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MANUAL OF STANDARDS FOR HOSPITAL FACILITIES



DECEMBER 1972

NEW JERSEY (STATE) DEPARTMENT OF HEALTH

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SOURCE OF AUTHORITY

Chapters 136 and 138, Laws of New Jersey 1971, Health Care Facilities Planning Act

(Chapter 136)
(NJSA 26:2H-1 et. seq.)

(Chapter 138)
(NJSA 26:2H-8)

Approved May 10, 1971

INTRODUCTION

The New Jersey State Legislature has delegated to the Department of Health the responsibility for the establishment and enforcement of standards for the operation and licensure of hospital facilities in New Jersey.

The Manual of Standards for Private Hospitals sets forth the minimum requirements for licensure purposes. As good patient care is the prime objective of a hospital facility, all hospitals shall be expected to exceed these minimum standards whenever the situation requires to assure the provision of an adequate and safe pattern of patient care.

In instances where full compliance with particular sections contained herein shall be found not applicable, appropriate waivers shall be granted provided that such waivers shall in no way jeopardize the health, safety and welfare of patients admitted or cared for within the facility.

Hospital patient care is essentially an entity composed of the activities of the patient's physician and hospital personnel consciously directed to the meeting of specific needs of the patient for diagnosis, treatment, rehabilitation, prevention of disease and personal care for the purpose of curing or alleviating the effects of disease, injuries, or disorders of health; promoting a positive state of health; and restoring the patient to effective living in accord with his disabilities, as well as with his abilities and capacities.

A high level of patient care, therefore, requires unity of purpose and effort on the part of the governing board, the administrator, the medical and nursing staffs and all other hospital personnel who contribute to the essential care of the patient during his hospital stay. Segmented patient care may be avoided by clearly delineating the role of each discipline and establishing the necessary cooperative relationships.

SECTION ONE

DEFINITIONS, CLASSIFICATIONS AND LICENSING POLICIES

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101 HOSPITALIZATION

Hospitalization shall be defined as the reception and care of any person for a continous period, longer than twenty-four hours, for the purpose of diagnosis and/or treatment bearing on the physical or mental health of such persons.

102 PRIVATE HOSPITAL

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

103 LICENSEE

A. The licensee is the corporation, association, partnership or individual operating an institution and on whom rests the responsibility for maintaining acceptable standards in all areas of operation.

B. Any agency of the government or any county or municipality which shall apply for and receive Federal funds under the provisions of P.L. 91-296 of the 91st Congress, shall be required to comply with the rules and regulations and the minimum standards of nursing and hospital care provided for in N.J.S.A. 30:11-1, et seq., as a condition prior to receiving such funds.

C. Any hospital which has received financial aid from the Federal government for construction and which, as a condition to the receipt of such funds, has agreed to provide accommodations for a special type of patient (rehabilitation, drug addiction, alcoholism, psychiatric, etc.) shall continue to maintain such special services as a condition for licensure unless a waiver is granted by the Department.

104 CLASSIFICATION OF INSTITUTIONS

A. Private hospitals shall be classified generally as:

1. Non-Profit

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 individual.

2. Proprietary or Profit

Any hospital owned and operated by an individual, partnership or corporation, the net proceeds of which are subject to distribution for the benefit of such individual, corporation or shareholders.

B. Hospitals shall be further classified as:

1. General Hospital

An institution which maintains and operates organized facilities and services for the diagnosis, treatment or care of persons suffering from acute illness, injury or deformity and/or obstetrics, 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

An institution which assures provision of comprehensive specialized diagnosis, care and treatment and rehabilitation where applicable on an in-patient basis for one or more specific categories of patients.

3. Mental Hospital

An institution which provides congregate maintenance and personal care of mentally ill persons.

4. Pulmonary Disease Hospital

An institution which assures the provision of comprehensive specialized diagnosis, care, treatment and rehabilitation where applicable on an in-patient basis for patients of all ages who are suspects of or definitely diagnosed as having tuberculosis or a pulmonary condition.

105 INSPECTION

A. A hospital for which a license or approval has been issued shall be periodically inspected by one or more duly appointed representatives of the Department of Health under the rules and regulations presented in this manual.

B. Visits to evaluate the physical plant, equipment and overall operation of the hospital shall be made during usual working hours of the day, except in an emergency when inspection may be made at any time.

106 EXCEPTIONS AND EXEMPTIONS

A. The word "hospital" as used herein shall not be deemed to include first aid stations for emergency medical or surgical treatment where no continuous bed care or protracted treatment is contemplated or performed.

B. The Department of Health does not have the power or authority to:

1. Require any hospital to practice or permit sterilization of human beings, euthanasia, birth control or any other similar practice contrary to the dogmatic or moral beliefs of any well established religious body or denominations.

2. Supervise or regulate or control the remedial care or treatment of individual patients who are adherents of any well recognized church or religious denomination which subscribes to the art of healing by prayer and the principles of which are opposed to medical treatment and who are resident in any home or institution operated by a member or members or by an association or corporation composed of members of such well recognized church or religious denomination.

3. Modify or repeal any laws, rules or regulations governing the control of communicable diseases.

107 LICENSE

A. No license provided shall be granted for a term exceeding one year.

B. No license issued shall be assignable or transferable and shall be immediately void if a hospital ceases to operate or its ownership changes.

C. The license shall be conspicuously posted on the premises.

D. The institution shall give written notice to the Department of Health at least 30 days prior to closing or transferring ownership of the facility.

E. Individual licenses shall not be required for separate hospital buildings located on the same or adjoining grounds if these are operated under one management.

F. If a hospital operates a long-term care facility under the same corporate body and administration and members of the hospital's medical staff are assigned responsibility for the medical care of patients admitted in each facility, the long-term care facility shall be considered an integral part of the hospital for licensure purposes regardless of whether it is physically established as a distinct part of the hospital, as a separate structure on the hospital premises, or as a separate structure on property distant from the hospital. Only one license shall be issued to the hospital to cover each facility with the stipulation that the allocation of bed capacities not be changed except by approval of the Hospital Licensing Board.

108 FEES

A. A license to operate a private hospital shall be issued upon the payment of a fee of $25.00 providing that the application and the hospital facility are in full compliance with the applicable regulations.

B. Licenses shall be renewed annually upon payment of a like fee.

C. All fees received by the Department under the provisions of this Act shall be paid into the General State Fund.

109 REVOCATION OR SUSPENSION OF LICENSE

A. The Department is authorized to suspend or revoke a license issued hereunder or to impose a money penalty on any of the following grounds:

1. Violation of any provisions of the statute or the rules and regulations issued pursuant thereto.

2. Permitting, aiding or abetting the commission of any illegal act in said institution.

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

B. Every hospital licensed to operate under the laws of the State of New Jersey shall comply with all existing legislation with respect to abortions. Any departure from the accepted practice in this regard shall subject the hospital to revocation of its license.

110 INFORMATION TO BE DISCLOSED

A. Information received by the Department of Health through surveys authorized under this Act, after September 28, 1972, will be made available to the public.

B. All requests for copies of such reports must be made in writing to the New Jersey State Department of Health, Division of Health Facilities, P. O. Box 1540, Trenton, New Jersey 08625, Attention: Chief, Bureau of Evaluation and Licensing.

111 PLANNING A NEW HOSPITAL - EXPANSION OF EXISTING FACILITIES

A. Groups, organizations or individuals planning the construction and establishment of a new hospital should conduct a preliminary survey which includes the following:

1. An estimate of the need for additional hospital beds in the area in question, together with some evaluation as to the adequacy or inadequacy of existing hospitals.

2. Evaluation of the potential financial resources which would be available to the proposed hospital.

3. The reaction of the general public to the proposed hospital, including a list of names of influential persons who might be willing to serve on the governing board.

4. A canvass of the opinions of physicians in the area and the reaction of the medical, osteopathic and other interested societies.

5. An estimate as to the approximate number of beds that are needed and a rough estimate of the cost of such an institution.

B. The proposed facility shall be in reasonable conformity with the principles, standards, priorities and overall needs of the State as expressed in the "New Jersey State Plan for the Construction of Hospitals and Related Medical Facilities."

C. The individual or group shall arrange for a conference with the Department to discuss the proposed project in detail. If the overall program is considered feasible, schematic architectural plans should be prepared and submitted to the Department for approval.

D. The group, organization or individual planning to operate a new hospital facility shall provide the complete information required in the license application form.

E. The likelihood of the proposed facility meeting the standards for accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association shall be given full consideration and the facilities unlikely to meet such standards would be obliged to present overpowering reasons for licensure.

F. All premises hereafter proposed for hospital use shall be:

1. Fire resistant construction (see 301 (A), 302 (A)).
2. Designed for hospital purposes.
3. Approved by the Department as readily adaptable for such purpose.

G. Any new hospital proposing to build must present a master plan, including schematic drawings, for a 200-bed hospital and must complete 100 beds within that plan.

H. If the new hospital will initially complete and operate fewer than 200 rated beds, the hospital must demonstrate that the other hospitals in the area are willing and able to provide the services excluded by the new hospital and that these services are adequate to meet the needs of the community served by the new hospital.

I. All hospitals shall be expected to provide care for the needy sick and no hospital shall withhold service from any person because of race, creed or national origin.

J. Any existing hospital of fewer than 200 beds proposing to expand must present a master plan, including schematic drawings, for orderly expansion to a 200 bed hospital. If the existing hospital has less than 100 beds, it must complete a minimum of 100 beds within the plan.

K. Full consideration should be given to possible merger of facilities and consolidation of planned or existing services with other hospitals before building new or expanding existing hospitals.

L. If the need is demonstrated, any satellite hospital facility may be smaller than 100 rated beds; but it must be affiliated with, and operated under, the effective supervision of the Board of Trustees of an existing 200 bed (or larger) hospital.

M. Any new satellite hospital facility must be planned and constructed under the effective supervision of the Board of Trustees of the hospital with which it is affiliated.*

*See Appendix page E-1, Criteria for a Satellite Hospital Facility.

N. If the need is demonstrated, an out-patient clinic service (including emergency services) of an existing hospital may be located in a separate building and at a distance from the hospital, but must be operated under the effective supervision of the Board of Trustees of an existing 200-bed (or larger) hospital.

O. The procedure for the approval of the license application and the architectural plans and specifications of a new hospital facility include the following:

1. The application form must be substantially complete before it will be accepted for consideration by the Department.

2. Preliminary plans, including written approval by the local zoning authority, must be submitted.

3. The license application and preliminary plans shall be presented to the Hospital Licensing Board for review and recommendation.

4. Approval or disapproval of the proposed hospital by the Hospital Licensing Board shall be subject to confirmation by the State Board of Control.

5. Final approval shall be dependent upon the submission of an application form which is complete and acceptable in all aspects with acceptable working drawings and specifications.

P. All new hospitals applying for license shall provide written evidence of approvals by local fire, building and health authorities.

Q. All hospitals applying for license shall provide the following professional departments, services and facilities:

1. Clinical and Pathological Laboratories

a. The laboratories shall be under the direction of a qualified 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 qualified pathologist as a consultant.

2. Morgue and Autopsy Facilities

a. The space, equipment and personnel available for necropsy service shall be adequate to meet the needs of the hospital.

b. Refrigeration facilities for two cadavers shall be provided for the first 100 bed capacity; an additional refrigeration unit or space shall be required for each additional 100 beds of capacity.

c. If the necessary facilities for necropsy are not provided within the hospital, these shall be conveniently located elsewhere.

3. 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 whole blood.

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.

4. Heart Station

a. The hospital shall provide at least one room equipped for electrocardiography. Sufficient space shall be provided for the maintenance of essential records and such office space as may be required by the physician-in-charge.

b. It is recommended that additional space be allocated and reserved for advanced procedures in cardiology.

5. Surgical Suite

a. The surgical suite shall not be used as a passageway to other hospital areas.

b. Every provision shall be made to insure safe and

aseptic surgical care and for the protection of patients from infection and from cross contamination from unclean or infectious cases.

6. Obstetrical Suite

a. The suite shall be located to prevent through traffic and shall be completely separated from the surgical suite.

b. A recovery room shall be provided in hospitals with an annual birth rate of more than 800.

7. Accident-Emergency Services

a. All hospitals shall provide accident and emergency services at all times and shall accept, when medically indicated, patients seeking such services without regard to their ability to pay.

b. All hospitals shall provide 24-hour licensed physician coverage in the emergency department according to a plan established by the medical staff and/or approved by the governing board. There shall be a licensed physician responsible for the prompt and efficient treatment of all emergency patients.

c. If the needs of a patient seeking accident or emergency services at the hospital cannot be adequately provided on a continuing basis, such patient shall not be discharged except after a medical review and under medical direction. The hospital shall be responsible for the transfer of such patient to an institution equipped to render the needed care and for completing arrangements for such care.

8. Diagnostic X-Ray Department

a. The governing authority shall appoint a qualified roentgenologist to direct the radiology service of the hospital.

b. Adequate qualified personnel shall be available at all times to provide the required services.

9. Central Service

a. The hospital shall provide, prepare, sterilize and store sufficient sterile supplies and medical and surgical

equipment and shall dispense these to all departments and services of the facility.

b. This service shall be carried on in an area designed, equipped and staffed for this purpose.

10. Post-operative Recovery Room

a. This unit shall be located in close proximity to the surgical suite and direct emergency communication shall be provided between the two areas.

b. The size shall be sufficient to provide adequate space for two recovery stretchers per operating room.

c. The unit shall be under the direct supervision of an anesthesiologist or a qualified physician designated by the governing board.

11. Out-Patient and Preventive Services

a. All hospitals shall provide, on a regular and continuing basis, out-patient and preventive clinics 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.

12. Anesthesia Department

a. The governing authority shall appoint a physician to direct the anesthesia service.

b. The administration of general anesthesia or analgesia shall be performed only by a qualified anesthesiologist or a qualfied nurse anesthetist who is a member of the anesthesia department and who is under the supervision thereof.

c. A system shall be established whereby personnel qualified to administer anesthesia shall be available at all times in sufficient numbers to meet emergency needs.

R. Any hospital applying for license shall establish and maintain the following paramedical and institutional service departments:

1. Administration
2. Nursing Service Department

3. Medical Record Department
4. Pharmacy Department
5. Dietetic Service Department
6. Housekeeping Department
7. Plant and Maintenance Department
8. Medical Library
9. Laundry Service
10. Purchasing and Central Stores

112 CIVIL RIGHTS

A hospital facility shall not practice discrimination against persons (patients, employees, visitors, etc.) because of race, creed, color, national origin, ancestry or age or because of their liability for service in the Armed Forces of the United States.

SECTION TWO

ADMINISTRATION

:ions

201 Non-Profit Hospitals
202 Proprietary or Profit Hospitals

201 NON-PROFIT HOSPITALS

A. There shall be a Board of Directors, Board of Trustees or other similar body in each institution which shall be the governing authority responsible for the management, control and operation of the hospital.

1. The Board shall be composed of at least five representative residents of the area served by the institution and such additional members, who need not be residents, as shall be required to provide for efficient direction.

2. Any hospital operated by a religious body or organization may have as its supreme authority a governing body composed and organized of officials or members of such religious bodies or organizations notwithstanding lack of residence in the area served by the institution.

3. The Board officers shall consist of at least a president, vice-president, secretary and treasurer.

4. The Board shall be empowered to appoint such officers and committees as it may require to assist in carrying out its functions.

5. The Board shall appoint a qualified medical staff, formulate administrative policy and provide for the proper control of all assets and funds, including annual audits thereof.

6. The Board shall appoint a full time chief executive officer or administrator and delegate to him executive authority and responsibility.

7. The Board shall conduct regular meetings and such special meetings as shall be required. Minutes of all meetings shall be recorded, signed and retained in the hospital as a permanent record.

B. The governing body shall appoint an administrator or a director who is qualified by education and/or experience.

1. The administrator shall serve under the direction of the governing authority and shall be responsible for carrying out its policies.

2. Hospitals operated by religious organizations shall conform to the accepted procedure of such religious groups. The religious authority under which the hospital operates shall be responsible for its direction and supervision so that its policies may be served effectively.

3. The administrator shall function in an administrative liaison capacity between the medical staff and the governing authority.

4. The administrator shall be responsible for directing, coordinating and supervising the overall activities of the hospital.

5. The Department of Health shall be advised in writing within 15 days following any change in the administrative officer.

202 PROPRIETARY OR PROFIT HOSPITALS

A. The owner, partners, or in the case of private corporations the Board of Trustees, of a proprietary or profit hospital, shal carry out the same functions reserved for the governing body of a non-profit institution.

