

CHAPTER 43G
HOSPITAL LICENSING STANDARDS

Authority

N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5(b).

Source and Effective Date

R.2005 d.279, effective July 22, 2005.
See: 37 N.J.R. 709(a), 37 N.J.R. 3365(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 43G, Hospital Licensing Standards, expires on January 18, 2011. See: 42 N.J.R. 1774(a).

Chapter Historical Note

Chapter 43G, Certificate of Need: Capital Policy, was adopted as R.1986 d.375, effective September 8, 1986. See: 18 N.J.R. 1242(a), 18 N.J.R. 1817(a).

Chapter 43G, Certificate of Need: Capital Policy, was repealed by R.1988 d.114, effective March 21, 1988. See: 19 N.J.R. 2365(b), 20 N.J.R. 645(d).

Subchapter 1, General Provisions, Subchapter 2, Licensure Procedure, Subchapter 5, Administration and Hospital-Wide Services, Subchapter 19, Obstetrics, Subchapter 21, Oncology, Subchapter 22, Pediatrics, Subchapter 24, Plant Maintenance and Fire and Emergency Preparedness, Subchapter 26, Psychiatry, Subchapter 29, Physical and Occupational Therapy, Subchapter 30, Renal Dialysis, Subchapter 31, Respiratory Care, and Subchapter 35, Postanesthesia Care, were adopted as new rules by R.1990 d.95, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2926(a), 22 N.J.R. 441(b).

Subchapter 4, Patient Rights, was adopted as new rules by R.1990 d.98, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2160(b), 22 N.J.R. 484(a).

Subchapter 6, Anesthesia, was recodified from N.J.A.C. 8:43B-18 by R.1990, d.77, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2925(a), 22 N.J.R. 488(a).

Subchapter 7, Cardiac, was adopted as new rules by R.1990 d.97, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2162(a), 22 N.J.R. 488(b).

Subchapter 8, Central Service, was adopted as new rules by R.1990 d.96, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1609, 22 N.J.R. 496(a).

Subchapter 9, Critical and Intermediate Care, was adopted as new rules by R.1990 d.94, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2167(a), 22 N.J.R. 498(a).

Subchapter 10, Dietary, was adopted as new rules by R.1990 d.78, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1611(a), 22 N.J.R. 505(a).

Subchapter 11, Discharge Planning, was adopted as new rules by R.1990 d.93, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1612(a), 22 N.J.R. 507(a).

Subchapter 12, Emergency Department, was adopted as new rules by R.1990 d.92, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1613(a), 22 N.J.R. 510(a).

Subchapter 13, Housekeeping and Laundry, was adopted as new rules by R.1990 d.91, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1616(a), 22 N.J.R. 514(a).

Subchapter 14, Infection Control and Sanitation, was adopted as new rules by R.1990 d.90, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1618(a), 22 N.J.R. 517(a).

Subchapter 15, Medical Records, was adopted as new rules by R.1990 d.88, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2171(a), 22 N.J.R. 520(a).

Subchapter 16, Medical Staff, was adopted as new rules by R.1990 d.89, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1621(a), 22 N.J.R. 524(a).

Subchapter 17, Nurse Staffing, was adopted as new rules by R.1990 d.87, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1623(a), 22 N.J.R. 530(a).

Subchapter 18, Nursing Care, was adopted as new rules by R.1990 d.86, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1624(a), 22 N.J.R. 531(a).

Subchapter 20, Employee Health, was adopted as new rules by R.1990 d.85, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2173(a), 22 N.J.R. 535(a).

Subchapter 23, Pharmacy, was adopted as new rules by R.1990 d.84, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1626(a), 22 N.J.R. 537(a).

Subchapter 25, Post Mortem, was adopted as new rules by R.1990 d.83, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1628(a), 22 N.J.R. 541(a).

Subchapter 27, Quality Assurance, was adopted as new rules by R.1990 d.82, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1630(a), 22 N.J.R. 542(a).

Subchapter 28, Radiology, was adopted as new rules by R.1990 d.81, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2174(a), 22 N.J.R. 544(a).

Subchapter 32, Same-Day Stay, and Subchapter 34, Surgery, were adopted as new rules by R.1990 d.80, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 2177(a), 22 N.J.R. 548(a).

Subchapter 33, Social Work, was adopted as new rules by R.1990 d.79, effective February 5, 1990, operative July 1, 1990. See: 21 N.J.R. 1631(a), 22 N.J.R. 555(a).

Pursuant to Executive Order No. 66(1978), Chapter 43G, Hospital Licensing Standards, was readopted as R.1995 d.124, effective February 3, 1995. See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

Pursuant to Executive Order No. 66(1978), Chapter 43G, Hospital Licensing Standards, was readopted as R.2000 d.71, effective January 27, 2000. See: 31 N.J.R. 2732(a), 32 N.J.R. 707(a).

Subchapter 36, Satellite Emergency Department, was adopted as new rules by R.2000 d.466, effective November 20, 2000. See: 32 N.J.R. 2184(a), 32 N.J.R. 4127(a).

Subchapter 37, Extracorporeal Shock Wave Lithotripsy, was adopted as new rules by R.2002 d.143, effective May 20, 2002. See: 33 N.J.R. 2624(a), 34 N.J.R. 1834(a).

Subchapter 22A, Licensure of Children's Hospital Designation, was adopted as new rules by R.2002 d.339, effective October 21, 2002. See: 34 N.J.R. 1305(a), 34 N.J.R. 3637(b).

Subchapter 38, Long Term Acute Care Hospitals General Requirements, was adopted as new rules by R.2003 d.49, effective January 21, 2003. See: 34 N.J.R. 490(a), 35 N.J.R. 4141(a).

Chapter 43G, Hospital Licensing Standards, was readopted as R.2005 d.279, effective July 22, 2005. As a part of R.2005 d.279, Subchapter 30, Renal Dialysis, was repealed and adopted as new rules by R.2005 d.279, effective September 6, 2005. See: Source and Effective Date. See, also, section annotations.

Subchapter 7A, Stroke Centers, was adopted as new rules by R.2007 d.35, effective February 5, 2007. See: 38 N.J.R. 91(a), 39 N.J.R. 439(a).

Subchapter 17A, Mandatory Staff Level Posting and Reporting Standards, was adopted as new rules by R.2008 d.63, effective March 17, 2008. See: 39 N.J.R. 1363(a), 40 N.J.R. 1647(a).

Subchapter 12A, Emergency Care for Sexual Assault Victims, was adopted as new rules by R.2009 d.282, effective September 21, 2009. See: 40 N.J.R. 5483(a), 41 N.J.R. 3424(a).

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SUBCHAPTER 1. GENERAL PROVISIONS

8:43G-1.1 Scope and purpose

(a) These rules and standards apply to each licensed general or special hospital facility. They are intended for use in State surveys of the hospitals and any ensuing enforcement actions. They are also designed to be useful to consumers and providers as a mechanism for privately assessing the quality of care provided in any acute care hospital.

(b) This chapter contains rules intended to assure the high quality of care delivered in hospital facilities throughout New Jersey. Components of quality care addressed by these rules and standards include access to care, continuity of care, comprehensiveness of care, coordination of services, humaneness of treatment, conservatism in intervention, safety of environ-

ment, professionalism of caregivers, and participation in useful studies.

8:43G-1.2 Definitions

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

“All payers case mix index” (CMI) means a specific hospital’s average charge per case divided by the Statewide average charge per case for a given year using the most recent complete data set available to the Department.

“Clinical practitioner” means a physician, dentist, podiatrist, certified nurse midwife, physician assistant, or nurse practitioner operating within his or her scope of practice.

“Commissioner” means the Commissioner of the New Jersey Department of Health and Senior Services or his or her designee.

“Department” means the New Jersey Department of Health and Senior Services.

“Hospital” means an institution, whether operated for profit or not, whether maintained, supervised or controlled by an agency of the government of the State or any county or municipality or not, which maintains and operates facilities for the diagnosis, treatment or care of two or more non-related individuals suffering from illness, injury or deformity and where emergency, out-patient, surgical, obstetrical, convalescent or other medical and nursing care is rendered for periods exceeding 24 hours.

“Hospital-based off-site ambulatory care service facility” means an ambulatory care service facility which has met the criteria as set forth in N.J.A.C. 8:43G-2.11(c) to be classified as same and which has applied for and received a license authorizing the facility to operate as a hospital-based off-site ambulatory care service facility.

“Hospitalization” means the admission and care of any person for a continuous period, longer than 24 hours, for the purpose of diagnosis and/or treatment bearing on the physical or mental health of such persons.

“Licensed practical nurse” shall have the meaning set forth in N.J.S.A. 45:11-27(d).

“Licensee” means the corporation, association, partnership or person authorized by the Department of Health to operate an institution and on whom rests the responsibility for maintaining acceptable standards in all areas of operation.

“Other licensed health care professionals” means:

1. “Physical therapist,” which shall have the meaning set forth in N.J.S.A. 45:9-37.13; and

2. “Respiratory care practitioner,” which shall have the meaning set forth in N.J.S.A. 45:14E-3.

“Patient” means a person who receives a health care service from a provider.

“Registered professional nurse” shall have the meaning set forth in N.J.S.A. 45:11-26(e) and such nurses shall be licensed by the New Jersey Board of Nursing.

“Unlicensed assistive personnel” or “UAP” means unlicensed individuals (formerly known as “ancillary nursing personnel”) to whom selective nursing tasks are delegated.

Amended by R.2000 d.71, effective February 22, 2000.

See: 31 N.J.R. 2732(a), 32 N.J.R. 707(a).

Inserted “Hospital-based off-site ambulatory care service facility”.

Amended by R.2004 d.302, effective August 2, 2004.

See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

Added “All payers case mix index”.

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

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

Added definition “Clinical practitioner”.

Amended by R.2008 d.63, effective March 17, 2008.

See: 39 N.J.R. 1363(a), 40 N.J.R. 1647(a).

Added definitions “Commissioner”, “Department”, “Licensed practical nurse”, “Other licensed health care professionals”, “Registered professional nurse” and “Unlicensed assistive personnel”.

Case Notes

Hospital exemption does not apply to health maintenance organization (HMO) facility property tax status; facility not a hospital as no continuous care provided and it does not exist to further the aims and goals of a functioning hospital. *New Brunswick v. Rutgers Community Health Plan, Inc.*, 7 N.J.Tax 491 (Tax Ct.1985).

8:43G-1.3 Classification of institutions

(a) Hospitals shall be classified generally as:

1. Private, non-profit, which shall include any hospital owned and operated by a corporation, association, religious or other organization, no part of the net earnings of which is applied, or may lawfully be applied, to the benefit of any private shareholder or person;

2. Private proprietary or profit, which shall include any hospital owned and operated by a person, partnership or corporation, the net proceeds of which are subject to distribution for the benefit of such person, corporation or shareholders; and

3. Public hospital, which shall include any institution maintained, supervised or controlled by an agency of the government of the State or any county or municipality that provides diagnostic and/or treatment services for the care of two or more non-related individuals suffering from illness, injury or deformity.

(b) Hospitals shall be further classified as:

1. General hospital, which shall include any hospital which maintains and operates organized facilities and services for the diagnosis, treatment or care of persons suffering from acute illness, injury or deformity and in which all diagnosis, treatment and care are administered by or performed under the direction of persons licensed to practice medicine or osteopathy in the State of New Jersey;

2. Special hospitals, which shall include any hospital which assures provision of comprehensive specialized diagnosis, care, treatment and rehabilitation where applicable on an inpatient basis for one or more specific categories and for a hospital that provides long term acute care through a broad spectrum of clinical care services for acutely ill/medically complex patients requiring, on average, a 25-day or greater length of stay. Special hospitals do not include hospitals or hospital units providing comprehensive rehabilitation services and licensed in accordance with the provisions of N.J.A.C. 8:43H. Special hospitals providing long term acute care services shall be further classified as follows:

i. Long term acute care hospital-within-a-hospital means a hospital established in accordance with the standards imposed by the United States Department of Health and Human Services at 42 CFR Part 412 et al. that occupies space in a building also used by another hospital and is licensed as a special hospital in accordance with N.J.A.C. 8:43G-38.

ii. Long term acute care hospital-freestanding means a hospital established in accordance with the standards imposed by the United States Department of Health and Human Services at 42 CFR Part 412 et al. that is a physically separate self-contained facility and is licensed as a special hospital in accordance with N.J.A.C. 8:43G-38; and

3. Psychiatric hospital, which shall include any hospital which assures provision of comprehensive specialized diagnosis, care, treatment and rehabilitation where applica-

ble on an in-patient basis for patients with primary psychiatric diagnoses.

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.2003 d.49, effective January 21, 2003.

See: 34 N.J.R. 490(a), 35 N.J.R. 414(a).

Rewrote (b)2.

Case Notes

Nursing home was not "hospital" which was exempt from local property tax. Intercare Health Systems, Inc. v. Cedar Grove Tp., 11 N.J.Tax 423 (1990), affirmed 12 N.J.Tax 273, certification denied 127 N.J. 558, 606 A.2d 369.

8:43G-1.4 Information and complaint procedure

(a) Questions regarding hospital licensure may be addressed to the Certificate of Need and Acute Care Licensure Program at the following address:

New Jersey State Department of Health and Senior Services
Division of Health Care Quality and Oversight
PO Box 360
Trenton, NJ 08625-0360

Current address and contact information can be obtained at the Department's website address: www.state.nj.us/health/hcsa/hcsaforms.html.

(b) To make a complaint about any New Jersey licensed health care facility, call:

1-800-792-9770 (toll-free hotline).

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

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

Rewrote (a) and (b).

SUBCHAPTER 2. LICENSURE PROCEDURE

8:43G-2.1 Certificate of Need

(a) Where, in accordance with N.J.S.A. 26:2H-1 et seq., as amended, a Certificate of Need is required, a hospital shall not be instituted, constructed, expanded or licensed to operate except upon application for and receipt of a Certificate of Need issued by the Commissioner of the Department of Health and Senior Services.

(b) Application forms for a Certificate of Need and instructions for completion may be obtained from:

Certificate of Need and Acute Care Licensure Program
Division of Health Care Quality and Oversight
New Jersey State Department of Health and Senior Services
PO Box 360
Trenton, New Jersey 08625-0360

(c) The hospital shall implement all conditions imposed by the Commissioner as specified in Certificate of Need approval letters. Failure to implement the conditions may result in the imposition of enforcement sanctions in accordance with N.J.S.A. 26:2H-13 and 14.

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.2005 d.279, effective September 6, 2005.

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

In (a), added "and Senior Services" following "Department of Health"; in (b), rewrote address.

Case Notes

Licensed beds not interchangeable between categories without hospital licensing board approval. *Desai v. St. Barnabas Medical Center*, 103 N.J. 79, 510 A.2d 662 (1986).

8:43G-2.2 Application for licensure

(a) Where applicable, following receipt of a Certificate of Need as a hospital, any person, organization, or corporation desiring to operate a hospital shall make application to the Commissioner for a license on forms prescribed by the Department. Such forms may be obtained from the Department's website address www.state.nj.us/health/hcsa/hcsaforms.html or from:

Director
Certificate of Need and Acute Care Licensure
Program
Division of Health Care Quality and Oversight
New Jersey State Department of Health and
Senior Services
PO Box 360
Trenton, New Jersey 08625-0360

(b) The Department shall charge a nonrefundable fee of \$10,000 for the filing of an application for licensure and each annual renewal of a general acute care, special or psychiatric hospital. These fees shall not exceed the maximum caps as set forth at N.J.S.A. 26:2H-12, as may be amended from time to time.

(c) The Department shall charge a nonrefundable fee of \$3,000 for the filing of an application to add services to an existing general acute care, special or psychiatric hospital.

(d) The Department shall charge a nonrefundable fee of \$375.00 for the filing of an application to reduce services at an existing general acute care, special or psychiatric hospital.

(e) The Department shall charge a nonrefundable fee of \$1,500 for the filing of an application for the relocation of a general acute care, special or psychiatric hospital.

(f) The Department shall charge a nonrefundable fee of \$1,500 for the filing of an application for the transfer of ownership of a general acute care, special or psychiatric hospital.

(g) Each general acute care, special and psychiatric hospital shall be assessed a biennial inspection fee of \$5,000. This fee shall be assessed in the year the facility will be inspected, along with the annual licensure fee for that year. The fee shall be added to the initial licensure fee for new facilities. Failure to pay the inspection fee shall result in nonrenewal of the license for existing facilities and the refusal to issue an initial license for new facilities. This fee shall be imposed only every other year even if inspections occur more frequently and only for the inspection required to either issue an initial license or to renew an existing license. This fee shall not be imposed for any other type of inspection.

(h) If a hospital operates a service that is subject to separate licensing regulation, for example, a long-term care or comprehensive rehabilitation facility, the Department shall charge an additional licensing fee for that service, as set forth in the applicable rules.

(i) All applicants shall demonstrate that they have the capacity to operate a hospital in accordance with the rules in this chapter. An application for a license or change in service may be denied if the applicant cannot demonstrate that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards or health care are fit and adequate and that there is reasonable assurance that the health care facility will be operated in accordance with the standards required by these rules. The Department shall consider an applicant's prior history in operating a health care facility either in New Jersey or in other states in making this determination. Any evidence of licensure violations representing serious risk of harm to patients may be considered by the Department, as well as any record of criminal convictions representing a risk of harm to the safety or welfare of patients.

(j) Any applicant denied a license to operate a facility shall have the right to a fair hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

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.1996 d.339, effective July 15, 1996.

See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).

Amended by R.1998 d.579, effective December 7, 1998.

See: 30 N.J.R. 3633(a), 30 N.J.R. 4221(b).

In (b), increased the fee from \$1,500 plus \$5.00 per bed to \$8,000; inserted a new (g); and recodified former (g) through (i) as (h) through (j).

Amended by R.2004 d.160, effective April 19, 2004.

See: 35 N.J.R. 4838(a), 36 N.J.R. 1962(a).

In (b) through (g), increased fees.

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

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

In (a), added "the Department's website address www.state.nj.us/health/hcsa/hcsaforms.html or from:" and deleted "." following "may be obtained from:", and rewrote mailing address.

8:43G-2.3 Newly constructed or expanded facilities

(a) The licensure application for a newly constructed or expanded hospital pursuant to N.J.A.C. 8:43G-2.2 shall include a copy of the Certificate of Occupancy, Certificate of Continuing Occupancy or a Certificate of Approval issued by the municipality in which the facility has been constructed in accordance with construction plan approval by:

Health Plan Review
Division of Codes and Standards
Department of Community Affairs
PO Box 815
Trenton, New Jersey 08625-0815
Telephone: 609-633-8151

(b) An on-site inspection of the construction of the physical plant shall be made at the Department's discretion by representatives of the Acute Care Survey Program to verify that the building has been constructed in accordance with the final architectural plans approved by the Department.

(c) Any health care facility which intends to undertake any alteration, renovation, or new construction of the physical plant, whether a Certificate of Need is required or not, shall submit plans to the Health Plan Review Program of the Department of Community Affairs for review and approval prior to the initiation of any work.

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.2005 d.279, effective September 6, 2005.

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

Rewrote (a); in (b), substituted "Acute Care Survey Program" for "Health Facilities Construction Service"; in (c), substituted "Health Plan Review Program of the Department of Community Affairs" for "Health Facilities Construction Service of the Department".

8:43G-2.4 Surveys and temporary license

(a) When the written application for licensure pursuant to N.J.A.C. 8:43G-2.2 is approved and the building is ready for occupancy, a survey of the facility by representatives of the Division of Health Care Quality and Oversight of the Department shall be conducted at the Department's discretion to determine if the facility meets the standards set forth in this chapter.

1. Representatives of the Division of Health Care Quality and Oversight of the Department shall discuss the findings of the survey, including any deficiencies found, with representatives of the hospital facility.

2. The hospital facility shall notify the Division of Health Care Quality and Oversight of the Department in writing when the deficiencies, if any, have been corrected. Following review of the hospital facility's report, the Division of Health Care Quality and Oversight's Acute Care Survey Program may schedule one or more surveys of the facility prior to occupancy.

