Objectives

• Understand why we document
• Recognize challenges of documentation in the electronic environment
• Be able to do optimal documentation
Question for Candy?

Why do we document the patient encounter?
To chronicle the patient encounter for ourselves, our colleagues, the coders, the payers, the auditors, the lawyers, and the patient.

Institutional Clinical Communication is Job #1!
Is it the same in the EHR?

Results:

CT Abdomen and Pelvis with Contrast (11-Jun-2013)

1. Large neoplastic pancreatic mass of 4.4cm x 3.0 cm in diameter with lymphadenopathy in the porta hepatis and 4 cm extension into the retroperitoneum, with encasement of the duodenal bulb and the gastric pylorus region, likely the origin of gastric outlet obstruction and distention of the stomach.

2. There is extension between the inferior vena cava and aorta and involvement of the celiac trunk, superior SMA and SMV, main portal vein, and the right diaphragm by the tumor. Obstruction of main portal vein in the extrahepatic portion with recanalization of the intrahepatic portal branches from collaterals.

3. Grossly stable to slightly enlarged appearance of multiple lung nodules as described above concerning for metastatic disease.

4. Consolidation in the left lower lobe concerning for metastasis, atelectasis, or infectious process.

5. Mildly dilated gallbladder with the central portion of the neck extending into the tumor, outlet obstruction is not excluded.


7. Stable right-sided iliac vein thrombosis extending into the common iliac and femoral veins. IVC filter.

8. High density material in the urinary bladder lateral right wall. Correlate with history of cystoscopy and intervention. Alternatively calcification.
Historical Perspective
Future State
What constitutes good documentation?
Good Documentation

- Accurate
- Relevant
- Complete, but concise
- Organized and easy to follow
- Timely
ED Note

H&P

Progress Notes

Results

Consults

Procedure/OR Notes

Clinical Event Notes

Off/On Service Notes

Discharge Summary

Death Summary

ED visit

Pt admitted

Direct admit

Hospital Course

Pt discharged
Substance is more important than length
Difficult History

• Patient is a challenging historian
• History is obtained from patient’s mother / wife / son / physician / newly employed caretaker
• History is obtained through an interpreter
• Unable to obtain history secondary to patient’s decreased level of consciousness.
• History gleaned from EMS run report and NH documentation.
Set the table
History Present Illness:

Chief complaint: Chest pain

72 y/o M with history of COPD and MI 2005, s/p 6 stents, complaining of 6/10 sharp, pleuritic right chest pain with shortness of breath, unrelieved by inhaler use or nitro.
Chief Complaint: Chest pain

History of Present Illness:
64 year old with history of previous MI 1999, c/o 1 week of intermittent achy 4/10 left sided chest pain with diaphoresis when walking his dog, relieved by rest.

Duration, Timing, Quality, Severity, Location, Associated signs and symptoms, Context
HPI Elements

- Location (place, site, position)
- Quality (dull, sharp, piercing, aching, etc.)
- Severity (mild, severe, rated X/10)
- Duration (when did it first start, how long has it been there?)
- Timing (sudden in onset, constant, intermittent, recurrent)
- Context (what brings it on, what were you doing when it started?)
- Modifying factors (ameliorating or exacerbating factors)
- Associated signs and symptoms

≥4 elements → Extended History
On February 17, 2013, she had an episode where "her left arm was going crazy," and she slid down the wall and "laid there like that and was twitching." Since then she has had ...
What should NOT be in the record?

Judgmental, inflammatory, or inappropriate language

- *Patient is a fruitcake*  
  vs.
  *Thought processes very disorganized*

- *Needs a bath*  
  vs.
  *Hair disheveled. Smells of sweat. Clothes soiled with urine.*

- *Refused*  
  vs.
  *Declined*
What should NOT be in the record?