1. Such person or Board shall be the ultimate authority in the hospital and shall be responsible for the formulation of its policies, management, control and overall operation, includi the appointment of a medical staff, the establishment of rules a regulations required for the proper care of patients and such ot duties and responsibilities as are necessary to carry out the purpose of the institution.

2. The owner, partners or the Board of Trustees of any privately incorporated hospital for profit shall certify to the Department of Health the names, addresses and occupations or professions of the owners.

3. In the case of a privately incorporated profit hospital, the names, addresses and occupations or professions of the persons acting as incorporators and the Board of Trustees shall be certified to the Department in writing.

4. Any changes in ownership or the identity of the person or persons acting as the ultimate authority in a profit institution shall be forwarded in writing to the Department within 30 days of the date when such changes occurred.

B. The person or persons exercising the ultimate authority in each proprietary or profit institution shall appoint an administrator or director who is qualified by education and/or experience.

1. The administrator shall be responsible for carrying out the policies of the owners and for the overall administration of all departments including the assignment of duties to the physicians, except that questions solely medical in nature shall be a matter for medical determination.

2. The name and address of the administrator shall be forwarded to the Department of Health within 15 days following the appointment.

C. Every proprietary hospital shall have a copy of its business name, partnership arrangement or charter and its corporation papers certified from the public records, together with all by-laws and amendments thereto filed with the Department of Health.

SECTION THREE

PHYSICAL PLANT

Sections

301 Building
302 Fire Protection and Safety
303 Lighting and Ventilation
304 Heating
305 Maintenance and Sanitation

301 BUILDING

A. Standards for design and construction shall conform to those promulgated by the U. S. Public Health Service and the New Jersey Supplementary Standards for Hospital Construction. These standards shall apply to all new construction, whether a complete new hospital facility or an addition or renovation to an existing institution.

B. Approval granted for the construction of a new hospital facility or an addition or renovation to an existing licensed facility shall be null and void unless actual construction begins within one year of the date of such approval. In the event that such applicant or licensee does not begin construction within the specified time but intends to do so at a later date, plans must be resubmitted for approval.

C. The licensee, prior to making any alterations or improvements to an existing facility, shall submit plans and specifications to the Department of Health for approval before commencing such work.

302 FIRE PROTECTION AND SAFETY

A. Fire protective measures provided through out the facility shall be in compliance with applicable sections of NFPA Standard No. 101, Life Safety Code.

B. Storage of flammable anesthetics, etc. shall be in accord with NFPA Standard No. 56, Code for the Use of Flammable Anesthetics.

C. Each hospital shall develop a master fire plan to fit the needs of the particular facility.

1. Provision shall be made for immediate contact with the local fire department in case of a fire, preferably by direct alarm.

2. Written fire emergency and evacuation plans shall be formulated and posted on each nursing unit and in strategic areas throughout the hospital.

3. Employees shall be instructed in the use of fire fighting equipment and in the rapid evacuation of the buildings.

a. Instruction should be planned on a regular basis to accommodate changes in personnel. Under no circumstances shall such instruction be given less than annually.

b. Drills shall be held at irregular intervals on all tours of duty. Such drills should be held at least once a month.

c. A record shall be maintained of staff performance, results of each drill and the corrective measures taken to resolve any difficulties encountered.

4. Adequate and appropriate fire extinguishers shall be readily accessible in all areas of the hospital. These shall be checked annually and shall be labeled with the date of the last inspection.

D. A written report of a fire or any other unusual event shall be forwarded as soon as possible to the Department of Institutions and Agencies.

E. The hospital shall establish a written disaster plan for the reception, treatment and disposition of mass casualties. Disaster drills shall be held at least twice a year.

F. All incidents and accidents occurring to a patient, employee, visitor or other person shall be fully investigated and documented.

G. Appropriate regulations and safety measures shall be instituted to eliminate possible fire hazards from smoking by patients, visitors or personnel.

H. Oxygen cylinders shall be stored in a well ventilated area and shall be secured against toppling.

303 LIGHTING AND VENTILATION

A. Artificial lighting shall be by electricity only.

B. Adequate and satisfactory lighting levels shall be maintained in all areas of the hospital.

C. All areas used by patients and personnel shall be provided with proper ventilation.

304 HEATING

A. During the coldest weather, the heating system shall be capable of maintaining a minimum temperature of 70 degrees Fahrenheit in all rooms used for patients.

B. A minimum temperature of 75 degrees Fahrenheit shall be maintained in the operating room, labor rooms, recovery room, delivery room and nursery.

305 MAINTENANCE AND SANITATION

A. All buildings shall be maintained in good repair at all times.

B. The building shall be adequately supplied with screens and shall be insect free at all times.

C. Adequate vermin and insect control shall be maintained to eliminate any problems.

D. Incineration facilities shall be provided for the disposal of infected dressings, surgical and obstetrical wastes. Other refuse shall be stored and removed from the premises in a manner which does not create a nuisance and is consistent with approved hygienic practices.

E. Suitable containers shall be provided for the collection of trash and garbage within the facility.

F. Soiled linen shall be collected with care to avoid microbial dissemination into the environment and shall be placed in bags or containers at the site of collection.

G. An acceptable housekeeping standard shall be maintained throughout the facility.

H. Sewage shall be disposed of in accordance with the requirements of the local ordinances and the standards of the local and State Department of Health.

I. The water supply shall be of safe and sanitary quality suitable for drinking purposes and shall be obtained from a water supply which conforms with the policies of the State Department of Health.

SECTION FOUR

DIETETIC SERVICES

Sections

401 Organization and Administration
402 Facilities
403 Service to the Patient

401 ORGANIZATION AND ADMINISTRATION

A. There shall be an organized dietary department directed by a qualified person and staffed by adequate numbers of professional dietitians, technical and clerical personnel. The qualifications established by the American Dietetic Association should be used as a guide in selecting qualified dietary personnel.

1. There shall be a written organizational plan of the dietetic service and its inter-relationships with all other hospital departments.

2. The director of the dietetic service shall attend and participate in departmental meetings and shall function as a key member of the hospital staff.

3. The number of professional dietitians employed shall depend upon the size of the facility and the scope and complexity of the dietary functions.

4. There shall be written policies and procedures governing all dietetic activities.

5. Written job specifications and duties shall be available for all classifications of personnel.

6. There shall be full compliance with local health regulations regarding food handlers.

7. In the absence of a full-time professional dietitian, there shall be a qualified person experienced in food service management who shall be responsible for the daily management aspects of the department with regular visits by a professional dietitian to insure that therapeutic diets are served as prescribed by the physicians and to assist in the educational programs established for personnel.

B. Hospitals having contracts with commercial food management companies for dietetic services shall require that the firm maintain the standards outlined herein.

402 FACILITIES

A. All dietary areas shall be conveniently located for efficient operation. These shall be adequate in size, well lighted, ventilated and acceptably maintained at all times.

B. The type, size and layout of equipment shall provide for ease of cleaning, optimal work flow and adequate food production to meet the regular and therapeutic diet requirements of the patients.

C. Food handling and storage shall be in compliance with the provisions of the Retail Food Establishment Code of New Jersey , New Jersey State Department of Health, 1965 or as amended, and the regulations adopted thereunder and shall be in compliance with sanitary requirements of the local Board of Health pertaining to restaurants.

403 SERVICE TO THE PATIENT

A. Therapeutic diets shall be prescribed by the physician on the patient's chart and shall be as accurate and complete as possible.

B. Nutrition needs shall be met in accordance with the current Recommended Dietary Allowances of the Food and Nutrition Board, National Research Council, and in accordance with the physicians' orders.

C. A current diet manual for all therapeutic diets, approved jointly by the dietitian and the medical staff, shall be available to nursing and dietary personnel.

SECTION FIVE

PERSONNEL

Sections

501 Personnel Practices
502 Departmentalization
503 Nursing Service

501 PERSONNEL PRACTICES

A. The hospital shall recruit qualified personnel and shall provide initial orientation of new employees, a continuing in-service training program and competent supervision designed to improve patient care and employee efficiency.

B. Personnel policies and procedures shall be established for each classification of employees concerning hours of work, pay days, sick leave, vacations, holidays, hospitalization, retirement plans, leaves of absences and other benefits or related personnel matters and a copy of all such policies shall be provided each employee upon commencing employment.

C. All regular paid personnel shall be given, within two weeks of employment, a physical examination including a chest x-ray or Tine test and stool cultures, if a history of typhoid fever is elicited.

D. These physical examinations, including the chest x-ray or Tine test, shall be repeated annually on all regular paid personnel.

E. All personnel who show signs of upper respiratory infections, skin lesions, diarrhea and other communicable diseases shall be excluded from work to return only after approval by a physician.

F. Personnel absent from duty because of any reportable communicable disease, infection or exposure thereto, shall be excluded from the hospital until examined by a physician designated for such purpose and certified by him to the administrator as not suffering from any condition that may endanger the health of the patients or employees.

G. The hospital shall make provision for emergency health care for employees.

H. Appropriate records, including employment and health records, shall be established and maintained for all employees.

502 DEPARTMENTALIZATION

A. The organization of the hospital shall be departmentalized into specific departments according to services provided and each department should be under the direction of a qualified supervisor.

B. The organizational plan of the hospital shall delineate the functional structure of each department, the lines of authority and the responsibilities of all hospital personnel.

503 NURSING SERVICE

A. The department of nursing service shall be organized to provide comprehensive and therapeutically effective nursing care to each patient.

1. The following documents shall be maintained by the nursing department:

a. a statement of the policy and objectives of the nursing department;
b. an organizational plan that delineates the authority and responsibility of personnel and the functional structure of the department; and
c. a job description for each category of personnel.

2. The following records shall be available in the nursing department:

a. the annual report for the previous year;
b. a list of the nursing department committees and other committees on which nursing is represented;
c. the minutes and records of attendance at all meetings;
d. a list of all licensed nursing personnel with each individual's current New Jersey State license number;
e. personnel records including an employment application and verified references for each department employee;
f. a master staffing plan for the current year; and,
g. the current nursing policy and procedure manuals with a visible index.

B. The department shall be under the direction of a professional nurse currently registered in New Jersey and qualified by education and experience to properly execute his/her functions and responsibilities.

C. There shall be sufficient nursing personnel qualified by education, experience and ability as determined by the department in the following categories:

1. assistants to the director for day, evening and night service;

2. supervisors for each specialty division of the nursing department;

3. registered professional nurses to provide direct patient care as needed and to supervise non-professional personnel;

4. licensed practical nurses as needed to supplement the registered professional nurses;

5. auxiliary nursing personnel as needed to provide physical care and assist with simple nursing procedures; and/or

6. ward clerks to perform specific clerical and non-nursing tasks on the nursing units.

D. Each nursing unit and major patient service area shall have an assigned currently registered professional nurse on duty at all times. Additional professional, licensed and auxiliary nursing personnel shall be provided to insure that the required safe care is available to all patients.

1. All licensed and auxiliary nursing personnel and volunteers performing nursing service functions shall be under the direct supervision of a registered professional nurse. Duties assigned shall be commensurate with experience, training and demonstrated abilities.

2. A registered professional nurse shall function as circulating nurse in the operating room and in areas of specialized procedures (e.g. cineangiography, hemodialysis).

3. The nurse coverage in self care units shall depend on the admission policy and the services required for the patient census.

E. Planned meetings shall be held periodically by the nursing department to discuss patient care, nursing service problems, administrative policies and to analyze the quality of nursing care rendered to patients.

F. Continuing planned educational activities shall be held for all nursing personnel. These activities shall include, but not be limited to, on-the-jon training and development programs. Records of these programs shall be maintained including the methods used and an evaluation of their effectiveness.

APPROPRIATE FUNCTIONS OF THE LICENSED PRACTICAL NURSE IN NURSING SERVICE

The licensed practical nurse participates in the nursing care of patients within the scope of the legal definition. The Nursing Practice Act (P. L. 1947, c.262, as amended) defines nurses as follows:

"The word 'nursing' includes 'professional nursing' and 'practical nursing'. 'Professional nursing' is the performance for compensation of any professional service requiring the application of principles of nursing based on biological, physical and social sciences, including responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts and carrying out of treatments and medications prescribed by a licensed physician, and the application of such nursing procedures as involve understanding of cause and effect in order to safeguard life and health of a patient and others. 'Practical nursing' is the performance for compensation of such duties as are required by a licensed physician requiring an understanding of elementary nursing but not requiring the professional service outlined in the definition of professional nursing."

THE LICENSED PRACTICAL NURSE SHOULD ACCEPT ONLY THOSE ASSIGNMENTS FOR WHICH HE OR SHE HAS BEEN PREPARED ACCORDING TO STATE LAW.

The licensed practical nurse gives direct patient care and functions as an integral part of the nursing team. The licensed practical nurse works independently in situations relatively free from complexity as a private practitioner in the home where she has a minimum of on-the-spot supervision from a professional nurse or the patient's physician. She also works with the registered professional nurse in more complex nursing situations, such as in hospitals or home health agencies.

The limitations of the licensed practical nurse's role are not so much in the nursing procedures which may or may not be performed, but in the individual situation and its requirement for safe nursing care. Whether a particular technique or procedure is within the sphere in which the licensed practical nurse may practice, or should be performed only by a registered professional nurse, depends upon the nature of judgement required to perform the procedure safely.

In each health agency, the responsibility for proper use of the licensed practical nurse rests with the registered professional nurse who assesses the nursing needs of patients and accordingly makes assignments, evaluates personnel competencies, and supervises activities. The registered professional nurse decides in which situations the licensed practical nurse can be permitted self-direction and in which the licensed practical nurse must work in a close relationship with the registered professional nurse.

The following considerations should be used in determining whether a particular practitioner will perform a procedure or function for a specific patient:

1. THE PATIENT'S

   a. condition
   b. type of assistive care and instruction required
   c. emotional and socioeconomic needs.

2. THE PRACTITIONER'S

   a. understanding of the procedure or function based upon educational preparation
   b. ability and skill acquired and demonstrated
   c. amount and character of direction required to perform the procedure or function

Both the employing agency and the individual practitioner have a responsibility for the continuous development of knowledge and skills of each employee. On- going in-service education, based on individual needs, is one means of helping the licensed practical nurse perfect skills and keep abreast of changing trends in the practice of nursing. Each employee needs to be evaluated individually, since every person varies in the extent of abilities. The value of the licensed practical nurse as a member of the nursing team is determined by the extent to which contribution is made to the quality as well as the quantity of patient care.

A registered professional nurse has ultimate responsibility for nursing service, including recommending the assignment of all nursing personnel In situations which are complex, a registered professional nurse must be immediately available for direct care, when necessary, or for guidance and consultation.

The following material is to be used as a guide and does not attempt to give an all-inclusive list of procedures and functions for the licensed practical nurse. Each individual agency should, through a nursing practice committee or similar group, prepare its own list in line with its philisophy and objectives of nursing care. Any doubt or question about a particular procedure should be directed to the Board of Nursing.

THE LICENSED PRACTICAL NURSE GIVES NURSING CARE IN SITUATIONS RELATIVELY FREE OF COMPLEXITY

FUNCTIONS

I. Performs those nursing procedures for which the licensed practical nurse has had an appropriate amount of preparation.

Subfunctions:

A. Assistance to the patient with activities of daily living and encouragement of appropriate self care.

Examples:

(1) Assists patient as required in personal hygiene, grooming, comfort, rest and nourishment, including tube feeding.

(2) Assists patient with simple exercises as prescribed.

B. Administration of treatments.

Examples:

(1) Applies dressings utilizing knowledge of sterile techniques.

(2) Irrigates functioning and regulated colostomies and catheters.

(3) Gives vaginal douches.

(4) Inserts urethral catheters.

(5) Administers oxygen specifically prescribed.

C. Preparation and care of patients receiving specialized treatments.

Examples:

(1) Gives preoperative and post-operative care.

(2) Assists physician with treatments, examinations, tests, etc.

(3) Maintains or discontinues infusions.

a. Adds second bottle to an existing IV.

b. Discontinues an infusion.

D. Performance of special nursing techniques in caring for patients with communicable diseases.

Examples:

(1) Maintains medical aseptic technique (i.e., gown, mask, gloves, etc., as indicated).

(2) Disposes of patient's wastes according to accepted practice.

E. Administration of first-aid measures.

Examples:

(1) Recognizes and takes immediate and appropriate steps to alleviate conditions of shock, respiratory failure, fainting, hemorrhage, etc.

