NEW JERSEY STATE LIBRARY
LNJ /KA8 H4/H8 1979
Manual of standards for hospital facilit
3 3009 00374 5595

MANUAL OF STANDARDS FOR HOSPITAL FACILITIES

OCTOBER 1979

NEW JERSEY STATE DEPARTMENT OF HEALTH

NJ/KA8
H4/H8
1979

DO NOT CIRCULATE

Copy 1

Amendment to the
Manual of Standards for Hospital Facilities
Section 1.0 Cardiac Diagnostic and Surgical Services
December 1979

Additions are underlined thus; deletions are in brackets [thus].

1.11.1 Cardiac Catheterization/Coronary Angiography Laboratory

A facility dedicated completely to Cardiac Catheterization/Coronary Angiographic Laboratories Suite shall comply with the State of New Jersey Uniform Construction Code, Chapter 23, Title 5, New Jersey Administrative Code and the [August 1, 1977] amendments to this code, Use Group I-2.

1.11.3 Cardiovascular Surgical Services

A facility dedicated completely to Cardiovascular Surgical Services shall comply with the State of New Jersey Uniform Construction Code, Chapter 23, Title 5, New Jersey Administrative Code and the [August 1, 1977] amendments to this code, Use Group I-2.

1.11.5 Cardiovascular Surgical Intensive Care Suite

The Construction Standards for this Unit shallbe the State of New Jersey Uniform Construction Code, Chapter 23, Title 5, New Jersey Administrative Code and the [August 1, 1977] amendments to this Code, Use Group I-2.

Note: (HRA) 74-4000 and (HRA) 7 [4] 9 - 14500 Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities can be purchased from:

Superintendent of Documents
U. S. Government Printing Office
Washington, D.C. 20402

Initial Adoption by HCAB 10/4/79
Final Adoption by HCAB 12/6/79
Effective 2/1/80

Amendment to the
Manual of Standards for Hospital Facilities
Section 1.0 Cardiac Diagnostic and Surgical Services
December 1979

Additions are underlined thus; deletions are in brackets [thus].

1.6.3.1 [Two] One physician[s], [one of whom] who shall be the physician-director [and one of whom shall be an associate to assist the director];

1.7.1 A regional cardiac surgical center shall provide, as a minimum, diagnostic services and cardiovascular surgical services, including open heart, closed heart, and coronary artery surgery as well as surgery of the great vessels. Diagnostic services shall meet the standards specified in 1.6.1 through 1.6.7.2[.] , with the exception of 1.6.3.1, and shall have two full-time physicians, one of whom shall be the physician-director, and one of whom shall be an associate to assist the director.

1.10.39.2 Associate Physician (regional cardiac surgical center) [(cardiac diagnostic facility)] shall mean a physician trained in cardiovascular catheterization, as defined and specified in the hospital's policy and procedure manual(s). (See 1.1.2.9)

Initial Adoption by HCAB 10/4/79
Final Adoption by HCAB 12/6/79
Effective 2/1/80

Amendment to the
Manual of Standards for Hospital Facilities
December 1979

Additions are underlined thus; deletions are in brackets [thus];

702.C.10b All telephone and verbal orders from a licensed physician shall be countersigned by the physician within 24 hours. All telephone and verbal orders shall be accepted only by a licensed professional nurse except for physical therapy orders which shall be accepted and recorded by a licensed professional nurse and/or a licensed physical therapist or respiratory therapy orders which shall be accepted and recorded by a licensed professional nurse and/or a respiratory therapist.

The following definition shall apply to Standard 702.C.10b:

"Respiratory Therapist" shall mean a person who is eligible for certification by the National Board for Respiratory Therapy.

Initial Adoption 10/14/79
Final Adoption 12/6/79
Effective 2/1/80

Amendment to the
Manual of Standards for Hospital Facilities
Criteria for Mixed Obstetrical and Gynecological
Floors (June 1976)

February 1980

Additions are underlined thus; deletions are in brackets [thus].

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

III.7.c — [Perioperative p] Prophylactic antibiotic[s in] treatment of patients otherwise free of infection who are undergoing surgery or in mid-trimester abortions. [They] Prophylactic antibiotics may not be administered more than six hours pre-operatively nor continued for more than [twelve] 72 hours following surgery.

Initial Adoption HCAB 12/6/79
Final Adoption HCAB 2/7/80
Effective 4/1/80

TABLE OF CONTENTS

PAGE

Source of Authority iv
Introduction vi

Section One

Definitions, Classifications and Licensing Policies

101 Hospitalization 1-1
102 Private Hospital 1-1
103 Licensee 1-1
104 Classification of Institutions 1-2
105 Inspection 1-3
106 Exceptions and Exemptions 1-3
107 License 1-4
108 Fees 1-5
109 Revocation or Suspension of License 1-5
110 Information Not To Be Disclosed 1-5
111 Planning a New Hospital 1-6
112 Civil Rights 1-12

Section Two

Administration

201 Non-Profit Hospitals 2-1
202 Proprietary or Profit Hospitals 2-2

Section Three

Physical Plant

301 Building 3-1
302 Fire Protection and Safety 3-1
303 Lighting and Ventilation 3-3
304 Heating 3-3
305 Maintenance and Sanitation 3-3

Section Four

Dietetic Services

401 Organization and Administration 4-1
402 Facilities 4-2
403 Service to the Patient 4-2

PAGE

Section Five

Personnel
501 Personnel Practices 5-1
502 Departmentalization 5-2
503 Nursing Service 5-2

Section Six

Medical Staff
601 Organization 6-1
602 Medical By-Laws 6-2
603 Staff Meetings 6-3
604 Medications and Treatments 6-4
605 Referral and Follow-Up of Patients 6-4
606 Medical Library 6-4

Section Seven

Medical Records
701 Medical Record Department 7-1
702 Patient Records 7-2
703 Hospital Records 7-4
704 Availability of Records 7-4

Section Eight

Maternal and Newborn Services
801 Applicability 8-1
802 Physical Standards 8-2
803 Operation Standards 8-4
804 Personnel Standards 8-8
805 Protection Against Hazards 8-9
806 Glossary of Terms 8-9

Section Nine

Psychiatric Services
901 Medical Staff 9-1
902 Nursing Services 9-1
903 Additional Services and Personnel 9-2
904 Security Measures 9-2
905 Records and Treatment 9-2

PAGE

Section Ten

Pharmaceutical Services
1001 Pharmacy Department 10-1
1002 Nursing Units 10-3

Section Eleven

Special Hospital
1101 General 11-1
1102 Definition 11-1
1103 Conditions 11-2
1104 Rehabilitation Commission 11-3

Section Twelve

Pulmonary Disease Hospitals
1201 General 12-1
1202 Definition 12-1
1203 Conditions 12-1

Section Thirteen

Long Term Care Units
1301 General 13-1
1302 Conditions 13-1
1303 Guidelines 13-1

Section Fourteen

Mental Hospitals
1401 General 14-1
1402 Definition 14-1
1403 Conditions 14-1

APPENDIX

Guide for Regulation on Patient Smoking C-1

PAGE

APPENDIX (cont'd)

Criteria for a Satellite Hospital Facility D-1

Criteria for Contracting Hospitals E-1

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

ADDENDA

1 - Criteria for Mixed Obsterical and Gynecological Floors, June 1976 — 1 - 11

2 - Revisions to Manual of Standards for Hospital Facilities (Administration of Drugs), February 1976 — 12 - 13

3 - Section Eight - Maternal and Newborn Services, March 1977 — 14

4 - Addition to All Licensure Standards for Health Care Facilities (Related to Ownership and Operation of Health Care Facilities), May 1977 — 15

5 - Addition to Section Eight: Nurse-Midwifery Services, Effective March 9, 1978 — 16 - 26

6 - Addition to Section Fifteen: Renal Dialysis Services, Effective March 9, 1978 — 27 - 58

7 - Amendment to Section Six - 604.A.1, Effective September 7, 1978 — 59

8 - Section One: Cardiac Diagnostic Facilities and Cardiac Surgical Centers Effective January 4, 1979 — 60 - 99

9 - Addition to Section Three: 306 - Pathological and Infectious Waste Disposal, Effective March 8, 1979 — 100 -101

10 - Amendment to Section Seven: 702.C-10b. Verbal Orders Accepted by Physical Therapist, Effective May 1, 1979 — 102

11 - Amendment to Section Seven: 702.D Authentication/Countersigning of Physician's Orders, Effective May 1, 1979 — 103

12 - Amendment to Section Seven: 704.C Availability of Records, Effective May 1, 1979 — 104

13 - Amendment to All Licensure Standards for Health Care Facilities (Regarding Sounding Device for Self-locking Doors), Effective July 5, 1979 — 105

14 - Amendment to Section One: 111.Q.7.b (Regarding Accident-Emergency Services), Effective December 1, 1979 — 106

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 or 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

Sections

101 Hospitalization
102 Private Hospital
103 Licensee
104 Classification of Institutions
105 Inspection
106 Exceptions and Exemptions
107 License
108 Fees
109 Revocation or Suspension of License
110 Information Not to be Disclosed
111 Planning a New Hospital
112 Civil Rights

101 HOSPITALIZATION

Hospitalization shall be defined as the reception and care of any person for a continuous 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

Sections

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, shall 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, including the appointment of a medical staff, the establishment of rules and regulations required for the proper care of patients and such other 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-job training and development programs. Records of these programs shall be maintained including the methods used and an evaluation of their effectiveness.

P. L. 1974, CHAPTER 109, approved September 30, 1974

1974 Senate No. 665 (Second Official Copy Reprint)

AN ACT to amend "An act to regulate and control the teaching and practice of nursing and to prescribe penalties for the violations thereof (revision of 1947)," approved June 11, 1947 (P.L. 1947, c. 262).

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

1 1. Section 1 of P. L. 1947, c. 262 (C. 45:11-23) is amended to
2 read as follows:

3 1. Definitions. As used in this act.

4 a. The words "the board" mean the New Jersey Board of Nursing
5 created by this act.

6 b. The (word "nursing" includes "professional nursing" and
7 "practical nursing." "Professional nursing" is the performance
8 for compensation of any professional service requiring the
9 application of principles of nursing based on biological, physical
10 and social sciences, including responsible supervision of a
11 patient requiring skill in observation of symptoms and reactions
12 and the accurate recording of the facts and carrying out of
13 treatments and medications prescribed by a licensed physician, and
14 the application of such nursing procedures as involve
15 understanding of cause and effect in order to safeguard life and
16 health of a patient and others) practice of nursing as a
17 registered professional nurse is defined as diagnosing and
18 treating human responses to actual or potential physical and
19 emotional health problems, through such services as casefinding,
20 health teaching, health counseling, and provision of care
21 supportive to or restorative of life and well-being, and
22 executing medical regimen as prescribed by a licensed or otherwise
23 legally authorized physician or dentist. Diagnosing in the context
24 of nursing practice means that identification of and discrimination

25 between physical and psychosocial signs and symptoms essential to
26 effective execution and management of the nursing regimen. Such
27 diagnostic privilege is distinct from a medical diagnosis.
28 Treating means selection and performance of those therapeutic
29 measures essential to the effective management and execution of the
30 nursing regimen. Human responses means those signs, symptoms, and
31 processes which denote the individual's health need or reaction to
32 an actual or potential health problem.

33 ("Practical nursing" is the performance for compensation of
34 such duties as are required in the care of a patient in carrying
35 out of medical orders prescribed by a licensed physician,
36 requiring an understanding of elementary nursing but not
37 requiring the professional service outlined in the definition of
38 professional nursing) The practice of nursing as a licensed
39 practical nurse is defined as performing tasks and responsibilities
40 within the framework of casefinding; reinforcing the patient and
41 family teaching program through health teaching, health counseling
42 and provision of supportive and restorative care, under the
43 direction of a registered nurse or licensed or otherwise legally
44 authorized physician or dentist.

45 The terms "nursing," "professional nursing," and "practical nursing"
46 as used in this act shall not be construed to include nursing by
47 students enrolled in a school of nursing accredited or approved by
48 the board performed in the prescribed course of study and training,
49 nor nursing performed in hospitals, institutions and agencies
50 approved by the board for this purpose by graduates of such schools
51 pending the results of the first licensing examination scheduled
52 by the board following completion of a course of study and training
53 and the attaining of age qualification for examination, or
54 thereafter with the approval of the board in the case of each
55 individual pending results of subsequent examinations; nor shall
56 any of said terms be construed to include nursing performed for a
57 period not exceeding 12 months unless the board shall approve a
58 longer period, in hospitals, institutions or agencies by a nurse
59 legally qualified under the laws of another state or country,
60 pending results of an application for licensing under this act, if
61 such nurse does not represent or hold himself or herself out as a
62 nurse licensed to practice under this act; nor shall any of said
63 terms be construed to include the practice of nursing in this
64 State by any legally qualified nurse of another state whose
65 engagement made outside of this State requires such nurse to
66 accompany and care for the patient while in this State during the
67 period of such engagement, not to exceed 6 months in this State,

68 if such nurse does not represent or hold himself or herself out as
69 a nurse licensed to practice in this State; nor shall any of said
70 terms be construed to include nursing performed by employees or
71 officers of the United States Government or any agency or service
72 thereof while in the discharge of his or her official duties; nor
73 shall any of said terms be construed to include services performed
74 by nurses aides, attendants, orderlies and ward helpers in hospitals,
75 institutions and agencies or by technicians, physiotherapists, or
76 medical secretaries, and such duties performed by said persons
77 aforementioned shall not be subject to rules or regulations which
78 the board may prescribe concerning nursing; nor shall any of said
79 terms be construed to include first aid nursing assistance, or
80 gratuitous care by friends or members of the family of a sick
81 or infirm person, or incidental care of the sick by a person
82 employed primarily as a domestic or housekeeper, notwithstanding
83 that the occasion for such employment may be sickness, if such
84 incidental care does not constitute professional nursing and
85 such person does not claim or purport to be a licensed nurse;
86 nor shall any of said terms be construed to include services
87 rendered in accordance with the practice of the religious tenets
88 of any well-recognized church or denomination which subscribes
89 to the art of healing by prayer. A person who is otherwise
90 qualified shall not be denied licensure as a professional nurse
91 or practical nurse by reason of the circumstances that such
92 person is in religious life and has taken a vow of poverty.

93 *Nothing in this act shall **(authorize nurses to practice
94 medicine and surgery except as provided in R. S. 45:9-21 (k). *)**
95 **confer the authority to a person licensed to practice nursing to
96 practice another health profession as currently defined in Title 45
97 of the Revised Statutes.**

1 2. This act shall take effect immediately.

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.

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 refri[illegible]rator, 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 assure 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 procedures.

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 1965.

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 participation 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 <u>not</u> 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 shall be designated as mental hospitals.

B. Plans and designs for new construction and additions or alterations to such facilities 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.

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 administrative, professional, paramedical, ancillary and institutional service requirements set forth in State regulations for the operation of general hospitals.

B. Unless specified by law, 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 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.

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, smoking regulations shall be adopted and shall include the following minimal 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 shall be provided in all areas where smoking is permitted. The most rigid discipline with regard to prohibition of smoking may not be nearly 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 buildings, 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 dangers of smoking in a medical facility. Sales in medical facilities should 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 instructed 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 exist.

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 transferred 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 services 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-pulmonary 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.

CRITERIA

FOR

MIXED OBSTETRICAL AND GYNECOLOGICAL FLOORS

BY

NEW JERSEY STATE DEPARTMENT OF HEALTH

JUNE 1976

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 obstetrical and gynecological floor and must meet the following requirements:

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

2. The hospital must maintain a maternity log book (Maternity Service Record).

3. The hospital must maintain a log book of all gynecological/female surgical patients admitted to the maternity floor (See Roman Numeral VI).

4. The hospital must 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. Representatives of administration and/or admissions office.

5. The Committee should meet at least once annually and at other times upon request of its chairman. A monthly report, however, shall be prepared and reviewed by the Chief of Obstetrics and signed. It would include the following:

   a. Review of the monthly summaries in the Gynecological/Female Surgical Log Book and the Maternity Service Record.

   b. Review of all gynecological/female surgical patients who were transferred from the maternity floor, making note of the reason for transfer and the organisms found in culture in those patients who were transferred for morbidity or infection.

   c. Review of all cases of maternal morbidity and causes, making note of the results of the culture.

   d. Review of all cases of infant morbidity and the causes, making note of the results of the cultures.

e. Review of problems involving administration of the program.

6. The hospital must be accredited by the Joint Commission for the Accreditation of Hospitals or the American Osteopathic Association and approved by the State Department of Health.

II. <u>Selection of the Gynecological and Approved Female Surgical Patients and Rules Governing Their Stay on the Maternity Floor</u>

1. Gynecological/female surgical patients are admissible to the non-segregated maternity floor only by members of the medical staff who have surgical privileges for the procedure planned.

2. Gynecological/female surgical patients must not be placed on the maternity floor to the exclusion of maternity patients. Gynecological/female surgical patients, except if pregnant, 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, gynecological/female surgical patients must be transferred to another part of the hospital so that at no time will the division be so full that a 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 gynecological 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 obstetrical and gynecological floor (sample of suggested format attached). The contents of this form will be as follows:

   a. <u>Admission Questionnaire</u> - to include answers to all questions listed on the sample form, and to be completed at the time of admission of each gynecological/female surgical patient.

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

c. Transfer/Morbidity/Infection Questionnaire - to include answers to all questions listed on the sample form, and to be completed on all gynecological/female surgical patients admitted to the maternity service.

5. The selection of gynecological/female surgical patients to be admitted or to stay on the maternity floor will be under the control of the Chief of Obstetrics or the physician designee. The Chief of Obstetrics or the physician designee will screen all admissions and indicate his/her approval by signing the admission questionnaire.

a. Types of gynecological/female surgical cases that may be admitted:

(1) All elective or emergency gynecological and selected approved female surgical cases considered to be free of infection, provided the diagnosis does not appear on the list of cases that may not be admitted. Some so-called cases of infection or conditions thought to be the result of infection such as chronic cervicitis, erosion of the cervix, polyp of the cervix and endometrial polyp may be admitted and are purposely omitted from this list.

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

(a) Dilitation and curettage of the uterus.

(b) Conization or biopsy of the cervix.

(c) Vaginal plastic repair and vaginal hysterectomy.

(d) Pelvic laparatomy for ectopic pregnancy, ovarian cysts, endometriosis, myomata and other benign conditions, including total abdominal hysterectomies.

(e) Breast biopsies.

(f) Those hospitals which are not always able to use all available empty beds because of an inadequate number

of gynecological patients who qualify for admission may admit selected female surgical patients. These cases would be limited to inguinal and femoral hernias, umbilical hernias, incisional hernias, varicose vein strippings and opthalmic surgery.

b. Types of gynecological/female surgical cases that <u>may not</u> be admitted:

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

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

(a) Acute diffuse inflammation of genital organs. (Vulvovagnitis, 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, not inactive, pelvic inflammatory disease as proven by a laboratory test such as the sedimentation rate.

(c) Any abscess of genital organs.

(d) Cellulitis.

(e) Rectovaginal fistula.

