PRSB

Professional
Record
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Body

NHS
Digital

PRSB Standards for the Structure and Content of Health and Care Records

July 2018

The PRSB Standards for the Structure and Content of Health and Care Records is part of the on–going service to update and revise standards for care records which NHS Digital has commissioned from the Professional Record Standards Body (PRSB). This project was supported by the Royal College of Physicians Health Informatics Unit (RCP HIU).

The PRSB adopted the Academy of Medical Royal Colleges (AoMRC) "Standards for the Clinical Structure and Content of Patient Records", published in 2013 when it was established in that same year. This release defines the structure and content of digital records based on a number of specified use cases (admission, referral, discharge, outpatient letter, and handover).

Since they were published further work has continued to develop more detailed structures and content for care records that support the transfer of structured, coded data and develop standards in other important areas such as crisis care. This further development has led to some additional structures being introduced for care records, some changes to their content and additional detail in the form of information models. This publication provides a single consistent set of current PRSB clinical record standards across all use cases to inform implementation in the NHS, in conjunction with NHS Digital technical specifications.

NHS Digital
1 Trevelyan Square
Boar Lane
Leeds LS1 6AE
www.digital.nhs.uk

Professional Record Standards Body
32–36 Loman Street
London SE1 0EH
www.theprsb.org

Royal College of Physicians
11 St Andrews Place
London NW1 4LE
www.rcplondon.ac.uk

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Introduction

This publication is an essential resource that describes the standardised information that should be gathered and shared in health and care records so that the right data can flow digitally across health and social care to support the provision of high quality, timely and efficient care.

It provides a comprehensive description of the structure and content of health and care records. The standards cover transfer of care communications from referral information to admissions clerking, handover information sharing and discharge from acute settings including hospital or mental health services, emergency services, as well as outpatient letters. It also describes the structure and content of integrated health and care records including digital care and support plans, and child health records.

PRSB has revised and aligned its standards to support the digital exchange of health and care records and communications using technology called Fast Healthcare Interoperability Resources (FHIR). When put together, standardised care records and FHIR technology are a powerful combination that will allow information to flow directly from one IT system to another helping professionals to provide safe, high quality, timely and efficient care.

Publication of the 2018 PRSB Standards for the Structure and Content of Health and Care Records replaces the 2013 Standards for the Clinical Structure and Content of Patient Records.

The PRSB standards have been updated to reflect current professional practice and were developed with input from thousands of professionals from all health and social care specialties, carers and people who access services. They agreed what information is essential to share in order to provide timely, high quality care efficiently that is well–coordinated and meets an individual's needs. The publication of standards are being endorsed by PRSB member organisations – a list of endorsers can be found at Appendix One.

01

Introduction

This is the first major release since 2013 and PRSB has produced guidance, FAQs and other materials to help organisations and system suppliers replace previous versions of the standards in their information systems.

This work forms part of the drive within the NHS and social care (Personalised Health and Care 2020) to improve the use of information and technology in order to:

- give patients more control over their health and well–being
- empower carers
- reduce the administrative burden for care professionals
- support the wider use of information for research, service planning and quality improvement

Rising demand for health and care, new models and ways of delivering services demand better information sharing. Safe, higher quality care depends on it as is evident from recent a report on the burden of prescribing errors and the Frances Report (www.gov.uk) in which better information sharing was cited as essential to the provision of safe care.

Professor Robert Wachter, in his landmark 2016 report Making IT Work (www.england.nhs.uk) concluded that if the NHS and social care are to continue to provide a high level of health and care at an affordable cost, we must create a fully digitised system that uses national standards as the basis upon which to build interoperability, transparency and efficiency. The development of local health and care record exemplars, global digital exemplars, and personalisation of health and care depend fundamentally on standards for information sharing as well.

The implementation of national standards for the structure and content of health and care records will facilitate shared care, enable interoperability between care settings, and produce comparable data to advance research and the life sciences, as well as improve management and planning of services and ultimately ensure clinicians, professionals and the people they care for reap the benefits of better quality services and outcomes of care.

02

Why we need standards for digital health and care records

In 2014 the NHS set out its vision to revolutionise the use of information and technology to improve health, transform the quality and reduce the cost of health and care services in Personalised Health and Care 2020. This included challenging targets for improving the flow of information between care settings by 2018. For information to be exchanged and re-used safely using digital technology it must be structured and standardised. Most importantly, the standards should reflect the ways that clinicians, professionals and patients value and share information to achieve the best outcomes of care possible. The PRSB was founded in 2013 (www.theprsb.org) to develop and maintain high quality health and care records to support safe and efficient care.

Beyond that the PRSB has a fundamental role to play in supporting other uses of information recorded in health and care records. These include research, quality improvement through audit and review, planning and management purposes, policy development, and commissioning care. Data must be fit for purpose and permissions for its use established. New legislation, the General Data Protection Regulations, and the National Data Opt Out for confidential patient information, are now in place to ensure information is well governed and consent is secured for wider use of data to advance improvements in care and treatments. Again, standards developed by the PRSB and its member organisations, working in partnership with the NHS and social care, are an essential underpinning to an individual's health and care record from which the relevant information may be extracted for other important uses in the health and care system.

The government's life sciences strategy and health and care research in general depend on high quality data being collected from large populations. The development of local health and care record exemplars not only will seek to address how information can be shared more effectively for direct care but also how data quality can be improved and linkages between data can be strengthened to address the health of specific populations, advance fields such as genomics and precision medicine, and yield new treatments and innovations. The possibilities of improving people's quality of life and extending their lifespans are dramatic and national standards and definitions for care records have an important role to play in achieving these greatly desirable outcomes.

03

How we developed the standards

PRSB standards are evidence-based and developed through a collaborative process that includes extensive consultation with the widest possible range of clinicians from the colleges and specialist societies, professionals who work in social care and informatics, system suppliers, patient representative groups and people who use health and social care services as well as carers. Consultations are undertaken via stakeholder workshops and online surveys, contributions number in the thousands for each standard produced.

The revised PRSB Standards for the Structure and Content of Health and Care Records build upon the 2013 Standards for the clinical structure and content of patient records and further work has been undertaken between December 2017 and April 2018 to align the clinical record standards to technical standards (FHIR profiles) necessary to ensure information can be shared interoperably from one IT system to another.

The work was undertaken in partnership with NHS Digital, INTEROPen and the Royal College of Physicians Health Informatics Unit.

For details of which organisations have endorsed the standards and which we are seeking further endorsement from please see Appendix One. The organisations listed demonstrate clinical and professional leadership in support of adoption and use of standards.

The standards consist of clinical, professional and patient-focused structured content including medications, allergies and diagnoses and a description of the information that should be recorded under each. The standards are presented at www.theprsb.org/standards using an easy to navigate tool as well as guidance on their use and other supporting documents.

For more information and help with queries please contact PRSB at info@theprsb.org.

04

Using the standards

When using the standards, information should be recorded as structured content, which is divided into the following sections:

- All record structured content
- Transfer of care
- Integrated care

- **All record structured content**: this is the full set of structured record content used in admission, handover, discharges, outpatient letters, referral communications and integrated care records. (Section One)

Transfers of care

- **Admission record:** the clinical, professional and personal information recorded in the hospital admission record at the time of admission. (Section Two)

- **Handover record:** handover of care from one professional or team to another including out of hours handover, or at the weekend. (Section Three)

- **Discharge records:** the information recorded in all discharge records sent from hospital services (including acute care discharge, mental health discharge and emergency care discharge) to GPs. (Section Four)

- **Outpatient letters:** the information recorded in an outpatient setting/ appointment including the initial and follow up outpatient visits and information in the outpatient letter sent to the GP and patient. (Section Five)

- **Crisis care:** the information shared between GPs and primary care with emergency care, ambulance services and community care during an emergency or acute episode. (Section Six)

- **Clinical referral information:** the information recorded in communication between GPs and consultants, copied to the patient. This may include other types of referrals. (Section Seven)

04

Using the standards

Integrated care records

- **Healthy child record:** the information recorded by the multi-disciplinary team on screening tests, immunisations and developmental milestones that should be accessible to ensure that children receive appropriate care. (Section Eight)

- **Digital care and support plan:** the information recorded in a multi-disciplinary care and support plan including clinical, professional as well as the patient's own preferences and needs. (Section Nine)

How to use

Not all the structured record content above will need to be used in all care settings or circumstances and the order in which it appears and how it is displayed in a digital patient record can be agreed by system suppliers and users.

Structured content that is not currently in use can be found at Appendix Two.

Section One: All record structured content

The structure and content of all records are listed below – they are included in one or more of admission, handover, transfers of care and integrated care records. '0' denotes absence and '1' denotes the presence of the preferred heading.

GP practice

Element	Description	D	M	E	O	C	A	H	R	HC	CP
GP practice identifier	The identifier of the registered GP practice.	1	1	1	1	1	1	1	1	1	1
GP practice details	Name and address of the patient's registered GP.	1	1	1	1	1	1	1	1	1	1
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.	1	1	1	1	1	1	1	1	1	1
GP Opt Out Indicator	Indication that parent/carer or child has opted out of registering with a GP themselves.	0	0	0	0	0	0	0	0	0	1

Referral details

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Referrer details	The name, role, grade, organisation and contact details of referrer. If not an individual, this could be, e.g. GP surgery, department, specialty, sub-specialty, educational institution, mental health team etc. Also needs to include self-referral.	1	1	1	1	0	1	0	1	1	0
Date	The date of the referral.	0	0	0	0	0	0	0	0	1	0
Referral method	The form in which a referral is sent and received. This may be a letter, email, transcript of a telephone conversation, Choose and Book, in person (self-referral) or unkonwn.	0	0	0	0	0	0	0	0	1	0
Referral to	The type of service or team that the patient has been referred into, e.g. GP surgery, department, specialty, subspecialty, educational establishment or mental health etc.	0	0	0	0	0	0	0	0	1	0
Speciality referred from	The type of service or team that the patient has been referred from.	0	0	0	0	0	0	0	0	1	0
Urgency of referral	Referrer's assessment of urgency, e.g. urgent, soon or routine).	0	0	0	0	0	0	0	0	1	0

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E: Emergency Care Discharge
O: Outpatient Letter
C: Crisis Care Plan
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CP: Digital Care and Support Plan

(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Reason for Referral	A clear statement of the purpose of the person making the referral, e.g. diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (e.g. palliative care), provide referrer with advice/guidance. This may include referral because of carer's concerns.	0	0	0	0	0	0	0	0	1	0
Attachments	Documents included as attachments which accompany the communication. This should include the following data items: • number of attachments • type of attachments • attached documents.	0	0	0	0	0	0	0	1	0	0
Details of other referrals	Other referrals related to this or associated conditions.	0	0	0	0	0	0	0	1	0	0
Referral criteria	Records whether specific criteria required for referral, to a particular service, have been met (may be nationally or locally determined).	0	0	0	0	0	0	0	1	0	0
Return response to	The name of care professional to be communicated with by the hospital, if not the referrer.	0	0	0	0	0	0	0	1	0	0

Patient demographics

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Patient name	The full name of the patient.	1	1	1	1	1	1	1	1	1	1
Patient preferred name	The name by which a patient wishes to be addressed.	1	1	0	1	1	1	1	1	1	1
Date of birth	The date of birth of the patient.	1	1	1	1	1	1	1	1	1	1
Gender	As the patient wishes to portray themselves.	1	1	1	1	1	1	1	1	1	1
Person alias	Record details where a person is known to use assumed identities to access health/care services.	0	0	0	0	1	0	0	0	0	1
Ethnicity	The ethnicity of a person as specified by the person.	0	0	0	0	1	1	1	1	1	1
Religion	The religious affiliation as specified by the person.	0	0	0	0	1	0	0	0	1	1
Sex	The person's phenotypic sex. This determines how the person will be treated clinically.	0	0	0	0	1	1	1	1	1	1
NHS number	The unique identifier for a patient within the NHS in England and Wales.	1	1	1	1	1	1	1	1	1	1
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.	1	1	1	1	1	1	1	1	1	1
Patient address	The Patient's usual place of residence.	1	1	1	1	1	1	1	1	1	1

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Patient email address	The email address of the patient.	1	1	1	1	1	1	1	1	1	1
Patient telephone number	The telephone contact details of the patient. To include, e.g. mobile, work and home number if available.	1	1	1	1	1	1	1	1	1	1
Relevant contacts	Include the most important contacts such as: • Personal contacts, e.g. next of kin, in case of emergency contact, lasting power of attorney, dependents and informal carers etc. • Health/care professional contacts, e.g. social worker, hospital clinician, care coordinator, key worker or Independent Mental Capacity Advocate (IMCA). Name, relationship, role (if formal role), contact details and availability, e.g. out of hours.	1	1	0	1	1	1	1	1	0	0
Communication preferences	The preferred contact method, e.g. sign language, letter and phone, etc. Also the preferred written communication format, e.g. large print, braille.	1	0	0	0	0	1	1	1	1	0
Educational establishment	If the patient is a child, include the name and address of where the child attends, e.g. play group, nursery or school.	0	0	1	1	0	0	0	0	0	0

Social context

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Household composition	E.g. lives alone, lives with family, lives with partner, etc. This may be free text.	1	1	0	1	1	1	1	1	1	0
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual.	1	1	0	1	0	1	0	1	0	0
Educational history	The current and/or previous relevant educational history of the patient/individual.	1	1	0	1	0	0	0	1	0	0
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, e.g. the record of the patient's physical activity level, pets, hobbies, and sexual habits.	0	0	0	1	0	1	0	1	1	0
Smoking	Current smoking observation.	0	0	0	1	0	1	0	1	1	0
Alcohol intake	Latest or current alcohol consumption observation.	0	1	0	1	0	1	0	1	1	0
Drug/substance use	Latest or current drug/substance use observation.	0	1	0	1	0	0	0	1	1	0

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(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Social circumstances	The record of a patient's social background, network and personal circumstances, e.g. housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependents or is a carer. This may include a reference to safeguarding issues that are recorded elsewhere in the record.	0	0	0	1	0	1	0	1	1	0
Services and care	The description of services and care providing support for the patient's health and social well-being.	0	0	0	1	1	1	0	1	0	0
Access	Special access requirements, e.g. key safe, coded lock, which door to use and stretcher access, etc.	0	0	0	0	1	0	0	0	0	0
Dependents	Provide details of any responsibility the person has for dependents. In the case of minors, provide additional details, e.g. date of birth etc.	0	0	0	0	1	0	0	0	0	0
Accommodation status	An indication of the type of accommodation where the child lives. This should be based on the main or permanent residence.	0	0	0	0	0	0	0	0	1	0
Family and household	Family and household details of social context.	0	0	0	0	0	0	0	0	1	0
Father's employment status	The employment status of the father and his occupation.	0	0	0	0	0	0	0	0	1	0
Household social services support	Whether or not any household member had/has social services support.	0	0	0	0	0	0	0	0	1	0
Household(s) environment	Factors in the household(s) which impact the child's health and well-being, to include smoking in the home, alcohol/substance use.	0	0	0	0	0	0	0	0	1	0
Mother's employment status	The employment status of the mother and her occupation.	0	0	0	0	0	0	0	0	1	0
Mother's educational status	The highest educational qualification attained by the child's mother.	0	0	0	0	0	0	0	0	1	0
Other significant individuals	Other significant individuals that do not live in the same household(s) but are deemed as key by the child's family and/or the healthcare professional..	0	0	0	0	0	0	0	0	1	0
Personal	Personal details of social context.	0	0	0	0	0	0	0	0	1	0

Individual requirements

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Individual requirements	Individual requirements that a person has. These may be communication, cultural, cognitive or mobility needs.	1	1	0	1	1	1	1	1	1	0
Accessible Information – requires communication professional	Requirement for a communication professional to be present in order to provide accessibility, with regard to disability.	0	0	0	0	0	0	0	0	1	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Accessible Information – communication support	Outlines capability and support required in order to provide accessibility, with regard to disability.	0	0	0	0	0	0	0	0	1	0
Accessible Information – requires specific contact method	Requirement for a specific contact method in order to provide accessibility, with regard to disability.	0	0	0	0	0	0	0	0	1	0
Accessible Information – requires specific information format	Requires information in a specific format in order to provide accessibility, with regard to disability.	0	0	0	0	0	0	0	0	1	0
Child or parent/carer/ guardian	An indicator of whether the individual requirement relates to the child or their primary carer.	0	0	0	0	0	0	0	0	1	0
Cognition	An indicator of cognitive impairment to be considered when communicating related to the child or their primary carer.	0	0	0	0	0	0	0	0	1	0
Mobility needs	A child or their primary carer's personal physical movement between two spaces that achieves participation and a degree of independence.	0	0	0	0	0	0	0	0	1	0

Participation in research

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Name of research study	Name of the research study/trial and/or drug/intervention.	1	1	0	1	0	1	1	1	0	0

Attendance details

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Date and time of contact	Date and time of the appointment, contact or attendance.	0	0	1	1	0	0	0	0	0	0
Contact type	First contact, follow-up contact.	0	0	0	1	0	0	0	0	0	0
Consultation method	The consultation method identifies the communication mechanism used to relay information between the care professional and the person who is the subject of the consultation, during the outpatient encounter.	0	0	0	1	0	0	0	0	0	0

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(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Responsible healthcare professional	The name and designation of the consultant, nurse consultant, midwife or allied health professional who has overall responsibility for the patient (may not actually see the patient).	0	0	0	1	0	0	0	0	0	0
Speciality	Specialties designated by royal colleges and faculties, e.g. orthopedics, renal medicine, endocrinology, etc.	0	0	0	1	0	0	0	0	0	0
Service	Treatment functions or services, e.g. hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy or pre-admission assessment clinic.	0	0	0	1	0	0	0	0	0	0
Seen by	The doctor, nurse or other healthcare professional that sees the patient. Record the most senior member of staff present. Include their name, role and telephone number.	0	0	0	1	0	0	0	0	0	0
Care professionals present	The name and designation of the additional individuals or team members including consultant(s), nurse consultant(s), allied health professional(s) and social worker(s).	0	0	0	1	0	0	0	0	0	0
Person accompanying patient	Identify, where clinically relevant, others accompanying the patient, e.g. relative, friend, informal carer or advocate. If the patient was not present, was an authorised representative present? Include: their name, relationship, role (patient advocate).	0	0	0	1	0	0	0	0	0	0
Outcome of outpatient attendance	This records the outcome of an outpatient attendance.	0	0	0	1	0	0	0	0	0	0

Admission details

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Reason for admission	The health problems and issues experienced by the patient that prompted the decision to admit them to hospital, e.g. chest pain, mental health crisis, blackout, fall, a specific procedure, intervention, investigation, treatment or non compliance with treatment.	1	1	0	0	0	1	1	0	1	0
Admission method	How the patient was admitted to hospital, e.g. elective, emergency, maternity or hospital transfer.	1	1	0	0	0	1	0	0	1	0
Legal status on admission	Record if the patient was admitted as informal or formal/detained.	0	1	0	0	0	0	0	0	0	0
Source of admission	Where the patient was immediately prior to admission, e.g. usual place of residence, temporary place of residence, penal establishment. National code.	1	1	0	0	0	1	0	0	1	0
Date/time of admission	Date and time the patient was admitted to hospital.	1	1	0	0	0	1	1	0	1	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Patient location	This is the physical location of the patient. For inpatient, e.g. hospital ward, bed or theatre. For ambulatory care, e.g. health center, clinic, resources centre or patient's home.	0	0	0	0	0	1	1	0	0	0
Responsible consultant	The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient).	0	0	0	0	0	1	1	0	1	0
Person accompanying patient	Identify others accompanying the patient, e.g. relative, friend, informed carer or advocate. If the patient was not present, was an authorised representative present? Include their name, relationship (e.g. spouse) and role (e.g. patient advocate).	0	0	0	0	0	1	0	0	1	0
Speciality	Specialties designated by royal colleges and Faculties, e.g orthopedics, renal medicine and endocrinology.	0	0	0	0	0	1	0	0	1	0
Admitted to	The ODS site code and description of where the child was admitted.	0	0	0	0	0	0	0	0	1	0

Discharge details

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Discharge destination unit.	The destination of the patient on discharge. National codes, e.g. high dependency.	0	0	1	0	0	0	0	0	1	0
Discharge status	The patient's status on discharge from emergency care.	0	0	1	0	0	0	0	0	0	0
Discharging consultant	The consultant responsible for the patient at the time of discharge.	1	1	0	0	0	0	0	0	1	0
Discharging specialty/ department	The specialty or department responsible for the patient at the time of discharge.	1	1	0	0	0	0	0	0	1	0
Discharge location	The ward or unit the patient was in immediately prior to discharge.	1	1	0	0	0	0	0	0	1	0
Date/time of discharge	The date and time of discharge.	1	1	1	0	0	0	0	0	1	0
Legal status on discharge	Record if the patient was discharged as informal or formal/detained.	0	1	0	0	0	0	0	0	0	0
Discharge method	The method of discharge from hospital. Use national codes, e.g. patient discharged on clinical advice or with clinical consent, patient discharged him/herself or was discharged by a relative or advocate, patient died or stillbirth.	1	1	0	0	0	0	0	0	1	0

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(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Discharge destination comprising:		1	1	0	0	0	0	0	0	0	0
Discharge type	The destination of the patient on discharge from hospital. Use national codes e.g. NHS-run care home.	1	1	0	0	0	0	0	0	0	0
Discharge address	The patient's discharge address. Only complete where this is not the usual place of residence.	1	1	0	0	0	0	0	0	1	0
Expected date of discharge	The date when the patient is currently expected to be discharged from hospital.	0	0	0	0	0	1	1	0	0	0

Relevant clinical risk factors

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Relevant clinical risk factor	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis, e.g. being overweight, smoker, no use of sun screen or an enzyme deficiency.	0	0	0	1	0	1	1	1	1	0
Clinical risk assessment	Specific risk assessments required/undertaken.	0	0	0	1	0	1	1	1	1	0
Risk mitigation	Action taken to reduce the clinical risk and date actions.	0	0	0	1	0	1	1	1	1	0
Patient at high risk	This patient is at high risk of clinical deterioration and will need an immediate response if called.	0	0	0	0	0	0	1	0	0	0

