

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).

Executive Order No. 66(1978) Expiration Date

Chapter 43G, Hospital Licensing Standards, expires on January 27, 2005.

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Chapter 43G, Certificate of Need: Capital Policy, was repealed by R.1988 d.114, effective March 21, 1988.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 content clearly indicates otherwise.

“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”.

Case Notes

Hospital exemption does not apply to health maintenance organization (HMO) facility property tax status; facility not a hospital as no continuous care provided and it does not exist to further the aims and goals of a functioning hospital. *New Brunswick v. Rutgers Community Health Plan, Inc.*, 7 N.J.Tax 491 (Tax Ct.1985).

8:43G-1.3 Classification of institutions

(a) Hospitals shall be classified generally as:

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)

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 Li-
censing
New Jersey State Department of Health
PO Box 367
Trenton, New Jersey 08625-0367

(b) The Department shall charge a nonrefundable fee of \$8,000 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 \$2,000 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 \$250.00 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 \$1,000 for the filing of an application for the relocation of a general acute care, special, or psychiatric hospital.

(e) The hospital administrator shall appoint a disaster planner for the hospital. The disaster planner shall meet with county and municipal emergency management officials at least annually to review and update the written, comprehensive disaster plan. If county or municipal officials are unavailable for this purpose, the hospital shall notify the New Jersey State Office of Emergency Management, Division of State Police, Department of Law and Public Safety, P.O. Box 7068, River Road, West Trenton, NJ 08628 (phone: 609-882-2000).

(f) While developing the hospital's plan for evacuating patients, the disaster planner shall communicate with the facility or facilities designated to receive relocated patients.

(g) Copies of the current plans for receiving and evacuating patients in the event of a disaster shall be sent to municipal and county emergency management officials and to the designated receiving facilities.

(h) The hospital shall conduct at least one evacuation drill each year, either simulated or using selected patients. An actual evacuation shall be considered a drill, if it is documented.

(i) The hospital shall conduct at least one drill each year in which a large influx of emergency patients is simulated. An actual emergency of this type shall be considered a drill, if it is documented.

(j) The hospital shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency.

(k) The hospital shall take corrective action if the temperature of the hospital is not in compliance with the requirements specified in Chapter 7 of the Guidelines for Construction and Equipment for Hospital and Medical Facilities (published by the American Institutes of Architects Press, 1735 New York Ave NW, Washington, D.C. 20006, publication # ISBN0-913962-96-1) for a continuous period of four hours or longer. The hospital shall notify the New Jersey State Department of Health if the corrective action is not effective.

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 (f) on communication with receiving facilities.

8:43G-5.17 (Reserved)

8:43G-5.18 Blood bank

(a) The governing board shall designate the pathologist or other qualified physician as physician-in-charge of the blood service.

(b) The hospital shall maintain an emergency supply of blood and shall have access to additional supplies as needed.

(c) The hospital shall maintain a current list of potential blood donors of all principal blood types and groups who are available in emergencies or it shall establish a stable source of blood supply, either through an integrated blood operation or by arrangement with an outside blood service.

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) regarding additional supplies of blood.

8:43G-5.19 Clinical and pathological laboratories

(a) The laboratories shall be under the direction of a pathologist on a full or part time basis.

(b) A qualified member of the medical staff may be appointed by the governing authority to assume a portion of the responsibilities involved, with a pathologist as a consultant.

8:43G-5.20 Electrocardiogram laboratory

The hospital shall provide at least one room designated for electrocardiography. Sufficient space shall be provided for the maintenance of essential records and such office space as may be required.

8:43G-5.21 Out-patient and preventive services

(a) All hospitals shall provide, on a regular and continuing basis, out-patient and preventive services, including clinic services for medically indigent patients, in those services provided on an in-patient basis.

(b) In no instance shall a hospital provide less than out-patient services in medicine and surgery.

SUBCHAPTER 6. ANESTHESIA

8:43G-6.1 Definitions

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

"Anesthesiologist" means a physician who has successfully completed an approved residency program in anesthesiology, or who is a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before 1972.

"Anesthetic agent" means any drug or combination of drugs administered with the purpose of creating conscious sedation, deep sedation, conduction anesthesia, or general anesthesia.

"Anesthetizing location" means any location in a health care facility where anesthetic agents are administered.

