MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES
OAKLEY YOUTH DEVELOPMENT CENTER

Subject: **Health Record: Structure, Documentation and Confidentiality**	Policy Number: **8**
Number of Pages: **5**	Section: **XI**

Attachments	Related Standards & References
Interdisciplinary Progress Notes Form XI.8.A Health Records Index Form XI.8.B Medical Abbreviations for Nursing Services XI.8.C Vital Signs Form XI.8.D	ACA Juvenile Healthcare Performance Based Standards 2009: 4-JCF-4C-07,4-JCF-4C-08,4-JCF-4C-31,4-JCF-4C-32,4-JCF-4C-33, 4-JCF-4C-41
Effective Date: 06/09/06 **Revised Date: 05/01/07, 02/04/08, 04/22/08, 02/25/09, 06/25/09, 05/01/11, 11/01/13** **Review Date: 11/1/14, 11/12/15**	**Approved:** **James V. Maccarone, Director**

I. POLICY

It is the policy of the Mississippi Department of Human Services, Division of Youth Services, that all youth have a health record. Guidelines shall be established to ensure that a structured health record is maintained on each youth admitted to Oakley. Information about a youth's health status is confidential. All employees are required to uphold the principle of confidentiality of the health records and support the following requirements:
(4-JCF-4C-31)

- All active health records shall be maintained separately from the confinement case records.
- Access to the health record shall be in accordance with state and federal law. The Director of Medical Services controls access to the health record.
- The Director of Medical Services shall approve the method of recording entries in the records, the forms and format of the records and procedures for their maintenance and safekeeping.
- The Director of Medical Services/designee, physician, dentist and/or psychiatrist shall share with the Facility Administrator information concerning a youth's medical management when necessary to preserve the health and safety of a youth, other youth, staff, volunteers, and/or visitors and within the guidelines of confidentiality. Information provided to staff shall address only the medical needs of the youth as they relate to housing, program placement, security, and transport.
  (4-JCF-4C-41)

The Director of Medical Services shall establish and approve the method of recording entries in the record, forms, and procedures for record maintenance and safekeeping.

The health record shall be made available to and shall be used for documentation by all health care personnel.
The health record file shall contain the following: (4-JCF-4C-32)

- Patient identification on each sheet;
- Receiving screening form;
- Health appraisal data and examination forms;
- Record of immunizations;
- Problem list;
- Diagnoses, treatments, and dispositions;
- Individualized treatment plan, when applicable;
- Progress reports;
- Place, date and time of health encounters;
- Record of prescribed medications and their administration records, if applicable;
- Laboratory, x-ray, and diagnostic studies;
- medical release summaries; and

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

Health Care Personnel – an individual, whose primary duty is to provide health, dental or mental health services to youth in keeping with their respective levels of education, training, and experience. The individual is licensed in the State of Mississippi without restriction to practice nursing, medicine, dentistry, or psychiatry.

Qualified Mental Health Professional (QMHP)- Qualified Mental Health Professional (QMHP)- include Psychologist, and licensed mental health professionals who by virtue of their education, credentials and experience are permitted by law to evaluate and care for the mental health needs of patients.

Health Record- The youth specific MDYS record that contains all medical, dental and psychiatric assessments, diagnoses, treatment summaries, clinic visits, progress noted, doctors' orders, laboratory reports, and any other information pertaining to the youth's medical, dental and mental health and treatment.

Narrative Charting Format- A format of documentation in the progress note. The narrative progress note includes at a minimum: complaint, assessment and treatment given.

Psychology Record- The youth specific MDYS record that contains pertinent mental health documentation

SOAP Charting Format- A format of documentation in the progress note. The progress note includes:

- *Subjective data:* Information the youth imparts, such as the chief complaint and other impressions.
- *Objective data:* Factual, measurable data gathered during the assessment process, such as observed signed and symptoms, vital signs, and laboratory test values.

- *Assessment data:* Conclusions based on the collective subjective and objective data and formulated patient problems and/or diagnosis. This dynamic and ongoing process changes, as more or different subjective and objective information becomes known.
- *Plan:* The strategy for relieving the youth's problem. The plan should include both immediate or short-term actions and long-term measures.

III. PROCEDURES

A. A health record shall be established upon admission on all youth. All medical related court documents shall be maintained within the youth's health record.

1. The active health record shall be maintained separate from the confinement case records.

2. The health record shall be maintained in a locked area in the medical department as a confidential document. Only health care personnel shall have key access to this area.

