



**Professional
Record
Standards
Body**

**Better records
for better care**

Implementation guidance report Emergency Care discharge standard

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1 Introduction

The Professional Record Standards Body (PRSB) provides professional and patient endorsed and evidence based clinical record standards. These provide the basis for technical (FHIR) specifications produced to enable industry to implement technical solutions.

The Academy of Medical Royal Colleges (AoMRC) “Standards for the Clinical Structure and Content of Patient Records”, published in 2013, were adopted by the PRSB, since it was established in 2013. This standard defines the headings, with descriptions, for electronic records based on a number of specified use cases (admission, referral, discharge, outpatient letter, and handover).

Since they were published further work has continued to develop more detail under the headings for the transfer of structured, coded data and develop standards in other important areas such as crisis care. This further development has led to some additional headings, some changes to the descriptions and additional detail in the form of information models. There is a need to bring these changes together and manage their release, alongside the technical message specifications and implementation plans of NHS Digital.

A single maintenance release will cover the standard developments for general hospital, mental health and emergency department discharge summaries, outpatient letters and crisis care documentation standards. This project is the first of a schedule of maintenance releases which are part of the on-going service which NHS Digital has commissioned from the PRSB. This maintenance release project is managed by the Royal College of Physicians Health Informatics Unit (RCP HIU).

This report provides consolidated implementation guidance, for the following standards:

- Crisis Care (2015)
- Mental Health Discharge Summary (2016)
- Hospital Discharge Summary (2016)
- Emergency Care Discharge Summary (2017)
- Outpatient Letters (2017)

2 Purpose

This document is intended to provide guidance to those implementing the PRSB clinical record standards. It contains information relevant to both industry and clinical practice. The intended audience is broad, encompassing all involved in the design, development and implementation of IT solutions which are deploying the standards, including those developing learning resources.

The guidance was derived from consultation during the development of the individual standards. It is therefore not able to provide definitive guidance and it is anticipated that it will be refined in response to findings and feedback during actual implementation of the standards.

The guidance has been developed with widespread consultation, but piloting it in live operation was excluded from scope of the work to date. Hence it has not yet been ‘road tested’. This is a vital prerequisite to the guidance being finalized as ‘fit for purpose’.

It is structured to provide guidance applicable to all standards in section 3, with subsequent sections containing use-case specific guidance.

3 Guidance applicable to all standards

3.1 General guidance

- 3.1.1 It is not anticipated that all headings will need to be used in all circumstances, only where they are relevant to a specific patient, ie headings should not be included in the message where there is no data recorded/available.
- 3.1.2 The order in which headings appear can be agreed locally.
- 3.1.3 Data quality and accuracy of coded data entry needs to be monitored and implementers will need to ensure sufficient training and monitoring of record keeping.
- 3.1.4 The section headings are intended to support navigation around the record and are clinical groupings of related subheadings, rather than having any semantic meaning.
- 3.1.5 The information can be displayed in any format as designed by the end user and supplier. The standards provide a common structure to the record, not a style guide. Different IT systems can display the same information in different ways, but the meaning will remain the same.
- 3.1.6 Where there is a heading and a subheading with the same name, there is no need to display the heading as well as the subheading.
- 3.1.7 Each record entry must have the date and time recorded and the identity of the person making the record. This information should be recorded in an electronic record automatically, by date and time stamping each record and associating it with the personal identification of the individual recording it.
- 3.1.8 Information recorded may be provided by other people and agencies, eg police, midwife, GP, patient's relative. Where this is the case, the source should be recorded.
- 3.1.9 Information should be auto-populated from Trust and GP practice Electronic Patient Records (EPRs) where appropriate, with the expectation that, in time, auto-population will include supply of appropriate SNOMED CT codes.
- 3.1.10 User interfaces should not restrict the order in which clinicians enter data, so that clinicians can navigate forwards and backwards to complete or partially-complete sections as information becomes available. This does not negate the rule which stipulates that a communication cannot be *sent* unless all MANDATORY sections are completed (*see section 3.2. for definitions of mandatory, required and optional*).
- 3.1.11 Clinicians should always use professional judgment to determine what information should be communicated. Just because the system records information does not always mean that it would be relevant to send to others. Systems should support this by enabling editing of communications by clinicians prior to them being sent.
- 3.1.12 Communications should be brief, where possible, containing only pertinent information, rather than duplicating information which the recipients (e.g. GPs) already have access to in their own records.
- 3.1.13 The extent to which information can be taken into the recipient system in structured/coded format will depend on the capabilities of the recipient system. Local decisions need to be made about what information is ingested into recipient systems in a structured coded format and what information is attached as a document.

