

iv. Documentation of telephone contact with the OPO.

5. A provision that the hospital shall permit the OPO to review the medical records of all deceased patients, as long as the OPO has agreed, in writing, to maintain the confidentiality of any patient identifying information.

6. A requirement that discretion and sensitivity to family circumstances and beliefs shall be maintained in all discussions regarding donations of organs, tissue or eyes.

(d) The hospital shall identify the position or job title of the person at the hospital who shall be responsible for serving as a hospital liaison to the hospital's OPO, and as coordinator of the hospital's donor activities. The hospital, in conjunction with the OPO shall provide in service training to such individuals. Such individual shall be responsible for overseeing the development and implementation of the hospital's protocols established in accordance with subsection (c) above.

(e) Recovery of human body parts for donation may be performed by a transplant recovery specialist. A physician is not required to be present during the recovery procedure.

(f) If the hospital performs organ transplants, the director of the medical staff shall ensure that satisfactory follow-up care and consultation are provided to all transplantation patients, including multidisciplinary conferences held at periodic intervals.

(g) If the hospital provides bone or tissue banking services, the hospital shall meet all guidelines set by the American Association of Tissue Banks for such services. Such guidelines are incorporated herein by reference and are available from the American Association of Tissue Banks, 1350 Beverly Road, Suite 220A, McLean, VA 22101 (703-827-9582).

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).

8:43G-5.5 Administrative and hospital-wide patient services

(a) To meet the needs of pediatric patients, the hospital shall have available medical and nursing staff with specialized pediatric training and shall have equipment adaptable to the needs of pediatric patients on-site.

(b) The hospital shall ensure the safe transport of patients within the hospital, according to each patient's medical needs. This system shall include at least interdepartmental reporting of incidents and changes in the patient's condition during transportation and during the period the patient is in another service and providing an accompanying health professional for those patients whose condition warrants it.

(c) The hospital shall provide interpretive services, when necessary, for patients who do not speak English and for

patients who are deaf. The facility shall provide other communication assistance, as needed, for patients who are blind.

(d) The hospital shall have a system to link patients with clergy or spiritual counselors, upon request.

(e) For patient and staff safety, the hospital shall have a security system which is rigidly enforced and includes at least an identification system for employees, volunteers, and medical staff and control of access to and egress from the hospital.

(f) There shall be a means to summon immediate emergency response for medical emergencies occurring in the hospital.

(g) Each department in the hospital providing direct patient care shall have a health care professional capable of initiating cardiopulmonary resuscitation on duty at all times when patients are present.

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

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

Text on CPR staff added at (i).

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

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

Rewrote (c); deleted former (e) and (f); and recodified former (g) through (i) as (e) through (g).

8:43G-5.6 (Reserved)

New Rule, R.1991 d.450, effective August 19, 1991 (operative October 15, 1991).

See: 22 N.J.R. 3469(a), 23 N.J.R. 2526(a).

Repealed by R.2008 d.52, effective March 3, 2008.

See: 39 N.J.R. 314(a), 40 N.J.R. 1094(a).

Section was "Reportable events".

8:43G-5.7 Administrative and hospital-wide staff education

(a) There shall be a formal orientation program for all new permanent staff that includes at least training in patient rights as found at N.J.A.C. 8:43G-4, a tour of the hospital, orientation to the hospital's security system and disaster plan, and review of procedures to follow in case of an emergency.

(b) There shall be a formal orientation program for all new temporary staff, nurses retained through an outside agency, and persons providing services by contract which includes, at a minimum, a tour of the department to which the individual is assigned, orientation of the hospital's security system, and review of procedures to follow in case of an emergency.

(c) The hospital shall provide, evaluate, and coordinate training and educational programs for all departments in the hospital.

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

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

Reference to Subchapter 4 added.

8:43G-5.8 (Reserved)**8:43G-5.9 Department education programs**

(a) Each department in the hospital shall develop, revise as necessary, and implement a written plan of staff education. The plan shall address the education needs, relevant to the service, of different categories of staff on all work shifts. The plan shall include education programs conducted at least annually in the service, in other areas of the hospital, or off-site.

(b) The plan shall include education programs that address at least the following:

1. Orientation of new staff to the service in which the individual will be employed, including a review of the service's equipment, policies, and procedures and identification of individual employee duties for receiving and evacuating patients in the event of a disaster;
2. Use of new clinical procedures, new equipment, and new technologies, including, where applicable, computers;
3. Individual staff requests for education programs;
4. Supervisor judgements about education needs based on assessment of staff performance;
5. Education on statutory requirements relevant to the specific service such as identification and reporting of victims of abuse; and
6. Areas identified by the hospital-wide quality assurance program as needing educational programs; and
7. Patient rights; and
8. Rights and responsibilities of staff under the New Jersey Advance Directives for Health Care Act (P.L. 1991, c.201) and the Federal Patient Self Determination Act (P.L. 101-508), and internal hospital policies and procedures to implement these laws.

(c) Implementation of the plan shall include records of attendance for each program and composite records of participation for each staff member.

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

Annual requirement added at (a); identification and reporting of abuse victims added at (b)6.

Amended by R.1992 d.132, effective March 16, 1992.

See: 23 N.J.R. 3256(a), 24 N.J.R. 942(a).

Text added at (b)7 on advance directives.

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 (b), inserted a new 7, and recodified former 7 as 8.

8:43G-5.10 Funding for regionalized services

(a) All hospitals providing emergency room services shall be members in good standing of the New Jersey Poison Information and Education System established pursuant to N.J.S.A. 26:2-119 et seq.

(b) All hospitals with licensed obstetric or pediatric beds or designated as a Community or Regional Perinatal Center pursuant to N.J.A.C. 8:33C shall be a member in good standing of a Maternal and Child Health Consortium as defined in N.J.A.C. 8:35.

(c) Prior to the designation of the Maternal and Child Health Consortium pursuant to the certificate of need process and after the expiration of the Robert Wood Johnson Foundation funding for consortia on or before March 1, 1993, all hospitals eligible for a perinatal adjustment in a 1993 revenue cap approved by the Hospital Rate Setting Commission shall make monthly payments based on that adjustment to the Maternal and Child Health Consortium to which they belong.

Emergency New Rule, R.1993 d.138, effective March 2, 1993 (expired May 1, 1993).

See: 25 N.J.R. 1295(a).

Continuity of funding to consortia specified at (c).

New Rule, R.1993 d.229, effective May 17, 1993.

See: 25 N.J.R. 792(a), 25 N.J.R. 1969(a).

Adoption of concurrent proposal by R.1993 d.236, effective April 29, 1993 (Readoption of emergency amendment) and June 7, 1993 (adoption of amendment).

See: 25 N.J.R. 1295(a), 25 N.J.R. 2555(a).

Amended by R.1993 d.286, effective June 7, 1993.

See: 25 N.J.R. 1117(a), 25 N.J.R. 2554(a).

Petition for Rulemaking: Health Care Quality and Oversight Branch: hospitals providing emergency room services: membership in New Jersey Poison Information and Education System.

See: 38 N.J.R. 1591(a).

(g) For all patients who receive discharge planning, the patient's medical record shall include on-going documentation and a summary or summaries of the patient's discharge plan prepared by a member of the discharge planning team at the time of discharge, or within 30 days of discharge.

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

Documentation requirements added at (b) and (g).
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(a).

In (e), substituted "within 24 hours of admission in accordance with N.J.A.C. 8:43G-18.5(d) and 33.2(c)" for "at an early stage of the patient's hospitalization" at the end of the first sentence.

8:43G-11.6 Discharge planning continuous quality improvement methods

(a) There shall be a program of continuous quality improvement for discharge planning 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. The program shall monitor at least:

1. That communication occurs among members of the multidisciplinary team, and the patient and family;
2. Appropriateness of referrals; and
3. Implementation of the discharge plan.

(b) There shall be a mechanism in place for monitoring the effectiveness of the discharge planning process on a periodic basis.

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(a).

In (a), substituted references to continuous quality improvement for references to quality assurance in the introductory paragraph.

Case Notes

Parents had no counterclaim against hospital under the Consumer Fraud Act for hospital's alleged improper practices in supposedly coercing son to remain in the hospital after need for treatment had ended for purposes of inflating hospital's gross income receipts. *Hampton Hosp. v. Bresan*, 288 N.J.Super. 372, 672 A.2d 725 (A.D.1996).

SUBCHAPTER 12. EMERGENCY DEPARTMENT AND TRAUMA SERVICES

8:43G-12.1 Emergency department structural organization

The hospital shall provide emergency services on a 24 hour basis, unless it is a licensed special or psychiatric hospital. Special and psychiatric hospitals shall have a written plan and a system to meet medical emergencies based on the types of patients and cases that are typically treated in the hospital. Those hospitals exempted under this section shall not offer emergency medical services to the general public.

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).
Inserted references to psychiatric hospitals throughout.

8:43G-12.2 Emergency department policies and procedures

(a) The emergency department shall have written policies and procedures for medical, trauma, and pediatric patients, that are reviewed at least once every three years, revised more frequently as needed, and implemented.

