

# Inpatient Documentation Prompter



A service of TMF Health Quality Institute.

Use this documentation prompter as a supplement to your standard medical record documentation guidelines

Document these components when appropriate to ensure a complete medical record.

All documentation must be legible and signed with the date and time.

Medical record components should always be completed on time and according to certifying/accrediting guidelines.

This material was prepared by TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-TX-HPPE-08-01

## HISTORY

**Chief** complaint, present illness

**Significant** medical/surgical history (existing comorbid conditions, current medications [prescription and OTC remedies], allergies and intolerances)

**Review** of systems

**Substantiation** for admission vs. outpatient observation/care

**Failed** outpatient therapy/treatment

**Relation** between current and previous recent admission(s)

## PHYSICAL

**Vital** signs and physical findings (comment on abnormal and pertinent negatives)

**Patient** distress, acuteness/severity of illness

**Patient** frailty/dependency/mental status

## PRESENT ON ADMISSION (POA)

**Identify** the conditions/diagnoses that the patient has on admission (including both acute and chronic); present on admission is defined as present at the time the order for inpatient admission occurs

## TESTING AND CONSULTATIONS

**Available** and pending test results at time of admission should be noted; also document consultations ordered or anticipated

## IMPRESSION

**Outline** provisional and differential diagnoses

**Rationale** for inpatient or observation admission status

## TREATMENT PLAN

**Outline** evaluation and treatment strategy

**Note** any limitations

**Initiate** discharge planning

## INVASIVE PROCEDURES

**Rationale** for invasive procedures

**Informed** consent (if applicable)

**Patient's** medical clearance for surgery

**Complete** anesthesia record

**Detailed** operative notes

**Postanesthesia** recovery notes

## ORDERS

**Admission** status with date/time/signature; write order clearly, such as "admit as inpatient" or "place in outpatient observation"

**Reason** for admission

**Physician(s)** responsible for patient care/management (e.g., Dr. Doe responsible for surgical care/management)

## PROGRESS NOTES

**Status** of unresolved problems

**Major** changes in condition and treatment plan

**Untoward** events and outcomes

**Abnormal** lab/x-ray/other diagnostic results with comment and appropriate follow-up

**Contradictory** observations from allied health professionals

## DISCHARGE SUMMARY

**Principal** diagnosis

**Secondary** diagnoses that affected the hospitalization and/or were treated and/or evaluated during the admission

**Principal** and secondary procedures

**Abnormal** and unavailable lab/X-ray/other diagnostic reports with comment and plans for appropriate follow-up

**Patient's** level of functioning and medical stability (if not fully stable, indicate why discharge appropriate)

**Special** problems (e.g., discharge AMA, patient request for limited services, etc.)

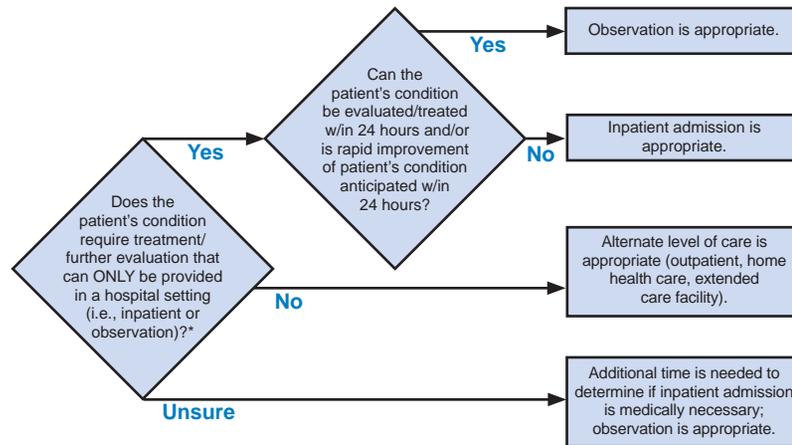
**Discharge** instructions (e.g., activity, diet, medications, wound care, caregiver arrangements, patient acknowledgement of discharge instructions, etc.)

**Follow-up** visits for patient medical management (when and by whom)

## ADDENDUM

**Abnormal** findings returned post-discharge (comments/treatment plan)

## OUTPATIENT OBSERVATION



\* The decision to admit a patient as an inpatient requires complex medical judgment including consideration of the patient's medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents.

### Key points to remember:

- Observation allows you time to determine if inpatient admission is necessary.
- Care in outpatient observation can be the same as inpatient care, but reimbursement is under the Outpatient Prospective Payment System.
- An order simply documented as "admit" will be treated as an inpatient admission. Use "inpatient admission" or "place patient in outpatient observation."
- Medicare coverage for observation services requires at least eight hours of monitoring and is limited to no more than 48 hours. The hospital is only reimbursed for 24 hours.
- An outpatient observation patient may be progressed to inpatient status when it is determined the patient's condition requires an inpatient level of care.
- An inpatient can be converted to outpatient if, before discharge or billing, the UR committee determines outpatient status is more appropriate and the physician concurs and documents this in the medical record. The physician must then bill all his/her services as outpatient services.
- Outpatient observation is not appropriate for convenience reasons, routine prep for and recovery after diagnostic testing, certain therapeutic services, normal post-procedure recovery time (4-6 hours) and procedures designated as "inpatient only" or that are appropriate as inpatient.
- Documentation must support the level of care provided (inpatient admission versus outpatient observation).