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SIGN 128 • The SIGN discharge document

June 2012



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Scottish Intercollegiate Guidelines Network

The SIGN discharge document



June 2012

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1 Introduction

1.1 THE NEED FOR A SIGN DISCHARGE DOCUMENT

The preparation and sharing of accurate and timely records of care and treatment are central aspects of good clinical practice and the principles of good medical practice set out by the General Medical Council (GMC)¹ will therefore apply in the provision of discharge documents.

Patients who are discharged from hospital will be discharged back into the care of the general practitioner (GP) with whom they are registered. Essential information about the patient's stay in hospital that allows the GP to continue the patient's care and management following their discharge from hospital is sent by the hospital to the patient's GP in the form of a Discharge Document (DD). There are currently two forms of DD in use: the Immediate Discharge Document (IDD), which should be sent to the GP on the day of discharge, and a discharge summary or letter, which contains more detailed information about the patient's stay in hospital and is sent out, ideally, within a week of the patient's discharge date. The content, structure and production (particularly the timeliness) of discharge documents have long been a cause for concern and in order to try to address these issues, a minimum dataset for the IDD was published by SIGN in 1996 (SIGN 5)² and revised and updated by SIGN in 2003 (SIGN 65).³

Improving the quality and timeliness of discharge documents may lead to improvements in patient safety by improving the process of transition from hospital to GP care.

1.1.1 THE NEED FOR AN UPDATE

This SIGN DD replaces SIGN 65 and reflects a number of developments including advances that have been made with regard to the production, use and transmission of electronic documents within NHSScotland, changes in terminology, and the importance of medicines reconciliation. SIGN 5 and SIGN 65 reflected the fact that many discharge documents were still produced and/or printed on paper and transmitted by post, hand or fax. This update reflects the fact that the production and communication of documents by electronic means within both primary and secondary care is becoming more common.

Despite these developments, the essential components of a DD remain largely unchanged with the content, quality and accuracy of the information contained in the DD and timely transmission to the GP being the key aspects.

1.2 REMIT OF THE SIGN DISCHARGE DOCUMENT

1.2.1 OVERALL OBJECTIVES

The aim of this document is to present a template for a single discharge document that can be used as both the IDD (in its core format) for every patient on the day of discharge, and as the final discharge summary/letter (in its extended format) for more complex cases.

The SIGN DD is designed for patients who are discharged from hospital following an inpatient stay, ie, a stay in hospital of one night or more. It could also, however, form the basis of a DD for patients receiving treatment on a day-case basis.

The SIGN IDD is not designed to cover discharges from psychiatric care because of the special information needs relating to this group of patients, but it could form the basis of a DD tailored to the needs of this group.

The SIGN DD is effectively a minimum dataset. As such the template should not limit the information provided and, where necessary, additional information relating to, for example, anticipatory care planning, should be provided either in the DD or separately, as appropriate.

1.2.2 TARGET USERS OF THE SIGN DICHARGE DOCUMENT

The SIGN DD is of relevance to all hospital medical and nursing staff, allied health professionals, general practitioners, community nurses, pharmacists, and out-of-hours services.

The SIGN DD is not intended to be the sole or main source of information for patients, their carers or relatives, although most will receive a copy at the time of discharge from hospital.

2 The discharge document

2.1 THE CONTENT OF THE DISCHARGE DOCUMENT

SIGN 5 argued the importance of a minimum dataset as a basis for electronic data transfer and specified such a dataset; SIGN 65² refined the original dataset to encourage improvements in the standard of discharge documents in this critical area of practice. It was recognised in SIGN 65 that a minimum dataset should be evidence based and include all those items seen as essential.³

The SIGN DD is based on a review of SIGN 65 by a multidisciplinary group (*see section 5.2*) using an amended version of the SIGN guideline development process (*see sections 5.1 and 5.3*). The content, although similar to SIGN 65, has been revised and updated; some existing items have been deleted or changed, new items have been added and the guidance notes have been reviewed and extended.

2.2 USE OF THE DISCHARGE DOCUMENT

The SIGN DD is a single discharge document template, with core and extended formats, for use within NHSScotland.