(f) Uterorectal fistula.

(g) Bartholin abscess.

(h) Venereal disease.

(i) Pyometra.

(j) Pyosalpinx.

(k) Septic abortion.

(3) Cases of known malignancy requiring extensive surgery or use of radium.

(4) All cases in which the patient or household contacts have a history of staphylococcal infection occurring within the month prior to admission, or history of any other evidence of infection or contagious diseases.

(5) Patients on whom a hemorrhoidectomy is planned as an additional procedure, with the exception of the excision of small hemorrhoidal tabs.

(6) Any major associated surgery not on the approved list will be performed during the same admission. If the planned sequence of events is such that the associated surgery will be done on a subsequent date from the approved surgery, and will follow the approved surgery, the patient may be admitted to the mixed obstetrical and gynecological floor, but must be transferred upon the day of the associated surgery.

(7) Patients who have received antibiotics or who have been admitted to a non-obstetrical hospital unit during the two week period prior to the current admission.

c. Types of gynecological/female surgical cases that must be transferred from the maternity floor:

(1) Patients having unexpected pus or infection, discovered at the time of surgery. This 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 pelvic inflammatory disease.

(2) Patients on whom a mastectomy is performed.

(3) Patient whose surgery includes insertion of radium.

(4) Patients who require bowel surgery with the exception of incidental appendectomies or the excision of small hemorrhoidal tabs.

(5) Patients who have had extensive surgery for malignancy.

(6) Patients who require intraperitoneal drains.

(7) Patients in whom morbidity is present, using the same standard adopted for maternity patients, except that it will be based on 100.4°F on any two successive days of the first ten postoperative days, exclusive of the first postoperative day. (See IV, 1.)

(8) Breakdowns in incision or other conditions requiring frequent change in dressing.

(9) Patients with infections not related to the gynecological or surgical condition.

(10) Cases of diarrhea.

(11) Cases so ordered by the Chief of Obstetrics or his/her designee who will make daily rounds to review the records of all gynecological/ female surgical patients and determine which patients should be transferred from the maternity floor.

(12) Cases of temperature of 100.4°F or higher occurring preoperatively, except when such elevation is directly related to the administration of a preoperative blood transfusion.

(13) Cases using antibiotics. (See exceptions, III, 7).

III. Rules Governing Hospital Care of Patients

1. Gynecological/female surgical and obstetrical patients are not to be placed in the same room except that a gynecological/female surgical patient may be placed in the room with a mother who has delivered a stillborn infant.

2. Gynecological/female surgical patients may not visit rooms occupied by obstetrical patients.

3. Hospitals having two maternity floors may place the gynecological/female surgical 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. 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. Gynecological/female surgical patients placed on the maternity floor will be subject to the same visiting limitation of the floor.

6. Surgery for gynecological/female surgical patients <u>not</u> involving pregnancy must be performed in the operating room <u>and not in the delivery room</u>.

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. Preoperative sterilization of the bowel when it is known that negligible amounts of the drug selected will be absorbed from the gastrointestinal tract.

   c. Periopertive prophylactic antibiotics in patients otherwise free of infection who are undergoing surgery or in mid-trimester abortions. They may not be administered more than six hours pre-operatively nor continued for more than twelve hours following surgery.

   d. Methenamine mandelate and its derivatives or nitrofurantin and its derivatives in the presence of or following the use of an an indwelling catheter.

   e. When a postoperative patient develops a urinary tract infection which has been proven by urinalysis and is related to catheterization, the use of antibiotics or chemotherapeutics will be permitted therapeutically. However, urine specimens for culture purposes must be obtained prior to the administration of the antibiotics. Although antibiotics are permitted under these circumstances, all patients who develop morbidity by temperature definition must be transferred from the maternity unit regardless of the cause or morbidity.

f. When the attending physician orders antibiotics for suspected urinary tract infection related to the 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/her designee must be contacted for approval to retain the patient on the unit.

8. The Chief of the Department of Obstetrics and Gynecology shall establish a protocol in writing as to when and how cultures shall be done on newborn infants, gynecological/female surgical and obstetrical patients.

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 temperature of 100.4°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. Temperature of 100.4°F or higher on the first postpartum day will be counted if it occurs more than twenty-four hours after delivery.

2. Reportable infant morbidity - Defined as a condition in any newborn who exhibits one or more of the following indices:

   a. Temperature of 100.4°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. Diarrhea.

V. Specific Methods

1. Temperature recording - Readings will be taken orally four times daily on all obstetrical, gynecological and female surgical patients and the thermometer will be left in the mouth at least three minutes. Infant temperatures, either axillary or rectal, will be taken twice a day (every twelve hours) and the thermometer left in place at least three minutes.

VI. <u>Reporting</u>

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

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

2. The Maternity Log Book (Maternity Service Record) has been accurately maintained. The data recorded in this log book shall be used for the purpose of preparing a monthly summary, including a list of

   all complications. The hospital chart numbers of all cases with morbidity will be placed in this summary, with a note of the cause of morbidity or the statement "cause unknown." The information shall also be a part of the final diagnosis on the patient's hospital record. It is also suggested that infant morbidity as defined in IV-2 be included in the log book under infant complications. If this is not feasible, the nursery shall keep a record of all infant morbidity.

3. The log book of gynecological/female surgical 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. Gynecological or surgical discharge diagnosis
   j. Other non-gynecological or non-surgical diagnosis (Medical complications)
   k. Names of operations
   l. Major or minor gynecological or approved female surgery
   m. Major or minor associated procedures (incidental appendectomy not included)
   n. Morbidity
   o. Cause of morbidity
   p. Transfer or discharge in lieu of transfer (Use T or D)

q. Reason for transfer
r. Hospital day of transfer
s. Postoperative day of transfer
t. Surgeon

The data recorded in this log book shall be used to prepare a monthly summary including the number of gynecological/female surgical patients admitted to the maternity floor, the number of patient days and the number of major or minor operations. The hospital chart numbers of all cases transferred from the maternity unit should be listed, noting 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 in the maternity unit even though they did not meet the criteria.

WJS:ah/996 etc.

ADMISSION

To be completed on all GYN/Female Surgical Patients

Temperature at time of admission	**CHECK-SHEET AND QUESTIONNAIRE**
Admission diagnosis	
Number of empty maternity beds at time of admission	

	YES	NO
Is diagnosis on approved list?	☐	☐
Does attending physician have gyn/surg privileges for proposed operation?	☐	☐
Has patient or any household contact had severe diarrhea during week prior to admission?	☐	☐
Has patient or any household contact had boils, abscesses, sties or other staphylococcal infections within month prior to admission?	☐	☐
Has patient or any household contact had any other evidence of infection, contagious diseases, etc?	☐	☐
Has patient been hospitalized within past two weeks?	☐	☐
Has patient had any antibiotics in past fourteen days?	☐	☐

Approved by Ch. of Obstetrics or his Physician Designee	Signature	Date

OPERATING ROOM

To be completed before patient returns to maternity floor. If any answer is yes, do not return patient to maternity floor.

	YES	NO
Was pus or any other sign of infection noted?	☐	☐
Were intraperitoneal drains or rodium inserted?	☐	☐
Exclusive of appendectomy and hemorrhoidectomy as defined in criteria, was bowel surgery performed?	☐	☐
Was mastectomy performed?	☐	☐

Signature	Date

TRANSFER/MORBIDITY/INFECTION

Was Culture done? ☐ Yes ☐ No

Did patient have morbidity? ☐ Yes ☐ No

Patient: Transferred or Discharged in lieu of transfer? ☐ Yes ☐ No

If yes, state reason ______________________________

Date of transfer or discharge?; ______________________________

Comments to be brought to the attention of the Committee

Signature	Date

P737

8:43B-10.2(b) All substances in Schedule II of the New Jersey Controlled Dangerous Substance Act (NJSA 24:21-1 et. seq.) shall be stored under double lock and the key shall be on the person of the professional nurse in charge or on the person of the charge nurse's delegated representative who shall meet the criteria as outlined in the Nurse Practice Act, NJSA 45:11-23 et. seq. (see *)

8:43B-10.2(b)3. A check inventory of all substances in Schedule II of the New Jersey Controlled Dangerous Substance Act (NJSA 24:21-1 et. seq.) retained on each nursing unit shall be made at the termination of each tour of duty. This record shall be signed by both the outgoing and incoming nurses who shall meet the criteria as outlined in the Nurse Practice Act, NJSA 45:11-23 et. seq. (see *)

8:43B-10.2(c)4. The key to the storage area of all substances in Schedule III and IV of the New Jersey Controlled Dangerous Substance Act (NJSA 24:21-1 et. seq.) at each nursing station shall be on the person of the professional nurse in charge or on the person of the charge nurse's delegated representative who shall meet the criteria as outlined in the Nurse Practice Act, NJSA 45:11-23 et. seq. (see *)

8:43B-10.2(c)5. A check inventory of all substances in Schedule III and IV of the New Jersey Controlled Dangerous Substance Act (NJSA 24:21-1 et. seq.) retained on each nursing unit shall be made at the termination of each tour of duty. This record shall be signed by both the outgoing and incoming nurses who shall meet the criteria as outlined in the Nurse Practice Act, NJSA 45:11-23 et. seq. (see *)

* Only the following nursing personnel are permitted to administer medications in the State of New Jersey under the direction of a licensed or otherwise legally authorized physician or dentist:

1. Licensed Registered Professional Nurses;

2. Licensed Practical Nurses having undergone formal training in State approved programs in the administration of medication;

3. Nurses with valid "permission to work" letters issued by the New Jersey Board of Nursing (NJAC 13:37-3.5; 13:37-4.6; 13:37-10.4; and 13:37-11.5). This would exclude the Foreign Exchange Visitor Nurses;

4. Graduate nurses from any domestically accredited nursing school pending the results of the first two consecutive licensing examinations immediately following the completion of their nursing program (NJAC 13:37-2.7 and 13:37-9.5);

5. Student nurses in an approved school of nursing under the direct supervision of a registered nurse.

Note - Direct supervision means within immediate sight.

February 1976

Revision to Manual of Standards
For Hospital Facilities

Section Eight
Maternal and Newborn Service

803 Operation Standards

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 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.

March 1977

Addition to All Licensure Standards for Health Care Facilities

No health care facility shall be owned or operated by a person convicted of a misdemeanor or a high misdemeanor relating adversely to his/her capability of owning or operating that facility unless that person is considered rehabilitated as stipulated in the Rehabilitated Convicted Offenders Act, N.J.S.A. 2A: 168A-1 et. seq.

May 1977

MANUAL OF STANDARDS

FOR

HOSPITAL FACILITIES

ADDITION TO SECTION EIGHT:

NURSE-MIDWIFERY SERVICES

Adopted February 2, 1978
Effective March 9, 1978

8.0 NURSE-MIDWIFERY SERVICES

8.1 GENERAL

8.1.1 This section shall apply to all hospitals providing nurse-midwifery services. Nurse-midwifery services, if provided, shall be included in the Department of Obstetrics and Gynecology.

8.1.2 The nurse-midwifery services shall be administered by the governing authority responsible for the management, control, and operation of the hospital. They shall be subject to the rules, regulations and periodic inspections applicable to the hospital, and shall be licensed as a part of the hospital. All regulations set forth in Sections One, Two, Three, Four, Five, Six, Seven, Eight and Ten of the hospital licensure manual shall apply to the nurse-midwifery service.

8.1.3 The hospital shall maintain the organization, management and operation of nurse-midwifery services in accordance with a written organizational plan which shall describe the responsibility, authority and accountability relationships of personnel, the functional structure of the service, and the relationship of the nurse-midwifery service to other staff and services in the hospital.

8.1.4 If the hospital employs more than one nurse-midwife, the governing authority shall appoint a director of nurse-midwifery services who shall be responsible for the direction, provision and quality of nurse-midwifery care.

8.1.5 A policy and procedure manual, supplementing the hospital policy and procedure manual, shall be approved by the governing authority. It shall be developed with the participation of the nurse-midwifery staff and in consultation with other staff including, but not limited to, nursing personnel, and shall serve as a guide for organization and operation of the nurse-midwifery service. It shall be reviewed, and the review signed and dated, at least annually and revised as necessary. The manual shall include:

8.1.5.1 A statement of the philosophy, goals and objectives of the nurse-midwifery service;

8.1.5.2 A description of the obstetrical team on which the nurse-midwife functions, including the team's organization, composition, structure, and allocation of responsibility and accountability down to the patient care level. This shall include the role of the nurse-midwife on the obstetrical team, and her/his relationship to its other members. The obstetrical team shall include, but not be limited to, an obstetrician/gynecologist,* a pediatrician, a nurse-midwife, a registered professional nurse, an anesthesiologist and/or a certified registered nurse anesthetist;

8.1.5.3 A delineation of the medical direction of the nurse-midwifery service, in accordance with regulations of the New Jersey State Board of Medical Examiners, and of the responsibilities of the obstetrician/gynecologist. These shall include, but not be limited to, the following:

8.1.5.3.1 Availability on an on-site or on-call basis, 24 hours a day;

8.1.5.3.2 Admission and discharge of patients to and from the hospital, according to rules and regulations approved by its governing authority;

8.1.5.3.3 Examination of the patient and a signed review of the nurse-midwifery management plan at least twice during her pregnancy, (during the first and last trimesters);

8.1.5.3.4 The completion of patient medical records, including countersigning of verbal or standing orders within 24 hours, as required by the rules and regulations of the hospital, and approved by its governing authority;

8.1.5.3.5 Provision of consultation and assistance to nurse-midwives; and

8.1.5.3.6 Provision of direct patient care;

*See definition of qualified obstetrician/gynecologist, 8.7.2. The definition applies throughout the standards for nurse midwifery.

8.1.5.4 Protocols defining the functions, techniques and procedures which nurse-midwives are and are not authorized to perform in the hospital;

8.1.5.5 Rules and regulations, incorporated into the medical by-laws, governing participation of nurse-midwives in the Department of Obstetrics and Gynecology, including, but not limited to, the following:

8.1.5.5.1 Provisions for the selection and appointment of nurse-midwives, including required qualifications;

8.1.5.5.2 Delineation of staff privileges for nurse-midwives, qualifications and procedures for their acceptance for staff privileges, conditions for retaining privileges, and process of revoking privileges. A list of nurse-midwives with staff privileges shall be kept on file in the Department of Obstetrics and Gynecology;

8.1.5.5.3 Requirements regarding nurse-midwife attendance at general, departmental, and nurse-midwifery service meetings, and the maintenance of minutes; and

8.1.5.5.4 Requirements for consultation when indicated;

8.1.5.6 Job descriptions for nurse-midwifery personnel, including qualifications, functions and responsibilities;

8.1.5.7 Criteria for acceptance and discharge of patients to and from nurse-midwifery care. The patient's record shall contain documentation that the patient has been informed that she will receive care from a nurse-midwife;

8.1.5.8 The nurse-midwife's responsibility for patient care during pregnancy, labor, delivery, postpartum, follow-up, and family planning;

8.1.5.9 Criteria for conditions which require the nurse-midwife's consultation with, or referral of the patient to, an obstetrician/gynecologist;

8.1.5.10 Procedures for assessment of the patient at least twice during her pregnancy by an obstetrician, (during the first and last trimesters), a registered professional nurse, a dietician, and if indicated, a social worker;

8.1.5.11 Provisions for anesthesia, including the responsibility and availability of the nurse-anesthetist (CRNA) and/or the anesthesiologist, in accordance with regulations of the New Jersey State Board of Medical Examiners;

8.1.5.12 Definitions of "on-call" for members of the obstetrical team, including the maximum allowable distance from, and travel time to, the hospital;

8.1.5.13 Standing orders for nurse-midwives for medications;

8.1.5.14 A description of the system for maintenance of patient records;

8.1.5.15 A description of the process of evaluation of patient care, including utilization and medical care review by medical, nursing and nurse-midwife members of the Department of Obstetrics and Gynecology;

8.1.5.16 Provisions for care of patients in medical and other emergencies. Medical care for emergencies shall be available 24 hours a day, 7 days a week. There shall be posted at the nursing station, a roster with the names of obstetricians/gynecologists and nurse-midwives to be called, when they are available for emergencies, and how they can be reached;

8.1.5.17 The role of nurse-midwives in patient and family counseling and education, including prenatal and postpartum care of mother and child, and family planning;

8.1.5.18 Methods used to encourage patient and family participation in planning for, and care during, pregnancy, childbirth, the postpartum period, and family planning;

8.1.5.19 Staff orientation and educational programs for nurse-midwives;

8.1.5.20 Statistics to be maintained, including, but not limited to, the number of deliveries performed by nurse midwives;

8.1.5.21 Policies and procedures for the maintenance of personnel records for each nurse-midwife employee, including pre-employment information, education and licensure requirements, staff education record, personnel evaluations, and job description;

8.1.5.22 Provisions to be made for continuity of patient care for mothers and infants, and for coordination of care with other services and personnel in the hospital;

8.1.5.23 Provisions for conferences of the nurse-midwifery service, including the intervals at which conferences shall be held;

8.1.5.24 Provisions for participation of nurse-midwives in interdepartmental meetings and in meetings of committees including, but not limited to, those concerned with patient care policies, evaluation, pharmaceuticals, discharge planning, and infection control; and

8.1.5.25 Policies and procedures governing nurse-midwives who are not hospital employees but who are employed by individual members of the medical staff and who use hospital facilities when providing care to patients. Such policies and procedures shall conform to the standards for hospital nurse-midwifery services.

8.1.6 The manual (8.1.5) shall be available in the Department of Obstetrics and Gynecology to all staff and to representatives of the Department of Health at all times.

8.1.7 The hospital shall establish and implement policies and procedures for nurse-midwifery personnel, including:

8.1.7.1 Staff pre-employment and annual physical examinations, as specified in Section Five of the hospital manual;

8.1.7.2 Documented orientation and education, as specified in the staff orientation and education plans. The nurse-midwifery service shall provide:

8.1.7.2.1 An orientation for each new employee, prior to or within one week of employment;

8.1.7.2.2 On-the-job training and in-service educational programs; and

8.1.7.2.3 Written records of these activities, including the names of persons attending, methods used, and an evaluation of their effectiveness.

8.1.8 The hospital shall provide orientation and education of staff of the Department of Obstetrics and Gynecology to the duties and responsibilities of the nurse-midwifery service.

8.2 Governing Authority

8.2.1 The governing authority of the hospital shall be responsible for:

8.2.1.1 Nurse-midwifery services provided, and the quality of care rendered to patients;

8.2.1.2 Provision of a safe physical plant equipped and staffed to maintain the facility and services;

8.2.1.3 Adoption and documented annual review of the policy and procedure manual;

8.2.1.4 The holding of meetings at intervals stated in the policy and procedure manual, and documentation of such meetings through minutes, including a record of attendance;

8.2.1.5 Establishment and implementation of a system whereby staff and patient grievances and/or recommendations can be identified within the nurse-midwifery service. This system shall include a "feed-back" mechanism through management to the governing authority, indicating that remedial action was taken; and

8.2.1.6 Establishment of a procedure by which nurse-midwifery personnel shall participate in hospital staff committees, including, but not limited to, those concerned with patient care policies, evaluation, pharmaceuticals, discharge planning, and infection control.

