Release Notes

Nursing care needs standard

V1.0

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The following changes have been made to the standard as part of publication following endorsement by the relevant professional bodies and key stakeholders.

- The Nursing Care Needs Standard underwent a clinical terminology review. Group-level data items are tagged with SNOMED CT Observable Entity codes where available. In the coded value field, only Finding codes are included, with a free text option (Table 1). This structures the model's data items in the system as an inferred question and answer, with the option for free text input. Users of the record are encouraged to use a coded value and only use free text to supplement the information.
- Within the Elimination group, the Elimination item has been removed and replaced with four new data concepts to align with the existing SNOMED CT codes, including Toileting capability, baseline toileting capability, continence capability and baseline continence capability, as shown in table 2.
  This aligns standards closer to the associated technical specifications (including SNOMED-CT and FHIR) and therefore makes them more implementable.
- The implementation guidance was reviewed and updated, and any misspellings were corrected.
- The final report (now v1.0) and use case example was updated to following supplier feedback.

Table 1. A table presenting an example of data items structured as an inferred question and answer with SNOMED CT codes.

Name	Description	Context
Hydration	The details of an individual's hydration state.	405006006 |Hydration status (observable entity)|
Coded value	Coded value for the hydration state.	The coded value field should contain only one SNOMED CT code from the following value set:

		Suggested SNOMED CT ID | Fully specified name (FSN) 251858002 | Negative fluid balance (finding) | 278022001 | Neutral fluid balance (finding) | 251857007 | Positive fluid balance (finding) | Where required codes are unavailable the free text field should be used and consideration given to submission of a new code request to the UK SNOMED CT request submission portal (see https://isd.digital.nhs.uk/rsp/user/guest/home.jsf). Contact info@thePRSB.org for further information.
Free text	Free text if coded value isn't available.	

Table 2. A table presenting the new data elements in the Elimination section in the information model.

Name	Description	Context
Elimination record entry	This is an elimination record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.	The information about the details of the initial state of toileting and continence. The nurse must record if the person is capable of toileting independently. The system should be able to receive and prepopulate fields and display information about a person's toileting and continence capability where other systems are conformant with the standard.
Toileting capability	Information regarding whether the person is capable of, and typically independently attends to their own toileting needs.	The system should be able to implement an option to allow clinicians to select a section from the Activities of Daily Living (ADL) as "Independent".
Baseline toileting capability	A record of what a person's typical toileting capability is, prior to meeting the nurse.	The information recorded by the nurse here should represent the person's typical ability to toilet prior to being seen by the nurse (e.g. what is typical for them). This may not match the information in the activity's capability at initial

		assessment if the person has improved or worsened.
Continence capability	Information regarding whether the person is capable of, and typically independently controls their bladder and/or their bowel on their own accord.	The system should be able to implement an option to allow clinicians to select a section from the Activities of Daily Living (ADL) as "Independent".
Baseline continence capability	A record of what a person's typical continence capability is, prior to meeting the nurse.	The information recorded by the nurse here should represent the person's typical ability to toilet prior to being seen by the nurse (e.g. what is typical for them). This may not match the information in the activity's capability at initial assessment if the person has improved or worsened.