hscic Health & Social Care Information Centre

ACADEMY OF MEDICAL ROYAL COLLEGES

Standards for the clinical structure and content of patient records

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Developed by the Health Informatics Unit,
Clinical Standards Department, Royal College of Physicians

The Health and Social Care Information Centre
From 1 April 2013, the Health and Social Care Information Centre (HSCIC) was made responsible for some of the functions previously undertaken by the Department of Health Informatics Directorate (DHID). This included the Clinical Data Standards Assurance (CDSA) programme. The CDSA programme brought together the clinical and professional communities in health and social care, patient representatives and technology resources to ensure that electronic health records reflected professional practice, and supported improved patient outcomes and safety.

Citation for this report: Health and Social Care Information Centre, Academy of Medical Royal Colleges. *Standards for the clinical structure and content of patient records*. London: HSCIC, 2013.

ISBN: 978-1-86016-514-6
eISBN: 978-1-86016-515-3

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Registered Charity No 210508

Layout and design: Corporate Communications and Publishing, Royal College of Physicians

Printed by Latimer Trend and Company Ltd

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HDMI
eSATA

Introduction

This document describes standards for the structure and content of patient records, covering hospital referral letters, inpatient clerking, handover communications, discharge summaries and outpatient letters. They have been developed using published evidence and consultation with doctors, patients, nurses and allied healthcare professionals. The standards were signed off as fit for purpose for the whole medical profession by the Academy of Medical Royal Colleges (www.aomrc.org.uk) in April 2013.

The rising demands on healthcare systems and associated costs require a much more efficient and transparent means of recording, transmitting and accessing reliable clinical information in order to manage and deliver high quality care to patients, and populations.

The Francis Report (www.midstaffspublicinquiry.com) has emphasised the need for better information and highlighted the risks that increasing service pressures bring to patients, particularly if there is more attention paid to meeting service targets than ensuring that quality of individual patient care is maintained.

The challenges can only be met by the development and use of electronic health records (EHRs) in which data are recorded consistently across all contexts. The implementation of national standards for the clinical structure and content will facilitate shared care, enable interoperability between locations and contexts, and yield comparable data to support the management and monitoring of services realising benefits for patients, clinicians and services (www.rcplondon.ac.uk/projects/healthcare-record-standards).

02

Standardised electronic health records

Clinical care, service delivery and management

In 2013 NHS England set challenging targets, for paperless communications between primary and secondary care by 2015, and a paperless NHS by 2018. To record clinical information in a way that can be shared and re-used safely in an electronic environment, the structure must be standardised. For this to be realistically achievable, the standards for structure must reflect the way that patients and clinicians work together to the common goal of best practice and high quality care. This necessity has been recognised by the establishment of an independent Professional Record Standards Body (www.theprsb.org.uk) to oversee rigorous development and maintenance of health and social care records (www.rcplondon.ac.uk/resources/joint-working-group-report).

First and foremost, electronic health records (EHRs) must support safe, high quality care, delivered in partnership between the patient and professionals, but in addition to supporting the care of the individual, there are many other uses of the data recorded in clinical records. These include clinical audit, management, planning, policy, commissioning and research. For all uses, the data must be fit for purpose and the necessary information governance and consent properly addressed. There is, however, abundant evidence that data quality is currently far from perfect, limiting the credibility of routinely collected data used for these additional purposes.

Information technology has the potential to deliver high quality information for these purposes, but to do so, the key data relating to the core transactions of healthcare – the record of the patient/clinician dialogue and the resulting decisions and actions taken – must be recorded accurately and be accessible to both patients and clinicians in all contexts in which care is delivered. To enable this, the EHR must be patient focused, and hold data recorded at the point of care using national standards and definitions, as set out by the Academy of Medical Royal Colleges in 2008 (www.aomrc.org.uk/publications/statements/doc_view/217-academy-statement-the-case-and-vision-for-patient-focused-records.html).

Research

Many studies have shown that imperfect data quality currently limits the research value of routinely collected data to the analysis of very large populations. However, there would be considerable benefits to patients and patient care through access to NHS-wide anonymised clinical datasets for the advancement of science and development of new medicines and technologies. Better quality phenotypic data will open up huge possibilities to answer research questions through data linkage, provided the data are recorded using national standards and definitions.

Developing the standards

These standards were developed in extensive consultation with representatives from the medical profession and specialist societies; healthcare professionals from multidisciplinary backgrounds; patients; carers and health information technology professionals. Consultations were carried out via online surveys and multi-stakeholder project workshops (www.rcplondon.ac.uk/projects/healthcare-record-standards). The development programme, the Clinical Documentation and Generic Record Standards (CDGRS) programme, was commissioned by the Health and Social Care Information Centre (originally NHS Connecting for Health) in England. It was led by the Health Informatics Unit (HIU) of the Royal College of Physicians, with the aim of producing evidence- and consensus-based national standards for the structure and content of clinical records.

The standards have been endorsed as fit for purpose by 50 organisations that give professional leadership to the medical, nursing and clinical professions. They were signed off as fit for purpose for the whole medical profession by the Academy of Medical Royal Colleges (www.aomrc.org.uk) in April 2013.

The CDGRS programme has also produced further technical information (www.rcplondon.ac.uk/resources/standards-admission-handover-discharge-outpatient-and-referral-technical-annex) and more detailed information on medication and medical device records (www.rcplondon.ac.uk/resources/medications-and-medical-device-records).

The standards
The standards consist of a list of clinical record headings and a description of the information that should be recorded under each heading. Individual specialties and services will require headings and information in addition to, and different from, these generic standards. The additional heading standards will be developed by those specialties and should be accommodated under the generic headings.

04

Using the standards

Organisation of the standards
The standards are organised in a series of sections:

- The full set of record headings identifying where they are used in admission, handover, discharge, outpatient, referral records and communications and in the priority core headings (Section 1).
- **Admission**: the clinical information recorded in the hospital admission record (Section 2).
- **Handover**: handover of patient care from one professional or team to another, including hospital at night, weekend and consultant team to consultant team (Section 3).
- **Discharge**: the clinical information recorded in the discharge record and included in the discharge summary communication from hospital to GP and patient (Section 4).
- **Outpatient**: the clinical information recorded in an outpatient setting, including the initial and follow-up outpatient visits, and the information included in the outpatient letter to the GP and patient. The outpatient standards also include the administrative information that precisely defines the attributes of outpatient and ambulatory care sessions (Section 5).
- **Referral**: the referral headings are primarily intended for recording the clinical information in referral communications between GPs and hospital doctors, copied to the patient. However, they may be used for other types of referral (Section 6).
- **Core**: the core clinical headings are those that are the priority for inclusion in electronic health records (EHRs), as they are generally items that are the priority for coding using SNOMED CT (Section 7).

The standards in practice
A full EHR should include all the headings listed above, which will be displayed for data recording, reviewing and communicating in an order appropriate for the context. Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

All EHRs should ensure that for every record entry, the date, time and the identity of the person making the entry should be automatically recorded.

Section 1: All record headings

The full set of record headings (ie names and clinical descriptions for those headings which are included in one or more of admission, handover, discharge, outpatient, referral and core headings) is listed below.

Columns throughout these tables labelled 'C' indicate the core headings; those labelled 'A' indicate the admission record headings; those labelled 'H' indicate the handover record headings; those labelled 'D' indicate the discharge record headings, those labelled 'O' indicate the outpatient record headings; and those labelled 'R' indicate the referral record headings. '0' denotes absence and '1' denotes the presence of the preferred heading.

