# Documentation Tips - 2017

**Medical Necessity: *No admission for Sxs…***

- *(No Dx? "Place" pt. in "Observation" for work-up…)*
- If a presumptive care plan → "Admit for": Presumptive, Probable, Likely, Suspected Dx;
- *Avoid term "R/O"; "Possible"=Too Uncertain;*
- A Diff. Dx List--- Must have ONE Probable Dx;
    - *WHAT specific inpt. care does a pt. need?*
    - *WHY does a pt. need care In a Hospital?*
    - *RISKS & DANGERS, If a pt. is sent home;*

**Specify "Manifestations" of common Dxs**

- Acute Resp Fail. d/t Pneumonia; or Sepsis d/t Cellulitis; or Acute Kidney Inj. d/t Sev. Dehydration;

The **Initial** Documentation of a Dx must have:

- *The Clinical Criteria -or- Your Clinical Assessment;*
- Specify ALL acute/chronic + med./surg. Dxs, *If **M**onitored, **E**ducated on, **A**ssessed -or- **T**reated*
- Avoid term "History Of" for ongoing Med. Dxs; *("H/O" is to be used for "resolved" Dxs--- ONLY…!)*
- *No "Active" Dxs in PMH / Put in Assessment/Plan;*

**ID all "POA" ("Present of Admission") Dxs**

- *ID all POA injuries, disabilities, DVT/PE*
- *Skin Ulcers, Poor Glycemic Control, MRSA/C-Diff;*

**ID Infection Sxs: At IV Catheter & Surg. Sites;**

- Consider checking UA, if Pt has Urinary Catheter;
- *(Recent h/o Urinary Straight Caths--- UA needed?)*