WAC 388-71-0746 What are the adult day center's client records requirements? (1) If the client's record is hand-written it must be legibly written in ink, dated, and signed by the recording person with his/her title. Identification of the author may be a signature, initials, or other unique identifier within the requirements of applicable licensing standards and center policy. All hand-written documentation must be legible to someone other than the author. If signature is a unique identifier, such as initials, there must be a key readily available for use by the department or their designee. The negotiated care plan must have the center's author's full name and title on the signature line.

(2) If the client's record is an automated electronic record then it must be within a secured client record system to ensure confidentiality for all records, in accordance with state and federal laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). If electronic signature is a unique identifier then there must be a key readily available for use by the department or their designee. The negotiated care plan must have the center's author's full name and title on the signature line.

(3) Progress notes must be entered into the file chronologically and timely. Adult day health centers' professional interventions must be charted directly after providing the service. Adult day care centers must have progress summary notes at least monthly. Client dates and hours of attendance are to be kept daily.

(4) Consultation, care plan reviews and updating orders, hardcopy or electronic records, must be dated and initialed by the center's reviewer(s) or authorizing practitioner. The authorizing practitioner must update the skilled clinical orders at least annually or when a significant change occurs warranting a change in the skilled clinical intervention. The authorizing practitioner does not need to review the care plan but does need to update skilled clinical orders as outlined above.

(5) Documentation of medication use must include the name of the medication, dosage, frequency of administration, route of administration, site of injection if applicable, date and time and signature or initials of the person administering the medication, title, and date.

(6) If the client records are thinned or archived, per your policy and procedure, all records must be readily available to the federal, state, or agency designee for monitoring purposes.

(7) Department-contracted adult day health centers must comply with all other applicable documentation requirements under WAC 182-502-0020.

[Statutory Authority: RCW 74.08.090. WSR 18-18-006, § 388-71-0746, filed 8/23/18, effective 9/23/18. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 15-01-174, § 388-71-0746, filed 12/23/14, effective 1/23/15. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. WSR 03-06-024, § 388-71-0746, filed 2/24/03, effective 7/1/03.]