Dorset HealthCare
University NHS Foundation Trust

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CLINICAL CODING POLICY AND PROCEDURES

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CLINICAL CODING POLICY AND PROCEDURES

1.0 INTRODUCTION

This policy has been produced with the intention of promoting good practice and consistency of clinical coding within Dorset Healthcare NHS Foundation Trust. It has been designed to ensure information produced during the coding process is accurate, timely and adheres to local and national policies and achieves national standards.

1.1 Clinical Coding Definition

Clinical Coding is the translation of medical terminology, as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised to support both statistical and clinical uses.

1.2 Clinical Coding Description

Coded clinical data (generated from classifications OPCS-4 and ICD-10) uses rules and conventions that, when applied accurately result in the provision of high quality statistically meaningful data.

This directly affects clinicians and all healthcare professionals, financial teams, information managers and data analysts along with IT Professionals.

The NHS requires input of accurate data to reflect clinical activity and trusts now have a financial incentive to ensure that coding is accurate, comprehensive and timely.

2.0 PURPOSE AND SCOPE

2.1 To provide accurate, complete, timely coded clinical information to support commissioning, local information requirements.

2.2 Adhere to national standards and classification rules and conventions as set out in the WHO ICD-10 4th edition Volumes 1-3, National Clinical Coding Standards ICD-10 4th edition, OPCS - 4.7 National Clinical Coding Standards manual OPCS 4.7 and the Health & Social Care Information Centre (hscic) Coding Clinics.

2.3 Ensure input into RiO, SystmOne, eCaMIS and iSoft Patient Administration Systems (PAS) of complete and accurately coded information, within designated time scales, to support the information requirements and commissioning of Dorset Healthcare NHS Foundation Trust.

2.4 Ensure all staff involved in the clinical coding process receives regular training to maintain and develop their clinical coding skills, regardless of experience and length of service.

2.5 Ensure continual improvement of the clinical coded information within Dorset Healthcare NHS Foundation Trust through systematic audit and quality assurance procedures.

2.6 Ensure all staff are aware of the trusts security and confidentiality policies when using patient identifiable information.

3 CLINICAL CODING PROCEDURES

3.1 Source document

The source documents for the coding of the Mental Health patients can be found on RiO in the form of an electronic discharge summary. Additional information can be found within the patient's medical progress notes and the core assessment. Every effort should be made to obtain as much information as possible relating to the hospital episode.

The source documents for the coding of the Community Health patients is an electronic discharge summary found within SystmOne. For the patients having attended the Swanage and Victoria hospitals for a procedure in theatre or the Endoscopy unit, then this information can be found within the patient's medical records.

The main source document used in the coding of the theatre patients at Blandford Community Hospital is the theatre register and the patient's letters available within iSoft (Dorset County Hospital's PAS system). For the patients that have attended Bridport Community Hospital for an Endoscopy procedure then this information can be found within ADAM, the endoscopy system owned by Dorset County Hospital (DCH). The main source document for the patients that have attended Bridport Community Hospital for a theatre procedure is the electronic discharge summary found within the DCH's intranet.

See Appendix A – Community Hospitals Information

3.2 Coding

The Trust uses ICD-10 (International Classification of Diseases and Related Health Problems 10th revision 2010 edition) and OPCS 4.7 (Office of Population Census & Surveys version 4.7).

ICD 10 codes are also available for reference on the World Health Organisation website: http://www.who.int/classifications/apps/icd/icd10online/

High cost drugs lists and Chemotherapy Regimens lists are available from Technology Reference data Update Distribution (TRUD) website: https://isd.hscic.gov.uk/trud3/user/authenticated/group/61/pack/10/subpack/27/releases

3.3 Timescales

The clinical coders will ensure that all the coding is completed by the third working day of the month. If this is not achieved then it is the duty of the clinical

coding lead to investigate accordingly the reasons for the delay in the completion of the coding.

4 VALIDATION OF CLINICAL CODED INFORMATION

4.1 Internal Audits

The Lead Clinical Coder will aim to undertake an internal audit every six months using a random sample of at least 30 clinical records.

4.2 External Audits

External audits are undertaken once a year. 50 clinical records are audited for the Mental Health hospitals. 100 clinical records are audited for the Community Health hospitals.

