SOP Template: Health Records Audit and Quality Assurance Checks

This SOP details the process for conducting **health records audit and quality assurance checks**, encompassing systematic review of patient health records, verification of data accuracy and completeness, adherence to regulatory and institutional standards, identification of discrepancies and areas for improvement, implementation of corrective actions, and continuous monitoring to enhance healthcare delivery and patient safety. The objective is to ensure the integrity, confidentiality, and reliability of health information through rigorous quality control measures.

1. Purpose

To establish a standard procedure for auditing health records and executing quality assurance checks ensuring compliance, data integrity, accuracy, and confidentiality.

2. Scope

Applies to all patient health records maintained by the institution, including electronic and paper-based documentation.

3. Responsibilities

- **Health Information Management (HIM) Staff:** Conduct audits, report findings, and implement corrective actions.
- **Quality Assurance (QA) Team:** Oversee QA checks and monitor compliance.
- **Department Heads:** Ensure team cooperation and timely response to identified issues.
- **Information Technology Support:** Support data access and security controls.

4. Procedure

1. **Preparation**
    - Define audit objectives and scope (*e.g., focus areas, sample size*).
    - Assemble the audit and QA team; ensure all members have requisite access and training.
2. **Data Collection & Review**
    - Select random or targeted samples of health records.
    - Review documentation for accuracy, completeness, legibility, and adherence to standards.
    - Verify patient identifiers, clinical entries, consent forms, and other key elements.
3. **Compliance Verification**
    - Check conformity with internal protocols, legal, and regulatory mandates (e.g., HIPAA, local health laws).
4. **Discrepancy Identification**
    - Document any inaccuracies, omissions, or non-compliance.
    - Assess potential risks to patient care, safety, or data privacy.
5. **Corrective Actions**
    - Communicate findings to relevant departments and initiate corrective plans.
    - Provide feedback and training where necessary.
6. **Reporting & Documentation**
    - Prepare detailed audit reports outlining findings, actions taken, and recommendations.
    - Maintain logs of all audits and corrective actions for future reference.
7. **Continuous Monitoring**
    - Schedule periodic follow-up audits and QA checks.

- Adjust procedures as needed based on observed trends and latest regulations.

5. Documentation & Records

- Audit checklists and forms
- Audit reports
- Corrective and preventive action documentation (CAPA)
- Training records
- Confidentiality and access logs

6. References

- Institutional policies on health records management
- Relevant laws and regulations (e.g., HIPAA)
- Accreditation standards (e.g., JCI, ISO 9001)

7. Review & Revision History

Date	Version	Author	Reviewed By	Description
2024-06-10	1.0	Health Information Manager	QA Team	Initial SOP release