Professional Record Standards Body

Better records for better care

CARE HOMES VIEW (OF SHARED HEALTH AND CARE RECORDS)

GUIDANCE 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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Name	Title	Date	Version
Project Board	Project Board	28/9/20	0.5
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Glossary of Terms

Term / Abbreviation	What it stands for
ADRT	Advanced Decision to Refuse Treatment
BNSSG	Bristol North Somerset and South Gloucestershire
CHI	Community Health Index
COVID - 19	Corona virus disease – 2019
CSP	Care and support plan. Used interchangeably with DCSP
DCB	Data Coordination Board
DCSP	Digital care and support plan. Used interchangeably with CSP
dm+d	Dictionary of medicines and devices
DoLS	Deprivation of Liberty Safeguard
DPIA	Data Privacy Impact Assessment
EHR	Electronic Health Record
EPR	Electronic Patient Record
FHIR	Fast Healthcare Interoperability Resources
GDPR	General Data Protection Regulation
GP	General Practitioner
HL7	Health Level 7
LHCR	Local Health and Care Record
LPA	Legal Power of Attorney
MCA	Mental Capacity Assessment
Metadata	A set of data that describes and gives information about other data
MHA	Mental Health Act

NHS	National Health Service
NHSD	NHS Digital
ODS	Organisation Data Service
PDS	Personal Demographic Service
PRSB	Professional Record Standards Body
RBAC	(RBAC) proposal for the Connecting Care digital shared
SCCI	Standardisation Committee for Care Information
SCDIA	Social Care Digital Innovation Accelerator
SCDIP	Social Care Digital Innovation Programme
SCP	Social Care Programme
SNOMED-CT	Systematized Nomenclature of Medicine - Clinical Terms

Contents

1 Executive summary

NHS Digital (NHSD) commissioned the Professional Record Standards Body (PRSB) to support the Social Care Programme (SCP); by development of (new and existing) national information products to support sharing of an individual's care information between health and social care. The aim was to incorporate local products developed by the Digital Social Care Pathfinder – the 'Connecting Care Partnership'– into existing PRSB national standard(s).

The Care Homes View (Of Shared Health and Care Records) is a guidance product that proposes a 'view' of the PRSB Core Information Standard (CIS) to be seen by care home staff in CQC registered care homes. It is not a standard in its own right. As such it should be used in conjunction with the PRSB deliverables as developed for the CIS. It is also strictly not designed to define information that residential and nursing homes might contribute to a shared care record or store in their own systems

As part of a shared care record, this information would be 'read-only' by care home staff and in practice could be comprised of information shared by various health and social care organisations to populate shared care records. This 'view' is the result of a thorough research and consultation process that has been tested with stakeholders including, but not limited to, care home staff and residents, primary and secondary care clinicians, allied health professionals and local authority representatives; via webinars, surveys and robust clinical safety case management.

However, it is critical to realise that local implementations by care homes will need to define their own 'view' of the data in the shared care record. Such a 'view' may include the Care Homes View (Of Shared Health and Care Records) as a minimum data set with additional sections included from the PRSB core information standard and / or from other validated sources as decided by the nominated individual responsible for the care home. The nominated individual's view of the record must not be filtered - this is a very important safety issue that must be adhered to in order to mitigate hazards identified in the project clinical safety case.

A 'view' of the record should define what information is needed by a professional (or person) in particular circumstances and may also include local definitions for role-based access control (RBAC) as decided by the nominated individual responsible for care home services.

The consultation process conducted by PRSB did not support or validate any particular RBAC proposal for the Care Homes View (Of Shared Health and Care Records). This should be decided locally during implementation and meet a minimum level of information governance compliance e.g., as per the General Data Protection Regulation (GDPR) in care homes.

How the information is presented to different care home professionals and residents with a view of the shared care record will be dependent on local decision making but it should be represented in such a way as to provide maximum benefit for different users (in different roles) in each given case.

2 Introduction

This section outlines the background, objectives and scope of the Care Homes View product. *NB*: In this document a care home is defined as per the NHS Data Dictionary as a place where personal care and accommodation are provided together that may be with or without nursing; as well as being Care Quality Commission (CQC) regulated. In addition, the product scope covers adult residents aged 18+.

2.1 Background

NHS Digital (NHSD) commissioned the Professional Record Standards Body (PRSB) to support the Social Care Programme (SCP); by development of (new and existing) national information products, to support sharing of an individual's care information between health and social care. The Care Homes View (of Shared Health and Care Records) is one of these products.

2.2 The Social Care Programme

The SCP[1] is an NHSD programme, commissioned and sponsored by the Department of Health and Social Care (DHSC), that aims to 'improv[e] digital maturity in the adult social care provider sector' and facilitate IT interoperability with the health sector. As part of SCP the Digital Social Care Pathfinders Programme (DSCPP)[2] has funded 16 local authorities to extend their successfully piloted digital solutions in health and social care to a national scale. From these, PRSB identified five use cases for consultation that were developed into the following national products, which taken together form the PRSB Digital Social Care Information Project:

Two new transfer of care standards:

- *Urgent Referral from Care Home to Hospital*
- *Hospital Referral for Assessment for Community Care and Support*

A new standard for local authority data and update of relevant sections of the PRSB Core Information Standard (CIS):

- *Local Authority Information (For Shared Health and Care Records)*

A 'view' of the PRSB Core Information Standard specifically for care home staff:

- ***Care Homes View (Of Shared Health and Care Records).***

[1] https://digital.nhs.uk/services/social-care-programme
[2] https://digital.nhs.uk/services/social-care-programme/digital-social-care-pathfinders-programme-2019-21

An update to the *About me* section of the following standards:

- Core Information Standard, Urgent Referral From Care Home to Hospital, Care Homes View (Of Shared Health and Care Records), Digital Care and Support Plan (DCSP)

Key implementation drivers include the integrated care agenda[3] that enables a model of national decentralisation and local integration so local health and social care organisations can develop a range of integrated care systems to best serve their local population. These are underpinned by the sharing of a person's health and care records across their local health and social care organisations e.g. the local health and care record (LHCR) initiatives.[4] The Social Care Digital Innovation Programme (SCDIP)[5] and more recently the Social Care Digital Innovation Accelerator projects (SCDIA)[6] have further hastened the pace of digital integration of services. In addition, the local authority information (for shared health and care records) standard was informed by the findings of the Local Government Association (LGA) Discovery Project.[7]

2.3 Sharing health and social care data with care homes

The Core Information Standard (CIS) originally defined a set of information that should be common to most systems and would be an amalgamation of records drawn from different settings in health and social care, which could be used to populate shared care records. When the CIS was created it was anticipated that various local implementations would be required to define their own read-only and different 'views' in their shared care record that may be required by professionals in different circumstances, settings and use cases.

During the wider Digital Social Care Information Project consultation process, care home staff have emphasised the extreme importance for care homes to have access to as much information as possible from other health organisations in order to meet a resident's direct care needs in a "holistic" and "person-centred" way. Health and social care organisations such as those in primary and secondary care and local authorities have access to data about a person that could be shared with the care home for direct care. A limited number of exemplars exist on a local level only, which includes the project from which the Care Homes View was developed; by the Pathfinder (A partnership of Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) in collaboration with Bristol City Council, North Somerset City Council and South Gloucestershire Council). This local exemplar is described in section 2.4 below.

[3] https://digital.nhs.uk/about-nhs-digital/our-work/transforming-health-and-care-through-technology/integrated-care-domain-d
[4] https://www.england.nhs.uk/publication/local-health-and-care-record-exemplars/
[5] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/local-investment-programme
[6] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/local-investment-programme/accelerator
[7] https://www.local.gov.uk/local-government-social-care-data-standards-and-interoperability

2.4 Social Care Digital Pathfinders Project: Care Homes on Connecting Care

The 'Pathfinder' partnership (aka 'Connecting Care Partnership') coordinated by BNSSG produced five scalable products to support the safe and lawful access of care homes to their shared digital Local Health and Care Record (LHCR) – 'Connecting Care'. The 'development phase' of the project occurred from July 2019 – November 2019 and involved a comprehensive consultation with six local care homes to co-design the products. The PRSB agreed to collaborate during the 'implementation phase' of the project in order to try to develop and incorporate two of these products into a 'view' of the CIS as a national standard. These were:

- The Care Homes Standard Dataset – A proposed minimum dataset for sharing health and social care information with care homes, based on the PRSB Core Information Standard (See Appendix A, this document).
- Use Case Profiles for role-based access control (RBAC) – A proposal giving two 'views' of the Connecting Care - Care home data subset for care home 'Administrators' (See Appendix B) and 'Professionals' (See Appendix C). *NB*: The adapted RBAC proposal for the Core Information Standard was not validated or supported by the PRSB consultation process – see section 5.

PRSB deliverables for the Care Homes View are outlined in section 2.5.2 below.

2.5 Objectives and PRSB deliverables for the Care Homes View

2.5.1 Objectives

Guiding principles of the Care Homes View include the following:

- Produce a 'view' of the CIS to enable care homes access to data about a resident that facilitates holistic, person-centred and joined up care – improving the person's care experience.
- Providing a 'view' of a shared health and care record that, when implemented, provides care home staff with up to date access to health and social care data – helping to ensure that, wherever possible, a resident "does not have to tell their story more than once".
- Produce a 'view' developed on the basis of extensive consultation with a large body of stakeholders representing clinicians in primary and secondary care, allied health professionals, social workers, and care home staff.
- Produce a 'view' that is supported by an extensive and robust clinical safety case (See section 4 of this document and the CIS Clinical Safety Case and Hazard Log).

2.5.2 PRSB Deliverables for the Care Homes View

The PRSB deliverables for the Care Homes View aspect of the Digital Social Care Information Project are:

Primary deliverables:

- Care Homes View (of Shared Health and Care Records) – A ‘view’ of the PRSB CIS standard for use nationwide (Outcome: supported by PRSB consultation process).
- Care Homes View Guidance product (this document).
- Updates to the PRSB CIS Clinical Safety Case and Hazard Log to incorporate the Care Homes View.
- Digital Social Care Information Final Report.

Secondary deliverable:

- A role-based access control proposal for the Care Homes View of the CIS standard (Outcome: Not supported by PRSB consultation process – See section 5 of this document).

2.6 Scope of the Care Homes View (Of Shared Health and Care Records)

This ‘view’ of the core information standard defines a set of information that will be held in the shared care record that care home staff need to see to assist provision of direct care.

2.7 What it is:

The Care Homes View **is**:

- a definition of the information from health and social care that residential and nursing homes need to see in a shared care record.
- a core set of information for which we have identified two authorisation levels / ‘views’ for role-based access (RBAC) purpose within the care home setting.
- an information set that is readily interpretable by professionals in a variety of health and care settings and consistent with the PRSB Core Information Standard.

2.8 What it is not:

The Care Homes View **is not**:

- to define information that residential and nursing homes might contribute to a shared care record or store in their own systems.
- for use in domiciliary care, extra care or supported living.
- an exhaustive definition of all the items recorded by health and social care organisations in the UK that care homes may require to provide direct care.

3 Methodology

The methodology for development of all the PRSB Digital Social Care Information Products, including the Care Homes View, is described in detail in the Digital Social Care Information Final Project Report.

3.1 Overview of methods:

Project Initiation (March 2020) →Evidence review (April 2020) → Mapping of Care Homes Standard Dataset to CIS (April 2020) → First Draft (April 2020) → Webinar (May 2020)→ Second Draft (May 2020) → Online Survey (July 2020) → Vendor webinar (August 2020) → Final Draft (September 2020) → Guidance product (September 2020)

Evidence review: See Digital Social Care Information Final Report

Mapping: The PRSB mapped the Care Homes Standard Dataset to the CIS (and other existing PRSB standards) in order to ensure compatibility

Webinar: First draft and RBAC proposal tested with multidisciplinary stakeholders in webinar.

Online Survey: The results of the online survey are discussed in section 3.2 below.

Vendor webinar: The second draft was tested with system suppliers.

Guidance product: This document.

3.2 Summary of survey findings

Survey findings relating to the Care Homes View are described in detail in the appendix of the Digital Social Care Information Final Report.

Overall, the respondents of the consultation survey (n=403) were very supportive of the Care Homes View. It was felt by the majority of respondents that commented that in order to "provide the highest standards of care" it is "extremely important"/ "important" / "essential" for the care home to have access to as much information about the resident as possible, so that they can provide a "safe" and "holistic" approach to care.

The majority of suggestions for additional elements / sections were already contained within the Care Homes View or were appropriate for inclusion in existing sections in the record. This supports that the consultation processes undertaken, initially by the Pathfinder and continued by PRSB, was extensive and robust.

4 Clinical safety

This section describes the PRSB Clinical Safety Case as it relates to the Care Homes View.

4.1 Overview of Clinical Safety Management for the Care Homes View

PRSB conducted a comprehensive clinical safety assessment for the Care Homes View including:

- Safety issues identified by clinical informaticians, clinical and professional advisors and patient advisors participating in hazard workshops on 8th July and 15th July 2020 and clinical safety meeting on 19th August 2020.

- Potential clinical safety issues identified by stakeholder participants during the consultation survey (n=403) and other consultations undertaken during the development of the Digital Social Care Information products.
- An update of the PRSB Core Information Standard Clinical Safety Case Report and Hazard Log to incorporate risks relating to the Care Homes View.

The clinical safety case documentation is handed over to NHS Digital Clinical Safety Group. The residual risk was acceptable for all hazards relevant to the Care Homes View following mitigation proposals. However, one particular hazard identified is important enough to discuss below.

4.2 Hazard 34: 'The care home view of the CIS record does not include some important information'

This hazard relates to the fact that as a filtered "view" of the CIS record the Care Homes View does may include certain safety critical information that may be included in the CIS. If the nominated individual responsible for the care home only has access to the Care Homes View of the CIS it may be that care home staff are not made aware of important information available in the shared care record that might be needed for direct care of a resident (or they are acting on incomplete information or missing data changes context of information) and as a consequence resident is harmed. In addition, visiting healthcare professionals such as GPs may also be affected if they access the Care Homes View, when visiting a resident.

This hazard was originally designated by the team as 'Level 3' (Medium risk with major consequences). So long as during the implementation of the Core Information Standard in care homes allows for additional flexibility to extend the "view" to the CIS in its entirety (and beyond to other validated data) as required this risk can be considered mitigated to 'Level 2' (Low risk with considerable consequences).

It is considered an absolute and safety critical requirement by PRSB that the nominated individual responsible for the care home (as defined by the CQC) is able to view the full CIS as well as any other safety critical data identified locally for inclusion in the shared care record.

In addition, a hazard relating to inappropriate RBAC is discussed in section 5.3.3 below.

5 Role-based access control proposal

This section outlines the development of the role-based access proposal for the Care Homes View and justification for why it could not be supported.

