CHAPTER 3
Unit Health Record System

A unit health record (UHR) shall be initiated and maintained for each patient. Health Record Services (HRS) shall ensure that all patient health-related information generated or collected by the California Department of Corrections (CDC) shall be maintained in the UHR system, as the record is developed, to ensure that the maximum information on an individual patient is readily available at all times to authorized users. All health care information, regardless of source shall be promptly incorporated into the patient’s health record. For licensed facilities which must maintain the original or a copy of their inpatient records onsite after the inmate transfers, copies of pertinent information shall be copied, and placed in the UHR. The original shall be maintained onsite for seven (7) years. See Section III.G below.

A UHR folder shall be initiated at the time of the patient's admission to the CDC system for all new commitments. Number assignments for ‘E’, ‘N’ and ‘S’ numbered UHRs shall be addressed in a separate policy. Existing health records (file folders) shall be converted to the UHR folder using the official CDC unit health record organization format. The UHR system shall ensure that the integrity of the record is maintained. The UHR shall accompany the patient at the time of transfer within the CDC system. The UHR shall be maintained as a unit record at all times. All health information collected, or generated by a CDC institution on an individual patient shall be organized in the patient UHR, or as required by licensing standards.

I. DEFINITIONS
   A. Unit Health Record System
      1. The UHR system ensures that the maximum information collected or generated by CDC about an individual patient is maintained together at all times to be readily available to the health care professional providing care and treatment, and to other authorized users of the patient UHR.
      2. The UHR system collects and assembles all divergently created records and maintains all information in one centrally located file space within the health record system. As information is generated, or collected, it is maintained as an ongoing chronological account of all care, treatment or services provided to the patient, as well as the patient's responses to the care. The UHR system ensures that the information accompanies the patient when he is transferred from one institution to another. The system moves the UHR into Paroles and finally into Archives.
      3. All institutions shall maintain the UHR system and folder at all times.
   
   B. Unit Health Record
      1. The UHR is the vehicle that contains the organized information collected and generated on an individual patient during his stay with CDC. The UHR maintains information within one designated file space to facilitate prompt retrieval of information. The design of the UHR folder organizes the varied contents of the patient record for easy retrieval of data and for prompt incorporation of information.
2. HRS staff, at each CDC Institution, shall incorporate and/or convert existing patient health record.

3. Health Care staff shall initiate a separate inpatient record for each patient admitted to an inpatient treatment area. The inpatient health record at the time of discharge, or transfer from the inpatient care area, shall be incorporated into the UHR as outlined in Section III.G below.

4. The institution shall maintain the UHR for each patient and transfer the UHR with the patient at the time of transfer to another institution.

C. Terminal Digit Filing System

The UHR will be filed utilizing the Terminal Digit Filing system. Each patient record is identified by the medical record number which is the 6 digit CDC number consisting of one alpha character followed by 5 numeric. The number is broken into three groups beginning from the right moving to the left, the last two numbers (terminal digits), the first three numbers (secondary digits), then an alpha character.

II. PROCEDURE

A. Reception Center - Creation of the Unit Health Record:

HRS staff shall:

1. Identify new commitments and return to custody patients from:
   a) The intake manifest
   b) The daily movement sheet
   c) Other documents received from Receiving and Release (R and R)

2. Compare the information for new commitments, ‘N’ numbers, and return to custody patients with the transportation information received from Central Files.

3. Verify the CDC identification number is correct.

4. Determine if the patient was assigned a previous CDC identification number because the patient was previously incarcerated in CDC.

5. Cross reference the new number with the previous number and enter both numbers into the Record locator /Record Tracking System.

6. Initiate a UHR folder for all patients without a previously established UHR, e.g., new arrivals and return to custody patients admitted or returned to CDC after October 1995.

7. Select the authorized folder using the assigned terminal digit number, e.g., J12345; use the last two digits 45.

8. Use a permanent black ink marker to write the number on the UHR folder.

9. Record the patient’s CDC number in the provided spaces. (right hand corner, top of folder) For example the CDC number J12345 shall be recorded as follows:
   a) Letter first, J then in the lined areas record 1, 2, and 3
   b) The terminal digit number 45 is preprinted on the folder

10. Enter the patient’s CDC number on the right hand side of the folder, back cover, the letter first, J then in the boxes provided enter 1-2-3-. The terminal digit number 45 is preprinted on the folder.
11. Record the patient’s name, (last, first and middle) on the front cover of the folder leaving a space between the last and first name.

12. Enter the patient’s date of birth; use zero to hold a number space. For example the patient’s date of birth is May 1, 1939, record as 05-01-39.