“Conduction anesthesia” means the administration of anesthetic agents to interrupt nerve impulses without loss of consciousness. Major conduction blocks include regional nerve blocks (epidural, caudal, and spinal anesthesia). Minor conduction blocks include local infiltration, local nerve blocks, and nerve blocks by direct pressure and refrigeration.

“Conscious sedation” means the administration of drugs to obtund, or dull or reduce the intensity of, pain and awareness without the loss of defensive reflexes.

“Credentialed” means having been granted privileges by the hospital to provide specified anesthesia services, such as administration or supervision of one or more types of anesthetic agents or procedures.

“Deep sedation” means the administration of drugs which results in some loss of defensive reflexes; the patient, however, remains arousable by strong stimulation.

“Defensive reflexes” means the ability of an individual to counteract noxious events, especially to defend the breathing passages against foreign material.

“General anesthesia” means the administration of drugs which cause loss of consciousness, that is, complete unawareness of routine surroundings. During general anesthesia, the patient cannot make meaningful responses to even the strongest stimulation.

“Local anesthetic” means an agent which produces a transient and reversible loss of sensation in a circumscribed portion of the body.

“Minor conduction block” means the injection of a local anesthetic to stop a painful sensation in a severely circumscribed area of the body (that is, local infiltration or local nerve block), or the block of a nerve by direct pressure and refrigeration.

“Monitoring” means the observation of a patient using instruments to measure, display, and record (continuously or intermittently) the values of certain physiologic variables such as pulse, blood pressure, oxygen saturation, and respiration.

“Operating room” means a unit for the performance of surgery.

“Pain management” means the administration of pharmacologic agents or drugs by any route for the purpose of alleviating acute or chronic pain. Administration of such agents or drugs shall be considered pain management only if it occurs in the absence of any invasive, operative, or manipulative procedure, and if the patient maintains consciousness and defensive reflexes.

“Regional anesthesia” means a major conduction block such as epidural, caudal, and spinal anesthesia.

“Special procedure” means patient care which requires entering the body with instruments in a potentially painful manner. Examples are: Endoscopy (diagnostic and surgical), oral surgery, radiologic procedures, or emergency procedures.

“Special procedure room” means the specially equipped hospital location in which special procedures are performed.

“Supervision” means responsibility by a physician who is credentialed in accordance with medical staff bylaws, and who is immediately available for overseeing the administration and monitoring of anesthesia by anesthesia personnel. Immediately available means that the supervising physician is present in the hospital and is available to respond and proceed immediately to the anesthetizing location.

New Rule, R.1991 d.451, effective August 19, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Prior text of section recodified to 8:43G-6.2 Anesthesia services policies and procedures.

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-6.2 Anesthesia services policies and procedures

(a) Anesthesia services shall be controlled by written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and followed. These policies and procedures shall include at least:

1. Monitoring of patients in the postanesthesia care unit, including availability of monitoring equipment, and discharge from the postanesthesia care unit;
2. Monitoring of patients in any special procedure rooms where patients receive anesthesia;
3. Reporting of morbidity and mortality; and
4. Preanesthesia evaluation, patient preparation and intraoperative management.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.1.

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.

Case Notes

Hospital required to provide an anesthesiology department, a physician department director and sufficient personnel for emergency needs; exclusive contract for anesthesiological services reasonable, not violative of public policy or antitrust law. *Belmar v. Cipolla*, 96 N.J. 199, 475 A.2d 533 (1984).

8:43G-6.3 Anesthesia staff: qualifications for administering anesthesia

(a) There shall be a physician director of anesthesia services who is a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a fellow of the American College of Anesthesiology before 1982.

(b) The physician director of anesthesia services shall participate in the credentialing process and delineation of privileges of all personnel who administer anesthetic agents. Criteria for hospital-wide anesthesia credentialing shall include at least:

1. Objective measures of training and experience in anesthesia care against which all candidates are evaluated; and
2. A requirement for continuing education in anesthesia care.

(c) Anesthetic agents administered with the purpose of creating conscious sedation, deep sedation, conduction anesthesia, or general anesthesia shall be administered in any location in the hospital only in accordance with medical staff policies and procedures.

