

Title: History & Physical Medical Staff

Document Owner: Chris Stefaniak	PI Team: N/A	Date Created: 08/01/2006
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Location: Saint Joseph Regional Medical Center- (SJRMC)		Department: Medical Staff Services

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POLICY:

1. A medical history and physical examination shall in all cases be performed and dictated no more than 30 days prior to admission or within 24 hours following admission of the patient or before surgery/procedure, and authenticated by a physician who is a member of the Medical Staff of SJRMC Mishawaka or SJRMC Plymouth. 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. H&P for inpatient admissions shall be a DICTATED/ELECTRONIC/TYPED document on the chart within 24 hours of admission, except those admissions less than 48 hours. If less than 48 hours a handwritten short stay H&P is acceptable.
- B. H&P for outpatient procedure/surgical cases with complications that require admission shall be a DICTATED/ELECTRONIC/TYPED document on the chart immediately post-operatively.
- C. A consultation dictated within 24 hours of admission may be accepted as the H&P providing it meets the elements listed below.
- D. Elements of an H&P:

	Inpatient Admission - Comprehensive H&P	Outpatient Procedure/ Surgical - Short Stay H&P
Chief Complaint	√	√
History of Present Illness	√	√
Significant Past Medical/Surgical History	√	√
Family History	√	√
Social History; to include but not limited to: 1. Alcohol Use 2. Tobacco Use 3. Other Non-Prescription Drug Use	√	√
Allergies	√	√ can be referred to electronic record
Current Medications	√	√ can be referred to electronic record
	Inpatient Admission - Comprehensive H&P	Outpatient Procedure/ Surgical - Short Stay H&P
Diagnostic Tests	√	n/a
Review of Systems;	√	√

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Title: History & Physical Medical Staff

	Inpatient Admission - Comprehensive H&P	Outpatient Procedure/ Surgical - Short Stay H&P
1. Cardiac 2. Respiratory 3. Other		cardiac and respiratory
Physical Examination; 1. Head: eye, ears, nose, throat 2. Heart 3. Lungs 4. Abdomen 5. Extremities 6. Neurological/Mental Status 7. Other	√ • two elements required per inpatient admission • relevant to present illness	√ • one element only required • relevant to present illness
Impression	√	√ pre-operative diagnosis sufficient
Plan	√	√
Surgical/Procedural cases involving moderate sedation must include a sedation evaluation	√	√

- E. **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 H&P was written or dictated, is completed upon admission and prior to any procedure confirming that the necessity for the care is still present and the H&P is still current. 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 or 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.
- F. **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 addressing the patient’s current status, regardless of whether there were any changes in the patient’s status immediately prior to procedure/surgery. The update note must be on or attached to the H&P; AND

Title: History & Physical Medical Staff

- 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, laser treatment of the eye and skin and a blood patch without sedation.
 - 5) Documentation from the Emergency Department is acceptable as an H&P for outpatient procedures performed within 24 hours of the Emergency Department visit.
- G. **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.
- H. **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. If the H&P is not completed prior to procedure/surgery, the patient's surgery will be cancelled, 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.
- I. **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.
- J. All H&Ps shall be written or dictated by a qualified physician who is a member of the medical staff. 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 full H&P examination must be completed by the appropriate qualified physician member of the medical staff. The credentialed supervising physician may authorize residents, approved medical students, medical staff assistants, and the physician's nurse practitioner (credentialed and not credentialed) 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.
- K. 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 inpatient H&P. An H&P must be obtained by the attending physician.

Title: History & Physical Medical Staff

- 1) Exception noted under F.5.
- L. If a patient is transferred from another hospital, the H&P from the transferring hospital may be used only if it has been done by a physician who is a member of the Medical Staff 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.
- M. A dictated H&P or comprehensive hand-written Short Stay H&P will be accepted as meeting the requirements of an H&P prior to procedure/surgery without further review of the content of the document.
- N. 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) Unless the physician indicates the H&P will be written in the holding area, the patient is not to be transferred to the holding area.
 - 3) If the H&P is not on the chart and the surgeon has not indicated the H&P will be written prior to procedure/surgery, the nurse shall contact one of the following to assist in the resolution of the H&P:
 - a) Director Surgical Services Phone: 574-335-2496
 - b) Chief Nursing Officer Phone: 574-952-1967
 - c) VP Quality Improvement Phone: 574-335-1035
 - d) Administrator on Call Phone: Doc Halo
 - e) Nursing Administrative Supervisor Phone: 574-335-7000
 - 4) Surgery staff may not take the patient to the procedure/surgery until approved by one of the above persons.

