
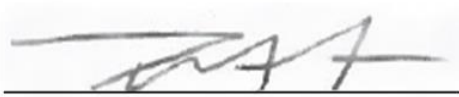


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CHAPTER 13: HEALTH CARE SERVICES		
	STATE of MAINE DEPARTMENT of CORRECTIONS Approved by Commissioner: 	PROFESSIONAL STANDARDS: See Section VIII
	EFFECTIVE DATE: December 1, 2003	LATEST REVISION: September 27, 2021

I. AUTHORITY

The Commissioner of Corrections adopts this policy pursuant to the authority contained in 34-A M.R.S.A. Section 1403.

II. APPLICABILITY

All Departmental Juvenile Facilities

III. POLICY

It is the policy of the Department of Corrections to maintain health care records for all residents to enable health care providers to accurately assess a resident’s health care status and document diagnoses, treatment and plan of care.

IV. DEFINITIONS

1. Juvenile community residential facility – housing outside the secure perimeter of Long Creek either on or off grounds in a staff supervised residential setting.

V. CONTENTS

- Procedure A: Health Care Records, General
- Procedure B: Transfer of Health Care Records
- Procedure C: Disposal or Retention of Health Care Records

VI. ATTACHMENTS

None

VII. PROCEDURES

Procedure A: Health Care Records, General

1. The health care records of each juvenile resident shall be maintained in an electronic format, except that a paper chart may also be maintained for a resident housed in an

off-grounds juvenile community residential facility, and shall include the resident's name, date of birth, and MDOC number.

2. Each resident's health care record (electronic and/or paper) shall contain, at a minimum, the following items filed in a uniform manner: *4-JCF-4C-32*
 - a. resident's name and MDOC number on each printed sheet;
 - b. admission health screening form, to include the mental health screening;
 - c. physical health assessment form;
 - d. mental health appraisal form;
 - e. problem list, including allergies;
 - f. all significant findings, diagnoses, treatments, and dispositions;
 - g. progress notes;
 - h. health care provider orders;
 - i. laboratory reports, if applicable;
 - j. x-ray reports, diagnostic studies, operative reports, pathology reports, specialty consultation reports, and telemedicine reports, if applicable;
 - k. consent to treat and/or refusal of treatment forms;
 - l. release of information forms;
 - m. flow sheets and chronic care clinics and wellness clinics (annual health assessment), and special needs treatment plan, if any;
 - n. physical activity limitation sheets;
 - o. Food Service Medical Clearance form;
 - p. immunization records;
 - q. Medication Administration Record (MAR);
 - r. sick call slips, if applicable;
 - s. advance directives, if applicable;
 - t. correspondence;
 - u. other mental health care records;
 - v. dental records;
 - w. optometry records;
 - x. physical therapy records, if applicable;
 - y. individualized treatment plan;
 - z. place, date and time of health encounters;
 - aa. urgent care, emergency department, and hospitalization discharge summaries, if applicable;
 - bb. summaries for outpatient treatments and special services, if applicable;

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- cc. information received as a result of release of information requests, if applicable;
 - dd. transfer and/or discharge health care summary forms; and
 - ee. documentation of resident death, if applicable.
3. In the case of an off-grounds juvenile community residential facility, all current medication and treatment orders shall be printed out and kept in the resident's paper health care chart, which shall also consist of at least the following records to the extent they are relevant to the resident's care while residing in the off-grounds facility:
- 3-JCRF-4C-28*
- a. a face sheet with basic demographic data;
 - b. admission health screening form, to include the mental health screening;
 - c. a list of current health problems;
 - d. provider orders;
 - e. documentation of consent to currently prescribed medication and refusal of consent to currently prescribed medication;
 - f. medication administration records (MARs) (a resident's current MAR may be kept in a binder with the current MARs of other residents until completed, at which point it will be placed in the resident's paper chart);
 - g. treatment administration records (TARs) (a resident's current TAR may be kept in a binder with the current TARs of other residents until completed, at which point it will be placed in the resident's paper chart);
 - h. instruction and education provided to the resident by facility health care staff;
 - i. certified residential medication assistant (CRMA) notes, including instruction and education provided by a CRMA to the resident;
 - j. documentation of outside health care visits, including specialist appointments, diagnostic results (i.e., lab results, x-rays, etc.) and urgent care or emergency visits; and
 - k. transfer and/or discharge health care summary forms.
4. Each entry into a resident's health care record shall include signature, title, date and time of entry. Each entry shall be made immediately following the event, unless impractical. A late entry shall be made as soon as possible and shall reflect the delay in making the entry.
5. The method of recording entries in the records, the form and format of the records, and the practices for their maintenance and safekeeping shall be approved by the Department's contracted health care services provider.
6. Access to resident health care records shall be in accordance with state and federal law, but generally be controlled by the facility Health Services Administrator, or designee. *4-JCF-4C-31*
7. A resident's health care information shall be disclosed to the facility Superintendent, or designee, to the extent necessary for the Superintendent, or designee, to make health

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care decisions as the statutory guardian for a resident who has not attained the age of eighteen (18) years.

8. A resident's health care information shall be disclosed to the facility Superintendent, or designee, the resident's unit treatment team, and other facility staff, regardless of the resident's age, to the extent necessary to ensure safety and security and to assess the resident's ability to participate in programs.
9. Information related to HIV testing, treatment, and follow-up shall only be disclosed in accordance with Department Policy (JF) 13.22, Consent to HIV Testing and Disclosure of Test Results and Department Policy (JF) 22.2, Confidentiality of Resident Information.
10. The disclosure of resident health care information shall otherwise be in accordance with Department Policy (JF) 22.2, Confidentiality of Resident Information and Policy (JF) 22.6, Resident Records Management.

