Oxford University Hospitals NHS
NHS Foundation Trust

Data Quality

Workbook for

Administrative staff with responsibility for patient administration

Introduction

This workbook offers a flexible way in which the basic level of theoretical knowledge needed for compliance within the topic of Data Quality can be met in accordance with the OUH Data Quality framework.

The Oxford University Hospitals NHS Trust recognises the importance of information in the provision of patient care and in reporting on its performance. Data quality is therefore crucial in ensuring complete, timely and accurate information is available in support of patient care, clinical governance, performance management and service planning.

The Trust is required to comply with a number of NHS information initiatives, including the Auditor's Local Evaluation and the Health & Social Care Information Centre Information Governance Toolkit. There are external annual assessments of the Trust's performance against the standards set within these initiatives.

Adherence to the trust data quality policy (which can be found on the trust intranet link below) will ensure compliance with the above requirements
http://ouh.oxnet.nhs.uk/InformationGovernance/Document%20Library/Policies%20and%20Procedures/Data%20Quality%20Policy%20v3.pdf

All line managers are responsible for ensuring staff within their teams either completes the e-assessment or the workbook provided whilst also ensuring the necessary assistance and support is given to aid their successful completion and for checking their responses against the answer sheets provided.
It is not always necessary for staff to work through the work books individually as they could be included within your own departmental training / meetings, this would enable your team to discuss certain issues or problems they may have in completing the booklet. Each member of staff must individually complete the question section and sign the declaration if they are not completing the on line e-assessment
If some staff members have concerns about reading the questions or completing the booklet, then the content may be discussed with them and the questions can be read to them and their answers recorded on their behalf.

Objectives

1. To achieve compliance with the Trusts Data Quality requirements.
2. To increase staff awareness within aspects of Data Quality theory and apply standards to the working environment and practice.
3. To provide assurance of knowledge/understanding which will assist with appraisals and development reviews.

Guidance for completing

1. The workbook contains 19 questions and should take no longer than 30 minutes to complete
2. If a pass mark of 85% is not achieved further training will be required and managers should encourage users to practice using the e-learning in the first instance
3. Please read the contents of the competency workbook provided
4. Remove the workbook from the question section and keep for future reference.
5. Complete all personal details on the front cover of the Question Section.
6. Answer all questions – partial completion will be recorded as a "did not pass"
Please be aware some questions require more than one answer.
7. Completed Questionnaires must be given to your line manager who will mark it following the relevant approved answer sheet.
8. Managers must sign and date the declaration and place the marked question section in an envelope sending it to.

You may choose to complete the e- assessment on line or via the attached question section which should then be submitted to: Francine Tanner- Data Quality programme Manager

Data Quality e- learning is also available via the eLMS site

Competency Workbook for Data Quality

Data Quality and you

Data Quality governs the rules that should be followed when recording information. It allows organisations and individuals to ensure that information is collected in line with the requirements of the data protection act and trust operational needs. Data Quality applies to all types of information collected

Every member of staff, who records patient information, whether on paper or electronically, has responsibility to take care to ensure that the data they collect is accurate and complete. Staff are accountable for the information they record and need to understand the implications of recording invalid, inaccurate, incomplete or poorly timed data. This should be a continuous process throughout the patient pathway.

The Data Quality diamond is a nationally recognised symbol of best practice and sets out data quality standards comprising of the following components:

- Validity
- Completeness
- Accuracy
- Reliability
- Relevance
- Timeliness

What is Data Quality?

The following are all necessary attributes to achieve a high level of high data quality:

Validity

All computerised data must be valid. Where codes are used, these should comply with national standards and definitions. Any locally defined codes must map to national definitions.

Completeness (including coverage)

All internally agreed data within a data set should be fully input, this includes both mandatory and non-mandatory trust required fields

Accuracy

Data should be recorded accurately. Processes of checking patient demographic data should be used routinely, and patients should be asked to supply relevant data with open questions rather than prompts (e.g. “Who is your GP?” rather than “Has your GP changed?” and which practice address are you registered at rather than assuming that the main surgery address is correct).

It is also important that the system accurately reflects what is happening to the patient and who is responsible for their care. Accurate information should also be recorded in "real time" or as close to it as possible but **always** in the correct sequence. This ensures that anyone looking at the patient record would know where they are located and /or which consultant is responsible for their care.