GP practice

Subheadings	Clinical description	C	A	H	D	O	R
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
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.	1	1	1	1	1	1
GP practice identifier	National code which identifies the practice.	1	1	1	1	1	1

Referral details

Subheadings	Clinical description	C	A	H	D	O	R
Referrer details	Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral.	0	1	0	1	1	1
Referral to	Name, designation and organisation. If not an individual, this could be a service, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc.	0	0	0	0	1	1
Referral method	A method of referral is 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.	0	0	0	0	1	1
Person to attend with patient	Identify others who will/may accompany the patient, eg, relative, carer, chaperone. Includes: • name • relationship (friend, relative, etc) • role (patient advocate, chaperone etc) • attendee's special requirements.	0	0	0	0	0	1
Attachments	Documents included as attachments which accompany the communication.	0	0	0	0	0	1

(continued overleaf)

Subheadings	Clinical description	C	A	H	D	O	R
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	1
Details of other referrals	Other referrals related to this or associated conditions.	0	0	0	0	0	1

Patient demographics

Subheadings	Clinical description	C	A	H	D	O	R
Patient name	The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed.	1	1	1	1	1	1
Date of birth	The date of birth of the patient.	1	1	1	1	1	1
Patient sex	Sex at birth. Determines how the individual will be treated clinically.	1	1	1	1	1	1
Gender	As the patient wishes to portray themselves.	1	1	1	1	1	1
Ethnicity	The ethnicity of a person as specified by the person.	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
Other identifier	Country specific or local identifier, eg, Community Health Index (CHI) in Scotland.	1	1	1	1	1	1
Patient address	Patient usual place of residence.	1	1	1	1	1	1
Patient telephone number	Telephone contact details of the person. To include, eg, mobile, work and home number if available.	1	1	1	1	1	1
Patient email address	Email address of the patient.	1	1	1	1	1	1
Communication preferences	Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille.	1	1	1	1	1	1
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Name, relationship and contact details.	1	1	1	1	1	1

Special requirements

Subheadings	Clinical description	C	A	H	D	O	R
Special requirements	Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements.	0	1	1	1	1	1

Participation in research							
Subheadings	**Clinical description**	**C**	**A**	**H**	**D**	**O**	**R**
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/ intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.	1	1	1	1	1	1

Content specific headings	These headings sit under relevant headings in their related set, eg, core, admission, handover, etc						
Subheadings	**Clinical description**	**C**	**A**	**H**	**D**	**O**	**R**
Expectation of referral	A clear statement of the expectations of the person making the referral as to the management of the patient, eg, advice only, diagnosis, treatment, etc.	0	0	0	0	0	1
Patient's expectation of referral	Patient's expectations of the referral including preferences. This may include any discussions that took place, the level of shared decision-making involved, information about patient's source of advice.	0	0	0	0	0	1
ADMISSION DETAILS		0	1	0	1	0	0
Admission method	How the patient was admitted to hospital. Eg: elective, emergency, maternity, transfer, etc.	0	1	0	1	0	0
Source of admission	Where the patient was immediately prior to admission, eg, usual place of residence, temporary place of residence, penal establishment. National code.	0	1	0	1	0	0
Patient location	This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home.	0	1	1	1	1	0
Responsible consultant	The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient).	0	1	1	0	0	0
Seen by	Doctor, nurse or other healthcare professional who sees the patient. Record the most senior member of staff present (eg, ward round or where there is a junior member of staff being supervised by a more senior staff member).	0	1	0	0	1	0
Person accompanying patient	Identify others accompanying the patient, eg, relative, friend, informal carer, advocate. If the patient was not present, was an authorised representative present?	0	1	0	0	1	0
HANDOVER DETAILS	**SECTION HEADING IN HANDOVER ONLY**	0	0	1	0	0	0
Planned patient location	If patient is changing location.	0	0	1	0	0	0

(continued overleaf)

Subheadings	Clinical description	C	A	H	D	O	R
Date of decision to handover	Date decision made to handover care.	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	1	0	0	0
Date handover accepted	Date decision made to accept handover of care.	0	0	1	0	0	0
Senior clinical contact	If there is a particular requirement to call a specific person, eg, consultant, SpR (specialist registrar) or special intervention team.	0	0	1	0	0	0
OUTPATIENT DETAILS	**SECTION HEADING IN OUTPATIENTS ONLY**	0	0	0	0	1	0
Contact type	First contact, follow-up contact. Also scheduled, unscheduled. This is always a coded response.	0	0	0	0	1	0
Consultation method	Face to face, telephone, teleconference, etc.	0	0	0	0	1	0
Purpose of contact	Explanatory statement of the purpose of the contact. Eg unscheduled contact because patient concerned, monitoring, screening, diagnosis, assessment, pre-admission assessment, etc.	0	0	0	0	1	0
Appointment time	The time the patient was due to be seen.	0	0	0	0	1	0
Time patient seen	The time the patient was seen.	0	0	0	0	1	0
Time consultation finished	To calculate duration of consultation.	0	0	0	0	1	0
Specialty	Specialties designated by royal colleges and faculties. Eg orthopaedics, renal medicine, endocrinology, etc.	0	1	1	0	1	0
Service	Subspecialties, treatment functions or services. Eg hand surgery, back surgery, hand clinic, TIA (transient ischaemic attack) clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic, etc.	0	1	1	0	1	0
Responsible healthcare professional	The name and designation of the consultant, nurse consultant, midwife, physiotherapist, etc who has overall responsibility for the patient (may not actually see the patient).	0	0	0	0	1	0
Care professional(s) present	The name and designation of the additional individuals or team members including consultant(s), nurse consultant(s), physiotherapist(s), surgeon(s), social worker(s), etc. Eg where two or more care professionals are jointly running a session.	0	0	0	0	1	0
DISCHARGE DETAILS	**SECTION HEADING IN DISCHARGE ONLY**	0	0	0	1	0	0
Date of admission	Date patient admitted to hospital.	0	1	1	1	0	0
Time of admission	Time patient admitted to hospital.	0	0	0	1	0	0
Discharging consultant	The consultant responsible for the patient at time of discharge.	0	0	0	1	0	0

Subheadings	Clinical description	C	A	H	D	O	R
Discharging specialty/ department	The specialty/department responsible for the patient at the time of discharge.	0	0	0	1	0	0
Expected date of discharge	The date the patient is currently expected to be discharged from hospital.	0	1	1	1	0	0
Date of discharge	Date patient discharged from hospital.	0	0	0	1	0	0
Time of discharge	Time patient discharged from hospital. Electronic environment only.	0	0	0	1	0	0
Discharge method	The method of discharge from hospital. National codes: eg, patient discharged on clinical advice or with clinical consent; patient discharged him/herself or was discharged by a relative or advocate; patient died; stillbirth.	0	0	0	1	0	0
Discharge destination	The destination of the patient on discharge from hospital. National codes. Eg, NHS-run care home.	0	0	0	1	0	0
Discharge address	Address to which patient discharged. Only completed where this is not the usual place of residence.	0	0	0	1	0	0

Relevant clinical risk factors

Subheadings	Clinical description	C	A	H	D	O	R
Relevant clinical risk factors	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc.	0	1	1	0	1	1
Clinical risk assessment	Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc.	0	1	1	0	1	1
Risk mitigation	Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned.	0	1	1	0	1	1
Patient at high risk	This patient is at high risk of clinical deterioration and will need an immediate response if called.	0	0	1	0	0	0

Reason for contact

Subheadings	Clinical description	C	A	H	D	O	R
Reason for admission	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment.	1	1	1	1	0	0
Reason for handover	A clear statement of the reason for the temporary or permanent handover of care, eg, low potassium, immediately post-op, unstable medical condition.	1	0	1	0	0	0

(continued overleaf)

Subheadings	Clinical description	C	A	H	D	O	R
Reason for referral	A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carers' concerns.	1	0	0	0	1	1
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, eg, by parent or carer.	1	0	0	0	1	1

Presenting complaints or issues

Subheadings	Clinical description	C	A	H	D	O	R
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment.	1	1	0	0	1	1

History

Subheadings	Clinical description	C	A	H	D	O	R
History of each presenting complaint or issue	Information directly related to the development and characteristics of each presenting complaint (eg, including travel history). Including if the information is given by the patient or their carer.	0	1	0	0	1	1
History since last contact	History since last attendance, discharge from hospital, etc.	0	0	0	0	1	0
Information brought by patient	Eg Patient Passport, diary data, pre-completed questionnaire, etc.	0	1	0	0	1	0
Relevant past medical, surgical and mental health history	The record of the patient'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).	0	1	1	0	1	1
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	1

