Professional Record Standards Body

Better records for better care

Implementation guidance report
Crisis Care standard

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:

- Crisis Care (2015)

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 crisis care standard

4.1 Person demographics

4.1.1 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.

4.2 Diagnoses

For a crisis care summary it is important that only relevant active or current diagnoses are recorded, rather than all diagnoses, problems and issues that a patient may have. This should be determined by the clinician and patient.

4.3 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.

4.4 Safety alerts

4.4.1 This section is subject to change pending the outcome of a review by the PRSB of the heading "safety alerts".

4.4.2 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.

4.4.3 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.

4.4.4 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.

4.5 Medications and medical devices

4.5.1 System design must allow separate sections for display of current medications, previous medications and those authorised for future use, so that the status of each medication item is clear.

4.5.2 Each attribute of the medication item (e.g. name, route, dose, frequency etc) should be presented in a clear and logical format (e.g. in tabular form). See National Patient Safety Agency (NPSA) guidance (http://www.nrls.npsa.nhs.uk/resources/collections/design-for-patient-safety/?entryid45=66713).

4.5.3 System design should allow for certain medications of particular importance (e.g. anticoagulants, steroids etc) to be prominently displayed so that they are not overlooked.

Communicating medication changes

4.5.4 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.

4.5.5 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/).

4.5.6 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.

4.5.7 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 summary. In this case, the 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

4.5.8 The 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.

4.5.9 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 summary.

4.6 Allergies

4.6.1 Separating out type of allergy/ adverse reaction/intolerance could require guidance/education.

4.6.2 System design should allow for serious allergic reactions to be prominently displayed so that they are not overlooked.

4.6.3 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.

4.7 Legal information

4.7.1 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.

4.7.2 ***Mental capacity assessment***

4.7.3 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.

4.7.4 ***Safeguarding issues***:

- Record which agencies 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.

4.7.5 ***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.

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

4.7.7 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.

4.8 End of life care plan

The end of life care headings may only be relevant in specific circumstances. We have not been able to fully consider this use case in the time available. Further work will be needed to determine how it is implemented.