PRSB e-discharge summary phase 2 – Procedures information model

Purpose

This paper provides an information model for procedures. It is based on the discharge summary heading 'Procedures' 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 the following sub headings (2013):

Procedure
Complications related to procedure
Specific anaesthesia issues

Description:
Under this heading information about all relevant therapeutic and diagnostic procedures should be included, relevance based on clinical decision

Rules for heading:

- Optional
- Cardinality 0 to 1
- Where no entry is made under this heading then the heading should be OMITTED

Information model

"Procedures"

Description:
Name: **Procedures**
This represents the AoMRC heading of the same name. Acts as a 'container'.
Handles all content entered under this heading relating to procedures. All relevant therapeutic and diagnostic procedures should be included (relevance to be based on clinical decision). If partial or incomplete information is available this should be clearly stated.

Rules for top 'entry' level (i.e. the container)
Optional
Cardinality 0 to 1
Omit this heading if nothing entered

Rules for content

- All therapeutic and diagnostic procedure items to be entered via **Procedure** entry
    - Can be 0 to many instances of procedure
    - Only one procedure per iteration

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Procedure entry

Description:
Name: **Procedure**
Handles all information entered for each individual therapeutic or diagnostic procedure. All relevant procedures should be included (relevance to be based on clinical decision). If partial or incomplete information is available then this should be clearly stated.

Rules:

- Only one therapeutic or diagnostic procedure per iteration
- Optional
- Cardinality 0 to many

Data items x 6:

Procedure
Choice of

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

Mandatory
Cardinality 1

The therapeutic or diagnostic procedure performed on the patient. This may be coded, or represented as free text.

Anatomical Site
Choice of

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

Optional
Cardinality 0 to 1

The body site of the procedure

Laterality
Choice of

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

Optional
Cardinality 0 to 1

Laterality of the procedure

Complications related to procedure
Choice of

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

Optional
Cardinality 0 to many

Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure. The intent is to be free text but use codes wherever possible

Specific anaesthesia issues
Choice of

- Text
- Coded text – constraint: SNOMED CT. A subset / refset containing a list of anaesthesia adverse reactions. Constraint binding: [SNOMED CT] subset=??? AnaestheticReactionSnCT

Optional
Cardinality 0 to many

Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.

Comment
Text

Optional
Cardinality 0 to 1

Any further textual comment to clarify such as statement that information is partial or incomplete