4.3 Correction of Errors

Errors are corrected as soon as they are identified.

4.4 Local Policies

When local policies are created, these will be agreed by the responsible consultants and the coders. The Clinical Coding Lead will inform all members of the team and ensure books are updated accordingly. Each member of staff will responsible for creating local policies and the consultants. All members of the team will sign each local policy to prove they have seen the policy.

Local policies will be divided into Mental Health and Community Health Services.

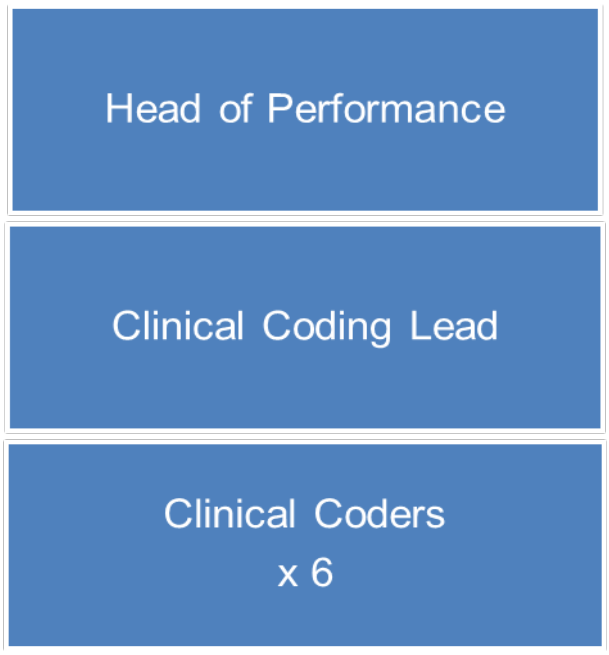
5 COMMUNICATIONS IN CLINICAL CODING

To ensure consistency and accuracy of coded information the following steps are in place:

- Clinical Coding Instruction manuals ICD-10 and OPCS – 4.7, Coding Clinics and Health and Social Care Information Centre (hscic) Clinical Coding Guidelines are used.
- Liaison with appropriate clinician on applicable ICD-10 and OPCS 4.7 codes. Clinical Coders ensure that the advice given does not contravene the rules and conventions of the classifications or national standards. Standards agreed with clinicians are documented appropriately.
- Reference to senior level coding staff to determine whether the query can be resolved internally.
- Referring any query to the National Clinical Coding Query Mechanism including completion of the relevant query proforma information if appropriate. See Appendix B.
- Distribute the resolution to the team.

6 CLINICAL CODING TEAM STRUCTURE AND TRAINING

6.1 Structure



6.2 Training

The Clinical Coding Lead will ensure that the team attends all training as necessary. The training requirements are as follows:

- Attendance of the Clinical Coding Standards course within six months of appointment for all untrained coders.
- Attendance on the Clinical Coding Refresher Training Course every 3 years for experienced clinical coding staff.
- Attendance on regular specialist training courses wherever available.
- Attendance on relevant computer training courses to keep their IT skills up-to-date.
- Attendance to other relevant mandatory training courses in line with trust policies (e.g. health and safety, fire training, security and confidentiality etc.).
- All clinical coders are encouraged to achieve accredited clinical coder (ACC) status by studying for the National Clinical Coding Qualification (NCCQ)

7 CLINICAL STAFF RESPONSIBILITIES IN RELATION TO CLINICAL CODING

There is an onus of responsibility on clinical staff at ward level to ensure that a discharge summary is completed for every patient on discharge. This includes patients who are being transferred to another facility outside of this trust and those who die.

They should attempt to ensure that the discharge summary gives clear and specific information relating to the following:

- Primary diagnosis
- Secondary diagnosis (co-morbidities)
- Primary procedures (with dates)
- Secondary procedures (with dates)
- Complications of treatment
- Other factors that may have delayed the patients discharge from hospital

Clinical staff can also assist the clinical coding staff in abstraction of relevant information and assignment of correct codes, by supplying advice and clarification on patient diagnosis and treatment when this is requested.

A top tips for coding guide has been supplied in this document. See Appendix three.

8 MONITORING AND COMPLIANCE

All staff (whether permanent, temporary or contracted), non-executive directors and contractors are responsible for ensuring that they are aware of the requirements incumbent upon them and for ensuring that they comply with these on a day-to-day basis.

