Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Information and Standards

Draft National Standard for Hospital Discharge Information*

For Public Consultation

September 2025

Version 2.0

*This standard is a revision of the National Standard for Patient Discharge Summary Information (2013).

Version Control

This table shows the version history for this standard.

Date	Version	Change
July 2013	1.0	Approved by the Minister for Health
September 2025	2.0	Proposed updates to the Draft National Standard for a Hospital Discharge Information within three information groups: Patient Information, Hospital Encounter Information and Document Information.

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.
- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

Visit www.hiqa.ie for more information.

Overview of the health information function of HIQA

Good information is the foundation of a high-quality health and social care service. As part of a person's journey through the health and social care system, information is collected and shared at different stages and used to inform their care. This is known as the primary use of information. High-quality data is also important for other purposes such as planning and managing services, policy-making, research and innovation. For example, information may be used to decide where to locate a new service or to understand how practice can be changed to improve a person's experience of care. This is known as the secondary use of information.

Whether used for primary or secondary purposes, it is essential that information is managed effectively and securely and used to its full potential to promote safer better care, improved outcomes and overall wellbeing for people using services. A human rights-based approach should be of central importance and seek to balance the rights of people with the broader societal value of using health and social care information. A strategic and coordinated approach that is aligned with information standards is also essential to ensure data is captured and managed in line with best practice. A well-embedded standards-based information environment will allow all stakeholders, including the general public, patients and service users, health and social care professionals and policy-makers, to make choices or decisions based on the best available information.

Electronic Health (eHealth), which is the use of digital technologies to improve health, is critical to ensuring that information is available when and where it is required. An effective eHealth infrastructure can support the secure, effective transfer of information by ensuring information is captured in the right format so that it can be shared easily and securely across services. The necessary information should be accessible by all health or social care professionals providing care and to the person it relates. This will lead to more efficient and effective delivery of care and ensure people do not have to provide the same information on multiple occasions.

The Health Information and Quality Authority (HIQA) has responsibility for setting standards for all aspects of health information and monitoring compliance against those standards, as set out in Section 8(1) of the Health Act 2007. [(1)] Under the Act, HIQA is also charged with evaluating the quality of the available information on health and social care and making recommendations to the Minister and the Health Service Executive (HSE) in relation to improving the health information system. The Health Information Bill (2024), proposes legislation to improve the use of health information in Ireland, to ensure best care and treatment for patients.[(2)] Through its health information function, HIQA also plays a key role in providing evidence to inform national health information policy and shape the health information landscape

in Ireland. HIQA works to ensure that high-quality health and social care information is available to support the delivery, planning and monitoring of services that ensures safer better care for all.

The aim of health information standards is to standardise the collection and recording of information so it can be exchanged. This approach promotes progressive quality improvements in the care and support provided in health and social care services. The standards set out by international standards development organisations, particularly those in the EU, must be considered in the Irish context to determine the feasibility of adopting and adapting these standards to meet the needs of the Irish health system. Standards that are well established internationally, provide a framework that allows different health systems to seamlessly communicate and share data in a safe and secure manner. This helps to ensure that patient and service user information is easily accessible across borders. It is important that standards set by HIQA are maintained and updated to ensure that they are fit for purpose.

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Glossary of abbreviations

CTTO	Chief Technology Transformation Office
CSO	Central Statistics Office
DoH	Department of Health
EHDS	European Health Data Space
EHR	Electronic Health Record
EU	European Union
GDPR	General Data Protection Regulation
GP	General Practitioner
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
HSPC	Health and Social Care Professionals
ICT	Information and Communication Technology
IHI	Individual Health Identifier
IPPOSI	Irish Platform for Patient Organisations, Science & Industry
ISO	International Organization for Standardization
NCEC	National Clinical Effectiveness Committee
NCPPC	National Clinical Programme for Palliative Care
NSAI	National Standards Authority of Ireland
PCRS	Primary Care Reimbursement Service
PHN	Public Health Nursing
RCPI	Royal College of Physicians of Ireland
SDOs	Standards Development Organisations
SNOMED CT	Systematized Nomenclature of Medicine – Clinical Terms
UK	United Kingdom

1. Introduction

Data and information are generated in huge volumes every day across the health and social care system. Safe and reliable health and social care depends on access to, and use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. For health information to flow in and between health and social care systems, it needs to be collected and recorded in a consistent way every time. Health information standards aim to contribute to safer better care by standardising health information so that it is gathered and exchanged consistently. The application of a health information standard removes duplication and variation within and between service providers when collecting patients' and service users' data. This is needed to promote progressive quality improvements in the care and support provided in health and social care services. An integrated health and social care system must be able to share accurate and relevant health information within and across organisational boundaries, both nationally and at EU level, as set out in national and international regulations and policies.

