SFHHI11 - SQA Code HD4D 04
Produce coded clinical data

Overview

This standard is about producing coded clinical data that can be used to support local and national initiatives, and inform the development of future plans for the delivery of care. You will need to be able to search for the evidence to support code assignment and accurately extract the correct clinical data from health records. Clinical data will relate to diagnosis and may include interventions or procedures. You will also need to establish the appropriate level of detail of clinical data as assigned by the professional, and record your decisions accurately and completely. You will need to assign codes to clinical data identified as relevant to the episode of care. This requires a significant depth of knowledge and understanding in relation to national clinical coding standards, clinical terminology, human anatomy, the nature of disease processes and how they are treated, according to clinical coding rules and conventions.

Users of this standard will need to ensure that practice reflects up to date information and policies.

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Performance criteria

You must be able to:

- P1 identify and extract the correct clinical data after searching the health records
- P2 identify any requirements for additional clinical data and take the appropriate action to obtain such information
- P3 refer any issues concerning the clarity and accuracy of the clinical data to the appropriate person for resolution
- P4 evaluate the relevance of health conditions and factors affecting the patient to establish the primary diagnosis
- P5 evaluate other health conditions and factors affecting the patient to establish co-morbid conditions relevant for assignment
- P6 evaluate any procedures, interventions and investigations carried out to establish the primary procedure and any relevant secondary procedures
- P7 establish the appropriate level of detail of clinical data to meet national standards
- P8 identify the correct clinical data within appropriate timescales
- P9 code all the relevant clinical data correctly and in accordance with approved rules and conventions, using the appropriate tools
- P10 establish and record the correct sequence and order of codes related to a single episode in accordance with national standards
- P11 record data clearly, accurately and completely
- P12 maintain confidentiality at all times
- P13 enter the relevant information accurately into the appropriate system
- P14 complete the process of assigning the correct codes from clinical data within appropriate timescales
- P15 select the appropriate classification cross map in accordance with national rules and standards from an identified clinical concept

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Knowledge and understanding

You need to know and understand:

K1 the relevant legislation, policies, procedures, codes of practice and guidelines in relation to clinical coding at local and national levels

K2 the use and meaning of clinical terminology

K3 the nature of disease processes and how they are treated

K4 basic anatomy and physiology

K5 how and where to access reliable information relating to clinical terminology

K6 the ways in which rules and conventions are applied to clinical data to achieve the correct clinical codes

K7 the importance of using the correct rules and conventions

K8 the ways in which classifications and nomenclatures are used to achieve accurate clinical coding

K9 the ways in which clinical data is indexed, stored and cross mapped from clinical terms to classifications

K10 the importance of the sequence of codes and the primary diagnosis and procedures/interventions

K11 the importance of recording error free clinical codes

K12 the uses of clinical coded data, including for national statistics, clinical audit and research, epidemiology, managerial decision making and cost referencing

K13 the type and level of detail which is required for clinical coding

K14 the ways in which health records are assembled and used, and where the best sources of accurate and reliable clinical data may be found

K15 the situations in which additional data is required and how such data may be obtained

K16 the situations in which particular aspects of the patients condition will have a bearing on the required clinical data

K17 where and who to go to in the event of unclear or inaccurate clinical data and the importance of others involvement in the process and system

K18 the relation between coded data and the consequences of that code in the system

K19 the different systems for coding across health

K20 the timescales within which clinical coding must take place and its relation to the patients overall plan of care

K21 the use of relevant software applications

K22 the development and use of Systematized Nomenclature of Medicine – Clinical Terms (SNOMED/CT)

K23 the future interface between clinical coding, electronic health records and electronic patient records and clinicians

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Additional Information

External Links

This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):

Dimension: IK2 Information collection and analysis

The candidate and assessor must only sign below when all Performance Criteria and Knowledge points have been met.

Unit assessed as being complete

Candidate's Name:	
Candidate's Signature:	
Date submitted to assessor as complete:	

Assessor's Name:	
Assessor's Signature:	
Date assessed as complete:	

Internal Verification —

to be completed in accordance with centre's IV strategy

Evidence for this Unit was sampled on the following date/s:	**IV's Signature**	**IV's Name**

This Unit has been subject to an admin check in keeping with the centre's IV strategy.

Date of admin check	**IV's Signature**	**IV's Name**

Unit completion confirmed

IV's Name:	
IV's Signature:	
Date complete:	