

## **Introduction**

This report reviews the coding of medical records in relation to the death of Mrs Judith Varley.

We acknowledge an incorrect clinical code was recorded in the patient record for Mrs Varley and recognise the distress this will have caused her family.

We also recognise the importance of ensuring the accuracy of clinical coding and to support continual learning. We have undertaken a review our process using best practice guidance and discussed this with our data and clinical teams.

The following matters of concern were noted in the Regulation 28 report in the inquest touching the death of Mrs Judith Varley:

1. *The computer coding entered by the practice in respect of Mrs Varley's 2013 procedures did not accurately describe the procedure undertaken*
2. *It was unclear whether the operating coding computer system in 2013 had the facility to be overridden to ensure an accurate description was entered on the system.*
3. *It was unclear if there was/is an auditing/quality control system in place in the practice to ensure accurate inputting of the information within the coding process.*

## **Matter 1 - Coding used in 2013**

*"The computer coding entered by the practice in respect of Mrs Varley's 2013 procedures did not accurately describe the procedure undertaken."*

The NHS used the CTV2 coding system in 2013. The coding system has been updated several times since 2013 and the current version is called "SNOMED CT". It is common for the same naming to carry over between updates but we have not been able to verify if the current codes are exactly as they were in 2013.

The code record in the patient record in 2013 was:

- Patch angioplasty of renal artery (XaLhR) (SNOMED: 426736009)

This code refers to the renal artery whereas the discharge letter refers to "ilio-femoral bypass stenosis".

We acknowledge that the code in the patient record did not accurately describe the procedure undertaken.

With regard to preventing future deaths, we can assure the coroner that the current coding system does include codes that identify the site of the patch. Using the current system we could apply two codes, one for the angioplasty and one for the patch repair:

- Prosthetic graft patch angioplasty (XaDyk) (SNOMED: 312610006) – we would also add free text to the code to state “ilio-femoral bypass stenosis”. This is discussed in the next section.
- Patch repair femoral artery (XaCLV) (SNOMED: 310621009)

## Matter 2 - Overriding or changing codes

*“It was unclear whether the operating coding computer system in 2013 had the facility to be overridden to ensure an accurate description was entered on the system.”*

The current methods for correct codes is the same as it was in 2013, namely:

- Incorrect entries in patient records (including codes, letters, consultation notes etc) can be given the status of “marked in error”, i.e. the entry is not deleted. This removes that entry from the visible record while also ensuring the error can be checked or reinstated.
- It is also possible to respectively add entries (including codes, letters, consultation notes etc). These appear in the record on the retrospective date, but please note that it is also possible to identify when that entry was added. For example we receive discharge letters for operations several days after the operation and we record the code for operation using the date the operation took place.
- Free text can be added to a code for clarity. This is often used to identify the site of a procedure or diagnosis. Examples include the location for a skin condition, or the left/right side of the body for arms, eyes, kidney etc.

The combination of the above methods means that incorrect codes can be corrected and free text can be used to add further detail to improve accuracy.

## Matter 3 – Quality Control

*It was unclear if there was/is an auditing/quality control system in place in the practice to ensure accurate inputting of the information within the coding process.*

### Process

Our processes for coding incoming communications has changed considerably since 2013. We have highlighted below where our current process differs from the system used in 2013. We reviewed our coding process against practice policy.

The process is:

1. Discharge forms are normally computer generated and imported into our clinical system by our team. This is a fully digital process whereas all our hospital communications in 2013 were paper based. For example Mrs Varley’s discharge summary in 2013 was a handwritten form received in the post. Note we do still receive some communications in the post but the number is low and we digitise those items on arrival.
2. Our Data Quality team review each communication (such as clinical letters, reports or discharge summaries), check it is in the correct patient record and apply appropriate clinical

coding. They also highlight on screen what they have coded and can add questions or comments in free text. The item is then assigned to a GP for review. In 2013 the data team would need to flit between the paper original and onscreen display.

3. The reviewing GP then reads the letter within the patient record. This automatically displays the applied codes on screen alongside the letter and any comments from the data team. The GP changes the status of the letter to “complete” once they have reviewed the letter, codes and associated tasks (for example a medication change).

This process includes the following checks:

- The coder checks the communication is attached the correct patient record.
- The GP checks the correct coding has been used.
- There is a feedback/learning loop when the GP returns items to the data team for correction.

The current process has become significantly more robust than in 2013:

- Discharge information is computer generated from the hospital record so we’re not relying on handwritten notes.
- Coding is directly linked to the letter on screen and it is easy to look up the correct code with the letter on screen.
- Items follow a fully digital process so there is much less risk of information being lost or overlooked.
- The fully digital process removes problems with handling a lot of paper, for example pages stuck together when scanned.
- Also, please note that now that the hospital uses digital process for generating letters it is easier to enquire about details on discharge letters because they no longer need to retrieve paper records from their archive. This makes it much easier to verify that the information we have been given is correct.

### Audit

We undertook the following audit in July 2021 to review the coding process for incoming documents. We plan to repeat this in 3 months including a review of the scale, scope and frequency.

A summary of the audit is below:

Aim:

- To review accuracy of coding and tasks associated with incoming clinical letters

Method:

- The letters were reviewed by a GP.

Sample:

- A random sample of 50 clinical letters were selected.

## Findings:

	Sample	Correct	Incorrect
Number of letters	50	49 (95%)	1 (5%)

- The incorrect letter had omitted a code that that a CT scan had been undertaken. The clinical aspects of the letter were correctly coded & actioned.

## Outcome:

- No items of significant concern were noted.
- Findings have been discussed with clinical team and data team
- This is a new audit process for the practice so we plan to repeat the audit cycle in 3 months. This is to include a review of the scale, scope and frequency required to ensure continued accuracy of coding clinical information.