(d) All anesthetic agents, except those utilized for conscious sedation or as minor conduction blocks, shall be administered and monitored only by the following:

1. An anesthesiologist;
2. Under the supervision of an anesthesiologist:
 - i. A registered nurse anesthetist who is a qualified candidate for certification under a program governed or approved by the American Association of Nurse Anesthetists (AANA), provided that no national examination for such certification has been administered since the nurse became a qualified candidate for certification; or
 - ii. A physician resident, a dental resident, or a student nurse anesthetist participating in a nationally approved graduate training program leading to a recognized specialty;
3. Under the supervision of a physician who has been credentialed in accordance with medical staff bylaws to administer or supervise the administration of anesthesia, a certified registered nurse anesthetist who holds a current certification under a program governed or approved by the AANA; or
4. For dental cases only, a dentist who has successfully completed a nationally approved graduate medical education program in anesthesiology or oral and maxillofacial surgery.

(e) The administration and monitoring of any anesthesia, except those agents utilized for conscious sedation or minor conduction blocks, shall be provided by an individual who is continuously present and separate from the individual who is performing the procedure.

(f) The supervision of any anesthesia, except those agents utilized for conscious sedation or minor conduction blocks, shall be provided by a physician who is immediately available. The supervising physician may concurrently be responsible for patient care if he or she is available to attend

to supervisory duties without jeopardizing the life or safety of patients under his or her care. While supervising anesthesia personnel, the supervising physician shall not perform surgery, except minor surgery as defined by medical staff policy, or administer anesthesia to patients under his or her direct care.

(g) Anesthetic agents used for conscious sedation shall be administered only by the following:

1. A physician who has been credentialed in accordance with medical staff bylaws to administer anesthetic agents used for conscious sedation; or
2. Under the supervision of a physician who has been credentialed in accordance with medical staff bylaws to administer or supervise anesthetic agents used for conscious sedation and who is immediately available:

- i. A certified registered nurse anesthetist who holds a current certification under a program governed or approved by the American Association of Nurse Anesthetists (AANA);

- ii. A registered nurse anesthetist who is a qualified candidate for certification under a program governed or approved by the AANA, provided that no national examination for such certification has been administered since the nurse became a qualified candidate for certification; or

- iii. A physician resident, a dental resident, or a student nurse anesthetist participating in a nationally approved graduate training program leading to a recognized specialty; or

- iv. For a supplemental dose or doses after administration of the initial dose by a credentialed physician who remains continuously in the procedure room, a registered nurse who is trained and experienced in the use of anesthetic agents; or

3. For dental cases only, a dentist who has successfully completed a nationally approved graduate medical education program in anesthesiology or oral and maxillofacial surgery.

(h) The monitoring of patients who have been given an anesthetic agent for the purpose of creating conscious sedation shall be provided by an individual who is continuously present for the primary purpose of anesthesia monitoring, and who is separate from the individual performing the procedure. This individual shall be one of the following:

1. One of the personnel identified in (g) above;
2. A registered professional nurse who is certified in basic cardiac life support and who has training and experience in the use of monitoring devices; or
3. For bronchoscopic procedures only, a licensed respiratory care practitioner.

(i) Minor conduction blocks shall be administered only by one of the following:

1. A physician who has been credentialed in accordance with medical staff bylaws to administer minor conduction blocks;

2. Under the supervision of a physician who has been credentialed in accordance with medical staff bylaws to administer or supervise minor conduction blocks and who is immediately available:

i. A certified registered nurse anesthetist who holds a current certification under a program governed or approved by the American Association of Nurse Anesthetists (AANA);

ii. A registered nurse anesthetist who is a qualified candidate for certification under a program governed or approved by the AANA, provided that no national examination for such certification has been administered since the nurse became a qualified candidate for certification; or

iii. A physician resident, a dental resident, or a student nurse anesthetist participating in a nationally approved graduate training program leading to a recognized specialty; or

3. For dental cases only, a dentist who has successfully completed a nationally approved graduate medical education program in anesthesiology or oral and maxillofacial surgery.

(j) Minor conduction blocks shall be monitored continuously by medical or licensed nursing personnel.

(k) Provision shall be made for remote monitoring of the patient if radiation or another direct hazard necessitates the removal of personnel.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.2. Deleted old (c) through (g). Added new (c) through (k).

Amended by R.1995 d.124, effective March 20, 1995.

See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

Administrative Correction.

See: 27 N.J.R. 1800(a).

