



PROVIDER CLINICAL DOCUMENTATION TIPS
Pediatrics

"Specificity and detail in the medical record is needed to accurately capture the complexity of the patient you are treating in order to justify and properly identify the resources needed to care for your patient. Your documentation affects the accuracy of publicly reported data including risk adjustment quality measures and outcomes data."

Always document:

- Reason for admission: Include possible, probable, or suspected diagnoses.
- Reason for change of status from OBS to in-patient
- Clinical diagnoses of significant labs (i.e. Low sodium=hyponatremia), radiology reports and pathology findings.
- Clear documentation linking baby and mom's conditions (maternal chorioamnionitis, prolonged rupture of membranes, maternal drug use, newborn hypoglycemia due to maternal GDM etc.)

"History of" means a condition existed in the past and has completely resolved. Consider "chronic" or drop 'history of' for monitored conditions.

Medical Linkage = "Due to" or "Secondary to"

When two conditions are related. Example: Sepsis "due to" aspiration pneumonia, UTI "due to" Foley catheter, Sepsis "secondary to" infected portacath.

Always carry through to the discharge summary any diagnoses that have not been ruled out. *Close the loop on conditions at discharge- define conditions as possible, probable, suspect, "ruled out" or "resolved".

Present on Admission status (POA):

- *Pressure Ulcers: Type, site and stage
- *Sepsis: If identified after study & not documented on admit
- *Infection due to Indwelling Device: Portacath, PICC, Foley, Hickman, Infusion Pump, VP Shunt

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Sepsis (Bacterial or Viral): Suspected or Confirmed:

Requires two or more of the following SIRS criteria **PLUS** a source of infection, suspected or proven (Bacterial or Viral):

- Abnormal temp (>38C/100.4F or <36C/96.8F) **AND/OR** Age-specific abnormality of the WBC

AND

- One of the following: tachycardia, bradycardia, respiratory distress, hypotension or pulmonary conditions up to requiring mechanical ventilation.

**Do Not need positive blood cultures. Early signs may be subtle-use clinical judgment

Age specific criteria:

Age	Tachy-cardia	Brady-cardia	RR	Leukocytes x103/mm	Hypo-tension (SBP)
0d- 1wk	>180	<100	>50	>34	<59
>1wk-1mo	>180	<100	>40	>19.5 or <5	<79
>1mo-1yr	>180	<90	>34	>17.5 or <5	<75
>1yr-5 yrs	>140	N/A	>22	>15.5 or <6	<74
>5 -12 yrs	>130	N/A	>18	>13.5 or <4.5	<83
>12-18 yrs	>110	N/A	>14	>11 or <4.5	<90

Severe Sepsis:

Sepsis with Organ Damage:

- Lactic acidosis, AKI, Encephalopathy, resp failure, hypotension

Septic Shock:

Sepsis induced hypotension that does not respond to fluid resuscitation or vasoactive medications that persists after the administration of ≥ 40 ml/kg of isotonic fluid in one hour

Shock:

Age	Systolic BP
0-28 days	<60 mmhg
1-12 months	<70 mmhg
1-9 years	<70 mmhg
>10 years	<90 mmhg

-**PLUS**, end organ damage (lactic acidosis, AKI)

Specify Type: Cardiogenic, Hypovolemic, Toxic, Neurogenic,

Anaphylactic, Postprocedural, Post-Traumatic, Septic,

Specify Treatment: IVF, blood transfusion **AND/OR** vasopressor

Pediatric Acute Respiratory Failure:

The respiratory system fails from inadequate ventilation or impaired alveolar gas (oxygenation and carbon dioxide) exchange often requiring respiratory support

-Requires some S/S of resp distress that need to be documented: Use of accessory muscles, shallow breathing, tachypnea, nasal flaring, altered mental status and/or increased respiratory rate.

Age	Resp Rate	
< 2mo	≥ 70	**ABGs are NOT required
2-12mos	≥ 60	
1-2 yrs	≥ 45	Specify: Acute, Chronic, or Acute on Chronic
2-6yrs	≥ 30	
6-11 yrs	≥ 25	Specify: Hypoxic &/or Hypercapnic
12-18 yrs	≥ 20	

Acute Hypoxic Respiratory Failure:

-ABG: arterial pO2 on room air <60mmHg

-SpO2<90% by pulse ox in a pt. w/o chronic resp failure

-P/F ratio (pO2/FIO2) <300 not applicable for A/C Resp Failure

Acute Hypercapnic Respiratory Failure:

-pCO2 >50mm Hg with pH of <7.35 or If baseline PCO2 is known, a 10-15 mmHg increase in baseline pCO2

Pediatric acute respiratory distress syndrome (PARDS): Know as acute lung injury (ALI), is due to inflammation and damage to the alveolar membranes causing fluid to leak into the alveolar air spaces that causes hypoxemia.

Treatment and mgmt: CPAP, Bipap or MV, HFNC, Intensive frequent repeated inhaled resp. modalities, Heliox or inhaled NO.

