PRSB
Professional Record Standards Body

Better records for better care

E-DISCHARGE SUMMARY (MENTAL HEALTH SUMMARY)

IMPLEMENTATION GUIDANCE V1.0

JULY 2016

The Professional Record Standards Body

The independent Professional Record Standards Body (PRSB) was registered as a Community Interest Company in May 2013 to oversee the further development and sustainability of professional record standards. Its stated purpose in its Articles of Association is: "to ensure that the requirements of those who provide and receive care can be fully expressed in the structure and content of health and social care records". Establishment of the PRSB was recommended in a Department of Health Information Directorate working group report in 2012.

Professional Record Standards Body

85 Tottenham Court Road,

London, W1T 4TQ.

www.theprsb.org

Community Interest Company No 8540834

Document management

Project	Discharge Summary Phase 2			
Project Director	Martin Orton			
Owner	Jan Hoogewerf			
Authors	John Williams (RCGP), John Williams (RCP) Paul Rastall (RCP) Jan Hoogewerf	**Version**		1.0
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Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility
John Williams	RCGP, Clinical Lead
John Williams	RCP, HIU Director
Expert clinical group: Leo Fogarty, Ian McNicoll, Anoop Shah, Paul Rastall, Ian Thompson, Jo Goulding, Ann Slee, Emma Melhuish, Keith Farrar, Colin Brown, Paul Miller, Phil Koczan, Ian Thompson.	
Munish Jokhani	HSCIC, Clinical Engagement Lead
Philip Scott	PRSB, technical assurance
Annette Gilmore	PRSB clinical and patient assurance
Advisory Board, PRSB	
Vendor Forum, PRSB	

Approved by

This document must be approved by the following people:

Name	Signature	Date	Version
Project Board			

Related documents

These documents will provide additional information.

Ref no	Title
[1]	e-discharge summary phase 2 PID v1
[2]	e-discharge summary phase 2 information models (final draft)
[3]	Standards for the Clinical Structure and Content of Patient Records. http://www.rcplondon.ac.uk/resources/standards-clinical-structure-and-content-patient-records
[4]	e-discharge summary clinical safety report

Contents

1   Introduction

1.1   Purpose

The purpose of this document is to update guidance published previously by HSCIC for the implementation of the [Academy of Medical Royal Colleges (AoMRC) clinical record headings](#) in electronic Discharge summaries sent from hospitals to registered GPs for inpatient and day cases.

The previous guidance supported transfer of discharge summaries as semi-structured or embedded documents. Further work has been done to develop information models to enable structured and coded data to be communicated in a more interoperable form in e-discharge summaries under the following clinical headings:

- Diagnoses
- Procedures
- Allergies and adverse reactions
- Medications and medical devices.

This document provides:

a) Guidance to implementers and suppliers on how to implement the AoMRC headings including the structured and coded data. It is intended to complement the HL7 Clinical Document Architecture (CDA) message specification to be published by the HSCIC and provide complementary guidance to implementers (NHS organisations and GP practices) and IT system suppliers on how to implement the messages.

b) Good practice guidance to clinicians relating to recording and receipt of information in the discharge summary.

The document does not include examples of discharge summaries as CDA documents, as they will be provided in the CDA specification. It also does not specify requirements for the way in which sending or receiving systems should operate as this will depend on functions and user interfaces of existing systems.

1.2   Background

The National Information Board published its framework for action in November 2014 which states:

'We propose the adoption of the Academy of Medical Royal Colleges' publication Standards for the clinical structure and content of patient records with a requirement that all organisations and clinical systems should implement the standards, following consultation and completion of an impact assessment.'

The AoMRC standards for the clinical structure and content of patient records were published in 2013. The scope included headings for admission, discharge, handover, referral and outpatient letters. The standard headings are common across all use cases to enable re-use (so that for example, the medication information recorded in a GP referral can be used by the hospital in medicines reconciliation during admission and to identify changes in medications for inclusion in the discharge summary). The AoMRC 2013 record headings form the structure for the e-discharge summary, where minor amendments have been made (eg to reflect changes in legislation and good practice) these are identified in an Appendix.

The standards have been endorsed as fit for purpose by 50 organisations that give professional leadership to the medical, nursing and clinical professions, including the AoMRC. The standards were adopted by the [Professional Records Standards Body](#) (PRSB).

