These Rules and Regulations have been adopted by the Vanderbilt University Medical Center Medical Board which is a Medical Staff Peer Review Committee within the meaning of T.C.A. Section 63-6-219. The functions of the board include, among other things, the evaluation and improvement of the quality of health care rendered by Vanderbilt University Medical Center and the determination that health care services were performed in compliance with appropriate standards of care. The findings, conclusions, and recommendations formulated pursuant to these Rules & Regulations are privileged under T.C.A. Section 63-6-219, are not public records and receive all protection available under the law.
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I. DEFINITIONS:

A. Applicability of Definitions

The definitions applicable to these Rules and Regulations of the Vanderbilt University Medical Center (“VUMC”) Medical Staff are those stated in the VUMC Medical Staff Bylaws and the definitions set forth below. In the event of any inconsistency between a definition in the Bylaws and a definition in these Rules and Regulations, the definition in these Rules and Regulations shall control.

1. **House Staff:**
   All residents and clinical fellows who are in a postgraduate training program and under the supervision of a member of the Medical Staff who holds a faculty appointment with Vanderbilt University.

2. **Institutional Review Board:**
   The committee that, on behalf of the Accreditation Council for Graduate Medical Education, reviews institutions that sponsor residency programs in one or more specialties.

3. **Program Director:**
   The individual responsible in a Clinical Department for the oversight of a particular residency training program. The Program Director must be certified in the particular medical specialty that is the subject of the training, or possess other qualification acceptable to the Residency Review Committee, and must be physically located at the primary program teaching site.

4. **Residency Review Committee:**
   A committee composed of physicians from various institutions who have recognized expertise in residency education pertaining to a particular medical specialty. The Accreditation Council for Graduate Medical Education (“ACGME”) relies on twenty-six (26) such residency review committees for periodic review and improvement of ACGME standards for review of accredited residency training programs.

5. **Nursing Staff:**
   All registered nurses and licensed practical nurses as defined by the Tennessee Board of Nursing employed by Vanderbilt University Medical Center.

6. **Professional Staff:**
   All Advance Nurse Practitioners, Certified Registered Nurse Anesthetists, Certified Nurse Mid-wives, Physician Assistants,
Opticians, Psychologists, Psychological Examiners, Licensed Clinical Social Workers, Podiatrists, Doctors of Education, and Registered Dieticians or others holding privileges that are not a part of the Medical Staff at Vanderbilt University Medical Center.

7. **Responsibility of Attending Physician:**
Responsibilities of attending physicians set forth throughout these Rules and Regulations may be delegated to another appropriately qualified physician or to an appropriately qualified Allied Health Professional unless the responsibility is described as non-delegable, in which case the responsibility must be personally performed by the attending physician. The physician who delegates the actual performance of any attending physician responsibility to a designee is responsible for delegating the responsibility to an appropriately qualified individual and also remains ultimately responsible for the quality of performance of each responsibility delegated to another.

8. **Supervising Physician:**
A member of the Medical Staff who has been identified as accepting the responsibility for supervising a midlevel providers or providers on the midlevel provider’s scope of practice statement maintained in the midlevel provider’s credentials file.

II. **GENERAL REQUIREMENTS**
A. **Patient Admissions**
1. **Admitting privileges required:**
   A patient may be admitted to or discharged from a Vanderbilt University Medical Center (VUMC) hospital only by an attending physician or dentist (sometimes referred to herein as “Attending”) who is a member in good standing of the Medical Staff of VUMC and who has been granted admitting privileges. The requirement set forth above does not prohibit the admission of obstetric patients by Certified Nurse Midwives who are credentialed and hold clinical privileges for delivering babies.

2. **Diagnosis required:**
   Except in an emergency, no patient shall be admitted to VUMC until a provisional diagnosis or valid reason for admission has been determined and documented in the medical record. In an emergency, a provisional diagnosis shall be documented in the medical record within twenty-four (24) hours of admission. Relevant behavioral or mental health findings shall also be documented in the medical record.
3. **Admitting Office:**
The attending physician or physician designee shall notify the Admitting Office of all patient admissions.

4. **Categories of Admission:**
The attending physician or physician designee shall assign a category of admission to each patient that is appropriate to the patient's condition. Patients are admitted based on appropriate bed availability and in the following order of priority (see OP 10-20.02):
   a. Emergency (Immediate non-elective care necessary consistent with EMTALA requirements and VUMC policies regarding patient transfers (see CL 30-03.07).)
   b. Urgent (non-elective care necessary within forty-eight (48) hours)
   c. Elective (care can be provided at a future/planned date)
   d. Observation (observation is reasonable and necessary to evaluate an outpatient’s condition to determine the need for a possible admission as an inpatient. The observation service must be ordered by a physician and terminated by a physician and can be charged by the facility on an hourly basis (see OP 40-10.09).)
   e. All other admissions are on an elective basis and are dependent upon bed availability.

5. **Utilization management:**
The attending physician is responsible for documenting the medical necessity for admission and continued hospital stay for each of his or her patients. Attending physicians have the following utilization management responsibilities:
   a. Each history and physical examination shall clearly justify admitting the patient. If admission is on an emergency basis, medical necessity for the admission shall be recorded on the patient’s chart as soon as possible and within twenty-four (24) hours of admission. Medical necessity for continued stay shall be documented in the progress notes.
   b. When the patient's admission or continued hospitalization does not meet applicable utilization review criteria, the attending physician will provide additional information and documentation. In situations where a question of medical necessity remains after the attending physician provides additional documentation, the case is referred to a VUMC physician reviewer, according to the “UR Physician
Referral Process" as outlined in the Utilization Review Plan.
c. Utilization Management shall be contacted if a patient is admitted under the Observation category as defined above.

B. Patient Transfers
1. Initial orders and transfers:
The admitting physician is responsible for initial orders necessary for a patient's care when the patient is first admitted to a VUMC hospital. When a patient’s needs are such that they can be better met by another physician or service, the patient is transferred to another appropriate physician. A patient may not be transferred from one service within VUMC to another, or from VUMC to another facility without a documented order by the transferring physician, and documented acceptance by the receiving physician in the receiving service or facility.

