

**WAC 246-335-650 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 and care;
  - (c) Payment source and patient responsibility for payment;
  - (d) Initial assessment when providing hospice and hospice care center services;
  - (e) Plan of care according to WAC 246-335-640, depending on 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 hospice and hospice care center services, authorized practitioner orders and documentation of response to medications and treatments ordered; and
  - (i) Other documentation as required by this chapter.
- (4) For patients receiving a one-time visit, provide the documentation required in WAC 246-335-640(5) 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.
- (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 to 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, § 246-335-650, filed 3/6/18, effective 4/6/18.]