5.1 Overview:

The use Case Profiles for role-based access control (RBAC) in Connecting Care were adapted by PRSB to ensure compatibility with the PRSB Core Information Standard. The original Connecting Care - Care home data subsets for care home 'Administrators' (and 'Professionals' can be found in the appendices (B and C

respectively). ‘Administrators’ corresponds to ‘Lower level access’ and ‘Professionals’ corresponds to the complete record (lower level + higher level access).

PRSB identified two possible levels of authorised access for both registered and unregistered persons (registered means persons who have professional registration for example a GP or registered social worker or the person in the care home who is responsible for the service as defined by the CQC). See section 5.2 below.

5.2 Role-Based Access Control Proposal for Care Homes View

The first list below is the minimum information set that we suggest all people working in a care home need to see, including both registered health and social care professionals and unregistered persons (e.g. care home deputy managers, care home administrators, care assistants or any other staff roles and individuals identified by the registered people in the care home).

Lower level access

Personal demographics - a person's details and contact information

Professional contacts - professionals with significant interaction with a person e.g. a social worker or a key worker

Personal contacts - people with significant interaction with a person e.g. an informal carer, next of kin, a friend or a relative

About me - information a person wishes people caring or supporting them to know about them

GP details - details of the person’s GP

Individual requirements - individual requirements of the person e.g. mobility needs e.g. from a moving and handling assessment

Reasonable adjustments - a person’s needs for which adjustments should be made by the health and care service to enable them to access the services (as set out in the equality act 2010) e.g. needing an interpreter

Impairments - impairments that result in the need for reasonable adjustments (as set out in the equality act 2010) e.g. living with a physical disability

Legal information - required or mandated legal information e.g. mental capacity assessment or deprivation of liberty safeguards.

Safeguarding - concerns that a person is at risk of abuse, harm or neglect

Care and support plan - details of a care and support plan covers what is most important for a person to reach their personal and health related goals

Contingency plans - details of a plan of what should be done if the individual's condition or other circumstances get worse

Additional support plans - details of an additional/specific care plan (e.g. wound management, behaviour support plan, dietetics), which the individual and care professional consider should be shared with others providing care and support to the individual

Referral information - the details of a person's referrals

Contact with professionals - details of encounters a person has had with health and care professionals

Admission details - details of the person's admission to hospital (recorded at the point at which they were admitted)

Discharge details - details of the person's discharge from hospital (recorded at the point at which they were discharged)

Future appointments - scheduled future appointments with health and care professionals

Alerts - a type of notification that conveys a warning of important, time-sensitive, and/or safety information e.g. unsteady on feet

The second list below contains information that may be accessed by registered health and social care professionals based on their role in the care home or where the care home (registered person responsible for the care home) authorises a higher level of access for unregistered care home staff, as required.

Higher level access

Risks - identified risks of harm to the person or others

Medications and medical devices - details of a person's prescribed and over the counter drugs e.g. dose and frequency. Details of the support a person needs to take the medication. Details of any medical devices the person may have.

Allergies and adverse reactions - description of a person's allergic reactions

End of life care - details of end of life preferences the person has specified e.g. advance statement, preferred place of care, preferred place of death

Investigations required - for recording which diagnostic tests have been requested

Investigations results - details of diagnostic test results

Examination findings - details of clinical findings from examinations

Assessments - details of a person's health and social care assessments. Information about the assessment that has taken place and the outcome of the assessment

Documents (including correspondence and images) - specifically, a person's relevant medical correspondence, charts and imaging

5.3 Consultation findings relating to RBAC

The following results are described in detail in the PRSB Online Survey Report, which is an appendix to the Digital Social Care Information Final Report.

5.3.1 Safety concerns over inappropriate RBAC

There was a significant belief amongst respondents to the online survey, in particular care home staff and management, that filtering of the record for care home staff should be achieved via appropriate role-based access control (RBAC) mechanisms. It was clear from the comments that there was a high expectation that this should only be done by the care home manager / nominated individual responsible for the care home:

- "Info should be supplied to management to decipher who to provide info to within the care home."
- "As only the registered manager (me) and those authorised by me would have access, I do not have concerns [about who has access to this information]."
- "Permissions should be held with senior staff. Some entries may cause conflict therefore roles with extensive professionalism must be maintained."

5.3.2 Quantitative evidence related to safety concerns

The table below shows quantitative responses from care home staff and other professionals working in health and social care relating to the proposed higher level of role-based access. *NB*: A very large majority of respondents supported the conclusion that it was "very important" or "essential" for all care home staff involved in direct care to be able to see the sections in the lower level access proposal.

	Registered practitioners only	All care home staff	Don't know
Risks	6.86%	92.00%	1.14%
Medications and medical devices	18.13%	79.67%	2.20%
Allergies and adverse reactions	2.72%	95.65%	1.63%
End of life care	12.57%	86.34%	1.09%
Investigations required	**62.50%**	35.33%	2.17%
Investigations results	**61.96%**	35.33%	2.72%
Examination findings	**59.24%**	38.59%	2.17%
Assessments	31.52%	64.67%	3.80%

Documents	36.61%	57.38%	6.01%

Table 1: Percentage (%) of respondents (care home staff and health professionals) who believe that the given sections of the standard should be seen either by 'All care home staff' or 'Registered practitioners only'.

It is clear from the data in table 1 that the RBAC proposal was strongly rejected by respondents for the following sections: Risks (92.00 % against), Medications and medical devices (79.67 % against), Allergies and adverse reactions (95.65% against), End of life care (86.34 % against). The RBAC proposal was also rejected by a slight majority for Assessments (64.67 % against) and Documents (57.38 % against). The RBAC proposal was supported by a slight majority for only three sections: Investigations required (62.50 % for), Investigations results (61.96 % for), and Examination findings (59.24 % for).

Key quotes:

- "There is information taken from examinations, assessments and investigations which would benefit [both] the resident and staff."
- "Care homes (especially without nursing) do not always have registered professionals onsite so a senior carer, or carer may need to see all information. However, as there is no professional register of care workers there is no professional accountability. Care home staff often cover many roles: from the manager stepping in to cook dinner and the laundry or domestic staff covering care shifts when required. Depending on what role someone is working at that time would depend on what level of access they would need. This would be in line with Caldicott guidance."
- "Access should be maintained via role-based access systems and the flexibility in place to allow staff members access as required / authorised";
- "[Information access] needs to be on a need to know basis for care staff but management should be aware of any potential issues and advise staff as necessary."
- "As the registered manager it is important to have oversight of all matters relating the needs of the individual to be able to plan and provide appropriate care."

5.3.3 Hazard 33: 'Inappropriate role-based access (RBAC) implementation'

This hazard might occur when either an appropriate end-user does not see information that they need to see, or an end-user has access to information that they should not see due to inappropriately allocated RBAC. For example, an appropriate user in the care home may not have access to important information such as safeguarding which may lead to an adverse outcome. Inappropriate user does have access to sensitive data. It may be that inappropriate RBAC was designated (e.g. due to lack of granularity of designated roles) by the nominated individual

responsible for services, but this is considered unlikely in general due to the high level of expertise and experience required for the role, and likely familiarity of the individual with local information requirements. In care homes assigning RBAC is the responsibility of the person in the care home who is responsible for the service (i.e. nominated individual) as defined by the CQC. *NB*: The NHS National RBAC Database (NRD) contains the national role-based access control (RBAC) attribute definitions for job roles, areas of work and activities along with the national Baseline Policy of NHSD. This hazard was originally designated by the team as 'Level 3' (medium risk with major consequences). With appropriate design of systems and training of individuals setting the RBAC roles, this risk was considered mitigated to 'Level 2' (low risk with considerable consequences). However, the risk would not be mitigated if the nominated individual did not have the flexibility to change the RBAC in order to adapt to the local care home situation / requirements.

5.3.4 Conclusion

Taken overall, the consultation process was unable to support the inclusion of a defined RBAC proposal for the Care Homes View of the CIS. Nominated individuals may choose, at their discretion to implement appropriate RBAC for their local setting.

6 Summary

NHS Digital (NHSD) commissioned the Professional Record Standards Body (PRSB) to support the Social Care Programme (SCP). The aim was to incorporate local products developed by the Digital Social Care Pathfinder – the 'Connecting Care Partnership' into the PRSB Core Information Standard (CIS).

The Care Homes View (Of Shared Health and Care Records) is a guidance product that proposes a 'view' of the CIS to be seen by care home staff in CQC registered care homes. It is not a standard in its own right. It is also strictly not designed to define information that residential and nursing homes might contribute to a shared care record or store in their own systems

This 'view' is the result of a thorough research and consultation process including robust clinical safety case management.

The Care Homes View was strongly supported in the consultation, but it is critical to realise that care homes will need to define their own local 'view' of the data in the shared care record. Such a 'view' may include additional sections from the CIS or other validated standards or sources as identified as appropriate by the nominated individual responsible for the care home. In general, it is not considered that there are any circumstances where the shared care record should be filtered prior to access by the nominated individual.

In addition, the consultation did not support or validate any particular proposal for role-based access control (RBAC), as decided by the nominated individual responsible for care home services.

7 Guidance

It is expected that during implementation of the Care Homes View in shared care records that the national products developed for the CIS will be read and utilised in parallel with this guidance product. You can find the original implementation guidance in the PRSB Core Information Standard.

The guidance was developed on the basis of extensive consultation as described in this document and the Digital Social Care Information Final Project Report. However, it is expected that the guidance will be refined and updated regularly in line with the CIS (Update in progress), and as further findings and feedback emerge during implementation.

It is recognised that different care homes will have varying levels of digital maturity and therefore differ in their capacity to implement a ‘view’ for care homes of digital records. The full interoperability of systems is still some way off in most health and social care environments. The Care Homes View would be ‘pulled’ from source systems without direct write back into those systems (see clinical safety case).

It is recognised that the conformance definitions (see section 7.1 below) for any ‘view’ of a shared care record seen by the care home will be determined outside of the care home (which would receive read-only data). Conformance involves designating sections, record entries, clusters and elements of a standard / record as either mandatory, required or optional. Mandatory data must be shared, required information must be shared if it exists, and optional data sharing is dependent on local decision making. Care homes are encouraged to draw up trading agreements with other organisations delivering data to the shared care record to ensure that data that they need to see is shared by organisations where it is considered optional. For more information on conformance and cardinality see the CIS implementation guidance.

The display of the record as part of the graphical user interface (GUI), including such considerations as the order in which sections appear in the record is to be determined by the care home in consultation with system suppliers. *NB*: Where there is a section and a subsection with the same name, there is no need to display the heading as well as the subheading.

7.1 Structure of the PRSB standards explained

An information standard is organised into sections made up of several data (information) elements, with record entries and clusters (subsections) to support repeated sets of information and grouping of related items.

The set of rules and instructions governing the type of information expected within a section, cluster, record entry and element and how it is communicated is defined in the information model under the headings Description, Cardinality and Conformance.

The PRSB information model structure and rules are explained in Table 1 and the annotated example below.

Information model components	Description
Section	A section groups together all the information related to a specific topic e.g. 'Medications and medical devices' and 'Person demographics'. It is the highest level to logically group data elements that may be independent or related. For example: - 'Legal information', includes a set of independent elements or information items, grouped in a logical section. - 'Medications and medical devices' includes sets of related elements with dependencies between the elements.
Record entry	A record entry within a section is used where a set of information is repeated for a particular item, and there can be multiple items; for example for each medication there is a set of information associated with that medication Other examples are Allergies or adverse reactions and Procedures.
Cluster	This is a set of elements put together as a group and which relate to each other; e.g. medication course details cluster which is the set of elements describing the course of the medication.
Element	The data item. An element can appear in one or more sections e.g. name, date.
Information model rules and instructions	**Explanations**
Description	This is the description of the section, record entry, cluster or element. For an element it describes the information

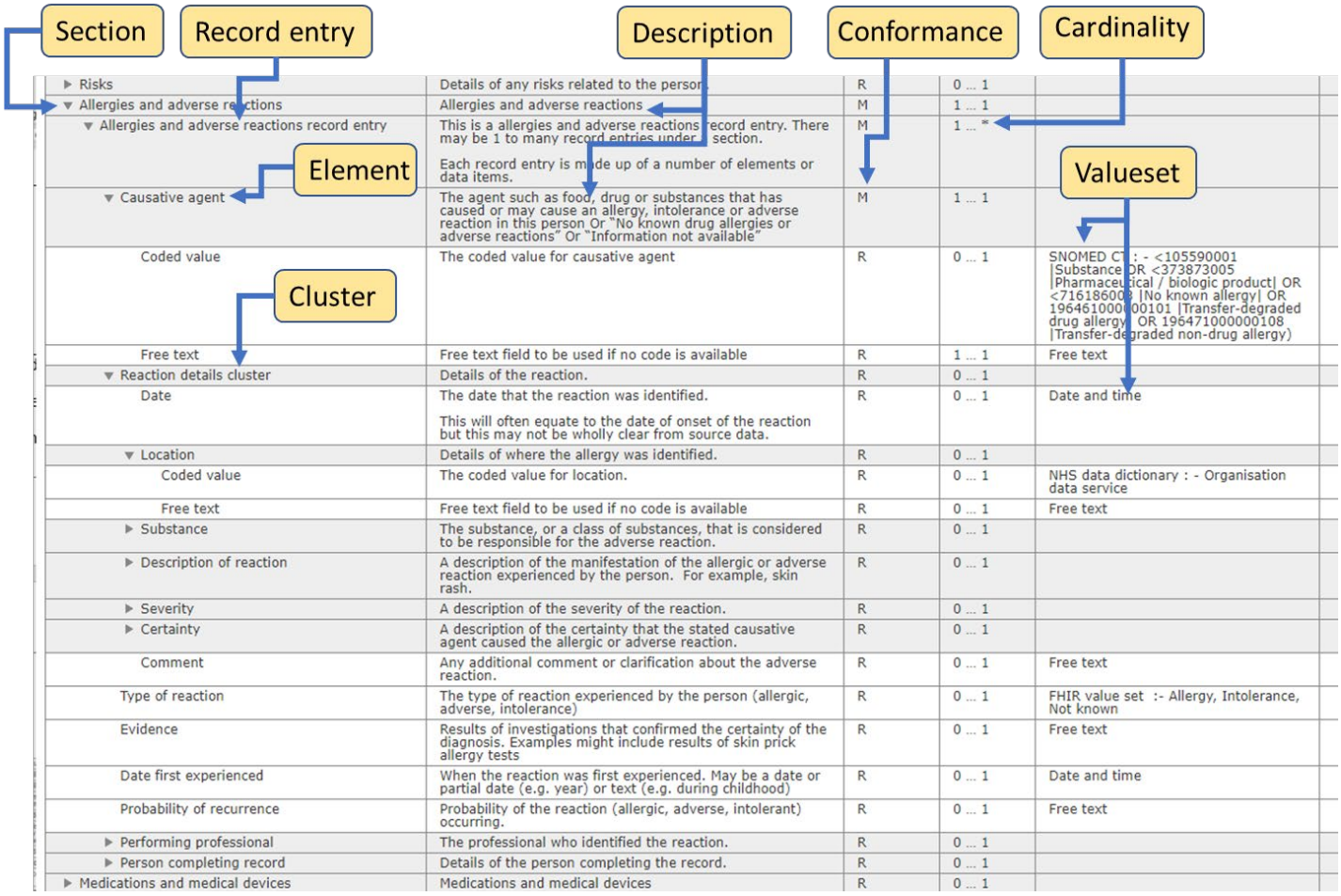
	that the element should contain in as plain English as possible.
Cardinality	Each section, record entry, cluster and element will have a statement of cardinality. This clarifies how many entries can be made i.e. zero, one or many entries. The number of records expected and allowed are displayed as: 0……* = zero to many record entries are allowed 0……1 = zero to one record entry is allowed 1……1 = one record is expected 1……* = one to many records are expected For example, the 'Medications and medical devices' section may have zero to many medication item records in it and is displayed as 0…… *.
Conformance	Conformance defines what information is 'mandatory', 'required' or 'optional' and applies to sections, record entries, clusters and elements. The IT system must be developed to be handle all the information elements that are defined in the Standard but not all the information is required for every individual record or information transfer. The following set of rules apply to enable implementers to cater for the end users (senders and receivers) requirements: • Mandatory – the information must be included • Required – if it exists, the information must be included • Optional – a local decision is made as to whether the information is included These rules apply at all levels and give the flexibility to allow local clinical or professional decisions on some information that is included, while being clear on what is important information to include. For example, a person subject to a referral may have many assessments, but not all of these will be relevant to the referral. The conformance can be used to allow just relevant assessments to be included. Assessment Section – Required – i.e. its important information you must include if you have it. Record entry level – Optional – allows a local decision on what assessments are included, so only relevant ones are included based on clinical or professional needs.