Presenting complaints or issues

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Presenting complaint or issue	The health problem or issue experienced by the patient resulting in their attendance. This may include disease state, medical condition, response and reactions to therapies, e.g. blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment.	0	0	1	0	0	0	0	0	0	0

Problems and issues

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings, symptoms and signs, which are likely to have relevance and are not a diagnosis.	0	0	0	1	1	1	1	0	1	0
Clinical risks	Description of clinical risks identified, e.g. problematic intubation, person with brittle diabetes, immunocompromised or risk of infection etc.	0	0	0	0	1	0	0	0	1	0
Comment	Any further textual comments to clarify, such as a statement that information is partial or incomplete.	0	0	0	0	0	0	0	0	1	0

Diagnosis

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Diagnosis	Confirmed diagnosis and symptoms or active diagnosis being treated.	1	1	1	1	1	0	1	0	1	0
Stage	The stage of the disease or disorder, where relevant.	1	1	0	1	0	0	0	0	1	0
Comment	Supporting text may be given covering diagnosis confirmation, active diagnosis being treated. Include severity, occurrence (first, recurrence, ongoing).	1	1	1	1	0	0	0	0	1	0
Awareness of diagnosis	The description of the level of awareness the person and their carer/family has regarding their diagnosis.	0	0	0	0	1	0	0	0	0	0
Date diagnosis made	The date when the diagnosis was made.	0	0	0	0	0	0	0	0	1	0

History

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Patient's reason for referral	The patient's stated reason for referral. This may include any discussions that took place, the level of shared decision making involved, information about the patient's source of advice. This may be expressed on behalf of the patient, e.g. by a parent or carer.	0	0	0	1	0	0	0	1	0	0

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Element	Description	D	M	E	O	C	A	H	R	HC	CP
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in the attendance. This may include disease state, medical condition, response and reaction to therapies, e.g. blackout, dizziness, chest pain, follow–up from admission, falls, a specific procedure, investigation or treatment.	0	0	1	1	0	1	0	1	0	0
History of each presenting complaint or issue	Information directly related to the development and characteristics of each presenting complaint (e.g. including travel history). Including if the information is given by the patient or their carer.	0	0	0	1	0	1	0	1	0	0
History since last contact	History since last attendance, discharge from hospital, etc.	0	0	0	1	0	0	0	0	0	0
Relevant past medical, surgical and mental health history	The record of the person's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations and specific anesthesia issues. (will include dental and obstetric history).	0	0	0	1	1	1	1	1	0	0
Reason for referral	A clear statement of the purpose of the person making the referral, e.g. diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (e.g. palliative care), provide referrer with advice/guidance. This may include referral because of carers' concerns.	0	0	0	0	0	0	0	1	0	0
Expectation of referral	A clear statement of the expectations of the person making the referral as to the management of the patient, e.g. advice only, diagnosis and treatment.	0	0	0	0	0	0	0	1	0	0
Patient's expectation of referral	The patient's expectations of the referral including preferences. This may include any discussions that took place, the level of shared decision making involved and information about patient's source of advice.	0	0	0	0	0	0	0	1	0	0
Management to date	Referrals, management, investigations and treatment that have already been undertaken, including the patient managing their own symptoms. This may include any procedures conducted with the date and procedure report.	0	0	0	0	0	0	0	1	0	0
Urgency of referral	The referrer's assessment of urgency, e.g. urgent, soon or routine. This may include the reason if other than routine. E.g. two data items: • level of urgency • reason.	0	0	0	0	0	0	0	1	0	0
Reason for admission	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, e.g. chest pains blackouts, falls, a specific procedure, investigation or treatment.	0	0	0	0	0	1	0	0	0	0
Information brought by patient	The information brought by the patient, e.g. patient passport, example diary data, pre–completed questionnaires, person–held maternity record, or personal child health record.	0	0	0	0	0	1	0	0	0	0

Procedures

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Procedure	The therapeutic or diagnostic procedure performed.	1	1	1	1	1	0	0	0	0	0
Anatomical site	The body site of the procedure.	1	1	1	1	0	0	0	0	0	0
Laterality	The laterality of the procedure.	1	1	1	1	0	0	0	0	0	0
Complications related to procedures	Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure.	1	1	1	1	0	0	0	0	0	0
Specific anaesthesia issues	Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Which may include problematic intubation or transfusion reaction.	1	1	1	1	0	0	0	0	0	0
Comment	Any further textual comments to clarify, such as a statement that information is partial or incomplete.	1	1	1	1	0	0	0	0	0	0

Clinical summary

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Clinical summary	A summary of the encounter. Where possible, this should be very brief. This may include interpretation of findings and results such as: differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'.	1	1	1	1	0	1	1	0	0	0
Formulation	An account, shared by a therapist and person, of the personal meaning and origins of a person's difficulties. This is viewed in the context of multiple factors including relationships, social circumstances and life events and will indicate the most helpful way forward.	0	1	0	0	0	0	0	0	0	0
Treatments and interventions and changes made to treatments.	The relevant treatments and interventions which the patient received during the inpatient stay. Include psychological therapies. All medications should be recorded under the medications section.	0	1	0	0	0	0	0	0	0	0
Clinical narrative	A description detailing a patient's reason for attendance, results from the diagnostic and treatment process.	0	0	1	0	0	0	0	0	0	0

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Family history

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Family history	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc.	0	1	0	1	0	1	0	1	1	0
Condition or diagnosis	The condition or diagnosis in family relations deemed to be significant to the care or health of the child.	0	0	0	0	0	0	0	0	1	0
Date	The date the family history was recorded.	0	0	0	0	0	0	0	0	1	0
Maternal or paternal relation	Record of whether the condition or diagnosis was on the mother's or father's side of the family, where needed e.g. paternal grandfather.	0	0	0	0	0	0	0	1	1	0
Relationship to patient	The relationship of the person with the condition to the patient.	0	0	0	0	0	0	0	1	1	0
Comment	Any further textual comment.	0	0	0	0	0	0	0	1	1	0

Investigation results

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Investigation	The investigation performed.	0	0	0	1	0	0	0	1	0	0
Investigation result	For each investigation, the result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date, and plans for acting upon investigation results).	1	1	0	1	0	1	1	1	0	0

Assessment scales

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Assessment scale	Structured assessment scales used as part of assessment and treatment, e.g. New York Heart Failure, Activities of Daily Living (ADL).	1	1	0	1	0	1	0	1	0	0
Assessment scale name	The name of the overarching assessment scale used e.g. Bayley, Griffiths, Ages & Stages Questionnaire etc.	0	0	0	0	0	0	0	0	1	0
Comment	Supporting text may be given regarding the assessment scale as a whole or a subscale.	0	0	0	0	0	0	0	0	1	0
Date	The date on which the assessment scale was recorded.	0	0	0	0	0	0	0	0	1	0
Global score	The total global score from the assessment.	0	0	0	0	0	0	0	0	1	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Location	The location where the assessment scale was recorded.	0	0	0	0	0	0	0	0	1	0
Performing Professional	Details of the professional performing the assessment scale (including name and role).	0	0	0	0	0	0	0	0	1	0
Subscale name	The name of the subscale used (where relevant).	0	0	0	0	0	0	0	0	1	0
Subscale score	The total subscale score from the assessment.	0	0	0	0	0	0	0	0	1	0

Legal information

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Mental Health Act or equivalent status	Record where a person diagnosed with a mental disorder is formally detained under the Mental Health Act or equivalent, including the section number and start date, start time and end date. If person subject to Community Treatment Order or Conditional Discharge (or equivalent) record here.	0	1	0	1	1	0	0	0	0	0
Advance decision to refuse treatment (ADRT)	A record of an advance decision to refuse one or more specific types of future treatment, made by a person who had capacity at the time of recording the decision. The decision only applies when the person no longer has the capacity to consent to or refuse the specific treatment being considered. An ADRT must be in writing, signed and witnessed. If the ADRT is refusing life-sustaining treatment it must state specifically that the treatment is refused even if the person's life is at risk.	1	1	0	1	1	0	0	1	0	0
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, e.g. child protection plan, protection of vulnerable adult.	1	1	0	1	1	1	1	1	0	0
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.	1	1	0	0	1	1	1	1	0	0
Consent for creation of end of life care plan	Separate explicit consent is required for creation of an end of life care record. This records how this consent has been granted in order to differentiate between person's explicit consent, best interest decision, Lasting Power of Attorney decision and withdrawal of consent.	0	0	0	0	1	0	0	0	0	0

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Consent for treatment record	Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent.	1	1	0	0	0	1	1	1	0	0
Consent for information sharing	This is a record of consent for information sharing. Where consent has been not been obtained or sought, the reason why must be provided. Include best interests decision where person lacks capacity.	1	1	0	1	1	1	1	1	0	0
Consent relating to child	Consideration of age and competency, applying Gillick competency or Fraser guidelines. Record of person with parental responsibility or appointed guardian where child lacks competency. Record if there is disagreement between patient and parent."	1	0	0	1	0	1	1	1	0	0
Parental responsibility	For children this is a record of person(s) with parental responsibility	0	0	0	0	1	0	0	0	0	0
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) person has been undertaken, if so, what capacity the decision relates to, who carried it out, when and the outcome of the assessment. Also record best interests decision if person lacks capacity.	1	1	0	1	0	1	1	1	0	0
Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	Record of one or more people who have been given power (LPA) by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make those decisions. To be valid, an LPA must have been registered with the Court of Protection. If life-sustaining treatment is being considered the LPA document must state specifically that the attorney has been given power to consent to or refuse life-sustaining treatment. Details of any person (deputy) appointed by the court to make decisions about the person's health and welfare. A deputy does not have the power to refuse life-sustaining treatment.	1	1	0	1	1	0	0	1	0	0
Deprivation of Liberty Safeguards or equivalent	Record of Deprivation of Liberty Safeguards (DoLS) or equivalent, including the reason for this.	0	1	0	1	1	0	0	0	0	0
Looked after child	Legal information	0	0	0	0	0	0	0	0	1	0
Child protection plan	Legal information	0	0	0	0	0	0	0	0	1	0
Local authority	The named local authority.	0	0	0	0	0	0	0	0	1	0

Safeguarding

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Safeguarding concerns	A record of any identification of concerns regarding safeguarding during attendance.	0	0	1	0	0	0	0	0	0	0
Comment	A comment providing further detail on a safeguarding concern.	0	0	1	0	0	0	0	0	0	0

Safety alerts

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Risks to self	Risks the patient poses to themselves, e.g. suicide, overdose, self-harm or self-neglect.	1	1	1	1	1	1	0	1	1	0
Risks to others	Risks to caring professionals or others.	1	1	1	1	1	1	0	1	1	0
Risk from others	Details of where an adult or child is at risk from an identified person, e.g. a family member.	1	1	1	1	1	1	0	1	1	0
Date	The date on which the safety alert was recorded.	0	0	0	0	0	0	0	0	1	0
Location	The location where the safety alert was recorded.	0	0	0	0	0	0	0	0	1	0
Performing professional	Details of the professional recording the safety alert (including name and role).	0	0	0	0	0	0	0	0	1	0

Allergies and adverse reactions

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. Or "no known drug allergies or adverse reactions" or "information not available".	1	1	1	1	1	1	1	1	1	0

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Element	Description	D	M	E	O	C	A	H	R	HC	CP
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. For example, skin rash.	1	1	1	1	1	1	1	1	1	0
Severity	A description of the severity of the reaction.	1	1	1	1	0	0	0	0	1	0
Certainty	A description of the certainty that the stated causative agent caused the allergic or adverse reaction.	1	1	1	1	0	0	0	0	1	0
Type of reaction	The type of reaction experienced by the patient (allergic, adverse, intolerance).	1	1	0	1	0	0	0	0	1	0
Evidence	Results of investigations that confirmed the certainty of the diagnosis. Examples might include results of skin prick allergy tests.	1	1	0	1	0	0	0	0	1	0
Date first experienced	The date when the reaction was first experienced. This may be a date or partial date (e.g. year) or text (e.g. during childhood).	1	1	0	1	0	1	1	1	1	0
Comment	Any additional comment or clarification about the adverse reaction.	1	1	1	0	0	0	0	0	1	0
Date recorded	The date that the reaction was clinically recorded/asserted. This will often equate to the date of onset of the reaction but this may not be wholly clear from source data.	1	1	0	0	0	0	0	0	1	0
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.	1	1	0	1	0	1	1	1	1	0

Patient concerns, expectations and wishes

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Patient concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/representative on behalf of the patient). Where the person lacks capacity this may include their representative's concerns, expectations or wishes.	1	1	0	1	1	1	1	1	1	0
Advance statement	Written requests and preferences made by a person with capacity conveying their wishes, beliefs and values for their future care should they lose capacity. Include the location of the document if known.	1	1	0	1	1	0	0	0	0	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Preferred place of care	The preferences that a person has identified as their preferred place to receive care.	0	0	0	0	1	0	0	0	0	0
Preferred place of death	The preferences that a person has identified as their preferred place to die.	0	0	0	0	1	0	0	0	0	0

Examination findings

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Examination	The examination performed, e.g. general appearance, vital signs, mental state, head and neck examination, oral examination, cardiovascular system, respiratory system, abdomen, genitourinary, nervous system, musculoskeletal system, skin. This could include site and must include laterality where applicable.	0	0	0	1	0	0	0	0	1	0
Examination findings	The record of findings from the examinations performed.	0	0	0	1	0	0	0	1	1	0
Vital signs	The record of essential physiological measurements, e.g. heart rate, blood pressure, temperature, pulse, respiratory rate, SpO2, level of consciousness etc. Use of Early Warning Score (which may be computed) chart where appropriate.	0	0	0	0	0	1	0	1	1	0
Performing professional	Details of the professional performing the examination (including name and role).	0	0	0	0	0	0	0	0	1	0
Location	The location where the examination was recorded.	0	0	0	0	0	0	0	0	1	0

Crisis care plan

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Care funding details	A record of the funding source and any conditions or limitations associated.	0	0	0	0	1	0	0	0	0	0
Priorities of care	The priorities agreed between the person and their health/care team, where the person has capacity: • to get better; please consider all treatment to prolong life. • to achieve a balance between getting better and ensuring good quality of life; please consider selected treatments. • comfort; please consider all treatments aimed at symptom control.	0	0	0	0	1	0	0	0	0	0

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Estimated prognosis	Where a person is terminally ill this is a clinical judgment indicating the anticipated period of time until death. This could be their last days, weeks, months or year of life. Also include the date the prognosis was made.	0	0	0	0	1	0	0	0	0	0
Awareness of prognosis	Description of the level of awareness the person and/or their carer/family has regarding their estimated prognosis.	0	0	0	0	1	0	0	0	0	0
Anticipatory actions	Please provide guidance on specific interventions or actions that may be required or should be avoided in specific situations.	0	0	0	0	1	0	0	0	0	0
Anticipatory medicines/equipment	Medicines or equipment available in the event of a crisis and their location.	0	0	0	0	1	0	0	0	0	0
Agreed with person or legitimate representative	Indicates whether the crisis care plan was discussed and agreed with the person or legitimate representative. If agreement cannot be obtained the reason for this should be documented.	0	0	0	0	1	0	0	0	0	0
Cardio-pulmonary resuscitation (CPR) decision	Please state here whether a decision has been made, the decision, who made the decision, the date of decision, date for review and location of documentation. Where the person or their family member/carer have not been informed of the clinical decision please state the reason why.	0	0	0	0	1	0	0	0	0	0
Planned review date	The date the plan is due for review.	0	0	0	0	1	0	0	0	0	0

End of life

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Certification of death	If the person is in their last weeks of life, is there a doctor who has seen the person recently who could potentially sign a death certificate? Provide contact details.	0	0	0	0	1	0	0	0	0	0
Actions taken in anticipation of death	The plan that has been agreed to facilitate certification of death and/or funeral arrangements, e.g. anticipatory discussions with coroner to arrange funeral within 24 hours.	0	0	0	0	1	0	0	0	0	0
Actual place of death	The location where the person actually died as recorded on the death certificate. If the person died somewhere other than their preferred place, record the reasons why this happened.	0	0	0	0	1	0	0	0	0	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Cause of death	The cause of death as recorded on the death certificate.	0	0	0	0	1	0	0	0	0	0
Date of death	The date on which a person died or is officially deemed to have died, as recorded on the death certificate.	0	0	0	0	1	0	0	0	0	0

Clinical review of symptoms

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Clinical review of systems	The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about specific symptoms from various physiological systems, including food intake (increasing/decreasing) weight change and swallowing difficulties.	0	0	0	1	0	1	0	0	0	0

Information and advice given

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Information and advice given	This includes: • what information • to whom it was given. • the oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. This may include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment.	1	1	1	1	0	1	1	1	1	0
Date	The date on which the information and advice was given.	0	0	0	0	0	0	0	0	1	0
Location	Details of where the information and advice was given.	0	0	0	0	0	0	0	0	1	0
Performing professional	Details of the professional giving the information and advice (including name and role).	0	0	0	0	0	0	0	0	1	0

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Plan and requested actions

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Actions	Including planned investigations, procedures, Interventions and treatment for a patient's identified conditions and priorities. For each action the following should be identified: a) person responsible - name and designation / department / hospital / patient etc or role (eg GP) responsible for carrying out the proposed action, and where action should take place. b) status - requested, planned or completed. c) When action requested for - requested date, time, or period - as relevant. d) suggested strategies - suggested strategies for potential problems. e) outcome expectations, including patient's expectations.	0	0	1	0	0	0	0	0	0	0
Actions for healthcare professionals	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities. For each action the following should be identified: outcome expectations, including patient's expectations	1	1	1	0	1	1	0	0	0	0
Agreed with patient or legitimate patient representative	Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments.	1	1	0	1	0	1	1	0	0	0
Care planning arrangements	Record if CPA (Care Programme Approach) documentation is available and how and where it can be accessed; care and treatment plan in Wales and Scotland. In Wales this is superseded by the Mental Health Measure 2010.	0	1	0	1	0	0	0	0	0	0
Special monitoring required	E.g. neuro-obs, 02 saturation etc.	0	0	0	0	0	1	0	0	0	0
Aims and limitations of treatment and special instructions	The current aim of treatment including limitations to treatment and communications issues, e.g. not for ITU.	0	0	0	0	0	0	1	0	0	0
Escalation plan	Who needs to be contacted in the event of significant problems or patient deterioration include, e.g. seniority/name/contact details of person to be called.	0	0	0	0	0	0	1	0	0	0
Investigations requested	This includes a name or description of the investigation requested and the date requested.	1	1	0	0	0	0	0	0	0	0
Procedures requested	These are the diagnostic or therapeutic procedures that have actually been requested (and the date requested).	1	1	0	0	0	0	0	0	0	0
Date	The date on which the plan and requested actions was recorded.	0	0	0	0	0	0	0	0	1	0
Performing professional	Details of the professional performing the plan and requested actions (including name and role).	0	0	0	0	0	0	0	0	1	0

Person completing record

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Name	The name of the person completing the record, preferably in a structured format.	1	1	1	1	1	1	0	1	0	0
Role	The role the person is playing within the organisation at the time record was updated.	1	1	0	1	1	1	0	1	0	0
Grade	The grade of the person completing the record.	1	1	0	1	0	1	0	1	0	0
Specialty	The main specialty of the person completing the record.	1	1	0	1	0	1	0	1	0	0
Professional identifier	Professional identifier for the person completing the record, e.g. GMC number, HCPC number etc. or the personal identifier used by the local organisation.	1	1	1	1	1	0	0	0	0	0
Date and time completed	The date and time the record was updated.	1	1	0	1	1	0	0	1	0	0
Contact details	Contact details of the person completing the record. For example a phone number, email address. Contact details are used to resolve queries about the record entry.	1	1	0	1	1	0	0	0	0	0
Organisation	The organisation the person completing the record works for.	1	1	0	0	1	0	0	0	0	0

Senior reviewing clinician

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Name	The name of the senior clinician responsible for reviewing the patient treatment and discharge plan.	0	0	0	1	0	1	0	0	0	0
Professional identifier	The unique identifier issued by the regulatory body, e.g. GMC number, HCPC number etc.	0	1	1	0	0	0	0	0	0	0

Contact for further information

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Contact for further information	The contact details of whom to contact for information regarding this attendance.	0	0	1	0	0	0	0	0	0	0

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Distribution list

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Name	If the communication is being sent to a named individual, then this is the name of the recipient, preferably in a structured format. An identifier for the individual, for example GMC code (for a GP), or an SDS identifier, a NHS number (for a patient) will be sent alongside the name, but may not displayed on rendered document.	1	1	0	1	0	0	0	1	0	0
Role	If the communication is being sent to either a named individual, or to a non–named person with a specific role, then this is the role of the recipient.	1	1	0	1	0	0	0	1	0	0
Grade	The recipient's grade.	1	1	0	1	0	0	0	1	0	0
Organisation name	The name of the organisation the recipient is representing or the organisation named as the receiving organisation. An identifier for the organisation will be sent alongside the name, but may not displayed on rendered document.	1	1	0	1	0	0	0	1	0	0
Team	Team that the recipient belongs to in the context of receiving this message, or the team acting as the recipient.	1	1	0	1	0	0	0	1	0	0
Relationship to subject	The relationship of the receiver to the patient, where the receiver has a personal relationship to the patient, for example, carer or parent	1	1	0	1	0	0	0	1	0	0

