eHealth Programme

(EH4001) CLINICAL DOCUMENT INDEXING STANDARDS

Version: 3.3

April 2018

Contents

1. Document Control

1.1 Summary information

Document Title	(eH4001) Clinical Document Indexing Standards
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Creation date	1st August 2011
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Document status	Approved for publication
Date of last update	November 2017
Date of publication	April 2018
Compliance	Use of this standard is RECOMMENDED, PROSPECTIVELY, in all clinical systems, in particular those sharing information across Health Boards.
Owner	Clinical Change Leads Group (CCLG)
Change Control	Will be managed by NHS National Services Scotland Information Services Division and a Virtual Reference Group. Contact: mailto:NSS.isdDataStandards@nhs.net
Date for revalidation	A revalidation case will be sought from the standard owner in March 2019.

1.2 Version control

Date	Author	Version	Modifications
01/8/11	CC	V0.1	Initial Draft
16/1/12	CC	V0.2	Feedback from consultation period incorporated.
3/7/12	PW	V0.3	feedback from CCLG and NSS input
19/10/2012	CL	V0.4	eHealth A&D not suitable owner. CCLG accepted ownership. Section 2.5 amended to reflect this.
06/11/2012	CL	V0.5	Amendments requested by PET before sign-off
5/12/12	CL	V2.0	Version control / configuration data updated following approval to publish
15/04/13	AMW	V2.1	Modification – Duplicate code (CL12 – Operation Note) removed following Virtual Reference Group Meeting approval.
01/08/13	AMW	V2.2	Creating of new code LA20 - Genetics
22/11/13	CJA	V2.3	Remove ETT from description under code RP02. Creation of new codes; LA09 – Histocompatibility & Immunogenetics MI03 – Legacy Bulk Scanned Record CA06 – Anticipatory Care Plan (ELT) CA07 – Anticipatory Care Plan (ITG) AS34 – Risk Assessment RP34 – ETT RP35 – Ambulatory ECG monitoring report RP36 – Implant Device Maintenance report
07/03/2014	KH	V2.3	AS35 – Gait Analysis Assessment
24/03/2014	KH	V2.4	Creation of new codes:

			RP37 - Endoscopy Report – Upper GI RP38 – Endoscopy Report – Lower GI
15/07/2014	CJA	V2.5	AS35 – Gait Analysis Assessment Record
09/12/2014	CJA	V2.6	Updated document control by removing version number and modifications under document status. Amended order of codes under each document type so codes 99 are now at the end of each listing. IN09 - UVA / PUVA Treatment Record RP39 – Visual Field Reports RP40 – Nuclear Medicine Report IM03 – Nuclear Medicine Images
12/06/2015	KH	V2.7	Creation of new code: RP41 Post Mortem/ Autopsy
18/08/2015	CJA	V2.8	Creation of new codes: RE01 Study Consent and Participant Information Sheet RE02 Study Visit Document RE03 Study Randomisation Documentations RE04 Study Adverse Event Documentation RE05 Study withdrawal/ Un-blinding RE99 Study Document – not otherwise specified
29/03/2016	CJA	V2.9	Amendment to description: IN05 – Record of radiological intervention e.g. Drainage of abscess under radiological guidance, coiling of aneurysm under radiological guidance, biopsy of tissue under radiological guidance Creation of new codes: IN10 - Implantation of cardiac electronic device - Record of initial or revision implant procedure including the procedure note and any initial programming or setup to the device itself. IN11 - Percutaneous Coronary Intervention - Record of intervention to a coronary artery e.g. stenting, balloon angioplasty, mechanical thrombectomy. Does not include reports for diagnostic only procedures where intervention does not occur. RP42 - Diagnostic Coronary Angiography - Report on the diagnostic angiogram. Specifically any coronary angiogram where images are acquired or attempted to be acquired. Not including any procedure where intervention e.g. a stent is placed. RP43 - Ambulatory BP Monitoring - Report on ambulatory blood pressure monitor results. e.g. hospital fitted BP monitor or recordings from GP fitted monitors or patients record of recording periods.
04/07/2016	CJA	V3.0	Amended 1.3 title from ‘Strategic Objectives’ to ‘Reviewers and Roles’ **Revalidation Update**: 2.4 Reference section – **removal of the following text** The content is also represented in the SNOMED-CT Correspondence Document Type subset.

