National Standard for Patient Discharge Summary Information

3 July 2013

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive continuous improvement in Ireland's health and personal social care services, monitor the safety and quality of these services and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.

- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.

- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Overview of Health Information function

Health is information-intensive, generating huge volumes of data every day. It is estimated that up to 30% of the total health budget may be spent one way or another on handling information, collecting it, looking for it, and storing it. It is therefore imperative that information is managed in the most effective way possible in order to ensure a high quality, safe service.

Safe, reliable healthcare depends on access to, and the use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. For example, when giving a patient a drug, a nurse needs to be sure that they are administering the appropriate dose of the correct drug to the right patient and that the patient is not allergic to it. Similarly, lack of up-to-date information can lead to the unnecessary duplication of tests – if critical diagnostic results are missing or overlooked, tests have be repeated unnecessarily and, at best, appropriate treatment is delayed or at worst not given.

In addition, health information has a key role to play in healthcare planning decisions – where to locate a new service, whether or not to introduce a new national screening programme and decisions on best value for money in health and social care provision.

Under section (8)(1)(k) of the Health Act 2007, the Authority has responsibility for setting standards for all aspects of health information and monitoring compliance with those standards. In addition, the Authority is charged with evaluating the quality of the information available on health and social care – Section (8)(1)(i) – and making recommendations in relation to improving the quality and filling in gaps where information is needed but is not currently available [Section (8) (1) (j)].

Information and communications technology (ICT) has a critical role to play in ensuring that information to drive quality and safety in health and social care settings is available when and where it is required. For example, it can generate alerts in the event that a patient is prescribed medication to which they are allergic. It can support a much faster, more reliable and safer referral system between the general practitioner (GP) and hospitals.

Although there are a number of examples of good practice, the current ICT infrastructure in health and social care services in Ireland is highly fragmented with major gaps and silos of information. This results in service users being asked to provide the same information on multiple occasions.

Information can be lost, documentation is poor, and there is over-reliance on memory. Equally those responsible for planning our services experience great difficulty in bringing together information in order to make informed decisions. Variability in practice leads to variability in outcomes and cost of care. Furthermore, we are all being encouraged to take more responsibility for our own health and wellbeing, yet it can be very difficult to find consistent, understandable and trustworthy information on which to base our decisions.

As a result of these deficiencies, there is a clear and pressing need to develop a coherent and integrated approach to health information, based on standards and international best practice. A robust health information environment will allow all stakeholders – patients and service users, health professionals, policy makers and the general public – to make choices or decisions based on the best available information. This is a fundamental requirement for a highly reliable healthcare system.

Through its health information function, the Authority is addressing these issues and working to ensure that high quality health and social care information is available to support the delivery, planning and monitoring of services.

One of the areas currently being addressed is the development of a clinical discharge summary data set. When a patient is discharged from secondary or tertiary care to primary care, it is essential that complete, relevant, reliable and valid information regarding the patient's stay in hospital is sent to the primary care healthcare professional in a timely manner, allowing the primary care healthcare professional to continue care and management following discharge.

Table of Contents

1. Introduction

Safe, reliable healthcare depends on access to, and use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. Ensuring that information can be shared efficiently and effectively and in a manner which protects the privacy and confidentiality of patients is critical.

The inability to share information leads to unnecessary duplication of tests and delays in patients receiving appropriate treatment. This can lead to potentially serious consequences which threaten both the safety and quality of care provided. Information should accompany the patient along the entire care pathway.

Modern clinical practice seeks to reduce a patient's time in an acute hospital to a minimum. Discharge planning occurs from early in a patient's inpatient stay. In order to ensure continuity of care during the transition from secondary or tertiary care to primary care, effective communication between healthcare practitioners is required. Timely access to complete documentation regarding an inpatient stay can lead to improved quality of care after discharge.

The clinical discharge summary generated at the end of an inpatient stay provides the basis for communication between healthcare professionals in different healthcare settings. In order for the clinical discharge summary to be effective it must be a complete, accurate and relevant record of the inpatient stay and must be sent to the primary care healthcare professional in a timely manner. An incomplete or delayed clinical discharge summary places the healthcare professional in primary care at a disadvantage, potentially reducing the quality and potentially also the safety of care received by the patient on their return to home or the community. Discharge summaries should be prepared in advance of discharge and available for transmission to the primary care healthcare professional on the day of the patient's discharge.

The discharge process requires the transfer of information which generally involves a clinical discharge summary document being sent from secondary or tertiary care to a patient's primary healthcare provider. This clinical discharge summary document can be in the form of a letter – handwritten or typed – or the completion of a clinical discharge summary form usually on paper, but in a few cases generated electronically through a clinical information system. A timely, safe and effective patient-centred discharge process depends critically on the quality of the information which is provided in this clinical discharge summary document. Quality information is defined as information that is accurate, complete, legible, relevant, reliable, timely and valid.[1-3]

The development of a National Standard for Patient Discharge Summary Information is an important step towards improving the whole care pathway and enabling the delivery of safe, person-centred care.

Under section (8)(1)(k) of the Health Act 2007, the Authority has responsibility for setting standards for all aspects of health information including, for example, information governance, common data definitions, and the exchange of electronic health information. This proposed National Standard for Patient Discharge Summary Information has been developed under this section of the act.

2. Benefits

What the Standard will mean for hospitals.

Hospital staff benefit as there is guidance on the information they need to include in the discharge summaries. There will be a reduction in the proliferation of discharge summaries developed locally by hospitals. Clinical discharge summaries developed using the National Standard for Patient Discharge Summary Information should improve the efficiency of the discharge process and the discharge summary should be a live document which is updated regularly through the whole of the patient's time in hospital. In addition a standardised complete discharge summary will assist coders in ensuring high quality data for the Hospital In-Patient Enquiry System.

What the Standard will mean for primary care healthcare practitioners.

Implementing the National Standard for Patient Discharge Summary Information will mean that the information sent to the primary care healthcare practitioners upon discharge of a patient from secondary or tertiary care will be standardised across organisations and services. There will be improved and more consistent clinical information in discharge summaries, facilitating a more effective transfer of patient care back in to the community. In time the National Standard for Patient Discharge Summary Information can form the basis for electronic discharge summaries which will lead to a more timely transmission of information between secondary or tertiary care and primary care and reduce the need for duplicate data entry.

What the Standard will mean for patients.

The standardisation of information contained in discharge summaries will facilitate the transfer of relevant clinical information thereby improving the consistency and quality of information. This represents a significant improvement in the safety of transfer of care back to the community from the acute hospital setting. In time there may be increased use of electronic transmission of discharge summaries leading to a more timely and efficient transfer of patients' information, ensuring that the primary care healthcare practitioners have access to important clinical information at the time of discharge.

