

	<b>Logical Record Architecture: Discharge Summary Requirements Specification</b>			
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## Logical Record Architecture: Discharge Summary Requirements Specification

### Amendment History:

Version	Date	Amendment History
0.1	18/03/2011	First complete draft for comment
0.2	01/04/2011	Revisions based on the Clinical & Business Expert Group discussion held 24/03/2011.
0.3-0.3.3	14/06/2011	Revisions based on Clinical & Business Expert Group email discussions, comments internally within NHS CFH, and comments during the related LRA technical models review (received between 02/04/2011 and 13/06/2011).
0.4	14/07/2011	Revisions based on requirements comments and queries made following the open review of the medications technical models, and updates to Section 3 (display illustration).
0.4.1	12/09/2011	No substantive revision; detailed requirements table has been reformatted, based on requirements modelling structural changes.

### Reviewers:

This document must be reviewed by the following:

Name	Signature	Title / Responsibility	Date	Version
Members of the LRA Discharge Summary Clinical & Business Expert Group				
Members of the LRA Programme Board				

### Approvals:

This document must be approved by the following:

Name	Signature	Title / Responsibility	Date	Version
J. G. Williams		LRA Discharge Summary clinical sponsor;		
N. Oughtibridge		Chair, LRA Programme Board; Acting Director, Data Standards & Products		

### Document Control:

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### Glossary of Terms:

Terms, acronyms and abbreviations commonly used within NHS CFH can be found in the Glossary of Terms

<http://intranet.connectingforhealth.nhs.uk/departments/npo/glossary/glossary>. If any terms are used in this document that are not currently included in the glossary please send them to [cfh.glossary@nhs.net](mailto:cfh.glossary@nhs.net).

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# 1 Introduction

## 1.1 Background

On a broad scale, the Logical Record Architecture (LRA) represents current recommendations for future best practice electronic implementation of health and social care records data, focusing particularly on data meaning and structure to support its automated interpretation, retrieval and analysis.

The LRA is intended to act as a guide for realising multiple professional and technical standards in the context of a care record information system, and also to make recommendations to standards developers that promote an improved logical consistency across care records standards in future.

As a representation of current recommendations about care records data, the LRA is expected to continue to evolve with time, experience, and ongoing feedback. Although expected to change, the LRA will act as a single centralised reference point (across standards development initiatives and information system implementations) that reflects current and collective thinking on record data requirements, meaning and electronic structures at the most detailed level deemed possible.

This work was commissioned by the LRA Programme Board<sup>1</sup>, to develop logical content specifications for hospital discharge summaries. It was motivated by an urgent need within the NHS to communicate this data electronically between information systems which use different data models and have the potential to implement professional record-keeping standards in different ways, by using different technical data standards or local strategies. At present, without the LRA or another shared data architecture, the information systems that receive electronic Discharge Summaries cannot automatically interpret that data or re-use it within their local patient records. At this time, for example, General Practitioners commonly read through stacks of paper Discharge Summaries and their local electronic patient records may only be updated with new information about the patient by manual entry. Also, in the absence of detailed electronic Discharge Summaries, patients often receive hand-written paper discharge notes or letters that are incomplete and difficult to read. This is a barrier to effective communications and can have a negative impact on the continuity of care for a person following hospital discharge.

This requirements specification represents best practice electronic implementation recommendations for Discharge Summary content, as initially provided by the LRA Discharge Summary Clinical & Business Expert Group. (The members of the expert group are listed in Appendix A.) This document may continue to be updated during the lifetime of the LRA Discharge Summary project (scheduled to end in October 2011).

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<sup>1</sup> Current LRA Programme Board members represent patients / carers, the Department of Health Informatics Directorate (both Technology Office and Clinical Division), the Royal College of Physicians, the Royal College of General Practitioners, the NHS Information Centre for health and social care, the NHS Information Standards Board for health and social care, the NHS Health Protection Agency, the Intellect information system supplier community, and Leeds Teaching Hospitals.

## 1.2 Purpose

This document, as the requirements part of the LRA for Discharge Summary, is intended to act as an open reference for future information systems design and data integration. These requirements will also be recommended for potential adoption in the design of future professional and technical data standards for Discharge Summary content.

This specification acts as the data meaning and use requirements<sup>2</sup> for designing the LRA technical models to support Discharge Summary content. The LRA Discharge Summary technical models will specify the machine-readable portion of the data architecture, including providing detailed references to encode-able concepts in the SNOMED Clinical Terminology.

The intended audience for this specification is anyone interested in sharing and contributing to precise meanings and structures for the content of Discharge Summaries.

This specification is a representation of current thinking with respect to records data best practice for NHS Discharge Summary. As such, it may be considered as a set of recommendations for potential adoption by professional and technical standards developers and a potential reference for data integration activities between systems that do not otherwise share a logical data model.

## 1.3 Scope

The scope of these data content requirements follows the content scope published for electronic Discharge Summaries in the Academy of Medical Royal Colleges' *A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital* (October 2008).

Based on LRA Discharge Summary Clinical & Business Expert Group recommendations, however, four significant additions for shared Discharge Summary data have been made to the Academy's content scope:

- The inclusion of **all medicines** current at the time of discharge (this has also been recommended in NICE Clinical Guideline 76: Medicines adherence)
- The addition of **medications stopped during this admission** (recommended in NICE Clinical Guideline 76: Medicines adherence)
- The option to record **other significant problems at discharge** (in addition to diagnoses at discharge)
- The addition of **a list of responsible consultants during the hospital stay**, to assist any clinical follow-up contact when a single admission involves a series of consultants responsible for patient care

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<sup>2</sup> The detailed requirements represented in Section 4 of this document are an output of Unified Model Language (UML) information analysis models, housed in the LRA models repository. These requirements models will be electronically linked to their related LRA technical models and change-controlled by the DH Informatics Directorate.

A record of where copies of the Discharge Summary had been distributed (as a record useful for information governance) has also been added, but this content would not be expected to be shared between information systems along with copies of the Discharge Summary (i.e. it is not part of the recommended shared Discharge Summary content as are the additions described above). The distribution record would be accessible within the organisation that produced the Discharge Summary.

## 1.4 Document Structure

This document contains:

- A summary of content headings included in this requirements specification
- An example user interface 'realisation' of the requirements specifications, for summary illustration purposes only
- The detailed data requirements from the perspectives of Discharge Summary authors and data users, for reference in LRA technical modelling and in information system design or in integrating data between information systems

Because of resource constraints, the LRA Discharge Summary work package has prioritised a subset of these detailed requirements for technical interoperability testing in 2011. This content subset is described in brief in Appendix B.

## 2 Overview of Discharge Summary Content

The following table summarises the sections or 'headings' included in this content specification.

Content added by this work package to the Academy of Medical Royal Colleges' discharge summary specification is indicated with a grey background. Explanations for these additions are provided in the Detailed Data Requirements (Section 4). These additions will be presented to the Royal College of Physicians (authors of the Academy's discharge summary specifications), for consideration to include in the next version of their work.

Note: As part of the iterative reviews cycle, change requests to this material (following the LRA Discharge Summary project end) will continue to be accepted by the LRA programme (for future architecture versions) on an ongoing basis.

Academy of Medical Royal Colleges Discharge Summary Heading	Academy of Medical Royal Colleges Discharge Summary Sub-Heading
GP details	GP name
	GP practice address
	GP practice code
Patient details	Patient surname, forename
	Name known as
	Date of birth
	Gender
	NHS Number
	Patient address
	Patient telephone number(s)
Admission details	Method of admission
	Source of admission
	Hospital site
	Responsible trust
	Date of admission
	Time of admission
Hospital Stay Responsible Consultants List	
Discharge details	Date of discharge
	Time of discharge
	Discharge method
	Discharge destination <ul style="list-style-type: none"> <li>Type of destination</li> <li>Destination address</li> </ul>
	Discharging consultant
	Discharging specialty / department
Clinical information	Diagnosis at discharge
	Other significant problems at discharge
	Operations and procedures
	Reason for admission and Presenting complaints
	Mental capacity
	Advance decisions to refuse treatment and Resuscitation status
	Allergies



Academy of Medical Royal Colleges Discharge Summary Heading	Academy of Medical Royal Colleges Discharge Summary Sub-Heading
	Risks and warnings
	Clinical narrative
	Relevant investigations and results
	Relevant treatment and changes made to treatments
	Measures of physical ability and cognitive function
	Current Medications, including all prescribed and non-prescribed (e.g. 'over the counter') medications at time of discharge and including changed medications and discharge medications
	Medication recommendations
	Stopped medications
Advice, recommendations, and future plan	Hospital
	GP
	Community and specialist services
Information given to patient and/or authorised representative	
Patient's concerns, expectations and wishes	
Results awaited	
Person completing summary	Doctor's name
	Grade
	Specialty
	Date of completion of discharge record
Distribution list	
Distribution record	

### 3 Example Electronic Discharge Summary Illustration

The example in this section has been provided to illustrate a data display realisation of the detailed implementation requirements specification that follows. Local variation in user interface design is expected – what appears in this document has been provided as an illustrative example only.

A few items of note in understanding this example and general issues of implementation:

- This illustration is of a display of data within an example (completed) Discharge Summary. Note that a screen designed for data input could look quite different to this illustration, in order to support efficient and correct data confirmation or entry (according to the guidelines for data meaning proposed in the detailed requirements described in Section 4 of this document). An example data input user interface has *not* been illustrated in this document.
- It is not assumed that every Discharge Summary will include data for every available section in this requirements specification.
- Some sections that have no data in the example illustration are included only to provide an overview summary of potential content. Because of this, the example Discharge Summary provided is greater in length than what would be expected for the same data in implementations in general.
- Whether particular data is mandatory or optional to record or to communicate in the Discharge Summary is not determined within the LRA. The LRA focuses on establishing common meaning and structure for data in order to support its purpose, where data is intended to be shared (e.g. wherever this data exists or is shared, it should have the same meaning, etc.). Issues related to standards 'conformance criteria' are a matter for standards development bodies, both professional and technical, to address within their jurisdictions of authority. For example, Discharge Summary content may be mandated by professional regulatory bodies or via business contracts related to information system development or communication.
  - In future, any data content that is mandated by various authorities may be reflected as references within future versions of the LRA. This may assist in preventing any conflicts in conformance requirements between professional standards and technical information system contracts in future.
- It is expected that providing complete data according to this requirements specification relies on 'building up' the Discharge Summary record content during the patient's hospital stay, starting with data available at admission (including, potentially in future, data submitted to a Trust from a GP within referral communications with respect to current diagnoses, problems, allergies, and medications, in addition to reasons for referral).
- This form design is an illustration only and has not been iterated and tested as a display of data to users in its proposed context of use (e.g. for different Discharge Summary readers). Where possible in this illustration, NHS

Common User Interface (CUI) guidance has been applied to the patient identification, medications display and demographic information. In the case of medications, the format used is focused on guidance that has been established for secondary care, and has not been validated fully as a display suitable for use between secondary care and other care settings.

- At this time, national or international standards for displaying clinical statements that contain a mix of both coded and non-coded clinical data have not been established. An option that was explored by the NHS CFH CUI team in 2009<sup>3</sup> has been adopted for the 'mock-up' user interface in this section – with bold text indicating encoded data, separated by a '|' symbol from unbolded text indicating non-coded (limited free text annotations) data. This convention applies to Sections 6-24 of the illustration.

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<sup>3</sup> *Display of Clinical Statements: Design Consultation Document, Version 1.0.0.0 Baseline*, Microsoft Corporation and Crown Copyright 2009.



Another Hospital, The Royal Another NHS Foundation Trust

# Discharge Summary

**PATIENT** SMITH, William (Mr)    **BORN** 01-Jan-1946 (63yr)    **GENDER** Male    **NHS No.** 123 728 7652  
**HOSPITAL No.** ABC12345

## 1. GP Details

**GP NAME:** Dr. Jane Anderson  
**GP IDENTIFIER:** G3345122  
**GP PRACTICE CODE:** 12345  
**GP PRACTICE ADDRESS:** Northfield Surgery  
 142 St. Heliers Road  
 Northfield  
 Slough  
 SL3 1DP

## 2. Patient Details

**PATIENT SURNAME, FIRST NAME:** SMITH, William (Mr)  
**NAME KNOWN AS:** Bill  
**DATE OF BIRTH:** 01-Jan-1946  
**GENDER:** Male  
**NHS NUMBER:** 123 728 7652  
**LOCAL IDENTIFIER:** 987 654321  
**PATIENT ADDRESS:** 196 Middleton Hall Road  
 Kings Norton  
 Slough  
 SL10 9DY  
**PATIENT TELEPHONE NUMBER(S):** 0121 459 9123 (home)  
 0121 628 1112 (work)

## 3. Admission Details

**METHOD OF ADMISSION:** Planned  
**SOURCE OF ADMISSION:** Usual place of residence  
**HOSPITAL SITE:** Reading Hospital  
**RESPONSIBLE TRUST:** The Royal Berkshire NHS  
 Foundation Trust  
**DATE OF ADMISSION:** 06-Nov-2009  
**TIME OF ADMISSION:** 09:12

## 4. Discharge Details

**DATE OF DISCHARGE:** 13-Nov-2009  
**TIME OF DISCHARGE:** 13:22  
**DISCHARGE METHOD:** Discharged upon clinical advice  
**TYPE OF DESTINATION:** Care Home  
**DESTINATION ADDRESS:** Slough Care Home  
 24 The Mount  
 Slough  
 SL6 6UP  
**DISCHARGING CONSULTANT:** Mr Greg Cross  
**DISCHARGING SPECIALTY / DEPARTMENT:** Orthopaedic Surgery

## 5. Hospital Stay Responsible Consultants List

(1 recorded)

CONSULTANT NAME	CONSULTANT SPECIALTY	CONSULTANT TREATMENT SPECIALTY	RESPONSIBILITY START DATE	RESPONSIBILITY END DATE
Mr Greg Cross	Orthopaedic Surgery	Orthopaedics	06-Nov-2009	13-Nov-2009

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Another Hospital, The Royal Another NHS Foundation Trust

# Discharge Summary

**PATIENT** SMITH, William (Mr) **BORN** 01-Jan-1946 (63yr) **GENDER** Male **NHS No.** 123 728 7652  
**HOSPITAL No.** ABC12345

## 6. All Current Diagnoses at Discharge (6 recorded)

DIAGNOSIS	DATE DIAGNOSIS MADE	PERSON RESPONSIBLE	TREATMENT SPECIALTY	DATE OF FIRST PRESENTATION
<b>Osteoarthritis of knee - right</b>	10-Sep-2009	Mr Greg Cross	Orthopaedics	May-2009
<i>A complication of Fractured knee-cap – right</i>	17-Jun-2006	Mr. Greg Cross	Orthopaedics	16-Jun-2006
<b>Anaemia</b>	02-Oct-2008	Dr. Jane Anderson	General Practice	25-Sep-2008
<b>COPD-Chronic obstructive pulmonary disease</b>	07-Aug-2006	Dr. Jane Anderson	General Practice	Jun-2006
<b>Post-operative pneumonia</b>	08-Nov-2009	Mr. Jeremy Jones	Respiratory Medicine	08-Nov-2009
<i>A complication of Primary cemented total knee replacement – right</i>	06-Nov-2006	Mr. Greg Cross	Orthopaedics	
<b>Hypotension</b>	09-Nov-2009	Mr. Greg Cross	Orthopaedics	09-Nov-2009
<b>Sensorineural hearing loss – left</b>	Jun-2002	Dr. Anne Bond	Otolaryngology	Jan-2002

## 7. Other Significant Problems at Discharge

PROBLEM	DATE PROBLEM RECORDED	PERSON RESPONSIBLE FOR RECORDING	TREATMENT SPECIALTY	DATE OF FIRST PRESENTATION
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## 8. Operations and Significant Procedures (1 recorded)

**PROCEDURE DESCRIPTION:** Primary cemented total knee replacement – right

**REASON FOR PROCEDURE:** Osteoarthritis of knee – right

**PROCEDURE COMMENTS:** Due to mild anaemia prior to surgery and subsequent operative blood loss, required a blood transfusion of three units

**PROCEDURE COMPLICATIONS:** Intraoperative haemorrhage

**DATE PERFORMED:** 06-Nov-2009

**CONSULTANT RESPONSIBLE:** Mr. Greg Cross

## 9. Reason for Admission and Presenting Complaints

**REASONS FOR ADMISSION:** Elective - total replacement of right knee joint

**PRESENTING COMPLAINTS:**

**DATE OF ONSET FOR PRESENTING COMPLAINT:**

## 10. Mental Capacity and Advance Decisions

**MENTAL CAPACITY:**

**ADVANCE DECISIONS TO REFUSE TREATMENT (INCLUDING RESUSCITATION STATUS):** None

**LINK TO ADRT DOCUMENT**



Another Hospital, The Royal Another NHS Foundation Trust

# Discharge Summary

**PATIENT** SMITH, William (Mr) **BORN** 01-Jan-1946 (63yr) **GENDER** Male **NHS No.** 123 728 7652  
**HOSPITAL No.** ABC12345

## 11. Allergies (2 recorded)

CAUSATIVE AGENT	TYPE OF CAUSATIVE AGENT	PROBABILITY OF CAUSATION	NEW PROPENSITY FLAG	NEW REACTION DESCRIPTION	DATE OF IDENTIFICATION	CLINICAL NOTES
penicillin	Drug				11-Jan-2001	
metoprolol	Drug	Probably present	New	Acute exacerbation of chronic obstructive airways disease	08-Nov-2009	

## 12. Risks and Warnings (1 recorded)

RISK DESCRIPTION	RISK CATEGORY	RISK PROBABILITY	OTHER RISK INFORMATION
Risk of – pressure sores   due to easily damaged skin	Risk to patient		

## 13. Clinical Narrative or Other Significant Information

**DESCRIPTION:** Admitted for elective, right Total Knee Replacement. Day 3, developed bilateral basal atelectasis. The FBC showed high WCC and high neutrophils. Commenced on doxycycline and chest physio. Due to mild anaemia prior to surgery and subsequent operative blood loss, required a blood transfusion of three units. Subsequently made steady progress, regaining good mobility in his knee and is able to mobilise with the aid of a stick. Right knee Xray showed no fracture or dislocation, with the total knee prosthesis well positioned post surgery.