Birth details

Element	Description	D	M	E	O	C	A	H	R	HC	CP
APGAR score	A set of observations made on the baby following birth to check adaptation to life outside the womb. This includes 1 minute, 5 minutes and 10 minutes.	0	0	0	0	0	0	0	0	1	0
Birth order	The sequence in which this baby was born (one of one, one of two etc.).	0	0	0	0	0	0	0	0	1	0
Birth weight	Numeric value for weight at birth.	0	0	0	0	0	0	0	0	1	0
Date & Time of birth	The date and time of birth of the baby.	0	0	0	0	0	0	0	0	1	0
Delivery place type	The type of place in which the baby was born, e.g. private health facility, domestic address, NHS hospital, midwifery led unit etc.	0	0	0	0	0	0	0	0	1	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Fetal problems diagnosed before birth	Problems with the fetus diagnosed with screening or ultrasound. e.g. Down syndrome, congenital heart disease etc.	0	0	0	0	0	0	0	0	1	0
Length of gestation	Gestational age in weeks and days (usually equivalent to length of pregnancy).	0	0	0	0	0	0	0	0	1	0
Location of birth	The place of birth (including the address and organisation name where relevant).	0	0	0	0	0	0	0	0	1	0
Maternal problems in pregnancy	Maternal medical conditions or infectious diseases arising in pregnancy which may have an impact on the fetus, e.g. gestational diabetes, rubella etc.	0	0	0	0	0	0	0	0	1	0
Multiple birth	Where the baby is one of a multiple birth, to include the total number of offspring and to include whether the baby is identical to one of the siblings.	0	0	0	0	0	0	0	0	1	0
Neonatal resuscitation	Details of neonatal resuscitation measures required, e.g. chest compression, oxygen mask etc.	0	0	0	0	0	0	0	0	1	0
Physical problems detected at birth	Physical problems identified with the baby at, or shortly after, birth, e.g. cleft lip/palate, extensive bruising, cephalohematoma etc.	0	0	0	0	0	0	0	0	1	0
Problems during delivery	Problems experienced by the baby during delivery, e.g. cord prolapse, meconium aspiration, fetal distress etc.	0	0	0	0	0	0	0	0	1	0
Put to breast	Whether or not the baby was put to the breast.	0	0	0	0	0	0	0	0	1	0
Spontaneous respiration	Details of neonatal resuscitation measures required, e.g. chest compression, oxygen mask etc.	0	0	0	0	0	0	0	0	1	0
Type of delivery	Type of delivery for the baby, e.g. vacuum extraction, breech extraction, elective caesarean section etc.	0	0	0	0	0	0	0	0	1	0
Types of delivery (attempted)	The type(s) of delivery for the baby that was attempted, but was not the final delivery method.	0	0	0	0	0	0	0	0	1	0

Demographic history

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Date of birth	History of date of birth changes.	0	0	0	0	0	0	0	0	1	0
Gender	History of gender change.	0	0	0	0	0	0	0	0	1	0
Patient address	History of Patient's usual place of residence.	0	0	0	0	0	0	0	0	1	0

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(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Patient name	Any previous names, aliases and preferred name. This will normally be given by a patient demographics service (PDS) patient trace, or the name of the patient held on the local patient administration system (PAS).	0	0	0	0	0	0	0	0	1	0
Patient telephone number	History of telephone contact details of the patient. To include, e.g. mobile, work and home number if available.	0	0	0	0	0	0	0	0	1	0

Developmental skills

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Date first achieved	The date the developmental skill was first achieved (developmental first) as reported by the parent. This is primarily for parent reporting as part of parent child health record at the time the skill is acquired.	0	0	0	0	0	0	0	0	1	0
Date of enquiry	The date the parent or carer was asked by a health professional about the developmental skill (milestone).	0	0	0	0	0	0	0	0	1	0
Date of observation	The date a health professional observed or tested a developmental skill (milestone).	0	0	0	0	0	0	0	0	1	0
Developmental skill	The name of the developmental skill (e.g. walks independently, smiles, finger feeds etc.).	0	0	0	0	0	0	0	0	1	0
Result of enquiry	Whether the developmental skill was achieved, not achieved or equivocal.	0	0	0	0	0	0	0	0	1	0
Result of observation	Whether the developmental skill was achieved, not achieved or equivocal.	0	0	0	0	0	0	0	0	1	0
Comments	Supporting text may be given regarding the developmental skill.	0	0	0	0	0	0	0	0	1	0

Educational history

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Educational assessment	The outcome of an educational assessment.	0	0	0	0	0	0	0	0	1	0
Educational establishment	Name of educational establishment.	0	0	0	0	0	0	0	0	1	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Type of educational establishment	Phase/type of education establishment.	0	0	0	0	0	0	0	0	1	0
Type of special educational need	The type of special educational needs for the child.	0	0	0	0	0	0	0	0	1	0
Year from	The year the child attended the school from.	0	0	0	0	0	0	0	0	1	0
Year to	The year the child left the school. if available.	0	0	0	0	0	0	0	0	1	0

Emergency care attendance

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Clinical narrative	A description detailing a patient's reason for attendance, results from the diagnostic and treatment process.	0	0	0	0	0	0	0	0	1	0
Date and time of attendance	Date and time patient arrived at the unscheduled care unit.	0	0	0	0	0	0	0	0	1	0
Date and time of discharge	The actual date and time of discharge.	0	0	0	0	0	0	0	0	1	0
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.	0	0	0	0	0	0	0	0	1	0
Discharge destination	The destination of the patient on discharge. National codes, e.g. High Dependency Unit.	0	0	0	0	0	0	0	0	1	0
Discharge status	Patient status on discharge from emergency care.	0	0	0	0	0	0	0	0	1	0
Location	Details of where the unscheduled care attendance took place.	0	0	0	0	0	0	0	0	1	0
Person accompanying patient	Identify others accompanying the patient, e.g. relative, friend, patient informal carer, advocate. If the patient was not present, was an authorised representative present. Include name and relationship (friend, relative, etc.)	0	0	0	0	0	0	0	0	1	0
Plan and requested actions	A simple free text description of the plan of action following the contact with the child. This may include actions for the parent, healthcare professional (e.g. health visitor) and review.	0	0	0	0	0	0	0	0	1	0
Presenting complaint or issue	The health problem or issue experienced by the patient resulting in their attendance. This may include disease state, medical condition, response and reactions to therapies, e.g. blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment.	0	0	0	0	0	0	0	0	1	0

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Element	Description	D	M	E	O	C	A	H	R	HC	CP
Procedure	The therapeutic or diagnostic procedure performed on the patient. This may be coded, or represented as free text.	0	0	0	0	0	0	0	0	1	0
Referral Source	Source of referral for Unscheduled care.	0	0	0	0	0	0	0	0	1	0
Safety alerts	Safety alerts at the emergency care attendance suggested to be pulled through from the safety alerts heading.	0	0	0	0	0	0	0	0	1	0

Feeding status

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Date	The date the feeding status was recorded.	0	0	0	0	0	0	0	0	1	0
Date breast milk feeding stopped	Date of last breast milk feed to the nearest month and year.	0	0	0	0	0	0	0	0	1	0
Feeding concerns	A record of any concerns about the baby's feeding.	0	0	0	0	0	0	0	0	1	0
Feeding method	A record of the predominant feeding method for the baby, e.g. breast fed, bottle/cup fed, gastrostomy, nasogastric feeds etc.	0	0	0	0	0	0	0	0	1	0
First milk feed	Whether or not the baby's first feed was breast milk.	0	0	0	0	0	0	0	0	1	0
Introduction of solids	Whether the baby has been introduced to solid foods at the time seen.	0	0	0	0	0	0	0	0	1	0
Milk feeding status of the baby	Whether the baby is totally breast milk fed, partially breast milk fed or not breast milk fed. To be recorded each time a baby has contact with a health professional.	0	0	0	0	0	0	0	0	1	0

Health and well-being assessment and reviews

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Date	The date the feeding status was recorded.	0	0	0	0	0	0	0	0	1	0
Post Birth Review	This details those checks and assessments done on the baby prior to leaving hospital that do not make up the NIPE screening.	0	0	0	0	0	0	0	0	1	0
New baby review	The details captured as part of the new baby review.	0	0	0	0	0	0	0	0	1	0
6–8 week health visitor review	The details captured as part of the 6–8 heath visitor review.	0	0	0	0	0	0	0	0	1	0
1 year review	The details captured as part of the 1 year review.	0	0	0	0	0	0	0	0	1	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
2–2 1/2 year health and development review	The details captured as part of the 2–2 1/2 health and development review.	0	0	0	0	0	0	0	0	1	0
School entry review	The details captured as part of the school entry review including the outcome of the hearing and screening check.	0	0	0	0	0	0	0	0	1	0
Ad-Hoc health review	The details captured as part of any ad-hoc health review undertaken.	0	0	0	0	0	0	0	0	1	0

Immunisations

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Batch number	The batch number of the vaccine.	0	0	0	0	0	0	0	0	1	0
Date	The date on which the Immunisation was administered.	0	0	0	0	0	0	0	0	1	0
Dose amount	Amount of vaccine administered.	0	0	0	0	0	0	0	0	1	0
Dose sequence	Nominal position in a series of vaccines.	0	0	0	0	0	0	0	0	1	0
Indication	The clinical indication or reason for administering the immunisation.	0	0	0	0	0	0	0	0	1	0
Location	Details of where the immunisation was performed.	0	0	0	0	0	0	0	0	1	0
Manufacturer	The vaccine manufacturer.	0	0	0	0	0	0	0	0	1	0
Name of immunisation	Which immunisation has been administered (SNOMED CT code – list of available immunisations).	0	0	0	0	0	0	0	0	1	0
Outcome status	Whether the vaccine was administered or not, including the reason why.	0	0	0	0	0	0	0	0	1	0
Performing professional	Details of the professional performing the immunisation (including name and role).	0	0	0	0	0	0	0	0	1	0
Reported	A flag to indicate the information was reported to a healthcare professional.	0	0	0	0	0	0	0	0	1	0
Route	How vaccine entered the body.	0	0	0	0	0	0	0	0	1	0
Site	Body site vaccine was administered into.	0	0	0	0	0	0	0	0	1	0
Vaccine product	Vaccine product administered.	0	0	0	0	0	0	0	0	1	0

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Measurements

Element	Description	D	M	E	O	C	A	H	R	HC	CP
BMI centile	Child BMI centile calculated using the height/weight/ gender and age of the child.	0	0	0	0	0	0	0	0	1	0
Date	The date on which the measurement was recorded.	0	0	0	0	0	0	0	0	1	0
Head circumference	Numeric value for the head circumference.	0	0	0	0	0	0	0	0	1	0
Height/length	Numeric value for the body length.	0	0	0	0	0	0	0	0	1	0
Location	The location where the measurement was recorded.	0	0	0	0	0	0	0	0	1	0
Performing professional	Details of the professional performing the measurement (including name and role).	0	0	0	0	0	0	0	0	1	0
Weight	Numeric value for weight.	0	0	0	0	0	0	0	0	1	0

National screening programme

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Newborn blood spot Screening	The details captured as part of the NBS programme which screens for sickle cell disease (SCD), cystic fibrosis (CF), congenital hypothyroidism (CHT) and inherited metabolic diseases (IMDs).	0	0	0	0	0	0	0	0	1	0
Newborn hearing screening	The details captured as part of the NHSP programme which offers 2 types of test for babies: • automated otoacoustic emission (AOAE) • automated auditory brainstem response (AABR).	0	0	0	0	0	0	0	0	1	0
Newborn and infant physical examination (72 hours)	The details captured as part of the NIPE programme which tests babies within 72 hours of birth for conditions relating to their: • heart • hips • eyes • testes.	0	0	0	0	0	0	0	0	1	0
Newborn and infant physical examination (6–8 weeks)	The details captured as part of the NIPE programme which tests babies again at 6–8 weeks for conditions relating to their: • heart • hips • eyes • testes.	0	0	0	0	0	0	0	0	1	0

Parent/guardian/personal comment

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Date	Date the comment was entered and shared.	0	0	0	0	0	0	0	0	1	0
Who	Who recorded the comment and what relationship they are to the child.	0	0	0	0	0	0	0	0	1	0
Parent/guardian or personal comment	Free text comment made by the parent/ guardian of the child, or the child themselves.	0	0	0	0	0	0	0	0	1	0

Personal contacts

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Name	The name of the person.	0	0	0	0	0	0	0	0	1	0
Relationship	The personal relationship the individual has to the child (e.g. father, grandmother, family friend etc.)	0	0	0	0	0	0	0	0	1	0
Parental responsibility	Flag to indicate whether the personal contact has parental responsibility.	0	0	0	0	0	0	0	0	1	0
Contact details	Contact details of the person (e.g. telephone number, email address etc.).	0	0	0	0	0	0	0	0	1	0
NHS number	The NHS number of the personal contact.	0	0	0	0	0	0	0	0	1	0

Professional contacts

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Name/Team	The name of the person or the team responsible.	0	0	0	0	0	0	0	0	1	0
Role	The professional role the individual has in relation to the child, e.g. nursery nurse, health visitor, school nurse etc.	0	0	0	0	0	0	0	0	1	0
Speciality	The specialty of the professional responsible, e.g. health visiting, school nursing etc.	0	0	0	0	0	0	0	0	1	0
Team	The name of the team, if the name of the person has been entered.	0	0	0	0	0	0	0	0	1	0
Organisation	The name of the organisation responsible.	0	0	0	0	0	0	0	0	1	0
Contact details	Contact details of the person (e.g. telephone number, email address etc.).	0	0	0	0	0	0	0	0	1	0

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Element	Description	D	M	E	O	C	A	H	R	HC	CP
Start date	The start date of the relationship with the health professional.	0	0	0	0	0	0	0	0	1	0
End date	The end date of the relationship with the health professional.	0	0	0	0	0	0	0	0	1	0

Reason for referral

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Reason for referral	A clear statement of the purpose of the person making the referral, e.g. diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (e.g. palliative care), provide referrer with advice/guidance. This may include referral because of carers' concerns.	0	0	0	0	0	0	0	1	0	0
Clinical urgency of referral	Referrer's assessment of urgency, (e.g. urgent/soon/ routine), may include reason if other than routine, e.g. two data items: • level of urgency • reason.	0	0	0	0	0	0	0	1	0	0
Expectation of referral	A clear statement of the expectations of the person making the referral as to the management of the patient, e.g. advice only, diagnosis, treatment, etc. To Include any specific patient expectation In general text. Risk not put in a procedure not already received.	0	0	0	0	0	0	0	1	0	0
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient precipitating referral. This may include disease state, medical condition, response and reaction to therapies, e.g. blackout, dizziness, chest pain, follow-up from admission, falls, a specific procedure, investigation, family history or treatment.	0	0	0	0	0	0	0	1	0	0
History of each presenting complaint or issue	Information directly related to the development and characteristics of each presenting complaint, (e.g. including travel history). Including if the information is given by the patient or their carer.	0	0	0	0	0	0	0	1	0	0
Management to date	Referrals, management, investigations and treatment that have already been undertaken, including patient managing their symptoms. Including: • procedures conducted – procedures carried out (and the date) and procedure report.	0	0	0	0	0	0	0	1	0	0

About me

Element	Description	D	M	E	O	C	A	H	R	HC	CP
About me	This is a record of the things that an individual feels it is important to communicate about their needs, strengths, values and preferences to others providing support and care.	0	0	0	0	0	0	0	0	0	1
Date	This is a record of the date that this information was last updated.	0	0	0	0	0	0	0	0	0	1
Supported to write this by	Where relevant, this is a record of name, relationship/role and contact details of the person who supported the individual to write this section, e.g. carer, family member, advocate, professional.	0	0	0	0	0	0	0	0	0	1

Contingency plan(s)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.	0	0	0	0	0	0	0	0	0	1
Anticipatory medicines/equipment	Medicines or equipment available that may be required in specific situations and their location.	0	0	0	0	0	0	0	0	0	1
Contingency plan name	Name of the contingency plan – what condition or circumstances it is addressing.	0	0	0	0	0	0	0	0	0	1
Date this plan was last updated	This is a record of the date that this contingency plan was last updated.	0	0	0	0	0	0	0	0	0	1
Planned review date/Interval	This is the date/interval when this contingency plan will next be reviewed.	0	0	0	0	0	0	0	0	0	1
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.	0	0	0	0	0	0	0	0	0	1
Trigger factors	Signs to watch out for that may indicate a significant change in health or other circumstances.	0	0	0	0	0	0	0	0	0	1
What should happen	To record guidance on specific actions or interventions that may be required or should be avoided in specific situations. This may include circumstances where action needs to be taken if a carer is unable to care for the individual.	0	0	0	0	0	0	0	0	0	1
Who should be contacted	Who should be contacted in the event of significant problems or deterioration in health or well-being including, e.g. name, designation and contact details of persons.	0	0	0	0	0	0	0	0	0	1

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Outstanding issues

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Tasks which must be done	Include timescales (appropriate seniority of staff for each task).	0	0	0	0	0	0	1	0	0	0
Tasks to be done if possible	E.g. test review, pre-discharge documents, criteria for discharge, including who may discharge the patient.	0	0	0	0	0	0	1	0	0	0

Person handing over

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Name	The name of the person completing the record, preferably in a structured format.	0	0	0	0	0	0	1	0	0	0
Role	The role the person is playing within the organisation at the time record was updated.	0	0	0	0	0	0	1	0	0	0
Grade	The grade of the person completing the record.	0	0	0	0	0	0	1	0	0	0
Specialty	The main specialty of the person completing the record.	0	0	0	0	0	0	1	0	0	0
Contact details	Contact details of the person completing the record. For example a phone number, email address. Contact details are used to resolve queries about the record entry.	0	0	0	0	0	0	1	0	0	0

Person receiving handover

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Name	The name of the person receiving the handover, preferably in a structured format.	0	0	0	0	0	0	1	0	0	0
Role	The role the person is playing within the organisation at the time of handover.	0	0	0	0	0	0	1	0	0	0
Grade	The grade of the person receiving the handover.	0	0	0	0	0	0	1	0	0	0
Specialty	The specialty of the person receiving the handover.	0	0	0	0	0	0	1	0	0	0
Contact details	Contact details of the person receiving the handover. For example a phone number, email address. Contact details are used to resolve queries about the record entry.	0	0	0	0	0	0	1	0	0	0

Handover details

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Patient location	This is the physical location of the patient. For inpatient, e.g. hospital ward, bed, theatre. For ambulatory care, e.g. health centre, clinic, resources centre, patient's home.	0	0	0	0	0	0	1	0	0	0
Planned patient location	If patient is changing location.	0	0	0	0	0	0	1	0	0	0
Date of admission	Date patient admitted to hospital.	0	0	0	0	0	0	1	0	0	0
Expected date of discharge	The date the patient is currently expected to be discharged from hospital.	0	0	0	0	0	0	1	0	0	0
Responsible consultant	The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient).	0	0	0	0	0	0	1	0	0	0
Specialty	Specialties designated by royal colleges and faculties, e.g. orthopedics, renal medicine, endocrinology, etc.	0	0	0	0	0	0	1	0	0	0
Service	Subspecialties, treatment functions or services, e.g. hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic etc.	0	0	0	0	0	0	1	0	0	0
Date of decision to handover	Date decision made to handover care.	0	0	0	0	0	0	1	0	0	0
New responsible consultant	The name and designation of the consultant who is accepting responsibility for the patient's inpatient care.	0	0	0	0	0	0	1	0	0	0
Date handover accepted	Date decision made to accept handover of care.	0	0	0	0	0	0	1	0	0	0
Reason for handover	A clear statement of the reason for the temporary or permanent handover of care, e.g. low potassium, immediately post-op, unstable medical condition.	0	0	0	0	0	0	1	0	0	0
Senior clinical contact	If there is a particular requirement to call a specific person, e.g. consultant, SpR or special intervention team.	0	0	0	0	0	0	1	0	0	0

Additional supporting plan(s)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Additional supporting plan name	The name of the particular additional supporting plan, e.g. dietician's plan, wound management plan, discharge management plan.	0	0	0	0	0	0	0	0	0	1

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O: Outpatient Letter
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A: Admission Record
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CP: Digital Care and Support Plan

(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Additional support	This is the content of any additional care and support plan which the individual and/or care professional consider should be shared with others providing care and support. It should be structured as recommended for the care and support plan and if contains additional detail, it may be referenced here.	0	0	0	0	0	0	0	0	0	1
Person completing record	This is the person contributing to the care and support plan. Should include their name, role, grade, specialty, organisation, professional identifier, date and time completed, contact details.	0	0	0	0	0	0	0	0	0	1
Planned review date/Interval	This is the date/interval when this information will next be reviewed.	0	0	0	0	0	0	0	0	0	1
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.	0	0	0	0	0	0	0	0	0	1
Date this plan was last updated	This is a record of the date that this information was last updated.	0	0	0	0	0	0	0	0	0	1

Care and support plan

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Actions and activities	Actions or activities the individual or others plan to take to achieve the individual's goals and the resources required to do this. For each action the following may be identified: Stage goal – a specific sub-goal that is related to the overall goal as agreed by the person in collaboration with a professional What – what the action is and how it is to be carried out? Who – name and designation, e.g. person, carer, GP, OT, etc., of the person, or a team, carrying out the proposed action, and, if relevant where action should take place When – planned date, time, or interval, as relevant Suggested strategies for potential problems Status – not started, started, completed, not applicable Confidence – how confident the person feels to carry it out Outcome – the outcome of the stage goal Date when action/activity record was last updated Review date – when the stage goal and action need to be reviewed.	0	0	0	0	0	0	0	0	0	1
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.	0	0	0	0	0	0	0	0	0	1

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Care funding source	A reference to the funding source and any conditions or limitations associated.	0	0	0	0	0	0	0	0	0	1
Date last updated	Date when action/activity record was last updated.	0	0	0	0	0	0	0	0	0	1
Date this plan was last updated	This is a record of the date that this care and support plan was last updated.	0	0	0	0	0	0	0	0	0	1
Goals and hopes	The overall goals, hopes, aims or targets that the individual has. Anything they want to achieve that relates to their future health and well-being. Each goal may include a description of why it is important to the person. Goals may also be ranked in order of importance or priority to the individual.	0	0	0	0	0	0	0	0	0	1
Needs, concerns or health problems	Needs, concerns or health problems an individual has that relate to their health and well-being.	0	0	0	0	0	0	0	0	0	1
Other care planning documents	Reference other care planning documents, including the type, location and date. This may include condition-specific plans, advance care plans, end of life care plan, etc.	0	0	0	0	0	0	0	0	0	1
Outcomes	Outcomes of each of the individual's goals, aims and targets. Includes comments recorded by the individual, date and status: fully achieved, partially achieved, not achieved, on-going, no longer applicable.	0	0	0	0	0	0	0	0	0	1
Planned review date/interval	This is the date/interval when this information will next be reviewed.	0	0	0	0	0	0	0	0	0	1
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.	0	0	0	0	0	0	0	0	0	1
Strengths	Any strengths and assets the individual has that relate to their goals and hopes about their health and well-being.	0	0	0	0	0	0	0	0	0	1

