HIQA — National Standard for Patient Discharge Summary Information

	HEADINGS	COMPONENTS	Comment	Optionality	Usage	Remarks
						The HIQA Patient Discharge Summary describes the headings of the letter but NOT the structure of the information. Therefor the SubjectAreaModel only can describe the structure of the Discharge letter but not the structured information, the coding systems used, etc., etc. Some indications /thoughts are provided as what SIAMM patterns, ContSys, and other codes apply. Any Discharge Summary will have the Archetype predicate: Administrative
PDS-1	**Patient details**		**This group includes headings which identify the patient the discharge summary relates to.**			
PDS1.1		**Forename**	A patient's first name or given name (s) as per their birth certificate.	M	A patient's first name or given name (s) as per their birth certificate.	SIAMM:NamedObject part of ContSys:SubjectOfCare
PDS1.2		**Surname**	The second part of a patient's name which denotes their family or marital name.	M	The second part of a patient's name which denotes their family or marital name.	SIAMM:NamedObject part of ContSys:SubjectOfCare
PDS1.3		**Address**	The location to be used to contact or correspond with the patient. This would normally be the patient's usual home address.	M	The particulars of the place where the patient lives.	SIAMM:NamedObject part of ContSys:SubjectOfCare
PDS1.4		**DateOfBirth**	Date of birth indicating the day, month, and year	M	The date of birth should be supplied in d/mm/yyyy	SIAMM:NamedObject part of ContSys:SubjectOfCare
PDS1.5		**Gender**	Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behavior and other aspects of a person's life.	M	Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behaviour and other aspects of a person's life.	SIAMM:NamedObject part of ContSys:SubjectOfCare PM: the EU PS uses the biological definition of gender
PDS1.6		**HealthIdentifier**	A number or code assigned to an individual to uniquely identify the individual within an organisation.	M	Both the code and the code type the code relates to should be provided e.g. 0987654321 Healthcare Record Number (HcRN). When a national individual healthcare number is available this should be carried in this heading.	SIAMM:NamedObject part of ContSys:SubjectOfCare
PDS1.7		**DischargeDestinationAddress**	The location the patient was discharged to if the patient was not discharged to the usual home address.	O	Both the code and the code type the code relates to should be provided e.g. 0987654321 Healthcare Record Number (HcRN). When a national individual healthcare number is available this should be carried in this heading.	SIAMM:NamedObject part of ContSys:SubjectOfCare
PDS-2	**Primary Care Healthcare Professional Details**		**This group details the minimum headings required to ensure the discharge summary can be delivered to the correct primary care healthcare practitioner.**			
PDS-2.1		**Forname**	First name or given name of primary care healthcare professional.	M	Where the primary care healthcare professional is registered with a professional body, the forename should be the forename registered with the professional body.	SIAMM:NamedObjectContSys:HealthcareProfessional
PDS2.2		**Surname**	The second part of a primary care healthcare professional's name which denotes their family or marital name.	M	Where the primary care healthcare professional is registered with a professional body the surname should be the forename registered with the professional body.	SIAMM:NamedObject part of ContSys:HealthcareProfessional
PDS-2.3		**Address**	The particulars of the place used to correspond with the patient's primary healthcare professional.	M	The particulars of the place used to correspond with the patient's primary healthcare professional.	SIAMM:NamedObject part of ContSys:HealthcareProfessional
PDS-3	**Admission and Discharge Details**		**This group contains headings relating to the admission and discharge details which will be important to the primary care healthcare professional.**			
PDS-3.1		**DateOfAdmission**	The date that the patient was admitted to the hospital ward.	M	The date of admission should be supplied in dd/mm/yyyy format.	SIAMM:ENTRY:Process=Episode Date use: ISO 8601 date standard
PDS-3.2		**SourcesOfReferral**	This describes who made the decision to refer the patient to the hospital.	M	Examples would include GP/self- referral/ ambulance service/out-of-hours service/ other hospital/other (please specify).	Use a predefined enumerated list.
PDS-3.3		**MethodOfAdmission**	The circumstances under which a patient was admitted to the hospital.	M	Example would include elective/emergency/ transfer.	Use a predefined enumerated list.
PDS-3.4		**HospitalSite**	The hospital site the patient was discharged from.	M	The hospital site the patient was discharged from.	SIAMM:NamedObject ContSys:HealthcareOrganisation. Question is site equal to address or name
PDS-3.5		<empty>	-	-	-	?
