SIGNIFICANT COMORBIDITIES DOCUMENTATION TIPS

HOSPITAL INFORMATION SYSTEM (HIS)

ALL POSITIONS WHO DOCUMENT SIGNIFICANT COMORBIDITIES

Most Responsible Diagnosis

The one diagnosis or condition described as being responsible for the patient's stay in hospital. (If more than one condition, the one held most responsible for the greatest portion of the LOS or greatest use of resources).

Pre-Admit Comorbidity

Significant condition present on admission (known or new) that has significant impact on LOS, management and treatment while in hospital.

Post Admit Comorbidity

Significant condition develops after admission that has significant impact on LOS, management and treatment while in hospital.

What is a significant condition?

- A condition that increases Length of Stay (LOS) 24 hours
- A condition that requires consultation for a previously undiagnosed condition
- A condition that requires consultation for a previously diagnosed condition that requires a change in treatment plan
- A condition requiring diagnostic intervention, inspection or biopsy
- A condition requiring an intervention on the Therapeutic "Flagged" intervention List (CIHI):
    - mechanical ventilation (>96 hrs & <= 96 hrs)
    - Feeding tubes
    - Tracheostomy
    - Cardioversion
    - Vascular access device
    - Radiotherapy
    - Pleurocentesis
    - Heart resuscitation
    - Chemotherapy
    - Cell saver
    - Dialysis
    - Per orifice endoscopy
    - Parenteral nutrition
    - Non-invasive biopsy
    - Paracentesis

Diagnoses must be supported by **physician documentation**. Nurse's notes, pathology reports, autopsy reports, medication profiles, radiological investigations, nuclear imaging, and other similar investigations are used for specificity. **Conditions documented in these reports cannot be captured as significant without supporting physician documentation**.

SIGNIFICANT COMORBIDITIES DOCUMENTATION TIPS

HOSPITAL INFORMATION SYSTEM (HIS)

General Documentation Tips

A lack of specificity in clinical documentation directly **impacts accurate coding and appropriate funding**.

Ensure all documentation is complete and specific by ensuring that:

- abbreviations are avoided, wherever possible
- established diagnoses linked to laboratory and diagnostic test results when these conditions are significant are documented
- significant conditions associated with interventions are documented
- significant conditions as iatrogenic, postoperative or postprocedural, when applicable, are documented
- "*delirium superimposed on dementia*" or "*acute confusion superimposed on dementia*" when this condition is significant is documented
- "*Palliative Care*" when appropriate – documentation includes palliative care, end of life care, supportive care, comfort care, compassionate care
- colonization and current infection when linked to drug resistant organisms are differentiated
- localized infection, generalized sepsis and severe sepsis (SIRS) are differentiated (Specify organisms linked to these conditions and identify any associated acute organ failure)
- underlying causes and manifestations of diseases currently being treated are documented; *avoid using symptoms* unless cause is unknown are documented
- specificity (e.g. causative organisms for infections) and relationships between diagnoses (e.g. If infection is due to a device, calculus, OR if CHF is due to hypertensive heart disease, etc.) are documented
- pneumonia is documented as either "bacterial" or "viral" when known

Discharge Summary

For a high-quality discharge summary, the following must be included:

- Reason for hospitalization, including descriptions of primary presenting condition and initial diagnostic evaluation
- Significant findings regarding the MRDx
- All comorbidities treated during the current hospital stay and identify all that contributed to an increase in the LOS by at least 24 hours; Any comorbidity not being treated but mandatory for capture in coding – diabetes with indication of type, hypertension and/or cancer
- Description of all procedures and treatments provided during hospital stay, along with the corresponding condition
- Dictate Discharge Summary at time of patient discharge.
- Patient health status upon discharge
- Any ordered homecare or follow up procedures

Questions? Contact **Debbie Bégin,** Data Quality Analyst ext. 41715/ debbie.begin@niagarahealth.on.ca and/or

Shannon Mitruk, Data Quality Analyst – ext. 32321/shannon.mitruk@niagarahealth.on.ca