8:43G-6.4 Anesthesiologist availability

An anesthesiologist shall be on-site or on call and available to reach the hospital within 30 minutes under normal transportation conditions at all times.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.3.

8:43G-6.5 Anesthesia patient services

(a) A preanesthesia note, reflecting evaluation of the patient and review of the patient record prior to administration of anesthesia, shall be made or certified by the physician administering or supervising the administration of anesthesia and entered into the medical record of each patient receiving anesthesia.

(b) A record of anesthesia that conforms with policies and procedures developed by the medical staff shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

(c) 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 and after the patient's discharge from the postanesthesia care unit.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.4.

In (a), added "physician administering or supervising administration of anesthesia".

In (c), stylistic revisions.

Deleted old (d) and (e).

8:43G-6.6 Anesthesia supplies and equipment; safety systems

(a) Diameter index safety systems or equivalent shall be used on all large cylinders of medical gases and wall and ceiling outlets of medical gases.

(b) Pin index safety systems with a single washer shall be used on all small cylinders to prevent interchangeability of medical gas cylinders.

(c) All medical gas hoses and adapters shall be color-coded.

(d) An oxygen failure-protection device ("fail-safe" system) shall be used on all anesthesia machines to announce a reduction in oxygen pressure, and, at lower levels of oxygen pressure, to discontinue other gases when the pressure of the supply of oxygen is reduced.

(e) A vaporizer exclusion ("interlock") system shall be used to assure that only one vaporizer, and therefore only a single agent, can be actuated on any anesthesia machine at one time.

(f) To prevent delivery of excess anesthesia during an oxygen flush, no vaporizer shall be placed in the circuit downstream of the oxygen flush valve.

(g) All anesthesia vaporizers shall be pressure-compensated in order to administer a constant non-pulsatile output.

(h) Accurate flow meters and controllers shall be used to prevent the delivery to a patient of an inadequate concentration of oxygen relative to the amount of nitrous oxide or other medical gas.

(i) Alarm systems shall be in place for high (disconnect), low (subatmospheric), and minimum ventilatory pressures in the breathing circuit for each patient under general anesthesia.

(j) There shall be a written protocol to assure that surgery does not proceed when there are disabled alarms, depleted batteries and inactive sensors in oxygen monitors, improperly positioned breathing-circuit sensors, or other insufficiencies.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.5.

In (a), added "or equivalent". In (d), added "a reduction in oxygen pressure". In (j), added "written" and deleted "when technical feasible". Deleted old (k).

8:43G-6.7 Anesthesia supplies and equipment; maintenance and inspections

(a) A record shall be maintained of all service and maintenance performed on all anesthesia machines, ventilators, and vaporizers. The record shall include machine identification; name of servicing agent; work performed; and date of work. This maintenance shall conform with maintenance requirements established by the machine manufacturer. Credentials of each servicing agent shall be approved by the machine manufacturer or be determined by the hospital's physician director to be equivalent to the credentials of manufacturers' servicing agents.

(b) All anesthesia equipment shall be inspected fully at the beginning of each day of use. A record of each such inspection shall be maintained for each machine. The inspection shall conform with a checklist that is supplied by the manufacturer of the machine; issued by the Federal Food and Drug Administration; or, alternatively, developed by the hospital's anesthesia services and approved by the hospital's physician director of anesthesia services.

(c) All anesthesia equipment shall be inspected before each use. A record of each inspection shall be maintained for each machine and contained in the patient's anesthesia record. The record may consist of a single phrase or check mark in a box on a form.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.6.

8:43G-6.8 Anesthesia supplies and equipment; patient monitoring

(a) An in-circuit oxygen analyzer shall monitor the oxygen concentration within the breathing circuit, displaying the

percent oxygen of the total mixture, for all patients receiving general anesthesia.

(b) A respirometer (volumeter) measuring exhaled tidal volume shall be used whenever the breathing circuit of a patient under general anesthesia allows.

(c) The body temperature of each patient under general or regional anesthesia shall be continuously monitored.

(d) Pulse oximetry shall be performed continuously during administration of general anesthesia, regional anesthesia, and conscious sedation at all anesthetizing locations, unless such monitoring is not clinically feasible for the patient. Any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness.