			For background information on the clinical document Indexing Standards, please refer to the following paper written by Paul Woolman in 2007:- eHealth WebSite - Document Indexing Paper 2007 **Additional text inserted:** This material includes SNOMED Clinical Terms® (SNOMED CT®) which is used by permission of the International Health Terminology Standards Development Organisation (IHTSDO). All rights reserved. SNOMED CT®, was originally created by The College of American Pathologists. "SNOMED" and "SNOMED CT" are registered trademarks of the IHTSDO. The full product can be downloaded from https://isd.hscic.gov.uk/trud3/user/guest/group/0/pack/26. For purposes of the Clinical Document Indexing Standard all the CDI codes will be assigned pre-coordinated SNOMED codes. **Amendments to Document Type/Subtype;** AS04 (SSA) – removed brackets IN10 – Inserted 'Record of' IN11 – Inserted 'Record of' LA01 – Inserted 'report' LA02 – expanded to 'Laboratory summary report' LA03 – LA99 – Inserted 'report' RP41 – Amended to Non Procurator Fiscal Post Mortem Report to align with SNOMED term.
06/2017	CJA	V3.1	Inserted missing SNOMED codes within the table of 3.4 Contents of Standard Insertion of new **Document Type/Subtype;** RP44 – Airway Endoscopy Report RP45 – Endoscopic Retrograde Cholangio-Pancreatography Report RP46 – Endoscopic Ultrasound Report RP47 – Endobronchial Ultrasound Report
11/2017	CJA	V3.2	Creation of new codes; RP48 – Combined Upper and Lower GI Endoscopy Report RP49 – Cystoscopy Report Previously requested SNOMED codes inserted for; RP44 RP45 RP46 RP47
04/2018	CJA	V3.3	Inserted missing SNOMED codes within the table of 3.4 Contents of Standard Insertion of new Document Type/Subtype; ME10 – Medication Review

1.3 Reviews and Roles

Reviewer	Role/Department	Date signed off
Consortium Project Team	Workshop Participants/Reviewers	8th June 2011
eHealth Programme Executive Team	Approvers	5th November 2012
Clinical Change Leadership Team	Approvers	19th September 2012
eHealth Leads	Approvers	
eHealth Programme Executive Team	Approvers (Publication)	4th December 2012
Virtual Reference Group	Approvers	15th April 2013
	Design Review and Approval Panel representative	

2. Introduction

2.1 Purpose

This document describes proposed revisions to the NHS Scotland Clinical Document Indexing Standard v1.0 (2007).

This standard has been produced through a collaborative exercise led by NHS Greater Glasgow and Clyde on behalf of all Boards, and is for the use of NHS Scotland information systems (IS) and eHealth projects.

This is **version 3.3 (2018)** of the Standard, approved for publication.

2.2 Background

As Health Boards modernise and reorganise patient/client care there is a growing requirement for patients/clients to move across traditional geographical and care boundaries. This requirement, in turn, creates a need to have greater sharing of information across the boundaries - whilst maintaining patient/client safety and adhering to appropriate standards.

Over the past few years, Health Boards in Scotland have embarked on various initiatives to enhance the availability and use of electronic information and to increase the volume and scope of electronic clinical information and documents.

Provision of electronic solutions to support this increased electronic sharing relies on effective, efficient and consistent indexing across all NHS boards.

Feedback received from different health boards suggested that the initial NHS Scotland Clinical Document Indexing Standard, published in 2007, required review and possible amendment.