	Assessment elements – Conformance set on the normal basis of which elements for an assessment are mandatory, required or optional. **NB:** It is permitted to upgrade a conformance rule but not to down grade one. For instance, a section that is classed as optional in the standard can be upgraded to required or mandatory in local implementations. However, one that is classed mandatory or required cannot be downgraded to required or optional.
Valuesets	Valuesets describe precisely how the information is recorded in the system and communicated between systems. This is required for interoperability (for information to flow between one IT system and another). The information can be text, multi-media or in a coded format. If coded it can be constrained to SNOMED CT and specific SNOMED CT reference sets, NHS Data Dictionary values or other code sets.

Table 1: PRSB information standard data structure

In the annotated example shown below for Allergies:

- The standard has a section for 'Allergies and adverse reactions', it's conformance is 'mandatory' and the cardinality is '1 only' (or 1...1) i.e. there must be just one allergies section
- It has a record entry to allow for multiple allergies, which is also 'mandatory' but with a cardinality of 1 to many (or 1...*). The record entry contains a set of elements, i.e. the set of information for each allergy and there must be at least 1 record entry.
- The record entry also includes a cluster (reaction details cluster), which groups the reaction details together.
- Each element has a description, conformance, cardinality and valueset. e.g. Causative agent, which is mandatory with a cardinality of 1 only (or 1…1) and a valueset with two options, coded value with a constrained set of SNOMED codes (including an option for "No known allergy") or free text if coded values are not available. Other elements are required in this example. i.e. the set of information for each allergy or adverse reaction must have a causative agent, and where available should have the other information such as reaction details, substance, severity etc.



▶ Risks	Details of any risks related to the person	R	0 … 1	
▼ Allergies and adverse reactions	Allergies and adverse reactions	M	1 … 1	
▼ Allergies and adverse reactions record entry	This is a allergies and adverse reactions record entry. There may be 1 to many record entries under a section. Each record entry is made up of a number of elements or data items.	M	1 … *	
▼ Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this person Or "No known drug allergies or adverse reactions" Or "Information not available"	M	1 … 1	
Coded value	The coded value for causative agent	R	0 … 1	SNOMED CT : - <105590001 |Substance OR <373873005 |Pharmaceutical / biologic product| OR <716186003 |No known allergy| OR 1964610000000101 |Transfer-degraded drug allergy| OR 1964710000000108 |Transfer-degraded non-drug allergy\)
Free text	Free text field to be used if no code is available	R	1 … 1	Free text
▼ Reaction details cluster	Details of the reaction.	R	0 … 1	
Date	The date that the reaction was identified. This will often equate to the date of onset of the reaction but this may not be wholly clear from source data.	R	0 … 1	Date and time
▼ Location	Details of where the allergy was identified.	R	0 … 1	
Coded value	The coded value for location.	R	0 … 1	NHS data dictionary : - Organisation data service
Free text	Free text field to be used if no code is available	R	0 … 1	Free text
▶ Substance	The substance, or a class of substances, that is considered to be responsible for the adverse reaction.	R	0 … 1	
▶ Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the person. For example, skin rash.	R	0 … 1	
▶ Severity	A description of the severity of the reaction.	R	0 … 1	
▶ Certainty	A description of the certainty that the stated causative agent caused the allergic or adverse reaction.	R	0 … 1	
Comment	Any additional comment or clarification about the adverse reaction.	R	0 … 1	Free text
Type of reaction	The type of reaction experienced by the person (allergic, adverse, intolerance)	R	0 … 1	FHIR value set :- Allergy, Intolerance, Not known
Evidence	Results of investigations that confirmed the certainty of the diagnosis. Examples might include results of skin prick allergy tests	R	0 … 1	Free text
Date first experienced	When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood)	R	0 … 1	Date and time
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.	R	0 … 1	Free text
▶ Performing professional	The professional who identified the reaction.	R	0 … 1	
▶ Person completing record	Details of the person completing the record.	R	0 … 1	
▶ Medications and medical devices	Medications and medical devices	R	0 … 1	

7.2 Section specific implementation guidance

Section specific implementation guidance as it applies to the Care Homes View is provided in tables 1 and 2 below, but this should not be used in isolation of the CIS products listed above.

Name	Description	Values	Implementation guidance
7.3 Person demographics	The person's details and contact information.		This section contains the person's demographic and contact details including key identifiers e.g. name, date of birth, NHS number, address etc. The PDS (Personal Demographics Service) should be used as the source of this information. The mandatory information in this section is person's name, date of birth and address. There can be multiple addresses associated with a person including temporary and correspondence addresses.
Person name	The full name of the person.	The legal name of the person from the Personal Demographics Service (PDS), or the name volunteered by the person. NHS data dictionary code: PERSON FULL NAME	
Person preferred name	The name by which a person wishes to be addressed.	The preferred name volunteered by the person or a preferred name given by PDS that the person has asked to be called by.	
Date of birth	The date of birth of the person.	NHS data dictionary code: PERSON BIRTH DATE	

7.3.1 **Gender**	The person's stated gender.	NHS data dictionary code: PERSON GENDER CODE	The definitions used for sex and gender use the NHS data dictionary definitions to ensure interoperability with other systems. However, we recognise that the definitions used do not reflect today's more inclusive society. We have provided feedback on this to NHS data dictionary team in NHS Digital who are actively addressing this area, and any updates to the NHS data dictionary will update our standards. Sex and gender data items may cause accidental disclosure of gender reassignment without consent. This is because both fields are included in the demographic model. Having both may show a difference and therefore disclose gender reassignment without consent. It is unlawful to disclose, without consent, a person's gender reassignment with or without a gender reassignment certificate. Section 22 of the Gender Reassignment Act 2004 makes it an offence to disclose the history of a transgender patient who has had formal gender reassignment under the Act, unless consent has been sought. The exemption of disclosure is for medical professionals involved in direct medical care, but not currently for administrative and non-medical staff. This risk can be mitigated by appropriate implementation in a shared care record; refer to the CIS clinical safety case report and hazard log. One option is to leave out the "Sex" field but the implications and potential risks of that will need to be considered. The alternative is to ensure the design of the Shared Care Record, including its Information Governance model, reduces this risk to an acceptable level as described in the clinical safety case and hazard log. A further mitigation on implementation could be to record self-expressed gender in the administrative area of systems, and record sex at birth in a separate clinical area, that can only be accessed by medical staff.

Name	Description	Values	Implementation guidance
Ethnicity	The ethnicity of the person as specified by the person.	NHS data dictionary code: ETHNIC CATEGORY CODE 2001 This code is expected to be replaced in future with the following: ETHNIC CATEGORY 2021	
Religion	The religious affiliation as specified by the person.	SNOMED CT: 999000531000000100 |Religious or other belief system affiliation simple reference set (foundation metadata concept)|	

Sex	The person's phenotypic sex. Determines how the person will be treated clinically.	NHS data dictionary code: PERSON PHENOTYPIC SEX CLASSIFICATION	The definitions used for sex and gender use the NHS data dictionary definitions to ensure interoperability with other systems. However, we recognise that the definitions used do not reflect today's more inclusive society. We have provided feedback on this to NHS data dictionary team in NHS Digital who are actively addressing this area, and any updates to the NHS data dictionary will update our standards. Sex and gender data items may cause accidental disclosure of gender reassignment without consent. This is because both fields are included in the demographic model. Having both may show a difference and therefore disclose gender reassignment without consent. It is unlawful to disclose, without consent, a person's gender reassignment with or without a gender reassignment certificate. Section 22 of the Gender Reassignment Act 2004 makes it an offence to disclose the history of a transgender patient who has had formal gender reassignment under the Act, unless consent has been sought. The exemption of disclosure is for medical professionals involved in direct medical care, but not currently for administrative and non-medical staff. This risk can be mitigated by appropriate implementation in a shared care record; refer to the CIS clinical safety case report and hazard log. One option is to leave out the "Sex" field but the implications and potential risks of that will need to be considered. The alternative is to ensure the design of the Shared Care Record, including its Information Governance model, reduces this risk to an acceptable level as described in the clinical safety case and hazard log. A further mitigation on implementation could be to record self-expressed gender in the administrative area of systems, and record sex at birth in a separate clinical area, that can only be accessed by medical staff.

Name	Description	Values	Implementation guidance
7.3.2 **NHS number**	The unique identifier for a person within the NHS in England and Wales.	NHS data dictionary code: NHS NUMBER	NHS number (or equivalent, e.g. CHI number in Scotland), is likely to be the primary identifier however existing national guidance should be followed, including how to handle patients without an NHS number, for example, overseas visitors.
Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland. There may be 0 to many record entries for this element.	NHS data dictionary code: LOCAL PATIENT IDENTIFIER HEALTH AND CARE NUMBER (NI only) COMMUNITY HEALTH INDEX NUMBER (Scotland only)	
Person's address	Person's usual place of residence, and where relevant temporary and correspondence addresses.		
Address line 1	Person's first line of address.	NHS data dictionary code: ADDRESS LINE 1	
Address line 2	Person's second line of address.	NHS data dictionary code: ADDRESS LINE 2	
Address line 3	Person's third line of address 3.	NHS data dictionary code: ADDRESS LINE 3	

Name	Description	Values	Implementation guidance
Address line 4	Person's fourth line of address.	NHS data dictionary code: ADDRESS LINE 4	
Address line 5	Person's fifth line of address.	NHS data dictionary code: ADDRESS LINE 5	
Postcode	The person's postcode.	NHS data dictionary code: ADDRESS ASSOCIATION TYPE	
Person's email address	Email address of the person.	NHS data dictionary code: CONTACT EMAIL ADDRESS (PATIENT OR LEAD CONTACT)	
Person's telephone number	Telephone contact details of the person. To include, e.g. mobile, work and home number if available.	NHS data dictionary code: COMMUNICATION CONTACT STRING	
Preferred contact method	Preferred contact method, e.g. email, letter, phone, text message etc.	NHS data dictionary code: COMMUNICATION CONTACT METHOD	
Place of birth	The country of birth of the person.	NHS data dictionary code: COUNTRY CODE (BIRTH)	

Name	Description	Values	Implementation guidance
7.4 About me	About me		This section has been updated as part of the Digital Social Care Information project. This section supports sharing of information that the person thinks it is important to share with professionals. This could include information about their needs, preferences, concerns and wishes. For example, it could include that a person has a pet that would need looking after were they to go into hospital. 'About me' should be prominently displayed in the record as it is important information about the person relevant to all care and support providers. This information may be available in multimedia formats e.g. jpeg, mp3 etc. These documents are likely to follow a variety of formats but should be transferred in their entirety. Care will need to be taken in local implementations to differentiate between 'About me' and things like 'Advance Directives' and preferences and wishes expressed in other care plans such as end of life plans.
About me	This is a record of the things that a person feels it is important to communicate about their needs, strengths, values, concerns and preferences to others providing support and care.		
What is most important to me	A description of what is most important to you.	Free text or multimedia file	

Name	Description	Values	Implementation guidance
	Emergency Information: Include any essential information that any professional in health and social care should know about you in any situation, including emergencies. Other Information: **This could include:** Values Spirituality/religion Ethnicity Culture Pets Goals and aspirations Meaningful activities including leisure activities, visiting places, sport and exercise, listening to music, employment, education, volunteering.		
People who are important to me	Details of who is important to you and why. They could be family members, carers,	Free text or multimedia file	

Name	Description	Values	Implementation guidance
	friends, members of staff etc. Include how you want the people important to you to be engaged and involved in your care and support in both emergency and normal situations. Who should not be contacted or consulted about your care and support and why, if you wish to say.		
How I communicate and how to communicate with me	A description of how you communicate normally including any communication aids you use, for example a hearing aid. Include your preferred language of communication, if your first language is not English. Include how you would communicate when you are in pain or distress. Include how you communicate choices.	Free text or multimedia file	

Name	Description	Values	Implementation guidance
	Include how you give feedback or raise a concern. Describe how you would like others to engage and communicate with you, including how you would like to be addressed.		
Please do and please don't	A description of things you want someone supporting you to do or not to do. For example, this might include: Talk to me not to my carer Remind me to take my medication Encourage me to wash my hands regularly Explain to me what is happening and why Respond to my communication A description of things you do not want someone supporting for you to do. For example, this might include:	Free text or multimedia file	

Name	Description	Values	Implementation guidance
	Asking questions about certain topics Making assumptions about something Providing support when it is not wanted Talking to you in a certain way		
My wellness (0.3)	A description covering what you are able to do, how you engage with others and how you feel on a typical day through to on a day when you are unwell. Include any causes that might result in you becoming unwell and strategies for avoiding or addressing the causes. For example, not drinking enough water could cause constipation. Include any signs that indicate you might be becoming unwell. On a bad day describe what is different about what you are able to do, how you	Free text or multimedia file	

Name	Description	Values	Implementation guidance
	engage with others and how you feel. Include any medical conditions e.g. dementia and any symptoms e.g. itchiness, cough, pain that you are living with and that that affect your everyday life and how you manage those conditions. Include past health issues or experiences that need to be considered.		
How and when to support me	A description of how and when you want someone caring for you to support you. This could include support needs in an emergency situation (for example taking blood). This could include support you need to maintain important routines or to carry out particular activities, for example: Personal care routines	Free text or multimedia file	

Name	Description	Values	Implementation guidance
	Eating and drinking Bedtime routines Taking medications Moving and transitioning This could also include support needed with: wearing glasses/hearing aids/false teeth etc. making informed choices or understanding dangers and risks. managing your emotions, moods and behaviours. memory or confusion. Include how your support needs change in different environments. Include any triggers that might result in you needing further support and strategies for avoiding or addressing the triggers. Include how you want the support to be provided.		