Trust clinicians and administrative staff should forward the provider spell summaries/discharge summary forms to the clinical coding team within twenty four hours of the patient's discharge.

Managers at all levels are responsible for ensuring that the staff for whom they are responsible are aware of and adhere to this policy. They should ensure that the policy and its supporting standards and guidelines are built into local processes. They are also responsible for ensuring that staff are updated in regard to any changes in this policy.

9 REVIEW

This policy will be reviewed every three years.

10 POLICY DISTRIBUTION

The clinical coding policy and guidelines will be made available to staff on the Trust intranet.

11 USEFUL CONTACTS

Name	Job Title	Contact Number	E-Mail Address
Margaret Setter	Clinical Coding Lead	01202 277364	Margaret.Setter@dhuft.nhs.uk
Teresa Brake	Clinical Coder	01202 856434	Teresa.Brake@dhuft.nhs.uk
Tracey Stone	Clinical Coder	01929 475046	Tracey.Stone@dhuft.nhs.uk
Hayley Ure	Clinical Coder	01202 277336	Hayley.Ure@dhuft.nhs.uk
Marianne Riggs	Clinical Coder	01202 277336	Marianne.Riggs@dhuft.nhs.uk
Sue Spence	Clinical Coder	01305 361370	Sue.Spence@dhuft.nhs.uk
Sharon Maddocks	Clinical Coder	01202 492036	Sharon.Maddocks@dhuft.nhs.uk

This document has been developed in line with the Trust's Policy for Procedural Documents, which is compliant with NHS Litigation Authority standards on procedural documents. Standards in relation to the following areas are covered within the Trust wide Policy for Procedural Documents, which this document complies with:

- Consultation and communication with stakeholders
- Committees responsible for approval of procedural documents
- Procedural documents required style and format
- Development process for Trust wide procedural documents including prioritisation of work, identification of stakeholders, responsibility for document development
- Consultation, approval and ratification process
- Review and revision arrangements
- Document control including archiving arrangements

Appendix A:

COMMUNITY HOSPITALS:

Blandford Hospital

The coding is captured on two different systems. The community health coding is captured on SystmOne and this is from the 18th February 2014. Prior to the 18th February, the coding was captured by the clinical coders from Dorset County Hospital (DCH) as per a previous agreement between Dorset Healthcare University Foundation Trust (DHUFT) and DCH.

All the theatre activity is captured on DCH's PAS which is iSOFT. The encoder used within iSOFT is Simplecode version 3.4

The main source document used for the community health patients is the discharge summary which is available on SystmOne. The coders use all the information that is written by the nurses, clinicians and allied health professionals on SytsmOne as the patient's paper medical records are no longer used to capture any information.

The coding for the theatre patients is obtained using the theatre register as well as the patient's letters that are accessed on the iSOFT system. These codes are then entered onto iSOFT.

Bridport Hospital

The coding is captured using two different IT systems. The coding for the community health patients is captured on SystmOne and this is from the 5th March 2014. Prior to the 5th March 2014, the clinical coders from DCH were coding all the activity for the DHUFT patients. The main source document is the electronic discharge summary available on SystmOne.

The activity that takes place in the theatres is captured using DCH's PAS which is iSOFT and the encoder within iSOFT is Simplecode version 3.4

A list of un-coded patients is generated every two weeks upon request by the clinical coding lead. The endoscopy reports are accessed via an IT programme called ADAM.

The clinical coding lead has been trained by the IT staff at DCH and given passwords to access the iSOFT PAS, ADAM and the patient's electronic discharge letters which are available on Dorchester County Hospital's intranet.

Alderney Hospital

The coding is captured using SystmOne. Alderney hospital went live with SystmOne on the 4th February 2014. Prior to the 4th February, the coding was captured on eCaMIS.

The main source document used is the electronic discharge summary available on SystmOne.

Portland Hospital

The coding for Portland hospital is captured using the SystmOne. Portland hospital went live with SystmOne on the 4th March 2014. The clinical coding was done by the DCH coders up until the 3rd March 2014 as per a previous agreement between the two Trusts.

The main source document used is the electronic discharge summary available on SystmOne.