3. Scope

The National Standard for Patient Discharge Summary Information defines the information required in a generic clinical discharge summary produced at the time of discharge from a secondary care or tertiary care setting.

A discharge summary document produced using the data set should provide a full picture to a patient's primary care healthcare practitioner on the inpatient stay, including patient details, admission and discharge details, clinical course during the inpatient stay, changes to medication and a full list of discharged medications, treatment plan and discharging details. The data set should be fit for purpose and not be so detailed as to delay the sending of the discharge summary on the day of discharge.

In terms of coverage, the scope of the National Standard for Patient Discharge Summary Information could include the information requirements needed to support all clinical specialties across the healthcare sector. The construction of such a comprehensive Standard would be a major undertaking, requiring detailed consultation with experts representing each specialty and subspecialty. Limiting the scope to include requirements which are common across the majority of clinical specialties is a more practical approach in the first instance. This is the same approach used when developing the National Standard for Patient Referral Information.

The Standard and any discharge summary derived from the Standard should be appropriate for people discharged to home, step-down care, nursing homes or to other institutions.

The Standard aims to be a generic data set fulfilling the needs of the majority of clinical specialities. It is possible that some clinical specialties have specific requirements regarding information they need to share with general practitioners on discharge; for example, psychiatry. It is likely that certain specialties may be able to use a significant amount of the data set but may need to adapt the heading in the clinical details section in order to make the data set appropriate to their clinical specialty.

The scope of the data set is for patients being discharged from the acute care setting following assessment in an Emergency Department or on discharge following admission to hospital. The scope includes patients who have been admitted electively and also those whose admission was not planned. It includes general admissions and those admitted as a day case. The data set is not designed with outpatient departments in mind.

4. Methodology

Initially a draft National Standard for Patient Discharge Summary Information was developed after analyses of several data sets developed in other jurisdictions, followed by a limited consultation with a number of stakeholders.

Northern Ireland has developed a minimum data set for clinical discharge summaries known as the Guidelines on Regional Immediate Discharge Documentation for patients Being Discharged from Secondary into Primary Care[4]. Scotland has developed a minimum data set known as the SIGN 128 Discharge Document[5].

In Australia, the National E-Health Transition Authority published a detailed specification of the content of an electronic discharge summary[6] which may be generated and sent electronically to general practitioners at the end of an inpatient episode. In England, the Royal College of Physicians [7] has undertaken work in this area and published a list of headings which should be included in a clinical discharge summary.

The demographic details and referrer details from the GP referral data set[8] previously published the Authority have also been included in the development of this draft data set, along with the mandated discharge summary components identified by the Joint Commission on the Accreditation of Healthcare Organizations.[9] Health Level 7, an international healthcare standards organisation, has developed specifications for a Continuity of Care document and a Discharge Summary and the content of these have also been reviewed[10,11].

The draft National Standard for Patient Discharge Summary Information for consultation was developed in conjunction with the members of the Authority's eHealth Standards Advisory Group (eSAG) and a limited consultation was undertaken with representatives of the Health Service Executive including representatives of the Integrated Discharge Planning Programme and the National Programme for Healthcare Records. Some of the Clinical Care Programmes were also consulted including the Acute Surgical Care Programme, Acute Medicine Programme and the Medication Safety Programme.

In order to consult with a broader range of stakeholders the Authority published a consultation document, *Standardising Patient Discharge Summary Information: a Draft National Data Set for Consultation.*[4] The purpose of this consultation document was to set out the draft set of headings to be included in discharge summaries generated at the time of discharging a patient from the acute care setting.

Standardising Patient Discharge Summary Information: a Draft National Data Set for Consultation was published in December 2012 for a ten-week period which ran until January 2013. A consultation feedback form was included which contained five questions (see Appendix 1). This form was made available on the Authority's website together with the consultation document itself. In order to engage as many people

as possible, targeted emails were sent to over 230 stakeholders inviting them to participate in the public consultation.

A total of 107 submissions were received all of which were submitted by email. Fifty respondents completed the online form, 55 submitted their comments by email and two respondents submitted their response by post. Of the 107 submissions, 59 were submitted on behalf of organisations and 48 were submitted in a personal capacity. Appendix 2 gives a full list of all the organisations that made a submission.

Each submission was read in its entirety and broken down into individual comments and recorded in a database. Comments were classified either as qualitative comments or functional requirements. Over 620 functional requirements were identified from the submissions and 300 comments were classified as qualitative comment. Functional requirements were specific comments relating to addition, removal or changes to existing headings in the national standard. Each functional requirement was then classified according to the heading to which it related. These were reviewed in consultation with a subgroup of the eSAG and the National Standard for Patient Discharge Summary Information was agreed. Appendix 3 provides a review of the qualitative comments made during the submission and the changes agreed as a result of the submissions received.

5. National Standard for Patient Discharge Summary Information

The National Standard for Patient Discharge Summary Information consists of the seven groups of headings: Patient details, Primary care healthcare professional details, Admission and discharge information, Clinical information, Medication information, Follow up and future management, and Person completing discharge summary.

Within each of the group multiple headings are provided. For example, Forename, Surname and Address. For each heading a name, definition and optionality and usage is provided. Optionality refers to whether a heading is mandatory, optional or conditional. Mandatory headings should be included in all discharge summaries. Optional headings may be omitted from a discharge summary if it is not relevant to the particular inpatient stay. Mandatory where Applicable are headings which should be populated if there is information relevant for the patient and the episode of care. Further details on the use of each of the headings are provided in the usage column.

5.1 Patient details

This group includes headings which identify the patient the discharge summary relates to.

Table 1 – Patient details

Name	Definition	Optionality	Usage
1.1 Forename	A patient's first name or given name (s) as per their birth certificate.	Mandatory	A patient's first name or given name (s) as per their birth certificate.
1.2 Surname	The second part of a patient's name which denotes their family or marital name.	Mandatory	The second part of a patient's name which denotes their family or marital name.
1.3 Address	The location to be used to contact or correspond with the patient. This would normally be the patient's usual home address.	Mandatory	The particulars of the place where the patient lives.
1.4 Date of birth	Date of birth indicating the day, month, and year	Mandatory	The date of birth should be supplied in

	when the patient was born.		dd/mm/yyyy format.
1.5 Gender	Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behaviour and other aspects of a person's life.	Mandatory	Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behaviour and other aspects of a person's life.
1.6 Health identifier	A number or code assigned to an individual to uniquely identify the individual within an organisation.	Mandatory	Both the code and the code type the code relates to should be provided e.g. 0987654321 Healthcare Record Number (HcRN). When a national individual healthcare number is available this should be carried in this heading.
1.7 Discharge destination address	The location the patient was discharged to if the patient was not discharged to the usual home address.	Optional	To be included in the discharge summary if the address to which the patient is discharged is different from the address contained in the heading 1.3. Address.

