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

Chapter 43G, Hospital Licensing Standards, expires on July 22, 2010.

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Chapter 43G, Certificate of Need: Capital Policy, was repealed by R.1988 d.114, effective March 21, 1988.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 Supply, 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 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 rule by R.2005 d.279, effective September 6, 2005. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

(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 8. CENTRAL SERVICE

8:43G–8.1 Central service policies and procedures

(a) The hospital's central service shall have written policies and procedures that are reviewed at least once every three years or as needed, revised as needed, and implemented. These policies and procedures shall be approved by the hospital's infection control committee.

(b) Policies and procedures for central service shall include at least decontamination and sterilization activities, including receiving, decontamination, storage, cleaning, packaging, disinfection, sterilization, and distribution of reusable items.

(c) All equipment and instruments in the hospital shall be processed according to central service cleaning and sterilization policies and procedures.

(d) Manufacturers' written recommendations for equipment use, testing, and cleaning shall be readily available in central service and in the department where the equipment is used.

(e) Methods for processing reusable medical devices shall conform with the following or revised or later editions, if in effect, incorporated herein by reference:

1. The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Good Hospital Practice: Steam Sterilization and Sterility Assurance." ST 46;

2. The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Flash Sterilization: Steam Sterilization of Patient Care Items for Immediate Use." ST 37;

3. The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Safe Use and Handling of Gultaraldehyde-based Products in Health Care Facilities." ST 58;

4. The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Guidelines for the Selection and use of Reusable Rigid Container Systems for Ethylene Oxide Sterilization and Steam Sterilization in Health Care Facilities." ST 33;

5. The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Steam Sterilization and Sterility Assurance Using Table Top Sterilizers in Office–Based, Ambulatory Care, Medical, Surgical and Dental Facilities," January 1998, ST 42R;

6. Society of Gastroenterology Nurses and Associates, Inc., "Standards of Infection Control in Reprocessing of Flexible Gastrointestinal Endoscopes" (2000);

7. The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Safe Handling and Biological Decontamination of Medical Devices in Health Care Facilities and in Nonclinical Settings," ST 35; and

8. The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Ethylene Oxide Sterilization in Health Care Facilities: Safety and Effectiveness," October 1998, ST 41R.

(f) The documents reference in (e) above are reviewed and/or revised every five years or more frequently as needed; the most current document is to be used. The AAMI requirements can be obtained from: The Association for the Advancement of Medical Instrumentation, 3330 Washington Building, Suite 400, Arlington, VA 22209 or at the AAMI website at www.aami.org. SGNA's Standards and Guidelines are available from the Society of Gastroenterology Nurses and Associates, Inc., 401 North Michigan Ave., Chicago, Il 60611–4267, or at www.sgna.org.

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 "at least once every three years, revised more frequently" for "annually, revised" following "reviewed".
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) through (c), substituted "central service" for "central supply service" ; in (d), inserted "written" preceding "recommendations" and deleted "supply" following "central"; added (e) and (f).

8:43G–8.2 Central service staff qualifications

(a) There shall be a full-time director or supervisor of central service.

(b) The director or supervisor of central services shall have two years of supervisory experience and shall be certified through a national sterile processing program recognized by the New Jersey Department of Health and Senior Services.

(c) All personnel involved in sterile processing shall be certified through a national sterile processing program recognized by the New Jersey Department of Health and Senior Services within three years of employment and by August 2, 2009.

3. Date of service;

4. Gender;

5. Date of birth (not age);

6. Zip code;

7. Baseline medical condition;

8. Mode of arrival;

9. Pre-hospital medical and/or procedural interventions, including emergency medical services times and vital signs;

10. Nature of presenting illness;

11. Physician professional characteristics (for example, board certification or other special training);

12. Chief complaint category;

13. Initial vital signs upon presentation;

14. Emergency department medical and/or procedural interventions (treatment rendered);

15. Clinical impression;

16. Time of call for transfer;

17. Mode of transport on transfer;

18. Transport team interventions;

19. Intensive care unit number;

20. Intensive care unit physician professional characteristics (for example, board certification or other special training);

21. Medical and/or procedural interventions during first hour in intensive care unit;

22. Initial critical care score;

23. Length of stay in intensive care unit;

24. Final disposition;

25. Functional neurologic status; and

26. Functional physiologic status.

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

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

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

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

(a) At all times at least one licensed physician who meets at least one of the qualifications in N.J.A.C. 8:43G–12.3(b) shall be present in the emergency department to attend to all emergencies.