8.3 Continuity of Patient Care

8.3.1 A system of patient registration shall be established whereby a patient is ensured enrollment in a program of obstetrical care.

Registration will initiate a scheduling and alerting system to ensure that all necessary appointments and follow-up visits for preventive, diagnostic and therapeutic services take place. The dignity and personal privacy of the patient shall not be infringed upon by the registration system.

8.3.2 A system shall be established whereby the patient is cared for by the same nurse-midwife or a member of the same obstetrical team, whenever possible.

8.3.3 Printed or written instructions, including multilingual as indicated, shall be available to the patient, in addition to oral instruction provided by nurse-midwives and other members of the obstetrical staff.

8.3.4 Telephone consultation with a nurse-midwife shall be available to the nurse-midwife's patients.

8.3.5 Results of all consultations, including telephone consultation and referrals both within the hospital and with other health and health-related agencies, shall be included in the patient's medical record.

8.4 <u>Coordination of Patient Care</u>

8.4.1 The nurse-midwife shall develop and implement a nurse-midwifery management plan for each patient, with the patient's participation.

8.4.2 Additional personnel and services of the hospital available to the nurse-midwifery service shall include, but not be limited to, medical, surgical, laboratory, radiological, dietary and nutritional, social, psychiatric, and psychological personnel and services.

8.4.3 A system of referrals and linkages shall be established with all sources of ambulatory and inpatient care, to attempt to coordinate the care provided to each patient. Written agreements shall be established with facilities which provide secondary and tertiary care.

8.4.4 A method of transfer of patient information to and from the hospital and receiving facilities shall be implemented.

8.5 Medical Records

8.5.1 Each patient shall have a medical record, in accordance with Section Seven of the hospital licensure manual and with the following:

8.5.1.1 The medical record information shall be safeguarded against loss, destruction or unauthorized use; and

8.5.1.2 The hospital shall have written policies and procedures which govern the use and release of information contained in medical records.

8.6 Glossary of Terms

8.6.1 Anesthesiologist shall mean a physician who is licensed or authorized by the Board of Medical Examiners to practice medicine in the State of New Jersey, pursuant to N.J.S.A. 45:9-1 et seq., and who is Board-certified or Board-eligible in anesthesiology; or has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

8.6.2 Certified Registered Nurse Anesthetist (CRNA) shall mean a registered professional nurse who is licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-26 et seq.; has satisfactorily completed a prescribed course of 18 months in a recognized school of anesthesiology; and has passed an examination of, and is certified by, the American Association of Nurse Anesthetists.

8.6.3 Nurse-Midwife (CNM) shall mean a person who is licensed to practice nurse-midwifery by the New Jersey Board of Medical Examiners, pursuant to N.J.S.A. 45:10-1 et seq.

8.6.4 Nurse-Midwifery Management Plan shall mean a written plan developed and implemented by the nurse-midwife at the time of the patient's acceptance for nurse-midwifery services. It shall include an initial assessment of the patient, an evaluation of the patient's needs, short and long-term goals, and care and treatment to be provided for the duration of the pregnancy, including laboratory studies and provision for the patient's health, psychosocial and nutritional needs. The patient shall be assessed

at least twice during her pregnancy, as stated in the policy and procedure manual, by an obstetrician, (during the first and last trimesters), a registered professional nurse, a dietitian, and, if indicated, a social worker.

8.6.5 Secondary Care shall mean care delivered by referral to a specialist or subspecialist by the primary care source. This may include ambulatory or inpatient care.

8.6.6 Staff Education Plan shall mean a written plan, developed and revised at least annually and implemented throughout the year, which describes a coordinated program for staff education, including inservice programs and education, staff development, on-the-job training, and continuing education, and the intervals and times at which these shall be given. Each employee shall receive education to develop skills and increase knowledge so as to improve patient care. (Occasional attendance at programs or conventions, or speakers invited to the facility, do not solely constitute an acceptable staff education plan.)

8.6.7 Staff Orientation Plan shall mean a written plan for the orientation of each new employee to his/her duties and responsibilities, as well as to the personnel policies of the facility. Orientation for each new employee shall be provided prior to or within one week of employment.

8.6.8 Standing Medication Orders shall mean both stat orders for a specific dosage given one time only, and orders which give the parameters within which decisions may be made.

8.6.9 Tertiary Care shall mean specialized inpatient care, for example, care received in an intensive care nursery.

8.7 Addendum to Section 806 of Manual of Standards for Hospital Facilities

8.7.1 Nursing care hours shall mean all professional and auxiliary nursing service hours of care available, exclusive of nurse-midwife hours.

8.7.2 Qualified obstetrician/gynecologist shall mean a physician who is licensed or authorized by the Board of Medical Examiners to practice medicine in the State of New Jersey, pursuant to N.J.S.A. 45:9-1 et seq.; is Board-certified or Board-eligible in obstetrics and gynecology, as defined by the American College of Obstetricians and Gynecologists; or has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

MANUAL OF STANDARDS

FOR

HOSPITAL FACILITIES

SECTION FIFTEEN:

RENAL DIALYSIS SERVICES

Adopted February 2, 1978
Effective March 9, 1978

SECTION FIFTEEN

RENAL DIALYSIS SERVICES

15.1 General

15.1.1 This section shall apply to all hospitals providing dialysis. The dialysis service shall be administered by the governing authority responsible for the management, control, and operation of the hospital. It shall be subject to the rules, regulations and inspections applicable to the hospital, and licensed as part of the hospital. The dialysis services included are:

15.1.1.1 Acute hemodialysis;

15.1.1.2 Chronic hemodialysis, including home (self) care dialysis training;

15.1.1.3 Peritoneal dialysis; and

15.1.1.4 Pediatric dialysis.

15.1.2 A policy and procedure manual, supplementing the hospital policy and procedure manual, and approved by the governing authority, shall be developed and implemented by the administrator, the nursing supervisor and the physician-director as a guide for organization and operation of the dialysis service. It shall be reviewed, signed and dated annually. The manual shall include:

15.1.2.1 A written narrative of the dialysis program, describing the services provided, staffing patterns, space requirements, relationships with other departments, and other information relating to the fulfillment of the program's objectives;

15.1.2.2 Lines of authority, responsibility and accountability, organized and functioning so as to ensure an integrated continuum of services for the patient. An organizational chart shall be provided, delineating the lines of authority for the delegation of responsibility down to the patient care level;

15.1.2.3	A description of the organization, structure and allocation of responsibility and accountability;
15.1.2.4	Provision for medical care 24 hours a day, 7 days a week;
15.1.2.5	Criteria and priorities for acceptance of patients;
15.1.2.6	Criteria for discharge or transfer of patients;
15.1.2.7	A list of standing orders, if any;
15.1.2.8	Policies and procedures for a staff and patient surveillance program of infection control, including, but not limited to, the following:
15.1.2.8.1	The care and treatment of patients with infectious and communicable diseases;
15.1.2.8.2	Hepatitis detection, control, and prevention. This shall include screening of patients and staff, at specified intervals of time, for positive antigen factors;
15.1.2.8.2.1	Patients who are hepatitis B positive shall be scheduled on the same shift, when unit capacity permits such scheduling. The staff assigned to care for those positive patients during that shift shall not care for nonpositive patients;
15.1.2.8.2.2	Cleaning of all equipment with approved viricidal agents shall be performed after each dialysis treatment before the equipment is used for subsequent patients;
15.1.2.8.2.3	The dialysis service shall comply with the recommendations of the HEW Center for Disease Control, "Hepatitis Surveillance," Report No. 41, September 1977;
15.1.2.8.3	Infection control related to housekeeping, laundry, ventilation, cleaning and sterilization of equipment, collection of laboratory specimens, and disposal of waste and contaminants;
15.1.2.8.4	Policies and procedures for blood transfusions;
15.1.2.8.5	Methods of personal hygiene, care of clothing, and use of protective clothing;

15.1.2.8.6	Use of disposable and non-disposable equipment and supplies; and
15.1.2.8.7	Regulations for visitors and traffic control within the dialysis service;
15.1.2.9	Policies and procedures for food handling, to include, but not be limited to, the following:
15.1.2.9.1	Food shall not be prepared in the dialysis treatment area;
15.1.2.9.2	Patients shall be permitted to bring their own food, limited to sandwiches and snacks, provided that it is consumed only in the dialysis treatment area, and only by the patient. Waste shall be disposed of in accordance with the policies for infection control;
15.1.2.9.3	Staff members shall not eat or drink in the dialysis treatment area, and no one shall smoke in the treatment area;
15.1.2.9.4	All trays, diets and food served to patients in the dialysis service shall be served in completely disposable food service equipment or trays, and shall be handled as stipulated in Chapter 12 of the New Jersey State Sanitary Code;
15.1.2.10	A description of referral mechanisms and linkages with other inpatient and ambulatory care facilities in order to provide continuity of patient care;
15.1.2.11	A description of surveillance of home adaptation, if the hospital has responsibility for home-care dialysis patients, including provisions for, and frequency of, home visits;
15.1.2.12	Policies and procedures for counseling and education of the patient and his/her family, including:
15.1.2.12.1	Understanding of illness, disability and needed treatment;
15.1.2.12.2	Implementing dietary management to ensure optimum nutrition within the parameters of the diet prescription;
15.1.2.12.3	Adjusting to social, psychological and physical problems associated with ESRD symptoms and treatment;

15.1.2.12.4 Integrating the patient's needs and schedule into the daily life of the family; and

15.1.2.12.5 Coping with restrictions on activities;

15.1.2.13 Policies and procedures, including the care of patients, to be followed in case of medical emergencies, fire and other disaster, and equipment breakdown. Responsibility shall be assigned for preventive and corrective maintenance of equipment;

15.1.2.14 A description of the system for maintenance of patient records;

15.1.2.15 A description of the system for transfer, including emergency transfer of patients and patient information. Information shall be transferred within one working day of the patient's transfer;

15.1.2.16 A description of the process of evaluation of patient care and staff performance;

15.1.2.17 A plan for staff orientation and education for the dialysis service; and

15.1.2.18 Policies and procedures for the maintenance of personnel records for each employee, including policies and procedures for pre-employment information, educational and licensure requirements (if applicable), staff education record, personnel evaluations, and job description. Personnel records may be under the supervision of, and located in, the central personnel office.

15.1.3 The manual(s) shall be available to dialysis service personnel and to representatives of the Department at all times. The policies and procedures in 15.1.2-15.1.2.18 shall be kept in the dialysis service.

15.1.4 The hospital shall establish and implement policies and procedures for staff including:

15.1.4.1 A system of staff pre-employment physical examinations and subsequent health examinations, including testing for hepatitis, as stated in the policy and procedure manual;

15.1.4.2 Staff orientation and education for the dialysis service, as specified in the staff orientation and education plans. Records of these activities shall be maintained, including dates given, the names of persons attending, methods used, and an evaluation of the effectiveness of the activities;

15.1.4.3 Hours of work and employee benefits, such as vacation time, sick leave, and fringe benefits; and

15.1.4.4 Written staffing patterns for the dialysis service and weekly duty schedules.

15.1.5 The hospital shall ensure that:

15.1.5.1 When not in use for seven consecutive days or longer, dialysis equipment is tested for at least one hour prior to use to ensure working condition. Dates and types of equipment testing performed shall be documented in writing and signed;

15.1.5.2 When both acute and chronic dialysis patients are treated in the same area of the hospital, they are scheduled for treatment so that acute dialysis patients are treated separately, either in a separate place (divided at least by privacy curtains), or at a separate time, from chronic dialysis patients; and

15.1.5.3 A system is available for scheduling dialysis at hours convenient for patients, and to accommodate employed patients who wish to be dialyzed during non-working hours, whenever feasible.

15.1.6 The dialysis service shall provide to the Department annual, written documentation of utilization rates, which shall meet the following criteria:

15.1.6.1 If the dialysis service is located in a standard metropolitan statistical area with a population of 500,000 or more, and if 20% or more of the dialysis is performed on outpatients, at least six dialysis units shall perform an average of at least 4.5 dialysis treatments per unit per week;

15.1.6.2 If the dialysis service is not located in a standard metropolitan statistical area, or serves a population of 500,000 or less, and if 20% or more of the dialysis is performed on outpatients, at least three dialysis units shall perform an average of at least 4.0 dialysis treatments per unit per week; and

15.1.6.3 If the dialysis service performs 20% or less of the dialysis on outpatients, at least three dialysis units shall perform an average of at least 4.0 dialysis treatments per unit per week.

15.2 **Governing Authority**

15.2.1 The hospital shall have a governing authority which shall assume full legal responsibility for the determination and implementation of policy and for management, operation and financial viability of the hospital. The governing authority shall be responsible for, but not limited to, the following:

15.2.1.1 Dialysis services provided and the quality of care rendered to patients;

15.2.1.2 Ensuring that medical specialists in at least the fields of urology, psychiatry, cardiology, hematology, neurology, endocrinology and vascular surgery are available to all dialysis patients;

15.2.1.3 Establishment of a written agreement with a transplant program if chronic dialysis services are offered to patients;

15.2.1.4 Establishment of a written agreement for consultant services and for services not provided in the facility. The written agreement shall:

15.2.1.4.1 Be dated and signed by a representative of the facility and by the person or agency providing the service;

15.2.1.4.2 Include each party's responsibilities, functions, objectives, number of hours and days of the week the provider is in the facility, the financial arrangements and charges, and duration of the written agreement;

15.2.1.4.3 Specify that the facility retain administrative responsibility for the services rendered;

15.2.1.4.4 Require compliance with the standards in this document; and

15.2.1.4.5 Specify that each consultant shall provide written documentation of each visit made to the facility, to include, but not be limited to, services rendered, problems noted and recommendations made;

15.2.1.5 Establishment and implementation of a system whereby patient and staff grievances and/or recommendations can be identified within the dialysis service. This system shall include a feed-back mechanism through management to the governing authority, indicating what action was taken; and

15.2.1.6 Establishment of a procedure by which medical and nursing staff in the dialysis service are encouraged to participate in hospital staff committees, including, but not limited to, those relating to patient care policies, evaluation, pharmaceuticals, and infection control.

15.3 Emergency Medical Services

15.3.1 The hospital shall provide emergency medical services by a physician 24 hours a day, 7 days a week. To this end:

15.3.1.1 A roster with the names of physicians to be called, noting when they are available for emergencies and how they can be reached, shall be kept at each dialysis nursing station;

15.3.1.2 Written policies shall be developed and implemented regarding the care of patients during medical emergencies when the service is not in operation, while patients are receiving dialysis, and for patients who are on home (self) care dialysis;

15.3.1.3 Written policies shall be established regarding emergency equipment, including the medications and supplies to be kept in the dialysis service. Oxygen, suction, and cardio-pulmonary resuscitation equipment shall be kept in the dialysis service; and

15.3.1.4 A crash cart shall be kept in the dialysis service at all times, and shall be used for emergencies only.

15.4 Medical Records

15.4.1 Each patient, whether on acute, chronic, home (self) care, peritoneal or pediatric dialysis, shall have a medical record, in accordance with Section Seven of the hospital licensure manual. The medical record shall be available to dialysis personnel. When the patient is under dialysis treatment, the record shall be in the dialysis service. The medical record shall include, but not be limited to, the following:

15.4.1.1 A signed, dated admission and medical history;

15.4.1.2 A report of physical examination, including results of chest x-rays, medical findings, diagnoses and rehabilitation potential;

15.4.1.3 All initial and subsequent orders for services to be provided to the patient;

15.4.1.4 A medical care plan;

15.4.1.5 The nursing, social service and dietary care plans. The patient care plan shall be included at the time of discharge;

15.4.1.6 A social service assessment;

15.4.1.7 Clinical notes;

15.4.1.8 Progress notes;

15.4.1.9 A record of medications administered, including the name and strength of the drug, date of administration, dosage administered, route of administration, and signature of the licensed nurse administering the drug. (Initials may be used after the licensed nurse's full signature appears at least once on each page of the documentation);

15.4.1.10 A patient long-term program, (for maintenance, home (self) care, peritoneal, and pediatric dialysis patients);

15.4.1.11 Summaries of conferences and consultations;

15.4.1.12 Referrals to outside social service resources and documentation of follow-up;

15.4.1.13 Documentation of home visits for patients on home-care dialysis; and

15.4.1.14 Social service and dietary discharge summaries and discharge plans.

15.4.2 The social worker or social work designee may file information relating to the patient apart from the patient's medical record (e.g., in the social service department), with an entry in the record indicating the availability of the additional material upon the social worker's or designee's approval.

15.4.3 Medical record information shall be safeguarded against loss, destruction or unauthorized use.

15.4.4 The facility shall have written policies and procedures governing the use and release of information contained in medical records.

15.5 **Staffing Patterns**

15.5.1 The governing authority shall appoint an administrator for the dialysis service who shall be available full-time. An alternate shall be designated in writing to act in the absence of the administrator. The administrator shall be responsible for, but not limited to, the following:

15.5.1.1 Planning for and administration of the management, operational, fiscal and reporting components of the dialysis service;

15.5.1.2 Ensuring the development of, implementing and enforcing all policies and procedures for the dialysis service;

15.5.1.3 Ensuring the employment and placement of all staff in the dailysis service;

15.5.1.4 Ensuring the provision of staff education and orientation to dialysis personnel;

15.5.1.5 Ensuring that a file is maintained for each staff member, including his/her name, qualifications, current license number (if applicable), personnel evaluations, and records of physical examination and staff education;

15.5.1.6 Participating in policy and administrative decision-making;

15.5.1.7 Administering and supervising the non-clinical operations of the dialysis service;

15.5.1.8 Acting as a liaison between the governing authority and the physician-director, the dialysis personnel, and the patients;

15.5.1.9 At the time of a patient's discharge, ensuring that the patient care plan, including the discharge summary and the discharge plan, are provided in the medical record; and

15.5.1.10 Together with the physician-director, developing and implementing procedures for:

15.5.1.10.1 Maintaining administrative relationships, communication and integration with support services and community resources; and

15.5.1.10.1.2 Communicating with dialysis personnel and the governing authority through meetings, individual conferences, written memoranda and/or other methods of exchanging information.

