

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 number of elements in a set. 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 single record, eg. a medication item or a diagnosis, which will be made up of one or more data items, eg. name, form route, dose amount of medication. |
| 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

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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