(b) Each hospital shall develop and implement policies and procedures for the evaluation and treatment by qualified medical personnel of all patients who come to the emergency department. An advanced practice nurse functioning as qualified medical personnel evaluating and treating patients in the emergency department shall establish and maintain a collaborative relationship, described in these policies and procedures, with an emergency physician regularly practicing in that hospital's emergency department. A physician assistant functioning as qualified medical personnel evaluating and treating patients in the emergency department shall be supervised by an emergency physician regularly practicing in that hospital's emergency department. Emergency physicians shall meet the qualifications required in N.J.A.C. 8:43G-12.3(b).

(c) There shall be a transfer protocol that governs inter-hospital transfers of patients, including but not limited to pediatric and trauma patients, in need of specialized care not provided in the hospital. Transfer protocols for trauma patients shall be in accordance with N.J.A.C. 8:43G-12.15(c) through (g).

(d) The emergency department shall have a written protocol that governs the management of psychiatric patients who require special services not available in the hospital. This protocol addresses the roles and involvement of hospital health professionals, social work services, law enforcement officials, and mental health services, when indicated.

(e) The emergency department shall have a written protocol that addresses the ability of family members and significant others to remain with patients during treatment. The protocol shall also address the special needs of patients who are unable to communicate for reasons of language, disability, age, or level of consciousness.

(f) The emergency department shall have a written protocol that governs referrals if a clinical speciality service is not available.

(g) The emergency department shall have policies to ensure compliance with regulations at 42 CFR 489.24 and 42 CFR 489.20 requiring examination and treatment for emergency conditions and women in labor.

(h) The emergency department shall have written policies for airway maintenance, adult and pediatric sedation, analgesia, and rapid sequence intubation.

(i) The hospital shall maintain a trauma registry in accordance with N.J.A.C. 8:43G-12.21(a) through (c).

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

Inability to communicate specified at (d).
Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

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

Rewrote the section.
Amended by R.2011 d.055, effective February 22, 2011.
See: 42 N.J.R. 1774(a), 42 N.J.R. 2561(a), 43 N.J.R. 401(b).

In (i), substituted "8:43G-12.21(a) through" for "8:43G-12.21() and".

8:43G-12.3 Emergency department staff qualifications

(a) There shall be a physician director of the emergency department who is board certified in emergency medicine or who has five years of full-time experience in emergency medicine, which may include three years residency in emergency medicine, within the past seven years.

(b) Each physician practicing in the emergency department, except residents functioning under supervision as part of the hospital's graduate residency training program, consulting physicians, and private physicians who are attending to their patients in the emergency department, shall meet at least one of the following qualifications:

1. Board certification in emergency medicine;
2. Successful completion of an approved residency program in emergency medicine, family medicine, general internal medicine, general surgery, or general pediatrics; or
3. Three years of full-time clinical experience in emergency medicine within the past five years.

(c) Each physician practicing in the emergency department, except residents functioning under direct supervision as part of the hospital's graduate residency program, consulting physicians, and private physicians who are attending to their patients in the emergency department, shall attain provider status in Advanced Cardiac Life Support and either Advanced Pediatric Life Support or Pediatric Advanced Life Support within 12 months of initial assignment, and shall continuously maintain this status thereafter. Physicians who are board certified in emergency medicine shall be exempt from this requirement.

(d) Each physician practicing in the emergency department, except residents functioning under direct supervision as part of the hospital's graduate residency program, consulting physicians, and private physicians who are attending to their patients in the emergency department, shall attain provider status in Advanced Trauma Life Support within 12 months of initial assignment, and shall continuously maintain this status thereafter. Physicians who are board certified in emergency medicine shall be exempt from this requirement.

(e) The emergency department shall be staffed at all times by at least one professional nurse who has attained and

continuously maintains provider status in Advanced Cardiac Life Support.

(f) The emergency department shall comply with the provisions of N.J.A.C. 8:41-7.4 in the utilization of paramedics.

(g) All registered professional nurses regularly assigned to the emergency department shall be trained and have completed courses in emergency care, including at least:

1. Basic life support (CPR);
2. Advanced Cardiac Life Support (ACLS), with ACLS provider status attained within 12 months of initial assignment and continuously maintained thereafter;
3. A minimum of eight contact hours of education every two years in basic trauma assessment, intervention, and stabilization; and
4. Pediatric Advanced Life Support (PALS), or Advanced Pediatric Life Support (APLS), or Emergency Nurse Pediatric Course (ENPC), with PALS or APLS or ENPC provider status attained within 12 months of initial assignment and continuously maintained thereafter.

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

Clinical experience requirements added to (a)3 and (c).
Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

Rewrote the section.

8:43G-12.4 Additional pediatric requirements

(a) Each emergency department shall have a designated pediatric liaison physician and a designated pediatric liaison nurse, who shall be responsible for review and approval of the emergency department's pediatric activities, including:

1. Policies and procedures for pediatric care;
2. Pediatric equipment;
3. Continuous quality improvement for pediatric patients;
4. Staff training and education for pediatric care; and
5. Pediatric emergency medicine registry.

(b) Upon 60 days notice by the Department, each emergency department shall implement and maintain a pediatric emergency medicine registry for all emergency department admissions under 18 years of age who either die or are admitted to an intensive care unit or step-down unit. This registry shall include the following data items:

1. Medical record number;
2. Hospital identifier number (assigned randomly);

3. Date of service;
4. Gender;
5. Date of birth (not age);
6. Zip code;
7. Baseline medical condition;
8. Mode of arrival;
9. Pre-hospital medical and/or procedural interventions, including emergency medical services times and vital signs;
10. Nature of presenting illness;
11. Physician professional characteristics (for example, board certification or other special training);
12. Chief complaint category;
13. Initial vital signs upon presentation;
14. Emergency department medical and/or procedural interventions (treatment rendered);
15. Clinical impression;
16. Time of call for transfer;
17. Mode of transport on transfer;
18. Transport team interventions;
19. Intensive care unit number;
20. Intensive care unit physician professional characteristics (for example, board certification or other special training);
21. Medical and/or procedural interventions during first hour in intensive care unit;
22. Initial critical care score;
23. Length of stay in intensive care unit;
24. Final disposition;
25. Functional neurologic status; and
26. Functional physiologic status.

(c) Based upon recommendations from the New Jersey Emergency Medical Services for Children Advisory Council, the Department may require, through promulgation of an amendment to (b) above, the inclusion of additional data items.

(d) Registry data shall be submitted on an annual basis to the Department in a form prescribed by the Department.

New Rule R.2001 d.60, effective February 20, 2001.
See: 32 N.J.R. 213(a), 33 N.J.R. 658(a).

8:43G-12.5 Emergency department staff time and availability

(a) At all times at least one licensed physician who meets at least one of the qualifications in N.J.A.C. 8:43G-12.3(b)

shall be present in the emergency department to attend to all emergencies.

(b) There shall be a physician specialist on call to the emergency department for each major clinical service provided by the hospital, including a physician who is credentialed by the hospital to care for children and who is either board certified in pediatrics or has attained provider status in Advanced Pediatric Life Support or Pediatric Advanced Life Support.

1. The hospital emergency department shall comply with the requirements set forth in N.J.A.C. 8:43G-5.1(l)2 for all emergency department patients deemed by a hospital clinical provider to require emergent care, regardless of whether the patient lacks a primary care physician. In addition, the hospital clinical provider making that judgment shall make a determination as to whether the responding on-call physician may be a resident or, rather, the emergency requires a physician who has completed all residency requirements.

2. A standing transfer agreement with a facility that can provide an appropriate level of care for pediatric patients may be substituted for the on-call physician credentialed and qualified to care for children if the hospital does not have the capability of providing such a physician for on-call duty.

(c) At least one registered professional nurse who has successfully completed the Emergency Nursing Pediatric Course, Advanced Pediatric Life Support or Pediatric Advanced Life Support shall be present at all times in the emergency department. The hospital shall have in place a protocol to increase nurse staffing based on volume and acuity.

Amended by R.1995 d.124, effective March 20, 1995.

See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

Amended by R.2002 d.98, effective April 1, 2002.

See: 33 N.J.R. 1174(a), 34 N.J.R. 1423(a).

In (a), amended the N.J.A.C. reference; rewrote (b) and (c).

Case Notes

Care and treatment for the needy sick. Perth Amboy Gen. Hosp. v. Middlesex Freeholders, 158 N.J.Super 556 (Law Div.1978). Att'y Gen.Form Op. 1977-No. 15.

Requirement of a 24-hour licensed physical coverage in emergency department. In re Kessler Memorial Hospital, 154 N.J.Super. 147 (App.Div.1977), rev'd 78 N.J. 564 (1979).

8:43G-12.6 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Comes to the emergency department” means, with respect to an individual requesting examination or treatment by him or herself or with another person, that the individual is on hospital property (including ambulances owned and operated by the hospital even if the ambulance is not on hospital

grounds). An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the emergency department.

“Emergency department” means, an organized clinical department of the hospital which, at a minimum, evaluates and treats emergency medical conditions.