- 3.1.14 Patients (or their designated carer or guardian where applicable) should generally get a copy of communications and so, as far as possible without affecting its efficacy as a clinical communication, it should be written in a way that is understandable to the general public. This may be difficult where technical information needs to be communicated, and in such circumstances, providing explanatory information in easy to read leaflets to patients should be considered. Providing the documentation in alternative formats and face to face communication should also be considered to meet individual requirements (see [the NHS accessible information standard](#).) Local implementation of the standards should involve patients and carers throughout to ensure that the content is expressed in a way which is person-centred and that support is provided to help patients and carers to understand the contents.
- 3.1.15 There may be circumstances where it is not appropriate to provide the patient with a copy of the communication, eg safeguarding issues. This may be handled in various ways, suppliers should consider providing the ability to enable information to be excluded where there is a need to communicate something privately.
- 3.1.16 Recipients should be able to read all of the content (ie any coded data should be carried with the associated text).
- 3.1.17 Where contributions are provided from multi-disciplinary team members, not just an individual clinician the local system should retain an audit trail of the provenance of all contributions.
- 3.1.18 The record standards provide a logical information model that identifies the information to be shared from a patient/citizen and health care professional perspective. NHS Digital have produced technical specifications, based on the record standards. It is anticipated that primary and secondary care and other health and care systems suppliers will develop solutions which enable mapping to/from their system headings and content to those in the technical specification. They will also develop new functionality to support the processes for sending and receiving discharge summaries in their systems. These should be done once nationally by each supplier.
- 3.1.19 Trading agreements will need to be drawn up between organisations, including:
- Details of the information to be communicated, including which optional sections will be utilised.
 - The sequence of the sections.
 - Which fields will be coded and which textual.
 - Mapping from local headings/fields to those in the standard. The mapping should be owned by a clinician in each organisation.
 - Requirements for receipt of the communication, e.g. use of a generic mailbox.
 - New work processes for producing and receiving the communication.

3.2 Mandatory and optional

- 3.2.1 Within the various standards, some of the record entries and fields within them will be mandatory, but others will be optional. The information models define which are mandatory and which are optional.
- 3.2.2 MANDATORY sections must always be included. Other sections are optional. Where there is no information recorded in an optional section, that section should be excluded, to avoid the recipient receiving a communication with blank sections.

- 3.2.3 A distinction has been made between sections which are REQUIRED or OPTIONAL. The definition of each is given below:
- REQUIRED: if there is information recorded it should be sent to the recipient.
 - OPTIONAL: a local decision as to whether information is sent to the recipient.
- 3.2.4 If a section is marked as MANDATORY or REQUIRED it should not be 'downgraded' to OPTIONAL by local agreement. However, it can by local agreement be upgraded from OPTIONAL to either REQUIRED or MANDATORY.
- 3.2.5 For each applicable use-case, all sections in the standards must be supported by IT systems, ie, it should be possible to record and communicate information in all sections. However, there should be flexibility as to which of the optional sections are included in local implementations. This means that all the sections should be available for local organisations to use, but there should be flexibility to allow local choice about which of the optional headings to use.

3.3 Coding

- 3.3.1 The *Personalised Health and Care 2020 framework for action* recommends the use of SNOMED CT and the dictionary of medicines and devices (dm+d). Local decisions need to be made about when these codes are to be carried, depending on local system capabilities and plans. Please note:
- The receiving GP systems are due to have been migrated to SNOMED CT by April 2018.
 - The ambition is for SNOMED CT and dm+d to be the only clinical coding schemes in use in the NHS by 2020.
- 3.3.2 Not all information sent in structured/coded format will be retained in this format at the receiving end. This will be dependent on the capability of the receiving end system, and will vary across organisations.
- 3.3.3 There may be circumstances where the end user needs to be able to see the actual code rather than the text. This could be done in a variety of ways, for example, 'mouse over'.

3.4 Patient demographics

- 3.4.1 NHS number (or equivalent, e.g. CHI number in Scotland) is mandatory, but with the option to record not known or not available. Existing national guidance should be followed, including how to handle patients without an NHS number, eg overseas visitors, services personnel, prisoners.
- 3.4.2 Spine compliant systems are needed to obtain traced NHS numbers. Where an organisation does not have a system linked to the Personal Demographics Service, other demographics fields will need to be used, with local person identity matching software.
- 3.4.3 Hospital numbers are not unique so either avoid including them or reference the organisation where the number was generated.