The PRSB is a Community Interest Company owned by UK health and social care professional bodies and patient organisations.
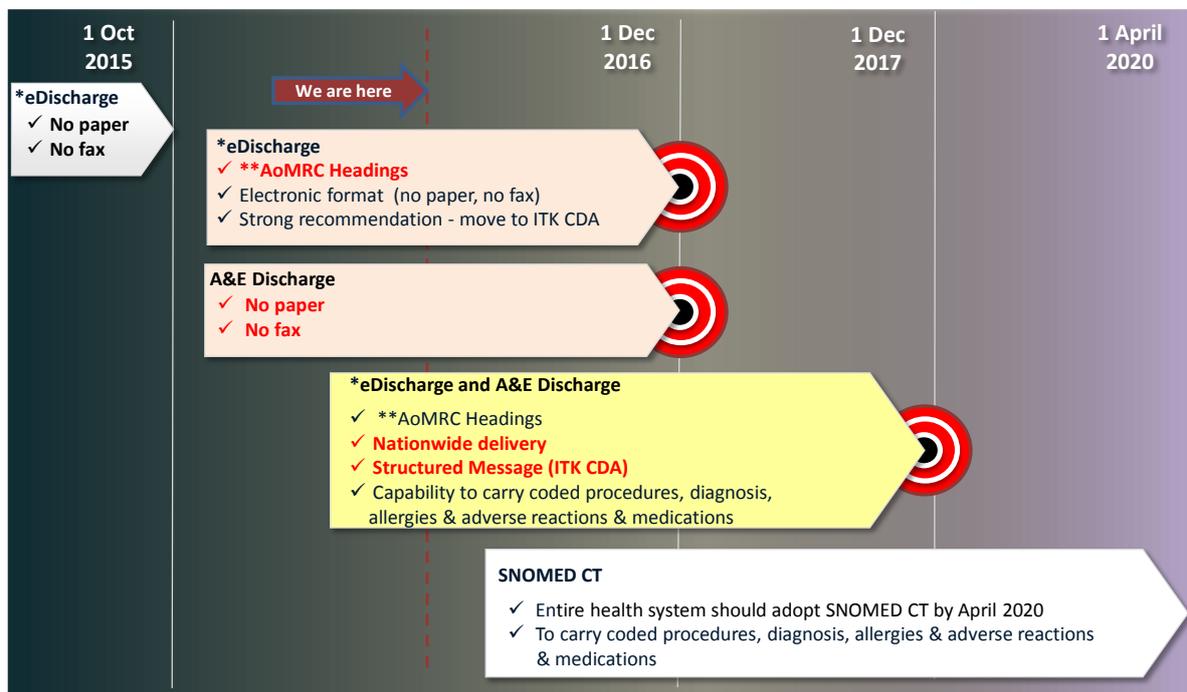
The [Transfer of Care initiative](#) has been established by the Health and Social Care Information Centre (HSCIC) with the primary purpose of driving the establishment and uptake of consistent professional and technical data standards across the health and care sector, with particular focus on the documents which support the transfer of care between organisations and care providers.   A message specification and associated guidance was produced in 2015 to support NHS organisations and GP practices in implementing the AoMRC standards in e-discharge summaries in 2016 using structured headings, with textual entry or embedded documents. It is available in the [HSCIC interoperability guidance](#).

The PRSB was commissioned by HSCIC in January 2016 to undertake a project to develop and assure information models to enable key structured and coded clinical data to be transferred in a computable form in e-discharge summaries.   A message specification based on these models will be published by the HSCIC in late 2016 and it is anticipated that this will be for implementation in 2017.

HSCIC has developed a road map for e-discharge summary implementation, including related parallel projects. There has been a requirement for all Trusts to produce electronic discharge summaries since 2016. From 2017 use of the AoMRC headings will be mandated in e-discharge summaries. It is anticipated that from 2018, the NHS Standard Contract will require structured e-discharge summaries, using the AoMRC headings, with SNOMED CT being used for diagnoses, procedures, allergies and medications. MESH or TMS services will provide the transport mechanism.

The GP Systems of Choice (GPSoC) contract requires GP systems to be able to receive CDA messages by 2016 and a programme to implement SNOMED CT on GP systems by June 2017. There is an SCCI Information Standards Notice for all medicines information to be communicated between systems and organisations using dm+d by June 2017.