“Emergency medical condition” means:

1. A medical condition manifesting itself by acute symptoms or sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that absence of immediate attention could reasonably be expected to result in:
 - i. Placing the health of the individual (or, with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy;
 - ii. Serious impairment to bodily functions; or
 - iii. Serious dysfunction of a bodily organ or part; or
2. With respect to a pregnant woman who is having contractions:
 - i. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

“Medical screening examination” means an examination and evaluation within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, performed by qualified medical personnel (as defined below and specified by hospital by-laws or policies and procedures) to determine whether or not an emergency medical condition exists.

“Qualified medical personnel” means a physician who meets the requirements at N.J.A.C. 8:43G-12.3, or an advanced practice nurse certified by the New Jersey State Board of Nursing, or a physician assistant licensed by the New Jersey State Board of Medical Examiners. The advanced practice nurse or licensed physician assistant shall have training and experience in emergency care.

“Stabilize” means to provide such medical treatment of an emergency medical condition that is necessary to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that the woman has delivered the child and the placenta.

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).

8:43G-12.7 Emergency department patient services

(a) When an individual comes to the emergency department requesting examination or treatment for a medical condition, or if a request is made on the individual’s behalf,

clinical priority for treatment shall be assigned by a registered professional nurse or qualified medical personnel.

(b) Treatment for life-threatening emergencies shall be initiated immediately.

(c) If an individual comes to the emergency department requesting examination or treatment for a medical condition, or if a request is made on the individual’s behalf, the hospital shall provide for an appropriate medical screening examination performed by qualified medical personnel. Medical screening may be provided in the emergency department or urgent care clinic or area accessible to the emergency department and on hospital grounds.

1. Qualified medical personnel shall perform all medical screenings designed to identify patients clinically suspected of presenting with a stroke.

2. If the hospital is a designated primary or comprehensive stroke center, whenever a clinical suspicion of stroke exists, the stroke team shall further evaluate the patient consistent with the stroke treatment protocols established by the hospital as required for designation in accordance with N.J.A.C. 8:43G-7A.

(d) If it is determined that an emergency medical condition exists, the patient must be evaluated by a physician and provided with such medical treatment as is necessary to assure that the condition has been stabilized, except as provided in (e) below.

(e) If a patient has an emergency medical condition which has not been stabilized, the hospital shall not transfer the patient unless:

1. The patient (or a legally responsible person acting on the patient’s behalf), after being informed of the hospital’s obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility; or

2. A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient and, in the case of labor, to the unborn child, from effecting the transfer. This certification shall include a summary of the risks and benefits upon which the certification is based.

(f) If it is determined that an emergency medical condition does not exist, the patient shall either be treated in the emergency department or shall be referred to an appropriate health care facility or provider; and the patient shall be discharged in accordance with (n) below.

(g) No patient who comes to the emergency department shall be discharged to home or another facility without being seen and evaluated by qualified medical personnel. This evaluation shall occur within four hours of the patient’s coming to the emergency department.

8:43G-19.1 Scope of obstetrical standards—definitions; structural organization

(a) The standards in this subchapter shall apply only to hospitals that have a separate, designated unit or service for obstetrics.

(b) The following terms, when used in this subchapter, shall have the following meanings:

“Advanced practice nurse” means a licensed registered professional nurse with certification in a specialty requiring expertise in maternal and child health who has been certified by the New Jersey Board of Nursing as specified in N.J.A.C. 13:37-7.

“Birth center” means an ambulatory care facility or a distinct part of a facility which is separately licensed as an ambulatory care facility and provides routine prenatal and intrapartum care. These facilities provide care to low-risk maternity patients who are expected to deliver neonates of a weight greater than 2,499 grams and at least 37 weeks gestational age and who require a stay of less than 24 hours after birth.

“Community Perinatal Center” (CPC) means a licensed hospital designated within a Maternal and Child Health Service Region as one of the following:

1. “Basic” provides care to uncomplicated maternity patients and neonates in accordance with the scope of functions delineated in its formal letter of agreement with the Regional Perinatal Center. Such a facility shall provide care to patients expected to deliver neonates greater than 2,499 grams and at least 36 weeks gestation.

2. “Intermediate” provides care to complicated maternity patients and neonates in accordance with the scope of functions delineated in its letter of agreement with the Regional Perinatal Center. Such a facility shall provide care to patients expected to deliver neonates greater than 1,499 grams and at least 32 weeks gestation.

3. “Intensive” provides care to complicated maternity patients and neonates in accordance with the scope of functions delineated in its letter of agreement with the Regional Perinatal Center. Such a facility shall provide care to patients expected to deliver neonates greater than 999 grams and at least 28 weeks gestation.

“Contact hour” means a unit of measurement that describes 50 minutes of an approved, organized learning experience, either didactic or clinical practice.

“Letter of agreement” means the document which defines the relationship between a Regional Perinatal Center and a Community Perinatal Center and specifies all tasks to be provided. This document must be developed in cooperation with the Maternal and Child Health Consortia in the region and signed by both facilities.

“Member in good standing” means that an acute care hospital has made timely payment of Maternal and Child Health Consortium (MCHC) financial assessments in accordance with the MCHC by-laws, which are based on a budget approved by the Department of Health and Senior Services.

“Obstetric patient” means a female patient at any stage of pregnancy, including antepartum, and up to six weeks post partum, whose primary diagnosis is related to the management of labor, pregnancy complications or complications of the puerperium.

“Risk reduction specialist” means a registered professional nurse, a licensed or certified social worker or other professional in a maternal and child health addiction related field, who has specialized training and experience in perinatal addiction.

(c) All hospitals with obstetric services shall satisfy the following conditions:

1. The hospital shall be designated as a Community Perinatal Center or a Regional Perinatal Center; and
2. The hospital shall be a member in good standing of a Maternal and Child Health Consortium.

(d) All hospitals shall provide services in accordance with a letter of agreement facilitated by the Maternal Child Health Consortium for its region. Such services shall include:

1. Prenatal and pediatric services in accordance with the HealthStart Standards, N.J.A.C. 10:49-3; and
2. Routine prenatal care which incorporates use of a comprehensive standardized perinatal record.

(e) All Community Perinatal Centers shall have a written protocol which addresses the management of patients assessed to be at risk during the prenatal period. This protocol shall assure referral of the patient to a provider with advanced capabilities in maternal-fetal medicine for initial consultation and, if appropriate, treatment.

(f) All Regional Perinatal Centers shall have a distinct prenatal clinic service devoted to women identified as high risk. This clinic shall be staffed by an advanced practice nurse on-site and a risk reduction specialist available during hours of operation. One individual may fill both positions.

(g) All Regional Perinatal Centers shall provide high risk infant follow-up service accordance with N.J.A.C. 8:33C.

Amended by R.1992 d.347, effective September 8, 1992.

See: 24 N.J.R. 2045(a), 24 N.J.R. 3165(a).

Definitions added at (b).

Amended by R.1993 d.286, effective June 7, 1993.

See: 25 N.J.R. 1117(a), 25 N.J.R. 2554(a).

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

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

Rewrote the section.

8:43G-19.2 Obstetrics policies and procedures

(a) The obstetric 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 be available in all areas of the obstetric service and include at least:

1. Criteria for the identification of high-risk obstetric and newborn patients;
2. Guidelines for when to call a physician during labor;
3. Qualifications for nurses who provide maternal and infant care appropriate to the level of care provided;
4. The use of fetal monitors;
5. A protocol for the use of oxytocics for induction and stimulation of labor, including physician assessment of the patient before the drug's use, monitoring of the patient and fetus during its use, indications for discontinuance of the drug, educating staff in the use of oxytocin and a policy which addresses the availability of a physician to manage any complications that may arise during infusion;
6. A system for identifying hospital personnel while they are working in the unit;
7. The attire required to be worn in the labor and delivery areas;
8. A visitors policy that includes who may visit the unit and at what times, security procedures for monitoring and controlling visitors, and infection control instructions;
9. Guidelines for rooming in, if applicable; and
10. A system to provide written and oral discharge instructions from professional staff to patients upon discharge.

(b) A current list of physicians and nurse-midwives, their specific obstetric service privileges, and an on-call schedule shall be available in the department to professional staff.

(c) On obstetric units where Cesarean sections are performed, all requirements of surgical standards shall apply.

(d) The hospital shall require submission of a copy of the prenatal record for all patients registered to deliver at the hospital once the patient reaches 34 weeks gestation. These prenatal records shall be accessible to the obstetrical unit at all times.

(e) Restrictions shall be established and posted governing entry into the delivery/cesarean suite.

(f) Entry into the surgical area shall be restricted to staff and support persons. Scrub attire shall be required.

(g) All pregnant women admitted to the hospital with unknown or undocumented hepatitis-B surface antigen (HBsAg) assay results shall be immediately screened for the hepatitis-B virus using the HBsAg test or other standardized hepatitis-B tests. Test results should be available within 24 hours but no later than 48 hours. All positive HBsAg test results shall be reported on a designated reporting form within five working days of determination to the New Jersey Department of Health and Senior Services, Immunization Program.

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

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

Text on prenatal record added at (f).

Amended by R.1992 d.347, effective September 8, 1992.

See: 24 N.J.R. 2045(a), 24 N.J.R. 3165(a).

Text regarding transfer of patients at (e) deleted; subsections recodified.