For these reasons three workshops were hosted by NHS Greater Glasgow and Clyde, supported by Scottish Government eHealth directorate. The first workshop concentrated on sharing experiences from document scanning projects in both primary and secondary care across NHS Scotland. The second and third workshops discussed the national speciality reference file and the NHS Scotland Clinical Document Indexing Standard, which includes a listing of document types and subtypes.

Feedback from the Boards, together with the outcomes of the workshops suggested that:

- The document indexing standard, and associated list of document types and subtypes, does not have any associated definitions
- The document indexing standard contains more options than are actually necessary and there appear to be some clinically relevant omissions
- Any amendments to the list should consider inclusion of non-medical specialties to ensure that nurse or therapy led service activity can be reported appropriately
- The costs associated with amending and implementing a new reference file, and the potential complexity of mapping existing document types and sub types to a new standard, need to be considered. There needs to be clear justification to amend the current document indexing standard.

2.3 Overview

This standard comprises of a list of clinical document indexes including document types and sub-types.

This list of index elements (metadata) is associated with a document and used for storage and future searching or sorting. One such element, the document 'Type' or category element demands a list of acceptable clinical document types that the NHS clinical community can approve as a standard list and would be fit for implementation in the various developments.

The current document standards have been in existence for a number of years. As a result, numerous changes to the standards were requested and added to the national reference file.

The indexing standards required to be considered and options assessed in light of the move towards electronic working and in the increased use of the standards. The 'do nothing' option was considered and rejected on the basis that current use of clinical documents was not reflected in the existing standards. This was discussed and agreed at the initial meeting of the group.

The revised indexing standards have made some small changes in indexing and classification of a few documents; this should not alter local storage of information and need not necessitate immediate change or cost to any board. Should a board wish to share information externally or to bring in external information from another board any subsequent project should detail the new mapping requirements and funding arrangements.

Updates to the files will be made by the custodians of the indexing standards and made available for NHS Boards for use. Where a review causes a change to the indexing used for any document consideration must be given to the historical content retained. The principle stated in the previous paragraph should be applied whenever possible.

A guidance document (**Document indexing guidance notes v3.0**) should be read alongside this standard. It dictates the set of metadata recommended to be stored and transmitted with a clinical document. It also illustrates the relationships between the various standards related to clinical document management.

2.4 References

A copy of the current document indexing standards can be found on the eHealth Standards Library web page and the ISD website .

The ISD national specialty list is to be used in document indexing, this is available as a reference file from ISD:- (http://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/).

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For purposes of the Clinical Document Indexing Standard all the CDI codes will be assigned pre-coordinated SNOMED codes.

Document Indexing Guidance Notes v3.0 (2016) published with this standard.

2.5 Ownership

Ownership of the Clinical Document Indexing Standards is with the Clinical Change Leadership Group (CCLG).

Ongoing maintenance of the standard, including a contact point for occasional additions or modifications will be provided by NHS Information Services (ISD) Data Management service. ISD will take a 'stewardship' role in respect of the standard and establish a Virtual Reference Group to that effect. The Virtual Reference Group should have representation from CCLG and NHS GGC, as the original authors, and will consider any requests for change.

NHS NSS will provide the following service:

1. ISD will maintain the clinical document type standard, as part of the funding it already receives for the Data Management, Data Advice Team.

2. ISD will as required convene a national stakeholder group drawing on previous specialist knowledge to include representatives of the clinical portal, SCI Store, boards, etc. This could function virtually depending on the discussion required.

3. Interim revisions required will be agreed by the Virtual Reference Group. If a change endorsed by the Virtual Reference Group is significant and its implementation would result in additional cost or implementation activity, it will be escalated to the full CCLG for approval. On approval ISD will make the required changes to the source file and publish on the web

In addition to the ongoing maintenance 'custodianship' provided by NSS, SG eHealth will instigate periodic reviews of the standard, likely to be on a two or three year period as with all other eHealth standards.