Subheadings	Clinical description	C	A	H	D	O	R
Urgency of referral	Referrer's assessment of urgency (eg, urgent/soon/routine). May include reason if other than routine.	0	0	0	0	1	1

Medications and medical devices

Subheadings	Clinical description	C	A	H	D	O	R
Medication name	May be generic name or brand name (as appropriate).	1	1	0	1	1	1
Medication form	Eg capsule, drops, tablet, lotion etc.	1	1	0	1	1	1
Route	Medication administration description (oral, IM (intramuscular), IV (intravenous), etc): may include method of administration, (eg, by infusion, via nebuliser, via NG (nasogastric) tube) and/or site of use (eg, 'to wound', 'to left eye', etc).	1	1	0	1	1	1
Dose	This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.	1	1	0	1	1	1
Medication frequency	Frequency of taking or administration of the therapeutic agent or medication.	1	1	0	1	1	1
Additional instructions	Allows for: • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg where specific brand required • patient requirements, eg, unable to swallow tablets.	1	1	0	1	1	1
Do not discontinue warning	To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario.	1	1	0	1	1	1
Reason for medication	Reason for medication being prescribed, where known.	1	1	0	1	1	1
Medication recommendations	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.	1	0	0	1	1	1
Medication status	Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status.	1	0	0	0	0	1
Medication change	Where a change is made to the medication, ie one drug stopped and another started or, eg, dose, frequency or route is changed.	1	1	0	1	1	1
Reason for medication change	Reason for change in medication, eg, sub-therapeutic dose, patient intolerant.	1	1	0	1	1	1
Medicine administered	Record of administration to the patient, including self-administration.	1	0	0	0	1	0

(continued overleaf)

Subheadings	Clinical description	C	A	H	D	O	R
Reason for non-administration	Reason why drug not administered (eg, patient refused, patient unavailable, drug not available).	1	0	0	0	1	0
Relevant previous medications	Record of relevant previous medications.	1	1	0	0	1	1
Medical devices	The record of dietary supplements, dressings and equipment that the patient is currently taking or using.	1	1	0	1	1	1

Allergies and adverse reaction

Subheadings	Clinical description	C	A	H	D	O	R
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.	1	1	1	1	1	1
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations).	1	1	1	1	1	1
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.	1	1	1	1	1	1
Date first experienced	When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood).	1	1	1	1	1	1

Safety alerts

Subheadings	Clinical description	C	A	H	D	O	R
Risks to self	Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect.	1	1	1	1	1	1
Risks to others	Risks to care professional or third party.	1	1	1	1	1	1

Legal information

Subheadings	Clinical description	C	A	H	D	O	R
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	1	1	1	1
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity.	1	1	1	1	1	1

Subheadings	Clinical description	C	A	H	D	O	R
Advance decisions about treatment	Three items: • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself.	1	1	1	1	1	1
Lasting or enduring power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: • whether there is a person with lasting or enduring power of attorney for personal welfare, independent mental capacity advocate (IMCA), court appointed deputy. • name and contact details for person.	1	1	1	1	1	1
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation, and if so, the location of the relevant information/ documents.	1	1	1	1	1	1
Consent relating to child	Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency.	1	1	1	1	1	1
Consent to information sharing	Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes.	1	1	1	1	1	1
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult.	1	1	1	1	1	1

Social context

Subheadings	Clinical description	C	A	H	D	O	R
Household composition	Eg: lives alone, lives with family, lives with partner, etc. This may be plain text.	0	1	1	1	1	1
Lives alone	Yes/no/don't know (Y/N/DK)	0	1	1	1	1	1
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits and the current and previous use of recreational drugs.	0	1	0	0	1	1
Smoking	Latest or current smoking observation.	0	1	0	0	1	1
Alcohol intake	Latest or current alcohol consumption observation.	0	1	0	0	1	1

(continued overleaf)

Subheadings	Clinical description	C	A	H	D	O	R
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history.	0	1	0	1	1	1
Social circumstances	The record of a patient's social background, network and personal circumstances, eg, housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependants or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record.	0	1	0	0	1	1
Services and care	The description of services and care providing support for patient's health and social well-being.	0	1	0	0	1	1

Family history

Subheadings	Clinical description	C	A	H	D	O	R
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.	1	1	0	0	1	1

Review of systems

Subheadings	Clinical description	C	A	H	D	O	R
Review of systems	The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties, mood/anxiety, etc.	0	1	0	0	1	0

Patient and carer concerns

Subheadings	Clinical description	C	A	H	D	O	R
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent or the parent of a young child.	1	1	1	1	1	1

Examination findings

Subheadings	Clinical description	C	A	H	D	O	R
Examination findings	The record of findings from clinical examination.	0	0	0	0	0	1
General appearance	The record of a clinician's 'first impression' assessment including general clinical examination finding, eg, clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight, etc.	0	1	0	0	1	0
Vital signs	The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of National Early Warning Score (NEWS) chart where appropriate.	0	1	0	0	1	1
Mental state	Formal mental state examination or general description, eg, depression, anxiety, confusion, delirium.	0	1	1	0	1	0
Head and neck examination	The record of findings from the head and neck examination.	0	1	0	0	1	0
Oral examination	The record of findings from the oral examination.	0	1	0	0	1	0
Cardiovascular system	The record of findings from the cardiovascular system examination.	0	1	0	0	1	0
Respiratory system	The record of findings from the respiratory system examination.	0	1	0	0	1	0
Abdomen	The record of findings from the abdominal examination.	0	1	0	0	1	0
Genitourinary	The record of findings from the genitourinary examination.	0	1	0	0	1	0
Nervous system	The record of findings from the nervous system examination.	0	1	0	0	1	0
Musculoskeletal system	The record of findings from the musculoskeletal system examination.	0	1	0	0	1	0
Skin	The record of findings from examination of the skin.	0	1	0	0	1	0
Examination procedure	A procedure completed as part of the examination of the patient. Eg sygmoidoscopy, lumbar puncture, pleural tap, etc.	0	1	0	0	1	0

Assessment scales

Subheadings	Clinical description	C	A	H	D	O	R
Assessment scales	Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc.	1	1	0	1	1	1

Problems and issues

Subheadings	Clinical description	C	A	H	D	O	R
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance, yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation.	1	1	1	0	1	0

Diagnoses

Subheadings	Clinical description	C	A	H	D	O	R
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.	1	0	1	1	1	0
Differential diagnosis	The determination of which one of several diseases may be producing the symptoms.	1	0	1	0	1	0
Episode (first, new, other, ongoing)	• First episode. • New episode. • Other, past or ongoing episode.	1	0	0	0	0	0
Date diagnosis made	The date when the diagnosis was made.	1	0	0	0	0	0
Date of first presentation	The date the diagnosis condition first presented.	1	0	0	0	0	0

Procedures

Subheadings	Clinical description	C	A	H	D	O	R
Procedure	The therapeutic procedure performed. This could include site and must include laterality where applicable.	1	0	0	1	1	0
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. The intent is to be plain text and/or images but use codes wherever possible.	1	0	0	1	1	0
Specific anaesthesia issues	Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.	1	0	0	1	1	0

Clinical summary

Subheadings	Clinical description	C	A	H	D	O	R
Clinical summary	Narrative summary of the episode. 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'.	0	1	1	1	1	0

Investigations and results

In discharge this is called: Investigations and procedures requested

Subheadings	Clinical description	C	A	H	D	O	R
Investigations requested	This includes a name or description of the investigation requested and the date requested.	1	1	1	1	1	1
Investigations results	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	1	0	1	1
Procedures requested	These are the diagnostic procedures that have been requested and the date requested.	1	0	0	1	1	1