The road map for e-discharge summary implementation, including related parallel projects is set out on the diagram, overleaf:

Timeline diagram showing milestones:

1 Oct 2015

*eDischarge
- ✓ No paper
- ✓ No fax

We are here

*eDischarge
- ✓ **AoMRC Headings
- ✓ Electronic format (no paper, no fax)
- ✓ Strong recommendation - move to ITK CDA

A&E Discharge
- ✓ No paper
- ✓ No fax

1 Dec 2016

*eDischarge and A&E Discharge
- ✓ **AoMRC Headings
- ✓ Nationwide delivery
- ✓ Structured Message (ITK CDA)
- ✓ Capability to carry coded procedures, diagnosis, allergies & adverse reactions & medications

1 Dec 2017

SNOMED CT
- ✓ Entire health system should adopt SNOMED CT by April 2020
- ✓ To carry coded procedures, diagnosis, allergies & adverse reactions & medications

1 April 2020

1.3 The discharge summary content

The content of the e-discharge summary is aligned based on the AoMRC clinical record standards 2013. To provide the context for this implementation guidance, the set of headings included in the discharge summary is provided on the diagram overleaf. Detailed information models are available in the HSCIC Clinical Knowledge Manager (CKM) system which will provide the basis for the CDA message specification produced by HSCIC.

2 Benefits of implementing interoperable discharge summaries

Anticipated benefits from having interoperable electronic discharge summaries, which reflect the requirements of patients and care professionals, are significant. They include:

- **Improved patient safety by:**
  - having information which is needed for safe continuity of care to be available on a timely basis.
  - avoiding transcription errors when medication information is electronically transferred to the GP record (following clinician review), without the need for re-entry.

- **Improvements to patient care and patient satisfaction by:**
  - having accurate, precise, consistent and timely information (including medications, diagnoses, procedures and allergies) transferred to all relevant care professionals and their GP practice.
  - providing patients with legible up to date information about their stay in hospital.
  - hospitals recording information on patients' individual requirements and using well structured documents can provide them with their discharge information in an appropriate format.
- **Support for new more integrated and person-centred ways of working, including:**
  - people being able to access and contribute to their records on line.
  - increased efficiency for multidisciplinary teams by providing structured and coded information on diagnoses, procedures and medications which can be reused for new ways of working as teams develop and expand.
- **Time savings for NHS organisations by:**
  - removing the need to develop and design content locally, by using national standards
  - reducing the duplication of recording.
- **Information being readily available for use in improving quality of care through:**
  - re-use in clinical audit and research.
  - increased ability to measure and improve actual patient clinical outcomes rather than process outcomes.
- **A hugely increased opportunity for future development of patient led care** by ensuring interoperability between multiple systems, including personal health records.

3 Guidance for implementation

3.1 General guidance

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.

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.

3. The recipient of the discharge summary should be able to read all the content of the discharge summary (ie any coded data should be carried with the associated text).

4. Patients (or their designated carer or guardian where applicable) should get a copy of the discharge summary and so 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.)

5. The discharge summary should be brief, containing only pertinent information on the hospital episode, rather than duplicating information which GPs already have access to in their own records.

6. The discharge summary may have contributions from multi-disciplinary team members, not just an individual clinician. The local hospital system should retain an audit trail of the provenance of all contributions.

7. The e-discharge summary is designed to be auto-populated as far as possible from Trust Electronic Patient Records (EPRs), with the expectation that, in time, auto-population will include supply of appropriate SNOMED CT codes.

8. Local implementation of the e-discharge summary 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 carer to understand the contents.

9. A trading agreement will need to be drawn up between the hospital and participating practices, including:

   a. Details of the information to be communicated, including which optional sections will be utilised.
   b. The sequence of the sections
   c. Which fields will be coded and which textual
   d. Mapping from local headings/fields to those in the discharge summary message. The mapping should be owned by a clinician in each organisation
   e. Requirements for receipt of the discharge summaries, e.g. use of a generic mailbox
   f. New work processes for producing and receiving the electronic discharge summaries.

10. Where there is no information recorded in a section in the discharge summary, that section should be excluded from the discharges summary message, to avoid the recipient receiving a communication with blank sections.

