 10.7861/fhj.9-2-s108

Coding method change during COVID-19: a catalyst to improving the quality of electronic discharge summaries

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Introduction

All inpatients discharged from hospital are expected to have a discharge summary to provide communication of important information to the community team and for the patient and any carers. At East Surrey Hospital, methods to increase compliance of completing discharge summaries, for example adding outstanding summaries to the medical division performance scorecard and including them on the risk register, resulted in an improvement of compliance from 68 to 83%. However, the quality of electronic discharge summaries was found to be lacking. During the COVID-19 initial response, coding was changed to electronic documentation, with coding taking 60% less time per patient. The coding team noted multiple errors on discharge summaries with four key disciplines identified: trauma and orthopaedics, general surgery, cardiology and stroke. Key concerns were surrounding primary diagnosis, use of 'likely or query' leading to symptom coding, poor recording of comorbidities and minimal information on complications. Admissions had to be recoded due to errors on discharge summaries and coders reverted to using written documentation. This led to a body of work to improve the quality of the content of discharge summaries.

Materials and methods

In total, 200 discharge summaries (50 from each key discipline) were randomly selected from August 2020 and reviewed using a unique tool created from the RCP discharge summary resources and Professional Record Standards Body guideline.[1,2] Multiple domains were analysed including 'Reason for admission', 'Past medical history', 'Rationale for medication changes' and 'Follow-up plan'. Limitations were interpretation by the assessing team, with some categories less relevant to certain specialties, ie procedures or mobility restrictions. A further analysis of 100 randomly selected discharge summaries across the medical division was conducted to evaluate the accuracy of diagnoses.

Results and discussion

The reason for admission and hospital follow-up plan were done well, with 74% having clear actions for the GP. However, 23% did not include a diagnosis. Of those that had a documented diagnosis 30% did not include the correct primary diagnosis. 45% did not have clear past medical history documented, leading to inaccurate coding of comorbidities. Analysis identified a potential cause for incorrect discharge diagnosis being the automatic inclusion of an initial diagnosis from the Emergency Department electronic system. Reasons for changes to medications were often poorly documented, although a medication list was usually included.

Conclusion

Improving discharge summary quality has many benefits including accurate coding, patient safety and handover of correct information to community teams. An action plan was developed with a focus on training, education and improving electronic systems. An online education programme concentrating on quality of discharge summaries as well as induction to the IT software was introduced for the foundation doctors starting at East Surrey Hospital in August 2021. East Surrey Hospital has a strong network of physician associates and the electronic records team suggested creating 'super users' to help support users in action. Junior doctor representation was recommended for the working group rolling out electronic records for East Surrey Hospital. A collaborative approach between clinicians, coding and the information technology team is encouraged for improving healthcare informatics. ■

References

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