HH 1000: Clinical Record Documentation

WAC: 246-335-550 Patient Records

Date of Origin: 03/01/20	Revised: 05/21/25

Policy Statement:

Hanford Home Health maintains a clinical record for each patient served in accordance with accepted professional standards and agency policy.

Procedure:

- Patient clinical records are considered the property of Hanford Home Health and patients may have access to their personal records.

- Patient clinical records are maintained in accordance with accepted professional standards and are considered confidential.

Hanford Home Health will assure the clinical record is:

- Accessible in an integrated document, in Hanford Home Health office, and available for review by appropriate direct care personnel, contractors and the department
- Written legibly in permanent ink or retrievable by electronic means
- Documented on Hanford Home Health's standardized forms, and in a legally acceptable manner
- Kept confidential
- Chronological in its entirety, or by the service category provided
- Fastened together to avoid loss of record contents
- Keep current with all documents filed in the clinical record within two weeks of the service date
- A chart order of content is maintained for each patient's clinical record.
- All clinical records are maintained in secured areas and are protected against loss, destruction, unauthorized use, and disclosure.
- Clinical record information is released only as required by laws and regulations or written permission of the patient or their legal representative.
- In the event of patient transfer to another program or healthcare facility, a copy of the clinical record or summary report will be forwarded to the new provider, upon request.
- Home healthcare staff members document all patient home healthcare on the day the service is rendered.

Documentation in the clinical record includes:

- Patient name, age, current address, and phone number
- Patient consent for service, care, and treatment
- Payment source and patient responsibility for payment
- Initial assessment of the patient
- Plan of Care, according to WAC 246-335-540, depending

- Signed or authenticated and dated notes documenting and describing services provided during each patient contact
- Observations and changes in the patient's condition or needs
- Authorized practitioner orders for services to be provided, except for Home Health Aide services
- Documentation of response to medications and treatments ordered
- Supervision of Home Health Aides
- Other documents as required in his chapter

Home healthcare staff document:

- On the clinical note and/or flow sheet
- Using black ball-point pen
- Writing legibly
- Charting entries without leaving blank lines or spaces in narrative notes
- Signing each entry with name and title.

The Director of Clinical Services:

- Reviews staff's documentation for compliance with agency policies and procedures
- Informs staff members of documentation problems/issues
- Implements corrective action with staff members for charting deficiencies by requesting correction of the deficiencies
- Identifies persistent problems in documentation as a performance improvement activity