

WAC 246-330-150 Management of information. The purpose of this section is to improve patient outcomes and ambulatory surgical facility performance through obtaining, managing, and use of information.

An ambulatory surgical facility 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) Indicates authentication after the record is transcribed;
 - (g) Are promptly filed, accessible, and retained according to facility policy; 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;
 - (c) Transmittal of medical data to ensure continuity of care; and
 - (d) Exclusion of clinical evidence from the medical record.

[Statutory Authority: Chapter 70.230 RCW. WSR 09-09-032, § 246-330-150, filed 4/7/09, effective 5/8/09.]