(b) A temporary license shall be issued to the operator of a facility when the following conditions are met:

1. An office conference for review of the conditions for licensure and operation has taken place between the Licensing and Certification Program and representatives of the hospital facility, who have been advised that the purpose of the temporary license is to allow the Department to determine the hospital's compliance with N.J.S.A. 26:2H-1 et seq., and amendments thereto, and the rules pursuant thereto;

2. Written approvals are on file with the Department from the local zoning, fire, health, and building authorities;

3. Written approvals of the water supply and sewage disposal system from local officials are on file with the Department for any water supply or sewage disposal system not connected to an approved municipal system; and

4. Survey(s) by representatives of the Department indicate that the hospital meets the mandatory standards set forth in this chapter.

(c) No hospital facility shall accept patients in any new service, unit, or facility until the hospital has a written approval and/or license issued by the Certificate of Need and Acute Care Licensure Program of the Department.

(d) The hospital shall accept only that number of patients for which it is approved and/or licensed.

(e) Survey visits may be made to a hospital at any time by authorized staff of the Department. Such visits may include, but are not limited to, the review of all hospital documents and patient records and conferences with patients.

(f) A temporary license shall be issued to the operator of a hospital facility for a period of six months and shall be renewed as determined by the Department.

1. The temporary license shall be conspicuously posted in the hospital facility.

2. The temporary license shall not be assignable or transferable and shall be immediately void if the facility ceases to operate, if the facility's ownership changes, or if the facility is relocated to a different site.

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.1996 d.339, effective July 15, 1996.

See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).

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

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

Substituted "Care Quality and Oversight" for "Facilities Evaluation and Licensing" in the introductory paragraph (a), (a)1 and (a)2; in (a)2, substituted "Care Quality and Oversight's Acute Care Survey Program" for "Facilities Evaluation and Licensing" preceding "may schedule"; in (c), substituted "Certificate of Need and Acute Care Licensure" for "Licensing and Certification".

8:43G-2.5 Full license

(a) A full license shall be issued to the operator on expiration of the temporary license, if the surveys by the Department have determined that the health care facility is

operated as required by N.J.S.A. 26:2H-1 et seq., and amendments thereto, and by the rules pursuant thereto.

(b) A license shall be granted for a period of one year or less as determined by the Department in accordance with (a) above.

(c) The license shall be conspicuously posted in the facility.

(d) The license shall not be assignable or transferable and shall be immediately void if the hospital ceases to operate, if its ownership changes, or if it is relocated to a different site. A representative of the hospital shall notify the Department of any change in the ownership form or controlling interests affecting hospital governance. The Department shall determine whether a certificate of need or licensing application must be completed prior to the implementation of any ownership changes based upon the information filed and the criteria within N.J.A.C. 8:33-3.3.

(e) The license, unless suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date.

1. The facility shall receive a request for renewal fee 30 days prior to expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department.

2. The license may not be renewed if Departmental rules, regulations and/or requirements are not met.

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.1996 d.339, effective July 15, 1996.
See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).

8:43G-2.6 Revocation or suspension of license

(a) The Department is authorized to suspend or revoke a license issued pursuant to this subchapter, order closure of a service or unit within the hospital, or impose a money penalty on any of the following grounds:

1. Violation of any provisions of N.J.S.A. 26:2H-1 et seq. or any rules and regulations issued pursuant thereto;
2. Permitting, aiding or abetting the commission of any illegal act in said facility; and/or
3. Conducting practices contrary to accepted procedures and detrimental to the welfare of the patient.

8:43G-2.7 Surrender of license

At least 30 days prior to voluntary surrender of its license where approved by Certificate of Need, or as directed under an order of revocation, refusal to renew, or suspension of license, a facility must directly notify each patient and the patient's physician concerned of the intended closure. The license shall be returned to the Licensing and Certification Program of the Department within seven calendar days from voluntary surrender, order of revocation, expiration, or suspension of license, whichever is applicable.

8:43G-2.8 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of N.J.S.A. 26:2H-1 et seq., and amendments thereto, and the standards in this chapter, waive sections of this chapter if, in his or her opinion, such waiver would not endanger the life, safety, or health of the patient or public.

1. Administration;
2. Anesthesia Department;
3. Blood Bank;
4. Central Supply;
5. Clinical and Pathological Laboratories;
6. Dietary Services;
7. Discharge Planning;
8. Emergency Department;
9. Employee and Occupational Health;
10. Electrocardiogram Laboratory;
11. Housekeeping and Laundry Services;
12. Infection Control and Sanitation;
13. Medical Library;
14. Medical Records;
15. Medical/Surgical Service;
16. Medical Staff;
17. Morgue and Autopsy Facilities;
18. Nursing Service;
19. Out-Patient and Preventive Services, including regularly scheduled clinic services for medically indigent patients;
20. Pharmacy Department;
21. Physical and Occupational Therapy;
22. Physical Plant and Maintenance;
23. Post Anesthesia Care Unit;
24. Quality Assurance;
25. Radiology;
26. Respiratory Therapy Services; and
27. Social Work Department.

(b) All psychiatric hospitals applying for licensure shall provide the following professional departments, services, facilities, or functions:

1. Administration;
2. Anesthesia department (only if electro-convulsive therapy is provided);
3. Dietary services;
4. Discharge planning;
5. Emergency department (8:43G-12.1 only);

6. Employee and occupational health;
7. Housekeeping and laundry services;
8. Infection control and sanitation;
9. Medical records;
10. Medical staff;
11. Post mortem services (8:43G-25.1 and 25.3(b) through (d) only);
12. Nursing service;
13. Patient rights;
14. Pharmacy services;
15. Rehabilitation therapy;
16. Physical plant and maintenance;
17. Psychiatric services;
18. Quality assurance; and
19. Social services.

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 (b).

8:43G-2.13 Child abuse and neglect

(a) The facility shall establish and implement written policies and procedures, reviewed by the Department and revised as required by the Department, for reporting all diagnosed and/or suspected cases of child abuse and/or neglect in compliance with N.J.S.A. 9:6-1 et seq.

(b) The facility shall have in effect written policies and procedures reviewed by the Department and revised as required by the Department to include, but not be limited to, the following:

1. The designation of a staff member(s) to be responsible for coordinating the reporting of diagnosed and/or suspected cases of child abuse and/or neglect on a 24-hour basis, recording the notification to the Division of Youth and Family Services on the medical record, and serving as a liaison between the facility and the Division of Youth and Family Services;

2. The development of written protocols for the identification and treatment of abused and/or neglected children for the emergency room, clinic, and pediatrics, where such services exist, for admission and/or transfer to another facility and for protective custody through the use of hospital hold in accordance with N.J.S.A. 9:6-8.16; and

3. The provision of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of child abuse and/or neglect and regarding the facility's policies and procedures on at least an annual basis.

Note: Copies of N.J.S.A. 9:6-1 et seq. can be obtained from the local district office of the Division of Youth and Family Services or from the Office of Program Support, Division of Youth and Family Services, Trenton, New Jersey 08625.

SUBCHAPTER 3. (RESERVED)

SUBCHAPTER 4. PATIENT RIGHTS

8:43G-4.1 Patient rights

(a) Every New Jersey hospital patient shall have the following rights, none of which shall be abridged by the hospital or any of its staff. The hospital administrator shall be responsible for developing and implementing policies to protect patient rights and to respond to questions and grievances pertaining to patient rights. These rights shall include at least the following:

1. To receive the care and health services that the hospital is required to provide under N.J.S.A. 26:1-1 et seq. and rules adopted by the Department of Health and Senior Services to implement this law;

2. To treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment;

3. To retain and exercise to the fullest extent possible all the constitutional, civil, and legal rights to which the patient is entitled by law;

4. To be informed of the names and functions of all physicians and other health care professionals who are providing direct care to the patient. These people shall identify themselves by introduction or by wearing a name tag;

5. To receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and the hospital's health care personnel;

6. To receive from the patient's physician(s) or clinical practitioner(s) — in terms that the patient understands — an explanation of his or her complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the patient's medical record;

7. To give informed, written consent prior to the start of specified nonemergency procedures or treatments only after a physician or clinical practitioner has explained — in terms that the patient understands — specific details about the recommended procedure or treatment, the risks involved, the possible duration of incapacitation, and any reasonable medical alternatives for care and treatment. The procedures requiring informed, written consent shall be specified in the hospital's policies and procedures. If the patient is incapable of giving informed, written consent, consent shall be sought from the patient's next of kin or guardian or through an advance directive, to the extent authorized by law. If the patient does not give written consent, a physician or clinical practitioner shall enter an explanation in the patient's medical record;

8. To refuse medication and treatment to the extent permitted by law and to be informed of the medical consequences of this act;

9. To be included in experimental research only when he or she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent patient in accordance with law and regulation. The patient may refuse to participate in experimental research, including the investigations of new drugs and medical devices;

10. To be informed if the hospital has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and may refuse to allow their participation in the patient's treatment;

11. To be informed of the hospital's policies and procedures regarding life-saving methods and the use or withdrawal of life-support mechanisms. Such policies and procedures shall be made available promptly in written format to the patient, his or her family or guardian, and to the public, upon request;

12. To be informed by the attending physician and other providers of health care services about any continuing health care requirements after the patient's discharge from the hospital. The patient shall also have the right to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge;

13. To receive sufficient time before discharge to have arrangements made for health care needs after hospitalization;

14. To be informed by the hospital about any discharge appeal process to which the patient is entitled by law;

15. To be transferred to another facility only for one of the following reasons, with the reason recorded in the patient's medical record:

- i. The transferring hospital is unable to provide the type or level of medical care appropriate for the patient's needs. The hospital shall make an immediate effort to notify the patient's primary care physician and the next of kin, and document that the notifications were received; or
 - ii. The transfer is requested by the patient, or by the patient's next of kin or guardian when the patient is mentally incapacitated or incompetent;
16. To receive from a physician an explanation of the reasons for transferring the patient to another facility, information about alternatives to the transfer, verification of acceptance from the receiving facility, and assurance that the movement associated with the transfer will not subject the patient to substantial, unnecessary risk of deterioration of his or her medical condition. This explanation of the transfer shall be given in advance to the patient, and/or to the patient's next of kin or guardian except in a life-threatening situation where immediate transfer is necessary;
 17. To be treated with courtesy, consideration, and respect for the patient's dignity and individuality;
 18. To freedom from physical and mental abuse;
 19. To freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the patient or others from injury;
 20. To have physical privacy during medical treatment and personal hygiene functions, such as bathing and using the toilet, unless the patient needs assistance for his or her own safety. The patient's privacy shall also be respected during other health care procedures and when hospital personnel are discussing the patient;
 21. To confidential treatment of information about the patient. Information in the patient's records shall not be released to anyone outside the hospital without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, a medical peer review, or the New Jersey State Department of Health. The hospital may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
 22. To receive a copy of the hospital payment rates, regardless of source of payment. Upon request, the patient or responsible party shall be provided with an itemized bill and an explanation of the charges if there are further questions. The patient or responsible party has a right to appeal the charges. The hospital shall provide the patient or responsible party with an explanation of procedures to follow in making such an appeal;
 23. To be advised in writing of the hospital rules and regulations that apply to the conduct of patients and visitors;
 24. To have prompt access to the information contained in the patient's medical record, unless a physician prohibits such access as detrimental to the patient's health, and explains the reason in the medical record. In that instance, the patient's next of kin or guardian shall have a right to see the record. This right continues after the patient is discharged from the hospital for as long as the hospital has a copy of the record;
 25. To obtain a copy of the patient's medical record, at a reasonable fee, within 30 days of a written request to the hospital. If access by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician;
 26. To have access to individual storage space in the patient's room for the patient's private use. If the patient is unable to assume responsibility for his or her personal items, there shall be a system in place to safeguard the patient's personal property until the patient or next of kin is able to assume responsibility for these items;
 27. To be given a summary of these patient rights, as approved by the New Jersey State Department of Health, and any additional policies and procedures established by the hospital involving patient rights and responsibilities. This summary shall also include the name and phone number of the hospital staff member to whom patients can complain about possible patient rights violations. This summary shall be provided in the patient's native language if 10 percent or more of the population in the hospital's service area speak that language. In addition, a summary of these patient rights, as approved by the New Jersey State Department of Health, shall be posted conspicuously in the patient's room and in public places throughout the hospital. Complete copies of this subchapter shall be available at nurse stations and other patient care registration areas in the hospital for review by patients and their families or guardians;
 28. To present his or her grievances to the hospital staff member designated by the hospital to respond to questions or grievances about patient rights and to receive an answer to those grievances within a reasonable period of time. The hospital is required to provide each patient or guardian with the names, addresses, and telephone numbers of the government agencies to which the patient can complain and ask questions, including the New Jersey Department of Health Complaint Hotline at 1-800-792-9770. This information shall also be posted conspicuously in public places throughout the hospital;
 29. To be assisted in obtaining public assistance and the private health care benefits to which the patient may be entitled. This includes being advised that they are indigent or lack the ability to pay and that they may be eligible for coverage, and receiving the information and other assis-

tance needed to qualify and file for benefits or reimbursement;

30. To contract directly with a New Jersey licensed registered professional nurse of the patient's choosing for private professional nursing care during his or her hospitalization. A registered professional nurse so contracted shall adhere to hospital policies and procedures in regard to treatment protocols, and policies and procedures so long as these requirements are the same for private duty and regularly employed nurses. The hospital, upon request, shall provide the patient or designee with a list of local non-profit professional nurses association registries that refer nurses for private professional nursing care; and

31. To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care, in accordance with N.J.A.C. 8:43E-6.

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

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

Native language and distribution requirements added at (a)27.

Petition for Rulemaking: Petition from N.J. Hospital Assoc.

See: 24 N.J.R. 4131(a), 24 N.J.R. 4290(a), 25 N.J.R. 4676(b).

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 (a)8.

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

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

In (a)1, added "and Senior Services" following "Department of Health"; in (a)6 and 7, added "or clinical practitioner" following "physician" throughout; in (a)29, delete "and" at the end of the paragraph; in (a)30, substituted "; and" for "." at the end of the paragraph; added (a)31.

Cross References

Regional Maternal and Child Health Consortia, compliance with patient confidentiality requirements in this section, see N.J.A.C. 8:33C-2.4.

8:43G-4.2 (Reserved)

SUBCHAPTER 5. HOSPITAL ADMINISTRATION AND GENERAL HOSPITAL-WIDE POLICIES

8:43G-5.1 Administrative and hospital-wide structural organization

(a) There shall be an organizational chart of the hospital and each service that shows lines of authority, responsibility, and communication between and within services.

(b) The hospital shall have an established and functioning governing body responsible for establishing hospital-wide policy, adopting bylaws, maintaining quality of care, and providing institutional management and planning. The hospital shall file the following with its license application or license renewal application:

1. The name of each member of the hospital's governing body;
2. The name of the chairperson of the hospital's governing body;
3. The term of office of the chairperson and each member of the governing body; and
4. The start date and end date of the term of office of each member of the governing body.

(c) The governing body shall designate an administrator or chief executive officer for the hospital and develop criteria used to evaluate the performance of the administrator or chief executive officer.

(d) The hospital shall advise the New Jersey State Department of Health and Senior Services, Office of Certificate of Need and Healthcare Facility Licensure, in writing within 15 days following any change in the designation of the administrator or chief executive officer of the hospital.

(e) The medical staff shall have the right of representation at governing body meetings.

(f) There shall be a formal mechanism for communication among the governing body, administration, and medical staff.

(g) Minutes of governing body meetings shall be recorded, signed, and retained in the hospital as a permanent record.

(h) The hospital shall have a multidisciplinary bioethics committee, and/or prognosis committee(s), or equivalent(s). The hospital shall assure participation by individuals with medical, nursing, legal, social work, and clergy backgrounds. The committee or committees shall have at least the following functions:

1. Participation in the formulation of hospital policy related to bio-ethical issues;
2. Participation in the formulation of hospital policy related to advance directives. Advance directive shall mean a written statement of the patient's instructions and directions for health care in the event of future decision making incapacity in accordance with the New Jersey Advance Directives for Health Care Act (P.L. 1991, c.201). An "advance directive" may include a proxy directive or an instruction directive, or both.
3. Participation in the resolution of patient-specific bio-ethical issues, and responsibility for conflict resolution concerning the patient's decision-making capacity and in the interpretation and application of advance directives. The committee may partially delegate responsibility for this function to any individual or individuals who are qualified by their backgrounds and/or experience to make clinical and ethical judgments; and

3. The signature of the physician who ordered the transfer;

4. The condition of the patient upon transfer;

5. Patient information collected by the sending hospital, as specified in N.J.A.C. 8:43G-15.2(e);

6. The name of the contact person at the receiving hospital; and

7. A copy of the patient's advance directive where available or notice that the individual has informed the sending hospital of the existence of an advance directive.

(c) The hospital shall not deny admission to patients on the basis of their inability to pay.

(d) Patients shall be discharged only on physician's orders or after signing a waiver that exempts the hospital and the physician from liability as a result of the patient's leaving the hospital against medical advice. Patient refusal to sign such a waiver shall be documented.

(e) The hospital shall have a patient identification system that is used for all patients in the hospital from the time of admission until the time the patient is released from the hospital.

(f) Upon arrival at a service location, an inpatient's treatment shall be initiated within 30 minutes. Following completion of treatment, the patient shall be returned to his or her hospital room within a reasonable length of time not to exceed 30 minutes.

(g) The hospital shall develop and implement a complaint procedure for patients, families, and other visitors. The procedure shall include, at least, a system for receiving complaints, a specified response time, assurance that complaints are referred appropriately for review, development of resolutions, and follow-up action.

(h) The hospital shall develop and implement a grievance procedure for all staff. The procedure shall include, at least, a system for receiving grievances, a specified response time, assurance that grievances are referred appropriately for review, development of resolutions, and follow-up action.

(i) There shall be written policies and procedures for personnel that are viewed annually, revised as needed, and implemented. They shall include at least:

1. A written job description for each category of personnel in the hospital and distribution of a copy to each newly hired employee;

2. Personnel policies in compliance with Federal requirements for Equal Employment Opportunity;

3. A system to ensure that written, job-relevant criteria are used in making evaluation, hiring, and promotion decisions;

4. A system to ensure that employees meet ongoing requirements for credentials; and

5. Written criteria for personnel actions that require disciplinary action.

(j) The hospital shall comply with all requirements of the professional licensing boards for reporting terminations, suspensions, revocation, or reduction of privileges for any health professionals licensed in the State of New Jersey.

(k) Personnel records shall be confidential material, accessible only to authorized personnel who have clearly established their identity.

(l) The hospital shall develop and implement a policy for the facility to be smoke-free by April 1, 1995. The hospital shall ensure that there is no smoking in the facility by employees, visitors or patients.

(m) The hospital shall develop and implement a method to prevent smoking by patients who have been designated as "not responsible".

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 (n) and (o) regarding smoking.
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 (a)4-12 and (b)7 on advance directives.
Petition for Rulemaking: Petition from N.J. Hospital Assoc.
See: 24 N.J.R. 4131(a), 24 N.J.R. 4290(a), 25 N.J.R. 4676(b).
Administrative Change.
See: 27 N.J.R. 1615(a).
Administrative Correction.
See: 27 N.J.R. 2215(a).

Rewrote and relettered (l) to (q) as (l) and (m).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.
Amended by R.2006 d.333, effective September 18, 2006.
See: 37 N.J.R. 4152(a), 38 N.J.R. 3898(b).

Added (a)3i through (a)3iii.

8:43G-5.3 Administrative and hospital-wide staff qualifications

(a) The administrator or chief executive officer of the hospital shall have at least one of the following qualifications:

1. A master's degree and at least three years of full-time experience in progressively responsible management positions;

2. A baccalaureate degree and at least five years of full-time experience in progressively responsible management positions; or

3. At least 10 years of full-time experience in hospital administration.

(b) The hospital shall verify through visual examination the professional credentials, required by this chapter, of all new employees.

(c) The hospital shall verify through visual examination that the professional credentials, required by this chapter, of all employees are current.

(d) If the hospital performs organ transplants, the director of the medical staff shall ensure that all health professionals serving the patient have sufficient clinical experience in transplantation care, based on predetermined criteria established in hospital policies and procedures or set by the National Organ Procurement and Transplantation Network.

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

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

National Organ Procurement and Transplantation Network added.

8:43G-5.4 Organ and tissue donation

(a) The hospital shall develop and implement written protocols for organ and tissue donation in accordance with N.J.S.A. 26:6-57 et seq., and the Uniform Anatomical Gift Act, P.L. 1969, c.161, as amended.

