



NEW MEXICO CORRECTIONS DEPARTMENT

Secretary
Alisha Tafoya Lucero

CD-170800 Medical Records Department

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Alisha Tafoya Lucero, Cabinet Secretary

Original Signed and Kept on File

AUTHORITY:

- A. NMSA, 1978, Section 33-1-6, as amended.
- B. NMSA, 1978, Section 36-2-32, as amended.
- C. NMAC 1.13.10
- C. 5 USCA, Section 522. A Privacy Act.
- D. Policies CD-170000, 170100.
- E. Public Law 93-579 (December 31, 1974).

REFERENCE:

- A. ACA Expected Practices 5-ACI-3D-16, 5-ACI-6C-03 (M), 5-ACI-6D-05 thru 5-ACI-6D-07, *Performance Based Standards and Expected Practices for Adult Correctional Institutions*, 5th Edition.
- B. ACA Standard 2-CO-4E-01, *Standards for the Administration of Correctional Agencies*, 1993.
- C. Medical Records Management, Huffman, 9th Edition, Physician's Record Company, 1990. Legal Handbook, New Mexico Hospital Association, 1984 Revision.

PURPOSE:

To set forth basic guidelines for the organization and functioning of the Medical Records services of the Health Services Department. **[2-CO-4E-01]**

APPLICABILITY:

This policy applies to all health services employees, contract health care providers, any employee assigned to a duty, which is related to the provision of health care, and to all inmates.

FORMS:

None

DEFINITIONS:

- A. Emergency Situation: A situation that could endanger an individual inmate or inmate population to the degree that death, injury, illness or riot could reasonably occur.

- B. Medical Chart (aka, Medical File): A medical chart is a confidential collection of medical record documents which contains detailed and comprehensive information on an individual and the health care experience related to that person. Medical charts are the collection of record documents of an individual's clinical status, care, history, and caregiver involvement. The specific information contained in the chart is intended to provide a record of a person's clinical condition by detailing diagnoses, treatments, tests and responses to treatment, as well as any other factors that may affect the person's health or clinical state. Medical charts can be maintained using paper or electronic health record system.
- C. Medical Record: A confidential written or electronic record of the actions taken in the provision of health care, an item regarding the provision of health care which is customarily preserved in a medical chart, or a collation of material that associates unique identifiers to medical information, for a particular individual or individuals.
- D. Privacy Rule (aka HIPAA Privacy Rule, Standards for Privacy of Individually Identifiable Health Information): Federal Statute located at 45 CFR Part 160 and Subparts A and E of Part 164, which governs the rules for privacy for covered entities.
- E. Record-level Patient Data: means those contents of a medical record document which contains unique and non-aggregated data elements that relate to a single identifiable individual, as well as specific medical information for that individual; as used in the Health Information System Act [24-14A-1 NMSA 1978]
- F. Redacted Medical Record: A medical record that has undergone redaction and no longer contains unique identifiers.
- G. Redaction: The process of indelibly altering, defacing or removing all unique identifiers from a medical record document.
- H. Record Spoliation: The intentional or negligent altering, destroying, or concealing an original medical record document or other material having potential evidentiary value in the review of patient care, whether or not such review is immediately anticipated.
- I. Terminal Digit Filing: A filing system utilizing the last two numbers of a patient's identifier first. A system that is set up in 100 primary sections beginning with 00 and running to 99. It allows for equal expansion of the files, confidentiality, eases purging, simplifies planning and substantially reduces misfiling.
- J. Transfer: Movement of an inmate from one New Mexico Corrections Department or private facility to another, usually on a permanent basis, or to a community corrections program or out-of-state.
- K. Transport: Movement of an inmate from a New Mexico Corrections Department or private facility to a hospital, court, another facility, a special program or the Forensic Treatment Unit. This transport can result in a temporary absence of several months.

- L. Unique Identifier: Any information, text, or symbol on a medical record document that permits the identification from that document of the individual for whom the medical record document was created. An essential element of "record-level patient data" that identifies an individual patient concretely and unambiguously.