Medications and medical devices

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Medication name	May be generic name or brand name (as appropriate).	1	1	1	1	1	1	0	1	1	0
Form	E.g. capsule, drops, tablet, lotion etc.	1	1	1	1	1	1	0	1	1	0
Route	Medication administration description (oral, IM, IV, etc.): may include method of administration, (e.g. by infusion, via nebuliser, via NG tube).	1	1	1	1	1	1	0	1	1	0

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(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Quantity supplied	The quantity of the medication (e.g. tablets, inhalers, etc.) provided to the patient on discharge. This may be dispensed by the pharmacy or on the ward.	1	1	1	1	1	1	0	1	0	0
Site	The anatomical site at which the medication is to be administered, e.g. "left eye".	1	1	1	1	1	1	0	1	0	0
Method	The technique or method by which the medication is to be administered.	1	1	1	1	1	1	0	1	0	0
Dose amount description	A description of the medication single dose amount, e.g. "30 mg" or "2 tabs".	1	1	1	1	1	1	0	1	0	0
Dose timing description	A description of the frequency of taking or administration of a medication dose, e.g. "twice a day", "at 8am 2pm and 10pm".	1	1	1	1	1	1	0	1	0	0
Dose directions description	A single plain text phrase describing the entire medication dosage and administration directions including dose quantity and medication frequency, e.g. "1 tablet at night or "2mg at 10pm". This is the form of dosage direction text normally available from UK GP systems.	1	0	0	1	0	0	0	1	1	0
Additional instructions	Allows for: • requirements for adherence support, e.g. compliance aids, prompts and packaging requirements • level of urgency additional information about specific medicines, e.g. where specific brand required • person requirements, e.g. unable to swallow tablets.	1	1	1	1	1	1	0	1	1	0
Indication	Reason for medication being prescribed, where known.	1	1	1	1	1	1	0	1	1	0
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.	1	1	1	1	1	1	0	1	1	0
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.	1	1	1	1	1	1	0	1	1	0
Performing professional	Details of the professional administering the medication (including name and role).	0	0	0	0	0	0	0	0	1	0
Location	Details of where the medication was administered.	0	0	0	0	0	0	0	0	1	0
Date	The date on which the medication was administered.	0	0	0	0	0	0	0	0	1	0
Start date/time	The date and/or time that the medication course should begin.	0	0	0	0	0	0	0	0	1	0
End date/time	The date and/or time that the medication course should finish.	0	0	0	0	0	0	0	0	1	0
Authorised date	Date prescriber created prescription.	0	0	0	0	0	0	0	1	0	0
Valid from date	Date the prescription can be issued from. Valid for 6 months.	0	0	0	0	0	0	0	1	0	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Request for advice	Request for advice and recommendation about medication	0	0	0	0	0	0	0	1	0	0
Repeat medications: This is the sub-section where all current repeat medications are recorded.		0	0	0	0	0	0	0	1	0	0
Medication name	Mandatory medication name coded using SNOMED CT/dm+d term where possible, allowing plain text for historical/patient reported items, extemporaneous preparations or those not registered in dm+d	0	0	0	0	0	0	0	1	0	0
Form	Form of the medicinal substance, e.g. capsules, tablets, liquid. Not normally required unless a specific form has been requested by the prescriber, e.g. “modified release capsules”.	0	0	0	0	0	0	0	1	0	0
Route	Optional medication route, using SNOMED CT terms where possible. Not generally applicable to product-based medication. Should not be used to specify a specific administration site, for which a separate archetype is used, e.g. the route is ‘intraocular’ the site may be ‘left eye’, e.g. “oral”, “intraocular”. Note that this element supports multiple routes to allow a choice to be specified by the prescriber.	0	0	0	0	0	0	0	1	0	0
Site	The anatomical site at which the medication is to be administered, e.g. “left eye”.	0	0	0	0	0	0	0	1	0	0
Method	The technique or method by which the medication is to be administered.	0	0	0	0	0	0	0	1	0	0
Dose amount description	A plain text description of medication single dose amount, as described in the AoMRC medication headings, e.g. “30 mg” or “2 tabs”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.	0	0	0	0	0	0	0	1	0	0
Dose directions description	A plain text description of the entire prescribed medication dosage and administration directions, including dose quantity and medication frequency.	0	0	0	0	0	0	0	1	0	0
Dose timing description	A plain text description of medication dose frequency, as described in the AoMRC medication headings, e.g. “twice a day”, “at 8am 2pm and 10pm”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.	0	0	0	0	0	0	0	1	0	0

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(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Prescribed quantity	Medication quantity prescribed.	0	0	0	0	0	0	0	1	0	0
Date started	This is when the medication was first prescribed.	0	0	0	0	0	0	0	1	0	0
Authorised date	Date prescriber created prescription.	0	0	0	0	0	0	0	1	0	0
Valid from date	Date the prescription can be issued from, e.g. valid for 6 months.	0	0	0	0	0	0	0	1	0	0
Number of issues permissible	The number of repeat issues permissible.	0	0	0	0	0	0	0	1	0	0
Number of issues made	The number of repeats already issued.	0	0	0	0	0	0	0	1	0	0
Valid to date	Date the prescription is valid to.	0	0	0	0	0	0	0	1	0	0
Additional instructions	Additional multiple dosage or administration instructions as plain text. This may include guidance to the prescriber, patient or person administering the medication. In some settings, specific administration instructions may be re–labelled as “patient advice” or ‘dispensing instruction’ to capture these flavors of instruction, e.g. “omit morning dose on day of procedure”, “for pain or fever”, “dispense weekly”.	0	0	0	0	0	0	0	1	0	0
Indication	Reason for medication was prescribed.	0	0	0	0	0	0	0	1	0	0
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.	0	0	0	0	0	0	0	1	0	0
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.	0	0	0	0	0	0	0	1	0	0
Repeat dispensed	This is an indicator as to whether the item will be repeat dispensed by pharmacy.	0	0	0	0	0	0	0	1	0	0
Request for advice	Request for advice and recommendation about medication	0	0	0	0	0	0	0	1	0	0
For medications that have been changed, i.e. additions, amendments and discontinued, in addition to the above, also record:											
Description of amendment	Where a change is made to the medication i.e. one drug stopped and another started or e.g. dose, frequency or route is changed.	1	1	1	1	0	1	0	1	0	0
Indication (for medication change)	Reason for change in medication, e.g. sub–therapeutic dose, patient intolerant.	1	1	1	1	0	1	0	1	0	0
Medication name	Mandatory medication name coded using SNOMED CT/dm+d term where possible, allowing plain text for historical/patient reported items, extemporaneous preparations or those not registered in dm+d.	0	0	0	0	0	0	0	1	0	0
Form	Form of the medicinal substance, e.g. capsules, tablets, liquid. Not normally required unless a specific form has been requested by the prescriber, e.g. “modified release capsules”.	0	0	0	0	0	0	0	1	0	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Route	Optional medication route, using SNOMED CT terms where possible. Not generally applicable to product–based medication. Should not be used to specify a specific administration site, for which a separate archetype is used, e.g. the route is 'intraocular' the site may be 'left eye', e.g. "oral", "intraocular". Note that this element supports multiple routes to allow a choice to be specified by the prescriber.	0	0	0	0	0	0	0	1	0	0
Site	The anatomical site at which the medication is to be administered, e.g. "left eye".	0	0	0	0	0	0	0	1	0	0
Method	The technique or method by which the medication is to be administered.	0	0	0	0	0	0	0	1	0	0
Dose amount description	A plain text description of medication single dose amount, as described in the AoMRC medication headings, e.g. "30 mg" or "2 tabs". UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.	0	0	0	0	0	0	0	1	0	0
Dose directions description	A plain text description of the entire prescribed medication dosage and administration directions, including dose quantity and medication frequency.	0	0	0	0	0	0	0	1	0	0
Dose timing description	A plain text description of medication dose frequency, as described in the AoMRC medication headings, e.g. "twice a day", "at 8am, 2pm and 10pm". UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.	0	0	0	0	0	0	0	1	0	0
Prescribed quantity	Medication quantity prescribed.	0	0	0	0	0	0	0	1	0	0
Date started	This is when the medication was first prescribed.	0	0	0	0	0	0	0	1	0	0
Authorised date	Date prescriber created prescription.	0	0	0	0	0	0	0	1	0	0
Valid from date	Date the prescription can be issued from, e.g. valid for 6 months.	0	0	0	0	0	0	0	1	0	0
Number of issues permissible	The number of repeat issues permissible.	0	0	0	0	0	0	0	1	0	0
Number of issues made	The number of repeats already issued.	0	0	0	0	0	0	0	1	0	0
Valid to date	Date the prescription is valid to.	0	0	0	0	0	0	0	1	0	0

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(continued overleaf)

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Additional instructions	Additional multiple dosage or administration instructions as plain text. This may include guidance to the prescriber, patient or person administering the medication. In some settings, specific administration instructions may be re–labelled as “patient advice’ or ‘dispensing Instruction’ to capture these flavors of instruction, e.g. “omit morning dose on day of procedure”, “for pain or fever”, “dispense weekly”.	0	0	0	0	0	0	0	1	0	0
Indication	Reason for medication was prescribed.	0	0	0	0	0	0	0	1	0	0
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.	0	0	0	0	0	0	0	1	0	0
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.	0	0	0	0	0	0	0	1	0	0
Prescribed elsewhere: Medication managed by another organisation											
Medication name	Mandatory medication name coded using SNOMED CT/dm+d term where possible, allowing plain text for historical/patient reported items, extemporaneous preparations or those not registered in dm+d.	0	0	0	0	0	0	0	1	0	0
Form	Form of the medicinal substance, e.g. capsules, tablets, liquid. Not normally required unless a specific form has been requested by the prescriber, e.g. “modified release capsules”.	0	0	0	0	0	0	0	1	0	0
Route	Optional medication route, using SNOMED CT terms where possible. Not generally applicable to product–based medication. Should not be used to specify a specific administration site, for which a separate archetype is used, e.g. the route is ‘intraocular’ the site may be ‘left eye’, e.g. “oral”, “intraocular”. Note that this element supports multiple routes to allow a choice to be specified by the prescriber.	0	0	0	0	0	0	0	1	0	0
Site	The anatomical site at which the medication is to be administered, e.g. “left eye”.	0	0	0	0	0	0	0	1	0	0
Method	The technique or method by which the medication is to be administered.	0	0	0	0	0	0	0	1	0	0

Element	Description	D	M	E	O	C	A	H	R	HC	CP
Dose amount description	A plain text description of medication single dose amount, as described in the AoMRC medication headings, e.g. “30 mg” or “2 tabs”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.	0	0	0	0	0	0	0	1	0	0
Dose timing description	A plain text description of medication dose frequency, as described in the AoMRC medication headings, e.g. “twice a day”, “at 8am, 2pm and 10pm”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.	0	0	0	0	0	0	0	1	0	0
Dose directions description	A plain text description of the entire prescribed medication dosage and administration directions, including dose quantity and medication frequency.	0	0	0	0	0	0	0	1	0	0
Date started	This is when the medication was first prescribed.	0	0	0	0	0	0	0	1	0	0
Additional instructions	Additional multiple dosage or administration instructions as plain text. This may include guidance to the prescriber, patient or person administering the medication. In some settings, specific Administration Instructions may be re–labelled as “patient advice’ or ‘dispensing instruction’ to capture these flavors of instruction, e.g. “omit morning dose on day of procedure”, “for pain or fever”, “dispense weekly”.	0	0	0	0	0	0	0	1	0	0
Indication	Reason for medication was prescribed.	0	0	0	0	0	0	0	1	0	0
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.	0	0	0	0	0	0	0	1	0	0
Organisation	Prescribing organisation.	0	0	0	0	0	0	0	1	0	0
Use the following heading for medical devices that do not have representation in the NHS dictionary of medicines and medical devices (dm+d):											
Medical devices	Any therapeutic medical device of relevance that does not have representation in the NHS dictionary of medicines and medical devices (dm+d).	1	1	0	1	1	1	0	1	1	0

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Section Two: Admission record

The structure and content for the health and care information to be recorded when a patient is admitted to hospital. Not all structured content will be used in all care settings or circumstances and the order in which they appear in the digital patient record, communications and letters can be agreed by system suppliers and users.

GP practice

Element	Description
GP practice identifier	The identifier of the registered GP practice.
GP practice details	Name and address of the patient's registered GP practice.
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.

Referrer details

Element	Description
Referrer details	Name, role, grade, organisation and contact details of referrer. If not an individual, this could be with a GP surgery, department, specialty, sub-specialty, educational institution, mental health team etc. Also needs to include self-referral.

Patient demographics

Element	Description
Patient name	The full name of the patient.
Patient preferred name	The name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Gender	As the patient wishes to portray themselves.
Ethnicity	The ethnicity of a person as specified by the person.
Sex	The person's phenotypic sex. Determines how the person will be treated clinically.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.
Patient address	Patient's usual place of residence.
Patient email address	Email address of the patient
Patient telephone number	Telephone contact details of the patient. To include, e.g. mobile, work and home number if available.

Element	Description
Relevant contacts	Include the most important contacts including: • Personal contacts, e.g. next of kin, in case of emergency contact, lasting power of attorney, dependents, informal carers etc. • Health/care professional contacts e.g. social worker, hospital clinician, care coordinator, key worker, Independent Mental Capacity Advocate (IMCA) etc. Name, relationship, role (if formal role), contact details and availability, e.g. out of hours.
Communication preferences	Preferred contact method, e.g. sign language, letter, phone, etc. Also preferred written communication format, e.g. large print, braille.

Social context

Element	Description
Household composition	E.g. lives alone, lives with family, lives with partner, etc. This may be free text.
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual.
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well–being, e.g. the record of the patient's physical activity level, pets, hobbies, and sexual habits.
Smoking	Current smoking observation.
Alcohol intake	Latest or current alcohol consumption observation.
Social circumstances	The record of a patient's social background, network and personal circumstances, e.g. housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependents or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record.
Services and care	The description of services and care providing support for patient's health and social well-being.

Individual requirements

Element	Description
Individual requirements	Individual requirements that a person has. These may be communication, cultural, cognitive or mobility needs.

Participation in research

Element	Description
Name of research study	Name of the research study/trial and/or drug/intervention.

Admission details

Element	Description
Reason for admission	The health problems and issues experienced by the patient that prompted the decision to admit to hospital, e.g. chest pain, mental health crisis, blackout, fall, a specific procedure, intervention, investigation or treatment, non compliance with treatment.
Admission method	How the patient was admitted to hospital. For example: elective, emergency, maternity, transfer etc.
Source of admission	Where the patient was immediately prior to admission, e.g. usual place of residence, temporary place of residence, penal establishment. National code.
Date/time of admission	Date and time patient admitted to hospital.
Patient location	This is the physical locations of the patient. For inpatient, e.g. hospital ward, bed, theatre. For ambulatory care, e.g. health centre, clinic, resources centre, patient's home.
Responsible consultant	The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient).
Person accompanying patient	Identify others accompanying the patient, e.g. relative, friend, informed carer, advocate. If the patient was not present was an authorised representative present? Includes name relationship (spouse, etc) role (patient advocate, etc.).
Speciality	Specialties designated by royal college and faculties, e.g. orthopaedics, renal medicine and endocrinology, etc.

Discharge details

Element	Description
Expected date of discharge	The date the patient is currently expected to be discharged from hospital.

Relevant clinical risk factors

Element	Description
Relevant clinical risk factor	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis, e.g. being overweight, smoker, no use of sun screen, enzyme deficiency.
Clinical risk assessment	Specific risk assessments required/undertaken.
Risk mitigation	Action taken to reduce the clinical risk and date actions.

Problems and issues

Element	Description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings, symptoms and signs, which are likely to have relevance and are not a diagnosis.

History

Element	Description
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in the attendance. This may include disease state, medical condition, response and reaction to therapies, e.g. blackout, dizziness, chest pain, follow-up from admission, falls, a specific procedure, investigation or treatment.
History of each presenting complaint or issue	Information directly related to the development and characteristics of each presenting complaint (e.g. including travel history). Including if the information is given by the patient or their carer.
Relevant past medical, surgical and mental health history	The record of the person's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history).
Reason for admission	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, e.g. chest pains blackouts, falls, a specific procedure, investigation or treatment.
Information brought by patient	E.g. patient passport, example diary data, pre-completed questionnaires, person-held maternity record, personal child health record, etc.

Clinical summary

Element	Description
Clinical summary	Summary of the encounter. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'.

Family history

Element	Description
Family history	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc.

Investigation results

Element	Description
Investigation result	For each investigation, the result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results.

Assessment scales

Element	Description
Assessment scale	Structured assessment scales used as part of assessment and treatment, e.g. New York Heart Failure, Activities of Daily Living (ADL).

Legal information

Element	Descriptionn
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, e.g. child protection plan, protection of vulnerable adult.
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.

Safety alerts

Element	Description
Risks to self	Risks the patient poses to themselves, e.g. suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to caring professionals or others.
Risk from others	Details of where an adult or child is at risk from an identified person, e.g. family member etc.

Allergies and adverse reactions

Element	Description
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. Or “no known drug allergies or adverse reactions” or “information not available”.
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. For example, skin rash.

Element	Description
Date first experienced	When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.

Patient concerns, expectations and wishes

Element	Description
Patient concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/representative on behalf of the patient). Where the person lacks capacity this may include their representative's concerns, expectations or wishes.

Examination findings

Element	Description
Vital signs	The record of essential physiological measurements, e.g. heart rate, blood pressure, temperature, pulse, respiratory rate, SpO2, level of consciousness etc. Use of Early Warning Score (which may be computed) chart where appropriate.

Clinical review of systems

Element	Description
Clinical review of systems	The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about specific symptoms from various physiological systems, including food intake (increasing/decreasing) weight change, swallowing difficulties etc.

Information and advice given

Element	Description
Information and advice given	This includes: • what information • to whom it was given. • the oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment.

Plan and requested actions

Element	Description
Actions for patient or their carer	For each action the following should be identified a) person responsible – name and designation, e.g. patient or carer responsible for carrying out the proposed action, and where action should take place. b) status – requested, planned or completed. c) When action requested for – requested date, time, or period – as relevant. d) suggested strategies – suggested strategies for potential problems, eg telephone contact for advice. e) outcome expectations, including patient's expectations.
Agreed with patient or legitimate patient representative	Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments.
Special monitoring required	E.g. neuro-obs, 02 saturation etc.

Person completing record

Element	Description
Name	The name of the person completing the record, preferably in a structured format.
Role	The role the person is playing within the organisation at the time record was updated.
Grade	The grade of the person completing the record.
Specialty	The main specialty of the person completing the record.

Medications and medical devices

Element	Description
Medication name	May be generic name or brand name (as appropriate).
Form	E.g. capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc.): may include method of administration, (e.g. by infusion, via nebuliser, via NG tube).
Quantity supplied	The quantity of the medication (e.g. tablets, inhalers, etc.) provided to the patient on discharge. This may be dispensed by the pharmacy or on the ward.
Site	The anatomical site at which the medication is to be administered, e.g. "left eye".
Method	The technique or method by which the medication is to be administered.
Dose amount description	A description of the medication single dose amount, e.g. "30 mg" or "2 tabs".
Dose timing description	A description of the frequency of taking or administration of a medication dose, e.g. "twice a day", "at 8am 2pm and 10pm".

Element	Description
Dose directions description	A single plain text phrase describing the entire medication dosage and administration directions including dose quantity and medication frequency. Comment, e.g. “1 tablet at night or “2mg at 10pm”. This is the form of dosage direction text normally available from UK GP systems.
Additional instructions	Allows for: • requirements for adherence support, e.g. compliance aids, prompts and packaging requirements • additional information about specific medicines, e.g. where specific brand required • person requirements, e.g. unable to swallow tablets.
Indication	Reason for medication being prescribed, where known.
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.
For medications that have been changed, ie additions, amendments and discontinued, in addition to the above, also record:	
Description of amendment	Where a change is made to the medication ie one drug stopped and another started or, e.g. dose, frequency or route is changed.
Indication (for medication change)	Reason for change in medication, e.g. sub–therapeutic dose, patient intolerant.
Use the following heading for medical devices that do not have representation in the NHS dictionary of medicines and medical devices (dm+d):	
Medical devices	Any therapeutic medical device of relevance that does not have representation in the NHS dictionary of medicines and medical devices (dm+d).

Section Three: Handover record

The structure and content for the health and care information to be recorded and used when a patient is handed over from one professional team to another within a hospital setting.

Not all structured content will be used in all care settings or circumstances and the order in which they appear in the digital patient record, communications and letters can be agreed by system suppliers and users.

GP practice

Element	Description
GP practice identifier	The identifier of the registered GP practice.
GP practice details	Name and address of the patient's registered GP practice.
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.

Patient demographics

Element	Description
Patient name	The full name of the patient.
Patient preferred name	The name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Gender	As the patient wishes to portray themselves.
Ethnicity	The ethnicity of a person as specified by the person.
Sex	The person's phenotypic sex. Determines how the person will be treated clinically.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.
Patient address	Patient's usual place of residence.
Patient email address	Email address of the patient.
Patient telephone number	Telephone contact details of the patient. To include, e.g. mobile, work and home number if available.
Relevant contacts	Include the most important contacts including: • Personal contacts, e.g. next of kin, in case of emergency contact, lasting power of attorney, dependents, informal carers etc. • Health/care professional contacts, e.g. social worker, hospital clinician, care coordinator, key worker, Independent Mental Capacity Advocate (IMCA) etc. Name, relationship, role (if formal role), contact details and availability, e.g. out of hours.
Communication preferences	Preferred contact method, e.g. sign language, letter, phone, etc. Also preferred written communication format, e.g. large print, braille.

