EasyAudit User Manual

woodward
ASSOCIATES
Innovative integration systems

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EasyAudit Quick Start

Introduction

This help documentation is to support the use of Woodward Associates EasyAudit application, a tool to help an auditor to produce error reports based upon re-coded clinical data.

EasyAudit provides a simple way of importing Trust data into an environment aimed to assist in performing a coding audit, and to produce error reports that include HRG impact.

The general work-flow for using the application is:

- Installing and starting EasyAudit
  There is a Guest user account - with a blank password
  To create your own user account you will need to obtain a registration key
- Import an audit dataset
  The dataset will need to conform to the expected layout
  A sample data set is provided for the Guest user account to test
- Auditing imported data
  Opening an episode for the first time will mark the audit as started
- Complete an audit
- Merge audit results
  If there are completed audits from more than multiple locations
- Reporting on an audit dataset
  Report on the currently audited record
  Report upon all records where the recoding has impacted upon the HRG
  Produce a summary report of the error code breakdown by specialty
- Exporting an audited dataset

Throughout this documentation, the following conventions are used:

Underlined coloured text is a clickable link to another section of the documentation.
Bold text refers to screen text or controls.
Italicised text is important or useful information.

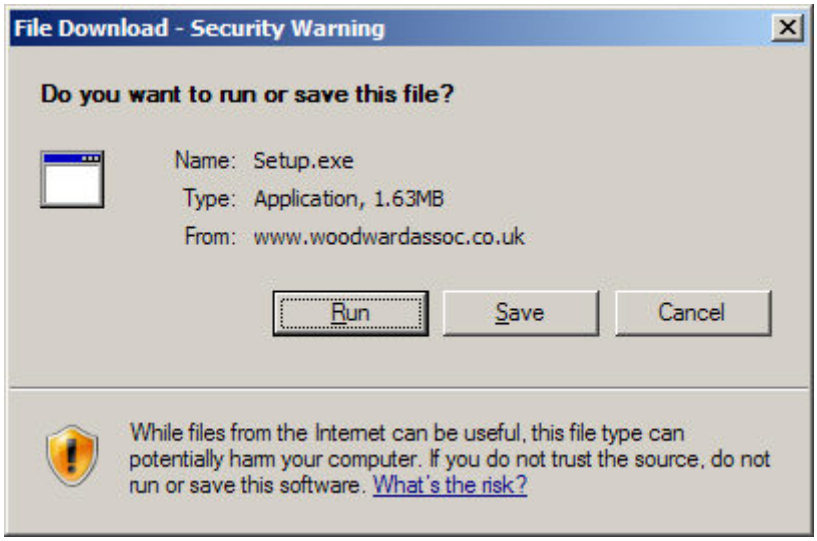
Read the licence agreement

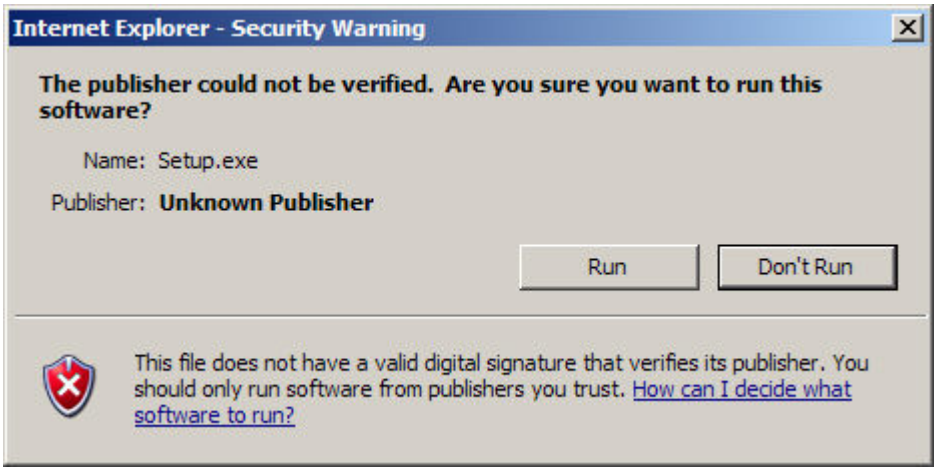
Installation and Starting

Installation

1. Download the application from the Woodward Associates website.

   If you are presented with the options to **Run** or **Save** the file, or to **Run** or **Don't Run** the application, select **Run** in each case.





2. Follow the on-screen instructions to install the application to the desired location and Program Group.

Start-up

1. Click upon the EasyAudit program icon installed within the Start Menu Program Group that was selected during installation, or the icon upon the desktop.

2. At the prompt enter the **Username** and if this is the first time you have logged on press the **Reset Password** button. In the **Registration Code** area that appears type the key you have been supplied with along with the details that you provided when registering in the accompanying boxes. Finally type a memorable **Password** and press the **Login** button.

   *If you just wish to trial the software, you may login with the **Username** "Guest" and enter a blank password.*

Uninstallation

1. Click upon the Uninstall icon that will be present in the Start Menu Program Group that was selected during installation.

Obtaining A Registration Key

To obtain a registration key please contact the support desk.

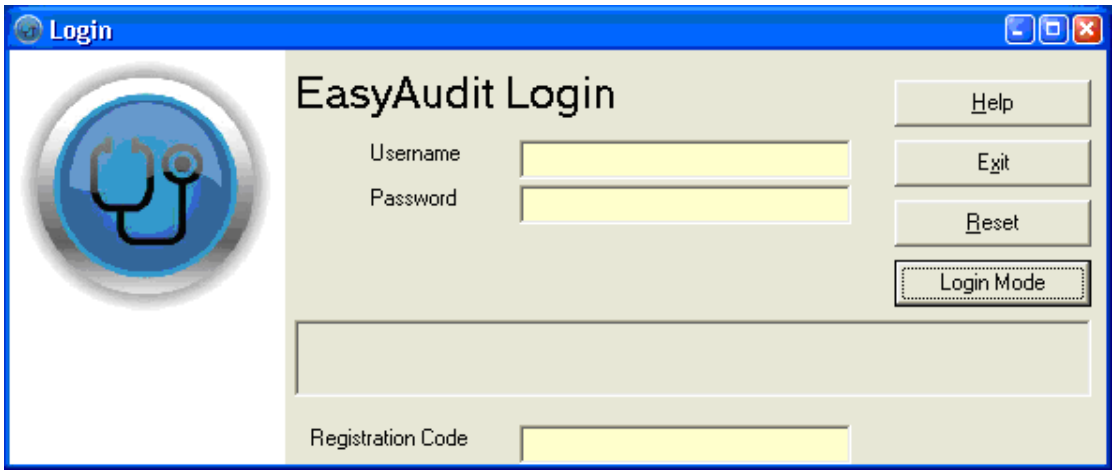
Please state your chosen user name:

- Submissions to another body such as the Audit Commission will contain your user name
- Your user name is case sensitive - so "John" is not the same as "john"
- Spaces are significant

It is suggested that your capitalized first and last names like JohnSmith with no spaces is used.

Resetting your password

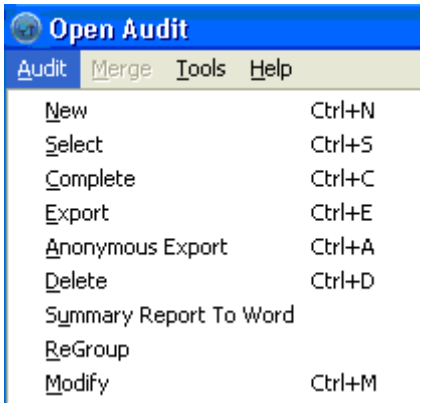
Click the **Reset Password** button.



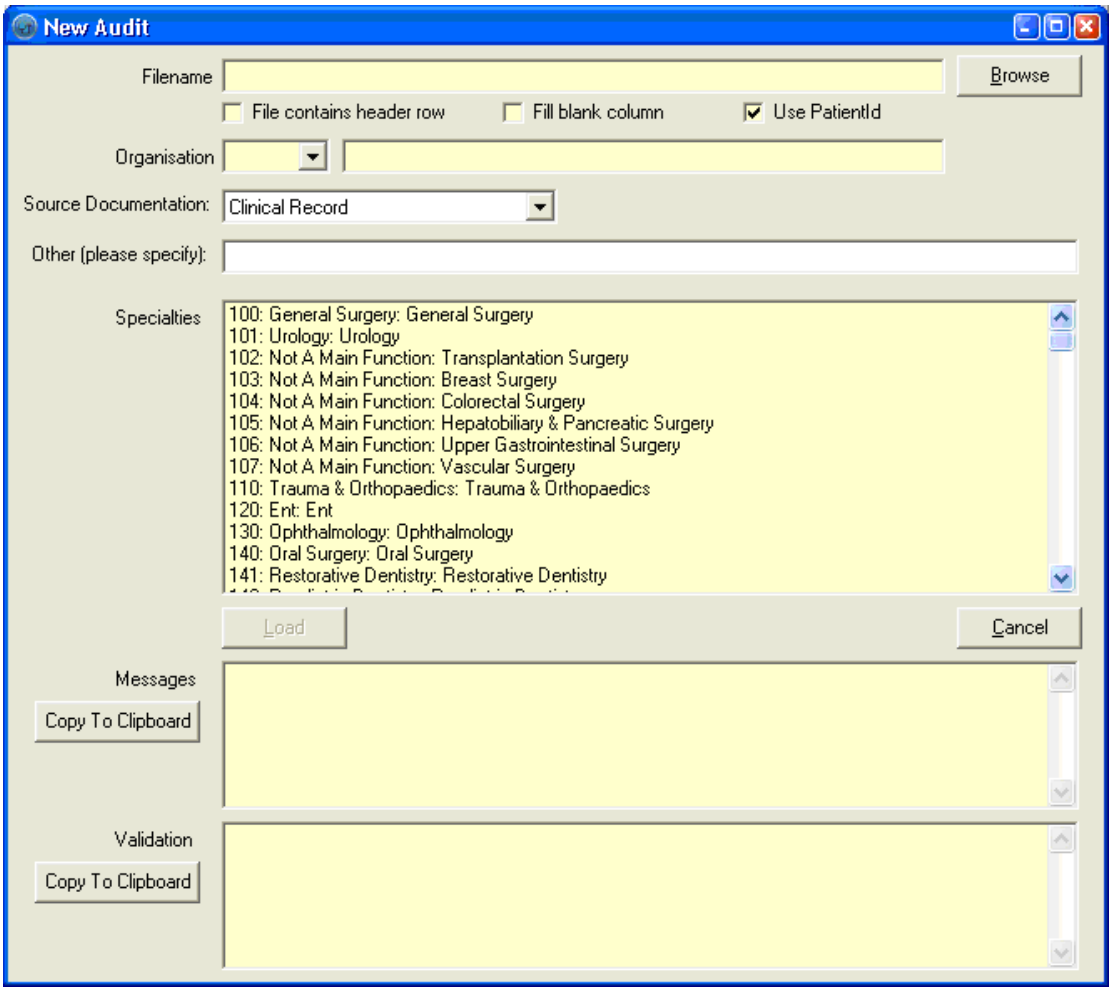
Now type in your **Username**, **Registration Code** and your new **Password** and press **Reset**. If you don't have or can't remember your Registration key then obtain one as detailed in the Obtaining A Registration Key section.