The **core discharge document (CDD)**, which replaces the IDD, must be produced for all patients on the day of discharge. In cases where the patient's stay in hospital is brief and uncomplicated and where there are no outstanding test results or investigations, the CDD will be the sole discharge document.

For more complex cases where more detailed information about the hospital stay or follow-up arrangements is required, or where the results of tests and investigations are awaited, an **extended discharge document (EDD)** will also have to be completed. In cases where an EDD is required, the CDD, which will be retained on the hospital information system, can be extended and augmented by the addition of more detailed information in specified fields to produce the EDD. When an EDD is produced it is important, for audit purposes, that the CDD is retained on the system unchanged.

The EDD should be sent out within seven days of the date of discharge to ensure that the GP has all the information required for the ongoing care and management of the patient. In cases where important information, such as test results, is not available within seven days, dispatch of the EDD can be delayed until the information is available but this delay should not exceed 14 days.

All relevant members of the multidisciplinary hospital team should be involved in the production of the CDD and the EDD. The facility to automatically transfer information from nursing, pharmacy, physiotherapy, occupational therapy and other relevant records would greatly facilitate this process.

2.2.1 CODING OF DIAGNOSES, OPERATIONS AND PROCEDURES

Accurate reporting of all diagnoses, operations and procedures relevant to a patient's admission is an essential part of both the CDD and the EDD. This information is central to the future care and management of the patient and essential for accurate coding and record keeping within hospital and general practice records systems. Clear textual descriptions of these items must therefore be given.

In addition to textual descriptions, both the CDD and the EDD ask for 'standard codes' to be provided for these items where possible. However, there is currently no national definition of 'standard codes' across NHSScotland with hospitals tending to use the International Statistical Classification of Diseases and Health-related Problems, tenth revision (ICD-10) and the Office of Population Censuses and Surveys Classification of Surgical Operations, fourth revision (OPCS-4) and general practices tending to use Read codes. Although the adoption of a single coding system (eg the Systemised Nomenclature of Medicine - Clinical Terms (SNOMED-CT) across NHSScotland would greatly facilitate the transfer of information between, for example, hospitals and general practices, until such a system is agreed the definition of what constitutes a 'standard code' will be a matter for local agreement. The extent to which 'standard codes' are included in the CDD and EDD will also depend on local systems and processes.

2.2.2 MEDICINES RECONCILIATION AT DISCHARGE

The accurate recording of medicines is an essential component of the CDD and EDD as it has a direct impact on patient care and management and is an important factor in improving patient safety. In the context of both the CDD and EDD, medicines reconciliation comprises the accurate recording and comparison of all medicines a patient was taking on admission to hospital with those they are taking at the time of discharge from hospital, documenting all changes that have taken place. Changes can include the prescription of new medicines, changes to existing medicines (such as changes to dose or frequency) and the stopping of medicines that the patient was taking at the time of admission to hospital.

To reflect the importance of including accurate information on all new, continuing and stopped medicines, the SIGN DD now includes separate and extended sections for recording this information along with more detailed guidance notes for completion.

Sharing the discharge document with the patient's community pharmacist is considered to be an important step in improving medicines reconciliation at discharge and enhancing patient safety relating to medicines. The decision to share the DD with the community pharmacy must, however, be made in accordance with local protocols.

2.2.3 CONSULTANT SIGN-OFF

In cases where the CDD is the sole discharge document it must be signed off by the consultant or senior doctor who is responsible for coordinating the care of the patient at the time of discharge. If consultant or senior doctor sign-off is not possible at the time of discharge, an unsigned copy of the CDD should be sent on the day of discharge followed by a signed copy within seven days of discharge.

In cases where the CDD is to be followed by an EDD, the CDD does not have to be signed by the consultant or senior doctor coordinating the care of the patient, although it is good practice to do so whenever possible.

The EDD must always be signed by the consultant or senior doctor responsible for coordinating the care of the patient at the time of discharge.

The definition of 'senior doctor' will be a matter for local agreement.

