2. A Community Perinatal Center—Intermediate shall not provide total parenteral nutrition, except in cases where authorization has been received from the neonatologist on-call at the Regional Perinatal Center. Authorization from the neonatologist on-call at the Regional Perinatal Center shall be obtained on a daily basis and shall be documented in the medical record.

3. A Community Perinatal Center—Intermediate shall transfer all neonates requiring a higher level of services than permitted to be provided by the facility in accordance with its letter of agreement.

(d) A Community Perinatal Center—Intensive may provide care to neonates greater than 999 grams and 28 weeks gestation. A Community Perinatal Center—Intensive may provide care to infants born in the facility who are below the specified weight and age criteria only if the infant does not require a higher level of care than otherwise specified for Community Perinatal Center(s)—Intensive and if it has been documented in the medical record that the birth was expected to meet the weight and age criteria. A Community Perinatal Center—Intensive may provide long term ventilatory support and total parenteral nutrition.

(e) A Regional Perinatal Center may provide long term ventilatory support and total parenteral nutrition.

(f) Each bassinet and incubator in the nursery shall bear the identification of the newborn to whom it is assigned. This identification shall include at least the newborn's last name, sex, date, time of birth, feeding method, the mother's first and last names, and the physician's name.

(g) There shall be a system for the identification of each newborn immediately upon delivery and during the hospital stay, and for maintaining the security of the newborn.

(h) There shall be a system for verifying the identity of mothers and infants whenever an infant is removed from, or returned to, the nursery.

(i) The hospital shall assist Medicaid-eligible patients, including newborns, by expediting the verification and documentation of hospital-based services. For example, the hospital may issue a document of birth for infants prior to discharge (including hospital of birth, mother's name, mother's Social Security number, newborn name, date of birth, and sex) to enable infants to receive Medicaid services from county welfare offices that accept such documentation before an official birth certificate is issued.

Amended by R.1992, d.347, effective September 8, 1992.
See: 24 N.J.R. 2045(a), 24 N.J.R. 3165(a).
Amended by R.1993 d.286, effective June 7, 1993.
See: 25 N.J.R. 1117(a), 25 N.J.R. 2554(a).

8:43G–19.21 Newborn care space and environment

The newborn nursery shall be in a closed unit, physically segregated from other areas.

8:43G–19.22 Newborn care supplies and equipment

(a) Each room used as a nursery accessory room shall be equipped with at least three foot-controlled, covered, and labeled receptacles: one for the disposal of wet or soiled diapers, one for the disposal of trash, and one for the sanitary disposal of linens other than wet or soiled diapers. Disposable liners shall be used in the diaper and trash receptacles.

(b) Bassinets and equipment not in routine use shall be stored outside the nurseries or nursery accessory rooms.

(c) Individual supplies, linen, and equipment shall be provided for each infant.

(d) If newborns are weighed on a common scale, an impervious cover that completely covers the surface of the scale pan shall be used and changed after each newborn is weighed.

(e) Prepackaged formula shall be used within the time period designated on the package.

(f) Each incubator and bassinet shall be cleaned and disinfected after each time a newborn occupying it is discharged. The detergent and disinfectant used shall be registered by the U.S. Environmental Protection Agency.

(g) Provisions shall be made for the emergency repair and replacement of equipment in the newborn nursery.

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

8:43G–19.23 Scope of nurse midwifery standards

The standards in N.J.A.C. 8:43G–19.24 through 19.29 shall apply only to hospitals that have a separate, designated service or unit for nurse-midwifery. Hospitals which do not have a separate, designated service or unit for nurse-midwifery but grant obstetrical privileges to nurse-midwives are not required to follow N.J.A.C. 8:43G–19.26(a) and 19.27.

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

8:43G–19.24 Nurse-midwifery structural organization

Nurse-midwifery services shall be organized as part of the obstetric service. The physician director of obstetrics shall be responsible for assuring that nurse-midwifery services conform with applicable rules and hospital policies and procedures.

