Rules and Regulations of the

Clinical Staff of the

University of Virginia Medical Center

Adopted as of November 26, 2002

Revised April 15, 2003
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DEFINITIONS

The Definitions appearing in the Amended and Restated Bylaws of the Clinical Staff of the University of Virginia Medical Center are adopted and incorporated into these Rules and Regulations of the Clinical Staff of the University of Virginia Medical Center.

CLINICAL STAFF RULES AND REGULATIONS

I INTRODUCTION

It is the duty and responsibility of each Member of the Clinical Staff to abide by these Rules and Regulations that are made a part of the Amended and Restated Bylaws of the Clinical Staff of the University of Virginia Medical Center (“Bylaws”). These Rules and Regulations shall be adopted in the manner specified in the Bylaws.

II ADMISSIONS

Who May Admit Patients

A patient may be admitted to the Medical Center only by a Member\(^1\) who has privileges to do so. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Medical Center has facilities and personnel. When the Medical Center does not provide the services required by a patient or a person seeking necessary medical care, or for any reason cannot be admitted to the Medical Center, the Medical Center or attending physician, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient. Except in an emergency, no patient shall be admitted to the Medical Center unless a provisional diagnosis has been stated. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible. The admitting physician shall be responsible for providing the Medical Center with such information concerning the patient as may be necessary to protect the patient, other patients, or Medical Center personnel from infection, disease, or other harm, and to protect the patient from self-harm. Physicians shall comply with Medical Center Policy Nos. 0039 and 0097 that specifies the process for admissions.

Attending Physician Responsibilities

Each patient shall be the responsibility of a designated attending physician. The attending physician shall ensure that patient medical records contain accurate documentation of the attending-of-record at all times. Such attending physicians shall be responsible for the medical care and treatment of the patient, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for ensuring that the patient is seen daily and for transmitting reports of the condition of the patient to the referring physician or agency. Whenever these responsibilities are transferred to another physician, or to a

\(^1\) The terms “physician” and/or “dentist”, as appropriate, shall be used in throughout this document to refer to a Member of the Clinical Staff of the University of Virginia Medical Center other than Ph.D. Clinical Pathologist Members who cannot admit or attend patients within the Medical Center. When these Rules and Regulations refer to residents who are members of the Housestaff, the term “resident physician” will be used.
resident physician who is supervised by the physician, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. If there is a resident physician involved in providing care and treatment to the patient, he or she shall be clearly identified in the patient’s medical record and in the MIS system.

Physicians shall provide education, as needed, to patients on topics including their diagnoses, medical conditions, medications, and continuing plans for care. Physicians shall attempt to individualize such education to specific patient needs and capabilities. Physicians shall comply with the requirements of Medical Center Policies Nos. 0024, 0029, 0094, and 0109 that specify general duties of attending physicians.

**Alternate Coverage**

Each attending physician shall assure the availability of adequate professional care for his or her patients in the Medical Center by being readily available by pager or beeper or by having available an alternate physician with whom prior arrangements have been made and who has Medical Center clinical privileges sufficient to provide care and treatment to the patient. Resident physicians may provide coverage only under the supervision of an attending physician.

**Emergency Admissions**

The history and physical examination must clearly justify any admission on an emergency basis and must be recorded on the patient’s chart no later than 24 hours after admission. In the case of emergency admission, patients who do not already have a personal admitting physician will be assigned to a physician with privileges in the clinical department appropriate to the admitting diagnosis. Physicians shall also comply with the requirements of Medical Center Policy No. 0214, Medical Screening and Stabilizing Treatment for Emergency Medical Conditions.

### MEDICAL RECORDS

**General Guidelines**

1. All medical records are the property of the Medical Center and shall be released only in the manner specified in Medical Center Policy.

2. Physicians shall not remove any part of the medical record for any reason.

3. The attending physician is responsible for the preparation of a complete medical record for each patient.

4. Diagnostic and therapeutic orders given by physicians shall be authenticated by the responsible physician or his/her designee.