(2) Takes immediate and appropriate steps to prevent further injury resulting from an accident.

F. Administration of medications depending upon knowledge of actions and reactions.

Examples:

(1) Gives medications orally, sub-cutaneously, intramuscularly, by instillation and:

a. Unit dosage properly labeled.

b. Precalculated dosage.

c. "P. r. n." to patient with stable condition.

II. Observes, records, and reports nursing facts.

Subfunctions:

A. Recognition of signs and symptoms indicative of changes in the general physical and mental condition of the patient.

Examples:

(1) Observes and reports:

a. Vital signs.

b. Alterations of skin.

c. Alterations of body emission.

d. Restlessness and listlessness.

B. Recognition and understanding of stresses in human relationships.

Examples:

(1) Observes alterations in behavior.

a. Mood.

b. Communication.

III. Assists in rehabilitating patients.

Subfunctions:

A. Awareness and encouragement of the interests and special aptitudes of patients.

Examples:

(1) Encourages:

a. Use of purposeful activities required in daily living.

b. Diversional activities.

B. Knowledge and application of the principles of prevention of deformities.

Examples:

(1) Assists the patient with normal range of joint motion.

(2) Applies principles of body mechanics and body alignment

C. Utilization of community services based on knowledge of programs and mechanics for referrals.

Examples:

(1) Assists patient and family in awareness and understanding of help available in the home through community services.

IV. Provides for the physical comfort and safety of patients.

Subfunctions:

A. Consideration of the needs of the patient for a safe, attractive and comfortable environment.

Examples:

(1) Removes and reports accident hazards.

(2) Regulates room temperature, ventilation and lighting.

(3) Maintains a neat and clean environment.

B. Preparation and after-care of equipment.

Examples:

(1) Cleans and sterilizes equipment.

V. Provides for the emotional support of patients.

Subfunctions:

A. Recognition and understanding of psycho-social, cultural, religious and economic needs of people.

Examples:

(1) Respects religious beliefs of the individual patient.

(2) Respects traditional patterns or mores of cultural groups

(3) Is aware of the here and now needs

(4) Is aware of financial burden and its effect on patient care in the home.

VI. Acts in a health service capacity.

Subfunctions:

A. Participation in the development, revision, and implementation of policies designed to insure safety and comfort of patients and personnel.

Examples:

(1) Participates on agency and community committees.

(2) Contributes to team conferences.

(3) Actively participates in safety programs and community projects.

B. Promotion of cooperative effort through understanding the functions of all personnel involved in patient care.

Examples:

(1) Has an appreciation of the functions of all levels of agency personnel.

(2) Knows channels of authority and lines of communication.

C. Utilizes opportunities in contacts to promote better understanding of the health service.

Examples:

(1) Is available during visiting hours to answer or refer questions.

(2) Reinforces the patient and family teaching program.

(3) Utilizes opportunities to promote good public relations.

IN MORE COMPLEX SITUATIONS THE LICENSED PRACTICAL NURSE FUNCTIONS AS AN ASSISTANT TO THE REGISTERED PROFESSIONAL NURSE.

FUNCTIONS

I. Works in specialized care units under the immediate direction and supervision of the registered professional nurse.

II. Participates in the planning and evaluation of nursing care under the guidance of the registered professional nurse.

SECTION SIX

MEDICAL STAFF

Sections

601 Organization
602 Medical By-Laws
603 Staff Meetings
604 Medications and Treatments
605 Referral and Follow-Up of Patients
606 Medical Library

601 ORGANIZATION

A. There shall be an organized medical staff which shall be responsible to the governing board of the hospital for the quality of all medical care provided to patients and for the ethical conduct and professional practices of its members.

1. The medical staff shall ensure clinical practice of the highest quality and each individual staff member shall be accountable for the appropriateness of care rendered to his patients.

2. The medical staff shall establish a formal method of monthly peer group reviews and evaluation of the clinical practice within the hospital.

3. Each member of the medical staff shall be qualified for membership and for performance of the clinical privileges granted to him.

4. The medical staff shall encourage and participate in the educational activities of the hospital staff.

B. The medical staff shall be under the direction of a President (Medical Director, Chairman) with such additional officers as shall be necessary to provide effective governance of its affairs and to ensure proper acceptance and discharge of its responsibility for providing quality medical care.

C. The medical staff shall be departmentalized into clinical services when the staff duties and functions become too complex to be handled by the staff as a whole.

602 MEDICAL BY-LAWS

A. The medical staff shall develop and adopt a set of rules, regulations and by-laws in conformity with the rules of the governing board of the hospital. By-laws of the medical staff approved by the New Jersey Medical Society, the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association should be used as guides.

The following provisions shall be included as a minimum:

1. Qualifications and procedures for admission to staff membership and the conditions for retaining such membership.

2. Delineation of the organizational structure of the medical staff.

3. Rules governing prohibition of unethical conduct.

4. Procedures for the assignment, reduction or withdrawal of privileges of physicians.

5. Methods for the selection of officers and department/service chairmen.

6. Composition and functions of standing committees as required by the complexity of the hospital.

7. Requirements regarding attendance at general and departmental meetings and the maintenance of adequate minutes.

8. Provisions requiring pre-operative diagnosis.

9. Requirements regarding the maintenance of complete medical records and the establishment of an acceptable format for retaining all necessary data.

10. Responsibilities of the chiefs of clinical services.

11. Requirements for all medical orders to be in writing, dated and signed.

12. Requirements for proper informed consents before procedures involving special risks.

13. Requirement for consultation when indicated.

14. Requirements for standard operating procedures covering routine situations.

15. Requirements for completion of each medical record and a case summary following discharge of a patient.

16. Provisions for active utilization review at specified appropriate intervals to determine need for hospitalization.

17. Responsibilities of the medical staff to provide licensed physicians for hospital and emergency services at all times.

B. Nothing in the preceding section shall limit the privileges of the medical staff to formulate such additional rules and regulations which it may deem necessary to facilitate providing quality patient care. Adherence to such adopted rules and regulations shall be consistent with acceptable practices.

C. A copy of the medical by-laws and subsequent revisions, as adopted, shall be forwarded to the Department of Health.

603 STAFF MEETINGS

A. General meetings of the medical staff shall be held at least quarterly with such additional special meetings as may be required.

B. Departmental meetings shall be held monthly to review the care and treatment of patients served by the hospital.

C. The agenda should be forwarded to all members prior to the scheduled meetings.

D. Records of attendance and adequate minutes shall be maintained of all meetings held.

E. Meetings should be directed toward increasing the efficiency of the medical staff, developing medical knowledge and improving the level of patient care rendered within the hospital.

F. Active members of the staff should be required to attend all meetings unless excused for legitimate reasons.

604 MEDICATION AND TREATMENTS

A. Medication and treatment for patients in the hospital shall be prescribed by physicians licensed to practice medicine or osteopathy in the State of New Jersey.

B. Authentication by a licensed physician shall be required for those sections of the patient's medical record written by medical personnel participating in approved educational programs.

605 REFERRAL AND FOLLOW-UP OF PATIENTS

A. There shall be a written policy established for the referral of patients in need of further community services upon discharge from the hospital.

B. The policy should include, but should not be limited to, agreements for the transfer of patients to extended care facilities, skilled nursing homes, convalescent homes and visiting nurse associations.

606 MEDICAL LIBRARY

A. The hospital shall provide library services appropriate to the professional and technical needs of the medical, nursing and other hospital staff.

B. Books, periodicals and other materials relative to the clinical services offered should be available.

C. The extent of library services will necessarily vary with the size, contents and programs of the library.

SECTION SEVEN

MEDICAL RECORDS

Sections

701 Medical Record Department
702 Patient Records
703 Hospital Records
704 Availability of Records

701 MEDICAL RECORD DEPARTMENT

A. The hospital shall establish and maintain a medical record department which shall be conveniently located and adequate in size and equipment to enable physicians to properly complete medical records.

1. The department shall be under the supervision of a medical record librarian or other person qualified by education, training and experience.

2. Such additional qualified personnel shall be employed on a full or part-time basis as are necessary for the efficient conduct of the department.

3. If a professionally qualified person is not available on a full-time basis, a registered medical record librarian shall be employed on a part-time or consultant basis and shall make regular visits to the department to evaluate maintenance of records and to advise on the overall operation of the service.

B. The filing equipment and storage space provided shall be adequate to accommodate all records and to facilitate retrieval.

1. A system of identification and filing which will insure the prompt location of patients' records shall be established.

2. A unit record shall be maintained so that treatment records on both an in-and-out patient basis are retained in one folder.

3. Medical records shall be preserved, either in the original or by microfilm, for a period of not less than 10 years following the most recent discharge of the patient or until the discharged patient reaches the age of 23, whichever is the longer period. X-ray films shall be retained for a period of five years.

C. An accurate and complete medical record shall be written for all patients.

1. Patient identification shall be available on each sheet of the medical record.

2. Records shall be completed within 15 days following discharge of the patient from the hospital.

3. Records shall be kept confidential and shall be accessible to authorized persons only.

4. Written consent of the patient is required for the release of medical information.

5. Medical records should not be removed from the hospital environment except upon subpoena.

702 PATIENT RECORDS

A. An individual medical record shall be established for every patient admitted to the hospital or given emergency or out-patient treatment at the facility.

B. The patients' records shall contain adequate information to justify the diagnosis and treatment and to document the results accurately.

C. The records maintained for each in-patient shall include the following:

1. Identification data and consent forms
2. Admission and provisional diagnosis
3. History
4. Physical examination
5. Physicians' progress notes
   a. Adequacy of recordings substantiated by the chronological picture presented of patient's progress and the course and results of treatments
   b. Frequency determined by the condition of the patient

6. Operative record
   a. Recorded by the surgeon immediately after surgery
   b. Contains description of findings, the technique used, tissue removed or altered and the post-operative diagnosis
7. Radiological diagnostic and treatment reports
8. Laboratory reports
9. Nurses' notes
   a. Limited to pertinent, meaningful observations and informational data
   b. Recorded and signed by licensed nursing personnel or nursing students under supervision
10. Physicians' orders
   a. Orders for medication and treatments shall be in writing, signed and dated
   b. Telephone orders shall be accepted and recorded by a professional nurse only and these should be limited to urgent circumstances. Such orders shall be signed by the responsible physician within 24 hours.
11. Medication and treatment record
   a. Record of medications and treatments administered by nursing personnel.
   b. Signature and status recorded for initials used
12. Consultations
13. Record of discharge or death
14. Autopsy findings
15. Final diagnosis
16. Discharge summary
   a. Recapitulation of the significant findings and events of the patient's hospitalization
   b. Condition of patient on discharge
   c. To be retained for a period of 20 years

D. Medical records shall be completed and authenticated by a licensed physician.

1. All records and reports shall be signed or authenticated by a licensed physician.

2. Histories and physical examinations shall be completed within 24-48 hours following admission.

3. Records of patients discharged shall be completed within 15 days following discharge.

4. If a patient is re-admitted to the hospital within a 30-day period for the same condition, reference to the previous history on file with an interval note and a current physical examination will suffice.

703 HOSPITAL RECORDS

A. The hospital shall maintain such additional records as shall be required to fully document the overall operation and to provide statistical data which may be required by the Department of Health.

B. The records of the hospital shall include as a minimum:

1. Record of admissions and discharge
2. Case and clinical records
3. Daily census
4. Register of births
5. Register of operative procedures
6. Narcotic register
7. Death records
8. Autopsy records
9. Consultations
10. Record of emergency and clinic services

C. A summary report of the activities of the hospital shall be forwarded to the Department of Health within three months of the termination of each calendar year.

704 AVAILABILITY OF RECORDS

A. Hospital and patient records shall be available for inspection at all times, within the limits of existing laws, to duly authorized representatives of the Department of Health.

B. In the event that a hospital discontinues operation for any reason whatsoever, the governing authority immediately preceding the discontinuance of the operation of the hospital shall notify the Department in writing where the medical records will be stored and serviced.

SECTION EIGHT

MATERNAL AND NEWBORN SERVICES

Sections

801 Applicability
802 Physical Standards
803 Operation Standards
804 Personnel Standards
805 Protection Against Hazards
806 Glossary of Terms

801 APPLICABILITY

This section shall apply to all hospitals having obstetrical and newborn services or premature infant services and to all institutions caring for infants 28 days of age or less or weighing more than 2500 grams (five and one-half pounds) and to the persons responsible for, or rendering this care in such hospitals and institutions.

A. If the hospital admits obstetrical patients, the governing authority shall establish a clinical obstetrical service in accordance with the requirements of this section.

B. Physicians performing obstetrics shall be classified as follows by the chief and the attending obstetrical staff:

1. Physicians permitted to perform all types of obstetric procedures and deliveries shall be limited to qualified obstetricians; and

2. Physicians permitted to perform deliveries or care for pregnancies of a normal, uncomplicated nature.

3. Exceptions may be granted by the obstetrical department.

A list of the physicians and their classifications shall be available in the administrator's office and in the office of the supervising nurse of the service.

802 PHYSICAL STANDARDS

A. Segregation of Service

1. The labor-delivery and nursery units shall be considered closed units, similar to the surgical suite and recovery room, and appropriate restrictions shall be established and posted governing entry into any such unit. Suitable conditions may be established to permit visiting by the patient's husband in the labor-delivery unit and in the observation area of the nursing unit.

2. The obstetrical department shall be maintained physically, separate and apart from any service not concerned with obstetrical care, except as authorized herein, and shall have separate utility rooms, pantry, bathrooms and other necessary work units.

B. Labor and Delivery Rooms

1. Delivery rooms shall be separate from operating rooms and shall be used only for deliveries and essential operative procedures related to the delivery.

2. It is desirable that a separate delivery room be available for infected cases. Where this is not practical, the delivery room used shall be considered contaminated and shall not be reused until properly cleaned and decontaminated. The infant shall be appropriately isolated. If these qualifications cannot be met, arrangements for transfer to a suitable institution with proper facilities should be carried out when conditions permit.

3. Labor rooms shall be provided near the delivery rooms. A ratio of one labor bed to ten obstetrical beds is desirable.

C. Newborn Nursery

1. At least one newborn nursery shall be provided with sufficient square feet per bassinet to provide for the necessary space for all working equipment and provision for crib side care of the infant.

2. No room used as a nursery shall communicate directly with any other room or rooms used as a nursery; pass-through windows between nurseries and nursery accessory rooms are prohibited.

3. Cubicles are prohibited.

4. A minimum space of two feet shall be maintained around infant units at all times.

5. Each room used as a nursery or as a nursery accessory room must be provided with a foot-controlled, covered receptacle for the disposal of wet or soiled diapers, a separate foot-controlled receptacle for the disposal of refuse and equipment for the sanitary disposal of linen other than wet or soiled diapers. Disposable liners shall be used in the refuse and diaper receptacles.

6. Common bathing and dressing tables shall be prohibited.

7. A lavatory with hot and cold running water shall be provided in each room used as a nursery or nursery accessory room and in the preparation area of the formula room.

8. No accessory room shall serve both as a newborn nursery and as an observation nursery.

9. No room shall be used as a temporary nursery without properly notifying the Department.

D. Formula Room

1. A separate formula room shall be provided where the formula is prepared in the hospital.

2. Pre-sterilized formula shall be readied in a clean area, associated with the nursery, and designated for this purpose.

3. A refrigerator shall be provided for storage of infant feedings requiring refrigeration and shall be used for no other purpose.

E. Equipment and Supplies

1. All exterior windows and doors used for ventilation in the obstetrical and newborn services, including the formula room, shall be effectively screened.

2. Only those supplies necessary for ongoing care of the patients or their environment shall be stored on the service. Such supplies shall be kept in their original containers or in containers with a securely attached legible label.

3. Extra bassinets and other non-essential equipment shall not be stored in any of the nurseries or nursery accessory rooms.

4. The use of stationary sitz baths is not recommended.

5. Individual supplies and equipment shall be provided for each patient on the obstetrical service and for each infant and all nursing care shall be carried out at the bedside.

6. A locked cabinet shall be provided for all medications. All medications shall be properly labeled and stored in this cabinet when not in use.

803 OPERATION STANDARDS

A. General Provisions

1. The nursery shall be under the direct supervision of a qualified pediatrician.

2. Modern aseptic techniques in the use of gowns, masks, etc., shall be followed at all times in accordance with generally accepted medical standards.

3. Individual techniques shall be carried out in the care of all patients on the obstetrical service and infants. All persons shall wash their hands with soap or soap substitute and water (or don sterile gloves if handwashing is medically contraindicated) before and after handling each patient or infant or their clothing or equipment.

