FN9R 04 (HI 11) Produce coded clinical data

About this Unit

This standard is about complying with an external audit of data and information. The standard does not cover carrying out an audit, which is dealt with separately. You will need to be able to support auditors to carry out an audit and maintain effective working relationships with them. This will involve preparing colleagues and others for the audit, providing auditors with necessary information and advice, and referring auditors to others. You will also need to be able to respond appropriately to the results of the audit. This will involve handling the recommendations of the audit, agreeing courses of action, communicating the response to the audit and recording the response

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

Your **knowledge and understanding** will be specifically related to legal requirements and codes of practice and conduct applicable to your job, and the NHS Knowledge and Skills Framework. This will relate to your work activities; the job you are doing, and the setting, eg in hospital and community, domiciliary, residential care, and the individuals you are working with.

Values — the values underpinning this Unit are embedded within the 2009 NHS Code of Conduct for Health Care Support Workers. These are stated in full within the Assessment Strategy and Guidance document for the awards.

Key Words and Concepts — a glossary of definitions, key words and concepts used in this Unit is contained in the Assessment Strategy and Guidance document.

In occupational standards it is quite common to find words or phrases used which you will be familiar with, but which, in the detail of the standards, may be used in a very particular way. **You should read the Assessment Strategy and Guidance document before you begin working with the standards and refer to it if you are unsure about anything in the Unit.**

Specific Evidence Requirements for the Unit
It is essential that you adhere to the Evidence Requirements for this Unit

SPECIFIC EVIDENCE REQUIREMENTS FOR THIS UNIT
Simulation:
♦ Simulation is **NOT** permitted for any part of this Unit.
♦ **The following forms of evidence ARE mandatory:**
♦ **Direct Observation:** Your assessor or expert witness must observe you in real work activities. Their confirmation of your practice will provide evidence for a significant amount of the performance criteria in this Unit. **For example**, your assessor may observe you code all the relevant clinical data correctly and in accordance with approved rules and conventions, using appropriate tools. ♦ **Professional discussion:** Describes your actions in a particular situation and reflect on the reason(s) why you practice that way. **For example**, your assessor may ask you to explain, using an example from practice, the different systems for coding across health.
Competence of performance and knowledge could also be demonstrated using a variety of evidence from the following:
♦ **Reflective Account:** These are written pieces of work which allow you to reflect on the course of action you took in a specific situation to identify any learning from the piece of work and to describe what you might do differently in the light of your new knowledge. ♦ **Questioning/professional discussion**: May be used to provide evidence of knowledge, legislation, policies and procedures which cannot be fully evidenced through direct observation or reflective accounts. In addition your assessor/mentor or expert witness may also ask questions to clarify aspects of your practice. ♦ **Expert Witness**: A designated expert witness, eg a senior member of staff, may provide a direct observation of your practice, or record a professional discussion they have held with you on a specific piece of practice. ♦ **Witness Testimony**: Can be a confirmation or authentication of the activities described in your evidence which your assessor or mentor has not seen. ♦ **Products:** These can be any record that you would normally use within your normal role, eg you should not put confidential records in your portfolio; they can remain where they are normally stored and be checked by your assessor and internal verifier. ♦ **Prior Learning:** You may be able to use recorded prior learning from a course of training you have attended within the last two years. Discussion on the relevance of this should form part of your assessment plan for each Unit. ♦ **Simulation:** There may be times when you have to demonstrate you are competent in a situation that does not arise naturally through your work role, eg dealing with violent or abusive behaviour. The Evidence Requirements in each Unit provide specific guidance regarding the use of simulation.
GENERAL GUIDANCE
♦ Prior to commencing this Unit you should agree and complete an assessment plan with your assessor which details the assessment methods you will be using, and the tasks you will be undertaking to demonstrate your competence. ♦ Evidence must be provided for ALL of the performance criteria, ALL of the knowledge. ♦ The evidence must reflect the policies and procedures of your workplace and be linked to current legislation, values and the principles of best practice within the Health Care sector. This will include the National Service Standards for your areas of work. ♦ All evidence must relate to your own work practice.

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KNOWLEDGE SPECIFICATION FOR THIS UNIT

Competent practice is a combination of the application of skills and knowledge informed by values and ethics. This specification details the knowledge and understanding required to carry out competent practice in the performance described in this Unit.

