General Surgery
Best Practice Documentation

Click on the desired Diagnoses link or press Enter to view all information.

Diagnoses:

- Anemia
- Debridement
- Lysis of Adhesions
- Lymph Node Chains
- Intraoperative and Postoperative Complications
- Hematoma due to a Procedure
- Pathology Findings

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Anemia

- Type:
  - Nutritional (Iron, B12, or Folate Deficiency)
  - Hemolytic
  - Aplastic
  - Due to blood loss
    - Due to Procedure
    - Unrelated to Procedure
- Acuity:
  - Acute
  - Chronic
  - Acute on chronic
- Document a “due to” underlying condition causing the anemia
- Link any associated medication or drug use

Anemia
Documentation Example

Insufficient Documentation

- Hgb dropped to 8.1 from 12.6 post-op. Will transfuse with 2 units PRBC

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- Hgb dropped to 8.1 from 12.6 pre-op. EBL 800ml. Will transfuse with 2 units PRBC. **Acute blood loss anemia due to ORIF of Femur.**

Debridement

Key Documentation Requirements for Debridements

- Depth
  - Skin
  - Subcutaneous tissue/fascia
  - Muscle
  - Joint
  - Bone
- Type
  - Excisional / Sharp (cutting away of tissue)
  - Non-excisional (removal of devitalized tissue, necrosis, or slough by irrigating, scrubbing, washing , etc.
- Specify the type of instrument used (required for physician billing)

Debridement Documentation Example

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- Bedside debridement of abdominal wound.

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- Bedside excisional debridement of necrotic abdominal subcutaneous tissue using #14 scalpel . Wound measures approximately 4 cm X 2.5 cm X 2.0. Packed with wet to dry gauze.

Lysis of Adhesions

Document the body part being released/freed. For example:

- Jejunum
- Ascending Colon
- Gallbladder
- Peritoneum
- Document the severity of adhesions
  - Complicated
  - Dense
  - Extensive, etc.

Lymph Node Chains

- Extent of excision/resection:
  - Entire lymph node chain
  - Portion of lymph node chain
- Anatomical Location of lymph node(s):
  - Head
  - Right/Left neck
  - Right/Left upper extremity
  - Right/Left axillary
  - Thorax
  - Right/Left internal mammary
  - Mesenteric
  - Pelvis
  - Aortic
  - Right/Left lower extremity
  - Right/Left inguinal

Intraoperative and Postoperative Complications

The terms “Post Op” and “Status Post” are considered vague and requires further clarification to determine if the condition is a complication. Key elements for best practice documentation include:

- The affected body system
- The specific condition
  - Acute blood loss anemia
  - Accidental laceration (of specified organ)
  - Hematoma
  - Ileus
- Whether the condition is a/an
  - Complication of care or due to the procedure
  - Expected procedural outcome
- When the complication occurred
  - Intraoperative Complication
  - Postoperative Complication

Post-Op Complications Documentation Example

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Post-op ileus. POD # 3.	S/P RHC POD # 3 Negative BS, NGT Prolonged ileus 2/2 extensive adhesions.
Patient VQ scan positive for pulmonary embolism. History of TKR two weeks ago.	Post-Op patient developed a pulmonary embolism most likely resulting from immobility from recent TKR.

CHRISTIANA CARE HEALTH SYSTEM

Hematoma due to a Procedure

- Site of the hematoma
  - Depth
    - Skin
    - Subcutaneous tissue
    - Musculoskeletal
- Procedure associated with the hematoma
  - The clinical significance of the hematoma
    - considered a postoperative complication
    - or an expected outcome
    - Unrelated to the procedure
      - Due to other chronic condition
      - Due to anticoagulants

Pathology Findings

Best Practice Documentation:

- Pathology known prior to surgery should be documented and reinforced in the operative report and progress notes.
- Suspected, possible, or likely pathology should be documented based on clinical judgment whenever possible.
- Pathology findings should be documented in a progress note, consult, or discharge summary as soon as reviewed or made available.
- When pathology results are available after discharge it is appropriate and compliant to document them in the acute care legal medical record.

Key Documentation Concepts

Best practice documentation requires you to hit all of the following key elements:

- Surgical Approach
- Document the body part being resected/excised to the highest degree of specificity
  - Generalities: Lung biopsy
  - Specifics: Right Upper Lobe of Right Lung biopsied
- Include if total organ/body part was removed
  - Generalities: small bowel resection
  - Specifics: partial resection of duodenum or total excision/resection of the duodenum
- Device/Implants Used

Take the Extra Step!

Document :

- ALL chronic conditions – present and stable but managed.
- Significance of abnormal tests (i.e.: UTI, electrolytes, echo)
- Clarify whether diagnoses are ruled in or ruled out
- Establish cause-and-effect relationships (i.e. PICC line infection)
- Laterality, if applicable
- Explain the "why" and " because" to support medical necessity
- Any tobacco use, abuse, dependence, history of smoke exposure (e.g., second hand, occupational, etc.)
- Document Present on Admission (POA) status , especially if diagnosis isn't confirmed until day two or three of admission.