Importing

1. To import data that has been prepared to be in the correct format, from the **Audit** menu on the Open Audit screen, select **New**.



2. On the New Audit screen that appears, press the **Browse** button and select the pre-prepared input file.



3. If the first line in the input file lists the field names, click on the **File contains header row** checkbox.

4. If the data has been produced or modified in an application that may have produced an irregular number of fields across records (such as in Excel where empty fields at the end of a record are often lost during a save), make sure that the **Fill blank column** checkbox is ticked.

5. **Use PatientID** can be unchecked if it is known that there are absolutely no duplicate episode numbers across spells in the input file. If at all unsure leave this checkbox ticked.

6. Using the **Organisation** drop down box, select the organisation code appropriate for the Trust from which the data originates. The accompanying text box will display the associated name of the organisation.

7. In the **Source Documentation** drop down box, select the main form of documentation from which the re-coding will be performed from. This can be one of; Clinical Record, Pro-Forma, Discharge Summary, Discharge Letter, or Other. If Other is selected, the precise description must be entered in the **Other (please specify)** text box below.

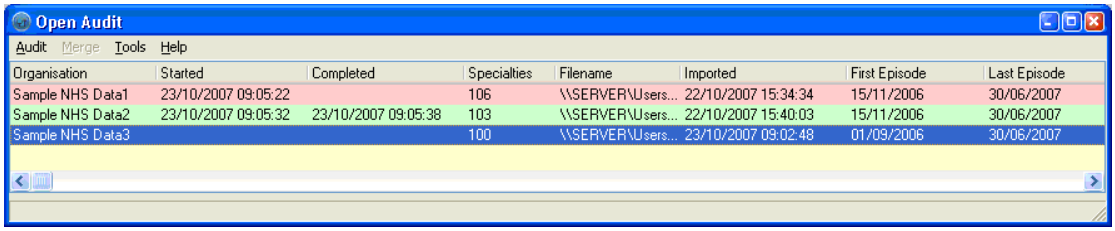
8. Within the **Specialties** list, highlight the specialties that are to be audited within the import dataset by clicking upon them with the mouse. To select more than one, hold the CTRL key whilst clicking. You can also change the specialty selection later

9. Finally click upon the **Load** button to import the new audit dataset. Any problems encountered will be shown in the **Messages** area, whilst data issues will be shown in the **Validation** area.

Any error or validation messages can be copied to the clipboard by pressing on the relevant button, these can then be pasted into another application such as Microsoft Word or Outlook.

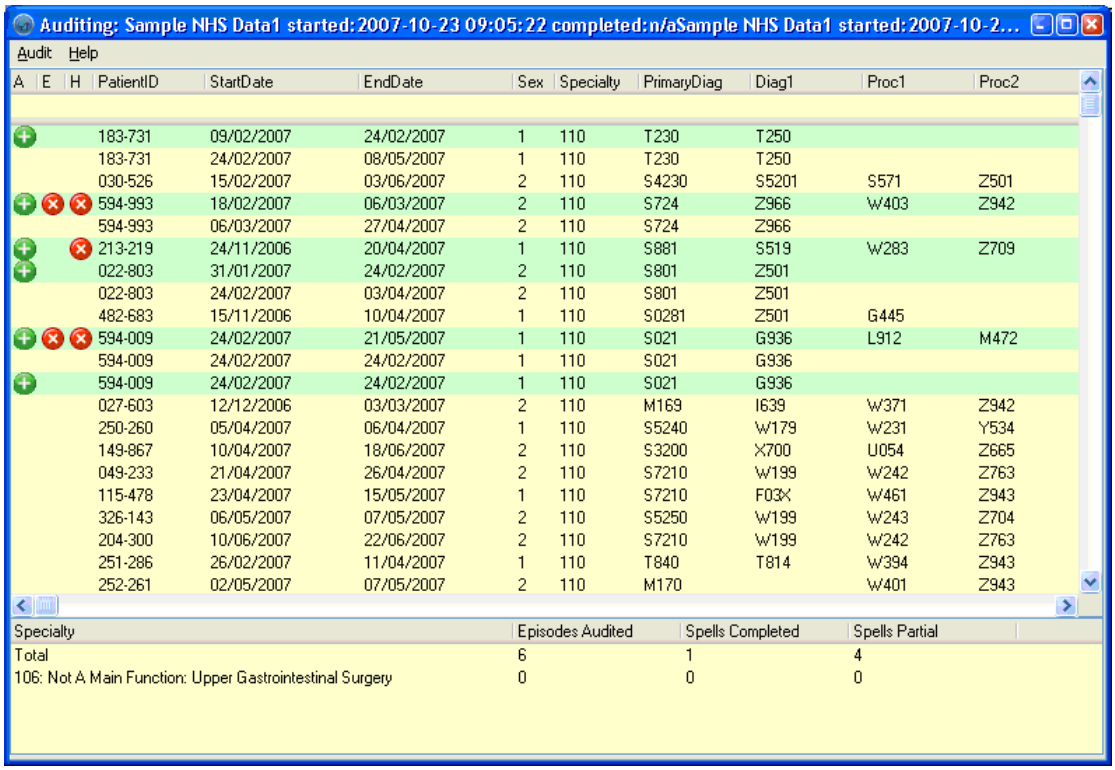
Auditing Records

1. On the Open Audit screen, double-click the audit that you wish to work upon.

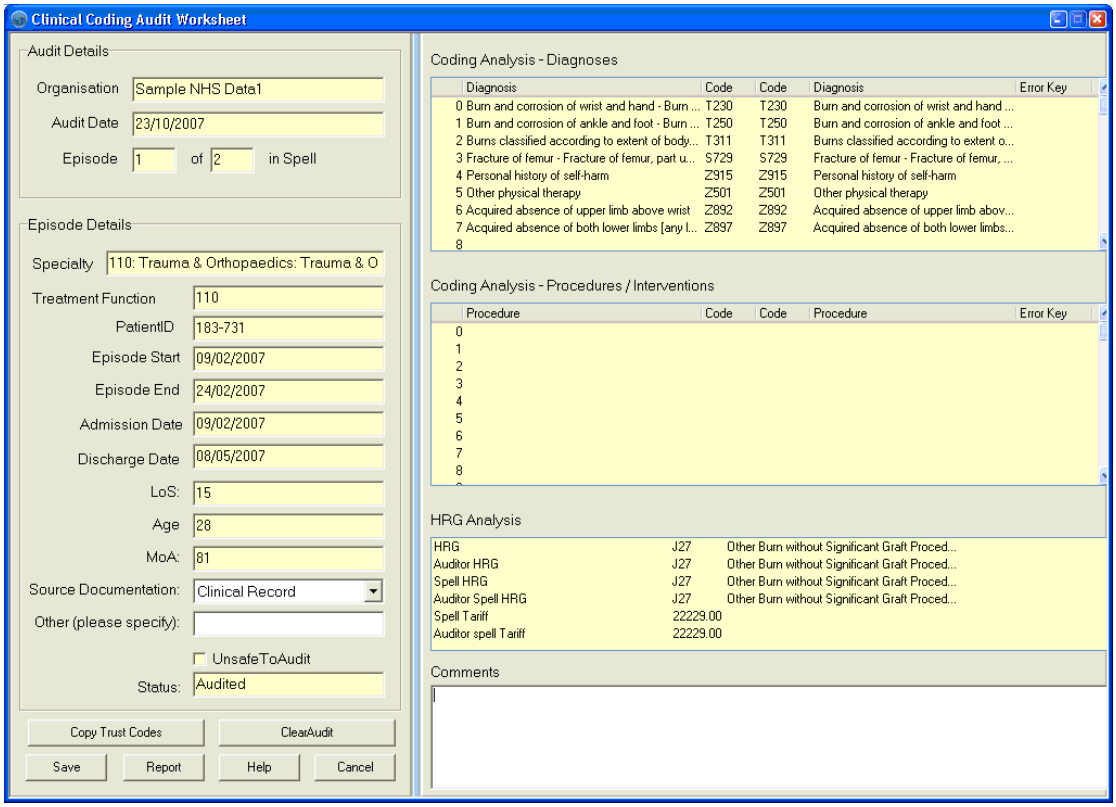


2. From the resulting Select Record screen, double-click upon a record to open it within the Worksheet screen for auditing.

   The columns within the header bar at the top of the record display can be clicked upon to order the data to assist in locating the corresponding record to the documentation you are re-coding from. Values can also be entered in the space below the header to filter the display of records.



3. Enter coding information in the space provided on the right-hand side of the Worksheet screen, and press the **Save** button when complete.

