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DIGITAL SOCIAL CARE INFORMATION FOR TRANSFERS OF CARE

SURVEY RESULTS AND ANALYSIS v 1.0

OCTOBER 2020

Acknowledgements

The Professional Record Standards Body

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

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Professional Record Standards Body
7 - 145 Great Dover Street, London, SE1 4YR
www.theprsb.org

Community Interest Company No 8540834

Revision History

Version	Date	Summary of Changes
0.1	10.09.2020	First draft created by James Critchlow based on template drafted by Alannah McGovern
0.2	22.09.2020	Updated following comments from project team and advisors
0.3	19.09.2020	Updated following feedback from assurance committee
1.0	20.09.2020	1st version for publication

Reviewers

This document was reviewed by the following people:

Reviewer name	Title / Responsibility
Professor Adam Gordon	PRSB Clinical Advisor, Clinical Associate Professor of Medicine of Older People – University of Nottingham, Consultant Geriatrician – Derby Teaching Hospitals NHS Trust, Vice President for Academic Affairs – British Geriatric Society
Beverley Latania	PRSB Social Care Advisor for Digital Social Care Information Project, Head of Mental Health Social Work – Islington Council
Katie Thorn	PRSB Social Care Advisor for Digital Social Care Information Project, Digital Engagement Manager – Registered Nursing Home Association, Project Lead – Digital Social Care
Samantha Goncalves	PRSB Citizen Lead for Digital Social Care Information Project
Dr John Robinson	PRSB Clinical Advisor for Digital Social Care Information Project, PRSB Clinical Safety Officer, Retired General Practitioner and Clinical Informatician

Approved by

This document was approved by the following:

Name	Title	Date	Version
Project Board	Project Board	28/9/20	0.3
Assurance Committee	Assurance Committee	28/9/20	0.3

Contents

1 Introduction

This is an appendix to the final report for the digital social care information project.

The online surveys were one part of the overall consultation approach in the development of the standards, after the detailed work on specific topic areas and national survey on the 5 areas of focus. We split the five topic areas over two surveys, and 820 people responded across the surveys. Feedback from the consultations prior to the surveys (webinars) aided the design. The surveys were aimed at frontline care professionals, people who use services and their carers as well as systems suppliers.

The surveys were shared widely, to our advisory board representatives, key contacts, newsletter subscribers, those who attending our topic specific webinars and the NHS Digital pathfinders and their networks. The surveys were featured in a number of publications, on professional platforms such as Ryver and with other groups including the Care Provider Alliance representing up to 2 million working in domiciliary care and care homes, system suppliers and patient groups such as the Patient Information Forum representing 300+ charities.

This report focuses on the results of ‘survey 2’ which ran from 29th June – 2nd August 2020 and includes the results and analysis of the survey. The findings from the survey are described further in the final report and were used to develop new standards to support particular transfer of care scenarios. Much of the content is common to existing standards, but both the “Urgent Referral from Care Home to Hospital” and “Hospital Referral for Assessment for Community Care and Support”[1] have new elements to meet the scenario requirements.

In total 360 people participated in survey 2.

2 Respondents

The initial survey questions related to respondents. Respondents were eligible to answer questions relating to both Digital Social Care Information Standards relating to transfers of care. In this section, the following quantitative data relating to respondents is shown:

- Q1: The first question identified whether respondents were answering the survey on behalf of themselves (n = 351, 97.50%) or supporting someone else to complete it (n = 9, 2.50%).
- Q2: The second question identified the respondents who worked in health or social care (n = 319, 88.61%) or did not (n=41, 11.39%).
- Q3: The third question identified the 360 respondents’ roles and the settings in which they work, which is shown in table 1 below.

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[1] *NB*: At the time the survey was conducted this standard was named “Hospital Referral to Local Authority”

- Q4: The fourth question identified, from the 320 respondents who work in health and social care services, the area in which they work most regularly; which is shown in table 2 below.
- Q5: The fifth question identified, from the 320 respondents who work in health and social care services, the setting in which they work most regularly (see table 3 below).