8:43G–19.25 Nurse-midwifery policies and procedures

(a) Nurse-midwifery services shall be based on written policies and procedures that are reviewed annually, revised as needed, and implemented. These policies and procedures shall include mechanisms by which medical staff in the

obstetric and newborn services consult with and assist nurse-midwives.

(b) The hospital shall delineate and fully review the privileges and credentials of each nurse-midwife periodically.

(c) There shall be standing orders for nurse-midwifery services.

8:43G–19.26 Nurse-midwifery staff qualifications

(a) There shall be a licensed nurse-midwife who serves as director of nurse-midwifery services, coordinates and is responsible for all nurse-midwifery services provided in the hospital, and monitors the quality of nurse-midwifery care.

(b) All nurse-midwives practicing in the hospital shall be registered professional nurses and currently licensed by the New Jersey Board of Medical Examiners.

8:43G–19.27 Nurse-midwifery staff education

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

8:43G–19.28 (Reserved)

8:43G–19.29 Nurse–midwifery quality assurance methods

The quality assurance program for nurse-midwifery services shall include physicians and nurse-midwives and shall monitor at least high-risk screening, transfers and return transfers, and mortality and morbidity by birth weight.

8:43G–19.30 Scope of obstetric/non-obstetric mix standards

The standards in N.J.A.C. 8:43G–19.31 through 19.33 shall apply to hospitals that place non-obstetric patients on obstetric patient care units. The obstetric/non-obstetric mix program is restricted to admission of female non-obstetric patients.

19:43G–19.31 Obstetric/non–obstetric mix structural organization

(a) If the hospital mixes obstetric and non-obstetric inpatients on the obstetric unit, there shall be an established obstetric/non-obstetric mix committee that meets at least once a year and includes at least:

1. The medical director of the obstetric service;
2. The nurse with administrative or clinical responsibility for nursing care on the obstetric service;
3. A medical records representative;
4. The operating suite supervisor or representative;
5. An admissions office representative;
6. The infection control practitioner; and
7. A representative of hospital administration.

(b) The medical director of the obstetric service shall sign and review monthly reports, that include the following:

1. Monthly summaries of the non-obstetric log book and the maternity log book;
2. Review of all non-obstetric patients who are transferred from the obstetric unit, with notes on the reason for transfer, and the results of cultures for those patients transferred for reasons for morbidity or infection;
3. Review of all cases of maternal morbidity and the causes, with notes on the results of cultures; and
4. Review of all cases of infant morbidity and the causes, with notes on the results of cultures.

8:43G–19.32 Obstetric/non–obstetric mix policies and procedures

(a) If the hospital mixes obstetric and non-obstetric inpatients on the obstetric and newborn unit, it shall have prior written permission from the Department of Health, Division of Health Facilities Evaluation.

(b) There shall be written policies and procedures for the obstetric/non-obstetric mix program that are reviewed annually by the obstetric/non-obstetric mix committee, revised as needed, and implemented. These policies shall include:

1. Criteria and procedures for admission;
2. Criteria for non-admission; and
3. Protocols for cultures of non-obstetric patients, including the type of cultures, when, and under what circumstances they are performed.

(c) A log book of non-obstetric patients admitted to the obstetric service shall be maintained. This log book shall include, in addition to patient's name, at least:

1. Patient's age;
2. Dates of hospital admission and discharge;
3. Admission and discharge diagnoses;
4. Date and type of surgery, if performed, including associated procedures, and name of surgeon;
5. Morbidity and cause, if applicable;
6. Destination, date, and reason for transfer to other units of the hospital; and
7. Medical record number.

(d) An admission check sheet and questionnaire, approved by the New Jersey Department of Health, shall be filled out upon admission to the hospital for every non-obstetric patient admitted to the obstetric service, and shall be included in the patient's medical record.