PRSB
PROFESSIONAL RECORD STANDARDS BODY
for health and social care

PRSB e-discharge summary phase 2 – Diagnoses information model

Purpose

This paper provides an information model for diagnoses. It is based on the discharge summary heading 'Diagnosis' published in the Academy of Medical Royal Colleges (AoMRC) Clinical Documentation and Generic Record Standards (2013). It provides an information model which the Health and Social Care Information Centre (HSCIC) will use to develop a CDA specification for an e-discharge summary.

Glossary

Glossary of terms used in the information model

Term	Definition
Cardinality	The numerical relationship between two parts of an information model. In this document, it refers to the number of times that a sub-component occurs within a 'container' ie document, section, sub-section or record entry. Eg. The medications and medical devices section may have 0 to many medication records in it.
Section or Container	This is the equivalent of a main heading in the AoMRC headings, eg. allergies and adverse reactions, procedures, etc.
Record entry	A group of related data items or elements which make up a record entry. They must be bound together and cannot stand alone as an entry. For example, diagnosis record entry is made up of the following data items: diagnosis/symptom, stage of disease and comment.
Cluster	A group of data items which make up a record entry, for example, diagnosis record entry is made up of the following data items: diagnosis/symptom, stage of disease and comment.
Iteration	A rule which applies to each repetition of a record entry, for example, only one medication item can be included in a medication record entry.

AoMRC heading

AoMRC discharge summary heading with sub heading (2013):

Diagnosis

Description:
Under this heading all identified diagnoses should be recorded. Where a diagnosis is not confirmed symptoms should be recorded

Rules for heading:

- Mandatory
- Cardinality 1

Information model

“Diagnoses”

Description:
Name: **Diagnoses**
This represents the AoMRC heading of the same name. Acts as a ‘container’.
Handles all content entered under this heading relating to diagnoses. All identified diagnoses should be recorded. Where a diagnosis is not confirmed symptoms should be recorded.

Rules for top ‘entry’ level (i.e. the container):
Mandatory
Cardinality 1

Rules for content:

- All diagnosis items to be entered via **Diagnosis** cluster
  - Can be 1 to many instances of diagnosis
  - Only one diagnosis per iteration

Diagnosis cluster

Description:
Name: **Diagnosis**
Handles information entered for each individual diagnosis. Confirmed diagnosis (or symptom); active diagnosis (or symptom) being treated. Should include the stage of the disease where relevant

Rules:

- Only one diagnosis or symptom concept per diagnosis
- Mandatory
- Cardinality 1 to many

Data Items x3:

Diagnosis/symptom
Choice of

- Text
- Coded text – constraint: SNOMED CT. A subset / refset containing a list of diagnoses and symptoms. Constraint binding: [SNOMED CT] subset=???

Mandatory
Cardinality 1

The diagnosis or symptom identified. This may be entered as free text or coded.

Stage of disease
Text
Optional
Cardinality 0-1

The stage of the disease where relevant

Comment
Text
Optional
Cardinality 0-1

Supporting text may be given covering diagnosis confirmation, active diagnosis being treated