Coders guide to use of nursing, midwifery & allied health documentation

Types of clinical documentation

High quality clinical documentation promotes effective communication between caregivers and facilitates continuity of patient care. It also facilitates accurate clinical coding – a diagnosis or procedure can only be coded if documented in the medical record.

Medical officer documentation

Diagnosis and treatment of medical conditions is the responsibility of the treating medical officer(s), therefore clinical coders predominantly use medical officer documentation.

Nursing, midwifery and allied health documentation

Documentation from clinicians other than medical officers (i.e. nurses, midwives, allied health professionals) is also used by coders. It can help to provide clarification and specificity about (or confirm existence of) a diagnosis or procedure documented by a medical officer. More importantly, if a nursing, midwifery or allied health documented diagnosis or procedure is appropriate to that clinician’s discipline, it can be coded regardless of whether the medical officer has documented it.

Examples

- A diagnosis of pneumonia can only be coded if documented by a medical officer.
- A diagnosis of pressure injury documented by a nurse (which the medical officer fails to document) can be coded because skin integrity management is appropriate to the nursing discipline.
- A diagnosis of post-partum haemorrhage documented by a midwife (which the medical officer fails to document) can be coded because it is appropriate to the midwifery discipline.
- A diagnosis of dysphagia documented by a speech pathologist (which the medical officer fails to document) can be coded because it is appropriate to the speech pathology discipline.
Use of nursing documentation

As per Australian Coding Standards, coding directly from nursing documentation is restricted to conditions appropriate to the nursing discipline. In the absence of national coding guidelines defining which conditions are appropriate to the nursing discipline, the Department of Health, WA interprets this to mean a condition where a nurse alone can initiate and complete treatment.

General nursing

The main areas of general nursing that may require coding are skin integrity and continence.

Skin integrity

Examples of documentation commonly required and used for coding:

- Ulcers – location; type; if pressure injury what is the stage? A new pressure injury sticker for WA public hospitals is being trialled at RPH. The sticker is designed to collect standardised information and is completed by nursing staff. This will provide useful information to coders for accurate coding of pressure injury.
- Wounds – location; type e.g. laceration, skin tear, abrasion
- Excoriation – location; cause
- Minor injuries in initial multiple trauma presentation – location; type e.g. contusion

Continence

Examples of documentation commonly required and used for coding:

- High bladder residuals; unable to void (R39.1 Other difficulties with micturition)
- Urine retention (R33 Retention of urine)
- Urine incontinence (R32) and faecal incontinence (R15) – use nursing documentation to determine if incontinence is a persistent problem:
  - Is incontinence persistent prior to admission?
  - Is incontinence present at discharge?
  - If incontinence is transient during admission, calculate duration (it is only coded if managed 7 days or longer, as per ACS 1808 Incontinence)

Other general nursing documentation

Examples of documentation commonly required and used for coding:

- IV cannulation
  “Tissued IV site” is not considered a complication and should not be coded. It is naturally expected that an IV site will eventually “tissue”, and repositioning is required if long term cannulation is planned. Significant complications of an IV line usually require medical officer attention/intervention. See also ACS 1904 Procedural complications.
Other general nursing documentation (continued)

- **Invasive and non-invasive ventilation**
  Nursing documentation may be used by coders in order to calculate the duration (hours) of ventilation. ICU forms are helpful for this purpose. In other situations the coder relies on progress notes or other documentation to calculate ventilation hours.

- **Hypoglycaemic episodes in diabetic patients, treated by nursing staff alone**
  Nursing documentation of “hypoglycaemia” may be used by coders when the nurse alone has initiated and completed treatment e.g. provided carbotest drink. Documentation of BSL readings alone, or “low BSL”, is inadequate to code hypoglycaemia.

Specialist nursing

A summary of documentation that is commonly used for coding is provided below.

**Tracheostomy and Stoma care**

Any obstruction, leakage or other complication? Is it non-transient? What, if any, intervention is required?

**Diabetic Educator**

Type of diabetes? Is insulin used? Any complications of diabetes e.g. PVD, retinopathy? Is diabetes poorly controlled? Documentation such as “poorly controlled”, “uncontrolled”, “for stabilisation”, “unstable” to enable coding of poor control.

**Midwifery**

Documentation commonly used for coding includes the record of labour and/or delivery and any complications that occur; interventions that are performed and any condition necessitating intervention.

In some hospitals, the STORK summary is regarded as the only discharge summary for delivery episodes. Midwives are recognised as clinicians in Obstetrics, however are not the admitting clinician ultimately responsible for admitted patient care. Therefore, if STORK is to be regarded as the only discharge summary:

- It must be checked and countersigned by the medical officer responsible for admitted patient care
- It will be expected the STORK summary is the instrument by which the care given is communicated to GPs and other health professionals in order to promote continuity of care.