(b) For the purposes of this rule, the following words shall have the following meanings:

1. "Designated requestor" means a hospital employee who has completed a course offered or approved by the designated Federally qualified organ procurement organization. This course shall be designed by the OPO with input from the regional tissue and eye bank community and shall incorporate the methodology to be used by the Designated Requestor for approaching potential donor families to request organ or tissue donation.

2. "OPO" means a hospital's designated Federally qualified organ procurement organization. The Federally qualified organ procurement organizations in New Jersey are:

- i. The New Jersey Organ and Tissue Sharing Network
150 Morris Avenue
Springfield, New Jersey 07081
(800-541-0075); and
- ii. Delaware Valley Transplant Program
2000 Hamilton Street
Philadelphia, Pennsylvania 19130
(800-543-6391)

3. "Organ" means human kidney, liver, heart, lung, pancreas, and any other solid organ.

4. "Tissue" means human skin, heart valves, saphenous veins, bone and other tissue, including ocular tissue.

5. "Transplant recovery specialist" means a medical professional licensed by the State of New Jersey or another State or technician trained by an organ procurement organization in accordance with Federal standards pursuant to 42

U.S.C. § 274(b) and nationally accredited standards for human body part removal.

(c) The protocols required by (a) above shall include, at a minimum, the following:

1. Procedures for the hospital to notify its OPO of each hospital patient whose death is imminent or who died in the hospital at or around the time of death of such hospital patient. The information to be provided by the hospital to its OPO shall include the following:

- i. Patient's name and identifier number;
- ii. Patient's age;
- iii. Cause of death or anticipated cause of death;
- iv. Past medical history; and
- v. Other pertinent medical information requested by the OPO;

2. A requirement that hospital personnel note in the patient's medical record the donor suitability determination made by the OPO. If the patient is determined to be an unsuitable candidate for donation, an explanatory notation shall be made part of the patient's medical record;

3. A requirement that, if the patient has a validly executed donor card, will, or other document of gift, driver's license or identification card evidencing anatomical gift, the OPO representative or the Designated Requestor, if any, shall attempt to notify an appropriate person under N.J.S.A. 26:6-58.1 to advise him or her of the gift. If there is no document of gift available to the OPO representative or Designated Requestor, he or she shall ask persons pursuant to N.J.S.A. 26:6-58.1 whether the decedent had a validly executed document of gift. If there is no such evidence of an anatomical gift, then the person designated under N.J.S.A. 26:6-58.1 shall be informed of the option to donate organs and tissue. A person authorized or under obligation to dispose of the body pursuant to N.J.S.A. 26:6-58.1(b)(6) shall include, but not be limited to, a hospital administrator, a designated health care representative, a holder of a durable medical power of attorney, or a person named in the decedent's will.

4. A requirement that a notation shall be made in a deceased person's medical record indicating whether or not consent for organ or tissue donation was granted. The notation shall include the following information:

- i. Whether consent was granted or refused;
- ii. The name of the person granting or refusing consent;
- iii. That person's relationship to the decedent; and

(e) The hospital administrator shall appoint a disaster planner for the hospital. The disaster planner shall meet with county and municipal emergency management officials at least annually to review and update the written, comprehensive disaster plan. If county or municipal officials are unavailable for this purpose, the hospital shall notify the New Jersey State Office of Emergency Management, Division of State Police, Department of Law and Public Safety, P.O. Box 7068, River Road, West Trenton, NJ 08628 (phone: 609-882-2000).

(f) While developing the hospital's plan for evacuating patients, the disaster planner shall communicate with the facility or facilities designated to receive relocated patients.

(g) Copies of the current plans for receiving and evacuating patients in the event of a disaster shall be sent to municipal and county emergency management officials and to the designated receiving facilities.

(h) The hospital shall conduct at least one evacuation drill each year, either simulated or using selected patients. An actual evacuation shall be considered a drill, if it is documented.

(i) The hospital shall conduct at least one drill each year in which a large influx of emergency patients is simulated. An actual emergency of this type shall be considered a drill, if it is documented.

(j) The hospital shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency.

(k) The hospital shall take corrective action if the temperature of the hospital is not in compliance with the requirements specified in Chapter 7 of the Guidelines for Construction and Equipment for Hospital and Medical Facilities (published by the American Institutes of Architects Press, 1735 New York Ave NW, Washington, D.C. 20006, publication # ISBN0-913962-96-1) for a continuous period of four hours or longer. The hospital shall notify the New Jersey State Department of Health if the corrective action is not effective.

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 (f) on communication with receiving facilities.

8:43G-5.17 (Reserved)

8:43G-5.18 Blood bank

(a) The governing board shall designate the pathologist or other qualified physician as physician-in-charge of the blood service.

(b) The hospital shall maintain an emergency supply of blood and shall have access to additional supplies as needed.

(c) The hospital shall maintain a current list of potential blood donors of all principal blood types and groups who are

available in emergencies or it shall establish a stable source of blood supply, either through an integrated blood operation or by arrangement with an outside blood service.

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) regarding additional supplies of blood.

8:43G-5.19 Clinical and pathological laboratories

(a) The laboratories shall be under the direction of a pathologist on a full or part time basis.

(b) A qualified member of the medical staff may be appointed by the governing authority to assume a portion of the responsibilities involved, with a pathologist as a consultant.

8:43G-5.20 Electrocardiogram laboratory

The hospital shall provide at least one room designated for electrocardiography. Sufficient space shall be provided for the maintenance of essential records and such office space as may be required.

8:43G-5.21 Out-patient and preventive services

(a) All hospitals shall provide, on a regular and continuing basis, out-patient and preventive services, including clinic services for medically indigent patients, in those services provided on an in-patient basis.

(b) In no instance shall a hospital provide less than out-patient services in medicine and surgery.

8:43G-5.22 General hospital governing body training

(a) In addition to any general orientation, a general hospital shall ensure that all members of the hospital's governing body complete a trustee training program as set forth in (b) below conducted by an approved training provider within six months of the member's appointment.

(b) The trustee training program shall consist of at least seven hours of instruction and address each of the following subjects:

1. The ethical and fiduciary responsibilities of a member of a hospital governing body;
2. The role of the governing body in improving health care quality and the mechanisms available for doing so;
3. Hospital financial management and understanding the financial statements of healthcare institutions and reimbursement and finance payment systems;
4. Hospital organization and governance; and
5. Legal and regulatory compliance issues.

(c) Instruction may be offered in-person at a classroom or seminar, on-line, audio/webinar, or simulcast.

(d) A general hospital shall maintain a copy of the certificate for each current governing body member issued by the training provider pursuant to N.J.A.C. 8:43-5.23(b).

(e) Any governing board member who has not completed a trustee training program conducted by an approved training provider, shall complete the trustee training program by May 17, 2009.

New Rule, R.2008 d.344, effective November 17, 2008.
See: 40 N.J.R. 3553(a), 40 N.J.R. 6611(a).
Amended by R.2009 d.313, effective October 19, 2009.
See: 40 N.J.R. 6719(a), 41 N.J.R. 3899(b).

In (a), deleted "appointed after April 30, 2007," following "body"; and in (e), deleted "appointed on or after April 30, 2007," following "member".

8:43G-5.23 Approved training providers; requirements

(a) In accordance with N.J.S.A. 26:2H-12.34b, the Department approves the following as trustee training providers:

1. Accredited academic institutions that do not have a direct interest, corporate relationship, or primary mission in the support or development of the hospital offering the trustee training program;
2. Non-profit hospital trade associations and/or their affiliates;
3. Non-profit healthcare foundations that do not have a direct interest, corporate relationship, or primary mission in the support or development of the hospital offering the trustee training program;
4. Providers of board development and/or governance leadership training programs for hospitals and/or healthcare providers, such as, but not limited to, the Governance Institute, the American Hospital Association's Center for Healthcare Governance or Estes Park Institute;
5. Non-profit providers of professional legal and/or medical continuing education with expertise in trustee education training; and
6. Any provider of continuing education training with expertise in trustee education training authorized by the International Association for Continuing Education and Training.

(b) The training provider shall issue a certificate to attendees who successfully complete a course.

(c) A general hospital shall submit the following in writing to the Department for review at least 60 days prior to the board member's attendance at a trustee training program or course that fulfills the requirements of N.J.A.C. 8:43G-5.22:

1. A description of the goals and objectives for each of the subject matter areas required by N.J.A.C. 8:43G-5.22;
2. The course names offered by the training providers described in (a) above for each of the subject matter areas required by N.J.A.C. 8:43G-5.22; and

3. An attestation that the course provided as part of the trustee training program offers continuing education credits for the course from an approved training provider in the subjects set forth in N.J.A.C. 8:43G-5.22(b) or that the course instructors and their qualifications demonstrate competency and expertise in the subjects set forth in N.J.A.C. 8:43G-5.22(b).

(d) The information required in (b) and (c) above shall be submitted to the Office of Certificate of Need and Healthcare Facility Licensure, New Jersey Department of Health and Senior Services, PO Box 358, Trenton, NJ 08625.

(e) The submission shall be deemed approved unless the Department issues a request for additional information within 10 days of receipt.

New Rule, R.2008 d.344, effective November 17, 2008.
See: 40 N.J.R. 3553(a), 40 N.J.R. 6611(a).

SUBCHAPTER 6. ANESTHESIA

8:43G-6.1 Definitions

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

"Advanced Cardiac Life Support" (ACLS) means that an individual has successfully completed a course of training offered by an individual who is currently certified as an instructor by the American Heart Association or by a recognized accrediting organization appropriate to the licensee's field of practice. For example, for those adult patients, training in ACLS is appropriate and for those treating children, training in pediatric advanced life support (PALS) is appropriate.

"Analgesia" means the absence of the sensibility to pain without loss of consciousness or decrease in the intensity of pain.

"Anesthesia" consists of general anesthesia, and spinal or major regional anesthesia. It does not include local anesthesia.

"Anesthesiologist" means a physician who has successfully completed an approved residency program in anesthesiology, or who is a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before 1982.

"Anesthetic agent" means any drug or combination of drugs administered with the purpose of creating conscious sedation, deep sedation, regional anesthesia, or general anesthesia.

“Anesthetizing location” means any location in a health care facility where anesthetic agents are administered.

“Certified registered nurse anesthetist” (CRNA) means a registered professional nurse who is licensed by the New Jersey State Board of Nursing and who holds current certification under a program governed or approved by the American Association of Nurse Anesthetists (AANA), and who meets the conditions for practice as set forth at N.J.A.C. 13:37-13.1.

“Conscious sedation” means a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain an open airway, and spontaneous ventilation is adequate. Adequate cardiovascular function is usually maintained. Within the context of this subchapter, “conscious sedation” shall be synonymous with the term “sedation/analgesia” as used by the American Society of Anesthesiologists.

“Deep sedation” means a drug induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

“Epidural” means an anesthetic injected into the epidural space surrounding the fluid filled sac (the dura) around the spine which partially numbs the abdomen and legs.

“General anesthesia” means a drug induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug induced depression of neuromuscular function. Cardiovascular function may be impaired.

“Labor analgesia” means the reduction or management of pain during labor, which involves the use of anesthetic agents and/or an epidural.

“Local anesthesia” consists of drugs or agents which produce a transient and reversible loss of sensation in a circumscribed portion of the body.

“Major regional anesthesia” means nerve blocks such as epidural, caudal, axillary, brachial, and spinal anesthesia.

“Minor regional block” means the injection of a local anesthetic agent to stop a painful sensation in a severely circumscribed area of the body (local infiltration or local nerve block), or the block of a nerve by direct pressure and refrigeration.

“Minor surgery” means surgery which can safely and comfortably be performed on a patient who has received no more than the maximum manufacturer recommended dose of local or topical anesthesia, without more than minimal pre-operative medication or minimal intraoperative tranquilization and where the likelihood of complications requiring hospitalization is remote. Minor surgery specifically excludes all procedures performed utilizing anesthesia services as defined in this section. Minor surgery also specifically excludes procedures which may be performed under local anesthesia, but which involve extensive manipulation or removal of tissue such as liposuction or lipo-injection, breast augmentation or reduction, and removal of breast implants. Minor surgery includes the excision of moles, warts, cysts, lipomas, skin biopsies, the repair of simple lacerations, or other surgery limited to the skin and tissue. Additional examples of minor surgery include closed reduction of a fracture, the incision and drainage of abscesses, certain simple ophthalmologic surgical procedures, such as treatment of chalazions and non-invasive ophthalmologic laser procedures performed with topical anesthesia, limited endoscopies such as flexible sigmoidoscopies, anoscopies, proctoscopies, arthrocenteses, thoracenteses and paracenteses. Minor surgery shall not include any procedure identified as “major surgery” within the meaning of N.J.A.C. 13:35-4.1

“Monitoring” means the observation of a patient including the use of instruments to measure, display, and/or record (continuously or intermittently) the values of certain physiologic variables such as temperature, pulse, respiration, blood pressure, and oxygen saturation.

“Operating room” means a unit for the performance of surgery.

“Pain management” means the administration of drugs to a patient, which are not intended to result in a loss of consciousness, awareness or defensive reflexes, but which are intended to alleviate pain occurring in the absence of an invasive, operative, or manipulative procedure.

"Practitioner" means a licensed physician, dentist or podiatrist.

"Privileges" means having been granted permission by a hospital to provide specified anesthesia services, such as administration or supervision of one or more types of anesthetic agents or procedures.

"Regional anesthesia" means the administration of anesthetic agents to interrupt nerve impulses.

"Registered nurse anesthetist" means an individual who is a qualified candidate for certification under a program governed or approved by the American Association of Nurse Anesthetists (AANA), subject to the limitations and restrictions established by the New Jersey State Board of Nursing (N.J.A.C. 13:37-13.2, Practice pending the results of the examination).

"Special procedure" means various diagnostic or therapeutic interventions which may require the administration of sedation, analgesia, or anesthesia. Examples include, but are not limited to, endoscopy, oral surgery, radiologic procedures or emergency procedures.

"Special procedure room" means the appropriately equipped hospital location in which special procedures are performed.

"Supervision" means responsibility by a physician who has obtained privileges in accordance with medical staff bylaws, and is immediately available on-site overseeing the administration and monitoring of anesthesia by anesthesia personnel. Immediately available on-site means that the supervising physician is present and is available to respond and proceed immediately to the anesthetizing location.

"Universal precautions" means a set of precautions, in accordance with the Centers for Disease Control and Prevention published guideline for Handwashing and Hospital Environmental Control, incorporated herein by reference, as amended and supplemented. That publication may be obtained by telephoning the Centers for Disease Control and Prevention at (800) 311-3435.

New Rule, R.1991 d.451, effective August 19, 1991.
See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Prior text of section recodified to 8:43G-6.2 Anesthesia services policies and procedures.

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.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

Rewrote the section.

8:43G-6.2 Anesthesia services, policies and procedures

(a) Anesthesia services shall be administered in accordance with written policies and procedures that are reviewed at least every three years, and revised more frequently as needed. They shall include at least the following:

1. Monitoring of patients in the postanesthesia care unit, including availability of monitoring equipment, and discharge from the postanesthesia care unit;
2. Monitoring of patients in any special procedure rooms where patients receive anesthesia;
3. Reporting of morbidity and mortality, and any unusual or untoward occurrences in compliance with N.J.A.C. 8:43G-6.10(c); and
4. Preanesthesia evaluation, patient preparation and intraoperative management.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.1.

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

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

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.

Amended by R.2003 d.57, effective February 3, 2003.

See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

Rewrote (a).

Case Notes

Hospital required to provide an anesthesiology department, a physician department director and sufficient personnel for emergency needs; exclusive contract for anesthesiological services reasonable, not violative of public policy or antitrust law. *Belmar v. Cipolla*, 96 N.J. 199, 475 A.2d 533 (1984).

8:43G-6.3 Anesthesia staff: qualifications for administering anesthesia

(a) There shall be a physician director of anesthesia services who is a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a fellow of the American College of Anesthesiology before 1982.

(b) The physician director of anesthesia services shall participate in the credentialing process and delineation of privileges of all personnel who administer anesthetic agents. Criteria for hospital-wide anesthesia credentialing shall include at least:

1. Objective measures of training and experience in anesthesia care against which all candidates are evaluated; and
2. A requirement for continuing education in anesthesia care.

(c) All anesthesia providers, except for those in accordance with N.J.A.C. 8:43G-12.3(c) who administer and/or supervise the administration of general anesthesia, major regional anesthesia, or conscious sedation anesthesia, shall maintain current training in Advanced Cardiac Life Support.

(d) Anesthetic agents administered with the purpose of creating conscious sedation, deep sedation, major regional anesthesia, or general anesthesia shall be administered in

any location in the hospital only in accordance with medical staff policies and procedures.

(e) General or major regional anesthesia shall be administered and monitored only by the following:

1. An anesthesiologist;
2. Under the supervision of an anesthesiologist:
 - i. A certified registered nurse anesthetist;
 - ii. A registered nurse anesthetist; or
 - iii. A physician resident, dental resident, or a student nurse anesthetist participating in a nationally approved graduate training program leading to a recognized specialty;
3. Under the supervision of a privileged physician who has privileges in accordance with medical staff bylaws to administer or supervise the administration of anesthesia:
 - i. A certified registered nurse anesthetist; or
 - ii. A dentist who has successfully completed a nationally approved graduate medical education program in anesthesiology and has privileges in accordance with the hospital's policy.

(f) The administration and monitoring of general or major regional anesthesia shall be provided by a qualified individual as set forth in (e)1 through 4 above, who is continuously present during the operation and is not performing or assisting with the procedure.

(g) The supervision of general or major regional anesthesia shall be provided by a physician who is immediately available. The supervising physician may concurrently be responsible for patient care, with the exception of performing major surgery, administering general anesthesia, or major regional anesthesia.

(h) Anesthetic agents used for conscious sedation shall be administered only by the following:

1. A physician or dentist who has privileges in accordance with medical staff bylaws to administer anesthetic agents used for conscious sedation; or
2. Under the supervision of a physician who has privileges in accordance with medical staff bylaws to administer or supervise anesthetic agents used for conscious sedation and who is immediately available:
 - i. A certified registered nurse anesthetist;
 - ii. A registered nurse anesthetist; or
 - iii. A physician resident, dental resident, or a student nurse anesthetist participating in a nationally approved graduate training program leading to a recognized specialty; or

iv. A registered nurse who is trained and experienced in the use of anesthetic agents used for conscious sedation shall be permitted to administer supplemental doses, after the initial dose is given by a privileged or supervising physician who remains present.

(i) The monitoring of patients who have been given an anesthetic agent for the purpose of creating conscious sedation shall be provided by an individual who is continuously present for the primary purpose of anesthesia monitoring, and who is separate from the individual performing the operation. This individual shall be currently trained in Advanced Cardiac Life Support and be one of the following:

1. One of the personnel identified in (h) above;
2. A registered professional nurse; or
3. For bronchoscopic procedures only, a licensed respiratory care therapist.

(j) Minor regional blocks shall be administered by the following:

1. A physician, podiatrist or dentist who has privileges in accordance with medical staff bylaws to administer minor regional blocks;
2. Under the supervision of a physician who has privileges in accordance with medical staff bylaws to administer or supervise minor regional blocks and who is immediately available:
 - i. A certified registered nurse anesthetist;
 - ii. A registered nurse anesthetist; or
 - iii. A physician resident, dental resident, or a student nurse anesthetist participating in a nationally approved graduate training program leading to a recognized specialty; or
 - iv. A certified nurse midwife, a physician assistant, or an advanced practice nurse as permitted by the scope of practice rules of the New Jersey State Board of Medicine Examiners and New Jersey State Board of Nursing, as applicable.

(k) Minor regional blocks shall be monitored in accordance with the hospital's policy.

(l) Provision shall be made for remote monitoring of the patient if radiation or another direct hazard necessitates the removal of personnel.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.2. Deleted old (c) through (g). Added new (c) through (k).

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

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

Administrative Correction.

See: 27 N.J.R. 1800(a).

Amended by R.2003 d.57, effective February 3, 2003.

See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).
Rewrote the section.

8:43G-6.4 Anesthesiologist availability

At all times, an anesthesiologist shall be on-site or on-call and available to reach the hospital within 30 minutes under normal transportation conditions.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.3.

Amended by R.2003 d.57, effective February 3, 2003.