Participants	**Percentage (n)**
Secondary care doctors	15.28 % (55)
Nurse	15.00 % (54)
NHS administration and management	8.33 % (30)
Service users and informal carers	7.78 % (28)
Care assistant / support worker / team leader	1.11 % (4)
Care home management	7.78 % (28)
Social services administration/ management	5.83 % (21)
Allied Health Professionals	6.39 % (23)
Social worker	5.00 % (18)
GP	4.44 % (16)
Health or social care IT systems supplier	2.5 % (9)
Midwife	2.78 % (10)
Other	14.44 % (52)
Healthcare assistant	0.28 % (1)
Volunteer	1.39 % (5)
Pharmacist	1,11 % (4)
Directors of social care	0.56 % (2)

(Specific roles identified in the 'Other' category included: Consultant and advisor to DHSC (Department of Health and Social Care), Student Midwife, Public Health worker, Manager in Activity Centre for Older People, Domiciliary Care Registered Manager, NHS IT Programme Manager, Social Care Analyst, Government Analyst, Health Services Inspector, Community Pharmacy IT Lead, Integration Lead, Patient Safety Programme Manager, Clinical Nurse Analyst, Commissioning Manager, Chair of BASW (British Association of Social Workers) England Adults Group, GP and Clinical Director for Healthy Aging at the Health Innovation Network, Community engagement Officer, Shared Lives Carer, Adult Social Care

Commissioner, Contracts Officer, Nurse and Digital Transformation Lead, Contracts Officer and Consultant Geriatrician.)

Table 1: Roles of survey respondents

What area do you work in?	Percentage (n)
Care of older people	40.94 % (131)
Other	23.44 % (75)
General medical services	6.56 % (21)
Frailty	6.25 % (20)
Community services	5.31 % (17)
Learning disabilities	2.50 % (8)
Long term conditions	3.13 % (10)
End of life	1.88 % (6)
Dementia	2.19 % (7)
Emergency Care	1.56 % (5)
Mental Health	1.56 % (5)
Acute care	1.56 % (5)
Physical disabilities	0.63 % (2)
Neurodevelopmental disorders	0.31% (1)
Adult’s nursing	0.94 % (3)
Other nursing (including children’s nurse)	0.31% (1)
Rehabilitation	0.94 % (3)

(Specific areas identified in the ‘Other’ category included: Maternity, data standards and interoperability, Midwifery, Strategic Planning and Partnerships, Pharmaceutical Public Health, CCG (Clinical Commissioning Group) Safeguarding, Commissioning (of services listed in table 2), Digital Services, Analysis, Discharge Planning in the Acute Sector, Care Homes Support Team, Higher Education, Digital Technology and Information Technology.)

Table 2: Area worked in by professional respondents

What setting do you work in?	Percentage (n)
Acute hospital	26.25 % (84)
Other	15.31 % (49)
Local authority	12.19 % (39)
Community care	10.94 % (35)
CCG, national NHS or social care body	8.13 % (26)
Primary care	7.50 % (24)
Care home with nursing	8.13 % (26)
Care home without nursing	4.38 % (14)
In a person’s home	1.88 % (6)
Specialist centre	1.56 % (5)
Urgent and emergency care	1.56 % (5)
Ambulance	0.63 % (2)
111	0.00 % (0)
Assisted living	0.31 % (1)
Mental health / learning disability hospital	0.31 % (1)
Hospice	0.94 % (3)

(Specific settings identified in the ‘Other’ category included: Care Home (Operations Director), Health Board, Activity Centre, Software Provider to Care Homes, ICP (Integrated Care Provider) Planning, Central Government, DHSC (Department of Health and Social Care), Academic Health Science Network (AHSN), HEI (Health Environment Inspectorate), Community Pharmacy, Outpatients, Hospital at Home Team, NHS CSU (Commissioning Support Unit), Community Hospital, and other Professional Bodies.)

Table 3: Setting worked in by professional respondents

NB: The qualitative responses to questions four and five in the ‘other’ category have significant overlap but help to illustrate the wide range of professional stakeholders who answered the survey.

3 Question Analysis

Each question is shown in the following section together with quantitative statistics and key themes that emerged from qualitative analysis of the comments (where provided) and (where appropriate) where / how the comment was addressed in the Standard, Implementation Guidance, or Clinical Safety Case.

