

## CHAPTER 43G

### HOSPITAL LICENSING STANDARDS

#### Authority

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

#### Source and Effective Date

R.2011 d.055, effective January 18, 2011.  
See: 42 N.J.R. 1774(a), 42 N.J.R. 2561(a), 43 N.J.R. 401(b).

#### Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 43G, Hospital Licensing Standards, expires on January 18, 2018. See: 43 N.J.R. 1203(a).

#### Chapter Historical Note

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

Chapter 43G, Certificate of Need: Capital Policy, was repealed by R.1988 d.114, effective March 21, 1988.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

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

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

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

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

Subchapter 8, Central Service, 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: 31 N.J.R. 2732(a), 32 N.J.R. 707(a).

Subchapter 36, Satellite Emergency Department, was adopted as new rules by R.2000 d.466, effective November 20, 2000. See: 32 N.J.R. 2184(a), 32 N.J.R. 4127(a).

Subchapter 37, Extracorporeal Shock Wave Lithotripsy, was adopted as new rules by R.2002 d.143, effective May 20, 2002. See: 33 N.J.R. 2624(a), 34 N.J.R. 1834(a).

Subchapter 22A, Licensure of Children's Hospital Designation, was adopted as new rules by R.2002 d.339, effective October 21, 2002. See: 34 N.J.R. 1305(a), 34 N.J.R. 3637(b).

Subchapter 38, Long Term Acute Care Hospitals General Requirements, was adopted as new rules by R.2003 d.49, effective January 21, 2003. See: 34 N.J.R. 490(a), 35 N.J.R. 4141(a).

Chapter 43G, Hospital Licensing Standards, was readopted as R.2005 d.279, effective July 22, 2005. As a part of R.2005 d.279, Subchapter 30, Renal Dialysis, was repealed and adopted as new rules, effective September 6, 2005. See: 37 N.J.R. 709(a), 37 N.J.R. 3365(a).

Subchapter 7A, Stroke Centers, was adopted as new rules by R.2007 d.35, effective February 5, 2007. See: 38 N.J.R. 91(a), 39 N.J.R. 439(a).

Subchapter 17A, Mandatory Staff Level Posting and Reporting Standards, was adopted as new rules by R.2008 d.63, effective March 17, 2008. See: 39 N.J.R. 1363(a), 40 N.J.R. 1647(a).

Subchapter 12A, Emergency Care for Sexual Assault Victims, was adopted as new rules by R.2009 d.282, effective September 21, 2009. See: 40 N.J.R. 5483(a), 41 N.J.R. 3424(a).

Petition for Rulemaking. See: 42 N.J.R. 529(a).

Chapter 43G, Hospital Licensing Standards, was readopted as R.2011 d.055, effective January 18, 2011. See: Source and Effective Date. See, also, section annotations.

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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.

(l) All hospitals are required to maintain an on-call list of appropriate primary care and sub-specialty physicians for all patients who require emergency department treatment or admission to the hospital for continuing care. All such patients being admitted to the hospital for continuing care shall be presumed to require routine care unless a clinical provider (physician, physician's assistant, advanced practice nurse, nurse practitioner, registered nurse) determines the patient's condition to be emergent. Routine and emergent cases shall be disposed as follows:

1. Consult requests designated as "routine" indicate that the requesting clinical provider wishes to present a patient to the on-call physician, but that the patient's condition does not require emergency consultation. The hospital shall have a by-law to determine the appropriate on-call physician response time to consult requests for routine cases.

2. Consult requests designated as "emergent" indicate that the requesting clinical provider wishes to present a patient to the on-call physician and that the patient's condition requires the on-call physician's prompt response. Since patient outcome in emergent cases may be directly related to care provided by the on-call physician, that physician shall respond by telephone within 20 minutes of receiving a call from hospital clinical staff. In addition, the treating physician present in the hospital and the on-call physician shall discuss and agree upon an appropriate in-person response time for the on-call physician. If the physicians are unable to reach an agreement as to an appropriate in-person response time for the on-call physician, then the opinion of the treating physician present in

the hospital shall govern. However, with regard to patients aged 18 or under, the in-person response time shall not be longer than 60 minutes after the initial call to the on-call physician. The hospital shall note on the patient's medical record the events occurring during the patient's stay in the emergency department. The hospital shall monitor that information and the hospital quality improvement staff shall review that information at least annually.