Plan and requested actions

Subheadings	Clinical description	C	A	H	D	O	R
Actions	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities: a) person responsible – name and designation/department/ hospital/patient etc responsible for carrying out the proposed action, and where action should take place b) action – 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.	1	1	1	1	1	0
Special monitoring required	Eg neuro-obs, 0_2 saturation etc.	0	1	0	0	0	0
DNACPR	Do not attempt cardiopulmonary resuscitation. This should be a record of the presence or absence of a DNACPR form.	0	1	1	0	0	0
Escalation plan	Who needs to be contacted in the event of significant problems or patient deterioration, eg, seniority/name/contact details of person to be called.	0	0	1	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 if any (yes/no).	1	1	1	1	1	0

(continued overleaf)

Subheadings	Clinical description	C	A	H	D	O	R
Aims and limitations of treatment and special instructions	The current aim of treatment including limitations to treatment and communication issues, eg, not for ITU.	0	0	1	0	0	0
Next appointment details	Eg booking follow-up appointment, etc.	0	0	0	0	1	0

Outstanding issues

Subheadings	Clinical description	C	A	H	D	O	R
Tasks which must be done	Include timescales (appropriate seniority of staff for each task).	0	0	1	0	0	0
Tasks to be done if possible	Eg test review, pre-discharge documents, criteria for discharge, including who may discharge the patient.	0	0	1	0	0	0

Information given

Subheadings	Clinical description	C	A	H	D	O	R
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 understands the information provided about diagnosis, prognosis and treatment.	1	1	1	1	1	1

Person completing record — In handover this is called: Person handing over

Subheadings	C	A	H	D	O	R
Name	0	1	1	1	1	1
Designation or role	0	1	1	1	1	1
Grade	0	1	1	1	1	0
Specialty	0	1	1	1	1	0
Contact details	0	0	1	0	0	0
Date completed	0	0	0	1	1	1

Person receiving handover

Subheadings	C	A	H	D	O	R
Name	0	0	1	0	0	0
Designation or role	0	0	1	0	0	0
Grade	0	0	1	0	0	0
Specialty	0	0	1	0	0	0
Contact details	0	0	1	0	0	0

Distribution list

Subheadings	Clinical description	C	A	H	D	O	R
Distribution list	Other individuals to receive copies of this communication/ referral letter.	0	0	0	1	1	1

Section 2: Admission record headings

Admission record standards: standard headings for the clinical information to be recorded when a patient is admitted to hospital.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

GP practice	
Subheading	**Clinical description**
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.
GP practice identifier	National code which identifies the practice.

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

Subheading	Clinical description
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Including: • full name • relationship (eg, next of kin) • role (eg, court appointed deputy) • contact details.

Special requirements

Subheading	Clinical description
Special requirements	Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. Includes: • preferred language • interpreter required • advocate required • transport required, etc.

Participation in research

Subheading	Clinical description
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.

Admission details

Subheading	Clinical description
Date of admission	Date patient admitted to hospital.
Admission method	How the patient was admitted to hospital. Eg elective, emergency, maternity, transfer, etc.
Referrer details	Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral. Includes: • name • role • specialty, department or team • organisation • contact details, eg, email, fax, telephone.
Source of admission	National code. Where the patient was immediately prior to admission, eg, usual place of residence, temporary place of residence, penal establishment.

(continued overleaf)

Subheading	Clinical description
Responsible consultant	The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient).
Specialty	Specialties designated by Royal Colleges and Faculties. Eg orthopaedics, renal medicine, endocrinology, etc.
Service	Subspecialties, treatment functions or services. Eg 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 who sees the patient. Record the most senior member of staff present (eg, ward round or where there is a junior member of staff being supervised by a more senior staff member). Includes: • name • role • telephone number.
Patient location	This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home.
Person accompanying patient	Identify others accompanying the patient, eg, relative, friend, informal carer, advocate. If the patient was not present was an authorised representative present? Includes: • name • relationship (spouse, etc) • role (patient advocate, etc).

History

Subheading	Clinical description
Reason for admission	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment.
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg 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 (eg, including travel history). Including if the information is given by the patient or their carer.
Information brought by patient	Eg Patient Passport, example diary data, pre-completed questionnaire, etc.
Relevant past medical, surgical and mental health history	The record of the patient'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).

Medications and medical devices	
Subheading	**Clinical description**
Medication name	May be generic name or brand name (as appropriate).
Medication form	Eg capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc).
Dose	This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.
Medication frequency	Frequency of taking or administration of the therapeutic agent or medication.
Additional instructions	Allows for: • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg where specific brand required • patient requirements, eg, unable to swallow tablets.
Do not discontinue warning	To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario.
Reason for medication	Reason for medication being prescribed, where known.
Medication recommendations	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Medication status	Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status.
Medication change	Where a change is made to the medication, ie one drug stopped and another started or, eg, dose, frequency or route is changed.
Reason for medication change	Reason for change in medication, eg, sub-therapeutic dose, patient intolerant.
Medicine administered	Record of administration to the patient, including self-administration.
Reason for non-administration	Reason why drug not administered (eg, patient refused, patient unavailable, drug not available).
Relevant previous medications	Record of relevant previous medications
Medical devices	The record of dietary supplements, dressings and equipment that the patient is currently taking or using.

Allergies and adverse reaction

Subheading	Clinical 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.
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.
Date first experienced	When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood).

Safety alerts

Subheading	Clinical description
Risks to self	Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to care professional or third party.

Family history

Subheading	Clinical 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.

Social context

Subheading	Clinical description
Household composition	Eg: lives alone, lives with family, lives with partner, etc. This may be plain text.
Lives alone	Yes/no/don't know (Y/N/DK).
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits and the current and previous use of recreational drugs.
Smoking	Latest or current smoking observation.
Alcohol intake	Latest or current alcohol consumption observation.

Subheading	Clinical description
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history.
Social circumstances	The record of a patient's social background, network and personal circumstances, eg, housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependants 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.

Patient and carer concerns

Subheading	Clinical description
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child.

Legal information

Subheading	Clinical description
Consent for treatment record	Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity.
Advance decisions about treatment	Three items: • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself.
Lasting or enduring power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy. • name and contact details for person.
Organ and tissue donation	Two data items: – has the person given consent for organ and/or tissue donation (yes/no)? – the location of the relevant information/documents.

(continued overleaf)

Subheading	Clinical description
Consent relating to child	Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency.
Consent to information sharing	Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult.

Review of systems

Subheading	Clinical description
Review of systems	The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties, mood/anxiety, etc.

Examination findings

Subheading	Clinical description
General appearance	The record of a clinician's 'first impression' assessment including general clinical examination finding, eg, clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight, etc.
Vital signs	The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of National Early Warning Score (NEWS) chart where appropriate.
Mental state	Formal mental state examination or general description, eg, depression, anxiety, confusion, delirium.
Head and neck examination	The record of findings from the head and neck examination.
Oral examination	The record of findings from the oral examination.
Cardiovascular system	The record of findings from the cardiovascular system examination.
Respiratory system	The record of findings from the respiratory system examination.
Abdomen	The record of findings from the abdominal examination.
Genitourinary	The record of findings from the genitourinary examination.
Nervous system	The record of findings from the nervous system examination.
Musculoskeletal system	The record of findings from the musculoskeletal system examination.
Skin	The record of findings from examination of the skin.
Examination procedure	A procedure completed as part of the examination of the patient. Eg sygmoidoscopy, lumbar puncture, pleural tap, etc.

Assessment scales

Subheading	Clinical description
Assessment scales	Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc.

Problems and issues

Subheading	Clinical description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance and yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation.

Relevant clinical risk factors

Subheading	Clinical description
Relevant clinical risk factors	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc.
Clinical risk assessment	Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc.
Risk mitigation	Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned.

Clinical summary

Subheading	Clinical description
Clinical summary	Narrative summary of the episode. 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’.
Expected date of discharge	The date the patient is currently expected to be discharged from hospital.

Investigations and results

Subheading	Clinical description
Investigations requested	This includes a name or description of the investigation requested and the date requested.
Investigations results	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.

Plan and requested actions

Subheading	Clinical description
Actions	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities: a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – 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.
Special monitoring required	Eg neuro-obs, 0_2 saturation etc.
DNACPR	Do not attempt cardiopulmonary resuscitation. This should be a record of the presence or absence of a DNACPR form.
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 if any (yes/no).