Procedure B: Transfer of Health Care Records 4-JCF-4C-09

1. The Juvenile Program Manager (JPM), or designee, shall be responsible to notify the health care staff or certified residential medication assistant (CRMA), as applicable, of juvenile resident transfers in a timely manner to facilitate the transfer of appropriate health care records.
2. When a resident is being transferred to a county jail or to a facility in another jurisdiction, the health care staff or the CRMA, shall provide to the transporting officer a copy of the current Medication Administration Record (MAR) and a summary of the resident's health care record.
3. When a resident is being transferred from housing inside the secure perimeter of Long Creek to an off-grounds juvenile community residential facility, health care staff shall provide to the transporting officer a copy of a face sheet with basic demographic data; a list of current health problems; provider orders; the current MAR and current Treatment Administration Record (TAR); consent to currently prescribed medication; and the Medical Transfer Form.
4. When a resident is being transferred to housing inside the secure perimeter of Long Creek from an off-grounds juvenile community residential facility, the CRMA shall provide the resident's paper health care chart to the transporting officer.
5. When a resident is being transferred to a Department adult facility, the health care staff shall prepare an electronic copy of the Medical Transfer Form.
6. Records being sent with the transporting officer shall be placed in a transport bag which is secured by health care staff or the CRMA.
7. Classification staff shall be responsible to notify the health care staff or certified residential medication assistant (CRMA), as applicable, of resident releases to the community (whether a release to community reintegration status or a discharge) in a timely manner to facilitate the provision of appropriate health care records.

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8. When a resident is being released to the community, a Health Care Discharge Summary (Policy 13.5, Health Care, Attachment F) shall be prepared and a copy given to a resident if the resident has attained the age of 18 and does not have a legal guardian. Otherwise, the summary shall be handed to the guardian.
9. Also, when a resident is being released to the community, health care information shall be provided to community health care providers only with the written authorization of the resident if the resident has attained the age of 18 and does not have a legal guardian. Otherwise, it shall be provided only with the written authorization of the resident's parent or legal guardian. *4-JCF-4C-33*

Procedure C: Scanning and Retention or Disposal of Health Care Records

1. Except for the paper chart being maintained at an off-grounds juvenile community residential facility, all paper health care documents shall be scanned into the juvenile resident's electronic health care record as soon as practicable after they are created or received and then the paper documents shall be disposed of as set out below.
2. When a resident is being transferred to housing inside the secure perimeter of Long Creek from an off-grounds juvenile community residential facility, the resident's paper health care chart shall be scanned into the resident's electronic health care record as soon as practicable after the transfer and then the paper chart shall be disposed of as set out below.
3. When a resident is being released from an off-grounds juvenile community residential facility to the community, the resident's paper health care chart shall be provided to facility health care staff within thirty (30) days of the release. The paper chart shall be scanned into the resident's electronic health care record as soon as practicable after it is received and then the paper chart shall be disposed of as set out below.
4. Paper health care records, once scanned into the electronic record, shall be shredded or turned over to an approved contractor for secure shredding.
5. Electronic health care records shall be retained or disposed of as set out in the Department's record retention schedules. *4-JCF-4C-33*

VIII. PROFESSIONAL STANDARDS

ACA

- 4-JCF-4C-09 A written medical summary is required for all intrasystem transfers to maintain continuity of care. When a juvenile is transferred, the following is required:**
1. The health record and medical summary shall be forwarded to the receiving facility prior to or provided at arrival.
 2. Confidentiality of the health record is maintained.
 3. Medically sensitive conditions and/or specific precautions to be taken by transportation officer(s) are addressed and documented prior to transport.
 4. Written instructions regarding medication or health interventions required en route should be provided to transporting officers and be separate from the medical record.

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4-JCF-4C-31 (MANDATORY) The principle of confidentiality applies to juvenile health-records and information about juvenile health status. The active health record is maintained separately from the confinement case record. The health authority, in accordance with state and federal law, controls access to the health-record.

4-JCF-4C-32 A juvenile's health records (paper and/or electronic) contain the following items filed in a uniform manner:

1. Patient Identification on each sheet
2. Receiving-screening form
3. Health-appraisal data and examination forms
4. Record of immunizations
5. Diagnoses, treatments, and dispositions
6. Individualized treatment plan, when appropriate
7. Progress reports
8. Place, date and time of health encounters
9. Record of prescribed medications and their administration, if applicable
10. Laboratory, x-ray and diagnostic studies
11. Release-of-information forms
12. Consent and refusal forms
13. Health service reports (for example, emergency department, dental, mental health, telemedicine, or other consultations)
14. Discharge summary of hospitalization and other termination summaries, (outpatient treatments and special services not requiring hospitalization but which have a documented endpoint)
15. Legible signatures and the titles of providers (may use ink, type, or stamp under the signature)

The health authority approves the method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping. The health record is made available to and used for documentation by all qualified health-care professionals and health-care practitioners.

4-JCF-4C-33 Inactive health-record files are retained as permanent records, in accordance with state and federal law. Health-record information is provided to specific and designated health-care practitioners or medical facilities in the community only on the written request or authorization of the juvenile's parent, guardian, or legal custodian.

3-JCRF-4C-28 The health record file contains the following:

1. the completed receiving screening form
2. health appraisal data forms
3. all findings, diagnoses, treatments, dispositions
4. prescribed medications and their administration
5. signature and title of documenter
6. consent and refusal forms
7. place, date, and time of health encounters
8. health service reports, e.g., dental, mental health, and consultations

The method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping are approved by the health authority.

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