**Health Information Management**

**Sample Policy and Procedure**

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| 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).

1. 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.
2. Documentation will be reviewed for maintenance of standard accuracy or error rates *[as dictated by your facility]*.
3. Each document sampled will be reviewed according to the items listed on the QA Review Form.
4. Refer to the AHDI Healthcare Documentation Quality Assessment and Management Best Practices toolkit for details of errors and measurements best practices.
5. All documentation completed by the clinician will be eligible for audit.
6. 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.
7. 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:
   1. Initial feedback regarding errors supplied to clinician.
   2. Continued repetitive errors reviewed in training session with clinician.
   3. 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:** A critical error is any error in a patient care record that has the potential to:

1. Adversely impact patient safety.

2. Alter the patient’s care or treatment.

3. Adversely impact the accuracy of coding and billing.

4. Result in a HIPAA violation.

5. Adversely affect medicolegal outcomes.

**Noncritical error:** Noncritical errors impact document integrity but do not have the potential to affect patient safety, care, or treatment, and/or do not alter the intended meaning of the author.

**NOTES**

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

**REFERENCES**

AHDI, MTIA, AHIMA. (2010/2011). *Healthcare Documentation Quality Assessment and Management Best Practices.* AHDI: Modesto, CA.

AHDI/AHIMA. (2014). *Clinician-Created Documentation: Reinstating Quality Assurance Programs to Safeguard Patients and Providers.* AHDI: Modesto, CA.