Information given

Subheading	Clinical 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 understands the information provided about diagnosis, prognosis and treatment.

Person completing record
Subheading
Name
Designation or role
Grade
Specialty

Section 3: Handover record headings

Handover record standards: standard headings for the clinical information that should be recorded and used for handover of patient care from one professional or team to another, including hospital at night, weekend and consultant team to consultant team.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

GP practice	
Subheading	**Clinical description**
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.
GP practice identifier	National code which identifies the practice.

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

Subheading	Clinical description
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Including: • full name • relationship (eg, next of kin) • role (eg, court appointed deputy) • contact details.

Social context

Subheading	Clinical description
Household composition	Eg: lives alone, lives with family, lives with partner, etc. This may be plain text.
Lives alone	Yes/no/don't know (Y/N/DK).

Special requirements

Subheading	Clinical description
Special requirements	Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. Includes: • preferred language • interpreter required • advocate required • transport required, etc.

Participation in research

Subheading	Clinical description
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.

Handover details

Subheading	Clinical description
Patient location	This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home.
Planned patient location	If patient is changing location.
Date of admission	Date patient admitted to hospital.
Expected date of discharge	The date the patient is currently expected to be discharged from hospital.

(continued overleaf)

Subheading	Clinical description
Responsible consultant	The name and designation of the consultant, who has overall responsibility for the patient (may not actually see the patient).
Specialty	Specialties designated by royal colleges and faculties. Eg orthopaedics, renal medicine, endocrinology, etc.
Service	Subspecialties, treatment functions or services. Eg hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic, etc.
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, eg, low potassium, immediately post-op, unstable medical condition.
Senior clinical contact	If there is a particular requirement to call a specific person, eg, consultant, SpR or special intervention team.

Clinical details

Subheading	Clinical description
Reason for admission	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment.
Clinical summary	Narrative summary of the episode. 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'.
Mental state	Formal mental state examination or general description, eg, depression, anxiety, confusion, delirium.
Relevant past medical, surgical and mental health history	The record of the patient'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).

Investigations and results

Subheading	Clinical description
Investigations requested	This includes a name or description of the investigation requested and the date requested.
Investigations results	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.

Diagnoses

Subheading	Clinical description
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.
Differential diagnosis	The determination of which one of several diseases may be producing the symptoms.

Problems and issues

Subheading	Clinical description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance and yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation.

Legal information

Subheading	Clinical description
Consent for treatment record	Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity.
Advance decisions about treatment	Three items: • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself.

(continued overleaf)

Subheading	Clinical description
Lasting or enduring power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy. • name and contact details for person.
Organ and tissue donation	Two data items: – has the person given consent for organ and/or tissue donation (yes/no)? – The location of the relevant information/documents.
Consent relating to child	Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency.
Consent to information sharing	Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult.

Relevant clinical risk factors

Subheading	Clinical description
Patient at high risk	This patient is at high risk of clinical deterioration and will need an immediate response if called.
Relevant clinical risk factors	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/ differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc.
Clinical risk assessment	Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc.
Risk mitigation	Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned.

Allergies and adverse reaction

Subheading	Clinical 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.
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations).

Subheading	Clinical description
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.
Date first experienced	When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood).

Safety alerts

Subheading	Clinical description
Risks to self	Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to care professional or third party.

Plan and requested actions

Subheading	Clinical description
Actions	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities: a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – 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.
Aims and limitations of treatment and special instructions	The current aim of treatment including limitations to treatment and communication issues, eg, not for ITU.
Escalation plan	Who needs to be contacted in the event of significant problems or patient deterioration include, eg, seniority/name/contact details of person to be called.
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 if any (yes/no).
DNACPR	Do not attempt cardiopulmonary resuscitation. This should be a record of the presence or absence of a DNACPR form.

Outstanding issues

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

Patient and carer concerns

Subheading	Clinical description
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent or the parent of a young child.

Information given

Subheading	Clinical 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 understands the information provided about diagnosis, prognosis and treatment.

Person handing over

Subheading
Name
Designation or role
Grade
Specialty
Contact details

Person receiving handover

Subheading
Name
Designation or role
Grade
Specialty
Contact details

Section 4: Discharge record headings

Discharge record standards: standard headings for the clinical information that should be recorded in the discharge record and included in the discharge summary communication from hospital to GP and patient.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

GP practice	
Subheading	**Clinical description**
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.
GP practice identifier	National code which identifies the practice.

Referral details	
Subheading	**Clinical description**
Referrer details	Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral.

Patient demographics	
Subheading	**Clinical description**
Patient name	The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Patient sex	Sex at birth. Determines how the individual will be treated clinically.
Gender	As the patient wishes to portray themselves.
Ethnicity	The ethnicity of a person as specified by the person.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: • type of identifier • identifier.
Patient address	Patient usual place of residence.

(continued overleaf)

Subheading	Clinical description
Patient telephone number	Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: • type • number.
Patient email address	Email address of the patient.
Communication preferences	Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille.
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Including: • full name • relationship (eg, next of kin) • role (eg, court appointed deputy) • contact details.

Social context

Subheading	Clinical description
Household composition	Eg: lives alone, lives with family, lives with partner, etc. This may be plain text.
Lives alone	Yes/no/don't know (Y/N/DK).
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history.

Special requirements

Subheading	Clinical description
Special requirements	Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. Includes: • preferred language • interpreter required • advocate required • transport required, etc.

Participation in research

Subheading	Clinical description
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.

Admission details

Subheading	Clinical description
Admission method	How the patient was admitted to hospital. Eg: elective, emergency, maternity, transfer, etc.
Source of admission	National code. Where the patient was immediately prior to admission, eg, usual place of residence, temporary place of residence, penal establishment.
Patient location	This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home.
Date of admission	Date patient admitted to hospital.
Time of admission	Time patient admitted to hospital.

Discharge details

Subheading	Clinical description
Discharging consultant	The consultant responsible for the patient at time of discharge.
Discharging specialty/ department	The specialty/department responsible for the patient at the time of discharge.
Expected date of discharge	The date the patient is currently expected to be discharged from hospital.
Date of discharge	
Time of discharge	Electronic environment only.
Discharge method	The method of discharge from hospital. National codes: eg, 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 destination	The destination of the patient on discharge from hospital. National codes. Eg NHS-run care home.
Discharge address	Address to which patient discharged. Only completed where this is not the usual place of residence.

Clinical details

Subheading	Clinical description
Reason for admission	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment.

Diagnoses

Subheading	Clinical description
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.

Procedures

Subheading	Clinical description
Procedure	The therapeutic procedure performed. This could include site and must include laterality where applicable.
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. The intent is to be plain text and/or images but use codes wherever possible.
Specific anaesthesia issues	Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.

Clinical summary

Subheading	Clinical description
Clinical summary	Narrative summary of the episode. 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	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

Subheading	Clinical description
Assessment scales	Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc.

Legal information

Subheading	Clinical description
Consent for treatment record	Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity.
Advance decisions about treatment	Three items: • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself.
Lasting or enduring power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: • whether there is a person with lasting or enduring power of attorney, Independent Mental Capacity Advocate (IMCA), court appointed deputy • name and contact details for person.
Organ and tissue donation	Two data items: – has the person given consent for organ and/or tissue donation (yes/no)? – the location of the relevant information/documents.
Consent relating to child	Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency.
Consent to information sharing	Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult.

Safety alerts

Subheading	Clinical description
Risks to self	Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to care professional or third party.

Medications and medical devices

Subheading	Clinical description
Medication name	May be generic name or brand name (as appropriate).
Medication form	Eg capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc).
Dose	This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.
Medication frequency	Frequency of taking or administration of the therapeutic agent or medication.
Additional instructions	Allows for: • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg, where specific brand required • patient requirements, eg, unable to swallow tablets.
Do not discontinue warning	To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario.
Reason for medication	Reason for medication being prescribed, where known.
Medication recommendations	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Medication change	Where a change is made to the medication, ie, one drug stopped and another started, or, eg, dose, frequency or route is changed.
Reason for medication change	Reason for change in medication, eg, sub-therapeutic dose, patient intolerant.
Medical devices	The record of dietary supplements, dressings and equipment that the patient is currently taking or using.

