DOCUMENTATION REQUIREMENTS FOR THE ACUTE PATIENT RECORD pdf

1: Documentation and Data Improvement Fundamentals

Documentation Requirements for the Acute Care Inpatient Record (AHIMA Practice Brief) The medical record is a tool for collecting, storing, and processing patient information.

If there is more information gained from this assessment than space allowed, additional information is documented in the progress notes. The plan of care should align with information on the patient journey board. Any relevant clinical information is entered in a timely manner such as; Abnormal assessment, eg. Uncontrolled pain, tachycardic, increased WOB, poor perfusion, hypotensive, febrile etc. Change in condition, eg. Patient deterioration, improvements, neurological status, desaturation, etc. Adverse findings or events, eg. Change in plan Any alterations or omissions from plan of care on patient care plan eg. Rest in bed, increase fluids, fasting, any clinical investigations bloods, xray , mobilisation status, medication changes, infusions etc. Patient outcomes after interventions eg. Dressing changes, pain management, mobilisation, hygiene, overall improvements, responses to care etc. Family centred care eg. Parent level of understanding, education outcomes, participation in care, child-family interactions, welfare issues, visiting arrangements etc. Accommodation, travel, financial, legal etc. Progress note entries should include nursing content and evidence of critical thinking. That is, they should not simply list tasks or events but provide information about what occurred, consider why and include details of the impact and outcome for the particular patient and family involved. All entries should be accurate and relevant to the individual patient. Duplication should be avoided. Professional nursing language is used for all entries to clearly communicate assessment, plan and care provided. Abbreviations should be consistent with RCH standards. Positive patient identification and ensure details are correct on documents. The first entry you make each shift must include your full signature, printed name and designation. Maybe relevant for admission notes or transfer from one dept to another. What does the patient look like? What have you done about it? Interventions, investigations, change in care or treatment required? How has the patient responded? What is your recommendation or plan for further interventions or care? Billie is describing increasing pain in left leg. Paracetamol given, massaged area with some effect. Education given to Mum at the bedside on providing regular massage in conjunction with regular analgesia. Continue pain score with observations. Episode of urinary incontinence. Urine bottle placed at bedside. Encourage oral fluids and diet, if tolerated, IV can be removed. Real-time progress notes are captured in either the clinical comments section of the observation charts or the in progress notes. Nursing Admissions are completed: The Emergency Department have department specific documentation tools, however progress notes should follow the structure as detailed above. The patient population in this unit requires assessment that is continuous throughout the shift and so commencement of shift assessment and plan of care are incorporated into progress notes. Nursing Admission - Day stay. May be used for patients staying less than 24hours in the areas of Day Medical Unit or Day of Surgery. Commencement of shift assessments are completed verbally within two hours of the shift commencing by contacting families. All plans for care are documented on the Patient care plan and real-time progress notes should follow the structure as detailed above. CVC Care Commencement of shift assessment, Patient care plan and real-time progress notes are documented.

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2: Documentation Requirements for the Acute Care Inpatient Record - New York Essays

Documentation Requirements for the Acute Care Inpatient Record () Documentation Requirements for the Acute Care Inpatient Record ().