POLICY:

A. Responsibility:

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 and maintained by the Medical Records Department. This responsibility shall include but not be limited to: **[5-ACI-6D-05]**

1. Terminal Digit Filing System applicable only to paper records.
2. Policy determinations of how information is provided to correctional and classification staff to address the medical needs of the offender as it relates to preparation and transport.
3. Offender transfers require that health record confidentiality be maintained at all times., Paper-based medical record summaries, originals, or copies may accompany the offender to the receiving facility when necessary, otherwise all the electronic medical records would be maintained system-wide with no need to physically move records. Health conditions, treatments, and allergies should be included in the record, determination of suitability for travel based on medical evaluation is made, with particular attention given to communicable disease clearance, written instructions regarding medication or health interventions required enroute should be provided to transporting officers separate from the medical record, specific precautions (including standard) are to be taken by transportation officers (for example, masks or gloves), a medical summary exchange is required for all inter and intra system transfers to maintain the provision of continuity of care. Information included does not require a release of information form. Inmates confined within a correctional complex with consolidated medical services do not require health screening for intra-system transfers. **[5-ACI-6D-06]**
4. Off-site appointment systems or designee appointed by HSA (with a medical background).
5. Health record confidentiality is to be maintained. The principle of confidentiality protects offender patients from disclosure of confidences entrusted to a health care provider during the course of treatment.
6. Assistance to the Medical Director and Continuous Quality Improvement (CQI).
7. Completion of medical records.
8. Maintenance of problem-oriented medical record format.
9. Intake and transfer medical clearance (hereby referred to as chronos).

B. Staffing:

The Health Services Administrator (HSA), and/or Registered Health Information Tech (RHIT), shall supervise the Medical Records Departments. Health information technicians are responsible for daily records operations.

C. Confidentiality:

1. The principle of confidentiality applies to an offender's health records and information about an offender's health status. **[5-ACI-6C-03 (M)]**
 - The active health record is maintained separately from the confinement case record.
 - Access to health records is in accordance with state and federal law.
 - To protect and preserve the integrity of the facility, the health authority will share with the superintendent or the Warden information regarding an offender's medical management, security and ability to participate in programs in accordance with state law.
 - The circumstances are specified when correctional staff should be advised on an offender's health status. Only that information necessary to preserve the health and safety of an offender, other offenders, volunteers, visitors, or the correctional staff, or otherwise serves a concrete and legitimate penological objective, is provided.
 - Procedure determines how information is provided to correctional and classification staff, to address the medical needs of the offender as it relates to housing, program placement, security, and transport.
 - The release of health information complies with the Health Insurance Portability and Accountability Act (HIPAA), where applicable, in a correctional setting.
2. The Privacy Rule guides but does not govern in matters of privacy of medical records within NMCD, unless NMCD becomes a covered entity under the terms of HIPAA.
3. Health record information is transmitted to specific and designated physicians or medical facilities in the community upon the written request or authorization of the offender. **[5-ACI-1G-01]**
4. Providers of addictions and/or mental health counseling services, who are licensed by the Registration and Licensing Department, and who care for and counsel NMCD client inmates, are authorized to review the medical chart/ file as a contributory resource for providing client inmate care.
5. All unredacted reproductions, photocopies, facsimiles and other collations or copies of a medical record document shall be handled with the same due consideration of privacy as the original medical documents themselves.

D. Production of Medical Record Charts:

1. To inmates: Upon request by the inmate whose file is requested, inmates who are either requesting or have filed a Notice of Claim with no lawsuit that asserts a medical condition, diagnosis, or treatment that is related to their claim, Health Services will provide the inmate

a copy of their Medical Record for review purposes only. The review shall take place with medical staff present and the inmate may not take with them any portion of the medical records. While incarcerated hard copies of medical records shall not be issued for the inmate to maintain in the living area due to security and privacy concerns. Once an inmate has actually filed a lawsuit and included in that lawsuit is an Order to Proceed in Forma Pauperis, pursuant to recent court decisions, Health Services is expected to provide the Medical Records to the plaintiff free of charge upon request by the inmate-party whose file is requested.

