Letters to the Editor

OVERVIEW

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Discharge communication

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Editor – I appreciate the excellent quality improvement research presented by Earnshaw and colleagues.[1] The authors have taken considerable effort with a rigorous approach to improving the quality of discharge summaries through a direct feedback system. I found their 'rapid improvement event' (RIE) using LEAN methodology, and their suggestion of greater involvement of allied healthcare professionals particularly worthy.

The importance of good discharge communication by new doctors was a subject we chose to tackle as near-peer teaching for the then new Final Year Transition course pioneered at Imperial College in 2012. Assessment of written communication, such as discharge summary writing, should by now be embedded in the UK undergraduate medical school curriculum.

Arguably, every junior doctor rotation should provide a specialty-specific induction handbook that includes common condition discharge summary criteria and useful guidelines.

Some are not aware that the annual NICOR National Heart Failure Audit evaluates standards on adequate heart failure planning documentation, discharge weight and electrocardiography findings, based upon discharge summary data. As the authors mention, an association of poor-quality discharge summary with higher rate of readmission for patients hospitalised with heart failure exacerbation has been reported previously in the USA.[2]

To take another example, in interventional cardiology, procedures are becoming more and more complex, and dual and triple anti-platelet regimens are increasingly convoluted and varied. The importance of clear discharge communication with expert review, for example at registrar or consultant level, is only likely to grow.

I suggest that the role of discharge written communication is not just in ensuring patient safety, for example by reducing prescribing errors and maintaining the long-valued rapport between primary and secondary care practitioners, but also in empowering and educating patients for self-care. There is a paucity of evidence on how this should be delivered.

Furthermore, I would like to propose that high-quality and in-depth feedback to a junior doctor using a discharge summary can be a valuable learning tool, perhaps a more robust approach to the case-based discussion. I suspect that the rich and structured nature of any hospital admission journey would yield a pragmatic and dynamic teaching resource of interest to teacher and student alike.

I look forward to the development of the authors' quality improvement research. ■

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References

1 Earnshaw C. Pedersen A, Evans J *et al.* Improving the quality of discharge summaries through a direct feedback system. *FHJ* 2020;7:149–54.
2 Salim Al-Damluji M, Dzara K, Hodshon B *et al.* Association of discharge summary quality with readmission risk for patients hospitalized with heart failure exacerbation. *Circ Cardiovasc Qual Outcomes* 2015;8:109–11.

Pleural and peritoneal work in the COVID-19 era in a north-east hospital

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Editor – Northumbria Healthcare NHS Foundation Trust runs a successful pleural and peritoneal service for patients with malignant pleural and peritoneal malignant fluid, pleural infection and pneumothorax.[1–4] Most of the work is done through medical ambulatory care or semi-elective theatre work. All patient records referred from 16 March 2020 to 17 June 2020 were reviewed. Inclusion criteria were those patients who required an interventional procedure and managed on an outpatient basis. Basic demographics, diagnoses and mode of diagnosis and performed investigations were collected. A descriptive analysis of the data was performed.

Four patients with pneumothoraces were seen (all secondary pneumothoraces). The mean age was 57.5 years, two were treated with a pleural vent over an average of 3 days. Two patients were managed with an ambulatory bag over an average of 22 days.

We previously reported that five patients who had been referred for local anaesthetic medical thoracoscopy (LAT) and symptoms pertaining to fluid were being palliated by indwelling pleural catheters (IPC).[5] Given cancellation of elective theatre work, day-case LAT was not an option for us. See supplementary material S1, Table S1, for a summary of patients with malignant effusions and their outcomes.

Six indwelling peritoneal catheters for patients with malignancy related ascites were inserted. The mean age was 59.7 years and mean number of preceding paracenteses was 0.67. All were done as day cases. The diagnoses were breast, gastric, pancreatic, bowel and unknown primary cancers. It is worth noting that one of the patients was SARS-CoV-2 positive at the time of the procedure.

We are past the peak of the pandemic and currently looking at ways to restart previous services. It has proved to be a challenging time with the surgical constraints in the COVID-19 era.[6] The future