2. Emergency screening and stabilization required:
Each patient that presents to the Emergency Department shall receive a medical screening exam and appropriate stabilization in compliance with all applicable state and federal regulations and VUMC policy. Patient transfers from VUMC to another facility, whether from the Emergency Department or from an inpatient unit are conducted in accordance with OP 10-40.25. Documentation must include the reasons for the transfer, the risks and benefits to the patient, medical necessity of transfer, consent by patient when appropriate, acceptance by the receiving facility and accepting physician and any other documentation required by state and federal law.

3. Transfer to a different bed:
All transfers of patients to different beds must be approved by the Admitting Office.

4. Patient transfer priorities:
The priorities for patient transfer are as follows:
   a. Patients being transferred from the Emergency Room to an appropriate patient bed, then
   b. Patients being transferred from Intensive Care Units to general care areas, and finally
   c. Patients being transferred from temporary placement in a non-service geographic or clinical service area to the appropriate area for that patient.
C. History and Physical Examination (“H&P”)

1. The attending physician is responsible for a complete initial assessment and H&P which is documented in the patient’s medical record in accordance with the requirements of Medical Records Policy MR 07-05. In the event that the attending physician delegates the performance of the H&P to a mid-level practitioner or House Staff, the attending physician reviews and attests to the H&P as soon as possible but no later than within twenty-four (24) hours of completion of the H&P by the mid-level practitioner or House Staff member. A dictated H&P performed by the attending physician must be signed (authenticated) within fourteen (14) days.

The history and physical examination report shall result in a durable and legible document that contains pertinent and accurate information involving the data elements:

a). History:

The information obtained by the interviewer is organized into a comprehensive statement about the patient’s health. It is recommended that the interviewer proceed through each of these major sections in a logical sequence and direct the questions relevantly to each area. The format of the history is as follows:

- Chief complaint
- History of present illness
- Past medical history
- Medications
- Allergies
- Family history
- Social history
- Review of systems

b.) Physical Examination:

Similar to the history, the information obtained by the physical examination is organized into a comprehensive picture of the patient’s health. The exam should consider, but not be limited to the following systems:
- Vital Signs
- Mental Status
- Head & Neck
- Cardiovascular
- Respiratory
- Abdominal
- Genitalia
- Rectal
- Musculoskeletal
- Neurological

c.) Statement of Conclusion or Impressions

The following persons may perform and complete a history and physical report:

- Physician
- Advanced Practice Nurse
- Physician assistant
- House Staff

**Inpatient Admissions**

The history and physical report shall be completed and recorded in the chart within 24 hours after admission. If the report is completed by someone other than a physician, a physician must approve or amend and sign the report within twenty-four (24) hours after admission.

**Surgical or Other Invasive Procedure**

Non-emergency Cases

(a.) All patients that fit the following criteria shall have a current or amended history and physical report in the chart prior to the procedure:

(i) a patient undergoing a surgical or other invasive procedure in an operating room

(ii) a patient undergoing an invasive intravascular procedure
(iii) a patient undergoing an endoscopic procedure on these premises

(b). All patients undergoing a therapeutic or diagnostic procedure that requires the use of general anesthesia shall have a current or amended history and physical report in the chart prior to the procedure.

(c.) Questions shall be directed to either the Chief Medical Officer or Department Chief for clarification prior to the beginning of a surgical or other invasive procedure.

**Emergency Cases**

The patient record shall have all pertinent information necessary to perform the procedure.

**Other**

All patients undergoing a procedure in an area in which a complete history and physical report is not required, as outlined above, shall have the following minimum required elements in place prior to the procedure being performed:

(a.) significant past medical history
(b.) allergies
(c.) current medications
(d.) diagnosis

2. **Consultations:**
A consultation may be acceptable as a history and physical examination if it meets the above requirements.

3. **Review of House Staff entries:**
The attending physician shall review each H&P performed and documented by a medical student or member of the House Staff for accuracy and quality.

**D. Responsibility for Care**

1. **Attending Physician:**
The attending physician is responsible for the care and treatment of each patient (within the scope of the Attending’s professional license and clinical privileges granted) that (s)he admits to
VUMC. Each attending physician of the Medical Staff shall provide, or arrange for, timely and professional quality care for his/her patients. Each attending physician or his/her physician designee is responsible for the prompt completion and accuracy of the medical record for each of his/her patients, for obtaining informed consent, for necessary special instructions, and for communicating the patient’s condition and treatment plan to the patient, referring physician (as appropriate) and to the relatives of the patient. Certified Nurse Midwives (“CNM”) with appropriate privileges may serve as the admitting provider for obstetric patients with the concurrence of an attending physician. In such cases, the admitting CNM has the documentation and patient care responsibilities of the attending physician described above, and shall seek the assistance of, and be under the supervision of, the obstetrician on service as necessary and appropriate.

2. Coverage:
Each attending physician shall comply with his or her Departmental requirements regarding taking call. Each attending physician shall be available to his/her patients personally or shall arrange for coverage by covering attending physician who has all necessary privileges at VUMC. Attending physician cross coverage may only be established with another physician who is a member of the Medical Staff and possesses the necessary privileges to properly care for the attending physician’s patient(s). Failure by an attending physician to arrange for appropriate coverage for his/her patients when necessary may result in loss of privileges.

