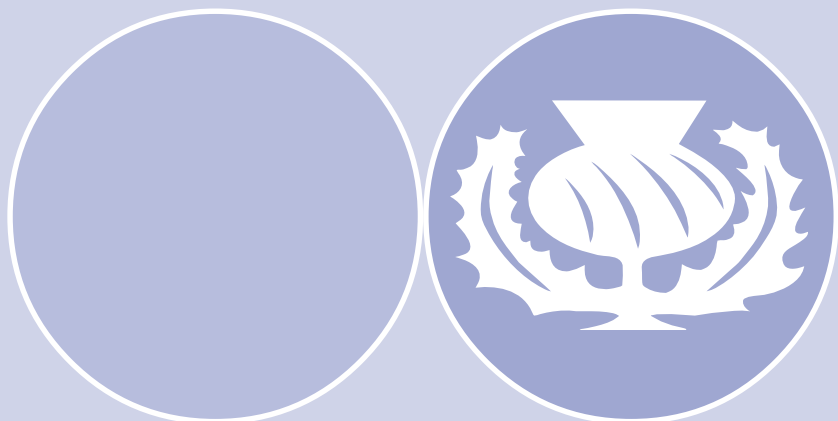


65 The Immediate Discharge Document

1	Introduction	1
2	The evidence base	3
3	The Immediate Discharge Document	6
4	Implementation and audit	8
5	Development of the manual	10
	References	12



KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS

LEVELS OF EVIDENCE

1 ⁺⁺	High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias
1 ⁺	Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1 ⁻	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2 ⁺⁺	High quality systematic reviews of case control or cohort studies High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2 ⁺	Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2 ⁻	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series
4	Expert opinion

GRADES OF RECOMMENDATION

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A	At least one meta-analysis, systematic review of RCTs, or RCT rated as 1 ⁺⁺ and directly applicable to the target population; <i>or</i> A body of evidence consisting principally of studies rated as 1 ⁺ , directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2 ⁺⁺ , directly applicable to the target population, and demonstrating overall consistency of results; <i>or</i> Extrapolated evidence from studies rated as 1 ⁺⁺ or 1 ⁺
C	A body of evidence including studies rated as 2 ⁺ , directly applicable to the target population and demonstrating overall consistency of results; <i>or</i> Extrapolated evidence from studies rated as 2 ⁺⁺
D	Evidence level 3 or 4; <i>or</i> Extrapolated evidence from studies rated as 2 ⁺

GOOD PRACTICE POINTS

<input checked="" type="checkbox"/>	Recommended best practice based on the clinical experience of the guideline development group
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1 Introduction

1.1 THE NEED FOR A REVIEW OF THE IMMEDIATE DISCHARGE DOCUMENT

The original SIGN Immediate Discharge Document (IDD) was published in 1996.¹ Since then, there have been major initiatives intended to improve documentation within, and communication between, primary and secondary care. A number of areas in Scotland have implemented the original IDD dataset, in particular those areas where electronic communication is being developed or considered. Whilst these technological initiatives have been a major stimulus to review the IDD dataset, conventional paper documentation is likely to remain a major feature of clinical practice for the foreseeable future. Few would deny the manifest deficiencies of existing documents and the potential benefit of a structured approach.

In 1998, the Accounts Commission for Scotland² suggested that: *Trusts should review their discharge documentation to ensure that it captures and disseminates the information required and aids high quality multidisciplinary discharge management.*

By refining the SIGN dataset and encouraging a more disciplined approach to discharge documentation it is hoped that standards in this critical area of practice will be improved.

1.2 REMIT OF THE IMMEDIATE DISCHARGE DOCUMENT

The IDD is an important instrument for communication between secondary and primary care. There is continuing evidence that the quality of immediate discharge documents used in NHSScotland fall far short of the ideal. These deficiencies occur in the content, structure and production of the document. The original IDD proposed a minimum dataset to address these issues.¹ The specification of a revised minimum dataset has implications for a number of contemporary activities related to data capture and document production.³

There are important implications for all clinical parties and for patients, their representatives and carers in the expeditious and accurate production of discharge documents. The dataset for the IDD should permit the production of a single discharge document for the maximum number of patients and serve as the template for the final document for the remainder. This document refers to the immediate discharge document that should be available at the time of patient discharge. Subsequent information may be necessary and this should be delivered as quickly as possible.