5.2 Primary care healthcare professional details

This group details the minimum headings required to ensure the discharge summary can be delivered to the correct primary care healthcare practitioner.

Table 2 – Primary care healthcare professional details

Name	Definition	Optionality	Usage
2.1 Forename	First name or given name of primary care healthcare professional.	Mandatory	Where the primary care healthcare professional is registered with a professional body, the forename should be the forename registered with the professional body.
2.2 Surname	The second part of a primary care healthcare professional's name which denotes their family or marital name.	Mandatory	Where the primary care healthcare professional is registered with a professional body the surname should be the forename registered with the professional body.
2.3 Address	The particulars of the place used to correspond with the patient's primary healthcare professional.	Mandatory	The particulars of the place used to correspond with the patient's primary healthcare professional.

5.3 Admission and discharge details

This group contains headings relating to the admission and discharge details which will be important to the primary care healthcare professional.

Table 3 – Admission and discharge details

Name	Definition	Optionality	Usage
3.1 Date of admission	The date that the patient was admitted to the hospital ward.	Mandatory	The date of admission should be supplied in dd/mm/yyyy format.
3.2 Source of referral	This describes who made the decision to refer the patient to the hospital.	Mandatory	Examples would include GP/self-referral/ambulance service/out-of-hours service/other hospital/other (please specify).
3.3 Method of admission	The circumstances under which a patient was admitted to the hospital.	Mandatory	Example would include elective/emergency/transfer.
3.4 Hospital site	The hospital site the patient was discharged from.	Mandatory	The hospital site the patient was discharged from.
3.6 Date of discharge	The date the patient departed the hospital.	Mandatory where applicable	Record the date the patient departed the hospital site. The date of discharge should be supplied in dd/mm/yyyy. This heading will be blank if the patient died during the inpatient stay.[1]
3.7 Discharge method	The circumstances under which a patient left hospital.	Mandatory where applicable	This heading can be used to indicate that a patient was discharged on clinical advice or with clinical consent, that a patient discharged him/herself against clinical advice or the patient

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[1] In cases when a patient died in hospital during the inpatient stay the Date of Discharge and Discharge Method are no longer relevant, but the Patient Died and Date of Death and post-mortem flag should be provided.

Name	Definition	Optionality	Usage
			was discharged by a relative or advocate.
3.8 Patient died	An indicator to signify if the patient died during the hospitalisation.	Mandatory where applicable	3.6 Date of discharge and 3.7 Discharge method will be blank if this heading contains an entry.
3.9 Date of death	The date and time the patient died.	Mandatory where applicable	If the patient died during inpatient stay in the hospital record the date and time of death. The date of death should be supplied in dd/mm/yyyy format.
3.10 Post-mortem flag	A flag to indicate whether a post-mortem is to be carried out	Mandatory where applicable	In cases where the patient dies in hospital and a post-mortem is to be undertaken this should be indicated on the discharge summary. Details of the post-mortem are not required in the discharge summary.

5.4 Clinical narrative

Primary care healthcare professionals require quality information in order to continue patients' care on their return to the community. This group defines the headings which will facilitate hospitals in providing a detailed picture of a patient's stay in hospital, reason for admission, interventions and treatments received and investigations undertaken.

Table 4 – Clinical narrative

Name	Definition	Optionality	Usage
4.1 Pertinent clinical information	Clinically significant information relating to the patient which the discharging doctor wishes to convey to the primary care healthcare professional.	Mandatory where applicable	This heading may be used to indicate an investigation which should be undertaken, or a course of treatment which should be considered by the primary care healthcare professional or information which the healthcare professional should be aware of, e.g. blood transfusions, difficult intubations, advance care directives or pressure sores.
4.2 Diagnoses	The diagnoses established after study to be chiefly responsible for occasioning an episode of admitted patient care and conditions or complaints either coexisting with the principal diagnosis or arising during the episode of admitted patient care.	Mandatory where applicable	The principal and additional diagnoses relevant to this inpatient stay should be recorded. The principal diagnosis is the main reason why the patient was admitted to hospital on this occasion and should be identified in the discharge summary. Additional diagnoses relevant to this inpatient stay should also be documented, including any relevant co-morbidity that could have contributed to or be affected by the primary diagnosis. For example, hypertension in a patient admitted for stroke. Acronyms and abbreviations should be avoided.

Name	Definition	Optionality	Usage
			The discharge summary should indicate whether a diagnosis is confirmed or provisional. Standard code(s) for the diagnoses should be provided using the ICD-10-AM 6th edition codes as used in the Hospital In-Patient Enquiry System when these are known to the person completing the discharge summary. The healthcare practitioner responsible for the care of a diagnosis for a patient should also be identified on the discharge summary if this healthcare practitioner differs from the discharge consultant's name (item 6.3.11).
4.3 Operations and procedures	Operations and procedures performed for definitive treatment, diagnostic or exploratory purposes.	Mandatory where applicable	All significant operations and/or procedures should be described. Avoid acronyms, for example, 'CABG', and abbreviations, as these could be misunderstood or misinterpreted by the recipient. When known to the person completing the discharge summary standard code(s) for the procedures should be provided using the Australian Classification of Healthcare Interventions codes as used in the Hospital In-Patient Enquiry System.
4.4 Clinical alerts	An alert is a piece of information about a specific patient required for the management of a patient in order to minimise risk to the patient concerned, healthcare staff, other patients and the organisation. It is a warning of a medical condition or risk factor that requires consideration before treatment is initiated.	Mandatory where applicable	The status of knowledge about the patient's clinical alerts. For example 'Known', 'None known' or 'Unknown' should be documented. Significant clinical alerts should be documented.
4.5 Allergies	Include information about all allergies known	Mandatory	The status of knowledge about the patient's

