

**WAC 246-320-166 Management of information.** The purpose of this section is to improve patient outcomes and hospital performance through obtaining, managing, and using information.

Hospitals must:

- (1) Provide medical staff, employees and other authorized persons with access to patient information systems, resources, and services;
- (2) Maintain confidentiality, security, and integrity of information;
- (3) Initiate and maintain a medical record for every patient assessed or treated including a process to review records for completeness, accuracy, and timeliness;
- (4) Create medical records that:
  - (a) Identify the patient;
  - (b) Have clinical data to support the diagnosis, course and results of treatment for the patient;
  - (c) Have signed consent documents;
  - (d) Promote continuity of care;
  - (e) Have accurately written, signed, dated, and timed entries;
  - (f) Indicate authentication after the record is transcribed;
  - (g) Are promptly filed, accessible, and retained according to RCW 70.41.190 and chapter 5.46 RCW; and
  - (h) Include verbal orders that are accepted and transcribed by qualified personnel;
- (5) Establish a systematic method for identifying each medical record, identification of service area, filing, and retrieval of all patient's records; and
- (6) Adopt and implement policies and procedures that address:
  - (a) Who has access to and release of confidential medical records according to chapter 70.02 RCW;
  - (b) Retention and preservation of medical records according to RCW 70.41.190;
  - (c) Transmittal of medical data to ensure continuity of care; and
  - (d) Exclusion of clinical evidence from the medical record.

[Statutory Authority: Chapter 70.41 RCW and RCW 43.70.040. WSR 09-07-050, § 246-320-166, filed 3/11/09, effective 4/11/09.]