## 14. Significant Investigations and Results (3 recorded)

DEPARTMENT	INVESTIGATION	REASON FOR INVESTIGATION	DATE PERFORMED	RESULT	CLINICAL INTERPRETATION	REFERENCE RANGE	RESULT STATUS
Haematology	White cell count		10-Nov-2009	20.0 x 10 <sup>9</sup> /L	HIGH	3.8 to 10.8 x 10 <sup>9</sup> /L,	Final
Haematology	Neutrophil cell count		10-Nov-2009	14.7x10 <sup>9</sup> /L	HIGH	2.0 to 7.5 x 10 <sup>9</sup> /L	Final
Radiology	Right knee x-ray		07-Nov-2001	No fracture or dislocation, prosthesis well positioned.	No obvious problems with prosthesis	N/A	Final

## 15. Significant Treatments and Changes Made to Treatments (Non-Procedural) (1 recorded)

TREATMENT	REASON FOR TREATMENT	START TIME	END TIME	TREATMENT COMMENTS	DOSE QUANTITY	MEDICATION TREATMENT DOSE FREQUENCY	ADMINISTERED METHOD
Physiotherapy		10-Nov-2009	13-Nov-2009				

## 16. Measures of Physical Ability and Cognitive Function

PHYSICAL ABILITY AT TIME OF DISCHARGE:

COGNITIVE FUNCTION AT TIME OF DISCHARGE:

No problems

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Another Hospital, The Royal Another NHS Foundation Trust

**PATIENT** SMITH, William (Mr) **BORN** 01-Jan-1946 (63yr) **GENDER** Male **NHS No.** 123 728 7652  
**HOSPITAL No.** ABC12345

## 17. Current Medications (5 recorded)

STATUS	DRUG DETAILS	DRUG MANAGEMENT
<b>New</b> Dispensed	<b>doxycycline</b> – 100 mg – dispersible tablet sugar free – <b>DOSE</b> 1 tablet – oral – once a day	<b>START DATE:</b> 13-Nov-2009 <b>END DATE:</b> 15-Nov-2009 <b>REVIEW DATE:</b> ---- <b>REVIEW RESPONSIBILITY:</b> ---- <b>QUANTITY DISPENSED:</b> 2 tablets <b>INSTRUCTIONS:</b> ---- <b>INDICATION:</b> Pneumonia
<b>New</b> Dispensed	<b>co-codamol</b> – 30 and 500 mg – tablet – <b>DOSE</b> 2 tablets – oral – as required maximum 8 per day	<b>START DATE:</b> 13-Nov-2009 <b>END DATE:</b> NA <b>REVIEW DATE:</b> ---- <b>REVIEW RESPONSIBILITY:</b> ---- <b>QUANTITY DISPENSED:</b> 20 tablets <b>INSTRUCTIONS:</b> ---- <b>INDICATION:</b> Pain Management
<b>Changed</b> Dispensed	<b>furosemide</b> – 40 mg – tablet – <b>DOSE</b> 1 tablet – oral – once a day	<b>START DATE:</b> ---- <b>END DATE:</b> ---- <b>REVIEW DATE:</b> ---- <b>REVIEW RESPONSIBILITY:</b> ---- <b>QUANTITY DISPENSED:</b> 100 tablets <b>INSTRUCTIONS:</b> ---- <b>INDICATION:</b> Fluid Retention <b>REASON FOR CHANGE:</b> Hypotension <b>CHANGE DESCRIPTION:</b> dose decreased from tablet twice a day <b>DATE OF LAST CHANGE:</b> 08-Nov-2009
<b>Continued</b>	<b>tiotropium</b> – 18 microgram – dry-powder inhaler – <b>DOSE</b> 1 capsule – inhalation – once a day	<b>START DATE:</b> ---- <b>END DATE:</b> ---- <b>REVIEW DATE:</b> ---- <b>REVIEW RESPONSIBILITY:</b> ---- <b>QUANTITY DISPENSED:</b> Patient's own supply <b>INSTRUCTIONS:</b> ---- <b>INDICATION:</b> COPD
<b>Changed</b> Dispensed	<b>aspirin</b> – 75 mg – dispersible tablet – <b>DOSE</b> 1 tablet – oral	<b>START DATE:</b> ---- <b>END DATE:</b> ---- <b>REVIEW DATE:</b> ---- <b>REVIEW RESPONSIBILITY:</b> GP <b>QUANTITY DISPENSED:</b> 30 tablets <b>INSTRUCTIONS:</b> Please recommence 1 tablet once daily by mouth, 3 days after discharge <b>INDICATION:</b> Anticoagulant prophylaxis <b>REASON FOR CHANGE:</b> Surgery <b>CHANGE DESCRIPTION:</b> Withheld

# Discharge Summary



Another Hospital, The Royal Another NHS Foundation Trust

**PATIENT** SMITH, William (Mr) **BORN** 01-Jan-1946 (63yr) **GENDER** Male **NHS No.** 123 728 7652  
**HOSPITAL No.** ABC12345

## 18. Medications-Related Recommendations (0 recorded)

RECOMMENDATION	DATE FOR ACTION	INTENDED RECIPIENT
		CONTACT ADDRESS:
		TELEPHONE NUMBERS:

## 19. Stopped Medications (2 recorded)

DRUG DETAILS	STOPPED DETAILS
<b>oxycodone hydrochloride</b> – 5 mg – capsule – <b>DOSE 1 capsule</b> – oral – as required	<b>START DATE:</b> ---- <b>STOPPED DATE:</b> 06-Nov-2009 <b>REASON FOR STOPPING:</b> No longer required <b>INDICATION:</b> ----
<b>celecoxib</b> – 200 mg – capsule – <b>DOSE 1 capsule</b> – oral – as required	<b>START DATE:</b> ---- <b>STOPPED DATE:</b> 06-Nov-2009 <b>REASON FOR STOPPING:</b> Ceased due to scheduled surgery <b>INDICATION:</b> ----

## 20. Actions to be taken by Hospital after discharge (1 recorded)

ACTION	CONTACT PERSON	SPECIALTY / DEPARTMENT RESPONSIBLE	DATE FOR ACTION	STATUS OR OTHER COMMENTS
<b>Post-discharge follow-up – hospital- based outpatient orthopaedics clinic</b>		Orthopaedic Surgery	15-Dec-2009	Booked

## 21. Recommended GP Actions (3 recorded)

ACTION	DATE FOR ACTION	STATUS OR OTHER COMMENTS
Please remove the staples.	18-Nov-2009	
Please ensure aspirin is recommenced 3 days post-discharge.	16-Nov-2009	
Please follow-up anaemia.		

## 22. Recommended or planned Community and Specialist Services Actions (1 recorded)

ACTION	SERVICE ORGANISATION RESPONSIBLE	CONTACT PERSON	CONTACT PERSON ADDRESS	CONTACT PERSON TELEPHONE NUMBER(S)	DATE FOR ACTION (STATUS)
<b>Mobility therapy</b>   continue	PhysioCare Limited	Mr Peter Owen	20 Chapel Street, SomePlace, Slough, SL4 2XA	0191 567 8991	As booked

## 23. Information Given To Patient and/or Authorised Representative (1 recipient recorded)

<b>RECIPIENT NAME:</b>	William Smith	<b>RELATIONSHIP TO PATIENT:</b>	Self
<b>VERBAL INFORMATION GIVEN:</b>	The good prognosis for return to activity was discussed with the patient.		
<b>WRITTEN INFORMATION GIVEN:</b>	Patient was given a brochure explaining the expected post-op recovery following a total knee replacement.		
<b>OTHER ADVICE FOR PATIENT:</b>	Return to GP on 18 November 2009 to have the staples removed. Keep up regular mobility routine as guided by physiotherapist.		

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# Discharge Summary



Another Hospital, The Royal Another NHS Foundation Trust

**PATIENT** SMITH, William (Mr) **BORN** 01-Jan-1946 (63yr) **GENDER** Male **NHS No.** 123 728 7652  
**HOSPITAL No.** ABC12345

## 24. Patient's Concerns, Expectations and Wishes

**DESCRIPTION:**

## 25. Results Awaited

(1 recorded)

INVESTIGATION	DATE INVESTIGATION PERFORMED OR REQUESTED	DATE OF EXPECTED RESULT	COMMENTS ON RESULT AWAITED
Hepatic Function Panel	10-Nov-2009	24-Nov-2009	

## 26. Persons Completing Summary

(1 recorded)

**AUTHOR NAME:** Jonathan Thomas

**VERSION NUMBER:** 1.0

**AUTHOR GRADE:** FY1

**AUTHOR SPECIALTY:** Orthopaedics

**TREATMENT SPECIALTY:**

**DATE OF AUTHORING:** 14-Nov-2009

**VERIFIER NAME:**

**VERIFIER GRADE:**

**VERIFIER SPECIALTY:**

**TREATMENT SPECIALTY:**

**DATE OF VERIFYING:**

## 27. Distribution List

(3 recorded)

RECIPIENT NAME	RECIPIENT ORGANISATION	RELATIONSHIP TO PATIENT	RECIPIENT ADDRESS
Mr. William Smith		Self	196 Middleton Hall Road Kings Norton Slough SL10 9DY
Dr. Jane Anderson		GP	142 St. Heliers Road Northfield Slough SL3 1DP
Mr. Peter Owen	PhysioCare Limited	Community physiotherapist	20 Chapel Street SomePlace Slough SL4 2XA

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*Other data associated with the Discharge Summary record – stored in the originating information system only:*

Distribution Record					(3 recorded)
RECIPIENT NAME	RECIPIENT ORGANISATION	DESCRIPTION OF CONTENT (VERSION REFERENCE)	PERSON DISTRIBUTING NAME	PERSON DISTRIBUTING ROLE	DATE OF DISTRIBUTION
Mr. William Smith	Patient	Full Discharge Summary (V1.0)	Jonathan Thomas	FY1 Orthopaedics	14-Nov-2009
Dr. Jane Anderson	GP	Full Discharge Summary (V1.0)	Jonathan Thomas	FY1 Orthopaedics	14-Nov-2009
Mr. Peter Owen	PhysioCare Limited	Full Discharge Summary (V1.0)	Jonathan Thomas	FY1 Orthopaedics	14-Nov-2009

## 4 Detailed Data Requirements

The requirements specified in table form in this section are also stored within the LRA repository in Unified Model Language (UML) model form. It is intended that these requirements models will be re-used and revised as appropriate, with ongoing care record architecture development and stakeholder feedback. The LRA models repository (including both requirements and technical models) is currently accessible via the Internet upon email request to the LRA programme, and is intended to be openly accessible for reference in autumn/winter 2011.

The 'Available Data Standards' referenced in this specification are intended as suggested options that meet the stated requirement.

### Section 01. GP Details

The details of the GP and the GP practice to whom the discharge summary of the patient has to be sent for follow up care within the primary care setting.

#### Requirement References:

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).
- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).

#### Proposed Requirement: GP Name

**Description:** The name of the patient's usual GP.

#### Requirement Reference:

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).
- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).

**Available Data Standards:** ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.

**Data Source:** PAS, PDS.

**Data Use:** Target for communication.

**Proposed Data Values:** [Prefixes][Given names][Family names][Suffixes].

#### Proposed Requirement: GP Code

**Description:** Unique identifier for the patient's usual GP.

**Requirement Reference:** LRA expert group discussion 2011 – to support efficient electronic routing within GP practices. It was noted that current practice, despite national policies, still supported patient relationships with individual GPs, and not only

**Available Data Standards:** Organisation Data Service code.

**Data Source:** PAS.

**Data Use:** Target for communication (particularly for electronic routing to an individual within a GP practice).

to whole GP practices.	<b>Proposed Data Values:</b> Unique GP identifier code.
<b>Proposed Requirement: GP Practice Code</b>	
<b>Description:</b> Unique identifier which defines the patient's registered GP practice. <b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	<b>Available Data Standards:</b> Organisation Data Service code. <b>Data Source:</b> PAS. <b>Data Use:</b> Target for communication. <b>Proposed Data Values:</b> Unique GP practice identifier code (with associated name).
<b>Proposed Requirement: GP Practice Address</b>	
<b>Description:</b> The address of the patient's registered GP practice. <b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	<b>Available Data Standards:</b> BS7666 address standard, e-GIF, NHS ISB 1500: Common User Interface - Address Input and Display. <b>Data Source:</b> PAS. <b>Data Use:</b> Target for communication. <b>Proposed Data Values:</b> Address Prefix, Building Name and Building Number; Dependent Street or Road Name, and Street or Road Name; Dependent Locality and Double dependent locality; Postal Town; Postal County; Postal Code; PAF Key - unique ID for an address allocated by the Royal Mail.

## Section 02. OtherContact Details

The details of other relevant contacts defined by the patient.

**Requirement Reference:** Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).

<b>Proposed Requirement: Contact Name</b>	
<b>Description:</b> The name of the patient's identified relevant contact person (for example, a consultant, a community pharmacist, a specialist nurse, a carer, etc.). <b>Requirement Reference:</b> Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).	<b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types. <b>Data Source:</b> Previous record entry or new entry. <b>Data Use:</b> Target for communication. <b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].
<b>Proposed Requirement: Contact Address</b>	
<b>Description:</b> The address of the patient's identified relevant contact person. <b>Requirement Reference:</b> Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).	<b>Available Data Standards:</b> BS7666 address standard, e-GIF, ISB 1500: Common User Interface - Address Input and Display. <b>Data Source:</b> PAS. <b>Data Use:</b> Target for communication.

	<b>Proposed Data Values:</b> Address Prefix, Building Name and Building Number; Dependent Street or Road Name, and Street or Road Name; Dependent Locality and Double dependent locality; Postal Town; Postal County; Postal Code; PAF Key - unique ID for an address allocated by the Royal Mail.
<b>Proposed Requirement: Contact Telephone Numbers</b>	
<p><b>Description:</b> Telephone number(s) associated with the patient's identified relevant contact person.</p> <p><b>Requirement Reference:</b> Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</p>	<p><b>Available Data Standards:</b></p> <p><b>Data Source:</b> Previous record entry or new entry.</p> <p><b>Data Use:</b> Contact.</p> <p><b>Proposed Data Values:</b> Telephone number(s), with an optional 'Use' code or set of codes which may be assigned to differentiate number type :</p> <ul style="list-style-type: none"> <li>- home</li> <li>- primary home</li> <li>- vacation home</li> <li>- work place</li> <li>- direct (to the person)</li> <li>- public</li> <li>- temporary</li> <li>- answering service</li> <li>- emergency contact</li> <li>- mobile contact</li> <li>- pager</li> </ul> <p>(NOTE: more than one of the use descriptions above may apply to the same number).</p>

### **Section 03. Patient Details**

Details of the person being discharged from hospital.

**Requirement References:**

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).
- Requirement for 'the Patient's demographics' in 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).