Name	Definition	Optionality	Usage
	about the patient that may put the patient at risk. The allergen, reaction, date of reaction and source of information should be provided.	where applicable	allergies. For example 'Known', 'None known', 'Unknown', 'Not asked'. Known allergies must be documented in the discharge summary.
4.6 Adverse events	Include information about all hypersensitivities and/or adverse events known about the patient that may put the patient at risk.	Mandatory where applicable	Known adverse events or hypersensitivities must be documented in the discharge summary. Where there are no known adverse events or hypersensitivities this should be documented in the discharge summary.
4.7 Hospital course	Include a detailed description on the course of the patient's illness during the inpatient stay.	Mandatory	The discharge summary should include a narrative description of the inpatient stay, describing the relevant sequence of events from admission to discharge.
4.8 Relevant investigations and results	Relevant assessments, investigations and/or observations undertaken on the patient during the inpatient stay.	Mandatory where applicable	Specify the type of investigations undertaken and results received or that are awaited at the time of discharge. Describe all investigations that are pending at the time of discharge.
4.9 Relevant treatments and changes made in treatments	The relevant treatments which the patient received during the inpatient stay. Can include medications given while an inpatient.	Mandatory where applicable	Information relating to procedures undertaken and medications received during the inpatient stay.
4.10 Diet	Information on dietary interventions, special dietary requirements, use of nutritional support during stay, e.g. oral nutritional supplements, enteral tube feeding and parenteral nutrition and any problems a client might have with eating, drinking or swallowing at time of discharge need to be documented.	Mandatory where applicable	Information on dietary interventions, special dietary requirements, use of nutritional support during stay, e.g. oral nutritional supplements, enteral tube feeding and parenteral nutrition and any problems a client might have with eating, drinking or swallowing at time of discharge need to be documented.
4.11 Functional state	An assessment and description of the patient's ability to perform activities of daily living.	Mandatory where applicable	The functional state may include the results of assessment tools, for example, the Activities of Daily Living or the American Society of

Name	Definition	Optionality	Usage
			Anesthesiologists score. A history of falls should also be provided.
4.12 Immunisations	This should detail the immunisations given to the patient during this inpatient stay.	Mandatory where applicable	This should detail the immunisations given to the patient during this inpatient stay.
4.13 Infection control status	This should detail information relating to the treatment, prevention, monitoring or investigation of infections.	Mandatory where applicable	Information relating to the treatment, prevention, monitoring or investigation of infections should be communicated.

5.5 Medication details

Primary care healthcare professionals require accurate information about the changes to the patient's medication during an inpatient stay and the complete list of medications that the patient is prescribed on discharge in order to continue their treatment after returning to their homes or to the community. The group provides headings to facilitate this.

Table 5 – Medication details

Name	Definition	Optionality	Usage
5.1 Medication on discharge	The medications the patient is intended to take after they have been discharged.	Mandatory	Record medicines prescribed at the time of discharge. The record should include: ▪ The generic name of the prescribed medication along with the dose and frequency of administration.[2] ▪ Duration of treatment – record the stop date for all medicines prescribed for a short term or defined course of treatment. Record 'repeat' if the patient is to continue taking the medicine after discharge and no specific stop date has been agreed. ▪ Aids to compliance – where appropriate provide a description of any aids to compliance, for example, easy-open containers, medication charts, compliance devices, medication management service via a carer – that have been provided to or are being used by the patient to aid the taking of medicines. ▪ Reason for change to admission medication –

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[2] In certain clinical circumstances when it is not appropriate to substitute generic drugs due to bioavailability issues relating to active ingredient it is advisable to use trade name on the prescriptions

Name	Definition	Optionality	Usage
			if changes have been made to the formulation, strength, dose, frequency or route of administration of medicines that the patient was taking at the time of admission, record the reasons why these changes were made. ▪ Indications for new medicines – for medicines that were not being taken by the patient at the time of admission, describe what the new medicine has been prescribed for as this may not be clear to the GP or patient from the name of the medicine alone. If there are no medications prescribed for the patient at the time of discharge this should be indicated on the discharge summary.
5.2 Medications stopped or withheld	A pertinent history of changes to the medication that the patient was taking at time of admission.	Mandatory	Record all medicines that the patient was taking at the time of admission but were not prescribed at the time of discharge. Describe the reason why each medicine listed here was stopped. This should include information on adverse reactions. The heading may also contain information on medication which are 'on hold' at the time of discharge, the reason why they are on hold and when the primary care healthcare professional should consider reintroducing them.

5.6 Future management

This group contains headings regarding the future management of the patient.

Table 6 – Future management

Name	Definition	Optionality	Usage
6.1 Hospital actions	Actions required/that will be carried out by the hospital department.	Mandatory where applicable	Any pending or future actions that the hospital or department has responsibility to organise should be documented.
6.2 GP actions	Actions that are requested of the general practitioner.	Mandatory where applicable	Any actions that the general practitioner has being requested to organise should be documented.
6.3 Social Care actions	Actions relating to the person's social care that have been requested to be undertaken.	Mandatory where applicable	Actions relating to the person's social care that have been requested to be undertaken.
6.4 Information given to patient and carer	Information, both verbal, written or in any other form which has been provided to the patient, relatives or carer.	Mandatory where applicable	This can include verbal information given to the patient, relatives and their carer and written information including leaflets, letters and any other documentation.
6.5 Advice, Recommendations and future plan	This should include any advice, recommendations or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme.	Mandatory where applicable	This should include any advice or actions that were requested from other healthcare professionals and health promotion activities the patient was advised to undertake. For example, a smoking cessation programme.

5.7 Person(s) completing discharge summary

This group contains headings regarding the healthcare professionals who created the summary and sign the discharge summary. The discharge summary may be completed by multiple healthcare professionals.

Table 7 – Person(s) completing discharge summary

Name	Definition	Optionality	Usage
7.1 Forename	A first name or given name of the person completing the discharge summary.	Mandatory	Where the person completing the discharge summary is registered with a professional body the forename should be the forename registered with the professional body.
7.2 Surname	The second part of a name which denotes their family or marital name of the person completing the discharge summary.	Mandatory	Where the person completing the discharge summary is registered with a professional body the surname should be the surname registered with the professional body.
7.3 Contact number	The usual contact number for the person completing the discharge summary.	Mandatory	A usual contact number for the person completing the discharge summary.
7.4 Job title	The job title of the person who completed the discharge summary.	Mandatory	The job title of the person who completed the discharge summary.
7.5 Professional body registration number	The professional registration number of the person completing the discharge summary.	Mandatory	Where the person completing the discharge summary is registered with a professional body their registration number should be included in the discharge summary, e.g. Irish Medical Council registration number, An Bord Altranais agus Cnáimhseachais na hÉireann registration number.
7.6 Signature	The signature of the person who created the discharge summary.	Mandatory	The signature of the person who created the discharge summary.
7.7 Copies to	A list of people to whom copies of the discharge summary should be sent.	Optional	A list of people to whom copies of the discharge summary should be sent.
7.8 Date of	The date the discharge summary was	Mandatory	The date of completion of discharge summary

Name	Definition	Optionality	Usage
completion of discharge summary	completed.		should be supplied in dd/mm/yyyy format.
7.9 Consultant sign off	If the person completing the discharge summary is not a consultant then the consultant may counter-sign the discharge summary.	Optional	If the person completing the discharge summary is not a consultant then the consultant should counter-sign the discharge summary.
7.10 Date of consultant sign off	The date the consultant countersigned the discharge summary.	Optional	The date of consultant sign off should be supplied in dd/mm/yyyy format.
7.11 Discharging consultant's name	The consultant responsible for the care of the patient at the time of discharge.	Mandatory	The consultant responsible for the care of the patient at the time of discharge.
7.12 Discharge specialty	The specialty of the consultant responsible for the care of the patient at the time of discharge.	Mandatory	The specialty of the consultant responsible for the care of the patient at the time of discharge.
7.13 Document reference number	An alphanumeric identifier which uniquely identifies the discharge summary document and may be used to reference the discharge summary document.	Optional	A document reference number may be associated with a clinical discharge summary and allow primary care healthcare professionals refer to the summary in any future correspondences.