Name	Description	Values	Implementation guidance
Also worth knowing about me	A description of what is also worth knowing about you for people caring or supporting you. This could include a short history of your life (where you have worked, where you lived, important events in your life, important people in your past life). This could include a short profile of your current life: your work / study your aspirations your skills your networks things you like e.g. particular foods, places, a football team and things you like to talk about. things you dislike This could also include any care and support preferences that have not been included elsewhere.	Free text or multimedia file	

Name	Description	Values	Implementation guidance
Date	This is a record of the date that this information was last updated.	Date and Time	
Supported to write this by	Where relevant, this is a record of name, relationship/role and contact details of the individual who supported the person to write this section e.g. carer, family member, advocate, professional.	Free text	

Name	Description	Values	Implementation guidance
7.5 Individual requirements	The individual requirements of the person.		This section allows for the sharing of any individual requirements the person may have, such as to support cognitive impairment or mobility issues. This may relate to special needs and would extend to include a record of reasonable adjustments which would be included in 'Other individual requirements'. Specific disabilities would be included in the 'Problem list' section of the CIS (*NB*: The Care Homes View of the CIS does not include problem list) however the requirements to support the disabilities (e.g. needs wheelchair access, needs large print etc.) would be included in this section. The accessible information requirements information would be the most recent requirement rather than a history of requirements.
7.5.1 **Reasonable adjustment**	A record of reasonable adjustments that must be provided by the service to comply with the Equality Act 2010.		
Reasonable adjustment record entry	This is an impairment record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		

Name	Description	Values	Implementation guidance
Location	The location where the reasonable adjustment was identified		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Reasonable adjustment	The reasonable adjustment required e.g. requires specific contact method, requires communication professional.		
Coded value	The coded value for the reasonable adjustment.	SNOMED CT	
Free text	Free text field to be used if no code is available	Free text.	
Reasonable adjustment additional detail	Further detail about the support required and the consequence of not providing it.	Free text	
Date	The date the reasonable adjustment was created.	Date and time	

Name	Description	Values	Implementation guidance
Performing professional	The professional who confirmed the need for the reasonable adjustment.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	A record of the details of the person that entered the reasonable adjustment and the date on which it was entered.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
7.5.2 **Impairment**	A record of any impairments for the person relating to reasonable adjustments.		
Impairment record entry	This is an impairment record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Location	The location where the impairment was identified		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	

Name	Description	Values	Implementation guidance
Impairment category	The category of the impairment e.g. Autism Dementia Physical disability Sensory disability - such as sight or hearing Long-term condition	SNOMED CT or free text	
Coded value	The coded value for the impairment	SNOMED CT	
Free text	Free text field to be used if no code is available	Free text.	
Impairment additional detail	Description of what the person can do with the impairment, what they want to be able to do and how they should be supported to do it and what the consequences are of not providing the support. Where there is a sensory disability include sensory processing difficulties (e.g. affects to balance and	Free text	

Name	Description	Values	Implementation guidance
	movement, oversensitive, under-sensitive).		
Date	The date the impairment was recorded.	Date and time	
Performing professional	The professional who confirmed the impairment.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	A record of the details of the person that entered the impairment and the date on which it was entered.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
7.5.3 **Mobility needs**	The mobility needs of the person that allows movement between two spaces and achieves participation and a degree of independence.	SNOMED CT or free text	
Date	The date when the mobility needs were identified.	Date and time	
Location	The location where the mobility needs were identified.		
Coded value	The coded value for location	NHS data dictionary code:	

Name	Description	Values	Implementation guidance
		ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Mobility	The mobility needs of the person that allows movement between two spaces and achieves participation and a degree of independence.		
Coded value	The coded value for mobility needs	999002551000000108 |Mobility findings simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who identified the mobility needs.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
7.5.4 **Other individual requirements**	Other individual requirements that a person may have.	Free text	
Date	The date when the other individual requirements were identified.	Date and time	
Location	The location where the other individual requirements were identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Other individual requirement	Other individual requirements that a person may have	Free text	
Performing professional	The professional who identified the other individual requirements.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
7.6 GP practice	Details of the person's GP practice.		This section contains details of the GP practice where the person is registered. This information would be sourced from PDS. This will include the GP practice identifier code. In situations where a person is not registered with a GP practice, the GP practice identifier would contain the appropriate code to indicate this. This section would also need to accommodate details for temporary GP where the patient is registered away from their usual place of residence.
GP practice record entry	This is an GP practice record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
GP name	The name of the person's GP.	Free text. If the person is registered with a GP practice, their usual GP name will be something volunteered by the person or their representative.	
GP practice details	Name and address of the person's registered GP practice.	Registered GP practice details are available from the Patient Demographics Service (PDS) or volunteered from the person or their representative. Include	

Name	Description	Values	Implementation guidance
		details of the practice name and address.	
GP practice identifier	The identifier of the registered GP practice.	NHS data dictionary code or free text. ORGANISATION CODE This includes codes to use where there is no registered GP practice.	
7.7 Alerts	Details of alerts.		This section allows for the sharing of alerts. It is unlikely that all alerts generated for a person would be shared as part of the core information standard as some alerts are dynamically generated in local systems, for example within decision support systems. The alerts that are shared as part of the core information standard should be determined locally. They might, for example, include the presence of a medical implant or MRSA diagnosis, the fact that the person has a dangerous dog or that a person requires reasonable adjustments. It is important that alerts are managed and removed when they are no longer relevant – e.g. “the dangerous dog” alert if the dog is no longer present. The alerts displayed to users viewing the core information may vary by use case and user’s role.
Alerts record entry	This is an alerts record entry. There may be 0 to many record entries under a section. Each record entry is		

Name	Description	Values	Implementation guidance
	made up of a number of elements or data items.		
Date	The date the alert was recorded.		
Alert	Any significant information meriting a specific and highly visible warning to any user (e.g. metallic implant, potentially dangerous pet).	Free text	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
7.8 Legal information	The legal information relating to the person.		This section identifies where there is legal or formal documentation relating to the care of the person. This includes Lasting Power of Attorney, Deprivation of Liberty Safeguards, Advance Decision to Refuse Treatment, Mental Capacity Assessment and Mental Health Act status; as we;; as Organ and tissue donation. Copies of the legal documents should be made available where possible as these may have a direct bearing on treatment. **NB:** Advance statement element is found in the End of life care section.
Mental capacity assessment	Details of the person's mental capacity assessment.		Mental capacity needs to be assessed at each instance where treatment decisions need to be made. Hence there should be provisions for more than one mental capacity assessment to be shared. If sharing the outcome of a mental capacity assessment it is important to record to which decision it relates. The mental capacity assessment is based on one of the following Acts: Mental Capacity Act 2005 (England and Wales) Adults with Incapacity Act 2000 (Scotland) Mental Capacity Act 2016 (Northern Ireland)
Date	The date when the mental capacity assessment was made.	Date and time.	

Name	Description	Values	Implementation guidance
Location	The location where the mental capacity assessment was made.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) person has been undertaken, if so, what capacity the decision relates to and the outcome of the assessment. Also record best interests decision if a person lacks capacity.	Free text.	
Location of document	The location of the mental capacity assessment information.	Free text or URL	
Performing professional	The professional who made the mental capacity assessment.	See Table 3 for the additional elements contained within the	

Name	Description	Values	Implementation guidance
		performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	Details of the person's LPA record or equivalent.		
Date	The date the LPA was recorded	Date and time	
Location	The location the LPA was recorded		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	Record of one or more people who have been given power (LPA) by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make		

Name	Description	Values	Implementation guidance
	those decisions. To be valid, an LPA must have been registered with the Court of Protection. If life-sustaining treatment is being considered the LPA document must state specifically that the attorney has been given power to consent to or refuse life-sustaining treatment. Details of any person (deputy) appointed by the court to make decisions about the person's health and welfare. A deputy does not have the power to refuse life-sustaining treatment.		
Coded value	The coded value for the LPA	SNOMED CT: 999001951000000107 |Personal welfare lasting power of attorney findings simple reference set (foundation metadata concept)|	
Location of document	The location of the lasting power of attorney information.	Free text or URL	

Name	Description	Values	Implementation guidance
Name of LPA	The name of any appointed people or deputies.	Free text	
Contact details	The contact details of the LPA	Free text	
Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	Record of one or more people who have been given power (LPA) by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make those decisions. To be valid, an LPA must have been registered with the Court of Protection. If life-sustaining treatment is being considered the LPA document must state specifically that the attorney has been given power to consent to or refuse life-sustaining treatment. Details of any person (deputy) appointed by the court to make decisions about the person's health and welfare. A deputy does not have the		

Name	Description	Values	Implementation guidance
	power to refuse life-sustaining treatment.		
Contact details	The contact details of the LPA	Free text	
Performing professional	The professional who made the decision to detain the person under the mental health act.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	See Table 3 for implementation guidance.
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	See Table 3 for implementation guidance.
Deprivation of Liberty Safeguards or equivalent	Details of the person's Deprivation of Liberty Safeguards (DoLS) or equivalent.	Free text.	
Application date	The date the application was made.	Date and time.	
Application status	The status of the DoLS application.	Requested or authorised.	
Deprivation of Liberty Safeguards or equivalent	Record of the person's Deprivation of Liberty Safeguards (DoLS) or	Free text	

Name	Description	Values	Implementation guidance
	equivalent, including the reason for this.		
Start date of authorisation	The date the DoLS was authorised.	Date and time.	
Planned or actual end date of authorisation	The planned or actual end date of authorisation.	Date and time.	
Performing professional	The professional who applied for the DoLS.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Mental Health Act or equivalent status	Record where a person diagnosed with a mental disorder is formally detained under the Mental Health Act or equivalent, including the section number. If person subject to Community Treatment Order or Conditional Discharge (or equivalent) record here.	Free text.	There can be more than one record of 'Mental health act status' (a record of a decision to detain the person diagnosed with a mental disorder under the Mental Health Act or equivalent).
Section start date	The date the person was detained.	Date and time.	
Section end date	The date the person was no longer detained.	Date and time.	

Name	Description	Values	Implementation guidance
Location	The location where the decision to detain the person was made under the mental health act.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Mental Health Act or equivalent status	Record where a person diagnosed with a mental disorder is formally detained under the Mental Health Act or equivalent, including the section number. If person subject to Community Treatment Order or Conditional Discharge (or equivalent) record here.		
Coded value	The coded value for the mental health act	NHS data dictionary: MENTAL HEALTH ACT CLASSIFICATION CODE	
Free text	Free text field to be used if no code is available	Free text	

Name	Description	Values	Implementation guidance
Supporting information	If person subject to Community Treatment Order or Conditional Discharge (or equivalent) record here.	NHS data dictionary: Community Treatment Order	
Performing professional	The professional who made the decision to detain the person under the mental health act.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Advance decision to refuse treatment (ADRT)	A record of an advance decision to refuse one or more specific types of future treatment, made by a person who had capacity at the time of recording the decision. The decision only applies when the person no longer has the capacity to consent to or refuse the specific treatment being considered. An ADRT must be in writing, signed and witnessed.	SNOMED CT codes (see National Information Standard (SCCI1580) and associated text). Where available a copy of the ADRT may be appended to the record. Where there has been a change in the ADRT this should be noted in the record in free text.	

Name	Description	Values	Implementation guidance
	If the ADRT is refusing life-sustaining treatment it must state specifically that the treatment is refused even if the person's life is at risk.		
Date	The date the ADRT was recorded	Date and time	Key contextual information.
Location	The location the ADRT was recorded		Key contextual information.
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Advance decision to refuse treatment (ADRT)	A record of an advance decision to refuse one or more specific types of future treatment, made by a person who had capacity at the time of recording the decision. The decision only applies when the person no longer has the capacity to consent to or refuse the specific treatment being considered.		SNOMED CT codes (see National Information Standard (SCCI1580) and associated text). Where available a copy of the ADRT may be appended to the record. Where there has been a change in the ADRT this should be noted in the record in free text.

Name	Description	Values	Implementation guidance
	An ADRT must be in writing, signed and witnessed. If the ADRT is refusing life-sustaining treatment it must state specifically that the treatment is refused even if the person's life is at risk.		
Coded value	The coded value for advance decision to refuse treatment.	SNOMED CT code: 999002181000000105 |Advance decision to refuse treatment preference findings simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text	
Performing professional	The professional who made the decision to detain the person under the mental health act.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. This is information provided by the national register.	Free text.	Organ and tissue donation is also included in this section, but this is information that would be obtained directly from the national register.
7.9 Safeguarding	The safeguarding details of the person.		This section includes any concerns in relation to safeguarding and is applicable to children and adults. This section includes whether a child is looked after and indicates the presence of a Child Protection Plan or Unborn Child Protection Plan. There may be situations where it is not advisable to share information in this section with the person to whom it relates, so local implementations may need to apply filters in these cases. Appropriate policies and technical solutions need to be in place for these situations. Access must be controlled to this information as per SCCI1609: Child Protection - Information Sharing.
Safeguarding concerns	Details of safeguarding concerns. There may be 0 to many record entries under a section.		
Coded value	The coded value for safeguarding concerns	SNOMED CT	

Name	Description	Values	Implementation guidance
Free text	Free text field to be used if no code is available	Free text.	
Safeguarding concerns start date	The date the safeguarding concerns were identified.	Date and time.	
Safeguarding concerns end date	The date safeguarding concerns ended.	Date and time.	
Location	The location where the safeguarding concerns were identified.		
Location	The location where the safeguarding concerns were identified.		Key contextual information.
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Safeguarding concerns	Identified safeguarding concerns.	Code or free text.	
Performing professional	The professional who identified the safeguarding concerns.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the	

Name	Description	Values	Implementation guidance
		person completing record cluster (this document).	
7.10 Professional contacts	The details of the person's professional contacts.		This section includes current and historic details of health and care professionals, teams or organisations involved in the care of the person. Third sector organisations can be included. The name of the person's current care coordinator or key worker should be included here.
Professional contacts record entry	This is a professional contacts record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Name	The name of the professional with responsibility for the care of the person.	Free text.	
Role	The role the professional has in relation to the person e.g. GP, physiotherapist, community nurse, social worker, key worker, care home manager, care coordinator, LA hospital liaison person, care home	NHS data dictionary code or free text if code is not available. CARE PROFESSIONAL TYPE	

Name	Description	Values	Implementation guidance
	contact, hospital clinician, Independent Mental Capacity Advocate (IMCA) etc.		
Key worker	A flag that identifies the personal contact is the key worker assigned to the person.	Yes or No.	
Speciality	The specialty of the professional e.g. physiotherapy, oncology, mental health etc.	NHS data dictionary code: MAIN SPECIALTY CODE	
Team	The name of the team.	Free text.	
Organisation	The name of the organisation.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Contact details	Contact details of the professional (e.g. telephone number, email address etc.).	Free text.	