3.5 GP practice

- 3.5.1 'GP practice identifier' does not need to be a displayed field. It is intended to be used to provide the GP practice details via lookup from national registers.
- 3.5.2 Many people will not offer a named GP. Only the 'GP practice details' heading would need to be completed in these situations
- 3.5.3 A patient may be registered with more than one GP practice. Normally patients are registered with one practice, but may be treated as a temporary registration (e.g. whilst on holiday) by another practice. The registered GP practice can be obtained from the PDS. Suppliers should enable more than one GP practice to be recorded to accommodate temporary registration. Communications will go to the GP surgery that the patient is permanently registered with. However, sometimes a GP who is serving a patient on a temporary basis may also need to access the transfer of care communication. In this instance, both GP practices should be recorded.
- 3.5.4 If a patient is not registered with a GP practice, then the GP practice record entry should appear with the text "No known GP practice".

4 Guidance for the emergency care discharge summary standard

4.1 General guidance

The scope of this communication is the discharge summary sent from emergency care to the GP. The NHS Standard Contract 2017/18-2018/19 (<https://www.england.nhs.uk/nhs-standard-contract/17-18/>) includes a requirement for discharge summaries following EC attendances to be sent from 1 October 2018 using the PRSB headings, as structured messages including narrative SNOMED CT and dm+d, sent electronically nationwide, not using email.

4.1.1 There are two forms of discharge summary required:

- where a patient is discharged from ED back to the GP, and
- an abbreviated version where a patient is transferred to an inpatient bed in the hospital or to another hospital.

4.2 Emergency Care Data Set (ECDS)

4.2.1 The ECDS includes clinical data items which will be relevant for the EC discharge summary but also a number of non-clinical data items (e.g. payment, performance monitoring items) which should not be included in the EC discharge summary.

4.2.2 It is expected that EC information systems which have implemented the ECDS will be able to automatically generate data to populate the EC discharge summary.

4.3 Guidance on specific sections

Guidance on completion of specific data items is included in the ECDS and so is not replicated here. The guidance below is supplementary to ECDS guidance and relates specifically to the EC discharge summary.

4.4 Presenting complaints or issues

4.4.1 The chief patient complaint as assessed by the EC clinician first assessing the patient should be recorded under this heading. The chief complaint could also be recorded by the patient, eg using a patient portal.

4.4.2 The ECDS Chief Complaint SNOMED CT subset should be used.

4.5 Referrer details

4.5.1 Referrer details should be copied forward from the referral or transfer of care where possible.

4.5.2 Coded text 'self-referral' should be used where the patient is not referred or transferred from a health/care organisation. Where 'self-referral' is recorded the referrer data items should be left blank.

4.6 Diagnoses

4.6.1 The discharge summary should inform the GP of the main diagnosis / diagnoses that were important during the EC attendance, including any new diagnosis that came to light during the attendance. The diagnoses should be recorded in order of their

relevance to the emergency presentation, with the most serious item first. Further guidance on recording diagnoses is provided in the ECDS.

- 4.6.2 Excluded diagnoses should not be recorded in structured coded fields, but may be listed in the 'clinical narrative'.
- 4.6.3 Historical inactive diagnoses, where they are clinically important, should be carried in the clinical narrative to provide some explanation, for example - prior history of breast cancer but no evidence of any recurrence on investigations carried out during this attendance.
- 4.6.4 'Co-morbidities' should be recorded as separate diagnoses where they are newly identified in EC.
- 4.6.5 Where a 'confirmed present' diagnosis exists (e.g. 'fractured tibia') this is used to populate the appropriate diagnosis entry 'diagnosis' data item, and will flow to the GP system where it will be easily available for integration into the GP record.
- 4.6.6 Where there is no 'confirmed present' diagnosis then:
- 4.6.7 The chief complaint (a symptom) is used to populate the diagnosis entry 'diagnosis data item, e.g. 'Shortness of breath'
- 4.6.8 The 'suspected' diagnosis is converted into a text entry and this is used to populate the diagnosis entry 'comment' data item. e.g. 'Suspected diagnosis: pulmonary embolus'.
- 4.6.9 This format allows the information about any 'suspected' diagnosis to be clearly and unambiguously presented to the receiving GP user. Furthermore, the combination of symptom plus text comment may then be easily incorporated into the GP record. As a result, the example provided above would appear as 'Shortness of breath', coupled with the extra information from the diagnosis comment box: 'suspected pulmonary embolus'. This requirement is safe and workable and:
 - meets the core parts of the PRSB standard for diagnoses.
 - requires no alteration to the arrangements already agreed and trialed for ECDS handling of diagnosis.
- 4.6.10 This requirement requires robust measures to ensure that every diagnosis is accompanied by the correct qualifier and processing to ensure that the EC to GP discharge summary message is populated as described.

