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Chapter 43G, Certificate of Need: Capital Policy, was repealed by R.1988 d.114, effective March 21, 1988.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 nonrelated 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 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 one or more specific categories of patients; 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).

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 Licensing
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.

Cross References

Regional Maternal and Child Health Consortia, compliance with patient confidentiality requirements in this section, see N.J.A.C. 8:33C–2.4.

8:43G–4.2 (Reserved)

SUBCHAPTER 5. ADMINISTRATIVE AND HOSPITAL–WIDE SERVICES

8:43G–5.1 Administrative and hospital-wide structural organization

(a) There shall be an organizational chart of the hospital and each service that shows lines of authority, responsibility, and communication between and within services.

(b) The hospital shall have an established and functioning governing body responsible for establishing hospital-wide policy, adopting bylaws, maintaining quality of care, and providing institutional management and planning.

(c) The governing body shall designate an administrator or chief executive officer for the hospital and develop criteria used to evaluate the performance of the administrator or chief executive officer.

(d) The hospital shall advise the New Jersey State Department of Health, Division of Health Facilities Evaluation and Licensing, in writing within 15 days following any change in the designation of the administrator or chief executive officer of the hospital.

(e) The medical staff shall have the right of representation at governing body meetings.

(f) There shall be a formal mechanism for communication among the governing body, administration, and medical staff.

(g) Minutes of governing body meetings shall be recorded, signed, and retained in the hospital as a permanent record.

(h) The hospital shall have a multidisciplinary bioethics committee, and/or prognosis committee(s), or equivalent(s). The hospital shall assure participation by individuals with medical, nursing, legal, social work, and clergy backgrounds. The committee or committees shall have at least the following functions:

1. Participation in the formulation of hospital policy related to bio-ethical issues;

2. Participation in the formulation of hospital policy related to advance directives. Advance directive shall mean a written statement of the patient's instructions and directions for health care in the event of future decision making incapacity in accordance with the New Jersey Advance Directives for Health Care Act (P.L. 1991, c.201). An "advance directive" may include a proxy directive or an instruction directive, or both.

3. Participation in the resolution of patient-specific bioethical issues, and responsibility for conflict resolution concerning the patient's decision-making capacity and in the interpretation and application of advance directives. The committee may partially delegate responsibility for this function to any individual or individuals who are qualified by their backgrounds and/or experience to make clinical and ethical judgments; and

4. Providing a forum for patients, families, and staff to discuss and reach decisions on ethical concerns relating to patients.

(i) The hospital shall establish a mechanism for involving consumers in the formulation of hospital policy related to bio-ethical issues.

(j) The hospital shall provide periodic community education programs, individually or in coordination with other area facilities or organizations, that provide information to consumers regarding advance directives and their rights under New Jersey law to execute advance directives.

(k) The hospital shall establish policies and procedures for the declaration of death of patients in accordance with N.J.S.A. 26:6 and the New Jersey Declaration of Death Act (P.L. 1991, c.90). The policies and procedures shall accommodate a patient's religious beliefs with respect to declaration of death. Such policies shall also be in conformance with regulations and policies promulgated by the New Jersey Board of Medical Examiners which address declaration of death based on neurological criteria, including the qualifications of physicians authorized to declare death based on neurological criteria and the acceptable medical criteria, tests, and procedures which may be used.

Amended by R.1992 d.132, effective March 16, 1992.
See: 23 N.J.R. 3256(a), 24 N.J.R. 942(a).
Text added on multidisciplinary committee and community education on advance directives at (h) and (j); on declaration of death at (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 Change.
See: 27 N.J.R. 1615(a).

Law Review and Journal Commentaries

Disputing Advance Care Directives, Robert J. Romano, Jr., 132 N.J.L.J. No. 15, 516 (1992).