The IDD is of relevance to all hospital medical and nursing staff, allied health professionals, general practitioners (GPs), community nurses and pharmacists.

The IDD and the dataset are not exclusive and additional documentation is often required to supplement this minimum. For many patients a detailed care plan is necessary to inform carers and relevant support organisations and this should involve all relevant members of the multidisciplinary team.

1.3 CONFIDENTIALITY

The IDD contains personal data and is subject to the Data Protection Act (1998) that covers manual records.⁴ The principles of data protection as stated in the Act and the recommendations of the Caldicott Committee, in particular the recommendation that all data flows should be tested against basic principles of good practice, have been considered. NHS staff should also be aware of the Scottish Executive Confidentiality and Security Advisory Group for Scotland (CSAGS) report which outlines both the principles of confidentiality (*section 12*) and the importance of consent in data processing (*section 7*).⁵ Further details are available on the SIGN website www.sign.ac.uk

1.4 STATEMENT OF INTENT

The IDD is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available and are subject to change as scientific knowledge and technology advance and patterns of care evolve. These parameters of practice should be considered guidelines to assist in optimising local practice.

1.5 UPDATING

This guideline was issued in 2003. Any updates to the manual will be noted on the SIGN website: www.sign.ac.uk

2 The evidence base

2.1 INTRODUCTION

The evidence for this manual was collected in accordance with SIGN methodology.⁶ Literature searches covered the Cochrane Library, EMBASE, MEDLINE and CINHALL databases. A general internet search was also undertaken for relevant studies. The search covers the period from 1993 to 2001. The search was extended to include all types of study, as the topic of discharge documentation does not lend itself to clinical trials.

The vast majority of the studies reported were either audits, case control or cohort studies. Only one randomised controlled trial was identified.⁷ The lack of high level evidence has resulted in no highly graded recommendations.

In view of the paucity of the literature on discharge documentation, a letter was sent to the Chief Executives of all NHS Trusts in Scotland inquiring about specific new or innovative practice in this area. A number of relevant and innovative approaches were identified and their originators were invited to present their work to the guideline development group.

2.2 EVIDENCE FROM AUDIT

Since the publication of the original document in 1996,¹ several publications have indicated continuing problems with the production of discharge documentation.⁸⁻¹⁰ The problems relate to content, the process of production and transmission.

A prospective audit of discharge summaries using a computerised system of discharge letter generation reported a 10% overall error rate, 22% of which were errors relating to the diagnosis.¹⁰ Another prospective audit scored 100 'interim' discharge letters on their level of completeness and found an average score of 13 out of a potential 16. Only 83% were legible and 30% did not name the doctor preparing the summary. Only 43% were dispatched within five days from discharge.⁹

One audit has revealed differences between the ward prescription and the discharge prescription in 13% of cases. Differences between the ward prescription and the final letter were identified in 29% of cases.¹¹ Fifty seven percent of patients had medication-related problems two weeks after discharge and some summaries did not reach the GP.¹¹

2.3 THE CONTENT OF THE DATASET

The original document argued the importance of a minimum dataset as a basis for system specification with a view to electronic data transfer. It also specified such a dataset, emphasising that it was only a minimum. A minimum dataset should be evidence based and include all those items seen as essential. A number of papers have examined what doctors, particularly GPs, perceive as being the important data items.¹²⁻¹⁷

A study investigating the influence of various factors on the quality of discharge summaries identified content as the most important factor in determining the quality of a summary.¹² Content was classified into preadmission information, hospital information, and discharge information. Discharge information was the most important determinant of quality, followed by hospital information.

3

The top ranking items were:

- Discharge diagnosis
- Discharge medications
- Active problems at discharge
- Therapeutic procedures
- Complications
- Medical or social issues outstanding at discharge
- Consultations during admission
- Follow up arrangements
- Community services arranged
- Prognosis
- Functional ability.

