CHRISTUS Santa Rosa Health System
Physician Integration and Accreditation Compliance

History & Physical (H&P)

~H&P must be completed and documented within 24 hours following admission of the patient, but prior to surgery or procedure requiring anesthesia services (including moderate sedation)

~ H&P Exams performed within 30 days prior to admission may be used if the following requirements are met:

> Physician documents "re-examined" note which is written on or attached to the H&P record within 24 hours of admission, and prior to surgery or invasive procedures, which ever comes first.

> The H&P and any assessments must be included in the medical record within 24 hours of admissions, and prior to surgery or invasive procedures, which ever comes first.

> The words "re-examined the patient" must be present. Required by CMS.

~ H&P performed more than 30 days prior to admission, outpatient, observation, or outpatient surgery does not comply with timeliness requirements. A new H&P must be performed.

Required elements of H&P are:

Chief Complaint	Medication	Family History	Impression/Conclusion
Present Illness	Social History	Review of Systems	Plan
Allergies	Past Medical History	Relevant Physical Exam	

Sign, Date and Time

~ SIGN, DATE, and TIME each entry in the medical record when the documentation occurs. This includes: History & Physical, Progress Notes, Physician Orders, Consents, Telephone Orders / Verbal Orders, Operative Notes.

Informed Consent

~ Include the plan for anesthesia / sedation in the order for the procedure. The order is used by the nurse to document the procedure and anesthesia / sedation plan on appropriate CSR Disclosure and Consent procedure form.

Immediate Post Procedure Note

~ Sign, Date and Time - Time is very important as it confirms that the note was recorded prior to moving the patient to the next level of care.

Date of Procedure	Anesthesiologist and Type of Anesthetic	Any Specimens / Tissue Removed
Name of Procedure	Post-Procedure Diagnosis	Devices/Grafts/Tissue/Transplant
Description of Procedure	Findings of the procedure	Immediate Post Op Condition
Pre-Procedure Diagnosis	Complications	
Proceduralist & Assistant(s)	Any Estimated Blood Loss	

Operative Report / Dictated or Written - *Content Requirements:*

>Post Procedure / Operative Reports should contain in addition to the elements listed above:

* Indications for procedure
* A full description of the Procedure

**Operative Reports should be done immediately or within 24 hours following procedure

Discharge Instructions / Summary

~ Provide a Discharge Summary including deceased patients regardless of duration of hospitalization. Required Elements:

Medical Problems (s) that led to hospitalization	Care, Treatment and Services provided	Discharge Destination	Significant Findings/Test Results
Final Diagnosis	Patient Condition and Disposition at Discharge Charge	Reference to Medication Reconciliation	Procedures Performed
Discharge Information Provided	Provision for Follow up Care		

Restraints - An order from an attending physician is required each and every time a patient is restrained.

~ Always use the CSR '*Restraint Order Form'*. The CSR '*Restraint Order Form'* captures all of the required regulatory elements for restraint episode.

~ Do Not use 'standing orders' or PRN orders for restraints.

CHRISTUS SANTA ROSA Health System