2. To attorneys: Health services will charge 25 cents per page for copies of paper records and 15 cents per page for records that are scanned and transmitted electronically.

E. Reproduction of Medical Record Documents for Review, Audit or Evaluation.

1. Medical records shall only be copied when there is a clear and convincing need to do so.
2. Collation of material that contains unique identifiers as well as medical information is as sensitive as unredacted medical chart documentation.
3. Creation of unredacted copies of medical records or collections of information must be done only to further an important individual patient interest in a way that is substantially related to that interest.
4. Any collection of copies of unredacted medical records shall be itemized in their entirety and indexed for their contents as soon as they are created. The index shall include the UI of the patient, the nature of the record and the date. An index is critically important if there is a loss of document security.
5. Both unredacted and redacted reproductions of medical records shall be destroyed when the need for their existence ends.

F. Retention of Medical Record Documents:

1. Active medical records will be stored on-site within the medical unit; or in electronic health system for designated amount of time.
2. Inactive paper-based files for male inmates will be forwarded to the Central New Mexico Correctional Facility, to be kept for a period of five years or as determined by the Health Services Bureau. Inactive files for female inmates will be forwarded to the Western New Mexico Correctional Facility, to be kept for a period of five years or as determined by the Health Services Bureau. At the end of the determined years, inmate files will be forwarded to State Records and Archives for a combined (facility and state archive) period of 10 total years. The storage of State records is governed by the regulations of the State of New Mexico Administrative Code on Public Records, e.g. 1.13.10 NMAC. [5-ACI-6D-07] In the event that an inmate returns to the system, the file may be retrieved.

3. Record Spoliation is an unacceptable infraction against state property. Any reasonable suggestion that a record has been deliberately or recklessly spoliated, or otherwise inadvertently damaged sufficient to cause the loss of medical information beyond reclaim, shall be reported to the NMCD medical director and/or the Office of Professional Standards (OPS) branch of NMCD.
- G. All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be retained in accordance with an established schedule. **[5-ACI-3D-16]**



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CD-170801 Medical Records Documentation Guidelines	Issued: 1/6/04 Effective: 1/6/04	Reviewed: 05/27/26 Revised: 05/27/26
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AUTHORITY:

Policy *CD-170800*

PROCEDURES: [5-ACI-3D-16]

- A. The health record file (paper and/or electronic) is complete and contains the following components in a uniform manner: **[5-ACI-6D-05]**
1. Patient identification on each sheet if paper-based records.
 2. A completed receiving screening component.
 3. Health appraisal data section.
 4. A problem summary list.
 5. A record of immunizations.
 6. All findings, diagnoses, treatments, and dispositions.
 7. A record of prescribed medications and their administration records, if applicable.
 8. Laboratory, x-ray, and diagnostic studies.
 9. The place, date, and time of health encounters.
 10. Health service reports (for example, emergency department, dental, mental, health, telemedicine, or other consultations)
 11. An individualized treatment plan, when applicable.
 12. Progress notes/reports.
 13. A discharge summary of hospitalization and other termination summaries.
 14. A legible signature (includes electronic) and the title/role of the provider (may use ink, type, stamp under the signature or electronic log).
 15. Consent and refusal documents.
 16. Release of information documents.
- 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. The health record is made available to and is used for documentation by all practitioners. **[5-ACI-6D-05]**
- B. Entries must be permanent time stamped in electronic record, or always using black ink or a typewriter if on paper.
- C. Entries must be well written the first time around, being:
1. Specific, avoiding generalizations.
 2. Objective, conclusions should not be drawn.

3. Complete, recording everything significant to patient's condition and course of treatment.
- D. Any special treatment and the reason for it shall be documented.
 - E. Unusual occurrences; i.e., a fall, shall be recorded together with the remedial steps taken and the patient's response or condition. DO NOT enter "incident report filed."
 - F. Thought processes shall be displayed; i.e., showing that all available evidence was prudently weighed and a decision was carefully made.
 - G. The S-O-A-P-E format will be used for notes, as follows:

S = Subjective Element - the patient's expression of his condition, pain, complaints, reactions etc.