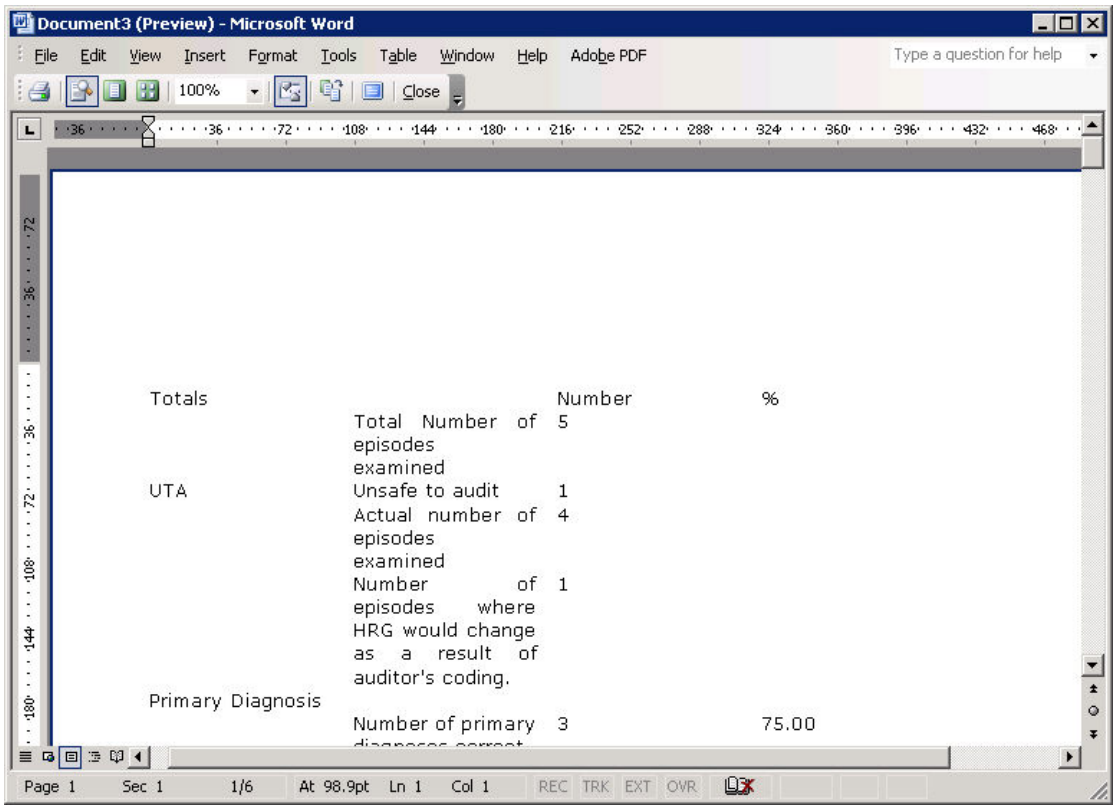


You will then be returned to the Select Record screen, with the record that has just been saved now highlighted in green to indicate that it has been audited. If errors were found during the re-coding there will also be a red icon with a cross in the **E** column as an indication. If these led to a difference in HRG assignment, there will be a similar red icon in the **H** column against that record.

Reporting

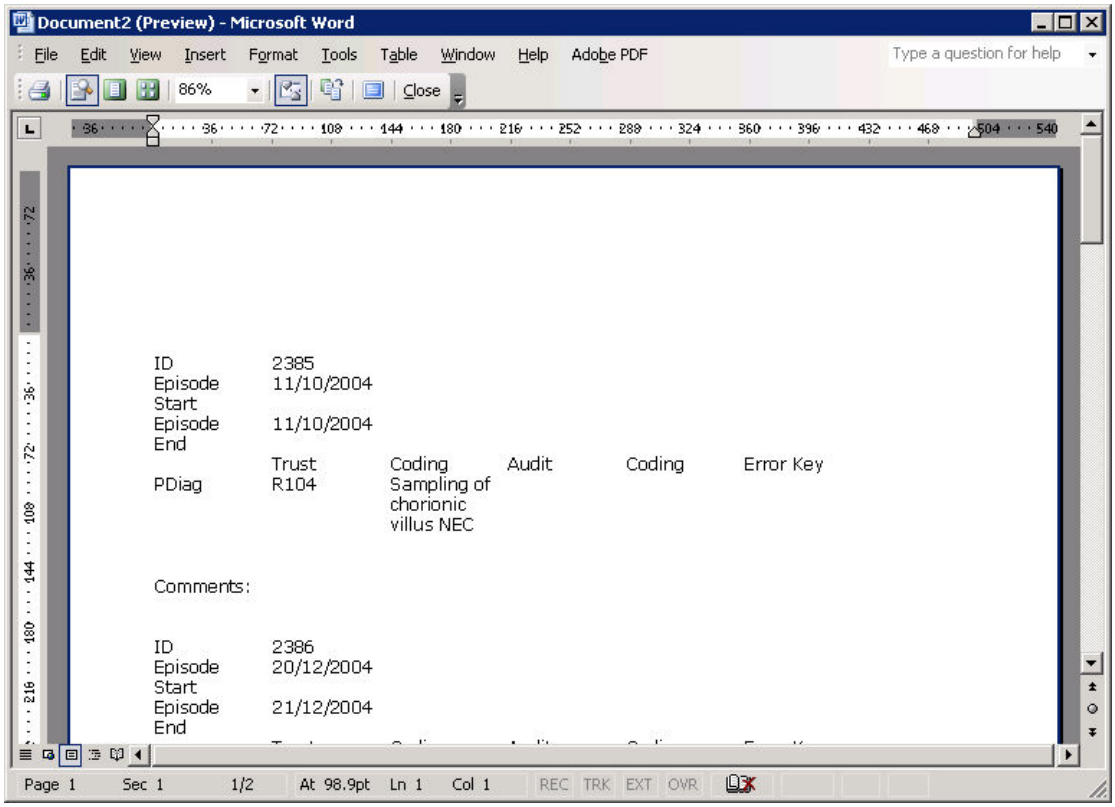
Audit Error Report

Selecting the Summary Report To Word option from the Open Audit screen will produce an Audit Error report in MS Word for the currently selected audit. All counts and calculations will have been pre-calculated and completed in the report.



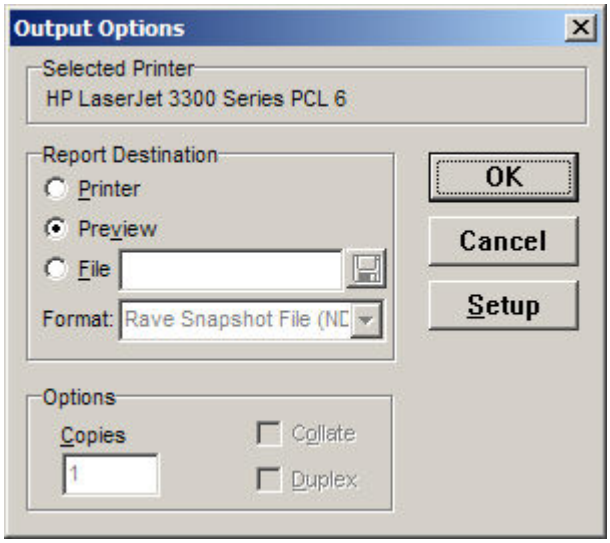
Record Summary Report

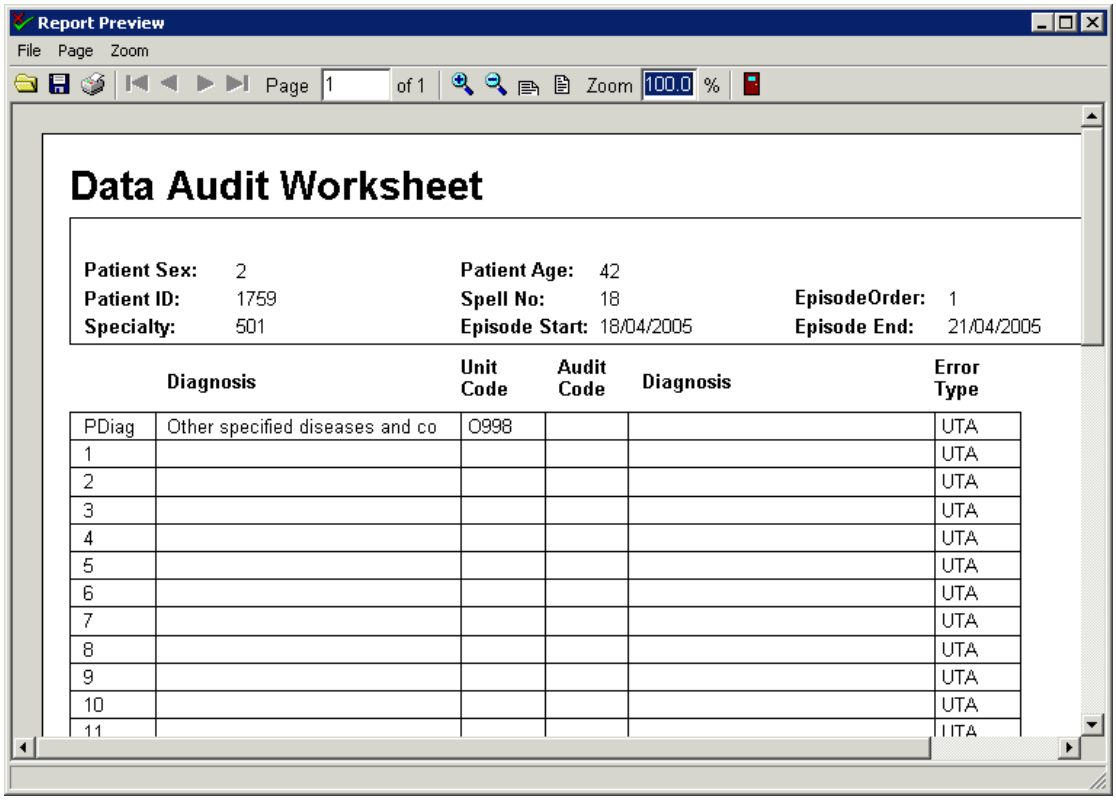
Selecting the Export Selected Episodes to Word option from the Select Record screen will create a summary report for the selected records within MS Word.



Worksheet Report

Pressing the Report button on the Worksheet screen will display a small dialog box that will allow selection of whether the Worksheet Report is sent to the printer, a file or to a preview that can subsequently be printed.



