Central Coast Local Health District
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Audit & Data Quality Plan

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Introduction

CCLHD HIS has implemented an auditing and data quality program within the LHD in the 18/19 FY.

The aims of the audit program are to:

- Assess compliance and accuracy of Document Imaging scanning processes
- Identify and action patient duplicates in the PAS
- Identify issues that impact on scanning, coding and medico legal timeliness
- Provide education and feedback to HIS and CCLHD staff on quality health record processes
- Improving health record documentation to the quality of the CCLHD Health Record

2016/2017Audits

CCLHD 2016/2017 Audits can be found on the Health Information Services intranet page:

http://intranet.cclhd.health.nsw.gov.au/clinical/ClinGov/his/Pages/DocumentImagingAudits.aspx

http://intranet.cclhd.health.nsw.gov.au/clinical/ClinGov/his/Pages/Quality-Projects.aspx

2017/2018 Audit Scope

Wyong Hospital	Document Imaging Audits Discharge Summary Completion Audit Targeted Audits
Gosford Hospital	Document Imaging Audits Discharge Summary Completion Audit MRN duplicates audit Targeted Audits

Document Imaging Audits

Criteria Audits

This Audit compares the paper work and the scanned images in PowerChart against a set criterion. All mandatory errors are corrected at the time of the audit by a senior HIS staff member. Approx. 5% of scanned batches are audited each month.

Mandatory Criteria Audit - Error A

Definition: Can potentially impact on clinical care. Information may have been scanned to an incorrect patient; there could be missing information or pages. This audit also identifies poor quality images.

Mandatory Optional Audit - Error B

Definition: Can impact on the integrity of the record however, the information is still available and would not jeopardise patient care in a normal situation. This audit identifies incorrect encounters, incorrect Event Set Hierarchy or form names and incorrect page ordering.

Mandatory Optional Audit - Error C

Definition: Does not impact patient care but could potentially slow viewing of images. This audit identifies blank forms and incorrect form rotation.

Digital Audits

The raw data digital audit uses the comma separated values (CSV) master Excel which summaries 100% of the Document Manager output data of all scanned batches. The Excel spreadsheet is embedded with automated formulas to detect:

- ***Potential incorrect patients*** *- detects mismatched MRNs based on KOFAX (Software) Batch Name and the MRN which was allocated during Validation.*
- ***Potential incorrect encounters –*** *detects when an encounter number changes mid-batch.*

The auditor checks each potential errors against PowerChart and corrects when necessary.

Results are provided to HIS Management. Ongoing feedback and training toolbox talks are provided to DI HIS staff as required.

Discharge Summary Completion Audit

Health Information Services works alongside the Director of Medical Services and the Clinical Governance Unit to ensure discharge summary completion across the CCLHD. HIS runs weekly reports which are disseminated to Clinical Leaders for follow up in their teams. HIS Managers are also actively participants in the CCLHD eDRS Quality Improvement Project.

MRN Duplicates Audit

MRN duplicates occur when one patient has more than one MRN within a CCLHD. The reporting and investigation of duplicate MRNs is vital for correct patient identification and clinical documentation.

Duplicate MRNs (or patient registrations) can be reported to Health Information Services by using the email address: CCLHD-HISDataQuality@health.nsw.gov.au or by phoning Health Information Services on 4320 2023

HIS Managers are currently engaged with ICT and NSLHD in the NSW Enterprise Patient Registry (EPR) Project to address the large volume of both cross and intra facility duplicate MRNs which can have the following impacts:

- Duplicate records create incomplete disjointed records which in turn creates ongoing data integrity issues as key clinical information for patients can be recorded under multiple records
- Incomplete or inaccurate patient information increases the risk of patient safety issues
- Patient information may not be sent to GPs via the GP secure messaging broker
- Clinical information may not be available in the eMR or other feeder systems.
- The potential duplicates identified by the EPR project are uploaded to the State Wide Patient Repository. This has a major impact on downstream systems such as My Health Record, Enterprise Imaging Repository and other enterprise wide systems. It must be noted that duplicate records may not have artefacts (ie discharge summaries or pathology results) published to them, which is a clinical risk

  (Source: Ann Mirapuri, Manager, Clinical Systems and eMR Program, ICT)

Target Quality Audits

Audits that are targeted to a specific speciality or process in HIS.
Examples may include:

- Deceased paperwork audit
- Medico Legal Release audit
- Release of Information audit
- Outpatients documentation audit

Reports and results

Audit reports and results will be housed on the HIS Departmental ‘I’ drive, and published on the HIS intranet page.

Results will also be distributed to relevant HIS staff.

Education

Results from audits will identify ongoing education needs . A number of education methods will be utilised to address these gaps including;

- Education in weekly HIS stand up meetings
- One-on-one training
- Education seminars will be arranged with specific specialties