Reliability

All staff who input data onto critical systems should receive regular training to maintain and develop their skills, regardless of experience or length of service enabling the trust to have assurance that information collected is reliable and trusted

Relevance

Data collected should be relevant and appropriate to support whole system accuracy

Timeliness

All data should be input within specified deadlines. Good practice is for data to be input at the time of an event or as close to it as possible but **always** in the correct sequence. All documentation received into the trust must be date stamped on the day of arrival

Data Quality Standards

In order to ensure consistent working practices throughout the Trust all staff must be aware of and work to the required data quality standards.

Training for the PAS element of the Electronic Patient Record is available through classroom training and via e-LMS in the form of e-assessments and e-learning which can be utilised by line managers as a means of ensuring staff have regular refresher training, this can then be embedded into Appraisal and Personal Development Plans to ensure training is continued post commencement.

Managers will proactively monitor poor performance against standards by retraining and reinforcing best practice where necessary. Consistent failure to comply with the Data Quality Standards could result in staff being taken through the performance and conduct procedure,

Divisional Directors and General Managers are required to ensure that poor performing staff are retrained and re-deployed if necessary.

Your responsibilities

All staff should be aware of their responsibilities and comply with trust standards and best practice when processing information. Following departmental standard operating procedures and protocols will ensure that all requirements are met as they give a step by step instruction of how to carry out specific tasks in your service
It is the responsibility of each individual staff member to be aware that they are accountable for the information they record and need to understand the implications of recording invalid, inaccurate, incomplete or poorly timed data.

Data Quality in Practice

Accurate patient& pathway information
In order to ensure the trust is both able to report accurate information and potentially contact a patient or their next of kin and relatives if needed, it is imperative that we collect as much information as possible. Details such as, mobile phone numbers, marital status, title, next of kin, whilst not mandatory fields in Electronic Patient Record are a trust requirement and are all key to meeting legal requirements managing effective communication for and on behalf of patients

Staff must also ensure that any data entered onto a system is accurate, relevant, valid, complete and timely. If you are required to complete information on more than one system, where the source data is replicated you should ensure an exact match.

Admissions Discharge & Transfers
Unless patients are admitted and transferred to the correct ward and bed and also under the correct consultant, clinicians cannot benefit from most of the clinical functionality within the Electronic Patient Record. Admissions, Discharges and Transfers should also be recorded in “real time” or as close to it as possible but **always** in the correct sequence.
Having a “real-time” bed state is key to a successful EPR and has significant efficiency benefits for the Trust as it enables better bed management

Implications of not recording accurate information
For any information collected and entered onto an electronic system it is each member of staff‘s responsibility to ensure that at every point where there is either a change in the clinical pathway, consultant change, or any other circumstance that requires a change of detail that this is updated.

The consequence of failing to keep accurate, relevant & timely information can result in potential clinical risk, inaccurate reporting of consultant activity and loss of income for overseas and private patients.

The inaccuracies against individual consultant workloads due to the incorrect recording of admissions/transfers have a detrimental effect on reporting through Dr Foster, HSMR as well as on individual consultant data.

Failing to record accurate information and inform the appropriate team pertaining to overseas and private patient's results in potential loss of income, inaccurate reporting, and the legal requirements set out by the Department Of Health. All staff that have contact with the patient are responsible for ensuring this information is collected and passed on as appropriate

Details of NHS patients are held on the PDS (Personal Demographics Service) which is the national spine for all users of the NHS. To avoid duplication of records held within the Trust's Electronic Patient Record searches must be thoroughly carried out. The first search you will be asked to do is of the local trust data base using either the MRN or NHS number.
If the patient record is found, the patient demographics will synchronise with the PDS. If this search fails to find the correct patient, you will be required to do a PDS search using the date of birth, gender and surname as mandatory search items.
If you have the patients NHS number but are unable to locate the patient on the spine, you should call the IM&T Service Desk before registering.

Records Management
Getting it right - Record keeping issues
- Medical records not tracked
- Case notes not filed in a timely manner
- Duplicate records

What is a good record?
All of the following make a good record.
- Legible writing
- Complete, i.e. all the information in one place
- Including accurate information
- Easy to locate
- Written, dated and filed contemporaneously, i.e. at the time an event occurred

Recording Quality Information and Good record keeping
Commitment 8 of the NHS Care Record Guarantee promises patients that the NHS will take appropriate steps to make sure personal information is accurate.
To meet this standard everyone needs to ensure that good record keeping is:

Accurate
Make sure that when you create a file or update a record the information you are recording is correct and clear. Give patients the opportunity to ensure that the records we hold are accurate by checking and confirming their details with them.

