

(j) The multidisciplinary plan of care shall be reassessed at least weekly by all members of the professional team who are involved in the patient's care.

(k) If the patient is admitted to the psychiatric unit through the emergency department and the patient gives consent, the patient's primary-care physician shall be contacted in order to inform the physician about the patient's condition and to obtain information about the patient's medical status.

(l) Written discharge plans shall be developed for each patient by members of a multidisciplinary team, who either meet or make notes individually in the patient's record.

(m) There shall be mechanisms for providing immediate security assistance to staff and patients.

(n) Patients shall be advised of the reasons for, and expected effects of, medications prescribed for them.

(o) There shall be a milieu program that includes patient community meetings and daily activities.

(p) An accurate schedule of activities shall be posted conspicuously in the unit.

#### 8:43G-26.8 (Reserved)

#### 8:43G-26.9 Psychiatry space and environment

(a) Interviews between staff and patients shall be conducted in a private setting.

(b) The unit shall have access to at least one acute care/seclusion room.

(c) Acute care/seclusion rooms shall be at least 100 square feet and shall be large enough to provide access to the patient from all sides of the bed or mattress and have room for emergency life-sustaining equipment.

(d) Patients in acute care/seclusion rooms shall be either under direct observation in a room near the nurses station or observed through the use of electronic monitoring equipment.

(e) The unit shall have a day room/dining room that allows for social interaction, dining, and therapy.

(f) Opportunities to participate in structured physical exercise programs shall be made available to patients.

(g) There shall be space in each patient room for storage of patients' personal belongings. There shall be a system for securing patients' valuable belongings.

(h) The psychiatric care unit shall comply with the suicide prevention regulations as provided in Federal Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1987 Edition, section 7.6, or later edition, if in effect,

which are hereby incorporated by reference, and are available from The American Institute of Architects Press, 1735 New York Ave. NW, Washington, D.C. 20006, Pub. No. ISBN 0-913962-96-1.

(i) Authorized security personnel shall have immediate access to locked units.

(j) There shall be a system for summoning help from other areas of the unit in an emergency.

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

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

Exercise requirements added at (f).

#### 8:43G-26.10 (Reserved)

#### 8:43G-26.11 Psychiatry supplies and equipment

(a) The restraint equipment needed by the unit shall be immediately available on the unit and accessible to unit staff.

(b) The recreation and therapy equipment and supplies needed for psychiatric care shall be available on the unit and stored in locked storage.

(c) Locked storage areas shall be available for supplies and the safekeeping of the individual, ongoing creative projects of patients.

#### 8:43G-26.12 Psychiatry staff education

(a) Requirements for the psychiatry service education program shall be as provided in N.J.A.C. 8:43G-5.9.

(b) The staff of the psychiatric unit shall receive annual training in handling the assaultive patient.

(c) The non-medical and non-nursing professional staff shall receive annual training in drug effects and side effects.

#### 8:43G-26.13 (Reserved)

#### 8:43G-26.14 Psychiatry quality assurance methods

(a) There shall be a program of quality assurance for psychiatric services that is integrated into the hospital quality assurance program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

(b) The ongoing quality assurance program of the psychiatric service shall include incident review and monitoring of such areas as suicide, attempted suicide, elopement, assaults, slips and falls, patient abuse and neglect, use of seclusion, and use of restraints.

(c) The medical staff shall review, on at least an annual basis, use of restraints, discharge planning, and outcomes.

## SUBCHAPTER 27. CONTINUOUS QUALITY IMPROVEMENT

### 8:43G-27.1 Continuous quality improvement structural organization

(a) The governing authority of the hospital (such as the board of trustees) shall have ultimate responsibility for the continuous quality improvement program.

(b) The hospital shall have a hospital-wide continuous quality improvement program based on a written continuous quality improvement plan that is implemented and that monitors the quality of patient care.

(c) Each clinical department shall have continuous quality improvement activities that are part of the overall hospital-wide plan, a multi-department plan, or an internally generated plan.

(d) There shall be a multidisciplinary committee responsible for the direction of the continuous quality improvement program. The committee shall include at least representation from the medical staff, nursing, and administration. The committee shall establish a mechanism to include participation of all disciplines in identifying areas of review that affect patient care throughout the hospital.

(e) The hospital shall perform risk management functions. Reports generated by risk management activities shall be routinely provided to the multidisciplinary committee responsible for coordinating the quality improvement program.