See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

8:43G-6.5 Anesthesia patient services

(a) A preanesthesia note, reflecting evaluation of the patient and review of the patient record prior to administration of anesthesia, shall be made or certified by the physician administering or supervising the administration of anesthesia and entered into the medical record of each patient receiving anesthesia at any anesthetizing location.

(b) A record of anesthesia that conforms with policies and procedures developed by the medical staff shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

(c) Upon arrival in the postanesthesia care unit a postanesthesia note shall be entered into the patient's anesthesia record by a member of the hospital's anesthesia team.

(d) An anesthesia team member shall make a postoperative discharge note for inpatients prior to the patient leaving the postanesthesia care unit and at the time of discharge for outpatients.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.4.

In (a), added "physician administering or supervising administration of anesthesia".

In (c), stylistic revisions.

Deleted old (d) and (e).

Amended by R.2003 d.57, effective February 3, 2003.

See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

In (a), added "at any anesthetizing location" at the end of the paragraph; rewrote (c); added (d).

8:43G-6.6 Anesthesia supplies and equipment; safety systems

(a) Diameter index safety systems or equivalent shall be used on all large cylinders of medical gases and wall and ceiling outlets of medical gases.

(b) Pin index safety systems with a single washer shall be used on all small cylinders to prevent interchangeability of medical gas cylinders.

(c) All medical gas hoses and adapters shall be color-coded and labeled according to current national standards,

that is, the Compressed Gas Association: Standard color marking for compressed gas containers intended for medical use as well as clear labeling. Publication (C-9) (ed. 3), Arlington, VA, 1988, incorporated herein by reference, as amended and supplemented. That publication may be obtained by telephoning the Compressed Gas Association at (703) 412-0900.

(d) An oxygen failure-protection device ("fail-safe" system) shall be used on all anesthesia machines to announce a reduction in oxygen pressure, and, at lower levels of oxygen pressure, to discontinue other gases when the pressure of supply oxygen is reduced.

(e) A vaporizer exclusion ("interlock") system shall be used to assure that only one vaporizer, and therefore only a single agent, can be actuated on any anesthesia machine at one time.

(f) To prevent delivery of excess anesthesia during an oxygen flush, no vaporizer shall be placed in the circuit downstream of the oxygen flush valve.

(g) All anesthesia vaporizers shall be pressure-compensated in order to administer a constant non-pulsatile output.

(h) Accurate flow meters and controllers shall be used to prevent the delivery to a patient of an inadequate concentration of oxygen relative to the amount of nitrous oxide or other medical gas.

(i) Alarm systems shall be in place for high (disconnect), low (subatmospheric), and minimum ventilatory pressures in the breathing circuit for each patient under general anesthesia.

(j) There shall be a written protocol to assure that surgery does not proceed when there are disabled alarms, depleted batteries and inactive sensors in oxygen monitors or carbon dioxide monitors, improperly positioned breathing-circuit sensors, or other insufficiencies.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.5.

In (a), added "or equivalent". In (d), added "a reduction in oxygen pressure". In (j), added "written" and deleted "when technical feasible". Deleted old (k).

Amended by R.2003 d.57, effective February 3, 2003.

See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

Rewrote (c); in (j), inserted "or carbon dioxide monitors" preceding "improperly".

8:43G-6.7 Anesthesia supplies and equipment; maintenance and inspections

(a) A record shall be maintained of all service and maintenance performed on all anesthesia machines, ventilators, and vaporizers. The record shall include machine identification; name of servicing agent; work performed; and date of work. This maintenance shall conform with maintenance

requirements established by the machine manufacturer. Credentials of each servicing agent shall be approved by the machine manufacturer or be determined by the hospital's physician director as equivalent to the credentials of manufacturers' servicing agents.

(b) All anesthesia equipment shall be inspected fully at the beginning of each day of use. A record of each such inspection shall be maintained for each machine. The inspection shall conform with a checklist that is supplied by the manufacturer of the machine; issued by the Federal Food and Drug Administration; or, alternatively, developed by the hospital's anesthesia services and approved by the hospital's physician director of anesthesia services.

(c) All anesthesia equipment shall be inspected before each use. A record of each inspection shall be indicated on the patient's anesthesia record. Each record may consist of a checklist or a single phrase explanation.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.6.

Amended by R.2003 d.57, effective February 3, 2003.

See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

Rewrote (c).

8:43G-6.8 Anesthesia supplies and equipment; patient monitoring

(a) An in-circuit oxygen analyzer shall monitor the oxygen concentration within the breathing circuit, displaying the percent oxygen of the total mixture, for all patients receiving general anesthesia.

(b) A respirometer (volumeter) measuring exhaled tidal volume shall be used whenever the breathing circuit of a patient under general anesthesia allows.

(c) The body temperature of each patient under general or major regional anesthesia lasting 45 minutes or more shall be continuously monitored and recorded at least every 15 minutes.

(d) Pulse oximetry shall be performed continuously during administration of general anesthesia, regional anesthesia, and conscious sedation at all anesthetizing locations, unless such monitoring is not clinically feasible for the patient. Any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness.

(e) End-tidal carbon dioxide monitoring shall be performed continuously during administration of all general anesthesia, unless such monitoring is not clinically feasible for the patient.

(f) An electrocardiogram monitor shall be used continuously on all patients receiving general anesthesia, regional anesthesia, or conscious sedation at any anesthetizing location.

(g) Blood pressure, pulse rate, and respirations shall be determined and charted at least every five minutes for all patients receiving anesthesia at any anesthetizing location, except for local anesthesia and minor regional blocks.

(h) The capacity for invasive monitoring of arterial pressure shall exist within the operating suite.

(i) A difficult airway container or cart shall be immediately available in each anesthesia department for handling emergencies. The following items are required for inclusion in the difficult airway container or cart: resuscitation equipment, emergency drugs, a laryngeal mask airway, or other items of similar technical capability.

(j) A precordial stethoscope or esophageal stethoscope shall be used when indicated on each patient receiving anesthesia. If necessary, the stethoscope may be positioned on the posterior chest wall or tracheal area.

(k) A peripheral nerve stimulator shall be available in any anesthetizing location in which patients receive general or regional anesthesia to monitor the patient's extent of muscle paralysis from muscle relaxants. Another peripheral nerve stimulator shall be available within the postanesthesia care unit.

(l) Monitoring of regional labor analgesia shall include: documented temperature, pulse, respiration, blood pressure, and oxygen saturation until the patient is deemed stable based on written criteria established by the Department of Anesthesia. The patient shall be monitored subsequently in accordance with hospital protocol.

(m) Supplemental oxygen and a delivery system appropriate to the patient's condition shall be immediately available for patient transport from the operating room to the postanesthesia care unit.

Amended by R.1991 d.451, effective August 19, 1991, operative October 15, 1991.

See: 22 N.J.R. 3470(a), 23 N.J.R. 2527(a).

Recodified from section 6.7. In (c), added "general or regional". In (d), deleted "all anesthesia, including intravenous, when technically feasible" and added "general anesthesia, regional anesthesia and conscious sedation unless monitoring not clinically feasible". In (e), deleted "when technically feasible" and added "unless monitoring not clinically feasible". In (f), added "regional anesthesia or conscious sedation". In (j), deleted "within the operating suite" and added "in any anesthetizing location in which patients receive general or regional anesthesia". Deleted old (k).

Amended by R.2003 d.57, effective February 3, 2003.

See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

Rewrote (c) and (g); added a new (i) and recodified existing (i) and (j) as (j) and (k); added a new (l) and (m).

(b) The continuous quality improvement program for surgery shall include at least:

1. Monitoring the volume of each service provided;
2. Infection and complication rates;
3. The incidence of mortality, morbidity, and other adverse occurrences in each service;
4. Patient factors that affect risk of complications in each service; and
5. Retrospective evaluation of emergency procedures in each service.

Recodified from N.J.A.C. 8:43G-7.35 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).

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

8:43G-7.42 (Reserved)

Recodified from N.J.A.C. 8:43G-7.36 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).

8:43G-7.43 Pediatric cardiac catheterization policies and procedures

(a) Pediatric invasive cardiac diagnostic procedures shall be performed only at pediatric cardiac surgery centers.

(b) The pediatric cardiac catheterization service may share the catheterization laboratory with the adult cardiac catheterization program. However, the staff who participates in the pediatric catheterization shall be trained and experienced in the care of the pediatric cardiac patient and the equipment used shall be appropriate to meet the needs of the pediatric patient.

(c) The pediatric cardiac catheterization laboratory shall perform a minimum of 150 pediatric cardiac catheterizations per year, excluding the first three years following initiation of services as referenced at N.J.A.C. 8:33E-1.11(d).

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

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

Old text at (b) deleted; new requirements added.

Recodified from N.J.A.C. 8:43G-7.37 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).

8:43G-7.44 Pediatric cardiac catheterization staff qualifications

(a) There shall be a director of the pediatric cardiac catheterization service who is board certified in pediatrics, in the subspecialty of pediatric cardiology, and who has completed at least one year of additional training in an accredited program for interventional pediatric cardiac procedures.

(b) Any physician performing pediatric cardiac catheterization in the pediatric cardiac catheterization laboratory shall be board certified in the subspecialty of pediatric cardiology,

or shall meet current requirements to be examined and shall be examined within two years of eligibility.

(c) Each physician performing diagnostic cardiac catheterization without supervision shall have performed at least 50 pediatric cardiac catheterizations as the primary operator. The hospital shall determine policy requiring the minimum number of annual procedures that a physician must perform.

(d) Each physician shall perform a minimum of 50 pediatric procedures per year with a minimum of 100 procedures over a two year period.

Recodified from N.J.A.C. 8:43G-7.38 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).

Added (d).

8:43G-7.45 Pediatric catheterization continuous quality improvement methods

There shall be a peer review committee for the pediatric cardiac catheterization service that includes at least the director of the pediatric catheterization laboratory, the director of pediatric cardiology, a pediatric catheterization cardiologist, and a non-catheterizing cardiologist. The committee shall review all mortalities, serious complications, and selected procedures done in the pediatric catheterization suite to identify trends and problems in the service. Minutes of these meetings shall be maintained.

Recodified from N.J.A.C. 8:43G-7.39 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).

8:43G-7.46 Staff qualifications waiver

(a) Exceptions for physicians with hospital privileges to these minimum board certification and training requirements may be granted by the Commissioner or his or her designee upon application by an institution providing acceptable documentation which assures that the physician's qualifications are at a level assuring the level of patient safety intended by the requirements of these rules. As part of the waiver request, the hospital shall provide documentation of the practitioner's qualifications that at a minimum addresses the following:

1. A curriculum vitae which describes the practitioner's academic training and professional experience;
2. Documentation of the volume of procedures that the practitioner has completed on an annual basis;
3. Length of experience in performance of procedure;
4. Current status and future intention to meet the requirements for board-certification; and
5. Documentation of the practitioner's complication rates in performing the procedure for which a waiver is sought.

(b) Additional information may be requested from the hospital by the Department in making a determination or it

may obtain the recommendations from the Commissioner's Cardiac Services Advisory Committee.

(c) Waivers may be granted for periods not to exceed three years and are renewable at the discretion of the Commissioner.

New Rule, R.1992 d.72, effective February 18, 1992.

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

Recodified from N.J.A.C. 8:43G-7.40 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).

SUBCHAPTER 7A. STROKE CENTERS

8:43G-7A.1 Stroke center standards; scope

This subchapter sets forth the standards for designation as a primary or comprehensive stroke center with which all applicants for the respective designations shall comply.

8:43G-7A.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings:

"Acute care rehabilitation" means the provision of occupational therapy, physical therapy and speech-language pathology, as medically necessary, during the acute phase of a stroke patient's hospital stay.

"Acute stroke" means the rapid onset of a focal neurological deficit with signs or symptoms persisting longer than 24 hours and not otherwise attributable to another disease process. The term "acute stroke" includes the subtype acute hemorrhagic stroke and the subtype acute ischemic stroke.

"Complex stroke" means a stroke occurring in a person who also suffers from one or more of the following comorbid conditions:

1. Any previous ipsilateral surgery or intervention;
2. Any previous ipsilateral stroke or intervention;
3. Known history of vascular disease or major vascular surgery within two years;
4. Severe (symptomatic) chronic obstructive pulmonary lung disease;
5. Class III or IV cardiac symptoms, or previous cardiac bypass surgery; or
6. History of radiation or any prior (even non-vascular) surgery to the neck.

"Comprehensive stroke center" means a licensed general hospital designated to evaluate, stabilize and provide emergency care to patients with acute stroke symptoms, that has the capability to provide specialized care to patients with complex strokes, including patients with acute stroke symptoms transferred from other general hospitals.

"Primary stroke center" means a licensed general hospital designated to evaluate, stabilize and provide emergency care to patients with acute stroke symptoms, and to admit such patients for inpatient services as appropriate to the needs of the patient, but which has limited capacity to provide inpatient care to patients with a complex stroke.

8:43G-7A.3 Primary stroke center licensure designation

(a) To be designated as a primary stroke center, a hospital shall, at a minimum, provide:

1. An acute stroke team available to see a patient identified as a potential acute stroke patient within 15 minutes following the patient's arrival at the hospital's emergency department or within 15 minutes following a diagnosis of a patient's potential acute stroke;
2. Written policies and procedures for stroke services that are reviewed at least every three years, revised more frequently as needed, and implemented.
 - i. These policies and procedures shall include written protocols and standardized orders for emergency care of stroke patients;
3. Neuro-imaging services capability that is available 24 hours a day, seven days a week, such that imaging shall be performed within 25 minutes following order entry. Such studies shall be interpreted by a board-certified radiologist, board-certified neurologist or residents who interpret such studies as part of their training in an Accreditation Council of Graduate Medical Education-approved radiology training program with concurrence by a board-certified radiologist or board-certified neurologist within 20 minutes of study completion.
 - i. Neuro-imaging services shall, at a minimum, include computerized tomography scanning or magnetic resonance imaging, as well as interpretation of the imaging.
 - ii. In the event that tele-radiology is used in image interpretation, all staffing and staff qualification requirements contained in this subchapter shall remain in effect and shall be documented by the hospital.
 - iii. For the purpose of this subsection, a qualified radiologist shall be board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.
 - iv. For the purpose of this subsection, a qualified neurologist shall be board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry;
4. Laboratory services capability 24 hours a day, seven days a week, such that services may be performed within 45 minutes following order entry.

i. Laboratory services shall, at a minimum, include blood testing, electrocardiography and x-ray services;

5. Intermediate, telemetry or critical care beds staffed in accordance with N.J.A.C. 8:43G-9.20 and 9.7, respectively;

6. Neurosurgical services that are available, including operating room availability, either directly or under agreement with a comprehensive stroke center, within two hours following admission of acute stroke patients to the primary stroke center;

7. Acute care rehabilitation services;

8. Documentation that it has current contractual agreements with at least one carrier that provides health insurance coverage through the State Medicaid Children's Health Care Coverage Program, established pursuant to N.J.S.A. 30:4I-1 et seq., and the New Jersey FamilyCare Health Coverage Program, established pursuant to N.J.S.A. 30:4J-8 et seq.; and

9. Transfer arrangements with a comprehensive stroke center in New Jersey that facilitate transfer of patients with complex strokes to the comprehensive stroke center for care when clinically warranted.

Amended by R.2007 d.353, effective November 19, 2007.

See: 39 N.J.R. 336(a), 39 N.J.R. 4928(b).

In (a)3, inserted "with concurrence by a board-certified radiologist or board-certified neurologist".

8:43G-7A.4 Primary stroke center staff qualifications

(a) There shall be a physician director of a primary stroke center, who may also serve as a physician member of a stroke team, who is board-certified in neurology or neurosurgery and who shall meet two or more of the following qualifications:

1. Completion of a stroke fellowship;

2. Participation (as an attendee or faculty) in at least two regional, national or international stroke courses or conferences each year;

3. Authorship of five or more peer-reviewed publications on stroke; and/or

4. Eight or more continuing medical education (CME) credits each year in the area of cerebrovascular disease.

(b) At a minimum, an acute care stroke team shall consist of:

1. A neurologist or emergency physician who is board-certified or board-eligible in neurology or emergency medicine with special competence in caring for acute stroke patients; and

2. A registered nurse, physician assistant or nurse practitioner who has demonstrated competency, as determined

by the physician director described in (a) above, in caring for acute stroke patients.

(c) Each physician member of a stroke team, except residents functioning under supervision as part of the hospital's graduate residency training program, shall meet one or more of the following qualifications:

1. Completion of a stroke fellowship;

2. Participation (as an attendee or faculty) in at least two regional, national or international stroke courses or conferences each year;

3. Authorship of five or more peer-reviewed publications on stroke; or

4. Eight or more CME credits each year in the area of cerebrovascular disease.

(d) Neurology and emergency department personnel shall be trained in the diagnosis and treatment of acute stroke in accordance with the training and education requirements set forth in N.J.A.C. 8:43G-7A.5(a)1.

(e) Nursing staff and unlicensed assistive personnel assigned to intermediate or telemetry or critical care beds utilized for acute stroke patients shall be trained and experienced in caring for acute stroke patients in accordance with the training and education requirements set forth in N.J.A.C. 8:43G-7A.5(a)1.

8:43G-7A.5 Primary stroke center education and training

(a) A hospital designated as a primary stroke center shall, under the direction of a stroke center physician director, provide education regarding acute stroke to both the hospital's personnel and the public.

1. The hospital shall provide to personnel engaged in direct patient care of acute stroke patients continuing education annually regarding diagnosis and treatment of acute stroke as follows:

i. For those personnel who are assigned to an acute stroke team, a minimum of eight CME credits or eight continuing education units (CEU) or eight hours of training for unlicensed assistive personnel, as applicable, each year in the area of cerebrovascular disease; and

ii. For those personnel who are not assigned to a stroke team but are regularly assigned to the care of acute stroke patients, a minimum of four CME credits or four CEU or four hours of training for unlicensed assistive personnel, as applicable, each year in the area of cerebrovascular disease.

2. The hospital shall provide to the public ongoing education regarding prevention, recognition, diagnosis and treatment of acute stroke, hosting at least two such programs annually.

8:43G-7A.6 Primary stroke center continuous quality improvement

(a) A hospital designated as a primary stroke center shall collect patient-level data to support evaluation of outcomes and quality improvement activities.

1. Data shall be collected on each patient evaluated for stroke and each patient receiving acute stroke interventional therapy.

2. Data shall be submitted on a quarterly basis, with quarterly data submitted within 45 days of the end of each quarter, either through an encrypted electronic transmission, or on a computer disk sent by overnight mail to:

Stroke Data Coordinator
Office of Health Care Quality Assessment
240 West State Street, 11th Floor
Trenton, New Jersey 08608

3. Instructions for the electronic transmission of data may be obtained from the stroke data collection instructions manual posted at the Office of Health Care Quality Assessment's website www.nj.gov/health/healthcarequality or by calling (609) 984-7334.

(b) The hospital shall submit, pursuant to (a) above, the patient-level data collection form established at N.J.A.C. 8:43G-7A Appendix, incorporated herein by reference, which shall include the following information:

1. Hospital identification and patient demographic data;
2. Pre-hospital emergency medical system data;
3. Hospitalization data;
4. Imaging information;
5. Symptom timeline;
6. Thrombolytic treatment;
7. Non-treatment with thrombolytics;
8. Medical history;
9. In-hospital procedures and treatment;
10. Other in-hospital complications; and
11. Discharge data.

(c) Every primary stroke center shall maintain the data required in (a) and (b) above in a database or registry capable of tracking patient outcomes.

1. The hospital shall have written policies regarding ongoing evaluation of the data and implementation of quality improvement activities based on data evaluation.

(d) The patient-level data submitted pursuant to this section contains medical information related to patients evaluated for stroke and patients receiving stroke interventional

therapy and shall not be considered "government records" subject to public access or inspection within the meaning of N.J.S.A. 47:1A-1 et seq., and shall be deemed information relating to medical history, diagnosis, treatment or evaluation within the meaning of Executive Order No. 26, §4(b)1 (McGreevey, August 13, 2002).

Amended by R.2009 d.256, effective August 17, 2009.

See: 41 N.J.R. 700(a), 41 N.J.R. 3077(a).

In (a)1, inserted "stroke"; added (a)2 and (a)3; rewrote (b); and added (d).