Up-to-date
Ask patients to confirm their details when attending appointments and ensure changes of address, name, next of kin details etc are updated as soon as possible.

Complete, including the NHS Number
Incomplete or inaccurate healthcare information can put patients at risk. For example, the lack of certain information could cause a patient to be given the wrong treatment or advice. Ensure patient records include their NHS number as well as the MRN (Medical Record's Number); as this helps ensure that the correct record is accessed for the correct patient.

Quick and easy to locate and accessible
You need to make sure that records and the information within them can be quickly located when required, e.g. by using a logical filing system that allows easy retrieval of records.
Make sure you comply with any procedures that aim for consistent and standardised filing of records, and for safe and secure records storage areas.

Free from duplication
Good record keeping should prevent record duplication. Before you create a new record, make sure that one doesn't already exist.
Having more than one record for the same patient could increase risks, as there may be missing vital information in one record. It would be pot luck which record is accessible in an emergency situation.

Written contemporaneously
Good record keeping requires that information is recorded at the same time an event has occurred or as soon as possible afterwards.
This means that records will be updated whilst the event, care or otherwise, is still fresh in your mind.

Good record keeping
There are other issues that you should be aware of and comply with to ensure good record keeping in your organisation.
All Staff have a legal and professional obligation to be responsible for any records which they create or use in the performance of their duties including any information requiring filing into the records

Tracking health records
Accurate recording and control of the location of all records is crucial if the information they contain is to be located quickly and effectively.
All staff that use patient records have a responsibility for the accurate and safe movement of the health records folders in and around the Trust. to ensure that:

- Records are tracked at each stage of their movement using the HIM tracking application within the Millennium System.

- Records are stored securely on wards and departments with clear labelling on shelves/cupboards/filing cabinets.

- Records are returned to their original filing system after use.

- Wards, departments, secretariats and clinical areas are designated location codes within EPR that allow users of the HIM Tracking Application to track records to the location area.

- On creation of the paper record the tracking audit trail should commence.

- Location codes should be updated every time the health record moves to a different location.
- Additional media type and volume numbers must be added to the patients details within the HIM Tracking Application at the point of creation.=

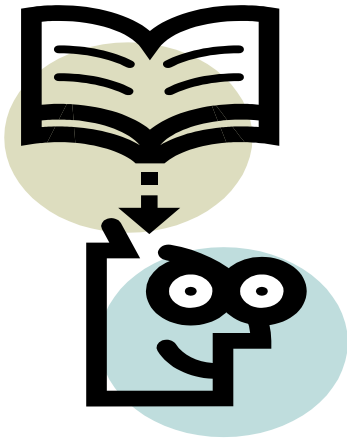
- Temporary folders may be created when all efforts have been made to source the patient's substantive health record. These should be created within the HIM Tracking Application as a temporary file. When health records cannot be found in the location to which they are tracked, this must be reported to the Senior Library Manager by completing form HRSD1 which can be found in the Health Records Procedure.

- Some specialities such as Oncology and ENT have health records which are separate to the standard Trust health record. Therefore care must be taken to ensure users of Millennium track the correct set of health records for a patient.

- For further information please refer to the Trust's Health Records Procedure.

Health records should never be removed from a hospital site unless for legal service reasons or face to face patient care i.e. peripheral clinics

Question Section for Data Quality Workbook



Question 1	
•Data Quality Responsibility	**Select one correct answer**
Who is responsible for Data Quality within the organisation?	a) My manager b) I am c) The Chief Executive d) The patient

Question 2	
• Data Quality Policy	**Select one correct answer**
Where can I find the most up to date copy of the Trust Data Quality Policy	a) On the office notice board b) In the office c) From the Trust Intranet d) From my manager

Question 3	
GP Information	**Select one correct answer**
Which of these questions is the most appropriate to ask a patient for GP information	a) Can you tell me who your GP is b) Is your GP still the same c) Have you changed your GP

Question 4	
Mandatory fields on Millennium EPR	**Select two correct answers**
When face to face with or on the telephone to a patient what should you ensure when adding information to mandatory fields?	a) Always check all information is up to date b) Use unknown or unable to obtain options and manager will complete later c) Ask the patient and enter information as given by them