3.1 Questions relating to the Hospital Referral for Assessment for Community Care and Support Standard (answered by person receiving care or their carers)

3.1.1 Q6: From the perspective of the person receiving care does this standard contain appropriate information to allow their care expectations to be met?

- A majority of respondents (85.71 %, n = 12) recorded ‘Yes’. The standard was considered to be “comprehensive” and “detailed”.
- A single respondent recorded ‘No’ – No comment was given.
- A single respondent recorded ‘Don’t know’ and expressed a concern as to whether the “…hospital staff will be able to gather the information fully given the limited time they have which is exacerbated by staff shortages”.

3.1.2 Q7: From a carer’s point of view, does this standard contain appropriate information to allow their care expectations to be met?

- A majority of respondents (78.57 %, n = 11) recorded ‘Yes’.
- Two respondents recorded ‘No’ – with a concern raised relating to the staff ensuring “involvement with family as per the Mental Capacity Act (2005)” in decision making. This concern was out of scope.
- A single respondent recorded ‘Don’t know’ and expressed a general concern that standards are “rarely adhered to in practice”. See Clinical Safety Case (Hazard 21: ‘Users don’t value the product’; Hazard 23: ‘Failure to adopt transfers of care record standard(s)’).

3.1.3 Q8: Will it be clear from the information that the person, their carers and family or representatives have been involved and have agreed with all the major decisions made to date?

- A majority of respondents recorded ‘Yes’ (42.86 %, n = 6) or ‘Partially’ (42.86 %, n = 6). A general theme was the importance of involvement of patients, family and carers in decision making. There was an appreciation that the information in the standard would help to ensure “…the patient is being looked after in all aspects”.
- Two respondents recorded ‘No’ – No comment was given.

3.1.4 Q9: Is there any information missing that should be included in this referral?

- A majority of respondents recorded ‘Yes’ (57.14 %, n = 8); five respondents recorded ‘No’ and a single respondent recorded ‘Don’t know’. Many suggestions made as comments were already covered in the standard.
- Significant concerns that were raised included:

    1. Will the “Carer/other next of kin understand all the terminology and are aware of everything that is being said and done?” See Clinical Safety Case (Hazard 3:’Incorrect

data or data is misinterpreted, or data is represented incorrectly'; Hazard 20: 'Competent patient or their carer unable to understand information recorded in sections.')

2. "How will the transferring authority know it has been read and understood?" See Clinical Safety Case (Hazard 50: "Referral never arrives'; 'Hazard 51: "Unread clinical referrals"; Hazard 52: "Unactioned clinical referral") and implementation guidance relating to the 'Return response to' element in the standard.

3.1.5 Q10: Is there any information that is not needed and should be removed?

- A majority of respondents (64.29 %, n = 9) recorded 'No'; Four respondents recorded 'Yes' (without identifying which elements should be removed) and a single respondent recorded 'Don't know'.
- One respondent suggested that "[t]here should be a place to record why a discharge is delayed, e.g. installation of required equipment". See implementation guidance relating to the 'Reason for withdrawal' in the standard.

3.2 Questions relating to the Hospital Referral for Assessment for Community Care and Support Standard (answered by professionals)

3.2.1 Q11: Will it be clear from the information that the person, their carers and family or representatives have been involved and have agreed with all the major decisions made to date?

- A majority of respondents recorded 'Yes' (48.86 %, n = 86) or 'Partially' (26.14 %, n = 46).
- A minority of respondents recorded 'No' (11.93%, n = 21) or 'Don't know' (13.07 %, n =23).
- Several comments referred to the fact it was not possible to ascertain from the standard whether carers, family or representatives had endorsed the contents of the record. This is not explicitly recorded in the standard and is a consideration for implementation. It was recognised by some respondents that some of this information would be available in the Legal and Discharge Details sections of the standard. None of the respondents implied that the standard would hinder the ability of clinicians to involve the aforementioned persons in the process where they decide appropriate.

3.2.2 Q12: Will it be clear from the information what actions are requested of the health and care staff and who is being asked to do them?