Allergies and adverse reaction

Subheading	Clinical 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.
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations).

Subheading	Clinical description
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.
Date first experienced	When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood).

Investigations and procedures requested

Subheading	Clinical description
Investigations requested	This includes a name or description of the investigation requested and the date requested.
Procedures requested	These are the diagnostic procedures that have actually been requested (and the date requested).

Patient and carer concerns

Subheading	Clinical description
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child.

Information given

Subheading	Clinical 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 understands the information provided about diagnosis, prognosis and treatment.

Plan and requested actions

Subheading	Clinical description
Actions	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities: a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – 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.
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 if any (yes/no).

Person completing record

Subheading
Name
Designation or role
Grade
Specialty
Date completed

Distribution list

Subheading	Clinical description
Distribution list	Other individuals to receive copies of this communication.

Section 5: Outpatient record headings

Outpatient record standards: standard headings for the clinical information recorded in an outpatient setting, including the initial and follow-up outpatient visits, and included in the outpatient letter to the GP and patient.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

The outpatient standards also include the administrative information that precisely defines the attributes of outpatient and ambulatory care sessions.

GP practice	
Subheading	**Clinical description**
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.
GP practice identifier	National code which identifies the practice.

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

(continued overleaf)

Subheading	Clinical description
Communication preferences	Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille.
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Including: • full name • relationship (eg, next of kin) • role (eg, court appointed deputy) • contact details.

Special requirements

Subheading	Clinical description
Special requirements	Eg level of language (literacy); preferred language (interpreter required)/ambulance required/ other transport arrangements required/ any other special requirements. Includes: • preferred language • interpreter required • advocate required • transport required, etc.

Participation in research

Subheading	Clinical description
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.

Outpatient details

Subheading	Clinical description
Contact type	First contact, follow-up contact. Also scheduled, unscheduled. This is always a coded response.
Consultation method	Face to face, telephone, teleconference, etc.
Purpose of contact	Explanatory statement of the purpose of the contact. Eg unscheduled contact because patient concerned, monitoring, screening, diagnosis, assessment, pre-admission assessment, etc.
Patient location	This is the physical location of the patient. For inpatient, eg, hospital ward, bed, theatre. For ambulatory care, eg, health centre, clinic, resource centre, patient's home.
Appointment time	The time the patient was due to be seen.

Subheading	Clinical description
Time patient seen	The time the patient was seen.
Time consultation finished	To calculate duration of consultation.
Specialty	Specialties designated by royal colleges and faculties. Eg orthopaedics, renal medicine, endocrinology, etc.
Service	Subspecialties, treatment functions or services. Eg hand surgery, back surgery, hand clinic, TIA clinic, falls clinic, speech and language therapy, dialysis, family therapy, pre-admission assessment clinic, etc.
Responsible healthcare professional	The name and designation of the consultant, nurse consultant, midwife, physiotherapist, etc. who has overall responsibility for the patient (may not actually see the patient).
Seen by	Doctor, nurse or other healthcare professional who sees the patient. Record the most senior member of staff present (eg, ward round or where there is a junior member of staff being supervised by a more senior staff member). Includes: • name • role • telephone number.
Care professional(s) present	The name and designation of the additional individuals or team members including consultant(s), nurse consultant(s), physiotherapist(s), surgeon(s), social worker(s), etc. Eg where two or more care professionals are jointly running a session: • name • role • ID.
Person accompanying patient	Identify others accompanying the patient, eg, relative, friend, informal carer, advocate. If the patient was not present, was an authorised representative present? Includes: • name • relationship (spouse, etc) • role (patient advocate, etc).

Referral details

Subheading	Clinical description
Referrer details	Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral. Includes: • name • role • specialty, department or team • organisation • contact details, eg, email, fax, telephone.

(continued overleaf)

Subheading	Clinical description
Referral method	A method of referral is 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	Name, designation and organisation. If not an individual, this could be a service, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Includes: • name • role • specialty, team, department • organisation.
Urgency of referral	Referrer's assessment of urgency (eg, urgent/soon/routine). May include reason if other than routine. Eg two data items: • level of urgency • reason.

History

Subheading	Clinical description
Reason for referral	A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carer's concerns.
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, eg, by parent or carer.
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg 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 (eg 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.
Information brought by patient	Eg Patient Passport, example diary data, pre-completed questionnaire, etc.
Relevant past medical, surgical and mental health history	The record of the patient'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).

Safety alerts

Subheading	Clinical description
Risks to self	Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to care professional or third party.

Medications and medical devices

Subheading	Clinical description
Medication name	May be generic name or brand name (as appropriate).
Medication form	Eg capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc).
Dose	This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.
Medication frequency	Frequency of taking or administration of the therapeutic agent or medication.
Additional instructions	Allows for: • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg, where specific brand required • patient requirements, eg, unable to swallow tablets.
Do not discontinue warning	To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario.
Reason for medication	Reason for medication being prescribed, where known.
Medication recommendations	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Medication change	Where a change is made to the medication ie one drug stopped and another started or, eg, dose, frequency or route is changed.
Reason for medication change	Reason for change in medication, eg, sub-therapeutic dose, patient intolerant.
Medicine administered	Record of administration to the patient, including self-administration.
Reason for non-administration	Reason why drug not administered (eg, patient refused, patient unavailable, drug not available).
Relevant previous medications	Record of relevant previous medications.
Medical devices	The record of dietary supplements, dressings and equipment that the patient is currently taking or using.

Allergies and adverse reaction

Subheading	Clinical 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.
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.
Date first experienced	When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood).

Legal information

Subheading	Clinical description
Consent for treatment record	Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity.
Advance decisions about treatment	Three items: • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself.
Lasting or enduring power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy • name and contact details for person.
Organ and tissue donation	Two data items: – Has the person given consent for organ and/or tissue donation (yes/no)? – The location of the relevant information/documents.
Consent relating to child	Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency.

Subheading	Clinical description
Consent to information sharing	Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult.

Social context

Subheading	Clinical description
Household composition	Eg: lives alone, lives with family, lives with partner, etc. This may be plain text.
Lives alone	Yes/no/don't know (Y/N/DK).
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits and the current and previous use of recreational drugs.
Smoking	Latest or current smoking observation.
Alcohol intake	Latest or current alcohol consumption observation.
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history.
Social circumstances	The record of a patient's social background, network and personal circumstances, eg, housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependants 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.

Family history

Subheading	Clinical 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.

Review of systems

Subheading	Clinical description
Review of systems	The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties, mood/anxiety, etc.

Patient and carer concerns

Subheading	Clinical description
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child.

Examination findings

Subheading	Clinical description
General appearance	The record of a clinician's 'first impression' assessment including general clinical examination finding, eg, clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight, etc.
Vital signs	The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of National Early Warning Score (NEWS) chart where appropriate.
Mental state	Formal mental state examination or general description, eg, depression, anxiety, confusion, delirium.
Head and neck examination	The record of findings from the head and neck examination.
Oral examination	The record of findings from the oral examination.
Cardiovascular system	The record of findings from the cardiovascular system examination.
Respiratory system	The record of findings from the respiratory system examination.
Abdomen	The record of findings from the abdominal examination.
Genitourinary	The record of findings from the genitourinary examination.
Nervous system	The record of findings from the nervous system examination.
Musculoskeletal system	The record of findings from the musculoskeletal system examination.
Skin	The record of findings from examination of the skin.
Examination procedure	A procedure completed as part of the examination of the patient. Eg sygmoidoscopy, lumbar puncture, pleural tap, etc.

Assessment scales

Subheading	Clinical description
Assessment scales	Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc.

Problems and issues

Subheading	Clinical description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance and yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation.

Diagnoses

Subheading	Clinical description
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.
Differential diagnosis	The determination of which one of several diseases may be producing the symptoms.