6. Next steps

The National Standard for Patient Discharge Summary Information has been approved by the board of the Authority and has been submitted to the Minister for Health as a standard for approval.

Reference List

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(10) Health Level 7. HL7/ASTM Implementation Guide for CDA Release 2 – Continuity of Care Document (CCD®) Release 1 Available online at www.HL7.org

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(12) HIQA. Standardising Patient Discharge Summary Information: a Draft National Data Set for Consultation 2012. Available online from: http://www.hiqa.ie/

Appendix 1 – Consultation questions

The Authority asked for responses to the following five questions.

1. Are there benefits in having a standardised data set for clinical discharge summaries, and, if so, what are the main benefits?

2. Have the appropriate groupings of data items been included in the data set?

3. Have all of the appropriate data items been included in the data set? Would you leave out any of the data items listed? Would you suggest additional data items?

4. Does the usage information provided in Tables 1−7 clearly explain the proposed use of each of the data items? If not, please suggest improvements.

5. Does the usage information provided in Tables 1−7 clearly explain the proposed use of each of the data items? If not, please suggest improvements.

Appendix 2 – Organisations that made submissions

This list details the names of organisations that made submissions to the public consultation in an organisational capacity. Submissions were also made by individuals in a personal capacity and each of them has received an acknowledgement of their contribution.

COPD Clinical Programmes
HSE Dublin Mid Leinster older person services
Daughters of Charity for Persons with an Intellectual Disability
Shannon Primary Care team nurses
HSE Corporate Pharmaceutical Unit
School of Nursing and Midwifery, National University Ireland, Galway
St John's community Hospital Enniscorthy
General Practice Information Technology Group
Aut Even Private Hospital
National Primary Care and Social Inclusion Manager
Nursing and Midwifery Board
Nursing and Midwifery Planning and Development Unit Merlin Park Galway
Public Health Nurse academic team at the School of Nursing, Midwifery and Health
Systems, University College Dublin
Healthcare Support Ltd. (inc Patient Advocate Services)
CompleteGP Ltd.
National Haemovigilance Office
National Clinical Programme in Anaesthesia
Cappagh National Orthopaedic Hospital
Irish Cancer Society
Association of Optometrists Ireland
Institute of Community Health Nursing
Prevention of Chronic Disease Clinical Care Programme, Clinical Strategy and
Programmes Directorate, HSE
Mater Private Hospital
Clane General Hospital
Mid Western Hospital Group
Mater Misericordiae University Hospital
Barringtons Hospital
Castlemanor nursing home
Saint John of God Hospital
Irish Cancer Society
State Claims Agency
Irish Hospice Foundation
Portiuncula Hospital
Nursing Homes Ireland
Irish Pharmacy Union
Citizens Information Board

Programme lead for healthcare records management
St John's Hospital Limerick
Irish Medical Organisation
Tallaght Hospital
Feedback on behalf of CUH Clinical Governance and Medical Board members
Irish Human Rights Commission
Irish Association for Palliative Care (IAPC)
Pavee Point
Irish Society for Clinical Nutrition and Metabolism
Royal College of Surgeons in Ireland
Irish Nutrition and Dietetic Institute, Department of Nutrition and Dietetics, Beaumount Hospital
Irish Society for Quality and Safety in Healthcare
Primary Care Services HSE West
Irish Medicines Board
Irish Hospital Consultants Association
Primary Community and Continuing Care Directorate Louth Local Health Office
National Drug Treatment Centre
Deafhear
Irish Society of Chartered Physiotherapists
Healthcare acquired infection Clinical Programme
Economic and Social Research Institute
Pharmaceutical Society of Ireland
Coronary Heart Attack Ireland Register

Appendix 3 – Statement of Outcomes for consultation

A total of 107 submissions were received during the consultation process. Each submission was read in its entirety and broken down into individual comments and recorded to create a database. Comments were classified either as qualitative comments or functional requirements. Over 620 functional requirements were identified from the submissions and 300 comments were classified as qualitative comments from the responses.

Functional Requirements

The total number of comments per section were Patient details (69), Primary care healthcare professionals details (43), Admission and discharge details (108), Clinical details (214), Medication details (80), Future plan (80) and Person completing discharge summary details(31). These are illustrated graphically in Figure 1 below.