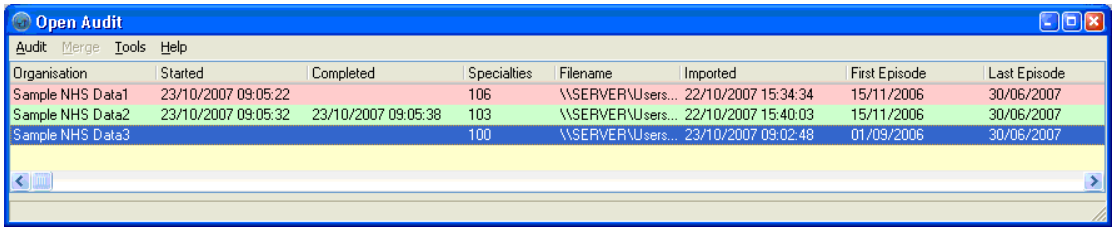

Report Preview
File Page Zoom
Page 1 of 1
Zoom 100.0 %
Data Audit Worksheet
Patient Sex: 2
Patient Age: 42
Patient ID: 1759
Spell No: 18
EpisodeOrder: 1
Specialty: 501
Episode Start: 18/04/2005
Episode End: 21/04/2005
Diagnosis
Unit Code
Audit Code
Diagnosis
Error Type
PDiag Other specified diseases and co O998 UTA
1 UTA
2 UTA
3 UTA
4 UTA
5 UTA
6 UTA
7 UTA
8 UTA
9 UTA
10 UTA
11 UTA

Exporting

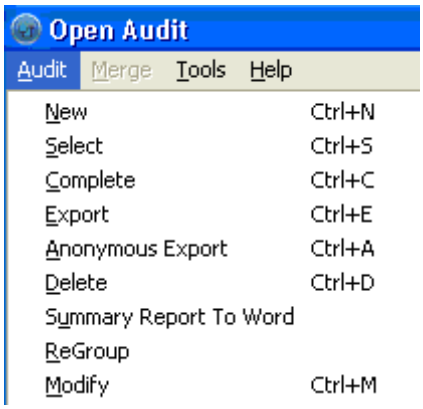
Either the entire audit can be exported to a CSV file suitable for import into a spreadsheet such as MS Excel or a database such as MS Access, or select records can be exported directly into MS Word.

To Export the Entire Audit

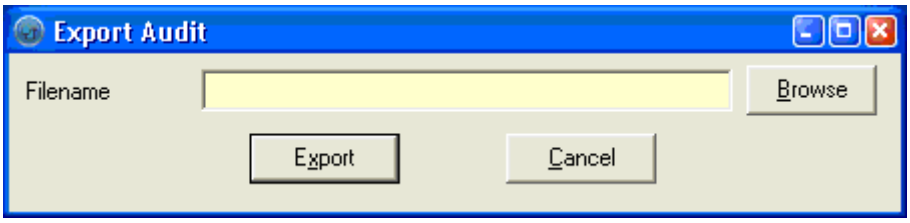
1. On the Open Audit screen, select the audit that you wish to export.



2. If the data must retain patient identifiers then select **Export** from the **Audit** menu, otherwise select **Anonymous Export** which will blank out the Patient ID field on all exported records.



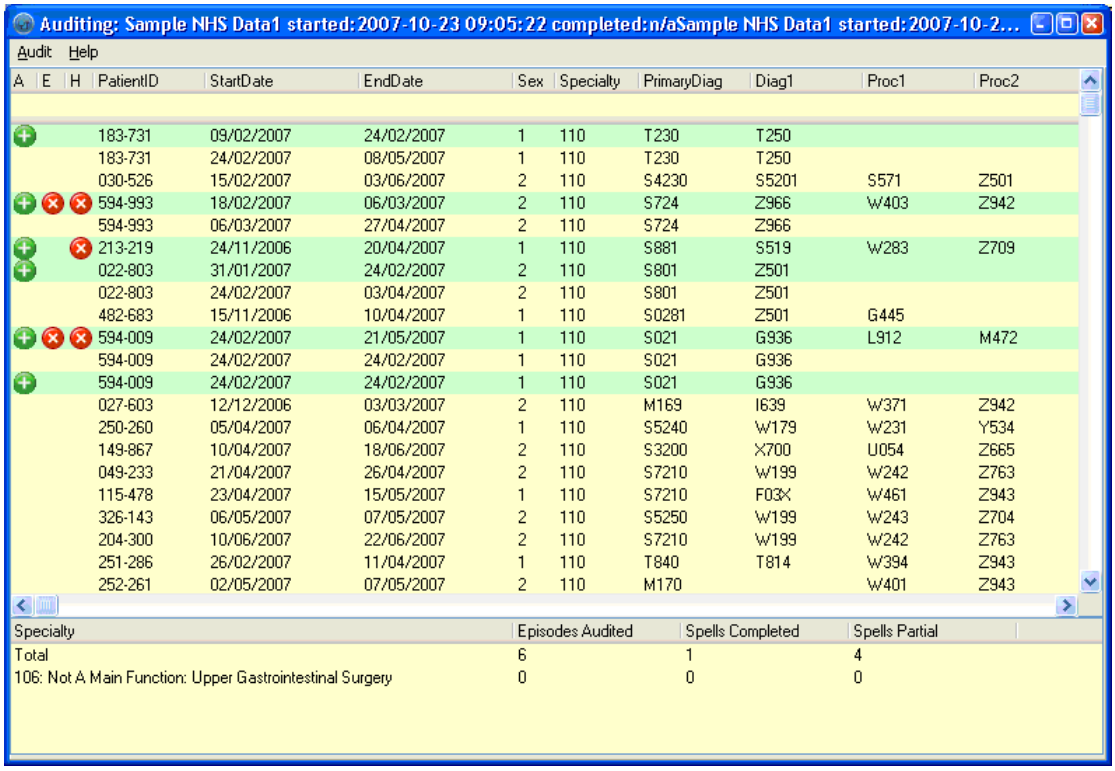
3. In the **Filename** box that appears, either enter a valid export filename or press the **Browse** button and select an export file.



4. Press the **Export** button - this will produce a CSV file with the filename you specified that is suited to being opened within other spreadsheet or database applications.

To Export Select Records

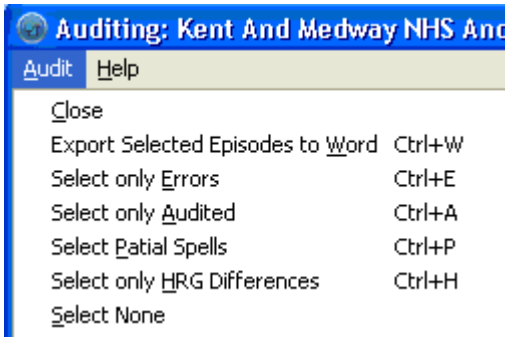
1. Open the Select Record screen for the desired audit.



2. From the **Audit** menu, select the option that corresponds to the subset of data you wish to export:

   - **Select Errors** will automatically highlight all the records that have been audited and marked as having an error.
   - **Select Audited** will automatically highlight all the records that have been audited, regardless of whether they have an error or not.

   Alternatively the specific records that are wanted in the export can be manually highlighted using the mouse.



3. From the **Audit** menu, select **Export Selected Episodes to Word** to produce a document containing the coding summary and commentary for each record currently selected.

EasyAudit User Guide

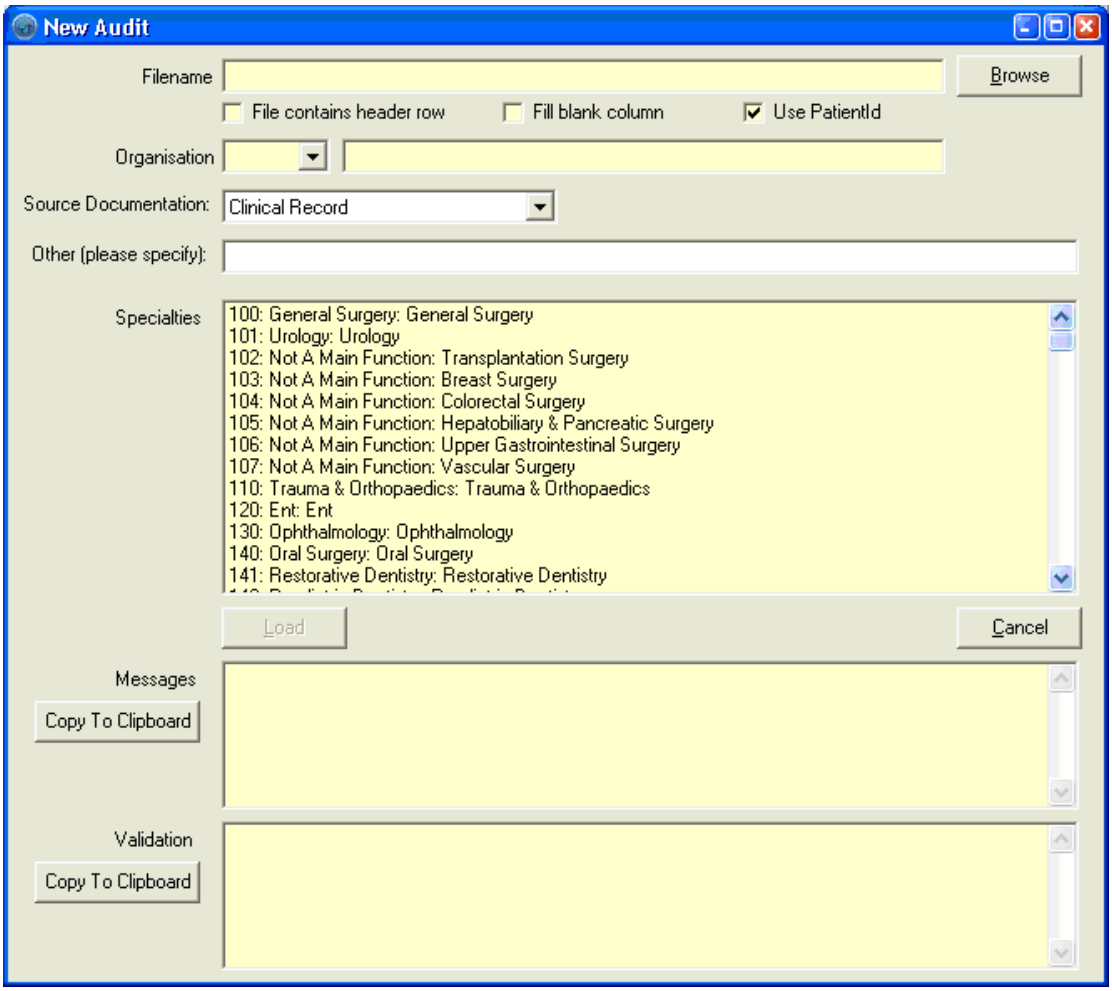
Logging In

If this is the first time the application has been run it will need to be registered, otherwise enter your **Username** and **Password** and then press the **Login** button.

After a successful login, the Open Audit screen will initially be displayed.

Pressing the **Exit** button will close the EasyAudit application.
Pressing the **Help** button will launch the help system.
Pressing the **Reset password** button will allow you to reset your password .

New Audit Screen



In the **Filename** area either type the name and location of the audit data file that is to be imported, or press the **Browse** button and select the file from the file browser.