3. The health record shall be maintained under hard cover. The front outside cover shall be stamped "Confidential."

4. Medical information about a youth's health status is confidential and may be shared by approval of the Director of Medical Services in accordance with state or federal law. The following personnel may have designated and unimpeded access to the health records and/or information

   - Division Director
   - Director of Institutions
   - Facility Administrator
   - Internal investigative staff
   - Departmental and accrediting body audit staff
   - Departmental Legal Counsel or other attorneys representing the Division
   - Persons authorized by an order or judgment of a court with appropriate jurisdiction
   - Psychology staff and, qualified mental health professionals. This shall include any interns or psychiatry residents that are directly supervised by one of the professionals aforementioned.
   - Psychology staff and qualified mental health professionals shall record the health record reviews in the appropriate log book located in the health record file room located in the medical clinics.

5. All other access to medical information while the youth resides in a facility shall be governed by the following specifications:

   a. When a facility receives a written request for release of information from a Physician or medical facility in the community for continuity of care only, the written request must specify the information requested, be accompanied by a

release of information signed and dated by a parent, guardian or legal custodian, and include the name and address to whom the records are to be sent.

b. Health records shall be shared with the approval of the Director of Medical Services.

c. When a youth is released from a facility and requires medical follow-up, the nurse shall copy related medical information and send it to the health care provider for continuity of care.

d. Documentation of shared information shall be completed in the youth's health record, Interdisciplinary Progress Notes XI.8.A

B. Continuity of care shall be required from admission to release from the facility, including referral to community-based providers when indicated. (4-JCF-4C-07,4-JCF-4C-08)

1. A medical summary shall be completed, when appropriate, on all youth when released to maintain the provision of continuity of care. (4-JCF-4C-08)

2. Inactive health records shall be retained as permanent records in compliance with the legal requirements of the jurisdiction and are shared with the approval of the Director of Medical Services. Medical and mental health records shall be shared with specific and designated physicians or medical/mental health facilities in the community for continuity of care only when written request and authorization of youth's parent, guardian or legal custodian. The written request for release of information from outside sources must specify the address of the Physician or mental health agency to which the records are to be sent. (4-JCF-4C-33)

C. The health record structure shall be divided into the following sections and chart tabs:

- Immunizations
- Psychiatry Notes
- Psychology notes and tests results
- Health History
- Problem List
- Medication Administrative Records
- Medical Release Summary
- Dental Record
- Special Health Care Plans
- OB Records
- Physician Orders
- Interdisciplinary Progress Notes
- Informed Consent
- Injury Assessments
- Exams and Assessments
- Consultations and Reports
- Miscellaneous

1. The health record shall contain the youth's name, date of birth, admission date and allergies on the outside cover.

2. Filing shall be completed in reverse chronological order. Only approved forms shall be filed in the medical record. All forms shall be filed within twenty-four (24) hours of receipt.

3. Refer to the Medical Record Index Form XI.8.B for proper form maintenance.

4. The following psychology department forms shall be forwarded to the medical clinic in a timely manner to be filed under the psychology tab in section one of the health record.
    - Sleep logs
    - For youth on suicide precautions
        - Suicide interview form
        - Suicide re-assessment form

D. Physicians, Dentists, Psychiatrists and Nurses shall document in the youth's health record, Interdisciplinary Progress Notes Forms XI.9.A by using the SOAP or narrative format. Heath care personnel shall:

1. Document a straightforward chronological account of the patient status, the nursing interventions performed, and the patient response to those interventions. The Nurse shall record specific and descriptive notes whenever the following is observed:
    - A change in the youth's condition (progression, regression or new problems)
    - A youth's response to a treatment or medication
    - The youth's response to teaching

2. Document exactly what is heard, observed, inspected, done or taught. Include as much specific, descriptive information as possible.

3. Read the interdisciplinary progress notes written by other health care personnel prior to charting. Document an event immediately after it occurs.

4. Date, time and signature, including the title, of the individual who is charting all entries in the medical record.

5. Document the youth's name, date of birth, and living unit on each form/document.

6. Document allergies on the Doctor's Order Form, the Medical Administration Record, Interdisciplinary Progress Notes and where otherwise indicated.

7. Vital Signs Form XI.8.D is used to document the youth's temperature, pulse, blood pressure, oxygen saturation, and peak/flow meter.

E. The Director of Medical Services shall revise this policy as necessary.