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

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

Rewrote the section.

8:43G-19.3 Obstetrics staff qualifications

(a) There shall be a physician director of the obstetric service who is responsible for all obstetric care in the hospital and is board certified in obstetrics.

(b) There shall be a nurse manager of the obstetric service, which may include labor and delivery, who is a registered professional nurse and who has:

1. A minimum of three years of experience in inpatient obstetric services within the five years immediately preceding the date of appointment;
2. Educational preparation in maternal-fetal neonatal nursing, in accordance with hospital policy; and
3. Completion of 24 contact hours in maternal-fetal or neonatal nursing approved by a nationally recognized nurse education accrediting body every three years.

(c) All health professionals assigned to the post-partum service shall be trained in the care of both mothers and infants.

(d) Hospitals designated as a CPC-Intensive or Regional Perinatal Center shall have an advanced practice nurse who is responsible for in-house and regional staff training and consultation in perinatal care. This individual shall be a registered professional nurse with a master's degree in a maternal and child health nursing specialty from an accredited college or university and who has:

1. A minimum of three years experience in maternal and child health inpatient services within the five years immediately preceding the date of appointment; and
2. Certification by the National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties or American Nurses' Association.

Amended by R.1992 d.347, effective September 8, 1992.

See: 24 N.J.R. 2045(a), 24 N.J.R. 3165(a).

Text added to require recent experience and education; new subsections (d)-(f) added.

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

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

Rewrote the section.

8:43G-19.4 Obstetrics staff time and availability

(a) The obstetric service in hospitals designated as a CPC-Basic shall be covered at all times by a board eligible or certified obstetrician or a board eligible or certified family practice physician with obstetric privileges, who is present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions. If coverage is provided by a family practice physician as described above, there shall be a mechanism of coverage to ensure that an obstetrician is able to arrive within 30 minutes of being summoned to perform a cesarean section.

(b) The obstetric service in hospitals designated as a CPC-Intermediate shall be covered at all times by a board eligible or certified obstetrician or board eligible or certified family practice physician with obstetric privileges, or an obstetric resident with at least three years of training, who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions. If coverage is provided by a family practice physician as described above, there shall be a mechanism of coverage to ensure that an obstetrician is able to arrive within 30 minutes of being summoned to perform a cesarean section.

(c) The obstetric service in hospitals designated as Community Perinatal Centers Intensive shall be covered at all times by a board eligible or certified obstetrician, who is present in the hospital.

(d) The obstetric service in hospitals designated as a Regional Perinatal Center shall be covered at all times by a board certified obstetrician with certification in maternal-fetal medicine, who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions. This physician may fulfill the requirement for physician coverage at (c) above during those times in which he or she is present in the hospital.

New Rule, R.1992 d.347, effective September 8, 1992.

See: 24 N.J.R. 2045(a), 24 N.J.R. 3165(a).

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

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

Rewrote the section.

Case Notes

Registered nurse requirement in labor-delivery and obstetrics rooms under former N.J.A.C. 8:43B-8.4. In re: Kessler Memorial Hospital, 154 N.J.Super. 147 (App.Div.1977), reversed 78 N.J. 564, 381 A.2d 44 (1979) dissenting opinion.

8:43G-19.5 Obstetrics patient services

(a) Obstetric patients shall be informed upon admission about hospital policies and procedures, including at least policies regarding visitors, and the unit's security procedures.

(b) Prenatal instruction shall be offered and include, at a minimum, information about childbirth, parenting, breast and breast/bottle feeding, immunizations, prevention of infection and disease in infants, and alternative methods of pain management during childbirth.

(c) There shall be the capability of starting a Cesarean section within 30 minutes of the decision to perform such a delivery method.

(d) The medical record for the obstetric patient shall include the prenatal record, documentation of the course of labor, including fetal monitoring strip or any other comparable electronic data record, delivery, and the postpartum period and a copy of any vital records filed in accord with N.J.S.A. 26.

(e) Criteria shall be developed in consultation with the social work department for identifying patients in need of social work services and/or discharge planning and making referrals as needed.

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

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

Text on dietary criteria added at (g).

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

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

Rewrote the section.

8:43G-19.6 Maternal-fetal transport and neonatal transport

(a) Maternal-fetal transports for maternal management shall only be accepted by a hospital designated as a Regional Perinatal Center. Maternal-fetal transports, when the expected birth weight or gestational age falls below the facility's certified capability for neonatal care, shall be made in accordance with the facility's letter of agreement to utilize the regional transport system within the consortium region.

(b) Each Community Perinatal Center shall establish and implement interhospital transport agreements for patients who require a higher level of care for maternal-fetal management or delivery than the hospital is designated to provide. Such agreements shall be facilitated by the maternal and child health consortium, documented in the facility's letter of agreement with the Regional Perinatal Center and shall be in accordance with the consortium's regional transport system.

(c) Facilities designated as a CPC-Intermediate, CPC-Intensive, or a Regional Perinatal Center shall establish criteria and implement transport agreements with birth centers within their region for patients who require a higher level of care for maternal management delivery, or neonatal

management than the birth center is designated to provide. Such agreements shall be facilitated by the maternal and child health consortium and be in accordance with the consortium's regional transport system.

(d) The maternal and child health consortium, in association with the Regional Perinatal Center shall develop transport criteria and implement policies and procedures that establish a regional maternal-fetal transport system which includes, at a minimum, a transport team staffed by health professionals with special training in maternal and fetal care in accordance with hospital policy. This transport system shall be in accordance with the regional perinatal plan.

(e) Each Community Perinatal Center shall establish and implement interhospital transport agreements for neonates who require a higher level of care than the hospital is designated to provide. Such agreements shall be facilitated by the maternal and child health consortium, documented in the facility's letter of agreement with hospitals designated as CPC-Intensive and/or Regional Perinatal Center, and shall be in accordance with the consortium's regional transport system. The transport agreement shall also include provisions for return of the neonate to the sending hospital when the problems that required transport have been resolved.

(f) All Regional Perinatal Centers and CPC-Intensives which have executed letters of agreement to accept neonatal transports shall have, at a minimum:

1. A transport team staffed by health professionals with special training in neonatology;
2. Board eligible or certified anesthesiologists available with special training in the care of neonates;
3. Formal consultative relationship with physicians in the following pediatric subspecialties: anesthesiology, cardiology, hematology/oncology, infectious diseases, nephrology, neurology, pulmonary, radiology, and surgery; and
4. Written policies and procedures specific to the required 30 minute arrival time for the physicians with pediatric subspecialties identified in (f) 3 above.

New Rule, R.1992 d.347, effective September 8, 1992.

See: 24 N.J.R. 2045(a), 24 N.J.R. 3165(a).

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

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

Rewrote the section.

8:43G-19.7 Obstetric space and environment

(a) The obstetric service shall be physically separate from any service not concerned with obstetric care.

(b) The obstetric service shall have a minimum of 10 obstetric beds.

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).

Added (a) designation; and added (b).

8:43G-19.8 Obstetric staff education and training

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

8:43G-19.9 (Reserved)

8:43G-19.10 Obstetric continuous quality improvement

(a) There shall be a continuous quality improvement program for obstetrics 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.

(b) The continuous quality improvement program for obstetrics should include at least: high-risk screening, review of unattended deliveries, transports to other facilities and return transports, appropriateness of Cesarean sections, use of oxytocic drugs, prevention of infections in the nursery, fetal morbidity and mortality and maternal and infant morbidity and mortality.

(c) If non-obstetric patients are admitted to the obstetric unit, the continuous quality improvement program shall review cases of all non-obstetric patients transferred from the obstetric unit.

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

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

Rewrote the section.

8:43G-19.11 Labor and delivery staff time and availability

(a) There shall be at least one registered professional nurse present whenever a patient is in a labor area. Nurse staffing assignments for patients in active labor shall be determined by patient acuity levels.

(b) All deliveries shall be attended by an obstetrician, a physician with obstetrical privileges, a certified nurse-midwife or an obstetric resident with at least three years of training.

(c) There shall be at least one registered professional nurse attending the patient once she reaches full dilation until she enters the recovery phase of delivery.

(d) If oxytocics are administered, the following shall occur within one hour prior to administration: the patient shall be examined vaginally by either a physician with obstetric privileges, a certified nurse midwife or an advance practice nurse in accordance with hospital bylaws, and electronic fetal heart rate monitoring shall be initiated.

(e) All obstetrics departments shall have the capability of starting an emergency cesarean section within 30 minutes of the decision to perform a cesarean section.

(f) A health professional certified in neonatal resuscitation shall be available within the obstetrics unit for each delivery.

(g) A pediatrician or pediatric resident shall be present in the delivery room for all high-risk deliveries.

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

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

Physician to examine patient prior to use of oxytocics; neonatal resuscitation to be available when infant is present.

Recodified from N.J.A.C. 8:43G-19.13 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote the section.

8:43G-19.12 Labor, delivery, anesthesia and recovery patient services

(a) A registry of all births shall be maintained through either the electronic certificate or a maternity log book located in the obstetrics area and shall include the minimum data set required by the Department of Health and Senior Services and in accordance with N.J.S.A. 26:8-30, and N.J.A.C. 8:2.