4. The requirements of the State Sanitary Code shall be followed in all cases of communicable diseases.

5. Each hospital shall maintain a blood bank or have formal arrangements whereby properly matched blood for transfusions may be promptly available in obstetrical emergencies.

6. Wherever possible, the blood type and RH determination shall have been made prior to admission and shall have been recorded in the patient's chart. If for any reason this has not been done, this determination shall be made as soon after admission as practicable.

7. Newborn infants shall not be kept in the same nursery or room with older children or any adults except healthy mothers.

8. Where newborn infants are cared for in a rooming-in program, the infant may remain in the mother's room on a continuous or an intermittent basis with nursery supervision of infants at night. An infant who is rooming in intermittently may, if necessary, return to the regular nursery. The mothers' rooms shall have lavatories and provisions for gowning by fathers.

9. When infants are weighed on a common scale, a fresh clean impervious cover of sufficient size to cover the surface of the scale pan shall be used for each infant.

10. The hospital, with the advice of the obstetrical and pediatric staffs, shall formulate a program of instruction for obstetrical patients in the fundamentals of normal infant care.

The hospital shall insure that a child born to an unwed mother shall be released only to the natural parent, adopting parent, brother, sister, aunt, uncle, grandparent or step-parent of such child or an agency approved as qualified to practice adoption in New Jersey. This statement is related to the Adoption Statute, N.J.R.S. 9:3-19A.

11. It is recommended that peri-natal conferences be held periodically.

B. Records and Identification

1. The hospital shall be responsible for maintaining a register of births, in which shall be recorded the name of each maternity patient admitted; date and time of admission; date and time of birth; type of delivery; all operative procedures; names of physicians, assistants and anesthetists and the sex and condition of infant at birth. (e.g. the Apgar Rating)

2. An effective means of identification of each newborn infant shall be established by the hospital. The newborn infant shall be properly identified with the mother.

3. Every bassinet, incubator, or heated crib in the nursery shall bear identification of the infant to whom it is assigned.

C. Isolation

1. A patient delivered before admission to the labor-delivery unit shall be appropriately isolated.

2. Proper isolation procedures shall be established for patients in labor with confirmed or suspected infection. (See 802 B 2)

3. Provision shall be made for the prompt transfer from the obstetric unit of sick and infected mothers and infants. In addition to those with an overt infection, patients with morbidity by temperature definition shall be transferred unless there is positive evidence that the fever is not due to a contagious condition.

D. Observation

1. An infant shall be placed promptly in observation under the following circumstances:

a. If born to a mother having diarrhea.
b. If the infant has been exposed to a potential source of infection.
c. If the infant has been born outside the labor-delivery suite.
d. When the infant has been removed temporarily from the obstetrical and newborn services.
e. When the infant is suspected of but not diagnosed as having diarrhea or some communicable condition.

2. An infant shall be removed from observation and placed in the newborn nursery only on the order of the attending physician.

E. Premature Infant

Adequate provision shall be made for the handling of premature infants or means established whereby such infants may be safely transferred to other hospitals where a premature service has been established.

F. Caesarean Sections and Non-Obstetric Surgical Procedures

1. Caesarean sections shall be performed only in an operating room or a delivery room which meets all the requirements of an approved operating room.

a. There shall be present in such delivery room an approved incubator, and

b. Compatible, properly stored blood shall be readily available in the hospital for transfusions; and

c. A competent physician shall be present for infant resuscitation.

2. Aseptic surgical techniques shall be carried out in all delivery rooms.

3. Tubal sterilization may be performed in a delivery room which meets all the requirements of an operating room if this procedure is done within 48 hours of delivery.

4. Obstetric patients requiring other non-infected surgical procedures (e.g. inguinal hernia, skin lesion) shall have these performed in the surgical area but may be returned to the obstetrical unit.

G. Gynecologic Patients

Non-infected gynecologic patients may be admitted to the obstetrical service under the following conditions:

1. The hospital desiring to participate in combining clean gynecologic patients with obstetric patients shall apply to the Hospital Licensing Board for approval. The application shall present adequate data to justify such procedures as well as the need for continuing the obstetrical service.

2. Where gynecologic patients are admitted to the obstetrical service, the criteria recommended by the State Department of Institutions and Agencies with the cooperation of the State Department of Health, shall be followed. A copy of the criteria may be found in the Appendix.

3. Decisions regarding the gynecologic patients to be housed on the obstetrical service shall be made by the chief of obstetrics or his designee. His decisions on choice of patients shall not be subject to review by any member of the hospital or medical staff.

4. The hospital approved to participate in combining clean gynecologic patients with obstetric patients shall be visited and evaluated on an unannounced basis in keeping with the following schedule unless otherwise indicated or deemed necessary by the Department:

a. Monthly for the first three months in the program.
b. Quarterly thereafter for the remainder of the first year in the program.
c. At the discretion of the Department following the first year in the program based upon the recommendation of the Hospital Licensing Board.

804 PERSONNEL STANDARDS

A. Separate personnel shall be assigned to the obstetrical service which shall be under direct supervision of a registered professional nurse at all times. If the caseload does not justify the total time of one nurse on each tour of duty, exception may be made by action of the Licensing Board after submission and approval of written techniques. In the event that exception is granted, such techniques shall be posted in the obstetrical unit and all personnel instructed.

B. There shall be at all times, day and night, registered professional nurse supervision of the nursing care of mothers and infants, and such other nursing supervision and coverage as is required.

C. All personnel who have a diagnosed or suspected communicable condition including but not limited to the common cold, diarrhea, skin infection or any febrile condition, shall be excluded from work with patients in the obstetrical and newborn services and from the formula room. A medical determination that such persons are free from communicable conditions shall be required before their return to such work.

805 PROTECTION AGAINST HAZARDS

A. No hospital, laundry or diaper service shall use inks or dyes containing aniline oil (aminobenzene) or oil of mirbane (nitrobenzene) or other benzene derivatives to stamp or otherwise mark diapers, sheets, gowns, towels or other clothing or linens unless the articles so marked are boiled by the agency doing the marking before they are delivered, stored or otherwise made available for use.

B. All containers used for dyes and inks containing aniline oil or oil of mirbane or other benzene derivatives used for marking diapers and hospital linens shall bear a label which conforms with the requirements of the Department and must also contain the statement, "DIAPERS, CLOTHING OR LINEN MARKED BY THIS DYE (OR INK) MUST BE LAUNDERED, INCLUDING BOILING, BEFORE BEING MADE AVAILABLE FOR USE."

806 GLOSSARY OF TERMS

Obstetrical and newborn services shall mean that part of the hospital or institution in which, as a regular practice, obstetrical patients and newborn infants receive care.

Obstetric patient shall mean any woman who is pregnant at any stage, parturient or recovering from parturition. Patients delivering a fetus weighing less than 500 Gms. must comply with the regulations outlined for gynecologic admissions to the obstetric floor in the Criteria.

Gynecologic patient shall mean a woman presenting or suspecting of having a condition relating to her reproductive organs and not currently in a state of pregnancy or recovery therefrom.

Labor room shall mean a room for parturient patients in labor distinct from patient bedrooms and from operating or delivery rooms.

Delivery room shall mean a room distinct from patients bedrooms and set apart for the delivery of parturient patients.

Obstetrical bed shall mean a bed located on the obstetrical service for an obstetrical patient other than a bed in a labor, delivery or recovery unit.

Rooming-in shall mean an arrangement which allows the mother and her newborn infant to be cared for together in a setting so that the mother may have access to her infant during all times of the day and not limited to feeding time.

Infant shall mean all newborns 28 days of age or less or weighing more than 2500 grams (five and one-half pounds).

Premature infant shall mean an infant weighing 2500 grams (five and one-half pounds) or less at birth.

Newborn nursery shall mean a room for housing infants who have not been exposed to potential sources of infection and who are not suspected of nor diagnosed as having diarrhea or any communicable condition.

Premature nursery shall mean a room for housing infants weighing 2500 grams (five and one-half pounds) or less at birth who have not been exposed to potential sources of infection and who are not suspected nor diagnosed as having diarrhea or any communicable condition.

Observation nursery shall mean a room, physically separate from the newborn nursery, where infants exposed to potential sources of infection and infants suspected of but not diagnosed as having diarrhea or any communicable condition may be observed pending diagnosis.

Isolation nursery shall mean a room, not located within the obstetrical and newborn services, for the isolation of infants diagnosed as having diarrhea or any communicable condition.

Nursery accessory room shall mean a room communicating with one or more newborn nurseries or a room communicating with one or more observation nurseries. In the case of newborn nurseries, the nursery accessory room shall mean a room which provides space for the examination and treatment of infants. The charting and gowning area shall not communicate with the newborn nursery. In the case of observation nurseries, the nursery accessory room shall mean a room which provides space for work and gowning.

Nursing care hours shall mean all professional and auxiliary nursing service hours of care available.

Bassinet shall include any bassinet, incubator or crib used for an infant.

Formula room shall mean a room used exclusively for the preparation and storage of infant formulas which shall provide space areas for the reception and washing of equipment and for the preparation of formulas.

Sub-sterilizing area shall mean an independent clean area which provides space for a high speed instrument sterilizer.

Floor pantry shall mean a separate area containing a refrigerator, a cupboard, hot-plate and running water.

Qualified obstetrician and qualified pediatrician shall mean a physician who is Board certified or Board eligible. If a physician with these qualifications is not available, the hospital must either provide a qualified physician or submit an alternate plan to the Hospital Licensing Board for approval.

SECTION NINE

PSYCHIATRIC SERVICES

Sections

901 Medical Staff
902 Nursing Service
903 Additional Services and Personnel
904 Security Measures
905 Records and Treatment

901 MEDICAL STAFF

A. In-patient services in a mental hospital or a general hospital providing a psychiatric service shall be under the supervision of a clinical director or service chief who is qualified to provide the leadership necessary to establish an intensive treatment program.

1. The clinical director or service chief shall be certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry or shall meet the training and experience requirements for examination by these Boards (Board eligible).

2. The number of psychiatrists provided shall be commensurate with the size and scope of the treatment program and each psychiatrist shall be legally, professionally and ethically qualified for the position to which he is appointed.

B. Physicians and other appropriate professional personnel shall be available at all times to provide the necessary medical, surgical, diagnostic and treatment services. If such services are not provided within the institution, qualified consultants and attending physicians shall be immediately available or satisfactory arrangements shall be established for transferring patients to a general hospital.

902 NURSING SERVICE

A. Nursing service shall be under the direct supervision of a professional nurse qualified by education and experience for the position and currently registered in New Jersey.

B. The number of additional professional registered nurses, licensed practical nurses and other nursing personnel shall be adequate to formulate and carry out the nursing components of the individual treatment plan for each patient.

C. The registered professional nurse staffing pattern shall insure that a sufficient number are assigned to each tour of duty for direct patient care and for supervision of the care provided by auxiliary nursing personnel.

903 ADDITIONAL SERVICES AND PERSONNEL

A. Psychological services shall be provided and shall be under the supervision of a qualified psychologist with such additional staff as shall be required to carry out the assigned responsibilities.

B. Social work services shall be provided by an adequate number of qualified personnel to fulfill the responsibilities related to individual patient and family needs, development of community resources and consultation to other staff members and community agencies.

C. Qualified therapists, consultants, volunteers and aides shall be sufficient in number to provide a comprehensive therapeutic program, including at least occupational and recreational therapy.

904 SECURITY MEASURES

A. The psychiatric unit shall be provided with such security measures as are deemed necessary to reduce potential suicide hazards and to provide maximum protection for the patients and personnel.

B. Physical restraints shall be used only on a written specific order of the physician.

905 RECORDS AND TREATMENT

A. All medications and treatments prescribed for and administered to patients and the results shall be fully documented and authenticated by licensed medical and nursing personnel.

B. Prescribed treatments shall be carried out by personnel who have adequate training and instruction in the particular procedur

SECTION TEN

PHARMACEUTICAL SERVICES

Sections

1001 Pharmacy Department
1002 Nursing Units

1001 PHARMACY DEPARTMENT

A. The pharmaceutical service in a hospital shall be directed by a professionally competent and legally qualified pharmacist.

1. The pharmacist shall be responsible to the administration of the hospital for the development, supervision and coordination of all the activities of the pharmacy.

2. Additional competent and qualified personnel shall be provided in keeping with the size and scope of services.

3. If the hospital does not have an organized pharmacy department on the premises, pharmaceutical services shall be obtained from another hospital providing such services or from a community pharmacy.

a. The packaged drugs received from the pharmacy shall be stored in and distributed from the hospital drug storage area.

b. A consulting pharmacist shall be available to assist in formulating the procedures, rules and regulations for the acceptable distribution of drugs and shall visit the hospital on a weekly basis to review all aspects of the service provided and to insure that proper controls are maintained.

4. Adequate provisions shall be made for emergency pharmaceutical services.

B. Adequate space and facilities shall be provided in the pharmacy for the storage, preparation, safe-guarding and dispensing of drugs.

1. Hospitals with an organized pharmaceutical service should have the necessary equipment and physical facilities for compounding and dispensing drugs, including parenteral preparations.

2. Drugs shall be issued to floor units in accordance with approved policies and procedures.

3. Drug cabinets on the nursing units shall be routinely checked by the pharmacist, on a weekly basis, to insure that all drugs retained are properly labeled, stored and controlled.

C. Control of narcotics, toxic and dangerous drugs shall be in compliance with applicable Federal and State laws and regulations.

1. The stock supply of narcotics shall be stored in a safe meeting Underwriters Laboratories' requirements for an X-60, TR-60 or TX-60 rating. (A safe with any of these ratings, or of equivalent construction, is considered a "strong" safe.)

a. Any safe weighing less than 750 pounds shall be securely anchored in concrete to the floor or wall to prevent its being carried away.

b. Other dangerous or drug abuse items may be retained in this safe at the discretion of the pharmacist.

c. The stock supply of narcotics shall be accessible to the pharmacist only or the person registered with the Justice Department Bureau of Narcotics and Dangerous Drugs as responsible for the reporting of the narcotic inventory and signing narcotic order forms.

2. Policies shall be established to control the administration of toxic and dangerous drugs with specific reference to duration of the order and the dosage.

a. The classification of drugs ordinarily considered as toxic or dangerous include narcotics, sedatives, anticoagulants, antibiotics, oxytocics and cortisone products.

b. Complete physical inventories shall be continually maintained for all depressant and stimulant drugs (DACA).

D. Records of all transactions of the pharmacy (or drug room) shall be maintained and correlated with other hospital records where indicated.

1. A satisfactory system of records and bookkeeping shall be established for maintaining control over the requisitioning and dispensing of all drugs and pharmaceutical supplies.

2. A record of the stock on hand and the dispensing of all narcotic and drug abuse items shall be maintained in such a manner that the disposition of any particular drug can be readily traced.

3. Complete records of all prescription drugs dispensed to each patient (in-patient and out-patient) shall be maintained.

E. A therapeutics and pharmacy committee composed of physicians and pharmacists shall be established.

1. The committee shall assist in the formulation of professional policies regarding the selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in hospitals.

2. The committee shall develop and review periodically a formulary or drug list for use in the hospital.

3. The committee shall meet at least quarterly, maintain minutes and present written reports to the medical staff.

4. Current pharmaceutical reference materials and specific drug information shall be made available to the medical and nursing staff.

1002 NURSING UNITS

A. Medicine cabinets shall be well lighted, equipped with locks and of sufficient size to permit storage without crowding. Adequate space for preparation of medications shall be provided.

1. All medications shall be retained in a locked cabinet or medication room.

2. Biologicals and other thermolabile medications shall be stored in a medication refrigerator.

3. Out dated medications, unlabeled or illegibly labeled containers and other unused or discontinued drugs shall be returned to the pharmacy.

4. An adequate supply of emergency drugs shall be kept readily available.

5. Medication storage and preparation areas shall be kept locked when not in use.

6. The supply of needles and syringes used to administer medications to patients shall be retained in a locked area and their use and disposal shall be controlled.

B. Narcotics shall be stored under double lock and the key shall be kept on the person of the professional registered nurse in charge or her delegated representative who must be a registered nurse.

1. No other drugs or valuables shall be stored with the narcotics.

2. Appropriate records shall be kept of all narcotics received on each nursing unit and administered to patients. Accounting shall be on a diminishing return basis.

3. A check inventory of the narcotic drugs retained on each nursing unit shall be made at the termination of each tour of duty. This record shall be signed by both the out-going and the in-coming professional nurse.

