Professional Record Standards Body

Better records for better care

# Implementation guidance report eDischarge standard

1 Introduction 1

2 Purpose 1

3 Guidance applicable to all standards 2

3.1 General guidance 2

3.2 Mandatory and optional 3

3.3 Coding 4

3.4 Patient demographics 4

3.5 GP practice 5

4 Guidance for the hospital discharge summary standard 5

4.1 General guidance 5

4.2 Patient demographics 5

4.3 Referrer details 5

4.4 Diagnoses 6

4.5 Procedures 6

4.6 Participation in research 7

4.7 Individual requirements 7

4.8 Safety alerts 7

4.9 Medications and medical devices 7

*Preparing the Medications and medical devices summary at the sending end* 7

*Handling the medicines and medical devices summary at the receiving end* 9

*Medicines Reconciliation* 10

*Dose based compared with Product based prescribing* 10

*Plans for future structured dose syntax* 11

4.10 Allergies and adverse reactions 11

4.11 Investigation results 12

4.12 Legal information 12

4.13 Plan and requested actions 13

4.14 Information and advice given 13

4.15 Distribution list 14

4.16 Person completing record 14

# 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 standard:

- Hospital Discharge Summary (2016)

# 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 hospital discharge summary standard

### 4.1 General guidance

4.1.1 The scope of this communication is the discharge summary sent by the hospital to the GP. Although copies of the communication may be sent by the hospital to others, eg community nurses, pharmacists, care home, etc., this would be by local agreement. Other services (eg social care) would be notified by other means of impending discharge to allow preparations.

4.1.2 There should be a single discharge summary, containing all pertinent information, sent out on a timely basis (within 24 hours). The practice of sending an initial brief summary and following up with a later more detailed letter should be deprecated.

### 4.2 Patient demographics

System design should allow the display of separate sections for health/care contacts and personal contacts (e.g. family, friends, relatives etc) under the ‘relevant contacts’ heading.

### 4.3 Referrer details

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

4.3.2 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.

## 4.4 Diagnoses

4.4.1 The discharge summary should inform the GP of the main diagnosis / diagnoses that were important during the admission (or symptom(s) if no diagnosis), including any new diagnosis that came to light during the admission.

4.4.2 When a diagnosis has not yet been made, the most granular clinical concept with the highest level of certainty should be recorded. This may be a problem, symptom, sign, or test result, and may evolve over time, as a conventional diagnosis is reached. For example, 'dyspepsia' may be the diagnosis when a patient first presents with indigestion, upgraded to 'gastric ulcer' when this is found at endoscopy, and 'gastric cancer' when biopsies reveal this.).

4.4.3 Co-morbidities' should be recorded as separate diagnoses. For example, dementia may be recorded as a primary diagnosis by a psycho-geriatrician, but as a co-morbidity where a patient is admitted for a hip replacement.

4.4.4 Unconfirmed or excluded diagnoses should not be recorded in structured coded fields, but may be listed in free text in the comments field. Thus, in the example above, gastric ulcer and gastric cancer may be in a list of differential diagnoses at presentation, but the symptom, dyspepsia, should be recorded in the diagnosis field. The differential diagnoses should only be recorded in free text in the comments field, and not in a coded diagnosis field until confirmed with confidence.

4.4.5 Historical inactive diagnoses, where they are clinically important, should be carried in the clinical summary as narrative to provide some explanation, for example - prior history of breast cancer but no evidence of any recurrence on CT carried out during this admission.

4.4.6 Diagnoses may also be 'problems' or 'issues', depending on the context in which they are recorded.

4.4.7 In some situations a diagnosis may need to be qualified by a number of attributes to give further detail. A generic approach to these attributes (such as grade; severity; distribution; behaviour; laterality etc) has not yet been agreed. Until this is achieved it is recommended that these features are recorded as free text comments.

4.4.8 Clinical coders use discharge summaries for coding hospital episodes. They need to know which diagnosis is the main one (ie primary) and which are secondary. Local implementations should decide how to handle the identification of primary and secondary diagnoses which could be done by either:

- Noting the primary diagnosis in the 'comments' field, e.g. 'primary diagnosis is gastric ulcer'.
- User guidance that the first diagnosis recorded should be the primary one.

## 4.5 Procedures

4.5.1 All procedures undertaken should be included in the e-discharge summary, including:

- diagnostic as well as therapeutic procedures
- procedures carried out on different days during the hospital stay.

