

**Heart Failure:** Always document if it is **acute**, **chronic**, or **acute on chronic** (exacerbation). Always document if it is systolic, diastolic, or systolic and diastolic.

- **Systolic:** can't pump; EF < ~50
- **Diastolic:** can't fill; EF > ~50

**Cardiogenic pulmonary edema = heart failure**

**Symptoms:** Try to link to a diagnosis, whether confirmed or suspected. Avoid linking to comparing/contrasting diagnoses—this will lead to the symptom being coded instead of the diagnoses.

**Respiratory Failure:** Should document evidence of increased work of breathing! Mechanical vent not required, but if patient is on a vent, most likely in acute respiratory failure! Consider when pt hypoxemic, hypercapneic, tachypneic, acidotic. Don't document respiratory failure in patient weaning normally after surgery.

**SEPSIS/SIRS: SIRS = 2+ findings due to inflammatory process:**

- **T > 100.4 or < 98.6**
- **WBC > 12000 or < 4000 or bands > 10%**
- **HR > 90**
- **RR > 20 or PaCO<sub>2</sub> > 32**
- **Hypotension, AMS, hyperglycemia in non-diabetic, oliguria**
- **Elevated CRP or procalcitonin, coagulopathies, ileus**
- **Hyperlactatemia, + fluid balance**  
**Sepsis = SIRS due to infection**  
**Bacteremia = nonspecific lab finding**  
**Severe sepsis = sepsis with acute organ dysfunction (must link sepsis to dysfunction)**  
**Septic shock = severe sepsis with hypotension and CV collapse**
- **Urosepsis = UTI without sepsis—DON'T WRITE UROSEPSIS!**

**Renal Disease:** Document the stage of CKD per KQODI Guidelines.

CKD = kidney damage or GFR < 60 x 3+ months

- Stage I – Kidney damage with normal kidney function- GFR > 90
- Stage II – Kidney damage with mildly decreased kidney function- GFR 60–90
- Stage III – moderately decreased kidney function- GFR 30–59
- Stage IV – severely decreased kidney function- GFR 15–29
- Stage V – Kidney Failure- GFR < 15

**Renal Failure:** Renal insufficiency is insufficient. If you document acute renal insufficiency when your patient is in **acute renal failure**, you will not capture severity of illness! Please consider RIFLE or AKIN criteria for acute kidney injury.

<b>Risk</b>	Increase in serum creatinine $\geq 1.5x$ baseline or decrease in GFR $\geq 25\%$	< 0.5 ml/kg/hr x 6 hours
<b>Injury</b>	Increase in serum creatinine $\geq 3.0x$ baseline or decrease in GFR $\geq 25\%$	< 0.5 ml/kg/hr x 12 hours
<b>Failure</b>	Increase in serum creatinine $\geq 3.0x$ baseline or decrease in GFR $\geq 75\%$ , or serum creatinine of $\geq 4$ mg/dl with acute rise $\geq 0.5$ mg/dl	< 0.5 ml/kg/hr x 24 hours, or anuria x 12 hours
<b>Loss</b>	Persistent acute renal failure = complete loss of kidney function > 4 weeks	
<b>End-stage kidney disease</b>	End-stage kidney disease > 3 months	

**Acute kidney injury** and **acute renal failure** can be documented interchangeably. Don't abbreviate "AKI" as it can mean insufficiency.



## Clinical Documentation Physician Tips

- Always document the reason for admission, including possible or suspected diagnoses
- Always document the disposition of each diagnosis, whether confirmed, ruled out, remains possible, etc.
- Always carry through to the discharge summary diagnoses that have not been ruled out
- Always document all conditions that affect the patient's stay, including chronic conditions for which medications have been ordered
- Always document the clinical significance of any abnormal labs, radiology reports, and pathology finding
- Always document adherence to core measures and quality standards

### Present on Admission (POA):

- Ulcers: identify type, location, and stage
- Sepsis if identified after study and not noted on admission
- Catheter-associated UTI, central line associated bloodstream infection
- Deep vein thrombosis
- If currently treating a condition, document it as current and not just "history of"

### Link!!

- Link conditions to underlying cause
- Link infections to organisms

Neurology	
Instead of...	think about documenting:
Altered mental status	<ul style="list-style-type: none"> <li>Metabolic encephalopathy</li> <li>Drug-induced delirium</li> <li>Dementia with delirium</li> </ul>
Mass effect	<ul style="list-style-type: none"> <li>Cerebral edema</li> <li>Brain compression</li> </ul>
Left or right sided weakness	<ul style="list-style-type: none"> <li>Left or right sided hemiparesis/hemiplegia, dominant/nondominant</li> </ul>
TIA	<ul style="list-style-type: none"> <li>Cerebral thrombus/embolus without infarct</li> </ul>

Cardiology	
Instead of...	think about documenting:
CHF	<ul style="list-style-type: none"> <li>Acute (systolic, diastolic) heart failure</li> <li>Chronic (systolic, diastolic) heart failure</li> <li>Acute on chronic (exacerbation or decompensated is ok) (systolic, diastolic) heart failure</li> </ul>
ACS	<ul style="list-style-type: none"> <li>NSTEMI</li> <li>Unstable angina</li> </ul>
Cardiomyopathy	<ul style="list-style-type: none"> <li>If there is a component of heart failure</li> </ul>
Troponin leak	<ul style="list-style-type: none"> <li>NSTEMI, demand ischemia</li> <li>Source of leak</li> </ul>
Chest pain	<ul style="list-style-type: none"> <li>Suspected or known cause</li> </ul>
Syncope	<ul style="list-style-type: none"> <li>Suspected or known cause</li> </ul>

Pulmonary	
Instead of...	think about documenting:
Respiratory distress/hypoxia/SOB	<ul style="list-style-type: none"> <li>Respiratory failure (specify acute or chronic), with or without hypoxia/hypercapnia</li> </ul>
Pneumonia CAP, HAP, or HCAP	<ul style="list-style-type: none"> <li>Type of pneumonia</li> <li>Known or suspected organism</li> </ul>
Pulmonary edema	<ul style="list-style-type: none"> <li>Acute pulmonary edema</li> <li>If cardiogenic, document heart failure (<i>see heart failure tips</i>)</li> </ul>

GI/GU	
Instead of...	think about documenting:
Urosepsis	<ul style="list-style-type: none"> <li>Sepsis due to UTI</li> <li>UTI (if no sepsis)</li> </ul>
Renal insufficiency	<ul style="list-style-type: none"> <li>ARF/AKI (if acute)</li> <li>CKD with stage (<i>if chronic</i>)</li> </ul>
+ UA	<ul style="list-style-type: none"> <li>UTI</li> <li>Catheter-associated infection</li> </ul>
GI bleed	<ul style="list-style-type: none"> <li>GI bleed linked to specific cause</li> </ul>

Metabolic	
Instead of...	think about documenting:
Cachexia, wt loss, muscle wasting	<ul style="list-style-type: none"> <li>Malnutrition—mild, moderate or severe</li> </ul>
IDDM or NIDDM	<ul style="list-style-type: none"> <li>Type 1 or Type 2, out of control, poorly or inadequately controlled</li> <li>Any link between DM and PVD, osteomyelitis, gastroparesis, retinopathy, neuropathy, ulcers, etc.</li> </ul>
Fluid overload	<ul style="list-style-type: none"> <li>Heart failure (<i>see heart failure tips</i>)</li> </ul>

Integumentary	
Instead of...	think about documenting:
I&D	<ul style="list-style-type: none"> <li>Debridement: excisional or nonexcisional</li> <li>Include instruments used, tissue debrided, depth reached</li> </ul>
Pressure ulcer	<ul style="list-style-type: none"> <li>Location and stage</li> </ul>

Hepatobiliary	
Instead of...	think about documenting:
Obstructive jaundice	<ul style="list-style-type: none"> <li>Bile duct obstruction</li> </ul>
Hepatitis	<ul style="list-style-type: none"> <li>Type and acuity</li> </ul>

Hematology/Oncology	
Instead of...	think about documenting:
Leukopenia, thrombocytopenia & anemia in pt on chemo	<ul style="list-style-type: none"> <li>Pancytopenia due to medications</li> </ul>
Anemia	<ul style="list-style-type: none"> <li>Anemia of acute/chronic blood loss</li> <li>Anemia due to chemotherapy</li> <li>Anemia of chronic disease</li> <li>Anemia due to (specified) nutritional deficit</li> </ul>

**A few last words:**

**Acuity!** If it can be described as acute, chronic, or acute on chronic, please do so.

**Laterality!** If it can be described as left, right or bilateral, please do so.

**Specificity!** If a site can be described down to a more exact location, please do so. If a condition can be described with more details, please do so.

Thanks!