Other studies¹³⁻¹⁵ show similar results. These items are a minimum requirement and there is a potential for including much more data in a discharge document.

In a study designed to assess the value of including a detailed functional assessment measure in a discharge document, 61% of general practitioners found such detailed information moderately useful and 28% found it very useful.¹⁶ In contrast, 44% of consultants receiving the same type of information found it moderately useful and 48% found it very useful. This may indicate that too much information can be included in a discharge document. A second study reported that conciseness is valued and suggested using a smaller size of paper.¹³

The variation in the perceptions of important data items between professional groups has also been investigated.^{12,15,17} Broad agreement between hospital and family practitioners on the relative importance of major data items has been reported. Significant differences were identified in the ratings given to continued care, prognosis, psychosocial factors and functional ability at discharge.^{12,15,17} These differences should be appreciated by hospital staff preparing discharge documentation to ensure the resulting document fulfils the needs of the recipient.

3

2.4 WHO SHOULD PREPARE THE IDD?

In current hospital practice the completion of discharge documentation is often delegated to the more junior medical staff.¹⁸ Audit has shown that senior staff produce discharge summaries with fewer errors.¹⁰ It has been estimated that a Senior House Officer (SHO) producing 20 final discharge letters per week may need up to four hours to complete this task with the consequence that other duties take priority.¹⁸ As a result letters are often sent out late. No evidence was identified that explored who was the best person to complete the IDD. The notes accompanying item 23 of the dataset give more details of who may complete the document.

- Senior staff should approve the content of every IDD.

2.5 FORMAT AND COMPLETION OF THE IDD

The majority of family doctors prefer a structured discharge document rather than one with a narrative format.^{7,13,19-21} The reasons for this preference include completeness, readability, conciseness and the ease of locating key information. Despite these perceived advantages, a study looking at the influence of headings and structure on the readability and retention of data was unable to show that headings improved either factor.²²

2+

Structured format discharge documents can easily be produced by computer systems. A randomised controlled trial comparing dictated discharge summaries to computer generated summaries found that computer generated summaries were shorter than dictated summaries and were produced more quickly.⁷ The computer-generated summaries contained data relating to active past medical history and medications more often than the dictated summaries but contained admission diagnosis and discharge functional status less often. A global assessment of quality found no difference between the two types of summary.⁷

1+

D The IDD should be laid out in a structured format.

Extrapolated from studies rated 2+

- Time should be set aside for completing the IDD at both junior and senior level.
- Regular audit should be performed to ensure that the quality of the IDD is maintained.

2.6 WHO SHOULD RECEIVE THE DISCHARGE DOCUMENT?

Discharge documentation serves many functions including the prescription of medicines, general communication and serving as a record of admission. Specialties such as obstetrics require more detailed information than is contained in the core dataset. The postdischarge requirements of all patients vary considerably, ranging from a discharge prescription for short term analgesia with no postdischarge review, to a comprehensive discharge plan with contributions from and for, for example, medical, nursing, occupational therapy and social work staff.

In many hospitals the discharge document acts as a prescription. Discrepancies between hospital and community prescriptions have been recorded.¹¹ A cohort study examining this problem found that sending a copy of the discharge document to a community pharmacist reduced the discrepancy rate from 52.7% to 32.2%.²³

2+

No evidence was identified addressing the wider distribution of the IDD. It is recognised that many people in addition to the patient's family doctor might wish to receive a copy of the discharge documentation including community pharmacists, other GPs and community nurses. Potentially complex arrangements require the involvement of carers and the necessary resources for optimal implementation. The IDD is not only for general practitioners.

The IDD is a form of communication for use between professionals but patients do have the right to see it. Patients should be given the option of having a copy of the IDD, although the production of separate patient-centred information may be more relevant. The production of patient-centred material is outside the remit of this document.³

- All relevant members of the primary health care team should have access to the IDD in accordance with the Data Protection Act.
- Patients, and when appropriate, carers, should be offered a copy of the IDD and the opportunity to discuss this with a relevant practitioner.