- A majority of respondents recorded 'Yes' (59.78 %, n = 107) or 'Partially' (22.91 %, n = 41).
- A minority of respondents recorded 'No' (10.06 %, n = 18) or 'Don't know' (7.26 %, n = 13).
- A significant number of comments referred to the fact that the answer of this question is dependent on the person completing the record including clear and appropriate instructions / information during data entry and data quality. None of the respondents implied that the standard would hinder the ability of clinicians to convey the such data to receivers. See Clinical Safety Case (Hazard 5: 'Poor quality data'; Hazard 56: 'Lack of clarity about required actions').
- Several comments referred to the fact that there was potential for a large information burden to be transferred and the importance of system design to ensure information is communicated clearly (out of scope). See Clinical Safety Case (Hazard 31: 'Too many sections').

3.2.3 Q13: Do you think it will be difficult for the hospital to collect and provide this information to the Local Authority team?

This question was answered with a five-point adapted Likert scale, as seen in table 4 below:

Response:	**Percentage (n)**
Very difficult	10.73 % (19)
Difficult	40.11 % (71)
Neutral	32.77 % (58)
Easy	14.12 % (25)
Very easy	2.26 % (4)
Total:	100.00 % (177)

Table 4: Respondent's estimated difficulty for provision of data to local authority

Respondents then answered the question, 'What issues and problems do you think can occur?':

- A significant number of comments from users who responded either 'Very difficult' or 'Difficult' referred to the burden on clinicians of the large amount of time they would need to collect and document all the required clinical information for the standard; particularly if digital systems are immature with limited coding, interoperability and auto-population. Several commenters observed that the standard was "multi-professionally completed" and that this was potentially logistically challenging. This issue is addressed in the Clinical Safety Case (Hazard 31: 'Too many sections'; Hazard 45: 'Burden on clinicians'). In this context of limited time, some comments expressed concerns regarding data quality. See Clinical Safety Case (Hazard 5: 'Poor quality data').
- Several comments related to the challenge of duplication of data between systems and identifying a trusted and clearly documented source of truth for the data; as well as the challenge of identifying social care information in the acute setting. See Clinical Safety Case (Hazard 4: 'Conflicting information'; Hazard 8: 'The context or provenance of the information unknown or misunderstood'; Hazard 29: 'Patient data error in interconnecting systems').
- Several comments emphasised the importance of compliance with "GDPR (General Data Protection Regulation) and consent". See Implementation Guidance and Clinical Safety Case (Hazard 14: 'Consent for information sharing may cause confusion'; Hazard 15: 'Sex data item may cause accidental disclosure of gender reassignment without consent'; Hazard 18: 'Risk of sharing confidential information inappropriately')
- Some comments emphasised the challenges of communication between hospital and local authority professionals and the differing use of terminology e.g. the use of a "Strength based approach' to problems in social care. See Clinical Safety Case (Hazard 3: 'Incorrect data or data is misinterpreted, or data is represented incorrectly').

3.2.4 Q14: Is there any information missing that should be included in this referral?

- A majority of respondents (46.02 %, n = 81) recorded ‘No’ or ‘Don’t know’ (30.68 %, n = 41) and a significant minority recorded ‘Yes’ (23.30 %, n = 41).
- Many suggestions made as comments were already covered in the standard (see table 5 below for a non-exhaustive list of examples – *NB*: sections / elements added following survey feedback are identified in the table). Please see the standard and implementation guidance for details.

Comment(s)	**Corresponding section / element**
“You might want to know which staff have been involved in the care so far”.	Professional contacts A ‘Performing professional’ is associated with most actions recorded in the standard
“Treatment escalation plan (TEP)”.	Contingency plan – Contingency plan name
“Patients own goals and wishes”.	Person and carer concerns expectations and wishes (note this section has been removed from the standard as it is the predecessor to About Me), About Me, Care and support plan
“If there are any mental capacity issues that necessitate best interests decisions / consent / best interests decision and reasons for recommendation”. “Power of attorney / advanced directives”.	Legal information
“Function ability prior to admission and on discharge - ongoing plan”.	Individual requirements - Reasonable adjustment Plan and requested actions Care needs summary Treatments and interventions
“It is important so confirm whether an individual has been or needs to be assessed for NHS Continuing Healthcare funding”.	NHS CHC assessment (added post-survey)
“The person's strengths and what they are capable of doing - in their words”.	About Me
“Frailty score”.	Assessments
“Clearer detail on a person's Mental Capacity status and any consideration given”.	Mental capacity assessment
“Previous care package”.	Services and care – Social care package name / type etc. (*NB*: This section is contained in the Local Authority information view of the PRSB Core

	Information Standard and is not included in the Hospital Referral for Assessment for Community Care and Support Standard. However local implementors may wish to include it).

