

The quality of national data on injuries requiring hospitalisation

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TO THE EDITOR: Quality data about patients with injuries requiring hospitalisation is vital to injury policy and prevention strategies.¹ The ICD-10-AM is used in Australia to assign codes to diagnoses, procedures, and causes of injury recorded in patient medical records.² This coded hospital morbidity data provides a key surveillance tool for injury researchers.

ICD classifications are designed for statistical reporting and are required for classifying all information encountered in hospital medical records. When insufficient information is available in the medical record to assign specific codes, the use of residual "Unspecified" categories helps to achieve this.

Detailed and accurate documentation provided by clinicians in patient medical records is imperative to produce high quality coded data.³ Poor documentation in medical records has been shown to decrease data quality by contributing to an overuse of "Unspecified" codes.⁴ This is especially so for documenting external cause of injury, which may not be seen as critical to the patient's care by the treating clinician, with the result that the relevant detail is incomplete or omitted altogether.

We aimed to identify the level of precision of coded injury data in Australian hospitals. Using the 2003–2004 national morbidity dataset, 445 098 records containing an injury and an external cause classified by intent were found (Box). At a broad intent level, the majority of injuries were assigned to a specific

mechanism code, although in two intent categories, "Accident" and "Assault", 11% and 13% of injuries, respectively, were assigned to "Unspecified" categories. It is concerning that 45 297 of the injuries requiring hospitalisation lacked adequate documentation in the medical record to permit meaningful code assignment for cause of injury.

A significant lack of precision was evident in recording mechanisms of accidental falls and poisonings (across all intents). A quarter of falls and 20% of poisoning cases had no specific information about the causal mechanism or substance. Being the most commonly reported accident mechanism, falls of unspecified cause represented 11% of accidents overall. This lack of detail is particularly concerning given the significant national priority now placed on falls and poisoning injury prevention.⁵

It is essential that clinicians and coders alike are aware of documentation and coding problems related to capturing data on cause of injury. By working together to improve the quality of injury-related coded data (through improved clinical documentation), accurate and comprehensive information pertaining to the circumstances surrounding injury events requiring hospitalisation will benefit injury policy and prevention initiatives.

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Guidelines for the management of acute coronary syndromes 2006

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TO THE EDITOR: The recommendation for managing acute ST-segment-elevation myocardial infarction with percutaneous coronary intervention (PCI) is that the door-to-balloon inflation time should be 90 minutes. However, it can be up to 120 minutes, depending on when patients present to the emergency department (ED) after the onset of their symptoms.¹ In such cases, an alternative immediate reperfusion strategy — fibrinolysis — should be considered.

At first glance, a door-to-balloon time of 90 minutes seems readily achievable, but what if the patient presents after hours, or presents to a hospital without PCI facilities?

The time required to refer the patient for PCI, organise ambulance transport and call in cardiac catheterisation laboratory staff can be considerable.

In the PRAGUE-2 trial from the Czech Republic, the average door-to-balloon time was 97 minutes.² The DANAMI-2 study from Denmark had a cohort of 27 080 patients and had door-to-balloon times of about 114 minutes for those patients transferred to another facility.³ The National Registry of Myocardial Infarction 4 investigators reported a median door-to-balloon time of 185 minutes for American patients transferred to centres capable of PCI, and a door-to-balloon time of less than 90 minutes for only 3% of patients.⁴

Doctors working in EDs without onsite access to PCI need to know the door-to-balloon times of the institutions to which they refer patients for PCI. Centres performing PCI may not be forthcoming with this

Precision of recorded cause of injury data across selected ICD-10-AM categories² for 2003–04

ICD-10-AM categories	Specified	Unspecified	Total
Intent			
Accident	347 781 (89.2%)	42 078 (10.8%)	389 859
Intentional self-harm	29 018 (99.6%)	130 (0.4%)	29 148
Assault	19 385 (87.2%)	2 841 (12.8%)	22 226
Undetermined intent	3 617 (93.6%)	248 (6.4%)	3 865
Total	399 801 (89.8%)	45 297 (10.2%)	445 098
Mechanism			
Accidental falls	130 089 (74.6%)	44 336 (25.4%)	174 425
Poisoning (all intents)	31 111 (80.0%)	7 798 (20.0%)	38 909