

WAC 246-337-095 Resident health care records. The licensee must ensure the RTF meets the following requirements:

(1) Develop and implement procedures for maintaining current health care records as required by chapter 70.02 RCW and other applicable laws.

(2) Health care records may be integrated into a resident's individual service plan so long as the requirements of this section are met.

(3) Make health care records accessible for review by appropriate direct care staff, the resident, the parent or guardian, and the department in accordance with applicable law.

(4) Document health care information in a standardized manner.

(5) Record health care information by the health care provider or direct care staff with resident contact to include typed or legible handwriting in ink, verified by signature or unique identifier, title, date and time.

(6) Maintain the confidentiality and security of health care records in accordance with applicable law.

(7) Maintain health care records in chronological order in their entirety or chronologically by sections.

(8) Keep health care records current with all documents filed according to the licensee's written timeline policy.

(9) Include the following, at a minimum, in each health care record:

(a) Resident's name, date of birth, sex, marital status, date of admission, voluntary or other commitment, name of health care prescriber, diagnosis, date of discharge, previous address and phone number, if any;

(b) Resident's receipt of notification of resident's rights;

(c) Resident's consent for health care provided by the RTF, unless the resident is admitted under an involuntary court order;

(d) A copy of any authorizations, advance directives, powers of attorney, letters of guardianship, or other similar documentation;

(e) Original reports, where available or, if not available, durable, legible copies of original reports on all tests, procedures, and examinations performed on the resident;

(f) Individual service plan according to WAC 246-337-100 or 246-337-103, as applicable;

(g) Individuals whom the resident consents for the RTF to freely communicate with regarding the health care of the resident including the individual's name, relationship to the resident, and address;

(h) Dated and signed notes describing all health care provided for each contact with the resident pertinent to the resident's individual service plan including:

(i) Physical and psychosocial history;

(ii) Health screening;

(iii) Health care service and treatment provided, including resident's response to treatment and any adverse reactions and resolution of health care issues and when applicable;

(iv) Medication administration, and medical staff notification of medication administration errors, adverse effects, or side effects;

(v) Use of restraint or seclusion consistent with WAC 246-337-110;

(vi) Staff actions or response to health care needs;

(vii) Instructions or teaching provided to the resident in connection with his or her health care; and

(viii) Discharge summary, including:

- (A) Summary of the resident's physical and mental history, as applicable;
 - (B) Condition upon discharge;
 - (C) List of current medications;
 - (D) Recommendations for services, follow-up or continuing care;
- and
- (E) Date and time of discharge.

(10) Retain the health care records at least six years beyond the resident's discharge or death date, whichever occurs sooner, and at least six years beyond the age of eighteen.

(11) Destroy the health care records in accordance with applicable law and in a manner that preserves confidentiality.

[Statutory Authority: RCW 71.12.670, 71.12.684 and 2017 c 263. WSR 19-02-036, § 246-337-095, filed 12/24/18, effective 1/1/19. Statutory Authority: RCW 71.12.670. WSR 18-06-092, § 246-337-095, filed 3/6/18, effective 4/16/18. Statutory Authority: Chapter 71.12 RCW. WSR 05-15-157, § 246-337-095, filed 7/20/05, effective 8/20/05.]