- Criticism of previous or consulting physicians
### Review of Systems (ROS)

<table>
<thead>
<tr>
<th>System</th>
<th>Example Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Ears, Nose, Mouth, Throat</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
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<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>GI</td>
<td></td>
</tr>
<tr>
<td>GU</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Allergy/Immuno</td>
</tr>
<tr>
<td>Integumentary</td>
<td></td>
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<tr>
<td>Neurological</td>
<td></td>
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<tr>
<td>Psychiatric</td>
<td></td>
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<tr>
<td>Endocrine</td>
<td></td>
</tr>
<tr>
<td>Heme/Lymphatic</td>
<td></td>
</tr>
<tr>
<td>Allergy/Immuno</td>
<td></td>
</tr>
</tbody>
</table>

- Problem pertinent: 1 system
- Extended: 2-9 systems
- Complete: 10 or more systems
Review of Systems (ROS)

• “Unable to obtain secondary to…”
• Document all **pertinent** positives AND negatives
• Complete ROS:
  
  “All other systems have been reviewed and are negative except as in HPI.”

Don’t say: “10 point ROS,” “noncontributory,” or “unremarkable”

**CAUTION**: In order to document a complete ROS, you need to **DO** a complete ROS
Incomplete ROS: sedated
All Other Systems: Negative
Physical Exam

• Do the examination appropriate to the chief complaint

• Help rule in or rule out diagnoses suggested by history →

  Document abnormalities, pertinent positives and negatives
Daily Progress Note for Visit: 123456789, Final, Entered, Signed in Full, General

Subjective Data: is a 90 year old Female who is Hospital Day #2.

Objective Data: Why is the patient still here?
Patient had an uneventful night.
Progress Notes

• Timely

• Don’t copy and paste from day to day

• Don’t leave everyone wondering why is the patient still here (because nothing seems to be happening or changing)

• Don’t let the only change from day to day, BE the day
New and Improved Neutrogena naturals

Face & Body Bar

Avocado & Olive Oil bionutrient rich bar
Gently cleanses & conditions skin

Dermatologist recommended brand

Net WT 3.5 oz (99 g)
Subsequent Hospital Days/Established Patient

- **(Hi)Story**
  - What has happened?
  - How is the patient feeling?
  - Have the symptoms changed?
  - Any clinical events of note?

- **Observations (PE and testing)**
  - Document your work-product
  - Make templates

- **Analysis and Plan (MDM)**
  - Status (original problem, new issues)
  - Interpretation of tests, procedures
  - Medical necessity for new orders
  - Focus of treatment
  - Documentation of definitive diagnoses
“Chief complaint”
(Is the abdominal pain still the main problem, or is the afib with RVR from the acute PE the current problem?)
Subjective Data:
ID Statement: MCCOY, ELISHA is a 12 month old Male who is Hospital Day # 2.

Please see admission note for full details.
Briefly, febrile, neutropenic (ANC 360 on adm), tonsilar exudate/erythema.

Overnight, with several temps > 38, and having pain (per mom). Last fever at 6am to 39.2. Last Motrin 6am.
Interval “Story”

• How is patient feeling? (I actually saw the patient today!)
  - Less short of breath today
  - Believes erythema has spread
  - No further chest pain since last night

• What has happened since yesterday?
  - Appreciate Dr. X’s consult and …
  - CT showed infiltrate
  - Had family meeting
Subjective Data: SMITH, JEFFREY is a 53 year old Male who is Hospital Day # 3.

Additional Information: Pt is feeling well this morning. States that his pain s/p abscess drainage is well controlled with percocet. Two drains are in place.
“Objective”

- Vital signs
- PE appropriate to current complaint/s and only today’s exam
  - Exam unchanged: (then elaborate)
- Results
  - What needs to be IN THE NOTE?
### STOP THE BLOAT!

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
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</thead>
<tbody>
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<td>Value 3</td>
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<td>Value 5</td>
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</tr>
<tr>
<td>Value 9</td>
<td>Value 10</td>
<td>Value 11</td>
<td>Value 12</td>
</tr>
</tbody>
</table>

Additional information and tables may be included here as needed.
Most important part of the documentation

Don’t regurgitate the HPI or the interval history – what do you think about the Hx, PE, and Data? What are you going to do?