(e) End-tidal carbon dioxide monitoring shall be performed continuously during administration of all general anesthesia, unless such monitoring is not clinically feasible for the patient.

(f) An electrocardiogram monitor shall be used continuously on all patients receiving general anesthesia, regional anesthesia, or conscious sedation at any anesthetizing location.

(g) Blood pressure, pulse rate, and respirations shall be determined and charted at least every five minutes for all patients receiving anesthesia at any anesthetizing location.

(h) The capacity for invasive monitoring of arterial pressure shall exist within the operating suite.

(i) A precordial stethoscope or esophageal stethoscope shall be used when indicated on each patient receiving anesthesia. If necessary, the stethoscope may be positioned on the posterior chest wall or tracheal area.

(j) A peripheral nerve stimulator shall be available in any anesthetizing location in which patients receive general or regional anesthesia to monitor the patient's extent of muscle paralysis from muscle relaxants. Another peripheral nerve stimulator shall be available within the postanesthesia care unit.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.7. In (c), added "general or regional". In (d), deleted "all anesthesia, including intravenous, when technically feasible" and added "general anesthesia, regional anesthesia and conscious sedation unless monitoring not clinically feasible". In (e), deleted "when technically feasible" and added "unless monitoring not clinically feasible". In (f), added "regional anesthesia or conscious sedation". In (j), deleted "within the operating suite" and added "in any anesthetizing location in which patients receive general or regional anesthesia". Deleted old (k).

8:43G-6.9 Anesthesia staff education and training

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

(b) Staff education programs and training sessions shall include patient safety and the inspection and use of equipment.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.8. Added new (a).

8:43G-6.10 Anesthesia continuous quality improvement methods

(a) There shall be a program of continuous quality improvement for anesthesia services that is integrated into the hospital continuous quality improvement program and includes routinely 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 continuous quality improvement program shall include morbidity and mortality conferences.

(c) The hospital shall notify the Division of Health Facilities Evaluation and Licensing, New Jersey State Department of Health by telephone at (609) 588-7727 or (800) 792-9770 within 24 hours, and in writing within 30 days, of all deaths in anesthetizing locations and unexpected intraoperative or postoperative events or outcomes related to anesthesia.

1. The written report shall be submitted on the form entitled "Confidential Report of Anesthesia-Related Incident" (HFE-5), available from the Department of Health, and shall include:

i. All deaths in anesthetizing locations, except those in which the patient expired prior to administration of anesthesia; and

ii. All unexpected severe intraoperative or postoperative untoward events or outcomes related to anesthesia.

2. Records of such reports and telephone calls shall be made available only to Department of Health personnel for official purposes and, for each report, to the specific facility to which the report pertains.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.9. In (c), changed report submission requirements.

Petition for Rulemaking.

See: 25 N.J.R. 3867(b), 25 N.J.R. 4337(b), 25 N.J.R. 4961(d).

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) and (b), substituted references to continuous quality improvement for references to quality assurance throughout.

SUBCHAPTER 7. CARDIAC**8:43G-7.1 Scope and definitions**

(a) The standards set forth in this subchapter shall apply only to separate, designated units or services for adult and/or pediatric cardiac surgery, cardiac catheterization, and interventional cardiac procedures. All hospitals licensed to provide any of these services shall also comply with all applicable staffing, staff qualification, volume, equipment and physical plant requirements contained in N.J.A.C. 8:33E.

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

"Cardiac catheterization" means the insertion of a thin, flexible tube (catheter) into a vein or artery and guiding it into the heart for purposes of determining cardiac anatomy and function.

"Cardiac surgery center" means a facility capable of providing invasive diagnostic catheterization, and all treatment modalities including open and closed heart surgical procedures. This includes: coronary artery bypass graft (CABG) surgery, PTCA and EPS studies.

"Complex electrophysiology study" (EPS) means the more complex variety of electrophysiology study, in contrast to non-complex electrophysiologic procedures, which primarily involve His Purkinje conduction evaluation without arrhythmia induction. EPS includes:

1. Procedures which intend to induce ventricular or supraventricular tachycardia;

2. Activation sequence mapping of cardiac tachyarrhythmias;

3. Electrode catheter ablative procedures; and

4. Implantation of anti-tachyarrhythmia devices and implantable cardioverter defibrillators.

"Diagnostic cardiac catheterization facility" means an acute care general hospital providing invasive cardiac diagnostic (cardiac catheterization) services to adult patients without surgery backup. These facilities have laboratories which perform procedures on at least 500 patients annually.