4.5.2 Outcomes or results of procedures should be recorded in the 'comments' field.

4.5.3 The discharge summary should include the operation which was actually carried out, not the planned procedure, as this may have been changed. The detail should be

taken from the record of the actual procedure (e.g. operating note) rather than the planned procedure (e.g. consent to treatment).

4.5.4 Clinical coders use discharge summaries for coding hospital episodes. All those deemed to be clinically important for future care should be listed. Thus venesection would not usually merit noting, unless undertaken as a therapeutic procedure for polycythaemia.

4.5.5 Whilst hospitals use OPCS codes for procedures, these cannot be used by GP practices, so should not be included in discharge summaries.

4.5.6 Adverse reactions to anaesthesia should be recorded in the allergies and adverse reactions section, rather than the procedures section, but should be displayed in both the allergies and adverse reactions section and the procedures section, under the specific anaesthesia issues heading. The anaesthesia issues recorded in this section could include for example, “short neck, difficult to intubate” and the actual intubation grade.

## 4.6 Participation in research

When a patient is enrolled on a drug trial/ intervention, the GP receives detailed information from the research sponsor. To avoid duplication the discharge summary need contain the following information only:

- Drug/intervention name
- Trial name (and URL if possible)
- Whether the patient is currently involved in a trial.

## 4.7 Individual requirements

Some of the information under this heading could be populated from the patient demographic service (e.g. person’s language etc), where it is recorded.

## 4.8 Safety alerts

4.8.1 This section is subject to change pending the outcome of a review by the PRSB of the heading “safety alerts”.

4.8.2 The safety alerts heading could potentially contain sensitive information. Therefore sufficient role based access controls should be in place to ensure this information is only shared with those care professionals where there is a need to do so.

4.8.3 There may be situations where it not advisable to share information in this section with the person to whom it relates. Appropriate policies and technical solutions need to be in place for these situations.

4.8.4 All information needs to be reviewed on a regular basis, but it is particularly important for this type of information, given its sensitive nature. There must be mechanisms in place to validate the information in this section and for it to be reviewed regularly.

## 4.9 Medications and medical devices

### *Preparing the Medications and medical devices summary at the sending end*

4.9.1 It is very important that a full and accurate summary record of medications is contained within the discharge summary. This should include:

- Any medications that were current at the time of admission and which the hospital wants the patient to continue following discharge
- Any changes made to medication that was current at the time of admission – such as changes of dosage
- Any medications that were current at the time of admission which were discontinued either during the admission or at the time of discharge
- Any new medications added since admission and which should be continued following discharge
- The reasons for any of the above (i.e. changes, discontinuations or additions of medication)

4.9.2 The discharge summary should NOT include details of medications that were both started and stopped in hospital.

4.9.3 Ideally the above information should be generated semi-automatically from a hospital 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, dosage amount and dosage timing 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.

4.9.4 Whilst medical devices that are prescribable in primary care are generally well represented in dm+d, there are other kinds of devices used in hospital care. 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 a hospital 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 admission 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.

4.9.5 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 GI 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***

4.9.6 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.

4.9.7 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/).

4.9.8 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.

4.9.9 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*

4.9.10 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.

4.9.11 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*

4.9.12 Guidelines for safe on screen display of medication items should be followed in design for display of medication in e-discharge summaries. The NPSA guidance can be accessed via the NPSA website.

4.9.13 Recipients of e-discharge summaries should be aware that the medications and medical devices summary is generated by the hospital 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 Where the hospital systems use dm+d, those items which are prescribable in primary care will be represented in dm+d. Those which are not prescribable in primary care will need to be recorded as textual items.

### *Medicines Reconciliation*

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

4.9.16 The discharge summary should inform the GP of medications that have been continued, changed, discontinued or added since the time of admission along with reasons for these changes. The responsible GP prescriber will therefore need to review the patient's GP medication record, which is likely still to represent the medications that were current at the time of admission, 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 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 hospital 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. Longer term, the expectation is that in many cases it will be possible to utilise both the dm+d code and also a structured statement of dosage to compute the most likely equivalent GP prescription and to present this to the GP prescriber.

4.9.18 For the avoidance of doubt, changes to the GP medication record resulting from hospital 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 In contrast Hospital systems often use "dose based prescribing" which is not dependent on using any particular product but starts with a drug name and then links this to a dose amount 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 It can be seen that in product based prescribing the size of the tablet / capsule / inhalation / etc. is usually 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 out of dose amount, route, and dose timing. Both of these prescribing patterns are therefore supported in the Medication item entry of the Discharge summary Medications and medical devices information model.