PDS-3.6		**DateOfDischarge**	The date the patient departed the hospital.	M'	Record the date the patient departed the hospital site. The date of discharge should be supplied in dd/mm/yyyy. This heading will be blank if the patient died during the inpatient stay. In cases when a patient died in hospital during the inpatient stay the Date of Discharge and Discharge Method are no longer relevant, but the Patient Died and Date of Death and post-mortem flag should be provided.	SIAMM:ENTRY:Process=Episode Date use: ISO 8601 date standard
PDS-3.7		**DischargeMethod**	The circumstances under which a patient left hospital.	M'	This heading can be used to indicate that a patient was discharged on clinical advice or with clinical consent, that a patient discharged him/herself against clinical advice or the patient was discharged by a relative or advocate. In cases when a patient died in hospital during the inpatient stay the Date of Discharge and Discharge Method are no longer relevant, but the Patient Died and Date of Death and post-mortem flag should be provided.	SIAMM:ENTRY:Process=Episode Use a enumerated code?
PDS-3.8		**PatientDied**	An indicator to signify if the patient died during the hospitalisation.	M'	3.6 Date of discharge and 3.7 Discharge method will be blank if this heading contains an entry.	SIAMM:NamedObject ContSys:SubjectOfCare
PDS-3.9		**DateOfDeath**	The date and time the patient died.	M'	If the patient died during inpatient stay in the hospital record the date and time of death. The date of death should be supplied in dd/mm/yyyy format.	SIAMM:NamedObject ContSys:SubjectOfCare Date use: ISO 8601 date standard
PDS-3.10		**PostMortemFlag**	A flag to indicate whether a post-mortem is to be carried out	M'	In cases where the patient dies in hospital and a post-mortem is to be undertaken this should be indicated on the discharge summary. Details of the post-mortem are not required in the discharge summary.	SIAMM:NamedObject ContSys:SubjectOfCare
PDS-4	**Clinical Narrative**		**Primary care healthcare professionals require quality information in order to continue patients' care on their return to the community. This group defines the headings which will facilitate hospitals in providing a detailed picture of a patient's stay in hospital, reason for admission, interventions and treatments received and investigations undertaken.**			
PDS-4.1		**PertinentClinicalInformation**	Clinically significant information relating to the patient which the discharging doctor wishes to convey to the primary care healthcare professional.	M'	This heading may be used to indicate an investigation which should be undertaken, or a course of treatment which should be considered by the primary care healthcare professional or information which the healthcare professional should be aware of, e.g. blood transfusions, difficult intubations, advance care directives or pressure sores.	This header will have many different topics that need to be enumerated and formalised: Reason for Referral Plans Risks Problems Observations Important eventsMedicalHistory Family, Social, Occupational, etc., History Procedures Medications etc.
PDS-4.2		**DIagnoses**	The diagnoses established after study to be chiefly responsible for occasioning an episode of admitted patient care and conditions or complaints either coexisting with the principal diagnosis or arising during the episode of admitted patient care.	M'	The principal and additional diagnoses relevant to this inpatient stay should be recorded. The principal diagnosis is the main reason why the patient was admitted to hospital on this occasion and should be identified in the discharge summary. Additional diagnoses relevant to this inpatient stay should also be documented, including any relevant co-morbidity that could have contributed to or be affected by the primary diagnosis.For example, hypertension in a patient admitted for stroke. Acronyms and abbreviations should be avoided. The principal and additional diagnoses relevant to this inpatient stay should be recorded. The principal diagnosis is the main reason why the patient was admitted to hospital on this occasion and should be identified in the discharge summary. Additional diagnoses relevant to this inpatient stay should also be documented, including any relevant co-morbidity that could have contributed to or be affected by the primary diagnosis.For example, hypertension in a patient admitted for stroke. Acronyms and abbreviations should be avoided.	SIAMM:Inferences One labeled as Principal plus additional diagnosis What is the preferred coding system? SNOMED-CT, ICD-X, ICPC
PDS-4.3		**OperationsAndProcedures**	Operations and procedures performed for definitive treatment, diagnostic or exploratory purposes.	M'	All significant operations and/or procedures should be described. Avoid acronyms, for example, 'CABG', and abbreviations, as these could be misunderstood or misinterpreted by the recipient. When known to the person completing the discharge summary standard code(s) for the procedures should be provided using the Australian Classification of Healthcare Interventions codes as used in the Hospital In- Patient Enquiry System.	SIAMM:ENTRY:Procedures Will dates and addition information be documented? What coding system(s)?
PDS-4.4		**ClinicalAlerts**	An alert is a piece of information about a specific patient required for the management of a patient in order to minimise risk to the patient concerned, healthcare staff, other patients and the organisation. It is a warning of a medical condition or risk factor that requires consideration before treatment is initiated.	M'	The status of knowledge about the patient's clinical alerts. For example 'Known', 'None known' or 'Unknown' should be documented. Significant clinical alerts should be documented.	SIAMM: SCP for qualifiers like: known, Not known, etc. Will dates and addition information be documented? What coding system(s)?