When using this specification **it is important to read the knowledge requirements in relation to expectations and requirements of your job role**.

You need to provide evidence for ALL knowledge points listed below. There are a variety of ways this can be achieved so it is essential that you read the 'knowledge evidence' section of the Assessment Guidance.

	You need to show that you know, understand and can apply in practice:	**Enter Evidence Numbers**
1	The relevant legislation, policies, procedures, codes of practice and guidelines in relation to clinical coding at local and national levels.	
2	The use and meaning of clinical terminology.	
3	The nature of disease processes and how they are treated.	
4	Basic anatomy and physiology.	
5	How and where to access reliable information relating to clinical terminology.	
6	The ways in which rules and conventions are applied to clinical data to achieve the correct clinical codes.	
7	The importance of using the correct rules and conventions.	
8	The ways in which classifications and nomenclatures are used to achieve accurate clinical coding.	
9	The ways in which clinical data is indexed, stored and cross mapped from clinical terms to classifications.	
10	The importance of the sequence of codes and the primary diagnosis and procedures/interventions.	
11	The importance of recording error-free clinical codes.	
12	The uses of clinical coded data, including for national statistics, clinical audit and research, epidemiology, managerial decision making and cost referencing.	
13	The type and level of detail which is required for clinical coding.	
14	The ways in which health records are assembled and used, and where the best sources of accurate and reliable clinical data may be found.	
15	The situations in which additional data is required and how such data may be obtained.	
16	The situations in which particular aspects of the patient's condition will have a bearing on the required clinical data.	
17	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.	
18	The relation between coded data and the consequences of that code in the system.	

You need to show that you know, understand and can apply in practice:	**Enter Evidence Numbers**
19 The different systems for coding across health.	
20 The timescales within which clinical coding must take place and its relation to the patients overall plan of care.	
21 The use of relevant software applications.	
22 The development and use of Systematized Nomenclature of Medicine — Clinical Terms (SNOMED/CT).	
23 The future interface between clinical coding, electronic health records and electronic patient records and clinicians.	

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Performance Criteria	DO	RA	EW	Q	P	WT	PD
1 Identify and extract the correct clinical data after searching the health records.							
2 Identify any requirements for additional clinical data and take the appropriate action to obtain such information.							
3 Refer any issues concerning the clarity and accuracy of the clinical data to the appropriate person for resolution.							
4 Evaluate the relevance of health conditions and factors affecting the patient to establish the primary diagnosis.							
5 Evaluate other health conditions and factors affecting the patient to establish co-morbid conditions relevant for assignment.							
6 Evaluate any procedures, interventions and investigations carried out to establish the primary procedure and any relevant secondary procedures.							
7 Establish the appropriate level of detail of clinical data to meet national standards.							
8 Identify the correct clinical data within appropriate timescales.							
9 Code all the relevant clinical data correctly and in accordance with approved rules and conventions, using the appropriate tools.							
10 Establish and record the correct sequence and order of codes related to a single episode in accordance with national standards.							
11 Record data clearly, accurately and completely.							
12 Maintain confidentiality at all times.							
13 Enter the relevant information accurately into the appropriate system.							
14 Complete the process of assigning the correct codes from clinical data within appropriate timescales.							
15 Select the appropriate classification cross map in accordance with national rules and standards from an identified clinical concept.							

DO = Direct Observation *RA = Reflective Account* *Q = Questions*
EW = Expert Witness *P = Product (Work)* *WT = Witness Testimony*
PD = Professional Discussion

To be completed by the candidate
I SUBMIT THIS AS A COMPLETE UNIT

Candidate's name: ……

Candidate's signature: ……..

Date: ……..

To be completed by the assessor
It is a shared responsibility of both the candidate and assessor to claim evidence, however, it is the responsibility of the assessor to ensure the accuracy/validity of each evidence claim and make the final decision.

I CERTIFY THAT SUFFICIENT EVIDENCE HAS BEEN PRODUCED TO MEET ALL THE ELEMENTS, PCS AND KNOWLEDGE OF THIS UNIT.

Assessor's name: ……..

Assessor's signature: ……..

Date: ……..

Assessor/Internal verifier feedback

To be completed by the internal verifier if applicable
This section only needs to be completed if the Unit is sampled by the internal verifier

Internal verifier's name: ……

Internal verifier's signature: ……..

Date: ……..……..