2.6 Contents

The remainder of this document is presented in the following sections:

Section 3 describes the scope of the standard i.e. which type of project the standard may apply to, and the associated timescales;

Section 3.4 contains the detail of the standard;

Section 4 describes the sign off process for the standard.

3. Scope

3.1 Overview

The scope recognises this as a National requirement and includes all NHS Scotland Boards. Input was sought directly from:

- NHS Greater Glasgow and Clyde (Lead Board)
- NHS Dumfries and Galloway
- NHS Forth Valley
- NHS Grampian
- NHS Tayside
- SCIMP
- NHS National Services Scotland
- Scottish Government – eHealth Division

3.2 Applicable systems

All clinical systems in particular those sharing information across Health Boards for example:-

- Clinical Portals
- SCI Store
- Letters Systems
- Clinical Systems
- GP Systems (EMIS & INPS)
- TrakCare

3.3 Timescales

The standard should to be implemented in accordance with eHealth and local Health Board strategies.

3.4 Contents of standard

Following on from workshops held, consultations and reviews, the current standards have been updated to reflect the discussion points and agreement reached with the stakeholders.

The proposed document type standards are as follows:-

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
AL	**Alerts & Risks**		
AL01	Allergies and Adverse Reactions	Any allergy or adverse reaction noted at a point in time	163221000000102
AL02	Alerts	Any alert noted at a point in time	37341000000109
AS	**Assessments**		
AS01	Nursing assessment tool	Any tool used by nursing staff for recording an assessment.	819981000000101
AS02	AHP Assessment	Any assessment completed by an AHP	819991000000104
AS03	CAF assessment	Common Assessment Framework - a standard approach to conducting assessments of children's additional needs.	820011000000105
AS04	SSA assessment	Single Shared Assessment - person-centred and more streamlined approach led by a single professional with other specialist involvement where appropriate.	820021000000104
AS05	CPA assessment	Care Programme Approach.	820031000000102
AS07	Multidisciplinary assessment	Any assessment completed by various clinical staff groups	820041000000106
AS08	Scored Assessment	Any completed scored assessment.	823571000000103

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
AS10	Pre-admission assessment	Any assessment completed prior to any admission.	820071000000100
AS11	Self-assessment form	Any assessment completed by a patient	820081000000103
AS12	Medical assessment	Any assessment completed by medical staff	820091000000101
AS13	Theatre Patient Checklist	Intervention/Procedure check prior to theatre	823591000000104
AS14	Social Services Assessment.	Any assessment completed for or by social services	820101000000109
AS15	Pre Op Assessment	Any assessment completed prior to an intervention/ procedure	823561000000105
AS16	Nursing Profile	Any profile used by nursing staff to assess a patient.	819981000000101
AS34	Risk Assessment	Self-explanatory	886831000000103
AS35	Gait Analysis Assessment Record	This is a structured assessment of an individual's gait which may include graphs and charts, images of the objective findings.	927061000000101
AS99	Assessment	Not Specified or for bulk scanning	325931000000109
CA	**Care Plans**		
CA03	Clinical Care Plan	Any care plan involving clinicians and/or social services which may or may not be integrated. Also includes Care Pathway.	325661000000106
CA04	MDT Plan	Any care plan involving multi disciplinary staff groups for example Lung MDT Plan	823581000000101
CA05	Discharge Plan	Any care plan used for discharge planning including nursing	820121000000100
CA06	Anticipatory Care Plan (ELT)	End of Life Treatment decisions	935921000000102
CA07	Anticipatory Care Plan (ITG)	Individualised Treatment Guidelines for a patient with an unusual condition or difficulty treating a condition	962891000000106
CA99	Care Plan	Not Specified or for bulk scanning	325661000000106
CH	**Observations**		