**Proposed Requirement: Patient Name**

<p><b>Description:</b> The name of the patient.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</li> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Available Data Standards:</b> [Prefixes][Given names][Family names][Suffixes].</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Identification.</p> <p><b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].</p>
<b>Proposed Requirement: Name Known As</b>	
<p><b>Description:</b> An alias name of the patient by which he/she is commonly known.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> ISO 21090 Health informatics data types, NHS ISB 1506: Common User Interface - Patient Name Input and Display, NHS ISB 1505: Patient Banner.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Identification.</p> <p><b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].</p>
<b>Proposed Requirement: Date Of Birth</b>	
<p><b>Description:</b> The patient's Date of Birth.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</li> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1505: Patient Banner, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Identification.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDD".</p>
<b>Proposed Requirement: Gender</b>	
<p><b>Description:</b> A coded representation of the current gender of the person. Gender is an individual's self-declared (or inferred by observation for those unable to declare) perception of being male or female. Person gender is behavioural (i.e. how an individual wishes to be treated socially) and must not be confused with person sex which can determine how an individual will be treated clinically.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and</li> </ul>	<p><b>Available Data Standards:</b> NHS ISB 1507: Common User Interface - Sex and Current Gender Input and Display, NHS ISB 1505: Common User Interface - Patient Banner.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Identification and for addressing personal communications appropriately with the patient.</p>

content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	<b>Proposed Data Values:</b> <ul style="list-style-type: none"> <li>- Not known</li> <li>- Male</li> <li>- Female</li> <li>- Other specific; The person has a clear idea of what their gender is, but it is neither discretely male nor female, e.g. 'intersex', 'transgender', 'third gender'.</li> <li>- Not specified; The person is unable to specify their current gender or does not have a clear idea of what their current gender is.</li> </ul>
<b>Proposed Requirement: NHS Number</b>	
<b>Description:</b> The unique patient identifier provided by the NHS in England and Wales. <b>Requirement Reference:</b> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</li> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<b>Available Data Standards:</b> Government Data Standards Catalogue, NHS ISB 1504: Common User Interface - NHS Number Input and Display, NHS ISB 1505: Patient Banner. <b>Data Source:</b> PAS. <b>Data Use:</b> Identification. <b>Proposed Data Values:</b> Patient's NHS number.
<b>Proposed Requirement: Local Identifier</b>	
<b>Description:</b> Used locally only, also useful when patient does not have a unique NHS Number (e.g. 'dummy' NHS Number for visitor). <b>Requirement Reference:</b> LRA DS expert group 2011 – to assist in tracing patient identification in cases where 'dummy' NHS numbers have been used.	<b>Available Data Standards:</b> NHS Data Model & Dictionary Version 3 - Local Patient Identifier. <b>Data Source:</b> PAS. <b>Data Use:</b> Identification. <b>Proposed Data Values:</b> Local ID code.
<b>Proposed Requirement: Patient Address</b>	
<b>Description:</b> A patient's usual address is the address at which (s)he currently lives and which the patient states is his usual address. <b>Requirement Reference:</b> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</li> <li>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal</li> </ul>	<b>Available Data Standards:</b> BS7666 address standard, ISB 1500: Common User Interface - Address Input and Display. <b>Data Source:</b> PAS. <b>Data Use:</b> Contact (unless different from discharge destination address). <b>Proposed Data Value:</b> Address Prefix, Building Name and Building Number; Dependent Street or Road Name, and Street or Road Name; Dependent Locality and Double dependent locality; Postal Town; Postal County; Postal Code; PAF Key - unique ID for an address allocated by the

Pharmaceutical Society (Final Draft 06/06/2011).	Royal Mail.
<b>Proposed Requirement: Patient Telephone Numbers</b>	
<p><b>Description:</b> Telephone number(s) associated with the patient.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> e-GIF GDSC standard for UK Telephone Number, ISB 1508: Common User Interface - Telephone Number Input and Display, Telecommunication Address Use codes from ISO 21090.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Contact.</p> <p><b>Proposed Data Values:</b> Telephone number(s), with an optional 'Use' code or set of codes which may be assigned to differentiate number type :</p> <ul style="list-style-type: none"> <li>- home</li> <li>- primary home</li> <li>- vacation home</li> <li>- work place</li> <li>- direct (to the person)</li> <li>- public</li> <li>- temporary</li> <li>- answering service</li> <li>- emergency contact</li> <li>- mobile contact</li> <li>- pager</li> </ul> <p>(NOTE: more than one of the use descriptions above may apply to the same number).</p>

## Section 04. Admission Details

Details of the patient's admission.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

<b>Proposed Requirement: Method Of Admission</b>	
<p><b>Description:</b> How the patient was admitted to hospital e.g. Emergency, Elective, Transfer, Maternity.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2:</p>	<p><b>Available Data Standards:</b> NHS Data Model &amp; Dictionary Version 3 - Admission Method.</p> <p><b>Data Source:</b> PAS (including A&amp;E PAS).</p>



<p>Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Data Use:</b> Central returns, research and audit, GP &amp; other specialities info.</p> <p><b>Proposed Data Values:</b></p> <ul style="list-style-type: none"> <li>- Elective Admission, when the DECISION TO ADMIT could be separated in time from the actual admission: <ul style="list-style-type: none"> <li>• Waiting list</li> <li>• Booked</li> <li>• Planned</li> </ul> </li> <li>- Emergency Admission, when admission is unpredictable and at short notice because of clinical need: <ul style="list-style-type: none"> <li>• Accident and emergency or dental casualty department of the Health Care Provider</li> <li>• GENERAL PRACTITIONER: after a request for immediate admission has been made direct to a Hospital Provider, i.e. not through a Bed bureau, by a GENERAL PRACTITIONER or deputy</li> <li>• Bed bureau</li> <li>• Consultant Clinic, of this or another Health Care Provider</li> <li>• Admission via Mental Health Crisis Resolution Team *</li> <li>• Other means, examples are: <ul style="list-style-type: none"> <li>- admitted from the Accident and Emergency Department of another provider where they had not been admitted</li> <li>- transfer of an admitted PATIENT from another Hospital Provider in an emergency</li> <li>- baby born at home as intended</li> <li>- Maternity Admission, of a pregnant or recently pregnant woman to a maternity ward (including delivery facilities) except when the intention is to terminate the pregnancy</li> </ul> </li> <li>• Admitted ante-partum</li> <li>• Admitted post-partum</li> <li>- Other Admission not specified above</li> <li>• The birth of a baby in this Health Care Provider</li> <li>• Baby born outside the Health Care Provider except when born at home as intended.</li> <li>• Transfer of any admitted PATIENT from other Hospital Provider other than in an emergency</li> </ul> </li> </ul> <p>NOTE: Some of these admission types may be out of scope for this LRA Discharge Summary work package.</p>
<p><b>Proposed Requirement: Source Of Admission</b></p>	

<p><b>Description:</b> Where the patient was resident immediately prior to admission e.g. usual place of residence, temporary place of residence, penal establishment.</p> <p>NOTE: This data may be available outside the Discharge Summary and questions have been raised about its accuracy / reliability.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> NHS Data Model &amp; Dictionary Version 3.</p> <p><b>Data Source:</b> PAS (including A&amp;E PAS).</p> <p><b>Data Use:</b> Research and audit, central returns, info for GP &amp; other specialities.</p> <p><b>Proposed Data Values:</b></p> <ul style="list-style-type: none"> <li>- Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by local authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes patients with no fixed abode.</li> <li>- Temporary place of residence when usually resident elsewhere (e.g. hotels, residential educational establishments)</li> <li>- Penal establishment, Court, or police station</li> <li>- NHS other hospital provider - high security psychiatric accommodation in an NHS hospital provider (NHS trust)</li> <li>- NHS other hospital provider - ward for general patients or the younger physically disabled or A &amp; E department</li> <li>- NHS other hospital provider - ward for maternity patients or neonates</li> <li>- NHS other hospital provider - ward for patients who are mentally ill or have learning disabilities</li> <li>- NHS run care home</li> <li>- Local Authority residential accommodation i.e. where care is provided</li> <li>- Local Authority foster care</li> <li>- Babies born in or on the way to hospital</li> <li>- Non-NHS (other than Local Authority) run care home</li> <li>- Non NHS run hospital</li> <li>- Non-NHS (other than Local Authority) run Hospice</li> </ul>
<p><b>Proposed Requirement: Hospital Site Name</b></p>	
<p><b>Description:</b> Name of physical provider site to which the patient was admitted.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</li> <li>- 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011)</li> </ul>	<p><b>Available Data Standards:</b> NHS Data Model &amp; Dictionary Version 3 - Organisation Code.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Research and audit, central returns.</p> <p><b>Proposed Data Values:</b> Code with associated name or free text as exception.</p> <p>NOTE: User interfaces could display just the organisation name associated with the code, rather than the code itself.</p>

**Proposed Requirement: Responsible Trust**

**Description:** The NHS hospital trust responsible for admitting the patient (this may not be the same as the name of the hospital).

**Requirement Reference:**

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

- 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).

**Available Data Standards:** NHS Data Model & Dictionary Version 3 - Organisation Code (Code Of Provider).

**Data Source:** PAS.

**Data Use:** Commissioning.

**Proposed Data Values:** Name of the responsible Trust.

**Proposed Requirement: Date And Time Of Admission**

**Description:** The date and time the patient was admitted to hospital.

**Requirement Reference:**

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).

- Date requirement only from 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).

**Available Data Standards:** ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.

**Data Source:** PAS.

**Data Use:** Audit, research, Commissioning (based on length of stay).

**Proposed Data Values:** A string with the format "YYYYMMDDHHMMSS.UUUU[+|-ZZzz]".

## Section 05. Discharge Details

Details of the patient's discharge.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Proposed Requirement: Date And Time Of Discharge**

**Description:** A record of the date and time that the patient was discharged from hospital.

**Requirement Reference:**

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).

- Date requirement only from 2011/12 Standard Terms and Conditions for Acute

**Available Data Standards:** ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.

**Data Source:** Audit, research, Commissioning (based on length of stay).

**Data Use:** PAS.

**Proposed Data Values:** A string with the format "YYYYMMDDHHMMSS.UUUU[+|-ZZzz]".

Hospital Services (Department of Health, April 2011).	
<b>Proposed Requirement: Discharge Method</b>	
<p><b>Description:</b> The mode of patient discharge from hospital.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> NHS Data Model &amp; Dictionary Version 3 - Discharge Method.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Audits, Research, Central returns.</p> <p><b>Proposed Data Values:</b></p> <ul style="list-style-type: none"> <li>- Patient discharged on clinical advice or with clinical consent</li> <li>- Patient discharged him/herself or was discharged by a relative or advocate</li> <li>- Patient died</li> <li>- Stillbirth</li> <li>- Patient discharged by mental health review tribunal, Home Secretary or court (remove for current RCP DS)</li> </ul>
<b>Proposed Requirement: Type Of Destination</b>	
<p><b>Description:</b> Type of patient destination on discharge, can include private dwelling, penal establishment, care home etc (National Code).</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> NHS Data Model &amp; Dictionary Version 3.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Central returns, Research, Audit and GP info.</p> <p><b>Proposed Data Values:</b></p> <ul style="list-style-type: none"> <li>- Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by local authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes patients with no fixed abode.</li> <li>- Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment)</li> <li>- Repatriation from high security psychiatric accommodation in an NHS Hospital Provider (NHS Trust)</li> <li>- Court</li> <li>- Penal establishment or police station</li> <li>- High Security Psychiatric Hospital, Scotland</li> <li>- NHS other hospital provider; high security psychiatric accommodation</li> <li>- NHS other hospital provider; medium secure unit</li> <li>- NHS other hospital provider; ward for general patients or the younger physically disabled</li> </ul>

	<ul style="list-style-type: none"> <li>- NHS other hospital provider; ward for maternity patients or neonates</li> <li>- NHS other hospital provider; ward for patients who are mentally ill or have learning disabilities</li> <li>- NHS run Care Home</li> <li>- Local Authority residential accommodation i.e. where care is provided</li> <li>- Local Authority foster care</li> <li>- Not applicable; patient died or still birth</li> <li>- Non-NHS run hospital; medium secure unit</li> <li>- Non-NHS (other than Local Authority) run Care Home</li> <li>- Non-NHS run hospital</li> <li>- Non-NHS (other than Local Authority) run Hospice</li> </ul>
<b>Proposed Requirement: Destination Address</b>	
<p><b>Description:</b> The address where the patient is being discharged.</p> <p>NOTE: Not required if patient's own home.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> BS7666 address standard, NHS ISB 1500: Common User Interface - Address Input and Display.</p> <p>NOTE: Needs business process to validate currency before discharge.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Contact (unless patient's address).</p> <p><b>Proposed Data Values:</b> Address Prefix, Building Name and Building Number; Dependent Street or Road Name, and Street or Road Name; Dependent Locality and Double dependent locality; Postal Town; Postal County; Postal Code; PAF Key - unique ID for an address allocated by the Royal Mail.</p>
<b>Proposed Requirement: Living Alone</b>	
<p><b>Description:</b> Indicator for whether the patient lives alone.</p> <p>NOTE: The LRA Discharge Summary expert group 2011 questioned how this would be consistently defined (i.e. what is the definition for 'living alone') and also who was expected to capture and use this data. (For example, if this was expected to have clinical significance, it was suggested that this data would more appropriately be included in the Clinical Narrative or Problems or Issues at Discharge, along with clinical context.) This requirement has been included in order to be consistent with the published Academy of Medical Royal Colleges Discharge Summary content standard, but clarification will be requested as input to future iterations of this professional standard.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Data Source:</b> Unknown.</p> <p><b>Data Use:</b> Unknown.</p> <p><b>Proposed Data Values:</b> Yes / No. [from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)].</p>

<b>Proposed Requirement: Discharge Destination Organisation</b>	
<p><b>Description:</b> A code (with associated name) which identifies an organisation uniquely.</p> <p><b>Requirement Reference:</b> Adapted from 'Discharge Destination' in, A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> NHS Data Model &amp; Dictionary Version 3 - Organisation Code.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> GP and allied health for after care.</p> <p><b>Proposed Data Values:</b> Organisation code (with associated name) or free text.</p>
<b>Proposed Requirement: Discharging Consultant Name</b>	
<p><b>Description:</b> Name of the consultant responsible for the patient at time of discharge.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</li> <li>- Adapted from 'Consultant' in, Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).</li> </ul>	<p><b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Follow-up contact.</p> <p><b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].</p>
<b>Proposed Requirement: Discharging Consultant ID</b>	
<p><b>Description:</b> Identifier of the consultant responsible for the patient at time of discharge.</p> <p><b>Requirement Reference:</b> Adapted from 'Consultant' in, Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</p>	<p><b>Available Data Standards:</b> NHS Data Model &amp; Dictionary Version 3 - Consultant Code.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> After care contact.</p> <p><b>Proposed Data Values:</b> Consultant unique identifier.</p>
<b>Proposed Requirement: Discharging Specialty Department</b>	
<p><b>Description:</b> The name of the speciality/department responsible for the patient at the time of discharge.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> After care contact.</p> <p><b>Proposed Data Values:</b> Locally-defined Trust department name in free text.</p>

## **Section 06. Hospital Stay Responsible Consultants List**

A list of any responsible consultants during the admission prior to the consultant responsible at time of discharge (the consultant responsible at time of discharge is provided under Discharge Details).

**Requirement Reference:** LRA DS expert group 2011.

Proposed Requirement: Responsible Consultant Name	
<p><b>Description:</b> Name of the Consultant responsible for a given Episode.</p> <p><b>Requirement References:</b></p> <ul style="list-style-type: none"> <li>- LRA DS expert group 2011 – useful for potential follow-up contact with consultants who were responsible for episodes that occurred prior to the one at discharge for this admission.</li> <li>- 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).</li> </ul>	<p><b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Follow-up contact.</p> <p><b>Proposed Data Value:</b> [Prefixes][Given names][Family names][Suffixes].</p> <p>NOTE: This may be displayed in any chosen order.</p>
Proposed Requirement: Responsible Consultant ID	
<p><b>Description:</b> The Consultant's identification code.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for potential follow-up contact with consultants who were responsible for episodes that occurred during this admission but completed prior to the episode at discharge.</p>	<p><b>Available Data Standards:</b> NHS Data Model &amp; Dictionary Version 3 - Consultant Code.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> GPs / other contacts in follow-up activities.</p> <p><b>Proposed Data Values:</b> Unique identifier.</p>
Proposed Requirement: Responsible Consultant Speciality	
<p><b>Description:</b> The specialty of the responsible consultant.</p> <p><b>Requirement References:</b> LRA DS expert group 2011 – useful for potential follow-up contact for consultants who were responsible for episodes that occurred prior to the one at discharge for this admission.</p>	<p><b>Available Data Standards:</b> European Commission medical specialties.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> GPs / others contacts in follow-up activities.</p> <p><b>Proposed Data Values:</b> Codes.</p>
Proposed Requirement: Responsible Consultant Treatment Speciality	
<p><b>Description:</b> Approved NHS sub-specialties and treatment specialties used by hospital consultants.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for potential follow-up contact for consultants who were responsible for episodes that occurred during this admission but completed prior to the episode at discharge.</p>	<p><b>Available Data Standards:</b> Speciality Titles maintained by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> GPs / others contacts in follow-up activities.</p> <p><b>Proposed Data Values:</b> Treatment Speciality code.</p>
Proposed Requirement: Responsibility Start Time	
<p><b>Description:</b> The start date and time of Consultant responsibility.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for potential follow-up contact for consultants who were responsible for episodes that occurred during this admission but completed prior to the episode at discharge.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> PAS.</p>

	<b>Data Use:</b> Time reference for follow-up contact. <b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".
<b>Proposed Requirement: Responsibility End Time</b>	
<b>Description:</b> The end date and time of Consultant responsibility. <b>Requirement Reference:</b> LRA DS expert group 2011 – useful for potential follow-up contact for consultants who were responsible for episodes that occurred during this admission but completed prior to the episode at discharge.	<b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display. <b>Data Source:</b> PAS. <b>Data Use:</b> Time reference for follow-up contact. <b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".

## Section 07. AllCurrent Diagnoses At Discharge

Primary diagnosis, secondary diagnoses and relevant previous diagnoses, including complications. [A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).]

NOTE: The LRA DS expert group advised that classifications of 'primary' and 'secondary' diagnoses were not useful to DS recipients (e.g. not used by GPs) and were also based on the perspective of a particular responsible specialty (and so will change if the responsible specialty department changes during the hospital stay). On this basis, reference to primary and secondary diagnoses are not included in this specification.

Diagnoses are decisions arrived at as a result of a synthesis of signs, symptoms, investigations (i.e. findings), and theoretical knowledge. These include diseases, disorders, syndromes and physiological states such as pregnancy. [NPFIT-NCR-DES-0135.07 NHS Care Record Elements].

All diagnoses current at the time of discharge and any diagnoses that were resolved during this admission.

It is proposed that the following data may be documented for each diagnosis at discharge.