Chronic Respiratory Failure:

Indicators: Hypoxic, elevated pCO2, elevated bicarb, normal pH (7.35 to 7.45)

AND Chronic use of continuous home O2- 24 hrs a day. (NOT Intermittent, exertional, or nocturnal use of O2.)

Acute on Chronic Respiratory Failure:

Indicators: (ABG's are NOT required)

-pCO2 >50 mmHg + pH of <7.35

-Increase in baseline pCO2 (if known) by 10mmHG or more

-pO2 <60 mmHg or SpO2 <90% with \geq usual home O2 rate

-worsening dyspnea requiring an increase in chronic supplemental oxygen

Pediatric Acute Kidney Injury: (Not Insufficiency)

-Increase in Cr level $\geq 1.5x$

baseline known/presumed within prior **7 days** or

-Increase in Cr level $\geq 0.3mg/dl$ in prior **48 hrs** or

-UOP: **< 0.5 ml/kg in 6 hrs.**

Specify Cause: Dehydration, Hypotension, Sepsis, Nephrotoxic medications etc.

Specify Type: Prerenal, Intrinsic, Postrenal.

Consider ATN: Meets criteria for AKI but expected to take >72 hrs to resolve.

Specify Causes of ATN: IV contrast, Sepsis, Shock, Drugs, Major Surgery, Rhabdomyolysis, Prolonged Hypotension

Chronic Kidney Disease:

Document: CKD Stage

Stage	G Stage	GFR
1	G1	≥ 90
2	G2	60-89
3	G3a	45-59
3	G3b	30-44
4	G4	15-29
5 or ESRD or on dialysis		
	G5	<15

Newborn Respiratory Specific Diagnosis (<28 days):

Newborn Respiratory Failure: Newborn respiratory failure is diagnosed when an infant requires at a minimum: respiratory intervention of oxygen at $\geq 21\%$ NC and/or any FIO₂ (>21%) OR, if there is need for any amount of respiratory support* at or after 30 minutes of delivery.

Symptoms **must** be documented: retractions, nasal flaring, grunting, or lethargy, Tachypnea (RR \geq 70), SpO₂ <88%, PCO₂ > 50, PO₂ < 60. *ABG's are NOT required.

Transient Tachypnea (TTN) or Wet lung syndrome: A self-limited condition commonly seen in full-term neonates due to excessive fluid accumulation in the lungs. **NOT** requiring O₂. RR >60 past the first 4 hours of life. Usually resolved within 24-72 hours. CXR: Fluid in fissures or peri-hilar streaking.

Transient Tachypnea (TTN) with Respiratory Failure: TTN progressing to require O₂ support.

Respiratory Distress of Newborn (RDS): includes Hyaline Membrane Disease. Caused by deficiency of surfactant resulting in collapse of alveoli. Infants with RDS are nearly always preterm. S/S: tachypnea, apnea, grunting, nasal flaring and retractions. CXR: ground glass appearance or air bronchograms. Surfactant may be administered.

Meconium Aspiration Syndrome: Meconium-stained amniotic fluid with respiratory distress at birth.

Persistent Pulmonary HTN (PPHN): Usually present within 24hrs with s/s of respiratory distress (cyanosis, grunting, retractions). A harsh systolic murmur consistent with tricuspid insufficiency may be heard in the left lower sternal border. May be treated with NO.

Neonatal AKI:

Suspected in a newborn with no urine output by 48 hours of age, a diminished urine output (less than 1 mL/kg per hour), or edema. Electrolyte imbalance/acidosis may co-exist.

Dx is **confirmed** w/ an abnl elevated serum creatinine (SCr) for gestational age (GA) or increasing SCr from a previous baseline, Neonatal KDIGO AKI criteria applied after 72 hours of life.

Stage	Serum Creatinine (SCr)	Urine Output
0	No change in SCr or rise of <0.3mg/dL	≥ 0.5 mL/kg/h
1	SCr rise ≥ 0.3 mg/dL within 48 h or SCr rise $\geq 1.5 - 1.9$ x reference Scr within 7 d	< 0.5 mL/kg/h for 6 - 12 hrs
2	SCr rise $\geq 2.0 - 2.9$ x reference SCr	< 0.5 mL/kg/h for ≥ 12 hrs
3	SCr rise ≥ 3 x reference SCr or SCr ≥ 2.5 mg/dL or Receipt of dialysis	< 0.3 mL/kg/h for ≥ 24 hrs or anuria for ≥ 12 hrs

-For preterm infants, AKI is based on exceeding critical SCr:

- GA 24 to 27 weeks: >1.6mg/dl
- GA 28 to 29 weeks: >1.1mg/dl
- GA 30-32 weeks: >1.0mg/dl

-Pre-renal: Hypovolemia, Reduction of effective circulation (eg. asphyxia, sepsis, NEC).

-Tubular/interstitial disease- ATN is the most common cause of intrinsic neonatal AKI: Ischemic injury (eg. renal hypoperfusion), Prenatal/postnatal nephrotoxic exposures

Drug Withdrawal/Neonatal Abstinence Syndrome:

-NAS scores ≥ 8

-Document newborn tox results (cord or stool)

-Document any associated conditions (tremors, skin excoriation, dermatitis etc.)