15.5.2 The governing authority or its designee shall appoint a physician-director who shall be directly or indirectly accountable to the administrator, and who shall be responsible for the direction, provision and quality of medical care provided in the dialysis service. The physician-director shall be responsible for, but not limited to, the following:

15.5.2.1 Delineating the responsibilities of attending physicians to ensure that they provide care to patients;

15.5.2.2 Ensuring that a medical care plan is written at the time of the patient's acceptance for treatment, and is kept current;

15.5.2.3 Participating in the selection of a suitable treatment and dialysis setting for each patient;

15.5.2.4 Ensuring the development of, reviewing annually, and revising as necessary, a written long-term program for each patient, in conjunction with the patient, next of kin and/or sponsor or guardian, and staff including, but not limited to, the attending physician, the nursing supervisor or charge nurse, a dietitian and a social worker;

15.5.2.5 Participating in the development of patient care plans;

15.5.2.6 Establishing written policies for utilization of consultant and specialist services;

15.5.2.7 Ensuring that nurses and ancillary personnel are trained in dialysis techniques;

15.5.2.8 Ensuring that patients and the dialysis process are monitored;

15.5.2.9 Ensuring that copies of the patient long-term program and patient care plan are sent with the patient on interfacility transfer or within one working day;

15.5.2.10 Monitoring those aspects of the health status of dialysis personnel that pertain to patient health;

15.5.2.11 Assisting nursing service and/or the administration in the documented investigation of incidents and accidents that occur in the dialysis service, in order to identify and correct hazards to health and safety;

15.5.2.12 Assisting nursing service in providing documented information to the administrator in order to ensure a safe and sanitary environment for patients and personnel;

15.5.2.13 With the administrator and the medical team, assuming responsibilitiy for the execution of patient care policies;

15.5.2.14 Ensuring the development and direction of staff orientation and educational programs;

15.5.2.15 Ensuring the development and maintenance of a system of medical audit and evaluation of patient care;

15.5.2.16 Holding conferences of the dialysis service at intervals stated in the policy and procedure manual, and ensuring participation at meetings of hospital staff committees specified by the governing authority, when such meetings pertain to dialysis services;

15.5.2.17 Participating in meetings of heads of departments, when such meetings pertain to dialysis services; and

15.5.2.18 Entering, or ensuring that the patient's attending physician enters, in the patient's medical record:

15.5.2.18.1 A signed, dated admission and medical history, and a report of physical examination, including results of chest x-rays, medical findings, diagnoses and rehabilitation potential. These shall be provided by the attending physician within 48 hours before or after the patient's acceptance for dialysis treatment, unless such history and examination were done within five days prior to acceptance for treatment, and documented in the patient's medical record;

15.5.2.18.2 A medical care plan;

15.5.2.18.3 All initial and subsequent orders for services to the patient; and

15.5.2.18.4 A long-term program (for maintenance, home (self) care, peritoneal, and pediatric dialysis patients).

15.5.2.19 The physician-director shall be available to the dialysis service for a minimum of 50 percent of his/her usual work day. (Available in this instance shall mean able to arrive at the facility within 15 minutes of being called.)

15.5.2.20 The physician-director shall designate, in writing, an alternate physician to act in his/her absence.

15.5.3 A nursing supervisor shall be appointed for the dialysis service. He/she shall come under the jurisdiction of the dialysis service, or when applicable, of the hospital director of nursing services. He/she shall be responsible for the direction, provision and quality of dialysis nursing care, including, but not limited to, the following:

15.5.3.1 Developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the dailysis nursing service that delineates the functional structure and mechanisms for co-operative planning and decision-making within the overall hospital organizational plan;

15.5.3.2 Participating in planning and budgeting for the dialyis nursing service, including recommending the number and levels of nursing and ancillary personnel to be employed;

15.5.3.3 Coordinating and integrating the dialysis nursing service with other patient care services in the hospital;

15.5.3.4 Encouraging participation of dialysis nursing personnel in meetings of hospital staff committees, including, but not limited to, those relating to patient care policies, evaluation, pharmaceuticals, and infection control;

15.5.3.5 Implementing staffing patterns for nursing and ancillary personnel in the dialysis service;

15.5.3.6 Developing and maintaining written job descriptions for nursing and ancillary personnel in the dialysis service, and assigning duties based upon education and training;

15.5.3.7 Ensuring that licensed practical nurses and ancillary personnel are under the direction of a registered professional nurse or a licensed or otherwise legally authorized physician;

15.5.3.8 Ensuring that a registered professional nurse prepares an individual nursing care plan for each patient at the time of acceptance for dialysis treatment, assesses and reassesses the nursing needs of each patient at least daily for acute and every 90 days for chronic dailysis patients, or in accordance with an alternative schedule which he/she justifies and documents in the patient's medical record, and writes clinical and progress notes;

15.5.3.9 Ensuring that each patient has a written patient care plan, developed and maintained by the dialysis nursing personnel according to the physician's medical care plan, and implemented at the time of the patient's acceptance for treatment;

15.5.3.10 Ensuring that at the time of discharge or transfer from the dialysis service, a patient care plan and nursing care plan are provided in the patient's medical record;

15.5.3.11 Providing a daily statistical summary, including, but not limited to, the daily census and staffing patterns, and indicating classification and number of nursing, ancillary and relief personnel who worked in the dialysis service for each shift;

15.5.3.12 Assisting in employment interviews and in hiring and assigning nursing and ancillary personnel to the dialysis service;

15.5.3.13 Making rounds to observe patients and nursing care;

15.5.3.14 Reviewing and evaluating patient care plans and nursing care plans;

15.5.3.15 Participating in the development of the patient's long-term program;

15.5.3.16 Ensuring supervision and evaluation of nursing and ancillary staff performance;

15.5.3.17 Consulting with the charge nurses to determine the nursing care and staffing needed;

15.5.3.18 Assisting in the development of, and participating in, orientation of staff to the dialysis service, and documenting these activities;

15.5.3.19 Determining staff educational needs, and planning and organizing staff educational programs for the dialysis service; and

15.5.3.20 Ensuring that licensed nursing personnel enter in the patient's medical record:

15.5.3.20.1 The nursing care plan. This shall be reviewed at least daily for acute and every 90 days for chronic dialysis patients, or in accordance with an alternative schedule which the nurse justifies and documents in the medical record;

15.5.3.20.2 The patient care plan. This shall be reviewed jointly by a registered professional nurse and the patient's attending physician at least every 30 days for acute and every 90 days for chronic dialysis patients, or in accordance with an alternative schedule which the physician justifies and documents in the patient's medical record;

15.5.3.20.3 Clinical notes;

15.5.3.20.4 Progress notes, written at least daily for acute and every seven days for chronic dialysis patients;

15.5.3.20.5 Summaries of conferences with a physician or other personnel; and

15.5.3.20.6 A record of medications administered, including the name and strength of the drug, date of administration, dosage administered, route of administration, and signature of the licensed nurse administering the drug. (Initials may be used after the licensed nurse's full signature appears at least once on each page of the documentation.)

15.5.3.21 The nursing supervisor shall not be included in computation of the staff:patient ratio.

15.5.4 The nursing supervisor shall designate in writing a charge nurse for each shift during which the dialysis service operates. The charge nurse shall be responsible for, but not limited to, the following:

15.5.4.1 Supervising and evaluating all nursing and ancillary personnel and activities related to the dialysis nursing service;

15.5.4.2 Participating in development of the patient's long-term program;

15.5.4.3 Assigning duties and delegating responsibility to nursing and ancillary personnel for provision of nursing care;

15.5.4.4 Assisting in the organization and implementation of staff orientation and educational programs for nursing and ancillary personnel;

15.5.4.5 Assisting the nursing supervisor in developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the dialysis nursing service;

15.5.4.6 Assuming responsibility for direct patient care;

15.5.4.7 In a dialysis service of fewer than 20 units, providing direct patient care; and

15.5.4.8 Assuming responsibility for observations, evaluations, and reporting of patient's symptoms, reactions and progress to the physician.

15.5.5 In accordance with written job descriptions, nursing and ancillary personnel shall be responsible for, but not limited to, the following:

15.5.5.1 For each treatment, recording clinical notes which shall include at least the patient's weight, blood pressure, and additives to the patient's blood during the dialysis process, such as blood, intravenous fluids, and medications;

15.5.5.2 Administering medications and/or treatments to patients upon written order of a physician, in accordance with the State of New Jersey Nursing Practice Act;

15.5.5.3 Assessing the needs of each patient and developing, reviewing, revising and implementing patient care plans and nursing care plans for meeting those needs;

15.5.5.4 Assessing, observing and monitoring the patient's response to dialysis and nursing care;

15.5.5.5 Coordinating nursing care with other patient care services; and

15.5.5.6 Teaching, supervising and consulting with other personnel, the patient and family members regarding methods of meeting the nursing care needs and other problems of the patient.

15.5.6 A minimum of one registered professional nurse trained in dialysis shall be available 24 hours per day to provide back-up dialysis care.

15.5.7 A social worker, or a designee who receives consultation from a social worker, shall be responsible for the direction, provision, and quality of the social services provided to dialysis patients. He/she shall be responsible for, but not limited to, the following:

15.5.7.1 Implementing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for social work services to dialysis patients, developed by the hospital social service department. These shall include policies and procedures for the use and coordination of social services available through hospitals, community health programs, and community social agencies;

15.5.7.2 Providing consultation to the person designated by the governing authority, in planning and budgeting for social work services provided to dialysis patients;

15.5.7.3 Coordinating and integrating social work services with other patient care services;

15.5.7.4 Providing ongoing individual and/or group counseling of patients and their families, sponsors, or guardians, and writing clinical and progress notes;

15.5.7.5 Assessing the patient at the time of his/her acceptance for treatment, and if the assessment so indicates, preparing an individual social service care plan, and reassessing the patient's response to social services at least every 90 days for chronic dialysis patients, or in accordance with an alternative schedule which the social worker or designee justifies and documents in the medical record. Assessment and preparation of a social service care plan for an acute patient shall be upon the attending physician's request;

15.5.7.6 Obtaining social services as specified in the social service care plan;

15.5.7.7 Contacting social and other agencies for information, referrals, and services;

15.5.7.8 Providing social work consultation to other dialysis personnel;

15.5.7.9 Participating in developing, reviewing and revising patient care plans and long-term programs; and

15.5.7.10 Entering in the patient's medical record:

15.5.7.10.1 A social service assessment (social service summary), completed at the time of the patient's acceptance for treatment, after an initial interview with the patient and his/her family, sponsor or guardian. This shall include a social history, including family background, education, employment, interests, activities, organizational memberships, psychosocial functioning, relationships with family and friends, and reactions to dialysis;

15.5.7.10.2 The social service care plan, if the initial or subsequent assessment indicates a need for social services, which shall be reviewed at least every 90 days for chronic patients, or in accordance with an alternative schedule which he/she justifies and documents in the medical record. Development of a social service care plan for an acute patient shall be upon the attending physician's request;

15.5.7.10.3 Clinical notes of counseling provided;

15.5.7.10.4 Progress notes if the patient is receiving social services. These shall be written at least every 30 days for acute and every 90 days for chronic dialysis patients, or in accordance with an alternative schedule which he/she justifies and documents in the patient's medical record;

15.5.7.10.5 All referrals to outside resources and documentation of follow-up;

15.5.7.10.6 Summaries of conferences with a physician or other personnel; and

15.5.7.10.7 The social service discharge summary and discharge plan.

15.5.8 A dietitian shall be responsible for the provision, direction, and quality of dietary care provided to dialysis patients. He/she shall be responsible for, but not limited to, the following:

15.5.8.1 Implementing written objectives, standards of practice , policies, a procedure manual, and an organizational plan for the dialysis dietary service, developed by the hospital dietary department;

15.5.8.2 Providing consultation to the person designated by the governing authority, in planning and budgeting for the dialysis dietary service, including developing methods of food cost control;

15.5.8.3 Coordinating and integrating the dietary service with other patient care services;

15.5.8.4 Providing dietary counseling to patients and their families;

15.5.8.5 Assessing the nutritional needs of each patient, preparing an individual dietary care plan, and reassessing the patient's response to dietary services at least every 90 days for chronic dialysis patients, or in accordance with an alternative schedule which the dietitian justifies and documents in the medical record. Assessment and preparation of the dietary care plan for an acute patient shall be upon the attending physician's request;

15.5.8.6 Providing dietary and nutritional consultation to other dialysis personnel;

15.5.8.7 Participating in developing, reviewing and revising patient care plans and long-term programs; and

15.5.8.8 Entering in the patient's medical record:

15.5.8.8.1 The dietary care plan, which shall be reviewed by the dietitian at least every 90 days for chronic dialysis patients, or in accordance with an alternative schedule which he/she justifies and documents in the medical record. Development of a dietary care plan for an acute patient shall be upon the attending physician's request;

15.5.8.8.2 Clinical notes;

15.5.8.8.3 Progress notes, written at least every 7 days for acute and every 30 days for chronic dialysis patients, or in accordance with an alternative schedule which he/she justifies and documents in the patient's medical record;

15.5.8.8.4 Summaries of conferences with a physician or other personnel; and

15.5.8.8.5 The dietary discharge summary and discharge plan, for the inpatient who is discharged from the hospital following an acute illness. If a discharge summary and plan were previously prepared, they need not be duplicated.

15.6 Acute Dialysis Services

15.6.1 The physician-director shall ensure that a nephrologist is in the hospital and available during the course of acute dialysis treatments.

15.6.2 The nursing supervisor shall ensure that a minimum of one licensed nurse is assigned per acute dialysis patient for each shift during which the service operates.

15.7 Chronic Dialysis Services

15.7.1 The nursing supervisor shall ensure that a minimum of one registered professional nurse and one licensed nurse or aide is assigned per six chronic dialysis patients for each shift during which the service operates.

15.7.2 A minimum of one registered professional nurse, in addition to the charge nurse, shall be assigned to the dialysis service to provide direct patient care for each shift during which the service operates. If fewer than three patients are undergoing dialysis, a registered professional nurse and a licensed nurse may provide the treatment.

15.8 Home (Self) Care Dialysis Training

15.8.1 The hospital shall provide home (self) care dialysis training as part of the chronic dialysis program, in accordance with the following:

15.8.1.1 A registered professional nurse shall be responsible for supervision of the home (self) care dialysis training program;

15.8.1.2 There shall be a minimum of one member of the nursing staff per two home (self) care dialysis training patients;

15.8.1.3 The home (self) care training program shall have a written outline of course material for persons undergoing training. The educational program shall include didactic and practical sessions which shall ensure trained helpers to perform unsupervised dialysis treatments; and

15.8.1.4 The hospital shall provide, either directly or through agreement with another health care facility, the following;

15.8.1.4.1 Surveillance of the patient's home adaptation, including provisions for visits by a staff member to the home and by the patient to the hospital. The number and content of surveillance visits shall be documented in the patient's medical record;

15.8.1.4.2 Ensurance that patient teaching materials are available for patient use during and after home (self) care dialysis training and at times other than during the dialysis procedure;

15.8.1.4.3 Consultation for the patient with a social worker and a dietitian;

15.8.1.4.4 A record-keeping system which ensures continuity of care;

15.8.1.4.5 Installation and maintenance of equipment in the home;

15.8.1.4.6 Testing and treatment of the water in the home, when indicated; and

15.8.1.4.7 Ordering of supplies for the home on an ongoing basis.

15.9 <u>Peritoneal Dialysis Services</u>

15.9.1 Standards for peritoneal dialysis will be developed at a future time.

15.10 <u>Pediatric Dialysis Services</u>

15.10.1 A hospital providing pediatric dialysis to two or more patients for two months or longer shall maintain a separate pediatric dialysis service, and shall meet the standards for acute and chronic dialysis, with the exception of 15.6.1 and 15.7.1.

15.10.2 The physician-director shall ensure that a minimum of one nephrologist is in the hospital and available to the pediatric dialysis service at all times during which the service operates, as well as during the course of acute pediatric dialysis treatments. Consultation by a pediatric nephrologist shall be available to the pediatric dialysis service at all times during which it operates.

15.10.3 The nephrologist shall be responsible for assisting in the development of a written patient care plan for each pediatric patient.

15.10.4 Nursing and ancillary personnel assigned to the pediatric dialysis service shall have a minimum of 6 months of experience in dialysis.

15.10.5 The nursing supervisor shall ensure that a minimum of two licensed nurses and/or ancillary staff members (exclusive of aides) are assigned per three chronic pediatric dialysis patients for each shift during which the service operates.

15.11 Glossary of Terms

15.11.1 Administrator shall mean a person with a bachelor's degree and two years of executive or supervisory experience in a health care facility, or the equivalent in years of experience and/or training in a health care facility.

15.11.2 Ancillary Personnel shall mean unlicensed workers, such as technicians and aides, who are employed to assist licensed nursing personnel. Ancillary personnel are trained on the job in accordance with the staff education plan, and are experienced in dialysis procedures.

15.11.3 Available shall mean: ready for immediate use (pertaining to equipment); capable of being reached (pertaining to personnel).

15.11.4 Care Plan (Nursing, Dietary, Social Service) shall mean a written plan documenting an evaluation of the individual patient's needs, short and long term goals, and care and treatment to be provided. Each service shall develop and implement its own care plan at the time of the patient's acceptance for dialysis treatment. The care plan for each service becomes part of the total patient care plan. The nursing care plan may be incorporated into the patient care plan rather

15.11.5 Charge Nurse shall mean a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to N.J.S.A. 45:11-25 et seq., and who:

15.11.5.1 Has at least 12 months of experience in clinical nursing, and an additional 6 months of experience in nursing care of the patient with permanent kidney failure or undergoing kidney transplantation, including training in and experience with the dialysis process; or

15.11.5.2 Has 12 months of experience in nursing care of the patient on maintenance dialysis, or in nursing care of the patient with a kidney transplant, including training in and experience with the dialysis process.

15.11.6 Clinical Note shall mean a dated, written and signed notation by each member of the medical, nursing, dietary and social service staff who renders a service to the patient. Notations include a description of signs and symptoms, treatments and/or medications given, the patient's reaction, and any changes in physical or emotional condition. Clinical notes are written into the patient's record on the same day service is rendered.

15.11.7 Crash Cart shall mean a mobile emergency cart containing medications, equipment and supplies as specified in the hospital policy and procedure manual.

15.11.8 Current shall mean: up-to-date; extending to the present time.

15.11.9 Dialysis shall mean a process by which waste products are removed from the patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.

15.11.9.1 Acute Dialysis shall mean the rendering of dialysis to a patient with previously life-supporting renal function who has sustained abrupt loss of kidney function. Recovery of kidney function is expected in such cases.

15.11.9.2 Chronic or Maintenance Dialysis shall mean the rendering of dialysis to a patient with end stage renal disease in whom recovery of renal function is not expected. Chronic dialysis services shall include:

15.11.9.2.1 Home (Self) Care Dialysis Training, which shall mean the education of the patient and a family member or other person in the use of the dialysis treatment machine.

15.11.9.3 Hemodialysis shall mean a process by which a patient's blood is circulated for the removal of uremic poisons in cases of acute or chronic renal failure, or for removal of drugs in cases of drug overdose.

15.11.9.4 Pediatric Dialysis shall mean dialysis provided to persons under 16 years of age.

15.11.9.5 Peritoneal Dialysis, an alternative to hemodialysis, shall mean a process by which the dialysate is introduced into the abdominal cavity, using the peritoneum as the semipermeable membrane.

15.11.10 Dialysis Treatment Machine (Treatment Machine) shall mean the apparatus which permits the cleansing of body waste from the blood by a mechanical method substituting for the human kidney. The dialyzer and dialysate delivery system comprise the total system used for hemodialysis.

15.11.11 Dietitian shall mean a person who:

15.11.11.1 Has a bachelor's degree from a college or university accredited by the American Dietetic Association and has completed a dietetic internship or traineeship approved by the American Dietetic Association, or a master's degree plus six months of full-time food service experience in a health care facility; or

15.11.11.2 Has a bachelor's degree from an accredited college or university with a major in foods or nutrition, or the equivalent course work for a major in the subject area, and one year of full-time or full-time equivalent experience in nutrition.