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).

Amended by R.2002 d.98, effective April 1, 2002

See: 33 N.J.R. 1174(a), 34 N.J.R. 1423(a).

Added (l).

Amended by R.2008 d.344, effective November 17, 2008.

See: 40 N.J.R. 3553(a), 40 N.J.R. 6611(a).

In the introductory paragraph of (b), inserted the last sentence; added (b)1 through (b)4; and in (d), substituted "and Senior Services, Office of Certificate of Need and Healthcare Facility Licensure" for "Division of Health Facilities Evaluation and Licensing".

#### 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;

i. The facility shall promptly notify a family member, guardian or contact person designated by the patient on admission about a patient's death. The facility shall maintain confirmation and written documentation of that notification. The facility shall adopt and maintain in its manual of policies and procedures a delineation of the responsibilities of the facility's staff in making such prompt notification regarding the death of a patient.

ii. As used in this paragraph, "promptly" means as soon as possible but not later than 60 minutes after the patient's death. If a first attempt to provide notification is made in a timely fashion but is not successful, a subsequent attempt must be made within each successive 60-minute period until notification is successfully made.

iii. Written documentation shall be made in the patient's medical record of each attempt at notification, including who made the attempt, when, how notification was made, and who the notification, when successful, was given to.

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:

1. The informed consent of the patient or responsible individual, in accordance with State law;

2. The reason for the transfer;

3. The signature of the physician who ordered the transfer;
4. The condition of the patient upon transfer;
5. Patient information collected by the sending hospital, as specified in N.J.A.C. 8:43G-15.2(e);
6. The name of the contact person at the receiving hospital; and
7. A copy of the patient's advance directive where available or notice that the individual has informed the sending hospital of the existence of an advance directive.

(c) The hospital shall not deny admission to patients on the basis of their inability to pay.

(d) Patients shall be discharged only on physician's orders or after signing a waiver that exempts the hospital and the physician from liability as a result of the patient's leaving the hospital against medical advice. Patient refusal to sign such a waiver shall be documented.

(e) The hospital shall have a patient identification system that is used for all patients in the hospital from the time of admission until the time the patient is released from the hospital.

(f) Upon arrival at a service location, an inpatient's treatment shall be initiated within 30 minutes. Following completion of treatment, the patient shall be returned to his or her hospital room within a reasonable length of time not to exceed 30 minutes.

(g) The hospital shall develop and implement a complaint procedure for patients, families, and other visitors. The procedure shall include, at least, a system for receiving complaints, a specified response time, assurance that complaints are referred appropriately for review, development of resolutions, and follow-up action.

(h) The hospital shall develop and implement a grievance procedure for all staff. The procedure shall include, at least, a system for receiving grievances, a specified response time, assurance that grievances are referred appropriately for review, development of resolutions, and follow-up action.

(i) There shall be written policies and procedures for personnel that are viewed annually, revised as needed, and implemented. They shall include at least:

1. A written job description for each category of personnel in the hospital and distribution of a copy to each newly hired employee;
2. Personnel policies in compliance with Federal requirements for Equal Employment Opportunity;
3. A system to ensure that written, job-relevant criteria are used in making evaluation, hiring, and promotion decisions;

4. A system to ensure that employees meet ongoing requirements for credentials; and

5. Written criteria for personnel actions that require disciplinary action.

(j) The hospital shall comply with all requirements of the professional licensing boards for reporting terminations, suspensions, revocation, or reduction of privileges for any health professionals licensed in the State of New Jersey.

(k) Personnel records shall be confidential material, accessible only to authorized personnel who have clearly established their identity.

(l) The hospital shall ensure that there is no smoking in the facility by employees, visitors or patients.

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 (n) and (o) regarding smoking.

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 at (a)4-12 and (b)7 on advance directives.

Petition for Rulemaking: Petition from N.J. Hospital Assoc.

See: 24 N.J.R. 4131(a), 24 N.J.R. 4290(a), 25 N.J.R. 4676(b).

Administrative Change.

See: 27 N.J.R. 1615(a).

Administrative Correction.