Social context

Element	Description
Household composition	E.g. lives alone, lives with family, lives with partner, etc. This may be free text.

Individual requirements

Element	Description
Individual requirements	Individual requirements that a person has. These may be communication, cultural, cognitive or mobility needs.

Participation in research

Element	Description
Name of research study	Name of the research study/trial and/or drug/intervention.

Admission details

Element	Description
Reason for admission	The health problems and issues experienced by the patient that prompted the decision to admit to hospital, e.g. chest pain, mental health crisis, blackout, fall, a specific procedure, intervention, investigation or treatment, non compliance with treatment.
Date/time of admission	Date and time patient admitted to hospital.
Patient location	This is the physical locations of the patient. For inpatient, e.g. hospital ward, bed, theatre. For ambulatory care, e.g. health centre, clinic, resources centre, patient's home.
Responsible consultant	The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient).

Discharge details

Element	Description
Expected date of discharge	The date the patient is currently expected to be discharged from hospital.

Relevant clinical risk factors

Element	Description
Relevant clinical risk factor	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis, e.g. being overweight, smoker, no use of sun screen, enzyme deficiency.
Clinical risk assessment	Specific risk assessments required/undertaken.
Risk mitigation	Action taken to reduce the clinical risk and date actions.
Patient at high risk	This patient is at high risk of clinical deterioration and will need an immediate response if called.

Problems and issues

Element	Description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings, symptoms and signs, which are likely to have relevance and are not a diagnosis.

Diagnoses

Element	Description
Diagnosis	Confirmed diagnosis (or symptom); active diagnosis being treated.

History

Element	Description
Relevant past medical, surgical and mental health history	The record of the person's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history).

Clinical summary

Element	Description
Clinical summary	Summary of the encounter. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'.

Investigation results

Element	Description
Investigation result	For each investigation, the result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date, and plans for acting upon investigation results.

Legal information

Element	Description
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, e.g. child protection plan, protection of vulnerable adult.
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.

Allergies and adverse reactions

Element	Description
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. Or “no known drug allergies or adverse reactions” or “information not available”.
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. For example, skin rash.
Date first experienced	When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.

Patient concerns, expectations and wishes

Element	Description
Patient concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/ representative on behalf of the patient). Where the person lacks capacity this may include their representative’s concerns, expectations or wishes.

Information and advice given

Element	Description
Information and advice given	This includes: • what information • to whom it was given. • the oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment".

Plan and requested actions

Element	Description
Actions for patient or their carer	For each action the following should be identified a) person responsible – name and designation, e.g. patient or carer responsible for carrying out the proposed action, and where action should take place. b) status – requested, planned or completed. c) When action requested for – requested date, time, or period – as relevant. d) suggested strategies – suggested strategies for potential problems, eg telephone contact for advice. e) outcome expectations, including patient's expectations.
Agreed with patient or legitimate patient representative	Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments.
Aims and limitations of treatment and special instructions	The current aim of treatment including limitations to treatment and communications issues, eg, not for ITU.
Escalation plan	Who needs to be contacted in the event of significant problems or patient deterioration include, e.g. seniority/name/ contact details of person to be called.

Outstanding issues

Element	Description
Tasks which must be done	Include timescales (appropriate seniority of staff for each task).
Tasks to be done if possible	E.g. test review, pre-discharge documents, criteria for discharge, including who may discharge the patient.

Person handing over

Element	Description
Name	The name of the person completing the record, preferably in a structured format.

Element	Description
Role	The role the person is playing within the organisation at the time record was updated.
Grade	The grade of the person completing the record.
Specialty	The main specialty of the person completing the record.
Contact details	Contact details of the person completing the record. For example a phone number, email address. Contact details are used to resolve queries about the record entry.

Person receiving handover

Element	Description
Name	The name of the person receiving the handover, preferably in a structured format.
Role	The role the person is playing within the organisation at the time of handover.
Grade	The grade of the person receving the handover.
Specialty	The speciality of the person receiving the handover.
Contact details	Contact details of the person receving the handover. For example a phone number, email address. Contact details are used to resolve queries about the record entry.

Handover details

Element	Description
Patient Location	This is the physical location of the patient. For inpatient, e.g. hospital ward, bed, theatre. For ambulatory care, e.g. health centre, clinic, resources centre, patient's home.
Planned patient location	If patient is changing location.
Date of admision	Date patient admitted to hospital.
Expected date of discharge	The date the patient is currently expected to be discharged from hospital.
Responsible consultant	The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient).
Specialty	Specialities designated by royal colleges and faculties. E.g. orthopaedics, renal medicine, endocrinology, etc.
Service	Subspecialties, treatment functions or services. E.g. hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre–admission assessment clinic etc.

(continued overleaf)

Element	Description
Date of decision to handover	Date decision made to handover care.
New responsible consultant	The name and designation of the consultant who is accepting responsibility for the patient's inpatient care.
Date handover accepted	Date decision made to accept handover of care.
Reason for handover	A clear statement of the reason for the temporary or permanent handover of care, e.g. low potassium, immediately post–op, unstable medical condition.
Senior clinical contact team	If there is a particular requirement to call a specific person, e.g. consultant, SpR or special intervention.

Section Four: Discharge record

The structure and content for the health and care information to be recorded in all discharge records and discharge summary communications sent from hospital services **(including acute care discharge, mental health discharge and emergency care discharge)** to GPs.

Not all structured content will be used in all care settings or circumstances and the order in which they appear in the digital patient record, communications and letters can be agreed by system suppliers and users.

GP practice

Element	Description	D	M	E
GP practice identifier	The identifier of the registered GP practice.	1	1	1
GP practice details	Name and address of the patient's registered GP practice.	1	1	1
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.	1	1	1

Referrer details

Element	Description	D	M	E
Referrer details	Name, role, grade, organisation and contact details of referrer. If not an individual, this could be a GP surgery, department, specialty, sub-specialty, educational institution, mental health team etc. Also needs to include self-referral.	1	1	1

Patient demographics

Element	Description	D	M	E
Patient name	The full name of the patient.	1	1	1
Patient preferred name	The name by which a patient wishes to be addressed.	1	1	0
Date of birth	The date of birth of the patient.	1	1	1
Gender	As the patient wishes to portray themselves.	1	1	1
NHS number	The unique identifier for a patient within the NHS in England and Wales.	1	1	1
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.	1	1	1
Patient address	Patient's usual place of residence.	1	1	1
Patient email address	Email address of the patient.	1	1	1
Patient telephone number	Telephone contact details of the patient. To include, e.g. mobile, work and home number if available.	1	1	1

(continued overleaf)

Element	Description	D	M	E
Relevant contacts	Include the most important contacts including: • Personal contacts, e.g. next of kin, in case of emergency contact, lasting power of attorney, dependents, informal carers etc. • Health/care professional contacts e.g. social worker, hospital clinician, care coordinator, key worker, Independent Mental Capacity Advocate (IMCA) etc. Name, relationship, role (if formal role), contact details and availability, e.g. out of hours.	1	1	0
Communication preferences	Preferred contact method, e.g. sign language, letter, phone, etc. Also preferred written communication format, e.g. large print, braille.	1	0	0
Educational establishment	If the patient is a child, name and address of where the child attends, e.g. play group, nursery, school.	0	0	1

Social context

Element	Description	D	M	E
Household composition	E.g. lives alone, lives with family, lives with partner, etc. This may be free text.	1	1	0
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual.	1	1	0
Educational history	The current and/or previous relevant educational history of the patient/individual.	1	1	0
Alcohol intake	Latest or current alcohol consumption observation.	0	1	0
Drug/substance use	Latest or current drug/ substance use observation.	0	1	0

Individual requirements

Element	Description	D	M	E
Individual requirements	Individual requirements that a person has. These may be communication, cultural, cognitive or mobility needs.	1	1	0

Participation in research

Element	Description	D	M	E
Name of research study	Name of the research study/trial and/or drug/intervention.	1	1	0

Attendance details

Element	Description	D	M	E
Date and time of contact	Date and time of the appointment, contact or attendance.	0	0	1

Admission details

Element	Description	D	M	E
Reason for admission	The health problems and issues experienced by the patient that prompted the decision to admit to hospital, e.g. chest pain, mental health crisis, blackout, fall, a specific procedure, intervention, investigation or treatment, non compliance with treatment.	1	1	0
Admission method	How the patient was admitted to hospital. For example: elective, emergency, maternity, transfer etc.	1	1	0
Legal Status on admission	Record if the patient was admitted as Informal or formal/detained.	0	1	0
Source of admission	Where the patient was immediately prior to admission, e.g. usual place of residence, temporary place of residence, penal establishment. National code.	1	1	0
Date/time of admission	Date and time patient admitted to hospital.	1	1	0

Discharge details

Element	Description	D	M	E
Discharge destination	The destination of the patient on discharge. National codes, e.g. high dependency unit.	0	0	1
Discharge status	Patient status on discharge from emergency care.	0	0	1
Discharging consultant	The consultant responsible for the patient at time of discharge.	1	1	0
Discharging specialty/department	The specialty or department responsible for the patient at the time of discharge.	1	1	0
Discharge location	The ward or unit the patient was in immediately prior to discharge.	1	1	0
Date/time of discharge	The actual date of discharge.	1	1	1
Legal Status on discharge	Record if the patient was discharged as Informal or formal/detained.	0	1	0
Discharge method	The method of discharge from hospital. National codes, e.g. patient discharged on clinical advice or with clinical consent; patient discharged him/herself or was discharged by a relative or advocate; patient died; stillbirth.	1	1	0

(continued overleaf)

Element	Description	D	M	E
Discharge destination comprising:		1	1	0
Discharge type	The destination of the patient on discharge from hospital. National codes, e.g. NHS-run care home.	1	1	0
Discharge address	Address to which patient discharged. Only complete where this is not the usual place of residence.	1	1	0

Presenting complaints or issues

Element	Description	D	M	E
Presenting complaint or issue	The health problem or issue experienced by the patient resulting in their attendance. This may include disease state, medical condition, response and reactions to therapies, e.g. blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment.	0	0	1

Diagnoses

Element	Description	D	M	E
Diagnosis	Confirmed diagnosis (or symptom); active diagnosis being treated.	1	1	1
Stage	Stage of the disease or disorder, where relevant.	1	1	0
Comment	Supporting text may be given covering diagnosis confirmation, active diagnosis being treated. Include severity, occurrence (first, recurrence, ongoing).	1	1	1

History

Element	Description	D	M	E
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in the attendance. This may include disease state, medical condition, response and reaction to therapies, e.g. blackout, dizziness, chest pain, follow-up from admission, falls, a specific procedure, investigation or treatment.	0	0	1

Procedures

Element	Description	D	M	E
Procedure	The therapeutic or diagnostic procedure performed.	1	1	1
Anatomical site	The body site of the procedure.	1	1	1
Laterality	Laterality of the procedure.	1	1	1
Complications related to procedure	Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure.	1	1	1
Specific anaesthesia issues	Details of any adverse reaction to any anesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.	1	1	1
Comment	Any further textual comment to clarify such as statement that information is partial or incomplete.	1	1	1

Clinical summary

Element	Description	D	M	E
Clinical summary	Summary of the encounter. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'.	1	1	1
Formulation	An account, shared by a therapist and person, of the personal meaning and origins of a person's difficulties. This is viewed in the context of multiple factors including relationships, social circumstances and life events and will indicate the most helpful way forward.	0	1	0
Treatments and interventions and changes made to treatments.	The relevant treatments and interventions which the patient received during the inpatient stay. Include psychological therapies. All medications should be recorded under the medications section.	0	1	0
Clinical narrative	A description detailing a patient's reason for attendance, results from the diagnostic and treatment process.	0	0	1

Family history

Element	Description	D	M	E
Family history	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc.	0	1	0

Investigation results

Element	Description	D	M	E
Investigation result	For each investigation, the result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results.	0	1	0

Assessment scales

Element	Description	D	M	E
Assessment scale	Structured assessment scales used as part of assessment and treatment, e.g. New York Heart Failure, Activities of Daily Living (ADL).	0	1	0

Legal information

Element	Description	D	M	E
Mental Health Act or equivalent status	Record where a person diagnosed with a mental disorder is formally detained under the Mental Health Act or equivalent, including the section number and start date, start time and end date. If person subject to community treatment order or conditional discharge (or equivalent) record here.	0	1	0
Advance decision to refuse treatment (ADRT)	A record of an advance decision to refuse one or more specific types of future treatment, made by a person who had capacity at the time of recording the decision. The decision only applies when the person no longer has the capacity to consent to or refuse the specific treatment being considered. An ADRT must be in writing, signed and witnessed. If the ADRT is refusing life–sustaining reatment it must state specifically that the treatment is refused even if the person's life is at risk.	1	1	0
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, e.g. child protection plan, protection of vulnerable adult.	1	1	0
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.	1	1	0
Consent for treatment record	Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent.	1	1	0
Consent for information sharing	This is a record of consent for information sharing. Where consent has been not been obtained or sought, the reason why must be provided. Include best interests decision where person lacks capacity.	1	1	0
Consent relating to child	Consideration of age and competency, applying Gillick competency or Fraser guidelines. Record of person with parental responsibility or appointed guardian where child lacks competency. Record if there is disagreement between patient and parent.	1	0	0

Element	Description	D	M	E
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) person has been undertaken, if so, what capacity the decision relates to, who carried it out, when and the outcome of the assessment. Also record best interests decision if person lacks capacity.	1	1	0
Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	Record of one or more people who have been given power (LPA) by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make those decisions. To be valid, an LPA must have been registered with the Court of Protection. If life-sustaining treatment is being considered the LPA document must state specifically that the attorney has been given power to consent to or refuse life-sustaining treatment. Details of any person (deputy) appointed by the court to make decisions about the person's health and welfare. A deputy does not have the power to refuse life-sustaining treatment.	1	1	0

Safeguarding

Element	Description	D	M	E
Safeguarding concerns	A record of any identification of concerns regarding safeguarding during attendance.	0	0	1
Comment	A comment providing further detail on a safeguarding concern.	0	0	1

Safety alerts

Element	Description	D	M	E
Risks to self	Risks the patient poses to themselves, e.g. suicide, overdose, self-harm, self-neglect.	1	1	1
Risks to others	Risks to caring professionals or others.	1	1	1
Risk from others	Details of where an adult or child is at risk from an identified person, e.g. family member etc.	1	1	1

Allergies and adverse reactions

Element	Description	D	M	E
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. Or "no known drug allergies or adverse reactions" or "information not available".	1	1	1
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. For example, skin rash.	1	1	1
Severity	A description of the severity of the reaction.	1	1	1

(continued overleaf)

Element	Description	D	M	E
Certainty	A description of the certainty that the stated causative agent caused the allergic or adverse reaction.	1	1	0
Type of reaction	The type of reaction experienced by the patient (allergic, adverse, intolerance).	1	1	1
Evidence	Results of investigations that confirmed the certainty of the diagnosis. Examples might include results of skin prick allergy tests.	1	1	0
Date first experienced	When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood).	1	1	0
Comment	Any additional comment or clarification about the adverse reaction.	1	1	0
Date recorded	The date that the reaction was clinically recorded/asserted. This will often equate to the date of onset of the reaction but this may not be wholly clear from source data.	1	1	1
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.	1	1	0
Advance statement	Written requests and preferences made by a person with capacity conveying their wishes, beliefs and values for their future care should they lose capacity. Include the location of the document if known.	1	1	0

Patient concerns, expectations and wishes

Element	Description	D	M	E
Patient concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/representative on behalf of the patient). Where the person lacks capacity this may include their representative's concerns, expectations or wishes.	1	1	0

Information and advice given

Element	Description	D	M	E
Information and advice given	This includes: • what information • to whom it was given. • the oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment.	1	1	1

Plan and requested actions

Element	Description	D	M	E
Actions for patient or their carer	For each action the following should be identified a) person responsible – name and designation, e.g. patient or carer responsible for carrying out the proposed action, and where action should take place. b) status – requested, planned or completed. c) When action requested for – requested date, time, or period – as relevant. d) suggested strategies – suggested strategies for potential problems, e.g. telephone contact for advice. e) outcome expectations, including patient's expectations.	1	1	1
Actions for healthcare professionals	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities. For each action the following should be identified: outcome expectations, including patient's expectations	1	1	0
Agreed with patient or legitimate patient representative	Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments.	1	1	0
Care planning arrangements	Record if CPA (Care Programme Approach) documentation is available and how and where it can be accessed; care and treatment plan in Wales and Scotland. In Wales this is superseded by the Mental Health Measure 2010.	0	1	0
Investigations requested	This includes a name or description of the investigation requested and the date requested.	1	1	0
Procedures requested	These are the diagnostic or therapeutic procedures that have actually been requested (and the date requested).	1	1	0

Person completing record

Element	Description	D	M	E
Name	The name of the person completing the record, preferably in a structured format.	1	1	1
Role	The role the person is playing within the organisation at the time record was updated.	1	1	0
Grade	The grade of the person completing the record.	1	1	0
Specialty	The main specialty of the person completing the record.	1	1	0
Professional identifier	Professional identifier for the person completing the record, e.g. GMC number, HCPC number etc. or the personal identifier used by the local organisation.	1	1	1
Date and time completed	The date and time the record was updated.	1	1	0
Contact details	Contact details of the person completing the record. For example a phone number, email address. Contact details are used to resolve queries about the record entry.	1	1	0
Organisation	The organisation the person completing the record works for.	1	1	0

Senior reviewing clinician

Element	Description	D	M	E
Name	The name of the senior clinician responsible for reviewing the patient treatment and discharge plan.	0	0	1
Professional identifier	The unique identifier issued by the regulatory body, e.g. GMC number, HCPC number etc.	0	1	1

Contact for further information

Element	Description	D	M	E
Contact for further information	The contact details of whom to contact for information regarding this attendance.	0	0	1

Distribution list

Element	Description	D	M	E
Name	If the communication is being sent to a named individual, then this is the name of the recipient, preferably in a structured format. An identifier for the individual, for example GMC code (for a GP), or an SDS identifier, a NHS Number (for a patient) will be sent alongside the name, but may not displayed on rendered document.	1	1	0
Role	If the communication is being sent to either a named individual, or to a non-named person with a specific role, then this is the role of the recipient.	1	1	0
Grade	The recipient's grade.	1	1	0
Organisation name	The name of the organisation the recipient is representing or the organisation named as the receiving organisation. An identifier for the organisation will be sent alongside the name, but may not displayed on rendered document.	1	1	0
Team	Team that the recipient belongs to in the context of receiving this message, or the team acting as the recipient.	1	1	0
Relationship to subject	The relationship of the receiver to the patient, where the receiver has a personal relationship to the patient, for example, carer or parent.	1	1	0

Medications and medical devices

Element	Description	D	M	E
Medication name	May be generic name or brand name (as appropriate).	1	1	1
Form	E.g. capsule, drops, tablet, lotion etc.	1	1	1
Route	Medication administration description (oral, IM, IV, etc.): may include method of administration, (e.g. by infusion, via nebuliser, via NG tube).	1	1	1
Quantity supplied	The quantity of the medication (e.g. tablets, inhalers, etc.) provided to the patient on discharge. This may be dispensed by the pharmacy or on the ward.	1	1	1
Site	The anatomical site at which the medication is to be administered, e.g. “left eye”.	1	1	1
Method	The technique or method by which the medication is to be administered.	1	1	1
Dose amount description	A description of the medication single dose amount, e.g. “30 mg” or “2 tabs”.	1	1	1
Dose timing description	A description of the frequency of taking or administration of a medication dose. e.g. “twice a day”, “at 8am 2pm and 10pm”.	1	1	1
Dose directions description	A single plain text phrase describing the entire medication dosage and administration directions including dose quantity and medication frequency, e.g. “1 tablet at night or “2mg at 10pm”. This is the form of dosage direction text normally available from UK GP systems.	1	0	0
Additional instructions	Allows for: • requirements for adherence support, e.g. compliance aids, prompts and packaging requirements • additional information about specific medicines, e.g. where specific brand required • person requirements, e.g. unable to swallow tablets.	1	1	1
Indication	Reason for medication being prescribed, where known.	1	1	1
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.	1	1	1
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.	1	1	1
For medications that have been changed, i.e. additions, amendments and discontinued, in addition to the above, also record:				
Description of amendment	Where a change is made to the medication i.e. one drug stopped and another started or, e.g. dose, frequency or route is changed.	1	1	1
Indication (for medication change)	Reason for change in medication, e.g. sub–therapeutic dose, patient intolerant.	1	1	1
Use the following heading for medical devices that do not have representation in the NHS dictionary of medicines and medical devices (dm+d):				
Medical devices	Any therapeutic medical device of relevance that does not have representation in the NHS dictionary of medicines and medical devices (dm+d).	1	1	0

Section Five: Outpatient Letter

The structure and content for the health and care information to be recorded in all outpatient letters sent from hospital to GP.

Not all structured content will be used in all care settings or circumstances and the order in which they appear in the digital patient record, communications and letters can be agreed by system suppliers and users.

GP practice

Element	Description
GP practice identifier	The identifier of the registered GP practice.
GP practice details	Name and address of the patient's registered GP practice.
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.

Referrer details

Element	Description
Referrer details	Name, role, grade, organisation and contact details of referrer. If not an individual, this could be e.g. GP surgery, department, specialty, sub-specialty, educational institution, mental health team etc. Also needs to include self-referral.

Patient demographics

Element	Description
Patient name	The full name of the patient.
Patient preferred name	The name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Gender	As the patient wishes to portray themselves.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.
Patient address	Patient's usual place of residence.
Patient email address	Email address of the patient.
Patient telephone number	Telephone contact details of the patient. To include, e.g. mobile, work and home number if available.