Synthesize, analyze

Readable

Evolving (progress notes). Don’t C&P the same assessment and plan every day.
Don’t be descriptive, be definitive!

Pulm: Intubated for desaturation
- Very large Aa- Gradient
- Continue Spiriva/Advair
- Duonebs every 6 hours
Evolution of Diagnoses

• Evolve diagnoses
• Resolve diagnoses
• Remove resolved diagnoses
• Recap major diagnoses in discharge summary
Evolution of Diagnoses

RLL infiltrate and SIRS: Probable sepsis likely secondary to Gram negative pneumonia

Sepsis secondary to probable Gram negative pneumonia

Sepsis resolved. Treating pneumonia

Cultures positive.

Assessment: Klebsiella pneumoniae pneumonia

DC Summary: Sepsis determined to be secondary to Klebsiella pneumonia, sepsis resolved Day 3, sent home on 5 more days of antibiotics
Let’s eat Grandma.
Let’s eat, Grandma.

PUNCTUATION SAVES LIVES
We’re going to cut and paste kids.

Commas matter.
According to research at Cambridge University, it doesn't matter in what order the letters in a word are, the only important thing is that the first and last letter be at the right place. The rest can be a total mess and you can still read it without a problem. This is because the human mind does not read every letter by itself, but the word as a whole.
is a 67 y/o M with pmh CLL being transferred from the floor with abdominal pain elevated lactate concernign for mesenteric ischemiaand labs concerning for tumor lysis PMHx: CLL (dx 6/2011, 17p-, 13q-, treated with rituximab/solumedrol starting 4/12, now on clinical trial at James Center in Columbus with ofatumumab and dinaciclib, last dose ofatumumab 2000mg 2/27/13)C/B disease burden in the mesenteric LN with wrapping around bowel and kidneys, and multiple admissions for SOB 2/2 pleural effusions Also perteient for recent PE in 2/'13, Afib but not on anticoag 2/2 thrombocytopenia, BPH HOPD and brief hospital course:| Presenting wwith abdominal pain over the past 1-2 weeks, worsened over the last 4 days. Sharp, 10.10 in intensity, worse lying on side, no BM for teh "several" days, able to apss some gas, has no apetitie and did not drink/eat much 2/2 pain SOB at rest adne xertional +orthopnea, no associaited CP, cough or fevers. In ED, patient received 500cc bolus KUb with no evidence of obstruction, transferred to the floor
On the floor, patietn was tachypneic to the 40s, and had a lactate of 6 with severe diffuse abdominal pain adn tenderness. ACS was consulted, CT abdomen w/o contrast doen and patietn transferred to MICU for further management
In teh MICU, upoin arrival vitals were stablea t HR of 90s, BP with SBPs 100s, Satting 94%on 2L, no UOP in the past 2 hours After routine patietn exam adn interview, ACS was called to comment on teh acute abdomen. Per ACS, no signs seen on CT concernign for ischemia. Will continue to observe.. If ghe does go to surgery high rate of mortality intra-op.
Idiopathic short stature
Individual Self-Rating Scale
Injury Severity Score
Inova Health System Sedation Scale
insulin sliding scale
Integrated Summary of Safety
irritable stomach syndrome
ischial spine sign
5/28 Cardomyopathy
- EF 25–30% on echo earlier in month
- Reintroduce hydralazine + will give 20 mg Lasix once today
- Will optimize HF meds

5/29 Cardomyopathy
- EF 25–30% on echo earlier in month
- Reintroduce hydralazine + will give 20 mg Lasix once today
- Will optimize HF meds

5/30 Cardomyopathy
- EF 25–30% on echo earlier in month
- Reintroduce hydralazine + will give 20 mg Lasix once today
- Will optimize HF meds

The patient underwent a colonoscopy (on last admission!)