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
CH03	Fluid Balance Chart	Any chart, form or document used to record fluid balance	526591000000108
CH04	Fundal height chart	Any chart, form or document used to record fundal height	820141000000107
CH05	Growth Chart	Any chart, form or document used to record growth	820161000000108
CH06	ITU & ICU chart	Any chart, form or document used to record intensive care or intensive therapy observations	823601000000105
CH07	Partogram	A graphical record of key data (maternal and fetal) during labour for example Cervical Dilatation	820191000000102
CH08	Temperature Chart	Any chart, form or document used to record temperature	824231000000100
CH09	Patient Safety Checklist	Any chart, form or document used for this purpose	820211000000103
CH10	Vital Signs Chart	Any chart, form or document used to vital signs	823611000000107
CH11	Weight Chart	Any chart, form or document used to record weight	820441000000103
CH99	Observation	Not specified or for bulk scanning	823621000000101
CL	**Clinical Notes**		
CL03	Inpatient medical note	Any inpatient information recorded by medical staff	820221000000109
CL04	Inpatient nursing note	Any inpatient information recorded by nursing staff	829201000000105
CL05	Medical note	Any information recorded by medical staff	820451000000100
CL06	Multidisciplinary note	Any information recorded by multiple staff groups	820461000000102
CL07	Nursing note	Any information recorded by nursing staff including community notes	820471000000109
CL08	OOH note	Any information recorded by Out of Hours service	823631000000104
CL09	Outpatient nursing note	Any outpatient	820481000000106

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
		information recorded by nursing staff	
CL10	Outpatient medical note	Any outpatient information recorded by medical staff	820491000000108
CL11	AHP note	Any information recorded by an AHP e.g.. Dietetic Record Card	823641000000108
CL13	Telephone Consultation	Any clinical information pertaining to a telephone consultation	24681000000104
CL14	Video Consultation	Any clinical information pertaining to a video consultation	325921000000107
CL15	Summary record	Any clinical summary noted at a point in time	824321000000109
CL16	ED Card	Emergency department clinical note e.g.. AE Card	445300006
CL99	Clinical note	Not Specified or for bulk scanning and remote notes including patient contacts by telephone and email.	823651000000106
CO	**Correspondence**		
CO02	Outpatient Letter	Created as a result of an out patient clinic attendance e.g.. clinic letter	823681000000100
CO03	Clinical letter	Containing clinical information, not a clinic attendance or discharge	823691000000103
CO04	Discharge letter	Created as a result of discharge from care	823701000000103
CO06	Inpatient Final Discharge letter	Final inpatient discharge letter Includes day case	824331000000106
CO08	Immediate Inpatient Discharge letter	Immediate inpatient discharge letter includes day case	824341000000102
CO09	Letter from patient	Letter received from a patient	25731000000109
CO10	Letter to patient	Clinical letter sent to a patient	24711000000100
CO14	Referral letter	Referral from any source about the patient	25611000000107
CO15	Social service letter	Letter from social services	823721000000107
CO16	Transfer letter	Transfer of care letter	823731000000109
CO17	Administrative Letter	Administrative letters sent to patient e.g. Invitation letter, Admission letter and	823761000000104

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
		Recall letter	
CO18	Did not Attend Letter	Letter sent to patient and/or GP advising of non-attendance and subsequent action.	909921000000109
CO19	Unscheduled Care	Unplanned/unscheduled contact e.g. AE letters, NHS24 letters, OOH	823771000000106
CO20	MDT Letter	Multi-Disciplinary Letter	823781000000108
CO99	Correspondence	Not Specified or for Bulk Scanning	163161000000103
IM	**Images**		
IM01	Radiology	Images which are sourced from else where and not available on other electronic systems e.g. PACS.	24611000000106
IM02	Medical Photograph	Photographic images related to patient management	820241000000102
IM03	Nuclear Medicine Images	Images sourced from nuclear medicine investigations	962381000000101
IM99	Images	Not specified or for bulk scanning	25831000000103
IN	**Interventions/Procedures**		
IN01	Anaesthetic record	Record of Anaesthesia	416779005
IN03	Nutritional record	Diet intake, enteral and parenteral feeding	820501000000102
IN04	Endoscopy record	Record of endoscopic intervention	820511000000100
IN05	Interventional radiology record	Record of radiological intervention e.g. Drainage of abscess under radiological guidance, coiling of aneurysm under radiological guidance, biopsy of tissue under radiological guidance	820251000000104
IN06	AHP therapy record	Record of AHP therapy	823831000000103
IN07	Operation note	Record of surgical intervention	823661000000109
IN08	Radiotherapy record	Record of radiotherapy treatment	823841000000107
IN09	UVA / PUVA Treatment Record	Intervention involving ultraviolet light therapy, often as an outpatient treatment	962901000000107
IN10	Record of Implantation of cardiac electronic device	Record of initial or revision implant	1054141000000102