Figure 1 – Number of responses by section
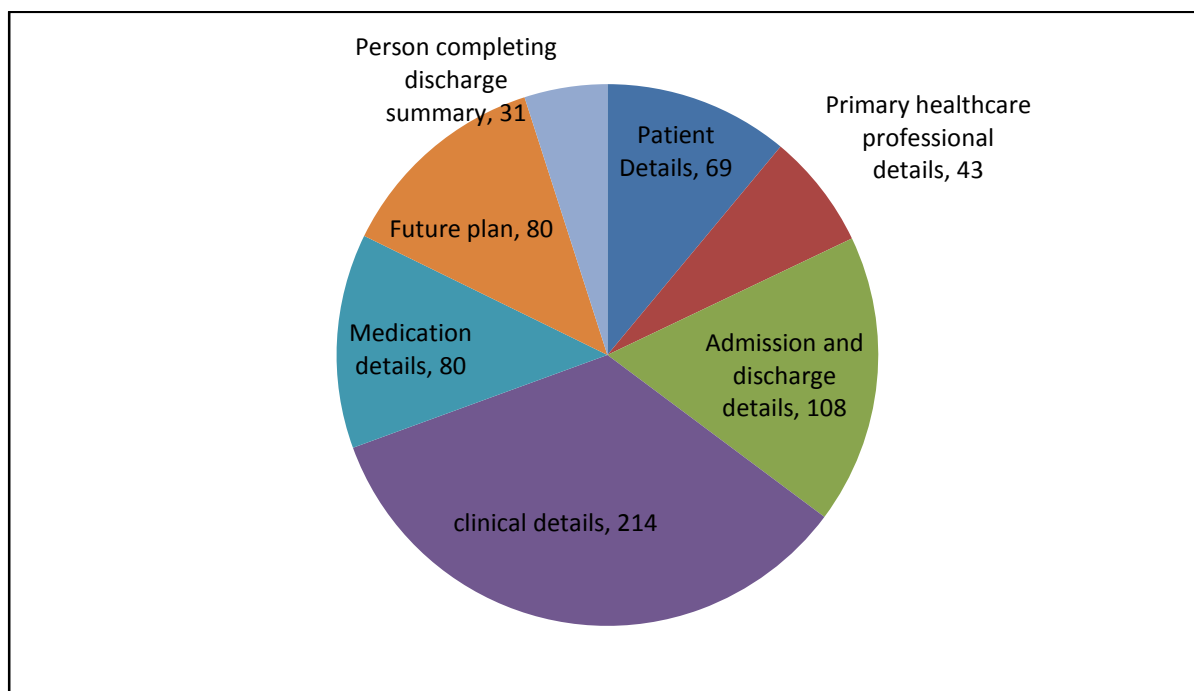
The percentage of comments per section were Patient details (11%), Primary care healthcare professionals details (7%), Admission and discharge details (17%), Clinical details (34%), Medication details (13%), Future plan (13%) and Person completing discharge summary details (5%). These are illustrated graphically in Figure 2 below.

Figure 2 – Percentage of responses per section
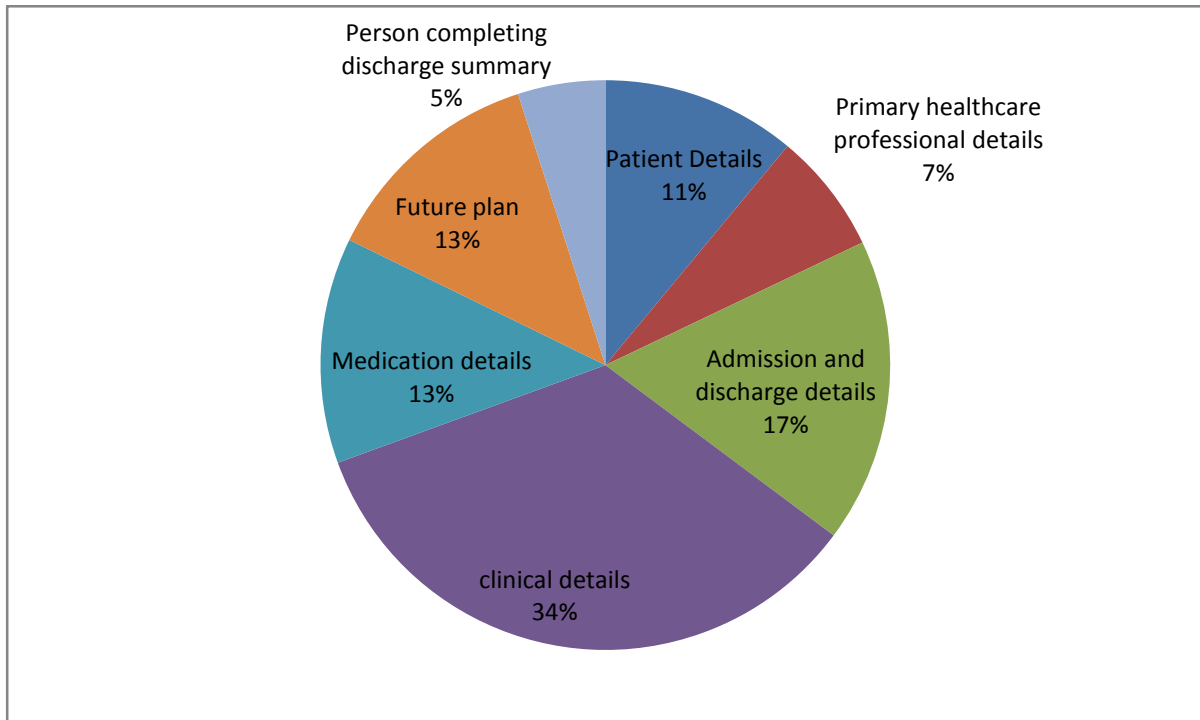
Qualitative responses

Over 300 qualitative comments were identified during the analysis. Samples of the comments are provided below categorised under the following themes: general, content, implementation, medication, data quality and timeliness.

General

"Good to aspire to these standards."

"The IHAI is fully supportive of adopting a standard approach to Clinical Discharge Summaries nationally."

"This will require buy in from all stakeholders so that the quality of information inputted into all sections is complete and accurate. It would then ensure that the receiving health care professional can make informed decisions on the plan of future care. The proposed patient discharge summary information would assist healthcare professionals to make decisions based on up-to date information, improve communication between healthcare professionals and therefore improve the quality of care for the individual I would welcome a standardised approach to patient discharge and believe it is long overdue."

"By the nature of past discharge letters to GPs it may be difficult to ger all consultants on board and in agreement to a specific discharge form but in time it should prove worthy and worthwhile."

"Comprehensive document…will be pleased to see it published and implemented."

"A standardised data set for clinical discharge summaries will ensure that the minimum information required to effectively provide on-going safe clinical care is promoted and enhanced. This will equip staff in primary care services to fully assess and review the care provided to each patient on discharge and account for any changes which may have occurred during the hospital stay. It will also enhance the accountability of the discharging professional and promote greater collaboration and information sharing between services/ professionals."

"A standardised data set for clinical discharge summaries is essential in order to optimize the care the patient receives, particularly at discharge."

"Providing complete discharge information regarding patient's inpatient stay to the primary care practitioner and to the community pharmacist is essential in improving patient care at and following discharge."

"Effort to standardise discharge (d/c) summaries nationally is to be welcomed. If one format is used, Practitioners will be able to find the relevant information, at a glance. In this area we deal with 3 maternity hospitals, 3 different forms are used to record what is largely the same information. It does take a little extra time to source the information on the different forms. A standardized form would be more efficient."

"Adequate communication between all healthcare professionals should ensure a more co-ordinated approach in assisting the patient make progress with their illness. More specifically, from a prevention of chronic disease perspective, there is a need to ensure that the principles set out in Theme 4 – Better Health and Well-being (HIQA National Standards for Safer Better Healthcare) are reflected in communications between healthcare professionals. Of note is the need to support service users in improving their own health and well-being. Unfortunately, the evidence would show that there is insufficient attention paid to this aspect of a service user's journey in the secondary/tertiary care setting, even though it may have a significant impact on the outcome for the service user. Standardised documentation such as this can flag for healthcare professionals what is important to be aware of from the point of view of collaborating between the service user and other service providers- e.g. whether or not a service user who smokes has been advised to quit and what supports were offered to them, both as an inpatient and in the community."