8:43G-7A.7 Comprehensive stroke center staffing

(a) In addition to meeting the requirements of N.J.A.C. 8:43G-7A.3 and 7A.4, a hospital designated as a comprehensive stroke center shall:

1. Satisfy the following staff qualifications, consistent with the on-call criteria set forth at N.J.A.C. 8:43G-5.1(j)2:

- i. A neurosurgical team capable of assessing and treating complex stroke and stroke-like syndromes;
- ii. A neuroradiologist with current Certificate of Added Qualifications in neuroradiology on staff; and
- iii. A physician with neuro-interventional angiographic training and skills on staff as deemed by the hospital's credentialing process;

2. Have available 24 hours a day, seven days a week, digital subtraction angiography and a special procedures suite equipped for neuro-interventional procedures, such that the procedures shall be performed within 60 minutes following order entry.

i. In the event that tele-radiology is used in image interpretation, all staffing and staff qualification requirements contained in this subchapter shall remain in effect and shall be documented by the hospital.

ii. A qualified radiologist shall be board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

iii. A qualified neurologist shall be board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry;

3. Provide comprehensive rehabilitation services either on site or by written transfer agreement with another health care facility licensed to provide such services; and

4. Enter into and maintain written transfer agreements with primary stroke centers in New Jersey to accept transfer of patients with complex strokes when clinically warranted.

Amended by R.2007 d.353, effective November 19, 2007.

See: 39 N.J.R. 336(a), 39 N.J.R. 4928(b).

In (a)2, substituted "60" for "20".

(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(i) and (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.

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);

1. All hospitals shall provide laundered scrub suits in the following areas: surgical suites, obstetrical surgical suites, postanesthesia care unit, central services, and those areas as determined by hospital policy.

(b) If the hospital has an in-house laundry, an established protocol shall be followed to reduce the number of bacteria in the fabrics. Equipment and surfaces that come into contact with soiled laundry and clean linen shall be sanitized.

(c) The laundry service shall monitor, and retain documentation for one year, at least the following:

1. Unsafe objects found;
2. Linen supply;
3. Stained linens; and
4. pH. A random sample of all laundry batches from all sources shall be sour tested to ensure neutralization of alkaline residues from built detergents. Sour testing is a test performed to indicate the degree of acidity or alkalinity of linens. Built detergents are a mixture of one or more alkaline detergents that contains not less than 50 percent anhydrous soap (pure soap, free from water). Fabric pH shall be maintained at 7.0 or below after souring when built detergents are used.

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

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

Bacterial monitoring deleted at (c)1.

Amended by R.2004 d.302, effective August 2, 2004.

See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

Rewrote (a) and (c), and recodified former (d) as (c)4.

8:43G-13.14 Laundry staff education and training

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

(b) Orientation for new laundry employees shall include protocols for handling and receiving soiled laundry and clean linen.

8:43G-13.15 Laundry continuous quality improvement methods

(a) There shall be a program of continuous quality improvement for the laundry service that is coordinated with the hospital continuous quality improvement program and includes regularly collecting and analyzing data to help identify problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data. (See N.J.A.C. 8:43G-27, Continuous Quality Improvement).

(b) Hospitals that contract with a commercial laundry service shall use continuous quality improvement measures to ensure that the standards of N.J.A.C. 8:43G-13.9 through this section are met.

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

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

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

Amended by R.2004 d.302, effective August 2, 2004.

See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

In (a), added the last sentence.

8:43G-13.16 Sanitation policies and procedures

The sanitation service shall have written policies and procedures that are reviewed every three years, revised as needed, and implemented. They include, at least, scope of responsibility, assignment by designated unit, and responsibility for all sanitation tasks.

New Rule, R.2004 d.302, effective August 2, 2004.

See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

8:43G-13.17 Sanitation staff qualifications

There shall be a designated director or supervisor of sanitation with specialized training or education in institutional sanitation service. A consultant may be used to fulfill this role.

New Rule, R.2004 d.302, effective August 2, 2004.

See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

8:43G-13.18 Sanitation patient services

(a) The water supply shall be adequate in quantity, of a safe sanitary quality, and from a water system that is constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act, N.J.S.A. 58:12A-1 et seq., and N.J.A.C. 7:10 and other applicable laws, ordinances, and regulations.

1. The Safe Drinking Water Act and rules can be obtained from:

The New Jersey Department of Environmental
Protection
Bureau of Potable Water
PO Box 209
Trenton, NJ 08625

(b) Hot running water (between 105 and 120 degrees Fahrenheit or 41 to 49 degrees Celsius) and cold running water shall be provided in patient care areas.

New Rule, R.2004 d.302, effective August 2, 2004.

See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

8:43G-13.19 Sanitation space and environment

(a) Water piping carrying non-potable water shall be clearly labeled as such.

(b) The sewage disposal system shall be maintained in good repair and operated in compliance with State and local laws, ordinances, and regulations.

(c) There shall be no direct physical connections between city and well water supplies. Any physical connection be-

tween a public community water supply and an unapproved water supply, such as a well used by a hospital for emergency purposes, must be approved by the New Jersey Department of Environmental Protection and the owner of the public community water supply and must conform with N.J.A.C. 7:10-10.

(d) There shall be no back siphonage conditions present.

(e) Equipment requiring water drainage, such as ice machines, shall be drained to a sanitary connection in a way that avoids splatter or overflow.

New Rule, R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

8:43G-13.20 Sanitation quality improvement methods

The hospital shall adhere to the water sampling schedule and the chemical and biological monitoring requirements of the water supply system set by the New Jersey Department of Environmental Protection. Records of the sampling and monitoring shall be maintained.

New Rule, R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

8:43G-13.21 Regulated medical waste policies and procedures

(a) The hospital shall develop and implement and the Infection Control Program shall review, approve, and audit written policies and procedures for collection, storage, handling, transport and disposal transport of medical waste, in conformance with applicable Federal and State laws and regulations.

(b) The hospital shall comply with the provisions of 42 U.S.C. § 6903, the Medical Waste Tracking Act of 1988 and N.J.S.A. 13:1E-48 et seq., the Comprehensive Regulated Medical Waste Management Act and all rules and regulations promulgated pursuant to the aforementioned Acts.

New Rule, R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

8:43G-13.22 Regulated medical waste and solid waste management

(a) Policies and procedures for solid waste and recyclables shall be established and enforced to ensure appropriate collection, storage and disposal and to maintain them clean and odor-free and to prevent the breeding of insects or vermin.

(b) Solid waste shall be stored within the containers provided for it in an area that is kept clean. Waste shall be collected from storage area regularly to prevent nuisances such as odors, flies, other vermin, or rodents, and so that waste does not overflow or accumulate beyond the capacity of the storage containers.

(c) Plastic bags shall be used for solid waste removal from patient care units and supporting departments. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal.

(d) Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be kept clean and shall be connected to the sanitary sewage disposal system.

(e) Outside storage containers for solid waste shall be kept covered, except those used for corrugated cardboard, recyclables, or construction materials.

New Rule, R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

SUBCHAPTER 14. INFECTION CONTROL

8:43G-14.1 Infection control program structural organization

(a) A hospital epidemiologist shall direct and oversee the hospital Infection Control Program. A hospital epidemiologist is defined as a physician who is board certified in a medical specialty, preferably Infectious Diseases, and has training (such as a Centers for Disease Control and Prevention Course, or Society for Healthcare Epidemiology of America, (SHEA) course, or a Master's Degree in Public Health) or at least five years experience in hospital epidemiology. The hospital epidemiologist may be a consultant.

(b) A hospital Infection Control Program shall be multidisciplinary and include a hospital epidemiologist, infection control professional(s), a clinical microbiologist, and a pharmacist. In addition, the program shall have an on-going surveillance system to monitor nosocomial infections, antimicrobial resistance, antimicrobial use, and outbreaks of infectious diseases.

(c) There shall be a hospital infection control committee that includes representatives from at least: infection control, medical staff, nursing service, dietary, administration, clinical microbiology, respiratory care services, surgical services, central services, environmental services, pharmacy, and the employee health service. The chairman of the committee shall be the hospital epidemiologist. The committee shall participate in the hospital's overall quality improvement program and shall receive formal advice from all other services upon its request.

(d) The infection control program shall oversee but not be limited to the following activities:

1. Formulating a system for surveillance, prevention, and control of nosocomial infections.

i. Surveillance: Surveillance of nosocomial infections shall be performed. The surveillance process shall include at least the following elements:

- (1) Identification and description of the problem or event to be studied;
- (2) Definition of the population at risk;
- (3) Selection of appropriate methods of measurements, including statistical tools and risk stratification;
- (4) Identification and description of data sources and data collection personnel and methods;
- (5) Definitions of numerators and denominators;
- (6) Preparation and distribution of reports to appropriate groups; and
- (7) Selection of specific events to be monitored and guided by validated, available benchmarks and appropriately adjusted for patient risks so that meaningful comparisons can be made.

ii. Rates are calculated from the above surveillance monitoring for internal quality improvement activities.

iii. Prevention and control: Activities shall be based on Centers for Disease Control and Prevention published guidelines and Hospital Infection Control Practices Advisory Committee (that is, HICPAC) recommendations. An exception to the adoption of the following guidelines shall be allowed providing that there is a sound infection control rationale based upon scientific research or epidemiologic data. The following published guidelines and recommendations are incorporated herein by reference, as amended and supplemented:

- (1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections (1981);
- (2) Guideline for Prevention of Intravascular Device-Related Infections (Infection Control and Hospital Epidemiology 1996; 17:438-73 and American Journal of Infection Control 1996; 24:262-93);
- (3) Guidelines for Prevention of Surgical Site Infections (1999) (Infection Control and Hospital Epidemiology 1999; 20:247-278);
- (4) Guideline for Prevention and Control of Nosocomial Pneumonia (American Journal of Infection Control, August 1994; 22:247-92 and Infection Con-

trol and Hospital Epidemiology, September 1994; 15:587-627 and Respiratory Care, December 1994; 39:1191-1236);

(5) Guideline for Handwashing and Hospital Environmental Control (1985);

(6) Guideline for Infection Control in Hospital Personnel (1998);

(7) Guideline for Isolation Precautions in Hospitals (Infection Control and Hospital Epidemiology 1996; 17:53-80 and the American Journal of Infection Control 1996; 24:24-52);

(8) Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health Care Facilities (Morbidity and Mortality Weekly Report 1994; 43:11-22); and

(9) HICPAC Recommendations for Preventing the Spread of Vancomycin Resistance. (Infection Control and Hospital Epidemiology 1995; 16:105-113)

iv. The guidelines listed in (d)1iii above are available from the National Technical Information Service (NTIS) by calling 703-487-4650 or writing the NTIS, 5285 Port Royal Road, Springfield, Virginia 22161. The complete set of the seven Guidelines for the Prevention and Control of Nosocomial Infections are listed under the publication number: PB86133022. Further information is available on the Centers for Disease Control and Prevention National Center of Infectious Diseases website at: <http://www.cdc.gov/ncidod/hip>. The HICPAC Recommendations for Preventing the Spread of Vancomycin Resistance is available on the CDC website at: <http://www.cdc.gov/ncidod/vancom.htm>, and CDC's Hospital Infections Program's Methicillin-resistant Staphylococcus Aureus: Facts for Healthcare Workers is available at: <http://www.cdc.gov/ncidod/hip/arsist/mrsahcw.htm>.

2. Developing and implementing a system of infection control and isolation procedures, including Universal (OSHA)/Standard (CDC) Precautions, using at least criteria which meet or exceed the criteria established by 29 CFR 1910.1030, OSHA's Blood Borne Pathogens regulation incorporated herein by reference, as amended and supplemented if in effect;

3. Reviewing and approving written policies and procedures for decontamination, disinfection, sterilization, and handling of regulated medical waste and all other solid waste. (See N.J.A.C. 8:43G-13, Housekeeping, Laundry, and Sanitation);

4. Reviewing, every three years or more frequently as necessary, the hospital's policies and procedures related to infection control such as: isolation, aseptic technique, employee health, and staff training. Review on at least an annual basis antimicrobial susceptibility and trends, the prevention of infection, and general improvement of patient care;

5. Identifying and reporting communicable diseases throughout the hospital, with the cooperation of the clinical laboratory, medical records, and the medical staff, as specified in N.J.A.C. 8:57-1 of "Communicable Diseases," also known as Chapter II of the State Sanitary Code; and

6. Identifying and reporting of HIV/AIDS as specified in N.J.A.C. 8:57-2, Reporting of Acquired Immunodeficiency Syndrome and Infection with Human Immunodeficiency Virus.

NOTE: Centers for Disease Control and Prevention publications can be obtained from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
or
Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

(e) The infection control program, with the cooperation of the infection control committee, shall share information, including problems, data, and relevant recommendations, with at least the quality improvement program, nursing service, administration, and the medical staff, and shall ensure that corrective actions are taken.

(f) The infection control committee shall meet at least six times per year with at least one meeting per quarter.

(g) The hospital epidemiologist and the infection control professional shall participate in the development of and shall approve all hospital policies and procedures related to infection control.

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

$$\frac{\text{Adjusted Occupied Beds}}{\text{Beds}} = \frac{(\text{Annual Inpatient Days})}{365} \times \frac{(\text{Inpatient Charges and Outpatient Charges})}{\text{Inpatient Charges}} \times \text{All Payer CMI}$$

For every hospital, there shall be at least one half-time infection control professional.

(c) Outpatient service areas provided by the hospital shall have a designated health care professional on site who is responsible for the day to day activities related to infection control.

Amended by R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).
Rewrote the section.

Respiratory care added at (a); nosocomial infection standard incorporated by reference.

Amended by R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).
Rewrote the section.

Case Notes

Dentist had duty to protect sanitation worker stuck in forearm by dental instrument while collecting trash; dentist consciously disregarded regulatory requirements regarding disposal of medical waste materials; sanitation worker claimed emotional distress, fearing HIV infection. De Milio v. Schrage, 285 N.J.Super. 183, 666 A.2d 627 (L.1995).

8:43G-14.2 (Reserved)

8:43G-14.3 Infection control and hospital epidemiology staff qualifications

The infection control professional shall have education or training in surveillance, prevention, and control of nosocomial infections. The infection control professional shall be certified in infection control within five years of beginning practice of infection control and shall maintain certification through the Certification Board of Infection Control (CBIC).

Amended by R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).
Rewrote the section.

8:43G-14.4 (Reserved)

8:43G-14.5 Infection control staff time and availability

(a) There shall be a hospital epidemiologist and infection control professional(s) who are responsible for coordination of the infection control program.

(b) There shall be a ratio of the equivalent of at least one full-time infection control professional to every 200 adjusted occupied beds, where the bed occupancy has been adjusted both for an outpatient factor and for the hospital's all-payer case mix index (CMI), using the most recent complete data set available to the Department and the following formula:

8:43G-14.6 Infection control patient services

(a) Between October 1, or earlier if the vaccination is available, and February 1 of every year, provided a patient's medical condition permits, every patient aged 65 or older shall be provided the opportunity to receive vaccination against influenza, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control in effect at the time of vaccination, incorporated herein by reference. Receipt of the vaccination shall be documented on the patient's chart and made a part of the patient's permanent hospital record. Prior to administration of the vaccination, diligence shall be exercised to determine whether the patient has already received the influenza vaccination for the year in question.

11. Medication record reflecting the drug given, date, time, dosage, route of administration, and signature and status of the person administering the drug. Initials may be used after the person's full signature appears at least once on each page of the medication record. Allergies, including allergy to latex, shall be listed on the medication record;

12. A record of self-administered medications, if the patient self-administers, in accordance with the policies and procedures of the hospital's pharmacy and therapeutic committee, or its equivalent;

13. Reports of laboratory, radiological, and diagnostic services;

14. A discharge summary, which includes the reason for admission, findings, treatment, condition on discharge, medication on discharge, final diagnosis, and, in the case of death, the events leading to death and the cause of death. For cases where the patient is discharged alive within 48 hours of admission and is not transferred to another facility, for normal newborns, and for uncomplicated deliveries, a discharge note may be substituted for the discharge summary. The discharge note includes at least the patient's condition on discharge, medications on discharge, and discharge instructions; and

15. A report of autopsy, if performed by the hospital, with provisional anatomic diagnoses recorded in the medical record within three days. The complete protocol is included in the medical record within the time specified in hospital policies and procedures.

(e) Any adverse incident, including patient injuries, shall be documented in the patient's medical record.

(f) If the patient is transferred to another health care facility (including a home health agency) on a nonemergency basis, the hospital shall maintain a transfer record reflecting the patient's immediate needs and send a copy of this record to the receiving facility at the time of transfer. The transfer record shall contain at least the following information:

1. Diagnoses, including history of any serious physical conditions unrelated to the proposed treatment which might require special attention to keep the patient safe;
2. Physician orders in effect at the time of discharge and the last time each medication was administered;
3. The patient's nursing needs;
4. Hazardous behavioral problems;
5. Drug and other allergies; and
6. A copy of the patient's advance directive, where available.

(g) Medical records shall be completed within 30 days of discharge.

(h) Medical records shall be retained and preserved in accordance with N.J.S.A. 26:8-5 et seq.

(i) Original medical records of components of medical records shall not leave hospital premises unless they are under court order or subpoena or in order to safeguard the record in case of a physical plant emergency or natural disaster.

(j) Any consent form for medical treatment that the patient signs shall be printed in an understandable format and the text written in clear, legible, nontechnical language. In the case where someone other than the patient signs the forms, the reason for the patient's not signing it shall be indicated on the face of the form, along with the relationship of the signer to the patient.

(k) The patient's death shall be documented in the patient's medical record upon death.

(l) Recording errors in the medical record shall be corrected by drawing a single line through the incorrect entry. The date of correction and legible signature or initials of the person correcting the error shall be included.

(m) All medical records, including outpatient medical records, shall be organized in a uniform format within each clinical service.

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

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

Electronic and fax order requirements specified at (b)1-2; outpatient records included at (c).

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

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

Text on documentation of advance directives added at (d) and (e).
Petition for Rulemaking.

See: 25 N.J.R. 3563(d).

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

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

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph; in (b), added a second sentence in 2iv; in (d), rewrote 6, and inserted a reference to allergy to latex in 1i; inserted a new (e); and recodified former (e) through (l) as (f) through (m).

8:43G-15.3 Medical record patient services

(a) Health care practitioners who provide clinical services to the patient shall enter clinical/progress notes in the patient's medical record, when the services are rendered.

(b) Notes that provide a full and accurate description of the care provided to the patient shall be made in the medical record at the time clinical services are provided. Notes that provide a description and an evaluation of the patient's response to treatment shall be made in the medical record.

(c) The medical record shall either accompany the patient when he or she leaves the patient care unit for clinical services in other departments of the hospital or shall be

retrievable by authorized personnel on a computerized system with a restricted access and entry system.

(d) If a patient or the patient's legally authorized representative requests, in writing, a copy of his or her medical record, a legible, written copy of the record shall be furnished at a fee based on actual costs. One copy of the medical record from an individual admission shall be provided to the patient or the patient's legally authorized representative within 30 days of the request, in accordance with the following:

1. The fee for copying records shall not exceed \$1.00 per page or \$100.00 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than \$0.25 per page may be charged for pages in excess of the first 100 pages, up to a maximum of \$200.00 for the entire record;

2. In addition to per page costs, the following charges are permitted:

i. A search fee of no more than \$10.00 per patient per request. (Although the patient may have had more than one admission, and thus more than one record is provided, only one search fee shall be permitted for that request. The search fee is permitted even though no medical record is found as a result of the search.); and

ii. A postage charge of actual costs for mailing. No charges shall be assessed other than those permitted in (d)1 and 2 above;

3. The hospital shall establish a policy assuring access to copies of medical records for patients who do not have the ability to pay; and

4. The hospital shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The patient or his or her representative, however, has a right to receive a full or certified copy of the medical record.

5. For purposes of this subsection, "legally authorized representative" means the following:

- i. Spouse;
- ii. Immediate next of kin;
- iii. Legal guardian;
- iv. Patient's attorney;
- v. Patient's third party insurer; and
- vi. Worker's compensation carriers, where access is permitted by contract or law, but limited only to that portion of the medical record which is relevant to the specific work-related incident at issue in the worker's compensation claim.

(e) The fee for copying medical records shall be based on actual costs, which in no case shall exceed \$1.00 per page and \$10.00 per search, in the case of the following:

1. Where the patient has authorized release of his or her medical record to a person or entity other than those identified in (d) above, including but not limited to physicians or other practitioners who provided care to the patient, or attorneys representing such providers; or

2. The patient subsequently requests additional copies of a medical record which has been furnished in accordance with (d) above.