4.7 Procedures

- 4.7.1 ECDS SNOMED CT subsets for EC interventions and treatments, including associated text, may be included under this heading.

4.8 Clinical narrative

- 4.8.1 There may be circumstances where a clinical narrative would not be provided, for example, where a patient was dead on arrival and the circumstances leading up to the death were not known by EC.
- 4.8.2 This heading should be displayed as Clinical Narrative, but the information model it is the same as Clinical Summary.

4.9 Medications and medical devices

Preparing the Medications and medical devices summary at the sending end

- 4.9.1 On discharge from emergency care, responsibility for prescribing transfers to the GP and the GP will need to undertake a reconciliation of medication changes arising from the emergency care attendance with the patient's on-going medications. To do so, the GP will need to know about medication changes (including new medications and recommendations to discontinue medications), but not about medications prescribed to a patient in emergency care, which are not to be continued.
- 4.9.2 It is very important for GPs to be informed of any changes to a patient's medications taking place in ED and the reasons why. Medication changes would include:
- Medication changes. Any changes made to medication that was current at the time of attendance – such as changes of dosage
 - Medications stopped. Any medications that were current at the time of attendance which were discontinued during the EC attendance
 - New medications. Any new medications which should be continued following discharge
 - The reasons for any of the above (i.e. changes, discontinuations or additions of medication)
- 4.9.3 The discharge summary should NOT include details of medications that were both started and stopped in EC.
- 4.9.4 Ideally the above information should be generated semi-automatically from an ED e-prescribing system such that drug names will be automatically represented by dm+d codes and also as far as possible the appropriate fields for route, form, dose amount description and dose timing description etc. will be completed. It is however recognised that, at least initially, much of this information will need to be entered manually. Please see section below which outlines the differences between dose based and product based prescribing and which provides guidance as to how the various fields available should be used in each case.
- 4.9.5 Whilst any medical device that is prescribable in primary care should be represented in dm+d, there may be other kinds of devices used in EC that will not necessarily be represented in dm+d. While these may well be codified in SNOMED CT or in some other proprietary coding scheme they will generally not be prescribable in primary care. The following rules apply ONLY for an ED system which uses dm+d. When entering information about medications and devices into the discharge summary the following rules should be applied:

- Any medication item or medical device that can be dm+d coded should be entered as a 'medication item' entry. Changes and reasons for change can be also handled here.
- Where any attendance medication has been discontinued this should be entered using the 'medication discontinued' entry
- Where a medical device has no dm+d code then this should be represented as text using the 'medical devices' record entry.

4.9.6 Where recording dose duration directions, the following examples are provided to clarify definitions for two of the coded text items which appear similar. In both cases, these directions are not an absolute instruction. They are:

- 'continue medication indefinitely' - ongoing treatment planned for example when starting daily aspirin or a statin. There will be circumstances where you would stop them such as a gastrointestinal bleed.
- 'do not discontinue' refers to medication where suddenly stopping could be dangerous, for example the abrupt withdrawal of long term steroids.

Communicating medication changes

4.9.7 Any alteration to a medication that might require a change to the GP prescription should be communicated to the GP with the status 'amended'. Amended generally means changes in VTM and, where relevant, dose. Changes in form or strength should also be communicated where clinically relevant.

4.9.8 Changes should be recorded in a structured way where possible. Changes in medication can be structured where the medication history was recorded electronically and the system can automatically recognise changes. For clinical safety, an automatic assessment of change would have to compare the exact medication statement(s) on admission and discharge for all drugs with the same VTM (erring on the side of marking a medication as a change if unsure). To match up corresponding medications between two lists for automatic reconciliation would be using the underlying VTM. Then the algorithm could compare the individual prescriptions and determine if there are any changes (this may include change from single to multiple statements for the same VTM and vice versa). The OPENeP system has a user interface to do this (<http://www.marand.com/thinkmeds/>).