Question 5	
Medical Records	**Select one correct answer**
Who is responsible for the tracking of patient records?	a) All Administrative staff b) All users of the patient records c) Only health records and clinic preparation staff

Question 6	
Correct GP information	**Select one correct answers**
What should you always ensure when choosing the patients GP from the GP search in Cerner Millennium?	a) That you choose any GP with the same initial & surname b) That you choose the GP with the exact first & surname c) That you choose a GP with the same surname

Question 7	
Medical Records	**Select two correct answers**
When are staff permitted to take medical record files off of OUH sites	a) For face to face patient care b) Never c) When they want to work at home d) For legal service reasons

Question 8	
Medical Records	**Select one correct answer**
At the end of an inpatient stay who is responsible for filing clinical documentation within the patient's health record?	a) Medical records and clinic preparation staff b) The Consultant c) All users of the patients' medical record during this period d) The specialty secretarial team

Question 9	
Correct Consultant	**Select one correct answer**
Who is responsible for ensuring that each patient is recorded under the correct consultant throughout each episode of care	a) The patient b) Anyone updating the patient record for that episode c) The clinical coders d) My manager

Question 10	
Referral letters	**Select one correct answer**
What is the first thing you should do when receiving a referral letter?	a) File b) Date Stamp c) Pass straight to consultant for triage d) Pass to secretary

Question 11	
Data Quality Diamond	**Select one correct answer**
Which of these elements constitute part of the data quality diamond	a) Relevance b) Accuracy c) Timeliness d) Validity e) All of the above

Question 12	
Correct GP Practice address information	**Select one correct answers**
What should you always ensure when choosing the patients GP from the GP search in Cerner Millennium?	a) That you choose the first address for your GP as shown from your GP search b) That you choose the main practice address for the GP c) That you choose the correct practice address for the location where the patient is registered

Question 13	
Best practice for recording any patient information	**Select three correct answers**
What should you aim to achieve when recording any patient information	a) That you record when you have time b) That you take the opportunity to ensure all information that you are aware of is correct c) That you record everything accurately d) That you record in real time wherever possible

Question 14	
Correct patient information	**Select one correct answer**
How do you ensure that you record information within the correct patients notes (either electronic or paper)	a) Always check name is correct b) Always check with the patient c) Always check both the NHS & health record numbers

Question 15	
Non-Mandatory fields on Millennium EPR	**Select one correct answer**
What information should you always attempt to collect that is not currently mandatory on Millennium EPR?	a) Title b) Marital Status c) Mobile Phone Number d) Next of Kin e) All of the above

Question 16	
Work processes	**Select one correct answer**
You have a job in a new department and have undertaken appropriate training to work on reception- What would you ask your manager for to ensure you follow due process	a) The service specific standard operating procedure document b) Hand written notes from a colleague c) A generic training guide

Question 17	
Work processes	**Select one correct answer**
What is a Standard Operating Procedure	a) Information on the exact process I should follow in my department for any particular task b) Details of how to perform a surgical operation c) The standard the trust should follow for clinical requirements only

Question 18	
Adding patients to Millennium EPR	**Select all correct answers**
What should you do before registering a new patient on Millennium EPR	a) Check that you have all patient demographics b) Choose patient with the same name c) Ensure you choose the correct patient with ALL matching demographics d) Log a helpdesk call if you have the NHS number but patient does not appear on spine

Question 19	
Overseas Patients	**Select one correct answer**
Who is responsible for ensuring that overseas visitors are identified	a) The Divisional General manager b) Anyone who has contact with the patient c) My manager d) The patient

To be completed if submitting workbook

I declare that I have completed this learning questionnaire personally and without assistance from any other person.

A pass mark has been achieved **Yes/No**

The applicant needs to attend a face to face session **Yes/No**
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Applicant's Personal Information

It is important that you complete ALL details

Applicant's Name (Block Capitals**)** ……

(As appears on pay slip)

Telephone Number …… Email …….

Department …….

Personnel/assignment number (found on payslip) …….

Manager's Name: ……..Date:……

Managers Signature: …….. Date:……

Applicant's Signature: …….. Date:…….

Please return to:

Name & Address
Francine Tanner- Level 1, Carillion Building (block 229), JR