Data Quality Policy

Statement

The recording of data within the practice is under the management and control of Dr Sukhdev Matharu.

The quality of data, the use of templates and the use of specific coding is reviewed on an on-going basis and the findings are discussed during our staff and clinical meetings, where examples of coding issues are cited as appropriate. The Caldecott Guardians are responsible for overall coding and data quality issues within the practice and will ensure accuracy and consistency in coding among the clinicians and the administrative or casual staff.

Mr Ahmad Syed is the non-clinical manager responsible for audit and exception identification and reporting within the practice.

This responsibility is supported by frequent audit and validation of data using QOF and other tools, and is also supported by a data administrator employed for this purpose.

It is the responsibility of the practice manager/ administrator/ summariser to distribute updates Read / SNOMED codes as and when they become available.

Purpose of this document

To provide information to all staff on how the surgery will manage data quality. Everyone has a responsibility for data quality, whether on paper, electronic or or on any other format, and the purpose of this document is to draw together the many strands of data quality in a complete and defining policy, the principles of which must be reflected in all aspects of the activity carried out within the surgery.

To define how data quality will be monitored and the reasons why high data quality is important. It will also define levels of responsibility for data and actions for poor data quality.

This policy summaries good practice and identifies the roles and responsibilities of staff regarding the completeness, accuracy and timeliness of all recorded data.

Used in:	All the relevant areas where data is gathered
Used by:	All staff members (clinical & non clinical)
Document review	20.03.2021
Status	Approved

Introduction

Data Quality is a fundamental requirement for not only the effective and prompt treatment of patients but also clinical governance, management requirements and service agreements for healthcare planning and accountability. All information within the practice is derived from individual data items and collected from a number of sources. Data quality is crucial and the availability of relevant, complete, accurate and timely data is important in facilitating translation into meaningful information whenever and wherever it is required.

Scope of the Policy

This policy must be followed by anyone collecting, recording processing or storing data. All data collection and information systems that hold data are covered, whether they are paper-based, electronic or any other format. It will also cover the following information

- Data quality standards
- Process for summarising new patient medical records
- Process for clinicians coding in consultations
- Process for coding from scanned documents
- Roles and responsibilities of key staff with regards to coding
- Staff training on coding
- Process for checking patient records for 3rd party references and sensitive information for SARs requests, patient online and medical reports
- Audits and spot checks carried out to ensure coding is accurate

Data Quality Standards

Although there are many aspects of good quality data, the key indicators commonly are:

Accuracy: It is very important that all recorded data must be correctly documented on the first instance, but can be updated as appropriate thereafter and must accurately reflect what actually happened to a patient. The practice must take every opportunity to check patient demographic details with the patient themselves. Inaccurate demographics may result in important letters being delayed, or incorrect identification of the patient, as well as incorrect/delayed income for the practice. The accurate recording of data items must however not be allowed to delay urgent treatment of the patient.

Completeness: All mandatory data within a data set must be completed. Use of default codes will only be used where appropriate, and not as a substitute for real data. If it is necessary to bypass a data item in order to progress the delivery of care to a service user, the missing data must be reported for immediate follow up by the staff member to the manager.

Timeliness: Recording of data in a timely fashion is not only beneficial for the treatment of the patient but also for the practice. Putting results of tests into the clinical system, recording diagnosis and operations or up-to-date information of patient admissions/transfers/discharges makes that information available to all relevant staff at the time that it is needed. All data will be recorded to agreed local deadlines that will enable the data to be submitted by the practice.

Validity: All the data held on practice computer systems and through other sources must be valid. Where codes are used, these will comply with national standards or map to national values. Wherever possible, computer systems are programmed to only accept valid entries and this facility should not be switched off or overridden by operational staff.

Coverage: Data will reflect all the work done by the Trust. Inpatient admissions, A&E attendances, outpatient attendances, ward attendances, operations, procedures, transfers and discharges must all be recorded. Correct departmental procedures are essential to ensure complete data capture and spot checks/audits must be undertaken to identify missing or inaccurate data. Comparisons between data systems must also be used to identify missing or inaccurate data when necessary.