Name	Description	Values	Implementation guidance
Start date	The start date of the professional relationship with the person.	Date and time.	
End date	The end date of the professional relationship with the person.	Date and time.	
7.11 Personal contacts	The details of the individual's personal contacts.		This section includes the personal contacts (e.g. family, friends, relatives etc.). Comments should be used to share information such as if a particular contact should be called in an emergency etc.
Personal contacts record entry	This is personal contacts record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Name	The name of the personal contact.	Free text.	
Relationship	The relationship the personal contact has to the person, e.g. father, grandmother, family friend etc.	FHIR value set recommended.	

Name	Description	Values	Implementation guidance
Relationship type	Additional roles the person performs on behalf of the other (e.g. Carer, Next of Kin, Emergency Contact, Dependent, etc.). There may be 0 to many record entries for this element.		NB: The term 'next of kin' has no legal basis. See here for further information.
Next of Kin	A flag that identifies the personal contact is the next of kin.	Yes or No.	NB: The term 'next of kin' has no legal basis. See here for further information.
Contact details	Contact details of the personal contact (e.g. telephone number, email address etc.).	Free Text.	
Comments	Notes on the significance of the personal contact to the person.	Free text.	
7.12 Referral details	The details of the referral.		This section includes a record of current and historic referrals. Referral details includes the service a person is being referred from. A service may not always be coded. If the service is known, and a code is available, it should be included otherwise the service should be described in free text.
Referral details record entry	This is the referral details record entry. There may be		

Name	Description	Values	Implementation guidance
	0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Date	The date of referral.	Date and time.	
Referrer details	The details of the referrer. This could be the person, GP surgery, department, specialty, sub-specialty, educational institution, mental health team etc.		
Name	The name of the referrer.	Free text.	
Role	Role of the referrer.	NHS data dictionary code or free text. CARE PROFESSIONAL TYPE	
Grade	The grade of the referrer.	Free text.	
Team	The team or department of the referrer.	Free text.	
Specialty	The specialty of the referrer.	NHS data dictionary code: MAIN SPECIALTY CODE	
Service	The service of the referrer.		

Name	Description	Values	Implementation guidance
Coded value	The coded value for service	SNOMED CT: 999000191000000106 |Care planning patient outgoing referral simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text	
Organisation	The organisation of the referrer.		Key contextual information.
Coded value	The code value for the organisation	NHS data dictionary code or free text. ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text	
Contact details	The contact details of the referrer.	Free text.	
Referral type	An indication of the type of referral (e.g. 'Hospital Discharge Notification to Social Care', 'GP Referral', etc.).		
Referral method	The method in which a referral is sent and received. This may be a letter, email,	Allow National Codes only: 1. Fax	

Name	Description	Values	Implementation guidance
	transcript of a telephone conversation, Choose and Book, in person (self-referral) etc.	2. Phone 3. Secure Messaging 4. Secure Email 5. Letter 6. NHS E-Referral Service 7. Self Referral	
Reason for referral	The reason for the referral, e.g. diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient (e.g. palliative care), or carer's concerns.		
Coded value	The coded value for reason for referral	SNOMED CT: 1127581000000103 |Health issues simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text	
Referral to	Details of where the referral is to be sent. If not an individual, this could be a service, e.g. GP surgery, department, specialty,		

Name	Description	Values	Implementation guidance
	subspecialty, educational institution, mental health etc.		
Name	Name of person the referral is to be sent to.	Free text.	
Role	Role of person where the referral is to be sent to.	NHS data dictionary code or free text. CARE PROFESSIONAL TYPE	
Grade	The grade of the person where the referral is sent to.	Free text.	
Team	The team or department of the person where the referral is being sent to.	Free text.	
Specialty	The specialty the referral is being sent to e.g. physiotherapy, oncology, mental health etc.	NHS data dictionary code: MAIN SPECIALTY CODE	
Service	The service of where the referral is sent to.	Free text.	Key contextual information.
Coded value	The coded value for service	SNOMED CT: 999000191000000106 |Care planning patient outgoing referral simple reference set (foundation metadata concept)|	

Name	Description	Values	Implementation guidance
Free text	Free text field to be used if no code is available	Free text	
Organisation	The organisation of where the referral is to be sent.		Key contextual information.
Coded value	The code value for the organisation	NHS data dictionary code or free text. ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text	
Contact details	The contact details of where the referral is to be sent.	Free text.	
Referral criteria	Records whether specific criteria required for referral, to a particular service, have been met (may be nationally or locally determined).	Free text.	This field is used to outline which criteria have been met where a service has indicated specific criteria and to explain the rationale for referral where criteria have not been met.
Return response to	Name of professional to be communicated with, if not the referrer	Free text.	

Name	Description	Values	Implementation guidance
7.13 Contacts with professionals	The details of the person's contact with a professional.		This section includes the details of the person's contacts with services, their encounters. This information may need to be filtered to only display what is relevant for a particular use case and professional's discipline. This includes outpatient appointments, home visits, hospital and outpatient attendances, out of hours GP visits, clinic appointments, social worker visits etc.
Contacts with professionals record entry	This is a contacts record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Date of contact	Date and time of the contact.	Date and time.	
Location of contact	The location where the contact took place.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Seen by	The professional that saw the person.		
Coded value	The coded value for location	SNOMED CT:	

Name	Description	Values	Implementation guidance
		307839005 |Seen by person (finding)|	
Free text	Free text field to be used if no code is available	Free text.	
Responsible professional	The name and role of the professional that had overall responsibility for the person e.g. consultant, nurse consultant, midwife, allied health professional (may not have actually seen the person).		
Name	The name of the responsible professional.	Free text	
Role	The role of the responsible professional	NHS data dictionary code or free text. CARE PROFESSIONAL TYPE	
Location type	The type of location where the contact took place e.g. person's home	NHS data dictionary code or free text. ACTIVITY LOCATION TYPE CODE	

Name	Description	Values	Implementation guidance
Contact type	Type of contact e.g. GP consultation, outpatient attendance	NHS data dictionary code or free text. CARE CONTACT TYPE	
Consultation method	Consultation method used e.g. face to face, telephone	NHS data dictionary code or free text. CONSULTATION MEDIUM USED	
Specialty	The specialty e.g. physiotherapy, oncology, mental health etc	NHS data dictionary code: MAIN SPECIALTY CODE	
Service	The service that was provided.	SNOMED CT or free text. 999000381000000107 |Correspondence care setting type simple reference set (foundation metadata concept)|	
Professionals present	The name, role of the additional individuals or team members including consultant(s), nurse consultant(s), allied health professional(s), social worker(s)		

Name	Description	Values	Implementation guidance
Name	The name of the professional present	Free text	
Role	The role of the professional present.	NHS data dictionary code or free text. CARE PROFESSIONAL TYPE	
Outcome of contact	This records the outcome of the contact.	NHS data dictionary code or free text. ATTENDED OR DID NOT ATTEND	
7.14 Admission details	Admission details		This section includes all instances where a person is admitted to an inpatient setting and would include the relevant site code according to the Organisation Data Service (ODS) codes.
Admission details record entry	This is the admission details record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Date of admission	Date and time the person was admitted to hospital.	The date and time of admission as recorded on the Patient Administration System (PAS)	

Name	Description	Values	Implementation guidance
Admitted to	The hospital the person was admitted to.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Responsible consultant	The consultant who has overall responsibility for the person (may not actually see the person)		
Name	The name of the responsible consultant.	Free text.	
Role	The role of the responsible consultant.	NHS data dictionary code or free text. CARE PROFESSIONAL TYPE	
Reason for admission	The health problems and issues experienced by the person that prompted the decision to admit to hospital e.g. chest pain, mental health crisis, blackout, fall, a specific procedure, intervention, investigation or		

Name	Description	Values	Implementation guidance
	treatment, non-compliance with treatment.		
Coded value	The coded value for reason for admission.	SNOMED CT: 1127581000000103 |Health issues simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text.	
Admission method	How the person was admitted to hospital e.g. elective, emergency, maternity, transfer etc.	NHS data dictionary code or free text. ADMISSION METHOD	
Coded value	The coded value for admission method	NHS data dictionary code: ADMISSION METHOD	
Free text	Free text field to be used if no code is available	Free text	
Legal status on admission	Whether the person was admitted as informal or formal/detained.	Free text	
Source of admission	Where the person was immediately prior to admission, e.g. usual place of residence, temporary		

Name	Description	Values	Implementation guidance
	place of residence, penal establishment.		
Coded value	The coded value for source of admission	NHS data dictionary code or free text. SOURCE OF ADMISSION	
Free text	Free text field to be used if no code is available	Free text	
Individual accompanying person	Details of the accompanying individual and the extent to which they have provided the information about the person.		
Name	Name of individual accompanying person.	Free text	
Role	Role of the individual accompanying the person.	NHS data dictionary code or free text. CARE PROFESSIONAL TYPE	
Relationship	Relationship of individual accompanying the person.	FHIR value set or free text. PATIENT RELATIONSHIP TYPE	
Coded value	The code value for relationship to person.	FHIR value set or free text. PATIENT RELATIONSHIP TYPE	

Name	Description	Values	Implementation guidance
Free text	Free text field to be used if no code is available	Free text	
Comment	Information about the extent to which the accompanying individual provided information about the person.	Free text.	
Speciality	The specialty e.g. physiotherapy, oncology, mental health etc		
Coded value	The code value for speciality.	NHS data dictionary code: MAIN SPECIALTY CODE	
Free text	Free text field to be used if no code is available	Free text	
7.15 Discharge details	Discharge details		This section includes the summary details of the person's discharge, but not the actual discharge content which is shared in the relevant sections such as problem list or procedures. This should include all instances of discharge from a healthcare setting with relevant ODS codes and readable names of the discharging wards or departments of organisations where available.
Discharge details record entry	This is the discharge details record entry. There may be 0 to many record entries under a section. Each record		

Name	Description	Values	Implementation guidance
	entry is made up of a number of elements or data items.		
Date of discharge	The date and time of discharge	The date and time of discharge as recorded by the PAS or discharging system.	
Discharge location	The hospital the person was discharged from.	NHS data dictionary code or free text. ORGANISATION CODE	
Discharging consultant	The consultant responsible for the person at time of discharge.		
Name	The name of the discharging consultant	Free text	
Free text	The role of the discharging consultant	NHS data dictionary code or free text. CARE PROFESSIONAL TYPE	
Discharge method	The method of discharge from hospital e.g. person discharged on clinical advice or with clinical consent; person discharged him/herself or was		

Name	Description	Values	Implementation guidance
	discharged by a relative or advocate.		
Coded value	The code value for discharge method.	NHS data dictionary code or free text. DISCHARGE METHOD	
Free text	Free text field to be used if no code is available	Free text	
Discharging specialty	The specialty of the consultant responsible for the person at the time of discharge.	NHS data dictionary code or free text: MAIN SPECIALTY CODE	
Discharging department	The department from which the person is discharged.	Free text	
Legal status on discharge	Whether the person was discharged as informal or formal/detained.	Free text	
Discharge destination			
Discharge destination	The destination of the person on discharge from hospital e.g. usual place of residence, NHS run care home.	NHS data dictionary code: DISCHARGE DESTINATION	

Name	Description	Values	Implementation guidance
Discharge address	Address to which the person is discharged if not the usual place of residence.	Free text.	
7.16 Future appointments	Details of future appointments.		This section includes the details of any future appointments the person may have. This can include both health and care appointments for example a home visit from a domiciliary care worker. The section includes both specialty and service. Specialty should be used where possible for secondary care appointments, but service can be used for example for social care where specialty doesn't apply.
Future appointments record entry	This is the future appointments record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Date of appointment	Date and time of future appointment.	Date and time	
Appointment status	The status of the appointment e.g. proposed, booked, confirmed, rejected.	Free text	
Reason for appointment	Reason this appointment is scheduled	Free text. The reason for the appointment e.g. diagnosis,	

Name	Description	Values	Implementation guidance
		investigation, treatment or assessment	
Location of future appointment	The location of the appointment.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Specialty	The specialty e.g. physiotherapy, oncology, mental health etc.	NHS data dictionary code or free text: MAIN SPECIALTY CODE	
Service	The service being provided.	SNOMED CT or free text. 999000381000000107 |Correspondence care setting type simple reference set (foundation metadata concept)|	
Professional seeing the person	The name and role of the professional e.g. consultant, care worker, nurse consultant.		
Name	The name of the professional seeing the person.	Free text	

Name	Description	Values	Implementation guidance
Role	The role of the professional seeing the person.	NHS data dictionary code or free text. CARE PROFESSIONAL TYPE	
7.17 Investigation results	Investigation results		This section includes details of the investigation results. Systems should allow copies of reports, scans, images related to the investigation results to be shared with the record. It allows for results in either structured format (e.g. blood tests) or unstructured format (e.g. genetic test with the result as a report). One or other of these should be used for the result. Investigation results received from laboratories may be imported into this section.
Investigation results record entry	This is a investigation result record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Date	The date and time when the investigation was performed	Date and time	
Performing professional	The professional who performed the investigation.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	

Name	Description	Values	Implementation guidance
Location	The location where the investigation took place.	NHS data dictionary code or free text. ORGANISATION CODE	
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Investigation	The investigation performed.		
Coded value	The coded value for location	SNOMED CT: 71388002 |Procedure (procedure)|	
Free text	Free text field to be used if no code is available	Free text.	
Investigation result	For each investigation, the result of the investigation. This can include a report which may have results for multiple tests.	Free text.	