4.9.9 Hospitals are required to use the Summary Care Record (SCR) for admission medication history, but for hospitals without electronic medication records reconciliation would need to be a manual process.

4.9.10 If the admission is short (e.g. surgical daycase) and detailed medicines reconciliation hasn't taken place, on-going medications that the patient is already taking may be omitted from the discharge summary. In this case, the discharge summary should make it clear that any medications listed may not be the only medications that the patient takes. In practice this is often done with a statement of 'no changes to patient's regular or pre-admission medication'.

Communicating quantity of medications

4.9.11 The discharge summary provides a statement of the medication the patient should be taking following discharge. Often it also functions as a prescription/request for those drugs, and some or all of them may be dispensed/supplied by the hospital pharmacy based on how much the patient already has.

4.9.12 Quantity may be expressed as the duration, eg number of days, or the number of items, eg tablets, inhalers etc supplied. The days prescribed/supplied should be recorded as a numeric value under the heading 'dose directions duration'. The quantity should be recorded as a textual value eg 30 tablets, 2 inhalers, etc. under medication quantity. Whether the quantity is that prescribed or dispensed should also be recorded in the discharge summary.

Handling the medicines and medical devices summary at the receiving end

4.9.13 Recipients of EC discharge summaries should be aware that the medications and medical devices summary is generated by the ED from the information that they have at their disposal around the time of discharge. Despite best intentions this information may neither be complete nor accurate.

4.9.14 For receiving systems, not all medications and medical devices can be expressed using dm+d. In cases where there is no dm+d representation a) such information can only be expressed in text and b) the item(s) will not be prescribable in primary care.

Medicines reconciliation

4.9.15 This section applies to the GP receiving system. When a patient is discharged from EC to GP care any change in medication generally involves a handover of responsibility for prescribing from EC clinician to GP.

4.9.16 The discharge summary should inform the GP of medications that have been changed, discontinued or added since the time of attendance along with reasons for these changes. The responsible GP prescriber will therefore need to review the patient's GP medication record and to reconcile this with medication recommendations in the discharge summary. It will therefore be helpful to enable the receiving GP prescriber easily to compare the intended list of discharge medications listed in the discharge summary with the patient's recorded current medication. Any changes that may as a result be made to the patient's current medication should be subject to the usual prescribing decision support / alerts as for any other addition / change / discontinuation of medication that prevails and any local formulary requirements when any change is made to the GP medication record.

4.9.17 In the short term this will require reading each individual discharge medication and then making any appropriate changes to the GP patient medication record manually. In time, as ED systems become able to transmit dm+d coded medications it may become possible for suppliers to utilise these codes to assist the GP in finding the appropriate medicinal product that needs to be added / changed / discontinued.

4.9.18 For the avoidance of doubt, changes to the GP medication record resulting from an EC discharge summary MUST always require the authorisation of the responsible GP prescriber.

Dose based compared with Product based prescribing

4.9.19 In UK General Practice systems "product based prescribing" is used, so called because medicinal products are prescribed. An example of this is: "Furosemide 40 mg tablets, take 2 at 8am".

4.9.20 "Dose based prescribing" is typically but not exclusively used by hospital inpatient systems. This starts with a drug name which is devoid of any strength or form and

then links this to a dose amount, plus either a route of administration or a form (or both), and a dose frequency. The same example as above but expressed as dose based prescription would be:

“Furosemide 80mg oral at 8 am”.

- 4.9.21 There is no consistency in the use of dose based versus product based prescribing in UK EC systems.
- 4.9.22 It can be seen that in product based prescribing the form (e.g. (tablet / capsule / inhalation / etc) and the strength are generally explicitly stated as part of the product name and that typically the route of administration is implicit. In contrast, dose based prescribing starts with the drug name and then typically explicitly builds a dose string by adding dose amount, route, and dose timing. Both of these prescribing patterns are supported in the Medication item entry of the discharge summary Medications and medical devices information model.
- 4.9.23 It is recommended that the fields in the Medication item entry should be used as follows.