Process for summarising new patient medical records

The purpose of this protocol is to provide the practice with the basis of culling and organising paper-based patient notes, and an outline of a procedure to follow to effectively summarise the data onto the computer record and safe storage of Lloyd George notes.

Surgeries will have computerised their patients notes at different times, using different clinical systems and until there is a system of transferring notes electrically than a manual procedure must take place. When notes are received they will be in the Lloyd George pockets with hopefully a computer printout.

RECORD PREPARATION

This will:

- Standardise patient records
- Simplify the process of summarising patient records
- Remove any unwanted correspondence, e.g. duplicated letters

PROCEDURE
- Sort letters and tag into date order, with the most recent letter on top
- Cut off any excess paper ensuring any relevant information is kept (e.g. patient hospital number, reference information)
- Use "treasury tags" to put each set of correspondence in date order, with the latest referral on top, write speciality, with date range, on the back of the record
- Sort doctors' clinical notes in date order like a book with the latest on top and secure at the top left corner with a treasury tag
- Keep all smear results on a tag (latest on top)
- Sort all path lab/x-ray results in date order

- Should it be necessary to replace "Lloyd George" file, ensure all information is transferred onto new file
- Label the records to show that a data summary must be completed

DISCARD

- Old Lloyd George envelopes (**with no writing on)**
- All "flimsy" discharge letters where a full discharge letter is present
- All letters where information is duplicated - keep most informative, most recent letters
- Letters from Specialists appertaining to minor abnormalities, e.g. wart removal **over 5 years old**
- Temporary resident cards **over 5 years old** (unless covering serious medical complaint)
- Out of date 1001s/1002s (contraceptive claims)
- Photocopies of Casualty notes **over 5 years old** if relating to minor illness only

KEEP

- All radiological results even if normal, e.g. CXRs Contrast Studies, barium studies, Isotope scans, Cholecystograms, Ultrasound Scans, IVPs etc
- All correspondence relating to medico-legal matters, e.g. claims, case conferences
- Antenatal cards + discharge notes relating to delivery
- All GP referral letters to document evidence of referral and date of referral

Summary Cards

- Capital letters
- Date entries (year & month only)
- Keep heading general and enter **ONLY MAJOR** diseases or operations
- Document appropriate investigations alongside heading, e.g. Renal colic - IVU normal
- Do record pregnancies (as relevant to future pathology in some cases)

SUMMARISING

This highlights and categorizes the relevant medical/social history and enables doctors and nurses to access the information in a speedy and accurate way. **NB** Notes of newly registered patients should be summarised within **2 MONTHS** of receipt by the practice.

PROCEDURE

- Read all letters
- Make note, including dates, of relevant conditions/operations/social history/allergies etc
- Read all doctors' notes adding any relevant further information, again, including dates
- Read results and add any relevant information to list, e.g. last/abnormal smear, cholesterol
- Add any abnormal investigations if not already noted and indicated in a letter or in doctors' notes
- Check there is no further information on back or front of file
- Note date of pneumococcal vaccination if relevant and latest adult tetanus
- Also enter on yellow vaccination card
- Note latest smear and any abnormal results
- Enter latest smear into template. This will ensure date of next follow-up will show automatically

- Note latest mammogram and any abnormal results
- Input all noted information into computer selecting Major, Minor, Active or Past according to the condition (See Appendix 1)
- Print out summary and attach to Lloyd George
- Add read codeto computer (Note Summary on Computer)
- Write year on front of notes in top left to indicate that notes have been summarized
- Write any allergies in red on front of notes and enter alert on computer
- See Appendix 2 for record sequence order
- **N.B.** If the patient is an Asylum Seeker, type in "Asylum"

Record all MAJOR DIAGNOSIS made, either past or present including any mental health disorders (depression, suicide attempts, anxiety states etc)

Record all FRACTURES (all in minor past)

Record all OPERATIONS AND PROCEDURES that have taken place during their life (no need to record all minor operations)

