# CHAPTER 43G

# HOSPITAL LICENSING STANDARDS

**Authority**

N.J.S.A. 26:2H-1 et seq., specifically 26:2H–5.

**Source and Effective Date**

R.2000 d.71, effective January 27, 2000.
See: 31 N.J.R. 2732(a), 32 N.J.R. 707(a).

**Chapter Expiration Date**

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 43G, Hospital Licensing Standards, expires on July 26, 2005. See: 37 N.J.R. 709(a).

**Chapter Historical Note**

Chapter 43G, Certificate of Need: Capital Policy, was adopted as R.1986 d.375, effective September 8, 1986. See: 18 N.J.R. 1242(a), 18 N.J.R. 1817(a).

Chapter 43G, Certificate of Need: Capital Policy, was repealed by R.1988 d.114, effective March 21, 1988. See: 19 N.J.R. 2365(b), 20 N.J.R. 645(d).

Subchapter 1, General Provisions, Subchapter 2, Licensure Procedure, Subchapter 5, Administration and Hospital-Wide Services, Subchapter 19, Obstetrics, Subchapter 21, Oncology, Subchapter 22, Pediatrics, Subchapter 24, Plant Maintenance and Fire and Emergency Preparedness, Subchapter 26, Psychiatry, Subchapter 29, Physical and Occupational Therapy, Subchapter 30, Renal Dialysis, Subchapter 31, Respiratory Care, and Subchapter 35, Postanesthesia Care, were adopted as new rules by R.1990 d.95, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2926(a), 22 N.J.R. 441(b).

Subchapter 4, Patient Rights, was adopted as new rules by R.1990 d.98, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2160(b), 22 N.J.R. 484(a).

Subchapter 6, Anesthesia, was recodified from N.J.A.C. 8:43B–18 by R.1990, d.77, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2925(a), 22 N.J.R. 488(a).

Subchapter 7, Cardiac, was adopted as new rules by R.1990 d.97, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2162(a), 22 N.J.R. 488(b).

Subchapter 8, Central Supply, was adopted as new rules by R.1990 d.96, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1609, 22 N.J.R. 496(a).

Subchapter 9, Critical and Intermediate Care, was adopted as new rules by R.1990 d.94, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2167(a), 22 N.J.R. 498(a).

Subchapter 10, Dietary, was adopted as new rules by R.1990 d.78, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1611(a), 22 N.J.R. 505(a).

Subchapter 11, Discharge Planning, was adopted as new rules by R.1990 d.93, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1612(a), 22 N.J.R. 507(a).

Subchapter 12, Emergency Department, was adopted as new rules by R.1990 d.92, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1613(a), 22 N.J.R. 510(a).

Subchapter 13, Housekeeping and Laundry, was adopted as new rules by R.1990 d.91, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1616(a), 22 N.J.R. 514(a).

Subchapter 14, Infection Control and Sanitation, was adopted as new rules by R.1990 d.90, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1618(a), 22 N.J.R. 517(a).

Subchapter 15, Medical Records, was adopted as new rules by R.1990 d.88, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2171(a), 22 N.J.R. 520(a).

Subchapter 16, Medical Staff, was adopted as new rules by R.1990 d.89, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1621(a), 22 N.J.R. 524(a).

Subchapter 17, Nurse Staffing, was adopted as new rules by R.1990 d.87, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1623(a), 22 N.J.R. 530(a).

Subchapter 18, Nursing Care, was adopted as new rules by R.1990 d.86, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1624(a), 22 N.J.R. 531(a).

Subchapter 20, Employee Health, was adopted as new rules by R.1990 d.85, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2173(a), 22 N.J.R. 535(a).

Subchapter 23, Pharmacy, was adopted as new rules by R.1990 d.84, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1626(a), 22 N.J.R. 537(a).

Subchapter 25, Post Mortem, was adopted as new rules by R.1990 d.83, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1628(a), 22 N.J.R. 541(a).

Subchapter 27, Quality Assurance, was adopted as new rules by R.1990 d.82, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1630(a), 22 N.J.R. 542(a).

Subchapter 28, Radiology, was adopted as new rules by R.1990 d.81, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2174(a), 22 N.J.R. 544(a).

Subchapter 32, Same-Day Stay, and Subchapter 34, Surgery, were adopted as new rules by R.1990 d.80, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2177(a), 22 N.J.R. 548(a).

Subchapter 33, Social Work, was adopted as new rules by R.1990 d.79, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1631(a), 22 N.J.R. 555(a).

Pursuant to Executive Order No. 66(1978), Chapter 43G, Hospital Licensing Standards, was readopted as R.1995 d.124, effective February 3, 1995. See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

Pursuant to Executive Order No. 66(1978), Chapter 43G, Hospital Licensing Standards, was readopted as R.2000 d.71, effective January 27, 2000. See: Source and Effective Date. See, also, section annotations.

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## SUBCHAPTER 1. GENERAL PROVISIONS

### 8:43G–1.1 Scope and purpose

(a) These rules and standards apply to each licensed general or special hospital facility. They are intended for use in State surveys of the hospitals and any ensuing enforcement actions. They are also designed to be useful to consumers and providers as a mechanism for privately assessing the quality of care provided in any acute care hospital.

(b) This chapter contains rules intended to assure the high quality of care delivered in hospital facilities throughout New Jersey. Components of quality care addressed by these rules and standards include access to care, continuity of care, comprehensiveness of care, coordination of services, humaneness of treatment, conservatism in intervention, safety of environment, professionalism of caregivers, and participation in useful studies.

### 8:43G–1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"All payers case mix index" (CMI) means a specific hospital's average charge per case divided by the Statewide average charge per case for a given year using the most recent complete data set available to the Department.

"Hospital" means an institution, whether operated for profit or not, whether maintained, supervised or controlled by an agency of the government of the State or any county or municipality or not, which maintains and operates facilities for the diagnosis, treatment or care of two or more non-related individuals suffering from illness, injury or deformity and where emergency, out-patient, surgical, obstetrical, convalescent or other medical and nursing care is rendered for periods exceeding 24 hours.

"Hospital-based off-site ambulatory care service facility" means an ambulatory care service facility which has met the criteria as set forth in N.J.A.C. 8:43G–2.11(c) to be classified as same and which has applied for and received a license authorizing the facility to operate as a hospital-based off-site ambulatory care service facility.

"Hospitalization" means the admission and care of any person for a continuous period, longer than 24 hours, for the purpose of diagnosis and/or treatment bearing on the physical or mental health of such persons.

"Licensee" means the corporation, association, partnership or person authorized by the Department of Health to operate an institution and on whom rests the responsibility for maintaining acceptable standards in all areas of operation.

"Patient" means a person who receives a health care service from a provider.

Amended by R.2000 d.71, effective February 22, 2000.
See: 31 N.J.R. 2732(a), 32 N.J.R. 707(a).
Inserted "Hospital-based off-site ambulatory care service facility".
Amended by R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).
Added "All payers case mix index".

1. Private, non-profit, which shall include any hospital owned and operated by a corporation, association, religious or other organization, no part of the net earnings of which is applied, or may lawfully be applied, to the benefit of any private shareholder or person;

2. Private proprietary or profit, which shall include any hospital owned and operated by a person, partnership or corporation, the net proceeds of which are subject to distribution for the benefit of such person, corporation or shareholders; and

3. Public hospital, which shall include any institution maintained, supervised or controlled by an agency of the government of the State or any county or municipality that provides diagnostic and/or treatment services for the care of two or more non-related individuals suffering from illness, injury or deformity.

(b) Hospitals shall be further classified as:

1. General hospital, which shall include any hospital which maintains and operates organized facilities and services for the diagnosis, treatment or care of persons suffering from acute illness, injury or deformity and in which all diagnosis, treatment and care are administered by or performed under the direction of persons licensed to practice medicine or osteopathy in the State of New Jersey;

2. Special hospitals, which shall include any hospital which assures provision of comprehensive specialized diagnosis, care, treatment and rehabilitation where applicable on an inpatient basis for one or more specific categories and for a hospital that provides long term acute care through a broad spectrum of clinical care services for acutely ill/medically complex patients requiring, on average, a 25–day or greater length of stay. Special hospitals do not include hospitals or hospital units providing comprehensive rehabilitation services and licensed in accordance with the provisions of N.J.A.C. 8:43H. Special hospitals providing long term acute care services shall be further classified as follows:

i. Long term acute care hospital-within-a-hospital means a hospital established in accordance with the standards imposed by the United States Department of Health and Human Services at 42 CFR Part 412 et al. that occupies space in a building also used by another hospital and is licensed as a special hospital in accordance with N.J.A.C. 8:43G–38.

ii. Long term acute care hospital-freestanding means a hospital established in accordance with the standards imposed by the United States Department of Health and Human Services at 42 CFR Part 412 et al. that is a physically separate self-contained facility and is licensed as a special hospital in accordance with N.J.A.C. 8:43G–38; and

3. Psychiatric hospital, which shall include any hospital which assures provision of comprehensive specialized diagnosis, care, treatment and rehabilitation where applicable on an in-patient basis for patients with primary psychiatric diagnoses.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.2003 d.49, effective January 21, 2003.
See: 34 N.J.R. 490(a), 35 N.J.R. 414(a).
Rewrote (b)2.

**Case Notes**

Nursing home was not "hospital" which was exempt from local property tax. Intercare Health Systems, Inc. v. Cedar Grove Tp., 11 N.J.Tax 423 (1990), affirmed 12 N.J.Tax 273, certification denied 127 N.J. 558, 606 A.2d 369.

### 8:43G–1.4 Information and complaint procedure

(a) Questions regarding hospital licensure may be addressed to the Inspections Program or the Licensing and Certification Program at the following address:

New Jersey State Department of Health
Division of Health Facilities Evaluation and Licensing
PO Box 367
Trenton, NJ 08625–0367
(609) 588–7725

(b) To make a complaint about a New Jersey licensed hospital or nursing home, call:

1–800–792–9770 (toll-free hotline)

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## SUBCHAPTER 2. LICENSURE PROCEDURE

### 8:43G–2.1 Certificate of Need

(a) Where, in accordance with N.J.S.A. 26:2H–1 et seq., as amended, a Certificate of Need is required, a hospital shall not be instituted, constructed, expanded or licensed to operate except upon application for and receipt of a Certificate of Need issued by the Commissioner of the Department of Health.

(b) Application forms for a Certificate of Need and instructions for completion may be obtained from:

Certificate of Need Program
Division of Health Planning and Resources Development
New Jersey State Department of Health
PO Box 360
Trenton, New Jersey 08625–0360

(c) The hospital shall implement all conditions imposed by the Commissioner as specified in Certificate of Need approval letters. Failure to implement the conditions may

result in the imposition of enforcement sanctions in accordance with N.J.S.A. 26:2H–13 and 14.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

**Case Notes**

Licensed beds not interchangeable between categories without hospital licensing board approval. Desai v. St. Barnabas Medical Center, 103 N.J. 79, 510 A.2d 662 (1986).

### 8:43G–2.2 Application for licensure

(a) Where applicable, following receipt of a Certificate of Need as a hospital, any person, organization, or corporation desiring to operate a hospital shall make application to the Commissioner for a license on forms prescribed by the Department. Such forms may be obtained from:

Director
Licensing, Certification and Standards
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
PO Box 367
Trenton, New Jersey 08625–0367

(b) The Department shall charge a nonrefundable fee of $10,000 for the filing of an application for licensure and each annual renewal of a general acute care, special or psychiatric hospital. These fees shall not exceed the maximum caps as set forth at N.J.S.A. 26:2H–12, as may be amended from time to time.

(c) The Department shall charge a nonrefundable fee of $3,000 for the filing of an application to add services to an existing general acute care, special or psychiatric hospital.

(d) The Department shall charge a nonrefundable fee of $375.00 for the filing of an application to reduce services at an existing general acute care, special or psychiatric hospital.

(e) The Department shall charge a nonrefundable fee of $1,500 for the filing of an application for the relocation of a general acute care, special or psychiatric hospital.

(f) The Department shall charge a nonrefundable fee of $1,500 for the filing of an application for the transfer of ownership of a general acute care, special or psychiatric hospital.

(g) Each general acute care, special and psychiatric hospital shall be assessed a biennial inspection fee of $5,000. This fee shall be assessed in the year the facility will be inspected, along with the annual licensure fee for that year. The fee shall be added to the initial licensure fee for new facilities. Failure to pay the inspection fee shall result in nonrenewal of the license for existing facilities and the refusal to issue an initial license for new facilities. This fee shall be imposed only every other year even if inspections occur more frequently and only for the inspection required to either issue an initial license or to renew an existing license. This fee shall not be imposed for any other type of inspection.

(h) If a hospital operates a service that is subject to separate licensing regulation, for example, a long-term care or comprehensive rehabilitation facility, the Department shall charge an additional licensing fee for that service, as set forth in the applicable rules.

(i) All applicants shall demonstrate that they have the capacity to operate a hospital in accordance with the rules in this chapter. An application for a license or change in service may be denied if the applicant cannot demonstrate that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards or health care are fit and adequate and that there is reasonable assurance that the health care facility will be operated in accordance with the standards required by these rules. The Department shall consider an applicant's prior history in operating a health care facility either in New Jersey or in other states in making this determination. Any evidence of licensure violations representing serious risk of harm to patients may be considered by the Department, as well as any record of criminal convictions representing a risk of harm to the safety or welfare of patients.

(j) Any applicant denied a license to operate a facility shall have the right to a fair hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.1996 d.339, effective July 15, 1996.
See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).
Amended by R.1998 d.579, effective December 7, 1998.
See: 30 N.J.R. 3633(a), 30 N.J.R. 4221(b).
In (b), increased the fee from $1,500 plus $5.00 per bed to $8,000; inserted a new (g); and recodified former (g) through (i) as (h) through (j).
Amended by R.2004 d.160, effective April 19, 2004.
See: 35 N.J.R. 4838(a), 36 N.J.R. 1962(a).
In (b) through (g), increased fees.

### 8:43G–2.3 Newly constructed or expanded facilities

(a) The application for a license pursuant to N.J.A.C. 8:43G–2.2 for the operation of a new hospital shall include written approval of final construction of the physical plant by:

Health Facilities Construction Service
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
PO Box 367
Trenton, NJ 08625–0367

(b) An on-site inspection of the construction of the physical plant shall be made at the Department's discretion by representatives of the Health Facilities Construction Service to verify that the building has been constructed in accordance with the final architectural plans approved by the Department.

(c) Any health care facility which intends to undertake any alteration, renovation, or new construction of the physical plant, whether a Certificate of Need is required or not, shall submit plans to the Health Facilities Construction Service of the Department for review and approval prior to the initiation of any work.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

**8:43G–2.4 Surveys and temporary license**

(a) When the written application for licensure pursuant to N.J.A.C. 8:43G–2.2 is approved and the building is ready for occupancy, a survey of the facility by representatives of the Division of Health Facilities Evaluation and Licensing of the Department shall be conducted at the Department's discretion to determine if the facility meets the standards set forth in this chapter.

1. Representatives of the Division of Health Facilities Evaluation and Licensing of the Department shall discuss the findings of the survey, including any deficiencies found, with representatives of the hospital facility.

2. The hospital facility shall notify the Division of Health Facilities Evaluation and Licensing of the Department in writing when the deficiencies, if any, have been corrected. Following review of the hospital facility's report, the Division of Health Facilities Evaluation and Licensing may schedule one or more surveys of the facility prior to occupancy.

(b) A temporary license shall be issued to the operator of a facility when the following conditions are met:

1. An office conference for review of the conditions for licensure and operation has taken place between the Licensing and Certification Program and representatives of the hospital facility, who have been advised that the purpose of the temporary license is to allow the Department to determine the hospital's compliance with N.J.S.A. 26:2H–1 et seq., and amendments thereto, and the rules pursuant thereto;

2. Written approvals are on file with the Department from the local zoning, fire, health, and building authorities;

3. Written approvals of the water supply and sewage disposal system from local officials are on file with the Department for any water supply or sewage disposal system not connected to an approved municipal system; and

4. Survey(s) by representatives of the Department indicate that the hospital meets the mandatory standards set forth in this chapter.

(c) No hospital facility shall accept patients in any new service, unit, or facility until the hospital has a written approval and/or license issued by the Licensing and Certification Program of the Department.

(d) The hospital shall accept only that number of patients for which it is approved and/or licensed.