3 The SIGN discharge document template

Item	Fields	Notes	
	<p>Items shown in bold are essential for the core and extended discharge document.</p> <p>Items not in bold are desirable for the extended discharge document.</p>	<p>The core discharge document (CDD) comprises all the items shown in bold and must be completed for all patients at the time of discharge. For uncomplicated cases, this will form the sole discharge document.</p> <p>The extended discharge document (EDD) comprises all the items shown in bold plus all the items not in bold and should be completed for more complex cases.</p>	
1	Hospital	Name	This will be automatically populated from the hospital's patient administration system (PAS).
2	Patient ID	<ul style="list-style-type: none"> • CHI number • title • forename* • alternative forename • surname* • address* • postcode* • date of birth* 	<p>This item will be automatically populated from the PAS.</p> <p>CHI - the Community Health Index number.</p> <p>* These fields will be populated automatically when the CHI number is entered.</p> <p>Alternative forename - the name by which the patient is usually known (if different from 'forename').</p>
3	GP ID	<ul style="list-style-type: none"> • forename • surname • GP practice (code) • address • postcode • other GP name 	<p>These fields will be automatically populated when the CHI number is entered.</p> <p>Other GP name - the GP responsible for the patient's admission, if different from above.</p>
4	Consultant ID	<ul style="list-style-type: none"> • forename • surname • specialty • contact details 	<p>The consultant responsible for the patient at the time of discharge.</p> <p>Contact details must be given. This can be, for example, telephone number, bleep number or email address, as agreed locally.</p>
5	Ward/ Department	Text	The number/name of the ward or department issuing the discharge document.
6	Contact	Telephone number	This is the contact telephone number for the ward or department responsible for the discharge.
7	Date of admission	Date	This is the date of admission to the hospital identified in item 1.
8a	Date of discharge	Date	If the patient was discharged alive, record the date of discharge from the hospital identified in item 1. If item 8a is completed, 8b must be blank.
8b	Date of death	Date	If the patient died during admission to the hospital identified in item 1, record the date of death. If item 8b is completed, item 8a must be blank.
9	Primary discharge diagnosis	<ul style="list-style-type: none"> • primary diagnosis (text) • confirmed/provisional • code 	<p>Record the primary discharge diagnosis relevant to this admission. This is the main reason why the patient was admitted to hospital on this occasion.</p> <ul style="list-style-type: none"> • Avoid acronyms, eg, 'STEMI', and abbreviations, as these may not be understood by the recipients, including patients. • State whether the diagnosis is confirmed or provisional. • Provide standard code(s) whenever possible.

Item		Fields	Notes
10	Secondary discharge diagnosis/es	<ul style="list-style-type: none"> secondary diagnosis/es confirmed or provisional code(s) 	<p>Record any secondary diagnosis/es relevant to this admission. Include any relevant comorbidities that could have contributed to or be affected by the primary diagnosis (eg, hypertension in a patient admitted for stroke).</p> <ul style="list-style-type: none"> Avoid acronyms, eg, 'PVD', and abbreviations, as these may not be understood by the recipients, including patients. State whether each diagnosis is confirmed or provisional. Provide standard code(s) wherever possible.
11	Presenting complaint	Text description	This is the reason why the patient was admitted to hospital, eg, breathlessness, chest pain, collapse.
12	Mode of admission	Elective/emergency/transfer	This will be automatically populated from the PAS.
13	Source of referral	GP/self-referral/ambulance service/out-of-hours service/other hospital/NHS24/other (please specify)	This describes who made the decision to refer the patient to (this) hospital.
14	Significant operations/procedures	<ul style="list-style-type: none"> text description dates of operations/procedures code(s) 	<p>All significant operations and/or procedures (eg, chemotherapy) should be described.</p> <ul style="list-style-type: none"> Avoid acronyms, eg, 'CABG', and abbreviations, as these may not be understood by the recipients, including patients. Give dates operations/procedures were undertaken if relevant for follow-on care. Provide standard code(s) wherever possible.
15	Clinical progress	<ul style="list-style-type: none"> text description investigations complications code(s) other relevant information 	<p>Provide a description of what happened to the patient during this admission including, as a minimum:</p> <ul style="list-style-type: none"> relevant investigations performed a description of any complications (medical and/or surgical) experienced by the patient. If none, this must be stated, eg, 'uncomplicated appendicectomy and recovery' adverse reactions to medicines (if not covered under item 19) or treatments. <p>Standard codes should be provided wherever possible.</p> <p>For extended discharge documents, record any other information that is relevant to the admission and which will assist follow-on care.</p>
16	Results awaited	Y/N If 'Yes' – specify (text)	Specify the type of results that are awaited, eg, pathology, investigations, imaging, and indications for tests/investigations/imaging.
17	Investigations pending	Y/N If 'Yes' – specify (text)	Describe all investigations that are pending at the time of discharge.
18	Allergies	Y/N/Undetermined If 'Yes' – specify (text)	Describe all known allergies and the form they take. For example: Allergy – penicillin; reaction – rash. Allergy – peanuts; reaction – anaphylaxis.