3.2 Mandatory and Optional

This section identifies what is mandatory and what is optional in an e-discharge summary from both a technical and a good clinical practice perspective.

3.2.1 Technical requirements

1. All e-discharge summary sections must be supported by IT systems, but they may not all be included in every local implementation.

2. A small number of the sections are MANDATORY and this means that they must be included in all e-discharge summaries sent by the sending organisation. The other headings will be included in an e-discharge summary where there is information recorded under the heading by the sending organisation. The MANDATORY headings are:

Mandatory Sections
Patient demographics
GP Practice
Discharge details
Diagnoses
Clinical summary
Allergies and adverse reactions
Person completing record
Distribution list

3. Within the above sections, 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 Good practice requirements

4. Good practice guidance is also provided for clinicians completing the discharge summaries. All of the AoMRC headings for the discharge summary have been included as they have been identified through evidence and consensus as being relevant information to communicate when discharging a patient from hospital. However, a distinction has been made between sections which are REQUIRED or OPTIONAL. The definition of each is given below:
   a. REQUIRED: if there is information recorded it should be sent to the recipient.
   b. OPTIONAL: a local decision as to whether information is sent to the recipient.

The required and optional headings are listed on the table below:

Required Sections	Optional Sections
Individual requirements	Participation in research
Referrer details	Assessment scales
Admission details	Social context
Procedures	Legal information
Medication and medical devices	Patient and carer concerns, expectations and wishes
Safety alerts	Information and advice given
Plan and requested actions	Investigation results
	Investigations and procedures requested

5. 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.

6. The order in which headings appear in the eDischarge summaries can be agreed locally.

7. The relative order of the sections in the received document can be configured by the receiver to suit their workflow.

3.3 Coding

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 codes are carried in e-discharge summaries, depending on local system capabilities and plans.

Please note:
- The receiving GP systems are due to be able to hold SNOMED CT encoded information by April 2018.

- In future years the ambition is for SNOMED CT to be the only clinical terminology in use in the NHS by 2020.

3.4 Explanation of terms used in clinical information models

This section provides explanation of terms used in the clinical information models.

Term	Definition
Cardinality	The number of elements in a set. Eg. The medications and medical devices section may have 0 to many medication records in it.
Section or Container	This is the equivalent of a main heading in the AoMRC

	headings, eg allergies and adverse reactions, procedures, etc.
Record entry	A single record, eg a medication item or a diagnosis, which will be made up of one or more data items, eg name, form route, dose amount of medication.
Cluster	A group of data items which make up a record entry, for example, diagnosis record entry is made up of the following data items: diagnosis/symptom, stage of disease and comment.
Iteration	A rule which applies to each repetition of a record entry, for example, only one medication item can be included in a medication record entry.

4 Guidance on specific sections

4.1 Diagnoses

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.

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.).

3. 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. 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.

5. The same guidance applies to the recording of 'co-morbidities', which should be recorded as separate diagnoses.

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

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.

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

4.2 Procedures

1. All procedures undertaken should be included in the e-discharge summary, including:
   a. diagnostic as well as therapeutic procedures
   b. procedures carried out on different days during the hospital stay.

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

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. 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.

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

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.

4.3 Medications and medical devices

4.3.1 Preparing the Medications and medical devices summary at the sending end

1. It is very important that a full and accurate summary record of medications is contained within the discharge summary. This should include:
   a. Any medications that were current at the time of admission and which the hospital wants the patient to continue following discharge
   b. Any changes made to medication that was current at the time of admission – such as changes of dosage

c. Any medications that were current at the time of admission which were discontinued either during the admission or at the time of discharge
d. Any new medications added since admission and which should be continued following discharge
e. The reasons for any of the above (i.e. changes, discontinuations or additions of medication)

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

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 (4.3.4) 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. 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:

a. 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.
b. Where any admission medication has been discontinued this should be entered using the 'medication discontinued' entry
c. Where a medical device has no dm+d code then this should be represented as text using the 'medical devices' record entry.

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:
a. '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.
b. 'do not discontinue' refers to medication where suddenly stopping could be dangerous, for example the abrupt withdrawal of long term steroids.

4.3.2 Handling the medicines and medical devices summary at the receiving end

1. 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.