Content

"A national discharge summary information document should be standardised enough so that all relevant information is communicated, but flexible enough to accommodate local population needs (ie children, vulnerable people)."

"While the Patient Discharge Summary Information document focuses on clinical data, the crossover between a person's medical condition and his/her personal and social care needs is central to an effective post-discharge care management system being put in place. People being discharged from hospital are not a homogenous group and, therefore, the type of discharge information should reflect individual circumstances."

"It may be prudent to add definitions of the terms "required", "optional" and "conditional""."

"Thanks for the invite to comment, As previously mentioned I would suggest that HIQA work to align this effort with the Academy of Medical Royal Colleges Standards for Health & Social Care Records., Several of the key Irish colleges eg RCPI and RCSI are part of the AoMRC."

"As above, given over ten years' experience of operating a standardised approach to Discharge Summaries, the IHAI would commend to the Authority the approach adopted by Joint Commission International and CHKS in this regard, which is based on global best practice standards."

Implementation

"Ideally this discharge summary needs to be supported by an IT system."

"In an ideal world the discharge document should begin to be populated even on admission as lots of data elements are not going to change reason for admission source of admission Patient ID and GP etc details so therefore ideally to expedite and ensure that it is in fact filled in a clear process needs to be in place with duplication reduced were possible. Education is essential particularly in the area of coding as Medical staff are not versed in this and where it is being completed are being supported by IT systems. Audit should be part of the implementation to look at completeness, timelines, accuracy and reasons for missing data i.e. delay in investigation outcomes etc. There will need to clinical champions in organisations and leadership to drive through this change. It should be done in a manner that takes into cognisance automation in the future or were possible now (Healthlink)."

"NCHD staff would benefit hugely from a standardised dataset however, the importance of the use of this Discharge Summary being included as part of their university education would be vital so that they are equipped with the knowledge on how to complete it from the moment they commence using them in hospitals."

"Emphasis also needs to be placed on the importance of completing the discharge summary fully, accurately and clearly."

"It is suggested that each page should have the patient details as a header/footer in case the pages become separated."

"It is suggested that where the notation of time is required there should be specific reference to documenting it in 24 hour (military) format to ensure consistent approach for documentation for hours."

Medications

"This question is raised in relation to the completion of Table 5 Medication details. Does Table 5 serve as the medication prescriptions for the patient at time of discharge? If a nurse or midwife is responsible for the discharge summary does it extend to this medication prescription writing? This section should be clarified based on this interpretation."

"It is noted that in section 6.5 "Medication Details" a significant amount of information on the patient's medication is required to be recorded in the patient discharge summary. This is welcomed by the Irish Pharmacy Union (IPU) as it will assist Community Pharmacists in providing pharmaceutical care to their patients at the time of discharge. It will help to ensure that the usage of the patient's medication is optimised so that they obtain the desired therapeutic outcome from the prescribed medication and do not experience an adverse drug reaction. The inclusion of fields detailing the reasons for changes to admission medication and the reasons for stopping a medication, including information on adverse drugs reactions, will provide Community Pharmacists with information essential for the provision of patient centred pharmaceutical care. The IPU has called for the inclusion of the indications for medicines on prescriptions for some time; this will facilitate the provision of the correct information and counselling to patients about their medication and therefore improve compliance and adherence. The appearance of this as one of the fields in the section on medication details is a positive development."

"There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem. Medication errors can significantly contribute to the risk of re-hospitalization, problems with medication are a main cause or contributory factor to one in four non-elective medical admissions. Increased involvement of pharmacists, at a hospital and community level, and greater interaction across the care interface at key points in the discharge/transfer planning process could reduce these risks and associated morbidity."

"A complete discharge summary delivered in a timely manner (in line with HIQA National Quality Standards for Residential Care Settings for Older People in Ireland) and in a standardized form will facilitate optimizing the

quality and safety of care that patients receive at care boundaries. Including the community pharmacist in this discharge summary will allow the community pharmacist to close the loop in the discharge planning process by ensuring the consistency and availability of all the patient's medications on discharge is ensured and also allowing a comprehensive medication review to be completed by the community pharmacist on discharge."

Data Quality

"This will become a teaching tool, all NCHDS will be taught the importance of information and will carry that standard across each organisation they work in."

"With constant change-over of hospital staff a standardised data set will provide guidance to an individual planning a discharge thereby ensuring continuity."

"The primary care healthcare professional can be assured that they will receive the information they require prior to assessment in order to prioritise and plan their work."

"In this respect improvements in the transfer of care back to the community from the acute hospital setting would support more timely, informed and efficient transfer of patients' information to ensure that the primary care healthcare practitioners have access to important clinical information at the time of discharge."

"From reviewing the required fields Summary Template Appendix 2 we would encourage you to widen the scope of this work to include Emergency Medicine and Outpatients –significant volumes of work are happening in these areas that interface with both community and acute settings. Failures of communication in these specialities have negatively impacted claims management. This project if expanded could help prevent this."

"Any health promotion activities and self care advise needs to be recorded in the event of misadventure."

Timeliness

"The benefit of a discharge summary is directly related to its timeliness, HIQA should also set a standard for the relationship between the time of patient discharge and the creation of the discharge summary. For example, the discharge summary must be dispatched to the GP on the day of discharge."

"It is not possible for hospital doctors to complete this discharge data set manually. They need the support of clinical information systems to generate the summary from clinical workflows."

"It should be noted that the standardisation of the information to appear on a patient discharge summary will only achieve its aim if the discharge summary is made available to all primary healthcare providers, including Community Pharmacists, at the time of discharge of the patient."

"It is not clear from the document what the timeframe is between discharge and receipt of this document in primary care, the mode(s) of data transfer e.g. patient facilitated, electronic, post and how primary care teams can acknowledge receipt."

Alterations to the draft data set for consultation.

As stated over 620 functional requirements were identified in the 107 responses received. These were reviewed with a working group of members of the eHealth Standards Advisory Group (see Appendix 3). Table 8 below lists the changes to the draft dataset as a result of the comments received during the consultation process.