(e) Survey visits may be made to a hospital at any time by authorized staff of the Department. Such visits may include, but are not limited to, the review of all hospital documents and patient records and conferences with patients.

(f) A temporary license shall be issued to the operator of a hospital facility for a period of six months and shall be renewed as determined by the Department.

1. The temporary license shall be conspicuously posted in the hospital facility.

2. The temporary license shall not be assignable or transferable and shall be immediately void if the facility ceases to operate, if the facility's ownership changes, or if the facility is relocated to a different site.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.1996 d.339, effective July 15, 1996.
See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).

**8:43G–2.5 Full license**

(a) A full license shall be issued to the operator on expiration of the temporary license, if the surveys by the Department have determined that the health care facility is operated as required by N.J.S.A. 26:2H–1 et seq., and amendments thereto, and by the rules pursuant thereto.

(b) A license shall be granted for a period of one year or less as determined by the Department in accordance with (a) above.

(c) The license shall be conspicuously posted in the facility.

(d) The license shall not be assignable or transferable and shall be immediately void if the hospital ceases to operate, if its ownership changes, or if it is relocated to a different site. A representative of the hospital shall notify the Department of any change in the ownership form or controlling interests affecting hospital governance. The Department shall determine whether a certificate of need or licensing application must be completed prior to the implementation of any ownership changes based upon the information filed and the criteria within N.J.A.C. 8:33–3.3.

(e) The license, unless suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date.

1. The facility shall receive a request for renewal fee 30 days prior to expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department.

2. The license may not be renewed if Departmental rules, regulations and/or requirements are not met.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.1996 d.339, effective July 15, 1996.
See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).

**8:43G–2.6 Revocation or suspension of license**

(a) The Department is authorized to suspend or revoke a license issued pursuant to this subchapter, order closure of a service or unit within the hospital, or impose a money penalty on any of the following grounds:

1. Violation of any provisions of N.J.S.A. 26:2H–1 et seq. or any rules and regulations issued pursuant thereto;

2. Permitting, aiding or abetting the commission of any illegal act in said facility; and/or

3. Conducting practices contrary to accepted procedures and detrimental to the welfare of the patient.

**8:43G–2.7 Surrender of license**

At least 30 days prior to voluntary surrender of its license where approved by Certificate of Need, or as directed under an order of revocation, refusal to renew, or suspension of license, a facility must directly notify each patient and the patient's physician concerned of the intended closure. The license shall be returned to the Licensing and Certification Program of the Department within seven calendar days from voluntary surrender, order of revocation, expiration, or suspension of license, whichever is applicable.

**8:43G–2.8 Waiver**

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of N.J.S.A. 26:2H–1 et seq., and amendments thereto, and the standards in this chapter, waive sections of this chapter if, in his or her opinion, such waiver would not endanger the life, safety, or health of the patient or public.

1. Administration;
2. Anesthesia Department;
3. Blood Bank;
4. Central Supply;
5. Clinical and Pathological Laboratories;
6. Dietary Services;
7. Discharge Planning;
8. Emergency Department;
9. Employee and Occupational Health;
10. Electrocardiogram Laboratory;
11. Housekeeping and Laundry Services;
12. Infection Control and Sanitation;
13. Medical Library;
14. Medical Records;
15. Medical/Surgical Service;
16. Medical Staff;
17. Morgue and Autopsy Facilities;
18. Nursing Service;
19. Out–Patient and Preventive Services, including regularly scheduled clinic services for medically indigent patients;
20. Pharmacy Department;
21. Physical and Occupational Therapy;
22. Physical Plant and Maintenance;
23. Post Anesthesia Care Unit;
24. Quality Assurance;
25. Radiology;
26. Respiratory Therapy Services; and
27. Social Work Department.

(b) All psychiatric hospitals applying for licensure shall provide the following professional departments, services, facilities, or functions:

1. Administration;
2. Anesthesia department (only if electro-convulsive therapy is provided);
3. Dietary services:
4. Discharge planning;
5. Emergency department (8:43G–12.1 only);
6. Employee and occupational health;
7. Housekeeping and laundry services;
8. Infection control and sanitation;
9. Medical records;
10. Medical staff;
11. Post mortem services (8:43G–25.1 and 25.3(b) through (d) only);
12. Nursing service;
13. Patient rights;
14. Pharmacy services;
15. Rehabilitation therapy;
16. Physical plant and maintenance;
17. Psychiatric services;
18. Quality assurance; and
19. Social services.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Added (b).

### 8:43G–2.13 Child abuse and neglect

(a) The facility shall establish and implement written policies and procedures, reviewed by the Department and revised as required by the Department, for reporting all diagnosed and/or suspected cases of child abuse and/or neglect in compliance with N.J.S.A. 9:6–1 et seq.

(b) The facility shall have in effect written policies and procedures reviewed by the Department and revised as required by the Department to include, but not be limited to, the following:

1. The designation of a staff member(s) to be responsible for coordinating the reporting of diagnosed and/or suspected cases of child abuse and/or neglect on a 24–hour basis, recording the notification to the Division of Youth and Family Services on the medical record, and serving as a liaison between the facility and the Division of Youth and Family Services;
2. The development of written protocols for the identification and treatment of abused and/or neglected children for the emergency room, clinic, and pediatrics, where such services exist, for admission and/or transfer to another facility and for protective custody through the use of hospital hold in accordance with N.J.S.A. 9:6–8.16; and

3. The provision of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of child abuse and/or neglect and regarding the facility's policies and procedures on at least an annual basis.

Note: Copies of N.J.S.A. 9:6–1 et seq. can be obtained from the local district office of the Division of Youth and Family Services or from the Office of Program Support, Division of Youth and Family Services, Trenton, New Jersey 08625.

## SUBCHAPTER 3. (RESERVED)

## SUBCHAPTER 4. PATIENT RIGHTS

**8:43G–4.1 Patient rights**

(a) Every New Jersey hospital patient shall have the following rights, none of which shall be abridged by the hospital or any of its staff. The hospital administrator shall be responsible for developing and implementing policies to protect patient rights and to respond to questions and grievances pertaining to patient rights. These rights shall include at least the following:

1. To receive the care and health services that the hospital is required to provide under N.J.S.A. 26:1–1 et seq. and rules adopted by the Department of Health to implement this law;

2. To treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment;

3. To retain and exercise to the fullest extent possible all the constitutional, civil, and legal rights to which the patient is entitled by law;

4. To be informed of the names and functions of all physicians and other health care professionals who are providing direct care to the patient. These people shall identify themselves by introduction or by wearing a name tag;

5. To receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and the hospital's health care personnel;

6. To receive from the patient's physician(s)—in terms that the patient understands—an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the patient's medical record;

7. To give informed, written consent prior to the start of specified nonemergency procedures or treatments only after a physician has explained—in terms that the patient understands—specific details about the recommended procedure or treatment, the risks involved, the possible duration of incapacitation, and any reasonable medical alternatives for care and treatment. The procedures requiring informed, written consent shall be specified in the hospital's policies and procedures. If the patient is incapable of giving informed, written consent, consent shall be sought from the patient's next of kin or guardian or through an advance directive, to the extent authorized by law. If the patient does not given written consent, a physician shall enter an explanation in the patient's medical record;

8. To refuse medication and treatment to the extent permitted by law and to be informed of the medical consequences of this act;

9. To be included in experimental research only when he or she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent patient in accordance with law and regulation. The patient may refuse to participate in experimental research, including the investigations of new drugs and medical devices;

10. To be informed if the hospital has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and may refuse to allow their participation in the patient's treatment;

11. To be informed of the hospital's policies and procedures regarding life-saving methods and the use or withdrawal of life-support mechanisms. Such policies and procedures shall be made available promptly in written format to the patient, his or her family or guardian, and to the public, upon request;

12. To be informed by the attending physician and other providers of health care services about any continuing health care requirements after the patient's discharge from the hospital. The patient shall also have the right to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge;

13. To receive sufficient time before discharge to have arrangements made for health care needs after hospitalization;

14. To be informed by the hospital about any discharge appeal process to which the patient is entitled by law;

15. To be transferred to another facility only for one of the following reasons, with the reason recorded in the patient's medical record:

i. The transferring hospital is unable to provide the type or level of medical care appropriate for the patient's needs. The hospital shall make an immediate effort to notify the patient's primary care physician and the next of kin, and document that the notifications were received; or

ii. The transfer is requested by the patient, or by the patient's next of kin or guardian when the patient is mentally incapacitated or incompetent;

16. To receive from a physician an explanation of the reasons for transferring the patient to another facility, information about alternatives to the transfer, verification of acceptance from the receiving facility, and assurance that the movement associated with the transfer will not subject the patient to substantial, unnecessary risk of deterioration of his or her medical condition. This explanation of the transfer shall be given in advance to the patient, and/or to the patient's next of kin or guardian except in a life-threatening situation where immediate transfer is necessary;

17. To be treated with courtesy, consideration, and respect for the patient's dignity and individuality;

18. To freedom from physical and mental abuse;

19. To freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the patient or others from injury;

20. To have physical privacy during medical treatment and personal hygiene functions, such as bathing and using the toilet, unless the patient needs assistance for his or her own safety. The patient's privacy shall also be respected during other health care procedures and when hospital personnel are discussing the patient;

21. To confidential treatment of information about the patient. Information in the patient's records shall not be released to anyone outside the hospital without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, a medical peer review, or the New Jersey State Department of Health. The hospital may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;

22. To receive a copy of the hospital payment rates, regardless of source of payment. Upon request, the patient or responsible party shall be provided with an itemized bill and an explanation of the charges if there are further questions. The patient or responsible party has a right to appeal the charges. The hospital shall provide the patient or responsible party with an explanation of procedures to follow in making such an appeal;

23. To be advised in writing of the hospital rules and regulations that apply to the conduct of patients and visitors;

24. To have prompt access to the information contained in the patient's medical record, unless a physician prohibits such access as detrimental to the patient's health, and explains the reason in the medical record. In that instance, the patient's next of kin or guardian shall have a right to see the record. This right continues after the patient is discharged from the hospital for as long as the hospital has a copy of the record;

25. To obtain a copy of the patient's medical record, at a reasonable fee, within 30 days of a written request to the hospital. If access by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician;

26. To have access to individual storage space in the patient's room for the patient's private use. If the patient is unable to assume responsibility for his or her personal items, there shall be a system in place to safeguard the patient's personal property until the patient or next of kin is able to assume responsibility for these items;

27. To be given a summary of these patient rights, as approved by the New Jersey State Department of Health, and any additional policies and procedures established by the hospital involving patient rights and responsibilities. This summary shall also include the name and phone number of the hospital staff member to whom patients can complain about possible patient rights violations. This summary shall be provided in the patient's native language if 10 percent or more of the population in the hospital's service area speak that language. In addition, a summary of these patient rights, as approved by the New Jersey State Department of Health, shall be posted conspicuously in the patient's room and in public places throughout the hospital. Complete copies of this subchapter shall be available at nurse stations and other patient care registration areas in the hospital for review by patients and their families or guardians;

28. To present his or her grievances to the hospital staff member designated by the hospital to respond to questions or grievances about patient rights and to receive an answer to those grievances within a reasonable period of time. The hospital is required to provide each patient or guardian with the names, addresses, and telephone numbers of the government agencies to which the patient can complain and ask questions, including the New Jersey Department of Health Complaint Hotline at 1–800–792–9770. This information shall also be posted conspicuously in public places throughout the hospital;

29. To be assisted in obtaining public assistance and the private health care benefits to which the patient may be entitled. This includes being advised that they are indigent or lack the ability to pay and that they may be eligible for coverage, and receiving the information and other assistance needed to qualify and file for benefits or reimbursement; and

30. To contract directly with a New Jersey licensed registered professional nurse of the patient's choosing for private professional nursing care during his or her hospitalization. A registered professional nurse so contracted shall adhere to hospital policies and procedures in regard to treatment protocols, and policies and procedures so long as these requirements are the same for private duty and regularly employed nurses. The hospital, upon request, shall provide the patient or designee with a list of local non-profit professional nurses association registries that refer nurses for private professional nursing care.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Native language and distribution requirements added at (a)27.
Petition for Rulemaking: Petition from N.J. Hospital Assoc.
See: 24 N.J.R. 4131(a), 24 N.J.R. 4290(a), 25 N.J.R. 4676(b).
Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote (a)8.

(f) The hospital shall require that all prescriptions and orders issued by registered first-year residents in the inpatient setting be countersigned by a licensed physician or permit holder (a person authorized in the State of New Jersey to engage in the practice of medicine in the second year of a graduate medical education program or beyond).

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Reference changed at (b).
Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years; revised more frequently" for "annually, revised" in the introductory paragraph.

### 8:43G–16.3 Medical staff qualifications

(a) All physicians with clinical privileges shall be licensed or authorized to practice medicine by the New Jersey Board of Medical Examiners. All non-physicians with privileges shall be licensed or authorized to practice in the State of New Jersey, as required by law.

(b) In any subchapter of these rules requiring a practitioner to be Board-certified within his or her medical specialty, it shall be deemed acceptable to possess:

i. Board certification from one of the recognized boards of osteopathic medicine; or

ii. Board certification from a foreign Board within the specified medical specialty where the American Board offers reciprocity with or officially recognizes the foreign board certification credential.

**Case Notes**

In action brought by physician challenging termination of staff privileges at hospital, regulation cited to support court's deference to decisions of hospitals to maintain a qualified medical staff. Nanavati v. Burdette Tomlin Memorial Hospital, 107 N.J. 240, 526 A.2d 697 (1987).

All hospital employees subject to regulatory supervision; restrictive staff admission policy invalid as not reasonably in furtherance of legitimate health objective. Desai v. St. Barnabas Medical Center, 103 N.J. 79, 510 A.2d 662 (1986).

Regulations require hospital to appoint organized medical staff responsible to governing board; hospitals must adopt rules concerning procedures for staff membership admission; qualified doctors may not be arbitrarily excluded from staff; exclusive contract for anesthesiological services reasonable, not violative of public policy and not illegal tying arrangement under Antitrust Act. Belmar v. Cipolla, 96 N.J. 199, 475 A.2d 533 (1984).

### 8:43G–16.4 (Reserved)

### 8:43G–16.5 Medical staff time and availability

(a) The hospital shall establish policies and procedures for response times for emergencies.

(b) There shall be an on-call list of medical and surgical specialists that is available to personnel in all patient care units.

### 8:43G–16.6 Medical staff patient services

(a) Each patient shall have an attending physician who has overall responsibility for the patient's care in the hospital.

(b) Each patient admitted to the hospital shall have a medical history and physical examination that includes a provisional diagnosis performed by a physician within seven days prior to admission or within 24 hours after admission. If the history and physical were performed within seven days prior to admission, the patient's history and physical examination record completed by the attending physician shall be included in the medical record, with any subsequent changes recorded at the time of admission.

(c) When there is a clinical consultant, he or she shall issue a report that states at least the assessment mechanisms used, findings, and opinion. This report shall be included in the medical record.

(d) The reason or reasons for requesting a clinical consultation shall be specified in the patient's medical record by the attending physician. The consultant shall provide consultation in accordance with the privileges accorded him or her by the hospital.

(e) Medical care shall be provided to all patients, regardless of their ability to pay.

(f) Every acute care patient shall receive a visit by a clinical practitioner every day unless there is a clinical basis to justify the patient not receiving such a visit that is documented in the medical record by the practitioner. In all cases a patient shall receive a visit by a practitioner at least once every two days.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Diagnosis to be provided seven days prior to or 24 hours after admission.

### 8:43G–16.7 Medical staff education

Requirements for the medical staff education program shall be as provided in N.J.A.C. 8:43G–5.9(a) and (b).

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Stylistic change.

