Department of Juvenile Justice
Health Services Operating Procedure

HSOP VOL IV - 4.3 – 1.15	**Statutory Authority:** Title 66 of the Code of Virginia
Subject: **Medical Record**	**Regulations:** 6VAC35-71-260; 6VAC35-71-1020 **Board Policy:** 12-001; 12-008
	ACA # 4-JCF-4C-31; 4-JCF-4C-32; 4-JCF-4C-33 **NCCHC #** Y-D-05; Y-E-12; Y-H-01; Y-H-02; Y-H-03; Y-H-04

1.15-1.0 PURPOSE

To establish the format, content, and location of medical records for residents committed to the Department of Juvenile Justice (DJJ).

1.15-2.0 SCOPE

These procedures apply to all Juvenile Correctional Center (JCC) employees and staff assigned to the JCCs by other units, agencies, or departments.

1.15-3.0 DEFINITIONS

Active Medical Record – The ongoing record of updated medical data for residents who are committed to DJJ.

Continuation Medical Record – The medical record currently in use when the original record becomes too large for a single record.

Inactive Medical Record – The record containing all medical data for residents who are no longer committed to DJJ.

1.15-4.0 PROCEDURES

The medical record shall be in a file separate from the case record. The medical record format and standardized medical forms shall be drafted by the Health Services Procedure Committee and approved by the Chief Physician, Health Services Administrator, and DJJ Director. The medical records shall be readily accessible in case of an emergency.

1.15-4.1 Medical Record Access

Confidentiality of all information contained in the record shall be maintained according to federal and state laws. Access to the medical record shall be limited to the health services staff, persons authorized by the Department for records review, and by others as authorized by law. The medical record shall be readily accessible in case of an emergency.

1.15-4.2 Medical Record Format

1. The medical record shall be created by the health services staff at the initial intake facility on

the same business day as the resident's admission.

2. The initial medical record shall be labeled VOL 1. If the medical record becomes too full and another record is required, the subsequent record shall be labeled VOL 1.2.

3. The front cover of each record shall be labeled "confidential".

4. The resident's name, race, sex, file number, date of birth, and juvenile number shall be documented on the tab of each record. All known allergies shall be documented on the front cover of the record.

5. The record shall have eight (8) sections. Each section shall be identified by a separate metal clasped divider and shall be organized chronologically from top to bottom.

6. The sequence from top to bottom of the medical record folder shall be as follows:

First Section:
Problem List
Progress Notes
Vaccine Administration Record
Tuberculosis Screening and Assessment
Immunization and Physical Record
Immunization Record (to include VIIS statements, if applicable)
Annual/ Release Medical Summary and Physical Examination
Physical Examination
Medical History

Second Section:
Physician Orders
Referrals and Consults
Lab Reports
X-Rays
Vision Screening
Hearing Screening

Third Section:
Distribution of Prosthetic and Assistive Devices, if applicable
Nursing Care Plans, if applicable
Treatment Flow Sheet, if applicable
Resident Identification Labels

Fourth Section:
Medical Status Change
Refusal of Medical Services
Resident Orientation to Health Services Forms
Resident Consent Forms
Release of Information Forms

Fifth Section:
Current Photograph

Intra-System Transfer Forms
Medical Provider Information
Health Insurance
Face Sheet
Transfer summaries and medical histories from non-DJJ facilities
Previous Immunization Records
Commitment Information and Apprehension Flyer/Alerts
Intake Questionnaire

Sixth Section:
Dental Records
Dental Consult
Dental Refusals

Seventh Section:
Behavioral Service Unit (BSU) Referral
Psychiatric Notes

Eighth Section:
Medical Service Request (MSR)
Nursing Protocols

7. A green folder shall be included within each medical record. The Medication Administration Records (MARs) shall be filed chronologically within the green folder.

1.15-4.3 Documentation

1. All documentation shall include the date, time, legible signature or initials, and credentials of the health services staff.

2. All documentation shall be made in black ink. Documentation of allergies and notations of all Physician Orders shall be documented in red ink. Residents with allergies shall have an additional alert sticker placed on the front of their medical record.

3. All forms shall be identified with the resident's name, date of birth, and any other information required by the form.

4. All information shall be recorded consecutively without allowing blank spaces or lines.

5. Corrections shall be made only when there has been an error in recording and not for errors in judgment. Erroneous entries shall be corrected by striking out the incorrect data with a single line in black ink (the error must remain legible). The strike out shall be dated, timed, the correct information shall be added as necessary, and the correction shall be signed using the staff's full name and credentials.

6. Late entries shall be documented with the current date, time, notation of "late entry" with the missed date, and then followed by the necessary information.

7. Each resident's medical record shall include written documentation of the following:

a. Initial physical examination in accordance with HSOP VOL IV-4.3-4.02 (New Admission Health Assessment);
b. Annual physical examination by or under the direction of a licensed physician including any recommendation for follow-up care in accordance with HSOP VOL IV-4.3-4.04 (Annual and Discharge Health Assessment); and
c. Documentation of the provision of follow-up medical care recommended by the physician.

8. Each resident's medical record shall include written documentation of an annual examination by a licensed dentist and documentation of follow-up dental care recommended by the dentist based on the needs of the resident in accordance with HSOP VOL IV-4.3-4.07 (Access to Dental Health Services).

9. Each resident's medical record shall include notations of health and dental complaints and injuries and shall summarize symptoms and treatment given in accordance with HSOP VOL IV-4.3-4.08 (Medical Service Requests).

1.15-4.4 Reactivation of Record

Whenever a resident is recommitted to DJJ, the initial intake facility health services staff shall retrieve the inactive medical record. A new active file shall be created and labeled the next volume sequence (i.e., VOL 2, VOL 3, etc.).

1.15-4.5 Location and Storage of Inactive Medical Records

The inactive medical record shall be stored in a secure, central location at the facility from which the resident was released. The health services staff will be responsible for securing, filing, maintaining, and transferring medical records. The RDC shall contact the facility where the inactive medical record is located when needed for reactivation or as otherwise necessary. Medical records shall be retained in accordance with the Library of Virginia records retention and disposition schedule.

1.15-5.0 RESPONSIBILITY

The Local Health Authority shall be responsible for implementing this procedure.

1.15-6.0 INTERPRETATION

The Health Services Administrator shall be responsible for the interpretation and the exception approval to this procedure.

1.15-7.0 REVIEW DATE

This procedure shall remain in effect until rescinded or otherwise modified by the appropriate authority.

Approved by Director:	**Date:** 9/10/2014
Approved by Health Administrator:	**Date:** 9/5/14
Approved by Chief Physician:	**Date:** 9/5/14
Effective Date: October 13, 2014	**Office of Primary Responsibility:** Health Services
Supersedes: July 26, 2013	**Forms:** None.