HEALTH SERVICES POLICY & PROCEDURE MANUAL

North Carolina Department Of Correction
Division Of Prisons

SECTION: Administrative – Medical Records

POLICY # AD VI-1

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SUBJECT: Purpose and Composition of the Medical Record

EFFECTIVE DATE: May 2008
SUPERCEDES DATE: May 2005

PURPOSE

To provide guidelines for ~~on~~ the composition of the medical record.

POLICY

Medical records shall be kept current and confidential. Records should be available for retrieval to provide continuity of patient care. The medical record must contain sufficient documentation to clearly identify the patient, support the diagnosis, justify the treatment and record the results accurately.

A. The medical record contains the medical information of a single patient, generated by health professionals contributing to patient evaluation and treatment during a medical encounter, mental health encounter, or hospitalization. The medical record will consist of the blue inpatient medical record, the green inpatient mental health/residential record and the yellow outpatient medical record. Only the yellow outpatient record is ~~to be~~ sent to the receiving unit at the time of discharge from the inpatient units.

   The purpose of the medical record is to:

   1. Provide a means of communication between the provider and other health care professionals contributing to the patient's care.
   2. Serve as a basis for planning individual patient care.
   3. Furnish documented evidence of the course of the patient's illness, treatment and response to treatment during each hospital admission or treatment visit.
   4. Serve as a basis for analysis, study, and evaluation of the quality of care rendered to the patient.
   5. Assist in protecting the legal interest of the patient, treatment facility, and health care provider.
   6. Provide clinical data for use in research and education.

B. The medical record of each patient shall include, but is not limited to:

   1. Identification data
   2. Medical history of the patient
   3. Reports of relevant physical examinations
   4. Diagnostic and therapeutic orders/results
   5. Appropriate informed consent
   6. Clinical observations (by correctional and community providers)
   7. Reports of procedures
   8. Discharge summaries of inpatient treatment from any correctional hospital or community hospital
   9. Medication Administration Records

Paula Y. Smith, M.D.

5/30/08

Paula Smith MD, Director of Health Services Date

SOR: Medical Record Manager