### 8:43G–16.8 Medical staff continuous quality improvement methods

There shall be a medical staff mechanism by which the quality of medical care is monitored, problems identified, solutions recommended and implemented, and follow-up conducted. Summary reports of these activities and problems in the quality of care shall be reviewed by the medical executive committee, or its equivalent.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

SUBCHAPTER 17. NURSE STAFFING

**8:43G–17.1 Nurse staffing**

(a) The hospital shall have in place a staffing plan that addresses nurse staffing requirements and identifies patient needs, including, at a minimum:

1. A daily staffing schedule that ensures at least one registered professional nurse in charge and assigned exclusively to each patient care unit on each shift;

2. A provision that at least 65 percent of direct patient care hours in inpatient units on a hospital wide average be provided by licensed nursing personnel;

3. A method for assessing each unit's additional nursing needs for each shift, including, at a minimum, objective criteria such as:

i. Documented skills, training and competency of staff to plan and provide nursing services in the nursing areas where they function;

ii. Patient data base incorporating objective factors such as case mix index, specific or aggregate patient diagnostic classifications or acuity levels, patient profiles, critical pathways or care progression plans, length of stay, and discharge plans;

iii. Operational factors such as unit size, design, and capacity, admission/discharge/transfer index, and support service availability;

iv. Contingency plans to address critical departures from staffing plan, including policies and procedures to regulate closure of available beds if staffing levels fall below specified levels;

v. Policies and procedures for the reassignment of staff including float and agency staff; and

4. On-going internal institutional evaluation of outcome-based quality indicators related to nursing care to assess and provide a safe and adequate level of patient care including at least:

i. Patient injury rate;

ii. Medication process errors;

iii. Maintenance of skin integrity;

iv. Nosocomial infection rates;

v. Hospital-wide patient satisfaction with overall care, including nursing care;

vi. Nursing turnover rate;

vii. Patient satisfaction with pain management; and

viii. Mix of RNs, LPNs and unlicensed staff caring for patients.

(b) There shall be a registered nurse manager for each patient care unit or units and for surgery, emergency department, and other units, as specified in the hospital organizational plan or policies and procedures.

(c) There shall be at least one registered professional nurse in charge and assigned exclusively to each patient care unit on each shift. Additional staff shall be assigned by the hospital as required by the acuity levels.

(d) Patient care assignments shall be made on an individual basis by a registered professional nurse and reflect staff competence, skill, and aptitude and patient needs.

(e) The hospital shall have in effect a contingency plan for assuring adequate nurse staffing at all times. The plan shall detail policies and procedures to regulate closure of available beds, if actual staffing levels fall below specified levels.

(f) Nurse staffing for all patient care units within the hospital shall also be in accordance with:

1. N.J.A.C. 8:43G–7.5(a), (b) and (c) in accordance with N.J.A.C. 8:43G–9.20(a)6 and (i);

2. N.J.A.C. 8:43G–7.15(d);

3. N.J.A.C. 8:43G–7.16(a)2 and 3i;

4. N.J.A.C. 8:43G–7.24(a)2 and 3i;

5. N.J.A.C. 8:43G–7.27(a)2 and 3i;

6. N.J.A.C. 8:43G–9.4(a)11;

7. N.J.A.C. 8:43G–9.5(c), (d) and (e);

8. N.J.A.C. 8:43G–9.5(c), (d) and (e);

9. N.J.A.C. 8:43G–9.7(a) and (b);

10. N.J.A.C. 8:43G–9.7(a) and (b);

11. N.J.A.C. 8:43G–9.7(a);

12. N.J.A.C. 8:43G–9.14;

13. N.J.A.C. 8:43G–9.20(a)6 and (c);

14. N.J.A.C. 8:43G–9.23;

15. N.J.A.C. 8:43G–11.4(a) and (b);

16. N.J.A.C. 8:43G–12.3(e), and (g)1 through 4;

17. N.J.A.C. 8:43G–12.5(e);

18. N.J.A.C. 8:43G–12.7(a);

19. N.J.A.C. 8:43G–12.16(c) and (d);

20. N.J.A.C. 8:43G–14.1(a);

21. N.J.A.C. 8:43G–16.6(a), (b) and (f);

22. N.J.A.C. 8:43G–19.1(b) and (f);

23. N.J.A.C. 8:43G–19.3(b)1 through 3 and (c);

(f) A health professional certified in neonatal resuscitation shall be available within the obstetrics unit for each delivery.

(g) A pediatrician or pediatric resident shall be present in the delivery room for all high-risk deliveries.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Physician to examine patient prior to use of oxytoxics; neonatal resuscitation to be available when infant is present.
Recodified from N.J.A.C. 8:43G–19.13 and amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote the section.

**8:43G–19.12 Labor, delivery, anesthesia and recovery patient services**

(a) A registry of all births shall be maintained through either the electronic certificate or a maternity log book located in the obstetrics area and shall include the minimum data set required by the Department of Health and Senior Services and in accordance with N.J.S.A. 26:8–30, and N.J.A.C. 8:2.

(b) Obstetrics anesthesia services policies and procedures shall include at least:

1. The obstetric service in consultation with the anesthesia service shall develop and implement written policies and procedures that govern anesthesia services in all labor, delivery and recovery areas. The policies and procedures shall be reviewed annually, revised and implemented.

2. All individuals who administer anesthetic agents to obstetric patients shall be credentialed in accordance with medical staff policies. The physician director of anesthesia services shall participate in the credentialing process and delineation of privileges of all personnel who administer anesthetic agents.

3. The obstetric service, in consultation with the anesthesia service, shall establish protocols governing the use of anesthetic agents for pain management. These shall include the qualifications and responsibilities of persons who administer the use of anesthetic agents for pain management. Policies and procedures shall address the use of patient monitoring equipment and identify the types and levels of agents which may be used for pain management.

4. A preanesthesia note, reflecting evaluation and classification of the patient according to American Society of Anesthesiologists (ASA) Physical Status system, shall be made or certified by the physician administering or supervising the administration of anesthesia and entered into the medical record of each patient who will be administered an anesthetic agent.

5. Anesthetic or pain control agents administered to non-surgical obstetric patients classified for anesthesia risk as an ASA Class I, II or III shall be administered and monitored in accordance with obstetric service policies and procedures governing anesthesia care.

6. Anesthetic or pain control agents administered to non-surgical obstetric patients classified for anesthesia risk as an ASA Class IV, V or Emergency shall be in accordance with the following sections of N.J.A.C. 8:43G–6, Anesthesia Services, as amended:

i. N.J.A.C. 8:43G–6.1, Definitions;

ii. N.J.A.C. 8:43G–6.3(d) through (k), Anesthesia qualifications for administering anesthesia;

iii. N.J.A.C. 8:43G–6.5(b), Anesthesia patient services;

iv. N.J.A.C. 8:43G–6.6, Anesthesia supplies and equipment; safety systems;

v. N.J.A.C. 8:43G–6.7, Anesthesia supplies and equipment; maintenance and inspection; and

vi. N.J.A.C. 8:43G–6.8, Anesthesia supplies and equipment; patient monitoring.

7. For patients undergoing surgical deliveries, including cesarean sections, anesthesia care shall be in accordance with all applicable sections of N.J.A.C. 8:43G–6, Anesthesia Services.

8. There shall be a program of quality assurance for anesthesia care provided in obstetric services that is integrated into the hospital and the anesthesia service quality assurance programs.

(c) There shall be written policies and procedures for the care of patients during the recovery phase of delivery. The policies and procedures shall be reviewed annually, revised as needed, and implemented. These policies and procedures shall include at least:

1. Delineation of the primary medical responsibility for postanesthesia care of the patient;

2. Monitoring of patients, including availability of monitoring equipment, and use of an objective scoring system to determine when the patient has recovered from anesthesia;

3. Requirements for documentation of patient status;

4. Protocol for patient emergencies;

5. Criteria and responsibility for discharge from recovery;

6. Recovery staff qualifications, which shall be as follows:

i. All registered professional nurses assigned to recovery services shall have training in basic cardiac life support.

ii. Recovery services shall be staffed at all times by at least one registered professional nurse with critical care training, as defined by the hospital, whenever a patient recovering from a cesarean section and/or classified as ASA Class III, IV, V or Emergency is present;

7. Recovery staff time and availability, which shall be as follows:

i. There shall be at least two health care personnel, one of whom is a registered professional nurse and the other of whom is either a registered professional nurse or a licensed practical nurse, present in recovery services whenever a patient in the recovery phase of delivery is present. The nurse identified in (c)6ii above may function as the registered professional nurse required herein.

ii. There shall be a ratio of at least one registered professional nurse present in the recovery service area for every three patients in the recovery phase of delivery; and

8. Recovery patient services, which shall be as follows:

i. Postanesthesia notes shall be entered into the patient's medical record by a member of the hospital's anesthesia team early in the postoperative period.

ii. The condition of each patient shall be continually evaluated, with an objective scoring system used to track the patient until she has recovered from anesthesia.

iii. The patient's vital signs shall be monitored and recorded at least every 15 minutes during recovery.

iv. Postanesthesia care for patients recovering from a cesarean section and/or classified as ASA Class III, IV, V or Emergency shall also follow 8:43G–35.4(a) through (i).

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Text added at (b) on anesthesia; at (c) on recovery.
Recodified from N.J.A.C. 8:43G–19.14 and amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote (a); and in (b), inserted a reference to ASA Class III in 5, and deleted a reference to ASA Class III in 6. Former N.J.A.C. 8:43G–19.12, Labor and delivery policies and procedures, repealed.

### 8:43G–19.13 Postpartum policies and procedures and staff time and availability

(a) At least one registered professional nurse shall be on duty in the postpartum area whenever a patient is present.

(b) Nurse staffing assignments for postpartum patients shall be determined by patient acuity levels.

(c) There shall be written policies and procedures for the care of postpartum patients. The policies and procedures shall be reviewed annually, and revised as needed, and shall include at least the following:

1. Monitoring and documentation of patient's vital signs, condition of uterus, and rate of bleeding.

2. Identification and management of postpartum complications; and

3. Physical care, including care of the perineum and breasts, and ambulation.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Text added at (c), requiring policies and procedures.
Recodified from N.J.A.C. 8:43G–19.15 by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Former N.J.A.C. 8:43G–19.13, Labor and delivery staff time and availability, recodified to N.J.A.C. 8:43G–19.11.

### 8:43G–19.14 Postpartum patient services

(a) The hospital shall provide or arrange for an organized program of education in self-care and newborn care.

(b) If a patient is discharged less than 48 hours after delivery, early follow-up care shall be offered to the patient and arranged on request. The patient's medical record shall include documentation of the offer and the plan for provision of home health services if the offer is accepted.

(c) The hospital shall have staff available to advise postpartum patients in order to prevent difficulties with breast feeding during the hospital stay.

Recodified from N.J.A.C. 8:43G–19.16 and amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), deleted "postpartum" preceding "education"; and in (b), added a second sentence. Former N.J.A.C. 8:43G–19.14, Labor, delivery, anesthesia and recovery patient services, recodified to N.J.A.C. 8:43G–19.12.

### 8:43G–19.15 Newborn care policies and procedures

(a) A current roster of physicians, their specific pediatric privileges, and an on-call schedule shall be kept in each nursing unit in newborn care.

(b) A physician or an advanced practice nurse skilled in neonatal assessment shall perform a complete physical examination of the neonate within 24 hours of birth. This examination may serve as both the initial and discharge examination if the neonate is discharged within 24 hours. If the neonate remains in the hospital for more than 24 hours, a second examination shall be performed prior to discharge.

(c) Isolation practices recommended by the Centers for Disease Control shall be used for isolation patients in the newborn nursery, and are incorporated herein by reference. (See CDC Guidelines for Isolation Precautions in Hospitals, publication number PB85927401, available from National Technical Information Services, 5285 Port Royal Rd., Springfield, VA 22161, telephone 703–487–4600.)

(d) The newborn nursery shall identify and report any outbreak of disease, or any single case of a disease as specified in N.J.A.C. 8:57–1.1 through 1.5 also known as Chapter II of the State Sanitary Code.

(e) The hospital shall comply with State laws for screening infants for high risk factors associated with hearing impairment (N.J.S.A. 26:2–101 et seq.), early detection of biochemical disorders in newborns (N.J.S.A. 26:2–110 and 111), reporting congenital defects (N.J.S.A. 26–8–40.20 et seq.), and completing birth certificates (N.J.S.A. 26:8–28) and death certificates.

(f) Policies and procedures for screening newborns for high risk factors associated with hearing impairment, in accordance with N.J.S.A. 26:2–101 et seq. shall be as follows:

1. A physician or registered professional nurse shall screen the newborn using the Newborn Hearing Screening Report Form of the New Jersey Hearing Evaluation Council and the Special Child Health Services Program of the Department; and

2. The facility shall send copies of the Newborn Hearing Screening Report Form for all at risk newborns, within one week of the infant's discharge to the Special Child Health Services Program of the Department or enter the data electronically through the New Jersey Department of Health and Senior Services Electronic Birth Certificate System, in accordance with N.J.A.C. 8:2.

(g) Policies and procedures for the early detection of biochemical disorders in newborn infants, including at least hypothyroidism, galactosemia, and phenylketonuria, pursuant to N.J.S.A. 26:2–110 and 111, shall include, but not be limited, to the following:

1. Collection of blood specimens from newborn infants on collection kits provided by the Department;

2. Collection of blood specimens 24 hours after the newborn infant's first feeding or 48 hours after the newborn infant's birth or upon the newborn infant's discharge from the facility, whichever comes first;

3. Development of a system within the facility for the submission of blood specimens to arrive at the Department's laboratory no later than 96 hours after the newborn infant's birth;

4. Designation of a staff member(s) to be responsible for receiving verbal and written positive screening test results and documenting the results in the newborn infant's medical record; and

5. Provision of written information, provided by the Department and/or the facility, to all parents and physicians regarding the testing of biochemical disorders and the possibility of incorrect screening test results if the blood specimen is not collected.

(h) The newborn's medical record shall include at least:

1. A summary of the mother's obstetric and relevant medical history;

2. Anesthesia, analgesia, and medications given to the mother;

3. Reasons for induction of labor and operative procedures, if performed;

4. Date and time of birth and copies of all vital records;

5. Birth weight and length;

6. Condition of the newborn at birth, including the one- and five-minute Apgar scores, time of sustained respirations, details of any physical abnormalities, and any pathological states observed and treatment given before transfer to the nursery;

7. Any abnormalities of the placenta and cord vessels;

8. Length of gestation;

9. Procedures performed in the delivery room;

10. A record of the newborn assessment, performed by a physician or registered professional nurse upon the newborn's admission to the nursery;

11. A plan of care;

12. A record of the initial physical examination, performed, signed, and dated by a physician;

13. A record of a physical examination on discharge or transfer to another facility, including head circumference, signed, and dated by a physician; and

14. Documentation of eye prophylaxis, as recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists for ophthalmia neonatorum, administration of any other medication or treatment and response, and performance of inborn error and hearing screenings.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Details of roster, notification procedure and ophthalmic treatment specified.
Recodified from N.J.A.C. 8:43G–19.17 and amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote (b); deleted a former (c); recodified former (d) through (i) as (c) through (h); in the new (e) and (g), deleted references to N.J.S.A. 26:2–112; and in the new (f), added a reference to electronic date entry at the end of 2. Former N.J.A.C. 8:43G–19.15, Postpartum policies and procedures and staff time and availability, recodified to N.J.A.C. 8:43G–19.13.

### 8:43G–19.16 Normal newborn nurse staff qualifications, staff time and availability

(a) Hospitals designated as a CPC–Basic may provide care to neonates born greater than 2,499 grams or at least 36 weeks gestation. The only exception to this criteria is if it has been documented in the medical record that the neonate was expected to meet the weight and age criteria and the neonate does not require a higher level of care than otherwise specified for a CPC–Basic. Service restrictions placed on CPC–Basic include:

1. Mechanical ventilatory support shall not be provided except for resuscitative measures; and

2. Total parenteral nutrition shall not be provided.

(b) The physician director of newborn care in hospitals designated as a CPC–Basic shall be board certified in pediatrics.

(c) There shall be a nurse manager of the normal newborn nursery who may also function as the nurse manager of the obstetric service. This individual shall be a registered professional nurse with, at a minimum:

1. Three-years of experience in inpatient neonatal services within the five years immediately preceding the date of appointment;

2. Educational preparation in maternal-fetal neonatal nursing, in accordance with hospital policy; and

3. Completion of 24 contact hours of maternal-fetal or neonatal nursing approved by a nationally recognized nurse education accrediting body every three years.

(d) There shall be a health professional certified in neonatal resuscitation available within the unit at all times.

(e) The normal newborn nursery shall be covered at all times by a pediatrician, family practice physician with pediatric privileges, or certified neonatal or pediatric nurse practitioner who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being, summoned, under normal transportation conditions.

(f) The normal newborn nursery shall have a registered professional nurse present whenever a neonate is in the newborn nursery. Additional staffing, assignments shall be determined by acuity levels appropriate to infants.