“Consider flu shot…”

There is an audit trail when you use the Copy Forward function
Consult: Myself

![Fraud Alert]
Mindful Editing
DO WHAT YOU SAY

SAY WHAT YOU DO

thyroid without mass or tenderness,

(thyroid without mass or tenderness,)

DO WHAT YOU SAY
Subjective Data:
POD # 3 for Nephrectomy…

A&P:
POD #3 s/p R renal exploration and unroofing of R renal cysts

Height: 175 cm
Weight: 116 kg (really 116 lbs!)
BMI: 38.1 (really 17.3)
Emaciated, temporal wasting, cachectic

Propofol running.
PE: Not sedated…

Will place patient on Lovenox (order never placed → DVT/PE)
yesterday morning. Patient to ask in the breakfast, and feel well. After taking at its. There are related off to know when he was sitting at the at the dinner table and his granddaughter was in his lab and he started feeling a lot of nausea, belching, Margaret abdominal pain, even to the bathroom 3 times yesterday. He was not work today, via he denies, fever, chills, sweating.
Wow! Your cholesterol has me really worried!

Gack!

Uh... you might want to actually look at the patient...
You can personalize this to give you the selection of the documents YOU use routinely.

Type here to enter document

Discharge Summary
Documentation Clarification Note
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Expanded Text</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>.htn</td>
<td>hypertension</td>
<td>User</td>
</tr>
<tr>
<td>bid</td>
<td>twice a day</td>
<td>Enterprise</td>
</tr>
<tr>
<td>gtts</td>
<td>drops</td>
<td>Enterprise</td>
</tr>
<tr>
<td>hs</td>
<td>at night</td>
<td>Enterprise</td>
</tr>
<tr>
<td>im</td>
<td>into muscle</td>
<td>Enterprise</td>
</tr>
<tr>
<td>IU</td>
<td>International Unit(s)</td>
<td>Enterprise</td>
</tr>
<tr>
<td>MgSO4</td>
<td>Magnesium Sulfate</td>
<td>Enterprise</td>
</tr>
<tr>
<td>MS</td>
<td>Morphine Sulfate</td>
<td>Enterprise</td>
</tr>
<tr>
<td>MSO4</td>
<td>Morphine Sulfate</td>
<td>Enterprise</td>
</tr>
<tr>
<td>od</td>
<td>into right eye</td>
<td>Enterprise</td>
</tr>
<tr>
<td>ou</td>
<td>into both eyes</td>
<td>Enterprise</td>
</tr>
<tr>
<td>po</td>
<td>by mouth</td>
<td>Enterprise</td>
</tr>
<tr>
<td>pr</td>
<td>into rectum</td>
<td>Enterprise</td>
</tr>
<tr>
<td>prn</td>
<td>as needed</td>
<td>Enterprise</td>
</tr>
<tr>
<td>q</td>
<td>every</td>
<td>Enterprise</td>
</tr>
<tr>
<td>q.d.</td>
<td>every day</td>
<td>Enterprise</td>
</tr>
<tr>
<td>qd</td>
<td>every day</td>
<td>Enterprise</td>
</tr>
<tr>
<td>qhs</td>
<td>every night</td>
<td>Enterprise</td>
</tr>
<tr>
<td>qid</td>
<td>four times a day</td>
<td>Enterprise</td>
</tr>
</tbody>
</table>

**.htn** → **hypertension**
Discharge Summary

- Automated
- Can pull in course from HOT
- This is the last opportunity to depict the patient encounter
- This is the first document authorities look at
- Must be completed and authenticated within 7 days
Running summary in the Hand-off Tool

1. Have final SUMMARY in mind. Take only pertinent facts from HPI

2. Each day update with a sentence or two giving a running narrative of the patient’s course.

3. Delete “pending” and substitute results.

4. At the end of the patient stay, update, for hospital course of discharge or death summary. Bonus: Can give a quick synopsis at any time (reference for consult, transfer on or off service, sign-out).
think

BEFORE YOU

type
Any questions, please contact me: Erica.Remer@UHHospitals.org
216-464-4248

For UHCare questions or issues:
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(286-6296) or MD Help Line: 286-6200