2.7 HOW SHOULD THE DISCHARGE DOCUMENT BE TRANSMITTED?

The time from discharge to receipt of document is a major cause of concern, with some discharge documentation not reaching the intended recipient.¹¹ Delays in the receipt of the document can lead to potential problems, including errors in prescribed drugs.¹¹

3

A cohort study investigating discrepancies between hospital and community prescriptions found that discrepancies can result from slow or non-delivery of discharge letters, but can also arise from errors made within the hospital.^{11,23} Three studies have investigated the advantage of fax transmissions of the discharge document and found that its use resulted in quicker transmission of a usually more legible, discharge documentation.²⁴⁻²⁶ Faxed transmission of discharge documents does speed delivery but carries the risk of transmission to an incorrect number. This can be minimised by using machines with preprogrammed abbreviated dialling codes. Current Scottish Executive Health Department guidance says that the use of fax transmissions for the transfer of personal health information in NHSScotland should only be performed with extreme caution.²⁷

2+

4

With the increasing use of computers to produce discharge documents there is the possibility of direct electronic transfer that should offer the same advantages of fax transmissions while reducing the need for the transcription of prescriptions.²⁸

- If fax transmissions are used they should comply with current Scottish Office guidance.

3 The Immediate Discharge Document

Item	Field	Notes
	Items shown in bold are essential Items not in bold are desirable	
1 Hospital	Text field	*
2 Patient ID	<ul style="list-style-type: none"> ■ national id number ■ local id number ■ title ■ first forename ■ preferred forename ■ surname ■ address 1 ■ address 2 ■ address 3 ■ address 4 ■ postcode ■ date of birth ■ occupation 	CHI is recommended *
3 Preferred GP ID	<ul style="list-style-type: none"> ■ forename ■ surname ■ address ■ address 1 ■ address 2 ■ address 3 ■ address 4 ■ postcode 	The minimum dataset requires that the discharge summary is sent to the preferred GP. In the absence of a preferred GP it should be sent to the GP with whom the patient is registered. Multiple copies of this document may be required, eg patients not returning to their own home immediately.
4 Consultant ID	<ul style="list-style-type: none"> ■ forename ■ surname ■ specialty 	An immediate discharge document should be produced after each significant episode, eg moving from a surgical to a general ward.
5 Ward/Department	text	The ward or department issuing the IDD should be specified.
6 Date of admission/transfer	date	To the unit issuing IDD. This may be a transfer from another unit.
7a Date of discharge/transfer	date	From the unit issuing the IDD. This will include transfer to another unit. 7a & 7b are mutually exclusive.
7b Date of death	date	7a & 7b are mutually exclusive.
8 Reason for admission/transfer	<ul style="list-style-type: none"> ■ text ■ code 	<ul style="list-style-type: none"> ■ Description of complaint or reason for admission ■ This may be coded.
9 Mode of admission	choice	Elective, emergency or transfer.
10 Source of admission	text	Source of referral for this admission.
11 Diagnosis/problems (multiple)	<ul style="list-style-type: none"> ■ text ■ code(s) ■ provisional/confirmed 	<ul style="list-style-type: none"> ■ Text description should be given for each significant condition ■ The diagnosis should be described ■ When possible standard code(s) should be provided ■ It should be made clear whether the diagnosis is provisional or confirmed.
12 Significant operations/procedures (multiple)	<ul style="list-style-type: none"> ■ text ■ code(s) ■ date of procedure 	<ul style="list-style-type: none"> ■ Operations/procedures (eg chemotherapy) should be described ■ When possible standard code(s) should be provided ■ Named consultant not required if IDD issued after each significant episode or event as already given in field 4.
13 Relevant investigations	<ul style="list-style-type: none"> ■ text ■ code(s) 	<ul style="list-style-type: none"> ■ Relevant investigations performed should be described ■ Standard codes optional.
14 Complications (multiple)	<ul style="list-style-type: none"> ■ text ■ code(s) 	<ul style="list-style-type: none"> ■ Complications should be described (medical and/or surgical) ■ When possible standard code(s) should be provided.