If the first row of the audit data file is a list of field names, click on the **File contains header row** checkbox. This will prevent the first row from being loaded as a record of data and will use the data item field names to validate that columns are correct when loading.

If the input file contains varying numbers of fields, ticking the **Fill blank column** checkbox will fill missing fields with blanks, allowing the import to proceed.

Prior to loading a dataset the originating organisation must be identified by selecting it within the **Organisation** drop-down list. The associated Trust name will be displayed in the adjacent text area.

Selecting a document type from which the coding will be performed from the **Source Documentation** drop-down list will use this as a default throughout

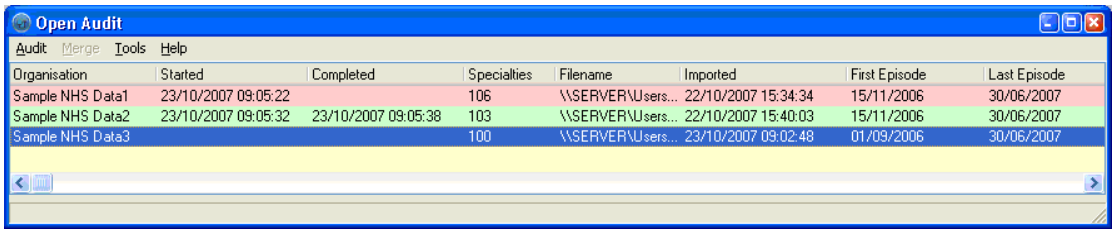
the audit. The available options are; Clinical Record, Pro-Forma, Discharge Summary, Discharge Letter, and Other. If Other is specified, a more precise description must be entered in the **Other (please specify)** text area.

Within the **Specialties** list box, select the specialty codes that are to be audited. To select multiple specialties, hold the CTRL key whilst clicking, or hold the SHIFT key and click to select contiguous ranges.

Finally click upon the **Load** button to import the data and create a new audit. Any errors will be listed in the **Messages** area.

Press **Cancel** to close this screen and return to the Open Audit screen.

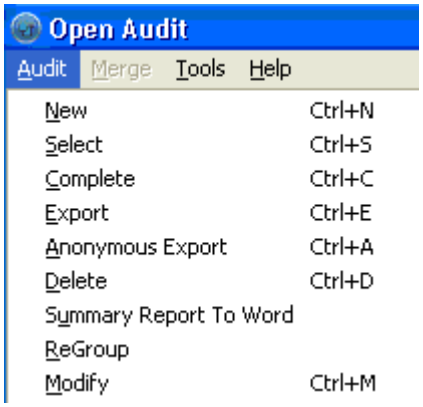
Open Audit Screen



This screen displays the currently loaded audits. They are highlighted in colour to indicate whether they are in progress (red), or have been completed (green). Start and completion dates are also indicated, as are the specialties and admission dates that the audit covers.

The list can be sorted by any of the items displayed by clicking upon the header bar.

Audit Menu

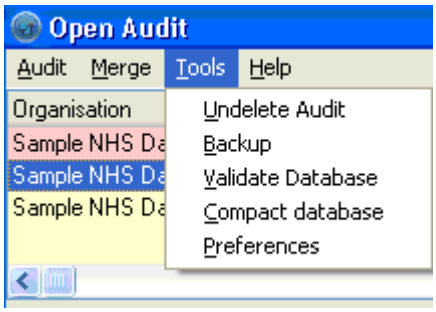


New	Opens the New Audit screen to allow the importing of an audit dataset
Select	Opens the Select Record screen
Complete	Marks an in-progress audit ad having been completed
Export	Will export the entire audit to a CSV file
Anonymous Export	Exports the entire audit to a CSV file, but without patient identifiers
Delete	Will ask for confirmation to delete an audit - it can be undeleted using the Tools menu
Summary Report To Word	Opens a summary report in MS Word
ReGroup	Will re-group the currently selected audit dataset
Modify	Opens the Modify Audit screen

Merge Menu

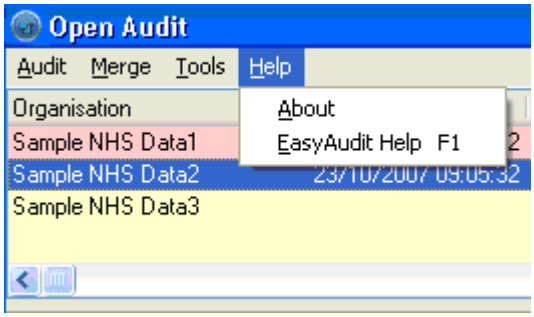
Export	Opens the Merge Audit Data screen for export of the currently selected completed audit
Import	Opens the Merge Audit Data screen for merge import of completed audits

Tools Menu



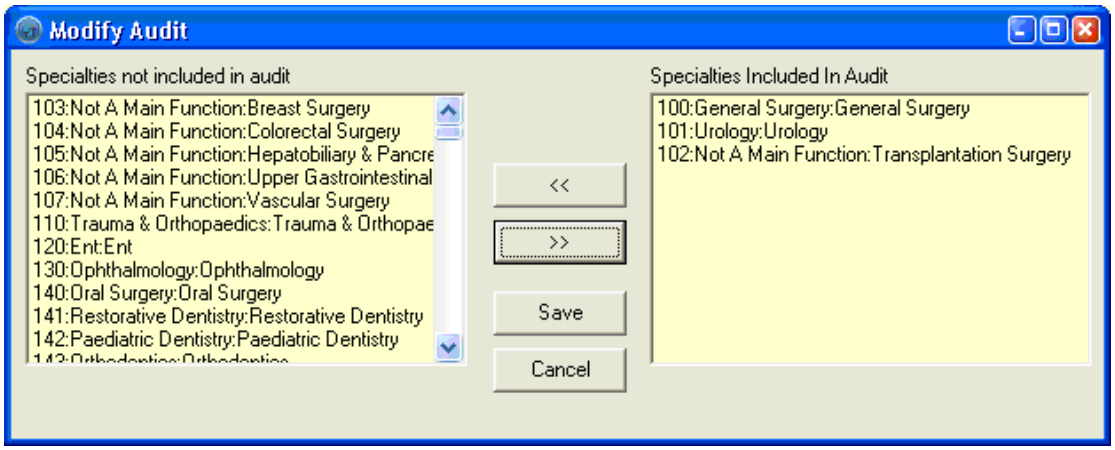
Undelete Audit	This will open the Undelete Audit screen
Backup	Creates a dated backup of the access_audit.mdb file
Validate Database	Will carry out particular fixes on old data issues
Compact Database	Attempts to compact the database to reduce it in size and improve performance
Preferences	Provides the facility to turn off the default formatting in exported Word reports

Help Menu



About	Displays the current version of the application
EasyAudit Help	Opens the electronic version of this documentation

Modify Audit Screen



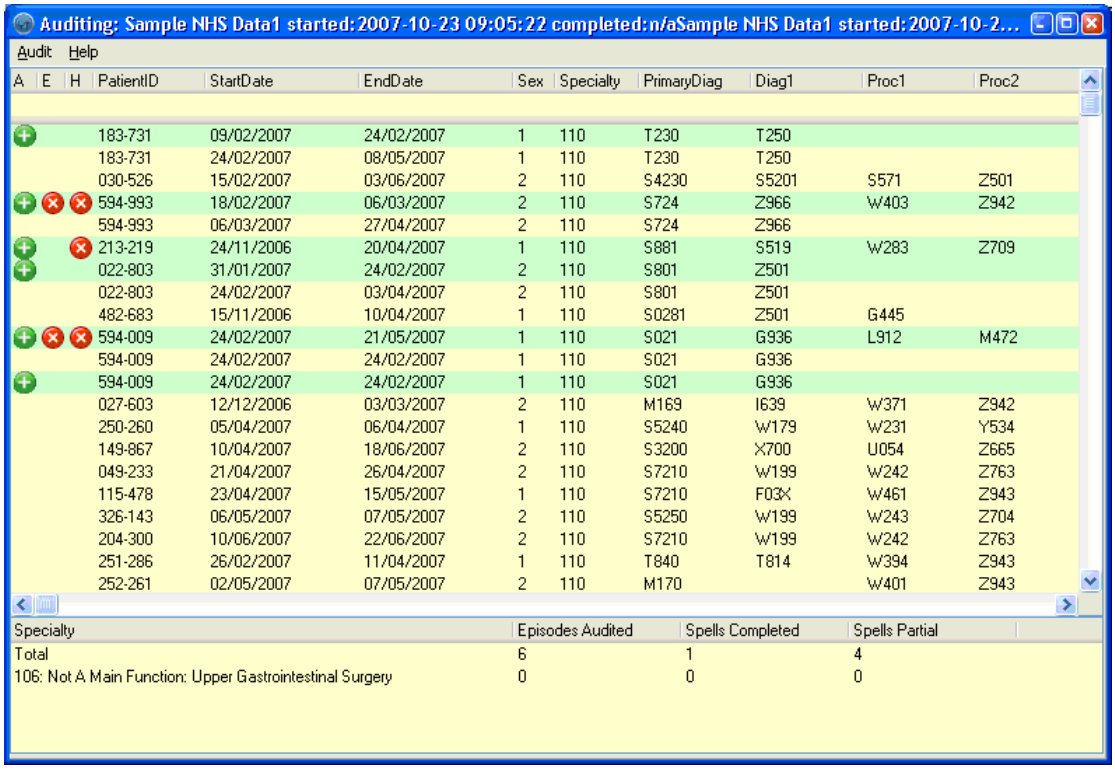
This screen allows the specialties included within a particular audit to be altered. Selecting specialties in the **Specialties not included in audit** or the **Specialties Included In Audit** areas and then pressing the **>>** or **<<** buttons will move the selection from in or out of the currently loaded audit.

You will not be able to remove specialties that already have audit information against them, to do so you will need to clear that audit information first.

When changes have been made, pressing the **Save** button will make the appropriate changes to the specialties within the audit and close this screen. Pressing **Cancel** will abandon any unsaved changes and will close the screen.

The episode display list at the foot of the Select Record Screen will reflect any changes made to the specialties included within an audit.