(g) The normal newborn nursery shall have at least one registered professional nurse to every eight neonates. However, so long as one registered nurse is on duty as required by (d) above, licensed practical nurses may be used to comply with the nurse:infant ratio requirement.

New Rule, R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Former N.J.A.C. 8:43G–19.16, Postpartum patient services, recodified to N.J.A.C. 8:43G–19.14.

### 8:43G–19.17 Intermediate nursery staff qualifications, staff time and availability

(a) Hospitals designated as a CPC–Intermediate may provide care to neonates born greater than 1,499 grams or at least 32 weeks gestation. The only exception to this criteria is if it has been documented in the medical record that the neonate was expected to meet the weight and age criteria and the neonate does not require a higher level of care than otherwise specified for a CPC–Intermediate. Service restrictions placed on CPC–Intermediate include:

1. In no case shall continuous or intermittent positive pressure ventilatory support be administered to an intubated neonate for more than 48 hours, except in cases where authorization has been received from the neonatologist on-call at the Regional Perinatal Center or the CPC–Intensive and the CPC–Intermediate has demonstrated the ability to intubate and is able to hourly monitor the partial pressure of oxygen in the neonate's blood. Authorization from the neonatologist on-call at the Regional Perinatal Center or the CPC–Intensive shall be obtained on a daily basis and shall be documented in the medical record; and

2. All neonates, regardless of birth weight, who require surgery, or other highly specialized services shall be transported to a higher level facility capable of providing the care.

(b) The physician director of newborn care in hospitals designated as a CPC–Intermediate shall be board certified in pediatrics.

(c) There shall be a nurse manager of the intermediate nursery who meets the qualifications of the nurse manager specified in N.J.A.C. 8:43G–19.16(c). This individual may also function as the nurse manager of the obstetric service.

(d) There shall be a health professional certified in neonatal resuscitation available within the unit at all times.

(e) The intermediate nursery shall be covered at all times by a board eligible or certified pediatrician with certification and/or training and experience in neonatal medicine or a certified neonatal or pediatric nurse practitioner who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned under normal transportation conditions. A physician who has training and experience in neonatal medicine or a certified neonatal or pediatric nurse practitioner shall be present in the hospital whenever a neonate is receiving any form of positive pressure oxygen therapy.

(f) The intermediate nursery shall have at least one registered professional nurse to every four infants requiring intermediate care services. Additional staffing assignments shall be determined by the acuity levels of the infants.

New Rule, R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Former N.J.A.C. 8:43G–19.17, Newborn care policies and procedures, recodified to N.J.A.C. 8:43G–19.15.

**8:43G–25.5 Post mortem supplies and equipment**

Refrigerated spaces in the morgue shall be maintained at temperatures between 32 and 45 degrees Fahrenheit (0 and 7.2 degrees Celsius) and shall have an automatic alarm system that monitors the temperature.

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## SUBCHAPTER 26. PSYCHIATRY

**8:43G–26.1 Scope of psychiatry standards**

The standards in this subchapter shall apply only to hospitals that have a separate, designated unit or service for psychiatry.

**8:43G–26.2 Psychiatry policies and procedures**

(a) The psychiatric service shall have written policies and procedures that are reviewed annually, revised as needed, and implemented. These policies and procedures shall be readily available on the inpatient unit and include at least the following:

1. Criteria for admission to and discharge from each component of the psychiatric unit. Admissions criteria shall be based solely on the patient's needs and the ability of the unit to meet these needs, and discharge policies shall preclude punitive discharge;

2. Safety and security precautions for the prevention of suicide, assault, elopement, and patient injury;

3. Emergency procedures for medical emergencies;

4. Infection control practices for the day/dining room, equipment, and rooms used by more than one patient. If these special practices are included in the hospital-wide infection control policies and procedures manual, which is available on the unit, then additional policies and procedures do not have to be developed by the psychiatric service for infection control;

5. Patient privileges;

6. Patient rights as delineated at N.J.A.C. 8:43G–4;

7. Family interviews for assessment and treatment purposes;

8. A clinical services plan describing the services provided;

9. Content of patient evaluations, including the components of care, time frames for goals, and staff assigned to the patient;

10. Release of information, in conformance with applicable statutes and the policies of the medical records department;

11. Informed consent, with special policies for patients undergoing electro-convulsive therapy;

12. Patient grievance procedures;

13. Criteria for use of seclusion in accordance with procedures delineated in the current or revised or later edition, if in effect, of the American Psychiatric Association Task Force Report No. 22 on Restraint and Seclusion, incorporated herein by reference, available from the American Psychiatric Association, 1400 K Street NW, Washington, D.C. 20005;

14. Review by physician director or designee of restraints or seclusion used in excess of 72 consecutive hours for a patient; and

15. Criteria for physician monitoring of patients in restraints more frequently than every 24 hours based on patient acuity.

(b) The psychiatric service shall develop and implement written policies and procedures for use of restraints in accordance with N.J.A.C. 8:43G–18.4.

(c) The psychiatric service shall develop and implement written policies and procedures for use of electroconvulsive therapy (ECT), in accordance with the recommendations of the current or revised or later edition, if in effect, of the American Psychiatric Task Force on ECT: "The Practice of ECT: Recommendations for Treatment, Training, and Privileging" and the New Jersey Patient's Bill of Rights at N.J.S.A. 30:4–24.2(d)(2), incorporated herein by reference, including at least:

1. Criteria specifying when ECT may be used;

2. The use of written informed consent;

3. The requirement that an anesthesiologist, a certified registered nurse anesthetist, or a physician granted privileges by the medical staff to administer anesthesia be present at the procedure;

4. Administration in an appropriately equipped area, with emergency equipment available;

5. Full documentation of the administration of ECT in the medical record; and

6. Observation of the patient's recovery immediately after the procedure is performed.

(d) There shall be a written affiliation or referral agreement with the community mental health agency or agencies designated within the hospital's service area by the New Jersey Division of Mental Health and Hospitals for referral, case management, and discharge planning.

(e) The hospital shall comply with the provisions of the New Jersey Screening and Commitment Law of 1988, N.J.S.A. 30:4–27.1 et seq., specifically N.J.S.A. 30:4–27.10(f), and all rules promulgated pursuant to the aforementioned Act in regards to the transfer of a patient to a psychiatric facility.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Discharge criteria deleted; seclusion, restraint and ECT standards added.

**8:43G–26.3 Psychiatry staff qualifications**

(a) Psychiatric care services shall be clinically supervised by a physician director who is responsible for the direction and quality of care provided by the medical staff.

(b) Any physician currently holding the position of director shall have completed a residence in psychiatry or neurology and shall be able to demonstrate the skills and experience at least equivalent to certification by the American Board of Psychiatry and Neurology. Effective July 1, 1990 any newly appointed physician director shall be board certified or shall meet the training and experience requirements for examination by the Board and shall be examined within two years of eligibility.

(c) Nursing on the psychiatric care unit shall be directed by a registered professional nurse with at least three years of clinical psychiatric experience.

(d) The social worker assigned to the inpatient psychiatric unit shall have at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education, or a bachelor's degree from an accredited social work program and one year of experience in social work or mental health.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Effective date added at (b).

**8:43G–26.4 (Reserved)**

**8:43G–26.5 Psychiatry staff time and availability**

(a) A psychiatrist shall be on-site or on call at all times.

(b) Nurse staffing shall be based on hospital acuity levels, but in no case shall fewer than two nursing staff members, at least one of whom is a registered professional nurse, be on the unit.

**8:43G–26.6 (Reserved)**

**8:43G–26.7 Psychiatry patient services**

(a) Psychiatric patients shall receive, when needed, all medical, surgical, diagnostic, and treatment services as ordered by a physician. If such services are not available within the hospital, qualified consultants and attending physicians shall be available and arrangements established for transferring patients to a facility where the needed services can be provided.

(b) All patients shall receive a complete history and physical examination by a physician within 24 hours of admission to the psychiatric unit.

(c) The following services shall be available as part of the program of the psychiatric care unit:

1. Individual, group, and family therapy;
2. Psychotropic medications;
3. Rehabilitative services;
4. Psychological services, including testing, provided by a psychologist licensed by the State of New Jersey; and
5. Recreational therapy.

(d) A social worker shall complete a psychosocial assessment for each patient which includes at least:

1. Identified problems;
2. Social and family history;
3. Educational and employment history;
4. Financial status; and
5. Present living arrangements.

(e) A written psychiatric evaluation shall be performed of each patient by a psychiatrist within 24 hours of admission to the unit.

(f) The psychiatric evaluation shall be documented in the medical record and shall include at least:

1. The chief complaint;
2. A history of present illness;
3. A family history;
4. A pertinent medical history, including previous reactions to psychotropic medications;
5. A mental status; and
6. A diagnostic impression.

(g) An individual, comprehensive, multidisciplinary care plan shall be developed for each patient based on an assessment of the patient's strengths and limitations. The written care plan shall include at least:

1. A psychiatric diagnosis specifying intercurrent diseases;
2. Observable treatment goals;
3. The specific treatment methods to be used; and
4. The responsibilities of each member of the interdisciplinary care team.

(h) The multidisciplinary care plan shall be discussed with the patient and implemented.

(i) Each patient's plan of care shall be formulated in a multidisciplinary conference, which includes members of all disciplines involved in treating the patient.

(j) The multidisciplinary plan of care shall be reassessed at least weekly by all members of the professional team who are involved in the patient's care.

(k) If the patient is admitted to the psychiatric unit through the emergency department and the patient gives consent, the patient's primary-care physician shall be contacted in order to inform the physician about the patient's condition and to obtain information about the patient's medical status.

(*l*) Written discharge plans shall be developed for each patient by members of a multidisciplinary team, who either meet or make notes individually in the patient's record.

(m) There shall be mechanisms for providing immediate security assistance to staff and patients.

(n) Patients shall be advised of the reasons for, and expected effects of, medications prescribed for them.

(*o*) There shall be a milieu program that includes patient community meetings and daily activities.

(p) An accurate schedule of activities shall be posted conspicuously in the unit.

**8:43G–26.8 (Reserved)**

**8:43G–26.9 Psychiatry space and environment**

(a) Interviews between staff and patients shall be conducted in a private setting.

(b) The unit shall have access to at least one acute care/seclusion room.

(c) Acute care/seclusion rooms shall be at least 100 square feet and shall be large enough to provide access to the patient from all sides of the bed or mattress and have room for emergency life-sustaining equipment.

(d) Patients in acute care/seclusion rooms shall be either under direct observation in a room near the nurses station or observed through the use of electronic monitoring equipment.

(e) The unit shall have a day room/dining room that allows for social interaction, dining, and therapy.

(f) Opportunities to participate in structured physical exercise programs shall be made available to patients.

(g) There shall be space in each patient room for storage of patients' personal belongings. There shall be a system for securing patients' valuable belongings.

(h) The psychiatric care unit shall comply with the suicide prevention regulations as provided in Federal Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1987 Edition, section 7.6, or later edition, if in effect, which are hereby incorporated by reference, and are available from The American Institute of Architects Press, 1735 New York Ave. NW, Washington, D.C. 20006, Pub. No. ISBN 0–913962–96–1.

(i) Authorized security personnel shall have immediate access to locked units.

(j) There shall be a system for summoning help from other areas of the unit in an emergency.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Exercise requirements added at (f).

**8:43G–26.10 (Reserved)**

**8:43G–26.11 Psychiatry supplies and equipment**

(a) The restraint equipment needed by the unit shall be immediately available on the unit and accessible to unit staff.

(b) The recreation and therapy equipment and supplies needed for psychiatric care shall be available on the unit and stored in locked storage.

(c) Locked storage areas shall be available for supplies and the safekeeping of the individual, ongoing creative projects of patients.

**8:43G–26.12 Psychiatry staff education**

(a) Requirements for the psychiatry service education program shall be as provided in N.J.A.C. 8:43G–5.9.

(b) The staff of the psychiatric unit shall receive annual training in handling the assaultive patient.

(c) The non-medical and non-nursing professional staff shall receive annual training in drug effects and side effects.

**8:43G–26.13 (Reserved)**

**8:43G–26.14 Psychiatry quality assurance methods**

(a) There shall be a program of quality assurance for psychiatric services that is integrated into the hospital quality assurance program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

(b) The ongoing quality assurance program of the psychiatric service shall include incident review and monitoring of such areas as suicide, attempted suicide, elopement, assaults, slips and falls, patient abuse and neglect, use of seclusion, and use of restraints.

(c) The medical staff shall review, on at least an annual basis, use of restraints, discharge planning, and outcomes.

## SUBCHAPTER 27. CONTINUOUS QUALITY IMPROVEMENT

### 8:43G–27.1 Continuous quality improvement structural organization

(a) The governing authority of the hospital (such as the board of trustees) shall have ultimate responsibility for the continuous quality improvement program.

(b) The hospital shall have a hospital-wide continuous quality improvement program based on a written continuous quality improvement plan that is implemented and that monitors the quality of patient care.

(c) Each clinical department shall have continuous quality improvement activities that are part of the overall hospital-wide plan, a multi-department plan, or an internally generated plan.

(d) There shall be a multidisciplinary committee responsible for the direction of the continuous quality improvement program. The committee shall include at least representation from the medical staff, nursing, and administration. The committee shall establish a mechanism to include participation of all disciplines in identifying areas of review that affect patient care throughout the hospital.

(e) The hospital shall perform risk management functions. Reports generated by risk management activities shall be routinely provided to the multidisciplinary committee responsible for coordinating the quality improvement program.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted references to continuous quality improvement for references to quality assurance throughout; in (c), substituted a reference to continuous quality improvement for a reference to continuous quality assurance; and in (e), substituted a reference to quality improvement for a reference to quality assurance.

### 8:43G–27.2 Continuous quality improvement policies and procedures

(a) The continuous quality improvement plan shall be reviewed at least annually and revised as necessary. Responsibility for reviewing and revising the plan shall be designated in the plan itself.

(b) The continuous quality improvement plan shall delineate lines of communication between the continuous quality improvement program and the medical staff, chief executive officer or administrator, and governing authority.

(c) The hospital-wide continuous quality improvement plan shall specify procedures for the development, implementation, and coordination of quality reviews. The plan shall also establish a mechanism for the evaluation of the continuous quality improvement program.

(d) The program shall disseminate its findings and the results of continuous quality improvement activities, as defined in the continuous quality improvement plan.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted references to continuous quality improvement for references to quality assurance throughout.

### 8:43G–27.3 Continuous quality improvement staff qualifications

There shall be an individual responsible for coordinating all aspects of the continuous quality improvement program.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted a reference to continuous quality improvement for a reference to quality assurance.

### 8:43G–27.4 (Reserved)

### 8:43G–27.5 Continuous quality improvement patient services

(a) There shall be an ongoing process of monitoring patient care. Evaluation of patient care throughout the hospital is criteria-based, so that certain review actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

(b) The continuous quality improvement coordinator shall be available to provide ongoing consultation to each department including assistance with the development of specific indicators used to evaluate service outcome in each department.

(c) The program shall follow up on its findings to assure that effective corrective actions have been taken, including at least policy revisions, procedural changes, educational activities, and follow-up on recommendations, or that additional actions are no longer indicated or needed.

(d) The continuous quality improvement program shall identify and establish indicators of quality care specific to the hospital that are monitored and evaluated and encompass at least:

1. Surgical case review;
2. Drug usage;
3. Medical record review;
4. Blood usage;
5. Pharmacy and therapeutics function; and
6. Appropriateness of specific diagnostic and therapeutic procedures, as selected by the continuous quality improvement program.

(e) The continuous quality improvement program shall provide information that is utilized in the evaluation of the clinical competence of all clinical practitioners.

(f) Each occupational therapy treatment shall be documented in the patient's medical record. A note shall be entered into the medical record at least weekly, or more frequently, if there is a significant change in the patient's status or treatment needs.

(g) The occupational therapist should discuss the plan of care with the patient and family, if possible.

(h) Hospitals that contract with an occupational therapy service shall ensure compliance with N.J.A.C. 8:43G–29.13 through 29.23.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Contracting requirements specified at (h).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.

**8:43G–29.14 (Reserved)**

**8:43G–29.15 Occupational therapy staff qualifications**

(a) The occupational therapy service shall be under the clinical direction of an occupational therapist registered by the American Occupational Therapy Association.