15.11.12 Discharge Plan (Dietary and Social Service) shall mean a written plan developed within seven days following the patient's admission and which includes the projected level(s) of care needed, the projected timetable for moving the patient to the next level of care, treatment and teaching needed prior to discharge, resources available for post-discharge care, and mechanisms for transfer to other levels of care.

15.11.13 Discharge Summary (Dietary and Social Service) shall mean a written summary prepared at the time of the patient's discharge and which includes treatment provided and results, reasons for discharge, preparation of the patient for discharge, and recommendations for the patient's maintenance regimen and continuity of care.

15.11.14 End State Renal Disease (ESRD) shall mean that stage of renal impairment which is usually irreversible , permanent, and unresponsive to medical treatment, and which requires dialysis and/or kidney transplantation to ameliorate uremic symptoms and maintain life and health.

15.11.15 Full-Time shall mean a time period established as a full working week by the hospital, as defined in its policy and procedure manual.

15.11.16 Governing Authority shall mean the organization, person or persons designated to assume full legal responsibility for the determination of policy, management, operation and financial viability of the hospital.

15.11.17 Home (Self) Care Dialysis Training Nurse shall mean a registered professional nurse who has at least three months of experience in training ESRD patients in home-care dialysis.

15.11.18 Licensed Nursing Personnel shall mean registered professional nurses or practical (vocational) nurses licensed in the State of New Jersey.

15.11.19 Licensed Practical Nurse shall mean a person who is licensed by the New Jersey State Board of Nursing, pursuant to the N.J.S.A. 45:11-27 et seq.

15.11.20 Medical Care Plan shall mean a written plan developed by the physician and implemented at the time of the patient's acceptance for treatment, which includes the level of care needed, special conditions, assessment of physical capability, and orders for medication, diet, permitted level of physical activity, rehabilitation therapy services, patient activities, special needs for the patient's health or safety, preventive or maintenance measures, and other patient care services.

It shall also include the frequency and length of dialysis, composition of dialysate, methods used for anticoagulation, weight adjustment, and transfusion requirements. This plan shall be reviewed and revised at least every 7 days for acute and every 30 days for chronic dialysis patients, or in accordance with an alternative schedule which the physician justifies and documents in the patient's medical record.

15.11.20.1 The HEW form, "ESRD Patient History and Treatment Plan," (Form SSA-2742) may be substituted for the medical care plan and shall be acceptable for the purpose of surveys by the Department.

15.11.21 Nephrologist shall mean a physician who is a member of the hospital medical staff, and who:

15.11.21.1 Is Board-certified or -eligible in internal medicine; and

15.11.21.2 Has two years of full-time training in nephrology, or is Board-certified or -eligible in nephrology.

15.11.22 Nursing Supervisor shall mean a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to N.J.S.A. 45:11-26 et seq., and who:

15.11.22.1 Has at least 12 months of experience in clinical nursing, and an additional 6 months of experience in nursing care of the patient with permanent kidney failure or undergoing kidney transplantation, including training in and experience with the dialysis process; or

15.11.22.2 Has 18 months of experience in nursing care of the patient on maintenance dialysis, or in nursing care of the patient with a kidney transplant, including training in and experience with the dialysis process.

15.11.23 Patient Care Plan shall mean a written plan developed and maintained by the nursing service, with the cooperation of all other services and the participation of the patient and/or the next of kin, sponsor and/or guardian, implemented at the time of the patient's admission, and included in the medical record at the time of discharge. It contains the physician's orders, goals of care to be provided, a care plan from each of the services, documentation of joint planning of care such as reports of patient care conferences, and documentation of care and services provided. The patient care plan shall be kept current and available to all personnel providing patient care.

15.11.24 Patient Long-Term Program (for maintenance, home (self) care, peritoneal, and pediatric dialysis patients) shall mean a long-range plan developed by the physician-director with the participation of the nursing supervisor or charge nurse, a dietitian, a social worker or social work designee, and the patient, next of kin and/or sponsor or guardian. The program shall specify the treatment modality and setting (i.e., dialysis or transplantation, home or self-care), based upon a medical, nursing, nutritional and social evaluation of the patient. The program shall be included in the medical record, and reviewed and revised in writing at least annually by those responsible for its development.

15.11.25 Pediatric Nephrologist shall mean a physician who is a member of the hospital medical staff, and who:

15.11.25.1 Is Board-certified or -eligible in pediatrics; and

15.11.25.2 Has two years of full-time training in pediatric nephrology; is Board-certified or -eligible in pediatric nephrology; or has five years of experience in the clinical practice of pediatric nephrology.

15.11.26 Physician shall mean a person who is authorized by the Board of Medical Examiners to practice medicine in the State of New Jersey, pursuant to N.J.S.A. 45:9-1 et seq.

15.11.26.1 Attending Physician shall mean the physician responsible for the medical care of a patient in the dialysis service. The physician-director may serve as an attending physician.

15.11.27 Physician-Director shall mean a nephrologist or pediatric nephrologist who is a member of the hospital staff, and who:

15.11.27.1 Has had at least 12 months of continuous experience or training (e.g., Fellowship) in the care of patients at ESRD facilities; and

15.11.27.2 Has a major, continuing interest in the field of nephrology, as documented by the nature of his/her practice. This shall be substantiated in writing by the hospital chief of medical staff.

15.11.28 Progress Note shall mean a signed, dated notation by each member of the medical, licensed nursing, dietary and social service staff who renders a service to the patient, summarizing information about care and services provided, and the patient's response.

15.11.29 Registered Professional Nurse shall mean a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to N.J.S.A. 45:11-26 et seq.

15.11.30 Shift (Workday) shall mean a period of time established as a full working day, as defined in the hospital policy and procedure manual.

15.11.31 Social Work Designee shall mean a person with a bachelor's degree in psychology, sociology or other field related to social work, and one year of social work experience in a health care setting under the supervision of a social worker.

15.11.32 Social Worker shall mean a person who has a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education, and at least one year of social work experience in a health care setting.

15.11.33 Staff Education Plan shall mean a written plan developed at least annually and implemented throughout the year, which describes a coordinated program for staff education for the dialysis service, including in-service programs and education, staff development, on-the-job training and continuing education, and the intervals and times at which these shall be given. Each employee shall receive education to develop skills and increase knowledge so as to improve patient care. (Occasional attendance at programs or conventions, or speakers invited to the facility, do not solely constitute an acceptable staff education plan.)

15.11.34 Staff Orientation Plan shall mean a written plan for the orientation of each new employee to the duties and responsibilities of the dialysis service, as well as to the personnel policies of the hospital. Orientation for each new employee shall be provided prior to or within one week of employment.

15.11.35 **Unit Record System** shall mean a system of filing the medical record as one unit, in one location within the hospital. The record shall be available to dialysis staff. When the patient is under dialysis treatment, the record shall be in the dialysis service.

15.12 Construction

15.12.1 Renal dialysis services in hospitals shall be in accordance with the Uniform Construction Code and the standards imposed by the United States Department of Health, Education and Welfare (HEW), the Department of Health, and the Department of Community Affairs, specifically the HEW Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities (HEW Publication No. HRA 74-4000). In order to avoid conflict, Section 302 (except as it pertains to area limitations), 1202.8, 1216.0, Article 5 except sections 513.0, 519.0, 520.0, 521.0, and Article 6 except Section 618.7 through 618.9.3 of the building sub-code of the New Jersey Uniform Code, shall not govern with respect to health care facilities. The HEW HRA 74-4000 shall serve as the Uniform Code of the State in all matters regulated by the sections herein specified.

15.13 Additional Requirements

15.13.1 The extent of the dialysis patient care services (administration, clinical and diagnostic facilities) to be provided will be determined by the services contemplated and estimated patient load, as described in the approved narrative program. The planning of the dialysis facilities should provide for privacy and dignity of the patient during interview, examination and treatment. The facilities shall be located so that outpatients do not traverse inpatient areas. If possible, the facilities should be located within close proximity of other services rendered by the hospital's program, such as outpatient, laboratory and radiology facilities.

If an intermediate dialysis suite is required by the narrative program, the following elements shall be provided.

15.13.2 **Dialysis Patient Care Service**

15.13.2.1 **Administration and Public Areas**

15.13.2.1.1 A reception and control area conveniently located near the entrance within the dialysis suite or available to the dialysis suite. This area can be shared with other services if not located within the dialysis suite;

15.13.2.1.2 Waiting space shall be adjacent to reception and control area if located within the dialysis suite (not to be shared with any other services within the hospital complex). If reception and control area are made available to the dialysis suite other than within the suite, then additional waiting space must be allocated for this service;

15.13.2.1.3 Public waiting space with toilet facilities, public telephone, drinking fountain and space allocated for the storage of wheelchairs or stretchers. (This can be an area shared by other services within the hospital complex);

15.13.2.1.4 Interviewer space(s) for outpatients. For private interviews relating to social service, credit and admissions;

15.13.2.1.5 Office space for the medical director and nurse supervisor, (can be omitted if not required in narrative program);

15.13.2.1.6 Multipurpose room(s) for conferences, meetings and health education purposes, which shall be equipped for sharing visual aids; and

15.13.2.1.7 Storage space for employees' personal effects, office supplies and files, or medical records on a schedule basis.

15.13.2.2 **Treatment Areas**

15.13.2.2.1 The treatment area shall be an open planned area separate from the administrative and service area. This open treatment area shall not exceed 3,000 square feet in area. Each machine or lounge shall have a privacy curtain.

15.13.2.2.2 The maximum capacity for treatment area shall be 20 patients, including spaces allocated for self-care dialysis training units.

15.13.2.2.3 The net usable square foot area shall be 80 square feet, with 100 square feet gross area for bed or lounge. The minimum distance to center of patient bed or lounge shall be 8'0".

15.13.2.2.4 Nurses' station shall be located within the open treatment area and so arranged as to permit direct visual observation by nursing staff.

15.13.2.3 Pediatric Dialysis Areas (optional)

15.13.2.3.1 If so provided in the narrative program which describes the functional space requirements, staffing pattern, departmental relationships and other basic information relating to the fulfillment of the institution's objectives, young children and adolescents shall be housed in a unit separate from the adults.

15.13.2.3.2 The area housing the pediatric dialysis unit must be located within the treatment area and considered a part of the maximum capacity not to exceed 20 patients.

15.13.2.3.3 This area housing the pediatric dialysis unit must not be less than two spaces allocated for the patients and of the same net usable square foot area as spelled out in Section 15.13.2.2.3 of these regulations.

15.13.2.3.4 The area housing the pediatric dialysis unit must be enclosed with fixed partitions that extend from finish floor to ceiling. (These partitions should not extend through the ceiling). Vision panels in partitions are required.

15.13.2.3.5 This unit shall have its own handwashing facilities.

15.13.2.4 Service Areas

15.13.2.4.1 The following service areas shall be located within the dialysis suite and readily available to the open treatment area. The size and location of each service area will depend upon the number of beds or lounges to be served.

15.13.2.4.2 Preparation space. Shall be adjacent to the open treatment area.

15.13.2.4.3 Handwashing facilities. There shall be convenient to the nurses' station and patient service units at least one handwashing facility available at patient service at the ratio of 1 per 4 units of service.

15.13.2.4.4 Charting facilities. These facilities for nurses and doctors could be located adjacent to the nurses' station.

15.13.2.4.5 Staff's toilet room. This room shall contain a water closet and a lavatory equipped for handwashing.

15.13.2.4.6 Lounge. A lounge shall be available nearby for staff personnel.

15.13.2.4.7 Locker room. For the safekeeping of personal effects of staff. If such facilities are available elsewhere in the hospital this item can be omitted.

15.13.2.4.8 Examination room(s). Shall contain work counter, storage facilities and lavatory equipped for handwashing.

15.13.2.3.9 Drug distribution station. This may be a medicine preparation room or unit, a self-contained medicine dispensary unit, or another approved system. If used, a medicine preparation room or unit shall be under the nursing staff's visual control and contain a work counter, refrigerator, and locked storage for biologicals and drugs. A medicine dispensary unit may be located at the nurses' station, in the clean workroom, or in an alcove or other space under direct control of the nursing or pharmacy staff.

15.13.2.4.10 Clean workroom or clean holding room. This may be a combined unit. This room shall contain work counter, handwashing and storage facilities for the distribution of clean and sterile supply material, or an alternate method acceptable to the Chronic Disease Program. A method of crash sterilization shall be provided.

15.13.2.4.11 Soiled workroom or soiled holding room. This may be a combined unit. This room shall contain a clinical sink or equivalent rim fixture, sink equipped for handwashing, work counters, waste receptacle and linen receptacle, or an alternate method acceptable to the Chronic Disease Program. Facilities for washing or flushing bed pans shall be provided.

15.13.2.4.12 Nourishment station. This shall contain a sink equipped for handwashing, equipment for serving nourishment, refrigerator, storage cabinets and ice maker-dispenser unit.

15.13.2.4.13 Clean linen storage. A separate closet or a designated area within the clean workroom shall be provided. If a closed cart system is used, storage may be in an alcove.

15.13.2.4.14 Equipment and emergency storage room(s). These can be a combined unit. The size will be determined by the variations in the program and equipment to be stored.

15.13.2.4.15 Storage room. If not located in the other areas of the hospital, to house working equipment to maintain the equipment applicable to the machines for the dialysis suite. At least one week of operation supplies must be available in the facility.

15.13.2.4.16 Janitor's closet. A closet containing a floor receptor or service sink and storage space for housekeeping supplies and equipment shall be provided.

15.13.2.4.17 Patient toilet. This room shall contain a water closet and lavatory equipped for handwashing. This room shall be barrier-free, contain emergency hardware and nurse-call equipment.

15.13.2.4.18 Storage space shall be provided for wheelchairs and stretchers out of direct line of traffic.

15.13.2.4.19 Storage and disposal of fluid and renal waste shall be provided within the unit until they are properly disposed of.

15.13.2.5 <u>Water</u>

15.13.2.5.1 Water used for dialysis purposes shall be analyzed periodically and treated as necessary to maintain a continuous water supply that is biologically and chemically compatible with acceptable dialysis techniques. Records of test results and equipment maintenance are maintained at the facility.

Manual of Standards for Hospital Facilities

Amendment - Effective September 7, 1978

Add 604-A.1

Medications and treatment may also be prescribed by podiatrists when such medication or treatment is given to treat ailments of the human foot in accord with NJSA 45:5-7 and as specified in the hospital's medical staff by-laws

---

MANUAL OF STANDARDS

FOR

HOSPITAL FACILITIES

SECTION ONE:

CARDIAC DIAGNOSTIC FACILITIES AND

CARDIAC SURGICAL CENTERS

September 1978
Adopted 12/7/78
Effective 1/4/79

1.0 **Cardiac Diagnostic and Surgical Services**

1.1 **General**

1.1.1 This section shall apply to all hospitals providing cardiac diagnostic facilities and cardiac surgical centers. These shall be administered by the governing authority responsible for the management, control, and operation of the hospital, shall be subject to the rules, regulations, and inspections applicable to the hospital, and shall be licensed as a part of the hospital. The cardiac diagnostic facilities and cardiac surgical centers included in this section are:

1.1.1.1 Cardiac diagnostic laboratory, either dedicated completely to cardiac catheterization/coronary angiographic procedures, or shared with other specialized radiologic procedures;

1.1.1.2 Cardiovascular surgical services, including cardiac diagnostic facility and cardiovascular surgical intensive care service or recovery room; and

1.1.1.3 Pediatric cardiac diagnostic facility and surgical center.

1.1.2 A policy and procedure manual, supplementing the hospital policy and procedure manual, and approved by the governing authority, shall be developed and implemented by the administrator, the nursing director, and the physician-director, or their alternates, as a guide for organization and operation of the cardiac diagnostic facility and/or surgical center. Cross-references to the hospital policy and procedure manual(s) are acceptable. The manual shall be reviewed, signed, and dated annually. The manual shall include:

1.1.2.1 A written narrative of the cardiac program, describing at least the services provided, staffing patterns, space requirements, and relationships with other departments;

1.1.2.2 Lines of authority, responsibility, and accountability, organized and functioning so as to ensure an integrated continuum of services for the patient. An organizational chart shall delineate lines of authority that provide for a continuum of services to the patient;

1.1.2.3	A description of the organization, structure, and allocation of responsibility and accountability;
1.1.2.4	Availability of care 24 hours a day, seven days a week;
1.1.2.5	Criteria and priorities for eligibility and acceptance of patients;
1.1.2.6	Criteria for discharge or transfer of patients;
1.1.2.7	A list of standing orders, if any;
1.1.2.8	Policies and procedures for a staff and patient surveillance program of infection control, including, but not limited to, the following:
1.1.2.8.1	Policies and procedures for investigating, documenting, and reporting to the administrator all infections, including post-operative surgical infections;
1.1.2.8.2	Provision for the care and treatment of patients with infectious and communicable diseases;
1.1.2.8.3	Infection control related to handwashing procedures, visitors, housekeeping, laundry, ventilation, cleaning and sterilization of equipment, collection of laboratory specimens, and disposal of wastes and contaminants;
1.1.2.8.4	Methods of personal hygiene, care of clothing, and use of protective clothing;
1.1.2.8.5	Use of disposable and reusable equipment and supplies; and
1.1.2.8.6	Regulations for visitors and traffic control;
1.1.2.9	Delineation of staff privileges for physicians, including authorization to assist in procedures, and qualifications and procedures for their acceptance for staff privileges, conditions for retaining privileges, and process of revoking or suspending privileges;
1.1.2.10	Functions and responsibilities of physicians, the surgical team, and other personnel;
1.1.2.11	Training and experience requirements for technicians;

1.1.2.12 Policies and procedures to ensure that diagnostic, surgical, and treatment procedures are performed by staff trained to work together as a team;

1.1.2.13 Requirements regarding physician attendance at general meetings and meetings of the cardiac diagnostic facility or surgical center, and the maintenance of minutes;

1.1.2.14 Methods of ensuring provision of laboratory and blood bank services at all times during which the cardiac diagnostic facility and/or cardiac surgical center are in operation, and procedures for the transfer of specimens to the laboratory;

1.1.2.15 Policies to ensure that staff are trained in cardiopulmonary resuscitation;

1.1.2.16 Policies to ensure that, during cardiac diagnostic and surgical procedures, the patient's medical record shall be in the room or suite, and shall contain information in accordance with Section Seven of the hospital licensure manual. (See N.J.A.C. 8:43B);

1.1.2.17 Policies and procedures for patient care. These policies and procedures shall include, but not be limited to, the following:

1.1.2.17.1 Pre-admission testing, if hospital policy permits, including the names of tests which shall be performed, and the maximum length of time prior to admission that pre-admission testing shall be allowed and accepted as valid upon admission;