(b) Obstetrics anesthesia services policies and procedures shall include at least:

1. The obstetric service in consultation with the anesthesia service shall develop and implement written policies and procedures that govern anesthesia services in all labor, delivery and recovery areas. The policies and procedures shall be reviewed annually, revised and implemented.

2. All individuals who administer anesthetic agents to obstetric patients shall be credentialed in accordance with medical staff policies. The physician director of anesthesia services shall participate in the credentialing process and delineation of privileges of all personnel who administer anesthetic agents.

3. The obstetric service, in consultation with the anesthesia service, shall establish protocols governing the use of anesthetic agents for pain management. These shall include the qualifications and responsibilities of persons who administer the use of anesthetic agents for pain management. Policies and procedures shall address the use of patient monitoring equipment and identify the types and levels of agents which may be used for pain management.

4. A preanesthesia note, reflecting evaluation and classification of the patient according to American Society of Anesthesiologists (ASA) Physical Status system, shall be made or certified by the physician administering or supervising the administration of anesthesia and entered into the medical record of each patient who will be administered an anesthetic agent.

5. Anesthetic or pain control agents administered to non-surgical obstetric patients classified for anesthesia risk as an ASA Class I, II or III shall be administered and

monitored in accordance with obstetric service policies and procedures governing anesthesia care.

6. Anesthetic or pain control agents administered to non-surgical obstetric patients classified for anesthesia risk as an ASA Class IV, V or Emergency shall be in accordance with the following sections of N.J.A.C. 8:43G-6, Anesthesia Services, as amended:

- i. N.J.A.C. 8:43G-6.1, Definitions;

- ii. N.J.A.C. 8:43G-6.3(d) through (k), Anesthesia qualifications for administering anesthesia;

- iii. N.J.A.C. 8:43G-6.5(b), Anesthesia patient services;

- iv. N.J.A.C. 8:43G-6.6, Anesthesia supplies and equipment; safety systems;

- v. N.J.A.C. 8:43G-6.7, Anesthesia supplies and equipment; maintenance and inspection; and

- vi. N.J.A.C. 8:43G-6.8, Anesthesia supplies and equipment; patient monitoring.

7. For patients undergoing surgical deliveries, including cesarean sections, anesthesia care shall be in accordance with all applicable sections of N.J.A.C. 8:43G-6, Anesthesia Services.

8. There shall be a program of quality assurance for anesthesia care provided in obstetric services that is integrated into the hospital and the anesthesia service quality assurance programs.

(c) There shall be written policies and procedures for the care of patients during the recovery phase of delivery. The policies and procedures shall be reviewed annually, revised as needed, and implemented. These policies and procedures shall include at least:

1. Delineation of the primary medical responsibility for postanesthesia care of the patient;

2. Monitoring of patients, including availability of monitoring equipment, and use of an objective scoring system to determine when the patient has recovered from anesthesia;

3. Requirements for documentation of patient status;

4. Protocol for patient emergencies;

5. Criteria and responsibility for discharge from recovery;

6. Recovery staff qualifications, which shall be as follows:

- i. All registered professional nurses assigned to recovery services shall have training in basic cardiac life support.

ii. Recovery services shall be staffed at all times by at least one registered professional nurse with critical care training, as defined by the hospital, whenever a patient recovering from a cesarean section and/or classified as ASA Class III, IV, V or Emergency is present;

7. Recovery staff time and availability, which shall be as follows:

i. There shall be at least two health care personnel, one of whom is a registered professional nurse and the other of whom is either a registered professional nurse or a licensed practical nurse, present in recovery services whenever a patient in the recovery phase of delivery is present. The nurse identified in (c)6ii above may function as the registered professional nurse required herein.

ii. There shall be a ratio of at least one registered professional nurse present in the recovery service area for every three patients in the recovery phase of delivery; and

8. Recovery patient services, which shall be as follows:

i. Postanesthesia notes shall be entered into the patient's medical record by a member of the hospital's anesthesia team early in the postoperative period.

ii. The condition of each patient shall be continually evaluated, with an objective scoring system used to track the patient until she has recovered from anesthesia.

iii. The patient's vital signs shall be monitored and recorded at least every 15 minutes during recovery.

iv. Postanesthesia care for patients recovering from a cesarean section and/or classified as ASA Class III, IV, V or Emergency shall also follow 8:43G-35.4(a) through (i).

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 anesthesia; at (c) on recovery.

Recodified from N.J.A.C. 8:43G-19.14 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote (a); and in (b), inserted a reference to ASA Class III in 5, and deleted a reference to ASA Class III in 6. Former N.J.A.C. 8:43G-19.12, Labor and delivery policies and procedures, repealed.

8:43G-19.13 Postpartum policies and procedures and staff time and availability

(a) At least one registered professional nurse shall be on duty in the postpartum area whenever a patient is present.

(b) Nurse staffing assignments for postpartum patients shall be determined by patient acuity levels.

(c) There shall be written policies and procedures for the care of postpartum patients. The policies and procedures shall be reviewed annually, and revised as needed, and shall include at least the following:

1. Monitoring and documentation of patient's vital signs, condition of uterus, and rate of bleeding.

2. Identification and management of postpartum complications; and

3. Physical care, including care of the perineum and breasts, and ambulation.

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 (c), requiring policies and procedures.

Recodified from N.J.A.C. 8:43G-19.15 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).

Former N.J.A.C. 8:43G-19.13, Labor and delivery staff time and availability, recodified to N.J.A.C. 8:43G-19.11.

8:43G-19.14 Postpartum patient services

(a) The hospital shall provide or arrange for an organized program of education in self-care and newborn care.

(b) If a patient is discharged less than 48 hours after delivery, early follow-up care shall be offered to the patient and arranged on request. The patient's medical record shall include documentation of the offer and the plan for provision of home health services if the offer is accepted.

(c) The hospital shall have staff available to advise postpartum patients in order to prevent difficulties with breast feeding during the hospital stay.

Recodified from N.J.A.C. 8:43G-19.16 and 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), deleted "postpartum" preceding "education"; and in (b), added a second sentence. Former N.J.A.C. 8:43G-19.14, Labor, delivery, anesthesia and recovery patient services, recodified to N.J.A.C. 8:43G-19.12.

8:43G-19.15 Newborn care policies and procedures

(a) A current roster of physicians, their specific pediatric privileges, and an on-call schedule shall be kept in each nursing unit in newborn care.

(b) A physician or an advanced practice nurse skilled in neonatal assessment shall perform a complete physical examination of the neonate within 24 hours of birth. This examination may serve as both the initial and discharge examination if the neonate is discharged within 24 hours. If the neonate remains in the hospital for more than 24 hours, a second examination shall be performed prior to discharge.

(c) Isolation practices recommended by the Centers for Disease Control shall be used for isolation patients in the newborn nursery, and are incorporated herein by reference. (See CDC Guidelines for Isolation Precautions in Hospitals, publication number PB85927401, available from National Technical Information Services, 5285 Port Royal Rd., Springfield, VA 22161, telephone 703-487-4600.)

(d) The newborn nursery shall identify and report any outbreak of disease, or any single case of a disease as specified in N.J.A.C. 8:57-1.1 through 1.5 also known as Chapter II of the State Sanitary Code.

(e) The hospital shall comply with State laws for screening infants for high risk factors associated with hearing impairment (N.J.S.A. 26:2-101 et seq.), early detection of biochemical disorders in newborns (N.J.S.A. 26:2-110 and 111), reporting congenital defects (N.J.S.A. 26-8-40.20 et seq.), and completing birth certificates (N.J.S.A. 26:8-28) and death certificates.

(f) Policies and procedures for screening all newborns for hearing impairment, in accordance with N.J.S.A. 26:2-103.1 et seq., shall require that the hospital or birth center:

1. Screen all newborns for hearing impairment using electrophysiologic measures;
2. Screen all newborns for high-risk indicators associated with hearing loss, using criteria established at N.J.A.C. 8:19-1.6, prior to discharge or no later than one month of age;
3. Complete and report to the Department all specified components of the Electronic Birth Certificate, including the hearing screening results within one week of discharge, in accordance with N.J.A.C. 8:19-1.2;
4. Designate a licensed physician or licensed audiologist to oversee the administration of newborn electrophysiologic screening by licensed physicians, licensed audiologists and/or other qualified individuals receiving direction and training by the designated licensed physician or audiologist to administer the electrophysiologic screening; and
5. Establish policies and procedures, in accordance with N.J.A.C. 8:19-1.3 and 1.4 for the provision of follow-up services for newborns that do not pass or receive electrophysiologic screening in one or both ears and for those that are identified as being at-risk of developing a hearing loss.