Female patients – record the following:

- PARITY STATUS
- MISCARRIAGES
- TERMINATIONS
- HRT

Enter the last recorded entry for each of the following:

- BLOOD PRESSURE
- SMEAR RESULT
- SMOKING STATUS
- ALCOHOL STATUS

Enter any recorded FAMILY HISTORY of the following, or extract from New Patient Questionnaire or new patient health check

- STROKE
- DIABETES
- CHD
- ASTHMA
- CANCER

Other entries:

- Allergies
- Immunisations for all patients especially children under 5
- Recall dates for new patient screen and smear tests
- If child is on Protection Register

THERE IS NO NEED TO RECORD ALL MINOR COMPLAINTS THAT PATIENTS ATTEND SURGERY FOR ON A REGULAR BASIS IE: COLDS, FEVERS, RASHES, TONSILLITIS, BRONCHITIS BUMPS AND SCRAPES, TWISTS AND SPRAINS ETC.

N.B. All of the following information should be entered with the exact date (e.g. 08 12 1968). If the exact date is not known but the month is known then use 1st of the month (e.g. 01 12 1968); if only the year is known then use 1st January and correct year (e.g. 01 01 1968)

- The date that the summarisation is being entered on to the computer system
- The date of the first consultation with a GP
- The latest health template information should be recorded if not done so already
- For chronic illness e.g. chronic obstructive airway disease, diabetes mellitus, heart disease, asthma etc. the commencement must be entered
- Any illness that requires a referral to a hospital consultant must be entered e.g. psychiatry, urology, cardiology etc
- Any bone fracture needs to be entered including site of fracture i.e. left or right limb etc and any treatment given (NB any manipulation procedure should be entered separately)
- Any operative procedure needs to be entered with the reason for the procedure entered as a separate entry. E.g. a hysterectomy for fibroids should have an entry for hysterectomy and a separate entry should be made for the fibroids
- The commencement date of all Hormone Replacement Therapy (HRT)
- Any important therapy especially for malignant illness, such as chemotherapy or radiotherapy
- Any illness that requires more than 4 weeks away from employment
- Any illness requiring repeat medication
- Any family history of illness should be entered e.g. atopy, heart disease, CVA/stroke, breast cancer, glaucoma, cancers, diabetes, hypertension, heart attacks, Huntingdon's Chorea etc. The deaths of any first-degree relative (parent, spouse or child) should be entered onto the system, with the cause of death if known
- Enter any illness that may have any significance for future health e.g. genital herpes, haemoglobinopathy etc
- In women all pregnancies should be recorded, including the mode of delivery e.g. normal delivery, forceps delivery, ventouse delivery, emergency/elective caesarean section. In the case of caesarean section include reason for operation e.g. cephalo-pelvic disproportion, breech, fetal distress etc
- Details of pathology results such as blood group, rhesus group, rubella status, Hepatitis B surface antigen
- In under 16 year olds all immunisations should be entered on to the system. For the over 16 year olds all recent vaccinations should be entered e.g. booster polio and tetanus, hepatitis A and B vaccinations, influenza vaccinations
- All significant life changing events should be included such as marriage, divorce, death of a relative etc, where available
- All previous smear tests
- All mammograms including result
-

Other Issues

Haemoglobinopaties: Sickle Cell, Thalassaemia, Haemaglobinopathy or Haemoglobin Electrophoresis results. If the patient is reported as having a haemaglobinopathy then this should be

displayed as an active problem on the front screen, as this can have consequences for future health or during pregnancy.

If the result is negative then it should be reported as significant past.

Virology Reports: Such as Hepatitis A, Hepatitis B and Rubella status should be included in the information added on to the system if it is not already present.

Blood Transfusion reports: Blood groups including rhesus and antibody status should be entered.

Biochemistry: If there is a report of previously raised cholesterol but there is no significant active problem recorded to account for this e.g. hypercholesterolaemia or the patient is not on medications for such a problem then the raised cholesterol test and value should be entered.