8:43G–5.2 Administrative and hospital-wide policies and procedures

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

1. Policies on the admission of patients, transfer of patients to another facility, and discharge of patients;

2. Procedures for obtaining the patient's written informed consent for all medical treatment;

3. Delineation of the responsibilities of the medical staff, nursing, and other staff in contacting the patient's family in the event of death, elopement, or a serious change in condition;

4. Policies addressing bio-ethical issues affecting individual patients, including at least removal of life support systems, discontinuance or refusal of treatment, and designation not to resuscitate. In accordance with the New Jersey Advance Directives for Health Care Act (P.L. 1991, c.201), private, religiously-affiliated health care institutions which decline to participate in the withholding or withdrawing of specified life-sustaining measures shall comply with the following:

i. The hospital shall establish written policies defining circumstances in which it will decline to participate in the withholding or withdrawing of specified life-sustaining measures in accordance with the patient's advance directive;

ii. The hospital shall provide prompt notice to patients or their families or health care representatives of these policies prior to or upon admission, or as soon after admission as is practical; and

iii. The hospital shall implement a timely and respectful transfer of the individual to another institution who will implement the patient's advance directive;

5. Procedures to ensure that there is a routine inquiry made of each adult patient, upon admission to the hospital and at other appropriate times, concerning the existence and location of an advance directive (as required and defined in the New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201). If the patient is incapable to respond to this inquiry, the hospital shall have procedures to request the information from the patient's family or in the absence of family, another individual with personal knowledge of the patient, if available and known to the hospital. The procedures must assure that the patient or family's response to this inquiry is documented in the medical record. Such procedures shall also define the role of hospital admissions, nursing, social service and other staff as well as the responsibilities of the attending physician;

6. Policies which identify circumstances in which an inquiry will be made of adult individuals receiving same day surgery, same day medical services, treatment in the emergency department or out-patient hemodialysis treatment regarding the existence and location of an advance directive;

7. Procedures to request and to take reasonable steps to promptly obtain a copy of currently executed advance directives from inpatients and other critically ill patients who are under treatment at the hospital. These shall be entered when received into the medical record of the patient. When there is a question of validity, procedures for promptly evaluating the validity of the advance directive must be established;

8. Procedures for promptly alerting physicians, nurses, and other professionals providing care to patients who have informed the hospital of the existence of an advance directive in instances where a copy is not immediately available for the medical record;

9. Policies for transfer of the responsibility for care of patients with advance directives in those instances where a health care professional declines as a matter of professional conscience to participate in withholding or withdrawing life-sustaining treatment. Such transfer shall assure that the patient's advance directive is implemented in accordance with their wishes within the hospital;

10. Means to provide each adult patient upon admission, or where the patient is unable to respond, family or other representative with a written statement of their rights under New Jersey law to make decisions concerning the right to refuse medical care and the right to formulate an advance directive. This statement of rights shall be issued by the Commissioner. Appropriate written information and materials on advance directives and the institution's written policies and procedures including the withdrawal or withholding of life-sustaining treatment shall be provided to each patient and others upon request. Such written information shall also be made available in any language which is spoken as the primary language by more than 10 percent of the population of the hospital's service area;

11. Procedures for referral of patients requesting assistance in executing an advance directive or additional information to either staff or community resource persons that can promptly advise and/or assist the patient during the inpatient stay; and

12. Policies to ensure application of the hospital's procedures for advance directives to patients who are receiving emergency room care for an urgent life-threatening situation.

(b) A patient shall be transferred to another hospital only for a valid medical reason, in order to comply with other applicable laws or Department rules, to comply with clearly expressed and documented patient choice, or in conformance with the New Jersey Advance Directives for Health Care Act.