<b>Proposed Requirement: Diagnosis</b>	
<b>Description:</b> A description of a diagnosis that is present at the time of discharge. Diagnoses are 'labels for communication which after consideration include all relevant diseases, disorders and syndromes' (from Headings for Communicating Clinical Information from the Personal Health Record: A Position Paper, Crown Copyright June 1998). The level of detail provided in this description is at the author's discretion. <b>Requirement Reference:</b> - A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008). - Requirement for 'a summary of the key diagnosis made during the Patient's admission' from 2011/12 Standard Terms and Conditions for Acute Hospital Services	<b>Available Data Standards:</b> SNOMED CT. <b>Data Examples:</b> - Acute myocardial infarction, first, confirmed present - Carcinoma of hepatic flexure, probably present, first episode - Diabetes mellitus - Asthma - Chronic obstructive pulmonary disease - RULED OUT ulcerative colitis <b>Data Source:</b> Copied from previous record entry. <b>Data Use:</b> Information for patients and care providers, updates to the patient's primary or shared care records, use in primary care decision support algorithms



(Department of Health, April 2011).	<p>Note: The values proposed for clinical severity are those currently in use in UK GP systems today. These values may be encoded to support efficient and readable human record-keeping, but further guidance and training is likely necessary to enable very precise and consistent clinical interpretations. Designers of decision support systems must apply discretion about the use of this data based on the reliability of its interpretation. Some clinical specialties may have fully-specified severity scoring frameworks, and these may be referenced in the LRA in future versions.</p> <p><b>Proposed Data Values:</b> Coded expression including Name and other descriptor, qualifiers or status modifiers. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p> <ul style="list-style-type: none"> <li>- Name</li> <li>- Site</li> <li>- Laterality</li> <li>- Episode <ul style="list-style-type: none"> <li>* First episode</li> <li>* New episode</li> <li>* Old episode</li> <li>* Ongoing episode</li> </ul> </li> <li>- Clinical Course <ul style="list-style-type: none"> <li>* Acute</li> <li>* Chronic</li> <li>* Transitory</li> </ul> </li> <li>- Severity <ul style="list-style-type: none"> <li>* Mild</li> <li>* Moderate</li> <li>* Severe</li> </ul> </li> <li>- Status (assumed to cover both the degree of certainty and the presence/absence of conditions of significance to diagnostic/comorbidity labelling): <ul style="list-style-type: none"> <li>* Known present</li> <li>* Known absent</li> <li>* Suspected</li> <li>* NOT suspected</li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li>* Definitely/confirmed present</li> <li>* Definitely NOT present/excluded/ruled out</li> <li>* Probably/possibly present</li> <li>* Probably NOT present</li> </ul>
<b>Proposed Requirement: Date Diagnosis Made</b>	
<p><b>Description:</b> The date and time when the diagnosis was made.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful to know for follow-up care when the diagnosis was determined.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient and care provider information.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>
<b>Proposed Requirement: Responsible Person</b>	
<p><b>Description:</b> Person responsible for making the diagnosis.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for follow-up contact.</p>	<p><b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Follow-up contact.</p> <p><b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].</p>
<b>Proposed Requirement: Responsible Consultant Treatment Specialty</b>	
<p><b>Description:</b> Treatment Speciality is based on specialty, but also includes approved sub-specialties and treatment specialties used by hospital consultants.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful as context to the diagnosis.</p>	<p><b>Available Data Standards:</b> NHS Hospital Episode Statistics 'Treatment Specialty'.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> Follow up care.</p> <p><b>Proposed Data Values:</b> Treatment Speciality code.</p>
<b>Proposed Requirement: Complication Aetiology</b>	
<p><b>Description:</b> The diagnosis or procedure that was the aetiological basis for a complication diagnosis.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 - useful for providing additional clinical detail for a comprehensive diagnosis list.</p>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Information for patient and decision support.</p> <p><b>Proposed Data Values:</b> Values as for diagnosis or for procedureDescription, linked to (as the aetiological basis for) a complication diagnosis.</p>
<b>Proposed Requirement: Complication Aetiology Date</b>	
<b>Description:</b> The date the complication aetiology diagnosis was made or the date the	<b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface -

<p>complication aetiology procedure was performed.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – part of a set of data related to complication aetiology.</p>	<p>Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Previous record entry.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+]-ZZzz".</p> <p>NOTE: Associated with a complication aetiology diagnosis or procedure.</p>
<b>Proposed Requirement: Complication Aetiology Responsible Person</b>	
<p><b>Description:</b> The name of the person responsible for making the complication's aetiological diagnosis or performing the procedure.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – part of a set of data related to complication aetiology.</p>	<p><b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.</p> <p><b>Data Source:</b> Previous record entry.</p> <p><b>Data Use:</b> Clinical context.</p> <p><b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].</p>
<b>Proposed Requirement: Complication Aetiology Treatment Specialty</b>	
<p><b>Description:</b> The treatment specialty of the person responsible for the complication aetiology diagnosis or procedure.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – part of a set of data related to complication aetiology.</p>	<p><b>Available Data Standards:</b> European Commission medical specialties.</p> <p><b>Data Source:</b> PAS.</p> <p><b>Data Use:</b> GPs / others contacts in follow-up activities.</p> <p><b>Proposed Data Values:</b> Codes for treatment specialty.</p> <p>Associated with a complication aetiology diagnosis or procedure.</p>
<b>Proposed Requirement: Complication Aetiology Date Of First Presentation</b>	
<p><b>Description:</b> The date the complication aetiology diagnosis first presented.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – part of a set of data related to complication aetiology.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Previous record entry.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+]-ZZzz".</p> <p>NOTE: Associated with a complication aetiology diagnosis.</p>
<b>Proposed Requirement: Date Of Presentation</b>	
<p><b>Description:</b> The date of first presentation of physical signs and symptoms associated with the diagnosis, if known.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – clinically useful, particularly when there is a significant time gap between first presentation and diagnosis.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient and care provider information, clinical research.</p>

	<b>Proposed Data Values:</b> A string with the format "YYYYMMDD".
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## Section 08. Other Significant Problems At Discharge

Opportunity to record other significant problems (issues requiring health service or carer attention) at discharge.

**Requirement Reference:** LRA DS expert group 2011.

### Proposed Requirement: Problem Description

**Description:** Issue requiring health service or carer attention.

**Requirement Reference:** LRA DS expert group 2011 - Useful in maintaining and communicating problem lists and allows the ability to identify non-diagnosis issues relevant to ongoing care at time of discharge.

**Available Data Standards:** SNOMED CT.

#### Data Examples:

- risk for falls
- chest pain on exertion
- family history of early cardiac death
- planned hysterectomy
- failure to take medications as prescribed
- status post Coronary Artery Bypass Graft
- lives alone without social support

**Data Source:** Copied from previous record entry.

**Data Use:** Information for patients and care providers, updates to the patient's primary or shared care records, use in primary care decision support algorithms.

**Proposed Data Values:** Coded expression. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).

### Proposed Requirement: Date Problem Recorded

**Description:** The date and time when the problem was recorded.

**Requirement Reference:** LRA DS expert group 2011 – useful to know for follow-up care.

**Available Data Standards:** ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.

**Data Source:** Copied from previous record entry.

**Data Use:** Patient and care provider information.

**Proposed Data Values:** A string with the format "YYYYMMDDHHMMSS.UUUU[+|-ZZzz]".

### Proposed Requirement: Responsible Person

<b>Description:</b> Person responsible for recording the problem. <b>Requirement Reference:</b> LRA DS expert group 2011 – useful for clinical context or follow-up.	<b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types. <b>Data Source:</b> PAS. <b>Data Use:</b> Follow-up contact. <b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].
<b>Proposed Requirement: Responsible Consultant Treatment Specialty</b>	
<b>Description:</b> Treatment Specialty is based on specialty, but also includes approved sub-specialties and treatment specialties used by hospital consultants. <b>Requirement Reference:</b> LRA DS expert group 2011 – useful as clinical context.	<b>Available Data Standards:</b> NHS Hospital Episode Statistics 'Treatment Specialty'. <b>Data Source:</b> PAS. <b>Data Use:</b> Provides clinical context. <b>Proposed Data Values:</b> Treatment Specialty code.

## Section 09. Operations And Significant Procedures

Descriptions of new and relevant therapeutic operations and procedures, including any complications and adverse events arising during the procedure.

Note: Procedures that are both therapeutic and investigative may appear either in this section or in the Investigations section or in both, at the author's discretion.

### Requirement References:

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).
- Requirement for 'details of any clinical procedure undertaken' in 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).

### Proposed Requirement: Procedure Performed Date

<b>Description:</b> The start date and optionally time when the procedure was performed. <b>Requirement Reference:</b> LRA DS expert group 2011 – clinically useful for follow-up care.	<b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display. <b>Data Source:</b> Copied from previous record entry. <b>Data Use:</b> Clinical audit / research, continuing care. <b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".
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### Proposed Requirement: Procedure Description

<b>Description:</b> A description of the therapeutic procedure performed. The procedure description could include the site and should include laterality where applicable. It may also include the status of the procedure and priority information, at the discretion of the author.  For data entry, some sites may prefer to require authors to enter some of the description separately (e.g. laterality) where it is applicable. The communication form,	<b>Available Data Standards:</b> SNOMED CT. <b>Data Examples:</b> <ul style="list-style-type: none"> <li>- Elective, Right colectomy, performed</li> <li>- Emergency, Appendectomy, performed</li> </ul>
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<p>however, should be a single expression.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</li> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> </ul>	<ul style="list-style-type: none"> <li>- Insertion of Chest Drain, right</li> </ul> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Clinical audits / research, continuing care.</p> <p><b>Proposed Data Values:</b> Coded expression for name, site, laterality and potentially also status and priority. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p> <ul style="list-style-type: none"> <li>- Name</li> <li>- Site</li> <li>- Laterality</li> <li>- Post-starting action status (at time of discharge):</li> <li>*Suspended</li> <li>*Performed (Done)</li> <li>*Discontinued (Stopped before completion)</li> <li>*Abandoned (Stopped before completion)</li> </ul> <p>[Context values for actions_EDC_19032009.doc]</p> <ul style="list-style-type: none"> <li>- Priority</li> <li>* Immediate</li> <li>* Urgent</li> <li>* Elective</li> <li>* Scheduled</li> </ul>
<b>Proposed Requirement: Consultant Responsible Name</b>	
<p><b>Description:</b> The consultant responsible for undertaking the procedure.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for potential follow-up contact.</p>	<p><b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.</p> <p><b>Data Source:</b> Previous record entry.</p> <p><b>Data Use:</b> Follow-up contact.</p> <p><b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].</p>
<b>Proposed Requirement: Consultant Responsible ID</b>	
<p><b>Description:</b> The Consultant's identification code.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – to add precision to</p>	<p><b>Available Data Standards:</b> General Medical Council code.</p> <p><b>Data Source:</b> Copied from previous record entry.</p>

consultantResponsibleName.	<b>Data Use:</b> Clinical audit, continuing care. <b>Proposed Data Values:</b> Consultant unique identifier.
<b>Proposed Requirement: Indications For Procedure</b>	
<b>Description:</b> The primary clinical reason(s) for the procedure performed. <b>Requirement Reference:</b> LRA DS expert group 2011 – allowance for additional detail at the discretion of the author.	<b>Available Data Standards:</b> SNOMED CT. <b>Data Examples:</b> <ul style="list-style-type: none"> <li>- Carcinoma of hepatic flexure</li> <li>- Abdominal pain, left iliac fossa</li> <li>- Right Pneumothorax</li> </ul> <b>Data Source:</b> Copied from previous record entry. <b>Data Use:</b> Clinical audit, continuing care. <b>Proposed Data Values:</b> Coded expressions for diagnosis, finding or problem also recorded elsewhere in the Discharge Summary. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).
<b>Proposed Requirement: Procedure Comments</b>	
<b>Description:</b> Any additional comments about a procedure. <b>Requirement Reference:</b> LRA DS expert group 2011 – allowance for additional detail at the discretion of the author.	<b>Data Source:</b> Copied from previous record entry. <b>Data Use:</b> Continuing care. <b>Proposed Data Values:</b> Free text.
<b>Proposed Requirement: Complications During Procedure</b>	
<b>Description:</b> Details of any intra-operative complications encountered during the procedure or arising during the patient's stay in the recovery unit. <b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	<b>Available Data Standards:</b> SNOMED CT. <b>Data Examples:</b> <ul style="list-style-type: none"> <li>- Cardiac arrest</li> <li>- Fracture of femur (during hip replacement)</li> <li>- Liver laceration (during cholecystectomy)</li> </ul> <b>Data Source:</b> Copied from procedure record. <b>Data Use:</b> Clinical audit / research, continuing care. <b>Proposed Data Values:</b> A coded expression describing the complication. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to

	automated interpretation).
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## Section 10. Reason For Admission And Presenting Complaints

The health problems and issues experienced by the patient resulting in their hospital admission, e.g. chest pain, blackout, fall, a specific procedure, investigation or treatment.

Note: admission may be the result of a combination of factors. An issue may be either a presenting complaint or a reason for admission or both.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

### Proposed Requirement: Reason For Contact

**Description:** A 'stated reason from a health care professional, patient or organisation on the necessity of the patient professional encounter' (from Headings for Communicating Clinical Information from the Personal Health Record: A Position Paper, Crown Copyright June 1998).

A reason for admission is a particular type of reason for contact.

The Discharge Summary may include multiple reasons for admission.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Available Data Standards:** SNOMED CT.

#### Data Examples:

- Colles fracture and lives alone without social support (reasons for admission)
- Elective left hip replacement

**Data Source:** Admission record.

**Data Use:** Continuing care, clinical audit / research.

**Proposed Data Values:** Coded expression, which may include disease state, medical condition, responses and reactions to therapies (with anatomical site and laterality identified where appropriate). The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).

### Proposed Requirement: Presenting Complaint

**Description:** An admission issue that represents a 'patient want or requirement for help' (adapted from 'Needs' in Headings for Communicating Clinical Information from the Personal Health Record: A Position Paper, Crown Copyright, June 1998).

Multiple presenting complaints may be recorded.

#### Requirement Reference:

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

- Adapted from 'presenting condition' in, Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).

**Available Data Standards:** SNOMED CT.

#### Data Examples:

- Wrist pain – left
- Chest pain
- Blackout
- Fall

**Data Source:** Admission record.

**Data Use:** Continuing care, clinical audit / research.

**Proposed Data Values:** Coded expression, which may include disease state, medical condition, responses and reactions to therapies (with anatomical site and laterality identified where



	appropriate). The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).
<b>Proposed Requirement: Issue Onset Date</b>	
<p><b>Description:</b> If applicable, the date of onset of the perceived problem, reason for admission or presenting complaint.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – clinically useful to know, if available, how long the issue has been present.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Admission record.</p> <p><b>Data Use:</b> Used in problem-oriented records for ongoing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>

## Section 11. Mental Capacity

The mental capacity of the patient to make decisions about treatment etc. Example, where an Independent Mental Capacity Advocate (IMCA) is required for decisions relating to discharge destination, medical treatment, ability to consent etc. Any information given to a significant other in relation to this matter.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

<b>Proposed Requirement: Mental Capacity</b>	
<p><b>Description:</b> The mental capacity of the patient to make decisions about treatment, including whether an Independent Mental Capacity Advocate is required for decisions relating to discharge destination or ongoing treatment.</p> <p><b>NOTE:</b> The LRA Discharge Summary expert group 2011 questioned how this data would be consistently interpreted and also who was expected to capture and use this data. (For example, if this is mainly about mental capacity to consent to treatment, this would be expected to be time-specific information, relevant at the time of requesting consent, but not necessarily useful at the time of discharge from hospital.) It was suggested that this type of data would more appropriately be included in the Clinical Narrative summary of the hospital stay, or Problems or Issues at Discharge, along with additional clinical context.) This requirement has been included in order to be consistent with the published Academy of Medical Royal Colleges Discharge Summary content standard, but clarification will be requested as input to future iterations of the Academy's professional standard.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Data Source:</b> Unknown.</p> <p><b>Data Use:</b> Unknown.</p> <p><b>Proposed Data Values:</b> Free text.</p>

## Section 12. Advance Decisions And Resuscitation Status

Advance Decisions to Refuse Treatment (ADRT) are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf later in the disease process. Includes Do Not Resuscitate orders.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

### Proposed Requirement: Advance Decisions To Refuse Treatment

**Description:** Description of any advance decision to refuse treatment, including with respect to resuscitation.

**NOTE:** The ADRT documentation states that if a person becomes mentally incapable of making decisions later on in life then the ADRT document written and signed by the patient when they were mentally well should be taken into account.

**Requirement Reference:** - A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Data Source:** Copied from previous record entry.

**Data Use:** Ongoing care.

**Proposed Data Values:** Free text.

### Proposed Requirement: Link To ADRT Document

**Description:** Link to a copy of the Advanced Decisions to Refuse Treatment document, completed and signed by the person indicating the ADRT. This document will include the person to be contacted to discuss the wishes of the patient.

**Requirement Reference:** LRA DS expert group 2011 – potentially useful, when a formal document exists.

**Data Source:** Copied from previous record entry.

**Data Use:** Ongoing care.

**Proposed Data Values:** Free text link to an Advanced Decision to Refuse Treatment document.

## Section 13. Allergies And Adverse Reactions

An Allergy is an acquired hypersensitivity caused by exposure to a particular antigen (allergen) resulting in a marked increase in reactivity to that antigen upon subsequent exposure. [NPFIT-NCR-DES-0135.07 NHS Care Record Elements]

It covers both propensity as well as the actual occurrence of a known or new allergy or adverse reaction.

This section should include a complete list of the patient's allergic propensities with a flag to indicate whether a listing is 'new' (identified during this admission).

Any reactions that occurred during this admission should be described in this section.

**NOTE:** Historical reactions data and their provenance may be held in the patient's ongoing allergies and adverse reactions list, managed by their GP.

### Requirement References:

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

- Requirement for 'any adverse reactions or allergies to medications or treatments observed in the Patient during admission' from) 2011/12 Standard Terms and Conditions

for Acute Hospital Services (Department of Health, April 2011).

#### Proposed Requirement: Causative Agent

**Description:** Agents such as food, drugs or substances that have caused or may cause an allergy or adverse reaction in this patient.

**Requirement Reference:**

- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).
- SCG Guidance on the Representation of Allergies and Adverse Reaction Information Using NHS Message Templates (Crown Copyright, 2008).
- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).

**Available Data Standards:** SNOMED CT, NHS dm+d.

**Data Examples:**

- Amoxicillin
- Latex
- Peanuts
- Floxapen
- Cat dander
- Alder pollen
- Zinc

**Data Source:** Copied from previous record.

**Data Use:** Information for ongoing care, used to check / update allergy alerts in receiving systems.

**Proposed Data Values:** Description of causative agent.

#### Proposed Requirement: Type Of Causative Agent

**Description:** Category of allergic propensity agent.

**Requirement Reference:** SCG Guidance on the Representation of Allergies and Adverse Reaction Information Using NHS Message Templates (Crown Copyright, 2008).

**Available Data Standards:** SNOMED CT.

**Data Source:** Copied from previous record entry.

**Data Use:** Systems may filter based on type of propensity – e.g. GP systems may prefer to list drug propensities first / separately from other types.