Common Diagnoses/Conditions Impacting SOI/ROM	
ABO/Rh Incompatibility	IUGR
Disturbance of Neonatal Thermoregulation (Temperature Instability)	Newborn affected by: - GBS - Chorioamnionitis - Maternal Diabetes - Maternal drug use (Rx or Illicit)
Small for gestational age (SGA)	Vomiting/Emesis
Newborn feeding problems (specify breast or bottle)	Ankyloglossia (Tongue Tie)
Hyponatremia	Hypermagnesemia
Thrombocytopenia	Victim of bullying

Newborn Hypoglycemia

< 40 mg/dL

Specify: Symptoms if present (Jittery, irritable, tachypnea, poor suck/feeding, hypotonia, weak or high-pitched cry, AMS.)

Treatment: Glucose gel, IV dextrose feeding, monitoring

Electrolytes:

Use diagnosis terms i.e. hyponatremia, not low sodium. Indicate treatment or lab monitoring.

Pancytopenia

Specify Cause: Chemo, radiation, malignancy, splenomegaly.

Seizures:

Specify type: (generalized, partial, partial complex, febrile etc.) and with or without intractable epilepsy or status epilepticus.

Cerebral Palsy:

Specify: Spastic Quadriplegic, Spastic Hemiplegia, Spastic diplegic, Athetoid.

Functional Quadriplegia:

Inability to use one's limbs and ambulate due to extreme debility by another medical condition without physical injury or damage to the spinal cord. Typically requires "total care". Common causes: Profound intellectual disability, advanced neuro-degenerative disorders (e.g. MS, CP, ALS), severe brain damage.

Pressure Ulcers/Wounds:

Provider must document site and POA of a pressure ulcer.

Specify Type: Pressure, Traumatic, Chronic Non-pressure, Nonhealing Surgical. **Specify Stage:** I-IV, Deep tissue pressure injury, Unstageable

Malnutrition:

Specify: Mild, moderate, mild, severe protein-calorie malnutrition. Refer to RD Consult for assistance.

Pediatric Obesity: BMI $\geq 95\%$ for age.

Pediatric Severe Obesity: BMI $\geq 120\%$ if the 95th percentile or an absolute BMI ≥ 35 kg/m², whichever is lower based on age and sex.

Intellectual Disabilities:

"Developmental Delay" does not affect SOI/ROM until severe or profound--**Specify: Severe** (IQ 20-35): Requires daily assistance with self-care activities and safety supervision
Profound (IQ <20): Requires 24hr care

Acute Encephalopathy:

-reversible and resolves when the underlying cause is corrected, structural changes do not occur.

-Not the same as delirium (a mental disorder or symptom)

Specify Type:

Metabolic: due to fever, dehydration, infection, acute hypoxia, electrolyte imbalance etc.

Septic: manifestation of severe sepsis.

Toxic: refers to the effects of drugs or toxins (iatrogenic or illicit substance).

Toxic Metabolic: suggests a combo of toxic and metabolic factors.

Hypoxic/anoxic: permanent chronic brain damage to sustained hypoxia.

HIE: applies to neonates as an acute or subacute brain injury due to oxygen deprivation at birth, seizures are a common manifestation. **Specify: Mild:** Characterized by hyper-alertness and excessive reaction to stimuli.

Moderate: associated with lethargy, clinical seizures, suppressed tendon reflexes, bradycardia and periodic breathing. **Severe:** accompanied by stupor or coma, primitive or no reflexes, variable heart rate and apnea.

Pneumonia:

"Healthcare Acquired or Community Acquired indicates where pneumonia was acquired and is not a codable diagnosis. Instead document according to type or organism".

Specify Type:

Aspiration, Interstitial, Viral, With Influenza, Bacterial

Specify Causative Organism: Including Probable, Possible, or Suspect Gram -, Gram +, Staphylococcal, Pneumococcal, Klebsiella, etc. Document "possible gram-neg pneumonia when treating for suspected or gram-neg pneumonia". Does not require culture confirmation to support a suspected/possible/probable diagnosis.

Asthma:

Specify the type and severity, exacerbation, status asthmaticus, Consider: acute hypoxic/hypercapnic respiratory failure.

Acute Blood Loss Anemia (ABLA):

-Drop in HGB of 2 gm or more due to acute blood loss

-Does not require a certain amount of blood loss/transfusion

-May or may not be symptomatic, -Monitored with Hgb labs

-Not a post procedural complication unless specified as a complication by provider

Social Determinants of Health Affect Quality, Mortality, & Expected Outcomes Data	
Illiteracy or low levels of literacy, school unavailable	Homelessness, inadequate housing, low income, or poverty
Social exclusion/rejection, problems living alone, lifestyle transition or acculturation difficulty	Inadequate parental supervision or control, parental overprotection, institutional upbringing
Conviction, imprisonment, victim of crime	Absence of family member, Alcoholism or drug addiction in family
Unemployment, workplace harassment	Occupational exposure to risk factors