Scanning Process and Clinical Coding

The visit to the HIM/Medical Records department is to understand the workflow in document scanning and clinical coding. The review team will expect to understand what space saving strategies have been deployed, if any, as the paper chart has been replaced by the EMR and how that space has been repurposed. During the validation, the inspectors should be enabled to understand:

- The source data used for clinical coding
- Organization of clinical coding team
- Performance management of coders work with certain specialties (e.g., handling backlog)
- Coding quality measurement (e.g., internal, and external audits; coders as auditor/trainer)
- Use of encoder and classifications
- Coding of inpatient episodes versus OPD, ED, and day cases

ID	Stage	Y	N	Compliance Statement
112	6			**Clinically relevant documents are available in CDR within 24 hours** Clinically relevant documents are scanned and available in Clinical Data Repository within 24 hours.
113	7			**Clinically relevant paper are available in the EMR within 24 hours** Clinically relevant paper (e.g., EKG strip documentation, Code documentation) is scanned and available in the EMR within 24 hours from the time it was created.
Specific paper documents that should not be present (should be absent) during a review of HIM scanning process include:				
114	7			**Assessment forms**
115	7			**Flowsheets**
116	7			**Order forms**
117	7			**Medication list**
118	7			**Problems and diagnoses lists**
119	7			**Progress notes**
120	7			**Dietary and ancillary therapy documentation**
121	7			**Other clinically relevant paper documentation**
Paper documents that are allowed, but must be scanned within 24 hours of creation:				
122	7			**Charting done during critical events.** (e.g. code blue / resuscitations)
123	7			**Blood transfusion forms** (as required by government regulations).
124	7			**EKG waveforms.**
125	7			**Cardiac and fetal monitoring waveforms are stored electronically** Cardiac and fetal monitoring waveforms are stored electronically; if not, then alarmed readings are considered clinically relevant and are scanned into the EMR within 24 hours.
126	7			**Anaesthesia intra/perioperative progress notes.**
127	7			**Complex chemotherapy orders.**
128	7			Clinically relevant documents received in ED scanned within 24-hours.

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