O = Objective Element - the evidence of tests, lab findings, observations, physical findings.

A = Assessment - the professional's clinical evaluation of the situation; his or her judgment based on the evidence currently on hand.

P = Plan - the course of treatment/action chosen.

E = Education – Professional instruction regarding what patient was trained in and what he or she should know and do.
 - H. Progress notes require special attention. Note the problem or symptom being addressed, the precise treatment administered, the patient's reaction and the patient's status at the time treatment was discontinued. Describe the reasons for undertaking; modifying or discontinuing a particular treatment (will be monitored in Observation room).
 - I. Special care shall be taken in documenting patient education and instructions in self-care. Documentation will be provided that the patient was fully and carefully informed and trained in what he or she must know and do.
 - J. All instances of informed consent shall be noted. Surgical procedure consent shall be complete and filed appropriately.
 - K. All entries will be made promptly, providing an instant replay of what just transpired in the patient's treatment.
 1. Intake screening will be completed at intake/receipt of transfer.
 2. Surgical/procedure notes will be recorded immediately after the surgical/procedure is completed.
 3. Telephone or other verbal orders are to be countersigned within 24 hours.
 - L. All documentation/notes will be written in EHR or legibly if on paper.

- M. If paper is utilized instead of HER, continuous entries will be made. Lines will not be skipped between entries or spaces left without entries; traditional formats will be used.
- N. Entries will be consistent, avoiding contradictions. Dates, body sizes, age, etc., will match with the corresponding inmate.
- O. Corrective entries will be made carefully. Material will not be obliterated on the record by scratching out, using "white out," felt-tip markers or typewriter XXXXX's, or electronically altered once signed. A record will NEVER be changed with self-serving intent. Any inappropriate changes are to be reported to the Health Services Administrator of the New Mexico Corrections Department. When changes to correct inaccuracies are absolutely necessary, an addendum should be used.
 - 1. If paper-based, a single, thin line will be drawn through each line of the inaccurate material, insuring that it is still legible (paper records). If electronic an addendum must be made and completed with 24 hours of original document.
 - 2. If paper-based the document must be dated, timed, and signed.
 - 3. A note will be added in the margin, indicating why the previous entry was replaced if paper-based.
 - 4. The entry the correction is replacing will be indicated.
 - 5. In questionable situations, a colleague shall witness the corrected notation.
- P. Time gaps will be avoided as they can cause serious problems.
- Q. A signature or entry will NEVER be made for someone else.
- R. The document shall be countersigned carefully.
- S. Extraneous remarks will be avoided.
- T. Abbreviations shall be kept to a minimum. Only nationally recognized abbreviations will be used.
- U. All allergies will be recorded, whether previously recorded or not.



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CD-170802 Medical Records Format	Issued: 1/6/04 Effective: 1/6/04	Reviewed: 05/27/26 Revised: 05/27/26
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AUTHORITY:

Policy *CD-170800*

PROCEDURES:

- A. The paper medical record is an eight-part press board folder. Filing in the folder is done in reverse chronological order with the most current on top.(medical record loose filings shall be included in the file within five working days). Electronic health records have a history section which list all documentation in reverse chronological order with current notated first.
- B. The following section designations and contents are used when paper filing:
 1. Section I:

Basic Health Appraisal Data (and related forms) containing: findings, diagnosis, treatment and disposition recommendations with signature and title of provider.

 - a. Problem List: On top of this section, in order to act as a quick reference.
 - b. Flow Sheets Treatment and/or Nursing Care Plans: Tracking forms for certain diagnosis and/or problems.
 - c. Special Monitoring: At any time during treatment, a special monitoring form may be placed over the Problem List. Upon completion of the monitoring, the form is filed by the last date seen in the 3rd section.
 - d. History, Physical and Receiving Screen: Kept in specific reverse chronological order. There may be many receiving screens between history and physicals.
 - e. Chronos-The most current medical/dental chronos appears on top of the problem list.
 - f. HCV Protocol forms.
 2. Section II:
 - a. Physician's Orders contains orders by providers, with corresponding encounter entries.