(g) Policies and procedures for the early detection of biochemical disorders in newborn infants, including at least hypothyroidism, galactosemia, and phenylketonuria, pursuant to N.J.S.A. 26:2-110 and 111, shall include, but not be limited, to the following:

1. Collection of blood specimens from newborn infants on collection kits provided by the Department;
2. Collection of blood specimens 24 hours after the newborn infant's first feeding or 48 hours after the newborn infant's birth or upon the newborn infant's discharge from the facility, whichever comes first;
3. Development of a system within the facility for the submission of blood specimens to arrive at the Department's laboratory no later than 96 hours after the newborn infant's birth;
4. Designation of a staff member(s) to be responsible for receiving verbal and written positive screening test results and documenting the results in the newborn infant's medical record; and

5. Provision of written information, provided by the Department and/or the facility, to all parents and physicians regarding the testing of biochemical disorders and the possibility of incorrect screening test results if the blood specimen is not collected.

(h) The newborn's medical record shall include at least:

1. A summary of the mother's obstetric and relevant medical history;
2. Anesthesia, analgesia, and medications given to the mother;
3. Reasons for induction of labor and operative procedures, if performed;
4. Date and time of birth and copies of all vital records;
5. Birth weight and length;
6. Condition of the newborn at birth, including the one- and five-minute Apgar scores, time of sustained respirations, details of any physical abnormalities, and any pathological states observed and treatment given before transfer to the nursery;
7. Any abnormalities of the placenta and cord vessels;
8. Length of gestation;
9. Procedures performed in the delivery room;
10. A record of the newborn assessment, performed by a physician or registered professional nurse upon the newborn's admission to the nursery;
11. A plan of care;
12. A record of the initial physical examination, performed, signed, and dated by a physician;
13. A record of a physical examination on discharge or transfer to another facility, including head circumference, signed, and dated by a physician; and
14. Documentation of eye prophylaxis, as recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists for ophthalmia neonatorum, administration of any other medication or treatment and response, and performance of inborn error and hearing screenings.

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

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

Details of roster, notification procedure and ophthalmic treatment specified.

Recodified from N.J.A.C. 8:43G-19.17 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote (b); deleted a former (c); recodified former (d) through (i) as (c) through (h); in the new (e) and (g), deleted references to N.J.S.A. 26:2-112; and in the new (f), added a reference to electronic date entry at the end of 2. Former N.J.A.C. 8:43G-19.15, Postpartum policies and procedures and staff time and availability, recodified to N.J.A.C. 8:43G-19.13.

Amended by R.2005 d.279, effective September 6, 2005.

See: 37 N.J.R. 709(a), 37 N.J.R. 3365(a).

Rewrote (f).

8:43G-19.16 Normal newborn nurse staff qualifications, staff time and availability

(a) Hospitals designated as a CPC-Basic may provide care to neonates born greater than 2,499 grams or at least 36 weeks gestation. The only exception to this criteria is if it has been documented in the medical record that the neonate was expected to meet the weight and age criteria and the neonate does not require a higher level of care than otherwise specified for a CPC-Basic. Service restrictions placed on CPC-Basic include:

1. Mechanical ventilatory support shall not be provided except for resuscitative measures; and
2. Total parenteral nutrition shall not be provided.

(b) The physician director of newborn care in hospitals designated as a CPC-Basic shall be board certified in pediatrics.

(c) There shall be a nurse manager of the normal newborn nursery who may also function as the nurse manager of the obstetric service. This individual shall be a registered professional nurse with, at a minimum:

1. Three-years of experience in inpatient neonatal services within the five years immediately preceding the date of appointment;
2. Educational preparation in maternal-fetal neonatal nursing, in accordance with hospital policy; and
3. Completion of 24 contact hours of maternal-fetal or neonatal nursing approved by a nationally recognized nurse education accrediting body every three years.

(d) There shall be a health professional certified in neonatal resuscitation available within the unit at all times.

(e) The normal newborn nursery shall be covered at all times by a pediatrician, family practice physician with pediatric privileges, or certified neonatal or pediatric nurse practitioner who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions.

(f) The normal newborn nursery shall have a registered professional nurse present whenever a neonate is in the newborn nursery. Additional staffing, assignments shall be determined by acuity levels appropriate to infants.

(g) The normal newborn nursery shall have at least one registered professional nurse to every eight neonates. However, so long as one registered nurse is on duty as required by (d) above, licensed practical nurses may be used to comply with the nurse:infant ratio requirement.

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).

Former N.J.A.C. 8:43G-19.16, Postpartum patient services, recodified to N.J.A.C. 8:43G-19.14.

8:43G-19.17 Intermediate nursery staff qualifications, staff time and availability

(a) Hospitals designated as a CPC-Intermediate may provide care to neonates born greater than 1,499 grams or at least 32 weeks gestation. The only exception to this criteria is if it has been documented in the medical record that the neonate was expected to meet the weight and age criteria and the neonate does not require a higher level of care than otherwise specified for a CPC-Intermediate. Service restrictions placed on CPC-Intermediate include:

1. In no case shall continuous or intermittent positive pressure ventilatory support be administered to an intubated neonate for more than 48 hours, except in cases where authorization has been received from the neonatologist on-call at the Regional Perinatal Center or the CPC-Intensive and the CPC-Intermediate has demonstrated the ability to intubate and is able to hourly monitor the partial pressure of oxygen in the neonate's blood. Authorization from the neonatologist on-call at the Regional Perinatal Center or the CPC-Intensive shall be obtained on a daily basis and shall be documented in the medical record; and
2. All neonates, regardless of birth weight, who require surgery, or other highly specialized services shall be transported to a higher level facility capable of providing the care.

(b) The physician director of newborn care in hospitals designated as a CPC-Intermediate shall be board certified in pediatrics.

(c) There shall be a nurse manager of the intermediate nursery who meets the qualifications of the nurse manager specified in N.J.A.C. 8:43G-19.16(c). This individual may also function as the nurse manager of the obstetric service.

(d) There shall be a health professional certified in neonatal resuscitation available within the unit at all times.

(e) The intermediate nursery shall be covered at all times by a board eligible or certified pediatrician with certification and/or training and experience in neonatal medicine or a certified neonatal or pediatric nurse practitioner who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned under normal transportation conditions. A physician who has training and experience in neonatal medicine or a certified neonatal or pediatric nurse practitioner shall be present in the hospital whenever a neonate is receiving any form of positive pressure oxygen therapy.

(f) The intermediate nursery shall have at least one registered professional nurse to every four infants requiring intermediate care services. Additional staffing assignments shall be determined by the acuity levels of the infants.

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).

Former N.J.A.C. 8:43G-19.17, Newborn care policies and procedures, recodified to N.J.A.C. 8:43G-19.15.

3. Method for ensuring that no obstetric patient is excluded from the obstetric service; and

4. Protocols for cultures of non-obstetric patients, including the type of cultures, when, and under what circumstances they are performed.

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

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

(c) An admission check sheet and questionnaire shall be filled out upon admission to the hospital for every non-obstetric patient admitted to the obstetric service, and shall be included in the patient's medical record.

Recodified from N.J.A.C. 8:43G-19.32 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote the section. Former N.J.A.C. 8:43G-19.27, Nurse-midwifery staff education, recodified to N.J.A.C. 8:43G-19.25.

8:43G-19.28 Obstetric/non-obstetric mix patient services

(a) A non-obstetric patient shall not be admitted to the obstetric service if she has any of the following conditions:

1. An oral temperature of 100.4 degrees Fahrenheit or higher upon admission;
2. Substance abuse or misuse;
3. A history of household contacts with staphylococcal infection or other contagious diseases that have occurred within one month prior to admission;
4. Known malignancy requiring the use of radioactive therapeutics;
5. Has received antibiotics other than prophylactic antibiotics, with the exception of local application of antibiotics such as bladder irrigation or local vaginal preparation during the two-week period prior to admission; or
6. Has received preoperative prophylactic antibiotics more than six hours prior to surgery or more than 72 hours following surgery.

(b) A non-obstetric patient shall be transferred from the obstetric service if she:

1. Has a fever as defined by hospital policy;

2. Has any sign of infection, including infection discovered at the time of surgery.

(c) All surgical procedures performed on non-obstetric patients on the obstetric service shall be performed in the operating suite.

(d) The same visitors policy shall apply to both obstetric and non-obstetric patients on the mixed obstetric service.

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

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

Patient priority specified at (b).

Recodified from N.J.A.C. 8:43G-19.33 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote the section.

8:43G-19.29 Physical plant general compliance for new construction, alteration or renovation for newborn care

Physical plant standards for newborn care areas shall be in compliance with N.J.A.C. 5:23-3.2 of the New Jersey Uniform Construction Code.

New Rule, R.1990 d.422, effective September 4, 1990.

See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).

Recodified from N.J.A.C. 8:43G-19.35 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).

Former N.J.A.C. 8:43G-19.29, Nurse-midwifery quality assurance methods, recodified to N.J.A.C. 8:43G-19.26.

8:43G-19.30 Functional areas for newborn care

(a) Functional areas for newborn care shall be as follows:

1. Neonatal Resuscitation Area or Room;
2. Admission/observation/Continuing Care Nursery or Area;
3. Normal Newborn Nursery or Holding Nursery;
4. Infectious Isolation Nursery;
5. Intermediate Care Nursery; and
6. Neonatal Intensive Care Nursery.

New Rule, R.1990 d.422, effective September 4, 1990.

See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).

Recodified from N.J.A.C. 8:43G-19.36 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote (a). Former N.J.A.C. 8:43G-19.30, Scope of obstetric/non-obstetric mix standards, repealed.