**Proposed Data Values:**

- Propensity to adverse reactions to drug
- Propensity to adverse reactions to food
- Propensity to adverse reactions to non-drug / non-food substance

#### Proposed Requirement: Probability Of Causation

**Description:** The probability that an allergic or adverse reaction may occur due to a causative agent.

**Requirement Reference:**

- SCG Guidance on the Representation of Allergies and Adverse Reaction Information Using NHS Message Templates (Crown Copyright, 2008).

**Available Data Standards:** As per SCG Guidelines on Allergies and Adverse Reactions.

**Data Source:** Copied from previous record entry.

**Data Use:** Continuing care.

**Proposed Data Values:**

<p>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</p>	<ul style="list-style-type: none"> <li>- Probably present</li> <li>- Suspected</li> <li>- Definitely present</li> <li>- Confirmed present</li> </ul>
<b>Proposed Requirement: New Propensity Flag</b>	
<p><b>Description:</b> Indicator that this propensity is an addition to the existing list of allergic propensities.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful to alert GPs as an update to their patient records.</p>	<p><b>Data Source:</b> Copied from previous record entry (or auto-filled at time of entry by system).</p> <p><b>Data Use:</b> Allows receiving systems to filter for new data to update their version of the patient's allergic propensity list.</p> <p><b>Proposed Data Values:</b> Yes / No.</p>
<b>Proposed Requirement: New Reaction Description</b>	
<p><b>Description:</b> A description of the manifestation of the allergic or adverse reaction experienced by the patient. The expression includes the name and may also include the severity of the allergic or adverse reaction which has occurred.</p> <p>NOTE: In Discharge Summary, used only for new allergic propensities (ones identified during this admission).</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- NHS CFH Standards Consulting Group Guidance on the Representation of Allergies and Adverse Reaction Information Using NHS Message Templates (Crown Copyright, 2008).</li> <li>- Adapted from 'Brief description of reaction'(limited here to new reaction during this hospital stay for Discharge Summaries) in Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Examples:</b></p> <ul style="list-style-type: none"> <li>- Blanching rash</li> <li>- Allergic angioedema</li> <li>- Otitis, external ear</li> <li>- Hypotension</li> </ul> <p><b>Data Source:</b> Copied from previous record.</p> <p><b>Data Use:</b> Patient and continuing care information, allows potential update of this patient's allergies and adverse reactions lists in receiving systems.</p> <p>NOTE: Severity level is clinically important as a 'severe' reaction may influence decisions (e.g. about future medications) even when the probability of cause is uncertain.</p> <p><b>Proposed Data Values:</b> Coded expression with Name, Site, Laterality and Severity. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p> <ul style="list-style-type: none"> <li>- Name</li> <li>- Site</li> <li>- Laterality</li> <li>- Severity concepts:</li> <li>* Mild</li> </ul>

	* Moderate * Severe
<b>Proposed Requirement: Date Of Identification</b>	
<b>Description:</b> The date the propensity was first identified or the reaction first experienced.  <b>Requirement Reference:</b> LRA DS expert group 2011 – clinically useful for ongoing primary care.	<b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.  <b>Data Source:</b> Copied from previous record entry.  <b>Data Use:</b> Continuing care.  <b>Proposed Data Values:</b> A string with the format "YYYYMMDD".
<b>Proposed Requirement: Clinical Notes</b>	
<b>Description:</b> A textual description of the reaction as experienced by the patient.  <b>Requirement Reference:</b> LRA DS expert group 2011 – allowance for additional detail at the discretion of the author.	<b>Data Source:</b> Copied from previous record.  <b>Data Use:</b> Patient and continuing care information.  <b>Proposed Data Values:</b> Free text.

## Section 14. Risks And Warnings

This is information that may be vital for a Care Professional to be made aware of quickly, concerning potential risks or warnings related to the presenting patient, or the Care Professional, or other third parties.

[NPFIT-NCR-DES-0135.07 NHS Care Record Elements].

Significant risks may include the patient's infectious disease status, any clinical alerts or risk of self-neglect, self-aggression, or exploitation by others.

[adapted from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)].

Includes 'whether the Patient has any relevant infection, for example MRSA' from the 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).

NOTE: Data may appear both in this section and in other sections of the Discharge Summary (e.g. a diagnosis may be a risk and may be a 'Diagnosis at Discharge' or Comorbidity). Authors should be able to label a data entry in the record as a risk during a single entry process. On editing the entry, the EHR system should be able to keep risk entries in synchrony with the same data where it appears elsewhere in the record.

NOTE: GPs are expected to manage the currency of data that appear on an ongoing Risks and Warnings list for the patient.

### Proposed Requirement: Risk Description

**Description:** Description of the risk to the patient or other parties. May include risk of disease/health, or self neglect/aggression/ exploitation by others, safeguarding risks (e.g. child safety concerns) and/or any clinical alerts stated as warnings.

**Available Data Standards:** SNOMED CT.

**Data Source:** Copied from previous record.

**Data Use:** Patient information and continuing care.

<p>May include anaesthetic risks (e.g. difficult airway / intubation).</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Proposed Data Values:</b> Coded concept expressions. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p>
<b>Proposed Requirement: Risk Category</b>	
<p><b>Description:</b> A broad indication of who is at risk.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- LRA DS expert group 2011 – useful to differentiate among individuals who may be at risk.</li> <li>- 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).</li> </ul>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Source:</b> Copied from previous entry.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Values:</b></p> <ul style="list-style-type: none"> <li>- Risk to Patient</li> <li>- Healthcare Professional at risk</li> <li>- High risk of harm to others</li> </ul>
<b>Proposed Requirement: Risk Probability</b>	
<p><b>Description:</b> The likelihood of the risk occurring to the patient and/or other parties.</p> <p>Note that this information is not applicable to all types of risk or warning.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – potentially clinically useful for ongoing care.</p>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Values:</b></p> <ul style="list-style-type: none"> <li>- Definite</li> <li>- Possible</li> <li>- Probable</li> <li>- Equivocal</li> </ul>
<b>Proposed Requirement: Other Risk Information</b>	
<p><b>Description:</b> A textual description of any additional risk details.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – allowance for additional detail at the discretion of the author.</p>	<p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Values:</b> Free text.</p>

## **Section 15. Clinical Narrative**

Opportunity to describe any additional significant information in narrative form.

Could include, for example, exceptional circumstances related to lack of consent to treatment, etc.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Proposed Requirement: Clinical Narrative**

**Description:** Very brief narrative description of the in-patient episode. Should include complications and nutritional status. (A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)).

Opportunity to describe any additional significant information in narrative form.

Could include, for example, exceptional circumstances related to lack of consent to treatment, etc.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Data Source:** New entry.

**Data Use:** Patient information, continuing care.

**Proposed Data Values:** Free text.

## Section 16. Significant Investigations And Results

The relevant investigations performed and their respective results, where present, e.g. endoscopy, CT Scan etc. It is important to highlight investigations and test results which relate to a GP action. (from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008))

Investigations are procedures that are undertaken to find out more information about a patient's state of health or wellbeing. [NPFIT-NCR-DES-0135.07 NHS Care Record Elements].

**Proposed Requirement: Investigating Department**

**Description:** The clinical department responsible for the investigation.

**Requirement Reference:** Suggested by a member of the NHS CFH Pathology Programme team, accepted by the LRA Discharge Summary expert group 2011.

**Data Source:** Copied from previous record or new entry.

**Data Use:** Patient information, continuing care.

**Proposed Data Values:** A subset of the list of Specialty codes defined by the National Workforce Data set (NWD) v2.2 approved by the NHS Information Centre.

**Proposed Requirement: Investigation Performed**

**Description:** A description of the investigation performed.

Investigations are 'a range of tests, measurements and procedures to obtain further information about an individual's status' (from Headings for Communicating Clinical Information from the Personal Health Record: A Position Paper, Crown Copyright June 1998).

The level of detail included in the description is at the author's discretion.

It has been suggested (in order to support brevity in the Discharge Summary) that it

**Available Data Standards:** For laboratory investigations, NHS National Laboratory Medicine Catalogue (NLMC) Test Request Name or Test Request Display Name (associated with appropriate SNOMED CT concepts), LOINC or NPU. SNOMED CT concept expression for non-laboratory investigations (including the UK National Interim Clinical Imaging Procedure (NICIP) code set).

**Data Examples:**

- abdominal ultrasound

<p>may be preferable to include only those results with an associated clinical interpretation recorded.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<ul style="list-style-type: none"> <li>- full blood count</li> <li>- mini mental state examination</li> <li>- ECT</li> <li>- gastroscopy</li> <li>- Waterlow Pressure Score</li> </ul> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Values:</b> Coded expression. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p>
<b>Proposed Requirement: Clinical Interpretation Of Result</b>	
<p><b>Description:</b> The clinical interpretation of the investigation result.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 - useful to know for patient information and to support ongoing care.</p>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Examples:</b></p> <ul style="list-style-type: none"> <li>- Atrial fibrillation with some lateral ischaemia</li> <li>- High red blood cell count</li> </ul> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Coded expression or free text by exception.</p>
<b>Proposed Requirement: Indication For Investigation</b>	
<p><b>Description:</b> The primary reason for carrying out the investigation.</p> <p><b>Requirement References:</b> LRA DS expert group 2011 – useful to know, for patient information and for ongoing care.</p>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Examples:</b></p> <ul style="list-style-type: none"> <li>- Suspected pneumonia</li> <li>- Family history of cancer of the colon</li> </ul> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b></p> <p><b>Proposed Data Values:</b> Coded expression. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p>
<b>Proposed Requirement: Date Investigation Performed</b>	



<p><b>Description:</b> The start date and optionally time when the investigation was performed.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful to know, for patient information and for ongoing care.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>
<b>Proposed Requirement: Time Investigation Result Available</b>	
<p><b>Description:</b> The date and (optionally) time the investigation result was available in the EHR.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful to know locally and potentially for care follow-up reference.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Clinical audit or follow-up reference.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>
<b>Proposed Requirement: Investigation Status</b>	
<p><b>Description:</b> The activity status of the investigation.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful to know, for patient information and for ongoing care.</p>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b></p> <ul style="list-style-type: none"> <li>* Post-starting action status (at discharge)</li> <li>* Suspended</li> <li>* Completed</li> <li>* Discontinued (Stopped before completion)</li> <li>* Cancelled (Stopped before completion)</li> </ul> <p>[adapted from Context values for actions_EDC_19032009.doc].</p>
<b>Proposed Requirement: Investigation Result</b>	
<p><b>Description:</b> The result value, with unit of observation where applicable.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> NHS National Laboratory Medicine Catalogue, LOINC, NPU and/or SNOMED CT.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Different types of values and units may be associated with different types of investigation.</p>

<b>Proposed Requirement: Reference Range</b>	
<p><b>Description:</b> The reference range applicable to the result, with unit of observation (where applicable).</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 - useful to know to understand the basis for the clinical interpretation of the result.</p>	<p><b>Available Data Standards:</b> Some guidance may be found in the NHS National Laboratory Medicine Catalogue.</p> <p><b>Data Source:</b> Copied from previous record entry (e.g. investigation result record).</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Different types of values and units may be associated with different types of investigation.</p>
<b>Proposed Requirement: Locating More Result Detail</b>	
<p><b>Description:</b> Optional information to guide the reader to more results detail. Depending on the technical environment, this could be a hyperlink to the original results record, etc.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful to know, for patient information and for ongoing care.</p>	<p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Follow-up care.</p> <p><b>Proposed Data Values:</b> Free text.</p>
<b>Proposed Requirement: Link To GP Action</b>	
<p><b>Description:</b> Indicator that this investigation result is linked to a GP action described in the Advice, recommendations and plan to GP section of the Discharge Summary.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful to know, for patient information and for ongoing care.</p>	<p><b>Data Source:</b> New record entry.</p> <p><b>Data Use:</b> Relates this data to other data in the same document.</p> <p><b>Proposed Data Values:</b> Yes / No.</p>

## Section 17. Significant Treatments And Changes Made To Treatments

The relevant treatments which the patient received during the inpatient stay. Can include medication treatments given whilst an inpatient. [A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)].

Note: this is for non-procedural treatments. [LRA DS expert group 2011].

<b>Proposed Requirement: Treatment Description</b>	
<p><b>Description:</b> Treatments are procedures that are intended to have a therapeutic, preventative, curative or palliative effect.</p> <p>[NPFIT-NCR-DES-0135.07 NHS Care Record Elements].</p> <p>If a medication treatment, the description may include dose form.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Examples:</b></p> <ul style="list-style-type: none"> <li>- blood transfusion</li> <li>- chemotherapy</li> </ul> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> SNOMED CT concept expressions for treatments. The intent is to use</p>

	<p>codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p> <p>If a medication treatment, the text string agreed as an unambiguous name for a concept in the UK dm+d (Drugs, Medicines and Devices terminology), according to the dm+d editorial policy [ePS].</p>
<b>Proposed Requirement: Comments</b>	
<p><b>Description:</b> General notes on the treatment administered to the patient during the inpatient stay.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for patient information and for ongoing care.</p>	<p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Free text.</p>
<b>Proposed Requirement: Treatment Onset Time</b>	
<p><b>Description:</b> Date and time treatment was begun.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for patient information and for ongoing care.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>
<b>Proposed Requirement: Treatment End Time</b>	
<p><b>Description:</b> Date and time treatment ended.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for patient information and for ongoing care.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>
<b>Proposed Requirement: Medication Treatment Dose Quantity</b>	
<p><b>Description:</b> A specified quantity of a therapeutic agent, such as a drug, prescribed to be taken at one time or at stated intervals [ePS]. Includes both value and unit of measure.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for patient information and for ongoing care.</p>	<p><b>Available Data Standards:</b> UCUM for units.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Real number or may depend on the therapeutic agent with units.</p>
<b>Proposed Requirement: Medication Treatment Dose Frequency</b>	
<p><b>Description:</b> The number of occurrences of a periodic or recurrent process per unit</p>	<p><b>Available Data Standards:</b> ISO health data types standard for frequency.</p>

time [ePS]. <b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for patient information and for ongoing care.	<b>Data Source:</b> Copied from previous record entry. <b>Data Use:</b> Patient information, continuing care. <b>Proposed Data Values:</b> Frequency at which the medication will be taken.
<b>Proposed Requirement: Medication Treatment Administration Description</b>	
<b>Description:</b> How the medication was administered so as to get into the body or into contact with the body and constitutes part of the “where” (the other part being site). It is the “way in” or the course the medication must take to get to its destination. May include method of administration (e.g. by infusion, via nebuliser, via NG tube) and/or site of use (e.g. ‘to wound’, to left eye, etc.).  The level of detail described is at the author’s discretion.  <b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for patient information and for ongoing care.	<b>Available Data Standards:</b> SNOMED CT. <b>Data Source:</b> Copied from previous record entry. <b>Data Use:</b> Patient information, continuing care. <b>Proposed Data Values:</b> Coded expression.

## Section 18. Measures Of Physical Ability And Cognitive Function

Activity of Daily Living and cognitive scale scores if not independent, function weight/nutritional status at discharge.

**Requirement Reference:** Adapted from A Clinician’s Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

<b>Proposed Requirement: Measures Of Physical Ability</b>	
<b>Description:</b> An assessment using a preferred assessment scale or clinical description to indicate the measure of physical ability of the patient at the time of discharge.  <b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for patient information and for ongoing care.	<b>Available Data Standards:</b> SNOMED CT. <b>Data Examples:</b> - Activity of Daily Living (with score). <b>Data Source:</b> Copied from previous record entry. <b>Data Use:</b> Patient information and continuing care. <b>Proposed Data Values:</b> Coded expression with numerical result value, if appropriate. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).
<b>Proposed Requirement: Cognitive Function</b>	
<b>Description:</b> An assessment of the cognitive function of the patient at the time of discharge which may be determined using suitable cognitive and behaviour assessment techniques or clinical descriptions.  <b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for patient	<b>Proposed Data Values:</b> Coded expression with numerical result value, if appropriate. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to

information and for ongoing care.	<p>automated interpretation).</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Data Examples:</b></p> <ul style="list-style-type: none"> <li>- Cognitive function scale (with score).</li> </ul> <p><b>Available Data Standards:</b> SNOMED CT.</p>
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## Section 19. Current Medications

A list of all prescribed or non-prescribed (e.g. over-the-counter) medications at time of discharge, including pre-admission medications that have changed or are continuing without change. This list is required for the following reasons:

1. To provide a complete list of the patient's current medications.
2. To ensure that GPs can check that the hospital was aware of all the patient's continuing medication.
3. To support the proper operation of prescribing interaction alerts / to avoid medication interactions with known negative effects.

Not to include medications given temporarily during admission and stopped prior to discharge.

Includes (but expands beyond) 'details of any medication prescribed at the time of the Patient's discharge' [2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011)].

Includes (but expands beyond) 'medication dispensed on discharge, medication prescribed and not dispensed (e.g. patient's own), medications to be commenced after discharge and medication compliance aids (e.g. NOMAD / pill dispenser) being used'. [A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)].

### Proposed Requirement: Reconciliation Status

**Description:** Indication as to whether a pre-admission medication is continued or changed during the admission or whether a medication has been newly prescribed during the admission.

A change could include a temporary suspension of a medication.

**Requirement Reference:** Medicines adherence: involving patients in decision about prescribed medicines and supporting adherence – NICE clinical guideline 76 (National Institute for Health and Clinical Excellence, January 2009).

**Data Source:** Copied from previous record entry or manual entry.

**Data Use:** Provides visual indication to Discharge Summary readers on the reconciliation status at discharge of current medications.