1.1.2.17.2 Policies and procedures for inhalation therapy, including pulmonary ventilation and humidification;

1.1.2.17.3 A description of the types of procedures to be performed, and policies regarding who shall perform specialized procedures, under what circumstances, and with what degree of supervision. Specialized procedures shall include, but not be limited to, cardiopulmonary resuscitation, tracheostomy, administration of parenteral fluids and electrolytes and other medications, and the obtaining of blood and other laboratory specimens;

1.1.2.17.4 Preparation of patients for diagnostic, operative, and post-operative procedures;

1.1.2.17.5 Monitoring of patients and procedures during diagnostic, operative, and post-operative procedures; and

1.1.2.17.6 Patient follow-up, and reporting in writing the results and findings to physicians responsible for the care of the patient;

1.1.2.18 Delegation of responsibility for counseling and education of the patient and his/her family. Such counseling and education shall include:

1.1.2.18.1 Understanding of illness, disability, and needed treatment;

1.1.2.18.2 Adjusting to social, psychological, and physical alterations associated with cardiac disease symptoms and treatment, including consultation related to diet, medication, exercise, and, if provided by the hospital, genetic counseling; and

1.1.2.18.3 Integrating the patient's needs and schedule into the daily life of other members of the family;

1.1.2.19 Policies and procedures, including the care of patients, to be followed in case of medical emergencies, fire and other disaster, and equipment breakdown;

1.1.2.20 Delegation of responsibility for preventive and corrective maintenance of equipment;

1.1.2.21 An inventory of the contents of the emergency cart, and policies regarding frequency of checking to verify contents;

1.1.2.22 An inventory of equipment in the cardiac diagnostic facility and/or surgical center, and policies regarding equipment maintenance and safety, including, but not limited to:

1.1.2.22.1 A written preventive maintenance program, including techniques for cleaning, contamination control, and periodic testing of equipment, with records to be kept on the premises of the dates and results of such testing and who performed it;

1.1.2.22.2 A description of precautions to ensure staff and patient safety from exposure to radiation;

1.1.2.22.3 Precautions related to grounding, current and radiation leakage, and safety of electronic devices. Documentation of safety testing shall be provided; and

1.1.2.22.4 Radiologic equipment, maintained in accordance with N.J.S.A. 26:2D-1 et seq.;

1.1.2.23 A description of the system for maintenance of patient records, including diagnostic records and cine films;

1.1.2.24 A description of the system for transfer, including emergency transfer, of patients and patient information. Patient information shall include X-rays, cine films, and/or videotapes. Information shall be transferred with the patient;

1.1.2.25 A description of referral mechanisms and linkages with other inpatient and ambulatory care facilities in order to provide continuity of patient care;

1.1.2.26 A description of the process of evaluation of patient care and staff performance;

1.1.2.27 A description of the mechanism for peer review. The peer review team for a cardiac diagnostic facility shall have available at least one cardiovascular surgeon from a surgical center with which the facility has a written agreement;

1.1.2.28 A plan for staff orientation and education for management of patients, including, but not limited to:

1.1.2.28.1 Recognition, interpretation, and recording of signs and symptoms in the cardiovascular patient, including electrocardiogram;

1.1.2.28.2 Cardiopulmonary resuscitation and the use of defibrillators and respirators;

1.1.2.28.3 Knowledge of parenteral administration of electrolytes and fluids, and of the drugs used in the management of cardiovascular diseases;

1.1.2.28.4 Understanding of pulmonary and cardiovascular physiology;

1.1.2.28.5 Location and use of supplies;

1.1.2.28.6 Specialized nursing procedures for cardiac patients;

1.1.2.28.7 Safety measures regarding the use of electrical and electronic equipment;

1.1.2.28.8 Prevention and control of infection; and

1.1.2.28.9 Recognition of, and provision for, the psychological and social needs of cardiac patients and their families; and

1.1.2.29 Policies and procedures for the maintenance of personnel records for each employee, including policies and procedures for the inclusion of previous employment and educational background data, educational and licensure requirements (if applicable), staff education record, personnel evaluations, job description, and emergency telephone number. Personnel records may be under the supervision of, and be located in, the central personnel office.

1.1.3 The manual(s) shall be available to personnel of the cardiac diagnostic facility and/or surgical center, and to representatives of the Department at all times. The policies and procedures in 1.1.2 through 1.1.2.29 shall be kept in the cardiac diagnostic facility and/or surgical center and shall be available to personnel of the cardiac diagnostic facility and/or surgical center, and to representatives of the Department at all times.

1.1.4 The hospital shall establish and implement policies and procedures for staff, including:

1.1.4.1 A system of staff pre-employment physical examinations and subsequent health examinations, as stated in the policy and procedure manual;

1.1.4.2 Staff orientation and education, as specified in the staff orientation and education plans. Records of these activities shall be maintained, including dates given, the names of persons attending, methods used, and an evaluation of the effectiveness of the activities;

1.1.4.3 Hours of work and employee benefits, such as vacation time, sick leave, and fringe benefits; and

1.1.4.4 Written staffing patterns for all personnel and weekly duty schedules.

1.1.5 The hospital shall ensure that equipment for cardiac diagnostic and surgical procedures is in good working condition and tested as required. Dates and types of testing performed shall be identified and signed.

1.1.6 If the hospital provides pediatric cardiovascular services, it shall establish and implement policies for recreation and education of patients during their hospital stay.

1.1.7 The cardiac diagnostic facility and surgical center shall maintain and provide statistical data as required by the Department. The data shall be reported on a quarterly basis on forms supplied by the Department.

1.2 <u>Governing Authority</u>

1.2.1 The hospital shall have a governing authority which shall assume full legal responsibility for the determination and implementation of policy and for management, operation, and financial viability of the hospital. The governing authority shall be legally responsible for, but not limited to, the following:

1.2.1.1 The quality of care rendered to patients;

1.2.1.2 Ensuring that at least the following specialists are available to cardiac patients: anesthesiologist, pathologist, hematologist, endocrinologist, radiologist, nephrologist, psychiatrist, and specialist in pulmonary medicine;

1.2.1.3 Ensuring that a pediatrician and a neonatologist, in addition to the specialists specified in 1.2.1.2, are available to pediatric cardiac patients;

1.2.1.4 Establishment of a written agreement for consultant services and for services not provided in the facility. The written agreement shall:

1.2.1.4.1 Be dated and signed by a representative of the facility and by the person, or representative of the agency or facility, providing the service;

1.2.1.4.2 Include each party's responsibilities, functions, objectives, number of hours and days of the week the provider is in the facility, the financial arrangements and charges, and duration of the written agreement;

1.2.1.4.3 Specify that the facility retain administrative responsibility for the services rendered;

1.2.1.4.4 Require compliance with the standards in this document; and

1.2.1.4.5 Specify that each consultant shall provide written documentation of each visit made to the facility, to include, but not be limited to, services rendered, problems noted, and recommendations made;

1.2.1.5 Establishment and implementation of a system for patient and staff grievances and/or recommendations. This system shall include a feedback mechanism through management to the governing authority, indicating that action was taken; and

1.2.1.6 Establishment of a procedure by which medical and nursing staff in the cardiac diagnostic facility and surgical center shall be encouraged to participate in hospital staff committees, including, but not limited to, those relating to patient care policies, evaluation, pharmaceuticals, discharge planning, and infection control.

1.3 Emergency Services

1.3.1 The hospital shall provide emergency services by a physician to the cardiac diagnostic facility and surgical center, 24 hours a day, seven days a week. To this end:

1.3.1.1 A roster with the names of physicians to be called, noting dates and hours when they are available for emergencies and how they can be reached, shall be kept at the nursing stations of the cardiac diagnostic facility and surgical center. (Available, in this instance, shall mean able to arrive at the facility within 30 minutes of being called);

1.3.1.2 A 24-hour schedule listing personnel to be on-call for the cardiac diagnostic facility and for the surgical center shall be conspicuously posted in the facility or center;

1.3.1.3 Written policies and procedures shall be developed and implemented regarding the care of patients during emergencies when the cardiac diagnostic facility and surgical center are not in operation, while patients are receiving cardiac diagnostic and surgical services, and for outpatients;

1.3.1.4 Written policies and procedures shall be established regarding emergency equipment, including medications and supplies to be kept in the cardiac diagnostic facility and surgical center. Oxygen, suction, and cardiopulmonary resuscitation equipment shall be kept;

1.3.1.5 A respirator, a suction machine, and an emergency cart shall be kept in areas of the hospital where cardiac patients receive services and/or treatment, and shall be used for emergencies only;

1.3.1.6 The emergency cart shall contain at least the following equipment:

1.3.1.6.1 Oxygen;

1.3.1.6.2 Mask for mouth-to-mask pulmonary ventilation;

1.3.1.6.3 Laryngoscope with multi-sized blades, and extra batteries and bulbs;

1.3.1.6.4 Oropharyngeal airways;

1.3.1.6.5 Endotracheal tubes;

1.3.1.6.6 Bag-valve-mask, with provisions for 100 percent oxygen pulmonary ventilation or a manually triggered (time-cycled) oxygen powered resuscitator;

1.3.1.6.7 Suction catheters;

1.3.1.6.8 Nasogastric tube;

1.3.1.6.9 Cricothyrotomy set;

1.3.1.6.10 Defibrillator-monitor;

1.3.1.6.11 Electrocardiogram machine;

1.3.1.6.12 Venous infusion sets;

1.3.1.6.13 Indwelling venous catheters;

1.3.1.6.14 Intravenous solutions;

1.3.1.6.15 Assorted syringes and needles, stopcocks, venous extension tubes;

1.3.1.6.16 Intracardiac needles;

1.3.1.6.17 Tourniquets, adhesive;

1.3.1.6.18 Cardiac arrest board;

1.3.1.6.19 Pacemaker equipment; and

1.3.1.6.20 Medications for emergency use, in single dose form.

1.3.1.7 Equipment on the emergency cart shall be available in various sizes for different age groups.

1.4 Medical Records

1.4.1 Each patient admitted for cardiac diagnostic or surgical services shall have a medical record, in accordance with Section Seven of the hospital licensure manual. (See N.J.A.C. 8:43B.) The medical record shall be available to personnel of the cardiac diagnostic facility and surgical center, and shall include, but not be limited to, the following:

1.4.1.1 A signed, dated admission, medical and surgical history, and a report of physical examination, completed within 24 hours of admission. The examination report shall include results of all tests and procedures performed, diagnoses, prognosis, and rehabilitation potential;

1.4.1.2 All orders for the patient, written, signed, and dated by the physician;

1.4.1.3 A physician's care plan, initiated upon admission and kept current;

1.4.1.4 A nursing care plan, and a care plan for each of the services providing care to the patient, initiated upon admission and kept current;

1.4.1.5 A signed informed consent prior to catheterization or surgery;

1.4.1.6 A cardiac catheterization summary sheet if cardiac catheterization is performed, including, but not limited to:

1.4.1.6.1 Pre- and post-catheterization diagnoses; and

1.4.1.6.2 Complications of the procedure, if any;

1.4.1.7 An operative report, if surgery has been performed, recorded immediately after surgery by the cardiovascular surgeon who performed the surgery, and including a description of findings, the technique used, surgical procedures, tissue removed or altered, sponge count, estimated blood loss, the post-operative diagnosis, and the names of the surgeon and assistants;

1.4.1.8 A pre-anesthesia record, including at least drug history, anesthesia history, and potential anesthetic problems;

1.4.1.9 An anesthesia record, describing at least induction and maintenance of anesthesia, including volume, route of administration, patient's vital signs, duration of anesthesia, any complications of anesthesia or analgesia management, and other drugs, intravenous fluids, blood and/or blood components administered;

1.4.1.10 A post-anesthetic note by the anesthesiologist describing any post-operative abnormalities or complications and stating the blood pressure, pulse, presence or absence of swallowing reflexes, cyanosis, and ability to move extremities;

1.4.1.11 Clinical notes;

1.4.1.12 Progress notes by physicians;

1.4.1.13 A record of medications administered, including the name and strength of the drug, date and time of administration, dosage administered, route of administration, and signature of the licensed nurse administering the drug;

1.4.1.14 Summaries of conferences and consultations;

1.4.1.15 Any referrals to outside resources and documentation of follow-up;

1.4.1.16 A clinical resume; and

1.4.1.17 A discharge plan for each of the services providing care to the patient.

1.4.2 All reports, including progress notes, contained in the patient's medical record shall be typewritten or written in ink, legible, dated, and signed by the recording person. All typed reports shall include the dates of dictation and transcription, and shall be signed by the person who dictated the report.

1.4.3 Medical record information shall be safeguarded against loss, destruction, or unauthorized use.

1.4.4 The facility shall have written policies and procedures governing the use and release of information contained in medical records.

1.5 <u>Staffing Patterns</u>

1.5.1 The governing authority shall designate an administrator or administrators for the cardiac diagnostic facility and surgical center, who may serve as administrator for other units, but who shall be available full-time. An alternate shall be designated in writing to act in the absence of the administrator. The administrator shall be responsible for, but not limited to, the following:

1.5.1.1 Planning for and administration of the management, operational, fiscal, and reporting components of the cardiac diagnostic facility and/or surgical center;

1.5.1.2 Ensuring the development, implementation, and enforcement of all policies and procedures;

1.5.1.3 Ensuring the employment and placement of all staff;

1.5.1.4 Ensuring the provision of staff education and orientation for each employee;

1.5.1.5	Ensuring that a file is maintained for each staff member, including his/her name, qualifications, current license number and its expiration date (if applicable), emergency telephone number, personnel evaluations, and records of physical examination and of attendance at staff educational activities;
1.5.1.6	Participating in policy and administrative decision-making;
1.5.1.7	Administering and supervising the managerial operations of the cardiac diagnostic facility and/or surgical center;
1.5.1.8	Acting as a liaison between the governing authority and the physician-director, personnel, and the patients;
1.5.1.9	At the time of a patient's discharge, ensuring that the clinical resume and the discharge plan are provided in the medical record; and
1.5.1.10	Together with the physician-director, developing and implementing procedures for:
1.5.1.10.1	Maintaining administrative relationships, communication, and integration with support services and community resources; and
1.5.1.10.2	Communicating with personnel and with the governing authority, through meetings, individual conferences, written memoranda, and/or other methods of exchanging information.
1.5.2	The governing authority or its alternate shall appoint a physician-director for the cardiac diagnostic facility and for the surgical center, who shall be directly or indirectly accountable to the administrator, and who shall be responsible for the direction, provision, and quality of medical care provided. The physician-director shall be responsible for, but not limited to, the following:
1.5.2.1	Delineating the responsibilities of physicians to ensure that they provide care to patients;
1.5.2.2	Ensuring that a physician's care plan is written at the time of the patient's acceptance for treatment, and is kept current;

1.5.2.3 Participating in the supervision or review of the selection of a suitable treatment for each patient;

1.5.2.4 Establishing written policies for utilization of consultant and specialist services;

1.5.2.5 Ensuring that personnel are trained in cardiac care techniques;

1.5.2.6 Ensuring that patients and procedures are monitored;

1.5.2.7 Assisting nursing service and/or the administration in the documented investigation of incidents and accidents that occur, in order to identify and correct hazards to health and safety;

1.5.2.8 Assisting nursing service in providing documented information to the administrator in order to ensure a safe and sanitary environment for patients and personnel;

1.5.2.9 With the administrator, assuming responsibility for the execution of patient care policies;

1.5.2.10 Ensuring the development and direction of staff orientation and educational programs;

1.5.2.11 Ensuring the development and maintenance of a system of patient care evaluation;

1.5.2.12 Holding conferences of the cardiac diagnostic facility or surgical center, at intervals stated in the policy and procedure manual, and ensuring participation at meetings of hospital staff committees specified by the governing authority, when such meetings pertain to the cardiac diagnostic facility or surgical center;

1.5.2.13 Participating in meetings of heads of departments, when such meetings pertain to the cardiac diagnostic facility or surgical center; and

1.5.2.14 Entering, or ensuring that the patient's physician enters, in the patient's medical record:

1.5.2.14.1 A signed, dated admission, medical and surgical history, and a report of physical examination, including results of all tests and procedures performed, diagnoses, prognosis, and rehabilitation potential;

1.5.2.14.2 A physician's care plan;

1.5.2.14.3 All initial and subsequent orders for services to the patient; and

1.5.2.14.4 A clinical resume.

1.5.2.15 The physician-director shall designate, in writing, an alternate physician to act in his/her absence.

1.5.3 A nursing supervisor shall be appointed for the cardiac diagnostic facility and for the surgical center, who may have other nursing supervisory responsibilities but who shall be available full-time. He/she shall be responsible for the direction, provision, and quality of cardiac nursing care provided, including, but not limited to, the following:

1.5.3.1 Developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational and evaluation plan for the nursing service that delineates the functional structure and mechanisms for cooperative planning and decision-making within the overall hospital organizational plan;

1.5.3.2 Participating in planning and budgeting for the nursing service of the cardiac diagnostic facility or surgical center, including recommending the number and levels of nursing personnel to be employed;

1.5.3.3 Coordinating and integrating the cardiac nursing service with other patient care services in the hospital;

1.5.3.4 Ensuring representation of nursing personnel in meetings of hospital staff committees, including, but not limited to, those relating to patient care policies, evaluation, pharmaceuticals, and infection control;

1.5.3.5 Implementing staffing patterns to maintain the nurse:patient ratio;

1.5.3.6 Developing and maintaining written job descriptions for nursing personnel, and assigning duties based upon education and training;

1.5.3.7 Ensuring that a registered professional nurse prepares an individual nursing care plan for each patient at the time of admission, assesses and reassesses the nursing needs of each patient in accordance with a schedule which he/she justifies and documents in the patient's medical record, and writes clinical notes for each shift;

1.5.3.8 Assuming responsibility for a registered professional nurse who shall implement the nursing care plan from the time of the patient's admission;

1.5.3.9 Providing a daily summary, including, but not limited to, the daily census (including categorization of patients' conditions) and staffing patterns, and indicating classification and number of nursing personnel who worked each shift;

1.5.3.10 Assisting in employment interviews and in hiring and giving assignments to nursing personnel;

1.5.3.11 Reviewing and evaluating nursing care plans;

1.5.3.12 Making daily rounds to observe patients and to ensure that nursing care is consistent with nursing care plans;

1.5.3.13 Ensuring supervision and evaluation of nursing personnel performance;

1.5.3.14 Consulting with the charge nurses to determine the nursing care and staffing needed;

1.5.3.15 Assisting in the development of, and participating in, orientation of staff to the cardiac diagnostic facility or surgical center, and documenting these activities;

1.5.3.16 Determining staff educational needs, and planning and organizing staff educational programs; and

1.5.3.17 Ensuring that licensed nursing personnel enter in the patient's medical record:

1.5.3.17.1 The nursing care plan (entered by a registered professional nurse). This shall be reviewed and revised in accordance with a schedule which the nurse justifies and documents in the patient's medical record;

1.5.3.17.2 Clinical notes;

1.5.3.17.3 Summaries of conferences with a physician or other personnel;

1.5.3.17.4 The nursing discharge plan; and

1.5.3.17.5 A record of medications administered, including the name and strength of the drug, date and time of administration, dosage administered, route of administration, and signature of the licensed nurse administering the drug.