Element	Description
Relevant contacts	Include the most important contacts including: • Personal contacts, e.g. next of kin, in case of emergency contact, lasting power of attorney, dependents, informal carers etc. • Health/care professional contacts e.g. social worker, hospital clinician, care coordinator, key worker, Independent Mental Capacity Advocate (IMCA) etc. Name, relationship, role (if formal role), contact details and availability, e.g. out of hours.
Communication preferences	Preferred contact method, e.g. sign language, letter, phone, etc. Also preferred written communication format, e.g. large print, braille.

Social context

Element	Description
Household composition	E.g. lives alone, lives with family, lives with partner, etc. This may be free text.
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual.
Educational history	The current and/or previous relevant educational history of the patient/individual.
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well–being, e.g. the record of the patient's physical activity level, pets, hobbies, and sexual habits.
Smoking	Current smoking observation.
Alcohol intake	Latest or current alcohol consumption observation.
Drug/substance use	Latest or current drug/substance use observation.
Social circumstances	The record of a patient's social background, network and personal circumstances, e.g. housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependents or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record.
Services and care	The description of services and care providing support for patient's health and social well-being.

Individual requirements

Element	Description
Individual requirements	Individual requirements that a person has. These may be communication, cultural, cognitive or mobility needs.

Participation in research

Element	Description
Name of research study	Name of the research study/trial and/or drug/intervention.

Attendance details

Element	Description
Date and time of contact	Date and time of the appointment, contact or attendance.
Contact type	First contact, follow-up contact.
Consultation method	Consultation method used identifies the communication mechanism used to relay information between the care professional and the person who is the subject of the consultation, during the outpatient encounter.
Responsible healthcare professional	The name and designation of the consultant, nurse consultant, midwife, allied health professional who has overall responsibility for the patient (may not actually see the patient).
Specialty	Specialties designated by royal colleges and faculties, e.g. orthopaedics, renal medicine, endocrinology, etc.
Service	Treatment functions or services, e.g. hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic, etc.
Seen by	Doctor, nurse or other healthcare professional that sees the patient. Record the most senior member of staff present. Includes name, role, telephone number.
Care professionals present	The name, designation of the additional individuals or team members including consultant(s), nurse consultant(s), allied health professional(s), social worker(s).
Person accompanying patient	Identify, where clinically relevant, others accompanying the patient, e.g. relative, friend, informal carer, advocate. If the patient was not present, was an authorised representative present? Includes: name, relationship, role (patient advocate).
Outcome of outpatient attendance	This records the outcome of an outpatient attendance.

Relevant clinical risk factors

Element	Description
Relevant clinical risk factor	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis, e.g. being overweight, smoker, no use of sun screen, enzyme deficiency.
Clinical risk assessment	Specific risk assessments required/undertaken.
Risk mitigation	Action taken to reduce the clinical risk and date actions.

Problems and issues

Element	Description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings, symptoms and signs, which are likely to have relevance and are not a diagnosis.

Diagnoses

Element	Description
Diagnosis	Confirmed diagnosis (or symptom); active diagnosis being treated.
Stage	Stage of the disease or disorder, where relevant.
Comment	Supporting text may be given covering diagnosis confirmation, active diagnosis being treated. Include severity, occurrence (first, recurrence, ongoing).

History

Element	Description
Patient's reason for referral	Patient stated reason for referral. This may include any discussions that took place, the level of shared decision making involved, information about patient's source of advice. This may be expressed on behalf of the patient, e.g. by parent or carer.
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in the attendance. This may include disease state, medical condition, response and reaction to therapies, e.g. blackout, dizziness, chest pain, follow-up from admission, falls, a specific procedure, investigation or treatment.
History of each presenting complaint or issue	Information directly related to the development and characteristics of each presenting complaint (e.g including travel history). Including if the information is given by the patient or their carer.
History since last contact	History since last attendance, discharge from hospital, etc.
Relevant past medical, surgical and mental health history	The record of the person's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history).

Procedures

Element	Description
Procedure	The therapeutic or diagnostic procedure performed.
Anatomical site	The body site of the procedure.
Laterality	Laterality of the procedure.
Complications related to procedure	Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure.
Specific anaesthesia issues	Details of any adverse reaction to any anesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.
Comment	Any further textual comment to clarify such as statement that information is partial or incomplete.

Clinical Summary

Element	Description
Clinical summary	Summary of the encounter. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'.

Family history

Element	Description
Family history	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc.

Investigation results

Element	Description
Investigation	The investigation performed.
Investigation result	For each investigation, the result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date, and plans for acting upon investigation results.)

Assessment scales

Element	Description
Assessment scale	Structured assessment scales used as part of assessment and treatment, e.g. New York Heart Failure, Activities of Daily Living (ADL).

Legal information

Element	Description
Mental Health Act or equivalent status	Record where a person diagnosed with a mental disorder is formally detained under the Mental Health Act or equivalent, including the section number and start date, start time and end date. If person subject to community treatment order or conditional discharge (or equivalent) record here.

Element	Description
Advance decision to refuse treatment (ADRT)	A record of an advance decision to refuse one or more specific types of future treatment, made by a person who had capacity at the time of recording the decision. The decision only applies when the person no longer has the capacity to consent to or refuse the specific treatment being considered. An ADRT must be in writing, signed and witnessed. If the ADRT is refusing life-sustaining treatment it must state specifically that the treatment is refused even if the person's life is at risk.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, e.g. child protection plan, protection of vulnerable adult.

Safety alerts

Element	Description
Risks to self	Risks the patient poses to themselves, e.g., suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to caring professionals or others.
Risk from others	Details of where an adult or child is at risk from an identified person e.g. family member etc.

Allergies and adverse reactions

Element	Description
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. Or "no known drug allergies or adverse reactions" or "information not available"
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. For example, skin rash.
Severity	A description of the severity of the reaction
Certainty	A description of the certainty that the stated causative agent caused the allergic or adverse reaction.
Type of reaction	The type of reaction experienced by the patient (allergic, adverse, intolerance)
Evidence	Results of investigations that confirmed the certainty of the diagnosis. Examples might include results of skin prick allergy tests
Date first experienced	When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.

Patient concerns, expectations and wishes

Element	Description
Patient concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/ representative on behalf of the patient). Where the person lacks capacity this may include their representative's concerns, expectations or wishes.
Advance statement	Written requests and preferences made by a person with capacity conveying their wishes, beliefs and values for their future care should they lose capacity. Include the location of the document if known.

Examination findings

Element	Description
Examination	The examination performed, e.g. general appearance, vital signs, mental state, head and neck examination, oral examination, cardiovascular system, respiratory system, abdomen, genitourinary, nervous system, musculoskeletal system, skin. This could include site and must include laterality where applicable.
Examination findings	The record of findings from the examinations performed.

Clinical review of systems

Element	Description
Clinical review of systems	The record of clinical information gathered in responses to questions to the patient about specific symptoms from various physiological systems, including food intake (increasing/decreasing) weight change, swallowing difficulties etc.

Information and advice given

Element	Description
Information and advice given	This includes: • what information • to whom it was given. • the oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment.

Plan and requested actions

Element	Description
Actions for patient or their carer	For each action the following should be identified a) person responsible – name and designation, e.g. patient or carer responsible for carrying out the proposed action, and where action should take place. b) status – requested, planned or completed. c) When action requested for – requested date, time, or period – as relevant. d) suggested strategies – suggested strategies for potential problems, e.g. telephone contact for advice. e) outcome expectations, including patient's expectations.
Actions for healthcare professionals	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities. For each action the following should be identified: outcome expectations, including patient's expectations.
Agreed with patient or legitimate patient representative	Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments.
Care planning arrangements	Record if CPA (Care Programme Approach) documentation is available and how and where it can be accessed; care and treatment plan in Wales and Scotland. In Wales this is superseded by the Mental Health Measure 2010.

Person completing record

Element	Description
Name	The name of the person completing the record, preferably in a structured format.
Role	The role the person is playing within the organisation at the time record was updated.
Grade	The grade of the person completing the record.
Specialty	The main specialty of the person completing the record.
Professional identifier	Professional identifier for the person completing the record, e.g. GMC number, HCPC number etc. or the personal identifier used by the local organisation.
Date and time completed	The date and time the record was updated.
Contact details	Contact details of the person completing the record. For example a phone number, email address. Contact details are used to resolve queries about the record entry.

Distribution list

Element	Description
Name	If the communication is being sent to a named individual, then this is the name of the recipient, preferably in a structured format. An identifier for the individual, for example GMC code (for a GP), or an SDS identifier, a NHS Number (for a patient) will be sent alongside the name, but may not displayed on rendered document.

(continued overleaf)

Element	Description
Role	If the communication is being sent to either a named individual, or to a non–named person with a specific role, then this is the role of the recipient.
Grade	The recipient's grade.
Organisation name	The name of the organisation the recipient is representing or the organisation named as the receiving organisation. An identifier for the organisation will be sent alongside the name, but may not displayed on rendered document.
Team	Team that the recipient belongs to in the context of receiving this message, or the team acting as the recipient.
Relationship to subject	The relationship of the receiver to the patient, where the receiver has a personal relationship to the patient, for example, carer or parent.

Medications and Medical Devices

Element	Description
Medication name	May be generic name or brand name (as appropriate).
Form	E.g. capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc.): may include method of administration, (e.g. by infusion, via nebuliser, via NG tube).
Quantity supplied	The quantity of the medication (e.g. tablets, inhalers, etc.) provided to the patient on discharge. This may be dispensed by the pharmacy or on the ward.
Site	The anatomical site at which the medication is to be administered, e.g. "left eye".
Method	The technique or method by which the medication is to be administered.
Dose amount description	A description of the medication single dose amount, e.g. "30 mg" or "2 tabs".
Dose timing description	A description of the frequency of taking or administration of a medication dose, e.g. "twice a day", "at 8am 2pm and 10pm".
Dose directions description	A single plain text phrase describing the entire medication dosage and administration directions including dose quantity and medication frequency, e.g. "1 tablet at night or "2mg at 10pm". This is the form of dosage direction text normally available from UK GP systems.
Additional instructions	Allows for: • requirements for adherence support, e.g. compliance aids, prompts and packaging requirements • additional information about specific medicines e.g. where specific brand required • person requirements, e.g. unable to swallow tablets.
Indication	Reason for medication being prescribed, where known.
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.

Element	Description
For medications that have been changed, i.e. additions, amendments and discontinued, in addition to the above, also record:	
Description of amendment	Where a change is made to the medication i.e. one drug stopped and another started or e.g. dose, frequency or route is changed.
Indication	Reason for change in medication, e.g. sub–therapeutic dose, patient intolerant. (for medication change).
Use the following heading for medical devices that do not have representation in the NHS dictionary of medicines and medical devices (dm+d):	
Medical devices	Any therapeutic medical device of relevance that does not have representation in the NHS dictionary of medicines and medical devices (dm+d).

Section Six: Crisis care plan

The structure and content for the health and care information to be recorded in crisis care plans in any health or social care setting.

Not all structured content will be used in all care settings or circumstances and the order in which they appear in the digital patient record, communications and letters can be agreed by system suppliers and users.

GP practice	
Element	**Description**
GP practice identifier	The identifier of the registered GP practice.
GP practice details	Name and address of the patient's registered GP practice.
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.

Patient demographics	
Element	**Description**
Patient name	The full name of the patient.
Patient preferred name	The name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Gender	As the patient wishes to portray themselves.
Person alias	Record details where a person is known to use assumed identities to access health/care services.
Ethnicity	The ethnicity of a person as specified by the person.
Religion	The religious affiliation as specified by the person.
Sex	The person's phenotypic sex. Determines how the person will be treated clinically.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.
Patient address	Patient's usual place of residence.
Patient email address	Email address of the patient.
Patient telephone number	Telephone contact details of the patient. To include, e.g. mobile, work and home number if available.
Relevant contacts	Include the most important contacts including: • Personal contacts e.g. next of kin, in case of emergency contact, lasting power of attorney, dependents, informal carers etc. • Health/care professional contacts e.g. social worker, hospital clinician, care coordinator, key worker, Independent Mental Capacity Advocate (IMCA) etc. Name, relationship, role (if formal role), contact details and availability, e.g. out of hours.

Social Context

Element	Description
Household composition	E.g. lives alone, lives with family, lives with partner, etc. This may be free text.
Services and care	The description of services and care providing support for patient's health and social well-being.
Access	Special access requirements e.g. key safe, coded lock, which door to use, stretcher access, etc.
Dependents	Provide details of any responsibility the person has for dependents. In the case of minors provide additional details e.g. date of birth etc.

Individual requirements

Element	Description
Individual requirements	Individual requirements that a person has. These may be communication, cultural, cognitive or mobility needs.

Problems and issues

Element	Description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings, symptoms and signs, which are likely to have relevance and are not a diagnosis.
Clinical risks	Description of clinical risks identified e.g. problematic intubation, person with brittle diabetes, immuno–compromised/risk of infection etc.

Diagnoses

Element	Description
Diagnosis	Confirmed diagnosis (or symptom); active diagnosis being treated.
Awareness of diagnosis	Description of the level of awareness the person and or their carer/family has regarding their diagnosis.

History

Element	Description
Relevant past medical, surgical and mental health history	The record of the person's significant medical, surgical and mental health history. Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc (will include dental and obstetric history).

Legal Information

Element	Description
Mental Health Act or equivalent status	Record where a person diagnosed with a mental disorder is formally detained under the Mental Health Act or equivalent, including the section number and start date, start time and end date. If person subject to community treatment order or conditional discharge (or equivalent) record here.
Advance decision to refuse treatment (ADRT)	A record of an advance decision to refuse one or more specific types of future treatment, made by a person who had capacity at the time of recording the decision. The decision only applies when the person no longer has the capacity to consent to or refuse the specific treatment being considered. An ADRT must be in writing, signed and witnessed. If the ADRT is refusing life-sustaining treatment it must state specifically that the treatment is refused even if the person's life is at risk.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, e.g. child protection plan, protection of vulnerable adult.
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.
Consent for creation of end of life care plan	Separate explicit consent is required for creation of an end of life care record. This records how this consent has been granted in order to differentiate between person's explicit consent, best interest decision, lasting power of attorney decision and withdrawal of consent.
Consent for information sharing	This is a record of consent for information sharing. Where consent has been not been obtained or sought, the reason why must be provided. Include best interests decision where person lacks capacity.
Parental responsibility	For children this is a record of person(s) with parental responsibility
Deprivation of Liberty Safeguards or equivalent	Record of Deprivation of Liberty Safeguards (DoLS) or equivalent, including the reason for this.
Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	Record of one or more people who have been given power (LPA) by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make those decisions. To be valid, an LPA must have been registered with the Court of Protection. If life-sustaining treatment is being considered the LPA document must state specifically that the attorney has been given power to consent to or refuse life-sustaining treatment. Details of any person (deputy) appointed by the court to make decisions about the person's health and welfare. A deputy does not have the power to refuse life-sustaining treatment.

Safety Alerts

Element	Description
Risks to self	Risks the patient poses to themselves, e.g. suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to caring professionals or others.
Risk from others	Details of where an adult or child is at risk from an identified person e.g. family member etc.

Allergies and Adverse Reactions

Element	Description
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. Or “no known drug allergies or adverse reactions” or “information not available”.
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. For example, skin rash.

Patient concerns, expectations and wishes

Element	Description
Patient concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/ representative on behalf of the patient). Where the person lacks capacity this may include their representative’s concerns, expectations or wishes.
Advance statement	Written requests and preferences made by a person with capacity conveying their wishes, beliefs and values for their future care should they lose capacity. Include the location of the document if known.
Preferred place of care	The preferences that a person has identified as their preferred place to receive care.
Preferred place of death	The preferences that a person has identified as their preferred place to die.

Crisis care plan

Element	Description
Care funding details	A record of the funding source and any conditions or limitations associated.
Priorities of care	The priorities agreed between the person and their health/care team, where the person has capacity: • to get better; please consider all treatment to prolong life. • to achieve a balance between getting better and ensuring good quality of life; please consider selected treatments. • comfort; please consider all treatments aimed at symptom control.
Estimated prognosis	Where a person is terminally ill this is a clinical judgment indicating the anticipated period of time until death, e.g. last days, weeks, months or year of life. Also include the date the prognosis was made.
Awareness of prognosis	Description of the level of awareness the person and or their carer/family has regarding their estimated prognosis.
Anticipatory actions	Please provide guidance on specific interventions or actions that may be required or should be avoided in specific situations.
Anticipatory medicines/equipment	Medicines or equipment available in the event of a crisis and their location.

(continued overleaf)

Element	Description
Agreed with person or legitimate representative	Indicates whether the crisis care plan was discussed and agreed with the person or legitimate representative. If agreement cannot be obtained the reason for this should be documented.
Cardio–pulmonary resuscitation (CPR) decision	Whether a decision has been made, the decision, who made the decision, the date of decision, date for review and location of documentation. Where the person or their family member/carer have not been informed of the clinical decision please state the reason why.
Planned review date	Date the plan is due for review.

End of life

Element	Description
Certification of death	If person is in their last weeks of life, is there a doctor who has seen the person recently who could potentially sign a death certificate? Provide contact details.
Actions taken in anticipation of death	Plan that has been agreed to facilitate certification of death and/or funeral arrangements, e.g. anticipatory discussions with coroner to arrange funeral within 24 hours etc.
Actual place of death	The location where the person actually died as recorded on the death certificate. If the person died somewhere other than their preferred place, record the reasons why this happened.
Cause of death	The cause of death as recorded on the death certificate.
Date of death	The date on which a person died or is officially deemed to have died, as recorded on the death certificate.

Person completing record

Element	Description
Name	The name of the person completing the record, preferably in a structured format.
Role	The role the person is playing within the organisation at the time record was updated.
Professional identifier	Professional identifier for the person completing the record, e.g. GMC number, HCPC number etc or the personal identifier used by the local organisation.
Date and time completed	The date and time the record was updated.
Contact details	Contact details of the person completing the record. For example a phone number, email address. Contact details are used to resolve queries about the record entry.
Organisation	The organisation the person completing the record works for.

Medications and medical devices

Element	Description
Medication name	May be generic name or brand name (as appropriate).
Form	E.g. capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc.): may include method of administration, (e.g. by infusion, via nebuliser, via NG tube).
Quantity supplied	The quantity of the medication (e.g. tablets, inhalers, etc.) provided to the patient on discharge. This may be dispensed by the pharmacy or on the ward.
Site	The anatomical site at which the medication is to be administered, e.g. "left eye".
Method	The technique or method by which the medication is to be administered.
Dose amount description	A description of the medication single dose amount e.g. "30 mg" or "2 tabs".
Dose timing description	A description of the frequency of taking or administration of a medication dose, e.g. "twice a day", "at 8am 2pm and 10pm".
Dose directions description	A single plain text phrase describing the entire medication dosage and administration directions including dose quantity and medication frequency, e.g. "1 tablet at night" or "2mg at 10pm". This is the form of dosage direction text normally available from UK GP systems.
Additional instructions requirements	Allows for: • requirements for adherence support, e.g. compliance aids, prompts and packaging • additional information about specific medicines e.g. where specific brand required • person requirements, e.g. "unable to swallow tablets".
Indication	Reason for medication being prescribed, where known.
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.
For medications that have been changed, i.e. additions, amendments and discontinued, in addition to the above, also record:	
Description of amendment	Where a change is made to the medication i.e. one drug stopped and another started or, e.g. dose, frequency or route is changed.
Indication (for medication change)	Reason for change in medication, e.g. sub–therapeutic dose, patient intolerant.
Use the following heading for medical devices that do not have representation in the NHS dictionary of medicines and medical devices (dm+d):	
Medical devices	Any therapeutic medical device of relevance that does not have representation in the NHS dictionary of medicines and medical devices (dm+d).

Section Seven: Clinical referral information

The structure and content for the health and care information to be recorded in all clinical referral information sent from GPs to secondary care consultants.

Not all structured content will be used in all care settings or circumstances and the order in which they appear in the digital patient record, communications and letters can be agreed by system suppliers and users.

GP practice

Element	Description
GP practice identifier	The identifier of the registered GP practice.
GP practice details	Name and address of the patient's registered GP practice.
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.

Referrer details

Element	Description
Referrer details	Name, role, grade, organisation and contact details of referrer. If not an individual, this could be, e.g. GP surgery, department, specialty, sub-specialty, educational institution, mental health team etc. Also needs to include self-referral.
Attachments	Documents included as attachments which accompany the communication Data items: • number of attachments • type of attachments • attached documents.
Details of other referrals	Other referrals related to this or associated conditions.
Referral criteria	Records whether specific criteria required for referral, to a particular service, have been met (may be nationally or locally determined).
Return response to	Name of care professional to be communicated with by the hospital, if not the referrer

Patient demographics

Element	Description
Patient name	The full name of the patient.
Patient preferred name	The name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Gender	As the patient wishes to portray themselves.
NHS number	The unique identifier for a patient within the NHS in England and Wales.

Element	Description
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.
Patient address	Patient's usual place of residence.
Patient email address	Email address of the patient.
Patient telephone number	Telephone contact details of the patient. To include, e.g. mobile, work and home number if available.
Relevant contacts	Include the most important contacts including: • Personal contacts, e.g. next of kin, in case of emergency contact, lasting power of attorney, dependents, informal carers etc. • Health/care professional contacts e.g. social worker, hospital clinician, care coordinator, key worker, ndependent mental capacity advocate (IMCA) etc. Name, relationship, role (if formal role), contact details and availability, e.g. out of hours.
Communication preferences	Preferred contact method, e.g. sign language, letter, phone, etc. Also preferred written communication format, e.g. large print, braille.
Educational establishment	If the patient is a child, name and address of where the child attends, e.g. play group, nursery, school.