Table 5: Example suggested additions to standard and sections / elements where covered

- One comment is highlighted here that emphasised the risks associated with discharge:

“…The discharge summary may state the patient has been transferred to a non-NHS or other NHS provider, but does not specify the full destination address and contact details. Wards continue to maintain paper Discharge folders and this information is not uploaded. This is a significant patient safety/quality risk and means that patients requiring follow up post-discharge from hospital are lost to follow up…”

See Clinical Safety Case (Hazard 50: ‘Referral never arrives’).

3.2.5 Q15: Is there any information that is not needed and should be removed?

- A majority of respondents (58.38 %, n = 101) recorded ‘No’ or ‘Don’t know’ (31.79 %, n = 55) and a significant minority recorded ‘Yes’ (9.83 %, n = 17).
- A significant number of comments expressed concerns about the time / work burden of information, noting that many sections will not be appropriate for every patient. Several comments recognised that although the total information content of standard is large, different sections are appropriate dependent on context and setting; too many sections could be mitigated with appropriate RBAC (Role-Based Access Control). See Clinical Safety Case (Hazard 31: ‘Too many sections’; Hazard 45: ‘Burden on clinicians’; Hazard 46: ‘Inappropriate role-based access implementation’).
- Concerns were raised about keeping the medication list up-to-date and accurate as well as whether it would be understood by the receiver. See Clinical Safety Case (Hazard 53: ‘Attached information is out of date’; See also Hazard 48: ‘OTC (over the counter) medication mistaken for prescribed medication’).
- Concerns were raised about consent and ensuring that “…more data may be provided than is necessary for provision of care”. See Clinical Safety Case (Hazard 18: ‘Risk of sharing confidential information inappropriately’).

3.3 Questions relating to the Urgent Referral from Care Home to Hospital Standard

3.3.1 Q16: How important do you think it is that the following information is sent from the care home to hospital when a care home resident is referred in an emergency?

Table 5 below shows the percentage (%) of respondents who recorded either ‘Important’ or ‘Very important’ for each section.

Section	**Percentage (n)**
Professional contacts	82.39 % (131)
Personal contacts	95.60 % (152)
About me	93.96 % (145)
Care needs summary	88.05 % (140)
Individual requirements	96.20 % (152)
Reasonable adjustments	87.34 % (138)
Impairments	95.57 % (151)
Observations	86.07 % (136)
Legal information	86.88 % (139)
Safeguarding	93.68 % (148)
Contingency plans	85.44 % (135)
Additional support plans	80.13 % (125)
Referral information	93.04 % (147)
Risks	93.71% (149)
Medications and medical devices	95.57 % (151)
Medication administration record	94.30 % (149)
Allergies and adverse reactions	98.11 % (156)
End of life care	94.96 % (151)
Investigations results	83.65 % (133)
Examination findings	83.01 % (132)
Assessments	82.39 % (131)
Documents	70.06 % (110)
Property and equipment	74.68 % (118)
Procedures	71.97 % (113)
Problem list	81.65 % (129)
Social context	81.76 % (130)

Table 5: Percentage (%) of respondents who recorded either ‘Important’ or ‘Very important’ for each section

Key themes identified:

- An urgent referral to hospital should not be delayed by information that is not required by the hospital team. Some data may not have been collected (e.g. observations) or may not be "recorded by the care home in a way that others can understand".
- Key quote: "This information will be useful but much of it will either not be held by the care home or if it is held may be out of date. It may not be possible to collate and or copy it in an emergency situation. It may also be too much information and in reality a succinct summary may be more useful".
- Data in the record should be up to date, accurate, contextually relevant, and facilitate "continuity of care" and "person centred", "holistic" and "compassionate" approach to care – "the more complete the picture the more effective the handover" and "the more information the hospital has the better". The importance of sending all the information if available was emphasised by stakeholders with experience of using the physical 'Red Bag'.
- Multiple sources of the truth may cause confusion: "Be careful that the differentiation between required information to be provided and information which is accessible through sharing are not mixed up…A single version of the truth will minimise confusion. Determine where shared data should reside to reduce the need to copy data in order to fill in a referral". See Clinical Safety Case (Hazard 22: 'Confusion re: transfers of care record; LCR, summary care record, etc').
- There may be a risk of duplication with the MAR (Medicine Administration Record).