Select Record Screen



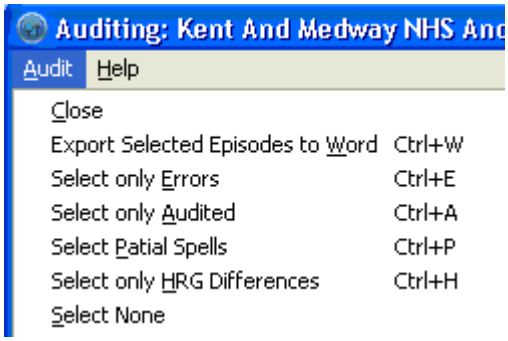
This screen displays the records within the currently selected audit. Records that have already been audited are highlighted in green and additionally have a green plus icon in the **A** column. Those that have been audited and have errors recorded additionally have a red cross icon in the **E** column. Where there are differences in the original HRG and that derived from the audited record, a red cross icon will be displayed within the **H** column.

Double-clicking upon a record will open it within the Worksheet screen for auditing.

The list can be sorted by any of the items displayed by clicking upon the header bar. Values can also be entered in the space below the header to filter the display of records.

Towards the bottom of the screen is an area that displays a summary of the number of records within each specialty that have been audited.

Audit Menu

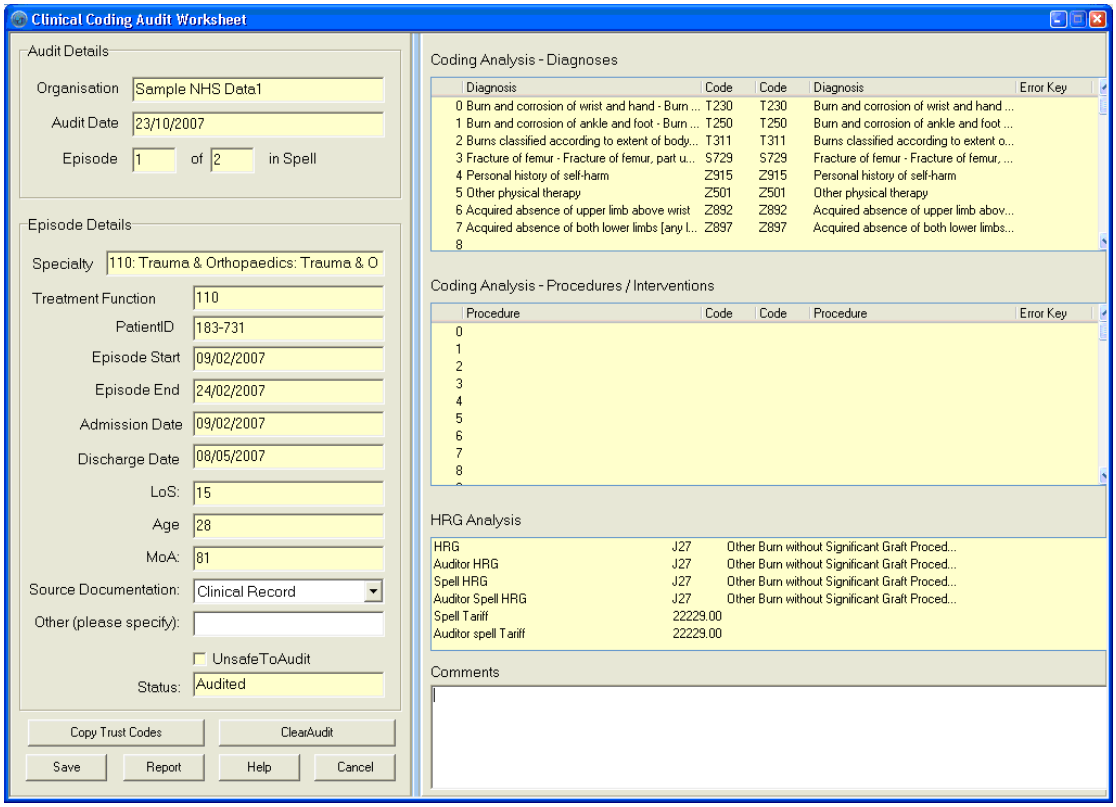


Close	Closes this screen
Export Selected Episodes to Word	Produces a summary report of the currently selected records in MS Word
Select only Errors	Selects only the records that are marked as having a coding error
Select only Audited	Selects only the records that are marked as audited
Select Partial Spells	Selects the records that seem to have partial spells
Select only HRG Differences	Selects only the records that have HRG differences
Select none	resets any previous select menu view

Help Menu

About	Displays the current version of the application
EasyAudit Help	Displays the online version of this help documentation

Worksheet Screen



The Worksheet screen displays the coding information for a selected record and provides space in which to provide audited re-coding.

Upon the left hand side of the screen is summary information covering the administration information from the record for reference purposes.

If the reference material differs to that displayed within the **Source Documentation** drop-down box, the appropriate source can be altered for this record. Doing this not affect the default that was selected when the audit was created.

If the record cannot be audited, the **Unsafe To Audit** checkbox can be checked to automatically fill in the Unsafe to Audit error code in all coding fields.

Towards the right hand side of the screen are the areas where re-coding can be entered along with the appropriate error code where differences have been found. The **Copy Trust Codes** button can be pressed to duplicate all the original coding for the re-coding fields, and pressing **Clear Audit** will blank them out. As re-coding is entered, the HRG groups within the **HRG Analysis** section will be updated accordingly.

*Clicking in the space provided for **Error Key** will display a drop-down list of valid error codes for quick selection.*

Additional supporting notes can be typed within the **Comments** text area.

Once a record has been completely audited, press the **Save** button to record the re-coding and to close this screen. Alternatively press **Cancel** to close this screen without saving any re-coding.

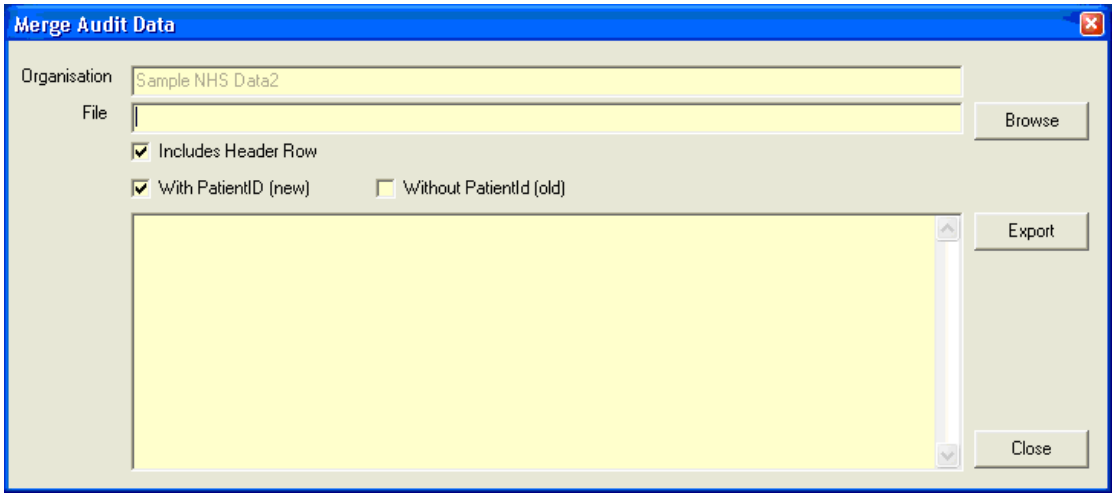
Pressing **Report** will produce the Worksheet Report for the currently selected audit.

Pressing the **Help** button will display the online version of this help documentation.

Merge Audit Data Screen

This screen is displayed when exporting or importing a completed audit for merging within EasyAudit.

Exporting



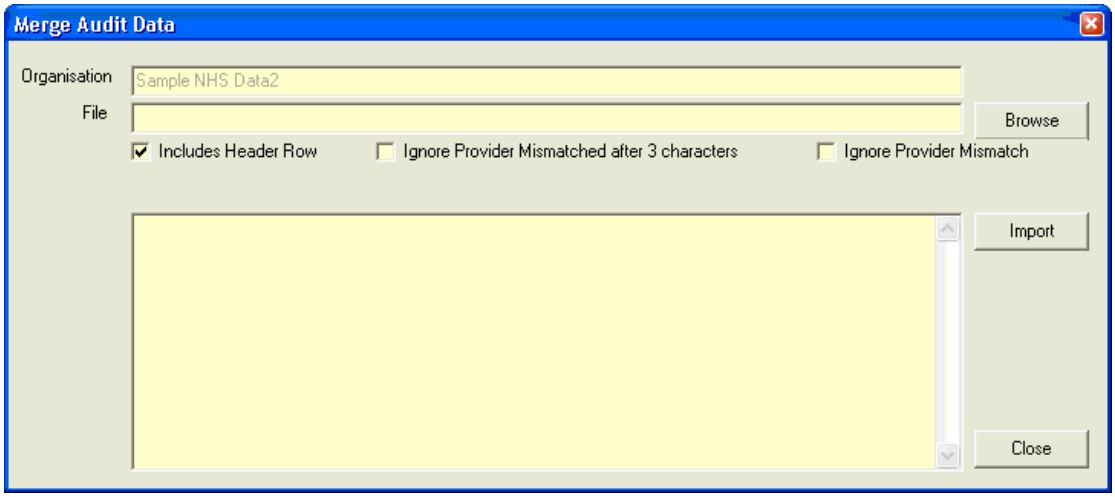
When exporting a completed audit, the name of the selected provider will be displayed in the **Organisation** area. Pressing the **Browse** button and selecting a file, or typing a valid output name and location in the adjacent **File** area will specify where the exported audit will be written to.

Ticking the **Includes Header Row** checkbox will create an additional record at the top of the output file that contains the names of the fields.

The **With PatientID (new)** or **Without PatientID (old)** checkboxes control whether the export merge dataset will be created with or without the PatientID being included for use as part of the spell identifier.

Finally, pressing **Export** will write the audit to the specified file. Any problems will be reported in the adjacent area.