Item		Fields	Notes
19	Stopped medicines on discharge	<ul style="list-style-type: none"> • name of medicine (generic where possible) • formulation • strength of preparation • current dose • route of administration • frequency • reason for stopping (text) 	<p>Record all medicines that the patient was taking at the time of admission but was not taking at the time of discharge.</p> <p>Describe the reason why each medicine listed here was stopped. This should include information on adverse reactions.</p> <p>In cases where the formulation, strength, dose, route of administration or frequency of a medicine has changed between admission and discharge, the medicine should be recorded under item 19 and the new prescription recorded under item 20.</p>
20	New medicines on discharge	<ul style="list-style-type: none"> • name of medicine (generic where possible) • formulation • strength of preparation • current dose • route of administration • frequency • duration of treatment (stop date or 'continue') • number of days supply • aids to compliance (text) • reason for change to admission medicines • indications for new medicines 	<p>Record new medicines prescribed during this hospital stay that are still being taken at the time of discharge. Do not include medicines that were only taken (ie, that were started and stopped) during the patient's stay in hospital.</p> <p>A 'new' medicine is defined as:</p> <ul style="list-style-type: none"> • any medicine that the patient was not taking at the time of admission • any medicine that the patient was taking at the time of admission but for which the formulation, strength, dose, frequency, or route of administration has been changed. In such cases a matched record must appear under item 19. <p>Duration of treatment:</p> <ul style="list-style-type: none"> • record the stop date for all medicines prescribed for a short term or defined course of treatment • record 'continue' if the patient is to continue taking the medicine after discharge and no specific stop date has been agreed. <p>Number of days supply – record the number of days supply of each medicine that was given to the patient, carer or relative at the time of discharge. If none, record 'none'.</p> <p>Aids to compliance – provide a description of any aids to compliance (eg, easy-open containers, medication charts, compliance devices, medication management service via carer) that have been provided to or are being used by the patient to aid the taking of medicines. If there are none, state 'none'.</p> <p>Reason for change to admission medication – if changes have been made to the formulation, strength, dose, frequency or route of administration of medicines that the patient was taking at the time of admission, record the reasons why these changes were made.</p> <p>Indications for new medicines – for medicines that are new, ie, that were not being taken by the patient at the time of admission, describe what the new medicine has been prescribed for as this may not be clear to the GP or patient from the name of the medicine alone.</p>