Health information standards are fundamental to supporting standardisation in the collection, organisation and timely sharing of health information to support the move from fragmented, often paper-based systems, to seamless interoperable electronic systems. The European Health Data Space (EHDS) Regulation emphasises seamless, secure, and interoperable health data exchange across EU Member States. The regulation is intended to give individuals more control of their personal health information, to support care and treatment (primary use of information) and to ensure high-quality health information is made available to policy-makers, researchers, and innovators in a secure and trusted way (secondary use of information).[3] Hospital Discharge Reports are one of the six priority categories of electronic health data, identified for reform by the EHDS Regulation, to enhance healthcare delivery and facilitate data reuse for research and policy-making.[3]

Developments in the health information ecosystem

The health information policy and legislative landscapes have advanced considerably at both national and European level in recent years. This includes the European General Data Protection Regulation (GDPR) Act, and nationally, the Data Protection Act, which acknowledge the potential that high-quality data has on improving services and performance, while recognising the challenges associated with balancing individuals' concerns regarding privacy and confidentiality.[4,5] Nationally, the Health Information Bill (2024), proposes the creation and assignment of electronic health records for every patient, supporting the national implementation of the EHDS Regulation.[2]

The Path to Universal Healthcare – Sláintecare & Programme for Government 2025+ highlights digital health transformation as central to reforming the delivery of health services.[6] Work has progressed nationally, to develop an Individual Health Identifier (IHI), to provide safe unique identification of each person who has used, is using or may use a health or social care service in Ireland, in compliance with the Health Identifiers Act (2014).[7]

The Department of Health's *Digital for Care - A Digital Health Framework for Ireland 2024-2030,* and the Health Service Executive's (HSE) *Digital Health Strategic Implementation Roadmap* (2024), provide the route for digital transformation in healthcare.[8,9] These publications recognise that health information standards, including the adoption and adaption of international and European standards where relevant, are key enablers to ensure data 'flow' between digital health systems to enable the joining up of health and social care services. In 2024, the Minister for Health approved the *National Standards for Information Management in Health and Social Care*.[10] These standards, developed by HIQA, aim to improve how information is managed in Ireland's health and social care services, and are underpinned by the principles of a human rights-based approach, safety and wellbeing, responsiveness and accountability.

Draft National Standard for Hospital Discharge Information

Primary use of health information is the collection, use and sharing of health information for the purpose of providing quality health and social care.[10] The primary clinical information in a hospital discharge information standard dataset is essential for providing core information about the patient's hospital journey, and for the continued management of clinical condition(s). Such information comprises data elements about the hospital stay and reasons for same, treatment, medications and clinical care plan on discharge from the hospital setting. Standardisation of such primary healthcare information can help to enhance continuity of care after hospital discharge, by providing an accurate and relevant, yet succinct record of care within the hospital journey, along with a plan of clinical care to be completed upon discharge to the community. In addition, standardisation of discharge information is a key step towards making data available for secondary use; that is, anonymised collection of clinical information for service planning, policy-making, research, and statistical analysis. Moreover, this standardisation can help to reduce duplication in a number of areas, including for example, fewer duplication of testing requests and medication prescribing, resulting in savings associated with time, administration and costs.

The *National Standard for Patient Discharge Summary,* was first published by HIQA in July 2013, to address a deficiency in hospital discharge information being shared

across the Irish health sector.[11] Since 2013, there have been significant changes in the health information ecosystem, as outlined above, which have prompted a revision of the national standard. In 2023, through collaboration with the Department of Health and Health Service Executive, HIQA's *National Standard for Patient Discharge Summary Information* (2013) was identified as a priority health information standard for revision.[11] The revision has resulted in expanding the core dataset of the national standard, identifying the conformance and cardinality of each data element within the standard, along with guidance on how to record the data elements.

The development of the Draft National Standard for Hospital Discharge Information has been undertaken with an awareness of work progressing at the European level, including the European Healthcare Network (EHN) Guidelines[12] and the technical specification being developed by the XT-EHR project.[13] The European Healthcare Network (EHN) Guideline for Hospital Discharge Report, identifies the core elements required in a patient discharge document, which may be accessed by healthcare professionals in any EU country to which the patient travels, allowing for relevant information to be shared between clinicians in a timely manner.[12] The Xt-EHR Joint Action Project, aims to establish requirements, guidelines, specifications and implementation guides to enhance the interoperability and exchange of healthcare data between European countries, paving the way for the implementation of the EHDS Regulation across EU member states.[13] HIQA is aware of the EU developments and our national work is both informed by and informing progress at the European level.

This document sets out the revised standard for a hospital discharge dataset, based on the changes outlined above, evidence reviewed and input from key stakeholders. HIQA now seeks the views of the public on this draft standard. The next phase of the project will be the testing of the draft standard. Following the next phase of the process, the standard will be submitted to the Minister for Health for approval.

For the purposes of the National Standard for Hospital Discharge Information, the term "discharge document" refers to a hospital discharge summary, report, template or discharge letter, currently used in the clinical healthcare environment, whether created in electronic or paper form.