H&P Quality Review – (Ref. TJC MS 03.01.01 EP 7)

A. Current HIM H&P Review Process includes:

- 1) 100% of charts are reviewed post discharge for H&Ps with the following identified on a monthly basis.
 - a) H&P Not Present on Discharge
 - b) Office H&P Over 30 Days Old
 - c) H&P by a Non-Staff Physician
 - d) Content Issue
- 2) HIM will notify the Medical Staff Office on any non-compliant H & Ps.
- 3) In addition, HIM will print 20 compliant H&Ps on a monthly basis and sent to the Medical Staff Office. (Inpatient and Outpatient needs to be identified)
- 4) Additional provider reviews can be requested thereafter if needed.

Title: History & Physical Medical Staff

- 5) Medical Staff Office will present the compliant H&Ps to a physician reviewer designated by the Council for review; acceptable, unacceptable. A worksheet will be completed and submitted to the Medical Staff Office.
- 6) The Medical Staff Office will inform the Department Chair of the findings.
- 7) The Medical Staff Office will inform the Medical Staff Professional Practice Council (MSPPC)
- 8) The Medical Staff Office will send a letter to physician(s) with reason(s) unacceptable with a copy of their H&P highlighted. This process is to educate the physicians.
- 9) Continue to trend results of review for Medical Staff Professional Practice Council as needed.

References/Standards:

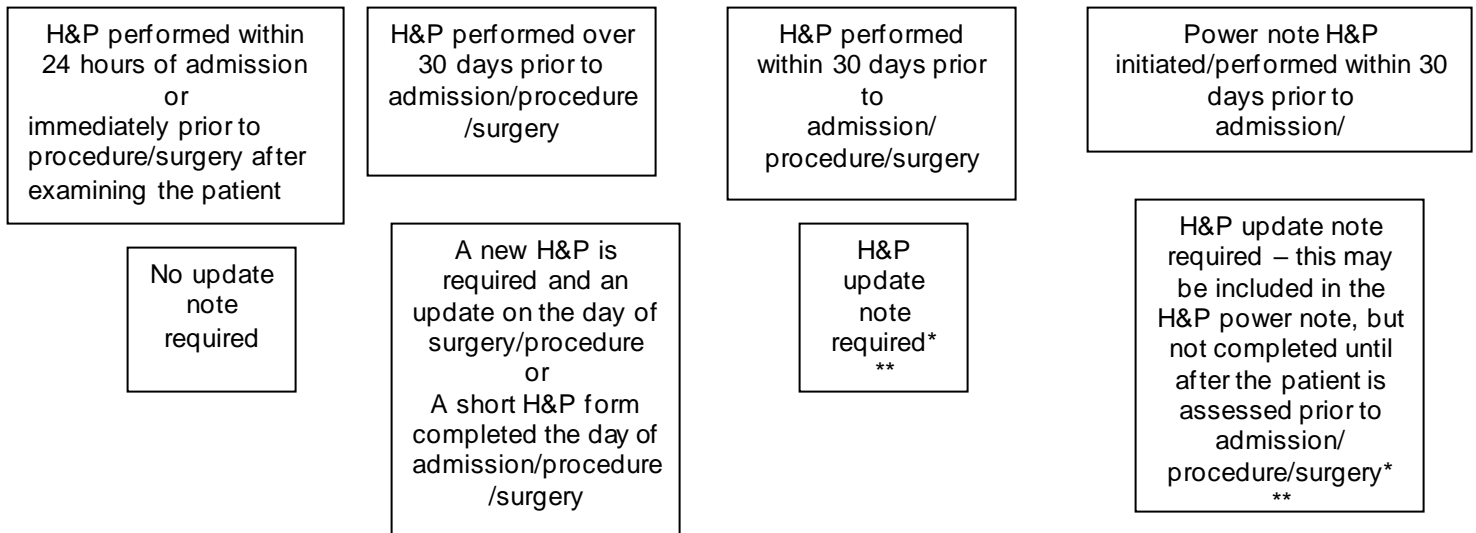
- CMS Standards June 5, 2009
- TJC Standards 2010
- Indiana State Administrative Code 410 Section 15 dated May 22, 2007
- Indiana State Administrative Code 410 Interpretive Guidelines December 23, 2008
- Policy Origin Date: August 2006
- Review Date: December 2009 , September 2010, December 2012, December 2015, June 2017, December 2018
- Revised Date: March 2010, December 2010, March 2011, Sept 2011, Dec 2011, June 2015, Sept 2015, March 2016, June 2017
- Effective Date: August 2006
- Reviewed/Recommended By: Medical Executive Committee
- Policy 145

Title: History & Physical Medical Staff

ATTACHMENTS/ILLUSTRATIONS:

H&P FLOWCHART

Examples of how 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.



* The "H&P Update Note" must address the patient's current status, regardless of whether there were any changes in the patient's status immediately prior to procedure/surgery.

** "Assessment" is defined 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.