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

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Aim: To improve the quality of content of electronic discharge summaries at East Surrey Hospital

Background

- 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.
- The quality of discharge summaries has clear links to patient safety for handover of clinical information and patient experience
- During the COVID-19 initial response, coding was changed to electronic documentation and an initial coding audit noted multiple themes of concern in discharge summaries, with 4 main disciplines identified.

Primary diagnosis often incorrect	'likely'/Query or ΔΔ lead to symptom coding
Recording of comorbidities is poor	Minimal info on complications

4 disciplines identified needing most improvement: Trauma & Orthopaedics, General Surgery, Cardiology, Stroke.

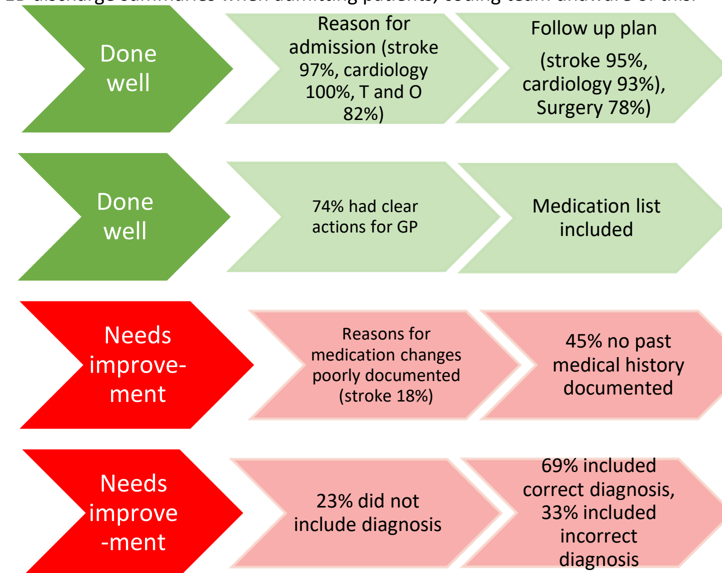
Method

- 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]
- 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 from January 21 across the medical division was conducted to evaluate the accuracy of diagnoses included on discharge summaries.

Areas assessed in tool
Reason for admission
Secondary diagnoses recorded
Comorbidities/PMHx
Complications
Changes to medications
Changes to mobility or cognition
Post discharge plan
Clear what is expected from GP
Clear how to access help

Results

Out of 200 patients 24 had no discharge summary (10 RIP, 4 SASH @home, 10 no summary). Findings for each area assessed were similar across each of the four domains. Analysis of data revealed back-end electronic systems perpetuating inaccurate diagnoses. i.e. auto-population of provisional diagnoses inserted from ED discharge summary and not *actively* deleted from inpatient discharge summary. 'Referral to service' not being used on ED discharge summaries when admitting patients, coding team unaware of this.



Conclusion and Action Plan

Improving discharge summary quality has many benefits including accurate coding, patient safety and handover of correct information to community teams. Following the data collection a SMART action plan was created and presented at the medical divisional meeting, leading to a body of work to improve the quality of discharge summaries. The coding team highlighted that it is 60% faster to code from electronic records, but the quality of the discharge summaries currently makes this impossible. A collaborative approach between clinicians, coding and the information technology team is encouraged for improving healthcare informatics.

Education and Training

Online education programme focusing on aspects of a good quality discharge summaries
Quality focus during induction as well as IT systems induction
Empowering Physicians Associates as 'Super Users'
Creation of discharge summary checklist
Education from coding team for junior doctors

E SASH programme

Junior doctor representation for working group rolling out electronic records across SASH
Work with IT to remove 'defect' of pulling initial diagnosis through to final discharge letter – 'systems freeze' a barrier to change

Areas for discussion

- MDT involvement in writing discharge summaries eg mobility restrictions or therapy follow up plans
- Balance between conciseness and quality
- Junior doctor involvement in healthcare informatics
- Review patient and GP complaints relating to discharge summaries.

References: 1. Royal College of Physicians (2019) *Improving discharge summaries - learning resource materials.* Availablefrom: https://www.rcplondon.ac.uk/guidelines-policy/improving-discharge-summaries-learning-resource-materials (Accessed 11/2/2022)
2. Professional Record Standards Body (2021) *EDischarge summary v2.1.* Availablefrom: https://theprsb.org/standards/edischargesummary/ (Accessed 11/2/2022))