3. Transfer of patient care to a different attending physician:
Whenever the responsibility for a patient’s care is transferred from one attending physician to another, the transferring attending physician shall document the transfer of responsibility on an order sheet and a progress sheet in the patient’s medical record. The transferring attending physician is not relieved from duty to care for a patient until the receiving attending physician has accepted responsibility for the patient’s care documented his/her acceptance on the progress sheet. This process does not apply to routine cross coverage arrangements. The attending physician is responsible for notifying appropriate parties, including message center and House Staff, prior to transferring care of any patient to another attending physician.
E. Supervisory Duties

1. House Staff:

House Staff are not granted independent practice privileges and require supervision by a member of the Medical Staff. The nature and scope of the supervision is determined by the Program Director within the context of the relevant Residency Review Committee. Supervision of House Staff is appropriate to level of training, experience and competency. The attending physician is responsible for clinical supervision. The Program Director is responsible for educational supervision. In all cases, the Chief of the Service to whom the House Staff member is assigned is ultimately responsible for the supervision of each House Staff member in the teaching program. All House Staff are allowed to perform the following activities without direct supervision:

a. Admit and discharge patients upon request of an attending physician
b. Perform a complete history and physical examination and record same in the patient’s medical record, which entries are reviewed and countersigned by the supervising physician within twenty-four (24) hours.
c. Perform basic cardiopulmonary resuscitation and other routine patient care procedures as directed by a supervising physician member of the Medical Staff, such as venipuncture, placing a cannula for intravenous infusion, documenting orders for therapeutic agents on the VUMC formulary, performing diagnostic procedures, and performing consultations.

2. Physician Assistants:

A physician assistant (“PA”) is authorized to perform selected medical services only under the supervision of a member of the Medical Staff. The following rules apply to services performed by a PA:

a. Physicians who have accepted the responsibility for supervising a PA shall be available for consultation with the PA at all times or shall make arrangements for a covering physician to be available. Supervision of a PA requires active and continuous oversight by the supervising physician to see that his/her directions and advice are implemented.
b. The nature and scope of services (including prescribing medications) that may be provided by each PA are set forth in written protocols developed by the PA and the supervising physician.
c. A PA may perform only those tasks that are within the PA’s range of skill and competence and are within the supervising physician’s usual scope of practice.

3. **Advanced Practice Nurses:**
An advanced practice nurse (“APN”) is authorized to perform selected medical services only under the supervision of a member of the Medical Staff who is designated as a Supervising Physician of the APN (“Supervising Physician”). The rules pertaining to supervision of services performed by an APN are as follows:

a. Physicians who have accepted the responsibility of serving as a supervising physician for an APN shall be available for consultation with the APN at all times or shall make arrangements for coverage by another Supervising Physician.
b. APNs who manage the medical aspects of a patient’s care must have written protocols, jointly developed by the APN and the Supervision Physician(s).
c. Only APNs who hold required certification may prescribe and/or issue non-controlled legend drugs.
d. Only APNs who hold the required certification to prescribe and/or issue controlled substances and who have jointly with the Supervising Physician developed supervisory rules concerning controlled substance prescription as required by Tennessee law, may prescribe and/or issue controlled substances.
e. The Supervising Physician must also review a minimum of twenty percent (20%) of the APN’s medical records for quality and compliance with approved protocols.

4. **Midlevel Provider members of the admitting/attending service in the Inpatient Setting (excluding Certified Nurse Midwives)**

a. Midlevel Providers (Advanced Practice Nurses and Physician Assistants) who hold a faculty appointment and appropriate credentials, scope of practice and protocol guidelines may serve as billing provider members of an admitting/attending service in the inpatient setting at VUMC.
b. A Midlevel Provider does not admit or serve as the attending provider for any patient, but may care for patients admitted by physicians who are members of the Active Medical Staff and who are designated as supervising physicians for the Midlevel Provider.

c. Midlevel Providers may perform admission evaluations, daily visits, and discharge functions within their scope of practice and approved protocol guidelines. They must enter admission notes, daily progress notes, and discharge summaries into the medical record on the day of the service.

d. Admission notes (which must include the plan of care), progress notes, and discharge summaries must be countersigned by the Attending Physician within 24 hours. The Attending Physician must visit the patient within 24 hours of admission, daily, and on the day of discharge. All notes entered into the medical record by the Midlevel Provider member of the attending service must be countersigned by the Attending Physician within 24 hours, signifying the approval of the plan of care as well as the fact of the visit. In addition, the Attending Physician will confirm the facts of the Admission Note, including the history and physical exam.

5. **Inpatient services provided by Midlevel Provider members of other consultative services**

a. Midlevel Providers who hold a faculty appointment and appropriate credentials, scope of practice and protocol guidelines may provide consultative serves as billing providers members of a consultative service in the inpatient setting at VUMC provided that a supervising physician reviews and documents concurrence with the consultant’s recommended plan of care within the time frame requested by the requesting service and, in the case of ongoing consultative service beyond an initial consult visit, that the supervising physician review and countersign all notes entered into the medical record by the Midlevel Provider within twenty-four (24) hours or within the time frame requested by the requesting service.
b. Midlevel Provider members of the TPN, Palliative Care and other consultative services as approved by the Medical Center Medical Board who hold a faculty appointment and appropriate credentials, scope of practice and protocol guidelines may provide consult services as billing providers to inpatients at VUMC with more limited physician supervision. These Midlevel Providers may perform consult evaluations and daily visits within their scope of practice and approved protocol guidelines. They must enter consult notes and daily progress notes into the medical record on the day of each service. A supervising physician must review and document concurrence with the overall plan of care for each patient being followed by a consultative service within forty-eight (48) hours in addition to meeting all supervisory requirements set forth in subsection E.3 above, but there is no requirement that other notes entered into the medical record by the Midlevel Provider member of the consultative service be countersigned by the Midlevel Provider’s supervising physician.

F. Consultations
1. **Consult request and response time:**
   For assistance with patient care from another department, an attending physician can request a consultation through the department's consultation service. If the Attending requests an emergency consult, the consultant responds as soon as possible, subject to conflicting emergency situations. If the attending physician indicates the request is non-emergent, the assisting consultation takes place and is documented within twenty-four (24) hours.

2. **Consult and response documentation:**
   The attending physician is responsible for requesting a consultation. The request for the consult, the consultant’s note and the Attending’s response to the consult is documented in the medical record.

3. **Surgical consult:**
   When a consult is requested in connection with an operative procedure, the consultation shall be performed and documented prior to the operation, except in emergency situations, which must be documented in the record.
4. **Psychiatric consult required:**
The attending is responsible for requesting a psychiatric consultation for any patient who is thought to be or has demonstrated a suicidal or homicidal risk.

5. **Consultant responsibility limited:**
Consultants do not assume overall responsibility for the patient. Consultants may document orders consistent with the patient's current plan of care and limited to the consultant's area of special expertise within the scope of the consultation.

6. **Authority to provide consults:**
In general, only physicians who are members of the Medical Staff of VUMC, and Nurse Practitioners or Physician Assistants who are members of the Professional Staff of VUMC, and within the scope of their approved written protocols, are permitted to serve as consultants. In special situations, other qualified physicians may be granted temporary or single case privileges to serve as consultants on a patient upon request.

7. **Consultation necessary/Quality of Care:**
If any physician or other licensed health care professional believes that consultation is needed for a particular patient and has not been obtained, or has any reason to doubt or question the care provided to any patient, (s)he shall call this to the attention of Chief of Staff. If warranted, the supervisor, Chief Nursing Officer or the Chief of Staff may bring the matter to the attention of the Attending. If the Attending fails to appropriately respond, the matter shall then be reported to the Attending’s Chief of Service. The Chief of Service, or Chief of Staff, may request the consultation directly, or may otherwise order or provide necessary care for the patient.

G. **Informed Consent**

Informed consent must be obtained from each patient or the patient's legally authorized representative prior to any invasive diagnostic, therapeutic, or operative procedure, or any procedure or treatment which presents a significant risk to the patient. Obtaining informed consent is a process by which the nature of the treatment or procedure, the risks, possible complications, expected benefits or effects, risk of no treatment, as well as alternatives to the treatment or procedure, and other information as may be required, are explained to the patient in terms understandable to the patient. The attending physician, or proceduralist (as defined in Informed Consent Policy OP 20-10.17) is responsible for
providing the patient with all information regarding the proposed treatment or procedure necessary for the patient to understand the risks and potential benefits of the proposed treatment or procedure in order to be able to make an informed decision, for documenting the specific risks, benefits and alternatives explained during the informed consent discussion, and for obtaining the patient’s signature on consent forms. If a patient is to receive preoperative medication, the patient must sign the consent form prior to administration of the preoperative medication. The responsibility for obtaining the patient’s signature on the consent form may be delegated by the attending physician to a member of the House Staff, Nursing Staff or other Professional Staff member provided there is documentation in the medical record that the Attending has obtained informed consent. The consent form must be signed by the attending physician and another witness.

H. **Emergency Exception to Informed Consent**

In the event that a patient, due to his/her medical or mental condition, is unable to give consent for a necessary special procedure, treatment or a surgical procedure, and there is no legal representative or surrogate decision maker immediately available to give consent, treatment may be undertaken to avoid death or serious harm or pain to the patient. These circumstances must be fully documented in the patient's medical record. A consultation in such instances is desirable before the emergency procedure is undertaken, if time permits.

I. **Discharges**

1. **Discharge by attending physician:**
   Patients shall be discharged only pursuant to the order of the attending physician responsible for the patient's care or his/her physician designee (see CL 30-05.06). The provision above does not prohibit the discharge of obstetric patients admitted by Certified Nurse Midwives from being discharged by the admitting Certified Nurse Midwife.

2. **AMA Discharge:**
   Prior to a potential Against Medical Advice (AMA) discharge, the physician must explain, or attempt to explain, to the patient the risk and benefits of leaving the hospital. When the patient leaves the hospital against the advice of his/her Attending or dentist, the attending physician or his/her designee must make a notation of the incident in the patient's medical record. The Attending shall document a patient’s AMA discharge in accordance with hospital policy.
III. MEDICAL RECORDS

A. Attending Physician Responsibility

The attending physician is responsible for documenting his/her own examination, opinion and recommended treatment in each patient’s medical record, and assuring that a complete and legible medical record is prepared for each patient and that it contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment and promote continuity of care among healthcare providers.

B. Documentation Requirements

1. Minimum requirements:
   Each medical record shall include, at a minimum, the following:
   a. demographic data;
   b. medical complaint;
   c. history and physical examination;
   d. consultations, clinical laboratory and radiology results and other diagnostic service, medical and surgical treatment;
   e. operative reports, pathologic findings;
   f. progress notes and orders;
   g. final diagnosis;
   h. condition on discharge;
   i. discharge note or summary;
   j. when performed, an autopsy report;
   k. pain;
   l. problem list; abuse.

2. Legible handwriting and pager number required:
   Attending physicians and House Staff shall legibly sign, or electronically enter, entries in the medical record. House Staff shall sign all entries in the medical record legibly and include their pager number following their signature.

3. Medical Record Completion:
   Procedures for appropriate documentation and other matters pertaining to medical records are contained in the VUMC Medical Records Manual. This manual is incorporated herein by this reference and members of the Medical Staff are hereby required to comply with the Medical Records Manual, including but not limited to the following requirements:
   a. When possible, records shall be completed before leaving the patient unit. Any medical record not completed within
fourteen (14) days of the date of discharge of the patient is a delinquent record.

b. The attending physician must complete all required documentation in the medical record before it may be permanently filed, or be considered complete. In the event the Attending dies or is otherwise unavailable permanently or protractedly, the Chief of Service or his/her designee shall complete the medical record.

4. **Progress Notes:**
   Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and appropriate and safe patient transfer. Each of the patient's known clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Inpatient progress notes shall be documented at least daily. All clinical entries in the patient's medical record shall be accurately dated and signed. Whenever possible, documents placed in a patient's medical record should be originals.

5. **Surgical Reports:**
   Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. (see MR 07-14)

6. **Obstetrical Record:**
   The current obstetrical record shall include a complete pre-natal record. For patients transferring to VUMC from another facility, as much pertinent information as can be obtained from the transferring facility is included in the record.

7. **Symbols and Abbreviations:**
   Symbols and abbreviations on the “Do Not Use” list approved by the Medical Record Committee are not used in the medical record. The official “Do Not Use” list is maintained in the Medical Record Department and in the Medical Record Manual.

8. **Discharge Summary:**
   A narrative discharge summary shall be documented in the final progress note for each patient discharged from VUMC, which shall include the following elements:
   a. Patient name
   b. Medical record number
   c. Attending physician name
   d. Date of discharge
   e. Final diagnoses
f. Reason for admission, including a brief clinical statement of the chief complaint and history of the present illness

g. Pertinent physical, laboratory, x-ray and other diagnostic procedures and studies

h. Medical and/or surgical treatment, including the patient's response, and complications

i. Consultations

j. Condition on discharge, including, for example ability to ambulate, degree of self-care, and ability to work

k. Instructions for continuing care, including information on diet, medications, activities and provider follow-up.

9. **Brief Discharge Note Sufficient:**
A brief discharge note, which includes the diagnosis, treatment, discharge plan, medications and other follow-up care, is sufficient for the following categories of patients:

   a. Newborn infants
   b. Routine obstetrical patients
   c. Healthy volunteers who participate in research protocols through the Clinical Research Center

10. **Discharge Summary for deceased patient:**
A complete summary is required on all cases in which the patient expired, regardless of the length of time the patient was hospitalized.

C. **Ownership of Medical Records**

   1. **Medical Records are Property of VUMC:**
   All records relating in any way to the performance of physician's professional responsibilities to patients of VUMC, including without limitation all clinical, medical or business records and related patient information, patient records and patient lists ("VUMC Records"), shall be and remain the sole property of VUMC to the extent permitted by law.

   2. **Removal of Records from VUMC Premises:**
   The medical record may be removed from VUMC only with the permission of the Vice Chancellor for Health Affairs or his/her designee, or in accordance with a valid court order, subpoena, or statute, or other purpose required by law. Unauthorized copying or removal of medical records from VUMC is grounds for suspension of the physician.

   3. **Patient Requests for Records:**
   Patients, or their authorized representative, may obtain copies of
the information in the medical record in accordance with VUMC policy.

4. **Return of Records Upon Termination:**
   Upon termination of Staff Membership, a physician shall immediately return to VUMC all copies and duplicates of VUMC Records, including without limitation VUMC Records on computer disks, printouts, paper copies or electronic means of storage, that physician has under his/her direction or control and shall not make or retain any copies. Only upon signed authorization by the patient or patient’s legal representative may a copy of the patient’s records be sent to the physician.

D. **Access for Research**
   With the approval of the attending physician, clinical staff in good standing performing bona fide study and research conducted under research protocols approved by the Institutional Review Board shall have free access to all medical records of appropriate patients, with the understanding that they will protect the confidentiality of personal information.

E. **Information System /Electronic Medical Record Access**
   Access to the VUMC Information System is provided to members of the Medical Staff in accordance with the VUMC Confidentiality Agreement. Each member of the Medical Staff is required to enter into the Confidentiality Agreement, arrange for system access, and maintain the confidentiality of the information accessible through the system.

F. **Confidentiality of Information**
   Protected patient information may not be accessed, disclosed or released to any person other than individuals involved in caring for the patient, the patient’s legally authorized representative(s), individuals authorized by the patient to receive his/her patient information, or in accordance with federal and state law and VUMC OP 10-40.01: Confidentiality of Protected Patient Information.

G. **Emergency Service Documentation**
   An Emergency Department attending physician initially serves as the attending physician for each patient admitted to the Emergency Department. The patient’s care may be transferred to the patient’s personal attending physician or an attending physician with another service who is physically present and personally assumes primary responsibility for the patient. An attending physician may assume care of an admitted patient through the physical presence of his or her House Staff member in the Emergency Department. Assumption of care of the patient by the attending physician occurs upon documentation by the
House Staff that he or she represents the attending physician and is functioning under the auspices of such attending physician. The patient’s attending physician at the time of disposition is responsible for documenting disposition of the patient in the Medical Record. Advance Practice Nurses and Physician Assistant’s may complete medical screenings pursuant to approved written protocols (see MR 07-13).

H. **Failure to Complete Medical Records**

1. **Written and Phone Notification:** Medical Staff Members who fail to meet the medical records documentation requirements in this Article III above and in the VUMC Medical Record Manual are notified by a representative of Medical Information Systems by phone call and/or email of the need to complete delinquent documentation, and are given an opportunity to complete the delinquent documentation within twenty-four (24) hours of this notification.

2. **Administrative Actions for Failure to Complete Medical Records:**
   
   a. **Delinquent Procedural Notes/Administrative Hold on Scheduling Elective Procedures:** In the event that a Medical Staff member fails to complete a delinquent procedural note within twenty-four (24) hours of notification by Medical Information Systems that the note is delinquent, VUMC automatically imposes a temporary hold on the Medical Staff member’s ability to schedule elective procedures. Elective procedures scheduled prior to this hold are not affected. The hold on scheduling elective procedures is triggered upon notice by Medical Information Services to the applicable Chief of Staff and appropriate Operative Services personnel when Medical Information Services verifies that the note in question is not complete by the end of the twenty-four (24) hour notice period described above. This hold on ability to schedule elective procedures is released upon notice by Medical Information Systems to appropriate Operative Services personnel and the applicable Chief of Staff that the procedural note in question is complete.

   b. **Delinquent Inpatient Documentation/Administrative Hold on New Admissions:** In the event that a Medical Staff member fails to complete a discharge summary or other inpatient documentation within twenty-four (24) hours of notification by Medical Information Systems that the documentation is delinquent, VUMC may impose a temporary hold on the Medical Staff member’s ability to admit new patients at VUMC. This hold on ability to admit is triggered upon notice by Medical Information Services to the applicable Chief of Staff and appropriate hospital operations personnel when Medical Information Services verifies that the documentation in question is not complete by the end of the twenty-four (24) hour notice period described above. This hold on ability to admit is released upon notice by Medical Information Systems to appropriate hospital operations personnel and the applicable Chief of Staff that the documentation in question is complete.
3. **Non-Reportable Administrative Action:** The automatic consequences described in sub-sections 2.a. and 2.b. above constitute administrative actions that do not require reporting to the National Practitioner Data Bank, or other professional board or body, nor shall such an administrative action constitute an adverse recommendation as defined in Hearing and Appellate Review Procedures of the VUMC Medical Staff Bylaws (Article XII).

4. **Corrective Action:** Any Medical Staff member, who fails to correct deficiencies in medical record documentation after the informal problem resolution actions set forth in Article X of the VUMC Medical Staff Bylaws, shall be subject to Corrective Action, including suspension of privileges under Article XI of the VUMC Medical Staff Bylaws.

### IV. TREATMENT AND THERAPEUTICS

#### A. Physician’s Orders

1. **Authority to initiate orders:**
   Only Medical Staff members, House Staff and Professional Staff within the authority of their approved protocols have the authority to order treatment, tests and procedures for patients. *(see MR 07-04)*

2. **Blanket reinstatement of orders:**
   Blanket reinstatement of previous orders (or a summary order to resume all previous orders) for medication are not acceptable.

3. **Orders automatically cancelled:**
   All previous orders are automatically canceled when a patient goes to the operating room, is transferred to another clinical service, or changes level of care. New orders must be documented for such patients after transfer or other change in level of care. *(See Section II References - DNR Policy OP 20-10.05)*

4. **Documentation required:**
   All orders for treatment shall be documented in writing or electronically through the electronic order entry system.

5. **Verbal/phone orders:**
   Verbal communication of orders and test results should be limited to situations where immediate written or electronic communication is not feasible. Members of the Medical Staff and House Staff may communicate verbal orders or phone orders only to authorized recipients. The recipient of a verbal order shall document the order verbatim and shall read the order back to the ordering physician. After confirming the accuracy of the order, the recipient of the order shall sign the order as the transcriber and shall record the date and time and name of the dictating physician.
The prescribing/ordering physician shall authenticate each verbal/phone order for an in-patient within forty-eight (48) hours of issuing the order, and at the time of service or the end of business day for outpatient services, but no later than within forty-eight (48) hours when a delay is necessary. The following individuals are authorized to receive verbal/phone orders:

a. Registered Nurses (RNs) may accept verbal orders or telephone orders.

b. Registered Pharmacists may accept verbal or telephone orders for medication.

c. Licensed Respiratory Care Therapists and Technologists (RRTs and CRTTs) may accept verbal or telephone orders within the scope of their license.

d. Licensed physical and Occupational Therapists and Speech Therapists may accept verbal or telephone orders for physical, occupational and speech therapy within the scope of their license.

e. Registered Dieticians may accept verbal or telephone orders for diet instructions or diet changes.

f. Licensed Clinical Social Workers (LCSWs) may accept verbal or telephone orders for discharge planning.

g. Registered Radiologic and Nuclear Medicine Technologists may accept verbal or telephone orders within the scope of their license.

h. Licensed Practical Nurses in ambulatory care settings may accept verbal orders and telephone orders.

i. See also: Verbal/Telephone Orders/Test Results - CL 30-05.02

B. Drugs

1. Approved drugs:
All drugs and medications administered to patients are US Pharmacopoeia, National Formulary, and FDA approved with the exception of investigational new drugs (IND) which are approved by The Committee for Protection of Human Subjects (Health Sciences). Any drug, not included in the categories above, must be approved by the Pharmacy & Therapeutics (P&T) Committee before it may be prescribed for a VUMC patient.

2. Metric system:
The metric system is used in prescriptions and drug orders.

3. Formulary:
VUMC maintains an official Formulary, which is available in
each patient care area. The formulary is approved by the Medical Staff. The drugs included in the formulary satisfy VUMC’s therapeutic requirements, are appropriate for a teaching and research environment, and are cost effective. There are four (4) tiers of drugs in the Formulary:

a. **Tier One:** These items are approved for use broadly, by any physician, without monitoring or requiring consensus of another physician.

b. **Tier Two:** These medications and other pharmaceuticals are approved for use by any physician, but the use of these items will be monitored as part of the P & T Committee's ongoing requirement to provide drug use evaluation. Examples of items, which will be monitored, include those that are high cost, high risk, and/or high use. The evaluation criteria for monitoring and methods of reporting is determined by the Medical Staff with input from pharmacy and nursing.

c. **Tier Three:** These medications and pharmaceuticals are extremely toxic, extremely costly or rarely used. Use of these medications is limited to specific physicians because of extreme expense (i.e. TPA) because of extreme risk (i.e. unusual antidotes) because of specialized use (i.e. botulism antitoxin for treatment or unusual hormones for treatment of endocrine disorders) or specialized indication (i.e. investigational drugs). Every agent proposed for Tier Three is in a consensus developing process with the prescribing physicians.

d. **Tier Four:** Tier Four items are not on the VUMC formulary. Tier Four medications and other Pharmaceuticals are not approved for use at VUMC and are not stocked in the Pharmacy. Tier Four items can be made available for unique individual patient situations. A physician who wishes to obtain a Tier Four item for a particular patient must complete a non-Formulary request form and forward it to a pharmacist. A twenty-four (24) hour wait is usually necessary for acquisition of a Tier Four product. The P & T Committee will perform appropriate monitoring of non-Formulary agents.

4. **Abbreviations:**
Drugs should be prescribed by full name. Abbreviations for drug
names are discouraged. However, drug abbreviations listed in the VUMC Formulary, may be used in prescribing medications.

5. **Schedule II drugs:**
   All Schedule II drug orders are automatically canceled after seventy-two (72) hours. Schedule II controlled drug orders may be renewed as necessary.

6. **Formulary:**
   Refer to the VUMC Formulary for further information regarding drugs selection, dosage and administration.

**C. Rules for Procedures that Require Anesthesia Support**

1. **Supervising Anesthesiologist:**
   The Anesthesiologist-in-Chief or designee shall assign a supervising anesthesiologist for all surgical cases that require anesthesia support and monitoring.

2. **Attending surgeon to be present prior to administration of anesthesia:**
   Except in emergencies, anesthesia will not be initiated until the attending surgeon is present at VUMC.

3. **Anesthesia Ready Time policy:**
   The attending surgeon should be ready to begin the operation after initiation of anesthesia and in accordance with the Anesthesia Ready Time and other policies as established by the Operating Room Committee.