PDS-4.5		**Allergies**	Include information about all allergies known about the patient that may put the patient at risk. The allergen, reaction, date of reaction and source of information should be provided	M'	The status of knowledge about the patient's allergies. For example 'Known', 'None known', 'Unknown', 'Not asked'. Known allergies must be documented in the discharge summary.	SIAMM: SCP for qualifiers like: known, Not known, etc. Will dates and addition information be documented? What coding system(s)?
PDS-4.6		**AdverseEvents**	Include information about all hypersensitivities and/or adverse events known about the patient that may put the patient at risk.	M'	Known adverse events or hypersensitivities must be documented in the discharge summary. Where there are no known adverse events or hypersensitivities this should be documented in the discharge summary.	Will dates and addition information be documented? What coding system(s)?
PDS-4.7		**HospitalCourse**	Include a detailed description on the course of the patient's illness during the inpatient stay.	M	The discharge summary should include a narrative description of the inpatient stay, describing the relevant sequence of events from admission to discharge.	SIAMM: Coded Free text or structured? What coding system(s)?
PDS-4.8		**RelevantInvestigationsAndResults**	Relevant assessments, investigations and/or observations undertaken on the patient during the inpatient stay.	M'	Specify the type of investigations undertaken and results received or that are awaited at the time of discharge. Describe all investigations that are pending at the time of discharge.	SIAMM: ENTRY:Observations and Evaluations SIAMM SCP for status information What coding system(s)?
PDS-4.9		**RelevantTreatmentsAndChangesMadeInTreatments**	Specify the type of investigations undertaken and results received or that are awaited at the time of discharge. Describe all investigations that are pending at the time of discharge.	M'	Information relating to procedures undertaken and medications received during the inpatient stay.	SIAMM: Diagnostic Procedures and Therapeutic Procedures and Evaluations SIAMM SCP for status information. What coding system(s)?
PDS-4.10		**Diet**	Information on dietary interventions, special dietary requirements, use of nutritional support during stay, e.g. oral nutritional supplements, enteral tube feeding and parenteral nutrition and any problems a client might have with eating, drinking or swallowing at time of discharge need to be documented.	M'	Information on dietary interventions, special dietary requirements, use of nutritional support during stay, e.g. oral nutritional supplements, enteral tube feeding and parenteral nutrition and any problems a client might have with eating, drinking or swallowing at time of discharge need to be documented.	How to be structured? What coding systems? What coding system(s)?
PDS-4.11		**FunctionalState**	An assessment and description of the patient's ability to perform activities of daily living.	M'	The functional state may include the results of assessment tools, for example, the Activities of Daily Living or the American Society of Anesthesiologists score. A history of falls should also be provided.	Or use the WHO ICF classification?
PDS-4.12		**Immunisations**	This should detail the immunisations given to the patient during this inpatient stay.	M'	This should detail the immunisations given to the patient during this inpatient stay.	Including dates, brandnames, etc?
PDS-4.13		**InfectionControlStatus**	This should detail information relating to the treatment, prevention, monitoring or investigation of infections.	M'	Information relating to the treatment, prevention, monitoring or investigation of infections should be communicated.	Many kinds of topics: Kinds of infections, risks, plans, tests. How to structure?
PDS-5	**Medication Details**		**Primary care healthcare professionals require accurate information about the changes to the patient's medication during an inpatient stay and the complete list of medications that the patient is prescribed on discharge in order to continue their treatment after returning to their homes or to the community. The group provides headings to facilitate this.**			
PDS-5.1		**MedicationDischarge**	The medications the patient is intended to take after they have been discharged.	M	Record medicines prescribed at the time of discharge. The record should include: The generic name of the prescribed medication along with the dose and frequency of administration. In certain clinical circumstances when it is not appropriate to substitute generic drugs due to bioavailability issues relating to active ingredient it is advisable to use trade name on the prescriptions - Duration of treatment – record the stop date for all medicines prescribed for a short term or defined course of treatment. Record 'repeat' if the patient is to continue taking the medicine after discharge and no specific stop date has been agreed. - Aids to compliance – where appropriate provide a description of any aids to compliance, for example, easy-open containers, medication charts, compliance devices, medication management service via a carer – that have been provided to or are being used by the patient to aid the taking of medicines. - Reason for change to admission medication – if changes have been made to the formulation, strength, dose, frequency or route of administration of medicines that	SIAMM: MedicinalProducts ContSys:TherapeuticProcedures What Coding systems will be used for medicinal products, forms, uses, etc. ? It will be a substantial effort to get agreement about these topics.