Item	Field	Notes
15 Medication on discharge (multiple fields as required)	<ul style="list-style-type: none"> ■ name of drug (generic where possible) ■ formulation ■ current dose ■ dose changed ■ drug stopped ■ new prescription ■ route of administration ■ frequency ■ length of treatment ■ supply given to patient ■ start and stop dates (where relevant) ■ reasons for starting and stopping (where relevant) ■ compliance aids Y/N/text 	<ul style="list-style-type: none"> ■ The minimum dataset is not a discharge prescription, however a full prescription history is advised unless the IDD follows an episode that does not result in a change to long term medication ■ Start and stop dates for short or defined courses of treatment should be detailed ■ Details of whether compliance aids are required or already given to the patient should be provided. If already provided, detail whether being used or not.
16 Adverse reactions	Text	Include all known allergies
17 Discharge plans	<ul style="list-style-type: none"> ■ destination - text ■ review at hospital Y/N ■ mobility / disability (see below) ■ care arrangements made Y/N ■ care arrangements - text ■ information to patient? Y/N/text ■ information to carer or relative? Y/N/text ■ early GP review recommended? Y/N/text 	<ul style="list-style-type: none"> ■ Further information eg destination to care home ■ Comment on whether hospital review required ■ Review date and by whom ■ Care arrangements made - this will vary greatly according to patient type eg district nurse/social worker /carer for elderly patients, none for others. Other agencies involved and eligibility for higher or lower free care should be noted ■ Information to patient, include whether written or verbal or both. If yes, explanatory text required ■ Information to carer or relative, include whether written or verbal or both ■ If early GP review recommended, explanatory text required.
18 Information to patient and/or carer/relative	<ul style="list-style-type: none"> ■ Y/N ■ sickness certification issued Y/N/NA 	If sickness certification issued state duration. ²⁹
19 Comment	free text to amplify minimum data	Optional - not required for straightforward admissions
20 Results awaited	Y/N (If Y specify)	eg pathology, investigations, imaging
21 Letter to follow	Y/N	
22 Contact	<ul style="list-style-type: none"> ■ Telephone number 	The minimum information required is an appropriate contact telephone number - to be decided locally.
23 Signature & name & rank/position	<ul style="list-style-type: none"> ■ Signature ■ Legible text of name ■ Job Title 	To be completed by the responsible person at the time of discharge eg resident, sister, senior nurse or senior medical staff. They are signing on behalf of the person named in field 4 who is responsible for the document.

**In an electronic system these data should be downloaded from a Patient Administration System (PAS) file*

Disability Scale <i>adapted from Rankin Scale³⁰</i>	Mobility Scale <i>adapted from Royal College of Physicians National Sentinel Audit³¹</i>
0 = well, no symptoms	0 = bedridden or wheelchair bound
1 = minor symptoms not affecting lifestyle	1 = sits without support
2 = minor handicap but independent in self care	2 = walks with help of another person
3 = moderate handicap but needing a little help with activities of daily living (ADL)	3 = walks with aid
4 = needing a lot of help with ADL	4 = walks 5 metres without aids
5 = needing constant attention day and night	5 = able to walk 200 metres outside

4 Implementation and audit

4.1 LOCAL IMPLEMENTATION

Implementation of national clinical guidelines is the responsibility of each NHS Trust and is an essential part of clinical governance.³² It is acknowledged that every Trust cannot implement every guideline immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons for any differences assessed and, where appropriate, addressed. These discussions should involve both clinical staff and management. Local arrangements may then be made to implement the national guideline in individual hospitals, units and practices, and to monitor compliance. This may be done by a variety of means including continuing education, training, and clinical audit. Approaches to reduce prescribing errors such as electronic prescribing and medicine administration and systems for the use of compliance aids should also be examined locally.

The following suggested implementation and audit measures are based on consensus within the guideline development group. It is recognised that this is a minimum dataset and therefore certain specialties, for example obstetrics, will have additional data field requirements.