(f) Access to the medical record shall be limited only to the extent necessary to protect the patient. A verbal explanation for any denial of access shall be given to the patient or legal guardian by the physician and there shall be documentation of this in the medical record. In the event that direct access to a copy by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician.

(g) The patient shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

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

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

Record copying fees and standards specified at (d) through (g).
Petition for Rulemaking.

See: 29 N.J.R. 5335(a), 30 N.J.R. 3338(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.

Petition for Rulemaking.

See: 35 N.J.R. 1962(a), 2751(b), 4333(a).

Administrative change.

See: 36 N.J.R. 1192(a).

Case Notes

Department of Health had jurisdictional authority to sanction violators of rule governing fees that health care providers could charge for copying medical records, but Department did not have exclusive jurisdiction to adjudicate such issues, and overcharged patients had a private cause of action against the violators. *Boldt v. Correspondence Management, Inc.*, 320 N.J.Super. 74, 726 A.2d 975 (N.J.Super.A.D. 1999).

8:43G-15.4 Medical records staff qualifications

There shall be a full-time medical record director who is an accredited record technician or a registered record administrator under a certification program approved by the American Medical Record Association.

8:43G-15.5 Staff education

Requirements for the medical record staff education and training program shall be as provided in N.J.A.C. 8:43G-5.9.

8:43G-15.6 (Reserved)

8:43G-15.7 Medical record continuous quality improvement methods

(a) There shall be a program of continuous quality improvement for medical records 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) Continuous quality improvement activities for the medical record department shall include monitoring medical records for accuracy, completeness, legibility, and accessibility.

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

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

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

SUBCHAPTER 16. MEDICAL STAFF

8:43G-16.1 Medical staff structural organization

(a) There shall be an organized medical staff that is responsible to the governing body of the hospital. Bylaws governing all medical staff members shall be implemented.

(b) Applications for membership, privileges, or initial appointment to the medical staff shall be processed under a system that includes, at least, the verification of applicants' credentials, periodic review of privileges, and obtaining information about any disciplinary action against the applicant available from the New Jersey Board of Medical Examiners or the Federal Clearinghouse established pursuant to the Health Care Quality Improvement Act, P.L. 99-660; 100 STAT 3743.

(c) Applications for medical staff membership, clinical privileges, or initial appointment submitted by health professionals who are not practitioners, shall be reviewed according to the same established criteria and procedures that govern physicians' applications, including obtaining information about any disciplinary action by New Jersey professional licensing boards.

(d) A committee or mechanism shall be established to be responsible for examining applications for appointment and reappointment to all categories of the medical staff. This committee shall recommend the conferring or withholding of all staff positions. It shall assure that all credentials are documented and verified.

(e) Medical staff privileges shall be specifically delineated and based on the practitioner's training, experience and demonstrations of clinical competence.

(f) The medical staff shall be divided into clinical departments. Each department shall be directed by a director, physician director, chairman or chief who is responsible for its administration and for taking or recommending action in those instances in which staff members fail to meet the department's standards of quality of care.

(g) There shall be an executive committee for the medical staff which performs supervisory functions, including reviewing patient care policies and procedures and serving as a

forum for discussing patient care issues identified by the clinical departments.

(h) A medical staff meeting shall be held at least annually for all active staff members.

(i) The hospital and medical staff shall have a formal program addressing impaired practitioners. This program shall include the following components:

i. Policies and a mechanism which encourage the voluntary or informal identification or reporting of practitioner impairment to the hospital;

ii. A mechanism for monitoring physician performance and for the limitation of clinical privileges if appropriate; and

iii. A procedure for the referral of impaired practitioners to appropriate treatment.

(j) The clinical privileges of all individuals shall be fully reviewed periodically. Actions which result in reduction or restriction of staff privileges based on this review shall be reported to the New Jersey Board of Medical Examiners in accordance with N.J.S.A. 26:2H-12.2.

(k) The hospital shall notify the New Jersey State Board of Medical Examiners, or a medical practitioner review panel created by legislation and subordinate to the Board, if a practitioner who is employed by, under contract to render professional services to, or has privileges at the hospital:

1. Voluntarily resigns from the staff while the facility is reviewing the practitioner's conduct or patient care or has through any member of the medical or administrative staff expressed an intention to do so;

2. Voluntarily relinquishes any partial privileges to perform a specific procedure while the hospital is reviewing the practitioner's conduct or patient care or has, through any member of the medical or administrative staff, expressed an intention to do so;

3. Has full or partial privileges summarily or temporarily revoked or suspended, permanently reduced, suspended or revoked, has been discharged from the staff or has had a contract to render professional services terminated or rescinded for reasons relating to the practitioner's incompetency misconduct, or impairment;

4. Agrees to the placement of conditions or limitations on the exercise of clinical privileges or practice within the health care facility including, but not limited to: second opinion requirements, non-routine concurrent or retrospective review of admissions or care, non-routine supervision by one or more members of the staff, or the completion of remedial education or training;

5. Is granted a leave of absence pursuant to which he or she may not exercise clinical privileges or practice within the hospital if the reasons provided in support of the leave relate to any physical, mental, or emotional

condition or drug or alcohol use, which might impair the practitioner's ability to practice with reasonable skill and safety;

6. Is a party to a medical malpractice liability suit in which the hospital is also a party, in which there is a settlement, judgement, or arbitration award; or

7. Has privileges, conditions or limitations reinstated or a leave of absence concluded where the results of the investigation clear the practitioner from all allegations of misconduct, impairment, or incompetence.

(l) Notifications required by (k) above shall be provided within seven days of the reported event and shall be submitted on forms approved by the Department of Health for that purpose.

(m) The hospital shall provide upon request to the State Board of Medical Examiners, or to a practitioner review panel created by legislation and reporting to the board, such additional information on individual instances of loss or change of physician privileges, possible impairments, and medical malpractice liability as the board or panel requests in accordance with law.

(n) The hospital shall provide to the following:

Office of the Assistant Commissioner
Division of Health Facilities Evaluation
New Jersey State Department of Health
PO Box 367
Trenton, N.J. 08625-0367

copies of all reports regarding physician hospital privileges sent to the New Jersey State Board of Medical Examiners, or to the practitioner review panel created by legislation and reporting to the board. All records regarding such copies shall be made available to the Department of Health personnel for official purposes and, for each report, to the specific facility mentioned in the report.

(o) For the purposes of (k) through (n) above, "practitioner" means only a person licensed to practice: medicine and surgery under N.J.S.A. 45:9-1 et seq. or a medical resident or intern; or podiatry under N.J.S.A. 45:5-1 et seq.

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

Notifications of practitioner status change required by (k) to be made in seven days.

Case Notes

Members of medical peer review committees had immunity for actions, recommendations or statements. *Bundy v. Sinopoli*, 243 N.J.Super. 563, 580 A.2d 1101 (L.1990).

Privilege of self-critical evaluation protects from discovery opinions, criticisms, or evaluations contained within peer review committee files. *Bundy v. Sinopoli*, 243 N.J.Super. 563, 580 A.2d 1101 (L.1990).

8:43G-16.2 Medical staff policies and procedures

(a) The medical staff shall have written policies, procedures, and bylaws that are reviewed at least once every three years; revised more frequently as needed, and implemented. They shall include at least:

1. Policies and procedures addressing the requirements for obtaining written informed consent from patients;

2. Requirements for the completeness and timing of the patient history and physical examination, including a listing of the minimum contents to be included in the medical record;

3. The minimum content of physician orders;

4. Specifications for verbal orders, including who may give verbal orders, who may receive them, and how soon they must be verified or countersigned in writing;

5. If applicable, policies and procedures related to the prescribing or ordering of medications or devices by certified nurse practitioners/clinical nurse specialists in accordance with New Jersey State Board of Nursing rules at N.J.A.C. 13:37-7; and

6. If applicable, the scope of practice, supervision, and record keeping requirements of licensed physician assistants in accordance with New Jersey State Board of Medical Examiners rules at N.J.A.C. 13:35-2B.

(b) All physician orders for medication, treatment, and restraints shall be in writing. All orders for restraints shall be made in accordance with requirements at N.J.A.C. 8:43G-18.4(c) through (e) and (i).

(c) The medical staff shall have a means to assess individual patient's competence to consent to treatment in conformance with current law. Measurement of patient competence may include such skills as ability to understand their medical condition and the consequences of procedures and treatments, and to communicate a choice. The hospital and physician shall follow the procedures for appointment of a special medical guardian where required in accordance with the Civil Practice Rules at 4:83-12.

(d) Each time the attending physician visits the patient, the physician shall enter a note into the medical record describing the findings about the patient's condition. If issues have been raised in the record by other disciplines, this note shall respond to them.

(e) The hospital shall comply with the New Jersey State Board of Medical Examiners rules concerning the registration and permit requirements for graduate medical education programs and practice, N.J.A.C. 13:35-1.5.

(f) The hospital shall require that all prescriptions and orders issued by registered first-year residents in the inpatient setting be countersigned by a licensed physician or permit holder (a person authorized in the State of New Jersey to engage in the practice of medicine in the second year of a graduate medical education program or beyond).

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

Reference changed at (b).

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).

In (a), substituted "at least once every three years; revised more frequently" for "annually, revised" in the introductory paragraph.

8:43G-16.3 Medical staff qualifications

(a) All physicians with clinical privileges shall be licensed or authorized to practice medicine by the New Jersey Board of Medical Examiners. All non-physicians with privileges shall be licensed or authorized to practice in the State of New Jersey, as required by law.

(b) In any subchapter of these rules requiring a practitioner to be Board-certified within his or her medical specialty, it shall be deemed acceptable to possess:

- i. Board certification from one of the recognized boards of osteopathic medicine; or
- ii. Board certification from a foreign Board within the specified medical specialty where the American Board offers reciprocity with or officially recognizes the foreign board certification credential.

Case Notes

In action brought by physician challenging termination of staff privileges at hospital, regulation cited to support court's deference to decisions of hospitals to maintain a qualified medical staff. *Nanavati v. Burdette Tomlin Memorial Hospital*, 107 N.J. 240, 526 A.2d 697 (1987).

All hospital employees subject to regulatory supervision; restrictive staff admission policy invalid as not reasonably in furtherance of legitimate health objective. *Desai v. St. Barnabas Medical Center*, 103 N.J. 79, 510 A.2d 662 (1986).

Regulations require hospital to appoint organized medical staff responsible to governing board; hospitals must adopt rules concerning procedures for staff membership admission; qualified doctors may not be arbitrarily excluded from staff; exclusive contract for anesthesia-logical services reasonable, not violative of public policy and not illegal tying arrangement under Antitrust Act. *Belmar v. Cipolla*, 96 N.J. 199, 475 A.2d 533 (1984).

8:43G-16.4 (Reserved)

8:43G-16.5 Medical staff time and availability

(a) The hospital shall establish policies and procedures for response times for emergencies.

(b) There shall be an on-call list of medical and surgical specialists that is available to personnel in all patient care units.

8:43G-16.6 Medical staff patient services

(a) Each patient shall have an attending physician who has overall responsibility for the patient's care in the hospital.

(b) Each patient admitted to the hospital shall have a medical history and physical examination that includes a provisional diagnosis performed by a clinical practitioner within seven days prior to admission or within 24 hours after admission. If the history and physical were performed within seven days prior to admission, the patient's history and physical examination record completed by the attending physician, advanced practice nurse or physician assistant shall be included in the medical record, with any subsequent changes recorded at the time of admission.

(c) When there is a clinical consultant, he or she shall issue a report that states at least the assessment mechanisms used, findings, and opinion. This report shall be included in the medical record.

(d) The reason or reasons for requesting a clinical consultation shall be specified in the patient's medical record by the attending physician. The consultant shall provide consultation in accordance with the privileges accorded him or her by the hospital.

(e) Medical care shall be provided to all patients, regardless of their ability to pay.

(f) Every acute care patient shall receive a visit by a clinical practitioner every day unless there is a clinical basis to justify the patient not receiving such a visit that is documented in the medical record by the practitioner. In all cases a patient shall receive a visit by a practitioner at least once every two days.

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

Diagnosis to be provided seven days prior to or 24 hours after admission.

Amended by R.2005 d.279, effective September 6, 2005.
See: 37 N.J.R. 709(a), 37 N.J.R. 3365(a).

Rewrote (b).

8:43G-16.7 Medical staff education

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

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

Stylistic change.

8:43G-16.8 Medical staff continuous quality improvement methods

There shall be a medical staff mechanism by which the quality of medical care is monitored, problems identified, solutions recommended and implemented, and follow-up conducted. Summary reports of these activities and problems in the quality of care shall be reviewed by the medical executive committee, or its equivalent.

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).

SUBCHAPTER 17. NURSE STAFFING

8:43G-17.1 Nurse staffing

(a) The hospital shall have in place a staffing plan that addresses nurse staffing requirements and identifies patient needs, including, at a minimum:

1. A daily staffing schedule that ensures at least one registered professional nurse in charge and assigned exclusively to each patient care unit on each shift;
2. A provision that at least 65 percent of direct patient care hours in inpatient units on a hospital wide average be provided by licensed nursing personnel;
3. A method for assessing each unit's additional nursing needs for each shift, including, at a minimum, objective criteria such as:
 - i. Documented skills, training and competency of staff to plan and provide nursing services in the nursing areas where they function;
 - ii. Patient data base incorporating objective factors such as case mix index, specific or aggregate patient diagnostic classifications or acuity levels, patient profiles, critical pathways or care progression plans, length of stay, and discharge plans;
 - iii. Operational factors such as unit size, design, and capacity, admission/discharge/transfer index, and support service availability;
 - iv. Contingency plans to address critical departures from staffing plan, including policies and procedures to regulate closure of available beds if staffing levels fall below specified levels;
 - v. Policies and procedures for the reassignment of staff including float and agency staff; and
4. On-going internal institutional evaluation of outcome-based quality indicators related to nursing care to assess and provide a safe and adequate level of patient care including at least:
 - i. Patient injury rate;
 - ii. Medication process errors;
 - iii. Maintenance of skin integrity;
 - iv. Nosocomial infection rates;
 - v. Hospital-wide patient satisfaction with overall care, including nursing care;
 - vi. Nursing turnover rate;
 - vii. Patient satisfaction with pain management; and
 - viii. Mix of RNs, LPNs and unlicensed staff caring for patients.

(b) There shall be a registered nurse manager for each patient care unit or units and for surgery, emergency department, and other units, as specified in the hospital organizational plan or policies and procedures.

(c) There shall be at least one registered professional nurse in charge and assigned exclusively to each patient care unit on each shift. Additional staff shall be assigned by the hospital as required by the acuity levels.

(d) Patient care assignments shall be made on an individual basis by a registered professional nurse and reflect staff competence, skill, and aptitude and patient needs.

(e) The hospital shall have in effect a contingency plan for assuring adequate nurse staffing at all times. The plan shall detail policies and procedures to regulate closure of available beds, if actual staffing levels fall below specified levels.

(f) Nurse staffing for all patient care units within the hospital shall also be in accordance with:

1. N.J.A.C. 8:43G-7.5(a), (b) and (c) in accordance with N.J.A.C. 8:43G-9.20(a)6 and (i);
2. N.J.A.C. 8:43G-7.15(d);
3. N.J.A.C. 8:43G-7.16(a)2 and 3i;
4. N.J.A.C. 8:43G-7.24(a)2 and 3i;
5. N.J.A.C. 8:43G-7.27(a)2 and 3i;
6. N.J.A.C. 8:43G-9.4(a)11;
7. N.J.A.C. 8:43G-9.5(c), (d) and (e);
8. N.J.A.C. 8:43G-9.5(c), (d) and (e);
9. N.J.A.C. 8:43G-9.7(a) and (b);
10. N.J.A.C. 8:43G-9.7(a) and (b);
11. N.J.A.C. 8:43G-9.7(a);
12. N.J.A.C. 8:43G-9.14;
13. N.J.A.C. 8:43G-9.20(a)6 and (c);
14. N.J.A.C. 8:43G-9.23;
15. N.J.A.C. 8:43G-11.4(a) and (b);
16. N.J.A.C. 8:43G-12.3(e), and (g)1 through 4;
17. N.J.A.C. 8:43G-12.5(e);
18. N.J.A.C. 8:43G-12.7(a);
19. N.J.A.C. 8:43G-12.16(c) and (d);
20. N.J.A.C. 8:43G-14.1(a);
21. N.J.A.C. 8:43G-16.6(a), (b) and (f);
22. N.J.A.C. 8:43G-19.1(b) and (f);
23. N.J.A.C. 8:43G-19.3(b)1 through 3 and (c);

(e) There shall be seven duplex receptacles for each infant care station.

(f) Storage facilities for the neonatal intensive care nursery shall be as follows:

1. There shall be storage and counter space for immediate use within the infant's room for each infant care station; and

2. There shall be at least 30 square feet of floor space for equipment for each infant care station immediately accessible to the nursery.

(g) A soiled utility room shall be provided.

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

(i) A free-standing handwashing sink with hands free controls shall be provided at the entrance to the intensive care nursery. One sink shall be provided for every three infant care stations within the nursery.

(j) There shall be on-call room(s) for staff on the same floor of the hospital with an adjoining toilet, lavatory and shower.

(k) There shall be at least three 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-19.52 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-19.37, General newborn care functional area requirements, recodified to N.J.A.C. 8:43G-19.31.

8:43G-19.38 Shared services

(a) If the intermediate care and neonatal intensive care nurseries are located in the same suite, then the following services may be shared:

1. Janitor's closet;
2. Soiled utility;
3. Clean utility;
4. The three multi-purpose rooms required for a intensive care nursery;
5. Storage room;
6. Male/female staff lockers, lounge and toilets; and
7. On-call 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-19.53 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-19.38, Staff offices and lounge, repealed.

8:43G-19.39 (Reserved)

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

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

Repealed 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).

Section was "Infant formula facilities".

8:43G-19.40 (Reserved)

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

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

Repealed 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).

Section was "Neonatal unit soiled utility room".

8:43G-19.41 (Reserved)

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

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

Repealed 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).

Section was "Neonatal unit clean work area or room".

8:43G-19.42 (Reserved)

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

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

Repealed 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).

Section was "Neonatal unit janitor's closet".

8:43G-19.43 (Reserved)

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

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

Repealed 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).

Section was "Neonatal unit clerical area".

8:43G-19.44 (Reserved)

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

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

Repealed 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).

Section was "Neonatal unit multipurpose rooms".

8:43G-19.45 (Reserved)

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

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

Repealed 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).

Section was "Neonatal unit nursery area".

8:43G-19.46 (Reserved)

Recodified to N.J.A.C. 8:43G-19.32 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).

8:43G-19.47 (Reserved)

Recodified to N.J.A.C. 8:43G-19.33 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).

8:43G-19.48 (Reserved)

Recodified to N.J.A.C. 8:43G-19.34 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).

8:43G-19.49 (Reserved)

New Rule, R.1990 d.422, effective September 4, 1990.
See: 21 N.J.R. 3642(a), 22 N.J.R. 2705(a).
Repealed 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).
Section was "Continuing care/growing area".

8:43G-19.50 (Reserved)

Recodified to 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).

8:43G-19.51 (Reserved)

Recodified to N.J.A.C. 8:43G-19.36 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).

8:43G-19.52 (Reserved)

Recodified to N.J.A.C. 8:43G-19.37 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).

8:43G-19.53 (Reserved)

Recodified to N.J.A.C. 8:43G-19.38 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).

SUBCHAPTER 20. EMPLOYEE HEALTH

8:43G-20.1 Employee health policies and procedures

(a) Employee health 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 shall be readily available for employees to review and include at least the following:

1. The content and frequency of employee health examinations performed by a registered professional nurse, physician, or other qualified medical personnel as defined at N.J.A.C. 8:43G-20.2(a);
2. Precautionary measures to prevent the transmission of communicable diseases from employees to patients;
3. Requirements for a physician note approving an employee's return to work after an absence due to a communicable disease; and
4. Clinical restrictions for employees exposed to rubella or rubeola who are seronegative and unvaccinated.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Clinical restrictions added at (a)5.

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).

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph, and rewrote 1.

8:43G-20.2 Employee health services

(a) Each new employee shall receive an initial health evaluation, which includes at least a documented history, which may be performed by a registered professional nurse, physician or other qualified personnel (defined as a licensed physician assistant or a certified nurse practitioner/clinical nurse specialist), and a physical examination.