- b. Encounters-containing findings, diagnosis, treatments and dispositions with signature and title of provider and place, date and time of encounter.
 - 1) Daily encounters by non-physician providers, nurses and on-site physicians in reverse chronological order with the newest on top. Transfers shall be placed in the appropriate place by date.
 - 2) Progress notes on patients in observation will be kept in this section.
3. Section III: Diagnostic Testing

All reports of on-site and off-site laboratory, x-ray, CT scanning, EKG's, etc., are filed in reverse chronological order in this section or historically if electronically stored
4. Section IV: Special Consultants
 - a. Psychiatry notes, RDC mental health assessments, medication consents, and psychiatry flow sheets.
 - b. On-site specialties may include dental encounters and optometry encounters.
 - c. Off-site consultations include off-site referrals, appointments, and information received from the consultation.
 - d. In-patient reports from consultants, both on-site and off-site, in reverse chronological order with the newest on top.
 - e. A colored sheet of paper will be placed on top and bottom of infirmary stay records. Top sheet will indicate admission and discharge date.
 - f. Hospital admission, discharge and surgical summaries.
 - g. Special monitoring sheets (after completion).
5. Section V: Medication Administration Record, including dates and times of administration.

Monthly profiles and insulin records filed in reverse chronological order. Non-preferred requests.
6. Section VI: Miscellaneous

Copies of requests to be seen, appointment slips, copies of medical records, copies of passes, correspondence, consent and refusal forms, release of information forms, discharge summary, receipts for glasses and other items.
7. Dental X-rays.
8. Dental Progress Note



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CD-170803 Terminal Digit Filing System	Issued: 1/6/04 Effective: 1/6/04	Reviewed: 05/27/26 Revised: 05/27/26
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AUTHORITY:

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PROCEDURES:

A. Paper & Electronic Filing:

1. Read the NMCD number on the medical record. Determine the terminal digit by locating the last two numbers on the end tab.

12 ---- Tertiary Digit;
03 ---- Middle Digit;
45 ---- Terminal Digit.

2. Locate the matching section in the Master Medical Record File. The medical record will be filed in that section. Sample: "3-45" will be filed in the "45" section after any "2-45" and before any "4-45's." If there are already records with the same middle digit in the file area, file the medical record in numerical order in the middle digit areas by the tertiary digits. Sample: "12-3-45" will be filed after "11-3-45" and before "13-3-45."

B. Retrieval:

To retrieve a medical record from the file, locate the appropriate area of the file by following the above procedure in A, 1-2.



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CD-170804 Release of Medical Information to Other Medical Entities	Issued: 1/6/04 Effective: 1/6/04	Reviewed: 05/27/26 Revised: 05/27/26
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AUTHORITY:

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PROCEDURES:

A. Upon Receipt of Request

1. The request will be stamped with the date received and sent to the Health Services Bureau for processing.
2. The HSB will determine if the patient is at any of the correctional facilities. If not, the offender information system - CMIS or OMNI system will be reviewed for the patient's location. If the patient is at an NMCD facility and the request can't be satisfied using electronic health records, the request will be sent to the responsible health services staff at that facility. If the patient is discharged, paroled, escaped, expired, etc., the request will be sent to Medical Records at the Central New Mexico Correctional Facility. The disposition of the request will be logged in the Medical Information Request Log.
3. If the inmate is at the facility, the request must be accompanied by a complete release of information documentation that will satisfy release requirements. If not, the request will be returned to the requestor. Upon request HSB may provide a copy of the Consent to Release of Medical Records document and Record Release Guidelines.
4. If the patient cannot be identified from the information enclosed, the request will be returned to the sender indicating that further information is needed. Return of the request will be documented.
5. If the records cannot be located, the request will be returned with a cover letter.
6. No fees will be assessed for copies requested by medical entities for continuity of care and any State or Federal Agency

B. Review and Copying of Medical Record:

1. The medical record will be reviewed and the contents responsive to the requests will be identified (Records Release Guidelines). Requests from medical entities are for continuity of patient care and the release of information should be restricted to:

- Problem list;
- Most recent history and physical;
- Consultation reports; psychiatrist notes will be excluded from the context of consultant.
- Pertinent lab and x-ray reports; and
- Flow charts.

