RCW 49.19.040 Violent acts—Records. Each health care setting shall keep a record of any violent act against an employee, a patient, or a visitor occurring at the setting. Each record shall be kept for at least five years following the act reported, during which time it shall be available for inspection by the department upon request. At a minimum, the record shall include:

(1) The health care setting's name and address;

(2) The date, time, and specific location at the health care setting where the act occurred;

(3) The name, job title, department or ward assignment, and staff identification or social security number of the victim if an employee;

(4) A description of the person against whom the act was committed as:

(a) A patient;

(b) A visitor;

(c) An employee; or

(d) Other;

(5) A description of the person committing the act as:

(a) A patient;

(b) A visitor;

(c) An employee; or

(d) Other;

(6) A description of the type of violent act as a:

(a) Threat of assault with no physical contact;

(b) Physical assault with contact but no physical injury;

(c) Physical assault with mild soreness, surface abrasions, scratches, or small bruises;

(d) Physical assault with major soreness, cuts, or large bruises;

(e) Physical assault with severe lacerations, a bone fracture, or a head injury; or

(f) Physical assault with loss of limb or death;

(7) An identification of any body part injured;

(8) A description of any weapon used;

(9) The number of employees in the vicinity of the act when it occurred; and

(10) A description of actions taken by employees and the health care setting in response to the act. [2019 c 430 § 4; 1999 c 377 § 5.]

Effective date—2019 c 430: See note following RCW 49.19.010.