**Proposed Data Values:**

- Continued (unchanged from pre-admission)
- Changed – Prescribed, not dispensed
- Changed – Dispensed
- New – Prescribed, not dispensed
- New – Dispensed

### Proposed Requirement: Current Medication Description

<p><b>Description:</b> A prescribed or non-prescribed (e.g. 'over the counter') medication either with no stop date indicated or with a stop date that occurs after the date of discharge.</p> <p>Includes medications suspended temporarily during the hospital stay (and not yet re-started at discharge), indicated as a changed medication.</p> <p>Should include name, dose form, strength and unit dose of the medication taken by the patient, where applicable.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence – NICE clinical guideline 76 (National Institute for Health and Clinical Excellence, January 2009).</li> <li>- Name, Form, and Dose Strength in Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Available Data Standards:</b> NHS dm+d.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Medication name, dose form, monitored dosage system.</p>
<b>Proposed Requirement: Medication Dose Quantity</b>	
<p><b>Description:</b> A specified quantity of a therapeutic agent, such as a drug, prescribed to be taken at one time or at stated intervals (from the NHS e-Prescription Service). Includes both value and unit of measure.</p> <p><b>Requirements References:</b> Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</p>	<p><b>Available Data Standards:</b> NHS dm+d for units.</p> <p><b>Data Source:</b> Copied from previous record.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Values and units.</p>
<b>Proposed Requirement: Medication Administration Description</b>	
<p><b>Description:</b> How the medication was administered so as to get into the body or into contact with the body and constitutes part of the "where" (the other part being site). It is the "way in" or the course the medication must take to get to its destination. May include method of administration (e.g. by infusion, via nebuliser, via NG tube) and/or site of use (e.g. 'to wound', to left eye, etc.).</p> <p>The level of detail described is at the author's discretion.</p> <p><b>Requirements References:</b></p> <ul style="list-style-type: none"> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Available Data Standards:</b> NHS dm+d for route and site. SNOMED CT for Method.</p> <p><b>Data Source:</b> Copied from previous record.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Coded expression. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p>
<b>Proposed Requirement: Medication Dose Frequency</b>	

<p><b>Description:</b> The number of occurrences of a periodic or recurrent process per unit time [ePS].</p> <p><b>Requirements References:</b></p> <ul style="list-style-type: none"> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Available Data Standards:</b> ISO health data types standard for frequency.</p> <p><b>Data Source:</b> Copied from previous record.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Frequency at which the medication will be taken.</p>
<b>Proposed Requirement: Medication Start Date</b>	
<p><b>Description:</b> Date the medication at this dose was first taken by the patient. This data should be recorded to the best precision known, but may be imprecise (e.g. year only or month and year only). This is not intended as the date when a medication was first recorded within the health record or became known to a health service provider.</p> <p>Note: Any change in dose for the same medication would require a new start date. A change in route for the same medication at the same dose would not require a new start date.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- LRA DS expert group 2011 – useful to know for continuing care.</li> <li>- Requirement specified for Changed Medications in Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Copied from previous record entry or new entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDD".</p>
<b>Proposed Requirement: Medication End Date</b>	
<p><b>Description:</b> Date for discontinuing the medication.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence – NICE clinical guideline 76 (National Institute for Health and Clinical Excellence, January 2009).</li> </ul>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDD".</p>
<b>Proposed Requirement: Medication Review Date</b>	
<p><b>Description:</b> Date for reviewing whether the medication should be continued or changed.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre,</li> </ul>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p>

2008). - Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence – NICE clinical guideline 76 (National Institute for Health and Clinical Excellence, January 2009).	<b>Proposed Data Values:</b> A string with the format "YYYYMMDD".
<b>Proposed Requirement: Medication Review Responsibility</b>	
<b>Description:</b> The person or organisation responsible for reviewing the medication. <b>Requirement Reference:</b> Input received during the open review of draft LRA Discharge Summary technical models (2011).	<b>Data Examples:</b> - GP - Specific GP Practice - This hospital - Specific nursing home - 'Homecare' service <b>Data Source:</b> Copied from hospital medication record. <b>Data Use:</b> Patient information and continuing care. <b>Proposed Data Values:</b> Free text.
<b>Proposed Requirement: Medication Quantity Dispensed</b>	
<b>Description:</b> The quantity of medication dispensed. <b>Requirement Reference:</b> LRA DS expert group 2011 – useful to know for continuing care.	<b>Available Data Standards:</b> UK dm+d. <b>Data Examples:</b> - 30 tablets. <b>Data Source:</b> Copied from hospital medication record. <b>Data Use:</b> Patient information and continuing care. <b>Proposed Data Values:</b> Real number (or further constrained) value with units.
<b>Proposed Requirement: Indication For Medication</b>	
<b>Description:</b> The clinical reason for providing the medication. More than one reason may be appropriate for providing a medication. <b>Requirements References:</b> - Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence – NICE clinical guideline 76 (National Institute for Health and Clinical Excellence, January 2009). - Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).	<b>Available Data Standards:</b> SNOMED CT. <b>Data Examples:</b> - Acute myocardial infarction, first, confirmed present. - Carcinoma of hepatic flexure, probably present, first episode. <b>Data Source:</b> Linked / copied from Diagnoses at Discharge, Allergy and Adverse Reactions, Operations and Procedures and Problems. <b>Data Use:</b> Information for patients and care providers, updates to the patient's primary or shared care records, use in primary care decision support algorithms



	<p>Note: The values proposed for clinical severity are those currently in use in UK GP systems today. These values may be encoded to support efficient and readable human record-keeping, but further guidance and training is likely necessary to enable very precise and consistent clinical interpretations. Designers of decision support systems must apply discretion about the use of this data based on the reliability of its interpretation. Some clinical specialties may have fully-specified severity scoring frameworks, and these may be referenced in the LRA in future versions.</p> <p><b>Proposed Data Values:</b> Coded expressions. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p>
<b>Proposed Requirement: Medication Instructions</b>	
<p><b>Description:</b> Guidance related to medication dose expressed in lay terms.</p> <p>Includes:</p> <ul style="list-style-type: none"> <li>- timing of the dosage (frequency and duration),</li> <li>- rate of administration,</li> <li>- "additional information" (e.g. swallow whole, on an empty stomach).</li> </ul> <p>May include details of variable dose regimens (e.g. oral corticosteroids, warfarin, etc.).</p> <p>May include information about storage, unusual prescriptions, unusual supply issues or monitoring information.</p> <p><b>Requirement Reference:</b> Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</p>	<p><b>Available Data Standards:</b> [Suggestion has been made to add a reference to a BMA Guideline for prescribing here].</p> <p><b>Data Examples:</b></p> <ul style="list-style-type: none"> <li>- GP to initiate.</li> <li>- Patient to start in 3 days.</li> </ul> <p><b>Data Source:</b> Copied from hospital medication record.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Values:</b> Free text.</p> <p>NOTE: Free text is also currently used in the NHS National Programme for IT's electronic Prescriptions Service for dosage instructions. Future work to structure medications dose instructions for the NHS is intended, but not yet scheduled.</p>
<b>Proposed Requirement: Indication For Medication Change</b>	
<p><b>Description:</b> The reason(s) for changing (between pre-admission and discharge) a current medication. This includes reasons for temporarily suspending a current medication.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- LRA DS expert group 2011 – useful to know for continuing care.</li> <li>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Data Source:</b> Manual entry or copied from a previous record (or linked with data elsewhere in this record).</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Free text.</p>
<b>Proposed Requirement: Medication Change Description</b>	
<p><b>Description:</b> Category of medication change between pre-admission and discharge. Includes changes in dose form, quantity, frequency or route. Includes temporary suspensions of a current medication to be recommenced following discharge (details</p>	<p><b>Data Source:</b> Copied from previous record or new entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p>

for which should be included here).	<b>Proposed Data Values:</b> Free text.
<b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	
<b>Proposed Requirement: Date Of Latest Medication Change</b>	
<b>Description:</b> The date of the latest change to this medication during this admission.	<b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.
<b>Requirement Reference:</b> LRA DS expert group 2011 – useful to know for continuing care.	<b>Data Source:</b> Manual entry.
	<b>Data Use:</b> Patient information, continuing care.
	<b>Proposed Data Values:</b> A string with the format "YYYYMMDD".
<b>Proposed Requirement: Medication Compliance Aid</b>	
<b>Description:</b> A device currently used by the patient to comply with their medication requirements. E.g. pill dispensers, medication reminder electronic devices etc.	<b>Available Data Standards:</b> SNOMED CT.
<b>Requirement Reference:</b> Adapted from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	<b>Data Examples:</b>
	- Pill dispenser.
	- Electronic medication reminders
	<b>Data Source:</b> Copied from previous record entry.
	<b>Data Use:</b> Patient information and continuing care.
	<b>Proposed Data Values:</b> Coded expression for medication device. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).
<b>Proposed Requirement: Medication Compliance Aid Comment</b>	
<b>Description:</b> Additional information about a medication compliance aid. Could include information about how often it should be filled (e.g. weekly, monthly, etc.) and who is responsible for filling, etc.	<b>Data Examples:</b>
<b>Requirement Reference:</b> Adapted from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	- To be filled monthly by patient's local pharmacy.
	<b>Data Source:</b> Copied from previous record entry or new entry.
	<b>Data Use:</b> Patient information and continuing care.
	<b>Proposed Data Values:</b> Free text.

## Section 20. Medication Recommendations

A list of medications (and medications-related) recommendations advised for action following discharge.

**Requirement Reference:** LRA DS expert group 2011.

#### Proposed Requirement: Medication Related Recommendation

**Description:** A suggestion about duration and/or review, ongoing monitoring requirements, advice or starting, discontinuing or changing items in a patient's medication record (to be actioned following discharge). Can include requirements for adherence support (e.g. compliance aids, prompts and packaging requirements). Can also include information about specific brand names or a special product where bioavailability or formulation issues arise. The recommendation may be made to another clinician or directly to the patient. It may be followed or ignored by subsequent carers. (from Medication Management in NPfIT, Version 17, 26/08/04 combined with Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011)).

**Requirement Reference:**

- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).
- Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence – NICE clinical guideline 76 (National Institute for Health and Clinical Excellence, January 2009).
- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).

**Data Examples:**

- Patient advised to visit community pharmacist post-discharge for a medicines use review (MUR).
- Consider change medication <a> to medication <b> if not effective
- Consider stopping medications <c> and <d>.
- Change dose of <z> after 3 weeks.
- Continue medications <x> and <y>.

**Data Source:** Copied from previous record entry or new entry.

**Data Use:** Patient information, continuing care.

**Proposed Data Values:** Free text.

#### Proposed Requirement: Service Organisation Recommendation Recipient

**Description:** The organisation intended as the recipient of the medication recommendation.

To be used only if the intended recipient is an organisation rather than an individual.

**Requirement Reference:** Input received during the open review of draft LRA Discharge Summary technical models (2011).

**Available Data Standards:** Organisational code used within the NHS England and Wales and provided and maintained by SDS.

**Data Source:** Copied from previous record or new entry.

**Data Use:** Contact, information for patient and follow-up care.

**Proposed Data Values:** Organisation codes.

#### Proposed Requirement: Person Recommendation Recipient

**Description:** Person who is the intended recipient for the medication recommendation.

**Requirement Reference:** Input received during the open review of draft LRA Discharge Summary technical models (2011).

**Available Data Standards:** ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.

**Data Source:** Copied from previous record entry or new record entry.

**Data Use:** Contact.

**Proposed Data Values:** [Prefixes][Given names][Family names][Suffixes].

Proposed Requirement: Contact Address	
<p><b>Description:</b> The address of the service.</p> <p><b>Requirement References:</b> LRA DS expert group 2011 – useful for contact.</p>	<p><b>Available Data Standards:</b> BS7666 address standard, ISB 1500: Common User Interface - Address Input and Display.</p> <p><b>Data Source:</b> Copied from previous record / PAS.</p> <p><b>Data Use:</b> Contact.</p> <p><b>Proposed Data Values:</b> Address Prefix, Building Name and Building Number; Dependent Street or Road Name, and Street or Road Name; Dependent Locality and Double dependent locality; Postal Town; Postal County; Postal Code; PAF Key - unique ID for an address allocated by the Royal Mail.</p>
Proposed Requirement: Contact Telephone Numbers	
<p><b>Description:</b> Telephone number(s) associated with the service.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for contact.</p>	<p><b>Available Data Standards:</b> e-GIF GDSC standard for UK Telephone Number, ISB 1508: Common User Interface - Telephone Number Input and Display, Telecommunication Address Use codes from ISO 21090.</p> <p><b>Data Source:</b> Previous record entry or new entry.</p> <p><b>Data Use:</b> Contact.</p> <p><b>Proposed Data Values:</b> Telephone number(s), with an optional 'Use' code or set of codes which may be assigned to differentiate number type :</p> <ul style="list-style-type: none"> <li>- home</li> <li>- primary home</li> <li>- vacation home</li> <li>- work place</li> <li>- direct (to the person)</li> <li>- public</li> <li>- temporary</li> <li>- answering service</li> <li>- emergency contact</li> <li>- mobile contact</li> <li>- pager</li> </ul> <p>(NOTE: more than one of the use descriptions above may apply to the same number).</p>
Proposed Requirement: Date For Actions	
<p><b>Description:</b> The date(s) and optionally time when the action is planned to be</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501:</p>

<p>executed.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p>Common User Interface - Time Display.</p> <p><b>Data Source:</b> Copied from previous record or new entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>
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## Section 21. Stopped Medications

A list of medications that were discontinued during this admission.

To include:

- Pre-admission medications stopped during admission and still discontinued at time of discharge.
- Medications started during this admission and stopped because of adverse reaction (this should also appear in the adverse reaction section of the Discharge Summary).
- Medications stopped because of ineffectiveness.
- Pre-admission medications stopped because of course conclusion (i.e. planned end date occurred during admission).

**Requirement Reference:** LRA DS expert group 2011.

### Proposed Requirement: Stopped Medication

**Description:** The name of the stopped medication. The medication will consist of the name and optionally the form, strength, and unit dose.

To include:

- Pre-admission medications stopped during admission and still discontinued at time of discharge.
- Medications started during this admission and stopped because of adverse reaction (this should also appear in the adverse reaction section of the Discharge Summary).
- Medications stopped because of ineffectiveness.
- Pre-admission medications stopped because of course conclusion (i.e. planned end date occurred during admission).

**Requirement Reference:**

- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).
- Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence – NICE clinical guideline 76 (National Institute for Health and Clinical Excellence, January 2009).

**Available Data Standards:** UK dm+d.

**Data Source:** Manual entry or copied from previous record entry.

**Data Use:** Patient information, continuing care (e.g. to allow for automated prompts to update the Current Medications lists for this patient in the patient records of Discharge Summary recipients).

**Proposed Data Values:** Name of stopped medication.

Proposed Requirement: Medication Start Date	
<p><b>Description:</b> Date the medication was first taken by the patient, if known (may be approximate).</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for reconciling current medications lists between care providers, and for patient / care provider information</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDD".</p>
Proposed Requirement: Medication Stop Date	
<p><b>Description:</b> The date the medication was discontinued.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for reconciling current medications lists between care providers, and for patient / care provider information.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> Copied from previous record entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDD".</p>
Proposed Requirement: Indication For Stopping Medication	
<p><b>Description:</b> Rationale for stopping the medication, current at the time of discharge.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre, 2008).</li> <li>- Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence – NICE clinical guideline 76 (National Institute for Health and Clinical Excellence, January 2009).</li> </ul>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Examples:</b></p> <ul style="list-style-type: none"> <li>- Achieved goal.</li> <li>- Lack of effect.</li> <li>- Patient declined.</li> <li>- No longer applicable (e.g. the patient was taking a pregnancy medication and is no longer pregnant).</li> <li>- Patient cannot swallow a particular tablet (this may also be entered as a Risk / Warning in the Discharge Summary).</li> <li>- Product discontinued (e.g. a new product has been launched to replace an older product).</li> </ul> <p><b>Data Source:</b> Linked / copied from Diagnoses at Discharge, Allergy and Adverse Reactions, Operations and Procedures and Problems.</p> <p><b>Data Use:</b> Information for patients and care providers.</p> <p><b>Proposed Data Values:</b> Coded expressions. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p>
Proposed Requirement: Indication For Medication Before Stopping	

<p><b>Description:</b> The reason the medication had been given (before being stopped).</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for reconciling current medications lists between care providers, and for patient / care provider information.</p>	<p><b>Available Data Standards:</b> SNOMED CT.</p> <p><b>Data Examples:</b></p> <ul style="list-style-type: none"> <li>- Acute myocardial infarction, first, confirmed present.</li> <li>- Carcinoma of hepatic flexure, probably present, first episode.</li> </ul> <p><b>Data Source:</b> Linked / copied from Diagnoses at Discharge, Allergy and Adverse Reactions, Operations and Procedures and Problems.</p> <p><b>Data Use:</b> Information for patients and care providers.</p> <p><b>Proposed Data Values:</b> Coded expressions. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).</p>
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## Section 22. Hospital Advice Recommendations And Future Plan

Actions required/that will be carried out by the hospital department. To include:

- Action (e.g. outpatient, pending investigations and results, outstanding issues)
- Person responsible
- Appropriate date and time.

[A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008 )].

Includes 'any planned follow-up arrangements' (2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011)).

### Proposed Requirement: Hospital Actions

**Description:** Actions required to be taken up by the hospital post discharge of the patient e.g. Outpatient activities, planned investigations, and other outstanding issues).

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Data Source:** Copied from previous record (e.g. procedure waiting list, investigations planned, planned clinic appointments) or manual entry where necessary.

**Data Use:** Patient information and continuing care.

**Proposed Data Values:** Coded value (free text as exception).

### Proposed Requirement: Contact Person

**Description:** The person, in the capacity of the role they play in the hospital, responsible for performing the action.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Available Data Standards:** ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.