1.5.3.18 The nursing supervisor shall not be included in computation of the nurse:patient ratio.

1.5.4 The nursing supervisor shall designate in writing a charge nurse for each shift during which the cardiac diagnostic facility or surgical center operates. The charge nurse shall be responsible for, but not limited to, the following:

1.5.4.1 Supervising and evaluating all nursing personnel and activities related to the cardiac nursing service;

1.5.4.2 Assigning duties and delegating responsibility to nursing personnel for provision of nursing care;

1.5.4.3 Evaluating the outcomes of nursing care provided;

1.5.4.4 Assisting in the organization and implementation of staff orientation and educational programs for nursing personnel;

1.5.4.5 Assisting the nursing supervisor in developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational and evaluation plan for the cardiac nursing service; and

1.5.4.6 Assuming responsibility for observation, evaluation, and reporting of patient's symptoms, reactions, and progress.

1.5.5 Licensed nursing personnel shall be responsible for, but not limited to, the following:

1.5.5.1 Administering medications and/or treatments to patients upon written order of a physician, in accordance with N.J.S.A. 45:11-26 et seq.;

1.5.5.2 For each nursing treatment, recording clinical notes;

1.5.5.3 Assessing the needs of each patient and developing, reviewing, revising, and implementing nursing care plans for meeting those needs;

1.5.5.4 Observing, monitoring, and assessing the patient's response to treatment and nursing care;

1.5.5.5 Coordinating nursing care with other patient care services;

1.5.5.6 Teaching, supervising, and consulting with other personnel, the patient, and family members regarding methods of meeting the nursing care needs and other problems of the patient; and

1.5.5.7 Exercising safety precautions in the use of electrical or electronic equipment.

1.5.6 The cardiac diagnostic facility and the surgical center (including the intensive care service or recovery room) shall have at least one person per shift, on duty elsewhere in the hospital, as backup for each member of the team. The person providing backup shall have training and experience equal to those of the team member being replaced, as defined in the glossary.

1.5.7 A social worker, or a designee who receives consultation from the social worker, a dietitian, and rehabilitation therapist(s) shall be available to cardiac patients. If services are provided, the social worker or designee, dieti-

tian, or rehabilitation therapist shall be responsible for the direction, provision, and quality of the social work, dietary, or rehabilitation services, respectively. The social worker or designee, dietitian, or rehabilitation therapist shall be responsible for, but not limited to, the following:

1.5.7.1 Implementing written objectives, standards of practice, policies, a procedure manual, and an organizational and evaluation plan for social, dietary, or rehabilitation therapy services to cardiac patients, developed by the hospital social service, dietary, or rehabilitation department, respectively;

1.5.7.2 Providing consultation to the hospital social service, dietary, or rehabilitation therapy department in planning and budgeting for social, dietary, or rehabilitation services provided to cardiac patients, and providing guidance and consultation to other personnel caring for cardiac patients;

1.5.7.3 Coordinating and integrating the social, dietary, or rehabilitation therapy service with other patient care services;

1.5.7.4 Assessing the social service, dietary, or rehabilitation needs of the patient receiving the service, preparing an individual care plan, and with a physician, reassessing the patient's response to services provided;

1.5.7.5 Providing services as specified in the care plan, reporting the patient's responses to the physician, and developing a maintenance regimen for the patient when approved by the physician, instructing other patient care personnel in its procedures, and reevaluating and revising the maintenance regimen, as indicated in the care plan; and

1.5.7.6 Entering in the medical record of each patient receiving the service:

1.5.7.6.1 The care plan, which shall be kept current;

1.5.7.6.2 Clinical notes; and

1.5.7.6.3 The social service, dietary, or rehabilitation therapy discharge plan.

1.6 Cardiac Diagnostic Facilities

1.6.1 A hospital providing cardic diagnostic services without surgery shall have written agreements with institutions providing open heart surgery and catheterization, specifying a mechanism for ensuring the quality of services provided, methods of referral for surgery, emergency backup procedures, and ongoing communication between the cardiologists performing catheterizations and the surgeons to whom patients are referred. At least one of the referral agreements shall be with a New Jersey cardiac surgical center, and at least one of the referral agreements shall be with a cardiac surgical center which is within one hour over-the-road travel time from the diagnostic facility. Written agreements shall also state that the receiving facility will either accept the results of the diagnostic facility's examinations, or specify a peer review mechanism for departure from this practice.

1.6.2 A cardiac diagnostic facility performing cardiac catheterization and coronary angiographic procedures shall also provide non-invasive diagnostic techniques.

1.6.3 The cardiac diagnostic facility shall have the following full-time personnel.

1.6.3.1 Two physicians, one of whom shall be the physician-director and one of whom shall be an associate to assist the director;

1.6.3.2 One registered professional nurse; and

1.6.3.3 Three technicians, including a cardiac catheterization technician, a radiologic technician, and a monitoring and recording technician.

1.6.4 A cardiologist shall be in the room during all catheterizations and coronary angiographic procedures.

1.6.5 The following personnel shall be available in the hospital during catheterization procedures:

1.6.5.1 An anesthesiologist; and

1.6.5.2 A radiologist.

1.6.6 An electronic and radiologic repair technician shall be available to the hospital during catheterization procedures. (Available, in this instance, shall mean able to arrive at the facility within 60 minutes of being called.)

1.6.7 The cardiac diagnostic facility shall provide to the Department annual, written documentation of utilization rates which shall meet the following criteria:

1.6.7.1 A facility dedicated completely to cardiac catheterization/coronary angiographic procedures (adult) shall perform catheterizations on at least 400 patients annually, 150 of whom shall be coronary arteriographic patients, until May 1980. As of May 1980, such a facility shall perform coronary angiographic examinations on 500 patients annually, 400 of whom shall be coronary arteriographic patients; and

1.6.7.2 A facility which is shared with other specialized radiologic procedures shall have a minimum of 200 cardiac catheterization patients annually. As of May 1980, such a facility shall have a minimum of 250 cardiac catheterization patients annually.

1.7 <u>Cardiovascular Surgical Services</u>

1.7.1 A regional cardiac surgical center shall provide, as a minimum, diagnostic services and cardiovascular surgical services, including open heart, closed heart, and coronary artery surgery as well as surgery of the great vessels. Diagnostic services shall meet the standards specified in 1.6.1 through 1.6.7.2.

1.7.2 The written agreements which the regional cardiac surgical center maintains with cardiac diagnostic facilities shall state that the center will either accept the results of the diagnostic facility's examinations, or specify a peer review mechanism for departure from this practice.

1.7.3 The hospital shall ensure pre- and post-operative examinations and care, and emergency examinations at all times. A 24-hour schedule for all personnel required to perform and assist in cardiovascular surgery shall be posted for the diagnostic facility and the surgical suite, and shall be available to the director of nursing and his/her alternate.

1.7.4 In addition to the policies and procedures contained in 1.1.2 through 1.1.2.29, written policies and procedures shall be developed and implemented, including, but not limited to the following:

1.7.4.1 Policies and procedures for the cardiovascular surgical operating room, including, but not limited to, the following:

1.7.4.1.1 Delineation of surgical and anesthesia privileges;

1.7.4.1.2 Purposes and types of surgical procedures for which the operating room is to be used;

1.7.4.1.3 Definitions of major and minor surgery and of who is qualified to act as first assistant in both categories of surgery. The first assistant in all major surgical procedures shall meet the requirements of N.J.S.A. 45-9:9-1 et seq.;

1.7.4.1.4 Methods for taking, and maintaining records of, sponge counts;

1.7.4.1.5 Procedures used to prime the pump for extracorporeal support during bypass;

1.7.4.1.6 Policies and procedures regarding operating room apparel; and

1.7.4.1.7 Safety measures regarding anesthetic gases, and the training of personnel in these measures;

1.7.4.2 Policies for the maintenance of a current register of cardiovascular surgical procedures, including, but not limited to:

1.7.4.2.1 Name, sex, and hospital admitting (identification) number of the patient;

1.7.4.2.2 Date and time of the operation, and the operating room number;

1.7.4.2.3 Pre-operative and post-operative diagnoses;

1.7.4.2.4 Names of all physicians, assistant physicians, nurses, and technicians;

1.7.4.2.5 Surgical procedures performed and anesthetic agents used; and

1.7.4.2.6 Complications of surgery, if any, and classification of each procedure for the purpose of infection control statistics;

1.7.4.3 Labeling and disposition of anatomical parts and tissue removed at operation, including delivery to the pathologist, filing reports in the patient's medical record, and retention and storage in the hospital of microscopic sections of tissue.

1.7.5 The physician-director in charge of the surgical suite shall be available to the cardiovascular surgical service at all times. (Available, in this instance, shall mean able to arrive at the facility within 30 minutes of being called.)

1.7.6 The cardiovascular surgical team shall include the following personnel:

1.7.6.1 The physician-in-charge of the surgery;

1.7.6.2 An assistant to the physician-in-charge;

1.7.6.3 An anesthesiologist, and an assistant; and

1.7.6.4 At least one registered professional nurse, who functions as circulating nurse, and three other licensed nursing personnel and/or operating room technicians.

1.7.7 The operating surgeon shall be responsible for overseeing and integrating all details of pre-operative evaluation and preparation of the operation procedures, and of post-operative care.

1.7.8 The following personnel shall be available in the hospital whenever cardiovascular surgery is scheduled:

1.7.8.1 A cardiologist; and

1.7.8.2 Two pump technicians.

1.7.9 The cardiac surgical center shall provide to the Department annual, written documentation that it has achieved a utilization rate of at least 75 open heart surgical procedures in the first year of its operation, and 200 procedures by the end of the third year of operation of the service. Thereafter it shall perform at least 200 open heart surgical procedures per year. Failure to perform minimal number of procedures per year shall be reason to terminate service authorization.

1.8 <u>Cardiovascular Surgical Intensive Care Service or Recovery Room</u>

1.8.1 Hospitals providing cardiovascular surgery shall maintain a cardiovascular surgical intensive care service or recovery room containing a minimum of three beds.

1.8.2 The cardiovascular surgical intensive care service or recovery room shall have equipment and staff to maintain at least the following capabilities:

1.8.2.1 Hemodynamic electrocardiogram monitoring;

1.8.2.2 Pacemaker insertion;

1.8.2.3 Cardiopulmonary resuscitation; and

1.8.2.4 Arrhythmia detection.

1.8.3 The physician-director of the cardiovascular surgical intensive care service or recovery room, who may be the physician-director of the surgical suite, shall be available to the service or recovery room. (Available, in this instance, shall mean able to arrive at the facility within 30 minutes of being called.)

1.8.4 There shall be a ratio of at least one registered professional nurse to one patient in the cardiovascular surgical intensive care service. The charge nurse shall not be included in the nurse:patient ratio if there are more than three patients in the service or recovery room.

1.8.5 The operating surgeon or an alternate shall be available during the entire period of the patient's stay in the cardiovascular surgical intensive care service or recovery room. (Available, in this instance, shall mean able to arrive at the facility within 30 minutes of being called.)

1.9 <u>Pediatric Cardiac Diagnostic Facility and Cardiac Surgical Center</u>

1.9.1 A hospital providing cardiac diagnostic procedures to pediatric patients shall also provide cardiovascular surgical and intensive care services.

1.9.2 A pediatric cardiac diagnostic facility and surgical center (including cardiovascular surgical intensive care service or recovery room) shall comply with the standards for adult services, with the exception of 1.6.4, 1.6.7 through 1.6.7.2, 1.7.8.1, and 1.7.9.

1.9.3 Staffing requirements and staff:patient ratios shall equal those for adult services, except that all staff who provide services to pediatric cardiac patients shall have training and experience in pediatrics as defined in the glossary.

1.9.4 A pediatric cardiologist shall be in the room during all pediatric catheterizations and coronary angiographic procedures, and shall be available in the hospital whenever pediatric cardiovascular surgery is scheduled.

1.9.5 All equipment, including equipment for resuscitation and other emergencies and procedures, and the contents of the emergency cart, shall be available in sizes adaptable to newborns, infants, and children.

1.9.6 Separate cardiovascular surgical intensive care units shall be maintained for pediatric patients under two years of age, including premature infants, newborns, and infants.

1.9.7 The pediatric cardiac diagnostic facility shall provide to the Department annual, written documentation that it has achieved a utilization rate of at least 150 pediatric cardiac catheterization patients per year.

1.10 Glossary of Terms

1.10.1 Administrator shall mean a person with a bachelor's degree and two years of executive or supervisory experience in a health care facility, or the equivalent in years of experience and/or training in a health care facility.

1.10.2 Anesthesiologist shall mean a physician who is a member of the hospital medical staff, and who is certified or eligible for certification by the American Board of Anesthesiology, Inc. or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.2.1 Assistant to the Anesthesiologist shall mean an anesthesiologist; a physician who has training and experience in cardiovascular surgery as specified in the hospital's policy and procedure manual(s). (See 1.1.2.9); or, a Certified Registered Nurse Anesthetist (CRNA). (See 1.10.10)

1.10.3 Arteriography shall mean roentgenography of arteries following the introduction of contrast materials into the vessels.

1.10.4 Available shall mean ready for immediate use (pertaining to equipment); capable of being reached (pertaining to personnel), unless otherwise defined in the text.

1.10.5 Cardiac Catheterization shall mean the passage of a catheter through the blood vessels into the heart for the purpose of obtaining cardiac blood samples, detecting abnormalities, calculating physiologic parameters, determining intracardiac pressure, and establishing a diagnosis. It shall also be used in this document as a generic category to include coronary angiography, arteriography, and all invasive cardiac diagnostic techniques. The implementation of pacemakers (temporary or permanent) shall not be considered a method of cardiac catheterization.

1.10.6 Cardiologist shall mean a physician who is a member of the hospital medical staff, and who is certified or eligible for certification by the American Board of Internal Medicine, in the subspecialty of cardiovascular disease, or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.7 Cardiovascular Surgeon shall mean a physician who is a member of the hospital medical staff, and who is certified or eligible for certification by the American Board of Thoracic Surgery, Inc. as a cardiovascular surgeon, or who has been granted privileges by the hospital to provide services equal to or greater than those provided by a Board-certified or Board-eligible physician.

1.10.8 Cardiovascular Surgery shall mean open heart, closed heart, and coronary artery surgery as well as surgery of the thoracic great vessels.

1.10.9 Care Plan (Nursing, Dietary, Social Service, and Rehabilitation) shall mean a written plan documenting an evaluation of the individual patient's needs, short- and long-term goals, care and treatment to be provided, and plans for patient and family education. Each service providing care to the patient shall develop and implement its own care plan in coordination with the physician's care plan, at the time of the patient's acceptance for treatment.

1.10.10 Certified Registered Nurse Anesthesist (CRNA) shall mean a registered professional nurse who is licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-26 et seq.; has satisfactorily completed a prescribed course of 18 months in a recognized school of anesthesiology; has passed an examination of, and is certified by, the American Association of Nurse Anesthetists; and who has training and experience in cardiovascular surgery as specified in the hospital's policy and procedure manual(s). (See 1.1.2.10)

1.10.11 Charge Nurse shall mean a registered professional nurse who has at least 12 months of administrative experience in a health care facility; and six months of experience in an intensive care or cardiac care unit plus six months of experience in a cardiac diagnostic facility or cardiac surgical center, or 12 months of experience in a cardiac diagnostic facility or cardiac surgical center. The charge nurse for a pediatric cardiac intensive care unit shall have an additional six months of experience in such a unit.

1.10.12 Cleaning shall mean the removal by scrubbing and washing, as with hot water, soap or detergent, and vacuuming, of infectious agents and of organic matter from surfaces on which and in which infectious agents may find conditions for surviving or multiplying.

1.10.13 Clinical Note shall mean a dated, written, and signed notation by each member of the nursing, dietary, social service, and rehabilitation therapy staff who renders a service to the patient. Notations shall include a description of the patient's progress, signs and symptoms, treatments, and/or medications given, the patient's reaction, and any changes in physical or emotional condition. Clinical notes are written into the patient's record on the same day service is rendered.

Clinical notes written at the time of the patient's discharge shall include a summary of treatment provided and results, reasons for discharge, preparation of the patient for discharge, patient education accomplished, and recommendations for the patient's maintenance regimen and continuity of care.

1.10.14 Clinical Resume shall mean a written summary, prepared by the physician at the time of the patient's discharge, which includes diagnoses, the reason for hospitalization, findings, all operative procedures, other procedures performed, treatment rendered, results, reasons for discharge, preparation of the patient for discharge, condition upon discharge, and recommendations for the patient's maintenance regimen and continuity of care, including any instructions given to the patient and/or family relating to physical activity, medications, diet, and follow-up care.

1.10.15 Communicable shall mean relating to a specific infectious agent or its toxic products and occuring through a transmission of that agent or its products from a reservoir to a susceptible host.

1.10.16 Coronary Angiographic Procedure shall mean a catheterization procedure in which a photographic study is performed by means of X-ray after the insertion of a catheter and dye into coronary arteries selectively.

1.10.17 Current shall mean up-to-date; extending to the present time.

1.10.18 Dietitian shall mean a person who:

1.10.18.1 Has a bachelor's degree from a college or university accredited by the American Dietetic Association and has completed a dietetic internship or traineeship approved by the American Dietetic Association, or has a master's degree plus six months of full-time food service experience in a health care facility; or

1.10.18.2 Has a bachelor's degree from an accredited college or university with a major in foods or nutrition, or the equivalent course work for a major in the subject area, and one year of full-time or full-time equivalent experience in nutrition.

1.10.19 Discharge Plan (Nursing, Dietary, Social Service, and Rehabilitation Therapy) shall mean a written plan developed upon the patient's admission to the service, by each service providing care to the patient, and which includes the projected level(s) of care needed, the projected timetable for moving the patient to the next level of care, treatment and teaching needed prior to discharge, resources available for post-discharge care, and mechanisms for transfer to other levels of care. The discharge plan may be incorporated into the care plan.

1.10.20 Endocrinologist shall mean a physician who is a member of the hospital medical staff and who is certified or eligible for certification by the American Board of Internal Medicine in the subspecialty of endocrinology and metabolism, or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.21 Full-Time shall mean a time period established as a full working week by the hospital, as defined in its policy and procedure manual.

1.10.22 Governing Authority shall mean the organization, person, or persons designated to assume full legal responsibility for the determination of policy, management, operation, and financial viability of the hospital.

1.10.23 Hematologist shall mean a physician who is a member of the hospital medical staff and who is certified or eligible for certification by the American Board of Internal Medicine in the subspecialty of hematology, or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.24 Licensed Nursing Personnel shall mean registered professional nurses or practical (vocational) nurses licensed in the State of New Jersey.

1.10.25 Licensed Practical Nurse shall mean a person who is licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-27 et seq.