(b) A medical staff committee or a physician shall be responsible for clinical services in the occupational therapy service.

(c) All occupational therapists shall be registered and all certified occupational therapy assistants shall be certified by the American Occupational Therapy Association.

**8:43G–29.16 (Reserved)**

**8:43G–29.17 Occupational therapy patient services**

(a) Occupational therapy services shall be available on-site.

(b) The occupational therapy service shall have the capacity to offer services, when required by a physician's order, at least five days a week, excluding holidays.

(c) Provisions for auditory privacy shall be made for all patients during evaluation and treatment, when clinically indicated.

(d) On discharge, patients shall receive written instructions regarding a home program of treatment, if clinically indicated. The instructions and their receipt shall be documented in the medical record.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Physician's order added at (b).

**8:43G–29.18 (Reserved)**

**8:43G–29.19 Occupational therapy space and environment**

(a) Privacy shall be provided for patients and staff when they need to change clothing before, during, or after treatment.

(b) Staff of the occupational therapy department shall be given space for developing documentation and storing reference books and personal items.

(c) There shall be lavatories with handwashing facilities that are in an accessible location, handicapped accessible, handicapped adapted, and well ventilated.

**8:43G–29.20 Occupational therapy supplies and equipment**

(a) All equipment shall be clean and in good repair.

(b) Occupational therapy equipment shall be stored in a safe and accessible place. It shall not be stored and used in public walkways and hallways.

(c) Call bells shall be provided to patients in the occupational therapy department who are not under visual supervision.

**8:43G–29.21 Occupational therapy staff education**

Requirements for the occupational therapy education program shall be as provided in N.J.A.C. 8:43G–5.9.

**8:43G–29.22 (Reserved)**

**8:43G–29.23 Occupational therapy continuous quality improvement methods**

There shall be a program of continuous quality for occupational therapy that is integrated into the hospital continuous quality program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted references to continuous quality improvement for references to quality assurance throughout.

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## SUBCHAPTER 30. RENAL DIALYSIS

**8:43G–30.1 Scope of renal dialysis standards**

The standards in this subchapter shall apply only to hospitals that have an on-site separate, designated unit or service for renal dialysis. If a hospital has a renal dialysis unit or service, the standards shall apply to both hemodialy-

sis and peritoneal dialysis units, and to both chronic and acute treatment.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
On-site added.

**8:43G–30.2 Renal dialysis policies and procedures**

(a) The renal dialysis service shall have written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and implemented. They shall include at least:

1. Criteria for acceptance of patients into the chronic dialysis service, including assurance that patients who have communicable or transmittable diseases will be accepted;

2. Handling the abusive or disruptive patient;

3. Orientation of new patients to the unit;

4. Medical and non-medical emergency procedures involving situations that occur during hours of operation and at other times, including, for example, equipment failure, medical emergency, and codes;

5. Instructing patients and medical staff about the medical and non-medical emergency procedures; and

6. The circumstances under which patients may bring food into the unit.

(b) The renal dialysis service shall have written infection control policies and procedures specific to the renal dialysis unit that includes universal precautions and meets at least the criteria of the hospital-wide infection control program.

(c) All staff members of the renal dialysis service shall be screened for hepatitis in accordance with the current edition of the Centers for Disease Control publication "Hepatitis Surveillance", as amended and supplemented, available from the Centers for Disease Control, Atlanta, Georgia 30333.

(d) The hospital shall provide an immunization program against hepatitis for all renal staff.

(e) The renal dialysis service shall maintain a written transfer agreement with an organ transplantation center for referral of patients.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Stylistic change.
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.

**8:43G–30.3 Renal dialysis staff qualifications**

(a) Renal dialysis services shall be under the supervision of a health care professional with at least one of the following qualifications:

1. A baccalaureate degree in a health care discipline from an accredited college or university and the equivalent of at least two years of full-time experience in renal dialysis; or

2. Five years full-time experience in renal dialysis experience and documentation of progressive supervisory experience for at least one year.

(b) Any physician currently holding the position of director of a renal dialysis unit shall have completed a residency in nephrology and shall be able to demonstrate skills and experience at least equivalent to certification by the American Board of Internal Medicine, subspecialty in Nephrology. Any newly appointed physician director shall be board certified in Nephrology, or shall meet the training and experience requirements for examination by the Board and shall be examined within two years of eligibility.

(c) A registered dietitian with at least one year of clinical experience as a registered dietitian shall be assigned to the renal dialysis unit.

(d) The social worker assigned to the renal dialysis unit shall have at least:

1. A master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; or

2. A bachelor's degree from an accredited social work program and one year of experience in social work, if the person was hired prior to 1976.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Bachelor's degree acceptable if hired before 1976.

**8:43G–30.4 (Reserved)**

**8:43G–30.5 Renal dialysis staff time and availability**

(a) There shall be a registered professional nurse with administrative or clinical responsibility for all nursing care in the dialysis service.

(b) There shall be at least one registered professional nurse (RN) on duty at all times in the unit while care is being provided.

(c) There shall be at least one RN, licensed practical nurse, or trained technician on duty in the unit for every three patients receiving care.

(d) Two of the nurses on duty in the unit shall be RNs whenever care is being provided to more than six patients.

(e) Nurses on the renal dialysis staff shall receive on-site training in renal dialysis techniques as determined by the hospital before they are permitted to work unsupervised with patients.

(f) The medical director or designated nephrologist shall be on site or on call at all times when the unit is in operation.

(g) The medical director or designated nephrologist and a registered professional nurse shall be on call when the unit is not in operation.

(h) A registered dietician shall be assigned either part time or full time to the renal dialysis unit.

(i) A social worker shall be assigned either part time or full time to the renal dialysis unit.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
R.N. to supervise dialysis unit nursing care.

**8:43G–30.6 Renal dialysis patient services**

(a) A written plan of care for each patient shall be developed by a multidisciplinary team consisting of, at least, a nephrologist, a registered professional nurse, a registered dietitian, and a social worker and shall include goals and expected outcomes.

(b) The written plan of care for the chronic renal dialysis patient shall be reviewed with the patient and/or family, implemented within four weeks of admission to the program, reviewed at least every six months, and revised if change has occurred. The written plan of care for the acute dialysis patient shall be implemented within 24 hours of initiation of acute dialysis and revised and updated weekly.

(c) Notes shall be entered for the chronic dialysis patient by each member of the multidisciplinary team that reflects the patient's response to the plan of care and makes recommendations for changes in the plan of care at least two times a year.

(d) There shall be multidisciplinary committee meetings that take place on a periodic basis to discuss multidisciplinary communication, management, and issues about the care of patients treated in the dialysis unit. The committee shall include representatives from at least nursing, the medical staff, dietary services, and social work services.

(e) The renal dialysis service shall adhere to the principles set out in the Trans–Atlantic Renal Council's Bill of Rights for renal patients.

(f) The hospital's policy on dialyzer reuse shall be explained to all renal dialysis patients. Patients who consent to reuse shall sign an informed consent form. If the patient declines reuse, arrangements shall be made for the patient to receive single-use treatment in the unit.

(g) If patients are permitted to bring food into the renal dialysis unit, they shall not be permitted to share it and must use only personal utensils, wrappers, and containers.

(h) All patients shall be screened for hepatitis and in accordance with the current edition of the Centers for Disease Control publication "Hepatitis Surveillance."

(i) Renal dialysis patients with communicable or transmittable diseases shall be treated in accordance with Centers for Disease Control guidelines.

Note: Centers for Disease Control publications can be obtained from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161

or:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

(j) If a renal dialysis patient is referred by, or is from, another health care facility, the renal dialysis service shall provide that facility with copies of summaries of the patient's progress, including dietary care, and results of laboratory tests upon discharge from the renal program or upon request from the facility.

(k) If a hospital provides home care training in renal dialysis, the training shall be directed by a registered professional nurse (RN). There shall be at least one RN or licensed practical nurse assigned to every two patients undergoing training on-site.

(*l*) The home (self) care training program shall have a written outline of course material for persons undergoing training which shall include didactic and practical sessions to prepare trained patients and/or helpers to perform unsupervised dialysis treatments.

(m) If a hospital has a home (self) care training program, the hospital shall provide, either directly or through agreement with another health care facility, the following services:

1. Surveillance of the patient's home adaption, including provisions for visits by a staff member to the home and by the patient to the hospital;

2. Documentation in the patient's medical record of the number and content of surveillance visits;

3. Ensurances that patient teaching materials are available for patient use during and after home (self) care dialysis training and at times other than during the dialysis procedure;

4. Consultation for the patient with a social worker and a dietician;

5. A recordkeeping system which ensures continuity of care;

6. Installation and maintenance of equipment in the home;

7. Testing and treatment of the water in the home, according to current industry wide practices for home dialysis; and

8. Ordering of supplies for the home on an on-going basis.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Home care requirements added.

**8:43G–30.7 (Reserved)**

**8:43G–30.8 Renal dialysis supplies and equipment**

(a) Patients shall be dialyzed in chairs that can be inclined so that the patient's head is lower than his or her feet, except when the patient is dialyzed in a hospital bed.

(b) Any reuse of a dialyzer shall conform with guidelines in the Association for the Advancement of Medical Instrumentation (AAMI) publication, "Recommended Practice for Reuse of Hemodialyzers," incorporated herein by reference.

(c) Water treatment equipment, water and dialysate shall conform with the requirements in the AAMI publication "American National Standard for Hemodialysis Systems", as amended and supplemented, incorporated herein by reference. Water and dialysate shall be microbiologically analyzed monthly. Water samples shall be taken immediately following the last water treatment device and at locations in the treatment area which will assure the water throughout the distribution lines conforms with AAMI standards. Chemical analysis of the water shall be performed every six months.

(d) A DPD test kit or similar method shall be used daily to detect chloramine break through and chloramine levels in water used to prepare dialysate and shall not exceed the AAMI standard of 0.1 ppm.

Note: AAMI publications can be obtained from:

Association for the Advancement of
Medical Instrumentation
Suite 602
1901 North Fort Myer Drive
Arlington, VA 22209

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Text at (c) and (d) deleted; new text added.

**8:43G–30.9 Renal dialysis staff education and training**

Requirements for the renal dialysis education program shall be as provided in N.J.A.C. 8:43G–5.9.

**8:43G–30.10 (Reserved)**

**8:43G–30.11 Renal dialysis continuous quality improvement methods**

There shall be a program of continuous quality improvement for the renal dialysis service that it integrated into the hospital quality improvement program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data. The program monitors those indicators required by the Trans Atlantic Renal Council and shall include monitoring of home dialysis patents.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Home dialysis included.
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted references to continuous quality improvement for references to quality assurance throughout.

**8:43G–30.12 (Reserved)**

**8:43G–30.13 Physical plant general compliance for new construction, alteration, or renovation**

(a) Physical plant standards for acute renal dialysis services shall be in compliance with N.J.A.C. 5:23–3.2 of the New Jersey Uniform Construction Code.

(b) The hospital shall submit plans and specifications to the Construction and Monitoring Program, Health Facilities Evaluation, New Jersey Department of Health, PO Box 367, Trenton, N.J. 08625–0367, for review and approval prior to construction, alteration, or renovation.

(c) Prior to approval, plan review fees shall be submitted, in accordance with N.J.A.C. 8:31–1.1.

New Rule, R.1990 d.423, effective September 4, 1990.
See: 21 N.J.R. 3406(a), 22 N.J.R. 2708(a).

**8:43G–30.14 Treatment area requirements for acute renal dialysis services**

(a) The treatment area for acute renal dialysis services shall be an open planned area separated from administrative and service areas.

(b) The floor area allocated for each machine shall be 100 square feet, with a net usable area of 80 square feet, with 30 inches of clear space maintained around each machine or lounge. Machines may be installed flush against the wall on one side only. There shall be a four foot space between beds or lounges.

(c) Cubicle curtains around each patient station shall be provided for privacy and dignity.

(d) A nurses' station shall be located within the open treatment dialysis area and shall provide visibility of all patients' stations.

(e) Charting facilities for nurses and doctors shall be located adjacent to the nurses' station.

(f) Handwashing facilities shall be provided at a ratio of one handsink per every three stations and shall be distributed throughout the dialysis area.

New Rule, R.1990 d.423, effective September 4, 1990.
See: 21 N.J.R. 3406(a), 22 N.J.R. 2708(a).

### 8:43G–30.15 Service areas requirements for acute renal dialysis service

(a) The size and location of each service area for acute renal dialysis services shall be based upon the number of beds or lounges to be served. The following service areas shall be located within the dialysis suite and readily available to the open treatment area:

1. Preparation space, which shall be adjacent to the open treatment area;

2. Separate clean and soiled work or utility rooms, which shall be within the suite. Soiled and clean utility rooms shall contain a minimum of 80 square feet each. Clean linen and clean utility room may be combined, and if combined, shall contain a minimum of 120 square feet and shall contain handwashing facilities. Soiled holding and soiled utility room may be combined, and if combined, shall contain a minimum of 120 square feet and shall contain handwashing facilities;

3. A separate janitor's closet, which shall be provided exclusively for the renal suite. The closet shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment;

4. If a separate employee kitchen or dining area is provided in the suite, it shall be separated from the patient area and shall not be utilized by patients. Employees shall not be permitted to eat in the dialysis treatment area;

5. Office space, which shall be provided for the medical director and nurse supervisor;

6. A lounge, locker room and staff toilet with handwashing facilities, which shall be available for staff;

7. A separate toilet room with handwashing facilities, which shall be provided for patients;

8. A drug distribution station, which may be a medicine preparation room or unit, a self-contained medicine dispensary unit, or another approved system. If used, a medicine preparation room or unit shall be under the nursing staff's visual control and contain a work counter with handwashing facilities, refrigerator, and locked storage for biologicals and drugs. A medicine dispensary unit may be located at the nurses' station, in the clean workroom, or in an alcove or other space under direct control of the nursing or pharmacy staff;

9. A nourishment station, which shall contain a sink equipped for handwashing, equipment for serving nourishment, refrigerator, storage cabinets and ice maker-dispenser unit;

10. Equipment and emergency storage room(s), which may be a combined unit. The size shall be determined by the needs in the program and the equipment to be stored;

11. A storage room or rooms, which shall be located either within or outside of the suite, which shall house the working equipment to maintain the equipment applicable to the machines for the dialysis suite. At least one week of operation supplies must be available in the facility. There shall be 70 square feet per machine/station of storage;

12. Storage space, which shall be provided for wheelchairs and stretchers out of direct line of traffic;

13. Storage space for renal waste, which shall be provided within the unit until it is properly disposed;

14. Patient toilet rooms, which shall have doors equipped with hardware which will permit access by staff in any emergency; and

15. Home training rooms or areas, which, if provided, shall be equipped with a sink for handwashing.

New Rule, R.1990 d.423, effective September 4, 1990.
See: 21 N.J.R. 3406(a), 22 N.J.R. 2708(a).

### 8:43G–30.16 Emergency generator and water supply

(a) An emergency generator shall be provided in a room which shall have a one-hour fire rating with an approved fresh air intake and an explosion release. All machines shall be connected to the emergency generator so that all machines will operate for at least four hours following a power shutdown or outage.

(b) Water supply systems shall be designed to supply water to the fixtures and equipment on the upper floors at a minimum pressure of 15 pounds per square inch during periods when fixtures and equipment are in use.

New Rule, R.1990 d.423, effective September 4, 1990.
See: 21 N.J.R. 3406(a), 22 N.J.R. 2708(a).

### 8:43G–30.17 Functional requirements for pediatric dialysis services

(a) If separate pediatric dialysis services are provided, the services for young children and adolescents shall be housed in a unit separate from the services provided to adults.

(b) The area housing the pediatric dialysis unit shall be located within the treatment area.

(c) The area allocated per patient dialysis station shall be the same net usable square foot area as required in N.J.A.C. 8:43G–30.13.

(d) The area housing the pediatric dialysis unit shall be enclosed with fixed partitions that extend from finished floor to ceiling. Vision panels in partitions are required.

(e) The pediatric dialysis unit shall have handwashing facilities separate from the adult unit.

(f) Pediatric dialysis service areas may be shared with the adult unit.

New Rule, R.1990 d.423, effective September 4, 1990.
See: 21 N.J.R. 3406(a), 22 N.J.R. 2708(a).