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

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

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

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

Amended by R.1995 d.124, effective March 20, 1995.
See: 26 N.J.R. 4537(a), 27 N.J.R. 1290(a).
Amended by R.2002 d.98, effective April 1, 2002.
See: 33 N.J.R. 1174(a), 34 N.J.R. 1423(a).
In (a), amended the N.J.A.C. reference; rewrote (b) and (c).

Case Notes

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

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

8:43G–12.6 Definitions

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

"Comes to the emergency department" means, with respect to an individual requesting examination or treatment by him or herself or with another person, that the individual is on hospital property (including ambulances owned and operated by the hospital even if the ambulance is not on hospital grounds). An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the emergency department.

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

"Emergency medical condition" means:

1. A medical condition manifesting itself by acute symptoms or sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that absence of immediate attention could reasonably be expected to result in:

i. Placing the health of the individual (or, with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy;

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of a bodily organ or part; or

2. With respect to a pregnant woman who is having contractions:

i. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

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

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

8:43G-12.7 Emergency department patient services

(a) When an individual comes to the emergency department requesting examination or treatment for a medical condition, or if a request is made on the individual's behalf, clinical priority for treatment shall be assigned by a registered professional nurse or qualified medical personnel.

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

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

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

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

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

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

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

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

1. Mode, date and time of arrival. After (one year after the adoption of these rules), the names of the ambulance provider and mobile intensive care unit provider, if applicable, and copies of all available prehospital care records shall be entered in the patient's emergency department medical record;

2. Allergies, including allergy to latex;

3. Medications used before coming to the emergency department;

4. Immunizations when relevant;

5. Timed vital signs;

6. Chief complaint;

7. Physician assessment;

8. Nursing assessment;

9. Treatment rendered, signed by the person who rendered the treatment;

10. Medications prescribed and administered while in the emergency department signed by the person who prescribed and the person who administered the medications;

11. Discharge instructions;

12. Last menstrual period, if relevant;

13. Whether the patient visited the emergency department within the previous 72 hours;

14. Age and sex of the patient; and

15. Transfer information, such as destination facility and reason for transfer.

(s) Deceased patients shall be removed from rooms occupied by other patients, when possible, or shall be curtained off. The deceased shall be transported in the hospital and removed from the hospital in a dignified manner.

(t) The emergency department staff shall conform with hospital policies and procedures for complying with applicable statutes and protocols to report child abuse, sexual abuse, and abuse of elderly or disabled adults, specified communicable disease, rabies, poisonings, and unattended or suspicious deaths.

(u) The emergency department shall be prepared to communicate and shall communicate with emergency medical services regarding patients about to arrive by emergency vehicles. The department shall be prepared to receive such patients when they arrive.

(v) The phone number of the designated regional or Statewide New Jersey Poison Information and Education System (1–800–962–1253) shall be posted in the emergency department.

(w) Radiology services for emergency needs shall be available to the emergency department 24 hours a day.

(x) Clinical laboratory services for emergency needs shall be available to the emergency department 24 hours a day.

(y) The emergency department shall have access to and utilize a record of hospital employees, medical staff members, and volunteers who can provide interpretive services to patients as required at N.J.A.C. 8:43G–5.5(c).

(z) Security personnel shall be available to the emergency department when needed.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
"Hospital" changed to "health care facility" at (m); documentation requirements added.
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote the section.

8:43G–12.8 (Reserved)

8:43G–12.9 Emergency department space and environment

(a) The emergency department shall meet criteria established by the Federal Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1987 Edition, section 7.9, or later edition, if in effect, which are hereby incorporated by reference.