4.9.22 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.)
- Route: Optional (e.g. “oral”, “intraocular”,” intramuscular” etc.)
- Dose amount: 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

### *Plans for future structured dose syntax*

4.9.23 The intended direction of travel is to move towards a future:

- where all health care prescribing systems express drug names using dm+d coding both for product based and for dose based prescribing and
- where all health care prescribing systems can also generate a parsable dose directions string that will incorporate all of the remaining information beyond the drug name that is essential to express an unambiguous prescription.

4.9.24 Through a combination of using dm+d and also parsing of these structured dose strings it should then be possible to convert a dose based prescription to a semantically equivalent product based prescription and vice versa. Depending on the structured dose syntax solution eventually adopted it is anticipated that upwards from 80% of all prescriptions could be automatically converted between dose based and product based expressions of prescriptions. Components are already included in the Medications and medical devices information model to support structured dose syntax and its processing.

## 4.10 Allergies and adverse reactions

4.10.1 A full record should be provided of:

- allergies that the patient tells the hospital about
- allergic and adverse reactions related to their admission.

4.10.2 If relevant investigations and observations have been carried out and no allergies or adverse reactions identified then this heading should appear in the eDischarge summary with the text **“No known drug allergies or adverse reactions”**. If no information is available about allergies or adverse reactions (but allergies or adverse

reactions may have been identified), then this heading should appear in the eDischarge summary with the text **"Information not available"**.

4.10.3 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 by the hospital.

4.10.4 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.

4.10.5 Information about probability of recurrence may be included under allergy text section if this was identified by clinician. There is no longer a separate heading for this information. This decision was reached by suppliers and clinicians during FHIR profile mapping.

## 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 Legal information

4.12.1 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.

4.12.2 ***Mental capacity assessment***

- Mental capacity needs to be assessed at each moment where treatment decisions need to be made. Hence there should be provisions for more than one MCA to be recorded.
    - Mental Capacity Act 2005 (England and Wales)
    - Adults with Incapacity Act 2000 (Scotland)
    - Mental Capacity Act 2016 (Northern Ireland).
- If there is a need to communicate the outcome of a mental capacity assessment it is important to record to which specific decision it relates.

4.12.3 ***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 section and accompanying guidance may change pending the outcome of a review by the PRSB.

- There may be circumstances where it is not appropriate to include safeguarding information in the copy given to the patient. The system should allow the clinician to make a decision about whether or not to omit this information.

4.12.4 ***Lasting power of attorney (LPA)*** should include details of one or more people who have been given power by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make those decisions. To be valid, an LPA must have been registered with the Court of Protection. If life-sustaining treatment is being considered the LPA document must state specifically that the attorney has been given power to consent to or refuse life-sustaining treatment.

4.12.5 To improve the accuracy of the ***organ and tissue donation*** heading systems should link directly to the organ donation register where possible.

4.12.6 A clinician should satisfy themselves that the ***Advance Decision to Refuse Treatment (ADRT)*** is valid and that the circumstances that they are dealing with are those envisaged when the person made the ADRT. A valid and applicable ADRT is legally binding. The record should include the location of the legal document. A clinician should satisfy themselves that the ADRT is valid and that the circumstances that they are dealing with are those envisaged when the person made the ADRT. A valid and applicable ADRT is legally binding.

## 4.13 Plan and requested actions

4.13.1 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 heath care professional. For example, follow up renal function test to be arranged by the GP within two weeks of appointment.

4.13.2 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 'Patients concerns, expectations and wishes'.

4.13.3 The plan could be presented in various ways in the system to prompt complete information to be recorded eg table, best practice prompts, etc.

## 4.14 Information and advice given

4.14.1 In some instances health care 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.

4.14.2 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.

4.14.3 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 summary.

## 4.15 Distribution list

4.15.1 This should be a list of people that the discharge summary is being sent to, as the patient and GP need to know where it is being sent.

4.15.2 Where local systems are capable of doing so, they may use this information to trigger the message to be sent.

4.15.3 Consideration should be given to sending copy discharge summaries to recipients by secure email where they are unable to receive a structured message, e.g. care homes, community pharmacies. The PRSB has provided guidance on use of secure email.

4.15.4 Who exactly should receive a copy of a discharge summary will be situation and service specific and should be agreed in a trading agreement with each participating organisation, e.g. whether the copy goes to generic mailbox or to an individual.

## 4.16 Person completing record

This should be the individual responsible for the completion of the discharge summary in the hospital. Others may have contributed to the discharge summary and a record will be maintained in the hospital system.