented format. It shall include documentation of all health care encounters provided on-site. Documentation of all relevant care will be requested from the outside healthcare facility and included in the record.

3. Documentation shall be accurate, complete and current in order to facilitate appropriate communication concerning the patient's present and past health status. All encounters with patients are documented in the EMR within 24-hours of the encounter for inpatient level of care and 72-hours for outpatient level of care.

4. Inactive records shall be maintained in the Saint Louis County Department of Public Health (DPH) in the EMR file according to local, state and federal laws for records retention. Paper records are used as part of downtime procedures. Paper records used prior to the initiation of the EMR or during EMR downtime shall be scanned into the EMR.

5. The EMR shall be maintained as a confidential document, as governed by local, state and federal laws. Medical records relating to care provided by Corrections Medicine may be required from the DPH medical records and will be released in accordance with applicable state and federal laws.

6. Content of medical record includes, but is not limited to:
   a. "Fit for Confinement" form if appropriate

b. Initial health screening form
c. Intake medical history/nursing assessment
d. Physician history and physical
e. Doctors/nurses notes
f. Consent forms
g. Consultants forms
h. Outside medical records provided to the facility
i. Medication logs
j. Refusal of medical treatment forms
k. Laboratory results
l. Imaging reports
m. Release of information forms
n. Treatment plans

V. **REFERENCES:**

American Correctional Association; Performance-Based Standards for Adult Local Detention Facilities, fourth edition; 2004; Standard 4-ALDF-4C-01

National Commission on Correctional Health Care; Standards for Health Services in Jails; 2014; Standard J-A-01, Standard J-E-01 and J-E-07

This policy revised Aug, 2014 to include previous Corrections Medicine Policies CM-32, CM-38, CM-38.1 and CM-39