WAC 246-329-140 Client records. The purpose of this section is to assure the center obtains, manages, and uses information to improve patient outcomes and the performance of the birth center in patient care.

(1) The birth center shall have a defined client record system, policies and procedures which provide for identification, security, confidentiality, control, retrieval, and preservation of client care data and information.

(2) The childbirth center must maintain a health record for each maternal and newborn client in a legally acceptable, integrated and chronological document on the licensee's standardized forms consistent with chapter 70.02 RCW, Medical records—Health care information access and disclosure. Each record must include:

(a) Client's demographic information and client identification to include at a minimum client's name, birth date, age, and address;

(b) Client's informed consent for care, service, treatment and receipt of the client bill of rights;

(c) Signed and authenticated notes describing the newborn and maternal status during prenatal, labor, birth, and recovery including, but not limited to:

(i) Documentation that verifies the client's low-risk maternal client status; and

(ii) Labor summary;

(iii) Newborn status including Apgar scores, maternal newborn interaction; and

(iv) Physical assessment of the mother and newborn during recovery;

(d) Documentation that a newborn screening specimen was collected (or signed refusal on the back of the specimen form) and submitted to the department's newborn screening program under WAC 246-650-020;

(e) Documentation and authentication of orders by clinical staff and birth center personnel who administer drugs and treatments or make observations and assessments;

(f) Laboratory and diagnostic testing results;

(g) Consultation reports;

(h) Referral, transfer of care, emergency transfer and transport documentation;

(i) Prophylactic treatment of the eyes of the newborn in accordance with WAC 246-100-206 (6)(b);

(j) Prenatal screening under chapters 70.54 RCW and 246-680 WAC, including client's refusal;

(k) Documentation of refusal of rapid HIV testing if documentation of an HIV test during prenatal care is not available;

(l) For HIV positive women, the antiretroviral medications during delivery and recommended lab tests;

(m) Intrapartum antibiotics for Group B Strep positive women per the CDC protocol;

(n) For Hepatitis B positive women, HBIG and Hepatitis B immunization for newborn;

(o) Refusal of any recommended test or treatment;

(p) Documentation of birth registration per chapter 70.58 RCW.

(3) For clients managed by a contractor in a birth center, the licensee shall ensure that each client record is maintained by the birth center and must contain the information as stated in subsection (2)(a) through (p) of this section. Services provided by the contrac-

tor, prior to the client's admission to the birth center, shall be summarized or placed in the record in their entirety.

(4) Entries in the client record shall be typewritten, retrievable by electronic means or written legibly in ink.

(5) Documentation and record keeping shall include:

(a) Completion of a birth certificate and, if applicable, a sentinel birth defect report under chapters 70.58 RCW and 246-491 WAC.

(b) Documentation of orders for medical treatment and/or medication. Each order shall be specific to the client and shall be authenticated, at the time the order is received, by an appropriate health care professional authorized to approve the order or medication.

(6) The licensee shall:

(a) Assure client records are kept confidential;

(b) Fasten client records together;

(c) Consider client records property of the birth center; and

(d) Provide a client access to their client record under the licensee's policy and procedure and applicable rules.

(7) When a client is transferred or discharged to another provider or facility, the birth center must provide a summary of care to the provider or facility to whom the client is transferred or discharged.

(8) The licensee shall maintain records for:

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

(b) Minors - three years after attaining age eighteen, or five years following discharge, whichever is longer.

(9) The licensee shall:

(a) Store records to prevent loss of information and to maintain the integrity of the record and protect against unauthorized use;

(b) Maintain or release records after a patient's or client's death according to chapter 70.02 RCW, Medical records—Health care information access and disclosure; and

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

[Statutory Authority: Chapter 18.46 RCW and RCW 43.70.040. WSR 07-07-075, § 246-329-140, filed 3/16/07, effective 4/16/07.]