5. All final diagnosis, complications, or procedures must be recorded without abbreviations. Symbols and abbreviations may be used only when approved by the Clinical Staff.
6. Progress notes are to be documented at the time of observation, should give a pertinent chronological report of the patient’s course in the Medical Center and reflect any change in condition and results of treatment.

7. The patient’s medical record requires the progress notes, final diagnosis, and discharge summary to be completed with authenticated dates and signatures and within the timeframes specified in Medical Center Policy No. 0029.

8. For patients receiving continuing ambulatory care services that include three or more outpatient visits, the medical record shall include a summary list of known significant diagnoses and conditions, known significant operative and invasive procedures, known adverse and allergic drug reactions and medications known to be prescribed for or used by the patient.

9. Physicians also shall comply with the requirements of Medical Center Policies Nos. 0029, 0037, 0094 and 0109, applicable to medical records.

**History and Physical Requirements**

1. A physical examination and medical history (“History and Physical” or “H&P”) is the responsibility of the attending physician but may be completed in part by other health care providers as designated in Medical Center Policy 0241 or utilize current information in the on-line record. The H&P shall be completed within seven (7) days prior to a planned admission, or within twenty-four (24) hours following any admission, or at the initial visit to an ambulatory clinic. Oral and maxillofacial surgeons may complete the History and Physical for patients admitted only for oral and maxillofacial surgery.

2. H&Ps must be completed prior to any operative, invasive, high-risk diagnostic or therapeutic procedure, or procedures requiring conscious sedation regardless of setting.

3. H&Ps are required in all primary care clinics. On subsequent primary care visits and in specialty clinics, the H&P can be focused based on the presenting problem(s).

4. When the H&P examination is not on the chart prior to the surgery or high-risk diagnostic or therapeutic procedure, the procedure shall be delayed until the H&P is completed unless it is an emergency.

5. If a completed H&P was obtained within seven (7) days prior to a planned admission, a durable legible copy of this report may be used in the patient’s medical record provided there have been no subsequent changes or the changes have been recorded at the time of admission. A completed H&P must include or reference current information collected by a health care provider or within the on-line record (as information is available):
   - chief complaint,
   - details of present illness (history),
   - past history (relevant - includes illnesses, injuries, and operations),
- social history,
- allergies and current medications,
- family history,
- review of systems pertinent to the diagnosis,
- physical examination pertinent to the diagnosis,
- pertinent normal and abnormal findings, and
- conclusion or a planned course of action.

6. A history and physical examination (H&P) will be completed within seven (7) days prior to a planned short stay admission, or within twelve (12) hours following admission.

7. Dentists are responsible for the part of their patient’s H&P that relates to dentistry.

8. Oral and maxillofacial surgeons may perform the H&P examination for patients admitted only for oral and maxillofacial surgery.

9. Podiatrists are responsible for completion of the portion of their patient’s H&P that relates to podiatry.

10. The attending physician is responsible for the complete H&P.

11. Resident physicians, nurse practitioners and physician’s assistants, appropriately privileged, may complete the H&P.

12. Physicians shall comply with the requirements of Medical Center Policy No. 0241, Patient Assessment and Documentation of Assessment.

**Informed Consent Requirements**

Physicians shall comply with Medical Center Policy No. 0024, Informed Consent.

**Operative Report Requirements**

Operative reports are the responsibility of the attending physician and shall be prepared in accordance with the requirements of Medical Center Policy No. 0029.

**Discharge Summary Requirements**

A discharge summary shall be completed for any patient occupying an inpatient bed, regardless of the bed status, e.g. inpatient admission or short stay in accordance with the requirements of Medical Center Policy 0029. A final discharge progress note may be substituted for the dictated discharge summary in cases of healthy newborns or GCRC patients.

**Complete Medical Records**

The attending physician or dentist is responsible for the preparation of a complete and legible medical record for each patient.
The record shall include:

- identification date, name, address, birth date, next of kin, patient history number, legal status (for behavioral health patients)
- initial diagnosis
- History and Physical
- orders
- clinical observation, progress note, consultations, and nurses’ notes
- documentation by other disciplines
- reports of procedures, tests, and results
- operative reports
- reports of consultations
- discharge summary
- all final diagnoses, complications, or procedures

**Medical Records Preparation and Completion**

The records of all discharged patients (inpatients and ambulatory) not completed within thirty (30) days of discharge will be considered delinquent.