1.1 Purpose of the national standard

A Draft National Standard for Hospital Discharge Information defines the core set of data elements required when a patient is discharged from an acute hospital back to the care of their primary healthcare professionals, in order to provide continued safe quality care and support. This is primary use of information. It is important that the person providing the discharge information ensures accurate and relevant

information is shared with the primary care healthcare professional, to enable them to continue delivering clinical care seamlessly. To this end, only information with specific relevance to the patient hospital stay and ongoing care plan should be included. The document should be produced at the time of patient discharge from an acute public or private hospital, with the dataset not so detailed as that it might delay being sent to the primary healthcare provider on the day of patient discharge.

The purpose of this standard is to promote the provision of safe quality care and support by:

- Ensuring the relevant and appropriate data elements are included in a hospital discharge dataset to ensure the correct information about the patient is shared in a safe, appropriate and timely manner, in order for ongoing care to be provided.
- Providing guidance on how data elements should be defined, structured and documented.

1.2 Scope of the national standard

- The Draft National Standard for Hospital Discharge Information applies to patients of any age (children and adults), where the patient is being discharged from acute hospital service to primary care. This includes assessment in an emergency department of a hospital.
- This standard can be applied in practice, regardless of the hospital or organisation, using paper or digital records.
- The standard is designed to be independent of any particular clinical specialty or technical platform, and to cover requirements that are common across the majority of clinical specialties. Additional information, outside the core components, may be provided if the discharging clinician deems it necessary.

1.3 HIQA's remit to develop national standards

The Health Act 2007 sets out HIQA's legislative remit in respect of health information. As set out in Section 8(1) of the act, HIQA has responsibility for setting standards for all aspects of health information and monitoring compliance against those standards.[1]

The Patient Safety (notifiable Incidents and Open Disclosure) Act commenced in September 2024, extending HIQA's remit to include private hospitals. [14]

The *National Standards for Information Management in Health and Social Care* aim to improve how information is managed in Ireland's health and social care services, and are underpinned by the principles of a human rights-based approach, safety and wellbeing, responsiveness and accountability. [10]

HIQA has developed a range of standards in the area of health information to contribute to safe quality care by providing a core set of data elements to support consistent, complete, and accurate recording of information. Please see Appendix 1 for further details.

1.4 How the draft national standard was revised

HIQA takes a collaborative approach to setting standards and works closely with those responsible for the implementation of the standards, to ensure that standards are fit for purpose in an Irish context.

- Firstly, the existing Draft National Standard for Hospital Discharge Information (2013) was reviewed, in line with HIQA's standard-setting process for health information standards.[11]
- Following this, a comprehensive evidence review was conducted to identify and describe current evidence and best practices relating to hospital discharge document data. National and international health information standards, guidelines and relevant legislation focused on health information were examined, in order to reflect changes in the health information landscape, including legislative and policy changes.
- A Standards Working Group was established to provide expert advice (see Appendix 2 for list of members). The group comprised a diverse range of interested and informed parties. The data elements, description of the data elements and their associated conformance, cardinality and guidance for use, as set out in this draft standard, were informed by the evidence review and consultation with the Standards Working Group. [1,2, 4-12, 14-18, 22-36]
- The next stage is to undertake a public consultation on the draft standard and to engage with stakeholders through focus groups, to inform revision of the standard. Individual meetings may also be undertaken if required.

1.5 Public consultation process

We are now at the public consultation phase of the process and the Draft National Standard for Hospital Discharge Information is available for public consultation for a six-week period. During this time, HIQA welcomes feedback on the data elements within this draft standard, to ensure inclusion of all the relevant information required

in a discharge document from hospital to primary care, in order to provide safe quality care and support.

The deadline for receipt of submissions is 5pm

Wednesday 05 November, 2025

HIQA will carefully assess all feedback received and use it, along with other available evidence, to further revise the draft standard. At the end of this consultation, comments will be collated, analysed and used to help inform the revision of the Draft National Standard for Hospital Discharge Information.

1.6 Key concepts and terms

Clinical and administrative information in healthcare records can be structured to support clarity of understanding, consistency in recording and support safe exchange of data. Healthcare records are built using a hierarchy of components – compositions, sections, record entries, clusters and elements – with each serving a distinct purpose. The use of these five components helps to organise data from broad categories into individual data points. The purpose of each of these components is described below.

Composition:

A composition represents a complete clinical document, created during a specific healthcare event or interaction between a healthcare professional and a patient. It brings together all of the information relevant to the event of interaction. It is usually a document authored by a clinician. Compositions consist of multiple sections. For example, a GP consultation note or a hospital discharge document.

Section:

A section groups together all the information related to a specific topic. Sections group together types of related data to make the information easier to navigate. A section may contain record entries, clusters and elements. For example, medications prescribed and changed during a patient's hospitalisation.

Record Entry:

Record entries are used to document a specific type of clinical action or event. A record entry groups together information, which is usually authored by a clinician and time stamped. For example, a procedure that was performed on the patient.

Cluster:

A cluster organises complex information into a logical group. Clusters are most commonly used to organise data that is very structured and consists of multiple distinct elements. For example, an address, which consists of multiple address lines, suburb or townland, district or county and postcode.

