ELMHURST OUTPATIENT SURGERY CENTER

POLICY/PROCEDURE:	**History and Physical**	**EFFECTIVE DATE:**	**1/2/10**
SECTION:	**Information Management**	**LAST REVISION:**	**7/16/12, 12/5/2012; 3/27/13**

OBJECTIVE

To ensure that a complete and timely history and physical is secured for all surgical patients prior to surgery based on Joint Commission standards and CMS's Conditions for Coverage.

PLAN COMPONENTS

Applicability and Timing

A comprehensive history and physical (H&P) must be performed on **all** patients within **thirty (30) days** of the date of surgery. Thirty days is defined by the date the H&P was **performed**, not the electronic signature date (if using an electronic medical record system). The H&P must be completed, signed and present in the patient's medical record prior to surgery.

Individuals Approved to Complete and H&P

- Any physician (MD or DO), whether or not he/she is on the EOSC medical staff
- Podiatrist (DPM), if on the EOSC medical staff and has been granted privileges to do so
- Physician's Assistant, if on the EOSC medical staff and has been granted privileges to do so
- Advanced Practice Nurses (APNs), including Certified Registered Nurse Anesthetists (CRNAs), if on the EOSC medical staff and have been granted privileges to do so
- Resident or fellow, if on the EOSC medical staff and has been granted privileges to do so

Content

At minimum, the H&P must include the following components:

- Medical history
- Assessment of the patient's heart, lungs and mental status
- Indications for surgery, including a description of the affected organ system/operative site

Acceptable Formats

Physicians may utilize the following formats for their H&Ps, providing however that the above **content guidelines** are met:

- EMDAT dictation system (access provided by EOSC)
- EOSC Physician Attestation/History and Physical Form (provided in patient's medical record on date of service)
- H&P from another physician (e.g., primary care physician)
- H&P from physician performing procedure (must be titled H&P and contain appropriate content)

Physicians using EMDAT must sign their H&Ps electronically **within 30 days of the date the H&P was performed.**

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Update to the Patient's Medical Condition

H&Ps completed prior to the date of service but within the 30 days of the surgery date must be updated on the date of service. Physicians must complete the Physician Attestation section of the EOSC Physician Attestation/H&P Form on the day of surgery that indicates that vital signs were reviewed and whether the patient's condition remains unchanged. The Physician Attestation section requires the physician's signature and must have a date/time.

If the physician brings an office/consult note from a visit that occurred within 30 days of the surgery date, the physician may use this as his/her H&P, however, the physician must still complete the Physician Attestation section as described above. If the office/consult note does not contain a physical exam, the physician must also complete the Physical Exam section.

Compliance

Compliance with H&P content is evaluated as part of the EOSC Peer Review Process.

Compliance with the presence, timing and format of the H&P is documented on the EOSC Surgical Safety Checklist. Both the pre-operative nurse and circulating nurse are responsible for ensuring compliance with the following items and documenting this appropriately on the Surgical Safety Checklist:

- Presence of a **signed** H&P on the chart prior to surgery performed within 30 days of the date of surgery.
- Completion of the Physician Attestation section of the EOSC Physician Attestation/H&P Form if the H&P occurred prior to the date of surgery.

Patients that do not have a valid H&P will not be allowed entrance to the operating room. For patients scheduled in the GI procedure room that do not have a valid H&P, the procedure will not commence until a valid H&P is present and signed by the physician.

Medical records will also be responsible for auditing the H&P for signatures and timeliness.

AUTHORITY AND RESPONSIBILITY

The Medical Director, as chairman of the Clinical Review Committee, is responsible for monitoring and enforcing this policy in regards to content. All Clinical Managers/Directors are responsible for enforcing this policy in regards to the nursing activities described above. The Manager of Operations, in her role of overseeing the medical records auditing process, will also have responsibility in terms of auditing the nursing components of this policy and bringing deficiencies to the attention of the appropriate clinical leadership.

EVALUATION AND IMPROVEMENT

The evaluation and effectiveness of this policy is conducted by the Manager of Operations and reported to the PCC, CRC and Board of Managers as appropriate. Included in the evaluation are recommendations for changes based on trends, incidents and regulatory standards. The CRC or Board of Managers may also

provide direction on additional measures they wish the Manager of Operations to implement in order to ensure the objectives of the policy are met.

REFERENCES

This policy was previously incorporated in the Medical Record Documentation Timelines policy but was separated to allow for easier reference.

Joint Commission Comprehensive Accreditation Manual 2012 Update 1, PC.03.01.03, EP 5, 6.

CMS (Rev 56, Issued: 12/30/09, Effective/Implementation: 12/30/09) *§416.52 condition for coverage – Patient Admission, Assessment and Discharge.*

Physician Assistant Practice Act of 1987 (225 ILCS95, Section 7.7)

Nurse Practice Act (225 ILCS 65, Section 65-45)

Ambulatory Surgical Treatment Center Act (210 ILCS 5, Section 6.5)

Note that this policy was previously part of the Medical Record Documentation Guidelines Policy.