(b) Employee health records shall be maintained for each employee. Employee health records shall be confidential, and kept in the employee health office separate from personnel records.

(c) The employee health record shall include documentation of all medical screening tests performed and the results.

(d) Tuberculosis screening: The facility shall establish policies and procedures for the detection and control of the transmission of *M. tuberculosis* that include, but are not limited to, developing a Tuberculosis Exposure Control Plan ("TB plan"), according to the guidelines set forth in "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Facilities, 1994," The Morbidity and Mortality Weekly Report published by the Epidemiology Program Office, Centers for Disease and Control and Prevention (CDC) and available from the Superintendent of Documents, US Government Printing Office, Washington, DC 20402-9325 (MMWR), October 28, 1994, Volume 43, Number RR-13, p. i-132, pursuant to the Occupational Safety and Health Act (OSH Act) of 1970, incorporated herein by reference as amended and supplemented.

1. Newly hired employees: The facility shall establish policies and procedures that will identify a new employee's baseline status of exposure to *M. tuberculosis*. Upon employment, the facility shall administer a two-step Mantoux tuberculin skin test, using five tuberculin units of purified protein derivative, to all employees. Employees are defined, for the purposes of this subsection, as full and part-time employees, volunteer staff, and physicians, either salaried by the facility or with clinical privileges to provide medical care at the facility.

i. Employees with a "negative" (less than 10 mm of induration or less than five mm of induration if the individual is immunosuppressed) result following the first Mantoux skin test are administered a second test in one to three weeks.

ii. Employees with a "positive" (greater than 10 mm of induration or greater than five mm of induration if the individual is immunosuppressed) result following either the first or second test are referred for a medical

evaluation to determine whether there is evidence of latent tuberculosis infection or active tuberculosis disease.

(1) The medical evaluation shall include, but is not limited to, a chest X-ray.

(2) The facility shall permit employees with positive Mantoux test results to begin working after the employee has submitted written medical clearance to the facility.

iii. Exceptions:

(1) Employees who provide documentation of negative results of a single Mantoux skin test performed within the 12 months preceding the start of employment shall receive only one Mantoux skin test upon hire.

(2) Employees with prior documentation of negative results of two Mantoux skin tests performed within 12 months preceding the start of employment, and without signs and symptoms of active tuberculosis, shall not be required to be tested upon hire; however, a Mantoux skin test shall be required within 12 months of the last tuberculin skin test.

(3) Employees who provide documentation of positive Mantoux skin test results shall be exempt from screening.

(4) Employees who provide documentation of having received and completed appropriate medical treatment for active tuberculosis disease or latent tuberculosis infection shall be exempt from screening.

2. Periodic screening of personnel: The facility shall establish policies and procedures for the periodic screening of *M. tuberculosis* in eligible personnel, including, but not limited to:

i. Testing: The facility shall administer a Mantoux skin test to all tuberculin-negative employees annually at minimum. Frequency of testing shall be determined by the level of risk assigned by the facility's TB plan.

ii. Recordkeeping: The facility shall maintain records of the results of employee Mantoux tuberculin testing.

3. Further information: Questions regarding tuberculosis control may be directed to:

New Jersey Department of Health and Senior Services
Tuberculosis Program
PO Box 369
Trenton, NJ 08625-0369
(609) 588-7522

(e) Rubella screening: Each employee, including members of the medical staff employed by the hospital, shall be given a

rubella screening test using the rubella hemagglutination inhibition test or other rubella screening test. The only exceptions are employees who can document seropositivity from a previous rubella screening test or who can document inoculation with rubella vaccine, or when medically contraindicated.

1. Each new employee, including members of the medical staff employed by the hospital, shall be given a rubella screening test upon employment.

(f) Measles (Rubeola) Screening: Each employee, including members of the medical staff employed by the hospital, born in 1957 or later shall be given a measles (rubeola) screening test using the Hemagglutination inhibition test or other rubeola screening test. The only exceptions are employees who can document receipt of live measles vaccine on or after their first birthday, physician-diagnosed measles, or serologic evidence of immunity.

1. Each new employee, including members of the medical staff employed by the hospital, born in 1957 or later shall be given a rubeola screening test, upon employment.

(g) The hospital shall offer rubella and rubeola vaccination to all employees and medical staff.

(h) The hospital shall maintain a list identifying the name of each employee who is seronegative and unvaccinated.

(i) The hospital shall comply with the reporting requirements of the Department of Health and Senior Services' Division of Epidemiology, Environmental and Occupational Health Services for tuberculin and rubella test results, pursuant to N.J.A.C. 8:57. Information regarding testing and reporting can be obtained from:

New Jersey State Department of Health and Senior Services
Communicable Disease Control Services
PO Box 369
Trenton, NJ 08625-0369

(j) The hospital shall provide initial health care for employees who become ill or have a work-related illness or injury. "Initial health care" means that the ill or injured employee shall be seen and evaluated by a physician, licensed physician assistant, or certified nurse practitioner/clinical nurse specialist and stabilized prior to referral for further treatment, as appropriate.

(k) Personnel who are absent from work because of any reportable communicable disease, infection, or exposure to infection, as defined in N.J.A.C. 8:57, shall be excluded from working in the hospital until they have been examined by a physician and certified by the physician as no longer endangering the health of patients or employees. If the absence is less than three full days, the hospital's employee health nurse may certify that the employee is able to return to work.

(l) The hospital shall have a program addressing the needs of impaired employees, which at a minimum, shall include

methods or mechanisms to identify and refer impaired employees to rehabilitation programs.

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 (f)-(i) on rubella/rubeola.

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 (a) and (m); in (d), inserted "(which will count as the first step; a second step shall be given prior to employment)" in the second sentence of the introductory paragraph, and added 3; in (g), deleted "in accordance with (e) above" at the end; in (h), deleted "by March 1, 1992" at the end of the first sentence; in (i), deleted "; in accordance with (g) above" at the end; and in (n), added a second sentence.

Amended by R.2004 d.302, effective August 2, 2004.

See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

Rewrote the section.

8:43G-20.3 (Reserved)

8:43G-20.4 Employee health education

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

8:43G-20.5 (Reserved)

8:43G-20.6 Employee health continuous quality improvement methods

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

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

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

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

SUBCHAPTER 21. ONCOLOGY

8:43G-21.1 Scope of oncology standards

The standards in this subchapter shall apply only to hospitals that have a separate, designated patient care unit for oncology.

8:43G-21.2 Oncology structural organization

(a) There shall be a multidisciplinary cancer committee, chaired by a physician, that is responsible for at least the development of oncology policies and procedures, tumor review, and tumor registry.

(b) There shall be a formal mechanism for communication between the oncology service and each of the following clinical areas: nursing, dietary, social work, and pharmacy.

8:43G-21.3 (Reserved)

8:43G-21.4 Oncology policies and procedures

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

1. Criteria for admission;
2. Guidelines for mixing chemotherapy, when performed on the unit, that reference Occupational Safety and Health Administration (OSHA) guidelines: "Work Practice Guidelines for Personnel Dealing with Cytotoxic Drugs," OSHA Instruction PUB 8-1.1, PB 89203301 Office of Occupational Medicine;
3. Guidelines for administering chemotherapy that follow national Oncology Nursing Society guidelines; available from the Oncology Nursing Society, 1016 Greentree Road, Pittsburgh, PA 15220-3125, telephone 412-921-7373.
4. Training of nursing and housekeeping staff in the disposal of chemotherapeutic agents;
5. Use, handling, storage, and disposal of specific chemicals, agents, and body wastes;
6. Assuring informed consents to chemotherapy; and
7. Psychological/social and spiritual aspects of patient care.

(b) There shall be written visiting policies for patients that allow for visits by children and 24-hour visitation rights for designated visitors.

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

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

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.

8:43G-21.5 Oncology staff qualifications

(a) There shall be a clinical coordinator with responsibility to administer the program of care who is a registered professional nurse with the equivalent of two years of full-time experience in oncology.

(b) There shall be a clinical resource person who is a registered professional nurse with the equivalent of two years of clinical experience in oncology who is available to the unit.

and ancillary information about these dosages are communicated to the personnel responsible for administering them.

(d) The pharmacy service shall develop and implement a system of control for legend drug doses. A pharmacist licensed to practice pharmacy in New Jersey shall check each cassette or container of drugs prepared by supportive personnel, as defined at N.J.A.C. 13:39-1.2, before it is delivered to a patient care unit.

(e) The hospital shall have a pharmacy-based intravenous infusion admixture program, which includes services related to preparation of total parenteral nutrition, antineoplastic agents, and large and small, continuous or intermittent volume products for infusion. A pharmacist licensed to practice pharmacy in New Jersey, or supportive personnel, as defined at N.J.A.C. 13:39-1.2, shall prepare, sterilize if necessary, and label parenteral medications and solutions, except in those areas or situations that have been excluded by the pharmacy and therapeutics committee or its equivalent.

(f) Cautionary instructions and ancillary information about medications shall be communicated in writing to the personnel responsible for administering medications.

(g) All medication orders shall specify the name of the drug, dose, frequency, and route of administration, and shall be dated and signed (or approved by authorization code if ordered through computer entry) by the prescriber.

(h) Allergies, including allergy to latex, shall be documented in the patient's pharmacy profile.

(i) Drugs in single dose or single use containers which are open or which have broken seals, drugs in containers missing drug source and exact identification (such as lot number), and outdated medications shall be returned to the pharmacy for disposal.

(j) Initials or identifying codes shall be used by pharmacy personnel, and a list of these initials or codes and the corresponding printed or typed names and signatures shall be kept for at least five years after termination of pharmacy service employment.

(k) Current antidote information shall be provided in the pharmacy. The telephone number of the designated Statewide or regional New Jersey Poison Information and Education System (1-800-962-1253) shall be provided in the pharmacy and in each patient care unit or area.

(l) Current Federal and State drug law information shall be available to the pharmacy service.

(m) Drug product defects shall be reported in accordance with the drug product problem reporting system of the United States Pharmacopoeia or of the Food and Drug Administration.

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

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

Written communication specified at (f).

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 (h), inserted a reference to allergy to latex.

8:43G-23.7 (Reserved)

8:43G-23.8 Pharmacy space and environment

(a) The pharmacy shall maintain drugs under proper conditions, as indicated in the United States Pharmacopoeia, product labeling, and/or package inserts.

(b) All drugs, needles, and syringes shall be kept in locked storage areas except those drugs exempted by the pharmacy and therapeutics committee or its equivalent under specified conditions.

8:43G-23.9 Pharmacy staff education and training

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

8:43G-23.10 Pharmacy continuous quality improvement methods

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

(b) The pharmacy service shall have in effect a patient profile system for monitoring drug therapy. This system shall be used by the hospital to identify inappropriate prescribing practices.

(c) The pharmacy service shall inspect at least once every two months all patient care areas in the hospital, and at least once every three months all other areas of the hospital where drugs intended for administration to patients are dispensed, administered, or stored. The pharmacy service shall maintain a record of the inspections. Identified problems shall be addressed.

(d) A quality improvement program of the pharmacy service shall monitor, at a minimum, the use of drugs, including medication errors and use of antibiotics. Serious or consistent patterns of medication error shall be reported to the pharmacy and therapeutics committee or its equivalent.

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

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

In (a), substituted references to continuous quality improvement for references to quality assurance throughout; and in (d), substituted a reference to quality improvement for a reference to quality assurance.

8:43G-23.11 (Reserved)**SUBCHAPTER 24. PLANT MAINTENANCE AND FIRE AND EMERGENCY PREPAREDNESS****8:43G-24.1 Plant maintenance structural organization**

(a) There shall be a multidisciplinary safety committee that develops a comprehensive hospital-wide safety program that is reviewed at least once every three years, revised more frequently as needed, and implemented.

(b) There shall be a mechanism to report all incidents, injuries and safety hazards to the safety committee.

(c) The safety committee shall review all reports and be responsible for ensuring that all reports are referred appropriately and follow-up action is documented.

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

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

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" following "reviewed".

8:43G-24.2 Plant maintenance policies and procedures

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

(b) The building maintenance service shall have a written preventive maintenance program for buildings, equipment and utilities.

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

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

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" following "reviewed".

8:43G-24.3 Plant maintenance staff qualifications

(a) The building maintenance service shall be under the supervision of an employee with at least one of the following qualifications:

1. Five years of experience in health care plant maintenance, three of which shall be in a supervisory capacity;

2. A baccalaureate degree in engineering from an accredited college or university and three years of experience in health care plant maintenance, two of which shall be in a supervisory capacity; or

3. A current professional engineer license in New Jersey and three years of experience in health care plant maintenance, two of which shall be in a supervisory capacity.

(b) There shall be an in-hospital or contracted biomedical electronics equipment maintenance and safety program under the supervision of an individual with at least:

1. A two-year associate's degree in biomedical engineering from an accredited college or university and two years of experience in the field of biomedical engineering; or

2. Four years of combined experience and/or training from an accredited technical school or military program.

8:43G-24.4 Plant maintenance services

(a) Records of preventive maintenance inspections and repairs of electrical and mechanical systems shall be maintained for at least one year.

(b) The building maintenance service shall be provided with copies of the written instructions for operating and maintaining departmental and unit equipment. These instructions shall be systematically retained in the departments or units in which the equipment is used.

(c) All life-sustaining equipment shall be plugged into outlets connected to the emergency power supply.

(d) Routine maintenance inspections of elevators shall be conducted in accordance with local ordinances.

(e) The standby emergency generator shall be checked weekly, tested under load monthly, and serviced in accordance with accepted engineering practices.

(f) Floors, ceilings, and walls shall be free of cracks and holes, discoloration, residue build-up, water stains, and other signs of disrepair.

8:43G-24.5 (Reserved)**8:43G-24.6 Plant maintenance staff education**

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

8:43G-24.7 (Reserved)**8:43G-24.8 Physical plant general compliance for new construction, alteration or renovation**

(a) The hospital shall comply with the New Jersey Uniform Construction Code (N.J.A.C. 5:23 under Use Group I-2), standards imposed by the United States Department of Health and Human Services (HHS), the New Jersey Department of Health and Senior Services and Community Affairs, and the Guidelines for Design and Construction of Hospital and Healthcare Facilities (2001 edition, as published by The American Institute of Architects Press, 1735 New York Ave., NW, Washington, D.C. 20006, ISBN 1-57165-992-04, as amended and supplemented, incorporated herein by reference. In order to avoid conflict between N.J.A.C. 5:23 and the other standards listed above, Sections 501.3, 610.4.1, 704.0, 705.0, 706.0, 708.0, and 916.5 of the 1987 BOCA Basic Building Code of the New Jersey Uniform Construction Code shall not govern with respect to health care facilities.

(b) The hospital shall submit plans and specifications to Health Plan Review, Division of Codes and Standards, Department of Community Affairs, P.O. Box 815, Trenton, New Jersey 08625-0815, for approval prior to construction, alteration, or renovation.

Amended by R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).
Rewrote the section.

8:43G-24.9 Construction and renovation

(a) Whenever construction and renovation projects are planned in and around a health care facility, a risk assessment shall be conducted to determine the impact of the project on patient areas, personnel, and mechanical systems.

1. The infection control program shall review areas of potential risk and populations at risk. The infection control program shall approve control measures, if necessary.

(b) The design phase shall include commissioning specifications of ventilation requirements used during and at completion of the construction project.

(c) An education program shall be established for facility employees of the areas affected, the contractor's employees, and the contractor to define the impact, risks, interventions and compliance issues.

Repealed by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

Formerly "Physical plant general compliance for construction, alteration or renovation completed during the period of July 1, 1979 through May 7, 1981 or May 8, 1981 through October 1, 1987; mandatory".

New Rule, R.2004 d.302, effective August 2, 2004.
See: 35 N.J.R. 2847(a), 35 N.J.R. 3782(a), 36 N.J.R. 3538(a).

8:43G-24.10 (Reserved)

Repealed by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

Formerly "Physical plant general compliance for construction, alteration or renovation completed during the period of August 1, 1977 through July 1, 1979; mandatory".

8:43G-24.11 (Reserved)

Repealed by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

Formerly "Physical plant general compliance for construction, alteration or renovation completed during the period of September, 1974 to August 1, 1977; mandatory".

8:43G-24.12 (Reserved)

Repealed by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).

Formerly "Physical plant maintenance general compliance for construction, alteration or renovation completed prior to September, 1974; mandatory".

8:43G-24.13 Fire and emergency preparedness

(a) The hospital shall comply with the 1985 edition of the National Fire Protection Association "Life Safety Code"

(N.F.P.A. 101, Chapter 12 for new construction and Chapter 13 for existing construction), available from NFPA, 1 Batterymarch Park, Quincy, MA, 02169, (1-800-344-3555). If the building was constructed prior to 1968, the hospital shall have the option of applying for approval from the State Department of Health under Fire Safety Evaluation System (FSSES) requirements. Such approval shall be obtained prior to the annual licensure inspection survey and shall include prearranged inspection by a State Department of Health surveyor.

(b) All employees, including part-time employees, temporary agency personnel, and private duty nurses shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and patient evacuation of hospital buildings as part of their initial orientation and at least annually thereafter.

(c) All employees, including part-time employees, temporary agency personnel, and private-duty nurses, shall receive printed instructions on procedures to be followed in case of emergency, including patient evacuation of the buildings.

(d) A written evacuation diagram specific to the unit that includes evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each patient care unit.

(e) Exits, stairways, doors, and corridors shall be kept free of obstructions.

(f) Fire drills shall be conducted at least 12 times per year, with at least one drill on each shift and one drill on a weekend.

(g) Fire extinguishers shall be visually inspected at least monthly; fully inspected at least annually, recharged, repaired and hydrotested as required by manufacturer's instructions; and labeled with the date of the last inspection.

(h) Fire detectors and alarm systems shall be inspected and tested at least twice a year by a certified testing agency. Written reports of the last two inspections shall be kept on file.

(i) Fire suppression systems shall be tested at least twice a year by an approved and certified testing agency. Written reports of the last two inspections shall be kept on file.

(j) There shall be a comprehensive, current, written preventive maintenance program for fire detectors, alarm systems, and fire suppression systems that includes regular visual inspection. This program shall be documented.

(k) There shall be a procedure for investigating and reporting fires. All fires that result in a patient or patients being moved shall be reported to the New Jersey State Department of Health immediately by telephone at (609) 588-7725 or (609) 392-2020 after business hours and followed up in writing within 72 hours. In addition, a written report of the investigation shall be forwarded to the Department of Health as soon as it becomes available.

(I) The hospital shall have an alternate emergency power supply. If such emergency power supply is a diesel emergency power generator, there shall be enough stored fuel to maintain power for at least 24 hours.

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

Most recent two inspections to be on file.

8:43G-24.14 (Reserved)

SUBCHAPTER 25. POST MORTEM

8:43G-25.1 Policies and procedures

(a) The hospital shall have written policies and procedures for post mortem services that are reviewed at least once every three years, revised more frequently as needed, and implemented. These policies shall delineate the responsibilities of the medical staff, nursing, and post mortem services staff, and shall include procedures for at least the following:

1. Identifying the body;
2. Safe and proper handling to prevent damage to the body;
3. Safeguarding personal effects of the deceased and release of personal effects to the appropriate individual;
4. Handling of toxic chemicals by morgue and house-keeping staff;
5. Infection control, including disinfection of equipment;
6. Identifying and handling high-risk and/or infectious bodies, in accordance with Centers for Disease Control guidelines, and in compliance with N.J.S.A. 26:6-8;
7. Release of the body to the county morgue or funeral director;
8. Autopsy requests;
9. Availability of autopsy reports, including reports of microscopic autopsy findings, to physicians and in medical records, within specified time frames; and

10. Completion of autopsy, including microscopic and other procedures, within specified time frames.

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

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

Identification, handling and reporting requirements further specified at (a)6, 7 and 10.

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

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

In (a), substituted a reference to hospitals for a reference to morgues and substituted "at least once every three years, revised more frequently" for "annually, revised" following "reviewed" in the first sentence, and substituted a reference to post mortem services staff for a reference to morgue staff in the introductory paragraph.

8:43G-25.2 Post mortem staff qualifications

The physician who routinely performs or supervises the performance of autopsies shall be Board Certified in Pathology.