See: 27 N.J.R. 2215(a).

Rewrote and relettered (l) to (q) as (l) and (m).

Amended by R.1999 d.436, effective December 20, 1999.

See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.

Amended by R.2006 d.333, effective September 18, 2006.

See: 37 N.J.R. 4152(a), 38 N.J.R. 3898(b).

Added (a)3i through (a)3iii.

Amended by R.2011 d.055, effective February 22, 2011.

See: 42 N.J.R. 1774(a), 42 N.J.R. 2561(a), 43 N.J.R. 401(b).

In (l), deleted the first sentence; and deleted (m).

### **8:43G-5.3 Administrative and hospital-wide staff qualifications**

(a) The administrator or chief executive officer of the hospital shall have at least one of the following qualifications:

1. A master's degree and at least three years of full-time experience in progressively responsible management positions;
2. A baccalaureate degree and at least five years of full-time experience in progressively responsible management positions; or
3. At least 10 years of full-time experience in hospital administration.

(b) The hospital shall verify through visual examination the professional credentials, required by this chapter, of all new employees.

(c) The hospital shall verify through visual examination that the professional credentials, required by this chapter, of all employees are current.



(d) If the hospital performs organ transplants, the director of the medical staff shall ensure that all health professionals serving the patient have sufficient clinical experience in transplantation care, based on predetermined criteria established in hospital policies and procedures or set by the National Organ Procurement and Transplantation Network.

Amended by R.1992 d.72, effective February 18, 1992.

See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).

National Organ Procurement and Transplantation Network added.

#### 8:43G-5.4 Organ and tissue donation

(a) The hospital shall develop and implement written protocols for organ and tissue donation in accordance with N.J.S.A. 26:6-57 et seq., and the Uniform Anatomical Gift Act, P.L. 1969, c.161, as amended.

(b) For the purposes of this rule, the following words shall have the following meanings:

1. "Designated requestor" means a hospital employee who has completed a course offered or approved by the designated Federally qualified organ procurement organization. This course shall be designed by the OPO with input from the regional tissue and eye bank community and shall incorporate the methodology to be used by the Designated Requestor for approaching potential donor families to request organ or tissue donation.

2. "OPO" means a hospital's designated Federally qualified organ procurement organization. The Federally qualified organ procurement organizations in New Jersey are:

- i. The New Jersey Organ and Tissue Sharing Network  
150 Morris Avenue  
Springfield, New Jersey 07081  
(800-541-0075); and
- ii. Delaware Valley Transplant Program  
2000 Hamilton Street  
Philadelphia, Pennsylvania 19130  
(800-543-6391)

3. "Organ" means human kidney, liver, heart, lung, pancreas, and any other solid organ.

4. "Tissue" means human skin, heart valves, saphenous veins, bone and other tissue, including ocular tissue.

5. "Transplant recovery specialist" means a medical professional licensed by the State of New Jersey or another State or technician trained by an organ procurement organization in accordance with Federal standards pursuant to 42 U.S.C. § 274(b) and nationally accredited standards for human body part removal.

(c) The protocols required by (a) above shall include, at a minimum, the following:

1. Procedures for the hospital to notify its OPO of each hospital patient whose death is imminent or who died in the hospital at or around the time of death of such hospital patient. The information to be provided by the hospital to its OPO shall include the following:

- i. Patient's name and identifier number;
- ii. Patient's age;
- iii. Cause of death or anticipated cause of death;
- iv. Past medical history; and
- v. Other pertinent medical information requested by the OPO;

2. A requirement that hospital personnel note in the patient's medical record the donor suitability determination made by the OPO. If the patient is determined to be an unsuitable candidate for donation, an explanatory notation shall be made part of the patient's medical record;

3. A requirement that, if the patient has a validly executed donor card, will, or other document of gift, driver's license or identification card evidencing anatomical gift, the OPO representative or the Designated Requestor, if any, shall attempt to notify an appropriate person under N.J.S.A. 26:6-58.1 to advise him or her of the gift. If there is no document of gift available to the OPO representative or Designated Requestor, he or she shall ask persons pursuant to N.J.S.A. 26:6-58.1 whether the decedent had a validly executed document of gift. If there is no such evidence of an anatomical gift, then the person designated under N.J.S.A. 26:6-58.1 shall be informed of the option to donate organs and tissue. A person authorized or under obligation to dispose of the body pursuant to N.J.S.A. 26:6-58.1(b)(6) shall include, but not be limited to, a hospital administrator, a designated health care representative, a holder of a durable medical power of attorney, or a person named in the decedent's will.