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## SUBCHAPTER 31. RESPIRATORY CARE

### 8:43G–31.1 Respiratory care structural organization; definitions

(a) The respiratory care service shall be represented on hospital committees responsible for neonatal, pediatric and adult intensive care, patient care, and infection control.

(b) The following term, when used in this subchapter, shall have the following meaning:

"Licensed respiratory care practitioner" means an individual who qualified and passed the National Board of Respiratory Care Entry Level Examination and is licensed by the State Board of Respiratory Care in accordance with N.J.A.C. 13:44F.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

### 8:43G–31.2 Respiratory care policies and procedures

(a) The respiratory care service shall have written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and implemented. They shall include at least:

1. A system for the reissuing and discontinuing of all respiratory therapy orders;

2. The duties and responsibilities of respiratory care practitioners;

3. The education, training, and experience requirements of respiratory care practitioners qualified to initiate and maintain therapies and in which special care units they may work;

4. Procedures for control of infection, the spread of infection, and electrical, explosive, and mechanical hazards; and

5. Protocols that encourage multidisciplinary input into the patient's written plan of care.

(b) Verbal or telephone respiratory care orders within the scope of practice of the licensed respiratory care practitioner shall be accepted and recorded by a licensed respiratory care practitioner.

(c) There shall be a protocol whereby the nurse is informed of any verbal or telephone order that is taken by the licensed respiratory care practitioner.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.

### 8:43G–31.3 Respiratory care staff qualifications

(a) There shall be a physician director of respiratory care or pulmonary medicine who is board certified or board eligible in pulmonary medicine, and who is responsible for all respiratory care rendered in the hospital.

(b) There shall be an administrative director of respiratory care who is licensed by the New Jersey State Board of Respiratory Care.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

### 8:43G–31.4 (Reserved)

### 8:43G–31.5 Respiratory care staff time and availability

(a) There shall be at least one licensed respiratory care practitioner assigned primarily to patients in licensed critical care units. Assignments shall be based on the acuity level of patient illness assessed each shift.

(b) There shall be at least one licensed respiratory care practitioner in the hospital or on call, at all times, in addition to the one who is primarily assigned to patients in the critical care unit.

Administrative Correction.
See: 22 N.J.R. 653(a).
Amended by R.1995 d.124, effective March 20, 1995.
See: 27 N.J.R. 1290(a).

### 8:43G–31.6 (Reserved)

### 8:43G–31.7 Respiratory care patient services

(a) There shall be an organized program for teaching patients to administer their own therapy, with adequate supervision and documentation, in any case where it is appropriate for the patient and where the patient is able to receive and follow therapy instructions.

(b) Written treatment plans, and respiratory therapy goals shall be written by the licensed respiratory care practitioner. The written treatment plans shall supplement the respiratory care orders written by physicians and become part of the medical record.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

**8:43G–31.8 (Reserved)**

**8:43G–31.9 Respiratory care space and environment**

(a) There shall be adequate space available to store all equipment not in routine use. No respiratory care equipment shall be stored in hallways.

(b) There shall be office space dedicated to members of the respiratory care service.

**8:43G–31.10 (Reserved)**

**8:43G–31.11 Respiratory care supplies and equipment**

(a) The respiratory care service shall have equipment available to evaluate respiratory therapy.

(b) Pulse oximeters and end-tidal $CO_2$ monitors shall be available for patients in the hospital who have a medical condition that requires oxygen and carbon dioxide monitoring.

(c) There shall be a documented system for preventive maintenance of all respiratory therapy equipment.

(d) All mechanical and electrical equipment shall be tested before using for the first time or after repairs.

**8:43G–31.12 Respiratory care staff education**

Requirements for the respiratory care education program shall be as provided in N.J.A.C. 8:43G–5.9.

**8:43G–31.13 (Reserved)**

**8:43G–31.14 Respiratory care continuous quality improvement methods**

There shall be a program of continuous quality improvement for respiratory care that is integrated into the hospital continuous quality improvement program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted references to continuous quality improvement for references to quality assurance throughout.

## SUBCHAPTER 32. SAME–DAY STAY

**8:43G–32.1 Scope**

The standards set forth in this subchapter apply only to hospitals that have a separate, designated unit or service for same-day stay.

**8:43G–32.2 Same–day surgery services structural organization**

(a) There shall be an organizational chart or alternative documentation clearly delineating the lines of responsibility, authority, and communication for the same-day surgery service and, if the same-day medical service is a separate entity, the lines of communication between the two services.

(b) There shall be a mechanism for approving policies and procedures and evaluating and reviewing the activities of the same-day surgery service.

**8:43G–32.3 Same-day surgery services policies and procedures**

(a) The same-day surgery service shall have written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and implemented. They shall include at least:

1. Infection control practices;

2. Criteria for the types of patients who may be admitted for same-day surgery;

3. Categories of surgical procedures that may be performed on a same-day basis;

4. When, where, and by whom preadmission testing may be performed;

5. Minimum requirements for preadmission testing for all types of anesthesia;

6. A system for handling medical and non-medical emergencies.

7. A system for securing the belongings and valuables of the patient;

8. Criteria and procedures for discharging a patient, which includes nursing assessments of self-care capability and who is responsible for discharging the patient; and

9. A requirement that patients who receive anesthesia, excluding minor local blocks, not drive themselves home after discharge and are accompanied home by a responsible adult. If the patient fails to comply with the requirement, the circumstances shall be documented in the patient's medical record.

(b) The policies and procedures for the postanesthesia care unit shall apply to same-day surgery service.

(c) A registered professional nurse shall be assigned to circulating nurse duties in each room where same-day surgery is being performed.

(d) When a same-day surgery patient is admitted to the hospital as an in-patient, a statement shall be made in his or her same-day medical record giving the reason for admission.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Text added at (a)6; minor local blocks excluded at (a)9.
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.

**8:43G–32.4 Same–day surgery services staff qualifications**

(a) There shall be a physician director who has clinical responsibility for the same-day surgery service who is board certified. Certification shall be by a board of the American Board of Medical Specialists. This may be the same person who is the physician director of the surgical service.

(b) If there is a postanesthesia care unit, or postoperative unit dedicated to same-day surgery patients, there shall be a registered professional nurse present whenever a patient is in the unit. Additional nursing staff shall be assigned based on the volume and case mix of patients in the unit.

(c) All registered professional nurses in the postanesthesia care unit or postoperative unit dedicated to same-day surgery patients shall have training in basic cardiac life support.

**8:43G–32.5 Same-day surgery patient services**

(a) There shall be documentation of perioperative patient education.

(b) There shall be a system to ensure checking of each patient's preoperative record for completeness before the procedure begins.

(c) Physician orders, specific for each patient, shall govern the postoperative care of each patient.

(d) After the surgical procedure and before discharge, the patient and/or significant other shall receive written and oral instructions on self-care, follow-up, signs and symptoms to be reported to the surgeon, and how to report signs and symptoms.

(e) The medical record for same-day surgery patients shall include at least:

1. The patient's written informed consent;

2. A preoperative note by the physician, dentist, or podiatrist, which includes the surgical plan;

3. A preoperative anesthesia note by the anesthesiologist, if applicable;

4. Documentation of the history and physical examination performed by a physician, licensed physician assistant, nurse practitioner/clinical nurse specialist, or, for obstetrical/gynecological procedures, a certified nurse midwife within seven days prior to the procedure;

5. Preadmission testing results;

6. A preoperative nursing assessment;

7. A perioperative nurses' note that describes the patient's condition during the procedure;

8. A medication record reflecting the drug given, date, time, dosage, route of administration, and signature and status of individual administering the drug;

9. Any physician orders;

10. The surgeon's postoperative note on the procedure;

11. The surgeon's discharge note, written prior to discharge from the hospital, which describes the disposition of the patient and discharge instructions; and

12. Nurses' notes that describe the patient's postoperative progress.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Documentation requirements added.
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote (e)4.

**8:43G–32.6 (Reserved)**

**8:43G–32.7 Same–day surgery services space and environment**

(a) If same-day surgery is performed in a suite dedicated to same-day patients, the suite shall be maintained as a closed unit. Access to the restricted zone of the surgical suite shall be through or past a control center.

(b) There shall be a waiting area for families and significant others of patients undergoing same-day surgery.

**8:43G–32.8 (Reserved)**

**8:43G–32.9 Same-day surgery services continuous quality improvement methods**

(a) There shall be a program of continuous quality improvement for same-day surgery that is integrated into the hospital continuous quality improvement program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data. Continuous quality improvement shall include monitoring at least:

1. Complications;

2. Inpatient admissions from the same-day surgery service;

3. Related admissions subsequent to discharge from same-day surgery;

4. Incidents; and

5. Medical emergencies.

(b) The infection control program shall monitor infection control practices and outcomes for same-day surgery services. If same-day surgery patients are treated on inpatient units, the infection control program for those units shall fulfill this requirement.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Text added at (b).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted references to continuous quality improvement for references to quality assurance throughout the introductory paragraph.

**8:43G–32.10 Same–day medical services standards; scope**

(a) The standards set forth in N.J.A.C. 8:43G–32.11 through 32.20 apply only to hospitals that have a separate, designated unit or service for medical same-day stay.

(b) Same-day medical services are defined as elective treatments, diagnostic and non-surgical procedures as defined in the ICD–9–CM codes, with the patient being discharged in a routine status before midnight of the day of admission or treatment.

**8:43G–32.11 Same–day medical services structural organization**

There shall be an organizational chart or alternative documentation clearly delineating the lines of responsibility, authority, and communication for the same-day medical service and, if the same-day surgery service is a separate entity, the lines of communication between the two services.

**8:43G–32.12 Same–day medical services policies and procedures**

(a) The same-day medical service shall have written policies and procedures that are reviewed annually, revised as needed, and implemented. They shall include at least:

1. Infection control practices;

2. Criteria for the types of patients who may be admitted for same-day medical services;

3. Categories of procedures and treatments that may be performed on a same-day basis;

4. A system for handling medical and non-medical emergencies;

5. A system for securing the belongings and valuables of patients; and

6. Criteria and procedures for discharging a patient.

(b) When a same-day medical patient is admitted to the hospital as an inpatient, a statement shall be made in his or her same-day medical record giving the reason for admission.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Stylistic changes.

**8:43G–32.13 Same–day medical services staff time and availability**

Same-day medical patients shall receive nursing care based on their acuity.

**8:43G–32.14 Same–day medical services patient services**

(a) There shall be a medical record for each patient admitted for same-day medical care. This record shall include, at least, documentation of a history and physical examination, results of tests, all treatments and the patient's response to treatments rendered.

(b) There shall be physician orders, specific for each patient, that govern the care of each same-day medical service patient.

**8:43G–32.15 (Reserved)**

**8:43G–32.16 Same–day medical services space and environment**

There shall be waiting areas for families and significant others of patients undergoing same-day medical procedures.

**8:43G–32.17 (Reserved)**

**8:43G–32.18 Same–day services education**

Requirements for the same-day services education program shall be as provided in N.J.A.C. 8:43G–5.9.

**8:43G–32.19 (Reserved)**

**8:43G–32.20 Same-day medical services continuous quality improvement methods**

(a) There shall be a program of continuous quality improvement for same-day medical service that is integrated into the hospital continuous quality improvement program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

(b) The infection control program shall monitor infection control practices and outcomes for same-day medical patients. If same-day medical patients are treated on inpa-

tient units, the infection control program for those units shall fulfill this requirement.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted references to continuous quality improvement for references to quality assurance throughout.

**8:43G–32.21 Observation services; scope**

The standards set forth in N.J.A.C. 8:43G–32.22 and 32.23 shall apply to a service, unit, or area(s), separate from the emergency department and designated by the hospital for the purpose of monitoring and/or observing patients who have not yet been determined to require inpatient admission.

New Rule, R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

**8:43G–32.22 Observation service policies and procedures**

(a) The hospital shall have a clearly defined plan and written policies and procedures for the use of an observation service that are reviewed at least once every three years, revised as needed, and implemented. These policies and procedures shall include at least:

1. Criteria for admission to and discharge from the service;

2. Professional nursing supervision and nurse staffing;

3. Criteria for length of stay (which shall be less than 24 hours total stay within the hospital unless the patient has been admitted); and

4. Quality assurance and review.

New Rule, R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

**8:43G–32.23 Observation service space and environment**

(a) Prior to implementation, the hospital shall inform the Department of Health and Senior Services in writing of the location and the number of spaces in the service.

(b) The hospital shall not mix observation beds and inpatient beds in the same room.

(c) Observation beds shall not be considered licensed beds.

New Rule, R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

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## SUBCHAPTER 33. SOCIAL WORK

**8:43G–33.1 Social work structural organization**

(a) Each hospital shall have an organized social services department or function, with social services performed by social workers under the direction of a licensed social worker.

(b) There shall be an organizational chart or alternative documentation clearly delineating the lines of responsibility, authority and communication for the social services department or function.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote the section.

**8:43G–33.2 Social work policies and procedures**

(a) The social work department shall have written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and implemented. The policies and procedures concerning the scope of social work services shall address the following areas: counseling, discharge management and planning, social work assessment, consultation and referral, patient advocacy, community liaison, and education.

(b) The social work department shall have a protocol to ensure that social work services are offered to all patients who need or request them.

(c) The social services department or function shall have criteria for identifying at the time of admission and promptly assessing high-risk patients in need of psychosocial intervention and/or discharge planning.

(d) The social work department shall participate in the development and review of the hospital's agreements with extended and long-term care facilities.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the first sentence; and rewrote (c).

**8:43G–33.3 Social work staff qualifications**

(a) There shall be a director of the social work department who is licensed by the New Jersey State Board of Social Work Examiners in compliance with rules at N.J.A.C. 13:44G.

(b) Each social worker shall be certified or licensed by the New Jersey State Board of Social Work Examiners.

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

**8:43G–33.4 (Reserved)**

**8:43G–33.5 (Reserved)**

**8:43G–33.6 Social work patient services**

(a) There shall be a system for clinical staff to refer patients directly to the social work department.

(b) The social worker shall consult with members of other disciplines in providing patient care services.

(c) Each patient who has received social work intervention shall be informed that he or she may call the social work department with questions after discharge.

(d) Families or guardians shall be included in services provided by the social work department, where indicated.

(e) The social work department shall assist patients directly or indirectly in identifying the need for, implementing, and verifying guardianship as part of discharge planning.

(f) The social work department shall coordinate child-abuse reporting and follow-up services with appropriate follow-up agencies in accordance with N.J.S.A. 9:6–1 et seq. The department shall participate in reporting and follow-up services for other victims of abuse.

(g) When a patient is transferred to another health care facility or linked to another health care agency after discharge, the social work department shall assure that relevant social work services documentation or information, if available, is provided to that agency or facility in order to assure continuity of care.

(h) When social work intervention is provided, the social work department shall enter into the medical record:

1. The reason for intervention;

2. The name or names of social workers involved and dates of intervention;

3. A social work assessment;

4. A treatment plan and referrals; and

5. Notes reflecting interventions before discharge.

(i) Social work staff shall be included in multidisciplinary patient care conferences or rounds.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Guardians added.

**8:43G–33.7 (Reserved)**

**8:43G–33.8 Social work space and environment**

(a) All reasonable efforts shall be made for privacy in patient and family interviews and in the handling of confidential phone calls by social workers.

(b) Social work department files on patients shall be kept physically secure and confidential.

**8:43G–33.9 Social work staff education and training**

Requirements for the social work staff education program shall be as provided in N.J.A.C. 8:43G–5.9.

**8:43G–33.10 Social work continuous quality improvement methods**

There shall be a program of continuous quality improvement for social work that is integrated into the hospital continuous quality improvement program and pertains to the scope of social work services provided. The program shall include regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted references to continuous quality improvement for references to quality assurance throughout.

## SUBCHAPTER 34. SURGERY

**8:43G–34.1 Surgery structural organization**

There shall be an organizational chart, or alternative documentation that delineates the lines of authority, responsibility, and accountability of staff in surgery services.

**8:43G–34.2 (Reserved)**

**8:43G–34.3 Surgery policies and procedures**

(a) Surgery services shall have written policies and procedures that are reviewed at least every three years, revised more frequently as needed, and implemented. They shall include at least:

1. Aseptic practices;

2. Infection control policies for the surgical suite, including attire which is commercially laundered;

3. Processing, packaging, and sterilization of materials in the suite; and

4. Special procedures for handling of trash from the surgical suite.

(b) The postanesthesia care unit shall maintain its own specific policies and procedures. Where applicable, these policies and procedures shall be integrated with the policies and procedures of the surgical suite.

