WAC 246-335-640 Hospice plan of care. Except as provided in subsection (5) of this section, the licensee must:

(1) Develop and implement a written hospice plan of care for each patient with input from the authorizing practitioner, appropriate interdisciplinary team members, and the patient, designated family member, or legal representative;

(2) Ensure each plan of care is developed by appropriately trained or credentialed agency personnel and is based on a patient and family assessment;

(3) Ensure the hospice plan of care includes:

(a) Current diagnoses and information on health status;

(b) Goals and outcome measures which are individualized for the patient;

(c) Symptom and pain management;

(d) Types and frequency of services to be provided;

(e) Palliative care, if applicable;

(f) Use of telehealth or telemedicine, if applicable;

(g) Home medical equipment and supplies used by the patient;

(h) Orders for treatments and their frequency to be provided and monitored by the licensee;

(i) Special nutritional needs and food allergies;

(j) Orders for medications to be administered and monitored by the licensee including name, dose, route, and frequency;

(k) Medication allergies;

(l) The patient's physical, cognitive and functional limitations;

(m) Patient and family education needs pertinent to the care being provided by the licensee;

(n) Indication that the patient has a signed advanced directive or POLST, if applicable. Include resuscitation status according to advance directives or POLST, if applicable; and

(o) The level of medication assistance to be provided.

(4) Develop and implement a system to:

(a) Ensure and document that the plan of care is reviewed by the appropriate interdisciplinary team members within the first week of admission and every two weeks thereafter;

(b) Ensure the plan of care is signed or authenticated and dated by appropriate agency personnel and the authorizing practitioner;

(c) Ensure the signed or authenticated plan of care is returned to the agency within sixty days from the initial date of service;

(d) Inform the authorizing practitioner regarding changes in the patient's condition that indicates a need to update the plan of care;

(e) Obtain approval from the authorizing practitioner for additions and modifications; and

(f) Ensure all verbal orders for modification to the plan of care are immediately documented in writing and signed or authenticated and dated by an agency individual authorized within the scope of practice to receive the order and signed or authenticated by the authorizing practitioner and returned to the agency within sixty days from the date the verbal orders were received.

(5) Hospice agencies providing a one-time visit for a patient may provide the following written documentation in lieu of the hospice plan of care requirements in subsection (3) of this section:

(a) Patient's name, age, current address, and phone number;

(b) Confirmation that the patient was provided a written bill of rights under WAC 246-335-635;

(c) Patient consent for services to be provided;

(d) Authorizing practitioner orders; and

(e) Documentation of services provided.

[Statutory Authority: RCW 70.127.120 and 43.70.250. WSR 18-06-093, § 246-335-640, filed 3/6/18, effective 4/6/18.]