Documentation and Data Improvement Fundamentals Ruthann Russo, JD, MPH, RHIT Introduction The absence of complete documentation in patient medical records can have a negative effect on statistical databases, financial planning, clinical preparedness, and gross revenue for the healthcare organization. It is for this reason that every healthcare organization should be focused on ensuring accuracy and completeness in clinical documentation, at any cost. Documentation improvement is not a new concept in healthcare, but rather an evolving trend. The healthcare system in the US is constantly changing. First, from a clinical perspective, we have seen a movement away from postponing care until patients are severely ill and in need of hospitalization to preventive medical care. Along with this trend, we have seen fewer, but more severe inpatient admissions and an increase in outpatient admissions over the past decade. Second, from an information management viewpoint, there has been an increasing trend toward computerization of medical records. The government has responded to this trend by implementing privacy and security protections through HIPAA legislation. Third, reimbursement to healthcare providers for services has evolved. These began with the Medicare fraud and abuse initiatives of the s and have continued through the present with CMS policy updates focusing on physician documentation. The two most important aspects of patient medical record documentation are as follows: In each case, the model stresses that in good documentation practices it is important for the attending physician to either interpret the documentation of other clinicians or tests, or confirm the findings of other physicians. Documentation is the key to appropriate billing. In the inpatient setting, some of the important pieces of inpatient documentation include: It is possible that the attending may be working with symptoms and differential diagnoses at the time of the history and physical exam. Although these conditions may be eliminated once a definitive diagnosis has been established, it is important to understand and have documented what the physician was working with in terms of initial or "working" diagnoses. This information can be used to substantiate any tests or consultations that are ordered during the stay. Progress Notes Progress notes from the attending physician chronicle the entire patient stay. Progress notes usually contain information regarding the "progress" that the patient is making. Response to testing, treatment, and medications should be recorded. Any new diagnoses or any diagnoses that have been definitively established should be documented. The importance of placing clinical documentation in the progress notes--as opposed to waiting until the discharge summary--can not be stressed enough. Eliminate or add working or differential diagnoses State whether a patient has any conditions that should be defined as "possible," "probable," or "rule out" Orders The attending physician must provide an order for all treatment and care that the patient receives. Without this direction from the attending physician, the team attending to the patient would be frozen. From a documentation perspective, it is important for the attending physician to document is the reason why an order is made. For an order for antibiotics for a patient, rather than simply "cipro mg b. The surgeon initially records findings at surgery in the progress notes. But the more detailed accounting of the procedure is in the dictated operative report. The body of the report should document every possible detail about the procedure. These may include consultants, anesthesiologists, and pathologists in the case of patients undergoing surgery. This may also include radiologists and cardiologists responsible for interpreting diagnostic test results. The report should include the results of any history and physical performed independently by the consultant. Anesthesia Reports In the case of any patient scheduled to undergo surgery, there is a requirement for an anesthesiology evaluation. The evaluation occurs both before and after surgery. Before surgery, it is important for the anesthesiologist to determine any conditions that the patient may have that would require special treatment or management during the surgical episode. Therefore, it is important for the anesthesiologist to clearly document any condition that the patient has that is impacting care. It should be

noted that this policy exists only in the inpatient setting. Pathology reports When tissue is removed during a surgical episode, it is sent to pathology for analysis. The pathologist is responsible for dictating a pathology report that details the findings of the pathological analysis. The radiologist is then responsible for dictating his findings and assessment in the form of a radiology report. Generally, the radiologist provides an "impression. Cardiology Reports If an attending physician orders an EKG, echocardiogram, or other cardiology test, the test is performed and interpreted by a cardiologist. The cardiologist is then responsible for dictating his findings and assessment for the test. From a reimbursement and coding perspective, the documentation provided by these clinicians is "supplementary" to the attending physician. So, without attending physician acknowledgement and documentation of the detail provided by ancillary clinicians, this information becomes lost in the actual patient record. A nursing note documents a patient with post-operative urinary retention. The attending physician orders a foley catheter placed, but does not document the reason for the order. The nursing staff places the catheter and notes that finally, on the second day post op, the patient has begun to urinate. In either case, the documentation should be as complete and detailed as possible. Most physicians prefer to spend the time they have actually treating the patient and not documenting it. However, it is important to understand that the treatment of the patient includes not only "one-to-one" care but also the documentation of that care. And, there is no time like the present--at the time the physician is actually treating the patient--to document the care being rendered. Concurrent documentation, for example in the progress notes, is one of the best ways to accurately record care and treatment of the patient. Concurrent documentation is reliable, accurate, and most likely to actually reflect what occurred during the patient encounter. As a result, current and future care is more likely to be of a higher quality , since it is based on correct historical information about the patient. Legal Protection Detail in documentation can provide strong legal protection to the healthcare organization. In the absence of documentation, a court will construe the evidence against the defendant in an action. Operations and Management The data that is abstracted from a hospital inpatient record in the form of ICDCM diagnostic and procedural codes is used by healthcare administrators to plan for operations and ongoing management. For example, the cardiology product line team may be following and trending the abstracted data for all cardiology diagnoses and cardiac catheterizations on a monthly basis. In this case, it is possible that effective operational management could be impeded without accurate data. Inaccurate documentation results in inaccurate coding assignment which results in inaccurate DRG assignment and payment to the hospital. Financial planning and budgeting uses prospective payment DRG assignment as the basis for gross revenue receipt for inpatient stays. Inaccurate documentation can have a significant impact on the hospital budgeting and financial planning process. Research Coded data in the form of ICDCM codes is used by teaching hospitals, state hospital associations, professional medical associations, government entities, and other organizations for research in many clinical areas. Research activities assume that the data is accurate, and projections are made based upon the data. In the event that documentation is inaccurate resulting in inaccurate coded data , the effectiveness of research activities is significantly impeded. In the absence of accurate documentation, a provider should assume that revenues are not accurate, as well.