(b) The emergency department shall have the necessary monitoring devices, supplies, and equipment to meet the needs of patients of all ages. Availability of pediatric equipment shall be in accordance with "Guidelines for Pediatric Equipment and Supplies for Emergency Departments," Committee on Pediatric Equipment and Supplies for Emergency Departments, National Emergency Medical Services for Children Resource Alliance, 31 Annals of Emergency Medicine 54, January, 1998, published by ACEP, PO Box 619911, Dallas, TX 75261–9911, (972) 550–0911, (800) 798–1822, incorporated herein by reference.

(c) The emergency department shall be equipped to stabilize all patients.

(d) The emergency department shall be equipped with, at least, patient monitoring equipment and resuscitation equipment.

(e) The emergency department shall have a functioning two way communications system operating on an assigned frequency of 155.340 MHz for communicating with ambulance services about arriving patients.

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

8:43G–12.10 Emergency department staff education and training

(a) Requirements for the emergency department education program shall be as provided in N.J.A.C. 8:43G–5.9.

(b) Regularly assigned emergency department staff shall attend training or educational programs related to the identification and reporting of child abuse and/or neglect in accordance with N.J.S.A. 9:6–1 et seq.; sexual abuse; domestic violence; and abuse of the elderly or disabled adult.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Text on domestic violence and disabled adults added at (b).

8:43G–12.11 Emergency department continuous quality improvement methods

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

(b) The continuous quality improvement program shall include periodic collection of emergency department data in at least the following areas:

1. Waiting time;
2. Appropriateness and timeliness of transfers;
3. Provision of written instructions;
4. Timeliness of diagnostic studies;
5. Appropriateness of treatment rendered;
6. Unscheduled revisits within 72 hours for the same condition;
7. Mortality; and
8. Care of patients who are retained in the emergency department for long periods of time.

(c) Continuous quality improvement shall include review of selected medical charts for both adult and pediatric patients.

(d) The quality assurance program shall assess whether physicians, including residents, are on duty for periods of time that have an adverse effect on patient care.

Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Substituted references to continuous quality improvement for references to quality assurance throughout; in (b), inserted a reference to timeliness in 2, inserted a new 6, and recodified former 6 and 7 as 7 and 8; and in (c), added "for both adult and pediatric patients" at the end.

8:43G–12.12 Trauma services; scope and purpose

(a) The requirements of N.J.A.C. 8:43G–12.12 through 12.23 shall apply to all hospitals designated by the Department of Health as Level I or Level II trauma centers, pursuant to Certificate of Need designation criteria at N.J.A.C. 8:33P.

(b) The purpose of the rules designated in (a) above is to specify the personnel, organization and other resources required for hospitals designated and licensed as trauma centers, and to delineate the joint responsibilities of community hospital emergency departments and trauma centers in the treatment of trauma patients.

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

8:43G–12.13 Trauma services; definitions

The following words and terms, when used in N.J.A.C. 8:43G–12.12 through 12.23, shall have the following meanings, unless the context clearly indicates otherwise:

"Advanced life support" means an advanced level of prehospital, interhospital, 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 level of prehospital care which includes patient stabilization, airway clearance, external closed chest cardiopulmonary resuscitation, control of hemorrhage, initial wound care, fracture stabilization, victim extrication, and other techniques and procedures authorized by the Commissioner.

"Commissioner" means Commissioner of Health and Senior Services.

"Department" means New Jersey Department of Health and Senior Services.

"Emergency medical technician" (EMT) means an individual who has completed a course of instruction and who has been issued certification by the Commissioner to provide basic life support services, in accordance with N.J.A.C. 8:41.

"In-hospital" means present at all times and immediately available to the trauma center. On call personnel are not considered to be in-hospital.

"Major trauma" means an injury to a trauma patient who sustains a sudden injury, due to violence or other forces, that requires medical/surgical intervention to prevent death or disability. Patients included are those with both injuries in the ICD–9 CM diagnosis or injury code range of 800.00 through 959.9 and an associated E (external cause of injury) code, with the exception of drowning or suffocation. Patients must also meet, as a result of such injury rather than another disease or condition, one or more of the following criteria: