SAINT JOSEPH
Regional Medical Center

Version #: 1

Title: HISTORY & PHYSICAL MEDICAL STAFF POLICY

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POLICY:

1. It is the policy of the medical staff to ensure timely completion of medical records in accordance with regulations and quality of care standards. A sample of reports will be monitored on an ongoing basis to ensure timely documentation. Results of these reviews will be reported to the IM Team and the appropriate medical staff committees.
2. The history and physical shall include a comprehensive current physical assessment of pertinent systems of the body and must also include the impression or reason for hospitalization/procedure/surgery as well as the plan for treatment.

PROCEDURE:

A. **Inpatient Admission H&P** – An H&P would meet the requirement that an H&P be performed no more than 30 days prior to admission or within 24 hours after admission if:

1) An appropriate assessment, to include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed, regardless of whether there were any changes in the patient's status prior to any procedure or within 24 hours after admission confirming that the necessity for the care is still present and the H&P is still current. If the patient is being admitted for a procedure/surgery an update note must be on or attached to the H&P immediately prior to procedure/surgery. By definition, a procedure involves the puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterization, endoscopies, angioplasties and implantations. The definition excludes peripheral venipuncture and intravenous therapy. Any procedure/surgery, which employs the use of moderate sedation, requires an H&P to be present. The sedation History and physical form may be used for this purpose. This updated assessment should be recorded in the admission progress note or on the original H&P document.

2) The H&P, including all updates and assessments, must be physically present within 24 hours after admission in the patient's medical record for this admission.

B. **Outpatient Procedure/Surgery H&P** – An H&P would meet the requirement that there must be a complete history and physical work-up in the chart of every patient prior to procedure/surgery if:

1) The H&P was performed within 30 days prior to the outpatient procedure/surgery; AND

2) The physician or other individual qualified to perform the H&P writes an update note prior to the procedure addressing the patient's current status, regardless of whether there were any changes in the patient's status immediately prior to the procedure/surgery. The update note must be on or attached to the H&P AND An appropriate assessment, to include a physical examination of the patient to update any components of the patient's current medical status

that may have changed since the prior H&P or to address any areas where more current data is needed, regardless of whether there were any changes in the patient's status. This updated assessment should be recorded on the H&P/Update Review form or in the EMR, AND

3) The H&P, including all updates and assessments, must be included in the patient's medical record, except in emergency situations prior to procedure/surgery.

4) An H&P is also required for all outpatient procedures/surgeries with the following exceptions: CT scans and MRIs, diagnostic lumbar punctures, epidural steroid injections, paracentesis, thoracentesis, joint aspirations, or injections, facet injection, EEG studies, outpatient tube thoracostomy, central line placement, fine needle aspiration, drainage tube exchanges or injections, needle aspirations/biopsy of superficial organs (i.e. thyroid, breast), bone marrow aspiration and biopsy, nasogastric tube placement, urodynamic studies, and laser treatment of the eye and skin.

5) A hand written template form H&P is appropriate for use under circumstances that include: GI lab procedures (all endoscopies), Transesophogeal Echo cardiograms, Eye surgeries, Local procedures without Anesthesia Providers, Outpatient surgeries ASA I or ASA II, add-on or after hours surgery cases, any circumstance where a transcribed report may be untimely.

6) Dictated History and Physicals would be required in Inpatient procedures, ASA III or above.

C. **Obstetric H&P** – A copy of the prenatal H&P done at the initiation of prenatal care, along with notes of the course of prenatal care, may serve as the H&P for patients admitted to obstetrics. An appropriate assessment (to include an updated physical examination and information where more current data is needed) shall be recorded in the admission progress note to authenticate the prenatal H&P. A separate history and physical would be required for Cesarean Sections, except in Emergency Cesarean Sections.

