Top 10 Clinical Documentation Tips for Hospital Admissions

1. Document the patient’s “reason for admission”
2. If the patient’s “reason for admission” is a symptom (chest pain) - document the most likely / probable / suspected cause (Unstable angina? GERD? Esophageal spasm?)
3. For each diagnosis, identify whether or not it was Present On Admission (POA)
4. Document every condition that is impacting the patient’s stay, including chronic conditions (CHF-systolic or diastolic, Hypertension, COPD, CKD stage, diabetes)
5. Document the clinical significance of every abnormal test result in the patient’s record
6. Coding rules prohibit use of ↑ ↓ -- document hyper- or hypo- natremia
7. Significant Radiology / Pathology / Lab report findings should be referenced in the progress notes – codes cannot be assigned from diagnostic reports alone
8. All medications and therapeutic treatments should be linked to a diagnosis
9. Document cause and effect relationship of infection / adverse reaction to vascular lines, urinary catheters, implants, grafts, and other post-procedure complications
10. If providing palliative care, document – palliative, comfort only, or end-of-life care

Clinical Documentation Improvement Team – 352.265.0680 ext 48769 or 44130