DATA QUALITY

All information needs to be entered onto a patient profile verbatim from the referral form. In addition, the referral form must be attached to the patient profile in a viewable PDF format, when the patient profile has been created.

The Patient referral must be annotated to state the date when the referral was received and **NOT** the date the referral was attached to the patient profile.

ONGOING RECORDED DATA

The following entries need to be completed into every patient profile to ensure fidelity of patient information:

- All communication – including letters and phone calls - time stamped
- Patient notes – containing all pertinent information relating to patient care not found in communications. Scan type, preparation, notes from communications – Time stamped
- Treatment and appointment records and DNA's – time stamped.
- Reports – cross referenced with relevant referral and images
- Patient consent form
- Patient Images
- Fax confirmation sheets attached

CROSS REFERENCING

Reports need to be annotated by the reporting sonographer and assistant to indicate the referral applicable to the scan. This is done through the clinical indication. For example:

- Referrals archived in attachment as ' Referral received '06/10/2016'
- Clinical indication on report for example: *'Clinical indication: C/O vague abdominal pain but more especially around renal angle bilaterally ? Cause (from referral received 06/10/2016)'*
- Images need to be recorded titled as example: *'Images from report 11/10/2016'*
- Consent forms need to be titles as example: *'Images from report 11/10/2016'*

As we received multiple requests for the same patient it is essential for clinical auditing purposes we identify the correct referral in the body of the report and are able to cross reference with an attachment of the same title.