The hospital's inability to care for the patient shall be considered a valid medical reason. The sending hospital shall receive approval from a physician and the receiving hospital before transferring the patient. Documentation for the transfer shall be sent with the patient, with a copy or summary maintained by the transferring hospital. This documentation shall include, at least:

3. Date of service;

4. Gender;

5. Date of birth (not age);

6. Zip code;

7. Baseline medical condition;

8. Mode of arrival;

9. Pre-hospital medical and/or procedural interventions, including emergency medical services times and vital signs;

10. Nature of presenting illness;

11. Physician professional characteristics (for example, board certification or other special training);

12. Chief complaint category;

13. Initial vital signs upon presentation;

14. Emergency department medical and/or procedural interventions (treatment rendered);

15. Clinical impression;

16. Time of call for transfer;

17. Mode of transport on transfer;

18. Transport team interventions;

19. Intensive care unit number;

20. Intensive care unit physician professional characteristics (for example, board certification or other special training);

21. Medical and/or procedural interventions during first hour in intensive care unit;

22. Initial critical care score;

23. Length of stay in intensive care unit;

24. Final disposition;

25. Functional neurologic status; and

26. Functional physiologic status.

(c) Based upon recommendations from the New Jersey Emergency Medical Services for Children Advisory Council, the Department may require, through promulgation of an amendment to (b) above, the inclusion of additional data items.

(d) Registry data shall be submitted on an annual basis to the Department in a form prescribed by the Department.

New Rule R.2001 d.60, effective February 20, 2001.
See: 32 N.J.R. 213(a), 33 N.J.R. 658(a).

8:43G–12.5 Emergency department staff time and availability

(a) At all times at least one licensed physician who meets at least one of the qualifications in N.J.A.C. 8:43G–12.3(a) shall be present in the emergency department to attend to all emergencies.

(b) There shall be a physician specialist on call to the emergency department for each major clinical service provided by the hospital. On-call physicians shall be able to arrive and shall arrive within 30 minutes after being summoned for a critical case, under normal transportation conditions.

(c) The emergency department shall be staffed at all times by a minimum of one registered professional nurse. The hospital shall have in place a protocol to increase nurse staffing based on volume and acuity.

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

Care and treatment for the needy sick. Perth Amboy Gen. Hosp. v. Middlesex Freeholders, 158 N.J.Super 556 (Law Div.1978). Att'y Gen.Form Op. 1977–No. 15.

Requirement of a 24–hour licensed physical coverage in emergency department. In re Kessler Memorial Hospital, 154 N.J.Super. 147 (App.Div.1977), rev'd 78 N.J. 564 (1979).

8:43G–12.6 Definitions

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

"Comes to the emergency department" means, with respect to an individual requesting examination or treatment by him or herself or with another person, that the individual is on hospital property (including ambulances owned and operated by the hospital even if the ambulance is not on hospital grounds). An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the emergency department.

"Emergency department" means, an organized clinical department of the hospital which, at a minimum, evaluates and treats emergency medical conditions.

"Emergency medical condition" means:

1. A medical condition manifesting itself by acute symptoms or sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that absence of immediate attention could reasonably be expected to result in:

   i. Placing the health of the individual (or, with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy;

   ii. Serious impairment to bodily functions; or

   iii. Serious dysfunction of a bodily organ or part; or

2. With respect to a pregnant woman who is having contractions:

   i. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

   ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

"Medical screening examination" means an examination and evaluation within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified medical personnel (as defined below and specified by hospital by-laws or policies and procedures) to determine whether or not an emergency medical condition exists.

"Qualified medical personnel" means a physician who meets the requirements at N.J.A.C. 8:43G–12.3, or an advanced practice nurse certified by the New Jersey State Board of Nursing, or a physician assistant licensed by the New Jersey State Board of Medical Examiners. The advanced practice nurse or licensed physician assistant shall have training and experience in emergency care.

"Stabilize" means to provide such medical treatment of an emergency medical condition that is necessary to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that the woman has delivered the child and the placenta.

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–12.7 Emergency department patient services

(a) When an individual comes to the emergency department requesting examination or treatment for a medical condition, or if a request is made on the individual's behalf, clinical priority for treatment shall be assigned by a registered professional nurse or qualified medical personnel.

(b) Treatment for life-threatening emergencies shall be initiated immediately.

(c) If an individual comes to the emergency department requesting examination or treatment for a medical condition, or if a request is made on the individual's behalf, the hospital shall provide for an appropriate medical screening examination performed by qualified medical personnel. Medical screening may be provided in the emergency department or urgent care clinic or area accessible to the emergency department and on hospital grounds.