3: Medical Records and Documentation Standards

Insufficient medical record documentation supporting that the provider tried conservative medical management but it failed (for example, medication administration records, therapy discharge summary) or was contraindicated.

4: Medical Record Documentation Standards

General Principles of Medical Record Documentation. â€¢ Certification requirements â€¢ Vehicle documentation â€¢ When it is to treat an acute.

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5: Four of the Basic Components of an Acute Care Health Record | Pocket Sense

Background. Documentation in the medical record facilitates the diagnosis and treatment of patients. Few studies have assessed the quality of outpatient medical record documentation, and to the authors' knowledge, none has conclusively determined the correlates of chart documentation.

6: Ahima Press :: Documentation for Health Records

TRICARE Policy Manual M, February 1, Chapter 1, Section Requirements For Documentation Of Treatment In Medical Records 3 All care rendered and billed must be appropriately documented in writing.

7: Documentation Requirements for the Acute Care Inpatient Record ()

Describe general behavioral health facility patient record documentation requirements and state purpose of each. Psychiatric evaluation (is pt suicidal, etc), H&P (must include neurological assessment of all cranial nerves.

8: OhioBWC - Provider - Service: Medical document policy

Documentation of Medical Records Introduction: â€¢ In a continuous care operation, it is critical to document each patient's condition and history of care.

9: Clinical Guidelines (Nursing) : Nursing documentation

Audiences for the Record. While writing the record, the clinician should keep in mind the possible reader audiences for the record, because this will help achieve sufficient clarity, avoid cryptic communication styles, and achieve the goals of the record in both patient care and liability prevention.

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Complete the healing Music directors complete handbook of forms Genius of the transcendent The nurses role : is it expanding or shrinking? Nancy S. Keller Implementing the ISTE technology standards in your portfolio Elements of literature textbook grade 10 Construction planning and management by b c punmia Californias gold country Kings, Rulers, and Statesmen Community Service for Teens Urban Regeneration Collins German Concise Dictionary, 4e (HarperCollins Concise Dictionaries) Early Canadian pottery Ensouling the world and raising the tree Lets Try Some Scottish Cooking (Lets Look at) Apocalypse Armada in Kyds Spanish tragedy Serway jewett physics 8th edition Envy olesha part 1 At the heart of freedom Therapeutic modalities for athletic trainers A christmas carol charles dickens burlington books Voices of the Revolutionary War Leaders (Voices of the Revolutionary War) Midnights master Communities, Identities and Crime Prints in the Western World Daring in the dark Development and use of weighted application blanks Aws certified advanced networking official study guide specialty exam An etymological vocabulary to the Libro de buen amor of Juan Ruiz, arcipreste de Hita Conclusion : an Englishmans house. Reel 245. Richland, Rock Island (part: EDs 1-246, sheet 35 Counties Your spirits walk beside us Marker model theory an introduction Modern Carpentry (Instructors Manual) Merriam-Webster Pocket Guide to Punctuation and Style People of the Plateau (Thompson, Linda, Native Peoples, Native Lands.) Sairin yuusha no fukushuu hanashi Human capital in economics The hill of the martyr Womens Studies Quarterly: Expanding the Classroom : Fostering Active Learning and Activism