13. Verify that the correct patient identifiers have been written onto the folder:
   a) Name
   b) CDC number
   c) Date of birth (day, month and year)
   d) Use the intake manifest, OBIS, or other documents supplied by the R and R, or the Identification (ID) Unit

14. Prepare an addressograph card for each patient.

15. Place the addressograph card in the pocket provided on the inside of the back folder cover.

16. Prepare a UHR for each patient as follows:
   a) Stamp the following blank forms with the addressograph card and insert into the folder:
      (1) Patient Identification, CDC Form 7313
      (2) Patient File Review Log, CDC Form 7289
      (3) Clinician’s Order, CDC Form 7221
      (4) Progress Note, CDC Form 7230
      (5) Lab collection sheet
      (6) Radiology collection sheet
      (7) Chrono collection sheet
      (8) Mental Health chrono collection sheet
   b) Incorporate the blank folders into the centralized filing system in terminal digital order, until the patient is seen by the health care provider.
   c) NOTE: Only UHR folders with blank forms can be given to the patient to give to the health care provider at the initial point of care.

17. Temporary folders shall not be used as a substitute for the UHR.

B. Receipt of the Unit Health Record
   HRS staff shall:
   1. Complete the usual new arrival procedures, which shall include converting all non-converted health records to the current UHR format.
   2. Charge in the UHR on the health records system's record tracking/locator system.
   3. Verify that information received includes, but is not limited to:
      a) Intake Screening
      b) Completed Confidential Medical/Mental Health Information Transfer Form (CDC 7371), which shall be filed in date order within the progress notes.
      c) Physical examination
      d) Dental evaluation
      e) Mental Health screening and evaluations, as appropriate
      f) Clinician’s orders for medications, diagnostic tests, immunizations, evaluations, and other care, as indicated by the patient’s condition
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g) Results of prescribed diagnostic tests
h) Immunization records
i) Chronos:
   (1) Mental Health
   (2) TB
   (3) Medical
   (4) Dental

4. Contact the HRS Supervisor of the sending institution to request any of the above items not received. Notify the designated nursing staff if the standardized intake screening form is missing, or incomplete.

5. Verify that the contents of the received UHR are filed in the order specified by the HCSD.
   a) Rearrange any misfiled information
   b) Put the record in good order for the next user, e.g., no loose pages, no pages hanging out
   c) Insert blank forms to ensure data is written in chronological order

6. Use the CDC Form 135 to verify that the UHR has been received.
7. Maintain control copies of all CDC 135 forms.
8. If the UHR is received late, retrieve the outguide, checking for loose documents requiring filing into the record.
9. Combine all information collected or generated on a patient into the UHR.
10. Determine immediately the current location of the patient.
11. If patient is retained in the institution, interfile the UHR in the centralized filing system.

C. Previously Established UHR Not Received

HRS staff shall:
1. Fax a request for UHRs not received from the parole region. The first request shall be made within three (3) days of the patient’s arrival date.
2. Follow-up daily with requests for the previous UHRs until the UHRs are received.
3. Check UHRs off the intake manifest, as received. (The intake manifest identifies UHRs received by C-File)
4. Incorporate loose documents into the pocket of a plastic outguide until the previously established unit health record(s) are received. If a request is made for the inmate’s UHR prior to its receipt:
   a) Inform the requester that there is only loose material. The chart has not yet been received.
   b) If the material is still needed for patient care, attach it firmly within the outguide, and send it. Instruct the requester to place any documents generated from the patient care encounter within the outguide, and return it to HRS.
5. Establish a tracking system to identify previous UHRs received and those not received.
D. Receipt of Health Information
   HRS staff shall:
   1. Promptly upon receipt of patient information, incorporate all health-related
      information into the UHR by the close of the next business day.
      a) Retrieve the UHR folder from the centralized filing area.
      b) Determine whether identified ALLERGIES have been written onto the
         folder by health care staff. If this information is not on the folder, and is clearly
         available in the information received, bring it forward and write known allergies
         into the boxes provided on the folder. If there is any question about allergies,
         check with the provider.
      c) Incorporate all health information into the UHR folder. Licensed facilities refer
         to Section G below for inpatient record processing.

E. Retrieval of the Unit Health Record
   HRS staff shall:
   1. Retrieve the UHR as requested for medical, dental, or mental health services for
      scheduled appointments, for emergencies or for urgent requests.
   2. Retrieve the UHR for all authorized users.
   3. Charge out UHRs on the record locator/record tracking system by documenting the
      requester's name and location, date requested, reason for request, e.g., "Dr. Jones, A
      Clinic, 09/29/95, 602."

F. Return of the UHR to HRS
   HRS staff shall:
   1. Check in the UHR following return.
   2. Review for completeness.
   3. Collect, process, assemble, and maintain all information generated by HRS to ensure
      continuous integrity of the UHR.
   4. Refile all UHRs into centralized files at the close of each business day.
   5. Refer to the policy, "Unit Health Record Organization of Contents" for instructions
      for incorporating mental health information.

G. Inpatient and Outpatient Housing Unit Records
   1. Inpatient and outpatient housing unit records shall be maintained as distinct episodes
      of care. Each separate admission/placement: General Acute Care Hospital (GACH);
      Skilled Nursing Facility (SNF); Correctional Treatment Center (CTC); Outpatient
      Housing Unit; or Hospice shall be filed chronologically.
   2. For inpatient admissions only, HRS staff shall:
      a) Photocopy the following for each episode of care:
         (1) Admission Record
         (2) History and Physical
         (3) Operative Reports
         (4) Physician’s Orders
         (5) Discharge Summary
(6) Consultations  
(7) Progress Notes  
(8) Diagnostic Reports  

b) Place copies into the UHR at the time of the patient's discharge or transfer from the inpatient status.  
c) Place originals into a separate folder which shall be kept at the institution for 7 years following the discharge of the inmate from CDC. After the inmate has been discharged from CDC for 7 years, the inpatient record may be destroyed.

3. For all episodes of care, HRS staff shall use dividers to separate episodes. Label the dividers with the dates of admission/placement and discharge.

H. Transfer of Unit Health Record to Another Institution  
1. The health record staff shall ensure that any patient transferred to another institution is accompanied at the time of transfer by his UHR.  
2. The health record staff shall prepare the record for transfer:  
   a) Promptly incorporate all existing records into the UHR.  
   b) Screen for completeness.  
   c) Incorporate any loose documents (check loose filing).  
   d) Check for missing data elements, find any missing elements, and incorporate them into the record.  
   e) Prepare necessary copies of all inpatient admissions for inclusion in UHR.  
   f) Follow all local facility transfer procedures

I. Patients No Longer Retained at Institution  
If the patient has been transferred to another institution, HRS staff shall:  
1. Immediately forward all information, as a UHR to the retaining institution.  
2. Enter the transfer information into the Record Locator/Record Tracking System.  
3. Prepare a CDC 134 to indicate the date the UHR was transferred.

J. Parole or Discharge  
Upon inmate parole or discharge, the UHR shall remain in the Health Record Department for five (5) business days to allow the incorporation of all loose material into the UHR. Health record staff shall:  
1. Search any and all backlogs, and file all loose material found into the appropriate UHR.  
2. Conduct a final check of any loose material on the 5th business day after parole or discharge.  
3. Forward all UHRs to the institution’s Case Records Office on the sixth (6) business day so that it can accompany the C-file to the appropriate parole region or Archives.

Every effort shall be made to ensure that all UHRs of paroled or discharged inmates are located, and forwarded to the institution Case Records Office so that they can accompany the C-file to the appropriate region or Archives. In the event that this does not occur,
forward any missed UHRs directly to the appropriate parole region or Archives if the C-file has already been sent.

K. Transfer Summary
A transfer summary shall accompany or precede the patient upon transfer from an inpatient setting to another facility where continuing care will be provided. The transfer summary shall include essential information relative to the patient's diagnosis, treatment course, medications, dietary requirements, known allergies and treatment plan.

L. Master Patient Index
1. To assure the maintenance and retrieval of health information, a master patient index (MPI) will be established. The increasing demands for health information require each health facility to maintain an effective and efficient information system.
2. The MPI will identify all patients who have ever been admitted or treated by an institution.
3. Traditionally, the MPI has been maintained by preparing an index card for each patient admitted or treated at a facility. These are usually arranged alphabetically in a vertical file. Due to increasing demands for information, and the availability of computers, most necessary data can now be maintained in an automated format.
4. With the implementation of the Health Care Cost and Utilization Program (HCCUP), a uniform system is currently available to partially meet the needs of the Master Patient Index.
5. The following information shall be minimally maintained for each patient:
   a) Full name of inmate (last name, first name, middle name)
   b) Inmate prison identification number (CDC number)
   c) Social Security number
   d) CII fingerprint identification number
   e) Race
   f) AKA - alias other names also known as
   g) Date of birth
   h) Date of admission
   i) Date of discharge
   j) Physicians name and code