3.3.2 Q17: When a care home resident is in hospital, how important is having access to a photograph of them as they look when they are well?

- A majority of respondents (61.14 %, n = 96) recorded either 'Important' (35.03 %, n = 55) or 'Very important' (26.11 %, n = 41).
- A minority of respondents recorded 'Not important' (3.82 %, n = 6)

Key themes identified:

- A photograph may help establish "what is normal" as well as "baseline functionality" in the context of additional information such as a "supporting narrative on what "well" is to the patient". See About Me implementation guidance.
- Key quotes: "Timeliness of data is important. How old is the picture, what has happened since the picture was taken must be considered in order to ascertain value".; "It needs to be an up to date photo…"; "[a photo] with date taken".; "Can be used for identification".

3.3.3 Q18: When a care home resident is in hospital, how important is having access to information held by the care home about the history of GP consultations, A&E attendances / admissions?

- A majority of respondents (83.65 %, n = 96) recorded either 'Important' (28.30 %, n = 45) or 'Very important' (55.35 %, n = 88).
- A minority of respondents recorded 'Not important' (2.52 %, n = 4)
- Key quotes: "[This should be] collected from the source, not second hand".; "Information held by the care home about these things tends to be limited and incomplete".; Several

respondents emphasised that this information may be useful if not available from elsewhere at the time of admission: “information on GP attendances may not always be available on hospital computer systems” and “Depends on degree of information sharing between primary and secondary care”.

3.3.4 Q19: When a care home resident is in hospital, how important is access to information held by the care home about whether the resident is participating in research?

- Results for this question were equivocal.
- A slight majority of respondents (48.42 %, n = 77) recorded either ‘Important’ (27.04 %, n = 43) or ‘Very important’ (21.38%, n = 34).
- A significant number of respondents (44.03 %, n = 70) recorded either ‘Moderately important’ (24.53 %, n = 39) or ‘Slightly important’ (19.50 %, n = 31).
- A minority of respondents recorded ‘Not important’ (7.55 %, n = 12)
- Several respondents expressed that the importance is context dependent e.g. is the patient involved in a clinical trial? If so then admitting staff should be made aware, especially if medication related.

3.3.5 Q20: When a care home resident is in hospital how important is access to information held by the care home about pregnancy status?

- A majority of respondents (73.72 %, n = 115) recorded either ‘Important’ (25.64 %, n = 40) or ‘Very important’ (48.08 %, n = 75).
- A minority of respondents recorded ‘Not important’ (13.46 %, n = 21)
- Due to the average age of most residents being > 65 years the majority of comments expressed pregnancy was unlikely but supported inclusion if there was a possibility a female resident was of childbearing age. See CIS Clinical Safety Case (Hazard 13: ‘Pregnancy status data item misinterpreted’).
- Key quotes: “This is very important for all female patients, irrespective of age”.

3.3.6 Q21: What information about over-the-counter medications do you think would be important for professionals caring for a care home resident in hospital to access?

Section	**Percentage (n) ‘Yes’**	**Percentage (n) ‘No’**
Medication name – generic or brand name	91.88 % (147)	3.75 % (6)
Indication – the reason the medication was being taken	93.75 % (150)	1.88 % (3)
Form – The form of the medication e.g. capsule, drops, tablet, lotion etc.	86.16 % (137)	8.81 % (14)
Site – The anatomical site at which the medication is administered	87.42 % (139)	5.66 % (9)
Method – The technique or method by which the	91.82 %	3.77 % (6)

medication is administered	(146)	
Dose directions description – describes the entire medication dosage and administration directions	91.82 % (146)	3.77 % (6)
Dose amount description – A description of the medication single dose amount e.g. “30 mg” or “2 tabs”	91.82 % (146)	3.77 % (6)
Dose timing description – A description of the frequency of taking or administration of a medication dose e.g. “Twice a day”, “At 8am, 2pm and 10pm”	91.19 % (145)	4.40 % (7)

Table 6: Percentage (%) of respondents who recorded ‘Yes’ or ‘No’ to proposed elements for OTC cluster in the standard

- There was a strong consensus from respondents that all the elements in the cluster should be included in the standard.
- Key quotes: “All above are core components of patient safety”.; “Accurate information about all treatment being taken is essential to allow safe decision-making about all treatment to be given in hospital”.