Cervical Smear Tests, Cytology: See Further Information Section

X-ray Reports: Enter if the report shows anything of future significance e.g. degeneration of bone.

Allergies and Intolerance: All allergies should be entered including as a comment the reaction that they caused e.g. rash, swelling, itching. These can very often be found on the patient record envelope.

N.B. It is very important to check that any details being added/changed are being changed to the correct computer patient record, always check before any changes or additions to information are made*.*

Any significant medical problems (refer to further information section) will need to be displayed on the front screen, thus making them immediately obvious to those entering the patient's record.

Check through the hand written "flimsies", check that each flimsy has the correct patient name and details on before adding/changing any information.

N.B. Sometimes handwriting can be difficult to interpret! In such cases the summariser should not guess at the contents but seek advice from medical personnel within the practice.

CODING

Practice coding is placed under the control of the clinical members of the practice who are familiar and competent in the technical use and application of the Read Code system.

Outside of clinical system templates, a practice list of preferred Read Codes should devised and actively maintained, supported by quality audits and regular discussion of the use of coding within clinical policy meetings.

FURTHER INFORMATION

<u>Common Vaccinations/Immunisations</u>

Immunisations and vaccinations are not considered Active Problems (use vaccination/immunisation templates and select dose).

- Diphtheria, tetanus, pertussis, polio and hib – 1st, 2nd or 3rd
- Diptheria, tetanus, pertussis and polio – 1st, 2nd or 3rd
- Rotavirus – 1st or 2nd
- Pneumococcal 1st, 2nd, 3rd or single
- Meningitis B – 1st, 2nd or 3rd
- Meningitis C – 1st , 2nd or single
- Hib/Meningitis – booster
- Measles, mumps and rubella (MMR) – 1st or booster
- Diphtheria, Tetanus and Polio (DTP) – booster
- Meningitis ACWY - single
- BCG
- Influenza – single (last recorded dose only)
- Pneumococcal (Pneumovax) – single (last recorded dose only)
- Shingles – single
- Hepatitis A (Havrix, Havrix Monodose, Havrix Monodose Junior, Avaxim) - 1st or booster
  Hepatitis B – use imms template select 1st, 2nd, 3rd or Booster
- Hep A and Hep B (Twinrix, Ambirix) enter as 1st 2nd 3rd or booster
- Hep A and Typhoid (Hepatyrix) entered as 1st Hep A and a separate entry for Typhoid. There is only one typhoid component therefore any subsequent immunisations should be added as booster Hep A only
- Meningitis ACWY – single (last recorded dose only)
- Rabies – 1st, 2nd, 3rd or booster
- Typhoid (Typhim V) – single (last recorded dose only)
- Japanese encephalitis – 1st, 2nd or 3rd
- Tick borne encephalitis – 1st or 2nd
- Yellow Fever – single (last recorded dose only)

Cervical Smear Tests and Cytology

1. Record all previous cervical smear results e.g. dyskaryosis, CIN, HPV and inflammatory changes. Record where the slide was taken e.g. GP surgery, hospital outpatients etc, the slide number (where available), the date and the result.
   Enter using cervical smear template.

Appendix 1: Selection criteria for conditions entered on the computer

<u>**Major**</u>
- Any long term condition, e.g. asthma, heart disease, diabetes
- Any life threatening condition, e.g. cancer, heart disease
- Any major operations, e.g. C.A.B.G
- Any condition that could have long-term implications, e.g. peptic ulcer, mental health problems, drug addiction/abuse
- Any significant social history, e.g. children on the child protection register

<u>**Minor**</u>
- Any condition that the patient will recover from with no on-going problems e.g. pregnancy with normal delivery, tonsillectomy, appendectomy