Relevant clinical risk factors

Subheading	Clinical description
Relevant clinical risk factors	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc.
Clinical risk assessment	Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc.
Risk mitigation	Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned.

Clinical summary

Subheading	Clinical description
Clinical summary	Narrative summary of the episode. 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’.

Investigations and results

Subheading	Clinical description
Investigations requested	This includes a name or description of the investigation requested and the date requested.
Investigation results	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.
Procedures requested	These are the diagnostic procedures that have actually been requested (and the date requested).

Procedures

Subheading	Clinical description
Procedure	The therapeutic procedure performed. This could include site and must include laterality where applicable.
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. The intent is to be plain text and or images but use codes wherever possible.
Specific anaesthesia issues	Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.

Plan and requested actions

Subheading	Clinical description
Actions	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities: a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – 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.
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 if any (yes/no).
Next appointment details	Eg booking follow-up appointment, etc.

Information given

Subheading	Clinical 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 understands the information provided about diagnosis, prognosis and treatment.

Person completing record

Subheading
Name
Designation or role
Grade
Specialty
Date completed

Distribution list

Subheading	Clinical description
Distribution list	Other individuals to receive copies of this communication.

Section 6: Referral record headings

Referral record standards: the referral headings are primarily intended for recording the clinical information in referral communication between general practitioners (GP) and hospital doctors, copied to the patient. However, they may be used for other types of referral.

Not all headings will need to be used in all care settings or circumstances, and the order in which they appear in EHR applications, communications and letters can be agreed by system providers and end users.

Patient demographics	
Subheading	**Clinical description**
Patient name	The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Patient sex	Sex at birth. Determines how the individual will be treated clinically.
Gender	As the patient wishes to portray themselves.
Ethnicity	The ethnicity of a person as specified by the person.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: • type of identifier • identifier.
Patient address	Patient usual place of residence.
Patient telephone number	Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: • type • number.
Patient email address	Email address of the patient.
Communication preferences	Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille.
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Including: • full name • relationship (eg, next of kin) • role (eg, court appointed deputy) • contact details.

GP practice

Subheading	Clinical description
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.
GP practice identifier	National code which identifies the practice.

Referral details

Subheading	Clinical description
Referral to	Name, designation and organisation. If not an individual, this could be a service, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Includes: • name • role • specialty, team, department • organisation.
Referrer details	Name, designation, organisation and contact details of referrer. If not an individual, this could be, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc. Also needs to include self-referral. Includes: • name • role • specialty, department or team • organisation • contact details, eg, email, fax, telephone.
Referral method	A method of referral is 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.
Person to attend with patient	Identify others who will/may accompany the patient, eg, relative, carer, chaperone. Includes: • name • relationship (friend, relative, etc) • role (patient advocate, chaperone etc) • attendee's special requirements.
Attachments	Documents included as attachments which accompany the communication Data items: • number of attachments • type of attachments • attached documents.
Referral criteria	Records whether specific criteria required for referral, to a particular service, have been met (may be nationally or locally determined).
Details of other referrals	Other referrals related to this or associated conditions.

Special requirements

Subheading	Clinical description
Special requirements	Eg level of language (literacy); preferred language (interpreter required)/ambulance required/other transport arrangements required/any other special requirements. Includes: • preferred language • interpreter required • advocate required • transport required, etc.

Participation in research

Subheading	Clinical description
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.

History

Subheading	Clinical description
Reason for referral	A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carer's concerns.
Expectation of referral	A clear statement of the expectations of the person making the referral as to the management of the patient, eg, advice only, diagnosis, treatment, etc.
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, eg, by parent or carer.
Patient's expectation of referral	Patient's expectations of the referral including preferences. This may include any discussions that took place, the level of shared decision making involved, information about patient's source of advice.
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg 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 (eg, including travel history). Including if the information is given by the patient or their carer.

Subheading	Clinical description
Relevant past medical, surgical and mental health history	The record of the patient'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).
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.
Urgency of referral	Referrer's assessment of urgency (eg, urgent/soon/routine). May include reason if other than routine. Eg two data items: • level of urgency • reason.

Examination findings

Subheading	Clinical description
Examination findings	The record of findings from clinical examination.
Vital signs	The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of National Early Warning Score (NEWS) chart where appropriate.

Assessment scales

Subheading	Clinical description
Assessment scales	Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc.

Relevant clinical risk factors

Subheading	Clinical description
Relevant clinical risk factors	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/differential diagnosis. Eg being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc.
Clinical risk assessment	Specific risk assessments required/undertaken, including thromboembolic risk assessment, etc.
Risk mitigation	Action taken to reduce the clinical risk, including thromboembolic preventative action and date actioned.

Investigations and results

Subheading	Clinical description
Investigations requested	This includes a name or description of the investigation requested and the date requested.
Investigation results	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.
Procedures requested	These are the diagnostic procedures that have actually been requested (and the date requested).

Family history

Subheading	Clinical 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.

Social context

Subheading	Clinical description
Household composition	Eg: lives alone, lives with family, lives with partner, etc. This may be plain text.
Lives alone	Yes/no/don't know (Y/N/DK).
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits and the current and previous use of recreational drugs.
Smoking	Latest or current smoking observation.
Alcohol intake	Latest or current alcohol consumption observation.
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history.
Social circumstances	The record of a patient's social background, network and personal circumstances, eg, housing, religious, ethnic and spiritual needs, social concerns and whether the patient has dependants 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.

Patient and carer concerns

Subheading	Clinical description
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child.

Medications and medical devices

Subheading	Clinical description
Medication name	May be generic name or brand name (as appropriate).
Medication form	Eg capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc).
Dose	This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.
Medication frequency	Frequency of taking or administration of the therapeutic agent or medication.
Additional instructions	Allows for: • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg, where specific brand required • patient requirements, eg, unable to swallow tablets.
Do not discontinue warning	To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario.
Reason for medication	Reason for medication being prescribed, where known.
Medication recommendations	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Medication status	Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status.
Medication change	Where a change is made to the medication ie one drug stopped and another started or, eg, dose, frequency or route is changed.
Reason for medication change	Reason for change in medication, eg, sub-therapeutic dose, patient intolerant.
Relevant previous medications	Record of relevant previous medications.
Medical devices	The record of dietary supplements, dressings and equipment that the patient is currently taking or using.

Allergies and adverse reaction

Subheading	Clinical 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.
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.
Date first experienced	When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood).

Safety alerts

Subheading	Clinical description
Risks to self	Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to care professional or third party.

Legal information

Subheading	Clinical description
Consent for treatment record	Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity.
Advance decisions about treatment	Three items: • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself.
Lasting or enduring power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy • name and contact details for person.

Subheading	Clinical description
Organ and tissue donation	Two data items: – has the person given consent for organ and/or tissue donation (yes/no) – the location of the relevant information/documents.
Consent relating to child	Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency.
Consent to information sharing	Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult.

Information given

Subheading	Clinical 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 understands the information provided about diagnosis, prognosis and treatment.

Person completing record

Subheading
Name
Designation or role
Date completed

Distribution list

Subheading	Clinical description
Distribution list	Other individuals to receive copies of this referral letter.

Section 7: Core clinical headings

Core clinical heading standards: the core clinical headings are those that are the priority for inclusion in EHRs, as they are generally items that are the priority for coding using SNOMED CT.

GP practice	
Subheading	**Clinical description**
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.
GP practice identifier	National code which identifies the practice.

Patient demographics	
Subheading	**Clinical description**
Patient name	The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient
Patient sex	Sex at birth. Determines how the individual will be treated clinically.
Gender	As the patient wishes to portray themselves.
Ethnicity	The ethnicity of a person as specified by the person.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, eg, Community Health Index (CHI) in Scotland. Two data items: • type of identifier • identifier.
Patient address	Patient usual place of residence.
Patient telephone number	Telephone contact details of the person. To include, eg, mobile, work and home number if available. Two data items: • type • number.
Patient email address	Email address of the patient.
Communication preferences	Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille.
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Including: • full name • relationship (eg, next of kin) • role (eg, court appointed deputy) • contact details.