Name	Description	Values	Implementation guidance
Coded value	The coded value for investigation result.	SNOMED CT: 404684003 |Clinical finding (finding)| OR 243796009 |Situation with explicit context (situation)|	
Free text	Free text field to be used if no code is available	Free text.	
Structured investigation result	A structured set of information for each investigation result.		
Value	The value of the investigation result.	Free text.	
Units	The units of the investigation result.	Free text.	
Reference ranges	The reference range for the investigation result.	Free text.	
Abnormal indicator	Indicator if the investigation is abnormal.	Abnormal or Normal	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the	

Name	Description	Values	Implementation guidance
		person completing record cluster (this document).	
7.18 Investigations requested	Details of any investigations requested		The section includes details of requested investigations as yet unfulfilled. This should include the reason and priority of the request. Investigations that have concluded, and for which results are available, should be included in the investigation results section.
Investigations requested record entry	This is an investigation requested record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.		
Date	The date the investigation was requested.	Date and time	
Location	The location where the investigation was requested.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	

Name	Description	Values	Implementation guidance
Performing professional	The professional who requested the investigation.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Investigation requested	The investigation may refer to an individual test or a group of related tests or broader investigation required (so the investigator can determine the appropriate tests)		
Coded value	The coded value for investigation requested.	SNOMED CT	
Free text	Free text field to be used if no code is available	Free text.	
Status of request	The status of the investigation request.	draft | active | suspended | completed | entered-in-error | cancelled	
Reason for request	An explanation or justification for why this investigation is being requested.	SNOMED CT or free text.	
Request priority	The urgency of the investigation requested.	routine | urgent | asap | stat	

Name	Description	Values	Implementation guidance
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
7.19 Examination findings	Examination findings		This section is a summary of key findings carried out as a result of an examination conducted by a healthcare professional. Each record of an 'Examination finding' should include a named examination and associated findings, which may include both coded and narrative elements. 'Observations' includes a record of essential physiological measurements, e.g., heart rate, blood pressure, weight, height, temperature, pulse, respiratory rate, oxygen saturation. For children, observations would also include weight, height/length and head circumference. *NB*: The Care Homes View of the core information standard is endorsed for adults only.
Examination findings record entry	This is a examination findings record entry. There may be 0 to many record entry/entries under a section. Each record entry is made up of a number of elements or data items.		
Date	The date the examination was performed.	Date and time	

Name	Description	Values	Implementation guidance
Performing professional	The professional who performed the examination.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Location	The location where the examination was performed.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Examination findings	The record of findings from the examinations performed.		
Coded value	The coded value for examination findings.	SNOMED CT: 1127581000000103 |Health issues simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text.	
Observations	The record of essential physiological measurements, e.g., heart rate, blood pressure, temperature, pulse, height,		

Name	Description	Values	Implementation guidance
	weight, respiratory rate, oxygen saturation.		
Coded value	The coded value for examination findings.	SNOMED CT	
Free text	Free text field to be used if no code is available	Free text.	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Comments	Any further textual comment to clarify such as the statement that information is partial or incomplete.	Free text.	

Name	Description	Values	Implementation guidance
7.20 Assessments	Assessment.		This section includes details of a person's assessments allowing for unstructured, semi structured and structured outputs from the assessment. Some assessment outputs will be narrative and may come with their own particular sub-headings e.g. psychiatry (Presenting Problem, Personal/Family History, Mental State Examination etc.). This section would also accommodate the results of any more structured assessment tools completed (e.g. screening tools/outcomes measures such as PHQ-9 or GAD-7). Numeric results of any assessments completed can also be included.
Assessments record entry	This is the assessments record entry. There may be 0 to many record entry/entries under a section. Each record entry is made up of a number of elements or data items.		
Date	The date the assessment was done.	Date and time.	
Location	The location where the assessment was done.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	

Name	Description	Values	Implementation guidance
Free text	Free text field to be used if no code is available	Free text.	
Assessment type	The type of the assessment e.g. social care needs assessment.	Free text.	
Assessment summary	The summary of the assessment.	Free text.	
Structured assessment	Details of the structured assessment.		
Structured assessment name	Structured assessment name e.g. New York Heart Failure, Glasgow Coma scale, Activities of Daily Living (ADL) etc.	SNOMED CT or free text.	
Assessment score	The structured assessment score.	SNOMED CT or free text.	
Assessment value	The structured assessment value.	Free text, alphanumeric or SNOMED CT.	
Global score	The total global score from the assessment.	Free text.	
Subscale score	The subscale score of the structured assessment.	SNOMED CT or free text.	

Name	Description	Values	Implementation guidance
Subscale value	The subscale value of the structured assessment.	Free text, alphanumeric or SNOMED CT.	
Performing professional	The professional who did the assessment.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Comment	Supporting text may be given regarding the assessment.	Free text.	
7.21 Risks	Details of any risks related to the person.		Risks are likely to fall into the categories set out in the core information standard – Risk to self, risk to others, etc. However, there is also a category for other risks. There should be mechanisms in place to validate the information in this section and for it to be reviewed regularly and if applicable ended, however the peculiarity of risk factors in mental health needs to be taken into consideration i.e. the most important factor in risk is history so information here should not be archived or filtered without careful consideration.
Risks to self	Details of the persons risks to self		
Start date of risk	The start date of the risk.	Date and time	

Name	Description	Values	Implementation guidance
End date of risk	The date the risk ended.	Date and time	
Risks to self	Risks the person poses to themselves, e.g., suicide, overdose, self-harm, self-neglect.	SNOMED CT: 281694009 |Finding of at risk (finding)|	
Location	The location where the risk was identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who identified the risk.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Risks to others	Details of the persons risks to others		
Start date of risk	The start date of the risk.	Date and time	

Name	Description	Values	Implementation guidance
End date of risk	The date the risk ended.	Date and time	
Risks to others	Risks to professionals or others	SNOMED CT: 391155006 |At risk of harming others (finding)|	
Location	The location where the risk was identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who identified the risk.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Risk from others	Details of the persons risks from others		
Start date of risk	The start date of the risk.	Date and time	

Name	Description	Values	Implementation guidance
End date of risk	The date the risk ended.	Date and time	
Risk from others	Risks to the person from an identified individual e.g. family member etc.	SMOMED CT: 281694009 |Finding of at risk (finding)|	
Location	The location where the risk was identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who identified the risk.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Risk of accidents	Details of the risks the person poses to themselves from accidents.		
Start date of risk	The start date of the risk.	Date and time	

Name	Description	Values	Implementation guidance
End date of risk	The date the risk ended.	Date and time	
Risk of accidents	Risks the person poses to themselves from accidents.	Free text	
Location	The location where the risk was identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who identified the risk.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Other risks	Details of other risks, factors or behaviours relating to the person.		
Start date of risk	The start date of the risk.	Date and time	
End date of risk	The date the risk ended.	Date and time	

Name	Description	Values	Implementation guidance
Other risks	Other risks, factors or behaviours relating to the person.	Free text.	
Location	The location where the risk was identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who identified the risk.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Infection risk	Details of any known infection of the person for which special handling might be required	SNOMED CT or free text.	
Start date of risk	The start date of the risk.	Date and time	
End date of risk	The date the risk ended.	Date and time	

Name	Description	Values	Implementation guidance
Location	The location where the risk was identified.	NHS data dictionary code or free text. ORGANISATION CODE	
Performing professional	The professional who identified the risk.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
7.22 Allergies and adverse reactions	Allergies and adverse reactions		Guidance on good practice recording of allergies and adverse reactions is provided by NICE A record should be provided of all allergic and adverse reactions relevant to the person. Coded information on causative agents is important to healthcare professionals to enable safe prescribing of medications. When an individual is diagnosed with an allergy related condition (e.g. anaphylactic shock or urticarial skin rash) this will be entered in addition into the diagnosis field in the healthcare system and will need to be cross referenced into the problem list and prominently displayed there. Where there is a diagnostic code for an allergy recorded in the system, the system should trigger an allergy entry. There is a significant risk to patient safety if allergies are not explicitly and prominently displayed. Adverse reactions need to be treated in a similar manner. Information about probability of recurrence may be included in the allergy comments element if this has been identified.
Allergies and adverse reactions record entry	This is a allergies and adverse reactions record entry. There may be 1 to many record entries under a section. Each record entry is made up of a number of elements or data items.		

Name	Description	Values	Implementation guidance
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this person Or “No known drug allergies or adverse reactions” Or “Information not available”		
Coded value	The coded value for causative agent	SNOMED CT: 105590001 |Substance (substance)| OR 373873005 |Pharmaceutical / biologic product (product)| OR 716186003 |No known allergy (situation)| OR 196461000000101 |Transfer-degraded drug allergy (record artifact)| OR	

Name	Description	Values	Implementation guidance
		196471000000108 |Transfer-degraded non-drug allergy (record artifact)| OR alternatively, one of the following statements: "No known drug allergies" OR "Information not available" OR a code from the v3 Code System NullFlavor specifying why a valid value is not present OR Choice of• Text• Coded text - constraint: SNOMED CT:Allergy Archetypes Drug Groups	
Free text	Free text field to be used if no code is available	Free text.	
Reaction details cluster	Details of the reaction.		
Date	The date that the reaction was identified. This will often equate to the date of onset of the reaction, but this may		

Name	Description	Values	Implementation guidance
	not be wholly clear from source data.		
Location	Details of where the allergy was identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Substance	The substance, or a class of substances, that is considered to be responsible for the adverse reaction.		
Coded value	The coded value for location	SNOMED CT	
Free text	Free text field to be used if no code is available	Free text.	
Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the person. For example, skin rash.		
Coded value	The coded value for description of reaction.	SNOMED CT:	

Name	Description	Values	Implementation guidance
		1127581000000103 |Health issues simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text.	
Severity	A description of the severity of the reaction		
Coded value	The coded value for severity.	SNOMED CT: 999004521000000108 |Health issue severity simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text.	
Certainty	A description of the certainty that the stated causative agent caused the allergic or adverse reaction.		
Coded value	The coded value for certainty.	SNOMED CT: 999004531000000105 |Health issue certainty simple reference set (foundation metadata concept)|	

Name	Description	Values	Implementation guidance
Free text	Free text field to be used if no code is available	Free text.	
Comment	Any additional comment or clarification about the adverse reaction.	Free text.	
Performing professional	The professional who identified the reaction.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
7.23 Medications and medical devices	Medications and medical devices		The medications section allows for using structured dose and timing information that is machine readable to facilitate the reading and transfer of medications information between systems and providers of care, through the structured dose direction cluster. Technical guidance for implementing the structured dose and timing in Fast Healthcare Interoperable Resource (FHIR) messaging is available from NHS Digital The free text Dose directions description is the form of dosage direction typically used in UK GP Systems. Dose direction duration can be derived from the start and end dates if no other information is available.
Medication administration record entry	Each entry holds details of medications administered		
Medication name	May be generic name or brand name.		
Coded value	The coded value for medication name	SNOMED CT: 999000581000001102 |National Health Service dictionary of medicines and devices virtual therapeutic moiety simple reference set (foundation metadata concept)| OR 999000561000001109 |National Health Service dictionary of medicines and devices virtual	

Name	Description	Values	Implementation guidance
		medicinal product simple reference set (foundation metadata concept)| OR 999000571000001104 |National Health Service dictionary of medicines and devices virtual medicinal product pack simple reference set (foundation metadata concept)| OR 999000541000001108 |National Health Service dictionary of medicines and devices actual medicinal product simple reference set (foundation metadata concept)| OR 999000551000001106 |National Health Service dictionary of medicines and devices actual medicinal product pack simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text.	

Name	Description	Values	Implementation guidance
Route	The route by which the medication is administered e.g. oral, IM, IV		
Coded value	The coded value for route.	SNOMED CT: 999000051000001100 |ePrescribing route of administration simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text.	
Dose administered	The quantity and units of medication administered	Free text. The quantity and units administered	
Administration date and time	The date and time when the medication was administered.	Date and time	
Medication item entry	All medications and devices that can be prescribed to be entered via this Medication item entry. Handles details of continuation / addition / amendment of admission medications.		

Name	Description	Values	Implementation guidance
Medication item cluster	Medication item cluster		
Date	The date on which the medication or medical device was prescribed.	Date and time	
Location	The location where the medication or the medical device was prescribed.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who prescribed the medication or medical device.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Medication name	May be generic name or brand name.		
Coded value	The coded value for the medication name.	SNOMED CT: 999000581000001102 |National Health Service dictionary of medicines and devices virtual therapeutic moiety simple reference set (foundation metadata concept)|	

Name	Description	Values	Implementation guidance
		OR 999000561000001109 |National Health Service dictionary of medicines and devices virtual medicinal product simple reference set (foundation metadata concept)| OR 999000571000001104 |National Health Service dictionary of medicines and devices virtual medicinal product pack simple reference set (foundation metadata concept)| OR 999000541000001108 |National Health Service dictionary of medicines and devices actual medicinal product simple reference set (foundation metadata concept)| OR 999000551000001106 |National Health Service dictionary of medicines and devices actual medicinal product pack simple reference set (foundation metadata concept)|	

Name	Description	Values	Implementation guidance
Free text	Free text field to be used if no code is available	Free text.	
Form	The form of the medication e.g. capsule, drops, tablet, lotion etc.		
Coded value	The coded value for form	SNOMED CT: 421967003 |Drug dose form (qualifier value)|	
Free text	Free text field to be used if no code is available	Free text.	
Route	The route by which the medication is administered e.g. oral, IM, IV		
Coded value	The coded value for route	SNOMED CT: 999000051000001100 |ePrescribing route of administration simple reference set (foundation metadata concept)|	
Free text	Free text field to be used if no code is available	Free text.	

Name	Description	Values	Implementation guidance
Site	The anatomical site at which the medication is to be administered.		
Coded value	The coded value for site	SNOMED CT	
Free text	Free text field to be used if no code is available	Free text.	
Method	The technique or method by which the medication is to be administered.	Free text	
Dose directions description	Describes the entire medication dosage and administration directions including dose quantity and medication frequency and optionally duration e.g. “1 tablet at night" or “2mg at 10pm”.	Free text	
Structured dose direction cluster	A structural representation of the elements carried by the dose syntax in 'parsable dose strength / timing' i.e. dose strength, dose timing, dose duration and maximum dose.		