St Leonards Hospital

The coding for St Leonards Hospital is captured on SystmOne. SystmOne went live at St Leonards on the 4th February 2014. Prior to this date the coding was captured on eCaMIS.

The main source document used is the electronic discharge summary available on SystmOne.

Swanage Hospital

All the theatre activity is captured on eCaMIS as the theatre module is not yet available on SystmOne. The encoder within eCaMIS is Simplecode and the version is 3.4. The main source document used to code from is the patient's medical records.

All the coding for the inpatient activity is captured on SystmOne. SystmOne went live on the 6th February 2014.

The main source document used for the coding of the community patients is the electronic discharge summary available on SystmOne.

Wareham Hospital

The clinical coding for the inpatient admissions is captured on SystmOne which went live on the 6th February 2014. Prior to this the coding was captured on eCaMIS.

The main source document used is the electronic discharge summary available on SystmOne.

Westhaven Hospital

The clinical coding is captured using SystmOne which went live on the 4th March 2014. Prior to the 4th March, the coding was captured on iSOFT by the clinical coders at DCH as per a previous agreement between DHUFT and DCH.

The main source document used is the electronic discharge summary available on SystmOne.

Westminster Memorial Hospital

The coding for Westminster hospital was done by a clinical coder from Salisbury District hospital until the 18th February 2014. This was due to a previous contract between DHUFT and Salisbury District Hospital. The coding was captured using their own PAS.

On the 18th February 2014, SystmOne went live at Westminster hospital and the coding is captured by the DHUFT coders.

The main source document used is the electronic discharge summary available on SystmOne.

Victoria Hospital, Wimborne

All the theatre activity for Victoria hospital is captured on eCaMIS as the theatre module for the main PAS SystmOne is not yet available. The encoder within eCaMIS is Simplecode and the version is 3.4. The main source document used to code from is the patient's medical records.

All the inpatient activity is captured on SystmOne which went live on the 20th January 2014. Prior to this date the coding was captured on eCaMIS.

The main source document used for the coding of the community patients is the electronic discharge summary available on SystmOne.

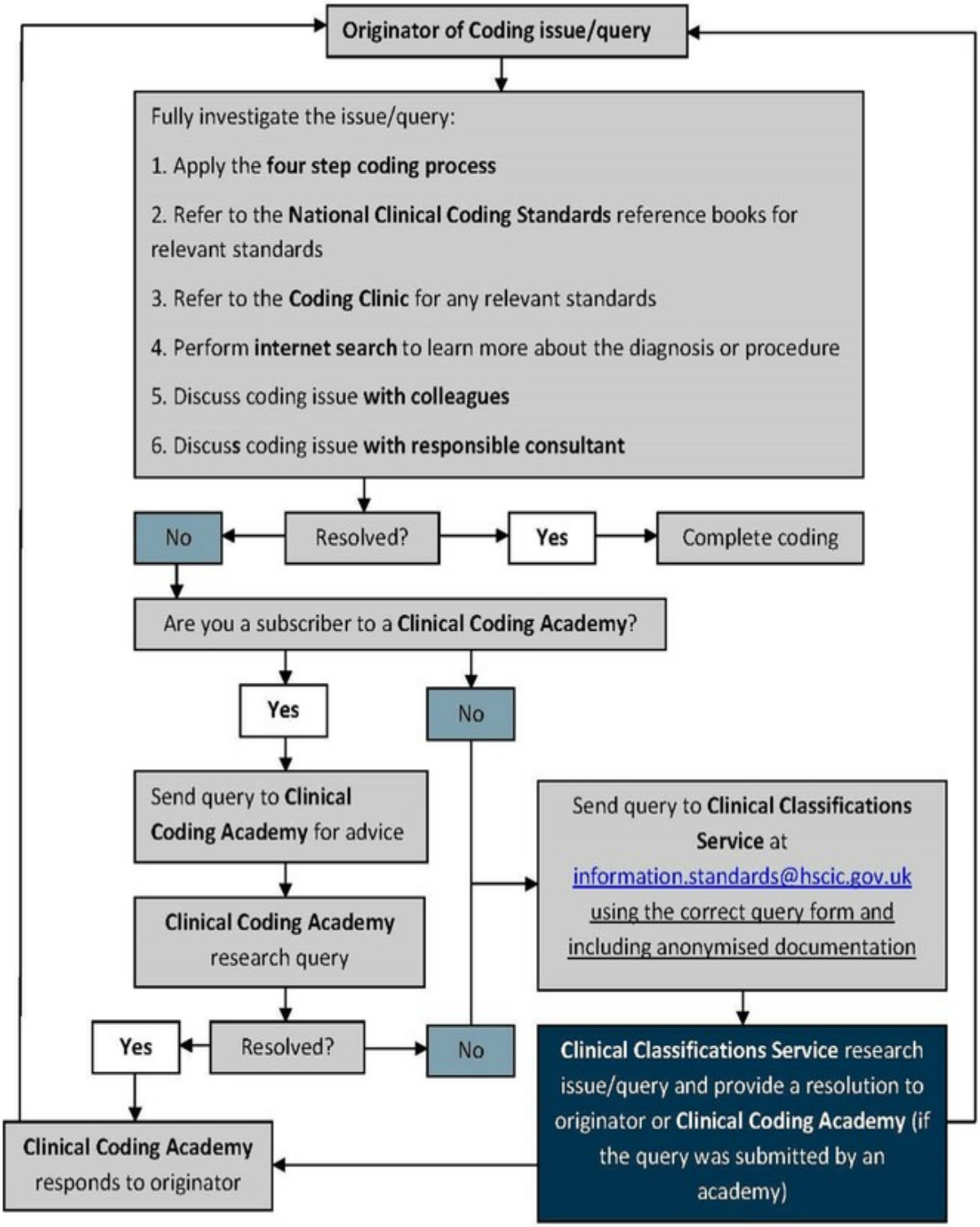
Yeatman Hospital

The coding is captured on SystmOne as of the 18th February 2014. Prior to the 18th February, the clinical coding was done by the coders at DCH due to a previous agreement between the two trusts. This coding was captured using iSOFT.

The main source document used is the electronic discharge summary available on SystmOne.

Appendix B:

Clinical Coding Query Support Mechanism



If you have followed the guidance above and the query still remains a problem submit your query, anonymised information and the outcome of your investigations using the relevant query form below:

- ICD-10 Query Form (DOC, 154.0kB)
- OPCS-4 Query Form (DOC, 152.5kB)
- Resolution follow up form (DOC, 145.5kB) (for use when querying resolutions received within the last 6 weeks)
- Cross-map Query Form (DOC, 137.5kB)(Please view the guidance (PDF, 30.1kB)before submitting your query)

Submit your completed query form to information.standards@hscic.gov.uk

You will receive an acknowledgement and a unique reference number.

Our primary aim is to provide a resolution within 10 working days to a coding query relating to NHS business and government requests. Queries from other sources such as marketing companies, private research or academic organisations and other more complex queries will be considered on an individual basis but will typically be resolved within 22 days.

You can also contact us on 0845 1300114. [i]

[1] http://systems.hscic.gov.uk/data/clinicalcoding/codingadvice/national/index_html

Appendix C:

Top Tips for Coding – A guide for Clinical Staff

Top tips for coding – A guide for clinical staff

Clinical Coding is the process whereby information written in the patient notes is translated into coded data and entered onto hospital information systems. This usually occurs after the patient has been discharged from hospital, and must be completed to strict deadlines in order for hospitals to be reimbursed for their activity.

Clinical coding staff are entirely dependent on clear, accurate information about all diagnoses and procedures in order to produce a true picture of hospital activity. The coded data is vitally important, and is used for:

- Monitoring the provision of health services across the UK
- Research and the monitoring of health trends and variations
- NHS financial planning and Payment by Results
- Local and national clinical audit and case-mix analysis
- Clinical governance

There are many ways in which clinicians can assist the process of clinical coding, some of which are summarised below. Each is based on the basic principles:

1. Write clearly and legibly in the notes and on discharge documentation. Make sure the patient is identified on every sheet of paper used in the notes.
2. Always communicate any transfers of care to ward administrative staff. This includes when patients go for an investigation or procedure performed by another clinical team.
3. Clearly record the details of **all of the diagnoses (including all co-morbidities) and procedures (including those done on the ward)** in the notes. Write the main diagnosis first. Best practice is to summarise all of these as the last (discharge) entry in the notes – this will make your discharge summaries easier too.
   For *injuries,* note the cause; for *overdoses,* note the drug; and for *infections,* note the organism.
4. Include details of all diagnoses and procedures on discharge summaries and TTO's (preliminary discharge summaries).
5. If a clear diagnosis has not been reached, make sure you detail the main symptoms in the notes or discharge summary. Any 'query' diagnosis e.g. likely, maybe, possibly, or diagnoses preceded by a '?' **cannot be coded** by clinical

coding staff. We are able to code a ‘probable’ diagnosis. If histology is awaited for a definitive diagnosis, note this down.

6. Avoid the use of new or ambiguous abbreviations (eg ‘M.S.’ could mean multiple sclerosis or mitral stenosis). Remember: clinical coding staff are not allowed to make any clinical inferences.
7. If your hospital has a standard proforma for admissions or discharge, use it! Fill in **all** the details it asks for.
8. Discharge summaries must be accurate and timely. Don’t let your discharge summaries pile up on a shelf for weeks on end, awaiting dictation – coding staff have strict deadlines to meet and delays cause huge problems. Discharge summaries should be complete within 24 hours of discharge to allow for 48 hour post discharge coding completion.
9. You may be asked queries by the coding team if all the relevant information is not on the discharge summary, try to avoid this by completing your discharge summary as above.

Dorset HealthCare University NHS Foundation Trust

Appendix D:

EQUALITY ANALYSIS

1. Policy/Practice/Service development	Directorate	New or existing?	Date of Assessment

2. Briefly provide an overview of the policy/practice/service development and describe the aims, objectives and purpose of the Policy/Service:

3. Who will be affected? E.g. staff, patients, service users etc

3. Please demonstrate below the potential impacts on people or equality groups with protected characteristics. List the main sources of data, research and other sources of evidence reviewed to determine the impact or potential impact on each equality group (protected characteristic)

Equality target group (protected characteristic)	Is the policy/ practice/ service development relevant to this equality area? Yes/No. If No what evidence did you rely on to reach this conclusion.	Assessment of Potential Impact: High/ Medium/ Low/ Not Known		Required Actions or Action Plans	
		Positive (+)	Negative (-)		
Gender reassignment					

Race					
Sex					
Disability					
Age					
Religion or Belief					
Sexual orientation					
Marriage and Civil Partnership					
Pregnancy and Maternity					

4. Engagement and Involvement. How have you engaged stakeholders in gathering evidence, testing the available evidence and what stakeholders/groups both internal and external were consulted and when? What was the outcome of that engagement and involvement?

5. Summary of Analysis: In considering the evidence and engagement activity listed above, summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether this is adverse or positive and for which groups. Detail how any negative impacts will be mitigated. Are there any alternative measures that could be taken which could achieve the desired aim without the adverse impact identified? Can the adverse impact or indirect discrimination be objectively justified? Specify how certain protected groups will be included in services or how their participation in public life will be expanded.

6. Consider and detail below how the proposals impact on and have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity between people who share a protected characteristic and those who do not and foster good relations between people who share a protected characteristic and those who do not**.**
6.1 Eliminate discrimination, harassment and victimisation. Where there is evidence address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation, marriage and civil partnership).
6.2 Advance equality of opportunity. Where there is evidence address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).
6.3 Promote good relations between groups. Where there is evidence address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).
7. What is the overall impact? Consider whether there are different levels of access experienced, needs or experiences, whether there are any barriers to engagement and what is the combined impact?
8. Addressing the impact on equalities. Provide an outline of what broad action should be considered by you or any other body to address any inequalities identified through the evidence and consultation. Outline what changes will be made to the policy, practice or service as a result, when and by whom.
9. Action planning for improvement and implementation. Provide an outline of the key actions based on any gaps, challenges and opportunities identified. Actions to improve the policy, practice or service development need to be summarised including any general action to address specific equality issues and data gaps that need to be addressed through further research or consultation. Use the attached Action Improvement Plan.

10. Monitoring and review. Detail the processes for monitoring, how this will be measured and when and how the policy, practice, service development will be reviewed.			
11. Publication. Outline how and where this assessment will be published			
Review Date			
Name of responsible Director			
Assessment Completed By		**Date signed**	