4.1.1 NON-ELECTRONIC IMPLEMENTATION

Problems exist regarding the accuracy of coding and the content of immediate discharge summaries. In most NHS Trusts there is a delay before the final discharge documentation is processed. Current paper systems result in duplication of effort and may waste a considerable amount of time. These problems are compounded by separating the immediate discharge document from the final discharge document and by running separate systems within different departments. This may increase the level of risk to patients.

- NHS Boards should aim to reduce duplication to a minimum
- all the fields in this document should be included in the discharge documentation; the precise content and presentation should be subject to local agreement
- the final discharge document should be either the IDD or follow with minimal delay
- access to required information should be improved to reduce errors and delays, for example, radiology, laboratory and pharmacy reports.

4.1.2 ELECTRONIC IMPLEMENTATION

Good quality standardised paper systems can provide a template for electronic versions. Electronic systems should be designed so that data are entered only once. Any electronic system should be available to all areas of the health service with access restricted to a “need to know basis”.

- the immediate discharge document should be the final discharge document wherever possible. This will require instant access to the results of all investigations
- coding should be carried out electronically and checked on discharge
- the electronic patient record should include the current medication details with a record of previous prescriptions and reasons for changes
- drug interactions should be highlighted and modified according to associated clinical conditions.

Standardised electronic implementation should improve the quality of patient information recorded, which may reduce the number of complaints. Properly designed systems will improve the quality of patient care and should improve communication across the service.

4.2 KEY POINTS FOR AUDIT

- baseline audit of current practice
- completeness of the immediate discharge document
- time of delivery of the IDD to primary care
- accuracy (including coding errors) of the IDD
- time required to complete the IDD.

4.3 RECOMMENDATIONS FOR RESEARCH

- whether electronic prescribing reduces the error rate of medication histories in discharge letters
- the best way of managing patient medicines to ensure accurate medication records can be maintained across primary and secondary care
- a comparison of quality of IDD use across NHS Boards in Scotland
- the difference between clinical terms and codes
- clinicians' coding preferences
- how electronic coding should be carried out
- how the accuracy and completeness of electronic coding should be checked on discharge
- the information needs of patient's carers on discharge
- the cost and benefits of one national system of IDD production versus multiple smaller systems.

4.4 SOURCES OF FURTHER INFORMATION FOR HEALTH PROFESSIONALS

Information and Statistics Division (ISD)

Common Services Agency for NHSScotland
Trinity Park House, South Trinity Road, Edinburgh, Scotland EH5 3SQ
Telephone : 0131 551 8899 Fax: 0131 551 1392
www.show.scot.nhs.uk/isd/index.htm

Electronic Clinical Communication Implementation (ECCI)

Contact: Mike Lister on 0131 244 1726
Mike.Lister@scotland.gsi.gov.uk
www.show.scot.nhs.uk/ecci

Scottish Health on the Web (SHOW)

www.show.scot.nhs.uk

5 Development of the manual

5.1 INTRODUCTION

SIGN is a collaborative network of clinicians and other healthcare professionals, funded by the Scottish Executive Health Department. SIGN guidelines are developed by multidisciplinary groups 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

5.2 THE GUIDELINE DEVELOPMENT GROUP

Professor Zygmunt H Krukowski (Chairman)	<i>Consultant in General Surgery, Aberdeen Royal Infirmary</i>
Dr Janet Bennison (Secretary)	<i>Specialist Registrar in Geriatric and General Internal Medicine, Borders General Hospital, Melrose</i>
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Mrs Monica Inglis	<i>Associate Director of Nursing, Forth Valley Acute Hospitals NHS Trust</i>
Mr David Large	<i>Consultant Orthopaedic Surgeon, Ayr Hospital</i>
Mrs Ann Richards	<i>Chief Officer, Forth Valley Health Council</i>
Mr Vincent M Summers	<i>Chief Pharmacist, Borders General Hospital, Melrose</i>
Mr Duncan Service	<i>Information Services Officer, SIGN</i>
Dr Paul Syme	<i>Consultant Physician, Borders General Hospital, Melrose</i>
Ms Joanne Topalian	<i>Programme Manager, SIGN</i>

The guideline development group is grateful to the following former members:

Ms Rhona Agnew	<i>District Nurse, Glasgow</i>
Mr Peter Ashe	<i>ECCI Project Team, ISD</i>
Ms Audrey Stacey	<i>Senior Information Consultant (retired), ISD</i>

The membership of the guideline development group was confirmed following consultation with the member organisations of SIGN. Declarations of interests were made by all members of the guideline development group. Further details are available from the SIGN Executive.