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
		procedure including the procedure note and any initial programming or setup to the device itself.	
IN11	Record of Percutaneous Coronary Intervention	Record of intervention to a coronary artery e.g. stenting, balloon angioplasty, mechanical thrombectomy. Does not include reports for diagnostic only procedures where intervention does not occur.	1067211000000108
IN99	Intervention	Not specified or for bulk scanning	826491000000106
LA	**Labs**		
LA01	Biochemistry Report	Any result from a test performed in a Biochemistry lab	4311000179106
LA02	Combined laboratory report	A summarised view of location/patient results	1076911000000107
LA03	Haematology Report	Any result from a test performed in a haematology lab	4321000179101
LA04	Cellular Pathology Report	Any result from a test performed in a cellular pathology lab, Includes Histopathology & Cytology	1054291000000102
LA05	Virology Report	Any result from a test performed in a virology lab	1054281000000104
LA06	Immunology Report	Any result from a test performed in an immunology lab	4331000179104
LA07	Microbiology Report	Any result from a test performed in a microbiology lab, including MSSU, MRSA Screening	4341000179107
LA08	Blood transfusion Report	Any result from a test performed in a blood transfusion lab	1054181000000105
LA09	Histocompatibility & Immunogenetics Report	Renal, Cardiac, Stem Cell transplant H&I investigations and HLA disease associations	909871000000100
LA20	Genetics Report	Any results from genetic investigations are to be filed here. Examples include: cytogenetics,	1054161000000101

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
		clinical genetics, biochemical and molecular.	
LA99	Laboratory Report	Not specified or for bulk scanning	371528001
ME	**Medication**		
ME01	Controlled drugs dispensing	Any chart, form or document recording the dispensing of controlled drugs e.g., Morphine, Diamorphine	820261000000101
ME03	Drug administration chart	Any record of the administration of medicine for example Insulin or Warfarin	824781000000106
ME07	Medication record	Any medication record including Prescription records and repeat prescriptions.	163111000000100
ME08	Prescription and administration record	Any record for the prescribing and administration of medicine, for example Kardex as used in some Health Boards.	824791000000108
ME09	Chemotherapy record	Record of chemotherapy treatment for cancer	820271000000108
ME10	Medication review	Any communication or record of a medication review (includes level 0-3 reviews) and / or medication reconciliation procedures.	New Code Request
ME99	Medication	Not specified or for bulk scanning	185361000000102
MI	**Miscellaneous**		
MI01	Miscellaneous	Non defined document within this section	826501000000100
MI02	Front sheet	Patient Master Index Sheet. For Bulk Scanning.	824801000000107
MI03	Legacy Bulk Scanned Record	Bulk scanned whole patient case record	24761000000103
NO	**Notification & Legal Documents**		
NO01	Fiscal Autopsy report	Formal Autopsy report from Fiscal office.	823871000000101
NO02	Child protection documentation	Record of child protection case conference, child safety action plan, summary of investigation.	229054004
NO03	Consent form	Document advising	824831000000101