Social context

Element	Description
Household composition	E.g. lives alone, lives with family, lives with partner, etc. This may be free text.
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual.
Educational history	The current and/or previous relevant educational history of the patient/individual.
Alcohol intake	Latest or current alcohol consumption observation.
Drug/substance use	Latest or current drug/substance use observation.
Social circumstances	The record of a patient's social background, network and personal circumstances, e.g. housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependents or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record.
Services and care	The description of services and care providing support for patient's health and social wellbeing.

Individual requirements

Element	Description
Individual requirements	Individual requirements that a person has. These may be communication, cultural, cognitive or mobility needs.

Participation in research

Element	Description
Name of research study	Name of the research study/trial and/or drug/intervention.

Relevant clinical risk factors

Element	Description
Relevant clinical risk factor	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis, e.g. being overweight, smoker, no use of sun screen, enzyme deficiency.
Clinical risk assessment	Specific risk assessments required/undertaken.
Risk mitigation	Action taken to reduce the clinical risk and date actions.

Family history

Element	Description
Family history	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc.
Maternal or paternal relation	Record of whether the condition or diagnosis was on the mother's or father's side of the family, where needed, e.g. paternal grandfather.
Relationship to patient	The relationship of the person with the condition to the patient.
Comment	Any further textual comment.

Investigation results

Element	Description
Investigation	The investigation performed.
Investigation result	For each investigation, the result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date, and plans for acting upon investigation results.)

Assessment scales

Element	Description
Assessment scale	Structured assessment scales used as part of assessment and treatment, e.g. New York Heart Failure, Activities of Daily Living (ADL).

Legal information

Element	Description
Advance decision to refuse treatment (ADRT)	A record of an advance decision to refuse one or more specific types of future treatment, made by a person who had capacity at the time of recording the decision. The decision only applies when the person no longer has the capacity to consent to or refuse the specific treatment being considered. An ADRT must be in writing, signed and witnessed. If the ADRT is refusing life-sustaining treatment it must state specifically that the treatment is refused even if the person's life is at risk.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, e.g. child protection plan, protection of vulnerable adult.
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.
Consent for treatment record or record of consent.	Whether consent has been obtained for the treatment. May include where record of consent is located
Consent for information sharing	This is a record of consent for information sharing. Where consent has been not been obtained or sought, the reason why must be provided. Include best interests decision where person lacks capacity.
Consent relating to child	Consideration of age and competency, applying Gillick competency or Fraser guidelines. Record of person with parental responsibility or appointed guardian where child lacks competency. Record if there is disagreement between patient and parent.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) person has been undertaken, if so, what capacity the decision relates to, who carried it out, when and the outcome of the assessment. Also record best interests decision if person lacks capacity.
Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	Record of one or more people who have been given power (LPA) by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make those decisions. To be valid, an LPA must have been registered with the Court of Protection. If life-sustaining treatment is being considered the LPA document must state specifically that the attorney has been given power to consent to or refuse life-sustaining treatment. Details of any person (deputy) appointed by the court to make decisions about the person's health and welfare. A deputy does not have the power to refuse life-sustaining treatment.

Safety alerts

Element	Description
Risks to self	Risks the patient poses to themselves, e.g. suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to caring professionals or others.
Risk from others	Details of where an adult or child is at risk from an identified person e.g. family member etc.

Allergies and adverse reactions

Element	Description
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. Or "no known drug allergies or adverse reactions" or "information not available.
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. For example, skin rash.
Date first experienced	When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.

Patient concerns, expectations and wishes

Element	Description
Patient concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/representative on behalf of the patient). Where the person lacks capacity this may include their representative's concerns, expectations or wishes.

Examination findings

Element	Description
Examination findings	The record of findings from the examinations performed.
Vital signs	The record of essential physiological measurements, e.g. heart rate, blood pressure, temperature, pulse, respiratory rate, SpO2, level of consciousness etc. Use of Early Warning Score (which may be computed) chart where appropriate.

Information and advice given

Element	Description
Information and advice given	This includes: • what information • to whom it was given. • the oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment.

Person completing record

Element	Description
Name	The name of the person completing the record, preferably in a structured format.
Role	The role the person is playing within the organisation at the time record was updated.
Grade	The grade of the person completing the record.
Specialty	The main specialty of the person completing the record.
Date and time completed	The date and time the record was updated.

Distribution list

Element	Description
Name	If the comunication is being sent to a named individual, then this is the name of the recipient, preferably in a structured format. An identifier for the individual, for example GMC code (for a GP), or an SDS identifier, an NHS Number (for a patient) will be sent alongside the name, but may not displayed on rendered document.
Role	If the communication is being sent to either a named individual, or to a non–named person with a specific role, then this is the role of the recipient.
Grade	The recipient's grade.
Organisation name	The name of the organisation the recipient is representing or the organisation named as the receiving organisation. An identifier for the organisation will be sent alongside the name, but may not displayed on rendered document.
Team	Team that the recipient belongs to in the context of receiving this message, or the team acting as the recipient.
Relationship to subject	The relationship of the receiver to the patient, where the receiver has a personal relationship to the patient, for example, carer or parent.

Reason for referral

Element	Description
Reason for referral	A clear statement of the purpose of the person making the referral, e.g. diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (e.g. palliative care), provide referrer with advice/guidance. This may include referral because of carers' concerns.
Clinical urgency of referral	Referrer's assessment of urgency (e.g. urgent/soon/routine). May include reason if other than routine, e.g. two data items: • level of urgency • reason.
Expectation of referral	A clear statement of the expectations of the person making the referral as to the management of the patient, e.g. advice only, diagnosis, treatment, etc. To Include any specific patient expectation In general text. Risk not put in a prcedure not already received.
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient precipitating referral. This may include disease state, medical condition, response and reaction to therapies, e.g. blackout, dizziness, chest pain, follow–up from admission, falls, a specific procedure, investigation, family history or treatment.
History of each presenting complaint or issue	Information directly related to the development and characteristics of each presenting complaint (e.g. including travel history). Including if the information is given by the patient or their carer.
Management to date	Referrals, management, investigations and treatment that have already been undertaken, including patient managing their symptoms. Including: • procedures conducted – procedures carried out (and the date) and procedure report.

Medications and medical devices

Element	Description
Medication name	May be generic name or brand name (as appropriate).
Form	E.g. capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc.): may include method of administration, (e.g. by infusion, via nebuliser, via NG tube).
Quantity supplied	The quantity of the medication (e.g. tablets, inhalers, etc.) provided to the patient on discharge. This may be dispensed by the pharmacy or on the ward.
Site	The anatomical site at which the medication is to be administered, e.g. "left eye".
Method	The technique or method by which the medication is to be administered.
Dose amount description	A description of the medication single dose amount, e.g. "30 mg" or "2 tabs".
Dose timing description	A description of the frequency of taking or administration of a medication dose, e.g. "twice a day", "at 8am 2pm and 10pm".
Dose directions description	A single plain text phrase describing the entire medication dosage and administration directions including dose quantity and medication frequency, e.g. "1 tablet at night or "2mg at 10pm". This is the form of dosage direction text normally available from UK GP systems.

Medications and medical devices

Element	Description
Additional instructions	Allows for: • requirements for adherence support, e.g. compliance aids, prompts and packaging requirements • additional information about specific medicines e.g. where specific brand required • person requirements, e.g. unable to swallow tablets.
Indication	Reason for medication being prescribed, where known.
Authorised date	Date prescriber created prescription.
Valid from date	Date the prescription can be issued from. Valid for 6 months.
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.
Request for advice	Request for advice and recommendation about medication
Repeat medications: This is the sub-section where all current repeat medications are recorded.	
Medication name	Mandatory medication name coded using SNOMED CT/dm+d term where possible, allowing plain text for historical/patient reported items, extemporaneous preparations or those not registered in dm+d.
Form	Form of the medicinal substance e.g capsules, tablets, liquid. Not normally required unless a specific form has been requested by the prescriber, e.g. “modified release capsules”.
Route	Optional medication route, using SNOMED CT terms where possible. Not generally applicable to product-based medication. Should not be used to specify a specific administration site, for which a separate archetype is used, e.g. the route is ‘intraocular’ the site may be ‘left eye’, e.g. “oral”, “intraocular”. Note that this element supports multiple routes to allow a choice to be specified by the prescriber.
Site	The anatomical site at which the medication is to be administered, e.g. “left eye”.
Method	The technique or method by which the medication is to be administered.
Dose amount description	A plain text description of medication single dose amount, as described in the AoMRC medication headings, e.g. “30 mg” or “2 tabs”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.”
Dose directions description	A plain text description of the entire prescribed medication dosage and administration directions, including dose quantity and medication frequency.
Dose timing description	A plain text description of medication dose frequency, as described in the AoMRC medication headings, e.g. “twice a day”, “at 8am 2pm and 10pm”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.
Prescribed quantity	Medication quantity prescribed.
Date started	This is when the medication was first prescribed.

(continued overleaf)

Element	Description
Authorised date	Date prescriber created prescription.
Valid from date	Date the prescription can be issued from, e.g. valid for 6 months.
Number of issues permissible	The number of repeat issues permissible.
Number of issues made	The number of repeats already issued.
Valid to date	Date the prescription is valid to.
Additional instructions	Additional multiple dosage or administration instructions as plain text. This may include guidance to the prescriber, patient or person administering the medication. In some settings, specific administration instructions may be re–labelled as "patient advice' or 'dispensing Instruction' to capture these flavours of instruction, e.g. "omit morning dose on day of procedure", "for pain or fever", "dispense weekly".
Indication	Reason for medication was prescribed.
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.
Repeat dispensed	This is an indicator as to whether the item will be repeat dispensed by pharmacy.
Request for advice	Request for advice and recommendation about medication.
For medications that have been changed, ie additions, amendments and discontinued, in addition to the above, also record:	
Description of amendment frequency or route is changed.	Where a change is made to the medication ie one drug stopped and another started or dose,
Indication (for medication change)	Reason for change in medication, e.g. sub–therapeutic dose, patient intolerant.
Discontinued medication extraction period	Date range of discontinued medications.
Medication name	Mandatory medication name coded using SNOMED CT/dm+d term where possible, allowing plain text for historical/patient reported items, extemporaneous preparations or those not registered in dm+d.
Form	Form of the medicinal substance, e.g capsules, tablets, liquid. Not normally required unless a specific form has been requested by the prescriber, e.g. "modified release capsules".
Route	Optional medication route, using SNOMED CT terms where possible. Not generally applicable to product–based medication. Should not be used to specify a specific administration site, for which a separate archetype is used, e.g. the route is 'intraocular' the site may be 'Left eye', e.g. "oral", "intraocular". Note that this element supports multiple routes to allow a choice to be specified by the prescriber.
Site	The anatomical site at which the medication is to be administered, "left eye".
Method	The technique or method by which the medication is to be administered.

Element	Description
Dose amount description	A plain text description of medication single dose amount, as described in the AoMRC medication headings, e.g. “30 mg” or “2 tabs”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.
Dose directions description	A plain text description of the entire prescribed medication dosage and administration directions, including dose quantity and medication frequency.
Dose timing description	A plain text description of medication dose frequency, as described in the AoMRC medication headings, e.g. “twice a day”, “at 8am 2pm and 10pm”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.
Prescribed quantity	Medication quantity prescribed.
Date started	This is when the medication was first prescribed.
Date discontinued	This is when the medication was stopped
Reason for discontinuation	Reason medication was discontinued.
Additional instructions	Additional multiple dosage or administration instructions as plain text. This may include guidance to the prescriber, patient or person administering the medication. In some settings, specific administration instructions may be re–labelled as “patient advice’ or ‘dispensing instruction’ to capture these flavours of instruction, e.g. “omit morning dose on day of procedure”, “for pain or fever”, “dispense weekly”.
Prescribed elsewhere: Medication managed by another organisation.	
Medication name	Mandatory medication name coded using SNOMED CT/dm+d term where possible, allowing plain text for historical/patient reported items, extemporaneous preparations or those not registered in dm+d.
Form	Form of the medicinal substance e.g capsules, tablets, liquid. Not normally required unless a specific form has been requested by the prescriber, e.g. “modified release capsules”.
Route	Optional medication route, using SNOMED CT terms where possible. Not generally applicable to product–based medication. Should not be used to specify a specific administration site, for which a separate archetype is used, e.g. the route is ‘intraocular’ the site may be ‘left eye’, e.g. “oral”, “intraocular”. Note that this element supports multiple routes to allow a choice to be specified by the prescriber.
Site	The anatomical site at which the medication is to be administered, e.g. “left eye”.
Method	The technique or method by which the medication is to be administered.
Dose amount description	A plain text description of medication single dose amount, as described in the AoMRC medication headings, e.g. “30 mg” or “2 tabs”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.
Dose timing description	A plain text description of medication dose frequency, as described in the AoMRC medication headings, e.g. “twice a day”, “at 8am 2pm and 10pm”. UK secondary care clinicians and systems normally minimally structure their dose directions, separating dose amount and dose timing (often referred to as dose and frequency). This format is currently used in GP systems, which can import dose and frequency descriptions concatenated into the single dose directions description.

(continued overleaf)

Element	Description
Dose directions description	A plain text description of the entire prescribed medication dosage and administration directions, including dose quantity and medication frequency.
Date started	This is when the medication was first prescribed.
Additional instructions	Additional multiple dosage or administration instructions as plain text. This may include guidance to the prescriber, patient or person administering the medication. In some settings, specific administration instructions may be re–labelled as “patient advice’ or ‘dispensing Instruction’ to capture these flavours of instruction, e.g. “omit morning dose on day of procedure”, “for pain or fever”, “dispense weekly”.
Indication	Reason for medication was prescribed.
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Organisation	Prescribing organisation.
Use the following heading for medical devices that do not have representation in the NHS dictionary of medicines and medical devices (dm+d):	
Medical devices	Any therapeutic medical device of relevance that does not have representation in the NHS dictionary of medicines and medical devices (dm+d).

Section Eight: Healthy child record

The structure and content for the health and care information to be recorded in the healthy child record by the relevant health and care professional in any care setting.

Not all structured content will be used in all care settings or circumstances and the order in which they appear in the digital patient record, communications and letters can be agreed by system suppliers and users.

GP practice

Element	Description
GP practice identifier	The identifier of the registered GP practice.
GP practice details	Name and address of the patient's registered GP practice.
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP Opt Out indicator	Indication that parent/carer or child has opted out of registering with a GP.

Referrer details

Element	Description
Referrer details	Name, role, grade, organisation and contact details of referrer. If not an individual, this could be a GP surgery, department, specialty, sub-specialty, educational institution, mental health team etc. Also needs to include self-referral.
Date	The date of referral.
Referral Method	The form in which a referral is sent and received. This may be a letter, email, transcript of a telephone conversation, choose and book, in person (self-referral), unknown etc.
Referral to	The type of service or team that the patient has been referred into, e.g. GP surgery, department, specialty, subspecialty, educational establishment, mental health etc.
Speciality referred from	The type of service or team that the patient has been referred from.
Urgency of referral	Referrer's assessment of urgency (e.g. urgent/soon/routine).
Reason for Referral	A clear statement of the purpose of the person making the referral, e.g. diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (e.g. palliative care), provide referrer with advice/guidance. This may include referral because of carer's concerns.

Patient demographics

Element	Description
Patient name	The full name of the patient.
Patient preferred name	The name by which a patient wishes to be addressed.

(continued overleaf)

Element	Description
Date of birth	The date of birth of the patient.
Gender	As the patient wishes to portray themselves.
Ethnicity	The ethnicity of a person as specified by the person.
Religion	The religious affiliation as specified by the person.
Sex	The person's phenotypic sex. Determines how the person will be treated clinically.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.
Patient address	Patient's usual place of residence.
Patient email address	Email address of the patient.
Patient telephone number	Telephone contact details of the patient. To include, e.g. mobile, work and home number if available.
Communication preferences	Preferred contact method, e.g. sign language, letter, phone, etc. Also preferred written communication format, e.g. large print, braille.

Social context

Element	Description
Household composition	E.g. lives alone, lives with family, lives with partner, etc. This may be free text.
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well–being, e.g. the record of the patient's physical activity level, pets, hobbies and sexual habits.
Smoking	Current smoking observation.
Alcohol intake	Latest or current alcohol consumption observation.
Drug/substance use	Latest or current drug/substance use observation.
Social circumstances	The record of a patient's social background, network and personal circumstances, e.g. housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependents or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record.
Accommodation status	An indication of the type of accommodation where the child lives. This should be based on the main or permanent residence.
Family and household	Family and household details of Social Context.
Father's employment status	The employment status of the father and his occupation.
Household social services support	Whether or not any household member had/has social services support.
Household(s) environment	Factors in the household(s) which impact the child's health and well-being, to include smoking in the home, alcohol/substance use etc.

Element	Description
Mother's employment status	The employment status of the mother and her occupation.
Mother's educational status	The highest educational qualification attained by the child's mother.
Other significant individuals	People deemed as key by family and or health care professional in the child's life that do not live in the home(s).
Personal	Personal details of Social Context.

Individual requirements

Element	Description
Individual requirements	Individual requirements that a person has. These may be communication, cultural, cognitive or mobility needs.
Accessible information – requires communication professional	Requirement for a communication professional to be present in order to provide accessibility, with regard to disability.
Accessible information – communication support	Outlines capability and support required in order to in order to provide accessibility, with regard to disability.
Accessible information – requires specific contact method	Requirement for a specific contact method in order to provide accessibility, with regard to disability.
Accessible information – requires specific information format	Requires information in a specific format in order to provide accessibility, with regard to disability.
Child or parent/carer/guardian	An indicator of whether the individual requirement relates to the child or their primary carer.
Cognition	An indicator of cognitive impairment to be considered when communicating related to the child or their primary carer.
Mobility needs	A child or their primary carers personal physical movement between two spaces that achieves participation and a degree of independence.

Admission Details

Element	Description
Reason for admission	The health problems and issues experienced by the patient that prompted the decision to admit to hospital, e.g. chest pain, mental health crisis, blackout, fall, a specific procedure, intervention, investigation or treatment, non compliance with treatment.
Admission method	How the patient was admitted to hospital, e.g. elective, emergency, maternity, transfer etc.
Source of admission	Where the patient was immediately prior to admission, e.g. usual place of residence, temporary place of residence, penal establishment. National code.

(continued overleaf)

Element	Description
Date/time of admission	Date and time patient admitted to hospital.
Responsible consultatnt	The name desigantion of th consultant, who has overall responsibility for the patient (may not actually see the patient).
Person accompanying patient	Identify others accompanying the patient, e.g. relative, friend, informed carer, advocate. If the patient was not present was an authorised representative present? Includes name, relationship, (spouse, etc) role (patient advocate, etc).
Speciality	Specialties designated by royal college and faculties, e.g. orthopaedics, renal medicine and endocrinology, etc.
Admitted to	The ODS site code and description of where the child was admitted.

Discharge details

Element	Description
Discharge destination	The destination of the patient on discharge. National codes, e.g. high dependency unit.
Discharging consultant	The consultant responsible for the patient at time of discharge.
Discharging specialty/ department	The specialty or department responsible for the patient at the time of discharge.
Discharge location	The ward or unit the patient was in immediately prior to discharge.
Date/time of discharge	The actual date of discharge.
Discharge method	The method of discharge from hospital. National codes, e.g. patient discharged on clinical advice or with clinical consent; patient discharged him/herself or was discharged by a relative or advocate; patient died; stillbirth.
Discharge address	Address to which patient discharged. Only complete where this is not the usual place of residence.

Relevant clinical risk factors

Element	Description
Relevant clinical risk factor	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis, e.g. being overweight, smoker, no use of sun screen, enzyme deficiency.
Clinical risk assessment	Specific risk assessments required/undertaken.
Risk mitigation	Action taken to reduce the clinical risk and date actions.

Problems and issues

Element	Description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings, symptoms and signs, which are likely to have relevance and are not a diagnosis.
Clinical risks	Description of clinical risks identified, e.g. problematic intubation, person with brittle diabetes, immuno–compromised/risk of infection etc.
Comment	Any further textual comment to clarify, such as statement that information is partial or incomplete.

Diagnoses

Element	Description
Diagnosis	Confirmed diagnosis (or symptom); active diagnosis being treated.
Stage	Stage of the disease or disorder, where relevant.
Comment	Supporting text may be given covering diagnosis confirmation, active diagnosis being treated. Include severity, occurrence (first, recurrence, ongoing).
Date diagnosis made	The date when the diagnosis was made.

Family history

Element	Description
Family history	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc.
Condition or diagnosis	The condition or diagnosis in family relations deemed to be significant to the care or health of the child.
Date	The date the family history was recorded.
Maternal or paternal relation	Record of whether the condition or diagnosis was on the mother's or father's side of the family, where needed, e.g. paternal grandfather.
Relationship to patient	The relationship of the person with the condition to the patient.
Comment	Any further textual comment.

Assessment scales

Element	Description
Assessment scale name	The name of the overarching assessment scale used e.g. Bayley, Griffiths, Ages & Stages Questionnaire etc.
Comment	Supporting text may be given regarding the assessment scale as a whole or a subscale.
Date	The date on which the assessment scale was recorded.
Global score	The total global score from the assessment.
Location	The location where the assessment scale was recorded.
Performing professional	Details of the professional performing the assessment scale (including name and role).
Subscale name	The name of the subscale used (where relevant).
Subscale score	The total subscale score from the assessment.

Legal information

Element	Description
Looked after child	Legal information for looked after child.
Child protection plan	Legal information for child protection plan.
Local Authority	The named local authority.

Safety alerts

Element	Description
Risks to self	Risks the patient poses to themselves, e.g. suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to caring professionals or others.
Risk from others	Details of where an adult or child is at risk from an identified person e.g. family member etc.
Date	The date on which the safety alert was recorded.
Location	The location where the safety alert was recorded.
Performing professional	Details of the professional recording the safety alert (including name and role).