4. Automatic or mechanical dispensing devices used by hospitals for routine dispensing and administration at the nurses' station or during the pharmacy off hours shall be acceptable providing that the same safeguards exist as are required for the manual control of all drugs.

C. Depressant and stimulant drugs shall be controlled under the applicable provisions of Public Law 89-74, the Federal Food Drug and Cosmetic Act; Drug Abuse Control Amendment of 196

1. Any drug which contains any quantity of a substance found to have a potential for abuse shall be handled in accordance with the requirements of the subject law.

2. All depressant and stimulant drugs shall be kept locked.

3. Appropriate records shall be maintained of all stimulant and depressant drugs retained on the nursing unit and administered from the stock supply. Accounting shall be kept on a diminishing return basis.

4. The key to the depressant and stimulant drug storage area on the nursing station shall be on the person of the professional nurse in charge or her delegated representative who must be a professional nurse.

5. A check inventory of stimulant and depressant drugs retained on each nursing unit shall be made at the termination of each tour of duty. This record shall be signed by both the out-going and the in-coming professional registered nurse.

SECTION ELEVEN

SPECIAL HOSPITAL

Sections

1101 General
1102 Definition
1103 Conditions
1104 Rehabilitation Commission

1101 GENERAL

A. These regulations shall be applicable to all groups, organizations or individuals seeking a license to operate a Special Hospital. The general hospital application form of the Department shall be utilized to secure basic information from all new applicants.

B. These standards and the application form shall not be retroactive and shall not apply to Special Hospitals now under full license and in operation.

C. The regulations shall not be construed to permit a general hospital of less than 100 beds to expand as a Special Hospital without meeting the minimum 100-bed requirement.

D. Plans and designs for Special Hospitals shall not be approved nor shall licenses be issued by the Department unless there is compliance with the following regulations and unless such plans and designs contemplate that, upon completion, all required services shall be provided as specified.

1102 DEFINITION

A. A Special Hospital is a medical institution which assures provision of comprehensive specialized diagnosis, care and treatment and rehabilitation where applicable on an in-patient basis for one or more specific categories of patients.

B. Categories of patients may be based on:

1. Diagnosis (e.g. eye, cerebral palsy, maternity)
2. Age (e.g. children, geriatrics)
3. Chronicity (e.g. rehabilitation)
4. Combination of above categories

1103 CONDITIONS

A. Special Hospitals shall conform to applicable administrative, professional, paramedical, ancillary and institutional service requirements set forth in State regulations for general hospitals.

B. Provision of beds and limitations of admissions shall not be restricted to any one region and shall be on a State-wide basis.

C. The physical plant of a Special Hospital shall meet the applicable requirements of Section Three of this manual.

D. A Special Hospital shall be under the medical direction of a Board-eligible or Board-certified physician in the particular specialty or one of the specialties for which the Hospital is licensed. He shall, on a day to day basis, be responsible for and shall be present as necessary to insure active medical direction and supervision of the hospital.

E. Each medical department shall be under the direction of a specialist. Such specialist shall be eligible for certification by an appropriate American Specialty Board.

F. Where two or more special categories of patients are hospitalized, the Special Hospital shall be departmentalized organizationally under the direction of corresponding medical department heads. There shall be a qualified consulting medical staff to assure comprehensive coverage of all medical needs of the patients.

G. Physician staffing shall be adequate to provide qualified physician-specialist supervision and care of all patients.

H. "By-Laws of the Medical Staff" approved by the Medical Society of New Jersey and the American Hospital Association or the American Osteopathic Association, and the organizational pattern provided in the manual of the Joint Commission on Accreditation of Hospitals may be used as a guide in the establishment of the Special Hospital organization. No Special Hospital shall be licensed when its standards are not considered to be equivalent to those required by national bodies for accreditation of hospitals.

I. The hospital shall have active utilization review procedures equivalent to those given in conditions of participation for hospitals under Title XVIII of the Social Security Amendments of 1965 or as amended.

J. Out-patient medical consultation services shall be provided on an appointment basis, in the specialties for which the hospital is licensed, and shall accept, when medically indicated, patients seeking such services regardless of their ability to pay.

K. Suitable and effective arrangements shall be made to provide x-ray, clinical laboratory and pathology services, (including autopsy services) and formal arrangements shall be maintained, either within or outside the Special Hospital, for provision of services in applicable specialties equivalent to those required for general hospitals.

L. Formal arrangements shall be provided for the immediate transfer of patients to a general hospital or other appropriate medical facility when required.

M. A Social Service Department shall be maintained which is adequate to assure expedient placement of patients in other facilities, to provide for the health, social and economic needs of the patient, or to effect their discharge when hospitalization is completed. There shall be a definite policy for referral of a patient who needs community service on his discharge from the hospital.

1104 REHABILITATION COMMISSION

Special Hospitals for rehabilitation, where primary emphasis is on physical restoration, social adjustment, vocational adjustment and sheltered employment, shall use the standards and the accreditation program of the Commission on Accreditation of Rehabilitation Facilities as criteria and shall obtain a recommendation from the New Jersey Rehabilitation Commission for classification as a rehabilitation facility.

SECTION TWELVE

PULMONARY DISEASE HOSPITALS

Sections

1201 General
1202 Definition
1203 Conditions

1201 GENERAL

A. The following regulations shall be applicable to all pulmonary disease hospitals and sanatoria.

B. Plans and designs for new construction and additions or alterations to pulmonary disease hospitals shall not be approved nor shall approval for operation be issued by the Department unless there is compliance with these regulations and unless such plans and designs contemplate that, upon completion, all required services shall be provided as specified.

1202 DEFINITION

A pulmonary disease hospital or sanatorium is a medical institution which assures the provision of comprehensive specialized diagnosis, care, treatment and rehabilitation where applicable on an in-patient basis for patients of all ages who are suspects of or definitely diagnosed as having tuberculosis or a related pulmonary condition.

1203 CONDITIONS

A. Pulmonary disease hospitals shall conform to applicable administrative, professional, paramedical, ancillary and institutional service requirements set forth in State regulations for the operation of general hospitals.

B. Provision of beds and limitation of admissions shall not necessarily be restricted to any one region and may be on a State-wide basis.

C. The physical plant shall meet insofar as possible the applicable requirements of Section Three of this manual.

D. A pulmonary disease hospital shall be under the medical direction of a qualified specialist in the field of tuberculosis and other pulmonary diseases. He shall, on a day to day basis, be responsible for and shall be present as necessary to insure active medical direction and supervision of the hospital.

E. Physician staffing shall be adequate to provide qualified physician-specialist supervision and care of all patients.

F. "By-Laws of the Medical Staff" approved by the Medical Society of New Jersey and the American Hospital Association, and the organizational pattern provided in the manual of the Joint Commission on Accreditation of Hospitals may be used as a guide in establishing the organization of the hospital. Pulmonary disease hospitals shall not be approved unless the standards established by the hospital are equivalent to those required by the Joint Commission on Accreditation of Hospitals.

G. In hospitals where patients without a positive diagnosis of tuberculosis are admitted and retained, these patients shall be appropriately isolated from known tuberculosis patients

H. The hospital shall have active utilization review procedures equivalent to those given in conditions for participatio for hospitals under Title XVIII of the Social Security Amendments of 1965 or as amended.

I. The hospital shall provide out-patient medical consultation and services on an appointment basis, in tuberculosis and other pulmonary diseases, and shall accept, when medically indicated, patients seeking such services regardless of their ability to pay.

J. The hospital shall have suitable and effective arrangements for provision of x-ray, clinical laboratory, and pathology services, (including autopsy services) and shall maintain formal arrangements, either within or outside of the hospital, for provision of services in applicable specialties equivalent to those required by State regulations for general hospitals.

K. Formal arrangements shall be provided for the immediate transfer of patients to a general hospital or other appropriate medical facility when required.

L. A Social Service Department shall be maintained which is adequate to assure expedient placement of patients in other facilities, to provide for the health, social and economic needs of the patient, or to effect their discharge when hospitalization is completed. There shall be a definite policy established for referral of a patient who needs community service to an appropriate agency on his discharge from the hospital.

SECTION THIRTEEN

LONG TERM CARE UNITS

Sections

1301 General
1302 Conditions
1303 Guidelines

1301 GENERAL

These regulations shall be applicable to all existing and new facilities licensed or approved as a hospital facility.

1302 CONDITIONS

A. A general hospital shall be permitted to operate a long term care unit as a patient department in the same manner as it operates medical, surgical, obstetrical, pediatric and other patient units.

B. A long term care unit of a hospital may be a free standing structure or a distinct and identifiable part of a hospital structure.

1. As a part of the hospital structure, the bed capacity of the long term care unit shall not exceed 50 percent of the total rated bed capacity of the hospital.

2. Prior to the transfer of acute care beds to long term care beds, approval of the Hospital Licensing Board shall be secured.

C. The general hospital section of the institution shall not be less than 100 beds.

D. If the long term care unit is certified for extended care, it shall meet the Conditions of Participation for Extended Care Facilities under the Social Security Amendments of 1965 or as amended.

1303 GUIDELINES

A. Long term care patients may be admitted directly to either the acute care or long term care units of the hospital, but under no circumstances shall acute or intensive care patients be admitted or maintained in the long term care unit.

B. Patients are to be transferred from the acute care section to the long term care unit at any time deemed feasible by the attending physician, with the criteria being the type of care needed by the patient. Patients who require less than 30 days care may be transferred and the average length of stay in a long term care unit need not be 30 days.

C. Patients who require acute or intensive care are not to be transferred to the long term care unit.

D. Patients who require sub-acute, progressive, convalescent, nursing, self, rehabilitation or long term care may occupy the long term care unit.

E. The hospital must maintain separate statistical reporting data so that no patient days in the acute or intensive care units will be identified as patient days in the long term care unit.

F. For purposes of the State Plan, long term care beds funded under the Hill-Burton program will continue to be carried as long term care beds.

SECTION FOURTEEN

MENTAL HOSPITALS

Sections

1401 General
1402 Definitions
1403 Conditions

1401 GENERAL

A. These regulations shall be applicable to all private and public institutional facilities other than those of the Department of Health which provide congregate maintenance and personal care of mentally ill persons. Such institutions sha be designated as mental hospitals.

B. Plans and designs for new construction and additions or alterations to such facilities shall not be approved nor shal approval for operation be issued by the Department unless the is compliance with these regulations and unless such plans and designs contemplate that, upon completion, all required services shall be provided as specified.

1402 DEFINITION

A mental hospital is a medical institution which provides congregate maintenance and personal care of mentally ill persons.

1403 CONDITIONS

A. Mental hospitals shall conform to applicable administrat professional, paramedical, ancillary and institutional servic requirements set forth in State regulations for the operation general hospitals.

B. Unless specified by law, provision of beds and limitatio of admissions shall not necessarily be restricted to any one region and may be on a State-wide basis.

C. The physical plant of a mental hospital shall meet insofar as possible the applicable requirements of Section Three of this manual.

D. A mental hospital shall be under the medical direction of a Board-eligible or Board-certified specialist in the field of psychiatry. He shall, on a day to day basis, be responsible for and shall be present as necessary to insure active medical direction and supervision of the facility.

E. Physician staffing shall be adequate to provide qualified physician-specialist supervision and care of all patients.

F. "By-laws of the medical staff" approved by the Medical Society of New Jersey and the American Hospital Association and the organization pattern provided in the manual of the Joint Commission on Accreditation of Hospitals may be used as guide in establishment of the staff organization. Mental hospitals shall not be approved unless the standards established by the facility are equivalent to those required by the Joint Commission on Accreditation of Hospitals.

G. The mental hospital shall have active utilization review procedures equivalent to those given in conditions of participation for hospitals under Title XVIII of the Social Security Amendments of 1965 or as amended.

H. When appropriate, mental hospitals shall provide out-patient professional consultation and services on an appointment basis, in psychiatric and related disorders; and shall accept, when medically indicated, patients seeking such services regardless of their ability to pay.

I. Mental hospitals shall have suitable and effective arrangements for provision of x-ray, clinical laboratory and pathology services, (including autopsy services) and shall maintain formal arrangements, either within or outside the facility, for provision of services in applicable specialties equivalent to those required by State regulations for general hospitals.

J. Suitable interior facilities and accessible outdoor space together with appropriately trained staff shall be provided for a well-rounded patient resocialization and activity program which may include such elements as occupational therapy, sports, remotivation meetings, dances, library projects, horticulture, social events and recreation.

K. Formal arrangements shall be provided for the immediate transfer of patients to a general hospital or other appropriate medical facility when required.

L. A Social Service Department shall be maintained to assure expedient placement and follow-up of patients in other facilities, adequate to provide for the health, social, and economic needs of the patient, or to effect their discharge when in-patient services are terminated. There shall be a definite policy established for referral of a patient who needs community service to an appropriate agency on his discharge from the institution.

CHP-D1
Aug. 71

New Jersey State
Department of Health
John Fitch Plaza, P. O. Box 1540
Trenton, New Jersey 08625

CHAPTERS 136 & 138, LAWS OF NEW JERSEY 1971
HEALTH CARE FACILITIES PLANNING ACT

(Chapter 136)
(NJSA 26:2H-1 et seq.)
(Chapter 138)
(NJSA 26:2H-8)

Approved May 10, 1971

An Act concerning the licensing and regulation of health care facilities, transferring certain powers and duties from the Department of Institutions and Agencies to the State Department of Health, and to amend "An act concerning hospital service corporations and regulating the establishment, maintenance and operation of hospital service plans, and supplementing Title 17 of the Revised Statutes by adding thereto a new chapter entitled 'Hospital Service Corporations,'" approved June 14, 1938 (P.L.1938, c. 366).

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, the State Department of Health, which has been designated as the sole agency in this State for comprehensive health planning under the "Comprehensive Health Planning and Public Health Services Amendments of 1966" (Federal Law 89-749), as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, serving principally as boarding, nursing or maternity homes or other homes for the sheltered care of adult persons or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

2. The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, out-patient clinic, dispensary, home health care agency, boarding home or other home for the sheltered care of adult persons and bioanalytical laboratory or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer.

b. "Health care service" means the preadmission, outpatient, in-patient and post-discharge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice or by practitioners of healing solely by prayer.

c. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, renovation, extension or modification of a health care facility, including its equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

d. "Board" means the Health Care Administration Board established pursuant to this act.

e. "Government agency" means a department, board, bureau, division office, agency, public benefit or other corporation, or any other unit, however described, of the State or political subdivision thereof.

f. "State Health Planning Council" means the existing State Health Planning Council formed under the provisions of Federal Law 89-749, as amended and supplemented.

g. "Comprehensive area-wide health planning agency" means an officially recognized health planning agency formed under the provisions of Federal Law 89-749, as amended and supplemented.

h. "Area planning council" means a voluntary, nonprofit organization composed of persons representative of hospitals, nursing homes, and consumers of medical care

services, formed for the purpose of planning the health facilities in a definite geographical area which is recognized by the commissioner through referral of applications for certificate of need as provided by this act.

i. "Department" means the State Department of Health.

j. "Commissioner" means the State Commissioner of Health.

3. The commissioner shall recognize the State Health Planning Council, the comprehensive area-wide health planning agencies and area planning councils as the recommending agencies in carrying out the purpose of this act. The State Health Planning Council shall act as the coordinating agency for the comprehensive area-wide health planning agencies and area planning councils in all matters, including but not limited to, comprehensive studies of requirements in various areas of the State for health care facilities.

4. There shall be in the State Department of Health, a Health Care Administration Board which shall consist of 13 members, 11 of whom shall be appointed by the Governor with the advice and consent of the Senate, and representative of medical and health care facilities and services, labor, industry and the public at large, and two of whom shall be ex-officio members. The State Commissioner of Health and the Commissioner of Insurance or their designated representatives, shall be ex-officio voting members of the board and shall serve on the board during their respective terms of office. Of the original members appointed to the board, four shall be appointed for terms of 3 years, four for terms of 2 years, and three for terms of 1 year. Following the expiration of the initial terms, members of the board shall be appointed for terms of 4 years. Any vacancy occurring in the membership of the board shall be filled in the same manner as the original appointment, but for the unexpired term only. The board shall meet at least quarterly and at such other times as its rules may prescribe or as in its judgment, may be necessary. The appointive members of the board shall serve without compensation but shall be reimbursed for necessary expenses incurred in the performance of their duties.