Elements

Elements are the lowest level of data and commonly hold one specific piece of information. Each data element in the standard is described using five components: description, conformance, cardinality, values and guidance. These components are described in Table 1 below and include examples of what they mean in practice.

Table 1. Data Elements

1. Description: A short description of what the data element means.	
2. Conformance: Indicates if collecting and recording of this data element is mandatory, required or optional.	
What each conformance rule means	**Examples of what conformance means in practice**
Mandatory The information must be included.	**8.1 Admission Date and Time** Date and time of admission to hospital must be recorded.
Required If it exists, the information must be included.	**7.3 Allergy /Adverse reaction** If an allergy occurred or was previously known, it must be recorded, and section completed.

Optional A local decision is made as to whether the information is included.	**7.3.2 Description of adverse reaction** A local decision is made as to whether to record a description of the adverse reaction which the patient experienced during the hospital encounter (For example, rash).If the person wishes to use a name title such as Mister (Mr) before their name, the title can be recorded.
3. Cardinality: Indicates how many entries can be made, that is zero, one or many entries.	
What each cardinality means	**Examples of what cardinality means in practice**
0…* Zero to many record entries are allowed	**20.3 Actions for which others, including nursing and or health and social care professionals** Actions which will be carried out by others who will be responsible for carrying out patient care plan after the patient has been discharged, including planned investigations, procedures and treatment for a patient's identified conditions and priorities. For example, daily dressings, occupational therapy review, or community physiotherapy. Discharging clinician must identify that the plan of care on discharge has been understood by and agreed with patient or carer.
0…1 Zero to one record entry is allowed	**20.1 Hospital Actions** This should include any outstanding tests, appointments or investigations, which will require the patient to return to the hospital setting after discharge. For example, "Patient to return for outpatient MRI of chest and abdomen-appointment date to be sent out to patient". One item per entry.
1…1 One record is expected	**7.3 Allergies/Adverse Events (Record Entry)** Must report to primary healthcare professional if allergy or adverse event occurred during the hospital encounter or existed previously. One entry per allergy. Multiple allergies can be recorded.
1…* One to many records are expected	**7.3.1 Causative Agents** List of causative agents. If no allergies or adverse reactions known, must document 'no known allergies'. This section may include food allergies, for example, peanut allergy.
4. Values: Values describe how the information is recorded in the system and communicated between systems. The information can be text or in a coded format (coded value).	

Clinical terms should be recorded in standardised structured and coded data using SNOMED CT where possible. Coded values have not yet been specified but can be informed by other data standards such as those developed by the International Organization for Standardization (ISO) and the Central Statistics Office and also those identified in the eHealth Network Guidelines, where appropriate.
5. Guidance: Information to inform and guide the use of the data element when collecting and recording it.

It is important to note that given the current maturity of health infrastructure, clinical documentation may be completed in either paper-based or electronic format.

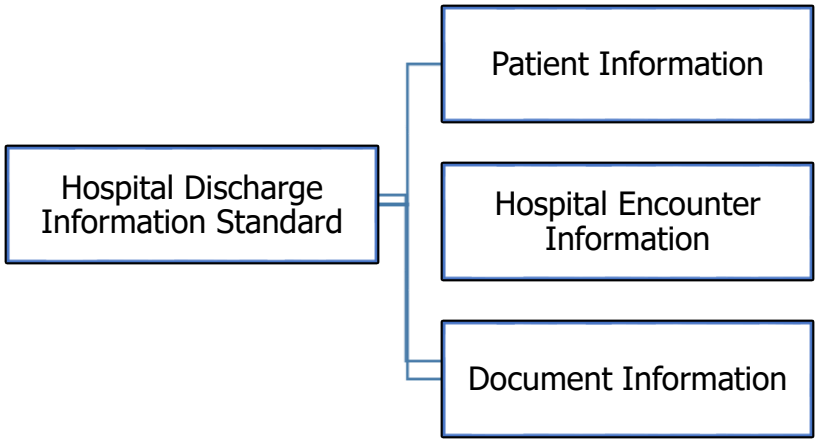
1.7 Structure of the Draft National Standard for Hospital Discharge Information

The Draft National Standard for Hospital Discharge Information is divided into three groups of information, as illustrated in Figure 1;

- Patient Information (information directly related to the patient)
- Hospital Encounter Information (information about the hospital encounter or journey)
- Document Information (information related to the clinician completing the document, sign-off and distribution list).

The order of the sections and data elements within the standard do not signify the importance or priority of the data, but lend to the flow of the patient journey through the hospital encounter back to primary care.