1.10.26 Neonatologist shall mean a physician who is a member of the hospital medical staff and who is certified or eligible for certification by the Sub-Board of Neonatal-Perinatal Medicine of the American Board of Pediatrics, Inc., or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.27 Nephrologist shall mean a physician who is a member of the hospital medical staff and who is certified or eligible for certification by the American Board of Internal Medicine in the subspecialty of nephrology, or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.28 Neurologist shall mean a physician who is a member of the hospital medical staff and who is certified or eligible for certification by the American Board of Psychiatry and Neurology, Inc., or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.29 Newborn and Premature Infants shall mean infants of 28 days of age or less (newborn); infants weighing less than 2500 grams at birth and/or with a period of gestation of less than 37 weeks, who risk nonsurvival outside the uterus (premature).

1.10.30 Non-Invasive Diagnostic Techniques shall mean diagnostic testing of heart function using, at a minimum, electrocardiogram and vectorcardiography instruments, stress testing, phono/pulse tracing/ECHO equipment, and Holter-type monitoring facilities.

1.10.31 Nursing-Supervisor shall mean a registered professional nurse who has at least two years of administrative experience in a health care facility; and six months of experience in an intensive care or cardiac care unit plus six months of experience in a cardiac diagnostic facility or cardiac surgical center, or 12 months of experience in a cardiac diagnostic facility or cardiac surgical center. The nursing supervisor for a pediatric cardiac diagnostic facility or surgical center shall have an additional six months of such experience.

1.10.32 Occupational Therapist shall mean a person who:

1.10.32.1 Is a graduate of an occupational therapy curriculum accredited jointly by the Council of Medical Education of the American Medical Association and the American Occupational Therapy Association; or

1.10.32.2 Is eligible for certification by the American Occupational Therapy Association as an occupational therapist, registered.

1.10.33 Open Heart Surgery shall mean a procedure which uses a heart-lung bypass machine to perform the functions of circulation during surgery.

1.10.34 Pathologist shall mean a physician who is a member of the hospital medical staff, and who is certified or eligible for certification by the American Board of Pathology, Inc., or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.35 Pediatric Cardiologist shall mean a physician who is a member of the hospital medical staff, and who is certified or eligible for certification by the Sub-Board of Pediatric Cardiology of the American Board of Pediatrics, Inc., or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.36 Pediatric Patient shall mean a patient who is less than 16 years of age.

1.10.37 <u>Pediatrician</u> shall mean a physician who is a member of the hospital medical staff, and who is certified or eligible for certification by the American Board of Pediatrics, Inc., or who has been granted privileges by the hospital to provide services equal to or greater than those provided by a Board-certified or Board-eligible physician.

1.10.38 <u>Physical Therapist</u> shall mean a person who is registered by the New Jersey Board of Medical Examiners, pursuant to Chapter 169, P.L. 1963, and who:

1.10.38.1 Has graduated from a physical therapy curriculum approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or

1.10.38.2 Prior to January 1966:

1.10.38.2.1 Was admitted to membership by the American Physical Therapy Association; or

1.10.38.2.2 Was admitted to registration by the American Registry of Physical Therapists; or

1.10.38.2.3 Graduated from a physical therapy curriculum in a four-year college or university approved by a state department of education, is licensed or registered as a physical therapist, and, where appropriate, has passed a state examination for licensure as a physical therapist; or

1.10.38.2.4 Had two years of full-time, or full-time equivalent, experience as a physical therapist and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the United States Public Health Service; or

1.10.38.2.5 Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time, or full-time equivalent, experience in the treatment of illness or injury through the practice of physical therapy, in which the therapist rendered services upon the order and under the direction of attending and referring physicians; or

1.10.38.3 If trained outside the United States:

1.10.38.3.1 Graduated after 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and

1.10.38.3.2 Is a member of a member organization of the World Confederation for Physical Therapy; and

1.10.38.3.3 Has acquired one year of full-time, or full-time equivalent, experience under the supervision of an active member of the American Physical Therapy Association; and

1.10.38.3.4 Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

1.10.39 Physician shall mean a person who is authorized by the Board of Medical Examiners to practice medicine in the State of New Jersey, pursuant to N.J.S.A. 45:9-1 et seq.

1.10.39.1 Assistant (Physician) to the Physician-in-Charge (cardiac surgical team) shall mean a cardiovascular surgeon.

1.10.39.2 Associate Physician (cardiac diagnostic facility) shall mean a physician trained in cardiovascular catheterization, as defined and specified in the hospital's policy and procedure manual(s). (See 1.1.2.9)

1.10.40 Physician-Director (cardiac diagnostic facility) shall mean a cardiologist or pediatric cardiologist.

1.10.41 Physician-in-Charge (cardiac surgical team) shall mean a cardiovascular surgeon.

1.10.42 Physician's Care Plan shall mean a written plan developed by the physician and implemented at the time of the patient's admission, which includes special conditions, assessment of physical capability, and orders for medication, diet, and permitted level of physical activity.

1.10.43 Progress Note shall mean a signed, dated notation by a physician, written at the time of his/her visit to the patient, summarizing information about care and services provided, and the patient's response.

1.10.44 <u>Psychiatrist</u> shall mean a physician who is a member of the hospital medical staff, and who is certified or eligible for certification by the American Board of Psychiatry and Neurology, Inc., or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.45 <u>Pulmonary Medicine Specialist</u> shall mean a physician who is a member of the hospital medical staff and who is certified or eligible for certification by the American Board of Internal Medicine in the subspecialty of pulmonary disease, or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.46 <u>Pump Technician</u> shall mean a person who is certified or eligible for certification by the American Board of Cardiac Perfusionists.

1.10.47 <u>Radiologist</u> shall mean a physician who is a member of the hospital medical staff, and who is certified or eligible for certification by the American Board of Radiology, Inc., or who has been granted privileges by the hospital to provide services equal to or higher than those provided by a Board-certified or Board-eligible physician.

1.10.48 <u>Radiologic Technician</u> shall mean a person who is authorized by the State Department of Environmental Protection to apply radiation to human beings pursuant to N.J.S.A. 45:25-1 et seq.

1.10.49 <u>Recreational Therapist</u> shall mean a person who:

1.10.49.1 Is a therapeutic recreation specialist, as defined by the National Therapeutic Recreation Society; or

1.10.49.2 Is an occupational therapist; or

1.10.49.3 Is a recreation administrator certified by the New Jersey Board of Recreation Examiners and who has at least two years of full-time, or full-time equivalent, experience in a patient activities program in a health care facility.

1.10.50 Registered Professional Nurse shall mean a person who is licensed by the State of New Jersey as a registered professional nurse, pursuant to N.J.S.A. 45:11-26 et seq.

1.10.51 Rehabilitation Therapist shall mean a physical therapist, occupational therapist, speech pathologist, or recreation therapist.

1.10.52 Shift shall mean a period of time established as a full working day, as defined in the hospital policy and procedure manual.

1.10.53 Signature shall mean the full name and title of a person legibly written with his/her own hand.

1.10.54 Social Work Designee shall mean a person with a bachelor's degree in psychology, sociology, or another field related to social work, and one year of social work experience in a health care setting under the supervision of a social worker.

1.10.55 Social Worker shall mean a person who has a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education, and at least one year of social work experience in a health care facility.

1.10.56 Speech Pathologist shall mean a person who:

1.10.56.1 Meets the requirements for education and experience for a Certificate of Clinical Competence in speech pathology granted by the American Speech and Hearing Association; or

1.10.56.2 Meets the educational requirements for certification and is in the process of accumulating the required supervised experience.

1.10.57 __Staff Education Plan__ shall mean a written plan developed at least annually and implemented throughout the year which describes a coordinated program for staff education for the cardiac care service, including in-service programs and education, staff development, on-the-job training and continuing education, and the intervals and times at which these shall be given. Each employee shall receive education to develop skills and increase knowledge so as to improve patient care. (Occasional attendance by staff at programs or conventions or at lectures by invited speakers does not alone constitute an acceptable staff education plan.)

1.10.58 __Staff Orientation Plan__ shall mean a written plan for the orientation of each new employee to the duties and responsibilities of the cardiac care service, as well as to the personnel policies of the hospital. Orientation for each new employee shall be provided prior to or within one week of employment.

1.10.59 __Sterilization__ shall mean a process of destroying all microorganisms, including those bearing spores, in and around an object.

1.10.60 __Team__ shall mean physicians, nursing personnel, and technicians who are assigned to work together to perform designated procedures.

1.10.61 __Technician__, including cardiac catheterization, monitoring and recording, electronic and radiologic, or operating room technician, shall mean a person who has training and experience as specified in the hospital's policy and procedure manual(s). (See 1.1.2.11)

1.11 __Cardiac Care Construction Standards__

1.11.1 __Cardiac Catheterization/Coronary Angiography Laboratory__

A facility dedicated completely to Cardiac Catheterization/Coronary Angiographic Laboratories Suite shall comply with the State of New Jersey Uniform Construction Code, Chapter 23, Title 5, New Jersey Administrative Code and the August 1, 1977 amendments to this code, Use Group I-2.

1.11.1.1 **Additional Licensing Requirements**

The following sections of (HRA) 79-14500, Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities.

1.11.1.2 **Section 7.7A - Change to Read - Procedure Room**

Procedure Room shall have a minimum clear area of 400 square feet exclusive of fixed and movable cabinets and shelves. The minimum dimension shall be 20'0".

1.11.1.3 **Control Room**

There shall be a control room large enough to contain and provide efficient function of the X-ray control unit, physiological monitoring equipment and image recording control. Minimum space requirements are 100 square feet.

1.11.1.4 **Equipment Room**

An equipment room or enclosure large enough to contain the X-ray transformers, power modules, associated electronics and electrical gear shall be provided approximately 100 square feet. The room shall be positioned to insure short, high voltage cables. Ready access for the servicing of equipment is essential.

1.11.1.5 **Recovery Room - 7.7C**

1.11.1.6 **Service Areas**

All Service Areas are required under Section 7.7D of (HRA) 79-14500, except Items D3, D7, D9, D10, D11 and D14 and D15.

1.11.1.7 **Radiology and Cine Room(s)**

Space with X-ray and cine equipment shall be readily available within the Suite for the development of films taken during the process performed in the Procedure Room.

1.11.1.8 **The following areas shall be readily available for use by this Suite:**

A. Viewing Room.

B. Film File Room.

C. Conference Room.

D. Library and Study Room.

E. Teaching Aids and File.

1.11.2 **Cardiac Catheterization/Coronary Shared with Other Specialized Radiologic Procedures**

1.11.2.1 The Construction Standards for this unit shall be the same as Section 1.11.1 except that the only requirements under Service Areas 7.7D are Items 1, 2, 4 & 5. The other areas may be shared if available in the Suite.

1.11.3 **Cardiovascular Surgical Services**

A facility dedicated completely to Cardiovascular Surgical Services shall comply with the State of New Jersey Uniform Construction Code, Chapter 23, Title 5, New Jersey Administrative Code and the August 1, 1977 amendment to this Code, Use Group I-2.

1.11.3.1 **Additional Licensing Requirements**

The following Sections under (HRA) 74-4000, Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities shall apply:

Section 7.7A - General Operating Room

This will apply for all cardiac surgery except where open heart surgery is to be performed by the facility, then a minimum clear area of 500 square feet must be provided with the minimum dimension shall be 20'0".

Section 7.7C - Recovery Room

Section 7.7D - Service Areas

All items under this Section shall apply except Items 9, 10, 11, 14 and 15.

1.11.3.2 **Pump Room with Storage Space**

In addition to the storage cabinets located within the cardiovascular operating room, a space designated in pump room as storage for bulky disposable materials and containers shall be provided. This space in a clean area as a pump room shall be provided. This space in a clean area as a pump room in which extra corporeal pump, oxygenators, pump assist devices for intra-aortic balloon and all necessary equipment are stored, conditioned and maintained. This space shall be located in surgical suite with both inside and outside access minimum of 100 square feet.

1.11.4 **Cardiovascular Surgical Services Shared with Surgical Suite**

The Construction Standards for this Unit shall be the same as Section 1.11.3 except that the requirements for Service Areas may be shared if available in the Suite.

1.11.5 **Cardiovascular Surgical Intensive Care Suite**

The Construction Standards for this Unit shall be the State of New Jersey Uniform Construction Code, Chapter 23, Title 5, New Jersey Administrative Code and the August 1, 1977 amendments to this Code, Use Group I-2.

1.11.6 **Pediatric Cardiac Catheterization/Coronary Angiography Laboratory**

The Construction Standards for this Unit shall be identical to the Standards contained in Section 1.11.1.

1.11.7 **Pediatric Cardiac Catheterization/Coronary Shared with Other Specialized Radiologic Procedures**

The Construction Standards for this Unit shall be identical to the Standards contained in Section 1.11.2.

1.11.8 **Pediatric Cardiovascular Surgical Services**

The Construction Standards for this Unit shall be identical to the Standards contained in Section 1.11.3.

1.11.9 **Pediatric Cardiovascular Surgical Services Suite Shared with Surgical Suite**

The Construction Standards for this Unit shall be identical to the Standards contained in Section 1.11.4.

1.11.10 **Pediatric Intensive Care**

The Construction Standards for this Unit shall be identical to the Standards contained in Section 1.11.5.

Note: (HRA) 74-4000 and (HRA) 74-14500 Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities can be purchased from:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

New Jersey Uniform Construction Code can be purchased from:

N.J. Dept. of Community Affairs
620 West State Street
Trenton, NJ 08610

P2300

Addition - Hospital Licensure Manual
Section 306. Amends Section 305.D sentence #1

306.0 **Pathological and Infectious Waste Disposal**

306.1 Each hospital shall develop and implement written policies and procedures for the collection, storage, handling and disposition of all pathological and infectious wastes within the facility, and for the collection, storage, handling and disposition of all pathological and infectious wastes to be removed from the facility. These policies and procedures shall, as a minimum, include the following:

306.1.1 Solid wastes from the microbiological laboratory shall be autoclaved or incinerated.

306.1.2 Liquid wastes from the microbiological laboratory shall be autoclaved prior to disposal into the laboratory sewage system.

306.1.3 All pathology specimens and wastes, including gross and microscopic tissue removed surgically or at autopsy, shall be incinerated unless otherwise provided for by law.

306.1.4 Solid sharp or rigid items such as needles, syringes and scalpel blades shall be autoclaved prior to disposal. Needles and syringes shall be destroyed as stipulated in N.J.S.A. 2A:170-25.17 and they, along with other sharp or rigid items, shall be either ground and flushed into the sewage system or placed in a rigid container and disposed with other solid waste material.

306.1.5 Solid non-rigid contaminated waste material such as blood tubing and disposable equipment and supplies shall be autoclaved, incinerated or removed from the hospital and disposed of in a manner approved by the Department of Environmental Protection.

306.1.5.1 All such material not autoclaved or incinerated within the hospital shall be doubly packaged in impervious plastic heavy duty bags prior to removal from the hospital and disposal in a manner approved by the Department of Environmental Protection.

306.1.6 Fecal matter shall be flushed into the municipal sewerage system.

306.1.7 **All containers used for storage of infectious wastes shall be sanitized by a method approved by the Department at least once every 24 hours.**

Approved 02-01-79

Effective 03-08-79

Amendment to the Manual of Standards
for Hospital Facilities
(Verbal Orders Accepted by Physical Therapist)
January 1979

Additions are underlined thus; deletions are in brackets [thus].

702.C [10b. 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.]

10b. All telephone and verbal orders from a licensed physician shall be countersigned by the physician within 24 hours. All telephone and verbal orders shall be accepted only by a licensed professional nurse except for physical therapy orders which shall be accepted and recorded by a licensed professional nurse and/or a licensed physical therapist.

Adopted 3/1/79
Effective 5/1/79

Amendments to the Manual
of Standards for Hospital Facilities
(Authentication/Countersigning of Physician's Orders)
January 1979

Additions are underlined thus; deletions are in brackets [thus].

702.D.1 All records and reports shall be signed or authenticated by a licensed physician. The requirement that all records and reports be signed or countersigned by a licensed physician shall not apply to progress notes written by physicians engaged in an approved intern or residency training program.

702.D.5 Physician's orders written for patient's care by unlicensed persons engaged in intern or residency training programs in a hospital or institution approved by the New Jersey Board of Medical Examiners, or physician's orders written by a person exempted from the prohibitory provisions of the Medical Practice Act, pursuant to N.J.S.A. 45:9-21 (n), shall be countersigned within 24 hours by a physician possessing a current unrestricted license to practice medicine and surgery in this State.

The following definitions shall apply to Standard D:

"Unlicensed physician" shall mean [any unlicensed] a graduate of a medical school, [such as, but not] limited to an intern or resident, who is engaged in an approved program or a person possessing an exemption pursuant to N.J.S.A. 45:9-21(n).

"Intern" shall mean an unlicensed graduate of a medical school who is engaged in a program which has been approved by the Board and which consists of the supervised practice in the science and art of medicine among patients in a hospital with continued instruction by the staff of the facility. The internship period shall be limited to one year.

"Resident" shall mean a graduate of a medical school or a licensed or unlicensed graduate of an approved internship who is engaged in an approved program for advanced training in a clinical division of medicine, surgery or other special field in preparation for the practice of a specialty, which training shall be continuously supervised by the staff of the facility. Such approved program must be properly accredited for residency training in the specialty programs or programs offered.

Adopted 3/1/79
Effective 5/1/79

Amendment to the Manual of Standards
for Hospital Facilities
(Availability of Records)
January 1979

Additions are underlined thus; deletions are in brackets (thus).

704 C 1.0 The facility shall develop and implement written policies and procedures, approved by the Department, governing the availability, release, and/or provision of copies of the medical record to patients and/or the patient's authorized representative.

1.1 The written policies and procedures shall include, but not be limited to, the following:

1.1.1 A description of the procedures to protect medical record information against loss, destruction, or unauthorized use;

1.1.2 A schedule of fees, as established by the facility, for obtaining copies of the medical record;

1.1.3 The business hours, as defined by the facility, during which the patient has access to his/her medical records; and

1.1.4 In the event that it is medically contraindicated (as documented by a physician in the patient's medical record) that the patient have access to or obtain copies of his/her medical record, the medical record shall be made available to the patient's authorized representative.

1.2 The facility shall ensure that a patient's medical record is provided within at least 30 calendar days of the written request.

The following definition shall apply to Standard 704C:

Medical Record: All records in a licensed hospital which pertain to the patient including X-ray films.

Adopted 3/1/79
Effective 5/1/79

Amendment to All Licensure
Standards for Health Care Facilities
June 1979

If the main entrance door, the back entrance door, and/or doors opening onto roofs and balconies are self-locking, such doors shall have a sounding device, such as a bell, buzzer, or chimes, which is in operating condition. This sounding device shall be affixed to the outside of the door or to the adjacent exterior wall and shall be audible to a nursing station or other area that is staffed 24 hours a day, seven days a week, for use in the event that a person is unable to enter the building.

Initial Adoption HCAB - 4/5/79
Final Adoption HCAB - 6/7/79
Effective-7/5/79

Amendment to the Manual
of Standards for Hospital Facilities
October 1979

111. Q. 7. 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. The Commissioner or his/her designee may waiver this requirement if, in his/her opinion, such waiver would not endanger the life, safety, or health of the patients, staff, or public and sufficient justification exists.

Initial Adoption by HCAB 8/3/79
Second Adoption by HCAB 10/4/79
Effective 12/1/79

P3038