Any medical records from other medical providers should not be provided. THE ORIGINAL PAPER-BASED RECORDS MUST NEVER BE SENT.

2. A cover letter will be completed with a copy of the request attached. Each page will be stamped with the confidentiality stamp. The records will be logged out to the requestor and mailed certified mail for tracking purposes. The consent and/or request form will be filed in the medical record.

C. Logging Requests:

1. Upon receipt of the request, it will be recorded by entering it into the Request Log. The date received patient's name, number and the requesting entity's name and address will also be recorded.
2. Upon forwarding or return of the request, the inclusion of where the request was sent, the date sent, and why it was sent will be recorded in the log.
3. Upon completion of copying, the date sent and what was sent will be recorded (Medical Information Request Log).



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CD-170805 Release of Medical Information to Attorneys	Issued: 1/6/04 Effective: 1/6/04	Reviewed: 05/27/26 Revised: 05/27/26
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AUTHORITY:

Policy *CD-170800*

PROCEDURES:

A. Receipt of Request:

1. The date received will be stamped on the request. The request will be logged in the Medical Information Request Log.
2. The CMIS or OMNI system will be used to determine the patient's location. If the patient's paper-based record requested is at another facility, the request will be sent to health services at that facility. If the patient is discharged, paroled, escaped, expired, etc., the request will be sent to Medical Records at the Central New Mexico Correctional Facility. The disposition of the request will be logged.
3. The request should be accompanied by a completed release of information document that will satisfy the release requirements, alternatively valid court documentation ordering release of information must be respected. If no valid supporting document justifying the request is provided, the request and the release will be returned to the requestor. Upon request, a copy of the Consent to Release of Medical Records may be provided to the requestor. General requests for records should not be followed blindly (Record Release Guidelines).
4. If the patient cannot be identified from the information enclosed, the request will be returned indicating that further information is needed. The procedure will be logged.
5. If the records cannot be located, the NMCD attorneys and RHIT will be notified immediately. The request will be returned with a cover letter indicating the reason we are unable to release information. This procedure will be logged.
6. Requests from attorneys verified to be representatives of the NMCD Contracted Health Care Provider/Corrections Department liability insurance carrier, the Attorney General or Corrections Department Counsel do not need a signed release from the patient. They must, however, make their request in writing on their professional letterhead, must specify if they are representing a recognized, governmental Corrections Department, and must specify what information they are seeking. There will be no photocopy charges.

7. If an inmate completes a release on-site, the inmate's attorney will be notified to confirm if he or she is requesting the records before proceeding. The disposition of the request will be logged. Fees will be paid prior to release of copies: 25 cents per page for copies of paper records and 15 cents per page for records that are scanned and transmitted electronically.

Review and Copying of the Medical Record:

- a. The medical record will be reviewed and identification of the contents responsive to the request will be made. **THE ORIGINALS WILL NOT BE SENT.** If the record is voluminous, the attorney will be contacted to verify the documents needed before copying the entire record.
- b. The appropriate pages in the record will be identified and copied.
- c. A cover letter appropriate to the planned disposition of the copies will be completed. The disposition of the records will be logged. The original request will be logged and copies of all letters will be placed in the 6th section of the medical record.