**IV. ORDERS**

**General Requirements**

1. All orders must be written clearly, legibly, and completely and must include date, time written, legible authentication, and the ordering physician’s pager ID or other similar contact information. Orders that are illegible or improperly written will not be carried out until they are clarified, rewritten, and are understood.

2. When a physician uses a personal rubber stamp signature, he/she is the only one who uses the personal stamp and must sign a statement to that effect. It is the responsibility of each physician to forward to the Clinical Staff Office a copy of the statement attesting to only personal use of the stamp signature. When a practitioner uses an electronic signature, he/she must ensure it is only used in accordance with departmental policies, regulatory guidelines and applicable law.

3. All previous orders are canceled when patients go to surgery or have an invasive procedure, despite location. Postoperative or prior orders may include an order to resume specific and clearly identifiable preoperative orders when written by the physician.
4. Orders will be rewritten when a patient is transferred from one service to another. A reorder for medication or treatment is to be written after an automatic stop order has been employed.

5. Only the abbreviations, signs, and symbols approved by the Clinical Staff shall be used in the medical record. These abbreviations are outlined in the *Charles Press Handbook of Current Abbreviations* and are available in the Department of Health Information Services.

6. Medications should be ordered within the Medical Center formulary. No medications may be administered except on or by the order of a physician, dentist, resident physician or allied health professional with appropriate privileges.

7. Admitting privileges and surgical or procedures privileges may be suspended for illegible orders. Illegible is defined as orders that three (3) other individuals cannot read. Suspension will occur after the physician, dentist resident physician or allied health professional has been notified, either orally or in writing, on three (3) separate occasions regarding legibility.

**Who May Write Orders**

Orders may be written by physicians, dentists, resident physicians and by allied health professionals (nurse practitioners and physician’s assistants) within the scope of their practice, delineated clinical privileges, and approved protocols. All orders must be written clearly, legibly, and completely and must include date, time written, legible authentication, and the ordering practitioner’s pager ID.

**Orders for Specific Procedures/Circumstances**

All requests for tests such as imaging and labs, etc. shall contain a statement of the reason for the examination.

1. All orders for therapy shall be entered in the patient’s record and signed by the ordering practitioner.

2. Therapeutic diets shall be prescribed by the attending physician or resident physician in written orders on the patient’s chart. Orders for diet must be specific as in the case of limited sodium diets where the desired sodium content must be stated in either milligrams or grams.

3. All orders for restraints shall include the type of restraint, the reason for the restraint, the length of time (not to exceed 24 hours), and alternatives attempted. Such orders must be signed and dated by the physician at the time restraints are ordered. Emergency verbal orders must be signed within one hour of the nurse initiating restraints. Verbal orders for restraints must be signed by the physician within twenty-four (24) hours. PRN orders are not acceptable.
4. When restraints are used for behavioral reasons, the patient must be seen by a physician within one hour of initiation.

Physicians shall comply with Medical Center Policy No. 0079, Do Not Resuscitate (DNR) Orders and Medical Center Policy No. 0159, Restraint and Seclusion of Patients.

**Verbal Orders**

1. A verbal order is defined as an urgent or emergent order that has not been written and is relayed verbally from the physician, dentist or resident physician. Physicians shall comply with Medical Center Policy No. 0109, Physician Verbal Orders.

2. Only those practitioners specified in Medical Center Policy 0109 may accept verbal orders and these practitioners may do so only under the restrictions established by that policy.

3. Verbal orders must be signed with credentials of the person accepting the order, dated and timed, and flagged for signature by the responsible physician, dentist or resident physician.

4. The name of the practitioner who dictated the order must be documented.

5. All verbal orders must be signed, timed, and dated by the responsible physician, dentist or resident physician within 24 hours.

