79627 Nursing Service General Requirements

(a)

Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the administration and medical director when required by governing body bylaws.

(b)

Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission. (B) Development of an individual, written patient care plan which specifies the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. Each inmate-patient's care shall be based on this plan. (C) Reviewing, evaluating and updating of the patient care plan, as necessary, by the nursing staff and other professional personnel involved in the care of the patient, at least monthly, and more often as the patient's condition warrants. (2) Notifying the attending physician or the attending clinician promptly of:(A) The admission of a patient.

(B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient. (C) An unusual occurrence involving a patient. (D) Any untoward response or reaction by a patient to a medication or treatment. (E) Any error in the administration of a medication or treatment to a patient. (F) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed when this presents a risk to the health, safety, or security of the patient. (G) The inmate-patient's refusal to accept a prescribed medication, treatment, or diagnostic procedure.

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The inmate-patient's refusal to accept a prescribed medication, treatment, or diagnostic procedure.

(c)

All attempts to notify physicians or the attending clinician shall be noted in the patient's health record including the time and method of communication and the name of the person acknowledging contact, if any.

(d)

Licensed nursing personnel shall verify that patients are served the diets as prescribed.

(e)

Nursing staff shall maintain timely and accurate patient record documentation including: (1) Signed, dated, nursing notes reflecting implementation of the patient care plan, the patient's response to care, and changes in patients' symptoms or behavior. (2) A record of all medications and treatments administered. (3) A record of all personal patient care including dietary intake and patient activity. (4) A record of patient vital signs, weight and other appropriate measurements. (5) An admission patient assessment and discharge summary.

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