(c) A policies and procedures manual governing the overall functions and responsibilities of the surgical suite shall be available to surgical suite staff whenever the suite is open.

(d) There shall be a written procedure established for the handling of soiled laundry and trash, which shall be bagged and collected at the termination of each procedure and transported to the soiled holding area.

(e) There shall be a written procedure for the handling of soiled laundry and trash, which shall be placed in closed

containers in each operating room. Medical waste and sharps shall be handled in accordance with current applicable State and Federal rules and regulations.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.
Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
In (a)2, added "which is commercially laundered"; rewrote (d); added (e).

### 8:43G–34.4 Surgery staff qualifications

(a) There shall be a physician director who is clinically responsible for surgical services and is board certified.

(b) There shall be a person with administrative responsibility for the surgical service.

(c) Each surgical suite shall have available a roster of physicians with delineation of current surgical privileges, including those with temporary privileges.

(d) The hospital shall maintain a list of surgical procedures that require the presence of a physician to act as first assistant.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote (a).

### 8:43G–34.5 Surgery staff time and availability

(a) A registered professional nurse shall be assigned to circulating nurse duties in each room where surgery is being performed.

(b) All registered professional nurses in the unit shall maintain certification in Basic Cardiac Life Support.

(c) During scheduled hours of operation, personnel who have received special training in cleaning the surgical suite shall be assigned to the surgical suite for cleaning and related duties.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote (b).

### 8:43G–34.6 Surgery patient services

(a) A patient identification system shall be implemented and patient identification shall be verified prior to any surgical procedure.

(b) There shall be a policy and procedure to verify the site and side of any and all surgical procedures. The procedure site and side shall be documented on the operative consent form.

(c) There shall be oral verification of the correct site and side of the surgical procedure in the operating room by a surgical team member in accordance with hospital policy.

(d) There shall be a system to ensure that surgical patients' personal effects are secured during surgery.

(e) The surgery services staff shall take precautions to prevent patient falls and injuries during transportation, transfer, and positioning through the use of side rails or restraint straps, and control devices on stretchers and operating tables.

(f) Each surgical patient shall have a medical record in accordance with the medical records policies of the hospital. The medical record shall be available to surgical suite personnel prior to surgery and shall include at least:

1. A written informed consent form signed by the patient or legal guardian or authorized person according to hospital policy that includes identification of the physician(s) performing the procedure prior to all procedures requiring informed consent;

2. A completed preoperative checklist;

3. A medical history and the results of a physical examination; and

4. Diagnostic tests results as determined by hospital policy.

(g) The surgical suite nursing staff shall make a preoperative note or notes for each surgical patient, which is part of the medical record and follows the patient to the patient care unit. The note shall describe intraoperative nursing care and patient reactions while in the operating suite.

(h) Operative reports shall be dictated or written in the medical record immediately after surgery.

(i) The completed operative report shall be reviewed for accuracy, signed and dated by the surgeon and filed in the medical record as soon as possible after surgery.

(j) There shall be a system in place for obtaining frozen section results on a timely basis.

(k) There shall be documentation of perioperative patient education.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote (a); added new (b) and (c); recodified existing (b) and (c) as (d) and (e); recodified and rewrote (d) and (e) as (f) and (g); recodified existing (f) through (i) as (h) through (k).

### 8:43G–34.7 Surgery space and environment

(a) The surgical suite shall be maintained as a closed unit. Access to the surgical suite shall be restricted in accordance with hospital policies and procedures.

(b) All staff in the surgical suite shall be attired in scrub attire. Individuals who are permitted limited access shall be attired according to hospital infection control policies.

(c) Procedures shall be in place for the handling of soiled laundry and trash, which shall be bagged and collected at the termination of each procedure and transported to the soiled holding area.

(d) Procedures shall be in place for the handling of soiled laundry and trash, which shall be placed in closed containers in each operating room. Medical waste and sharps shall be handled in accordance with current applicable State and Federal rules and regulations.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote (a) through (c); added new (d).

**8:43G–34.8 Surgery supplies and equipment**

(a) Emergency equipment available in the surgical suite shall include at least the following:

1. An emergency call system to include at least an emergency communication system that connects each operating room and postanesthesia care unit with the control center of the suite.

2. A difficult airway container or cart shall be immediately available for handling emergencies. The following items are required for inclusion in the difficult airway container or cart:

i. Manual breathing apparatus;

ii. A cardiac monitor;

iii. A defibrillator;

iv. A portable suction setup;

v. A thoractomy set; and

vi. A tracheostomy set and endotracheal tubes including sizes adaptable to newborns, infants and children; and

3. There shall be a mechanism for testing the emergency equipment on a regular basis and documenting that it is in working condition.

(b) There shall be a system to ensure that sterile supplies are immediately available. This system shall include rotation and inventory of packaged items; evaluation of the integrity of drapes, gowns, and sterile supplies; and periodic review of policies and procedures for processing, packaging, and sterilization of materials.

(c) All used surgical suite linens and apparel shall be laundered between uses by the hospital laundry service. Employees shall not take these materials home to wash them.

(d) All surgical suite equipment and supplies shall be maintained in a clean condition, without tears or tape.

(e) All surgical staff shall comply with the current universal precautions as set forth in the Centers for Disease Control and Prevention Guideline for Handwashing and Hospital Environmental Control (Infection Control and Hospital Epidemiology 1999, incorporated herein by reference, as amended and supplemented). That publication may be obtained by telephoning the Centers for Disease Control and Prevention at (800) 311–3435.

(f) Clean linen shall be stored separately from soiled laundry in the surgical suite.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote (a) and (e); in (c), substituted "between uses" for "daily" following "laundered".

**8:43G–34.9 Surgery staff education**

Requirements for the surgery staff education program shall be as provided in N.J.A.C. 8:43G–5.9.

**8:43G–34.10 (Reserved)**

**8:43G–34.11 Surgery continuous quality improvement**

(a) There shall be a complete and current record of all surgical procedures.

(b) The hospital's quality improvement program shall include a systematic review and evaluation of patient care, anesthesia practices and anesthesia techniques. The surgical staff shall identify problem-prone processes which manifest undesirable patterns. The hospital shall develop a plan by which to collect and analyze data in order to evaluate outcomes or performance of the problem-prone processes. Data analysis shall focus on recommendations for implementing corrective actions and improving performance.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (b), substituted references to continuous quality improvement for references to quality assurance throughout.
Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote (b).

**8:43G–34.12 (Reserved)**

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## SUBCHAPTER 35. POSTANESTHESIA CARE

**8:43G–35.1 Postanesthesia care policies and procedures**

(a) The postanesthesia care unit shall have written policies and procedures that are reviewed at least every three years, revised more frequently as needed, and implemented. They shall include at least:

1. Criteria for admission to and discharge from the unit;

2. Delineation of the primary medical responsibility for postanesthesia and postsurgical care of the patient in the unit;

3. Monitoring of patients in the postanesthesia care unit, including availability of monitoring equipment;

4. Protocol of care for all patients;

5. Protocol for patient emergencies;

6. Orders for intravenous administration of medications; and

7. Requirements for documentation of patient status.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.
Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
In (a), deleted "once" preceding "every three years" in the introductory paragraph.

### 8:43G–35.2 Postanesthesia care staff qualifications

(a) There shall be a physician director with overall responsibility for postanesthesia care. The physician director may also be the director of anesthesia services.

(b) There shall be a registered professional nurse with administrative responsibility for nursing care in the postanesthesia care unit.

(c) Documentation shall be available to show that all registered professional nurses assigned to the postanesthesia care unit meet the minimum competence levels, including at least:

1. Management of airway and ventilatory functions;

2. Monitoring of cardiac function, arrhythmia recognition, and treatment of life-threatening emergencies;

3. Management of the patient during altered states of consciousness;

4. Management of monitoring and respiratory equipment;

5. Management of fluid lines, tubes, drains, and catheters;

6. Administration of drugs and identification of drug-related problems; and

7. Recognition of the actions and interactions of anesthetic techniques.

(d) All registered professional nurses in the postanesthesia care unit shall maintain training in Advanced Cardiac Life Support.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Stylistic changes.
Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote (c) and (d); deleted (e).

### 8:43G–35.3 Postanesthesia care staff time and availability

(a) There shall be at least two health care personnel, one of whom is a registered professional nurse and the other of whom is either a licensed practical nurse, a registered professional nurse, or a physician, present whenever a patient is in the postanesthesia care unit.

(b) There shall be a ratio of at least one registered professional nurse for every three patients in the postanesthesia care unit.

Administrative Correction to (a): Added text.
See: 22 N.J.R. 1265(b).

### 8:43G–35.4 Postanesthesia care patient services

(a) The patient shall be accompanied to the postanesthesia care unit by two individuals, one of whom, stationed at the patient's head, shall be responsible for the patient's airway.

(b) An oral report on the patient's condition shall be given to postanesthesia care unit nursing staff by a member of the anesthesia team when the patient is admitted to the postanesthesia care unit.

(c) A member of the anesthesia team shall stay with the patient in the postanesthesia care unit at least until the patient's vital signs, including temperature, pulse, respiration, and blood pressure, are recorded.

(d) The postanesthesia care unit staff shall continually evaluate the condition of each patient and maintain an accurate written report of his or her vital signs, with an objective scoring system used to track the patient's recovery from anesthesia from the time of admission to the unit until discharge.

(e) Electrocardiographic monitoring shall be conducted for each patient, unless such monitoring is not clinically feasible for the patient.

(f) Each patient shall be monitored by pulse oximetry, unless such monitoring is not clinically feasible for the patient.

(g) The postanesthesia care unit shall have immediate access to end-tidal carbon dioxide monitoring, if general anesthesia is administered to intubated patients in the facility.

(h) The medical record maintained for each patient in the postanesthesia care unit shall include at least such preoperative data as allergies, physical and mental impairments, prostheses, electrocardiogram, vital signs, radiologic findings, laboratory values, drug use, and mobile limitations.

(i) The Post Anesthesia Care Unit record maintained for each patient in the postanesthesia unit care shall include at least such postoperative data as the patient's general condition, respiration, consciousness, circulation, temperature, special problems or precautions, summary of fluids received during surgery, and oxygen saturation.

(j) Patients shall be discharged from the postanesthesia care unit using discharge criteria, including authority to discharge, which have been developed through the postanesthesia policies and procedures set forth at N.J.A.C. 8:43G–35.1(a)1.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
In (a), substituted "responsible for the patient's airway" for "a member of the anesthesia team"; in (c), inserted "temperature" preceding "pulse"; in (d), inserted "staff" following "care unit"; rewrote (g); in (i), substituted "Post Anesthesia Care Unit" for "medical" and inserted "temperature" following "circulation"; in (j), substituted "set forth" for "specified" preceding the N.J.A.C. reference.

### 8:43G–35.5 (Reserved)

### 8:43G–35.6 Postanesthesia care supplies and equipment

(a) Postanesthesia care units shall be adjacent to or within the operating suite and the obstetrics suite.

(b) The postanesthesia care unit shall be maintained as a closed unit. Access to the postanesthesia care unit shall be in accordance with hospital policies and procedures.

(c) All staff in the postanesthesia care unit shall be attired in scrub attire. Individuals who are permitted limited access shall be attired according to hospital infection control policies.

(d) Equipment available in the postanesthesia care unit shall include at least a crash cart with defibrillator, drugs, pulse oximetry, electrocardiographic monitoring, body temperature monitoring, equipment necessary for intubation and various means of oxygen delivery. Constant and intermittent suction, blood pressure monitoring, adequate lighting, peripheral nerve stimulator, immediate access to a ventilator, and end-tidal carbon dioxide monitoring in accordance with N.J.A.C. 8:43G–35.4(g) shall be made available. Provisions to ensure the patient's privacy shall be made.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote (b), (c) and (d).

### 8:43G–35.7 Postanesthesia care staff education and training

Requirements for the postanesthesia education program shall conform to the standards set forth in N.J.A.C. 8:43G–5.9.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Substituted "conform to the standards set forth" for "be as provided".

### 8:43G–35.8 (Reserved)

### 8:43G–35.9 Postanesthesia care continuous quality improvement

(a) The hospital's quality improvement program shall include a systematic review and evaluation of patient care, anesthesia practices and anesthesia techniques. The surgical staff shall identify problem-prone processes which manifest undesirable patterns. The hospital shall develop a plan by which to collect and analyze data in order to evaluate outcomes or performance of the problem-prone processes. Data analysis shall focus on recommendations for implementing corrective actions and improving performance.

(b) Continuous quality improvement activities shall include at least the monitoring of outcomes for patients receiving anesthetic agents and postdischarge follow-up of surgical procedures.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted references to continuous quality improvement for references to quality assurance throughout.
Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote the section.

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## SUBCHAPTER 36. SATELLITE EMERGENCY DEPARTMENTS

**Authority**

N.J.S.A. 26:2H–1 et seq., specifically 26:2H–5.

**Source and Effective Date**

R.2000 d.466, effective November 20, 2000.
See: 32 N.J.R. 2184(a), 32 N.J.R. 4127(a).

**8:43G–36.1 Scope**

(a) All satellite emergency departments shall be owned and operated by an acute care general hospital and shall comply with the rules in this subchapter and all applicable requirements of this chapter. All satellite emergency departments shall provide emergency treatment and care within the scope of this subchapter for those patients, who are transported by basic life support (BLS) transport service and other ambulatory arrivals.

(b) A satellite emergency department shall be licensed only to replace the full service emergency department of a licensed general acute care hospital which has approval from the Department to cease operation of all of its licensed acute care beds. The satellite emergency department shall be located in as close proximity to the closed full service emergency department as is possible. This location shall require the prior written approval of the Department.

1. For each full service emergency department which has closed, only one satellite emergency department shall be licensed to provide care.

2. Priority for licensing satellite emergency departments shall be given to the entity or its parent which was previously licensed to operate the full service emergency department or to an entity with a formal affiliation to one of the latter at the time licensing of the satellite emergency department is requested.

(c) The Department may consider a waiver to (b) above where the proposed operator of a satellite emergency department is able to demonstrate to the satisfaction of the Department that its proposed location will serve to eliminate or substantially mitigate problems of access to appropriate emergency care affecting a community or communities.

(d) Although a satellite emergency department may provide care and services to all patients, cases more appropriately treated in an acute care hospital emergency department include the following:

1. Patients attended by advanced life support (ALS) personnel/mobile intensive care unit (MICU) personnel and requiring ALS/MICU care and services;

2. Individuals with altered mental status or under the influence of alcohol or other substances; and

3. Pregnant women greater than 20 weeks with conditions relating to pregnancy.

(e) A certificate of need application and certificate of need approval is not required in order for a licensed hospital to institute, construct, expand or operate a satellite emergency department. However, a licensed hospital which chooses to establish a satellite emergency department shall make application for licensure to the Certificate of Need and Acute Care Licensing Program as required in N.J.A.C. 8:43G–2.2(a) and comply with the requirements of N.J.A.C. 8:43G–2.2 through 2.11. If the satellite emergency department applies for licensure as a free-standing ambulatory care facility, it shall also meet the applicable requirements set forth in N.J.A.C. 8:43A.

(f) A satellite emergency department may be located in a building formerly licensed as an acute care hospital or another building and shall comply with the physical plant requirements specified at N.J.A.C. 8:43G–36.15.

(g) The Department shall charge a non-refundable biennial inspection fee of $2,000 and an annual licensure fee of $2,500 for the operation of a satellite emergency department.

(h) Each satellite emergency department shall provide services 24 hours per day, seven days per week during the first full year after licensing. After one year, if the facility can document a low utilization of patients during any eight hour period, it may cease operation during that time period, following Department of Health and Senior Services (DHSS) approval. In no case shall a satellite emergency department operate less than 16 hours per day, seven days per week after the first year of licensing. Policies and procedures addressing after hours care shall be developed by the satellite emergency department or owner/operator hospital and approved by the DHSS prior to revising hours of operation.

1. The satellite emergency department may apply to the Department to reduce hours of operation to 16 hours per day after one year of operation. Such requests shall include documentation of low utilization as defined in N.J.A.C. 8:43G–36.2.

i. Hospital owned and operated satellite emergency departments shall not contain any licensed beds. However, the satellite emergency department may have observation beds, which shall only be used for a time period of not more than 12 hours from time of registration and in the care of patients likely or expected to be discharged home, unless, the patient is awaiting test results or transfer to another facility.

