



Australian Government

HLTCCD002 Interpret and navigate health care records

Release: 2

HLTCCD002 Interpret and navigate health care records

Modification History

Release	Comments
Release 2	Release 2 HLTCCD002 Interpret and navigate health care records supersedes and is equivalent to Release 1 HLTCCD002 Interpret and navigate health care records. Updated: Mapping details and minor corrections
Release 1	HLTCCD002 Interpret and navigate health care records no equivalent unit.

Application

This unit describes the performance outcomes, skills and knowledge required to accurately interpret information in health care records to support accurate clinical coding of an episode of care.

This unit applies to clinical coders who are responsible for extracting and interpreting patient clinical information for the purposes of clinical coding. Work may be performed as an individual or as part of a team under limited supervision.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian standards and industry codes of practice.

No occupational licensing, certification or specific legislative requirements apply to this unit at the time of publication.

Pre-requisite Unit

Unit code	Unit title
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HLTCCD001	Apply an understanding of the health care system to clinical coding practice.
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Competency Field

Clinical Coding

Unit Sector

Health Administration

Elements and Performance Criteria

ELEMENTS

Elements describe the essential outcomes

1. Locate patient information.
2. Review content of patient health care records.
3. Analyse relationship between patient health care records and clinical coding.
4. Maintain privacy and confidentiality of patient health care records.

PERFORMANCE CRITERIA

Performance criteria describe the performance needed to demonstrate achievement of the element.

- 1.1. Select method for accessing patient information held in hard copy or electronic formats.
- 1.2. Locate patient health care records using Patient Administration System (PAS).
- 1.3. Access and manage patient health care records according to organisational policies and procedures for privacy and confidentiality.
- 2.1. Identify categories of information recorded in patient health care records taking into account structure and layout.
- 2.2. Identify documentation flow in relation to the patient journey in a health care service provider setting.
- 2.3. Identify mandatory data elements for admitted patient health care records that must be reported to the Commonwealth and State or Territory jurisdictions.
- 3.1. Analyse health care records to determine the reason for patient admission, surgery, interventions performed and conditions that arise during episode of care.
- 3.2. Clarify absent and incomplete information according to organisational policies and procedures.
- 3.3. Determine completeness of health care record information for clinical coding.
- 4.1. Discuss patient-related matters within confines of the facility and with appropriate personnel.
- 4.2. Identify and meet legal and ethical responsibilities, including prompt disclosure of conflict of interest to supervisor when dealing with patient health care records.
- 4.3. Seek advice and clarification from supervisor where potential confidentiality issues arise in dealings with patient health care records.

Foundation Skills

Foundation skills essential to performance are explicit in the performance criteria of this unit of competency.

Unit Mapping Information

No Equivalent Unit

Links

Companion Volume implementation guides are found in VETNet -

<https://vetnet.gov.au/Pages/TrainingDocs.aspx?q=ced1390f-48d9-4ab0-bd50-b015e5485705>

Assessment Requirements for HLTCCD002 Interpret and navigate health care records

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Performance Evidence

Evidence of the ability to complete tasks outlined in elements and performance criteria of this unit in the context of the job role, and:

- for three different patients, use a Patient Administration System (PAS) to analyse the health care record including:
 - recognising the key steps in the patient journey
 - identifying mandatory data elements for coding and reporting
 - clarifying issues that affect the clarity and accuracy of the information contained in the patient health care record
 - referring to privacy legislation and organisational policies and procedures for maintaining confidentiality of health care information.

Knowledge Evidence

Demonstrated knowledge required to complete the tasks outlined in elements and performance criteria of this unit:

- Patient Administration Systems (PAS) used to store patient demographic, administrative and clinical information.
- Patient Administration System (PAS) functions and operations
- organisational protocols:
 - storage, access and use of patient health care records and data
 - handling issues affecting clarity and accuracy of patient health care records
 - requirements for maintaining privacy and confidentiality of patient health care records

- relationship between patient health care records and accurate coding of health care information
- Commonwealth and State or Territory privacy legislation
- sources of key information in patient health care records.

Assessment Conditions

Skills must be demonstrated in the workplace or in a simulated environment that reflects workplace conditions.

Assessment must ensure:

- real-life patient health care records, or de-identified real patient health care records, either electronic or hard copy, that reflect current clinical practice
- organisational policies and procedures
- modelling of industry operating conditions including:
 - integration of situations requiring problem solving

Assessors must satisfy the Standards for Registered Training Organisations' requirements for assessors.

Links

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