Name	Description	Values	Implementation guidance
Structured dose amount	A structural representation of dose amount, e.g. 20mg or 2 tablets. This element will generally only be used when persisting data within systems with 'parsable dose directions' being used to exchange the same information between systems.	As per: FHIR Dose Syntax Implementation Guidance (NHS Digital)	
Structured dose timing	A slot containing a structural, computable representation of dose timing and maximum dose. This element will generally only be used when persisting data within systems with 'parsable dose directions' being used to exchange the same information between systems.	As per: FHIR Dose Syntax Implementation Guidance (NHS Digital)	
Dose direction duration	Recommendation of the time period for which the	Choice of Coded Text:	When sharing Dose direction duration, the following examples are provided to clarify definitions for two of

Name	Description	Values	Implementation guidance
	medication should be continued, including direction not to discontinue.	Continue indefinitely [The medication should be continued indefinitely.] Do not discontinue [The medication should be continued indefinitely and the prescriber highly recommends that it should never be discontinued. This is an AoMRC Clinical Headings recommendation.] Stop when course complete. [The medication should be stopped when the currently prescribed course has been completed.] Duration: Allowed values: years, months, weeks, days, hours >=0 days	the coded text items which appear similar. In both cases, these directions are not an absolute instruction. They are: • 'continue medication indefinitely' - ongoing treatment planned for example when starting daily aspirin or a statin. There will be circumstances where you would stop them such as a GI bleed. • 'do not discontinue' refers to medication where suddenly stopping could be dangerous, for example the abrupt withdrawal of long-term steroids.
Additional instructions	Allows for: * requirements for adherence support, e.g. compliance aids, prompts and packaging requirements * additional information about specific medicines e.g. where specific brand required	TextRuntime name constraint:Additional instruction [Additional multiple dosage or administration instructions as plain text. This may include guidance to the prescriber, person administering the medication. In some settings, specific Administration Instructions may be re-labelled	

Name	Description	Values	Implementation guidance
	* person requirements, e.g. unable to swallow tablets.	as "person advice' or 'Dispensing Instruction' to capture these flavours of instruction.]Dispensing instruction [Multiple plain text to record complex dispensing arrangements, particularly for Controlled Drug instalment dispensing. 'Dispensing instructions' may be used as a specific label to overwrite 'Additional instructions' to align with legacy GP system behaviour.]Person advice [Multiple plain text instructions intended for person or carer. 'Person advice' may be used as a specific label to overwrite 'Additional instructions' to align with legacy GP system behaviour.]Monitoring [Special instructions related to monitoring of medication, such as lab tests.] or Free text	
Course details cluster	Details of the overall course of medication.		
Course status	The status of this prescription.	Choice of Coded text:	

Name	Description	Values	Implementation guidance
		Active [This is an active medication.] Discontinued [This is a medication that has been issued. dispensed or administered but has now been discontinued.] Never active [A medication which was ordered or authorised but has been cancelled prior to being issued, dispensed or administered.] Completed [The medication course has been completed.] Obsolete [This medication order has been superseded by another.]	
Indication	Reason for medication being prescribed, where known.	A free text or Coded text term giving the clinical indication or reason for ordering the medication. Coded terms are preferable.	
Start date/time	The date and/or time that the medication course should begin.	Date and time	

Name	Description	Values	Implementation guidance
End date/time	The date and/or time that the medication course should finish.	Date and time	
Link to indication record	A link to the record which contains the indication for this medication order.	Free text with URL	
Comment/recommendation	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.	Free text. Additional comment or recommendation about the medication course e.g. 'Patient named supply', 'unlicensed medication', 'Foreign brand' or monitoring recommendations	
Medication change summary cluster	Records the changes made to medication.		The medication change cluster and medications discontinued cluster both derive from discharge standards to ensure clarity of what medications had changed or been stopped in hospital. They are retained in the core information standard as they may still be useful to professionals in understanding previous medications.
Status	The nature of any change made to the medication.	Choice of Coded text: Continued [Medicine present on both admission and discharge with no amendments.] Added [Medicine present on discharge but not on admission]	

Name	Description	Values	Implementation guidance
		Amended [Medicine present on both admission and discharge but with amendment(s) since admission.] On-hold [Suspended with the intention that they are to be reinstated at some point in the future] Discontinued [The medication is no longer to be taken by the patient]	
Indication	Reason for change in medication, e.g. sub-therapeutic dose, person intolerant.	A free text or coded text term giving the clinical indication or reason for change in medication.	
Date of change	The date of the change - addition, or amendment	Date and time	
Description of amendment	Where a change is made to the medication i.e. one drug stopped and another started or e.g. dose, frequency or route is changed.	Free text.	
Total dose daily quantity	The total daily dose of this medication. This is helpful for estimating optimal adherence to dosing	Free text.	

Name	Description	Values	Implementation guidance
	guidance. It may be computed from product/dose strength and frequency or entered manually.		
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Medication discontinued entry	Medication discontinued entry		The medication change cluster and medications discontinued cluster both derive from discharge standards to ensure clarity of what medications had changed or been stopped in hospital. They are retained in the core information standard as they may still be useful to professionals in understanding previous medications.
Name of discontinued medication	The name of the medication or medical device being discontinued	Choice ofTextCoded text - constraint: MedicationName. Any AMP/VMP/VTM/AMPP/VMPP subsets from the dm+d terminology. NHS dm+d AMP ::352201000001139 NHS dm+d AMPP ::352401000001135 NHS dm+d VMP ::352701000001133 NHS dm+d VMPP ::352301000001131 NHS dm+d VTM ::352601000001138.	

Name	Description	Values	Implementation guidance
		Constraint binding: [dm+d]subset=NHS_dm+d	
Coded value	The coded value for medication name.	SNOMED CT	See medication name – coded value for appropriate SNOMED CT codes.
Free text	Free text field to be used if no code is available	Free text.	
Status	The status of any change made to the medication.	Free text	
Indication	The clinical indication for any changes in medication status	A free text or coded text term giving the clinical indication or reason for change in medication.	
Date of change	The date of the discontinuation	Date and time	
Description of amendment	A description of any amendment	Free text.	
Comment	Any additional comment about the discontinuation.	Free text.	
Medical devices entry	Medical devices		The Medical devices element is for medical devices that cannot be prescribed and do not have representation in the NHS dictionary of medicines and medical devices (dm+d). Whilst medical devices that can be prescribed in primary care are generally well represented in dm+d, there are other kinds of devices

Name	Description	Values	Implementation guidance
			used in hospital care which may not be so this section provides for this.
Medical device	Any medical device that isn't prescribed.	Free text.	
Comments	Any information regarding the medical device.	Free text.	
7.24 Care and support plan	This records the decisions reached during conversation between the individual and health and care professional about future plans and also records progress.		It is anticipated that there will be a single care and support plan for a person. Linked to this there can be multiplate additional supporting plans (that may be for a specific condition e.g. dementia or asthma). There may also be multiple contingency plans. See the detailed guidance in the Digital Care and Support Plan for further information
Strengths	Any strengths and assets the person has relating to their goals and hopes about their health and well-being.	Free text.	
Needs, concerns or health problems	Needs, concerns or health problems the person has that relating to their health and well-being.	Free text. May be linked to the problem list from the person's record to avoid duplication.	
Goals and hopes	The overall goals, hopes, aims or targets that the person has. Including anything that the person wants to achieve that	Free text. May be SNOMED CT coded. Coded status of goal: Achieved, partially achieved, not achieved, Not applicable	

Name	Description	Values	Implementation guidance
	relates to their future health and wellbeing. Each goal may include a description of why it is important to the person. Goals may also be ranked in order of importance or priority to the person.		
Actions and activities	Actions or activities the person or others plan to take to achieve the person's goals and the resources required to do this.		
Stage goal	A specific sub-goal that is related to the overall goal as agreed by the person in collaboration with a professional.	Free text.	
What	What the action is and how it is to be carried out?	Free text.	
Who	Name and role (e.g. person, carer, GP, OT, etc.) of the person, or a team, carrying out the proposed action, and, if relevant where action should take place.	Free text.	

Name	Description	Values	Implementation guidance
When	Planned date, time, or interval, as relevant	Date and time or free text.	
Suggested strategies	Suggested strategies for potential problems.	Free text.	
Status	The status of the action or activity e.g. started, not started, completed, not applicable.	Free text.	
Confidence	How confident the person feels to carry it out	Free text.	
Outcome	The outcome of the stage goal	Free text.	
Date last updated	Date when action/activity record was last updated	Date and time	
Review date	When the stage goal and action need to be reviewed.	Date and time	
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.	A record of the agreement of the decisions made.	
Care funding source	A reference to the funding source and any conditions or limitations associated.	Free text.	

Name	Description	Values	Implementation guidance
Date this plan was last updated	This is a record of the date that this care and support plan was last updated.	Date and time	
Other care planning documents	Reference other care planning documents, including the type, location and date.	Free text.	
Outcomes	Outcomes of each of the person's goals, aims and targets. Includes comments recorded by the person, date and status.	Free text. May be SNOMED CT coded. Coded text: fully achieved, partially achieved, not achieved, on-going, no longer applicable.	
Planned review date/interval	This is the date/interval when this information will next be reviewed.	Date and time or free text.	
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.	Free text.	
Location	The location where the care and support plan was prepared.		

Name	Description	Values	Implementation guidance
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who prepared the care and support plan.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
7.25 Contingency plans	Contingency plans.		This section includes contingency / crisis plans for those people who have specific and predictable risks associated with their health and wellbeing. It describes how disruptions to the care and support plan should be addressed. A contingency plan sets out what should be done if the person's condition or other circumstances get worse. Not everyone who has a care and support plan will need a contingency / crisis plan. It is, however, widely used in mental health. Contingency plans may include end of life care planning elements. These may form part of an initial conversation but a full end of life care plan should also be included where appropriate as an additional supporting plan.
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.	Free text.	
Anticipatory medicines/equipment	Medicines or equipment available that may be required in specific situations and their location.	Free text. A statement regarding the availability or location of the anticipatory medicines/equipment.	
Contingency plan name	Name of the contingency plan – what condition or circumstances it is addressing.	SNOMED CT or free text.	

Name	Description	Values	Implementation guidance
Date this plan was last updated	The date that this contingency plan was last updated.	Date and time	
Planned review date/interval	This is the date/interval when this contingency plan will next be reviewed.	Date and time or free text.	
Responsibility for review	This is who has responsibility for arranging review of this information. Should include their name, role and contact details.	Free text.	
Trigger factors	Signs to watch out for that may indicate a significant change in health or other circumstances.	Free text. A statement of trigger factors.	
What should happen	Guidance on specific actions or interventions that may be required or should be avoided in specific situations. This may include circumstances where action needs to be taken if a carer is unable to care for the person.	Free text. A statement of suggested actions. Usually expressed as: in the event of X do Y.	

Name	Description	Values	Implementation guidance
Who should be contacted	Who should be contacted in the event of significant problems or deterioration in health or wellbeing. E.g. name, role and contact details.	Free text. This may be obtained from the record of professional or personal contacts elsewhere in the person's record.	
Location	The location where the contingency plan was prepared.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who prepared the contingency plans.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
7.26 Additional support plans	Additional support plans		This section includes additional supporting plans, which may be linked to the care and support plan. Examples of additional supporting plans include: The Asthma UK action plan, a mental health plan (for people that are supported by a Care Programme Approach package), tissue viability plans, nutrition plans, a falls prevention plan, an end of life care plan, a maternity management plan or a birth plan, a hospital or other service transfer of care plan etc. The format of additional supporting plans will vary according to the type of plan. Some may be structured and coded, others may include diagrams or images. Additional supporting plans should be available for others to view, but will only be created, updated and ended by the service creating the plan.
Additional support plan name	The name of the particular additional supporting plan, e.g. dieticians plan, wound management plan, discharge management plan and behaviour support plan.	Free text.	
Additional support plan content	This is the content of any additional care and support plan which the person and/or care professional consider should be shared with others providing care and support.	Free text. May be structured in different ways, e.g. tables, diagrams, images. This is the content of any additional care and support plan which the individual and/or care professional consider should be shared with others providing	

Name	Description	Values	Implementation guidance
		care and support. It should be structured as recommended for the care and support plan and if contains additional detail, it may be referenced here.	
Planned review date/interval	This is the date/interval when this information will next be reviewed.	Date and time or free text.	
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.	Free text.	
Date this plan was last updated	This is a record of the date that this information was last updated.	Date and time	
Location	The location where the additional support plan was prepared.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	

Name	Description	Values	Implementation guidance
Performing professional	The professional who prepared the additional support plan.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
7.27 End of life care	Information relating to end of life care. N.B. This is not an end of life care plan but contains information that would be found in an end of life care plan.		This section contains information that would be expected in an end of life care plan that does not appear elsewhere in the core information standard. This is not a representation of an end of life care plan as it would be expected to include this information as well as information covered elsewhere in the standard. The information included in the standard is consistent with the end of life minimum dataset and SCCI1580. However, PRSB recognises that there is work to do to develop a nationally agreed information standard for an end of life care plan. **NB:** Lasting power of attorney and advance decision to refuse treatment components of the standard are found in the Legal section.
Cardio-pulmonary resuscitation (CPR) decision	Whether a decision has been made, the decision, who made the decision, the date of decision, date for review and location of documentation. Where the person or their family		

Name	Description	Values	Implementation guidance
	member/carer have not been informed of the clinical decision please state the reason why.		
Date	The date when the cardio-pulmonary resuscitation decision was made.	Date and time.	
Location	The location where the cardio-pulmonary resuscitation decision was made.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Cardio-pulmonary resuscitation (CPR) decision	The Cardio-pulmonary resuscitation (CPR) decision.		
Coded value	The coded value for CPR	SNOMED CT: 450475007 |For cardiopulmonary resuscitation (finding)| OR	

Name	Description	Values	Implementation guidance
		450476008 |Not for cardiopulmonary resuscitation (finding)|	
Free text	Free text field to be used if no code is available	Free text.	
Date for review	The date for review of CPR decision.	Date and time	
Location of document	The location of the CPR decision document.	Free text or URL	
Performing professional	The professional who made the cardio-pulmonary resuscitation decision.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Estimated prognosis	Details of the person's estimated prognosis.		
Date	The date when the estimated prognosis was made.	Date and time.	

Name	Description	Values	Implementation guidance
Location	The location where the estimated prognosis was made.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Estimated prognosis	Where a person is terminally ill this is a clinical judgment indicating the anticipated period of time until death e.g. last days, weeks, months or year of life.	Free text.	
Performing professional	The professional who made the estimated prognosis.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Awareness of prognosis	Details of the person's awareness of prognosis.		

Name	Description	Values	Implementation guidance
Date	The date when the assessment of the level of awareness of the prognosis was made.	Date and time.	
Location	The location where the assessment of the level of awareness of the prognosis was made.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Awareness of prognosis	Description of the level of awareness the person and or their carer/family has regarding their estimated prognosis.	Free text.	
Performing professional	The professional who made the assessment of the level of awareness of the prognosis.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the	

Name	Description	Values	Implementation guidance
		person completing record cluster (this document).	
Advance statement	Details of the person's advance statement		
Date	The date when the advanced statement was made.	Date and time.	
Location	The location where the advanced statement was made.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Advance statement	Written requests and preferences made by a person with capacity conveying their wishes, beliefs and values for their future care should they lose capacity. Include the location of the document if known.		

Name	Description	Values	Implementation guidance
Coded value	The coded value for the advance statement.	SNOMED CT: 816281000000101. Has advance statement (Mental Capacity Act 2005).	The content of the advance statement should also be included attached as a document where available.
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who made the advance statement.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Anticipatory actions	Details of the person's anticipatory actions.		
Date	The date when the anticipatory actions were identified.	Date and time.	
Location	The location where the anticipatory actions were identified.		
Coded value	The coded value for location	NHS data dictionary code:	

Name	Description	Values	Implementation guidance
		ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Anticipatory actions	Guidance on specific interventions or actions that may be required or should be avoided in specific situations.	Free text, A statement of anticipatory actions. Usually expressed as: in the event of X do Y.	
Performing professional	The professional who identified the anticipatory actions.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Anticipatory medicines/equipment	Details of a person's availability or location regarding their anticipatory medications or equipment.		
Date	The date when the statement regarding anticipatory medicines/equipment was made.	Date and time.	