<u>**Active**</u>
- Any on-going condition, e.g. recent operations, current illness
- Any long term or life threatening condition, e.g. diabetes, mental health problems
- Any significant social history, e.g. child protection register
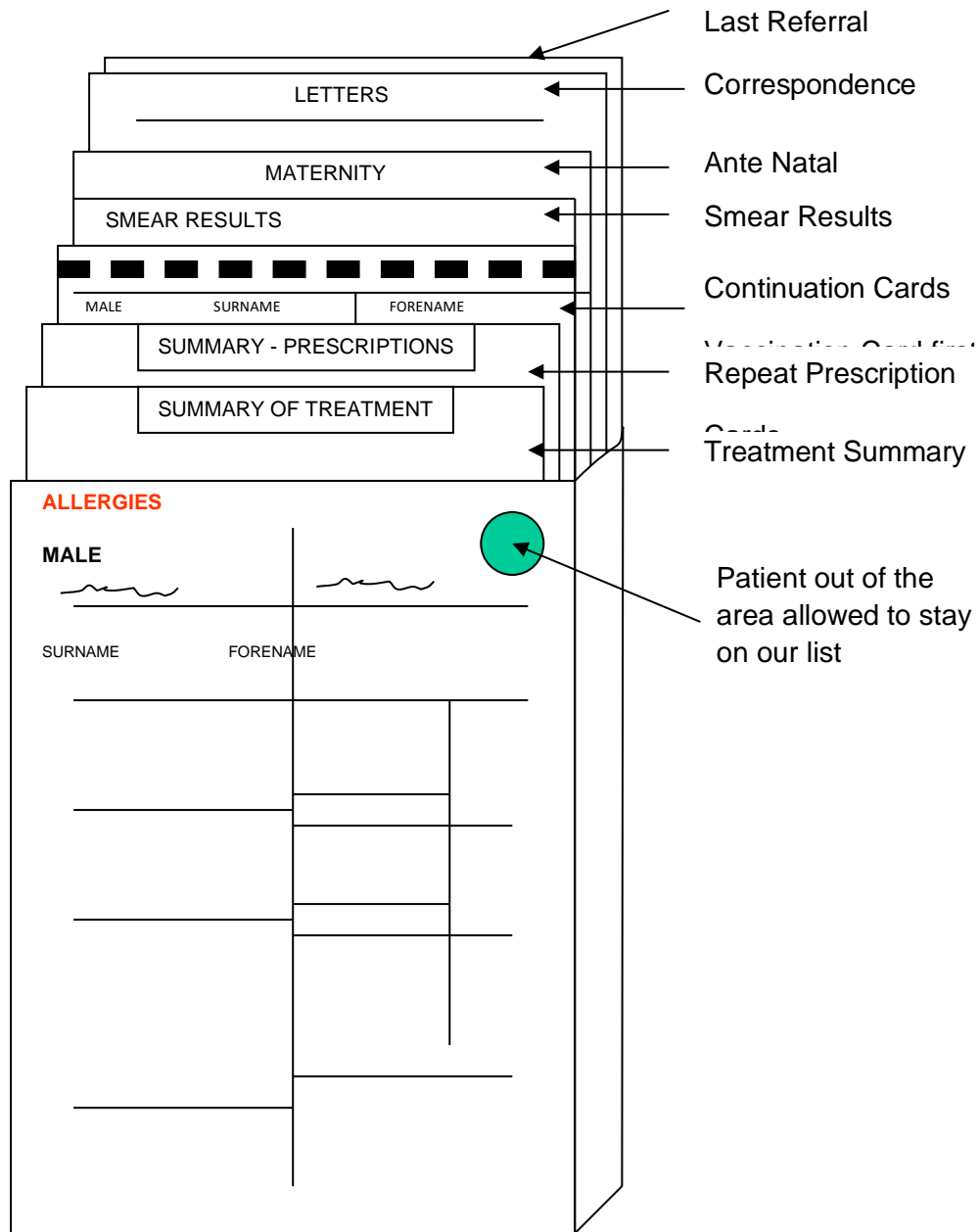
<u>**Significant Past**</u>
- Any condition which is no longer a current problem but may have implications for the future, e.g. mastectomy, hip replacement, drug/alcohol abuse

<u>**Minor Past**</u>
- Any condition which the patient has recovered from with no expected long term problems, e.g. simple fractures, tonsillectomy, appendectomy

<u>N.B.</u> These are only general guidelines as each patient is individual and therefore there will be exceptions to these examples.

