LETTERS

Audit in prisons

The call by Rees and Longfield for "encouraging collaboration through audit"¹ between the NHS and the Health Care Service for Prisoners is timely. Because of its relative poverty and restricted pool of expertise, the prison service is most unlikely to be able to develop effective audit on its own. However, it is extremely doubtful that "help from visiting NHS consultants" will prove a good "way of transferring expertise". This was suggested some time ago by the Royal College of Psychiatrists,² but the brief encounters typical between such outsiders and the service have not nurtured a hardy culture of quality.

Rees and Longfield note "prison doctors' efforts at integration had largely been ineffective" but much health care for prisoners involves professionals who already have to function "outside and inside." Such general practitioners, therapists, or pharmacists provide a bridge between the prisons and community care with its growing experience of audit.

For prison and community standards of care to converge, two long term organisational priorities could promote better quality care. The first priority is for continuity of care (many prisoners have problems which outlast their period of custody).³ A sustained collaboration between prison and aftercare services,⁴ which grew in parallel with nursing led community keyworking⁵ did stimulate clinical audit which proved educational and teambuilding. The second priority is the need for individual clinicians who work part time for the health service and the Home Office to maintain good standards of practice for all their clients. Problems around record keeping, best practice, and case management should be solved by extension of local community practice into audit of care for local prisoners.

This grass roots approach would produce heterogeneity in audit, between different areas. Likely benefits include facilitating treatment which entails prisoners moving through local NHS facilities⁶ (for example, by developing consistent referral criteria and transfer of information at the interface⁷ or tracing health events linkage⁸) and providing an opportunity for regional audit training⁹ to influence the planning of good quality care.

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Improving accuracy of coding plastic surgical operations

Clinical information and other hospital activity data such as number and types of surgical operations performed are usually recorded in coded form by highly trained clerical, but non-medically qualified, staff, who often work in isolation from medical staff and sometimes have to extract the data from poorly handwritten entries and disordered records. The coders also have to understand the clinical procedures or surgical operations recorded to assign the appropriate codes. Some plastic surgical operations and techniques can, however, tax the understanding of those other than plastic surgeons, even trained medical coders, and they are a potential source of coding inaccuracy.

Previous studies have shown significant inaccuracy with data coded by Hospital Activity Analysis (HAA) clerical staff.^{1,3} Since this information underpins general hospital administration, clinical audit, and research its accuracy needs to be ensured. James and Reid found significantly lower agreement between codes produced by medical staff and those produced by professional coders on a study panel,⁴ but they did not distinguish between accuracy of coding and agreement between coders.

We describe here a study designed to assess the accuracy of coding plastic surgical operations when jointly reviewed by clinicians and a coder.

Our commonly performed plastic surgical operations were assigned to minor, intermediate, and major categories with a modified British United Provident Association (BUPA) classification, and 50 cases in each were randomly selected from operations performed in 1992. The operation records were jointly reviewed by clinicians (AA, IT) and a senior medical coder (AW), and an OPCS 4 code (study code) was selected for the main operative procedure in each case, without prior knowledge of the code previously assigned by the coding clerks.

The study codes were compared with the previous codes, discrepancies were resolved by referring to the main text of the OPCS 4 codes, and the most accurate codes were selected for entry.

Among the 150 cases reviewed, six coding discrepancies were found, all of which were resolved in favour of the study codes. This implies an original coding error of 4%. Five of the six miscoded cases were in the major category and one in the intermediate category. Apart from one case in which there was no appropriate code for the operative procedure, all miscodings arose from poor understanding of the operations by the coding clerks; no errors resulted from poorly documented records or illegible handwritten entries in the case notes.

Medical staff working closely with the senior coder improved the accuracy of coding, from its previously high level (96%), and such collaboration under routine working conditions might produce a similar improvement, as suggested by Wilkinson and Harvey.⁵

Some centres provide more accurate clinical codes than others.⁶ The high level of accuracy of the initial codes in this study correlates well with that found in the south west regional clinical coding audit for 1992, in which this hospital was ranked first out of nine hospitals in the region, with only 3.6% errors among 391 codes sampled. However, quality needs to be assured if the data are to be of real value.

Studies have shown that the same mistake is often repeated with coded information, suggesting a deficient monitoring procedure.² Closer collaboration between clinicians and coders could help to prevent this and to improve coding accuracy, especially in specialties such as plastic surgery with its myriad complex reconstructive techniques.

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Assessing and treating patients admitted to hospital with chronic airways obstruction

Exacerbations of chronic airways obstruction are a major cause of admission in the United Kingdom (Lung and Asthma Information Agency, personal communication). In our experience patients with this condition are often poorly assessed and are treated with a combination of antibiotics, bronchodilators, and steroids, the individual effect of which is inadequately reported.

To record how these patients are managed, we studied the case notes of 97 randomly selected patients admitted with chronic airways obstruction (International Classification of Diseases 490, 491, 492, 496) to seven hospitals in the London area, during 1993. The patients were under the care of chest physicians, general physicians, and geriatricians. A questionnaire covering the patients' degree of disability, social circumstances, examination, history of respiratory function, blood gas measurements, and