6. Unsigned verbal orders for controlled substances in Schedules II through V must be discontinued after 24 hours.
   - The responsible physician, dentist or resident physician must be notified by a nurse of the discontinuation.
   - Documentation of notification of the physician, dentist or resident physician must appear in the medical record.

**V CONSULTATIONS**

*Who May Give Consultations*

Any physician can be asked for consultation within his or her area of expertise. In circumstances of grave urgency, or where consultation is required by these Rules, as stated below, the President of the Clinical Staff, or the appropriate Department Chair, or the designee of either of the above, shall at all times have the right to call in a consultant or consultants. Physicians shall also comply with Medical Center Policy No. 0090, Physician Consultation Guidelines, with respect to all consultations.

*Required Consultations*

1. Consultations are required in all cases in which, in the judgment of the attending physician:
a. the diagnosis is obscure after ordinary diagnostic procedures have been completed,
b. there is doubt as to the choice of therapeutic measures to be utilized,
c. unusually complicated situations are present that may require specific skills of other practitioners, or
d. the patient exhibits severe symptoms of mental illness.

2. Department chairs shall regularly assess whether physicians have requested consultations appropriately.

Contents of Consultation Report

Each consultation report should contain a written opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient’s medical record. This report shall be made a part of the patient’s record. While the consultant may acknowledge data gathered by a resident physician, a limited statement, such as “I concur” alone does not constitute an acceptable consultation report. When operative or invasive procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations and so verified on the record. The consultation report shall contain the date and time of the consultation and the signature of the consultant.

Emergency Department Consultations

Specialists who are requested as consultants to the Emergency Department (ED) must respond in a timely fashion. In addition, any specialist who provides a consultation in the ED for a patient with an urgent condition is responsible for providing appropriate follow-up care. It is the policy of the ED that all patients are seen by an attending physician physically present in the ED. Resident physicians evaluating patients in the ED for the purpose of consultation are expected to confer with the responsible attending physician within their given specialty who is physically present in the ED; if such an attending is not physically present, the attending physician responsible for overseeing the patient’s care will default to the ED attending physician while in the ED. Any consultation provided by resident physicians shall be cosigned by the supervising physician. Requested consultation shall be provided to any patient at any time when such services are requested by the attending ED physician.

VI SUICIDAL AND/OR PSYCHIATRIC PATIENTS

Any patient known to have suicidal intent or who has a primary diagnosis of psychiatric disorder shall be admitted to the appropriate psychiatric unit unless the patient’s urgent medical needs require treatment on another unit. Any patient known or suspected to be suicidal or with a primary diagnosis of psychiatric disorder who is admitted to a non-psychiatric unit must have an emergency consultation by a physician in the Department of Psychiatry at the time of the admission. Physicians shall also comply with Medical Center Policy No. 0197, Suicide Precautions.
VII PATIENT DISCHARGE

Who May Discharge

Patients shall be discharged only on the order of the attending/covering physician. Should a patient leave the Medical Center against the advice of the attending physician or without proper discharge, a notation of the incident shall be made in the patient’s medical record and the patient will be asked to sign the Medical Center’s hospital release form. Physicians shall also comply with Medical Center Policies Nos. 0025, 0029 and 0102, pertaining to discharges.

Discharge of Minors and Other Incompetent Patients

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing, and the statement shall become a part of the permanent medical record of the patient.

Transfer of Patient

Patients may be transferred to another medical care facility after arrangements for transfer and admission to the facility have been made. Clinical records of sufficient content to ensure continuity of care shall accompany the patient.

Death of Patient

Should a patient die while being treated at the Medical Center, the attending physician should be notified immediately. A physician shall sign the medical certification portion of the death certificate within twenty-four hours of the patient’s death unless inquiry or investigation by a medical examiner is required by Virginia law. The physician shall notify the family and any referring physician of the death as soon as possible and assure that the organ procurement agency has been notified. Physicians shall comply with the requirements of Medical Center Policy No. 0014, Death Certificates, Fetal Death Reports and Consultation/Disposition Forms.