Importing

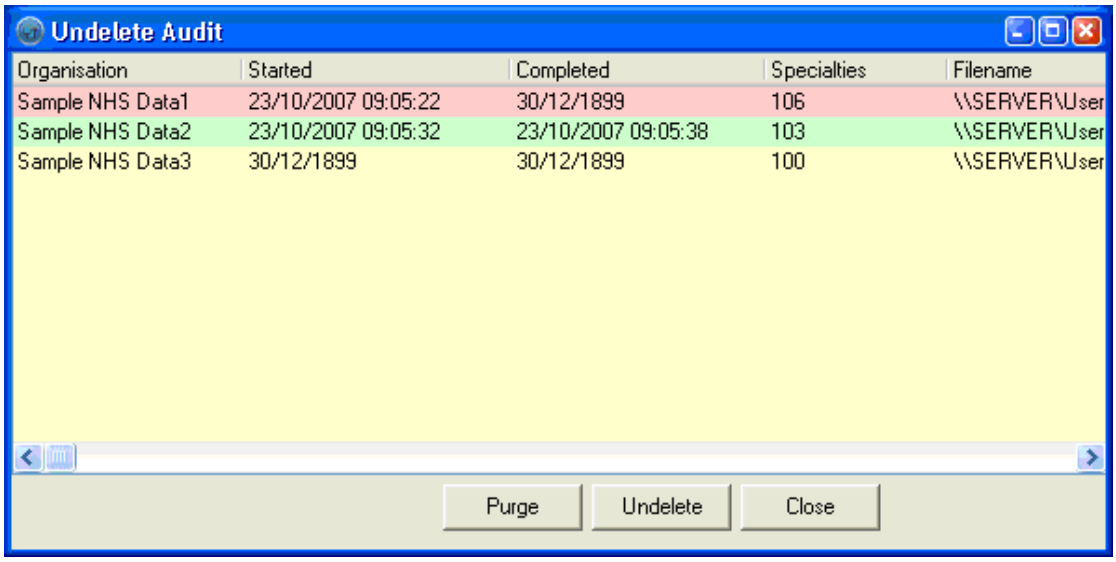


When importing and merging a completed audit, the name of the selected provider will be displayed in the **Organisation** area. Pressing the **Browse** button and selecting a file, or typing a valid output name and location in the adjacent **File** area will specify which file contains the data to be merged with the currently selected audit.

Ticking the **Includes Header Row** checkbox will use the field names in the first record in the input file to be used for validation that field positions are correct. **Ignore Provider Mismatched after 3 characters** will cause the import to ignore the site portion of the organisation code, minimising the number of errors that would be reported if multi-site provider data is being imported. **Ignore Provider Mismatch** will perform the import merge regardless of the precise provider code in the dataset.

Pressing **Import** will read in the data from the specified file, merging the records with the currently selected audit. Any problems will be reported in the adjacent area.

Undelete Audit Screen



This screen allows the restoration of previously deleted audits. Selecting one within the list and then pressing the **Undelete** button will return that audit into the active list on the Open Audit screen. Pressing the **Purge** button will completely remove the selected audit - it will no longer be available for undeletion.

Purging an audit is an irreversible action.

EasyAudit Reference

Error Key Descriptions

Unsafe to Audit Error Key

UTA	**UNSAFE TO AUDIT** The auditor is unable to audit the coded clinical data against the source documentation. For example: • There is no clinical information regarding the episode in the auditor's source documentation to support the auditors code assignment.

Primary Diagnosis Error Keys

Coder Error	
PD3	**PRIMARY DIAGNOSIS INCORRECT AT THREE CHARACTER LEVEL** The primary diagnosis code has been allocated to an incorrect three character code. Or, where it is clear the code allocated to classify the disease or health related problem is incorrect at third character level and incorrectly sequenced within a secondary field.
PD4	**PRIMARY DIAGNOSIS INCORRECT AT FOUR CHARACTER LEVEL** The primary diagnosis code has been allocated to an incorrect fourth character. Or, where it is clear the code allocated to classify the disease or health related problem is incorrect at fourth character level and incorrectly sequenced within a secondary field.
PD5	**PRIMARY DIAGNOSIS INCORRECT AT FIVE CHARACTER LEVEL** The primary diagnosis code has been allocated to an incorrect fifth character. Or, where it is clear the code allocated to classify the disease or health related problem is incorrect at fifth character level and incorrectly sequenced within a secondary field.
PDIS	**PRIMARY DIAGNOSIS INCORRECTLY SEQUENCED** The primary diagnosis code recorded by the auditor has been accurately coded but not sequenced as the primary diagnosis by the coder.
PDO	**PRIMARY DIAGNOSIS OMITTED** The primary diagnosis recorded by the auditor has not been recorded by the coder in any diagnosis field.
Non-Coder Error	
PDI	**INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT AVAILABLE AT THE TIME OF CODING**

	Information available to the auditors was not available at the time of coding. This is where information regarding the episode became available after the episode was coded. This error key is not to be used if the information was not accessed by the clinical coder at the point of coding, for example, with histopathology reports. This error key would also be assigned by the auditor when the source documentation used at the time of coding did not contain all pertinent information required for accurate and complete coding and the coder did not have access to this information, for example, coding from proforma with no access to the casenotes.
PDD	**PRIMARY DIAGNOSIS DOCUMENTATION ISSUE** The auditor's code allocated from the source documentation differs from that of the Trusts due to unclear or inconsistent information. For example: • Inconsistency between information recorded by clinical staff contained on source documentation and it is not clear which is correct • The source documentation is illegible.
PDM	**PRIMARY DIAGNOSIS CODED TO MANAGEMENT SPECIFICATION** There is a clear and documented directive from management to contravene coding to national standards. For example: • by unbundling diagnoses or procedures into component parts • by adding or optimising the coded clinical data to alter the derived HRG .
PDC	**PRIMARY DIAGNOSIS CODED TO CLINICIAN SPECIFICATION** There is a clear and documented directive from clinicians to contravene coding to national standards or capture those instances where a clinician has requested that coding be done in a particular way as it more accurately captures the diagnosis. For example: • by unbundling diagnoses or procedures into component parts.
PDSC	**PRIMARY DIAGNOSIS CODED DUE TO SYSTEM CONSTRAINT** Due to the system that the Organisation uses the primary diagnosis codes is technically incorrect at some level, omitted or sequenced incorrectly.

Secondary diagnosis error key descriptions

Coder Error	
SD3	**SECONDARY DIAGNOSIS INCORRECT AT THREE CHARACTER LEVEL** The secondary diagnosis code has been allocated to an incorrect three character code. Or, where it is clear the code allocated to classify the disease or health related problem is incorrect at third character level and incorrectly sequenced.

SD4	**SECONDARY DIAGNOSIS INCORRECT AT FOUR CHARACTER LEVEL** The secondary diagnosis code has been allocated to an incorrect four character code. Or, where it is clear the code allocated to classify the disease or health related problem is incorrect at fourth character level and incorrectly sequenced.
SD5	**SECONDARY DIAGNOSIS INCORRECT AT FIVE CHARACTER LEVEL** The secondary diagnosis code has been allocated to an incorrect five character code. Or, where it is clear the code allocated to classify the disease or health related problem is incorrect at fifth character level and incorrectly sequenced.
SDNR	**SECONDARY DIAGNOSIS NOT RELEVANT** The secondary diagnosis code recorded by the coder is not relevant to the episode of care.
SDO	**SECONDARY DIAGNOSIS OMITTED** Diagnosis that has been recorded by the auditor as relevant but is missing from the Organisation's recorded episode.
SDIS	**SECONDARY DIAGNOSIS INCORRECT SEQUENCING** The sequencing of the secondary codes contravenes national standards. This error key can only be assigned for error in the following national standards: 1. Outcome of delivery (Z37 and Z38 if not well baby) 2. Asterisk codes must be preceded by a dagger code 3. Specific coding conventions in ICD-10 i.e. use additional code 4. Extent of body surface in burns (T31, T32)
ECI	**EXTERNAL CAUSE CODE INCORRECT** The external cause code recorded by the Organisation is incorrect at any character level.
ECO	**EXTERNAL CAUSE CODE OMITTED** The external cause code has been omitted from the Organisation's recorded episode.
ECNR	**EXTERNAL CAUSE CODE NOT RELEVANT** The external cause code recorded by the coder is not relevant to the episode of care.
Non-Coder Error	
SDI	**INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT AVAILABLE AT THE TIME OF CODING** See PDI.
SDD	**SECONDARY DIAGNOSIS DOCUMENTATION ISSUE** The auditor's code allocated from the source documentation differs from that of the Trusts due to unclear or inconsistent information. For example: • Inconsistency between information recorded by clinical staff contained on source documentation and it is not clear which is correct • The source documentation is illegible.

SDM	**SECONDARY DIAGNOSIS CODED TO MANAGEMENT SPECIFICATION** There is a clear and documented directive from management to contravene coding to national standards. For example: • by unbundling diagnoses or procedures into component parts • by adding or optimising the coded clinical data to alter the derived HRG.
SDC	**SECONDARY DIAGNOSIS CODED TO CLINICIAN SPECIFICATION** There is a clear and documented directive from clinicians to contravene coding to national standards or capture those instances where a clinician has requested that coding be done in a particular way as it more accurately captures the diagnosis. For example: • by unbundling diagnoses or procedures into component parts.
SDSC	**SECONDARY DIAGNOSIS CODED DUE TO SYSTEM CONSTRAINT** Due to the system that the Organisation uses, codes are technically incorrect at some level, omitted or sequenced incorrectly.

Primary procedure error key descriptions

Coder Error	
PP3	**PRIMARY PROCEDURE INCORRECT AT THREE CHARACTER LEVEL** The primary procedure code has been allocated to an incorrect three character code. Or, where it is clear the code allocated to classify the procedure or intervention is incorrect at third character level and incorrectly sequenced within a secondary field.
PP4	**PRIMARY PROCEDURE INCORRECT AT FOUR CHARACTER LEVEL** The primary procedure code has been allocated to an incorrect four character code. Or, where it is clear the code allocated to classify the procedure or intervention is incorrect at fourth character level and incorrectly sequenced within a secondary field.
PPIS	**PRIMARY PROCEDURE INCORRECTLY SEQUENCED** The primary procedure or intervention code recorded by the auditor has been accurately coded but not sequenced as the primary procedure by the coder.
PPO	**PRIMARY PROCEDURE OMITTED** The primary procedure recorded by the auditor has not been recorded by the coder in any procedure field.
PPNR	**PRIMARY PROCEDURE NOT RELEVANT** The primary procedure recorded by the coder is not relevant to the episode of care.
Non-Coder Error	
PPI	**INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT**

	AVAILABLE AT THE TIME OF CODING See PDI.
PPD	**PRIMARY PROCEDURE DOCUMENTATION ISSUE** The auditor is unable to code the clinical data from the source documentation and compare against that of the Trusts due to unclear or inconsistent information. For example: • Inconsistency between information recorded by clinical staff contained on the source documentation and it is not clear which is correct • The source documentation is illegible.
PPM	**PRIMARY PROCEDURE CODED TO MANAGEMENT SPECIFICATION** There is a clear and documented directive from management to contravene coding to national standards. For example: • by unbundling diagnoses or procedures into component parts • by adding or optimising the coded clinical data to alter the derived HRG.
PPC	**PRIMARY PROCEDURE CODED TO CLINICIAN SPECIFICATION** There is a clear and documented directive from clinicians to contravene coding to national standards or capture those instances where a clinician has requested that coding be done in a particular way as it more accurately captures the intervention that occurred. For example: • by unbundling diagnoses or procedures into component parts.
PPSC	**PRIMARY PROCEDURE CODED DUE TO SYSTEM CONSTRAINT** Due to the system that the Organisation uses codes are technically incorrect at any level, omitted or sequenced incorrectly.