5.3 NATIONAL OPEN MEETING

The national open meeting is the main consultative phase of SIGN guideline development, at which the development group presents its draft recommendations for the first time. The national open meeting for this document was held in January 2002 and was attended by representatives of all of the key specialties relevant to the document. The draft document was also available on the SIGN website for a limited period at this stage to allow those unable to attend the meeting to contribute to the development of the document.

5.4 SPECIALIST REVIEW

The manual was also reviewed in draft form by a panel of independent expert referees, who were asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the document. SIGN is very grateful to all of these experts for their contribution to this document.

Dr James Beattie	<i>Director of Guidelines, Royal College of General Practitioners, Edinburgh</i>
Dr Laura Cassidy	<i>Consultant Gynaecologist, Inverclyde Royal Hospital, Greenock</i>
Dr James Chalmers	<i>Consultant in Public Health Medicine, ISD, Edinburgh</i>
Mr Donald Coxon	<i>Chief Pharmacist, Queen Margaret Hospital, Fife</i>
Dr Gareth Davies	<i>Medical Director, Forth Valley Primary Care Trust, Larbert</i>
Ms Lyndsey Davidson	<i>LHCC Administrator, West Fife Local Health Service</i>
Mrs Fiona Halcrow	<i>Directorate Manager, Royal Infirmary of Edinburgh</i>
Ms Kate Harley	<i>Head of Data Intelligence Group, ISD, Edinburgh</i>
Mr Douglas Harper	<i>Consultant Surgeon, Aberdeen Royal Infirmary</i>
Dr Mike Hendry	<i>General Practitioner, Cupar Health Centre</i>
Ms Susan Hunter	<i>District Nurse, Stenhousemuir</i>
Dr Ken McLean	<i>General Practitioner, Carronbank Health Centre, Denny</i>
Dr Robin Mann	<i>Health Informatics Unit, Royal College of Physicians, London</i>
Dr Dorothy Moir	<i>Director of Public Health, Lanarkshire Health Board</i>
Dr Rod Muir	<i>Consultant in Public Health Medicine, ISD, Edinburgh</i>
Dr Gillian Penney	<i>Programme Co-ordinator, Scottish Programme for Clinical Effectiveness in Reproductive Health, Aberdeen</i>
Ms Nicola Ring	<i>Lecturer, Department of Nursing & Midwifery, University of Stirling</i>
Dr Ian Reeves	<i>Acting Consultant Physician, Stobhill Hospital, Glasgow</i>
Ms Fiona Smith	<i>RCN Adviser in Paediatric Nursing</i>
Ms Jan Warner	<i>Director of Reviews, Clinical Standards Board for Scotland</i>

The document was then reviewed by an Editorial Group comprised of relevant specialty representatives from SIGN Council, to ensure that the peer reviewers' comments had been addressed adequately and that any risk of bias in the guideline development process as a whole had been minimised. The Editorial Group for this document was as follows:

Dr Jonathan Best	<i>Association of Trust Chief Executives</i>
Professor Ian Campbell	<i>Royal College of Physicians, Edinburgh</i>
Mr Robert Carachi	<i>Royal College of Physicians & Surgeons of Glasgow</i>
Professor Gordon Lowe	<i>Chairman of SIGN, Co-editor</i>
Dr Gawn McIlwaine	<i>Royal College of Ophthalmologists</i>
Miss Tracy Nairn	<i>Allied Health Professionals</i>
Dr Safia Qureshi	<i>SIGN Programme Director, Co-editor</i>

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