Item		Fields	Notes
21	Continuing medicines on discharge	<ul style="list-style-type: none"> • name of medicine (generic where possible) • formulation • strength of preparation • current dose • route of administration • frequency • duration of treatment (stop date or 'ongoing') • number of days supply • aids to compliance (text) 	<p>Record all medicines where the admission and discharge prescription details are the same.</p> <p>If any aspect of the prescription has changed, the medicine must be recorded in item 19 and then the new prescription recorded in item 20. This includes changes to the formulation, strength, dose, route of administration or frequency.</p> <p>Duration of treatment:</p> <ul style="list-style-type: none"> • record the stop date for all medicines prescribed for a short term or defined course of treatment • record 'continue' if the patient is to continue taking the medicine after discharge and no specific stop date has been agreed. <p>Number of days supply – record the number of days supply of each medicine that was given to the patient, carer or relative at the time of discharge. If none, record 'none'.</p> <p>Aids to compliance – provide a description of any aids to compliance (eg, easy-open containers, medication charts, compliance devices, medication management service via carer) that have been provided to or are being used by the patient to aid the taking of medicines. If there are none, state 'none'.</p>
22	Follow up arrangements	<ul style="list-style-type: none"> • Y/N • If 'Yes', specify (text) • Text description 	<p>Specify the type of follow up that is required, stating when and by whom. Give dates if known. Include, for example:</p> <ul style="list-style-type: none"> • early review by GP • hospital review (state by whom, eg, rheumatology) • social work • nursing (state for what) • allied health professional (specify which and for what) • voluntary organisations (eg, Macmillan, British Heart Foundation, Parkinson's UK). <p>In complex cases, a text description detailing the nature of the follow-up arrangements should be provided along with details of support already provided or arranged.</p>
23	Copy to community pharmacy	Y/N If 'Yes' specify (text)	Select 'Yes' if a copy of the discharge document has been sent to the community pharmacy and give the name of the pharmacy.
24	Copy to patient	Y/N	Select 'Yes' if a copy of the discharge document has been given to the patient.
25	Copy to carer/relative	Y/N If 'Yes' specify (text)	Select 'Yes' if a copy of the discharge document has been given to the patient's carer or relative and state carer/relative's relationship to patient.

Item		Fields	Notes
26	Extended discharge document to follow	Y/N	<p>Select 'Yes' if this document forms the core discharge document only and an extended discharge document is to follow. This will apply to more complex cases where all relevant information was not available at the time of discharge.</p> <p>For all other cases, select 'No'.</p>
27	Other information	Text	<p>Record any other information considered important and relevant to this patient that is not captured elsewhere in the DD. This might include, for example:</p> <ul style="list-style-type: none"> information on medicines on admission not known or incomplete prior to discharge information on anticipatory care planning information relating to the patient's understanding of their condition details of information that has been provided to the patient and/or their carer or relative information on the patient's fitness to work. <p>Additional information relating specifically to follow-up arrangements should appear in item 22.</p>
28	Consultant sign-off and comment	<ul style="list-style-type: none"> Y/N Comment 	<p>The consultant responsible for the patient at the time of discharge (as named in item 4) must check and sign off the discharge document (see section 2.2.3).</p> <p>Select 'yes' if this is:</p> <ul style="list-style-type: none"> the core discharge document checked and signed by the consultant on the day of discharge a signed replacement for a previously unsigned core discharge document an extended discharge document. <p>Select 'no' only if this is an unsigned core discharge document. In all such cases either a signed core discharge document or an extended discharge document must follow within seven days of discharge.</p>
29	Signature and name and position	<ul style="list-style-type: none"> signature legible text of name job title contact telephone number 	<p>To be completed by the responsible person at the time of discharge, eg, charge nurse, senior nurse or senior medical staff. They are signing on behalf of the person named in item 4 who is responsible for the document.</p>

4 Implementing the SIGN discharge document

4.1 INTRODUCTION

The SIGN DD provides a standard template for discharge documents across NHSScotland incorporating all the key fields required in a CDD and an EDD along with a description of how the different items and fields should be completed. If used consistently across NHSScotland the template should lead to improvements in the quality of discharge documents by facilitating the inclusion of all key items of information. Improvements in the quality and timeliness of discharge documents, however, will be dependent upon the existence of local systems and processes for their production and transmission and it is the responsibility of NHS boards to ensure that these are in place.

It is recognised that the development and use of systems for the capture, use and transmission of electronic information relevant to the discharge document varies across Scotland, within NHS boards and between hospitals and local GP practices, and for that reason no specific recommendations are made about how the SIGN DD should be generated, updated and used.

The CDD and EDD reflect the minimum information that should be captured for both straightforward and more complex discharges. It can, of course, be augmented as required to reflect local priorities and circumstances.

