TO Be Updated when Cerner is implemented

Quality Assurance

1. Clinical Records Committee policies will be incorporated into the standard Agency format and maintained in the B.C. Cancer Agency Policy Manual.

2. BCCA Quality Assurance Processes - General

2.1 For New Physician Hires

The responsible professional practice leader will perform selected a minimum of 5 charts for audits at **3** and **6** months to ensure the documentation standards have been followed, the clinical reasoning is sound and the use of resource, e.g. investigation requests, is appropriate. The selection of charts will reflect on the types of tumour site responsibility of the physician.

Policy

2.2 For reappointment

Annual reappointment
Per annual reappointment process

In depth review
Per PHSA IDR process including chart audits of 2-5 charts

2.3 **The Mortality Review Committee** composed of Oncologists reviews the records of patients who have died on the In patient wards.

3 Qualitative analysis:

- of in-patient records includes checks for history and physical and discharge summary. Also, a check is made

for consultations from non-BCCA physicians.

- of day care surgery patient records includes checks for consultation and operative reports.
- of ambulatory care patient records includes checks for Oncology consultations. Coders check for staging diagrams.

Deficient charts are sent to the Doctor for completion. Incomplete charts, returned by the Doctor, are filed incomplete with notation of the deficiency on the paper record.

4. Audit of Outstanding Items in Action Lists of Medical Staff:
   - ✓ Once a month, Health Record Analyst performs an audit of Physicians' Action Lists to count the number of reports outstanding greater than 3 weeks from time reports were routed to the action lists and to give the date of the oldest report outstanding in the action list. The audit includes not only unsigned transcribed reports but also diagnostic and other reports sent to the physician.
   - ✓ Health Record Analyst emails completed audit for physicians in each Centre to the HIM Coordinator in that Centre.
   - ✓ HIM Coordinator in each Centre emails section of the audit to the Medical Staff Professional Practice Leaders pertaining to their department so that the Leaders are aware of status of physician action lists.
   - ✓ Medical Staff Leaders in each Centre will review and may discuss the action lists with their physicians. If necessary, follow up corrective steps will be initiated with the Regional Medical Staff Leaders after discussion with the Provinical Practice Leaders or VP – Medical Affairs.

5. Audit of Most Responsible Physician (MRP) entered into Patient's Electronic Record (CAIS)
   - ▪ The Ambulatory Care Unit Clerks are responsible for entering the name of the Most Responsible Physician (MRP) into the patient's electronic record (CAIS). Entering the name triggers a request to accept responsibility as MRP being sent to the Oncologist's action list. As soon as he/she signs acceptance, he/she becomes MRP until the patient is discharged.
   - ▪ A daily audit of missing MRP for patient's who had their first appointment with the Oncologist the previous day is performed by the Health Record Analyst..
   - ▪ The H|IM Coordinator enters the name of the MRP for any

patient who has been missed..

6. Audit of 5 Minimum Data Set Entered into Patient's Electronic Record (CAIS)
   - Best Practice Registration Standards have been established by the Province. These include Patient's Name, PHN, Date of Birth, Address and Postal Code.
   - Daily and monthly audits of missing/incorrectly entered data elements in the patient's electronic record are performed by the Health Record Analyst. HIM Staff correct the errors.
   - Monthly, a report showing percentage of compliance with the 5 Minimum Data Set standard is performed by a Health Record Analyst.