SFHHI12
Prepare, conduct and report the results of a clinical coding audit

Overview

This standard is about conducting a clinical coding audit. You will need to be able to prepare for the audit by carrying out pre-audit interviews, analysing pre-audit questionnaires and agreeing aims and objectives with health professionals. You will then need to implement agreed audit methodologies looking at both the clinical coding and the supporting processes that facilitate the coding function. Subsequent analysis of the audit findings will inform the outline of conclusions and recommendations. Following on from this you will need to be able to produce a final report detailing your findings, conclusions and recommendations.

Users of this standard will need to ensure that practice reflects up to date information and policies.

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Performance criteria

You must be able to:

P1 conduct effective pre-interviews with the appropriate health professionals
P2 analyse pre-audit questionnaires correctly
P3 negotiate and agree the necessary scope, aims and objectives with health professional(s)
P4 define and implement the agreed audit methodologies within the required timescales
P5 locate, abstract and summarise the specified audit data according to national
P6 carry out data validation according to national standards
P7 examine supporting operational processes
P8 analyse the audit data accurately and present it in the agreed format
P9 complete auditing processes within the agreed timescale
P10 maintain confidentiality at all times
P11 analyse and present the available data in the agreed format and timescale
P12 collate and document reliable evidence to support the final report
P13 conduct an effective post-audit interview
P14 produce a final report that is clear, factual, concise and covers all the salient points
P15 disseminate the final report to authorised persons

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Knowledge and understanding

You need to know and understand:

K1 the relevant legislation, policies, procedures, codes of practice and guidelines in relation to clinical coding

K2 the clinical coding audit process and how it impacts on data validation in accordance with local and national standards

K3 the recognised clinical coding audit methodology

K4 the importance of a policy and procedures document at national and local level

K5 the ways in which health records are assembled and used, and where the best sources of accurate and reliable clinical data may be found

K6 the ways in which rules and conventions are applied to clinical data to achieve the correct clinical codes

K7 the importance of using the correct types of rules and conventions

K8 the ways in which classifications and nomenclatures are used to achieve accurate clinical coding

K9 the ways in which clinical data is indexed, stored and cross mapped to clinical terms within classification systems

K10 the importance of the sequence of codes and the primary diagnosis

K11 the uses to which clinical coded data may be put

K12 the importance of communicating accurately and clearly with others in order to elicit the required information

K13 how to conduct a clinical coding audit

K14 the national audit methodology and the principles behind it

K15 how to produce a final report

K16 how to use information systems and technologies to analyse and present data

K17 how and where to access reliable information relating to medical terminology

K18 the nature of disease processes and how they are treated

K19 basic anatomy and physiology

K20 the assignment of co-morbidity and complications

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Additional Information

Links to other NOS

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: IK2 Information collection and analysis

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