PDS5.2		**MedicationStoppedOrWithheld**	A pertinent history of changes to the medication that the patient was taking at time of admission.	M	Record all medicines that the patient was taking at the time of admission but were not prescribed at the time of discharge. Describe the reason why each medicine listed here was stopped. This should include information on adverse reactions. The heading may also contain information on medication which are 'on hold' at the time of discharge, the reason why they are on hold and when the primary care healthcare professional should consider reintroducing them.	vide supra
PDS-6	**Future Management**		**This group contains headings regarding the future management of the patient.**			
PDS-6.1		**HospitalActions**	Actions required/that will be carried out by the hospital department.	M'	This should include any advice, recommendations or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme.	SIAMM/Contsys: Risks, Advice, Plans What coding system to code Actions?
PDS-6.2		**GPActions**	Actions that are requested of the general practitioner.	M'	This should include any advice, recommendations or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme.	SIAMM/Contsys: Risks, Advice, Plans What coding system to code Actions?
PDS-6.3	**PDS-1**	**SocialCareActions**	Actions relating to the person's social care that have been requested to be undertaken.	M'	This should include any advice, recommendations or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme.	SIAMM/Contsys: Risks, Advice, Plans What coding system to code Actions?
PDS-6.4		**InformationGivenToPatientAndCarer**	Information, both verbal, written or in any other form which has been provided to the patient, relatives or carer.	M'	This should include any advice, recommendations or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme.	SIAMM/COntSys: Risks, Advice, Plans What coding system to code Actions?
PDS-6.5		**Advice,RecommendationsAndFuturePlans**	This should include any advice, recommendations or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme.	M'	This should include any advice, recommendations or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme.	SIAMM/COntSys: Risks, Advice, Plans What coding system to code Actions?
PDS-7	**Persons Completing Discharge Summary**		**This group contains headings regarding the healthcare professionals who created the summary and sign the discharge summary. The discharge summary may be completed by multiple healthcare professionals.**			
PDS-7.1		**Forename**	A first name or given name of the person completing the discharge summary.	M	The specialty of the consultant responsible for the care of the patient at the time of discharge.	SIAMM: AdministrativeProcess:NamedObject
PDS-7.2		**Surname**	The second part of a name which denotes their family or marital name of the person completing the discharge summary.	M	The second part of a name which denotes their family or marital name of the person completing the discharge summary.	SIAMM: AdministrativeProcess:NamedObject
PDS-7.3		**ContactNumber**	The usual contact number for the person completing the discharge summary.	M	The usual contact number for the person completing the discharge summary.	SIAMM: AdministrativeProcess:NamedObject
PDS-7.4		**JobTitle**	The job title of the person who completed the discharge summary.	M	The job title of the person who completed the discharge summary.	SIAMM: AdministrativeProcess:NamedObject What coding system for Roles and Entitlements?
PDS-7.5		**ProfessionalBodyRegistrationNumber**	The professional registration number of the person completing the discharge summary.	M	Where the person completing the discharge summary is registered with a professional body their registration number should be included in the discharge summary, e.g. Irish Medical Council registration number, An Bord Altranais agus Cnáimhseachais na hÉireann registration number.	SIAMM: AdministrativeProcess:NamedObject
PDS-7.6		**Signature**	The signature of the person who created the discharge summary.	M	The signature of the person who created the discharge summary.	Or digital signature when available? Data of singing is missing
PDS_7.7		**CopiesTo**	A list of people to whom copies of the discharge summary should be sent.	O	A list of people to whom copies of the discharge summary should be sent.	
PDS-7.8		**DateOfCompletionOfDischargeSummary**	Date the discharge summary was completed	M	The date of completion of discharge summary should be supplied in dd/mm/yyyy format.	SIAMM: AdministrativeProcess:NamedObject
PDS-7.9		**ConsultantSignOff**	If the person completing the discharge summary is not a consultant then the consultant should counter-sign the discharge summary.	O	If the person completing the discharge summary is not a consultant then the consultant should counter-sign the discharge summa	SIAMM: Participation. AdministrativeProcess:NamedObject Or digital signature when available?
PDS-7.10		**DateOfConsutantSignOff**	The date the consultant countersigned the discharge summary.	O	The date of consultant sign off should be supplied in dd/mm/yyyy format.	SIAMM: Participation. AdministrativeProcess:NamedObject
PDS-7.11		**DischargingConsultantsName**	The consultant responsible for the care of the patient at the time of discharge.	M	The consultant responsible for the care of the patient at the time of discharge.	SIAMM: Participation. AdministrativeProcess:NamedObject
PDS-7.12		**DischargeSpeciality**	The specialty of the consultant responsible for the care of the patient at the time of discharge.	M	The consultant responsible for the care of the patient at the time of discharge.	SIAMM: Participation. AdministrativeProcess:NamedObject What coding system for Roles and Entitlements?
PDS-7.13		**DocumentReferenceNumber**	An alphanumeric identifier which uniquely identifies the discharge summary document and may be used to reference the discharge summary document.	O	A document reference number may be associated with a clinical discharge summary and allow primary care healthcare professionals refer to the summary in any future correspondences.	Free text or automatically generated Identifier?