4. A requirement that a notation shall be made in a deceased person's medical record indicating whether or not consent for organ or tissue donation was granted. The notation shall include the following information:

- i. Whether consent was granted or refused;
- ii. The name of the person granting or refusing consent;
- iii. That person's relationship to the decedent; and

iv. Documentation of telephone contact with the OPO.

5. A provision that the hospital shall permit the OPO to review the medical records of all deceased patients, as long as the OPO has agreed, in writing, to maintain the confidentiality of any patient identifying information.

6. A requirement that discretion and sensitivity to family circumstances and beliefs shall be maintained in all discussions regarding donations of organs, tissue or eyes.

(d) The hospital shall identify the position or job title of the person at the hospital who shall be responsible for serving as a hospital liaison to the hospital's OPO, and as coordinator of the hospital's donor activities. The hospital, in conjunction with the OPO shall provide in service training to such individuals. Such individual shall be responsible for overseeing the development and implementation of the hospital's protocols established in accordance with subsection (c) above.

(e) Recovery of human body parts for donation may be performed by a transplant recovery specialist. A physician is not required to be present during the recovery procedure.

(f) If the hospital performs organ transplants, the director of the medical staff shall ensure that satisfactory follow-up care and consultation are provided to all transplantation patients, including multidisciplinary conferences held at periodic intervals.

(g) If the hospital provides bone or tissue banking services, the hospital shall meet all guidelines set by the American Association of Tissue Banks for such services. Such guidelines are incorporated herein by reference and are available from the American Association of Tissue Banks, 1350 Beverly Road, Suite 220A, McLean, VA 22101 (703-827-9582).

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-5.5 Administrative and hospital-wide patient services**

(a) To meet the needs of pediatric patients, the hospital shall have available medical and nursing staff with specialized pediatric training and shall have equipment adaptable to the needs of pediatric patients on-site.

(b) The hospital shall ensure the safe transport of patients within the hospital, according to each patient's medical needs. This system shall include at least interdepartmental reporting of incidents and changes in the patient's condition during transportation and during the period the patient is in another service and providing an accompanying health professional for those patients whose condition warrants it.

(c) The hospital shall provide interpretive services, when necessary, for patients who do not speak English and for

patients who are deaf. The facility shall provide other communication assistance, as needed, for patients who are blind.

(d) The hospital shall have a system to link patients with clergy or spiritual counselors, upon request.

(e) For patient and staff safety, the hospital shall have a security system which is rigidly enforced and includes at least an identification system for employees, volunteers, and medical staff and control of access to and egress from the hospital.

(f) There shall be a means to summon immediate emergency response for medical emergencies occurring in the hospital.

(g) Each department in the hospital providing direct patient care shall have a health care professional capable of initiating cardiopulmonary resuscitation on duty at all times when patients are present.

(h) The hospital shall develop and implement written policies and procedures for identifying and supporting the needs of a breastfeeding mother and/or a child at the point of entry into the facility, that is, at registration in the emergency department, upon arrival for same-day surgery, and on admission to the facility.

1. These policies and procedures shall require appropriate staff to:

- i. Document breastfeeding needs in the medical record; and
- ii. Review these policies and procedures every three years and make revisions at any time as necessary.

Amended by R.1992 d.72, effective February 18, 1992.

See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).

Text on CPR staff added at (i).

Amended by R.1999 d.436, effective December 20, 1999.

See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

Rewrote (c); deleted former (e) and (f); and recodified former (g) through (i) as (e) through (g).

Amended by R.2014 d.025, effective January 21, 2014.

See: 45 N.J.R. 194(a), 46 N.J.R. 214(a).

Added (h).

#### **8:43G-5.6 (Reserved)**

New Rule, R.1991 d.450, effective August 19, 1991 (operative October 15, 1991).

See: 22 N.J.R. 3469(a), 23 N.J.R. 2526(a).

