

OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-H-04

SUBJECT: ACCESS TO CUSTODY INFORMATION

POLICY: The sharing of information among professionals responsible for the care, custody and treatment of inmates is a result of balancing the interests of the patient and the interests of others. There may be information in the patient's arrest and confinement record that could influence clinical decisions; therefore it is important that clinicians have access to those records.

REFERENCE: NCCHC Standard P-H-04
P&P #P-A-08 Communication on Patients' Health Needs
P&P #P-H-02 Confidentiality of Health Records
P&P #P-H-02.1, Notification in Emergencies
HIPAA 164.512 (5) (i) (ii)

PROCEDURE:

- A. Guidelines for Use of Information about Inmates Contained in Paper or Electronic form.
1. Health care personnel have unlimited access to information contained in the prison main file or on the automated offender database.
 - a. Information that may be useful to the clinician in the provision of health care may include but is not limited to the inmate's history of violence, drug and alcohol use, mental condition at the time of arrest, possession of medication, or the details of the crime leading to arrest.
 2. Health care personnel are expected to use professional judgment when accessing information from the prison main file or automated offender database. Guidelines to making a decision to seek information from the prison main file or automated offender database include:
 - a. The relevancy of the information to decisions about the care and treatment of the patient.
 - b. The ability of health care personnel to maintain neutrality and objectivity in the relationship with the patient.
 - c. The benefit to the patient resulting from a treatment decision based upon the information in the confinement record.
 - d. The ability of the health care professional to preserve the privacy and trust of the patient/provider relationship.

- e. The relevancy of the information to the role of the health care provider seeking the information.
3. Health care personnel who access offender information shall be accountable for the use of the information obtained according to the guidelines outlined above.

Effective Date: _____
Review date: August 2014
Supersedes P&P dated: March 2012

SCCI Site Specific Attachment
P-H-04 Management of Health Records

- 1) Health care records are stored in the Medical Records room in the Medical Services building.
- 2) Health care records may be removed to the following areas only:
 - a) Medical Clinic – sick call, provider call-out, chart reviews
 - b) Dental Clinic
 - c) Optometry Clinic
- 3) Charts are removed by the day shift nurse for clinics the following day and stored in a closet within the clinic area until needed. Charts will be separated into the various clinics as needed.
- 4) In the case of clinic add-ins, the nurse adding the patient into a clinic is responsible for obtaining the medical record and placing it in the proper area.
- 5) At the end of clinic and/or when the nurse has completed documentation the chart will be returned to the Medical Records room.

NOTE: Records are filed alphabetically in the Medical Records room.

The Medical Records room and closet are keyed separately from the primary building/clinic key in order to provide a higher level of confidentiality.

Updated 9/2014