Figure 1. National Standard for Hospital Discharge Information composition

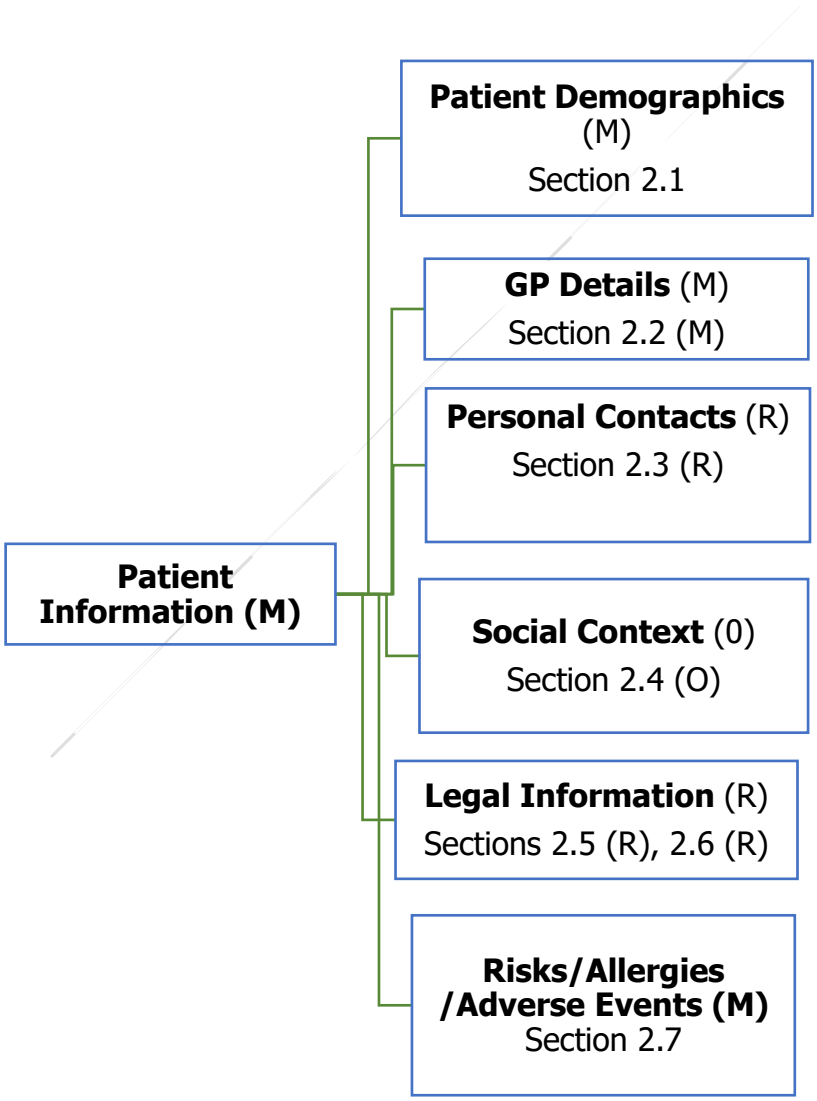


Patient Information

The Patient Information group contains six component sections as illustrated in Figure 2 below and which can be found in Sections 2.1-2.7, in chapter 2. The components which are considered mandatory are identified with an (M), the required components with an (R) and the optional components with an (O).

The detail of each component in the Patient Information group may consist of either a single section or multiple sections. For example, 'Personal Contacts' is required (R) and the reader is pointed towards Section 2.3 in chapter 2 for the details regarding patient contact. 'Legal Information' is also Required (R), and the reader is referred to sections 2.5 and 2.6 in chapter 2 for details.