**Data Source:** Copied from previous record or new record entry.

**Data Use:** Future communication.

<b>Proposed Requirement: Specialty Department Responsible For Action</b>	
<b>Description:</b> The speciality/department responsible for action. <b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	<b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes]. <b>Data Source:</b> Copied from previous record or new entry. <b>Data Use:</b> Patient information, continuing care. <b>Proposed Data Values:</b> The list of Specialty codes defined by the National Workforce Data set (NWD) v2.2 approved by the NHS Information Centre.
<b>Proposed Requirement: Date For Actions</b>	
<b>Description:</b> The date and optionally time when the action is planned to be executed by the hospital. <b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	<b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display. <b>Data Source:</b> Copied from previous record entry or new entry. <b>Data Use:</b> Patient information, continuing care. <b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".
<b>Proposed Requirement: Comments</b>	
<b>Description:</b> Opportunity to record additional information about the future action. May include the status of the action in terms of Booked, Proposed, Requested. <b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for added detail at the author's discretion.	<b>Data Source:</b> Copied from previous record entry or new entry. <b>Data Use:</b> Patient information, continuing care. <b>Proposed Data Values:</b> Free text.

## Section 23. GP Advice Recommendations And Future Plan

Actions advised or recommended to the GP. To include:

- Action (e.g. specific actions, pending investigations and results, outstanding issues, HRT and cervical screening).
- Person responsible
- Appropriate date and time
- Suggested strategies for potential problems, e.g. telephone contact for advice

[A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)].

Includes 'any immediate post-discharge requirement from the primary healthcare team' (2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011)).

### Proposed Requirement: GP Actions



<p><b>Description:</b> Action suggestions directed to the GP by the hospital at the time of discharge of the patient. These may include a clinical review to be performed (e.g. BP check, investigations, etc), a prescribing review (based on medication recommendations and discharge medications prescribed), vaccination, referral to another service, strategies for potential problems, etc.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</li> <li>- 2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011).</li> </ul>	<p><b>Data Source:</b> Copied from previous record or new entry.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Values:</b> Coded value (free text as exception).</p>
<b>Proposed Requirement: Date For Actions</b>	
<p><b>Description:</b> The date(s) and optionally time when the action is planned to be executed.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> Copied from previous record or new entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>
<b>Proposed Requirement: Comments</b>	
<p><b>Description:</b> Opportunity to record additional information about the future action. May include the status of the action in terms of Booked, Proposed or Requested.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful for added detail, at the author's discretion.</p>	<p><b>Data Source:</b> Copied from previous record or new entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Values:</b> Free text.</p>

## Section 24. Community And Specialist Services Advice Recommendations And Future Plan

Actions requested/planned/agreed directly with community services (community matron, palliative care, specialist nurse practitioner, rehab team, social services, community service). Actions via the GP for these services would be recorded as advice to the GP. To include:

- Action.
- Person responsible.
- Appropriate date and time.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Proposed Requirement: Community And Specialist Services Actions**

<p><b>Description:</b> Advice, recommendations or plan actions directed to community and specialty services.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Data Source:</b> Copied from previous record or new entry.</p> <p><b>Data Use:</b> Patient information and continuing care.</p> <p><b>Proposed Data Value:</b> Free text.</p>
<b>Proposed Requirement: Service Organisation Responsible For Action</b>	
<p><b>Description:</b> The organisation responsible for taking a community or specialist service action.</p> <p>To be used only if the responsibility lies with an organisation rather than an individual.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> Organisational code used within the NHS England and Wales and provided and maintained by SDS.</p> <p><b>Data Source:</b> Copied from previous record or new entry.</p> <p><b>Data Use:</b> Contact, information for patient and follow-up care.</p> <p><b>Proposed Data Value:</b> Organisation codes.</p>
<b>Proposed Requirement: Contact Person</b>	
<p><b>Description:</b> Service person who may be contacted concerning this action.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.</p> <p><b>Data Source:</b> Copied from previous record entry or new record entry.</p> <p><b>Data Use:</b> Contact.</p> <p><b>Proposed Data Value:</b> [Prefixes][Given names][Family names][Suffixes].</p>
<b>Proposed Requirement: Contact Address</b>	
<p><b>Description:</b> The address of the service.</p> <p><b>Requirement References:</b> LRA DS expert group 2011 – useful for contact.</p>	<p><b>Available Data Standards:</b> BS7666 address standard, ISB 1500: Common User Interface - Address Input and Display.</p> <p><b>Data Source:</b> Copied from previous record / PAS.</p> <p><b>Data Use:</b> Contact.</p> <p><b>Proposed Data Value:</b> Address Prefix, Building Name and Building Number; Dependent Street or Road Name, and Street or Road Name; Dependent Locality and Double dependent locality; Postal Town; Postal County; Postal Code; PAF Key - unique ID for an address allocated by the Royal Mail.</p>
<b>Proposed Requirement: Contact Telephone Numbers</b>	
<p><b>Description:</b> Telephone numbers associated with the service.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – useful for contact.</p>	<p><b>Available Data Standards:</b> e-GIF GDSC standard for UK Telephone Number, ISB 1508: Common User Interface - Telephone Number Input and Display, Telecommunication Address Use codes from ISO 21090.</p> <p><b>Data Source:</b> Previous record entry or new entry.</p> <p><b>Data Use:</b> Contact.</p>

	<p><b>Proposed Data Value:</b> Telephone number(s), with an optional 'Use' code or set of codes which may be assigned to differentiate number type :</p> <ul style="list-style-type: none"> <li>- home</li> <li>- primary home</li> <li>- vacation home</li> <li>- work place</li> <li>- direct (to the person)</li> <li>- public</li> <li>- temporary</li> <li>- answering service</li> <li>- emergency contact</li> <li>- mobile contact</li> <li>- pager</li> </ul> <p>(NOTE: more than one of the use descriptions above may apply to the same number).</p>
<b>Proposed Requirement: Date For Actions</b>	
<p><b>Description:</b> The date(s) and optionally time when the action is planned to be executed.</p> <p><b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> Copied from previous record or new entry.</p> <p><b>Data Use:</b> Patient information, continuing care.</p> <p><b>Proposed Data Value:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>

## Section 25. Information For Patient

Information within the Discharge Summary intended as advice given directly to the patient (as a recipient of the Discharge Summary). [LRA DS expert group 2011].

Includes 'any other relevant or necessary instructions (for the Patient)' [2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011)].

### Proposed Requirement: Advice For Patient

**Description:** Any additional advice intended for the patient's attention.

May include advice about actions related to medicines or other ongoing care activities.

**Requirement Reference:** 2011/12 Standard Terms and Conditions for Acute Hospital

**Data Source:** New entry.

**Data Use:** Self-care.

**Proposed Data Values:** Free text.

Services (Department of Health, April 2011).

## Section 26. Information Given To Patient And Or Authorised Representative

The verbal or written information or advice given to the patient and/or authorised representative such as relatives and carers. Differentiation is required between information given to patients, carers and any other authorised representatives. [Adapted from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)].

Includes 'any other relevant or necessary information (for the Patient)'. [2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011)].

### Proposed Requirement: Recipient Name

**Description:** The name of the person who received verbal or written information or advice.

**Requirement Reference:** LRA DS expert group 2011 – useful to support information governance.

**Available Data Standards:** ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.

**Data Source:** PAS.

**Data Use:** Information for patient and continuing care.

**Proposed Data Values:** [Prefixes][Given names][Family names][Suffixes].

### Proposed Requirement: Relationship To Patient

**Description:** The relationship of the Recipient to the patient.

**Requirement Reference:** LRA DS expert group 2011 – useful to support information governance.

**Available Data Standards:** A potential extension of NHS Data Model & Dictionary Version 3.

**Data Source:** New entry.

**Data Use:** Patient information governance.

**Proposed Data Values:**

- Self
- Carer
- Spouse or civil partner
- Parent or Guardian
- Son or daughter
- Sibling
- Grandparent
- Grandchild
- Uncle or aunt
- Nephew or Niece
- Power of Attorney

	<ul style="list-style-type: none"> <li>- Proxy; Contact</li> <li>- Proxy; Communication</li> <li>- Proxy; Contact and Communication</li> <li>- GP</li> <li>- Other health service provider</li> <li>- Social care service provider</li> </ul>
<b>Proposed Requirement: Verbal Communication Given</b>	
<b>Description:</b> A description of information communicated verbally. <b>Requirement Reference:</b> LRA DS expert group 2011 – useful to patient and for follow-up care.	<b>Data Source:</b> New entry. <b>Data Use:</b> Follow-up care. <b>Proposed Data Values:</b> Free text.
<b>Proposed Requirement: Written Communication Given</b>	
<b>Description:</b> A description of written communication provided. NOTE: The written information including leaflets should include local as well as national information. NOTE: All information given to patients/carers should be given in a simple understandable format without the use of acronyms and clinical jargon. <b>Requirement Reference:</b> LRA DS expert group 2011 – useful to patient and for follow-up care.	<b>Data Source:</b> New entry. <b>Data Use:</b> Follow-up care. <b>Proposed Data Values:</b> Free text.

## Section 27. Patients Concerns Expectations And Wishes

The patient's expressed wishes, expectations and concerns.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

### Proposed Requirement: Patients Concerns Expectations And Wishes

<b>Description:</b> This will be a free text field, examples of use include: <ul style="list-style-type: none"> <li>- Continuity of care in the community to avoid gaps in the service when leaving the hospital setting, providing care where required, wherever the patient may be.</li> <li>- Patients with long term conditions, e.g. requiring recovery time from operations, radiotherapy. chemotherapy and many more, may require social services for sickness and disability benefits for the patient and their families to be able to manage financially whilst off work sick.</li> <li>- Ensuring correct support systems for the parents of children with long term</li> </ul>	<b>Data Source:</b> Copied from previous record or new entry. <b>Data Use:</b> Patient influence in ongoing care. <b>Proposed Data Values:</b> Free text.
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conditions, including both mental and physical.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

## Section 28. Results Awaited

Brief description of the results awaited e.g. pathology, investigations, imaging.

**Requirement Reference:** Adapted from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

### Proposed Requirement: Investigation Name

**Description:** The name of the investigation.

**NOTE:** The Investigation expression could include the site and laterality where the investigation was performed.

**Requirement Reference:** A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

**Available Data Standards:** SNOMED CT.

**Data Source:** Copied from previous record.

**Data Use:** Patient information, continuing care.

**Proposed Data Values:** Coded expression. The intent is to use codes wherever applicable (to allow automated record updates and analyses), but where authors want to add free text annotation, this should also be supported. Where no appropriate code exists, this value should be free text. (Note that free text data would not be accessible to automated interpretation).

### Proposed Requirement: Investigation Request Date

**Description:** Date the investigation was requested.

**Requirement Reference:** LRA DS expert group 2011 – useful to patient and for follow-up care.

**Available Data Standards:** ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.

**Data Source:** Copied from previous record.

**Data Use:** Patient information, continuing care.

**Proposed Data Values:** A string with the format "YYYYMMDD".

### Proposed Requirement: Investigation Date Result Expected

**Description:** Date of expected result, if known.

**Requirement Reference:** LRA DS expert group 2011 – useful to patient and for follow-up care.

**Available Data Standards:** ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.

**Data Source:** Copied from previous record or new entry.

**Data Use:** Patient information, continuing care.

**Proposed Data Values:** A string with the format "YYYYMMDD".

### Proposed Requirement: Comments On Results Awaited

**Description:** Opportunity to record any advice or instructions related to pending

**Data Source:** Copied from previous record entry.

results.  <b>Requirement Reference:</b> LRA DS expert group 2011 – potentially useful to patient and for follow-up care.	<b>Data Use:</b> Patient information and continuing care.  <b>Proposed Data Values:</b> Free text.
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## Section 29. Person Entering Data

Details of the user entering the discharge summary data.

**Requirement Reference:** LRA DS expert group 2011.

<b>Proposed Requirement: Person Entering Data Name</b>	
<b>Description:</b> Name of the user entering the discharge summary data into the system.  <b>Requirement Reference:</b> LRA DS expert group 2011 – local audit purposes.	<b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.  <b>Data Source:</b> EHR system user identification.  <b>Data Use:</b> Local data provenance.  <b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].
<b>Proposed Requirement: Person Entering Data Role</b>	
<b>Description:</b> Grade of the user entering the discharge summary data into the system.  <b>Requirement Reference:</b> LRA DS expert group 2011 – local audit purposes.	<b>Available Data Standards:</b> Job Roles National Workforce Dataset v2.2.  <b>Data Source:</b> System sign on.  <b>Data Use:</b> Local data provenance.  <b>Proposed Data Values:</b> Role code.
<b>Proposed Requirement: Date Of Discharge Record Entry</b>	
<b>Description:</b> Date of completion of discharge record.  <b>Requirement Reference:</b> LRA DS expert group 2011 – local audit purposes.	<b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1503: Common User Interface - Date Display.  <b>Data Source:</b> System generated date stamp for 'last modified on', Manual entry by exception.  <b>Data Use:</b> Local data provenance.  <b>Proposed Data Values:</b> A string with the format "YYYYMMDD".
<b>Proposed Requirement: Document Version</b>	
<b>Description:</b> Version of the discharge summary once the data has been entered.  NOTE: If a discharge summary is being updated, then the document version number will be incremented.  <b>Requirement Reference:</b> LRA DS expert group – useful to track any updates made to the document.	<b>Data Source:</b> Data author.  <b>Data Use:</b> Shared reference for data integrity.  <b>Proposed Data Values:</b> Undefined.

## Section 30. Person Authoring Data

Details of the healthcare professional(s) authoring the summary. [Adapted from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)].

Includes 'the name and position of the person to whom questions about the content of the Discharge Summary may be addressed, and complete and accurate contact details (including a telephone number) for that person. [2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011)].

Includes 'contact details for the Provider's facility'. [2011/12 Standard Terms and Conditions for Acute Hospital Services (Department of Health, April 2011)].

### Proposed Requirement: Person Authoring Data Name

**Description:** Name of the person who takes overall responsibility for the complete discharge summary data.

**Requirement Reference:**

- LRA DS expert group 2011 – for data provenance.
- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).

**Available Data Standards:** ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.

**Data Source:** EHR system user identification.

**Data Use:** Data provenance (used locally only).

**Proposed Data Values:** [Prefixes][Given names][Family names][Suffixes].

### Proposed Requirement: Person Authoring Data Grade

**Description:** Grade of the person who authored the data.

**Requirement Reference:**

- LRA DS expert group 2011 – for data provenance.
- Equivalent to 'job title' in Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).

**Available Data Standards:** As per the Job Roles National Workforce Dataset v2.2.

**Data Source:** System sign on, manual entry by exception.

**Data Use:** Follow up care / contact.

**Proposed Data Values:** Grade of person authoring data.

### Proposed Requirement: Person Authoring Data Specialty

**Description:** Speciality of the person who authors the discharge summary data.

**Requirement Reference:** LRA DS expert group 2011 – for data provenance.

**Available Data Standards:** Specialty of a Consultant as per the National Workforce Dataset (NWD) v2.2.

**Data Source:** System sign on, manual entry by exception.

**Data Use:** Follow up care.

**Proposed Data Values:** Speciality of person authoring data.

### Proposed Requirement: Person Authoring Data Treatment Specialty

**Description:** Treatment Speciality is based on specialty, but also includes approved sub-specialties and treatment specialties used by lead care professionals including hospital consultants.

**Available Data Standards:** NHS Data Model & Dictionary Version 3 Treatment Function Code.

**Data Source:** PAS.



<p><b>Requirement Reference:</b> LRA DS expert group 2011 – for data provenance.</p>	<p><b>Data Use:</b> Follow up care.</p> <p><b>Proposed Data Values:</b> Treatment Speciality of person authoring data.</p>
<p><b>Proposed Requirement: Contact Telephone Numbers</b></p>	
<p><b>Description:</b> Telephone number(s) associated with the person authoring the Discharge Summary.</p> <p><b>Requirement Reference:</b> Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</p>	<p><b>Available Data Standards:</b> e-GIF GDSC standard for UK Telephone Number, ISB 1508: Common User Interface - Telephone Number Input and Display, Telecommunication Address Use codes from ISO 21090.</p> <p><b>Data Source:</b> Previous record entry or new entry.</p> <p><b>Data Use:</b> Contact.</p> <p><b>Proposed Data Values:</b> Telephone number(s), with an optional 'Use' code or set of codes which may be assigned to differentiate number type:</p> <ul style="list-style-type: none"> <li>- home</li> <li>- primary home</li> <li>- vacation home</li> <li>- work place</li> <li>- direct (to the person)</li> <li>- public</li> <li>- temporary</li> <li>- answering service</li> <li>- emergency contact</li> <li>- mobile contact</li> <li>- pager</li> </ul> <p>(NOTE: more than one of the use descriptions above may apply to the same number).</p>
<p><b>Proposed Requirement: Discharge Summary Authoring Date</b></p>	
<p><b>Description:</b> Date and time the discharge summary data was authored.</p> <p><b>Requirement Reference:</b></p> <ul style="list-style-type: none"> <li>- LRA DS expert group 2011 – for data provenance.</li> <li>- Keeping patients safe when they transfer between care providers – getting the medicines right, Part 1: Good practice guidance for health professions, Royal Pharmaceutical Society (Final Draft 06/06/2011).</li> </ul>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502:NHS ISB 1503: Common User Interface - Date Display, NHS ISB 1501: Common User Interface - Time Display.</p> <p><b>Data Source:</b> System generated time and date stamp for 'last modified on', manual entry by exception.</p> <p><b>Data Use:</b> Policy requirements.</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDDHHMMSS.UUUU[+ -ZZzz]".</p>

## Section 31. Person Verifying Data

Details of the healthcare professional(s) verifying the summary.