4.2 IMPLEMENTATION STRATEGY

1. SIGN will work with the e-Health lead at Healthcare Improvement Scotland, the e-Health leads in NHSScotland and other relevant professionals to support the implementation of the SIGN DD.
2. A coordinated approach to implementation will be taken in conjunction with other relevant initiatives and groups within Healthcare Improvement Scotland including:
 - National Clinical Data Advisory Group
 - Scottish Patient Safety Programme in Primary Care.
3. An initial targeted distribution will be undertaken and the DD will be freely available to download from the SIGN website.
4. Awareness-raising activities will be undertaken whenever possible, via relevant meetings, conferences and organisations, including, in the first instance:
 - distribution of copies of the DD at the NHSScotland event in June 2012
 - inclusion of a poster at the primary care satellite event, held as part of the NHSScotland event.
5. Audit tools for healthcare professionals in training and others working in NHSScotland will be developed to support audit of key aspects of the DD such as:
 - consultant sign-off
 - proportion of CDDs sent out on the day of discharge and the proportion of EDDs sent out within seven days of discharge
 - pharmacy audit of medication errors.

5 Development of the SIGN discharge document

5.1 INTRODUCTION

SIGN is a collaborative network of clinicians, other healthcare professionals and patient organisations and is part of Healthcare Improvement Scotland. SIGN guidelines are developed by multidisciplinary groups of practising clinicians using a standard methodology based on a systematic review of the evidence. Further details about SIGN and the guideline development methodology are contained in 'SIGN 50: A Guideline Developer's Handbook', available at www.sign.ac.uk.

The SIGN DD is not a guideline as such but an update of and replacement for the IDD that formed section 3 of SIGN 65. The usual process for guideline development set out in SIGN 50 does not therefore apply. In particular, a systematic review of the literature was not undertaken because the content of the discharge document (in terms of topics covered) remains largely unchanged (*see section 1.1.1*) and the focus of much of the recent literature is on the processes surrounding the production, use and transmission of discharge documents and consideration of these is not within the remit of this document. In common with the usual process for guideline development, however, the review was conducted by a multidisciplinary group convened specifically for this purpose and a draft of the DD was sent out for expert peer review and made publically available for comment on the SIGN website prior to being finalised (*see section 5.3*).

5.2 THE SIGN DISCHARGE DOCUMENT DEVELOPMENT GROUP

Dr Keith Brown (Chair)	<i>Chair, SIGN</i>
Mrs Jackie Caldwell	<i>Information Consultant, Information Services Division, Edinburgh</i>
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Ms Beatrice Cant	<i>Programme Manager, SIGN</i>
Dr Allan Cameron	<i>Consultant Physician, Glasgow Royal Infirmary</i>
Mr Mike Cohen	<i>Community Pharmacist, Meadowbank Health Centre, Polmont</i>
Dr Lynne Galloway	<i>General Practitioner, Kelburn Surgery, Paisley</i>
Dr Claire Gordon	<i>Consultant in Acute Medicine, Western General Hospital, Edinburgh</i>
Dr Rachel Green	<i>GP Trainee, Edinburgh</i>
Mr Peter Lamb	<i>Consultant Surgeon, Royal Infirmary of Edinburgh</i>
Dr John McKnight	<i>Consultant Physician, Western General Hospital, Edinburgh</i>
Dr Libby Morris	<i>General Practitioner, Hermitage Medical Practice, Edinburgh</i>
Mr Richard Murray	<i>Clinical Standards Facilitator (Mental Health), Royal Edinburgh Hospital</i>
Professor Aziz Sheikh	<i>Professor of Primary Care Research and Development, University of Edinburgh</i>
Dr Gregor Smith	<i>Divisional Medical Director, NHS Lanarkshire, Bothwell</i>

The membership of the guideline development group was confirmed following consultation with the member organisations of SIGN. All members of the guideline development group made declarations of interest and further details of these are available on request from the SIGN Executive.

Guideline development expertise, support and facilitation were provided by the SIGN Executive. All members of the SIGN Executive make yearly declarations of interest and further details of these are available on request.