Allergies and adverse reactions

Element	Description
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient. Or “no known drug allergies or adverse reactions” or “Information not available”.
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. For example, skin rash.
Severity	A description of the severity of the reaction.
Certainty	A description of the certainty that the stated causative agent caused the allergic or adverse reaction.
Type of reaction	The type of reaction experienced by the patient (allergic, adverse, intolerance).
Evidence	Results of investigations that confirmed the certainty of the diagnosis. Examples might include results of skin prick allergy tests.
Date first experienced	When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood).
Comment	Any additional comment or clarification about the adverse reaction.
Date recorded	The date that the reaction was clinically recorded/asserted. This will often equate to the date of onset of the reaction but this may not be wholly clear from source data.
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.

Patient concerns, expectations and wishes

Element	Description
Patient concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Record who has expressed these (patient or carer/representative on behalf of the patient). Where the person lacks capacity this may include their representative’s concerns, expectations or wishes.

Examination findings

Element	Description
Examination	The examination performed, e.g. general appearance, vital signs, mental state, head and neck examination, oral examination, cardiovascular system, respiratory system, abdomen, genitourinary, nervous system, musculoskeletal system, skin. This could include site and must include laterality where applicable.
Examination findings	The record of findings from the examinations performed.
Vital signs	The record of essential physiological measurements, e.g. heart rate, blood pressure, temperature, pulse, respiratory rate, SpO2, level of consciousness etc. Use of Early Warning Score (which may be computed) chart where appropriate.

(continued overleaf)

Element	Description
Performing professional	Details of the professional performing the examination (including name and role).
Location	The location where the examination was recorded.

Information and advice given

Element	Description
Information and advice given	This includes: • what information • to whom it was given. • the oral or written information or advice given to the patient, carer, other authorised representative, care professional or other third party. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment.
Date	The date on which the information and advice was given.
Location	Details of where the information and advice was given.
Performing professional	Details of the professional giving the information and advice (including name and role).

Plan and requested actions

Element	Description
Date	The date on which the plan and requested actions was recorded.
Performing professional	Details of the professional performing the plan and requested actions (including name and role).

Birth details

Element	Description
APGAR score	A set of observations made on the baby following birth to check adaptation to life outside the womb. This includes 1 minute, 5 minutes and 10 minutes.
Birth order	The sequence in which this baby was born (one of one, one of two etc).
Birth weight	Numeric value for weight at birth.
Date & time of birth	The date and time of birth of the baby.
Delivery place type	The type of place in which the baby was born, e.g. private health facility, domestic address, NHS hospital, midwifery led unit etc.

Element	Description
Fetal problems diagnosed before birth	Problems with the fetus diagnosed with screening or ultrasound. e.g. Down Syndrome, congenital heart disease etc.
Length of gestation	Gestational age in weeks and days (usually equivalent to length of pregnancy).
Location of birth	The place of birth (including the address and organisation name where relevant).
Maternal problems in pregnancy	Maternal medical conditions or infectious diseases arising in pregnancy which may have an impact on the fetus, e.g. gestational diabetes, rubella etc.
Multiple birth	Where the baby is one of a multiple birth, to include the total number of offspring and to include whether the baby is identical to one of the siblings.
Neonatal resuscitation	Details of neonatal resuscitation measures required, e.g. chest compression, oxygen mask etc.
Physical problems detected at birth	Physical problems identified with the baby at, or shortly after, birth, e.g. cleft lip/palate, extensive bruising, cephalohematoma etc.
Problems during delivery	Problems experienced by the baby during delivery, e.g. cord prolapse, meconium aspiration, fetal distress etc.
Put To Breast	Whether or not the baby was put to the breast.
Spontaneous respiration	Details of neonatal resuscitation measures required, e.g. chest compression, oxygen mask etc.
Type of delivery	Type of delivery for the baby, e.g. vacuum extraction, breech extraction, elective caesarean section etc.
Types of delivery (attempted)	The type(s) of delivery for the baby that was attempted, but was not the final delivery method.

Demographic history

Element	Description
Date of birth	History of date of birth changes.
Gender	History of gender change.
Patient address	History of Patient's usual place of residence.
Patient name	Any previous names, aliases and preferred name. This will normally be given by a patient demographics ervice (PDS) patient trace, or the name of the patient held on the local patient administration system (PAS).
Patient telephone number	History of telephone contact details of the patient. To include, e.g. mobile, work and home number if available.

Developmental skills

Element	Description
Comments	Supporting text may be given regarding the developmental skill.

(continued overleaf)

Element	Description
Date first achieved	The date the developmental skill was first achieved (developmental first) as reported by the parent. This is primarily for parent reporting as part of parent child health record at the time the skill is acquired.
Date of enquiry	The date the parent or carer was asked by a health professional about the developmental skill (milestone).
Date of observation	The date a health professional observed or tested a developmental skill (milestone).
Developmental Skill	The name of the developmental skill, e.g. walks independently, smiles, finger feeds etc.
Result of enquiry	Whether the developmental skill was achieved, not achieved or equivocal.
Result of observation	Whether the developmental skill was achieved, not achieved or equivocal.

Educational history

Element	Description
Educational assessment	The outcome of an educational assessment.
Educational establishment	Name of educational establishment.
Type of educational establishment	Phase/type of education establishment.
Type of special educational need	The type of special educational needs for the child.
Year from	The year the child attended the school from.
Year to	The year the child left the school.

Emergency care attendance

Element	Description
Clinical narrative	A description detailing a patient's reason for attendance, results from the diagnostic and treatment process.
Date and time of attendance	Date and time patient arrived at the unscheduled care unit.
Date and time of discharge	The actual date and time of discharge.
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.
Discharge destination	The destination of the patient on discharge. National codes. E.g. High Dependency Unit.
Discharge status	Patient status on discharge from emergency care.
Location	Details of where the unscheduled care attendance took place.

Element	Description
Person accompanying patient	Identify others accompanying the patient, e.g. relative, friend, patient informal carer, advocate. If the patient was not present, was an authorised representative present. Include name andrelationship (friend, relative, etc.).
Plan and requested actions	A simple free text description of the plan of action following the contact with the child. This may include actions for the parent, healthcare professional, e.g. health visitor and review.
Presenting complaint or issue	The health problem or issue experienced by the patient resulting in their attendance. This may include disease state, medical condition, response and reactions to therapies, e.g. blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment.
Procedure	The therapeutic or diagnostic procedure performed on the patient. This may be coded, or represented as free text.
Referral source	Source of referral for unscheduled care.
Safety alerts	Safety alerts at the emergency care attendance suggested to be pulled through from the safety alerts heading.

Feeding status

Element	Description
Date	The date the feeding status was recorded.
Date breast milk feeding stopped	Date of last breast milk feed to the nearest month and year.
Feeding concerns	A record of any concerns about the baby's feeding.
Feeding method	A record of the predominant feeding method for the baby, e.g. breast fed, bottle/cup fed, gastrostomy, nasogastric feeds etc.
First milk feed	Whether or not the baby's first feed was breast milk.
Introduction of solids	Whether the baby has been introduced to solid foods at the time seen.
Milk feeding status of the baby	Whether the baby is totally breast milk fed, partially breast milk fedor not breast milk fed. To be recorded each time a baby has contact with a health professional.

Health and well-being assessment and reviews

Element	Description
Date	The date the feeding status was recorded.
Post birth review	This details those checks and assessments done on the baby prior to leaving hospital that do not make up the NIPE screening.

(continued overleaf)

Element	Description
New baby review	The details captured as part of the new baby review.
6–8 week health visitor review	The details captured as part of the 6–8 heath visitor review.
1 year review	The details captured as part of the 1 year teview.
2–2 1/2 year health and development review	The details captured as part of the 2–2 1/2 health and development review.
school entry review	The details captured as part of the school entry review including the outcome of the hearing and screening check.
Ad–Hoc health review	The details captured as part of any ad–hoc health review undertaken.

Immunisations

Element	Description
Batch number	The batch number of the vaccine.
Date	The date on which the Immunisation was administered.
Dose amount	Amount of vaccine administered.
Dose sequence	Nominal position in a series of vaccines.
Indication	The clinical indication or reason for administering the immunisation.
Location	Details of where the immunisation was performed.
Manufacturer	The vaccine manufacturer.
Name of immunisation	Which immunisation has been administered (SNOMED CT code – list of available immunisations).
Outcome status	Whether the vaccine was administered or not, including the reason why.
Performing professional	Details of the professional performing the immunisation (including name and role).
Reported	A flag to indicate the information was reported to a healthcare professional.
Route	How vaccine entered the body.
Site	Body site vaccine was administered into.
Vaccine product	Vaccine product administered.

Measurements

Element	Description
BMI centile	Child BMI centile calculated using the height/weight/gender and age of the child.
Date	The date on which the measurement was recorded.
Head circumference	Numeric value for the head circumference.
Height/length	Numeric value for the body length.
Location	The location where the measurement was recorded.
Performing professional	Details of the professional performing the measurement (including name and role).
Weight	Numeric value for weight.

National screening programme

Element	Description
Newborn blood spot screening	The details captured as part of the NBS programme which screens for sickle cell disease (SCD), cystic fibrosis (CF), congenital hypothyroidism (CHT) and inherited metabolic diseases (IMDs).
Newborn hearing screening	The details captured as part of the NHSP programme which offers 2 types of test for babies: • automated otoacoustic emission (AOAE) • automated auditory brainstem response (AABR).
Newborn and infant physical examination (72 hours)	The details captured as part of the NIPE programme which tests babies within 72 hours of birth for conditions relating to their: • heart • hips • eyes • testes.
Newborn and infant physical examination (6–8 Weeks)	The details captured as part of the NIPE programme which tests babies again at 6–8 weeks for conditions relating to their: • heart • hips • eyes • testes.

Parent/guardian/personal comment

Element	Description
Date	Date the comment was entered and shared.
Who	Who recorded the comment and what relationship they are to the child.
Parent/guardian or personal comment	Free text comment made by the parent/guardian of the child, or the child themselves.

Personal contacts

Element	Description
Name	The name of the person.
Relationship	The personal relationship the individual has to the child, e.g. father, grandmother, family friend etc.
Parental responsibility	Flag to indicate whether the personal contact has parental responsibility.
Contact details	Contact details of the person, e.g. telephone number, email address etc.
NHS Number	The NHS number of the personal contact.

Professional contacts

Element	Description
Name/Team	The name of the person or the team responsible.
Role	The professional role the individual has in relation to the child, e.g. nursery nurse, health visitor, school nurse etc.)
Speciality	The speciality of the professional responsible (e.g. health visiting, school nursing etc.)
Team	The name of the team, if the name of the person has been entered.
Organisation	The name of the organisation responsible.
Contact details	Contact details of the person (e.g. telephone number, email address etc.)
Start date	The start date of the relationship with the health professional.
End date	The end date of the relationship with the health professional.

Medications and medical devices

Element	Description
Medication name	May be generic name or brand name (as appropriate).
Form	E.g. capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc.): may include method of administration, (e.g. by infusion, via nebuliser, via NG tube).
Quantity supplied	The quantity of the medication, (e.g. tablets, inhalers, etc.) provided to the patient on discharge. This may be dispensed by the pharmacy or on the ward.
Site	The anatomical site at which the medication is to be administered, e.g. “left eye”.

Element	Description
Method	The technique or method by which the medication is to be administered.
Dose amount description	A description of the medication single dose amount, e.g. “30 mg” or “2 tabs”.
Dose timing description	A description of the frequency of taking or administration of a medication dose, e.g. “twice a day”, “at 8am 2pm and 10pm”.
Dose directions description	A single plain text phrase describing the entire medication dosage and administration directions including dose quantity and medication frequency, e.g. “1 tablet at night or “2mg at 10pm”. This is the form of dosage direction text normally available from UK GP systems.
Additional instructions	Allows for: • requirements for adherence support, e.g. compliance aids, prompts and packaging requirements • additional information about specific medicines e.g. where specific brand required • person requirements, e.g. unable to swallow tablets.
Indication	Reason for medication being prescribed, where known.
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Dose direction duration	Recommendation of the time period for which the medication should be continued, including direction not to discontinue.
For medications that have been changed, ie additions, amendments and discontinued, in addition to the above, also record:	
Description of amendment	Where a change is made to the medication ie one drug stopped and another started or, e.g. dose, frequency or route is changed.
Indication (for medication change)	Reason for change in medication, eg sub–therapeutic dose, patient intolerant.
Use the following heading for medical devices that do not have representation in the NHS dictionary of medicines and medical devices (dm+d):	
Medical devices	Any therapeutic medical device of relevance that does not have representation in the NHS dictionary of medicines and medical devices (dm+d).

Section Nine: Digital care and support plan

The structure and content for the health and care information to be recorded in digital care and support plans recorded in any care setting.

Not all structured content will be used in all care settings or circumstances and the order in which they appear in the digital patient record, communications and letters can be agreed by system suppliers and users.

GP practice	
Element	**Description**
GP practice identifier	The identifier of the registered GP practice.
GP practice details	Name and address of the patient's registered GP practice.
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.

Patient demographics	
Element	**Description**
Patient name	The full name of the patient.
Patient preferred name	The name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Gender	As the patient wishes to portray themselves.
Person alias	Record details where a person is known to use assumed identities to access health/care services.
Ethnicity	The ethnicity of a person as specified by the person.
Religion	The religious affiliation as specified by the person.
Sex	The person's phenotypic sex. Determines how the person will be treated clinically.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. Two data items: type of identifier and identifier.
Patient address	Patient's usual place of residence.
Patient email address	Email address of the patient.
Patient telephone number	Telephone contact details of the patient. To include, e.g. mobile, work and home number if available.

About me

Element	Description
About me	This is a record of the things that an individual feels it is important to communicate about their needs, strengths, values and preferences to others providing support and care.
Date	This is a record of the date that this information was last updated.
Supported to write this by	Where relevant, this is a record of name, relationship/role and contact details of the person who supported the individual to write this section, e.g. carer, family member, advocate, professional.

Contingency plan(s)

Element	Description
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.
Anticipatory medicines/equipment	Medicines or equipment available that may be required in specific situations and their location.
Contingency plan name	Name of the contingency plan – what condition or circumstances it is addressing.
Date this plan was last updated	This is a record of the date that this contingency plan was last updated.
Planned review date/Interval	This is the date/interval when this contingency plan will next be reviewed.
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.
Trigger factors	Signs to watch out for that may indicate a significant change in health or other circumstances.
What should happen	To record guidance on specific actions or interventions that may be required or should be avoided in specific situations. This may include circumstances where action needs to be taken if a carer is unable to care for the individual.
Who should be contacted	Who should be contacted in the event of significant problems or deterioration in health or well-being including name, designation and contact details of persons.

Additional supporting plan(s)

Element	Description
Additional supporting plan name	The name of the particular additional supporting plan, e.g. dieticians plan, wound management plan, discharge management plan.
Additional support plan content	Insert this into description bow: This is the content of any additional care and support plan which the individual and/or care professional consider should be shared with others providing care and support. It should be structured as recommended for the care and support plan and if contains additional detail, it may be referenced here.

(continued overleaf)

Element	Description
Person completing record	This is the person contributing to the care and support plan. Should include their name, role, grade, specialty, organisation, professional identifier, date and time completed, contact details.
Planned review date/interval	This is the date/interval when this information will next be reviewed.
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.
Date this plan was last updated	This is a record of the date that this information was last updated.

Care and support plan

Element	Description
Actions and activities	Actions or activities the individual or others plan to take to achieve the individual's goals and the resources required to do this. For each action the following may be identified: Stage goal – a specific sub-goal that is related to the overall goal as agreed by the person in collaboration with a professional What – what the action is and how it is to be carried out? Who – name and designation, e.g. person, carer, GP, OT, etc., of the person, or a team, carrying out the proposed action, and, if relevant where action should take place When – planned date, time, or interval, as relevant Suggested strategies for potential problems Status – not started, started, completed, not applicable Confidence – how confident the person feels to carry it out Outcome – the outcome of the stage goal Date when action/activity record was last updated Review date – when the stage goal and action need to be reviewed.
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.
Care funding source	A reference to the funding source and any conditions or limitations associated.
Date last updated	Date when action/activity record was last updated.
Date this plan was last updated	This is a record of the date that this care and support plan was last updated.
Goals and hopes	The overall goals, hopes, aims or targets that the individual has. Anything they want to achieve that relates to their future health and well-being. Each goal may include a description of why it is important to the person. Goals may also be ranked in order of importance or priority to the individual.
Needs, concerns or health problems	Needs, concerns or health problems an individual has that relate to their health and well-being.

Element	Description
Other care planning documents	Reference other care planning documents, including the type, location and date. This may include condition–specific plans, advance care plans, end of life care plan, etc.
Outcomes	Outcomes of each of the individual's goals, aims and targets. Includes comments recorded by the individual, date and status: fully achieved, partially achieved, not achieved, on–going, no longer applicable.
Planned review date/interval	This is the date/interval when this information will next be reviewed.
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.
Strengths	Any strengths and assets the individual has that relate to their goals and hopes about their health and well–being.

Appendix One: Endorsement

The PRSB transfer of care and integrated care standards have been endorsed by PRSB member organisations as follows:

Association of British Paediatric Nurses
Association of Directors of Adult Social Services (ADASS)*
Association of Palliative Medicine
Association of UK Dieticians (BDA)
British & Irish Orthoptic Society.
British Academy of Childhood Disability
British Association of Community Child Health
British Association of Perinatal Medicine*
British Psychological Society
Care Providers Alliance
College of Paramedics
College of Paramedics
Community Practitioners and Health Visitors Association
Institute of Health Records and Information Management
National Council of Palliative Care
Public Health England
RCGP
RCN
RCOG
Resuscitation Council UK
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of Midwives
Royal College of Occupational Therapists
Royal College of Paediatrics & Child Health
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Radiologists Faculty of Clinical Oncology*
Royal College of Surgeons
Royal Pharmaceutical Society
TechUK
The Chartered Society of Physiotherapy
The Royal College of Speech and Language Therapists

To support this new publication, PRSB Standards for the Structure and Content of Health and Care Records, the PRSB will be asking for continued endorsement from 46 organisations that endorsed the 2013 published standards. They are as follows:

College of Paramedics
College of Physiotherapy
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Occupational Therapists
Royal College of Paediatrics and Child Health Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Speech and Language Therapy
Royal College of Surgeons
Royal Pharmaceutical Society

Specialist societies:

Association for Clinical Biochemistry
Association for Palliative Medicine of Great Britain & Ireland
Association of British Clinical Diabetologists
Association of Cancer Physicians
British Association for Sexual Health and HIV
British Association of Audiovestibular Physicians
British Association of Dermatologists
British Association of Plastic Reconstructive and Aesthetic Surgeons
British Association of Stroke Physicians
British Association of Urological Surgeons
British Cardiovascular Society
British Dietetic Association
British Geriatrics Society
British Infection Association
British Orthodontics Society
British Pain Society
British Society for Gastroenterology
British Society for Haematology
British Society for Immunology
British Society of Rheumatology
British Thoracic Society
ENT-UK
Health and social care leadership and management
Institute of Health Records and Information Managers (IHRIM)
Renal Association
Royal College of Opthalmologists
Society of British Neurological Surgeons

Industry:

TechUK
INTEROPen

*These organisations provided a statement of support for the detailed standards.

Appendix Two: 2013 Structured content not currently used in use cases (2018)

Referrer details

Element	Description	Changes since 2013
Person to attend with patient	Identify others who will/may accompany the patient, e.g. relative, carer, chaperone. Includes: • name • relationship (friend, relative, etc) • role (patient advocate, chaperone etc) • attendee's special requirements.	Included in core headings in 2013, not in use cases

Diagnoses

Element	Description	Changes since 2013
Episode (first, new, other, ongoing)	• First episode. • New episode. • Other, past or ongoing episode.	Included in core headings in 2013, not in use cases
Date of first presentation	The date the diagnosis or condition first presented.	Included in core headings in 2013, not in use cases
Differential diagnosis	The determination of which one of several diseases may be producing the symptoms.	Covered in clinical risk factors

Examination findings

Element	Description	Changes since 2013
General appearance	The record of a clinician's 'first impression' assessment including general clinical examination findings, e.g, clubbing, pallor, jaundice, obese/malnourished/cachectic, height, weight, etc.	Covered in examination findings
Mental state	Formal mental state examination or general description, e.g. depression, anxiety, confusion, delirium, dementia.	Covered in examination findings
Cardiovascular system	The record of findings from the cardiovascular system examination (including electrocardiogram [ECG] etc).	Covered in examination findings
Respiratory system	The record of findings from the respiratory system examination.	Covered in examination findings
Abdomen	The record of findings from the abdominal examination.	Covered in examination findings
Musculoskeletal system	The record of findings from the musculoskeletal system examination.	Covered in examination findings
Skin	The record of findings from examination of the skin.	Covered in examination findings

(continued overleaf)

Element	Description	Changes since 2013
Nervous system	The record of findings from the nervous system examination.	Covered in examination findings
Genitourinary	The record of findings from the genitourinary examination.	Covered in examination findings
Head and neck examination	The record of findings from the head and neck examination.	Covered in examination findings
Oral examination	The record of findings from oral examination.	Covered in examination findings
Obstetrics and gynaecology	The record of relevant findings related to obstetrics and gynaecology.	Covered in examination findings
Major trauma	The record of relevant findings related to major trauma.	Covered in examination findings
Examination procedure	A procedure completed as part of the examination of the patient, e.g. sigmoidoscopy, lumbar puncture, pleural tap, etc	Covered in examination findings
Medicine administered	Record of administration to the person, including self-administration.	Covered in examination findings

Medications and medical devices

Element	Description	Changes since 2013
Reason for non-administration	Reason why drug not administered, e.g. patient refused, patient not available, drug not available.	Included in core headings in 2013, not in use cases
Relevant previous medications	Record of relevant previous medications.	Included in core headings in 2013, not in use cases
Medication status	Whether or not a medication is currently used, previously used or authorised for future use.	Included in core headings in 2013, not in use cases

NHS Digital
1 Trevelyan Square
Boar Lane
Leeds LS1 6AE

www.digital.nhs.uk

The PRSB
32-36 Loman Street
London
SE1 0EH

www.theprsb.org

Professional Record Standards Body

NHS Digital