5. a. The commissioner, to effectuate the provisions and purposes of this act, shall have the power to inquire into health care services and the operation of health care facilities and to conduct periodic inspections of such facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and bylaws and the adequacy of financial resources and sources of future revenues.

b. The commissioner, with the approval of the board, shall adopt and amend rules and regulations in accordance with the Administrative Procedure Act P.L.1968,c.410 (C.52:14B-1 et seq.) to effectuate the provisions and purposes of this act, including but not limited to: (1) the establishment of requirements for a uniform State-wide system of reports and audit relating to the quality of health care provided, health care facility utilization and costs; (2) certification by the department of schedules of rates, payments, reimbursement, grants and other charges for health care services as provided in section 18; and (3) standards and procedures relating to the licensing of health care facilities and the institution of additional health care services.

c. The commissioner may enter into contracts with any government agency, institution of higher learning, voluntary nonprofit agency, or appropriate planning agency or council; and such entities are authorized to enter into contracts with the commissioner to effectuate the provisions and purposes of this act.

d. The commissioner may provide consultation and assistance to health care facilities in operational techniques, including but not limited to, planning, principles of management, and standards of health care services.

e. At the request of the commissioner, health care facilities shall furnish to the Department of Health such reports and information as it may require to effectuate the provisions and purposes of this act, excluding confidential communications from patients.

f. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this act or the determinations, rules, regulations and orders of the commissioner.

6. The commissioner shall designate an appropriate organizational unit in the State Department of Health to carry out the provisions and purposes of this act, which shall be under the supervision of a person who shall be appointed by and receive the compensation fixed by the commissioner, subject to appropriations made therefor.

7. No health care facility shall be constructed or expanded, and no new health care services shall be instituted after the effective date of this act except upon application for and receipt of a certificate of need as provided by this act. No agency of the State or of any county or municipal government shall approve any grant of funds for, or issue any license to, a health care facility which is constructed or expanded, or which institutes a new health care service, in violation of the provisions of this act.

8. No certificate of need shall be issued unless the action proposed in the application for such certificate is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care services. In making such determinations there shall be taken into consideration (a) the availability of facilities or services which may serve as alternatives or substitutes, (b) the need for special equipment and services in the area, (c) the possible economies and improvement in services to be anticipated from the operation of joint central services, (d) the adequacy of financial resources and sources of present and future revenues; (e) the availability of sufficient manpower in the several professional disciplines, and (f) such other factors as may be established by regulation. The commissioner shall cause appropriate surveys and studies to be made concerning the need for health care facilities and keep current records and statistics thereon by designated areas or regions of the State.

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In the case of an application by a health care facility established or operated by any recognized religious body or denomination the needs of the members of such religious body or denomination for care and treatment in accordance

with their religious or ethical convictions may be considered to be public need.

9. Certificates of need shall be issued by the commissioner in accordance with the provisions of this act and based upon criteria and standards therefor promulgated by the commissioner. The commissioner shall establish minimum needs for health care facilities in each area or region, and any applicant requesting a certificate of need who falls within such minimum needs, and who otherwise complies in all respects with this act and the criteria and standards established pursuant thereto shall be issued such certificate.

No such certificate shall be denied without the approval of the board and prior to the determination by the board, the applicant shall have been granted opportunity for hearing; and no decision shall be made contrary to the recommendations of the State Health Planning Council unless the council and the applicant shall have been granted opportunity for hearing. The department shall arrange within 60 days for fair hearings on all such cases and the commissioner or his designee shall furnish the board, the council and the applicant in writing his recommendations and reasons therefor. The board within 30 days shall make its determination.

10. Application for a certificate of need shall be made to the department, and shall be in such form and contain such information as the department may prescribe. The department shall charge a nonreturnable fee, not less than $20.00 and not more than $250.00 for the filing of an application for a certificate of need as it shall from time to time fix in rules or regulations. Upon receipt of an application, copies thereof shall be referred by the department to the appropriate planning agencies or councils for review.

These appropriate agencies and councils shall provide adequate mechanisms for full consideration of each application submitted to them and for developing recommendations thereon. Such recommendations, whether favorable or unfavorable, shall be forwarded to the commissioner within 60 days of the date of referral of the application. A copy of the recommendations made shall be forwarded to the applicant.

Recommendations concerning certificates of need shall be governed and based upon the principles and considerations set forth in section 8 hereof.

No member, officer or employee of any planning body shall be subject to civil action in any court as the result of any act done or failure to act, or of any statement made or opinion given, while discharging his duties under this act as such member, officer, or employee, provided he acted in good faith with reasonable care and upon proper cause.

11. A certificate of need shall be valid for 1 year from the date of issue, except that the commissioner may renew the certificate for further periods where the applicant has shown to the satisfaction of the commissioner by adequate proof that substantial progress towards completion of the project has been demonstrated.

12. a. No health care facility shall be operated unless it shall: (1) possess a valid license issued pursuant to this act, which license shall specify the kind or kinds of health care services the facility is authorized to provide; (2) establish and maintain a uniform system of cost accounting approved by the commissioner; (3) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner; and (4) prepare and review annually a long range plan for the provision of health care services, which plan shall be compatible with the State Health Plan established pursuant to the "Comprehensive Health Planning and Public Health Services Amendments of 1966" (Federal Law 89-749) as related to medical health services, health care services, and health manpower.

b. (1) Application for a license for a health care facility shall be made upon forms prescribed by the department. The department shall charge such nonrefundable fees, not less than $50.00 and not more than $250.00 for the filing of an application for a license and any renewal thereof, as it shall from time to time fix in rules or regulations. The application shall contain the name of the health care facility, the kind or kinds of health care service to be provided, the location and physical description of the institution, and such other information as the department may require. (2) A license shall be issued by the department upon its findings that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required by this act and rules and regulations thereunder.

c. A license issued before the effective date of this act to a health care facility for its operation, upon the first renewal date thereafter, may be extended for a 1 year period of time, provided the facility then meets the requirements for licensure at the time said license was issued and submits an acceptable plan to meet current requirements at the end of said period of time.

13. In addition to authority granted to the department by this act or any other law, the department after serving the licensee with specific charges in writing, may assess penalties and collect the same within the limitations imposed by this act, deny, place on probationary or provisional license, revoke or suspend any and all licenses granted under authority of this act to any person, firm, partnership, corporation or association violating or failing to comply with the provisions of this act, or the rules and regulations promulgated hereunder.

Notice of the assessment of penalties, revocation, suspension, the placing on probationary or provisional license or denial of a license together with a specification of charges shall be served on the applicant or licensee, personally or sent by certified mail to the address of record and the notice shall set forth the particular reasons for the assessment, denial, suspension, the placing on probationary or provisional license or revocation of the license. Such assessment, denial, suspension, the placing on probationary or provisional license, or revocation shall become effective 30 days after mailing, unless the applicant or licensee, within such 30-day period shall meet the requirements of the department or shall file with the department a written answer to the charges and give written notice to the department of its desire for a hearing in which case the assessment, denial, suspension, the placing on probationary

or provisional license, or revocation may be held in abeyance until the hearing has been concluded and a final decision rendered.

The department shall afford the licensee an opportunity for a prompt hearing on the question of the assessment of penalties, the issuance, suspension or the placing on a probationary or provisional license, or revocation of the license. The procedure governing such hearings shall be in accordance with the rules and regulations of the department. Either party may be represented by counsel of his own choosing, and shall have the right to subpoena witnesses and to compel their attendance on forms furnished by the department.

The commissioner shall arrange for prompt and fair hearings on all such cases, render written decisions stating conclusions and reasons therefor upon each matter so heard, and is empowered to enter orders of denial, suspension, placing on probationary or provisional license or revocation consistent with the circumstances in each case, and may assess penalties and collect the same within the limitations imposed by this act.

14. Any person, firm, partnership, corporation or association who shall operate or conduct a health care facility without first obtaining the license required by this act, or who shall operate such health care facility after revocation or suspension of license, shall be liable to a penalty of $50.00 for each day of operation in violation hereof for the first offense and for any subsequent offense shall be liable to a penalty of $100.00 for each day of operation in violation hereof. Any person, firm, partnership, corporation or association who shall be found guilty of violating any rule or regulation adopted in accordance with this act as the same pertains to the care of patients and neglects to rectify same within 7 days after receiving notice from the department of such violation or who neglects to commence, within 7 days, such repairs to his licensed establishment after receiving notice from the department that hazardous or unsafe condition exists in or upon the structure in which the licensed premises is maintained shall be subject to a penalty of not less than $10.00 or more than $100.00 for each day that he is in violation of such rule or regulation. If, within 1 year after such violation such person, firm, partnership, corporation or association is found guilty of the same violation such penalties as hereinbefore set forth shall be doubled, and if there be a third violation within such time, such penalties shall be tripled. In addition thereto the department may, in its discretion, suspend the license for such time as it may deem proper.

Any person, firm, partnership, corporation or association who shall, except in cases of an emergency, maintain more patients in his premises than he is licensed so to do, shall be subject to a penalty in an amount equal to the charge collected from such patient or patients plus $25.00 for each extra patient so maintained.

15. Whenever a boarding home for sheltered care, boarding house or rest home or facility or institution of like character, not licensed hereunder, by public or private advertising or by other means holds out to the public that it is equipped to provide postoperative or convalescent care for persons mentally ill or mentally retarded or who are suffering or recovering from illness or injury, or who are chronically ill, or whenever there is reason to believe that any such facility or institution, not licensed hereunder, is violating any of the provisions of this act, then, and in such case, the department shall be permitted reasonable inspection of such premises for the purpose of ascertaining whether there is any violation of the provisions hereof. If any such boarding home for sheltered care,boarding house, rest home or other facility or institution shall operate as a private mental hospital, convalescent home, private nursing home or private hospital in violation of the provisions of this act, then the same shall be liable to the penalties which are prescribed and capable of being assessed against health care facilities pursuant to this act.

Any person, firm, association, partnership or corporation, not licensed hereunder, but who holds out to the public by advertising or other means that the medical and nursing care contemplated by this act will be furnished to persons seeking admission as patients, shall cease and desist from such practice and shall be liable to a penalty of $100.00 for the first offense and $500.00 for each subsequent offense, such penalty to be recovered as provided for herein.

16. The penalties prescribed and authorized by this act shall be recovered in a summary civil proceeding, brought in the name of the State in the Superior Court, a County Court or a county district court pursuant to the Penalty Enforcement Law (N.J. S. 2A:58-1 et seq.).

The commissioner may, in his discretion and subject to rules and regulations, accept from any licensee an offer in compromise in such amount as may in his judgment be proper under the circumstances in lieu of any suspension of any license by the commissioner. Any sums of money so collected by the commissioner shall be paid forthwith into the State Treasury for the general purposes of the State. In no case shall the penalty be compromised for a sum less than $250.00 for the first offense and $500.00 for the second and each subsequent offense; provided, however, that any penalty of less than $250.00 or $500.00, as the case may be, may be compromised for a lesser sum.

The department may maintain an action in the name of the State to enjoin any person, firm, partnership, association or corporation from continuing to conduct, manage or operate a health care facility without a license, or after suspension or revocation of license, or in violation of rules and regulations promulgated hereunder.

17. All orders or determinations under this act shall be subject to review by a court of competent jurisdiction in accordance with the Rules of Court.

18. a. No government agency and no hospital service corporation organized under the laws of the State shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him.

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the

costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

19. All of the functions, powers and duties of the State Board of Control, the Commissioner of Institutions and Agencies and the Department of Institutions and Agencies and its Hospital Licensing Board related to administration of laws governing and concerning boarding homes for the sheltered, care of children and adult persons, private mental hospitals, convalescent homes, private nursing homes and private hospitals, and relating to the planning, construction and licensing of health care facilities as defined in this act and the power to receive, allocate, expend, and authorize the expenditure of Federal moneys available for health care facility construction and renovation are hereby transferred and assigned to, assumed by and devolved upon the State Department of Health. To effectuate such transfer there shall also be transferred such officers and employees as are necessary, all appropriations or reappropriations, to the extent of remaining unexpended or unencumbered balances thereof, whether allocated or unallocated and whether obligated or unobligated, and all necessary books, papers, records and property. All rules, regulations, acts, determinations and decisions in force at the time of such transfer and proceedings or other such matters undertaken or commenced by or before the Department of Institutions and Agencies or the Hospital Licensing Board pertaining to the planning, construction, licensing and operation of such health care facilities, and the administration of Federal moneys for health care facility construction, and renovation pending at the time of such transfer, shall continue in force and effect until duly modified, abrogated or completed by the Department of Health.

20. Employees of the present Bureau of Community Institutions in the Department of Institutions and Agencies responsible for administration of laws governing and concerning boarding homes for the sheltered care of adult persons, private mental hospitals, convalescent homes, private nursing homes and private hospitals are hereby transferred to the State Department of Health. Persons so transferred shall be assigned such duties as the State Commissioner of Health shall determine.

21. All functions, powers, duties, records, and property of the Department of Institutions and Agencies, and personnel of the Bureau of Medical Facilities Construction and Planning relating to receipt of money from the Federal Government for the purpose of making payments for construction of hospitals, including public health centers and related facilities within the State, and for an inventory and survey in connection therewith under or pursuant to any Federal law providing for the payment of such moneys as established and authorized by the provisions of c.83, P.L. 1947 (C.30:1-19 et seq.), are hereby transferred to the State Department of Health.

22. The Hospital Licensing Board created pursuant to P.L. 1947, c.340, s.7 (c.30:11-6) is hereby abolished. Upon the establishment of the Health Care Administration Board, all the functions, powers and duties of the Hospital Licensing Board, transferred to and vested in the Department of Health pursuant to section 19 of this act, shall be assumed by and devolved upon the Department of Health, to be exercised by the said Health Care Administration Board. Pending the appointment of members, establishment and convening of said Health Care Administration Board, all the functions, powers and duties thereof shall be exercised by the department.

23. With respect to the functions, powers and duties of the State Board of Control, the Commissioner of Institutions and Agencies and the Department of Institutions and Agencies, which are herein transferred and vested in the Department of Health, whenever in any law, rule, regulation, contract, document or otherwise, reference is made to the State Board of Control or the Department of Institutions and Agencies the same shall be deemed to mean and refer to the Department of Health, and reference to the Commissioner of Institutions and Agencies in connection therewith shall be deemed to mean and refer to the Commissioner of Health.

24. If any clause, sentence, paragraph, subsection or section of this act shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subsection or section thereof directly involved in the controversy in which this judgment shall have been rendered.

25. Section 1 of c.366, P.L. 1938 (C.17:48-1) is amended to read as follows:

1. A hospital service corporation is hereby declared to be any corporation organized, without capital stock and not for profit, for the purpose of establishing, maintaining and operating a non-profit hospital service plan. A hospital service plan is hereby defined as a plan whereby health care services are provided by a hospital service corporation or by a health care facility with which the corporation has a contract for such health care services to persons who become subscribers under contracts with the corporation. Health care services provided by a hospital service corporation shall include health care provided (a) through a health care facility which is maintained by a State or any of its political subdivisions; (b) through a health care facility licensed by the Department of Health; (c) through such other health care facilities as shall have been designated by the Department of Health for health care services; (d) through health care facilities located in other states, which are subject to the supervision of such other States provided that such last mentioned health care facilities, if they were located in this State, would be eligible to be licensed or designated by the Department of Health; (e) through non-profit hospital service plans of other States approved by the Commissioner of Insurance.

26. Section 7 of c.366, P.L. 1938 (C.17:48-7) is amended to read as follows:

7. Any hospital service corporation may enter into contracts with health care facilities for the rendering of health care services to any of its subscribers only with licensed health care facilities.

Rates of payment by such hospital service corporation pursuant to written contract with a hospital or institution for the services contracted thereunder may be in the form of a level per diem amount established for the particular hospital or institution for each day of health care services and prior to payment, shall be approved as to reasonableness by the Commissioner of Insurance following certification made pursuant to section 18 of the Health Care Facilities Planning Act (P.L. 1971,c - 136). The maximum rate of payment to eligible hospitals and institutions not under contract with such hospital service corporation shall not exceed the particular hospital's or institution's regular charges to the general public for the same services and shall be set forth in the certificate issued by such hospital service corporation to any subscriber. The basis and extent of payment, if any, by such hospital service corporation under agreement with nonprofit hospital service plans of other states shall be subject to the approval of the Commissioner of Insurance.

27. Nothing in this act shall be construed to deprive any person of any tenure rights or of any right or protection provided him by Title 11 of the Revised Statutes, Civil Service, or under any pension law or retirement system.