Figure 2. Components of Patient Information group



Hospital Encounter Information

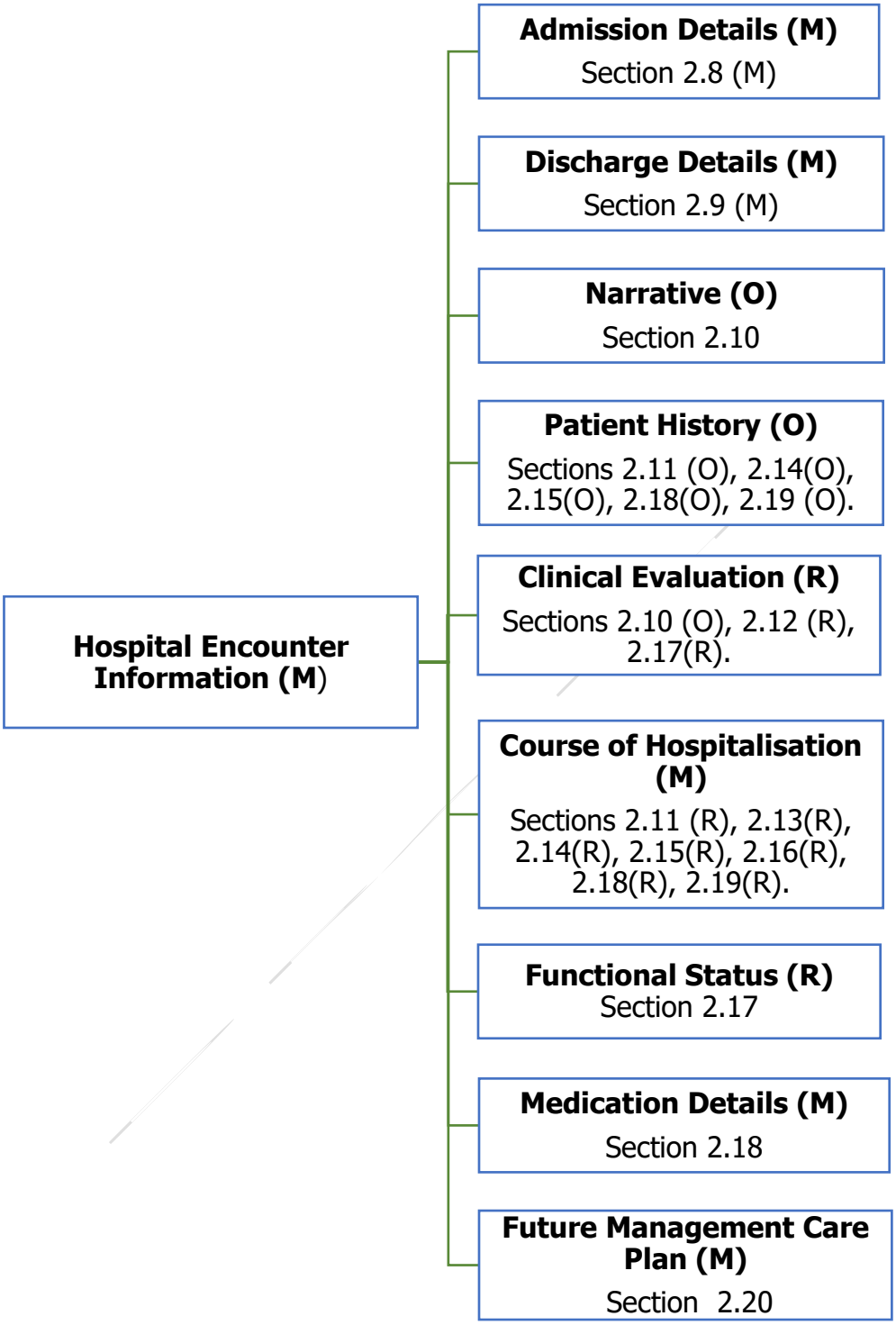
Information about the patient's hospital encounter is created by recording information from a number of data sections (sections 2.8-2.20). This group of data describes the patient clinical journey through admission and hospital encounter, to the care plan following hospital discharge. The Hospital Encounter Information Group contains nine components as set out in Figure 3 below. The components considered mandatory, are identified with an (M), the required components with an (R) and the optional components with an (O).

The detail of each component in the Hospital Encounter Information group may consist of either a single section or multiple sections, for example:

- 'Admission Details' is mandatory (M), and the reader is pointed towards section 2.8 in Chapter 2 for details.
- 'Patient History' is optional (O), and the reader is referred to sections 2.11, 2.14, 2.15, 2.18 and 2.19 in Chapter 2 for details.
- 'Course of Hospitalisation' is mandatory (M). It is not an identified section, rather it refers to all clinical activity during the patient stay, as reported by the discharging clinician and the reader is referred to the relevant sections in Chapter 2.

The hospital discharge information provided should be comprehensive, succinct, appropriate and relevant to ensure that the primary healthcare professional can identify a clear diagnosis, carry out the relevant treatment, and provide the appropriate care plan following patient discharge from hospital.

Figure 3. Components of the Hospital Encounter Information group

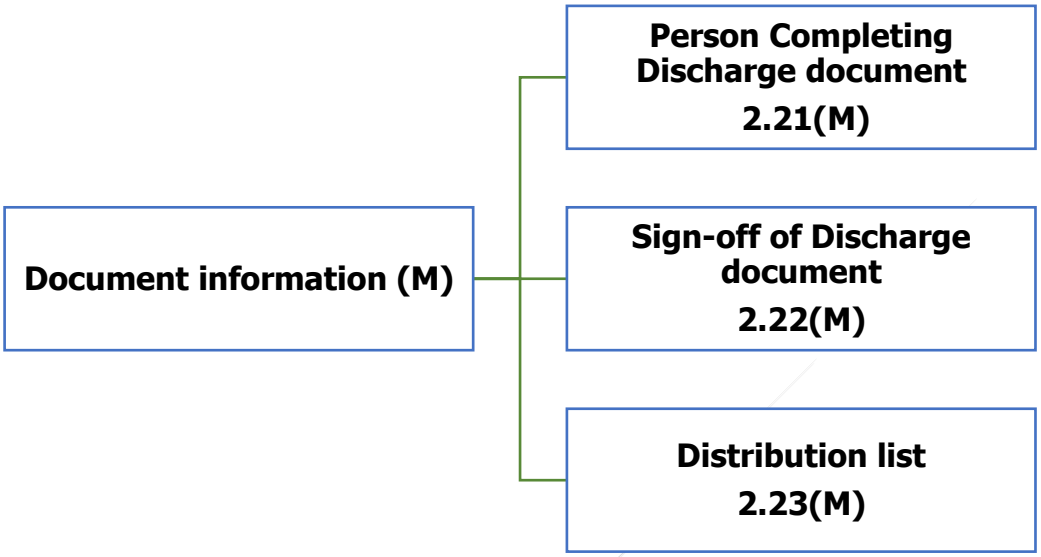


Document Information

Information about the patient's hospital discharge document is created by recording information from a number of data sections (sections 2.21-2.23). This group of data

describes the hospital discharge document itself, including information about the person completing the document, the healthcare professional with responsibility for the patient during the hospital stay, and the list of healthcare professionals to whom the document should be sent. The Document Information Group contains three components as set out in Figure 4 below; each of these are mandatory.

