Introduction Discharge diagnoses can have significant implications on patient management from a clinical governance point of view. It can further impact the clinical coding with a risk of potential financial loss to the service provider. Accurate clinical coding also contributes to appropriate data collection and analysis in audit and research.

Aims To look at the accuracy of discharge letter primary diagnosis and co-morbidities

To look at the relation between clinical coding and potential financial loss

Methods We did a retrospective review of 50 discharge letters randomly selected from the paediatric wards in August 2014.

An excel spread sheet was used to collect the data which included: date of admission and discharge, discharge diagnosis and any co-morbidity. The accuracy of the diagnosis was ascertained by looking through the patient notes and cross-checking them with clinical coders and against the ICD-10 manual.

Results 13 out of 50 discharge letters (26%) had inaccurate diagnosis.

6 out of 50 case notes (12%) had co-morbidities that were not included on discharge letters.

We looked thorough seven case notes’ discharge diagnosis (7/13) in detail and compared the financial tariff between the diagnosis.

We estimated an income loss of £1,359.

Discussion Coding accuracy on average is high in the United Kingdom, especially for operations and procedures.1

Inaccurate coding can have significant financial implications.2

There is a need to raise the awareness of the importance of accurate clinical coding for all clinicians.

Conclusion

1. Our audit demonstrated that inaccurate diagnosis can have significant financial implications

2. A Do’s and Don’ts table was designed and circulated to all the clinical staff (see Figure 1)

3. We aim to raise the awareness of clinical coding during junior doctors induction and aim to re-audit in 6 months’ time.

References


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**G310(P)** AUDIT OF DISCHARGE LETTER DIAGNOSIS AND ITS EFFECT ON CLINICAL CODING

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10.1136/archdischild-2015-308599.287

**G311(P)** AUDIT OF SPINAL ULTRASOUND (SU) FOR NEONATAL SACRAL DIMPLES

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10.1136/archdischild-2015-308599.288

**G312(P)** SINGLE CENTRE, MULTI-LOCATION, INTERPROFESSIONAL REAL TIME OUTREACH SIMULATION

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Abstract G310(P) Figure 1
Seriously ill children presenting to small district general hospitals face increased risk unless cared for by a team trained to recognize, stabilise and manage them prior to retrieval by a specialist transport team. Simulation is a teaching technique that enhances the clinical skills of inter-professional teams, identifying learning needs whilst not exposing patients to harm. A real time simulation was instigated as part of a quality improvement program. This unannounced single site, multi departmental, inter-professional simulation was designed and implemented to offer staff training opportunities to enhance their skills when faced with acute life threatening illness in the paediatric patient. Support was received from stakeholders and the regional simulation team.

Method
The simulation followed the real life patient journey of a child with serious illness; from arrival in the resuscitation room of the Emergency Department, transfer to the acute paediatric ward for further stabilisation before being moved to the operating department recovery area, for intubation and ventilation. Staff from all areas participated in this simulated real life event caring for the high fidelity wireless simulated patient, who was accompanied by actor parents to add authenticity to the situation. Contingency plans were established to manage any emergency during simulation.

Results
The simulation exercise was fully observed by stakeholders from all departments. Immediate verbal feedback was provided to departments after transition of the patient to the next care team. This process identified latent risks and raised human factors awareness and an action plan was produced. Many of the recommendations were implemented the same day to address key areas of patient safety and clinical care.

Conclusion
This simulated patient journey demonstrated the feasibility and value of real time outreach training in small district general hospitals helping to improve availability of safe healthcare irrespective of location. It helped strengthen multidisciplinary working relationships and improve patient safety.

Stakeholder feedback was positive and has identified a strong desire for further simulated training opportunities.

REFERENCES

Abstract G313(P) Figure 1 Association of maternal and fetal TNF-α with infant adiposity at birth Simple linear regression

**G313(P)** IMPACT OF MATERNAL AND FETAL INFLAMMATORY MARKERS ON NEONATAL AND INFANT ADIPOSITY

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Aims
To determine the association of maternal and fetal inflammatory factors with neonatal and infant adiposity

Methods
Data from 265 mother-child pairs at birth and 280 pairs at 6 months postnatal from a randomised control trial assessing the effect of a low glycaemic index diet on birth weight were analysed. Maternal TNF-alpha (TNFα) and Interleukin 6 (IL-6) were measured in early and late pregnancy and fetal levels from cord blood. Anthropometric measurements were recorded at birth and at 6 months. The sum of all skinfolds and the sum of Subscapular plus Triceps skinfolds [SS+TR] were used as markers of general adiposity and the ratio of SS/TR skinfolds as a marker of central adiposity.

Results
Maternal TNFα in early pregnancy was associated with neonatal anthropometry including biceps [p = 0.048], triceps [p = 0.027] and subscapular [p = 0.002] skinfold thicknesses. TNFα in early and late pregnancy correlated with general...