Participation in research

Subheading	Clinical description
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.

Reasons for contact

Subheading	Clinical description
Reason for admission	The health problems and issues experienced by the patient resulting in their referral by a healthcare professional for hospital admission, eg, chest pain, blackout, fall, a specific procedure, investigation or treatment.
Reason for handover	A clear statement of the reason for the temporary or permanent handover of care, eg, low potassium, immediately post-op, unstable medical condition.
Reason for referral	A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carer's concerns.
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, eg, by parent or carer.

Presenting complaints or issues

Subheading	Clinical description
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment.

Family history

Subheading	Clinical 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.

Diagnoses

Subheading	Clinical description
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.
Differential diagnosis	The determination of which one of several diseases may be producing the symptoms.
Episode (first, new, other, ongoing)	• First episode • New episode • Other, past or ongoing episode.
Date diagnosis made	The date when the diagnosis was made.
Date of first presentation	The date the diagnosis condition first presented.

Procedures

Subheading	Clinical description
Procedure	The therapeutic procedure performed. This could include site and must include laterality where applicable.
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. The intent is to be plain text and/or images but use codes wherever possible.
Specific anaesthesia issues	Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.

Assessment scales

Subheading	Clinical description
Assessment scales	Assessment scales used, eg, New York Heart Failure scale, Activities of Daily Living (ADL), cognitive function, mood assessment scales, developmental scales, MUST (nutrition), BPI (pain), etc.

Investigations and results

Subheading	Clinical description
Investigations requested	This includes a name or description of the investigation requested and the date requested.
Investigations results	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.

Subheading	Clinical description
Procedures requested	These are the diagnostic procedures that have actually been requested (and the date requested).

Problems and issues

Subheading	Clinical description
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance and yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation.

Patient and carer concerns

Subheading	Clinical description
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child.

Medications and medical devices

Subheading	Clinical description
Medication name	May be generic name or brand name (as appropriate).
Medication form	Eg capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc): may include method of administration (eg, by infusion, via nebuliser, via NG tube) and/or site of use (eg, 'to wound', 'to left eye', etc).
Dose	This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.
Medication frequency	Frequency of taking or administration of the therapeutic agent or medication.
Additional instructions	Allows for: • requirements for adherence support, eg, compliance aids, prompts and packaging requirements • additional information about specific medicines, eg, where specific brand required • patient requirements, eg, unable to swallow tablets.
Do not discontinue warning	To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario.
Reason for medication	Reason for medication being prescribed, where known.

(continued overleaf)

Subheading	Clinical description
Medication recommendations	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Medication status	Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status.
Medication change	Where a change is made to the medication, ie one drug stopped and another started, or eg, dose, frequency or route is changed.
Reason for medication change	Reason for change in medication, eg, sub-therapeutic dose, patient intolerant.
Medicine administered	Record of administration to the patient, including self-administration.
Reason for non-administration	Reason why drug not administered (eg, patient refused, patient unavailable, drug not available).
Relevant previous medications	Record of relevant previous medications.
Medical devices	The record of dietary supplements, dressings and equipment that the patient is currently taking or using.

Allergies and adverse reaction

Subheading	Clinical 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.
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: • manifestation, eg, skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg, results of investigations).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.
Date first experienced	When the reaction was first experienced. May be a date or partial date (eg, year) or text (eg, during childhood).

Safety alerts

Subheading	Clinical description
Risks to self	Risks the patient poses to themself, eg, suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to care professional or third party.

Plan and requested actions

Subheading	Clinical description
Actions	Including planned investigations, procedures and treatment for a patient's identified conditions and priorities: a) person responsible – name and designation/department/hospital/patient/etc responsible for carrying out the proposed action, and where action should take place b) action – 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.
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 if any (yes/no).

Information given

Subheading	Clinical 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 understands the information provided about diagnosis, prognosis and treatment.

Legal information

Subheading	Clinical description
Consent for treatment record	Whether consent has been obtained for the treatment. May include where record of consent is located or record of consent.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity.
Advance decisions about treatment	Three items: • whether there are written documents, completed and signed when a person is legally competent, that explain a person's medical wishes in advance, allowing someone else to make treatment decisions on his or her behalf late in the disease process • location of these documents • may be copy of the document itself.

(continued overleaf)

Subheading	Clinical description
Lasting or enduring power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: • whether there is a person with lasting or enduring power of attorney, independent mental capacity advocate (IMCA), court appointed deputy • name and contact details for person.
Organ and tissue donation	Two data items: – has the person given consent for organ and/or tissue donation (yes/no) – the location of the relevant information/documents.
Consent relating to child	Consideration of age and competency, including Gillick competency. Record of person with parental responsibility or appointed guardian where child lacks competency.
Consent to information sharing	Record of consent to information sharing, including any restrictions on sharing information with others, eg, family members, other healthcare professionals. Also use of identifiable information for research purposes.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult.

Organisations contributing to the review of all record standards headings

Acute and mental health trust medical directors
Association for Clinical Biochemistry
Association for Palliative Medicine of Great Britain and Ireland
Association of British Clinical Diabetologists
Association of Cancer Physicians
Association of Directors of Adult Social Services
Association of Surgeons of Great Britain and Ireland
British Association for Parenteral and Enteral Nutrition
British Association for Sexual Health and HIV
British Association of Audiovestibular Physicians
British Association of Dermatologists
British Association of Oral and Maxillofacial Surgeons
British Association of Otorhinolaryngology
British Association of Paediatric Surgeons
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 Orthodontic Society
British Orthopaedic Association
British Pain Society
British Pharmacological Society
British Psychological Society
British Society for Gastroenterology
British Society for Haematology
British Society for Human Genetics
British Society for Immunology
British Society of Rehabilitation Medicine
British Thoracic Society
Chartered Society of Physiotherapy
Choose and Book clinical leads
Chronic Pain Policy Coalition
Clinical Genetics Society
College of Emergency Medicine
College of Occupational Therapists
Department of Health Informatics Directorate – Patients and Public Clinical Division
EMIS
Faculty of Occupational Medicine
Faculty of Pharmaceutical Medicine
Faculty of Sport and Exercise Medicine
Health and Care Professions Council
In Practice Systems
Intensive Care Society
Local Medical Committee Chairs
National Voices
NHS London
Nursing and Midwifery Council
Nutrition Society
TPP
Renal Association
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians – Patient and Carer Network
Royal College of Physicians and Surgeons Glasgow
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of Edinburgh
Royal Pharmaceutical Society of Great Britain
Society of British Neurological Surgeons
UK Terminology Centre

Organisations which signed off the record standards headings May 2013

Association for Clinical Biochemistry
Association for Palliative Medicine of Great Britain & Ireland
Association of British Clinical Diabetologists
Association of Cancer Physicians
Association of Surgeons of Great Britain and Ireland
British Association for Parenteral & Enteral Nutrition
British Association of Audiovestibular Physicians
British Association of Dermatologists
British Association of Otorhinolaryngology (Ears, Nose and Throat) (ENT – UK)
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 Orthodontic Society
British Orthopaedic Association
British Pain Society
British Psychological Society
British Society for Gastroenterology
British Society for Haematology
British Society for Genetic Medicine
British Society for Immunology
British Thoracic Society
Chartered Society of Physiotherapy
Chronic Pain Policy Coalition (CPPC)
Clinical Genetics Society
College of Emergency Medicine
College of Occupational Therapists
Faculty of Occupational Medicine
Faculty of Sport and Exercise Medicine
Intensive Care Society
Renal Association
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists (RCOG)
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians and Surgeons Glasgow
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of Edinburgh
The Royal College of Surgeons of England
Royal Pharmaceutical Society (RPS)
Society of British Neurological Surgeons

Health and Social Care Information Centre
1 Trevelyan Square
Boar Lane
Leeds LS1 6AE
www.hscic.gov.uk

Academy of Medical Royal Colleges
10 Dallington Street
London EC1V 0DB
www.aomrc.org.uk

hscic Health & Social Care Information Centre

ACADEMY OF MEDICAL ROYAL COLLEGES