4. **Preoperative documentation:**
   The preoperative diagnosis, required laboratory tests, and a history and physical exam must be recorded in the patient's medical record prior to any surgical procedure, except in the event of an emergency, in which case the surgeon shall certify in the medical record that a delay incurred for this purpose constituted a hazard to the patient. (See MR 07-19)

5. **Removed tissue:**
   All tissue or other material removed during an operation (except hardware or teeth and tissues removed during routine dental extractions in the outpatient department) shall be sent to the Surgical Pathology Laboratory. A completed "Pathology Examination Request Form", including appropriate clinical data, shall also be sent following every operative procedure involving removal of tissue from the patient. The pathologist is responsible for examination and interpretation of specimens and for consultation with the Surgical Case Review Committee when
indicated. No specimen may be removed from VUMC premises without review and documentation by a VUMC pathologist.

6. **Informed consent:**
A surgical procedure shall be performed only with the informed consent of the patient or the patient’s surrogate decision maker. However, in an emergency or when informed consent cannot reasonably be obtained from the patient, the responsible surgeon shall document on the consent form the reasons why the operation must proceed immediately to protect the and safely of the patient and that delay to obtain consent would constitute an unacceptable detriment to the patient. (See OP 20-10.17)

7. **Operative note/report required:**
A brief operative note or a final operative report must be recorded in the progress notes immediately after the procedure is performed. (see MR 07-14) If a final operative report is not completed and available in the patient’s medical record immediately after the procedure, it must be completed and available in the patient’s medical record within twenty-four (24) hours of the procedure.

8. **Confirmation of tissue diagnosis:**
When a relevant tissue diagnosis has been made by a pathological laboratory of another hospital, the diagnostic material must be reviewed and the diagnosis confirmed by a VUMC pathologist before the patient receives treatment at VUMC. This requirement may be waived if, in the judgment of the attending physician, circumstances indicate the need for immediate treatment.

9. **Confirmation of tissue diagnosis not feasible:**
If confirmation of a tissue diagnosis is not feasible before radiation therapy, chemotherapy and/or surgery is instituted, a consultation is obtained from a member of the appropriate clinical service to determine the procedure to be followed before instituting therapy. (Reasonable efforts shall be made to obtain a tissue or hematological diagnosis for the medical record of the patient.)

10. **Clinical Policies and Procedures:**
Medical Staff are responsible for adherence to all clinical policies and procedures, including without limitation, Identification of Correct Patient, Procedure, Site and Side. (see CL 30-04.16)

**D. Other Procedures**

1. **Pre-procedure documentation:**
The diagnosis, required laboratory tests, and a history and
physical exam must be recorded in the patient's medical record prior to any invasive procedure, except in the event of an emergency, in which case the proceduralist shall certify in the medical record that a delay incurred for this purpose constituted a hazard to the patient. (See MR 07-19)

2. **Removed tissue:**
   All tissue or other material removed during a procedure except Exempt Tissue/Material described in the Submission of Surgical Specimens to Pathology policy OP: ______________ shall be sent to the Pathology Department for examination. Each submission to the Pathology Department shall include completion of a pathology examination request form to provide appropriate clinical data to the pathologist. The pathologist is responsible for examination and interpretation of specimens and for consultation with the appropriate case review committee when indicated. No specimen may be removed from VUMC premises without review and documentation by a VUMC pathologist unless the tissue is sent for examination to an outside pathology laboratory approved by the VUMC Pathology Department.

3. **Informed consent:**
   An invasive procedure shall be performed only with the informed consent of the patient or the patient's surrogate decision maker. However, in an emergency or when informed consent cannot reasonably be obtained from the patient, the responsible proceduralist shall document on the consent form the reasons why the procedure must be undertaken immediately to protect the and safely of the patient and that delay to obtain consent would constitute an unacceptable detriment to the patient. (See OP 20-10.17)

4. **Procedure note/report required:**
   A brief operative note or a final operative report must be recorded in the progress notes immediately after the procedure is performed. (see MR 07-14) If a final operative report is not completed and available in the patient’s medical record immediately after the procedure, it must be completed and available in the patient’s medical record within twenty-four (24) hours of the procedure.

5. **Confirmation of tissue diagnosis:**
   When a relevant tissue diagnosis has been made by a pathological laboratory of another hospital, the diagnostic material must be reviewed and the diagnosis confirmed by a VUMC pathologist
before the patient receives treatment at VUMC. This requirement may be waived if, in the judgment of the attending physician, circumstances indicate the need for immediate treatment.

6. **Confirmation of tissue diagnosis not feasible:**
   If confirmation of a tissue diagnosis is not feasible before radiation therapy, chemotherapy and/or invasive procedure is instituted, a consultation is obtained from a member of the appropriate clinical service to determine the procedure to be followed before instituting therapy. (Reasonable efforts shall be made to obtain a tissue or hematological diagnosis for the medical record of the patient.)

7. **Clinical Policies and Procedures:**
   Medical Staff are responsible for adherence to all clinical policies and procedures, including without limitation, Identification of Correct Patient, Procedure, Site and Side. (see CL 30-04.16)

V. **DEATH/AUTOPSIES**

A. **Deaths**

1. **Inpatient death:**
   In the event of an inpatient death, the attending physician or physician designee shall make the official pronouncement of death within two (2) hours of learning of the patient’s death, and shall document the patient’s death in the medical record. It is the responsibility of the attending physician or physician designee to inform the decedent’s next of kin.

2. **Release of body:**
   A decedent’s body shall not be released from the patient unit until the attending physician or physician designee has documented the death in the medical record and signed it. Exceptions can be made in those instances of incontrovertible and irreversible terminal disease wherein the patient’s course has been adequately documented within a few hours of death. VUMC complies with all applicable state and local law regarding certification of death, release of dead bodies from VUMC, and the reporting of deaths to the medical examiner under circumstances required by state law to facilitate the performance of inquests. (see MR 07-12)

3. **Report of Death form:**
   A Report of Death form is completed in Star panel by the physician in charge of the patient’s care for the illness or condition that resulted in death within forty-eight (48) hours of the patient’s death. The Medical Examiner will assume the
responsibility for signing the Death Certificate when the case has been accepted by their office.