Figure 4. Components of the Document Information group



1.8 Use cases

To illustrate how the Draft National Standard for Hospital Discharge Information can map to a "live–case scenario", two use cases have been developed. Each use case consists of a clinical scenario, mapping to the sections in this standard and a sample hospital discharge document in semi-structure and narrative format (these being the most common formats of discharge documents which primary healthcare professionals in Ireland currently receive). The use cases can be found in Appendices 3 and 4.

- These use case samples have been developed to demonstrate hospital discharge documents for a simple case admission (John) and a complex discharge case (Peggy).
- The scenarios contain fictitious information and do not represent any real cases. They are purely for illustrative purposes, and will not require feedback in the public consultation process.
- The information produced in the hospital discharge document is extracted from the three information groups as demonstrated in section 1.7 above.

Chapter 2. Draft Revised National Standard

As described previously, Chapter 2 is divided into three groups; Patient Information, Hospital Encounter Information and Document Information. Some information will be required in more than one group and its conformance may be different, depending on the information being provided. For example, the patient may disclose any medication they are taking in the Patient History section (but this is optional), while the discharging healthcare practitioner is required to record any medications prescribed on discharge in the Hospital Encounter Information.

Patient Information

Please note that the Draft National Standard for a Demographic Dataset for Health and Social Care is currently under review. This project will adopt findings of the review relevant to the National Standard for Hospital Discharge Information when complete. It is anticipated that this will include data elements from the Patient Demographics, General Practitioner Details and Personal Contact Details sections.

Section 1 Patient Demographic Details

Section 1.1 Patient Name

Section	Description				
1.1 Patient Name	This section includes headings relating to the patient's legal name. The legal name is the name recorded on an official public register that is recognised, for example a birth certificate, current passport or current public service card. Forename, middle name, surname and name suffix are included in Patient Name. Preferred name may be recorded if appropriate.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
1.1.1 Name Title	The title relevant to a specific family name for this person.	Optional	0 … *	Coded value/ Free text	Name titles may be used wherever the person's name is formally represented. Multiple name titles may be recorded. Name title options include Doctor (Dr) and Mister (Mr).

1.1.2 Forename	The patient's legal identifying name. This is also referred to as given name or first name.	Mandatory	1 … 1	Free text	The first name by which the person is legally identified. This includes a double barrel name and this is a single record entry. The legal name is the name recorded on an official public register that is recognised, for example a birth certificate, current passport or current public service card. For example, Sarah-Jane
1.1.3 Middle Name (s)	The person's legal middle name(s).	Required	0…*	Free text	This refers to the middle name(s) recorded on an official public register that is recognised, for example a birth certificate, current passport or current public service card. Multiple middle names should be separated by a space. For example, Sarah-Jane Ellen Marie
1.1.4 Surname	The second part of the person's name, which denotes their family, or marital name. This is also referred to as family name or last name.	Mandatory	1 … *	Free text	This is the family or marital name of the person. For example, Smith. If a person has more than one family name, enter all surnames as recorded on an official public register that is recognised, for example a birth certificate, current passport or current public service card.
1.1.5 Name Suffix	Additional term used following a person's name to identify a person usually in relation to others in the person's family, or to acknowledge qualifications,	Optional	0 … *	Coded value	Identifies the person's name suffix, for instance, Senior (Sr) or Junior (Jr). Multiple name suffix may be recorded. Do not put a name suffix within the forename or surname field.

	positions held and honours awarded.				
1.1.6 Preferred Name	Indicates the name by which the person prefers to be identified and is a name used other than the forename entered. This is also referred to as patient alias.	Required	0 … 1	Free text	Only one forename record should be recorded as the preferred name. For example, the person's forename is Jonathan, but Jack is his preferred name.

Section 1.2 Address

Section	**Description**				
1.2 Address	This section provides information relating to the address for the person. It provides the facility to record various types of addresses, for example a home, or temporary address. The address section is broken down into separate, structured fields to help ensure proper interoperability and allow for efficient sharing of records between systems and services. A full address should not be recorded in one data field.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
1.2.1 Address Line(s)	This is an address field consisting of some but not all of; Building complex subunit type abbreviation, Building complex subunit number, Address site name, House or property number, Street name and type.	Required	0 … *	Free text	This field allows for collection of address information regarding building, house or apartment number and street. This can be more than one physical address line. It is any address information that goes before suburb/town/townland/locality.