8:43G-19.31 General newborn care functional area requirements

(a) General requirements for functional areas designated in N.J.A.C. 8:43G-19.36 shall be as required in (b) through (s) below.

(b) Provisions shall be made for indirect lighting and high-intensity lighting in all nurseries. The level of general

lighting shall be adjustable to satisfy diagnostic and procedural requirements.

(c) Viewing windows shall be extensive throughout the newborn suite. Exterior windows shall be energy efficient and insulated.

(d) Newborn care areas shall have oxygen and medical air piped from a central source in accordance with National Fire Protection Association 99 Standard for Health Care Facilities (NFPA 99), published by the NFPA, Box 9101, One Batterymarch Park, Quincy, MA 02269-9101, incorporated herein by reference.

(e) Oxygen air and suction systems shall have chime alarms to signal loss of suction or low oxygen and air supply.

(f) A temperature of 75 degrees Fahrenheit and a relative humidity of 50 percent shall be maintained.

(g) An emergency call system shall be provided in each nursery.

(h) A free-standing handwashing sink shall be provided with hands free control in a bowl large and deep enough to prevent splashing. A liquid soap dispenser and disposable towel dispenser shall be provided at each sink.

(i) Each infant station shall be supplied by at least two branch circuits.

(j) Ventilation requirements shall be in accordance with Section 7.31.D of the "Guidelines for Construction and Equipment of Hospital and Health Care Facilities" (The American Institute of Architects Press), 1996-97 edition, as amended and supplemented, published by the AIA, 1735 New York Ave. NW, Washington, DC 20006, (202) 626-7475, incorporated herein by reference.

(k) The newborn nursery shall be a closed unit, physically segregated from other areas.

(l) There shall be a waiting room available in the obstetrics area.

(m) There shall be a toilet and telephone available for use by the public in the obstetrics area.

(n) A separate room or area within the nursery workroom or clean utility room shall be provided for the storage of infant formula and breast milk. A refrigerator/freezer used only for the storage of breast milk and formula shall be provided.

(o) There shall be at least one staff office and a staff lounge in, or adjacent to, the obstetrics area.

(p) There shall be a soiled utility room which shall contain the following:

1. A clinical sink;

2. A work counter;
3. A handwashing sink;
4. Liquid soap dispensers;
5. A paper towel dispenser; and
6. Space for storage of soiled equipment, soiled linen and trash receptacles.

(q) There shall be a neonatal unit clean work area or room which shall contain:

1. A counter with cabinets;
2. A refrigerator;
3. A handwashing sink;
4. Liquid soap dispensers;
5. A paper towel dispenser; and
6. Space for storage of clean equipment and clean linen.

(r) There shall be a housekeeping room in the obstetrics area which shall contain a floor receptor or service sink and provisions for storage of supplies and housekeeping equipment.

(s) There shall be an administrative center or nurses station which may be combined with or include a center for reception and communication. This area shall be designed to permit visual observation into the newborn nurseries and storage space.

New Rule. R.1990 d.422, effective September 4, 1990.

See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).

Recodified from N.J.A.C. 8:43G-19.37 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote the section. Former N.J.A.C. 8:43G-19.31, Obstetric/non-obstetric mix structural organization, repealed.

8:43G-19.32 Neonatal unit resuscitation area

(a) There shall be an infant resuscitation area for each cesarean/delivery room. This area shall be located either within the cesarean/delivery room or in a separate but immediately accessible room. The square footage requirement for the infant resuscitation area is as follows:

1. If the resuscitation area is located within the cesarean/delivery room, a minimum of 40 square feet of additional clear floor area shall be provided; or
2. If the resuscitation area is located in a separate room, this room shall have a minimum of 150 square feet of clear floor area and shall also contain a free-standing handwashing sink.

(b) The resuscitation area shall have a minimum of:

1. An overhead source of radiant heat;

2. A large wall clock with a clearly visible second hand;
3. A flat working surface for charting;
4. A table or flat surface for trays;
5. One oxygen outlet;
6. One medical air outlet; and
7. One suction outlet.

(c) A minimum of six single or three duplex electrical outlets shall be provided in each resuscitation area or room. If a separate resuscitation room is provided, an electrical outlet to accommodate a portable X-ray machine shall also be provided.

New Rule, R.1990 d.422, effective September 4, 1990.

See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).

Recodified from N.J.A.C. 8:43G-19.46 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote the section. Former N.J.A.C. 8:43G-19.32, Obstetric/non-obstetric mix policies and procedures, recodified to N.J.A.C. 8:43G-19.27.

8:43G-19.33 Neonatal admission/observation/continuing care nursery or area

(a) There shall be an admission/observation/continuing care nursery available for infants who are stable but require frequent feedings or close observation. This nursery may be located in the normal newborn nursery or may be provided in a separate area.

(b) If the admission/observation/continuing care nursery is provided in a separate area, the following physical plant requirements shall be followed:

1. There shall be a minimum of 24 square feet of floor area exclusive of auxiliary work areas for each infant station with a minimum of three feet between bassinets;
2. One oxygen outlet, one medical air outlet and one vacuum outlet shall be provided for each infant station;
3. Two duplex electrical receptacles shall be provided for each infant station;
4. A hands-free handwashing sink shall be provided in the room; and
5. This area shall be served by a connecting work-room.

New Rule, R.1990 d.422, effective September 4, 1990.

See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).

Recodified from N.J.A.C. 8:43G-19.47 and amended by R.1999 d.436, effective December 20, 1999.

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

Rewrote the section. Former N.J.A.C. 8:43G-19.33, Obstetric/non-obstetric mix patient services, recodified to N.J.A.C. 8:43G-19.28.

8:43G-19.34 Normal newborn nursery or holding nursery

(a) There shall be either a normal newborn nursery or a holding nursery. A normal newborn nursery shall be located close to the postpartum unit and shall be inaccessible to unrelated traffic. If a holding nursery is provided, it shall meet the requirements of (b) through (g) below.

(b) The number of bassinets shall equal the number of licensed obstetric beds.

(c) A minimum of 24 square feet for each bassinet exclusive of auxiliary work areas shall be provided, with three feet between bassinets in all directions from edge of one to the other with a separate aisle four feet wide, in addition to the required bed space.

(d) A maximum of 16 bassinets shall be permitted in one normal newborn nursery.

(e) One oxygen outlet, one medical air outlet and one vacuum outlet for each infant station shall be provided.

(f) Oxygen air and suction systems shall have chime alarms to signal loss of suction or low oxygen and air supply.

(g) Two duplex wall-mounted electrical receptacles shall be provided for every infant station.

(h) A free-standing handwashing sink with hands free controls shall be provided, with a minimum of one sink at each end of the nursery, and at a ratio of one sink for every six infant stations.

(i) There shall be at least one multi-purpose room available for consultation, breast feeding, lactation training and conferences.

(j) A soiled utility room shall be provided.

(k) A clean utility room or area shall be provided.

(l) An examination and treatment room or work area shall be provided within the suite. Such room or work area shall contain a work-counter, storage, and a free-standing sink equipped for handwashing with foot control.

(m) Storage facilities for the newborn nursery shall be as follows:

1. There shall be storage space for items such as linens and formula within the area;
2. There shall be an equipment storage room for large items of equipment; and
3. There shall be storage space within the nursery area for an emergency cart.

(n) The normal newborn nursery shall be served by a connecting workroom.

(o) There shall be separate changing areas for men and women, located so that staff are able to change clothing prior to entering the clean area of the neonatal nursery unit.

(p) A scrub gowning area shall be provided for staff and housekeeping personnel at the entrance of each nursery, but separate from the work area. The scrub gowning area shall contain a free-standing handwashing sink with hands free controls and a bowl large enough to prevent splashing. The following shall be provided:

1. Racks, hooks or lockers for storage of street clothes and personal items;
2. Cabinets with clean gowns; and
3. A receptacle for used gowns.

New Rule, R.1990 d.422, effective September 4, 1990.
See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).
Recodified from N.J.A.C. 8:43G-19.48 and amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote the section.

8:43G-19.35 Infectious nursery

(a) An infectious isolation nursery shall be available in at least one level of nursery care.

(b) The infectious isolation nursery shall be an enclosed and separate room within the nursery unit with provision for observation of the neonate from adjacent nurseries or control area.

(c) The isolation nursery shall be served by an anteroom that contains a freestanding handwashing sink with hands free controls and separate storage facilities for clean and soiled materials and gowns.

(d) One oxygen outlet, one medical air outlet and one vacuum outlet shall be provided for each infant station.

(e) Two duplex receptacles shall be provided for each infant station.

New Rule, R.1990 d.422, effective September 4, 1990.
See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).
Recodified from N.J.A.C. 8:43G-19.50 and amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote the section. Former N.J.A.C. 8:43G-19.35, Physical plant general compliance for new construction, alteration or renovation for newborn care, recodified to N.J.A.C. 8:43G-19.29.

8:43G-19.36 Intermediate care nursery

(a) The intermediate care nursery shall be a separate nursery designed exclusively for the care of intermediate level infants located away from general hospital traffic and close to the delivery room and the intensive care nursery, if provided.