"Hospital-based" means the provisions of a health care service that is physically located on the campus of, and is a permanent structure within, a licensed care hospital offering inpatient support services.

"Left-heart catheterization" means the measurement of left heart hemodynamics and definitions of left heart anatomy/function by catheter delivered radiopaque contrast media.

(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 once 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;
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, which includes bagging and covering soiled laundry at the site of use before transport to the soiled holding area and removing soiled laundry from each operating room following every procedure.

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-34.4 Surgery staff qualifications

(a) There shall be a physician director who has clinical responsibility for the surgical service who is board certified. Certification shall be by a board of the American Board of Medical Specialists.

(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.

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 have training 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.

8:43G-34.6 Surgery patient services

(a) There shall be a system to verify patient identification prior to any surgical procedure.

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

(c) 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.

(d) 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 signed by the patient or legal guardian that includes identification of the physician(s) performing the procedure prior to all procedures requiring informed consent;

2. A completed preoperative checklist; and

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

(e) The surgical suite nursing staff shall make a perioperative 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 nursing care and patient reactions while in the operating suite.

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

(g) 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.

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

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

8:43G-34.7 Surgery space and environment

(a) The surgical 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) All staff in the surgical suite shall be attired in scrub attire. Individuals permitted limited access may wear cover gowns or jumpsuits as substitutes.

(c) Trash shall be collected in closed containers in each operating room before transport to the soiled holding area. All trash shall be removed from each operating room after each patient is discharged from the operating room.

8:43G-34.8 Surgery supplies and equipment

(a) The emergency equipment in the surgical suite shall include at least an emergency communication system that connects each operating room and postanesthesia care unit with the control center of the suite, a cardiac monitor, a resuscitator, an ambu bag, a defibrillator, a suction set, a thoracotomy set, a tracheostomy set and endotracheal tubes. This equipment shall be available in sizes adaptable to newborns, infants, and children. 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 daily 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) Staff who have been handling soiled linens or supplies shall wash their hands properly before handling clean linen and supplies.

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

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 methods

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

(b) There shall be a program of continuous quality improvement for the surgical suite 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).

In (b), substituted references to continuous quality improvement for references to quality assurance throughout.

8:43G-34.12 (Reserved)

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 once 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.

8:43G-35.2 Postanesthesia care staff qualifications; mandatory

(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) All registered professional nurses assigned to the postanesthesia care unit shall be trained in postanesthesia care, including at least:

1. The 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. Cardiopulmonary resuscitation;
7. Administration of drugs and identification of drug-related problems; and
8. Recognition of the actions and interactions of anesthetic techniques.

(d) All registered professional nurses in the postanesthesia care unit shall have training in basic cardiac life support.

(e) All registered professional nurses in the postanesthesia care unit shall have training in critical care.

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-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 a member of the anesthesia team.

(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 blood pressure, pulse, and respiration, are recorded.

(d) The postanesthesia care unit 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.

(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 mobility limitations.

(i) The medical record maintained for each patient in the postanesthesia care unit shall include at least such postoperative data as: the patient's general condition, respiration, consciousness, circulation, 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 specified at N.J.A.C. 8:43G-35.1(a)1.

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 restricted zone of the postanesthesia care unit shall be through or past a control center.

(c) All staff in the postanesthesia care unit shall be attired in scrub attire. Individuals who are permitted limited access may wear cover gowns or jumpsuits as substitutes.

(d) Equipment available in the postanesthesia care unit shall include at least: emergency equipment and drugs, pulse oximetry, equipment necessary for extubation, respirator, various means of oxygen delivery, constant and intermittent suction, blood pressure monitoring, adjustable lighting, immediate access to ventilator, and equipment which ensures protection of the patient's privacy.

8:43G-35.7 Postanesthesia care staff education and training

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

8:43G-35.8 (Reserved)

8:43G-35.9 Postanesthesia care continuous quality improvement methods

(a) There shall be a program of continuous quality improvement for the postanesthesia care unit 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) Continuous quality improvement activities shall include at least monitoring outcomes of patients receiving anesthetic agents.

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 36. SATELLITE EMERGENCY DEPARTMENTS

Authority

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