Repealed by R.2008 d.52, effective March 3, 2008.

See: 39 N.J.R. 314(a), 40 N.J.R. 1094(a).

Section was "Reportable events".

#### **8:43G-5.7 Administrative and hospital-wide staff education**

(a) There shall be a formal orientation program for all new permanent staff that includes at least training in patient rights as found at N.J.A.C. 8:43G-4, a tour of the hospital, orientation to the hospital's security system and disaster plan, and review of procedures to follow in case of an emergency.



(b) There shall be a formal orientation program for all new temporary staff, nurses retained through an outside agency, and persons providing services by contract which includes, at a minimum, a tour of the department to which the individual is assigned, orientation of the hospital's security system, and review of procedures to follow in case of an emergency.

(c) The hospital shall provide, evaluate, and coordinate training and educational programs for all departments in the hospital.

Amended by R.1992 d.72, effective February 18, 1992.  
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).  
Reference to Subchapter 4 added.

### 8:43G-5.8 (Reserved)

### 8:43G-5.9 Department education programs

(a) Each department in the hospital shall develop, revise as necessary, and implement a written plan of staff education. The plan shall address the education needs, relevant to the service, of different categories of staff on all work shifts. The plan shall include education programs conducted at least annually in the service, in other areas of the hospital, or off-site.

(b) The plan shall include education programs that address at least the following:

1. Orientation of new staff to the service in which the individual will be employed, including a review of the service's equipment, policies, and procedures and identification of individual employee duties for receiving and evacuating patients in the event of a disaster;
2. Use of new clinical procedures, new equipment, and new technologies, including, where applicable, computers;
3. Individual staff requests for education programs;
4. Supervisor judgements about education needs based on assessment of staff performance;
5. Education on statutory requirements relevant to the specific service such as identification and reporting of victims of abuse; and
6. Areas identified by the hospital-wide quality assurance program as needing educational programs; and
7. Patient rights; and
8. Rights and responsibilities of staff under the New Jersey Advance Directives for Health Care Act (P.L. 1991,

c.201) and the Federal Patient Self Determination Act (P.L. 101-508), and internal hospital policies and procedures to implement these laws.

(c) Implementation of the plan shall include records of attendance for each program and composite records of participation for each staff member.

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

Annual requirement added at (a); identification and reporting of abuse victims added at (b)6.

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 at (b)7 on advance directives.

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), inserted a new 7, and recodified former 7 as 8.

### 8:43G-5.10 Funding for regionalized services

(a) All hospitals providing emergency room services shall be members in good standing of the New Jersey Poison Information and Education System established pursuant to N.J.S.A. 26:2-119 et seq.

(b) All hospitals with licensed obstetric or pediatric beds or designated as a Community or Regional Perinatal Center pursuant to N.J.A.C. 8:33C shall be a member in good standing of a Maternal and Child Health Consortium as defined in N.J.A.C. 8:35.

(c) Prior to the designation of the Maternal and Child Health Consortium pursuant to the certificate of need process and after the expiration of the Robert Wood Johnson Foundation funding for consortia on or before March 1, 1993, all hospitals eligible for a perinatal adjustment in a 1993 revenue cap approved by the Hospital Rate Setting Commission shall make monthly payments based on that adjustment to the Maternal and Child Health Consortium to which they belong.

Emergency New Rule, R.1993 d.138, effective March 2, 1993 (expired May 1, 1993).

See: 25 N.J.R. 1295(a).

Continuity of funding to consortia specified at (c).

New Rule, R.1993 d.229, effective May 17, 1993.

See: 25 N.J.R. 792(a), 25 N.J.R. 1969(a).

Adoption of concurrent proposal by R.1993 d.236, effective April 29, 1993 (Readoption of emergency amendment) and June 7, 1993 (adoption of amendment).

See: 25 N.J.R. 1295(a), 25 N.J.R. 2555(a).

Amended by R.1993 d.286, effective June 7, 1993.

See: 25 N.J.R. 1117(a), 25 N.J.R. 2554(a).

Petition for Rulemaking: Health Care Quality and Oversight Branch: hospitals providing emergency room services: membership in New Jersey Poison Information and Education System.

See: 38 N.J.R. 1591(a).