

Title: **HISTORY AND PHYSICAL**

 Approved By: **Robert Prichard, MD, SVP & CMO**

 Responsible Party: **Michele Kenner, Director**

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 Interdisciplinary Review: **Medical Executive Committee, Health Information Management**
POLICY:

A History & Physical examination (“H&P”) is necessary to document the medical, physical, and psychosocial status of the patient. The History & Physical should be pertinent and relevant and should include sufficient information necessary to provide the care and services required to address the patient’s conditions and needs.

The history should include*:

- Chief Complaint
- History of Present Illness
- Past Medical History
- Review of Systems
- Physical Examination
- Impressions
- Plan of Treatment (which may be referenced in another section of the medical record)

The physical examination should include:

- Vital Signs
- Examination of Organ Systems relevant to the patient’s admitting condition
- Other examinations as indicated by the setting and the patient’s level of care, treatment and services
- H&P’s for Outpatient Procedures - The scope and/or minimal content of an H&P may vary from the above listing by setting or nature of the outpatient surgery or procedure. Any such variations of what constitutes a complete H&P are to be approved by the Medical Executive Committee.

The medical staff is responsible for the quality of the H & P examinations.

Admission H&P

The admitting physician or designee is responsible for the completion of an admission H&P. The patient’s history and physical examination is to be completed in the chart within 24 hours of admission as an inpatient. This includes observation patients.

- **H&P Update:** H&P’s not completed at the time of admission, (i.e., old H&P up to 30 days used) must be updated within 24 hours of the inpatient admission, and prior to surgery or a procedure requiring anesthesia services. To update an H&P, the physician must complete the H&P Update in

EPIC under the “update H&P” navigator noting that the patient was examined and that the H & P is still current or document any changes or additions to the H & P. Surgeries/procedures should not be started until the H & P Update is complete.

Pre-procedure/Preoperative H&P

Patients receiving invasive diagnostic/therapeutic/interventional procedures or noninvasive procedures that may place the patient at risk should have a relevant and appropriate H&P documented on the chart prior to the procedure or surgery. Patients scheduled for local anesthesia (no anesthesia provider is present) are excluded.

- **Outpatient H&P Update:** Any H&P completed within 30 days prior to an outpatient surgery or procedure may be used, but must be updated. This update is to occur at the time the patient presents for the outpatient service, and prior to the surgery or a procedure involving the use of moderate to deep sedation or anesthesia. To update an H&P, the physician should evaluate the patient appropriate to the nature of the surgery or procedure to be performed, and note that the patient was examined and that the H&P is still current, or document any changes or additions to the H&P in EPIC under the “H&P Update” navigator. Surgeries/procedures should not be started until the H&P Update is complete.
- **Inpatients:** If an inpatient requires surgery, or a procedure which requires an H&P, the admission H&P is good for the entire length of stay. Any changes in the patient’s condition prior to surgery/procedure should be documented in the progress notes.

GUIDELINES:

1. Other licensed practitioners who are credentialed to provide patient care services may perform and document all or part of the H&P examination, if granted such privileges. However, an H&P completed by a licensed practitioner, such as an Allied Health Professional, should be validated and countersigned by the supervising physician or physician designee by the next calendar day. This co-signature indicates the H&P has been reviewed by the responsible physician and that he/she agrees, unless otherwise noted, with the H&P content.
2. H&P’s should only be accepted from Medical Staff members who have been privileged to perform H&P’s. H&Ps from physicians who are licensed in the State of Kentucky, including Medical Staff Members who do not hold H&P privileges and non-Medical Staff Members, may be utilized provided the H&P is updated by a practitioner who is so privileged. The privileged practitioner should:
 - a. Review the H&P document.
 - b. Determine if the information is compliant with the organization’s defined minimal content.
 - c. Obtain missing information through further assessment and examination.
 - d. The practitioner should examine the patient and any difference in the examination must be noted in the H & P.
 - e. Update information and findings as necessary, which may include, but are not limited to:

- i. Inclusion of absent or incomplete required information.
 - ii. A description of the patient's condition and course of care since the H&P was performed.
 - iii. A signature, date and time on any document with updated or revised information as an attestation that it is current.
3. If a practitioner uses St. Elizabeth's Transcription Services to document the H&P, dictation should be completed within 12-16 hours of admission, or 12-16 hours before the procedure to allow for transcription, distribution, and placement on the chart. It is not acceptable to indicate that the H&P "was dictated." A hand written or typed H&P must be entered into the patient's medical record to be considered in compliance.
4. A practitioner's transcribed H&P does not have to be authenticated within 24 hours to be considered complete.
5. Completion of a Medical Staff approved form should also accommodate documentation of an H&P.
6. In the event of an emergency, when there is not time to record a complete H&P examination, a note indicating the urgency and preoperative diagnosis should be documented.
7. An ambulatory progress note/office visit note completed in EPIC which includes the following may be considered an admission H&P as long as it is completed within 30 days prior to an outpatient surgery or procedure:
 - Chief Complaint
 - History of Present Illness
 - Past Medical History
 - Review of Systems
 - Physical Examination
 - Impressions
 - Plan of Treatment
8. Maternal Child Health - A prenatal record is considered the H&P for obstetrical patients provided it is updated to reflect the patient's condition at the time the patient presents for service and/or admission, and prior to the surgery or a procedure involving the use of moderate to deep sedation or anesthesia. If prenatal information is not available, the obstetrician is responsible for documenting or dictating an H&P within 24 hours of admission or pre-procedure