D. **Emergency Procedure/Surgery** - Except in extreme emergencies, the patient's H&P, any laboratory and x-ray results, the preoperative diagnosis and a properly executed consent form must be present on the medical record prior to performing any procedure/surgery. This is required unless the surgeon states in writing that such a delay would constitute a hazard to the patient and documents in the progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before procedure/surgery utilizing a short stay H&P format. A signed short stay history and physical or a progress note that contains the following is acceptable:

1) Medications
2) Chief complaint/indications for procedure
3) History of past/present conditions
4) Physical examination
5) Pertinent diagnostic data and impression
6) Plan of Treatment

E. **Physician Responsibility to Update Inpatient Documentation Prior to Procedure/Surgery** - The update to the patient's condition is usually documented in the Progress Notes. Any changes in the patient's condition after the H&P prior to procedure/surgery should be documented in the progress notes including pertinent interval hospital event(s) i.e. AMI during hospitalization and prior to surgery.

F. **All H&Ps shall be written or dictated by a qualified individual as outlined in the medical staff bylaws and as granted in individual practitioner's core privilege or scope of practice.** Oral and maxillofacial surgeons may be allowed to perform history and physical examinations by the granting of specific privileges to do so based on training, competence and experience respective to their areas of expertise only. Dentists are responsible for the part of their patients' history and physical examinations that relate to dentistry. Podiatrists may be allowed to perform history and physical examinations for ASA class 1 & 2 patients by the granting of specific privileges to do so based on training competence and experience respective to their areas of expertise only. For non-ASA Class 1 & 2 patients Podiatrists are responsible for the part of their patients' history and physical examinations that relate to podiatry. For dental admissions, the appropriate qualified physician member of the medical staff must complete the full H&P examination. The supervising physician may authorize residents, approved medical students and medical staff assistants, to take a medical history and perform a physical examination, record pertinent data and write progress notes in the medical record that are then required to be countersigned by a physician prior to any procedure/surgery or within 24 hours, whichever occurs first.

   If the patient is admitted through the Emergency Department, the ED physician also documents the patient's condition at the time of admission in the ED record. The Emergency Department note cannot be used as an H&P. The attending physician must obtain an H&P.

G. If a patient is transferred from another hospital, the H&P from the transferring hospital may be used only if a physician who is a member of the Medical Staff has done it and only if it has been done within the above stated conditions. If the H&P is to be used from the transferring hospital, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that any subsequent changes have been documented on the report. If there are no changes, the physician must indicate so and sign the updated note.

H. A dictated H&P or hand-written template form H&P will be accepted as meeting the requirements of an H&P prior to procedure/surgery if it contains the necessary components listed below. Any other document thought to be the physician's H&P is to be reviewed for presence of required content before assuming it meets the requirements of an H&P. **Components that must be present include:**

   1) Medications
   2) Chief complaint/indications for procedure
   3) History of past and present medical conditions
   4) Surgical history
   5) Physical exam (which at least includes documented assessment of the heart, lungs, neuro or mental status)
   6) Pertinent diagnostic data and Impression
   7) Plan of treatment

I. **Action when H&P not present:** If it appears a patient will be going to have a procedure/surgery without an H&P which meets the above requirements, the following steps shall be taken:

   1) Upon preparation for procedure/surgery, the RN determines the presence of an H&P. If not present to meet all of the above, the RN notifies the surgeon.
   2) Without a written H&P, the patient is not to be transferred to the holding area.

3) If the H&P is not on the chart within 30 minutes of the scheduled procedure/surgery and the surgeon has not indicated the H&P will be written prior to procedure/surgery, the nurse shall page one of the following to assist in the resolution of the H&P:
   a) Director, Surgical Services
   b) Chief Nursing Officer
   c) Service Chief of Surgery
4) Surgery staff may not take the patient to the procedure/surgery area until issue is resolved.

J. The immediate post-op note must be completed immediately following surgery prior to the transfer of the patient.

Related Documents:

- Flowchart

References/Standards:

- CMS Standards June 5, 2009
- TJC Standards 2010
- Indiana State Administrative Code 410 Section 15 dated May 22, 2007
- Indiana State Administrative Code 410 Interpretive Guidelines December 23, 2008
- Policy Origin Date: October 2007
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