Generic Documentation Tips

Medical Patients

Purpose - These guidelines have been developed to assist clinical staff to appropriately document co morbidities / complications that impact patient care. This is important for:

- safe and high quality patient care;
- demonstrating the acuity and complexity of the patients that we care for;
- accurate DRG assignment and subsequent funding for the care that we have provided

TIP: Document the 'what' and the 'why' of your treatment plan e.g. "patient HB↓89, recheck HB in the morning."

Conditions that in combination will shift the DRG from a less complex DRG to a more complex DRG

Condition	*Documentation hints*
Acute/chronic renal failure/impairment	*documentation of renal failure/impairment alone is insufficient – acute or chronic must be specified*
Acute/chronic respiratory failure	*Acute or chronic respiratory failure must be specified – documentation of respiratory failure alone is insufficient* *Documentation of type 1 or type 2 respiratory failure must also be further specified as acute or chronic*
Anaemia	*specify type of anaemia e.g. chronic due to blood loss*
Atrial Fibrillation	*document if present*
Chronic conditions e.g. Parkinsons, MS	*document if present*
COAD	*specify if acute or infective exacerbation*
Decubitus Ulcer/Pressure Area	*include stage of severity*
Delirium	*document "delirium" rather than confusion if appropriate* *document dementia if also present.*
Diabetes – unstable/poor control	*document "unstable" diabetes for any diabetes requiring increased monitoring, new medication, adjustment of doses, referral to dietician, diabetic educator or endocrinologist*
Diabetes with features of insulin resistance	*document "insulin resistance" or any lipid disturbances, obesity, overweight, hypercholesterolaemia*
Diabetes with ophthalmic complication	*specify complication or history of e.g. retinopathy, cataract*
Diabetes with peripheral vascular disease	*specify complication e.g. claudication, rest pain, gangrene, ulceration*
Diabetes with renal complication	*specify complication e.g. acute or chronic kidney failure/impairment*
Heart failure	*Specify type of heart failure e.g. CCF, LVF*
Hypokalaemia/hyperkalaemia	*document condition or use ↑/↓ (e.g. hypokalaemia or ↓K3.3) – documentation of abnormal level is insufficient (e.g. K3.3)*
Hyponatraemia/hypernatraemia	*document condition or use ↑/↓ (e.g. hyponatraemia or ↓Na127) –documentation of abnormal level is insufficient (e.g. Na127)*
IV site infection/inflammation	*document if IV site becomes red/sluggish or infected and/or needs to be removed/resited*
Leg/foot ulcer	*document infected ulcer if appropriate and bacterial organism if any cultured, document any debridement (including on ward) performed*
Liver impairment	*specify "liver impairment" not just abnormal LFTs, if appropriate*
Malnutrition	*document if present*
NSTEMI	*if troponin outside normal range and no other defined cause – document NSTEMI rather than "troponin rise" if appropriate*
Pneumonia	*document "pneumonia" rather than consolidation if appropriate, document bacterial organism*
Pleural effusion	*document if present*
Sepsis/septicaemia	*specify if generalised and/or localised infection, document organism*
Tobacco dependence	*document "tobacco dependence" rather than "smoker"*
Unstable INRs	*document "unstable INRs", "Overwarfarinisation" or "abnormal bleeding time" where this occurs rather than just INR readings*
Urinary and faecal incontinence	*document if present on admission, present on discharge and/or when present during the admission*
Urinary retention	*document "urinary retention" if it is the reason for IDC insertion or urinary output monitoring*
Urinary tract infection	*document organism if any cultured*