

Trauma Documentation

Etiology

Majority of the time documentation of underlying cause is very important for example: “AKI due to dehydration present on admission”. Document a baseline if known for example: “baseline creatinine is 1.2”

Coagulation Defect

Need to “link” the bleed to the drug. Did the drugs contribute to the bleeding- use **the linking term “due to”** or **“contributed to”** (“in the setting of” or “with” does not link or establish a cause and effect relationship):

Bleeding due to aspirin (or Plavix, other anti-coagulant or antiplatelet), **Quantitative platelet defect due to aspirin**, **Coagulation defect due to Coumadin complicating GI bleed**, **Coagulation defect due to Plavix complicating Traumatic SDH**

Acute blood loss anemia

Etiology - was the acute blood loss anemia due to the trauma (acute blood loss anemia due to multiple injuries)

Shock

Specify hypovolemia, hemorrhagic, or traumatic shock present on admission, etiology such as due to crush injury

Fractures/Dislocations

Document the fracture or dislocation of each bone and whether by stabilization or surgery or no treatment

Document the number of rib fractures on each side

Intracranial Injuries

Specify if Traumatic is the cause (this cannot be assumed) Traumatic SDH/SAH, Traumatic Cerebral Edema

GCS Scores

Break them down (not the total score) into verbal, eye, and motor (WNL’s still increases the O/E for Mortality)

LOC

Was there LOC due to trauma? Document the presence or history of cerebral concussion or cause of transient LOC

Document the length of time for the LOC if this is known or estimated (even if brief affects O/E for Mortality)

Chest Injuries

Specify whether due to trauma: Traumatic pneumothorax, Traumatic hemothorax, Traumatic hemopneumothorax

Penetrating Injuries

Specify whether penetrating the thoracic cavity, abdominal cavity, peritoneal cavity, or other ie retroperitoneal

Respiratory Failure

What is the underlying etiology (ie due to fat embolism, pulmonary contusion, exacerbation of COPD, aspiration pneumonitis, alcohol or drug abuse). Example: **Acute hypoxic respiratory failure due to brain compression due to traumatic SDH present on admission.**

Present on admission

Be clear of all conditions POA by documenting the diagnosis and underlying cause (Traumatic anuria due to crush injury of the kidneys) All fluid and electrolyte disorders - clarify if POA & underlying cause. (affects O/E)

Clinically unable to determine counts as a “yes” for poa (Unknown counts as a “no”)

Other Injuries

Internal organ: Traumatic spleen, liver, kidney laceration - specify grade due to trauma

Specificity: Traumatic rhabdomyolysis, Traumatic subcutaneous emphysema, Traumatic ischemia of muscle, Traumatic fat/air embolism , Traumatic secondary and recurrent hemorrhage and seroma.

Complications

Must address if expected and inherent or an unexpected complication

Must address if the condition is due to the trauma or due to the surgery (pancreatic artery bleed due to trauma)

There must be a cause and effect relationship between the care provided and the condition

Clarify whether the diagnostic condition was a complication of the procedure or provide the **etiology** to explain its presence (ie caused by the disease, caused by anesthesia, was poa but not identified at the time)

If the condition is due to an identifiable disease, make the **“link”** (ie acute urinary retention due to BPH, atelectasis due to morbid obesity, respiratory failure due to exacerbation of COPD, respiratory failure due to degenerative neurological/musculoskeletal condition)

Terms to use: due to, secondary to, related to, necessary, to facilitate, required, intentional, intended, inherent, integral, routinely expected, due to other factors other than the operative procedure (Trauma)

Terms not to use: with, post-operative, after, post procedural, following (don't use as a time stamp)

Chronic Conditions

Document other chronic, stable conditions that are under treatment, even if they are followed by another physician while the patient is in the hospital. Do not say PMH or past medical history if the patient is still undergoing active treatment. Document “Patient has HTN, DM2 (add any manifestations or complications from DM), CKD Stage 3, chronic respiratory failure dependent on home oxygen, Morbid Obesity, left sided hemiplegia due to previous stroke, & chronic A-fib.

Uncertain Conditions/Diagnoses

Likely, suspected, or probable conditions if still uncertain at time of discharge need to be clearly documented on the Discharge Summary in order to be coded (inpatient only)

Are you talking in terms of symptoms and in treatments—for example, ‘shift’ instead of brain compression and ‘pressor dependent’ instead of hypovolemic shock.

It's important to supplement this language with a diagnosis (it's your diagnostic statement that counts)