This does not preclude medical officers choosing to supply a medical discharge summary over and above the STORK summary.
Neonatal

- Commencement and cessation date/time for phototherapy of newborns. The coder is required to calculate total hours of phototherapy
- Admission weight of neonate in subsequent admissions after the birth episode. It is a mandatory data requirement and can affect DRG.

Nursing and midwifery documentation not coded

Nursing and midwifery documentation is expected to provide evidence of all care given to the patient. However, for coding purposes, not all care will meet the definition of being ‘appropriate to the nursing or midwifery discipline’ and would therefore not be coded from nursing or midwifery documentation alone.

Examples of conditions not considered appropriate to the nursing or midwifery discipline for coding purposes:

- Heartburn
- Headache
- Low BP
- Constipation
- Haemorrhoids
- Abdominal pain

A nurse or midwife can independently administer Schedule 2 and 3 drugs for some conditions, however this has historically been deemed insignificant for coding purposes as these drugs are available over-the-counter and can be self-administered by patients outside of hospital. Also, if nurse or midwife initiated medication is to continue after 24 hours of the initial administration, it must be ordered by a medical officer. Therefore the nurse or midwife cannot alone initiate and complete treatment of such conditions consistently, making these conditions not appropriate to the nursing/midwifery discipline for coding purposes.

Example of Nurse initiated medication list - Schedule 2 and 3 drugs

**Aperients**
- Bowel stimulants
  - Docusate (Coloxyl)
  - Docusate with Senna (Coloxyl with Senna)
- Bulk Laxatives
  - Fybogel
- Bowel Preparation
  - Colonlytely / Golightly
  - Picoprep

**Antiflatulents**
- Peppermint Water
- Simethicone

**Enemas & Suppositories**
- Glycerine Suppositories
- Microlax Enema
- Durolax Suppositories

**Antacids**
- Aluminium Hydroxide (Gaviscon™, Mylanta™)

**Anti-Fungal Agents**
- Nystatin Oral Drops
- Clotrimazole Pessaries and Cream

**Analgesics**
- Paracetamol (Oral & PR)
- Paracetamol 500 mg and Codeine Phosphate 8mg

**Intravenous Flushes**
- Normal Saline flushes for maintaining IV cannulas

**Incidentals**
- Glucamom solution
- Ural Sachets
- Saliva Substitute
- Cepacol Lozenges
- Occular Lubricants
- Nicotine replacement therapy (patches and inhalers)

Conditions documented by nurses and midwives should not be ignored as they may flag a diagnosis or procedure that the medical officer inadvertently failed to document. For example, nurse documents “Slow K given as charted”, but no relevant medical officer documentation is present. The coder should seek further information to determine the reason for the procedure. For example, check the laboratory results and if potassium is below the normal level, the clinician should be asked to clarify whether hypokalaemia was present.

**Telephone orders**

If a medical officer is not in attendance but is providing telephone orders e.g. after-hours, in remote/rural hospitals, the information exchange must be thoroughly documented and can be used by the clinical coder. This includes information conveyed to the medical officer, and any diagnosis and treatment order made by the medical officer. Medication orders should be charted by the medical officer when they next attend. The coder should check the medication chart to ensure the medication was given i.e. the condition was treated.

**Use of allied health documentation**

As per Australian Coding Standards, coding directly from allied health documentation is restricted to conditions appropriate to the allied health professional’s discipline. In the absence of national coding guidelines defining which conditions are appropriate to an allied health discipline, the Department of Health, WA interprets this to mean a condition where an allied health professional alone can **initiate and complete** treatment.

Diagnosis information is commonly found in the allied health professional’s assessment notes. Issues to consider when using allied health documentation:

- Results/scores from testing tools (e.g. post-traumatic amnesia assessment score) should not be interpreted by coders. The condition must be documented by the allied professional to be used by the coder
- Documentation such as “Dysphagia review” should have a clear final assessment documenting whether patient has the condition

**Mandatory conditions**

Australian Coding Standards and national advice instruct that some conditions or status codes should always be coded when documented. Examples include:

- Diabetes mellitus (ACS 0401)
- Hepatitis B and C (ACS 0104)
- HIV (ACS 0102)
- Tobacco smoking status (ACS 0503)
- Pacemaker status for procedural cases (ACS 0936)
- Multiple injuries (ACS 1907)

The above conditions can be coded based on nursing documentation alone, but general coding and abstraction guidelines should still be followed. As instructed in the Introduction to the Australian Coding Standards: “When a diagnosis is recorded for which there is no...
supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code”.
Patient questionnaire answers should not be used for coding, except to determine tobacco smoking status, and to flag the presence of mandatory conditions which should be verified elsewhere in the medical record before being coded.