Data Quality Policy for Spring House Medical Centre

1 Introduction

1. What is Data Quality

Patient care depends on having good patient information at the time that clinical decisions are made.

It is important because:

- Acceptable data quality is crucial to operational and transactional processes and to the reliability of business intelligence reporting
- High quality information leads to improved decision making which in turn results in better patient care, well-being and safety. There are potentially serious consequences if information is not correct, secure and up to date.
- Management information produced from patient date is essential for the efficient running of the surgery and to maximize utilization of resources for the benefit of patients and staff.
- Poor data quality puts organisations at significant risk of damaging trust from CCG and patients and can also incur financial loss and poor value for money.

As well as the above and the potential impact that poor data can have on finances, data controllers are required under the Data Protection Act 1998, principle 4 to ensure that “data are kept up to date and accurate”.

In order to comply with this provision, organisations should:

- Take reasonable steps to ensure the accuracy of any personal data obtained
- Ensure that the source of any personal data is clear
- Carefully consider any challenges to the accuracy of information
- Consider whether it is necessary to update the information

2. Purpose and Scope of the policy

Information quality is the basis for this policy. This can be split into several headings;

- Information quality and modern general practice
- Capturing information in the consultation
- Capturing information from outside the practice
- Recognising high quality patient records
- System-specific issues
- Data quality and shared records including SAR’s

<u>Information Quality</u>

Effective and reliable use of information from patient’s records and efficient and informative communications are vital at many levels. This applies not just to clinical

data but also to demographic, appointments, administrative and other data held for a variety of purposes.

Creating high quality records requires not only high-quality data but also that data is arranged in the record to support the various purposes to which the record might be put.

As with data quality, record quality depends on the quality of the data recorded and the capability of the Clinician and other users.

Training should be provided for all staff on information governance, cyber security, SAR's and the importance of good record keeping etc. Training is often "in-house" but external trainers provided by the CCG are also brought into the practice whenever necessary. The MDU also provide a good module on good record keeping and have delivered this for some of the staff at Spring House.

All users at Spring House are also aware that they should report any suspected clinical safety issues that may come to light. If errors are made or information added incorrectly or to the wrong record etc., the Caldicott Guardian – Dr Royce Abrahams would be informed. Corrections should always be made as soon as any error is identified.

Capturing information in the consultation

It is important for users to understand that electronic patient records are designed to be "human-readable" and "machine-readable". Having high quality data in computable form is critical to enable patient data to be "processed" e.g. for QOF, extracts from public health, audits and for managing any MHRA alerts etc.

Where information can be adequately recorded using codes and structure data entry, it is generally better to do so, but where this is not possible, free-text clinical narrative can be used instead of or to clarify structured data entry.

Capturing information from outside the practice

A GP surgery today, continually received large volumes of information from a wide variety of different formats. Spring House have recently reviewed the paperwork and sources

Spring House has taken on EZ documents to manage this closely and this is audited on a regular basis by one of the Clinicians – Dr Naomi Silk. This is kept under constant review.

Individual team members processing the post and EZ docs are now;

- Clear about their roles in these processes and of relevant practice polices
- Have had appropriate training
- Have appropriate levels of responsibility
- Regular audits take place.
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Recognising High quality patient records

A high quality record is one that supports the purposes for which it was created and will be used. It needs to contain high quality data and be structured so that the data can be viewed and manipulated in ways that support the uses to which it will be put.

Data quality has five key attributes;

- Completeness
- Accuracy
- Relevance
- Accessibility
- Timeliness
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At Spring House, regular audits of our summarising are completed by our Nurse Manager to ensure accuracy of data entry and coded records.

System specific issues

Every GP system has its strengths and weaknesses. Spring House use SystmOne which is good and fit for purpose.

It is important that every member of the practice team should have training in the use of SystmOne that is commensurate with his or her role. Spring House has clear policies supported by system-specific training for those users whose roles or responsibilities involve entering information relating to;

- Identifying patients/registration
- Consultations to include medications, prescribing, problem orientation, searches, summaries, file attachments and allergies.

Data quality and shared records including SAR's

An independent study by the University College London was conducted in 2008 and this emphasised the importance of clearly understanding the scope and purpose for which records are to be shared.

The implications of poor records due to be shared could result in the possibility that such shared systems might therefore have a low uptake.

SAR's have been recognised to be one of the high risk areas for Spring House Medical Centre as patients records are being shared with third parties. Staff training and understanding of the process for consent, is vital.

3. Handling incidents

Spring House do have procedures in place for handling any incidents relating to their data.

A significant events form is completed and discussed with the DPO and Caldicott Guardian at the time of any incident. It is then discussed in detail at the following

Clinical meeting and any learning points are then actioned and new procedures, recorded and implemented where necessary.

The Caldicott Guardian and DPO for Spring House review all data quality incidents regularly and subsequently provided additional guidance on any specific incidents where appropriate.

4. Disposal of data

Arguably the biggest concern from a data security and protection view point is towards the end of the lifecycle. There are plenty of high profile cases where records have been inappropriately disposed of, leading to data breaches or alternatively, disposed of earlier than they should have been.

Spring House have a list of retention periods for personnel data.

Spring House also have a contract with Shred-it to dispose of our confidential documents appropriately.

Shred it provide certificates of destruction on completion. The Caldicott Guardian or Data Protection Officer for Spring House will also audit this process periodically.

The type of items that should be included in this audit are;

- onsite inspection of the contractor disposal site, ensuring sufficient physical segregation of different customer disposal items where necessary.
- If the items are to be recycled, examining a finalised refurbished asset for any data remnants.
- Verifying the employees carrying out the shredding on site and ensuring that due diligence has taken place with the company.

5. Conclusion

It is essential to understand the various purposes for which those records will be used together with the factors that contribute to make the records fit for purpose.

As well as these records, it is the care and skill of the record keeper and the capabilities of the particular clinical system being used, that contribute to the quality of the record.

Record keeping user training should be designed to make the best of the system being used and it is essential to understand that assuring and maintaining data and record quality is an on-going process, requiring active audit and intervention, supported by an ongoing education and training strategy

Leadership and teamwork are both essential pre-requisites for building high-quality patient records. Spring House tries to create an environment where they continually strive to improve their data quality.