3.3.7 Q22: Social context covers a range of areas. Which of the following information, if held by the care home about the resident, do you think professionals caring for the care home resident in hospital should be able to access?

Section	Percentage (n) ‘Yes’	Percentage (n) ‘No’
Occupational history – previous occupation(s) of a person	76.43 % (120)	14.65 % (23)
Educational history – educational history of a person	39.49 % (62)	43.31 % (68)
Smoking status – latest or current smoking status	96.23 % (153)	1.89 % (3)
Alcohol intake – latest or current alcohol consumption	94.97 % (151)	3.77 % (6)
Drug / substance use – latest or current drug / substance use	98.11 % (156)	0.00 % (0)
Lifestyle choices – the lifestyle choices made by the person which are pertinent to his or her health and well-being e.g. physical activity level, pets, hobbies and sexual habits	77.36 % (123)	13.84 % (2)
Social circumstances – a person’s social background, network and personal circumstances	81.13 % (129)	10.06 % (16)

e.g. housing		

Table 7: Percentage (%) of respondents who recorded 'Yes' to proposed elements for Social context cluster in the standard

- There was a strong consensus from respondents that all the elements in the cluster should be included in the standard with the exception of educational history, which was equivocal.
- Key quotes: "To truly enable holistic and person/relationship centred care, they need to fully understand who the person is/was. The hospital may need to make decisions on behalf of a person who lacks capacity and can only do so in their best interests if they know how they would have responded or lived their lives previously"; "All required to support a full clinical assessment of the resident and inform treatment options/conditions to investigate - e.g. smoker and previous exposure to asbestos important for lung conditions" or for "diagnosis and management of delirium + general good care"; "This information is certainly very helpful. Some are more essential than others, but the more information that can be shared in a transfer document the better, in terms of continuity of care and person-centred care".

3.3.8 Q23: Is there any other information that a care home may hold about a resident that would aid professionals caring for the care home resident in hospital?

- Results for this question were equivocal.
- Respondents recorded either 'Yes' (34.19 %, n = 53), 'No' (25.16 %, n = 39) or 'Don't know' (40.65 %, n = 63), which was the majority.
- Several comments stated that the information required was context dependent.
- Several suggestions exist or are covered elsewhere in the standard e.g. "safeguarding concerns" (Safeguarding),, "lasting powers of attorney" (Legal information), "religious beliefs" (Person demographics – religion), "dietary wishes" (About Me); "routines and preferences" (About me), "Anticipatory care plans" (Contingency plans), "Advance care planning" (End of life care), "DNACPR status, DoLs" (Legal information), "Likes and dislikes, preferred name, best time of day to communicate" (About Me, Person demographics), "Any reasonable adjustments" (Individual requirements - Reasonable adjustments). See standard and implementation guidance for further detail on the above components of the standard.
- Key quotes: "There might be [other information], but as with any other person encountering healthcare, IF additional information is needed - ask the patient, or carers at the time within the context of the clinical / care / discharge needs". See Clinical Safety Case (Hazard 25: 'Assumption that data will replace human interaction".

3.3.9 Q24: Do you have any other comments about this information standard?

- Respondent comments from this section were taken into account during the final drafting of the standard.
  Key quotes: "It would be good to have this standard part of in-house e-learning for all staff and for the standards to be displayed in all Care homes, Primary Care, Community Trusts and Acute NHS Trusts".: "It is all important but how well the information is collected and recorded will affect how effective this standard is".; "…The sources of information identified are likely to be held by different actors and on different systems and with different vocabulary and syntax - the standard would needs to understand where responsibility (and burden) lies in collecting and integrating this information…".