Generic Documentation Tips

Surgical 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 acute blood loss anaemia* *specify if anaemia due to surgery or blood loss*
Atelectasis	*specify if requires chest physio, repeat CXR or other monitoring*
Atrial Fibrillation	*Document if present and/or related to the procedure*
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 ophthalmic complication	*specify complication 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*
Failed or difficult intubation	*specify if intubation was difficult and how this was managed (e.g. repeated attempts, use of bougie, or other intubation aid) [anaesthetist]*
Haemorrhage/haematoma	*document any haemorrhage/haematoma that occurs intraoperatively or post operatively*
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	*specify if IV site becomes infected or inflamed* *document bacterial organism if any cultured*
NSTEMI	*if troponin outside normal range and no other defined cause – document NSTEMI rather than "troponin rise" if appropriate*
Sepsis/septicaemia	*Specify if generalised and/or localised infection, document any bacterial organism cultured*
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 retention	*document if present*
Urinary tract infection	*document organism if any cultured*
Wound infection	*document wound infection for any confirmed infection [or suspected wound infection] where antibiotics are commenced/adjusted* *document bacterial organism if any cultured* *document wound abscess rather than wound collection, if appropriate*
Wound ooze	*document if present and requires management e.g. reinforcement of dressing, change of dressing type*