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

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

Substituted references to continuous quality improvement for references to quality assurance throughout; in (c), substituted a reference to continuous quality improvement for a reference to continuous quality assurance; and in (e), substituted a reference to quality improvement for a reference to quality assurance.

### 8:43G-27.2 Continuous quality improvement policies and procedures

(a) The continuous quality improvement plan shall be reviewed at least annually and revised as necessary. Responsibility for reviewing and revising the plan shall be designated in the plan itself.

(b) The continuous quality improvement plan shall delineate lines of communication between the continuous quality improvement program and the medical staff, chief executive officer or administrator, and governing authority.

(c) The hospital-wide continuous quality improvement plan shall specify procedures for the development, implementation, and coordination of quality reviews. The plan shall also establish a mechanism for the evaluation of the continuous quality improvement program.

(d) The program shall disseminate its findings and the results of continuous quality improvement activities, as defined in the continuous quality improvement plan.

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

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

Substituted references to continuous quality improvement for references to quality assurance throughout.

### 8:43G-27.3 Continuous quality improvement staff qualifications

There shall be an individual responsible for coordinating all aspects of the continuous quality improvement program.

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

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

Substituted a reference to continuous quality improvement for a reference to quality assurance.

### 8:43G-27.4 (Reserved)

### 8:43G-27.5 Continuous quality improvement patient services

(a) There shall be an ongoing process of monitoring patient care. Evaluation of patient care throughout the hospital is criteria-based, so that certain review actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

(b) The continuous quality improvement coordinator shall be available to provide ongoing consultation to each department including assistance with the development of specific indicators used to evaluate service outcome in each department.

(c) The program shall follow up on its findings to assure that effective corrective actions have been taken, including at least policy revisions, procedural changes, educational activities, and follow-up on recommendations, or that additional actions are no longer indicated or needed.

(d) The continuous quality improvement program shall identify and establish indicators of quality care specific to the hospital that are monitored and evaluated and encompass at least:

1. Surgical case review;
2. Drug usage;
3. Medical record review;
4. Blood usage;
5. Pharmacy and therapeutics function; and
6. Appropriateness of specific diagnostic and therapeutic procedures, as selected by the continuous quality improvement program.

(e) The continuous quality improvement program shall provide information that is utilized in the evaluation of the clinical competence of all clinical practitioners.

Amended by R.1999 d.436, effective December 20, 1999.  
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

Substituted references to continuous quality improvement for references to quality assurance throughout.

#### 8:43G-27.6 Performance measurement and assessment system

(a) The Department shall establish a Quality Improvement Advisory Committee (QIAC), including provider, consumer and individuals with quality of care research expertise representation, to advise the Department in developing a performance measurement and assessment system for monitoring the hospital-wide quality of care.

(b) The Quality Improvement Advisory Committee shall advise the Department on the development of a uniform data reporting system to obtain reliable, standardized and comparable information from all hospitals. This reporting system shall include at least the following indicators of care:

1. Percentage of board certified physicians;
2. Cesarean section rate, including primary, repeat, and vaginal births after C-sections;
3. Cardiac surgical mortality;
4. Cardiac catheterization mortality; and
5. Average waiting time for medical screening examination in the emergency department.

(c) No data shall be required to be reported until the Quality Improvement Advisory Committee has submitted its advise to the Department and appropriate regulations are promulgated.

(d) Beginning June 20, 2001, and annually thereafter, the hospital shall report the following indicators, as well as those noted in N.J.A.C. 8:43G-17, in a uniform data reporting system developed by the Quality Improvement Advisory Committee:

1. Unscheduled returns to a critical care unit during the same hospitalization;
2. Unscheduled admissions to hospital for the same condition within 72 hours of discharge from the emergency department;
3. Unscheduled returns to the operating room for the same condition;
4. Registered professional nurses in medical/surgical units as a percentage of total medical/surgical nursing staff; and
5. Direct service indicators of care, including at least:
  - i. Patient injury rate;
  - ii. Medication process errors;
  - iii. Maintenance of skin integrity;
  - iv. Nosocomial infection rates;

v. Hospital-wide patient satisfaction with overall care, including nursing care; and

vi. Patient satisfaction with pain management.

(e) During the development and implementation of the uniform data reporting system, the QIAC shall address the following:

1. The relevance, validity and reliability of each measure selected to be an indicator of performance;
2. Protection of confidentiality of patient-specific information;
3. Cost and difficulty of data collection;
4. Measures to reduce duplicative reporting of information; and
5. Public release of data in formats useful to purchasers and/or consumers.

