

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 PaCO₂ > 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.

Risk	Increase in serum creatinine $\geq 1.5x$ baseline or decrease in GFR $\geq 25\%$	< 0.5 ml/kg/hr x 6 hours
Injury	Increase in serum creatinine $\geq 3.0x$ baseline or decrease in GFR $\geq 25\%$	< 0.5 ml/kg/hr x 12 hours
Failure	Increase in serum creatinine $\geq 3.0x$ baseline or decrease in GFR $\geq 75\%$, or serum creatinine of ≥ 4 mg/dl with acute rise ≥ 0.5 mg/dl	< 0.5 ml/kg/hr x 24 hours, or anuria x 12 hours
Loss	Persistent acute renal failure = complete loss of kidney function > 4 weeks	
End-stage kidney disease	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"> Metabolic encephalopathy Drug-induced delirium Dementia with delirium
Mass effect	<ul style="list-style-type: none"> Cerebral edema Brain compression
Left or right sided weakness	<ul style="list-style-type: none"> Left or right sided hemiparesis/hemiplegia, dominant/nondominant
TIA	<ul style="list-style-type: none"> Cerebral thrombus/embolus without infarct

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

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

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

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

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

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

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

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!