(d) If it is determined that an emergency medical condition exists, the patient must be evaluated by a physician and provided with such medical treatment as is necessary to assure that the condition has been stabilized, except as provided in (e) below.

(e) If a patient has an emergency medical condition which has not been stabilized, the hospital shall not transfer the patient unless:

1. The patient (or a legally responsible person acting on the patient's behalf), after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility; or

2. A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient and, in the case of labor, to the unborn child, from effecting the transfer. This certification shall include a summary of the risks and benefits upon which the certification is based.

(f) If it is determined that an emergency medical condition does not exist, the patient shall either be treated in the emergency department or shall be referred to an appropriate health care facility or provider; and the patient shall be discharged in accordance with (n) below.

(g) No patient who comes to the 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 emergency department.

(h) The hospital shall implement a protocol for meeting the needs of patients in a timely manner, such as augmenting staff and notifying or diverting ambulances when a specified volume of patients in the emergency department is reached, or patient waiting time before initial evaluation by qualified medical personnel exceeds four hours.

(i) The emergency department shall have a written protocol for the care and disposition of patients who stay in the department for protracted periods of time, for example, in awaiting inpatient beds. This protocol shall address areas such as patient monitoring, patient privacy, provision for family members or significant others, and the active seeking of inpatient beds or transfer by emergency department staff.

(j) A patient shall be transferred from the emergency department to the in-patient service of the hospital, to a facility that provides care unavailable at the hospital, or discharged to home no more than 12 hours after the patient is initially treated on an emergency basis or is stabilized. Exceptions to the 12 hour requirement shall pertain when:

1. Test results are pending and will be used to determine discharge action;

2. The patient is under clinical observation; or

3. The patient is waiting after transport has been summoned.

(k) The hospital shall maintain documentation in all cases in which patients are retained for more than 12 hours in the emergency department.

(*l*) No patient for whom inpatient admission is required shall be held under clinical observation in the emergency department for more than eight hours if a bed is available in an inpatient unit that has the correct monitoring equipment or can meet the needs of the patient.

(m) A registry of all individuals who come to the emergency department shall be maintained that includes the patient name and a least:

1. Medical record number;

2. Date and time arrived. After December 20, 2000, the names of the ambulance provider and mobile intensive care unit provider, if applicable, shall be entered in the registry;

3. Time discharged;

4. The name(s) of qualified medical personnel who provided the emergency medical screening examination;

5. The name(s) of treating qualified medical personnel;

6. Chief complaint and/or medical diagnosis; and

7. Disposition of the patient.

(n) Upon discharge from the emergency department following a medical screening examination and/or treatment, the patient or his or her representative shall be given written instructions and an oral explanation of those instructions. Documentation of instructions, the name of the physician who ordered the instructions, the name of the person who gave the oral explanation, and the name of the person receiving the instructions shall be entered legibly in the medical record.

(*o*) Patients requiring post-discharge care shall be referred after clinical evaluation to needed health care or health-related resources. The hospital shall provide assistance, such as referral to the social work department, to a patient requiring assistance in obtaining needed services.

(p) A patient shall be transferred to another health care facility only for a valid medical reason or by patient choice. The sending emergency department shall receive approval from a physician and the receiving health care facility before transferring the patient. Documentation for the transfer shall be sent with the patient, with a copy or summary maintained by the transferring hospital. This documentation shall include at least:

1. Informed consent of the patient or responsible individual, if possible;

2. Reason for transfer;

3. Signature of the physician who ordered the transfer;

4. Condition of the patient upon transfer;

5. Patient information collected by the sending emergency department, including x-ray films or written interpretation by a radiologist; and

6. Name of the contact person at the receiving hospital.

(q) Documentation of a patient's transfer sent by the transferring hospital shall be a permanent part of the patient's medical record at the receiving hospital.

(r) A medical record shall be established and maintained for each patient treated in the emergency department and include at least: