OPERATIONAL DIRECTIVE

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Subject: CLINICAL INFORMATION AUDIT PROGRAM
HOSPITAL ACTIVITY REPORTING

1. Purpose

The purpose of this Operational Directive is to prescribe the program for auditing the clinical information used to measure and report hospital activity. It is mandatory that public health organisations comply with this Operational Directive.

Audits will be undertaken to measure and promote compliance with reporting rules set out in Department of Health (DOH) Operational Instructions and Directives, including, but not confined to, those which refer to admissions and those which relate to the clinical information submitted to the Hospital Morbidity Data System (HMDS). A list of source documents for these reporting rules is included (item 4).

2. Background

A systematic monitoring of information sources is needed to ensure the quality of the information used in the monitoring, planning and program development process. A planned program of auditing also seeks to measure the accuracy of Diagnosis Related Groups (DRGs) as the basis for activity-based funding and reporting.

3. Information

3.1 Hospital Inpatient Activity Audits: Overview and Schedule
The admitted patient audits will measure:
- compliance with WA Admission Policy
- accuracy and completeness of the clinical documentation
- compliance with “episode of care type” reporting and
- accuracy of clinical coding and subsequent DRG assignment.

The audit schedule has been revised to allow greater emphasis on areas of high volume inpatient activity. From the commencement of the financial year 2009/10 the following schedule will apply:

- teaching hospitals: annual audit
- metropolitan non-teaching: biennial audit
- regional hospitals: biennial audit.
A small selection of district hospitals will be audited in conjunction with each regional hospital audit. The selection of district hospitals will be varied to aim for complete coverage over a 6 to 8 year cycle.

3.2 Hospital Inpatient Activity Audits – Methodology
A random sample of inpatient episodes over a specified time period will be examined. The sampling methods will ensure a representative sample. The audited population will include all inpatient activity with the exception of:

- high volume DRGs (R63Z: chemotherapy; L61Z: renal dialysis)
- boarders
- healthy newborns.

High volume DRGs will be audited separately (see item 3.4).

Audit cases will be subjected to blind re-coding. The re-coded cases will then be grouped, independently of the original grouping processes, to arrive at the audit DRG.

Medical Records will be reviewed to assess specifically:

- compliance with admission criteria;
- clinical substantiation of the source information provided for coding (documentation in the medical record should substantiate the diagnoses and procedure descriptions listed for coding with appropriate investigation test results filed in the medical record for reference);
- provision of either a summarised coding sheet or a discharge summary signed by the treating medical officer (correct sequencing and code assignment should be supported by clinical documentation);
- accuracy of clinical coding (code assignment must adhere to current standards for clinical coding):
  - WA Coding Standards
  - The International Classification of Diseases, 10th Revision, Australian Modification, current edition. (ICD 10 AM)
  - Coding Matters (the quarterly publication of the National Centre for Classification in Health)
  - WA Coding Committee Rulings;
- documentation of the acuity of the episode of care;
- completion of acute care certificates where required;
- completeness and accuracy of emergency department documentation;
- and to ensure that in general, data items are reported in compliance with the instructions contained in the Hospital Morbidity Data System Reference Manual, current edition.

3.3 Audit Process
(a) Hospital Responsibilities
The hospital processes are as follows:

- to have records ready for the auditors when required (usually within 4 weeks of notification of the proposed audit);
- to facilitate access to relevant hospital records and personnel;
- to provide appropriate working space for those conducting the audit;
- to refile the audited medical records; and
- to liaise with Information Management and Reporting (IMR), Dept. of Health, to ensure that information is corrected after audit.
(b) Department of Health Responsibilities
The responsibilities of the Department are as follows:

- to notify the hospital of the unit record numbers of the files to be audited;
- to commence the audit within 2 weeks of notification that the records are ready;
- where there are discrepancies, to resolve them with the assistance and input of the clinical coder before the audit report is published;
- to send copies of the audit report to the hospital and the health service executive after the completion of the audit.

3.4 Department-based Audits of Hospital Morbidity Data System (HMDS).
A continuous program of audits of selected DRGs on the HMDS masterfile will be undertaken. These audits will include, but are not confined to:

**High volume DRGs**
- L61Z renal dialysis
- R63Z chemotherapy

**High cost DRGs**
- Z71Z – Z76Z, Z60A, Z60B Rehabilitation
- A01Z – A41Z Transplants, Ventilation > 96 hours
- 801A – 801C Operating Room Procedure Unrelated to Principal Diagnosis.

When necessary, hospital-based audits may be arranged to further investigate issues arising.

4. Operational Directives (OD), Technical Bulletins (TB) and Other References for Audit Purposes

- TB 17/3 Admission Policy for WA Hospitals
- TB 10/6 Hospital Morbidity Information
- TB 26/5 Reporting Different Episodes of Care
- TB 14/5 Neonatal Care information Reporting
- TB 50/0 Transferred Patients
- TB 78/0 Hospital in the Home Care
- OD 0147/08 Acute Care Certification
- OD 0179/09 Reporting of Contracted Services for Admitted Patients
- OD 0154/08 WA Coding Standards

International Classification of Diseases, 10th Revision, Australian Modification (ICD 10 AM)
5. **Notes for Clinical Coders:**

- If the coder considers that the medical officer responsible for care has selected a principal diagnosis which differs from the definition of the principal diagnosis in the Australian Coding Standards, the doctor should be contacted for clarification of the case. Documentation of discussion with the clinician should be retained.

- If the codes on a signed coding sheet or summary are different to the doctor's written text the coder should retain a record of contact with the medical officer. This information may assist the auditor to clarify conflicting information at audit.

- DOH policy is that hospitals use the Australian Standards for Coding in most instances. However, when there are differences, the directions in an operational directive take precedence over an Australian coding standard (see OD 154/08: WA Coding Standards).

- Where coding is performed without discharge summary, on an interim basis, it is essential that coding be updated, when the discharge summary becomes available.

- Hospitals should work with IMR to update data on both the hospital system and departmental database (HMDS) when errors occur. The HMDS is the information system used to inform activity-based funding and reporting models. It is the responsibility of both the hospital and IMR to ensure that all updates to data items on the hospital system also flow through to the HMDS.

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