**8:43G–36.2 Definitions**

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Advanced life support" means an advanced level of prehospital, inter-hospital, and emergency service care which includes basic life support functions, cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices,

trauma care, and other techniques and procedures authorized by the Commissioner.

"Basic life support" means a basic level of pre-hospital care which includes patient stabilization, airway clearance, cardiopulmonary resuscitation, control of hemorrhage, initial wound care, fracture stabilization, and other techniques and procedures specified in N.J.A.C. 8:40A–1.2 and authorized by the Commissioner.

"Department" means the New Jersey State Department of Health and Senior Services.

"Licensee" means acute care hospital authorized by the Department of Health and Senior Services to own and operate a satellite emergency department and on whom the responsibility for maintaining acceptable standards in all areas of operation of the satellite emergency department.

"Low utilization" means an average of 16 patients or less over an eight hour consecutive period of time for the most recent six months prior to the request to reduce hours of operation.

"Satellite emergency department" means a facility, which is owned and operated by a licensed New Jersey general acute care hospital, which shall provide emergency care and treatment for patients.

**8:43G–36.3 Services in satellite emergency departments**

(a) All laboratory services provided in the satellite emergency department shall comply with the requirements of N.J.A.C. 8:45, Standards for Clinical Laboratory Services, and all radiology services shall comply with applicable requirements of N.J.A.C. 7:28–19, Medical Exposure to Ionizing Radiation by Radiological Technologists.

(b) All satellite emergency departments applying for licensure shall provide the following services:

1. Basic life support emergency care and services;
2. Basic and stat laboratory services including:
   i. Arterial blood gases;
   ii. Creatinine;
   iii. Electrolytes;
   iv. Glucose (blood);
   v. CBC;
   vi. Strep screening;
   vii. Urinalysis; and
   viii. Pregnancy tests; and
3. Basic radiology services, which shall include at a minimum non-enhanced and non-contrast radiographs.

(c) Services in addition to those in (b) above may be provided at the discretion of the facility.

(d) Although a satellite emergency department may provide care and services to all patients, the following cases are more appropriately treated in an acute care hospital emergency department.

1. Patients attended by advanced life support (ALS) personnel/mobile intensive care unit (MICU) personnel and requiring ALS/MICU care and services;
2. Individuals with altered mental status or under the influence of alcohol or other substances; and
3. Pregnant women greater than 20 weeks with conditions relating to pregnancy.

**8:43G–36.4 Child abuse and neglect**

Satellite emergency departments shall comply with N.J.A.C. 8:43G–2.13.

**8:43G–36.5 Patient rights**

Every New Jersey satellite emergency department patient has the same rights as required in N.J.A.C. 8:43G–4, with the exception of N.J.A.C. 8:43G–4.1(a)14. None of the patient rights shall be abridged by the satellite emergency department or the hospital that owns and operates the satellite emergency department. The administrator of the satellite emergency department or the administrator of the hospital licensed to operate the satellite emergency shall be responsible for developing and implementing policies to protect patient rights and to respond to questions and grievances pertaining to patients rights.

**8:43G–36.6 Administrative and structural organization**

(a) A satellite emergency department may be licensed as a free-standing ambulatory care facility owned and operated by a hospital or as part of the hospital. If licensed as an ambulatory care facility, it must comply with the general ambulatory care facility requirements set forth in N.J.A.C. 8:43A as well as this subchapter. If the satellite emergency department is licensed as part of the hospital, it shall comply with the requirements set forth in N.J.A.C. 8:43G–2.5 and the criteria set forth in N.J.A.C. 8:43G–2.11, as well as this subchapter.

(b) An administrator of the satellite emergency department shall be designated in writing.

(c) The satellite emergency department shall have policies and procedures which pertain to:

1. All staff;
2. Admission and discharge of patients;
3. Procedures for obtaining patient's written consent for all medical treatment;
4. Patient advance directives;

5. Elder abuse;

6. Domestic violence;

7. The ability of family members and significant others to remain with patients during treatment;

8. Referrals to primary care physicians and specialists, to assure access to all appropriate clinical services and specialties even though immediate consultation is not necessary;

9. Transfer protocol;

i. Written transfer agreements must be in place assuring timely response to accomplish basic and advanced level transfers from a satellite emergency department to an acute care facility;

ii. Transfers requiring basic life support services shall be accomplished by a licensed ambulance in accordance with N.J.A.C. 8:40;

iii. Transfers requiring advanced life support care shall be accomplished with a critical care transport team including a registered nurse and a licensed ambulance in accordance with N.J.A.C. 8:40–6.22; and

iv. Transfers may be by other means as deemed appropriate by the physician;

10. Pharmacy services, including controlled substances;

11. Procedural sedation;

12. Infection control;

13. Dietary;

14. Linens;

15. Housekeeping;

16. Lab services;

17. Payment source;

18. Policies and procedures for handling an unexpected influx of patients; and

19. Policies and procedures for maintaining a record of hospital employees, medical staff members, and volunteers who can speak languages other than English or know sign language for the hearing impaired and can provide interpretive services to patients. This record shall include the work shifts of hospital employees.

(d) The satellite emergency department shall maintain a copy of all policies and procedures which apply to the facility onsite.

**8:43G–36.7 Reportable events**

The satellite emergency department shall comply with the requirements of N.J.A.C. 8:43G–5.6.

**8:43G–36.8 Administrative and staff qualifications**

(a) Physician qualifications for satellite emergency departments are as follows:

1. There shall be a physician director of the satellite emergency department, who may also be the director of the hospital's emergency department, who is board certified in emergency medicine or who has five years of full-time experience in emergency medicine, which may include three years residency in emergency medicine, within the past seven years. If the physician director of the satellite emergency department is not the physician director of the hospital emergency department, then there shall be coordination of all care and services between the two to ensure care delivery and quality improvement in accordance with N.J.A.C. 8:43G–5.16.

2. Each physician practicing in the satellite emergency department, except residents functioning under supervision as part of a hospital's graduate residency training program, consulting physicians, and private physicians who are attending to their patients in the satellite emergency department, shall meet at least one of the following qualifications:

i. Board certification or current eligibility to be certified in emergency medicine;

ii. Successful completion of an approved residency program in emergency medicine, family medicine, general internal medicine, general surgery, or general pediatrics; or

iii. Three years of full-time clinical experience in emergency medicine within the past five years.

3. Each physician practicing in the satellite emergency department, except residents functioning under direct supervision as part of the hospital's residency program, consulting physicians, and private physicians who are attending to their patients in the emergency department, shall attain provider status in Advanced Cardiac Life Support and either Advanced Pediatric Life Support or Pediatric Advanced Life Support within 12 months of initial assignment, and shall continuously maintain this status thereafter. Physicians who are board certified in emergency medicine shall be exempt from this requirement.

4. Each physician practicing in the satellite emergency department, except residents functioning under direct supervision as part of a hospital's graduate residency program, consulting physicians, and private physicians who are attending to their patients in the satellite emergency department, shall attain provider status in Advanced Trauma Life Support within 12 months of initial assignment, and shall continuously maintain this status thereafter. Physicians who are board certified in emergency medicine shall be exempt from this requirement.

(b) One licensed registered professional nurse certified in Advanced Cardiac Life Support (ACLS) and either Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS) or Emergency Nurse Pediatric Course (ENPC), with at least one year of emergency room experience, shall be on duty at all times in the satellite emergency department.

(c) One New Jersey licensed x-ray technician shall be on duty at all times.

(d) One staff person deemed competent by the laboratory director to perform lab tests specified in this chapter shall be on duty at all times.

(e) One current staff person who meets the qualifications identified in (c) and (d) above may be designated responsible for these areas of care and service.

(f) The facility must have policies and procedures in place to address and ensure increased staffing to address increased patient volume and acuity.

**8:43G–36.9 Staff time and availability**

(a) The satellite emergency department shall have all personnel identified in N.J.A.C. 8:43G–36.8(a) onsite at all times during hours of operation.

(b) No patient who comes to the satellite emergency department shall be discharged to home or another facility without being seen and evaluated by qualified medical personnel. This evaluation shall occur within four hours of the patient's coming to the satellite emergency department.

**8:43G–36.10 Administrative and staff education**

The satellite emergency departments shall comply with the requirements of N.J.A.C. 8:43G–5.7 and 5.9.

**8:43G–36.11 Occupational health structural organization**

The satellite emergency department shall comply with the requirements of N.J.A.C. 8:43G–5.11, 5.12, 5.13, 5.14 and 5.15.

**8:43G–36.12 Disaster planning**

The satellite emergency department shall comply with N.J.A.C. 8:43G–5.16.

**8:43G–36.13 Mandatory equipment**

(a) The following equipment shall be located within the satellite emergency department at all times:

1. Basic and stat laboratory equipment/supplies, with at least the capability to perform the following laboratory testing and evaluation:
   i. Arterial blood gases;
   ii. Creatinine;
   iii. Electrolytes;
   iv. Glucose (blood);
   v. CBC;
   vi. Strep screening;
   vii. Urinalysis; and
   viii. Pregnancy tests;
2. Defibrillator(s) with external pacemaker capability;
3. Advanced airway equipment;
4. Surgical airway equipment;
5. Suction equipment;
6. Obstetric kit with capability to keep patients warm;
7. Emergency chest decompression equipment; and
8. Basic radiology services, which shall include at a minimum non-enhanced and non-contrast radiographs.

(b) In addition to (a) above, the satellite limited emergency department shall comply with N.J.A.C. 8:43G–12.9(b), (c), (d) and (e).

**8:43G–36.14 Continuous quality improvement**

(a) The satellite emergency department shall comply with N.J.A.C. 8:43G–5.15.

(b) On a quarterly basis, beginning with the closest calendar quarter after commencing operation, the satellite emergency department shall submit the following information to the Department's Certificate of Need and Acute Care Licensure Program:

1. The total volume of patients for the quarter;
2. The number of transfers to the hospital licensed to operate the satellite emergency department (which statistics shall identify a breakout of all BLS and ALS levels);
3. The number of transfers to other hospitals;
4. The mode of arrival at the satellite emergency department for each patient during the quarter; and
5. The number of transfers for further diagnostic study.

**8:43G–36.15 Physical plant**

A building or structure being considered for use as a satellite emergency department, located independent from an acute care hospital shall comply with all the requirements of Use Group B, and section 13.6 of the NFPA 101, 1985 edition, as referenced in N.J.A.C. 8:43G–24.13(a). A satellite emergency department that remains located in a former acute care hospital shall continue to comply with the requirements of Use Group I–2, as noted in N.J.A.C. 8:43A–19.1 of the Standards for Licensure of Ambulatory Care Facilities.

## SUBCHAPTER 37. EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY SERVICES

**Authority**

N.J.S.A. 26:2H–1 et seq., specifically 26:2H–8.

**Source and Effective Date**

R.2002 d.143, effective May 20, 2002.
See: 33 N.J.R. 2624(a), 34 N.J.R. 1834(a).

### 8:43G–37.1 Extracorporeal shock wave lithotripsy services

All general hospitals providing extracorporeal shock wave lithotripsy services shall conform to the applicable criteria set forth in this chapter as well as the provisions set forth in N.J.A.C. 8:43A–29.

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## SUBCHAPTER 38. LONG TERM ACUTE CARE HOSPITALS GENERAL REQUIREMENTS

**Authority**

N.J.S.A. 26:2H–1 et seq., specifically 26:2H–5.

**Source and Effective Date**

R.2003 d.49, effective January 21, 2003.
See: 34 N.J.R. 490(a), 35 N.J.R. 414(a).

### 8:43G–38.1 Scope

(a) Special hospitals providing long term acute care services shall comply with all standards set forth in this subchapter and all applicable provisions of this chapter.

(b) The rules in this subchapter apply to special hospitals providing long term acute care services either as a free-standing facility or as part of a licensed general hospital (hospital within a hospital).

### 8:43G–38.2 Compliance with rules and laws

(a) All special hospitals providing long term acute care services (LTAC) shall be licensed by the New Jersey Department of Health and Senior Services and comply with the licensing procedures set forth at N.J.A.C. 8:43G–2.

(b) All beds maintained by a special hospital providing long term acute care services shall be licensed as long term acute care beds.

(c) All special hospitals providing long term acute care services shall comply with the rules of the United States Department of Health and Human Services at 42 CFR Part 412 et al. incorporated herein by reference as amended and supplemented.

(d) All special hospitals applying for licensure shall provide or arrange for the provision of the following professional departments, services, facilities or functions:

1. Administration;
2. Anesthesia/Sedation Services;
3. Blood Bank;
4. Central Supply;
5. Clinical and Pathological Laboratories;
6. Dietary Services;
7. Discharge Planning;
8. Employee and Occupational Health;
9. Electrocardiogram Laboratory;
10. Housekeeping and Laundry Services;
11. Infection Control and Sanitation;
12. Medical Library;
13. Medical Records;
14. Medical Services;
15. Medical Staff;
16. Morgue and Autopsy Facilities;
17. Nursing Service;
18. Pharmacy Department;
19. Physical and Occupational Therapy;
20. Physical Plant and Maintenance;
21. Post Anesthesia Care Unit;
22. Quality Assurance;
23. Radiology;
24. Respiratory Therapy Services; and
25. Social Work Department.

(e) Special hospitals providing long term acute care services shall comply with the physical plant requirements at N.J.A.C. 8:43G–24.8. In addition to the standard construction requirements for hospitals, the following shall be required:

1. Ventilation care units shall have piped in oxygen, suction equipment, emergency electrical outlets, and additional square footage for ventilator equipment and supplies; and

2. The standby emergency generator shall be checked weekly, tested under load monthly, and serviced in accordance with acceptable engineering practices.

### 8:43G–38.3 Special hospital policies and procedures

(a) Special hospitals shall have written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and implemented. They shall include at least:

1. Criteria for admission to, and discharge and transfer from, the hospital;

2. A visitors policy that specifies visiting hours and number of visitors permitted each patient at one time, subject to the discretion of the patient's physician or primary care nurse;

3. Protocols for transfer and transport of patients within the hospital or from the hospital to another facility, including who shall accompany the patient being transferred or transported;

4. A policy defining the physician specialist and consulting physician to be called for patient emergencies, including a response time for physicians to respond to patient emergencies;

5. Standing orders for patient emergencies;

6. A policy on the removal of a patient's life support system pursuant to N.J.A.C. 8:43G–4; and

7. Educational policies for the patient and families to manage their present and future healthcare needs.

**8:43G–38.4 Special hospital staff qualifications**

(a) There shall be a physician director with clinical responsibility for the care rendered throughout the facility.

(b) The physician director shall be board certified in internal medicine and licensed or authorized to practice medicine by the New Jersey Board of Medical Examiners.

(c) A physician shall visit each patient at least on a daily basis and as needed.

(d) A physician shall be present in a freestanding special hospital providing LTAC services at all times. A hospital-within-hospital LTAC shall have a physician availability agreement with the host facility, which arranges for physician consultative or care services to be available within 15 minutes of the LTAC's notification of the host facility.

**8:43G–38.5 Staff time and availability**

(a) Nursing staff shall be determined by the acuity of illness of the patient. The hospital shall develop written policies and procedures for determining and relating patient acuity to nursing staff levels.

(b) There shall be a full-time director of nursing or nursing administrator who is a registered professional nurse licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11–23 et seq. and N.J.A.C. 13:38, who has at least two years of supervisory experience in providing care to patients with acute illness/injury superimposed on complex or multiple co-morbidities.

(c) In the case of specialized care units treating ventilation dependent patients, the facility shall provide staffing for the nursing unit on which the ventilation beds are located that includes the 24–hour per day presence on the unit of at least one registered nurse and the 24–hour per day on site presence of at least one respiratory therapist.

(d) There shall be a mechanism in place to access nutritional support services for advice on both enteral and parenteral nutritional techniques.

**8:43G–38.6 Quality improvement methods**

(a) There shall be a program of continuous quality improvement which includes regularly collecting and analyzing data to help identify health-service problems and their extent, and for recommending, implementing, and monitoring corrective actions on the basis of these data.

(b) The continuous quality improvement activities shall include morbidity and mortality conferences.

(c) The continuous quality improvement program shall include review of cases involving removal of life support.