**Health Information Management**

**Sample Policy and Procedure**

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

**Policy Statement:** To ensure quality healthcare documentation.

**Procedure:** Healthcare documentation transcribed or edited by healthcare documentation specialists will be routinely reviewed for accuracy using a form of preset sampling method (e.g., random or systematic sampling, see the Sampling Guidelines section in *Healthcare Documentation Quality Assessment and Management Best Practices*).

1. Newly hired HDSs will be reviewed for 100 percent of all documentation until cleared for routine QA sampling, depending on staffing. Thereafter, a random sampling *[or a specific percentage]* of all documentation will be reviewed monthly (or your facility specifications) for each HDS 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 (Appendix C in the AHDI *Healthcare Documentation Quality Assessment and Management Best Practices* toolkit).
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 HDS 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. {*or according to your facility standards]*.
7. Due to the high level of quality required in patients’ health records, if an HDS fails their quality review, *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 HDS; 100% QA review will occur for a period as determined by QA staffing ability.
   2. Continued repetitive errors may result in formal corrective counseling; (according to your facility standards).

**DEFINITIONS**

**Healthcare documentation specialist (HDS) quality review:** Comprehensive quality review of the complete narrative and associated data to protect patient, caregiver(s), and organizational integrity.

**QA integrity auditor:** See the AHDI *Healthcare Documentation Quality Assessment and Management Best Practices* toolkit.

**Critical Errors (-3)**

**Definition:** 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 Errors (-1)**

**Definition:** 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.