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CD-170806 Court Order Subpoenas for Medical Records	Issued: 1/6/04 Effective: 1/6/04	Reviewed: 05/27/26 Revised: 05/27/26
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AUTHORITY:

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PROCEDURES:

- A. Upon Receipt of Court Order or Subpoena:
 1. Determine the location of the inmate.
 2. If he or she is not currently at the facility, the attorneys will be notified that the court order or subpoena cannot be honored, due to no record of the inmate at the facility.
 3. NMCD attorneys will be notified of the possible legal action.
- B. Court Order:
 1. Determine if the court order is signed by a judge. If not, it is likely that the order is not valid. If necessary, verify the document by contacting the appropriate judicial district.
 2. NMCD attorneys will be notified by telephone immediately. The court order will be delivered immediately.
 3. Log the court order in the Records Release Log.
 4. A copy of the medical record will be prepared, and a cover letter certifying to the authenticity and completeness of the copy will be prepared.
 5. NMCD attorneys will provide direction in terms of complying with Court orders.
- C. Subpoena:
 1. Determine if the subpoena is valid. A valid subpoena usually contains the following information:
 - a. Name of court or other official body in which the proceeding is being held;
 - b. Name of plaintiff and defendant;
 - c. Docket number of the case;

- d. Date, time and place of requested appearance;
 - e. Specific documents sought;
 - f. Name and telephone number of the attorney who caused the subpoena to be issued;
and
 - g. Signature or stamp and seal of the office empowered to issue the subpoena.
2. Log the subpoena into the Records Release Log.
 3. Notification will be made to the Health Services Administrator/NMCD attorneys.
 - a. NMCD attorneys will be contacted by telephone to notify them of receipt of the subpoena. If necessary, the contents of the subpoena shall be read over the telephone and tele-faxed.
 - b. If directed by NMCD attorneys to proceed, the medical record will be copied in its entirety or the specific records indicated will be copied and a signed cover letter certifying to the authenticity and completeness of the copies will be prepared.
 - c. NMCD attorneys will provide direction in terms of responding to the subpoena.
 - d. NMCD attorneys shall contact the issuing party and handle the situation from that point. This is especially true in records containing drug and alcohol abuse treatment records.
 - e. The Health Services Administrator will be notified of the outcome.
 - f. The disposition of the subpoena will be logged.
 - g. A note of the outcome will be made on a copy of the subpoena and it will be filed in section 6 of the medical record.



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CD-170807 Intra-Facility Requests for Release of Medical Information	Issued: 1/6/04 Effective: 1/6/04	Reviewed: 05/27/26 Revised: 05/27/26
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PROCEDURES:

A. Medical Incident Reports:

1. An “incident” is any happening which is not consistent with the routine operation of the facility or the routine care of the inmate. These include accidents that befall inmates as well as inmates examined after altercations and inmates treated for overdose or illegal drug use. Any employee screened after an on-the-job injury or a visitor screened after an accident also qualify.
2. A Medical Incident Report must be completed for each episode of treatment following an incident. The contents of the report will be restricted to the following information regarding medical treatment:
 - a. Incident and Patient Identification: The date and time of presentation to health services or of the emergency call will be recorded. The name of the employee/visitor will be recorded. The name of the facility will also be recorded.
 - b. Cause of Encounter: Indicate why the patient is presented for care; i.e., fall, hit on the head, found unconscious. Identify the source of information.
 - c. Length of Disability: Use the following definitions to indicate the amount of time lost from the ability to hold a job or participate in daily activities determined by the health authority:
 - No loss of time - patient may return to the same job. No restriction on education or activities of daily living.
 - Minimal loss of time - patient may return to work but not at the same level of job as before due to temporary restriction secondary to injuries or physical state. (Record actual work limitations in the space provided.)
 - Greater loss of time - Loss of six (6) days or more of work. Requires follow-up for determination of period loss. Requires that a **medical chrono** (*CD-170802.A*) be generated to the Classification Department indicating restrictions.

- Unknown at this time - actual or expected length and type of restriction cannot be determined at this time.
 - Work or activity restriction - the specific restriction to work, education or activity level that will affect the patient's ability to participate in activities of daily living.
- d. Disposition of Case: The disposition of the case will be indicated by marking the appropriate box or filling in the blank.
 - e. Name and Title of Person Caring for Patient: The name and title of the person who actually cared for the patient will be recorded.
3. Copies of the report will be distributed to the appropriate personnel as indicated by job title on the form.
 4. The original or any copy of the form will NOT be filed in the medical record. The form will not be referred to under any circumstances. If necessary, a separate file will be kept in the Health Services Bureau .