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
		consent has been obtained	
NO04	Death certificate	Certificate of death	307930005
NO05	Exemption form	Any record that relates to patient exemptions	826511000000103
NO06	Infectious disease notification	Notification of infectious disease for example to Public Health	820291000000107
NO07	Legal notice	Any legal notice	826621000000105
NO08	Mental Health Act notice	Emergency Detention Certificate, Short Term Detention Certificate, Compulsory Treatment Order, Revocation.	826631000000107
NO09	Refusal Form	Notice that patient has refused treatment	826521000000109
NO10	Employment report	Self-explanatory	308575004
NO11	Housing report	Self-explanatory	310854009
NO12	War Pensions report	Self-explanatory	308619006
NO13	Disabled driver badge report	Self-explanatory	270372007
NO14	Driving licence fitness report	Self-explanatory	270370004
NO15	DSS RMO RM2 report	Self-explanatory	307881004
NO16	Insurance (life) report	Self-explanatory	270358003
NO17	RM10-DHSS DMO report	Self-explanatory	308621001
NO18	DLA 370 report	Self-explanatory	308584004
NO19	DS 1500 report	Self-explanatory	308585003
NO20	Adoption Report	Self-explanatory	820301000000106
NO21	Adult Incapacity Report	Self-explanatory	823951000000100
NO22	Power of attorney/Legal Guardianship	Self-explanatory	826541000000102
NO99	Notification & Legal Document	Not specified or for bulk scanning	826651000000100
PH	**Patient held records**		
PH01	Patient held record	Any record held by the patient	408403008
PA	**Patient Preferences/Instructions**		
PA01	DNAR order	Any patient instruction regarding resuscitation	823881000000104
PA02	Living Wills & Advance directives	Any patient instruction regarding treatment/care	827701000000106
PA03	Organ donor card	Any patient instruction regarding organ donation	822751000000105
PA99	Patient Preferences/Instruction	Not Specified or for bulk scanning	822761000000108
RE	**Research/Study**		
RE01	Research Study Consent and Participant Information	Signed Consent Form and associated	824831000000101

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
	Sheet	Participant Information Sheet. From a practical and governance perspective, it is important that the correct, matching-paired versions of PIS and Consent are always stored together. Additionally, it is often the case that these are supplied as single, combined documents. It is therefore best to categorise these as the same document sub-type.	
RE02	Research Study Visit document	Documents used by Clinical Trials Staff, Research Nurses or Investigators to collect study data during patient visits – examples include Source Data Worksheets, Study Data Capture Forms, Clinical Sheets	1054111000000103
RE03	Research Study Randomisation documentation	Any documentation detailing randomisation	1054101000000100
RE04	Research Study Adverse Event document	Details of any participant adverse events. This category would only be used where details of the Adverse Event are not recorded elsewhere – e.g. within a Study Visit Document. Sponsors' SAE/ SUSAR Forms, etc., are stored in the CRF rather than the medical notes.	1054091000000108
RE05	Research Study withdrawal / un-blinding	Any study document completed as a result of withdrawal or un-blinding of a study participant	1054071000000109
RE99	Research Study Document – not otherwise specified	Any other study-specific document that does not fit into any of the above categories or for bulk scanning	1054061000000102
RP	**Reports**		
RP02	ECG	For example ECG	827711000000108