For Product based prescribing:

- Medication name: Enter the medicinal product (e.g. “Furosemide 40 mg tablets”). In dm+d terms this would be either Actual Medicinal Product (AMP) or Virtual Medicinal Product (VMP)
- Dose directions description: Enter the remaining dose direction (e.g. “take 2 at 8 am”). Information about route may also be included in this same text string but is generally omitted

For Dose based prescribing:

- Medication name: Enter the drug name (e.g. “Furosemide”). In dm+d terms this would be Virtual Therapeutic Moiety (VTM)
- Form: Optional (e.g. “capsules”, “tablets”, “liquid” etc.), using SNOMED CT subset if possible
- Route: Optional (e.g. “oral”, “intraocular”, “intramuscular” etc.), using SNOMED CT subset if possible
- Dose amount: Ideally this would be a numeric amount with clear units of measure, but initially it is likely to be a plain text description of dose amount (e.g. “80 mg”)
- Dose timing: A plain text description of medication dose frequency (e.g. “once daily”, “at 8 am”)
- Site and method are other optional fields that may be used.

4.10 Allergies and adverse reactions

- 4.10.1 A record should be provided of new allergic and adverse reactions relevant to the patient’s EC attendance. Coded information on causative agents is important to GPs to enable safe operation of prescribing decision support. The model proposed here is being adopted across the GP domain to enable interoperable drug allergy information to support patient safety at transfer of care.
- 4.10.2 When a patient is diagnosed with an allergy related condition (e.g. anaphylactic shock or urticarial skin rash) this will be entered into the diagnosis field in the EC system. It

is important that all new allergies are explicitly incorporated into the discharge message as 'allergies'. Therefore for this information to be safely transmitted to GP systems, it must also be messaged to the GP system as an allergy, not just a diagnosis.

- 4.10.3 Where there is a diagnostic code for an allergy recorded in the EC system, the system should trigger an allergy entry (see information model – allergies and adverse reactions section). This will ensure that allergies will be entered into the GP system as such and will then be incorporated into the next update of the Summary Care Record. There is a significant risk to patient safety if allergies are not explicitly notified to GPs as allergies.
- 4.10.4 Guidance on good practice recording of allergies and adverse reactions is provided by NICE (<https://www.nice.org.uk/guidance/CG183/chapter/1-Recommendations>). This relates to end systems rather than the discharge summary, but is included here as its use should improve quality of the information communicated.
- 4.10.5 Adverse reactions other than allergies are mapped to intolerances when communicating them outside the Trust so that the information can be carried within FHIR messages.

4.11 Investigation results

- 4.11.1 Only important or relevant results should be included, ie those that the clinician wants to communicate. This is to reduce the risk of overload of irrelevant information.
- 4.11.2 This can be a difficult decision to make and so consideration should be given to ways that a clinician could be helped in this task.
- 4.11.3 It is important to record why test have been done and where relevant, who is going to follow up (i.e. GP or hospital). Follow up should be recorded in the plan and requested actions section.
- 4.11.4 Investigations carried out where results are not yet available should be recorded in this section.

4.12 Plan and requested actions

- 4.12.1 The plan should make clear who is expected to take responsibility for actions following the encounter, eg the person receiving care or their carer; the GP or another health care professional. For example, follow up renal function test to be arranged by the GP within two weeks of appointment.
- 4.12.2 Shared decision making principles should apply to the development of the plan and where the patient's opinions differ, this should be recorded under the heading 'clinical narrative'.
- 4.12.3 The plan could be presented in various ways in the system to prompt complete information to be recorded eg table, best practice prompts, etc.

4.13 Information and advice given

- 4.13.1 In some instances EC professionals may want to communicate to the GP specific information and advice which was given to the patient. It is important that this is concise and is only information which it is pertinent for the GP to be aware of.
- 4.13.2 Where patients are provided with literature (e.g. pamphlets) there is no need to provide details of the information contained in the literature e.g simply state that the patient was provided with a pamphlet.
- 4.13.3 The default is that patients (or their designated carer or guardian where applicable) should get a copy of the discharge summary. Where this is not possible an explanation should be provided in the clinical narrative.

4.14 Legal information

- 4.14.1 Systems should allow copies of legal documentation to be attached to the record where it would be necessary to see copies of the original documents.

4.14.2 **Safeguarding issues:**

- Record which agencies (i.e. social services, police, voluntary sector) have been sent relevant documentation with their contact details and dates e.g. adult safeguarding. Please note that this data item is subject and accompanying guidance may change pending the outcome of a review by the Professional Record Standards Body.
- ECDS safeguarding codes and the associated textual terms may be included in this section, together with any associated commentary. Any significant actions should be included in the plan.
- There may be circumstances where it is not appropriate to include safeguarding information in the copy of the EC discharge summary given to the patient. The system should allow the clinician to make a decision about whether or not to omit this information.

4.15 Person completing record

The person completing the record is the person taking responsibility for the discharge from EC.