B. Classification Request:

1. A medical chrono form or electronic document will be prepared indicating the appropriate facilities that will provide the services according to the patient's needs. Any work or school restrictions will be identified for the patient and indicated on the form.
2. The original chrono will be sent to the Classification Bureau with a copy being retained for the medical record.
3. Copies of the actual medical record will not be provided without an appropriate release from the patient (Consent to Release of Medical Records). Requests for records should not be followed blindly. Information requested for pre-parole plans shall be sent directly to the outside treatment program only on written release from the patient.

C. Disciplinary Requests:

Requests for information to support disciplinary action, other than that provided on the Medical Incident Report, must be in writing from the Warden and may not be honored without an appropriate release from the patient.



NEW MEXICO CORRECTIONS DEPARTMENT

Secretary
Alisha Tafoya Lucero

CD-170808 Completion of Medical Encounter Forms	Issued: 1/6/04 Effective: 1/6/04	Reviewed: 05/27/26 Revised: 05/27/26
Alisha Tafoya Lucero, Cabinet Secretary		<i>Original Signed and Kept on File</i>

AUTHORITY:

Policy *CD-130700*

PROCEDURES:

- A. A Medical Encounter Form or progress note is filled out via electronic health record) every time an inmate or an employee is seen by medical staff.
- B. The Medical Encounter Form will be completed as follows:
 1. Enter the date, time, name (last, first, middle), number.
 2. Enter facility initials at bottom of paper record or into designated section in electronic record.
 3. If the patient is an employee, his or her name will be indicated on the form or electronic record.
 4. Fill in the patient's chief complaint, vital signs, allergies (specify or write "NKDA" (no known drug allergies). Mark the time of encounter:
 - a. Check "unscheduled";
 - b. Check sick call, physician appointment, etc. If an intake screening, write "intake" in this area; and
 - c. Initial the form in the box provided or designated section of electronic record.
 5. Subjective: Record the patient's complaints. Note what he/she tells you about his/her physical or mental condition, i.e., "My throat has been sore for two days and I feel sick," or patient states throat has been sore for two days and he/she feels like he/she has a temperature.
 6. Objective: Record what is observed about the patient. Write specific findings on examination; i.e., throat is red, tonsils edematous and white irregular patches cover the area, nose clear, bilateral cervical lymph nodes enlarged, ears clear, B/P 120/70, TPR 100.6100 20.
 7. Assessment:
 - a. Diagnosis: Made by physician or physician's assistant only.

- b. Evaluation: Nursing statements are recorded as specifically observed symptoms, or as probable, or as a statement of previously stated diagnosis.
8. Plan: Record any medications, treatments, follow-up, special instructions that relate to the care provided the patient.
 - a. Medication order must contain the following:
 - Medication by name;
 - Dosage;
 - Route of administration;
 - Times of administration; and
 - Stop date or specific number of days, and any verbal orders must be written as such.
 - b. The nurse will not write a medication order without a verbal order from a licensed practitioner or from the Treatment Protocols. Orders from the Treatment Protocols must be identified as such when written.
9. Education: Professional instruction regarding what patient was trained in and what he or she should know and do.
10. Taking off Orders:
 - a. Orders should be taken off as soon as possible after the written encounter is completed.
 - b. Each individual order is checked before it is taken off.
 - c. For paper forms: the acknowledgement of the receipt of the order will be recorded by drawing a line down the left side and across the bottom. The first initial, last name and title of the person taking off the order will be recorded to the left of the orders. The date and time of the signature will be recorded to indicate when the orders were taken off.
 - d. For electronic records there will be a signature, date, pending, or completed section on the record for initiation of orders.

C. Disposition of Copies (paper-based records):

1. The white copy (original) will be filed in the medical record.
2. Medication Order- to on-site Pharmacy for faxing to contract pharmacy.
3. Encounters done on employees are kept in file in the DON'S office for one year, and then disposed.