WAC 246-335-550 Patient records. The licensee must:

(1) Maintain a current record for each patient consistent with chapter 70.02 RCW;

(2) Ensure that patient records are:

(a) Accessible in the licensee's office location for review by appropriate direct care personnel, volunteers, contractors, and the department;

(b) Written legibly in permanent ink or retrievable by electronic means;

(c) On the licensee's standardized forms or electronic templates;

(d) In a legally acceptable manner;

(e) Kept confidential;

(f) Chronological in its entirety or by the service provided;

(g) Fastened together to avoid loss of record contents (paper documents); and

(h) Kept current with all documents filed according to agency time frames per agency policies and procedures.

(3) Except as provided in subsection (4) of this section, include documentation of the following in each record:

(a) Patient's name, age, current address and phone number;

(b) Patient's consent for services, care, and treatments;

(c) Payment source and patient responsibility for payment;

(d) Initial assessment when providing home health services, except when providing home health aide only services under WAC 246-335-540(5);

(e) Plan of care according to WAC 246-335-540, depending upon the services provided;

(f) Signed or electronically authenticated and dated notes documenting and describing services provided during each patient contact;

(g) Observations and changes in the patient's condition or needs;

(h) For patients receiving home health, with the exception of home health aide only services per WAC 246-335-540(5), authorized practitioner orders and documentation of response to medications and treatments ordered;

(i) Supervision of home health aide services according to WAC 246-335-545(7); and

(j) Other documentation as required by this chapter.

(4) For patients receiving a one-time visit, provide the documentation required in WAC 246-335-540(6) in lieu of the requirements in subsection (3) of this section;

(5) Consider the records as property of the licensee and allow the patient access to his or her own record; and

(6) Upon request and according to agency policy and procedure, provide patient information or a summary of care when the patient is transferred or discharged to another agency or facility.

(7) The licensee must keep patient records for:

(a) Adults - Three years following the date of termination of services;

(b) Minors - Three years after attaining age eighteen, or five years following discharge, whichever is longer; and

(c) Patient death - Three years following the last date or termination of services if patient was on services when death occurred.

(8) The licensee must:

(a) Store patient records in a safe and secure manner to prevent loss of information, to maintain the integrity of the record, and to protect against unauthorized use;

(b) Maintain or release records in accordance with chapter 70.02 RCW; and

(c) After ceasing operation, retain or dispose of patient records in a confidential manner according to the time frames in subsection (7) of this section.

[Statutory Authority: RCW 70.127.120 and 43.70.250. WSR 18-06-093, § 246-335-550, filed 3/6/18, effective 4/6/18.]