EvidenceCare

Key Phrases & Documentation Tips

AdmissionCare

MCG utilizes phrases consistently across the INPT and OBS guidelines. As physicians become familiar with these phrases, it will allow them to be more efficient when utilizing AdmissionCare and to be apply the guidelines appropriately based on the patient's condition.

Despite observation care:
used when a patient is currently in OBS bed status and is not improving.

- This term is applicable when converting an OBS patient to INPT.
- Does NOT apply to care in the emergency department.
- Can only be accessed by switching to "Subsequent Review" on the toggle.

Beyond observation care:
provider anticipates hospital care that will go beyond the scope of OBS status or time, therefore necessitating INPT status.

- Document why you feel this patient needs INPT care beyond OBS status.

Vital sign abnormality:
needs to be sustained. Can NOT be a one-time reading or the patient's baseline

Unstable vital signs:
fluctuating vital signs. Could change for the worse at any time and negatively impact the patient's clinical condition.

Altered mental status:
different from the patient's baseline mental status.

- Need to document what the patient's baseline is and how their current status is different.

Abnormal laboratory results:
different from the patient's baseline values.

Physician Documentation Drives Medical Necessity

Documentation must support that the patient's condition is severe enough to warrant the need for services that can only be furnished safely in the hospital.

Inpatient (INPT)

Admissions must include reason for hospitalization as well as supporting documentation which may include:

- Complex medical history / comorbidities
- Severity of signs and symptoms
- Current medical needs

Observation (OBS)

Status must include reason for stay in the hospital:

- Risk of adverse event if sent home
- Reason for need for continued monitoring
- Supportive clinical data (vital signs / lab abnormalities)

Keys for Success

1. **Condition at time of decision** = criteria to select
   - Select criteria that reflects current status at time of admission decision (labs, vital signs, condition).
2. **Supportive documentation**
   - Use AdmissionCare to place documentation of guideline and criteria selected into H&P/Progress note in chart. Ensure your notes support the criteria selected.
   - Altered mental status must be different from baseline
   - Abnormal or unstable vital signs need to be sustained
   - O2 sat on room air
   - Risk / Severity Scores
3. **Think in ink**
   - If it isn't in the medical record, it didn't happen
   - Examples:
     - If strong suspicion of CVA due to gait impairment, evaluation must be noted in the medical record
     - If patient has recurrent seizures, this must be documented

Examples of Supportive Documentation

- Sustained abnormal vital signs (tachypnea, hypotension, hypertension, hypoxemia)
- Always document any dyspnea, aphasia, dysphasia, lethargy, confusion, etc.
- Further testing needed to diagnose post-emergency room care.
- Risk of adverse event if sent home.