State of Iowa Department of Corrections
Policy and Procedures

Policy Number: HSP-103
Applicability: Institutions
Policy Code: Public Access
Iowa Code Reference: 904.602, 904.603
Chapter 6: HEALTH SERVICES
Sub Chapter: ADMINISTRATION
Related DOC Policies: AD-PR-29
Administrative Code Reference: 481-661-.1 (36)
Subject: HEALTH INFORMATION
ACA Standards N/A
PREA Standards: N/A
Responsibility: Dr. Michael Riley
Effective Date: September 4, 2026
Authority:

1. PURPOSE

To outline requirements for release of information and follow all regulatory agency requirements for privacy, storage and transmission of patient health care information.

2. POLICY

The Iowa Department of Corrections (DOC) utilizes an electronic medical record to protect and standardize documentation of patient health records. This policy also establishes standards for the timely, accurate, complete, and secure documentation of health care services in accordance with applicable Iowa Department of Corrections requirements and professional licensure standards.

CONTENTS

A. Electronic Health Records

B. Rules of Documentation/Charting

C. Data Reports

D. Iowa Correction Offender Network (ICON)

3. DEFINITIONS - As used in this policy:

Electronic Health Record (EHR) - An electronic record is an electronic record of health information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

Staff - refers to anyone who has access to complete documentation with the Electronic Health Record (EHR).

4. PROCEDURE

A. Electronic Health Records

Health record documentation by professional staff must meet record keeping standards. This ensures continuity of care and the retention/retrieval of essential health care information.

B. Each patient will have:

1. A complete and comprehensive health record which will include the initial assessment and plan of care/treatment and episodic documentation as appropriate for changes in health status.

2. Individualized documentation by staff making the observation or performing the intervention.

3. Documentation to address the care plan/treatment plan which includes goals, progress and any pertinent information.

C. Rules of documentation/charting include:

1. Minimal use of approved DOC abbreviations

2. Action taken for the patient and their response to an intervention. It shall not include speculation.

3. Recording of significant information pertaining directly to the patient.

4. Complete, concise and objective entries.

5. Descriptive observations as specific and objective as possible. Subjective interpretations shall be accompanied by a description of actual behavior.

6. Shall not include positive or negative statements reflective of other staff.

7. Document Standards

    a. Documentation shall be factual, objective, accurate, legible, and completed at the time of patient care or as soon as reasonably practicable thereafter.

    b. Entries shall accurately reflect the assessment, intervention, treatment, patient response, and disposition of the patient.

    c. Staff shall not postpone routine documentation to a subsequent work shift except under approved extenuating circumstances. The Department's expectation is that all medical record documentation will be completed before the end of the employee's scheduled shift.

    d. Documentation entered after the date of time of service shall be identified as a late entry and shall include the date and time the entry is made.

    e. Staff shall not create, alter, backdate, or intentionally omit information from the health record.

D. Data Reports

The IDOC Health Services Administrator is responsible for determining medical/mental health data that requires collection.

1. The Health Authority at each institution will utilize the reports generated by the electronic health record for the accurate collection of health services data. The Health Authority at each institution is directly responsible for ensuring that this data is properly acquired and forwarded to the Warden of the institution upon request.

2. Health services provided to patients will be summarized quarterly by the IDOC Health Services Administrator and forwarded to the Deputy Directors.

E. Iowa Correction Offender Network (ICON)

1. IDOC health professionals and other staff whose job responsibilities include the provision of specific services, (i.e. clerical staff), necessary for the efficient and effective delivery of health services may request authorization for access to patient health information recorded in the ICON Medical system. Institutional managers may also request authorization for access to this same information

from the IDOC Administrator of Nursing. A request for access to the ICON Medical system is to be approved by the institution's primary coordinator of health services if approved by the IDOC Administrator of Nursing.

a. Forms **AD-PR-29**, **F-1**, **F-2**, and **F-3**, *Authorization and Confidentiality of Information* – ICON Medical are completed for staff access to Medical ICON.

b. Authorized forms are submitted to the Administrator of Nursing Services for final approval.

2. Authorization for access to the ICON Medical system shall be restricted and/or terminated upon confirmation of failure to abide by confidentiality standards pertaining to patient health information.

3. Please refer to the Electronic Medical Record Manual for specific instruction on use of the computerized record.