Table 8 – Alterations to the draft dataset

Section Heading	
Data item	**Change agreed**
6.1 Patient Details	
6.1.1 Forename	Change definition and usage from 'A patient's first name or given name as per their service user's birth certificate' to 'A patient's first name or given name (s) as per their birth certificate.'
6.1.3 Address	The definition to be changed from 'A composite of one or more address components that describe at a low level the geographical/physical description of a location followed by the high-level address components, i.e. suburb/town/locality/name' to 'The location to be used to contact or correspond with the patient. This would normally be the patient's usual home address.' Change usage to 'The particulars of the place where someone lives or where an organisation is situated.'
6.1.5 Gender	Change from Optional to Mandatory.
6.1.6 Health Identifier	Change usage to 'Both the code and the code type the code relates to should be provided e.g. 0987654321 Healthcare Record Number (HcRN). When a national individual healthcare number is available this should be carried in this heading.'
6.1.7 Discharge Destination address	Change the definition to 'The particulars of the place where someone lives or where an organisation is situated.' Change usage to 'If the patient is discharged to an address which is not their usual place of residence then this heading should be used to indicate this and should provide details of the address the patient was discharged to.' Moved to section 6.1 from section 6.3

6.2 Primary care healthcare professional	
6.2.3 Address	The definition to be changed to 'The particulars of the place used to correspond with the patient's primary healthcare professional.'
6.2.4 Professional body registration number	Remove from dataset
6.3 Admission and Discharge Details	
6.3.1 Date of admission	Change this to date of admission. Change the description from 'The date and time that the patient was admitted to the hospital ward' to 'The date the patient was admitted to the hospital ward.' Change the usage to 'The date and time of admission should be supplied in dd/mm/yyyy hh:mm format' to 'The date of admission should be supplied in dd/mm/yyyy format.'
6.3.2 Source of referral	Change to Mandatory.
6.3.3 Method of Admission	Change to Mandatory.
6.3.4 Hospital site	Add into usage 'The hospital site the patient was discharged from.'
6.3.5 Hospital Ward	Remove this heading from the dataset.
6.3.6 Date of Discharge	Change this to date of discharge. Change the description from 'The date and time that the patient was discharged from the hospital' to 'The date the patient left the hospital.' Change the usage to 'If the patient was discharged alive, record the date of discharge from the hospital. This heading will be blank if the patient died during the inpatient stay. The date of discharge should be supplied in dd/mm/yyyy format.'
6.3.7 Discharge Method	Change to Mandatory
6.3.8 Patient died	Change the usage to indicate that if a patient died in hospital then many of the headings in 6.4, 6.5 and 6.6 do not need to be completed.
6.3.9 Date of Death	Change the usage to indicate that if a patient died in hospital then many of the headings in 6.4, 6.5 and 6.6 do not need to be completed.
6.3.10 Discharge Destination address	Change the definition to 'The particulars of the place where someone lives or where an organisation is situated.' Change usage to 'If the patient is discharged to an address which is not their usual place of residence then this heading

	should be used to indicate this and should provide details of the address the patient was discharged to.' Move to section 6.1
6.3.11 Discharging consultant's name	Move to section 6.7
6.3.12 Discharge specialty	Move to section 6.7
6.3.13 Document reference number	Move to section 6.7
	Add into dataset whether a post-mortem is to be undertaken. It is not required that any details of the post-mortem are provided at the time of creating the discharge summary.
6.4 Clinical Narrative	
6.4.1 Pertinent Information	Usage to be expanded to include blood transfusions, difficult intubations, advance care directives, pressure sores. Also I will need to change the text in the document where the optionality is explained.
6.4.2 Diagnosis	Alter usage to 'where known to the person completing the discharge summary standard code(s) for the diagnosis should be provided.'
6.4.3 Operations	Include 'Australian Classification of Health Interventions (ACHI)' in the example for coding operations.
6.4.4 Clinical alerts	Include 'It is a warning of a medical condition or risk factor that requires consideration before treatment is initiated.'
6.4.5 Allergies	Include in usage the allergen, reaction, date of reaction, source of information should be provided. Remove 'not asked' from the description as this is poor practice.
6.4.6 Adverse Events	Change usage to 'This section should include information about all hypersensitivities AND/OR adverse events.'
6.4.10 Diet	Changing usage to 'Information on dietary interventions, special dietary requirements, use of nutritional support during stay, e.g. oral nutritional supplements, enteral tube feeding and parenteral nutrition and any problems a client might have with eating, drinking or swallowing at time of discharge need to be documented.'
6.4.11 Functional State	Include in the usage that a history of falls should also be documented.
6.4.12 Immunisations	Change usage to 'document the immunisations given to the patient during this inpatient stay.'
4.4.13	Add in a new section on hospital acquired infection controls
6.5 Medication Details	
6.5.1 Medication Details	Many comments, mainly on the quality, some comments on need for a prescription, one comment to change usage from 'continue' to 'repeat'. Indicate the generic name of the drug should be written on the prescription.

6.5.2 Medication changes	Change title from 'medication changes' to 'medications stopped or withheld.'
6.5.3 Pharmacy details	Remove, not actually needed.
6.6 Follow Up	
6.6.2 GP Actions	Change usage to 'any actions that the GP has been requested to organise should be documented.'
6.3 Social care actions	New field added to the dataset.
6.6.4 Advise, Recommendations and Future Plan	Add into usage a note to include health promotion/prevention advised or commenced, i.e. smoking cessation, referrals to other PCT members of services which have been organised.
6.7 Person completing Discharge Summary	
6.7.3 Contact number	Add into usage 'The usual contact number for the person completing the summary should be given.'
6.7.11 Discharging consultant's name	Moved from section 6.3
6.7.12 Discharge specialty	Moved from section 6.3
6.7.13 Document reference number	Moved from section 6.3

Appendix 3 – eHealth Standards Advisory Group members

Professor Jane Grimson – Health Information and Quality Authority (chair)
Dr Brian O'Mahony – General Practice Information Technology Group and Irish College of General Practitioners
Dr Damon Berry – National Standards Authority of Ireland
Dr George Mellotte – Royal College of Physicians of Ireland
Dr Marie Staunton – Faculty of Pathology, Royal College of Physicians of Ireland
Dr Niall Sheehy – Faculty of Radiologists Royal College of Surgeons in Ireland
Mr Gerard Hurl – Health Service Executive Information and Communications Technology
Mr Peter Connolly – Health Service Executive Information and Communications Technology
Mr Gerry Kelliher – Royal College of Surgeons in Ireland
Mr Jack Shanahan – Irish Pharmaceutical Union
Mr John Kenny – Health Service Executive Quality and Patient Safety Directorate
Mr Kevin Conlon – Department of Health
Ms Eileen Whelan – Irish Association of Directors of Nursing and Midwifery
Professor Ronan O'Sullivan – Health Service Executive Clinical Strategy and National Clinical Programmes
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