Appendix 2: RECORD SORTING ORDER

Last Referral

LETTERS

Correspondence

Ante Natal

MATERNITY

SMEAR RESULTS

Smear Results

Continuation Cards

MALE   SURNAME   FORENAME

SUMMARY - PRESCRIPTIONS

Repeat Prescription

SUMMARY OF TREATMENT

Treatment Summary

ALLERGIES

MALE

SURNAME   FORENAME

Patient out of the area allowed to stay on our list

Process for clinicians coding in consultations

Clinical Coding is the translation of medical Terminology that describes a patient's complaint, problem, treatment or other reasons for seeking medical attention into codes that can then be easily tabulated, aggregated and sorted for statistical analysis in an efficient and meaningful manner.

This segment details the procedures regarding the clinical coding of all clinical care. It outlines the responsibilities of clinical staff and the timescales in which coding should be completed. This must be followed by all the staff involved in the coding of patient activities.

Clinical coding must be consistent with the appropriate National Standards and an up to date read code formulary must be uploaded. Practice must also ensure that their clinical systems are using most recent data entry templates.

Practice currently is using clinical system SystmOne which is quite robust in capturing all the relevant consultations in a chronological manner. Consultation includes different segments for recording medical history, examination, diagnosis and plan. Each segment must be used to record relevant data set. Furthermore each segment auto generates a relevant read code during recording process.

Clinician must record patient medical history into "History tab" this not only allows data entry accuracy but also help distinguish data from other clinical notes. Examination tab gives an opportunity to record any examination carried out during consultation and based on examination clinicians' than uses diagnosis tab to record diagnosis.

Similarly all the relevant QOF data must be captured using up-to-date QOF templates that are updated and released by the clinical system providers. Practice must make sure that they configure these templates if they are using custom menus within clinical notes.

Any change in medication or new medication issue must be recorded into the medication segment. All new acute medication should be recorded under acute tabs. Clinicians must make sure that up-to-date drug formulary is used.

Similarly referrals and communications must be recorded into their separate segments and must be read coded accordingly.

Pathology and Radiology reports are coded automatically upon receiving, clinicians must make sure that the right read code is assigned to the relevant findings.

All the data must be captured in a timely manner and must be processed at least on the same day.

Patient history, Examination, Diagnosis & Plan: Must be recorded during the consultation and must be saved before patient leaves the clinical room. In certain circumstances it might not be possible and clinician might need to complete this at later stage, in such cases history, examination and plan must be discussed with patient before they leave.

Referrals and Medication: Preferably it needs to be completed before patient leaves but can be delayed till the end of the day if it is not urgent or patient is asked to collect medication later on day or patient has signed for an EPS.

Process for coding from scanned documents:

The purpose of this segment is to highlight a process of all information which is scanned or uploaded into electronic clinical information systems from secondary care or any other third party service provider. Practice follows a stick routine of scanning all the incoming correspondence of the patients irrelevant to any specific department.

Clinical system SystmOne provides an inbuilt scanning feature that enables user to scan the document directly into clinical system. Once scanned an administrator or data entry clerk can than process the document accordingly by adding relevant read codes, assigning tasks or forwarding it to the attention of clinical staff.

Aim: The aim of processing/scanning records is to make sure

- Records are available when needed
- Records can be accessed
- Records are secure
- Records are retained and disposed of appropriately

Preparation of paper documents prior to scanning

All paper documents need to be examined prior to the scanning process, to ensure that as high a quality image as possible is obtained.