Autopsy

An autopsy shall be performed when:

1. The family requests an autopsy
2. The death falls within the jurisdiction of the Medical Examiner.
3. The attending physician requests an autopsy based on the College of American Pathologists criteria. This criteria includes:
   - unanticipated death,
- death occurring while the patient is being treated under a new therapeutic trial regimen,
- intra-operative or intra-procedural death,
- death occurring within forty-eight (48) hours after surgery or an invasive diagnostic procedure,
- death incident to pregnancy or within seven (7) days following a delivery,
- deaths where the cause is sufficiently obscure to delay completion of the death certificate,
- death in infants/children with congenital malformations,
- when the physician had not made a firm diagnosis,
- whenever death follows unexpected medical complications,
- when death follows dental or surgical procedures done for diagnostic purposes and when the cause does not come under the jurisdiction of a medical examiner or coroner or both,
- when there are concerns about a hereditary disease that might affect other family members,
- when there are concerns for the possible spread of contagious disease, and
- any other instance in which the physician feels an autopsy is desired.

4. No autopsy shall be performed without written consent of a responsible relative or authorized person unless inquiry or examination by the Medical Examiner is required by Virginia law.

5. The attending physician shall be notified whenever an autopsy is being performed.

Duties of the Physician for Obtaining an Autopsy

1. Determine whether the death falls within the jurisdiction of the Medical Examiner.

2. Obtain permits for organ donation when applicable. Physicians shall comply with Medical Center Policy No. 0098, Organ, Tissue and Eye Donation.

3. Documentation of request for autopsy must be completed, authenticated, and placed in the medical record.

Scope of Autopsy

1. The scope of the autopsy should be sufficient to answer all questions posed by the attending physician and by the pathologist, upon review of the clinical database.

2. The autopsy report should include: a summary of the clinical history, diagnoses, gross descriptions, microscopic descriptions, and a final summary that includes a clinical/pathologic correlation.

3. The autopsy findings should be promptly communicated to the attending physician along with all additional information the pathologist considers relevant to the case. The referring physician, as applicable, shall be notified of the results of the autopsy.

4. The results of autopsies will be monitored as a part of performance improvement.
VIII EMERGENCY PROCEDURE

Physicians shall follow the procedures specified in Medical Center Policies No. 0052, 0054, 0166, 0172 and 0175.

IX EMERGENCY MEDICAL SCREENING

Physicians shall follow Medical Center Policy No. 0214, which governs medical screening and stabilizing treatment for emergency medical conditions.

X RESIDENT PHYSICIANS

Resident physicians at the University of Virginia Medical Center shall not be eligible to become Members of the Clinical Staff and shall not be eligible to admit patients. Resident physicians are authorized to carry out those duties and functions normally engaged in by housestaff according to their defined job descriptions and/or scope of practice under the supervision of a physician. Supervision of resident physicians is required. Supervision includes, but is not limited to, counter signature in the medical record by the attending physician, participation by the resident physician in rounds, one-on-one conferences between the resident physician and attending, and the attending physician’s participation in and observation of care being delivered by the resident physician.

In the event of a life-threatening emergency, resident physicians may provide patient care independently when delay in initiating care would adversely affect the patient. In such situations, a supervising physician must be contacted to assist as soon as is reasonable.

Notwithstanding any other provision of the Amended and Restated Bylaws or these Rules and Regulations, all practitioners who hold clinical privileges in the Medical Center shall comply with these Rules and Regulations.

XI PEER REVIEW

All physicians shall be included in peer review processes conducted by individual departments. Evidence from these peer review processes shall be made available to the Credentials Committee and shall form the basis of credentialing decisions that affect the level of privileges approved for the physician at the Medical Center.

Peer review processes are appropriate to the specific clinical privileges held and include, but are not limited to, measurement, assessment and improvement of the following processes: medical assessment and treatment of patients; use of medications; use of blood and blood components; use of operative and other procedures; efficiency of clinical practice patterns and significant departures from established patterns of clinical practice.
XII  APPROVAL SIGNATURE

__________________________________
George A. Beller, M.D.
President, Clinical Staff and Chair,
Clinical Staff Executive Committee
University of Virginia Medical Center

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