(b) Each infant patient station shall have a minimum of 50 square feet of floor space, excluding ancillary space for storage. There shall be four feet between incubators or bassinets with a separate aisle five feet wide, in addition to required bed space.

(c) Each infant care station shall have two oxygen outlets, two medical air outlets and two vacuum outlets.

(d) Oxygen air and suction systems shall have chime alarms to signal loss of suction or low oxygen and air supply.

(e) Four duplex receptacles shall be provided for each station.

(f) A handwashing sink with hands free controls, soap dispenser and towel dispenser shall be provided at the entrance of the intermediate care nursery. One sink shall be provided for every three infant care stations within the nursery.

(g) A soiled utility room shall be provided.

(h) A clean utility room or area shall be provided.

(i) Storage facilities for the intermediate care nursery shall be as follows:

1. There shall be storage for supplies needed for immediate use for each infant care station; and
2. There shall be at least 20 square feet of floor space for equipment for each infant care station immediate accessible to the nursery.

(j) There shall be at least two multi-purpose rooms available for consultation, breast feeding, lactation training and conferences.

New Rule, R.1990 d.422, effective September 4, 1990.
See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).
Recodified from N.J.A.C. 8:43G-19.51 and amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote the section. Former N.J.A.C. 8:43G-19.36, Functional areas for newborn care, recodified to N.J.A.C. 8:43G-19.30.

8:43G-19.37 Neonatal intensive care nursery

(a) The neonatal intensive care nursery shall be near the cesarean/ delivery room and shall be removed from routine hospital traffic.

(b) The intensive care nursery shall provide 100 square feet per bassinet or incubator allowing a minimum of six feet between bassinets and at a minimum, an eight foot wide aisle.

(c) There shall be three oxygen outlets, three medical air outlets and four vacuum outlets for each infant care station.

(d) Oxygen air and suction systems shall have chime alarms to signal loss of suction or low oxygen and air supply;

(b) All satellite emergency departments applying for licensure shall provide the following services:

1. Basic life support emergency care and services;
2. Basic and stat laboratory services including:
 - i. Arterial blood gases;
 - ii. Creatinine;
 - iii. Electrolytes;
 - iv. Glucose (blood);
 - v. CBC;
 - vi. Strep screening;
 - vii. Urinalysis; and
 - viii. Pregnancy tests;
3. Basic radiology services, which shall include at a minimum non-enhanced and non-contrast radiographs; and
4. Emergency contraception, upon request, to sexual assault victims and medically and factually accurate and objective verbal and written information about emergency contraception and sexually transmitted diseases, pursuant to N.J.A.C. 8:43G-12A.

(c) Services in addition to those in (b) above may be provided at the discretion of the facility.

(d) Although a satellite emergency department may provide care and services to all patients, the following cases are more appropriately treated in an acute care hospital emergency department.

1. Patients attended by advanced life support (ALS) personnel/mobile intensive care unit (MICU) personnel and requiring ALS/MICU care and services;
2. Individuals with altered mental status or under the influence of alcohol or other substances; and
3. Pregnant women greater than 20 weeks with conditions relating to pregnancy.

Amended by R.2009 d.282, effective September 21, 2009.
See: 40 N.J.R. 5483(a), 41 N.J.R. 3424(a).

In (b)2viii, deleted "and" from the end; in (b)3, substituted "; and" for a period at the end; and added (b)4.

8:43G-36.4 Child abuse and neglect

Satellite emergency departments shall comply with N.J.A.C. 8:43G-2.13.

8:43G-36.5 Patient rights

Every New Jersey satellite emergency department patient has the same rights as required in N.J.A.C. 8:43G-4, with the exception of N.J.A.C. 8:43G-4.1(a) 14. None of the patient rights shall be abridged by the satellite emergency department or the hospital that owns and operates the satellite emergency department. The administrator of the satellite emergency

department or the administrator of the hospital licensed to operate the satellite emergency shall be responsible for developing and implementing policies to protect patient rights and to respond to questions and grievances pertaining to patients rights.

8:43G-36.6 Administrative and structural organization

(a) A satellite emergency department may be licensed as a free-standing ambulatory care facility owned and operated by a hospital or as part of the hospital. If licensed as an ambulatory care facility, it must comply with the general ambulatory care facility requirements set forth in N.J.A.C. 8:43A as well as this subchapter. If the satellite emergency department is licensed as part of the hospital, it shall comply with the requirements set forth in N.J.A.C. 8:43G-2.5 and the criteria set forth in N.J.A.C. 8:43G-2.11, as well as this subchapter.

(b) An administrator of the satellite emergency department shall be designated in writing.

(c) The satellite emergency department shall have policies and procedures which pertain to:

1. All staff;
2. Admission and discharge of patients;
3. Procedures for obtaining patient's written consent for all medical treatment;
4. Patient advance directives;
5. Elder abuse;
6. Domestic violence;
7. The ability of family members and significant others to remain with patients during treatment;
8. Referrals to primary care physicians and specialists, to assure access to all appropriate clinical services and specialties even though immediate consultation is not necessary;
9. Transfer protocol;
 - i. Written transfer agreements must be in place assuring timely response to accomplish basic and advanced level transfers from a satellite emergency department to an acute care facility;
 - ii. Transfers requiring basic life support services shall be accomplished by a licensed ambulance in accordance with N.J.A.C. 8:40;
 - iii. Transfers requiring advanced life support care shall be accomplished with a critical care transport team including a registered nurse and a licensed ambulance in accordance with N.J.A.C. 8:40-6.22; and
 - iv. Transfers may be by other means as deemed appropriate by the physician;
10. Pharmacy services, including controlled substances;

11. Procedural sedation;
12. Infection control;
13. Dietary;
14. Linens;
15. Housekeeping;
16. Lab services;
17. Payment source;
18. Policies and procedures for handling an unexpected influx of patients; and
19. Policies and procedures for maintaining a record of hospital employees, medical staff members, and volunteers who can speak languages other than English or know sign language for the hearing impaired and can provide interpretive services to patients. This record shall include the work shifts of hospital employees.

(d) The satellite emergency department shall maintain a copy of all policies and procedures which apply to the facility onsite.

8:43G-36.7 Reportable events

The satellite emergency department shall comply with the requirements of N.J.A.C. 8:43G-5.6.

8:43G-36.8 Administrative and staff qualifications

(a) Physician qualifications for satellite emergency departments are as follows:

1. There shall be a physician director of the satellite emergency department, who may also be the director of the hospital's emergency department, who is board certified in emergency medicine or who has five years of full-time experience in emergency medicine, which may include three years residency in emergency medicine, within the past seven years. If the physician director of the satellite emergency department is not the physician director of the hospital emergency department, then there shall be coordination of all care and services between the two to ensure care delivery and quality improvement in accordance with N.J.A.C. 8:43G-5.16.
2. Each physician practicing in the satellite emergency department, except residents functioning under supervision as part of a hospital's graduate residency training program, consulting physicians, and private physicians who are attending to their patients in the satellite emergency department, shall meet at least one of the following qualifications:
 - i. Board certification or current eligibility to be certified in emergency medicine;
 - ii. Successful completion of an approved residency program in emergency medicine, family medicine, general internal medicine, general surgery, or general pediatrics; or

iii. Three years of full-time clinical experience in emergency medicine within the past five years.

3. Each physician practicing in the satellite emergency department, except residents functioning under direct supervision as part of the hospital's residency program, consulting physicians, and private physicians who are attending to their patients in the emergency department, shall attain provider status in Advanced Cardiac Life Support and either Advanced Pediatric Life Support or Pediatric Advanced Life Support within 12 months of initial assignment, and shall continuously maintain this status thereafter. Physicians who are board certified in emergency medicine shall be exempt from this requirement.

4. Each physician practicing in the satellite emergency department, except residents functioning under direct supervision as part of a hospital's graduate residency program, consulting physicians, and private physicians who are attending to their patients in the satellite emergency department, shall attain provider status in Advanced Trauma Life Support within 12 months of initial assignment, and shall continuously maintain this status thereafter. Physicians who are board certified in emergency medicine shall be exempt from this requirement.

(b) One licensed registered professional nurse certified in Advanced Cardiac Life Support (ACLS) and either Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS) or Emergency Nurse Pediatric Course (ENPC), with at least one year of emergency room experience, shall be on duty at all times in the satellite emergency department.

(c) One New Jersey licensed x-ray technician shall be on duty at all times.

(d) One staff person deemed competent by the laboratory director to perform lab tests specified in this chapter shall be on duty at all times.

(e) One current staff person who meets the qualifications identified in (c) and (d) above may be designated responsible for these areas of care and service.

(f) The facility must have policies and procedures in place to address and ensure increased staffing to address increased patient volume and acuity.

8:43G-36.9 Staff time and availability

(a) The satellite emergency department shall have all personnel identified in N.J.A.C. 8:43G-36.8(a) onsite at all times during hours of operation.

(b) No patient who comes to the satellite emergency department shall be discharged to home or another facility without being seen and evaluated by qualified medical personnel. This evaluation shall occur within four hours of the patient's coming to the satellite emergency department.