Lisa Birch	<i>Distribution and Office Coordinator</i>
Stuart Neville	<i>Publications Designer, SIGN Executive</i>
Gaynor Rattray	<i>Senior Guideline Coordinator, SIGN Executive</i>

5.2.1 ACKNOWLEDGEMENTS

SIGN would like to acknowledge the guideline development group responsible for the development of SIGN 65 The Immediate Discharge Document, on which this discharge document is based.

5.3 CONSULTATION AND PEER REVIEW

5.3.1 PUBLIC CONSULTATION

The draft SIGN DD was available on the SIGN website for three weeks to allow all interested parties to comment.

5.3.2 SPECIALIST REVIEW

This DD was also reviewed in draft form by the following independent expert referees, who were asked to comment primarily on the comprehensiveness of the document. The development group addresses every comment made by an external reviewer, and must justify any disagreement with the reviewers' comments. All expert referees made declarations of interest and further details of these are available on request from the SIGN Executive.

SIGN is very grateful to all of these experts for their contribution to the discharge document.

Miss Wendy Ackroyd	<i>Lead Clinical Pharmacist, Mental Health, Dumfries and Galloway Royal Infirmary</i>
Mr Andrew de Beaux	<i>Consultant Surgeon, Edinburgh Royal Infirmary</i>
Mrs Margo Biggs	<i>Lay representative, Falkirk</i>
Ms Susan Bishop	<i>National Lead Primary Care, Community and Outpatients, Scottish Government</i>
Ms Kate Burton	<i>Public Health Practitioner, NHS Lothian</i>
Dr Patrick Cadigan	<i>Registrar, Royal College of Physicians, London</i>
Professor John Coia	<i>Specialty Adviser for Medical Microbiology, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Adviser</i>
Mr Graeme Conn	<i>Specialty Adviser for Urology, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Adviser</i>
Dr Wendy Craig	<i>Clinical Research Fellow and Specialist Registrar in General Surgery, Aberdeen Royal Infirmary</i>
Dr Patricia Donald	<i>Specialty Adviser for General Practice, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Adviser</i>
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Dr Liz Junor	<i>Consultant Clinical Oncologist, Edinburgh Cancer Centre, Western General Hospital, Edinburgh</i>
Dr Aileen Keel	<i>Deputy Chief Medical Officer, The Scottish Government</i>
Dr Graham Kramer	<i>General Practitioner, Links Health Centre, Montrose</i>

Dr Diane Kelly	<i>National Lead for GP CPD, Assistant Director Collective Learning, NHS Education for Scotland</i>
Dr John Paul Leach	<i>Specialty Adviser for Neurology, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Advisers</i>
Dr Alastair Leckie	<i>Specialty Adviser for Occupational Health, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Adviser</i>
Professor Graham Leese	<i>Specialty Adviser for Diabetes/Endocrinology, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Adviser</i>
Dr Katherine Leighton	<i>Specialty Adviser for Child & Adolescent Psychiatry, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Adviser</i>
Dr Christopher Lush	<i>Specialty Adviser for Haematology, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Adviser</i>
Dr Carrie MacEwen	<i>Specialty Adviser for Ophthalmology, Scottish Medical and Scientific Advisory Committee and SGHSCD Specialty Adviser</i>
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5.3.3 SIGN EDITORIAL GROUP

As a final quality control check, the discharge document was reviewed by an editorial group comprising the relevant specialty representatives on SIGN Council to ensure that the specialist reviewers' comments were addressed adequately and that any risk of bias in the development process as a whole was minimised. The editorial group for this discharge document was as follows. All members of the SIGN Editorial group make yearly declarations of interest and further details of these are available on request from the SIGN Executive.

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Abbreviations

CDD	core discharge document
CHI	Community Health Index number
DD	discharge document
EDD	extended discharge document
GMC	General Medical Council
GP	general practitioner
ICD-10	The International Statistical Classification of Diseases and Related Health Problems, tenth revision
IDD	immediate discharge document
OPCS-4	Office of Population Censuses and Surveys classification of surgical operations, fourth revision
PAS	patient administration system
SIGN	Scottish Intercollegiate Guidelines Network
SNOMED-CT	The Systematised Nomenclature of Medicine - Clinical Terms

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are key components of our organisation.

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