

**WAC 246-320-226 Patient care services.** This section guides the development of a plan for patient care. This is accomplished by supervising staff, establishing, monitoring, and enforcing policies and procedures that define and outline the use of materials, resources, and promote the delivery of care.

Hospitals must:

(1) Provide personnel, space, equipment, reference materials, training, and supplies for the appropriate care and treatment of patients;

(2) Have a registered nurse available for consultation in the hospital at all times;

(3) Adopt, implement, review and revise patient care policies and procedures designed to guide staff that address:

(a) Criteria for patient admission to general and specialized service areas;

(b) Reliable method for personal identification of each patient;

(c) Conditions that require patient transfer within the facility, to specialized care areas and outside facilities;

(d) Patient safety measures;

(e) Staff access to patient care areas;

(f) Use of physical and chemical restraints or seclusion consistent with C.F.R. 42.482;

(g) Use of preestablished patient care guidelines or protocols. When used, these must be documented in the medical record and be pre-approved or authenticated by an authorized practitioner;

(h) Care and handling of patients whose condition require special medical or medical-legal consideration;

(i) Preparation and administration of blood and blood products; and

(j) Discharge planning;

(4) Have a system to plan and document care in an interdisciplinary manner, including:

(a) Development of an individualized patient plan of care, based on an initial assessment;

(b) Periodic review and revision of individualized plan of care based on patient reassessment; and

(c) Periodic assessment for risk of falls, skin condition, pressure ulcers, pain, medication use, therapeutic effects and side or adverse effects;

(5) Complete and document an initial assessment of each patient's physical condition, emotional, and social needs in the medical record. Initial assessment includes:

(a) Patient history and physical assessment including but not limited to falls, mental status and skin condition;

(b) Current needs;

(c) Need for discharge planning;

(d) Immunization status for pediatric patients;

(e) Physical examination, if within thirty days prior to admission, and updated as needed if patient status has changed;

(f) Ongoing specialized assessments depending on the patient's condition or needs, including:

(i) Nutritional status;

(ii) Functional status; and

(iii) Social, psychological, and physiological status;

(g) Reassessments according to plan of care and patient's condition; and

(h) Discharge plans when appropriate, coordinated with:

- (i) Patient, family or caregiver; and
- (ii) Receiving agency, when necessary.

[Statutory Authority: Chapter 70.41 RCW and RCW 43.70.040. WSR 09-07-050, § 246-320-226, filed 3/11/09, effective 4/11/09.]