28. This act shall be known and may be cited as the "Health Care Facilities Planning Act."

29. This act shall take effect at the beginning of the eighth biweekly pay period following enactment except that all arrangements and actions necessary and appropriate to enable this act to become fully operative on such date shall be made as promptly as possible as though this act were effective and operative immediately.

APPENDIX B

RECOMMENDED CRITERIA FOR MIXED OBSTETRIC AND GYNECOLOGIC FLOORS

I. Qualifications for Participating Hospitals

Hospitals must request permission in writing from the New Jersey State Department of Health in order to conduct a mixed obstetric and gynecologic floor and must meet the following requirements:

1. The hospital must have a Department of Obstetrics and Gynecology or independent separate Obstetric and Gynecologic Departments of the medical staff.

2. Maintain a maternity log book (Maternity Service Record).

3. Maintain a log book of all gynecologic patients admitted to the maternity floor. (See Roman Numeral VI).

4. Establish a Committee which will have as members at least one of each of the following:

   a. Obstetrician and Gynecologist
   b. Pathologist
   c. Internist or General Practitioner
   d. Maternity Nurse
   e. Pediatrician
   f. Record Room Librarian
   g. Representative of administration and/or admission office

5. This Committee should meet at least quarterly and copies of the minutes should be available for the proper authorities to review. The agenda for these meetings should include the following:

   a. Review of the monthly summaries in the gynecologic log book and the maternity service record.

   b. Review of all gynecologic patients that were transferred from the maternity floor.

   c. Review of all cases of maternal morbidity and causes.

   d. Review of all cases of infant morbidity and causes.

   e. Review of problems involving administration of the program.

6. Accreditation by the Joint Commission for the Accreditation of Hospitals or the American Osteopathic Association and approval by the Hospital Licensing Board.

II. Selection of Gynecologic Patients and Rules Governing Their Stay on the Maternity Floor

1. Gynecologic patients are admissible to the non-segregated maternity floor only by members of the Medical Staff who have gynecologic surgical privileges.

2. Gynecologic patients must never be placed on the maternity floor to the point of excluding maternity patients. The margin of empty beds which will be required before a gynecologic patient can be admitted will vary with each hospital, depending on the local situation. In any case, gynecologic patients may not be admitted unless the minimum number of empty beds available for maternity patients exceeds the average number of deliveries for that hospital within a twenty-four hour period. If necessary, gynecologic patients must be transferred to another part of the hospital so that at no time will the division be so full that prompt acceptance of a patient from the delivery room area will be delayed.

3. Obstetrical patient shall mean any woman who is pregnant at any stage, parturient or recovering from parturition. Patients delivering a fetus weighing less than 500 Gms. must comply with all the gynecologic rules governing their stay on the maternity floor.

4. A check-sheet and questionnaire form will be attached to the chart of each patient admitted to the mixed obstetric and gynecologic floor (sample of suggested format attached). The contents of this form will be as follows:

   a. Admission Questionnaire - to include answers to all questions listed on the sample form, and to be completed at the time of admission of each gynecologic patient.

   b. Operating Room Questionnaire - to include answers to all questions listed on the sample form, and to be completed on each gynecologic patient undergoing surgery before return of the patient to the maternity floor.

c. Daily Check-Sheet - to include answers to all questions listed on the sample form, and to be completed on all patients admitted to the maternity service, exclusive of patients in the labor-delivery area. It is to be completed at approximately the same time every day, and information recorded will be for the preceding calendar day.

d. Transfer/Morbidity/Infection Questionnaire - to include answers to all questions listed on the sample form, and to be completed on all patients admitted to the maternity service, exclusive of patients in the labor-delivery area.

5. The selection of gynecologic patients to be admitted or to stay on the maternity floor will be under the control of the Chief of Obstetrics or his designee. The Chief of Obstetrics or his designee will screen all admissions and indicate his approval by signing the admission questionnaire. The selection will be governed by the following rules:

a. Type of Gynecologic Cases that May be admitted:

(1) All elective or emergency gynecologic cases considered to be free of infection or malignancy and provided the diagnosis does not appear in the list of Type of Gynecologic Cases that May Not be Admitted. Some so-called cases of infection or conditions thought to be the result of infection such as chronic cervitis, erosion of the cervix, polyp of the cervix and endometrial polyp may be admitted and are purposely omitted from the list of Cases that May Not be Admitted.

(2) Patients with ca-in-situ which has been proven by previous excision of the cervix (not just biopsy) regardless of the original classification of the Pap smear. (See 5.b. (3))

(3) Types of surgical procedures that may be performed are:

(a) Dilation and curettage of the uterus.

(b) Conization or biopsy of the cervix.

(c) Vaginal plastic repair and vaginal hysterectomy.

(d) Pelvic laparotomy for ectopic pregnancy, ovarian cysts, endometriosis, myomata and other benign conditions. This includes total abdominal hysterectomy.

(e) The practice of placing gynecologic patients on the mixed floor when both vaginal surgery and a hemorrhoidectomy are planned is discouraged. However, the excision of small hemorrhoidal tabs, etc. shall not disqualify a patient for admission. Therefore, the admission of these patients will be permitted provided the following conditions exist:

The hemorrhoid surgery planned is not extensive.

The homorrhoidectomy is being done at the same time as the gynecologic procedure.

The hemorrhoidectomy is being done by the gynecologist who is doing vaginal surgery, and who is a member of the Obstetric and Gynecologic Department.

Consultation by a proctologist or a surgeon who is not a member of the Gynecologic Department is not required at the time of surgery as the result of adding the hemorrhoidectomy to the total procedure.

If an unplanned hemorrhoidectomy is done at the time of vaginal surgery, transfer from the floor will not be required, provided the same four conditions are met.

b. Type of Gynecologic Cases that <u>May Not</u> be Admitted:

(1) Patients with an admission temperature (oral) of 100.4 degrees F. or higher.

(2) All cases of known or questionable infection such as:

(a) Acute diffuse inflammation of genital organs (vulvovaginitis, endometritis, salpingo-oophoritis).

(b) Chronic diffuse inflammation of genital organs. This would not include patients admitted for occluded tubes, pelvic adhesions, etc., thought to be due to an old, now inactive, pelvic inflammatory disease as proven by a laboratory test such as the sedimentation rate.

(c) Any abcess of genital organs.

(d) Cellulitis.

(e) Recto-vaginal fistula.

(f) Uterorectal fistula.

(g) Bartholin cyst.

(h) Venereal disease.

(i) Pyometra.

(j) Pyosalpinx.

(k) Septic abortion.

(3) Cases of known malignancy (Including Class IV and V Pap Smear). This does not include non-invasive intra-epithelial carcinoma of the cervix. (ca-in-situ). (See 5.a. (2))

(4) Breast surgery is not considered to be gynecologic.

(5) In all cases when the patient or household contacts have a history of Staphylococcal infection occurring within the month prior to admission or severe diarrheal disease during the week prior to admission, or history of any other evidence of infection or contagious diseases.

(6) If any <u>major</u> associated non-gynecologic surgery will be performed by a surgeon who is not a member of the Obstetric and Gynecologic Department, during the same admission. If the planned sequence of events is such that the non-gynecologic surgery will be done on a different date than the gynecologic surgery and will follow the gynecologic surgery, the patient may be admitted to the mixed obstetric and gynecologic floor but must be transferred upon the day of the non-gynecologic surgery.

c. Type of Gynecologic Cases that Must Be Transferred from the Maternity Floor:

(1) When unexpected pus, infection or malignancy is discovered at the time of surgery. This does not include non-invasive, intra-epithelial carcinoma of the cervix (ca-in-situ). It also does not include chronic "burned out" pelvic inflammatory disease when the only findings are pelvic adhesions or anomalies of the tubes thought to be the result of an old P.I.D.

(2) When patients require bowel surgery, with the exception of incidental appendectomy and certain hemorrhoidectomies as noted on Pages 3 and 4.

(3) When surgery includes insertion of radium.

(4) When patients require intraperitoneal drains.

(5) When morbidity is present, using the same standard adopted for maternity patients, except that it will be based on 100.4 degrees F. on any two successive days of the first ten postoperative days, exclusive of the first postoperative day. (See Roman Numeral IV, 1.)

(6) When breakdown in incision or other condition requiring frequent change in dressing has occurred.

(7) When other infections not related to the gynecologic condition are present.

(8) When diarrhea occurs.

(9) When ordered by the Chief of Obstetrics or his designee, who will make daily rounds to review the records of all gynecologic patients and determine which patients should be transferred from the maternity floor.

(10) When a temperature of 100.4 degrees F. or higher occurs pre-operatively.

(11) When antibiotics are used (See exceptions, Roman Numeral III, 6).

III. Rules Governing Hospital Care of Patients

1. Gynecologic and obstetric patients are not to be placed in the same room except that a gynecologic patient may be placed in the room with a mother who has delivered a stillborn infant.

2. Gynecologic patients may not visit rooms occupied by obstetric patients.

3. Hospitals having two maternity floors may place the gynecologic patients on either floor.

4. Nurses working on the non-segregated service may not be assigned to the labor room, delivery room or newborn nursery during the same tour of duty without the necessary scrub and gown change technique. In no case may a nurse from a department other than the maternity division be assigned to the non-segregated service during the same tour of duty.

5. Gynecologic patients placed on the maternity floor will be subject to the same visiting limitations that apply to the obstetric patients.

6. The surgery for the gynecologic patient must be performed in the operating room and not in the delivery room.

7. The use of antibiotics or chemotherapeutics shall not be permitted, with the following exceptions:

   a. Local application of antibiotics, including bladder irrigation, local preparation of the vagina, etc.

   b. Pre-operative sterilization of the bowel when it is known that negligible amounts of the drugs selected will be absorbed from the gastro-intestinal tract.

   c. Methamine Mandelate or Nitrofurantoin in the presence of, or following the use of an indwelling catheter.

   d. When a post-operative patient develops urinary tract infection which has been proven by urinalysis and is related to catheterization, the use of antibiotics or chemotherapeutics will be permitted. However, cultures must be obtained prior to the administration of the antibiotics.

   e. When the attending physician orders antibiotics for suspected urinary tract infection related to catheterization and the microscopic urinalysis indicates less than 10 WBC/HPF, the progress notes must indicate evidence for treatment. The Chief of the Department of Obstetrics and Gynecology or his designee must be contacted for approval to retain the patient on the unit.

IV. Definitions

1. Maternal Febrile Morbidity - Defined (as accepted by the American College of Obstetricians and Gynecologists and the American Association for Maternal and Child Health) as a temperature of 100.4 degrees F. or higher which occurs on any two successive days of the first ten postpartum days, exclusive of the first twenty-four hours following delivery, to be taken by mouth by a standard technique (as noted below under Specific Methods) at least four times daily. Temperatures of 100.4 degrees F. or higher on the first postpartum day will be counted if they occur more than twenty-four hours after delivery.

2. Reportable Infant Morbidity - Defined as any newborn which exhibits one or more of the following indices:

   a. Temperature of 100.4 degrees F. or higher at any time, to be taken by a standard technique as noted below under Specific Methods.

   b. All pustular skin lesions regardless of size.

   c. When diarrhea occurs.

V. Specific Methods

1. Temperature Recording - Readings will be taken four times daily on all obstetric and gynecologic patients. They will be oral and the thermometer will be left in the mouth at least three minutes. Infant temperatures will be taken either axillary or rectally twice a day (every twelve hours) and the thermometer left in place at least three minutes.

2. Cultures are to be done on newborn infants, obstetric and gynecologic patients as follows:

   a. On all incisions that break down, including episiotomy.

   b. On all suspected infections that are non-obstetric or non-gynecologic.

   c. Nasal and cervical (vaginal) cultures when morbidity by definition occurs in adult patients, or when a temperature of 100.4 degrees F. or higher occurs in pre-operative patients.

   d. All pustular skin lesions of infants regardless of size.

   e. Nasal and umbilical stump cultures on infants if temperature reaches 100.4 degrees F. or higher.

All organisms will be recorded on the hospital charts by their generic names. Further identification of coagulase positive Staphylococcus by phage typing will not be required.

VI. Reporting

The hospital may be asked to submit a report at any time. Any statistical information which might be requested should be readily available provided the following requirements have been met:

1. The hospital has complied with all of the rules and regulations and other provisions of the "Criteria for Mixed Obstetric and Gynecologic Floors."

2. The Maternity Log Book (Maternity Service Record) has been accurately maintained. The book which is already in use at New Jersey Hospitals includes columns for the following items:

   a. Hospital chart number
   b. Delivery
      (1) Date
      (2) Time
   c. Name of Patient
   d. Age
   e. Color
   f. Gravida
   g. Para
   h. Weeks of pregnancy
   i. Care
      (1) None
      (2) Clinic
      (3) Private
   j. Pregnancy
      (1) Single
      (2) Twins
      (3) Triplets
   k. Total length of labor to nearest hour
   l. Delivery
      (1) Spontaneous breech or vertex
      (2) Low forceps
      (3) Mid forceps
      (4) High forceps
      (5) Primary Cesarean Section
      (6) Repeat Cesarean Section
      (7) Cesarean Hysterectomy
      (8) Assisted Breech
      (9) Breech Extraction
      (10) Version and Extraction
      (11) Other, specify under other procedures

m. Other procedures

A. (1) Episiotomy
(2) Tubal Ligation
(3) Cervical Circlage (Shirodkar, etc.)
(4) Elective Induction
(5) Indicated Induction
(6) Stimulation of Labor
(7) Antepartum Oxytocics
(8) Amniotomy 1 hour A.P. or more

B. Post Partum
(1) Hysterectomy
(2) D & C
(3) Packing
(4) Artery Ligations

C. Anesthesia
(1) Inhalation
(2) Conductive (Caudal, Saddle, etc.)
(3) Local
(4) Paracervical
(5) No Anesthesia

n. Maternal Transfusion(s)
o. Name of Physician attending and/or Consultant
p. Blood Loss
q. Maternal Complications
(1) BOW ruptured over 24 hours
(2) Antepartum infections
(3) Post partum morbidity
(4) Morbidity after Cesarean Section
(5) Preeclampsia
(6) Eclampsia
(7) Other toxemia
(8) Placenta praevia
(9) Abruptio placenta
(10) Post partum hemorrhage
(11) Heart disease
(12) Diabetes
(13) Fetal distress
(14) Isoimmunization
(15) Arrested progress
(16) Fetopelvic disproportion
(17) Mal presentation
(18) Lacerations, all including cervix
(19) Ruptured uterus
(20) Maternal death
r. Weight of baby
s. Sex of baby

t. Live birth
   (1) Apgar 6 or less
   (2) Apgar 7 or more
   (3) Premature Apgar 6 or less
   (4) Premature Apgar 7 or more
u. Died in hospital
   (1) Apgar 6 or less
   (2) Apgar 7 or more
   (3) Premature Apgar 6 or less
   (4) Premature Apgar 7 or more
v. Admitted after birth and died in hospital
w. Fetal death
   (1) Term
   (2) Premature
x. New born complications
   (1) Malformations
   (2) Respiratory
   (3) Diarrhea
   (4) Eye Infection
   (5) Skin Infection
   (6) Erythroblastosis
   (7) Jaundice, all causes
   (8) Exchange transfusions
   (9) Cord less than 3 vessels
   (10) Other infant complications
y. Other maternal and newborn procedures
z. Other maternal and newborn complications

It is suggested that a page be saved in the log book at the end of each month for the purpose of recording a summary of the month. This would include a list of all complications. The hospital chart number of all cases with morbidity will be placed in this summary, making note of the cause of morbidity or the statement "cause unknown".

Infant morbidity as defined on Page C-6 shall be included in the log book under infant complications.

3. The log book of gynecologic patients admitted to the maternity floor has been accurately maintained and includes columns for the following items:

a. Patient's name
b. Hospital chart number
c. Age
d. Date of admission
e. Date of discharge
f. Date of surgery

g. Number of hospital days
h. Admission diagnosis
i. Gynecologic discharge diagnosis
j. Other non-gynecologic diagnosis (Medical complications)
k. Names of operations
l. Major or minor gynecologic surgery
m. Major or minor associated procedures (incidental appendectomy not included)
n. Morbidity
o. Cause of morbidity
p. Transferred or discharged in lieu of transfer (Use T or D)
q. Reason for transfer
r. Hospital day of transfer
s. Postoperative day of transfer
t. Surgeon

It is suggested that a page be saved in the log book at the end of each month for the purpose of recording a summary of the month. This would include the number of gynecologic patients admitted to the maternity floor, and the number of major and minor operations. The hospital chart numbers of all cases transferred from the maternity unit should be listed with the reasons for transfer. The hospital chart numbers of all cases with morbidity should be listed, making note of the causes of morbidity, if known, or the statement "cause unknown". This summary should also include the hospital chart numbers of all patients inadvertently permitted to stay on the maternity unit even though they did not meet the Criteria.