Secondary Procedure error key descriptions

Coder Error	
SP3	**SECONDARY PROCEDURE INCORRECT AT THREE CHARACTER LEVEL** The secondary procedure code has been allocated to an incorrect three character code. Or, where it is clear the code allocated to classify the procedure or intervention is incorrect at third character level and incorrectly sequenced.
SP4	**SECONDARY PROCEDURE INCORRECT AT FOUR CHARACTER LEVEL** The secondary procedure code has been allocated to an incorrect four character code. Or, where it is clear the code allocated to classify the procedure or intervention is incorrect at fourth character level and incorrectly sequenced.
SPIS	**SECONDARY PROCEDURE INCORRECTLY SEQUENCED** The Organisation has not sequenced the procedure coding

	according to the rules and conventions of the classification. For example: • See use as secondary code when associated with…
SPO	**SECONDARY PROCEDURE OMITTED** Secondary procedure that has been recorded by the auditor as relevant but is missing from the Organisation's recorded episode.
SPNR	**SECONDARY PROCEDURE NOT RELEVANT** The secondary procedure code recorded by the coder is not relevant to the episode of care.
Non-Coder Error	
SPI	**INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT AVAILABLE AT THE TIME OF CODING** See PDI.
SPD	**SECONDARY PROCEDURE DOCUMENTATION ISSUE** The auditor is unable to code the clinical data from the source documentation and compare against that of the Trusts due to unclear or inconsistent information. For example: • Inconsistency between information recorded by clinical staff contained on the source documentation and it is not clear which is correct • The source documentation is illegible.
SPM	**SECONDARY PROCEDURE CODED TO MANAGEMENT SPECIFICATION** There is a clear and documented directive from management to contravene coding to national standards. For example: • by unbundling diagnoses or procedures into component parts • by adding or optimising the coded clinical data to alter the derived HRG.
SPC	**SECONDARY PROCEDURE CODED TO CLINICIAN SPECIFICATION** There is a clear and documented directive from clinicians to contravene coding to national standards or capture those instances where a clinician has requested that coding be done in a particular way as it more accurately captures the intervention that occurred. For example: • by unbundling diagnoses or procedures into component parts.
SPSC	**SECONDARY PROCEDURE CODED DUE TO SYSTEM CONSTRAINT** Due to the system that the Organisation uses codes are technically incorrect at any level, omitted or sequenced incorrectly.

Import Dataset Format

General requirements

The data supplied for audit must be standard ASCII .

You should have been notified which Specialties are to be audited.

The data must consist of defined data values supplied in a fixed CSV format:

- The columns in which data fields should be provided are fixed
- The values in those columns must conform to Data Dictionary definitions.

If necessary reference can be made to:

http://www.connectingforhealth.nhs.uk/datadictionary/index.asp

and

http://www.hesonline.nhs.uk/

Data requirements

If any of the following data fields cannot be provided then please notify your auditor immediately (note that if you do not have FCE or Spell HRG these can be left off).

Dates should be formatted as YYYYMMDD.

The data should be provided in the following columns:

Start Column	End Column	Field contents
1		Provider Code (PROCODET)
2		Purchaser (PCT) code
3		Hospital Provider Spell Number (PROVSPNO)
4		Episode Order (EPIORDER)
5		Admission Start Date (ADMIDATE)
6		Admission End Date (DISDATE)
7		Episode Start Date (EPISTART)
8		Episode End Date (EPIEND)
9		Age at start of episode (STARTAGE)
10		Sex (SEX)
11		Patient Classification (CLASSPAT)
12		Admission Source (ADMISORC)
13		Admission Method (ADMIMETH)
14		Discharge Destination (DISDEST)

15		Discharge Method (DISMETH)
16		Episode Duration (EPIDUR)
17		Main Specialty (MAINSPEF)
18		Neonatal level of care (NEOCARE)
19		Treatment Function Code (TRETSPEF)
20		Legal Status (LEGLSTAT)
21		Consultant Code (CONSULT)
22		Primary diagnosis (DIAG_01)
23	35	13 secondary diagnoses (DIAG_NN)
36	47	12 procedure codes (OPER_NN)
48		Patient ID (to allow Auditor to reference casenotes)
49		FCE HRG (as derived onsite)
50		Spell HRG (as derived onsite)

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Database Validation Checks

The current database validation checks are:

- Procedure1 lower case "h" removal
  Any records with a "h" in the Procedure1 field will be reported, and the option of deleting that character will be given.

- Duplicate record removal
  Prior to version 1.0.12 it was possible to introduce duplicate records into the database due to the handling of the comments field. This option will attempt to identify the duplicates and the option of deleting them will be given, if a problem with the identification arises instructions to contact technical support may be given instead.

Support and Troubleshooting

Release History

Version 1.2.0 (current)

- added support for larger file sets of over 15,000 records
- new grouper HRG handling for erroneous spells with over 77 episodes
- added check for PatientID in spells
- added Ignore Provider Code checkbox to cope with changing identifiers during an audit
- added check for changed codes - but no error key in worksheet saves
- added scroll bars for Merge/Import and re-located to top of message list
- added option (default=on) to separate key values by "_" for a load
- changed load message box to log problems to errors window
- added option (default=on) to add PatientID to key - too many systems have duplicate episode numbers

Version 1.1.0

- added validation on import
- added copy to clipboard buttons for loading errors and validation
- added tariff on worksheet display & report
- added splash screen
- added password reset
- added Guest user
- updated help system
- fixed column alignment on HRG (Trust) on export
- blanked out null dates on audit selection window

Version 1.0.21

- added export fields for completeness
- updated select only errors, select only HRG, slect only audited now to only select those episodes

Version 1.0.20

- added export fields for grouper
    - PatClass
    - UTA
- fixed quote handling for organisation name

Version 1.0.19

- updated organisation name to allow longer names
- added preferences turn off formatting for word report
- changed comments to memo type to allow more content

- added select HRG differences - though can already click on the filter for hrg to sort and select.

Version 1.0.18
- added basic formatting to the worksheet word report

Version 1.0.17
- fixed merge comments with quotes both ' on import and '' on export
- updated set max 250 chars on comments
- added compact DB
- added backup before validate
- added backup before compact

Version 1.0.16
- added spell HRG calculations

Version 1.0.15
- updated code validation to allows dot codes i.e. J60.9
- added validation for age and epidur to not allow non numeric values
- fixed some spellings
- fixed missing rows in worksheet word export when code and audit code were blank but eroor code exists - i.e. SDNR
- fixed some minor sizing behaviour - some non-sizeable , others restricted, other anchored
- fixed some titles
- updated so merge only allowed for completed audits - status bar added for hint text
- disable load for user DA
- added function to select episodes part of partial spells

Version 1.0.14
- changed totals to ignore *NR - now % add up without *NR

Version 1.0.13
- added missing ECNR to summary reports for secondary diag
- added error message for non coded error keys
- changed totals to take account of *NR keys with black codes

Version 1.0.12
- update - sort order for specialties on load screen
- fixed transaction issue in worksheet save
- added check DB function for problems in this case - looks for duplicate dpcodes caused by comments bug in worksheet save

- added AuditInputID hint for started column
- added proc1=h validation and removal
- added help button to login screen

Version 1.0.11

- fixed a quote in the comments in worksheet
- added abilty to add specialties to the audit
- added ability to compare only to 3rd character on provider for merge/import

Version 1.0.10

- changed grouper interface slightly & rdf files to be in sync

Version 1.0.9

- changed the patient id filter to trim both sides
- added a ErrKey filter
- fixed an OPCS lookup issue (PrimDiag ...) in word export

Version 1.0.8

- limit view to 500 records
- fixed login bug

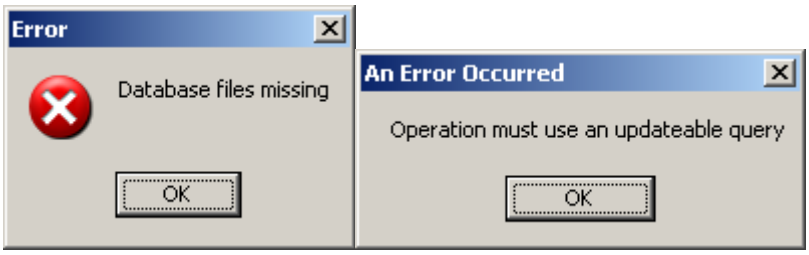
Version 1.0.7

- added tools: delete, undelete, purge
- added backup mechanism
- changed limit audit display to 100 episodes
- fixed strange focus issue on dialogs
- fixed quotes in the comments export
- updated merge window to be wider
- updated merge window to list all duplicate episodes so they can be fixed in one go
- fixed grouper ini file issue

Known Issues

Installation

1. On start-up one of the following error messages occur



Problem
The "Program Files" default installation location has locally been set to be read-only, either as permissions on the folder or by security policy.

Resolution
Either remove the read-only restriction, or uninstall EasyAudit and re-install it to a completely different location such as "C:\EasyAudit".

Support and Troubleshooting

A helpdesk is available for support issues with this application between 0900 and 1700 Monday to Friday.

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Glossary

A

ASCII: American Standard Code for Information Interchange is a way of representing the typable range of characters, numbers and punctuation marks within computer data.

C

CSV: Comma Separated Variable is a format where data in individual fields is separated by a comma, suited to importing into databases or into spreadsheets.

H

HRG: Healthcare Resource Groups are a classification of patient activity for Payment by Results purposes developed and published by the NHS Information Centre.

P

PbR: Payment by Results is the method of controlling financial flows within the NHS between providers and purchasers based upon patient activity as described by HRGs.

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