2. 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.

3. 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.

4.3.3 Medicines Reconciliation

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.

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.

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.

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.

4.3.4 Dose based compared with Product based prescribing

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"
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".

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.

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

4.3.5 Plans for future structured dose syntax

The intended direction of travel is to move towards a future:
  a) where all health care prescribing systems express drug names using dm+d coding both for product based and for dose based prescribing and
  b) 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.

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

4.4 Allergies and adverse reactions

1. A full record should be provided of:
   a. allergies that the patient tells the hospital about
   b. allergic and adverse reactions related to their admission.

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"**.

3. Guidance on good practice recording of allergies and adverse reactions is provided by [NICE](). 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.

4.5 Investigations and results

1. Only important or relevant results should be included in the discharge summary, ie those that the clinician wants to communicate to the GP.

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.

3. It is important for the hospital clinician to record why they have done the test and where relevant, who is going to follow up (i.e. GP or hospital).

4. Investigations carried out where results are not yet available should be recorded in this section.

4.6 Investigations and procedures requested

1. Investigations and procedures **requested** by the hospital should be recorded under this section rather than the investigations and results section, which records investigations and procedures already undertaken.

2. As a general rule, a test requested by the inpatient team, invokes responsibility on the inpatient team/consultant to have a clear process for tracking, reading and acting on that result e.g. post discharge colonoscopy or CT brain scan. However, where specific care pathways have been designed and agreed between hospital clinicians and GPs then these should be followed and should be noted in the plan and requested actions section (see below)

4.7 Plan and requested actions

1. The plan should make clear who is expected to take responsibility for actions following discharge, ie the hospital, patient or GP.   For example, follow up renal function test to be arranged by the GP within 2 weeks of discharge.

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'.

4.8 GP practice

1. If a patient is not registered with a GP practice, then the GP practice record entry should appear in the e-discharge summary with the text "No known GP practice".

2. Normally patients are registered with one GP practice, but can access another GP practice by registering on a temporary basis. Discharge summaries 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 discharge summary. In this instance, both GP practices should be recorded.

4.9 Referrer details

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

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.

4.10 Person completing record

1. 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.

4.11 Distribution list

2. 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.

3. Where local systems are capable of doing so, they may use this information to trigger the message to be sent, where it is possible to do so, via a CDA message.

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

5. 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.

Annex - Changes from AoMRC headings 2013

Since the AoMRC headings were published in 2013, there has been feedback suggesting changes to some of the headings. Consultation has been undertaken and the following headings have been changed. Where the original headings have already been implemented, implementers will need to consider updating their local information models. To inform this, the original and the new heading or change are set out on the table below:

2013 Heading	Change made	Reason
Referral details	Referrer details	Referrer is more appropriate as the section only contains information about the referrer.
Social context	Lives alone removed	Covered by household composition heading.
Social context	Educational history added	Relevant to children and young people
Special requirements	Individual requirements	Feedback from patients and carers.
Clinical details	Reason for admission moved to Admission details section	Reason for admission is part of admission details.
Clinical summary	Investigation results moved into its own section	Records of investigations and results should be separated from a textual clinical summary.
Legal information	Advance decisions about treatment has been changed to advance decisions to refuse treatment (ADRT) and a separate heading, 'advance decisions' has been moved to patient and carer concerns expectations and wishes section. ADRT description has been updated.	ADRT are legally binding, but advance decisions are not.
Legal information	Lasting or enduring power of attorney or similar has been changed to lasting power of attorney for personal welfare or equivalent. Description has been updated.	Heading and description made more specific.
Safety alerts	Risk from others added	To record where a person is at risk from someone else

2013 Heading	Change made	Reason
Medications and medical devices	The terms 'reason for medication' and 'reason for medication' change have been changed to 'indication'.	For consistency with the SCIMP (Scottish clinical information management in practice) medications information model.
Medications and medical devices	Placeholders for structured dose syntax have been added to the model.	Further work is required to develop structured dose syntax. Placeholders used for the two modelling options.
Allergies and adverse reaction	Changed to allergies and adverse reaction<u>s</u>	May be multiple adverse reactions recorded.
Patient and carer concerns	Changed to patient and carer concerns expectations and wishes	Section heading and label given to the content should be the same.
Information given	Information and advice given	As above