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
RP05	Pulmonary Investigation	For example, PFT, Sleep tests	822771000000101
RP08	Vascular Investigation	For example, Carotid, DVT	822781000000104
RP09	Gastro Investigation	For example, Breath tests, PH studies	822801000000103
RP11	Cardiac Investigation	All other Cardiac tests except those in sub-types ECG & Echos e.g. Ambulatory BP	822791000000102
RP12	Urodynamics	For example, Urethral function test, Cystometry	827721000000102
RP13	Neuro Investigation	For example, Carpal tunnel, EEG & nerve conduction studies	822811000000101
RP29	Ambulance Patient Report Form	For example ePRF (Electronic Patient Report Form)	824861000000106
RP30	Radiology	For example, X-ray, CT	371527006
RP31	Echo	For example, Echocardiogram	822821000000107
RP32	Audiology Investigation	For example, Hearing Aids, Tinnitus	822831000000109
RP33	AHP Investigation	For example, balance test, swallowing tests	823891000000102
RP34	ETT	Exercise Tolerance Test report	914861000000106
RP35	Ambulatory ECG monitoring report	For example 24 hour ECG	914851000000108
RP36	Implanted Device Maintenance Report	For example maintenance can include device check, replacement of leads, reprogramming, repositioning, testing etc	918401000000103
RP37	Endoscopy Report – Upper GI	Self-explanatory	927071000000108
RP38	Endoscopy Report – Lower GI	Self-explanatory	927081000000105
RP39	Visual Field Report	A report detailing a plot of patient's visual fields and any associated defects.	962401000000101
RP40	Nuclear Medicine Report	A report on nuclear medicine imaging, 2D scintigraphy, 3D SPECT and PET scan reports e.g. bone scan, myocardial perfusion, V/Q scan, PET.	962391000000104
RP41	Non Procurator Fiscal Post	Report of a post mortem	983701000000101

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
	Mortem Report	examination / autopsy not carried out under the auspices of the procurator fiscal's office.	
RP42	Diagnostic Coronary Angiography Report	Report on the diagnostic angiogram. Specifically any coronary angiogram where images are acquired or attempted to be acquired. Not including any procedure where intervention e.g. a stent is placed.	1054131000000106
RP43	Ambulatory BP Monitoring	Report on ambulatory blood pressure monitor results. e.g. hospital fitted BP monitor or recordings from GP fitted monitors or patients record of recording periods.	1054121000000109
RP44	Airway Endoscopy Report	A report on an endoscopic technique of visualizing the inside of the airways for diagnostic and therapeutic purposes,	1083371000000100
RP45	Endoscopic Retrograde Cholangio-Pancreatography Report.	ERCP - A report on an endoscopic procedure to examine the pancreatic and bile ducts.	1083361000000107
RP46	Endoscopic Ultrasound Report	EUS – A report on an endoscopic procedure employing ultrasound, commonly used to assess gastrointestinal, abdominal and lung related pathology but possibly utilised in other areas. Excludes EBUS – Endobronchial Ultrasound Report.	1083351000000109
RP47	Endobronchial Ultrasound Report	EBUS - A report on a technique that uses ultrasound along with a bronchoscope to visualise the airway wall and adjacent structures.	1083341000000106
RP48	Combined Upper and Lower GI endoscopy Report	A single report on a combined upper and lower GI endoscopic investigation. E.g. combined upper GI endoscopy plus	1095251000000101

REVISED DOCUMENT INDEXING STANDARDS (April 2018)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
		sigmoidoscopy report, combined upper GI endoscopy plus colonoscopy report	
RP49	Cystoscopy Report	A report on an inspection of the urethra and bladder.	1095241000000104
RP99	Report	Not specified or for bulk scanning	229059009
TH	**Third party documents**		
TH01	Non-Statutory provider document	Any document from a non-statutory organisation for example, local authority information	823901000000101
TH02	Private provider note	Any document from private health care provision	823931000000107
TH99	Third party document	Not specified or for bulk scanning	823941000000103
Document Types = 17 & Document Sub Types = 166			

Guidance Notes have been produced which provide further clarity when applying the indexing standards to documents and act as a quick reference to ensure there is an agreed and consistent approach for storing and retrieving electronic clinical documentation.

3.5 Data items

Data items are not applicable as this is a document management standard.

4. Document approval and sign-off

4.1 Current status

This standard is currently at **version 3.3**. It has been issued for final approval by the eHealth Programmes Executive Team.

4.2 Final sign off

This standard will be completed according to the standard review and authoring process as defined in relevant e-Health process document and the standard will be reviewed and signed off as described in section 4.1.