8:43G-25.3 Post mortem patient services

(a) Bodies and body parts in the morgue shall be kept refrigerated or in chemical fixation in a non-putrescent state.

(b) The medical staff shall attempt to secure autopsies in cases of unusual deaths, deaths from unknown causes, and cases of medicolegal and educational interest, unless otherwise provided for by law.

(c) Autopsies shall be performed only with the consent of the patient's family or guardian in accordance with N.J.S.A. 26:6-50. Consent shall not be required for medical examiner cases.

(d) The hospital shall notify the county medical examiner or prosecutor immediately upon a patient's death when the circumstances of the death fall within the criteria specified in N.J.S.A. 52:17B-86 of the State Medical Examiners Act, N.J.S.A. 52:17B-78 et seq.

8:43G-25.4 Post mortem space and environment

The morgue shall be equipped with refrigerated space to store at least two bodies. Hospitals with more than 100 beds shall provide additional space using a ratio of one space to every additional 100 beds.

6. A medication station that includes a work counter with hand washing facilities, refrigerator, and locked storage for syringes, biologicals and drugs, and which may be either:

i. A room or area designated to store and prepare individual patients' medication for administration, located in a space that is under the nursing staff's visual control; or

ii. A room or area designated to prepare individual patients' medication for administration, in which patients' medication is self-contained in a medication-dispensing machine, such as a Pyxis system or other such system approved for use by the Department, and which may be located at the nurses' station, in a clean work room, or in another space that is under direct control of the nursing or pharmacy staff;

7. A storage room or rooms, which shall be located either within or outside of the suite, which shall house the supplies and equipment necessary to maintain the machines for the dialysis suite. At least one week of operational supplies must be available in the facility;

8. Storage space for medical waste shall be provided until it is properly disposed;

9. If patient toilet rooms are provided, they shall have doors equipped with hardware which will permit access by staff in any emergency; and

10. If home training is provided, patient education rooms or areas shall be equipped with a sink for hand washing.

(h) For hospitals using contract or outside vendors to manage inpatient dialysis services, the hospital shall assure that appropriate documentation from the vendor verifying the training competencies and health status of staff is available upon request of the Department.

8:43G-30.6 Staffing requirements for inpatient dialysis services

(a) A nephrologist shall be present prior to the initiation of the following:

1. A patient's first inpatient dialysis treatment;

i. Chronic dialysis patients who are dialytically stable and who have been admitted to the hospital for conditions unrelated to their end stage renal disease shall be exempt from (a)1 above; and

2. Emergency dialysis to a patient with a life-threatening situation, as determined by medical staff.

i. In the case of emergency dialysis, the nephrologist shall be present during the dialysis and until the patient is deemed stable.

(b) The staffing ratio in the inpatient dialysis setting shall be no greater than one registered nurse to three patients, except in the critical care setting which shall be a ratio of one to one. Staffing shall be increased if warranted by the acuity needs of the patients.

(c) In those instances where the staffing ratio requirement is one to one, a registered nurse with a minimum of six months experience in hemodialysis, obtained within the last 24 months, shall provide the service. In those instances where the staffing requirement is other than one to one, for the first three patients, a registered nurse meeting the requirement identified above shall provide the treatments.

(d) An inpatient facility providing dialysis services shall have at least one registered nurse providing treatments to the first three patients. There shall be an additional registered nurse, licensed practical nurse, or trained technician to assist the required registered nurse for the next three patients. There shall be two additional staff, one of which is a registered nurse, for each additional group of one to six patients.

8:43G-30.7 Inpatient care plan

(a) A written plan of care for each patient shall be developed by a multidisciplinary team consisting of, at least, a nephrologist, a registered professional nurse, a dietitian, and a licensed social worker (the current outpatient dialysis care plan for previously diagnosed ESRD patients may be used to meet the requirement for the social worker review). The plan of care shall specify goals and expected outcomes.

(b) The written care plan for each inpatient dialysis patient shall be discussed with the patient and/or family, and implemented within 24 hours of admission to the facility.

SUBCHAPTER 31. RESPIRATORY CARE

8:43G-31.1 Respiratory care structural organization; definitions

(a) The respiratory care service shall be represented on hospital committees responsible for neonatal, pediatric and adult intensive care, patient care, and infection control.

(b) The following term, when used in this subchapter, shall have the following meaning:

"Licensed respiratory care practitioner" means an individual who qualified and passed the National Board of Respiratory Care Entry Level Examination and is licensed by the State Board of Respiratory Care in accordance with N.J.A.C. 13:44F.

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

8:43G-31.2 Respiratory care policies and procedures

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

1. A system for the reissuing and discontinuing of all respiratory therapy orders;
2. The duties and responsibilities of respiratory care practitioners;
3. The education, training, and experience requirements of respiratory care practitioners qualified to initiate and maintain therapies and in which special care units they may work;
4. Procedures for control of infection, the spread of infection, and electrical, explosive, and mechanical hazards; and
5. Protocols that encourage multidisciplinary input into the patient's written plan of care.

(b) Verbal or telephone respiratory care orders within the scope of practice of the licensed respiratory care practitioner shall be accepted and recorded by a licensed respiratory care practitioner.

(c) There shall be a protocol whereby the nurse is informed of any verbal or telephone order that is taken by the licensed respiratory care practitioner.

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).

In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph.

8:43G-31.3 Respiratory care staff qualifications

(a) There shall be a physician director of respiratory care or pulmonary medicine who is board certified or board eligible in pulmonary medicine, and who is responsible for all respiratory care rendered in the hospital.

(b) There shall be an administrative director of respiratory care who is licensed by the New Jersey State Board of Respiratory Care.

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

8:43G-31.4 (Reserved)**8:43G-31.5 Respiratory care staff time and availability**

(a) There shall be at least one licensed respiratory care practitioner assigned primarily to patients in licensed critical care units. Assignments shall be based on the acuity level of patient illness assessed each shift.

(b) There shall be at least one licensed respiratory care practitioner in the hospital or on call, at all times, in addition to the one who is primarily assigned to patients in the critical care unit.

Administrative Correction.

See: 22 N.J.R. 653(a).

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

See: 27 N.J.R. 1290(a).

8:43G-31.6 (Reserved)**8:43G-31.7 Respiratory care patient services**

(a) There shall be an organized program for teaching patients to administer their own therapy, with adequate supervision and documentation, in any case where it is appropriate for the patient and where the patient is able to receive and follow therapy instructions.

(b) Written treatment plans, and respiratory therapy goals shall be written by the licensed respiratory care practitioner. The written treatment plans shall supplement the respiratory care orders written by physicians and become part of the medical record.

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

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

8:43G-31.8 (Reserved)**8:43G-31.9 Respiratory care space and environment**

(a) There shall be adequate space available to store all equipment not in routine use. No respiratory care equipment shall be stored in hallways.

(b) There shall be office space dedicated to members of the respiratory care service.

8:43G-31.10 (Reserved)**8:43G-31.11 Respiratory care supplies and equipment**

(a) The respiratory care service shall have equipment available to evaluate respiratory therapy.

(b) Pulse oximeters and end-tidal CO₂ monitors shall be available for patients in the hospital who have a medical condition that requires oxygen and carbon dioxide monitoring.

(c) There shall be a documented system for preventive maintenance of all respiratory therapy equipment.

(d) All mechanical and electrical equipment shall be tested before using for the first time or after repairs.

postanesthesia policies and procedures set forth at N.J.A.C. 8:43G-35.1(a)1.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

In (a), substituted "responsible for the patient's airway" for "a member of the anesthesia team"; in (c), inserted "temperature" preceding "pulse"; in (d), inserted "staff" following "care unit"; rewrote (g); in (i), substituted "Post Anesthesia Care Unit" for "medical" and inserted "temperature" following "circulation"; in (j), substituted "set forth" for "specified" preceding the N.J.A.C. reference.

8:43G-35.5 (Reserved)

8:43G-35.6 Postanesthesia care supplies and equipment

(a) Postanesthesia care units shall be adjacent to or within the operating suite and the obstetrics suite.

(b) The postanesthesia care unit shall be maintained as a closed unit. Access to the postanesthesia care unit shall be in accordance with hospital policies and procedures.

(c) All staff in the postanesthesia care unit shall be attired in scrub attire. Individuals who are permitted limited access shall be attired according to hospital infection control policies.

(d) Equipment available in the postanesthesia care unit shall include at least a crash cart with defibrillator, drugs, pulse oximetry, electrocardiographic monitoring, body temperature monitoring, equipment necessary for intubation and various means of oxygen delivery. Constant and intermittent suction, blood pressure monitoring, adequate lighting, peripheral nerve stimulator, immediate access to a ventilator, and end-tidal carbon dioxide monitoring in accordance with N.J.A.C. 8:43G-35.4(g) shall be made available. Provisions to ensure the patient's privacy shall be made.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

Rewrote (b), (c) and (d).

8:43G-35.7 Postanesthesia care staff education and training

Requirements for the postanesthesia education program shall conform to the standards set forth in N.J.A.C. 8:43G-5.9.

Amended by R.2003 d.57, effective February 3, 2003.
See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

Substituted "conform to the standards set forth" for "be as provided".

8:43G-35.8 (Reserved)

8:43G-35.9 Postanesthesia care continuous quality improvement

(a) The hospital's quality improvement program shall include a systematic review and evaluation of patient care, anesthesia practices and anesthesia techniques. The surgical

staff shall identify problem-prone processes which manifest undesirable patterns. The hospital shall develop a plan by which to collect and analyze data in order to evaluate outcomes or performance of the problem-prone processes. Data analysis shall focus on recommendations for implementing corrective actions and improving performance.

(b) Continuous quality improvement activities shall include at least the monitoring of outcomes for patients receiving anesthetic agents and postdischarge follow-up of surgical procedures.

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

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

Amended by R.2003 d.57, effective February 3, 2003.

See: 34 N.J.R. 232(a), 35 N.J.R. 865(a).

Rewrote the section.

SUBCHAPTER 36. SATELLITE EMERGENCY DEPARTMENTS

Authority

N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

8:43G-36.1 Scope

(a) All satellite emergency departments shall be owned and operated by an acute care general hospital and shall comply with the rules in this subchapter and all applicable requirements of this chapter. All satellite emergency departments shall provide emergency treatment and care within the scope of this subchapter for those patients, who are transported by basic life support (BLS) transport service and other ambulatory arrivals.

(b) A satellite emergency department shall be licensed only to replace the full service emergency department of a licensed general acute care hospital which has approval from the Department to cease operation of all of its licensed acute care beds. The satellite emergency department shall be located in as close proximity to the closed full service emergency department as is possible. This location shall require the prior written approval of the Department.

1. For each full service emergency department which has closed, only one satellite emergency department shall be licensed to provide care.

2. Priority for licensing satellite emergency departments shall be given to the entity or its parent which was previously licensed to operate the full service emergency department or to an entity with a formal affiliation to one of the latter at the time licensing of the satellite emergency department is requested.

(c) The Department may consider a waiver to (b) above where the proposed operator of a satellite emergency

department is able to demonstrate to the satisfaction of the Department that its proposed location will serve to eliminate or substantially mitigate problems of access to appropriate emergency care affecting a community or communities.

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

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.

(e) A certificate of need application and certificate of need approval is not required in order for a licensed hospital to institute, construct, expand or operate a satellite emergency department. However, a licensed hospital which chooses to establish a satellite emergency department shall make application for licensure to the Certificate of Need and Acute Care Licensing Program as required in N.J.A.C. 8:43G-2.2(a) and comply with the requirements of N.J.A.C. 8:43G-2.2 through 2.11. If the satellite emergency department applies for licensure as a free-standing ambulatory care facility, it shall also meet the applicable requirements set forth in N.J.A.C. 8:43A.

(f) A satellite emergency department may be located in a building formerly licensed as an acute care hospital or another building and shall comply with the physical plant requirements specified at N.J.A.C. 8:43G-36.15.

(g) The Department shall charge a non-refundable biennial inspection fee of \$2,000 and an annual licensure fee of \$2,500 for the operation of a satellite emergency department.

(h) Each satellite emergency department shall provide services 24 hours per day, seven days per week during the first full year after licensing. After one year, if the facility can document a low utilization of patients during any eight hour period, it may cease operation during that time period, following Department of Health and Senior Services (DHSS) approval. In no case shall a satellite emergency department operate less than 16 hours per day, seven days per week after the first year of licensing. Policies and procedures addressing after hours care shall be developed by the satellite emergency department or owner/operator hospital and approved by the DHSS prior to revising hours of operation.

1. The satellite emergency department may apply to the Department to reduce hours of operation to 16 hours per day after one year of operation. Such requests shall include documentation of low utilization as defined in N.J.A.C. 8:43G-36.2.

- i. Hospital owned and operated satellite emergency departments shall not contain any licensed beds. However, the satellite emergency department may have observation beds, which shall only be used for a time period of not more than 12 hours from time of registration and in the care of patients likely or expected to be discharged home, unless, the patient is awaiting test results or transfer to another facility.

8:43G-36.2 Definitions

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

“Advanced life support” means an advanced level of pre-hospital, inter-hospital, and emergency service care which includes basic life support functions, cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care, and other techniques and procedures authorized by the Commissioner.

“Basic life support” means a basic level of pre-hospital care which includes patient stabilization, airway clearance, cardiopulmonary resuscitation, control of hemorrhage, initial wound care, fracture stabilization, and other techniques and procedures specified in N.J.A.C. 8:40A-1.2 and authorized by the Commissioner.

“Department” means the New Jersey State Department of Health and Senior Services.

“Licensee” means acute care hospital authorized by the Department of Health and Senior Services to own and operate a satellite emergency department and on whom the responsibility for maintaining acceptable standards in all areas of operation of the satellite emergency department.

“Low utilization” means an average of 16 patients or less over an eight hour consecutive period of time for the most recent six months prior to the request to reduce hours of operation.

“Satellite emergency department” means a facility, which is owned and operated by a licensed New Jersey general acute care hospital, which shall provide emergency care and treatment for patients.

8:43G-36.3 Services in satellite emergency departments

- (a) All laboratory services provided in the satellite emergency department shall comply with the requirements of N.J.A.C. 8:45, Standards for Clinical Laboratory Services, and all radiology services shall comply with applicable requirements of N.J.A.C. 7:28-19, Medical Exposure to Ionizing Radiation by Radiological Technologists.

8:43G-36.10 Administrative and staff education

The satellite emergency departments shall comply with the requirements of N.J.A.C. 8:43G-5.7 and 5.9.

8:43G-36.11 Occupational health structural organization

The satellite emergency department shall comply with the requirements of N.J.A.C. 8:43G-5.11, 5.12, 5.13, 5.14 and 5.15.

8:43G-36.12 Disaster planning

The satellite emergency department shall comply with N.J.A.C. 8:43G-5.16.

8:43G-36.13 Mandatory equipment

(a) The following equipment shall be located within the satellite emergency department at all times:

- 1. Basic and stat laboratory equipment/supplies, with at least the capability to perform the following laboratory testing and evaluation:
 - i. Arterial blood gases;
 - ii. Creatinine;
 - iii. Electrolytes;
 - iv. Glucose (blood);
 - v. CBC;
 - vi. Strep screening;
 - vii. Urinalysis; and
 - viii. Pregnancy tests;
- 2. Defibrillator(s) with external pacemaker capability;
- 3. Advanced airway equipment;
- 4. Surgical airway equipment;
- 5. Suction equipment;
- 6. Obstetric kit with capability to keep patients warm;
- 7. Emergency chest decompression equipment; and
- 8. Basic radiology services, which shall include at a minimum non-enhanced and non-contrast radiographs.

(b) In addition to (a) above, the satellite limited emergency department shall comply with N.J.A.C. 8:43G-12.9(b), (c), (d) and (e).

8:43G-36.14 Continuous quality improvement

(a) The satellite emergency department shall comply with N.J.A.C. 8:43G-5.15.

(b) On a quarterly basis, beginning with the closest calendar quarter after commencing operation, the satellite emergency department shall submit the following information to the Department's Certificate of Need and Acute Care Licensure Program:

- 1. The total volume of patients for the quarter;
- 2. The number of transfers to the hospital licensed to operate the satellite emergency department (which statistics shall identify a breakout of all BLS and ALS levels);
- 3. The number of transfers to other hospitals;
- 4. The mode of arrival at the satellite emergency department for each patient during the quarter; and
- 5. The number of transfers for further diagnostic study.

8:43G-36.15 Physical plant

A building or structure being considered for use as a satellite emergency department, located independent from an acute care hospital shall comply with all the requirements of Use Group B, and section 13.6 of the NFPA 101, 1985 edition, as referenced in N.J.A.C. 8:43G-24.13(a). A satellite emergency department that remains located in a former acute care hospital shall continue to comply with the requirements of Use Group I-2, as noted in N.J.A.C. 8:43A-19.1 of the Standards for Licensure of Ambulatory Care Facilities.

SUBCHAPTER 37. EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY SERVICES

Authority

N.J.S.A. 26:2H-1 et seq., specifically 26:2H-8.

8:43G-37.1 Extracorporeal shock wave lithotripsy services

All general hospitals providing extracorporeal shock wave lithotripsy services shall conform to the applicable criteria set forth in this chapter as well as the provisions set forth in N.J.A.C. 8:43A-29.

SUBCHAPTER 38. LONG TERM ACUTE CARE HOSPITALS GENERAL REQUIREMENTS

Authority

N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

8:43G-38.1 Scope

(a) Special hospitals providing long term acute care services shall comply with all standards set forth in this subchapter and all applicable provisions of this chapter.

(b) The rules in this subchapter apply to special hospitals providing long term acute care services either as a freestanding facility or as part of a licensed general hospital (hospital within a hospital).

8:43G-38.2 Compliance with rules and laws

(a) All special hospitals providing long term acute care services (LTAC) shall be licensed by the New Jersey Department of Health and Senior Services and comply with the licensing procedures set forth at N.J.A.C. 8:43G-2.

(b) All beds maintained by a special hospital providing long term acute care services shall be licensed as long term acute care beds.

(c) All special hospitals providing long term acute care services shall comply with the rules of the United States Department of Health and Human Services at 42 CFR Part 412 et al. incorporated herein by reference as amended and supplemented.

(d) All special hospitals applying for licensure shall provide or arrange for the provision of the following professional departments, services, facilities or functions:

1. Administration;
2. Anesthesia/Sedation Services;
3. Blood Bank;
4. Central Supply;
5. Clinical and Pathological Laboratories;
6. Dietary Services;
7. Discharge Planning;
8. Employee and Occupational Health;
9. Electrocardiogram Laboratory;
10. Housekeeping and Laundry Services;
11. Infection Control and Sanitation;
12. Medical Library;
13. Medical Records;
14. Medical Services;
15. Medical Staff;
16. Morgue and Autopsy Facilities;
17. Nursing Service;
18. Pharmacy Department;
19. Physical and Occupational Therapy;
20. Physical Plant and Maintenance;
21. Post Anesthesia Care Unit;

22. Quality Assurance;

23. Radiology;

24. Respiratory Therapy Services; and

25. Social Work Department.

(e) Special hospitals providing long term acute care services shall comply with the physical plant requirements at N.J.A.C. 8:43G-24.8. In addition to the standard construction requirements for hospitals, the following shall be required:

1. Ventilation care units shall have piped in oxygen, suction equipment, emergency electrical outlets, and additional square footage for ventilator equipment and supplies; and

2. The standby emergency generator shall be checked weekly, tested under load monthly, and serviced in accordance with acceptable engineering practices.

8:43G-38.3 Special hospital policies and procedures

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

1. Criteria for admission to, and discharge and transfer from, the hospital;

2. A visitors policy that specifies visiting hours and number of visitors permitted each patient at one time, subject to the discretion of the patient's physician or primary care nurse;

3. Protocols for transfer and transport of patients within the hospital or from the hospital to another facility, including who shall accompany the patient being transferred or transported;

4. A policy defining the physician specialist and consulting physician to be called for patient emergencies, including a response time for physicians to respond to patient emergencies;

5. Standing orders for patient emergencies;

6. A policy on the removal of a patient's life support system pursuant to N.J.A.C. 8:43G-4; and

7. Educational policies for the patient and families to manage their present and future healthcare needs.

8:43G-38.4 Special hospital staff qualifications

(a) There shall be a physician director with clinical responsibility for the care rendered throughout the facility.

(b) The physician director shall be board certified in internal medicine and licensed or authorized to practice medicine by the New Jersey Board of Medical Examiners.