(f) The QIAC shall meet on an ongoing basis to evaluate data as it is received by the Department, and shall establish a process for disseminating aggregate data to hospitals for review prior to public release and for use in internal quality improvement programs.

New Rule, R.1999 d.436, effective December 20, 1999.  
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).  
Public Notice: Postponement of effective date for hospitals to report indicators of care.  
See: 33 N.J.R. 2348(a).

## SUBCHAPTER 28. RADIOLOGY AND RADIATION ONCOLOGY

### 8:43G-28.1 Radiology structural organization

Radiological services shall be provided on-site, except for specialized services that have been approved through the Certificate of Need process to be provided on an off-site regional basis.

Amended by R.1992 d.72, effective February 18, 1992.  
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).  
CN approval required for off-site service.

### 8:43G-28.2 Radiology policies and procedures

(a) The radiology service shall have written policies and procedures that are reviewed at least once every three years, revised more frequently as needed, and implemented. These policies and procedures shall include at least:

1. Safety practices;
2. Emergencies;
3. Adverse reactions;
4. Management of the critically ill patient; and

5. Infection control, including patients in isolation.

(b) The radiology service's policies and procedures manual shall be available to staff in the radiology unit.

(c) There shall be a written protocol for managing medical emergencies in the radiological suite. All radiological staff shall be instructed in this protocol and know their roles in the case of such an emergency.

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

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

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the first sentence, and inserted "shall" in the second sentence of the introductory paragraph.

**8:43G-28.3 (Reserved)**

**8:43G-28.4 (Reserved)**

**8:43G-28.5 Radiology continuous quality improvement methods**

There shall be a program of continuous quality improvement for the radiology service that is integrated into the hospital continuous quality improvement program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

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

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

Substituted references to continuous quality improvement for references to quality assurance throughout.

**8:43G-28.6 (Reserved)**

**8:43G-28.7 Diagnostic services staff qualifications**

All radiologists performing diagnostic radiology services in the hospital shall have successfully completed an approved graduate medical education residency training program in radiology.

**8:43G-28.8 Diagnostic services staff time and availability**

(a) A radiologist who has completed a residency training program in radiology shall be able to arrive, and shall arrive, at the hospital within 30 minutes of being summoned, under normal transportation conditions.

(b) A currently licensed radiologic technologist shall be present in the hospital or on call at all times; if on call, the technologist shall be able to arrive, and shall arrive, at the hospital within 30 minutes of being summoned, under normal transportation conditions.

(c) A registered professional nurse shall be available in the radiology service when needed, in the physician's judgment, to administer medications and perform other nursing duties.

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

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

Text added at (b) on radiologic technician availability.

**8:43G-28.9 (Reserved)**

**8:43G-28.10 Diagnostic services patient services**

(a) Radiologists shall supervise and interpret all radiologic procedures, unless performed by clinical practitioners in specialty areas who are trained and experienced in these procedures.

(b) All radiologic tests shall be interpreted, on a preliminary basis, within 24 hours of the time that test results are available for interpretation.

(c) If provided by the hospital, computer tomography shall be available within one hour at all times, when deemed appropriate in the judgement of the radiologist, unless the machinery is temporarily disabled or in use.

(d) Ultrasound shall be available within one hour at all times, unless the machinery is temporarily disabled or in use.

(e) If provided by the hospital, nuclear medicine shall be available within one hour at all times, unless the machinery is temporarily disabled or in use, or unless the needed pharmaceutical product is unavailable.

(f) If provided by the hospital, special procedures such as angiography and interventional procedures shall be available within one hour at all times, when deemed appropriate in the judgement of the radiologist, unless the machinery is temporarily disabled or in use.

(g) The radiology staff shall make every effort to ensure that patients waiting for radiology services or transport from radiology are comfortable while waiting and that the service responsible for transporting the patient back to the unit is notified when the patient is ready to be returned.

(h) Fluoroscopy with image intensification and a general radiographic room, and a mobile x-ray unit, shall be available.

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

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

Ultrasound required in (d).

**8:43G-28.11 (Reserved)**

**8:43G-28.12 Diagnostic services supplies and equipment**

(a) Cardiopulmonary resuscitation technology shall be immediately available to radiology services on all shifts. This technology shall include at least:

1. A patient monitor and defibrillator;
2. Emergency drugs; and
3. Means of maintaining respiration.