

PostScript

LETTERS

Awareness of guidelines on pleural infection

Guidelines for the management of pleural infection in children were published in 2005 as a supplement in *Thorax*¹ with an accompanying editorial.² They are also available on the British Thoracic Society (BTS) website (www.brit-thoracic.org.uk). Additionally, the guidelines were endorsed by the Royal College of Paediatrics and Child Health (RCPCH) after scrutiny by their Quality and Practice Committee. RCPCH published a guideline review in the *Education and Practice Edition of Archives of Disease in Childhood*,³ mailed their guideline appraisal to all College members, and placed it on their website (www.rcpch.ac.uk). The guidelines were also presented at the BTS Winter Meeting (2004) and annual RCPCH meeting (2005). They have been widely disseminated and the aim of this study was to ascertain, 1 year later, how aware general paediatric and respiratory trainees were of the guidelines.

All tertiary paediatric respiratory units in the UK were selected (from the 11th BTS *Directory of training posts and services in adult and paediatric respiratory medicine*, 2006), excluding our own centre. An alphabetical list of all district general hospitals (DGHs) was taken from the *Guardian NHS and Social Services directory 2004-05* and every 10th hospital was selected. A questionnaire was devised and the on-call general or respiratory paediatric middle grade trainee was telephoned (on weekday afternoons) and asked to take part. In a yes/no/don't know format, we ascertained whether the department used any local guidelines, and whether the trainee was aware, familiar with or unaware of the BTS guidelines.

All 105 trainees agreed to take part: 77 in DGHs and 28 in tertiary respiratory centres. All had been in the post at least 1 month apart from one person who had only been there for 1 day. Cases were managed in 5/77 DGHs and 23/28 specialist centres. In the 28 centres managing cases, 18/28 (64%) had their own local guidelines for empyema management, six (21%) did not and in four (14%) the trainees were unsure. Comparison of guideline awareness between trainees in DGHs and specialist centres is shown in fig 1.

Awareness is less than optimal among specialist, and particularly general paediatric,

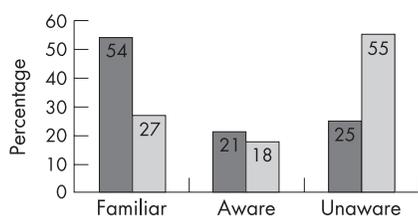


Figure 1 Familiarity of middle grade paediatric trainees with the BTS guidelines on management of pleural infection in children, in 28 respiratory specialist centres (dark grey) and 77 district general hospitals (light grey).

trainees. We simply accepted their answers; there was no "testing" of their supposed familiarity with the guidelines, so if anything, our figures may be an overestimate. Although better than the DGHs, the tertiary centres can not afford to be complacent, as in 25% of them the on-call trainee was unaware of the BTS guidelines. This study only surveyed middle grade trainees, and it may be that all the on-call consultants were very familiar with the guidelines and, once informed by the trainee about the case, would institute appropriate management. Worryingly, out of the five DGHs that managed cases themselves, in two of them there were no local guidelines, and in the same two centres the trainee was unaware of the national guidelines. In conclusion, writing the pleural infection guidelines was a useful process as it clarified many issues and pointed to where evidence was required. However, it is disappointing that despite extensive attempts to disseminate the guidelines, a large number of middle grade trainees were unaware they even existed, let alone were familiar with their contents.

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doi: 10.1136/adc.2006.115485

Competing interests: None.

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- 2 Balfour-Lynn IM. Some consensus but little evidence: guidelines on management of pleural infection in children. *Thorax* 2005;60:94-6.
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KMR: a clinical audit

In the current financial situation, where trusts receive finance based on payment by results, accurate record keeping is very important. Many trusts have lost funding despite having a good patient load because of an inability to produce appropriate data. Information on the performance of a trust is largely obtained from data produced by clinical coding, which in turn is mainly based on information provided on the Körner Medical Records (KMR) form. The KMR is a record reflecting the number of patients admitted and discharged, the clinical problems encountered, lengths of stay and other relevant information. Most KMRs are not timely or adequately filled in due to changing shifts and junior doctors' lack of awareness.

We conducted a short audit on the appropriate completion of KMRs. The objectives were: (i) to determine the accuracy and completeness of the diagnosis noted on the KMR in relation to the clinical findings, (ii) to determine the appropriateness of sections completed, (iii) to identify

any missed information (such as dates, co-morbidities and names of associated non-paediatric consultants) and (iv) to identify any problems experienced from the time of discharge to clinical coding leading to a delay in completing the form. According to our standards, all KMRs should have appropriate and complete information in the relevant sections and should be completed at or soon after discharge. The information to be included should consist of dates of admission and discharge, co-morbidities, the name of any associated consultant, procedures, transfers between consultants and between hospitals, death if applicable and self-discharge.

The data were collected retrospectively from 10th May 2005 to 24th May 2005 and included information on principal diagnosis, co-morbidities, primary and associate consultants, primary procedure and length of time between discharge and the completion of the KMR and clinical coding. Errors were found in (i) diagnosis and clinical coding and (ii) the appropriateness of sections completed on the KMR.

There were 46 discharges. The KMR was completed for 76% of these discharges (28/46 vs 9/46). An appropriate diagnosis in relation to the clinical findings and clinical codes was noted in 68% (19/28) of KMRs, whereas 32% (9/28) of diagnoses filled in were inappropriate. Appropriate sections including information on co-morbidities were filled in for 93% (26/28) of the KMRs. All KMRs except one were completed by 2 weeks after discharge, with most being filled in between 6 and 8 days after discharge.

We found that a large proportion of KMRs were incomplete, with missing or inappropriate diagnoses noted. Much of the data had been entered into incorrect sections and information on co-morbidities and the name of the associate consultant were often missing. Problems observed were short admissions out of hours, temporary files and files sent to the offices of consultants or other senior clinicians for various reasons.

As the KMR is important, we recommend that it should be appropriately and accurately completed at the time of discharge along with the TTO (To Take Home) form or shortly afterwards. There is a need to increase awareness of the KMR and clinical coding among junior doctors and a process to accomplish this should be identified. Monthly feedback on clinical coding performance should be provided to specialities. In the absence of improvement, the involvement of senior staff is required.

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doi: 10.1136/adc.2006.114231

Competing interests: None.



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Arch Dis Child 2007 92: 652

doi: 10.1136/adc.2006.115485

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