Name	Description	Values	Implementation guidance
Location	The location where the statement regarding anticipatory medicines/equipment was made.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Anticipatory medicines/equipment	A statement regarding the availability or location of the anticipatory medicines/equipment.	Free text.	
Performing professional	The professional who made the statement regarding anticipatory medicines/equipment was made.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	

Name	Description	Values	Implementation guidance
Preferred place of death	The preferences that a person has identified as their preferred place to die.	End of life care plan use case only. Preferences will be identified as 1st/2nd choice etc as given by the person. Each recorded preference should include the name of the place that the person has identified. It may also include coded values from the National Information Standard (SCCI1580), together with the associated text:10: Hospital (Acute/Community/Other) 20: Private residence 21: Patient's own home 22: Other private residence (e.g. relatives home, carers home) 30: Hospice (inpatient specialist palliative care) 40: Care Home 50: Other (free text e.g. secure and detained settings) 517111000000103 Preferred place of death: patient unable to express preference 517131000000106 Preferred place of death: discussion not appropriate	

Name	Description	Values	Implementation guidance
		766391000000108 Preferred place of death: patient declined discussion 517161000000101 Preferred place of death: patient undecided	
Date	The date when the preferred place of death was identified.	Date and time.	
Location	The location where the preferred place of death was identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Preferred place of death 1st	The preferences that a person has identified as their preferred place to die.	SCCI1580 code: 10: Hospital (Acute/Community/Other) 20: Private residence 21: Patient's own home 22: Other private residence (e.g. relatives home, carers home)	

Name	Description	Values	Implementation guidance
		30: Hospice (inpatient specialist palliative care) 40: Care Home 50: Other (free text e.g. secure and detained settings) 517111000000103 Preferred place of death: patient unable to express preference 517131000000106 Preferred place of death: discussion not appropriate 766391000000108 Preferred place of death: patient declined discussion 517161000000101 Preferred place of death: patient undecided	
Name of the place	The name of the preferred place of death	Free text.	
Type of place	The type of the preferred place of death.		
Preferred place of death 2nd	The preferences that a person has identified as their preferred place to die.	SCCI1580 code: 10: Hospital (Acute/Community/Other)	

Name	Description	Values	Implementation guidance
		20: Private residence 21: Patient's own home 22: Other private residence (e.g. relatives home, carers home) 30: Hospice (inpatient specialist palliative care) 40: Care Home 50: Other (free text e.g. secure and detained settings) 517111000000103 Preferred place of death: patient unable to express preference 517131000000106 Preferred place of death: discussion not appropriate 766391000000108 Preferred place of death: patient declined discussion 517161000000101 Preferred place of death: patient undecided	
Name of the place	The name of the preferred place of death	Free text.	
Type of place	The type of the preferred place of death.		

Name	Description	Values	Implementation guidance
Performing professional	The professional who identified the preferred place of death.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Preferred place of care	The preferences that the person has identified as their preferred place to receive care.	Free text.	
Date	The date when the preferred place of care was identified.	Date and time.	
Location	The location where the preferred place of care was identified.		
Coded value	The coded value for location	NHS data dictionary code: ORGANISATION CODE	
Free text	Free text field to be used if no code is available	Free text.	
Performing professional	The professional who identified the preferred place of care.	See Table 3 for the additional elements contained within the	

Name	Description	Values	Implementation guidance
		performing professional cluster (this document).	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
7.28 Documents (including correspondence and images)	Details about documents related to the person.		This section includes details for documents and images. It includes the metadata that is required for the document or image and a link to the actual document or image. When displayed in a record, documents and images should be organised logically in date order. Local implementations will need to determine the best logical groupings for use here. A specific cluster is included for images as these are a special case where there is a document (e.g. a KOS document) with information about the image and often produced by the machine or imaging system, and a specific set of additional information (such as event code list and format code). Note that this document is separate from the investigation report which provides the results or interpretation of the imaging. For images the performing professional will be the person performing the imaging procedure rather than the author.
Documents	This is the documents record entry. There may be 0 to many record entries under a section. Each record entry is made up of a		

Name	Description	Values	Implementation guidance
	number of elements or data items.		
Date	The date and time the document was created.	Date and time	
Performing professional	The professional who authored the document.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Documentation location	The URL for the document.	Free text.	
Confidentiality	The code specifying the level of confidentiality of the document.	Free text, recommend the use of the FHIR values set: V3 Value Set Confidentiality Classification	
Class	The document type e.g. report, summary, images, treatment plan, patient preferences, workflow	SNOMED CT or free text.	
Document title	The title of the document.	Free text.	
Document name	The name of the document. This should align to the PRSB document naming standard. Where the document is a KOS document this field		

Name	Description	Values	Implementation guidance
	(designated typeCode) is used to carry the DICOM Imaging procedure: This attribute shall be populated by the XDS-I Imaging Document Source from a code in the Procedure Code Sequence (0008,1032) of the performed procedure with which the document is associated. Values may be found in a suitable DICOM browser		
Document MIME type	MIME type of the document e.g. application, pdf	Free text.	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Service	The high level imaging speciality code e.g. (R-3027B, SRT, “Radiology”)	SNOMED CT or free text. 999000381000000107 |Correspondence care setting type simple reference set (foundation metadata concept)|	

Name	Description	Values	Implementation guidance
Comments	Comments associated with the document.	Free text.	
Additional information required for images.	Additional information required for images.		
Image procedure	The procedure used to capture the image	Free text Using DICOM code set https://dicom.innolitics.com/ciods	
Image procedure date	The date and time the image procedure was performed.	Date and time	
Performing professional	The professional who performed the image procedure.	See Table 3 for the additional elements contained within the performing professional cluster (this document).	
Images			
Image capture date	The date and time when the image was captured.	Date and time	
Image ID	A unique image identifier generated by the system.	Free text.	
Image location	The URL for the image	Free text.	
Format code	The format code of the document which provides information on how to display the document.	Free text.	

Name	Description	Values	Implementation guidance
Event code list	The type of image (acquisition modality) and the anatomical site imaged.	DICOM code or free text.	
Person completing record	Details of the person completing the record.	See Table 3 for the additional elements contained within the person completing record cluster (this document).	
Comments	Comments associated with the imaging.	Free text.	

Table 2: Implementation guidance by section, subsection and element for the Care Homes View (of Shared Health and Care Records)

Name	Description	Values	Implementation guidance	MRO
7.29 Performing professional	The professional who performed the activity.			R
Name	The name of the professional.	Free text.		R
Role	The role the professional has in relation to the person e.g. GP, physiotherapist, community nurse, social worker etc.	NHS data dictionary code or free text if code is not available. CARE PROFESSIONAL TYPE	Key contextual information.	R
Grade	The grade of the professional.	Free text.	Key contextual information.	R

Name	Description	Values	Implementation guidance	MRO
Speciality	The specialty of the professional e.g. physiotherapy, oncology, mental health etc.	NHS data dictionary code: MAIN SPECIALTY CODE	Key contextual information.	R
Professional identifier	Professional identifier for the professional e.g. GMC number, HCPC number etc or the personal identifier used by the local organisation.	Free text.	Key contextual information.	R
Organisation	The name of the organisation the professional works for.	NHS data dictionary code or free text. ORGANISATION CODE	Key contextual information.	R
Contact details	Contact details of the professional (e.g. telephone number, email address etc.).	Free text.	Key contextual information.	R
7.30 Person completing record	Details of the person completing the record.			R
Name	The name of the person completing the record.	Free text.		R
Organisational role	The organisational role of the person completing record.	NHS data dictionary code or free text if code is not available. CARE PROFESSIONAL TYPE	Key contextual information.	R
Grade	The grade of the person completing the record.	Free text.	Key contextual information.	R

Name	Description	Values	Implementation guidance	MRO
Specialty	The main specialty of the person completing the record.	NHS data dictionary code: MAIN SPECIALTY CODE		R
Organisation	The organisation the person completing the record works for.	NHS data dictionary code or free text. ORGANISATION CODE	Key contextual information.	R
Professional identifier	Professional identifier for the person completing the record e.g. GMC number, HCPC number etc, or the personal identifier used by the local organisation.	Free text.	Key contextual information.	R
Date completed	The date and time the record was completed.	Date and time.	Key contextual information.	R
Contact details	Contact details of the person completing the record (e.g. telephone number, email address etc.).	Free text.		R

Table 3: Implementation guidance by section, subsection and element for performing professional and person completing record vital contextual sub-sect

8 PRSB support

The PRSB support service is available for any help, enquiries or issues with the using or implementing the standards. Any feedback on the standard (including proposed changes) resulting from putting the standard into practice would also be welcome.

Contact is via support@theprsb.org or Tel: 02079227976

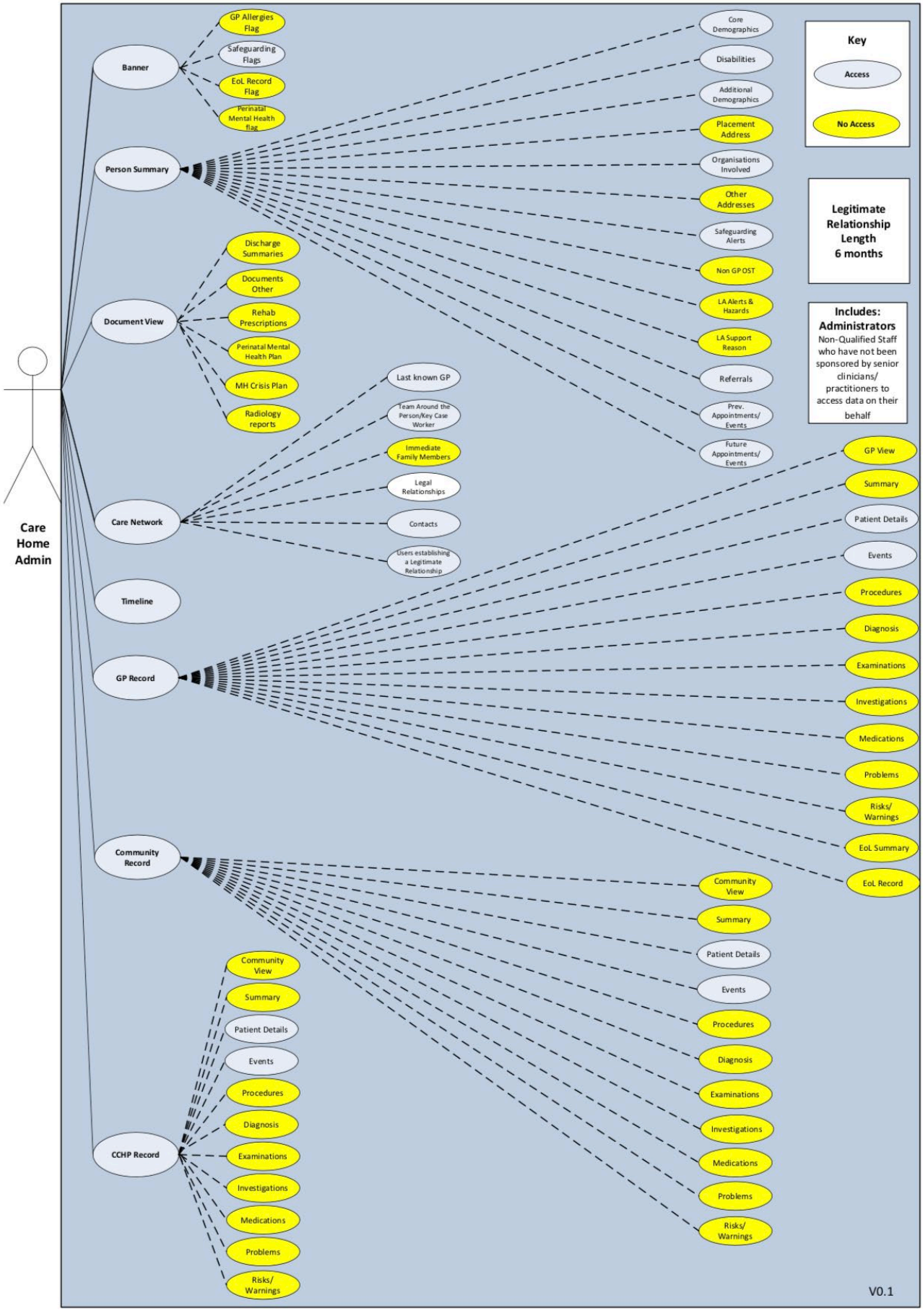
9 APPENDIX A – BNSSG Care Homes Standard Dataset

Standard Dataset			
Standard Dataset for Care Homes. Dataset is based on PRSB Person Core Information Standard			
Section	**Sub-section**	**Element**	**Description**
View Demographics and Contacts	Person Demographics	Person name	The full name of the person.
		Person preferred name	The name by which a person wishes to be addressed.
		Date of birth	The date of birth of the person.
		Gender	The person's stated gender.
		Ethnicity	The ethnicity of the person as specified by the person.
		Religion	The religious affiliation as specified by the person.
		Sex	The person's phenotypic sex. Determines how the person will be treated clinically.
		NHS number	The unique identifier for a person within the NHS in England and Wales.
		Other identifier	Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland.
		Person's address	Person's usual place of residence, and where relevant temporary and correspondence addresses.
		Person's email address	Email address of the person
		Person's telephone number	Telephone contact details of the person. To include, e.g. mobile, work and home number if available.
		Communication preferences	Preferred contact method, e.g. sign language, letter, phone, etc. Also preferred written communication format, e.g. large print, braille.
		Place of birth	The town and country of birth of the person.
	Professional contacts	Professional contacts record entry	This is a professional contacts record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.
		Name	The name of the professional with responsibility for the care of the person.

		Role	The role the professional has in relation to the person e.g. GP, physiotherapist, community nurse, social worker etc
		Speciality	The specialty of the professional e.g. physiotherapy, oncology, mental health etc
		Team	The name of the team.
		Organisation	The name of the organisation.
		Contact details	Contact details of the professional (e.g. telephone number, email address etc.).
		Start date	The start date of the professional relationship with the person.
		End date	The end date of the professional relationship with the person.
	Personal contacts	Personal contacts record entry	This is personal contacts record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items.
		Name	The name of the personal contact.
		Relationship	The relationship the personal contact has to the person, e.g. father, grandmother, family friend etc.
		Next of Kin	A flag that identifies the personal contact is the next of kin
		Contact details	Contact details of the personal contact (e.g. telephone number, email address etc.)
		Comments	Notes on the significance of the personal contact to the person.
Alerts	Alert	Alert	Any significant information meriting a specific and highly visible warning to any user (e.g. metallic implant, potential dangerous pet).
Legal Information	Legal Information	Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) person has been undertaken, if so, what capacity the decision relates to and the outcome of the assessment. Also record best interests decision if person lacks capacity.
		Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	Record of one or more people who have been given power (LPA) by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make those decisions.

		Deprivation of Liberty Safeguards or equivalent	Record of Deprivation of Liberty Safeguards (DoLS) or equivalent, including the reason for this.
		Mental Health Act or equivalent status	Record where a person diagnosed with a mental disorder is formally detained under the Mental Health Act or equivalent, including the section number.
		Advance decision to refuse treatment (ADRT)	A record of an advance decision to refuse one or more specific types of future treatment, made by a person who had capacity at the time of recording the decision.

10 APPENDIX B – BNSSG Care Home Administrator Role-Based Access Proposal for Connecting Care Digital Shared Care Records System



11 APPENDIX C – BNSSG Care Home Professional Role-Based Access Proposal for Connecting Care Digital Shared Care Records System