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.2005 d.279, effective July 22, 2005.
See: 37 N.J.R. 709(a), 37 N.J.R. 3365(a).

Chapter Expiration Date

Chapter 43G, Hospital Licensing Standards, expires on July 22, 2010.

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Chapter 43G, Certificate of Need: Capital Policy, was repealed by R.1988 d.114, effective March 21, 1988.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: 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 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 by R.2005 d.279, effective September 6, 2005. See: Source and Effective Date. See, also, section annotations.

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).

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

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

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

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

18. To freedom from physical and mental abuse;

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

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

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

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

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

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

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

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

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

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

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

assistance needed to qualify and file for benefits or reimbursement;

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

31. To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care, in accordance with N.J.A.C. 8:43E-6.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Native language and distribution requirements added at (a)27.
Petition for Rulemaking: Petition from N.J. Hospital Assoc.
See: 24 N.J.R. 4131(a), 24 N.J.R. 4290(a), 25 N.J.R. 4676(b).
Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote (a)8.
Amended by R.2005 d.279, effective September 6, 2005.
See: 37 N.J.R. 709(a), 37 N.J.R. 3365(a).
In (a)1, added "and Senior Services" following "Department of Health"; in (a)6 and 7, added "or clinical practitioner" following "physician" throughout; in (a)29, delete "and" at the end of the paragraph; in (a)30, substituted "; and" for "." at the end of the paragraph; added (a)31.

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. HOSPITAL ADMINISTRATION AND GENERAL HOSPITAL-WIDE POLICIES

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 bioethical 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*).

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 develop and implement a policy for the facility to be smoke-free by April 1, 1995. The hospital shall ensure that there is no smoking in the facility by employees, visitors or patients.

(m) The hospital shall develop and implement a method to prevent smoking by patients who have been designated as "not responsible".

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.

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, hear, 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 care 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

(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 # ISBNO–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:

"Advanced Cardiac Life Support" (ACLS) means that an individual has successfully completed a course of training offered by an individual who is currently certified as an instructor by the American Heart Association or by a recognized accrediting organization appropriate to the licensee's field of practice. For example, for those adult patients, training in ACLS is appropriate and for those treating children, training in pediatric advanced life support (PALS) is appropriate.

"Analgesia" means the absence of the sensibility to pain without loss of consciousness or decrease in the intensity of pain.

"Anesthesia" consists of general anesthesia, and spinal or major regional anesthesia. It does not include local anesthesia.

"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 1982.

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

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

"Certified registered nurse anesthetist" (CRNA) means a registered professional nurse who is licensed by the New Jersey State Board of Nursing and who holds current certification under a program governed or approved by the American Association of Nurse Anesthetists (AANA), and who meets the conditions for practice as set forth at N.J.A.C. 13:37–13.1.

"Conscious sedation" means a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain an open airway, and spontaneous ventilation is adequate. Adequate cardiovascular function is usually maintained. Within the context of this subchapter, "conscious sedation" shall be synonymous with the term "sedation/analgesia" as used by the American Society of Anesthesiologists.

"Deep sedation" means a drug induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

"Epidural" means an anesthetic injected into the epidural space surrounding the fluid filled sac (the dura) around the spine which partially numbs the abdomen and legs.

"General anesthesia" means a drug induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug induced depression of neuromuscular function. Cardiovascular function may be impaired.

"Labor analgesia" means the reduction or management of pain during labor, which involves the use of anesthetic agents and/or an epidural.

"Local anesthesia" consists of drugs or agents which produce a transient and reversible loss of sensation in a circumscribed portion of the body.

"Major regional anesthesia" means nerve blocks such as epidural, caudal, axillary, brachial, and spinal anesthesia.

"Minor regional block" means the injection of a local anesthetic agent to stop a painful sensation in a severely circumscribed area of the body (local infiltration or local nerve block), or the block of a nerve by direct pressure and refrigeration.

"Minor surgery" means surgery which can safely and comfortably be performed on a patient who has received no more than the maximum manufacturer recommended dose of local or topical anesthesia, without more than minimal pre-operative medication or minimal intraoperative tranquilization and where the likelihood of complications requiring hospitalization is remote. Minor surgery specifically excludes all procedures performed utilizing anesthesia services as defined in this section. Minor surgery also specifically excludes procedures which may be performed under local anesthesia, but which involve extensive manipulation or removal of tissue such as liposuction or lipo-injection, breast augmentation or reduction, and removal of breast implants. Minor surgery includes the excision of moles, warts, cysts, lipomas, skin biopsies, the repair of simple lacerations, or other surgery limited to the skin and tissue. Additional examples of minor surgery include closed reduction of a fracture, the incision and drainage of abscesses, certain simple opthalmologic surgical procedures, such as treatment of chalazions and non-invasive ophthalmologic laser procedures performed with topical anesthesia, limited endoscopies such as flexible sigmoidoscopies, anoscopies, proctoscopies, arthrocenteses, thoracenteses and paracenteses. Minor surgery shall not include any procedure identified as "major surgery" within the meaning of N.J.A.C. 13:35–4.1

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

"Operating room" means a unit for the performance of surgery.

"Pain management" means the administration of drugs to a patient, which are not intended to result in a loss of consciousness, awareness or defensive reflexes, but which are intended to alleviate pain occurring in the absence of an invasive, operative, or manipulative procedure.