• Remove all staples, clips or other document bindings ensuring that there is no damage to the original that may affect the capture of information from the document
• Remove any poly pockets / plastic wallets
• Ensure that all physical attachments e.g. post it notes, medical results attached to mount sheets, are removed and photocopied separately before scanning
• Anything stuck onto a page such as labels must be firmly attached, especially at the edges. They should not be obscuring anything underneath
• Where the paper is very old and thin and unlikely to pass through the scanner this should be photocopied initially and then scanned.
• If the quality of the print is poor this should be photocopied with a higher resolution using the photocopier. Handwriting (or hand drawing) using pencils can be faint, and difficult to reproduce. Care should be taken when scanning to ensure that image brightness and contrast are appropriate for these images.
• Ensure all pages of a multi- page document is kept together and in the appropriate order before, during and after scanning
 • Where originals are photocopied please check the quality of the photocopy.
• Ensure that all the information contained on the original is retained on the photocopy
• Anything that has been successfully photocopied can by removed and destroyed in the confidential waste bin. (Thus ensuring that nothing is duplicated in the scanning process).
• Ensure every page and the entire page is copied/scanned.
• Scan the documents in chronological order.
• Check that all the information in the document pertains to the same patient (NHS number, name and date of birth). If misfiled information is found it must be removed and relocated in the appropriate record.

How to scan & read code into clinical notes

- Login into SystmOne with your smartcard.
- Insert the documents facedown in the scanner. If it is a flatbed scanner or put it into the document feeder, make sure that the scanner is clean and free of debris.
- Press the 'Scan' button from the options provided at the top menu
- On the Scanning options ensure that the image resolution is set to a minimum of 200dpi.
- Wait for the document to scan and once completed check the scanned image is acceptable. If acceptable save with an appropriate batch for further processes.
- Time stamp the document with time & date along with your initials.
- SystmOne docman feature has an OCR feature that reads the documents and capture certain data. This includes patient demographics, hospital/organisation and department.
- Make sure to match patient demographics to ensure that the correct patient is selected.
- User must match the hospital and department deducted by OCR feature with the actual letter.
- Coder must make sure it has picked up the correct read codes
- Users at this stage can add further read codes (i.e. reason of the visit, diagnosis, medication ect) or can forward the letter to a clinical staff.

Beside this, practice also receives EPR (electronic patient records). These are usually clinical letters received from different departments electronically. These correspondences are received as tasks and are downloaded into system. These documents do not require scanning but sits into scanned documents batch for further processing. They are handled in a similar manner as of any hard copy that is scanned into notes.

Roles and responsibilities of key staff with regards to coding

Practice has trained non clinical staffs that are responsible for scanning and coding clinical letters. These are as following;

Name	Responsibilities in terms of coding
Nicola Sutton, Claire Delarge	Data entry read coding

Staff training on coding

There is a need for training identified. In accordance with the classification of training outlined in the practice Learning and Development Strategy this training has been identified as mandatory training for all those who enter codes into an electronic patient record

• All new coding staff will attend the standards course within six months of employment (if needed).

• All staff will attend a HSCIC Refresher Workshop every 3 years.

For coding queries that cannot be resolved internally, reference should be made to the National Coding Query mechanism provided by HSCIC. Information received back should be documented and

shared with the appropriate staff.

Additionally, practice performs regular audits on the codes entered by non-clinical staff to ensure that the codes entered are accurate and valid.

Process for checking patient records for 3rd party references and sensitive information for SARs requests, patient online and medical reports

Practice has a policy that is in line with the GDPR that covers this segment. In summary;

- Practice must perform data quality checks before releasing notes.
- Practice must perform data cleansing processes on patient notes.
- Practice must mark any sensitive or 3rd party data as private.
- Practice must follow confidentiality policy inline to SAR.
- Practice must have procedure in place to record any data that is marked privately and should document the reason.

Audits and spot checks carried out to ensure coding is accurate

Practice has a policy in place to perform audits and spot checks on those staff members who are responsible for data coding to ensure the accuracy of the read codes. These audits are than discussed in meetings with senior management and clinical staff.

Conclusion

 Good quality data is not an optional extra. It is a fundamental basis for the business and reputation of the practice. As such it must always be considered at the centre of any future developments and kept under review. The practice will ensure that it keeps up-to-date with any future requirements and conforms to recognised good practice.