**Requirement Reference:** Adapted from A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).

### Proposed Requirement: Person Verifying Data Name

**Description:** Name of the person who verifies the discharge summary data.

**Requirement Reference:** LRA DS expert group 2011 – for data provenance.

**Available Data Standards:** ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.

**Data Source:** EHR system user identification.

**Data Use:** Data provenance (used locally only).

**Proposed Data Values:** [Prefixes][Given names][Family names][Suffixes].

### Proposed Requirement: Person Verifying Data Grade

**Description:** Grade of the person who verifies the discharge summary data.

**Requirement Reference:** LRA DS expert group 2011 – for data provenance.

**Available Data Standards:** UK Job Roles National Workforce Dataset v2.2.

**Data Source:** System sign on, manual entry by exception.

**Data Use:** Follow up care.

**Proposed Data Values:** Grade of person verifying data.

### Proposed Requirement: Person Verifying Data Specialty

**Description:** Speciality of the person who verifies the discharge summary data.

**Requirement Reference:** LRA DS expert group 2011 – for data provenance.

**Available Data Standards:** Specialty of a Consultant as per the National Workforce Dataset (NWD) v2.2.

**Data Source:** System sign on, manual entry by exception.

**Data Use:** Follow up care.

**Proposed Data Values:** Speciality of person verifying data.

### Proposed Requirement: Person Verifying Data Treatment Speciality

**Description:** Treatment Speciality is based on specialty, but also includes approved sub-specialties and treatment specialties used by lead care professionals including hospital consultants.

**Requirement Reference:** LRA DS expert group 2011 – for data provenance.

**Available Data Standards:** NHS Data Model & Dictionary Version 3 Treatment Function Code.

**Data Source:** PAS.

**Data Use:** Follow up care.

**Proposed Data Values:** Treatment Speciality of person verifying data.

### Proposed Requirement: Discharge Summary Verification Date

**Description:** Date the discharge summary data was verified.

**Available Data Standards:** ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface -

<b>Requirement Reference:</b> LRA DS expert group 2011 – for data provenance.	Date and Time Input, NHS ISB 1503: Common User Interface - Date Display. <b>Data Source:</b> System generated date stamp for 'last modified on', manual entry by exception. <b>Data Use:</b> Policy requirements. <b>Proposed Data Values:</b> A string with the format "YYYYMMDD".
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## Section 32. Distribution List

The parties that will be provided copies of the discharge summary. [A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008)].

NOTE: there may be a link (managed mentally by the Discharge Summary author) between Living Alone information, and Patient's wishes, concerns, etc. re communications and the parties on this list. The LRA DS Expert Group 2011 noted that in principle, patient consent for all parties on the distribution list should be managed and also noted that this may be achieved in various ways operationally so as to be efficient within the care workflow.

<b>Proposed Requirement: Recipient Name</b>	
<b>Description:</b> The name of a person who is intended to receive a copy of the Discharge Summary.  <b>Requirement Reference:</b> A Clinician's Guide to Record Standards – Part 2: Standards for the structure and content of medical records and communications when patients are admitted to hospital (Academy of Medical Royal Colleges, October 2008).	<b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.  <b>Data Source:</b> EHR system user identification.  <b>Data Use:</b> Information governance.  <b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].
<b>Proposed Requirement: Organisation Name</b>	
<b>Description:</b> The name of the organisation associated with the Recipient.  <b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.	<b>Available Data Standards:</b> This is the organisational code used within the NHS England and Wales and provided and maintained by SDS. This information is optional and needs to be completed only if the discharge summary is being sent to an organisation or department rather than an individual.  <b>Data Source:</b> PAS or previous record entry.  <b>Data Use:</b> Information governance.  <b>Proposed Data Values:</b> Organisation name associated with coded identifier.
<b>Proposed Requirement: Recipient Address</b>	
<b>Description:</b> The address of the Recipient.  <b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.	<b>Available Data Standards:</b> BS7666 address standard.  <b>Data Source:</b> PAS.  <b>Data Use:</b> Information governance.  <b>Proposed Data Values:</b> Address Prefix, Building Name and Building Number; Dependent Street or Road Name, and Street or Road Name; Dependent Locality and Double dependent locality;

	Postal Town; Postal County; Postal Code; PAF Key - unique ID for an address allocated by the Royal Mail.
<b>Proposed Requirement: Relationship To Patient</b>	
<p><b>Description:</b> The relationship that the recipient of the information has with the patient. This may include the patient himself/herself or a person who represents the patient.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.</p>	<p><b>Available Data Standards:</b> A potential extension of the NHS Data Model &amp; Dictionary Version 3.</p> <p><b>Data Source:</b> Coded manual entry.</p> <p><b>Data Use:</b> Information governance.</p> <p><b>Proposed Data Values:</b></p> <ul style="list-style-type: none"> <li>- Self</li> <li>- Carer</li> <li>- Spouse or civil partner</li> <li>- Parent or Guardian</li> <li>- Son or daughter</li> <li>- Sibling</li> <li>- Grandparent</li> <li>- Grandchild</li> <li>- Uncle or aunt</li> <li>- Nephew or Niece</li> <li>- Power of Attorney</li> <li>- Proxy; Contact</li> <li>- Proxy; Communication</li> <li>- Proxy; Contact and Communication</li> <li>- Other</li> </ul>

### Section 33. Distribution Record

A record of what was sent within the Discharge Summary, when and by whom. This is separate from the Distribution List. The Distribution Record is recorded in the EHR after the Summary is finished signed off and sent to its intended recipients. The person involved in sending could be an entirely new person who didn't have a role in authoring the Discharge Summary.

**Requirement Reference:** LRA DS expert group 2011.

#### Proposed Requirement: Distribution Recipient Name

**Description:** The name of a person who is intended to receive a copy of the

**Available Data Standards:**

<p>Discharge Summary, to store as confidentiality information alongside the Discharge Summary in the originating system (not to be communicated to other information systems with a copy of the Discharge Summary).</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.</p>	<p><b>Data Source:</b> New entry.</p> <p><b>Data Use:</b> Information governance (local audit).</p> <p><b>Proposed Data Values:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.</p>
<b>Proposed Requirement: Distribution Recipient Organisation Name</b>	
<p><b>Description:</b> The name of the organisation associated with the Recipient, to store as confidentiality information alongside the Discharge Summary in the originating system (not to be communicated to other information systems with a copy of the Discharge Summary).</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.</p>	<p><b>Available Data Standards:</b> Organisational code used within the NHS England and Wales and provided and maintained by SDS.</p> <p><b>Data Source:</b> PAS or new entry.</p> <p><b>Data Use:</b> Information governance (local audit).</p> <p><b>Proposed Data Values:</b> Organisation name associated with coded identifier.</p>
<b>Proposed Requirement: Description Of Distributed Content</b>	
<p><b>Description:</b> A description of the content to distributed within the Discharge Summary, to store as confidentiality information alongside the Discharge Summary in the originating system (not to be communicated to other information systems with a copy of the Discharge Summary).</p> <p>Note: Includes version reference.</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.</p>	<p><b>Data Source:</b> New entry.</p> <p><b>Data Use:</b> Information governance (local audit).</p> <p><b>Proposed Data Values:</b> Free text.</p>
<b>Proposed Requirement: Person Responsible For Distribution Name</b>	
<p><b>Description:</b> Name of the user who distributes the Discharge Summary, to store as confidentiality information alongside the Discharge Summary in the originating system (not to be communicated to other information systems with a copy of the Discharge Summary).</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.</p>	<p><b>Available Data Standards:</b> ISO 21090 Health informatics data types, HL7 V3 Data Types, NHS MIM data types.</p> <p><b>Data Source:</b> System sign-on or new entry.</p> <p><b>Data Use:</b> Information governance (local audit).</p> <p><b>Proposed Data Values:</b> [Prefixes][Given names][Family names][Suffixes].</p>
<b>Proposed Requirement: Person Responsible For Distribution Role</b>	
<p><b>Description:</b> Role of the user who distributes the Discharge Summary, to store as confidentiality information alongside the Discharge Summary in the originating system (not to be communicated to other information systems with a copy of the Discharge Summary).</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.</p>	<p><b>Available Data Standards:</b> Job Roles National Workforce Dataset v2.2.</p> <p><b>Data Source:</b> System sign-on or new entry.</p> <p><b>Data Use:</b> Information governance (local audit).</p> <p><b>Proposed Data Values:</b> Job roles codes.</p>
<b>Proposed Requirement: Distribution Date</b>	

<p><b>Description:</b> Date and Time the Discharge Summary was sent to the intended recipients, to store as confidentiality information alongside the Discharge Summary in the originating system (not to be communicated to other information systems with a copy of the Discharge Summary).</p> <p><b>Requirement Reference:</b> LRA DS expert group 2011 – for information governance.</p>	<p><b>Available Data Standards:</b> ISO 11404 - Point in Time, NHS ISB 1502: Common User Interface - Date and Time Input, NHS ISB 1503: Common User Interface - Date Display.</p> <p><b>Data Source:</b> New entry.</p> <p><b>Data Use:</b> Information governance (local audit).</p> <p><b>Proposed Data Values:</b> A string with the format "YYYYMMDD".</p>
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## Appendix A: Members of the LRA Discharge Summary Clinical & Business Expert Group

Name	Area of Expertise
Alison Wallis	e-Health Advisor, Royal College of Nursing
Allen Hobbs	Clinical informatics with a focus on security, privacy and standards development. I am a clinician, although not currently practicing.
Brendan Delaney	Clinical research informatics, including the use of UML and reference models. A practicing GP. Professor of Primary Care Research at King's College London, with a research interest in medical informatics and decision making.
Charles Waudby	I have been developing clinical software since 1999 and was part of the group that drafted the original "Kettering" XML referral and discharge messages (and implemented pilots at Kettering General Hospital). Since then my focus has been on clinical software for use by doctors and which can export discharge and outpatient clinic letters for transfer electronically to GP practices, many still using the Kettering XML message. In the last 10 years over 1M referral and discharge messages have been received/sent by EPOC software. I agreed to participate in order to share with the project the practical experience gained working with clinicians in this area for ten years. eDischarge and messaging is a minor (easy) part of the process which requires significant process re-engineering to derive the most benefit and the optimal clinician support.
Chris Austin	I work three days a week for the Occupational Therapists professional body, the College of Occupational Therapists. I lead on understanding informatics developments and assessing their likely impact on Occupational Therapy: including practice, education, research and management. I am not currently practicing.
Dai Evans	Currently a part-time GP. Clinical Director of PRIMIS+, University of Nottingham. Areas of expertise: terminology, audit & query specification, informatics training & education, general business processes, Data Quality.
Danish Jafri	Electronic Patient Records Implementation Manager, Royal Devon & Exeter NHS Foundation Trust
David Jehring	Healthcare software designer for the past 20 years, designing GP clinical systems, GP document workflow systems and reporting and audit software. I am a GP by training, but am no longer practicing.
Dilys Lai	I am a Respiratory Consultant at Chelsea & Westminster hospital and have worked closely with our coding and IT departments to improve our coding and in-patient discharge summaries. I am a full-time clinician.

Name	Area of Expertise
Emma Hunter	Pharmacist, not currently practicing but a member of the General Pharmaceutical Council and the Royal Pharmaceutical Society. Specialise in healthcare IT, in particular, the areas of medications management and interoperability and sharing information between different health care settings.
Frank Cross	Consultant surgeon (4 days a week) and NHS CFH senior clinical advisor (1 day a week). Interested in electronic care records in general and discharge summaries in particular. Have a paper on the subject in press with the Annals of the Royal College of Surgeons of England.
Giovanna Polato	I am a technical analyst with over 20 years experience on datasets design, use, mapping, analysis and coverage. I work as a Team Leader within the Intelligence Directorate at the NHS Care Quality Commission, with a focus on the analysis of large datasets, aiming to improve the precision and usefulness of the data used to inform assessments. I contribute to the design, maintenance and update of several datasets.
Heidi Wright	Practice and policy lead for England for the Royal Pharmaceutical Society. Leading on a piece of work which is looking at the transfer of information about medicines when patients are transferred from one care setting to another, which includes discharge.
James Berry	Chief Technical Officer, Advanced Health & Care. Am interested in generating discharge notices from our Adastra product.
Joe West	Clinical Associate Professor and Consultant Gastroenterologist. I am a practicing clinician. I am involved in the group as I am interested in all types of electronic health records and making them fit for the purposes of practical medicine and use in research.
John White	Consultant Orthopaedic Surgeon & Clinical Director IM&T, Barking, Havering & Redbridge University Hospitals NHS Trust ; Chairman, London Clinical Content and Terminology Group, NHS CFH ; Member, National Clinical Data Standards Network, NHS CFH
John Williams	GP for 32+ years with an interest in health informatics for 15+ years. I am a clinical lead to the Clinical Data Standards Assurance programme and actively participating in that programme's Discharge Summary Implementation project. GMC registered and potentially able to practice, but currently no involved in clinical work since July 2010.
Julie Oldroyd	Cancer patient. Chair of the Derby-Burton Cancer Patients Forum 2002-2007. Currently vice chair of the National User Steering Group for Cancer Peer Review, vice chair of the Lincolnshire Cancer Patients and Carers Forum, Steering Group member of the Information Prescriptions



Name	Area of Expertise
	Lincolnshire, Steering Group member of the Derby-Burton Cancer Research Network, Consumer Liaison Group member NCRI. Personal experience of various discharge summary information documents following 8 operations plus knowledge of the experience of family and friends.
Lucille Hagues	A cancer patient since 2000 and a carer for her mother for a number of years. I am one of the founding members of a blood cancer support group called SMYLLE Support group for MYeloma, Lymphoma and Leukemia. I have also chaired the Cancer Patients and Carers Forum for 5 years retiring June 2010 besides sitting as a patient advocate on several groups for both Lincolnshire and Nottinghamshire over the last 10 years. I am a member of NCRI sitting on Lymphoma CSG (Clinical Studies Group) Myeloma CSG as well as the CLG (Consumer Liaison Group). I am also a trained Peer Reviewer for Cancer services (5 Years)
Malcolm Duncan	Physician with background in Internal Medicine and Clinical Biochemistry, now full time in Health Informatics. My special interests are terminology and decision support. I am not in active clinical practice. I work mainly with FirstDataBank Europe (suppliers of the Multilex Drug Data File used within many UK primary and secondary care systems as well as community pharmacies).
Mireya Calderbank	Head of Clinical Coding, Chelsea & Westminster Hospital, NHS Foundation Trust. I have worked within the NHS for over 20 years; and in that time worked for the NHS Information Authority, NHS NPfIT and NHS CFH. My specialist interests are in clinical coding, cross-mapping terminology (SCT) – ICD classifications, data quality and care pathways. Trust lead for participation in the 'Discharge Summary Implementation' Project and also worked on various national projects around the electronic care record and care pathways.
Peter Murphy	Consultant in Paediatric Anaesthesia and Intensive Care and NHS CFH National Clinical Lead for hospital doctors.
Reza Hashim	A consultant psychiatrist in a mental health assertive community treatment team (0.4 wte). In recent years, I have worked nearly two years each as a duty team psychiatrist in the community and an acute inpatients ward, both 0.4 wte. I also work 0.4 wte as clinical director, a medical manager post in which role I am lead medic for a group of 13 consultant psychiatrists. Remainder of my work is as NHS London Programme for IT as MH clinical lead.
Richard Lewis	Currently practicing Senior House Officer in Emergency Medicine at Winchester Hospital in Hampshire. I also have reasonable clinical knowledge in Sexual Health and Family Planning, due to my last service mobilisation role. I no longer practice medicine full time, and decided to follow an IT career. I have been an advanced computer

Name	Area of Expertise
	programmer for over 11 years, and now work part-time in medicine. I have worked with NHS CFH in London, with the Southern Programme for IT in Slough, and also worked for iSOFT. I mainly advise organisations on re-aligning their clinical pathways and IT Systems. I have been exposed to several different patient record systems and I'm hoping to use my experience in these different settings to help define good standards for data interoperability that can improve clinical communications across care boundaries.
Rob Challen	Health informatics with a background in Paediatrics and Neonatology. I am not currently practicing.
Rong Chen	Medical informatics, in particular semantic interoperability of EHRs. I am very interested in EHR standards, the 13606/openEHR archetype approach and reference terminologies. I want to learn as well as contribute to the NHS LRA work. Sweden has a similar approach based on openEHR/SNOMED CT on the national level. I sense there could be opportunities for collaboration and at least sharing of experiences. I am current not practicing medicine.
Sabarna Mukhopadhyay	CEO, Cal2Cal Europe Limited
Sally Wiltshire	Registered nurse and midwife, with 18 years clinical experience in gynaecology and midwifery, and qualified IT teacher. 12 years engagement in EPR solution design and implementation, with additional experience in dataset design at the national level.
Stan Huff	A board-certified Clinical Pathologist by training. However, my area of expertise is in data structures, modeling, and terminology for representing biomedical data. I am licensed to practice medicine but I am not in active practice.
Steve Harris	James Martin Research Fellow, Oxford University Computing Laboratory
Tito Castillo	I'm originally a Medical Physicist and software developer and am currently the manager of the secure epidemiology computer service at the MRC Centre of Epidemiology for Child Health and member of the British Society of Gastroenterology's Information Group.

Note: The Terms of Reference for this group included a requirement for practicing clinicians to compose at least one quarter of the membership. Practicing clinicians in this group represented 30% of the members (9/30).

## **Appendix B: Content prioritised for technical interoperability testing**

Because of limited technical modelling resources within this work package, and based on informal prioritisation input from the Clinical & Business Expert Group (particularly the practicing GP and patient perspectives represented in the group), the following content subset will be technically modelled and tested in 2011:

- Demographics (GP details, Patient details)
- Admission details
- Discharge details
- Diagnoses at discharge
- Operations and procedures
- Reason for admission and presenting complaints
- Allergies
- Risks and warnings
- Clinical narrative / other significant information
- Current and stopped medications
- Advice, recommendations and future plans
- Information given to the patient and/or authorised representative
- Person(s) completing summary
- Distribution list