DAILY CHECK SHEET

To be completed on all OB-GYN patients

Date	DAY	Pre –OR Postoperative Ante –OR Postpartum: Temperature Elevation of 100.4°F. or Higher? Yes	No	Breakdown of Incision – With or Without Drainage? Yes	No	Diarrhea, Boils or Any Other Evidence of Infection or Contagious Diseases? Yes	No	SIGNATURE

TRANSFER/MORBIDITY/INFECTION QUESTIONNAIRE

Were cultures done? [ ] Yes [ ] No

If not done, why? _____

_____

Date of discharge or transfer _____

If transfered or discharged in lieu of transfer, state cause. _____

_____

ADMISSION QUESTIONNAIRE FOR GYNECOLOGIC PATIENTS

1. Temperature at time of admission _____°F.
2. Admission diagnosis _____

   _____

   Is it on the approved list? [ ] Yes [ ] No
3. Does the attending physician have gynecologic surgical privileges? [ ] Yes [ ] No
4. The number of empty beds on the maternity floor at the time of admission. _____
5. Has the patient or any household contacts had severe diarrhea during the week prior to admission?

   _____
6. Has the patient or any household contacts had boils, abscesses, sties or other Staphylococcal infections within the month prior to admission?

   _____
7. Has the patient or any household contacts had any other evidence of infection, contagious diseases, etc.?

   _____
8. Has the patient been hospitalized within the past two weeks? [ ] Yes [ ] No _____
9. Has the patient had any antibiotics in the past 14 days? [ ] Yes [ ] No _____

Approved by the Chief of Obstetrics (or Designee)

_____ M.D. _____

Signature Date

OPERATING ROOM QUESTIONNAIRE

(To be completed before patient's return to maternity floor.)

If any answer is "Yes," do not return patient to maternity floor.

1. Was pus or any other sign of infection noted?
   [ ] Yes [ ] No
2. Were intraperitoneal drains or radium inserted?
   [ ] Yes [ ] No
3. Exclusive of appendectomy and hemorrhoidectomy as defined in the criteria, was bowel surgery performed? [ ] Yes [ ] No
4. Was there any malignancy? [ ] Yes [ ] No
5. Will antibiotics be prescribed? [ ] Yes [ ] No

_____ _____

Signature Date

M6061

APPENDIX C

GUIDE FOR REGULATION ON PATIENT SMOKING

The guide for regulation on patient smoking is applicable to all hospital facilities licensed or approved by the Department.

A. As provided in the rules of the National Fire Code, smoki regulations shall be adopted and shall include the following minima provisions:

1. Smoking shall be prohibited in any room, ward, or compartment where inflammable liquids, combustible gases, or oxygen are used or stored and in any other hazardous location. Such areas shall be posted with NO SMOKING signs.

2. Smoking by patients classified as not responsible shall be prohibited.

3. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.

4. Metal containers with self-closing cover devices sha be provided in all areas where smoking is permitted. The most rigid discipline with regard to prohibition of smoking may not be n so effective in reducing incipient fires from surreptitious smoking as the open recognition of smoking. Proper education and training of the staff and attendants in the ordinary fire hazards and their abatement is unquestionably essential. The problem is a broad one, variable with different types of arrangements and buildi and the effectiveness of rules and procedures, necessarily flexible, depends in large part upon the management.

B. Since the removal of cigarette vending machines does not seemingly decrease smoking or the hazards due to smoking, these should have affixed to each a prominent sign emphasizing the danger of smoking in a medical facility. Sales in medical facilities shou be limited to vending machines or coffee shops, not carts.

C. Educational programs for personnel and patients employing pictures, pamphlets, and lectures should be instituted.

D. Physicians, nurses, and other personnel should be instruct not to smoke in the lobby, in the corridors, or in the presence of patients.

E. Smoking areas for physicians, employees, visitors, and ambulatory patients should be designated.

F. Smoking by patients in bed shall be permitted under regulations promulgated for the safety and welfare of the patient. In all cases, the bedside table should have an ashtray large enough to retain a smoldering cigarette however it may fall after it burns.

APPENDIX D

CRITERIA FOR A SATELLITE HOSPITAL FACILITY

FOREWORD

Intelligent regional health planning seeks to promote the orderly organization and growth of an efficient system for the delivery of quality health care. Implicit in such a system is accessibility to such care commensurate with need, as well as the avoidance of wasteful duplication of specialized medical services in order to insure maximum utilization of expensive physical facilities, services and skilled personnel.

It is apparent that to achieve these objectives, there must be greater coordination and cooperation among existing hospitals to encourage the creation of new facilities where adequate facilities do not now exis

Circumstances may arise in an area of reasonable inaccessibility to an existing hospital that necessitates the establishment of a new facility. State regulations relating to licensure of medical care facilities require that a new independent hospital be at least 100 beds in size. If the demonstrated need in the community will not support the range of services and disciplines required in a 100-bed hospital, then alternative arrangements must be provided. Under such circumstances, a hospital of sufficient size (200 beds or larger), providing basic specialty services normally provided in a 200-bed hospital, may sponsor a "satellite" facility. Such a Sponsoring Institution should be located within a reasonable time and distance from the "satellite" facility.

It is necessary to define the type of institution and to provide certain safeguards to insure that the patient in a "satellite" receives care comparable to that which would be provided at the sponsoring institution

A. SPONSORSHIP BY AN EXISTING HOSPITAL

1. A "satellite" is defined as an organized unit of an existing hospital (200 beds or larger) operated under the direction and control of one board of trustees, one medical staff, the same by-laws and license, and providing facilities and services in those geographical areas where it is either inconvenient or uneconomical for the community to provide the broad range of services normally found in an acute general hospital.

2. Title to the land and buildings may be held by a local group, but the facility must be leased or rented to the sponsoring institution.

3. It is important to look beyond the physical aspects to insure that patients who use these facilities are assured quality service.

B. In order to make the fullest use of available physical facilities and skilled personnel and to insure the widest distribution of quality health services, the following guidelines shall be applicable:

1. MEDICAL STAFF

a. There shall be but one medical staff for both facilities. The physicians serving the "satellite" shall be given staff appointments in accordance with the procedures and requirements of the sponsoring institution as described in its constitution, by-laws, rules and regulations.

b. The activities of the medical staff and medical services at both the sponsoring institution and the "satellite" shall be under the direction of the staff officers and department heads of the medical staff.

c. The professional medical services at both the sponsoring institution and the "satellite" shall function under the supervision of the Tissue, Audit, Utilization and Infection or other similar committees of the medical staff.

d. Generally, physicians shall enjoy the same privileges in both the sponsoring institution and the "satellite" for which they have been qualified in the context of their staff appointment.

e. It is suggested that a medical representative of the "satellite" serve on the Medical Executive Committee or Joint Conference Committee of the sponsoring institution.

2. PROFESSIONAL MEDICAL SERVICES

a. Professional medical services shall be the responsibility of the sponsoring institution and should be regulated by its constitution, by-laws, rules and regulations.

b. Professional medical services should include, but not be limited to, the following:

(1) Emergency room service: Staffed on a 24-hour basis, by licensed physicians or house staff supplemented by local physicians on an "on-call" basis as the need requires. The emergency room shall include adequate facilities and equipment for such emergencies as cardio-pulmonary resuscitation, etc.

(2) Hospitalization for urgent and emergency cases: If the required medical service is of a limited nature, hospitalization may be provided in the "satellite." If medical service requires comprehensive or specialized medical care, the patient may be transferr to the sponsoring institution or the specialty service brought to the "satellite."

(3) Specialized medical care should be available to the "satellite" at all times.

(4) Facilities for emergencies requiring limited surgical procedures, primarily those associated with accidental injuries, should be provided. If provided, such facilities shall be staffed with qualified personnel.

(5) Emergency delivery room service should be provided. As soon as possible after emergency delivery, the mother and newborn shall be transported to the sponsoring institution. If provided, such facilities shall be staffed with qualified personnel.

(6) Radiologic services as required to provide emergency care shall be staffed with qualified technical personnel.

(7) Clinical laboratory services as required to provide emergency care shall be staffed with qualified technical personnel. This should include electrocardiographic service.

3. COMMON SERVICES THAT MAY BE PROVIDED

a. In order to avoid wasteful duplication of specialized servi and to insure maximum utilization of expensive physical facilities and manpower, it is recommended that the following services, if provided, should be shared to the maximum extent feasible under the supervision and control of the sponsoring institution.

(1) Administrative and general services including, but not limited to, the following: management services, purchasing, personnel, data processing, laundry, food services and housekeeping.

(2) Professional and technical services including, but not limited to, the following: laboratories, radiology, cardio-pulmona resuscitation, inhalation therapy, pharmacy, and other services complementary to general, medical, surgical and pediatric care.

b. It is understood that the more sophisticated functions in each category will be provided at the sponsoring institution.

4. ARCHITECTURAL REQUIREMENTS

a. The building should be designed to provide adequate space to accommodate the contemplated services and must conform to all federal, State and local standards as they apply to general hospital construction.

b. Since, in all likelihood, a facility of this kind will require expansion, it is recommended that the facility be designed in such a manner as to provide for necessary future expansion without disruption of existing services.

5. STAFFING REQUIREMENTS

Staffing patterns must conform to licensing standards, rules and regulations as promulgated by the Department of Health.

APPENDIX E

CRITERIA FOR CONTRACTING HOSPITALS*

THE PLAN'S PRIMARY OBJECTIVE is to offer its subscribers a reasonably priced prepayment program in relation to cost for high standards of hospital services through facilities which are efficiently and ecomonically planned and operated. Hospital facilities and services can be provided at minimum cost only by cooperative efforts on the part of hospitals through planning, in order to avoid construction, maintenance and operation of excess facilities and duplication of adequate existing services. The justification for new or expanded facilities or services should be demonstrated by impartial studies. In furtherance of this objective, the Plan will seek the advice of existing regional planning organizations, the New Jersey Comprehensive Health Planning Agency, and appropriate governmental agencies.

The Plan will be guided by the following criteria in contracting with hospitals. However, the Plan reserves the right to determine in its own discretion those individual hospitals with which it may wish to contract for purchase of services for subscribers, and to exclude from its payments to hospitals costs associated with unnecessary facilities or services.

NEW HOSPITALS

1. The hospital should be planned and built in response to a clearly evident need for additional hospital beds in its service area. The Plan will seek the recommendation of existing regional planning organizations and the New Jersey Comprehensive Health Planning Agency concerning the justification for the new hospital in the area for which it has been planned. In making its determination whether or not it will enter into a contracting agreement, the Plan will give consideration to the recommendations of the planning agencies and will review the underlying factors upon which such recommendations are based. The Plan will also consider such other factors as it deems appropriate, including the bed need for the area as determined by the formula set forth in the "New Jersey State Plan For The Construction Of Hospitals And Related Medical Facilities" (State Hill-Burton Plan), the financial feasibility of the project, and the cost of capital indebtedness.

In no event will the Plan contract with a hospital when the proposed project exceeds the bed need for the area as determined under the State Hill-Burton Plan. Further, the Plan will not contract with a hospital when the proposed indebtedness exceeds 50% of the total capital cost of the project.

* Hospital Service Plan of New Jersey (Blue Cross), 500 Broad Street, Newark, 07101, January 1971

2. The hospital must either be licensed or in lieu thereof must have received a temporary permit to operate from the State of New Jersey.

3. The hospital, if operated under voluntary or proprietary auspices, shall assure the Plan that it has applied for listing with the American Hospital Association and that prompt steps have been or will be taken to apply for accreditation by the Joint Commission on Accreditation of Hospitals. If the hospital is operated under osteopathic auspices, then such hospital shall assure the Plan that similar steps will be taken to obtain accreditation or approval from the American Osteopathic Hospital Association. The Plan will evaluate the individual hospital's progress in obtaining accreditation periodically during the first Contract year and thereafter at the time of annual renewal of the Plan-Hospital Contracting Agreement.

4. The hospital must submit the Plan's prescribed form of application as to corporate structure, including the following financial information, upon application for a contract:

a. details of financing and construction
b. hospital's proposed operating budget; income and expense projections
c. sources and amounts of non-operating income available for operations
d. details of existing or proposed lease agreements

HOSPITALS PRESENTLY UNDER CONTRACT

1. Expansion of Facilities: The Plan will seek the recommendation of existing regional planning organizations and the New Jersey Comprehensive Health Planning Agency concerning the justification for the expansion of or addition to hospital facilities. In the absence of a favorable recommendation by the regional planning organization and the New Jersey Comprehensive Health Planning Agency, and in situations where the proposed increase in beds exceeds the bed need for the area as determined by the formula set forth in the "New Jersey State Plan For The Construction Of Hospitals And Related Medical Facilities" (State Hill-Burton Plan), the Plan will modify its payment to the hospital to eliminate participation in the capital and operating costs of such portions of the facility determined to be unnecessary. For example, the Plan will exclude from reimbursement, payment for depreciation of that part of the facility which is determined to be unnecessary and interest on capital debt related to such portions of the new facility. Furthermore, the per diem cost of a hospital having an abnormally low percentage of occupancy will be adjusted to eliminate the cost of unused facilities.

Added Services: The Plan will seek the recommendation of existing regional planning organizations and the New Jersey Comprehensive Health Planning Agency concerning the proposal for provision of additional hospital services in the area. In the absence of a favorable recommendation of the proposed additional services by the regional planning organization and the New Jersey Comprehensive Health Planning Agency, the Plan will not participate in any cost relating to such services determined to be unnecessary.

2. The hospital must be licensed by the State of New Jersey.

3. Contracting voluntary and proprietary hospitals should be accredited by the Joint Commission on the Accreditation of Hospitals and osteopathic hospitals should have similar accreditation or approval from the American Osteopathic Hospital Association. The Plan will review annually the accreditation status of hospitals to determine if the Plan-Hospital Contracting Agreement should be continued or terminated.

APPENDIX F

REFERENCE MATERIAL

Accreditation Requirements, American Osteopathic Association, 212 East Ohio Street, Chicago, Illinois, 60611.

By Laws of the Medical Staff, Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey.

Care of Children in Hospitals, American Academy of Pediatrics, Inc., 1801 Hinman Avenue, Evanston, Illinois.

Code for the Use of Flammable Anesthetics, NFPA No. 56, National Fire Protection Association, 60 Batterymarch Street, Boston, Massachusetts, 02110.

Control of Infectious Diseases in General Hospitals, Franklin H. Top, M.D., Editor, American Public Health Association, 1740 Broadway, New York, New York, 10019.

Hospital Care of Newborn Infants, American Academy of Pediatrics, Inc. 1801 Hinman Avenue, Evanston, Illinois.

Isolation Techniques for Use in Hospitals, U.S. Department of Health, Education and Welfare, Public Health Service, National Communicable Disease Center, Atlanta, Georgia, 30333.

Life Safety Code, NFPA No. 101, National Fire Protection Association, 60 Batterymarch Street, Boston, Massachusetts, 02110.

New Jersey Pharmacy Laws - Regulations and Excerpts of Narcotic Drug Laws, Department of Law and Public Safety, Board of Pharmacy, 1100 Raymond Boulevard, Newark, New Jersey.

Principles of Maternity and New Born Care, New Jersey State Department of Health, John Fitch Way Plaza, Box 1540, Trenton, New Jersey, 08625.

Recommended Dietary Allowances, 7th Edition, 1968 (or as amended), National Academy of Sciences, Printing and Publishing Office, 2101 Constitution Avenue,NW, Washington, D.C. 20418.

Regulations No. 1,2,3 and 4 - Hospitals and Nursing Homes, New Jersey State Board of Pharmacy, 1100 Raymond Boulevard, Newark, New Jersey.

Retail Food Establishment Code of New Jersey, 1965 (or as amended), New Jersey State Department of Health, John Fitch Way Plaza, Box 1540, Trenton, New Jersey, 08625.

Standards for Accreditation of Hospitals, Joint Commission on Accreditation of Hospitals, 645 North Michigan Avenue, Chicago, Illinois, 60611.

Standards for Hospitals and Clinics, American Psychiatric Association, 1700 18th Street, NW, Washington, D.C. 20009.

Standards for Formula Rooms and Formula Preparation, New Jersey State Department of Health, John Fitch Way Plaza, Box 1540 Trenton, New Jersey, 08625.

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