Health Information Management Sample Policy and Procedure

POLICY:	HIM-QA-001
TITLE:	Clinician-Created Documentation Quality Review
APPROVING AUTHORITY:	Director of Health Information Management
DATE APPROVED:	
REVIEWED/REVISED:	

Policy Statement: To ensure quality documentation is created routinely by all clinicians for input into the electronic health record.

Procedure: Clinician-created documentation will be routinely reviewed for accuracy using a form of preset sampling method (e.g., random or systematic sampling).

A. Upon implementation of the QA program, 100 percent of all documentation for each clinician may be reviewed, depending on staffing. Thereafter, a random sampling *[or a specific percentage]* of all documentation will be reviewed on a monthly basis for each clinician as appropriate to the facility.

B. Documentation will be reviewed for maintenance of standard accuracy or error rates *[as dictated by your facility]*.

C. Each document sampled will be reviewed according to the items listed on the QA Review Form.

D. Refer to the AHDI-AHIMA Clinician-Created Documentation Quality Assurance Resource Kit for details of errors and measurements best practices.

E. All documentation completed by the clinician will be eligible for audit.

F. Corrections need to be made by the clinician who authored the documentation. If documentation is greater than 24 hours old, correction should be made in the form of an addendum *[or according to your facility standards]*. Also, if the documentation has already been signed, correction should be made in the form of an addendum.

G. Due to the high level of quality required in our patients' health records, at the discretion of the clinician or administrative champion and *[insert the appropriate person for your facility, e.g., HIM Director, EHR Documentation Trainer, Health Record Integrity Auditor, EHR Technician, HIM Analyst]*, the following steps may be taken:

    a. Initial feedback regarding errors supplied to clinician.
    b. Continued repetitive errors reviewed in training session with clinician.
    c. Further critical documentation errors presented to Medical Records Committee. *[These steps should be adapted to your specific facility.]*

DEFINITIONS

Clinician-created documentation quality review: Comprehensive quality review of the complete narrative and associated data to protect patient, caregiver(s), and organizational integrity.

Critical error: An error that has the potential to impact patient care. All critical errors must be corrected.

Noncritical error: An error that impacts the integrity and quality of the documentation.

NOTES:

AHIMA. (2012). *Transcription Toolkit.* AHIMA Press. Chicago

REFERENCES:

AHDI, MTIA, AHIMA. (2010/2011). *Healthcare Documentation Quality Assessment and Management Best Practices. Retrieved from:* *http://www.ahdionline.org/LinkClick.aspx?fileticket=f3sQg96ixiQ%3d&tabid=601*

AHDI/AHIMA. (2014). *Clinician-Created Documentation: Reinstating Quality Assurance Programs to Safeguard Patients and Providers. Retrieved from:* *http://www.ahdionline.org/ProfessionalPractices/BestPracticesandStandardGuidelines/tabid/228/Default.aspx*.