B. Autopsies

1. Autopsies performed when possible:
   Autopsies provide valuable information to assist with evaluating healthcare quality, teaching, continuing medical education, and research. In furtherance of its education mission, VUMC seeks permission to perform an autopsy in connection with a death of the following types of patients:
   a. Outpatients who have been followed regularly at VUMC.
   b. Patients recently hospitalized at a VUMC hospital.

2. Authorization from the Pathologist-On-Call:
   After approaching the patient’s family and obtaining permission for an autopsy, the clinician must contact the Pathologist-On-Call or the bereavement liaison who then contacts the Pathologist regarding performing the autopsy.

3. Pathologist to perform autopsies:
   A VUMC Pathologist or his/her designee shall perform all autopsies.

4. Attending physician to seek permission for autopsy:
   It is the responsibility of the attending physician or his/her physician designee to discuss the benefits of an autopsy with the patient’s legal representative, and to obtain written permission prior to performance of the autopsy. Autopsies are not performed, and permission for an autopsy is not discussed with a patient’s family, when the patient’s death may be reportable to the Medical Examiner under section V.C. below.

5. Autopsy consent form:
   Written consent for an autopsy is documented on the VUMC autopsy consent form, which may be obtained at the nursing stations or in the Admitting Office. It is the responsibility of the attending physician or his/her designee to complete the autopsy consent form in duplicate and to obtain all necessary signatures including the signature of a witness. Any questions concerning the proper completion of the form should be referred to the Department of Pathology. (see MR 07-11)

6. Verbal consent to an autopsy:
   Verbal consent for an autopsy may be obtained by telephone with a witness listening on an interconnected line. A physician who obtained telephone consent to an autopsy also requests that the telephonic consent be confirmed by telegram or other form of
written documentation. The date, time, and signature of the witness to the telephone consent for an autopsy must be included on the consent form.

7. **Provisional anatomic diagnosis:**
   When an autopsy is performed, a provisional anatomic diagnosis is recorded in the electronic medical record within two (2) business days, and the Final Anatomic Protocol is made a part of the electronic medical record within ninety (90) days.

C. **Medical Examiner Cases**

1. The physician in charge of the patient’s care for the illness or condition that resulted in the patient’s death shall report any death due to, apparently due to, or admitted for the follow causes, regardless of the interval between event and time of death to the Davidson County Medical Examiner’s Office:

   a) Homicide;
   b) poisoning;
   c) traffic accidents;
   d) falls;
   e) stabbing;
   f) drowning;
   g) shooting;
   h) suicide;
   i) hanging;
   j) burns (whether death is caused by burn or smoke inhalation);
   k) airplane crash;
   l) all other trauma (regardless of interval between injury and time of death);
   m) sudden death (when in apparent good health) including Sudden Infant Death Syndrome;
   n) individuals found dead, unless death is apparently the result of a disease the individual is known to have had;
   o) maternal deaths;
   p) prisoners dying under treatment in a hospital or while in prison;
   q) any death occurring in prison;
   r) any suspicious, unusual or unnatural death, including unexplained surgical and anesthetic deaths;
   s) prior to the cremation of any body following death, including fetuses over 500 grams or 22 weeks gestation;
t) death of nursing home or extended care resident when abuse, neglect or overmedication is strongly suspected or confirmed as the cause of death;
u) death believed to present a public health hazard (e.g. Meningitis, Rocky Mountain Spotted Fever);
v) death related to overdose of drugs, alcohol, or legal medication;
w) death occurring on the job or related to employment.

2. Autopsy Not Requested of Family:
   In Medical Examiner Cases, permission for autopsy is not solicited from the patient’s family. In addition to the responsible physician’s report to the Davidson County medical Examiner’s Office, the death is also reported to the family under appropriate circumstances.

VI. EMERGENCY PREPAREDNESS PLAN
   A copy of the VUMC Emergency Preparedness Plan (“PLAN”) is available in all departments of the medical center. Members of the Medical Staff designated to take responsibilities pursuant to the PLAN are expected to be familiar with their role under the PLAN in the event that it is necessary to implement its provisions (see Vanderbilt University Medical Center Safety and Disaster Manual and SA 110-15)

VII. AMENDMENTS
   These Rules and Regulations shall be reviewed annually by the Administrative Affairs Committee, which shall recommend to the Medical Center Medical Board any amendments necessary to promote the smooth and efficient organization and functioning of the Medical Staff. The Medical Center Medical Board has the power to adopt such amendments to these Rules and Regulations as are, in its judgment, necessary and appropriate to achieve and maintain compliance with regulatory and accrediting authorities and to otherwise regulate the affairs of the Medical Staff. Such amendments shall be effective immediately and shall be permanent upon ratification by the MCBEC - BOT at its next regularly scheduled meeting. After ratification by the MCBET - BOT, such amendments shall be communicated by some reasonable mechanism and in writing to the Medical Staff.

References (Selected Vanderbilt University Medical Center Policies)

Admissions OP 10-20.02

Transfers from VUMC OP 10-40.25
Discharge Planning CL 30-05.06
Confidentiality of Patient Information OP 10-40.01
Suspected Abuse and/or Neglect OP 20-10.26
Media Access OP 10-10.06
Anatomical Gifts OP 20-10.11
Organ/Tissue Donation OP 20-10.01
Claims Management OP 10-30.01
DNR Policy OP 20-10.05
Overnight Visitor Policy OP 10-50.02
Smoking Policy SA 40-10.02
Emergency Preparedness Plan SA 10-10.10
Observation Status OP 40-10.09
Ambulatory Surgery, Invasive Procedures OP 10-10.08
Emergency Department Record MR 07-13
Guidelines for Orders MR 07-04
Deaths MR 07-12
Autopsy Consent/Report MR 07-11
Operative Notes and Reports MR 07-14
Pre-Operative Documentation MR 07-19
Informed Consent OP 20-10.17
MR 07-06
Deaths Requiring Reporting to the Medical Examiner OP 20-10.14
H & P section modified as approved in June 2009
Modified as approved in June 2009
Modified as approved in June 2009
Modified as approved in June 2009