1.2.2 Suburb/ Town/ Townland/ Locality	The full name of the locality describing the specific address of a person.	Required	0 … 1	Free text	The full name of the locality describing the specific address of a person. This should identify the location that the person currently resides in. Intended to be used in conjunction with 2.1 Address line(s). For Dublin addresses only, the postal district number if known, (for example, Dublin 2) should be entered in this field and not the county field.
1.2.3 District/ County	The full name of the county where the person resides.	Mandatory	1 … 1	Free text	Intended to be used in conjunction with 1.2.1 Address line(s) and 1.2.2 Suburb/Town/Townland/Locality. For example, Dublin 7 or County Cork, or Copenhagen, (if outside Ireland).
1.2.4 Country	The full name of the country where the person resides.	Required	0 … 1	Coded value/ Free text	The full name of the country where the person resides (For example, Ireland, Netherlands).
1.2.5 Postcode	A code representing the address of the person (For example, Eircode in Ireland, Postcode in the United Kingdom or Zip Code in the USA).	Required	0 … 1	Alpha-numeric	

1.2.6 Address type	Multiple addresses may be recorded. Each address should have an associated address type code. There should only be one current postal address for correspondence.	Mandatory	1 … 1	Coded value	Indicates the type of address record that has been recorded, for example place of residence or temporary accommodation. Homelessness (if relevant) should be captured in this data field.

Section 1.3 Health Identifiers

Section	**Description**				
1.3 Health Identifiers	This section allows for recording of a person's identifiers. Identifiers used in health and social care link the individual to their health records and facilitate the secure exchange of information across providers and systems. Examples of identifiers used in health and social care include PPS Number, Individual Health Identifier (IHI), Medical Record Number (MRN), Tusla's Case Management System (TCM) Person ID or a General Medical Card (GMS) Number. Such identifiers help ensure precise and secure identification, enabling seamless care coordination and accurate service delivery.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
1.3.1 Personal Public Service Number (PPS Number)	A Personal Public Service (PPS) number comprises seven numbers followed by either one or two letters. The PPS number helps a person to access social welfare benefits, public services and information in	Required	0 … 1	Alpha-numeric	The PPS number should consist of both numbers and other characters that are unique to the person. If a person has more than one PPS number, only enter one number. This PPS number must be actively valid, and the one that the person uses for validation; not just a valid PPS number.

	Ireland [Department of Social Protection, 2025].				The Health Identifiers Act 2014 includes PPS number in the list of 'identifying particulars' that the HSE may collect for the purposes of assigning an Individual Health Identifier to a person and for the search and retrieval of same.(7)
1.3.2 Individual Health Identifier (IHI)	The IHI is a national healthcare patient ID in Ireland. It is a number that uniquely and safely identifies each person that has used, is using or may use a health or social care service.	Required	0 … 1	Numeric	A unique 18 or 10-digit number used to identify individuals and is provided by the HSE in Ireland. The IHI is applicable in Ireland only. For individuals who are living outside of Ireland, record their healthcare patient ID under 1.3.3 'Other health identifiers'.
1.3.3 Other identifiers used in health and social care details (cluster)		Required	0 … *		
1.3.3.1 Other identifiers used in health and social care - Type	Other identifiers may be assigned at a local, regional or national level or outside of Ireland and can uniquely identify that person.	Required	0 … *	Coded value	Examples include the Medical Record Number (MRN), Primary Care Reimbursement Service Number (medical card/GP visit card), Long-Term Illness card, GP Record Number, NHS number in England and Wales, European Health Insurance Card (EHIC) number, Private Health Insurance Number.

1.3.3.2 Other identifiers used in health and social care-Value	Identifiers are a number or code associated with the type of identifier used in health and social care that is recorded in 3.3.1	Required	0 … *	Alpha-numeric	Multiple numbers or codes may be collected. One code should be recorded consisting of numbers or other characters or both numbers and other characters that uniquely identifies the person.

Section 1.4 Additional Demographic Details

Section	Description				
1.4 Additional Demographic Details	This section allows for the recording of additional identifying data elements that are associated with a person, when interacting with services and service providers. Data elements in this section include date of birth and nationality. This section includes categories of personal sensitive data that in some situations can assist in clinical decision-making and service planning. However, personal data revealing racial or ethnic origin for example, are categorised as special category data under the General Data Protection Regulation 2018. Consequently, explicit consent and strong legal justification are required to collect these data.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
1.4.1 Date of birth details (cluster)		Mandatory	1 … 1		
1.4.1.1 Date of birth	The date of birth of the person.	Mandatory	1 … 1	Date	It is preferred to use the following format: YEAR-MONTH-DAY (YYYY-MM-DD)[16] This should not be a text entry and the format MM-DD-YYYY should not be used.

1.4.1.2 Estimated age	If the person's date of birth is not known, an approximate age is provided.	Optional	0 … 1	Numeric	This data field should be recorded if date of birth is unknown or cannot be obtained. Estimated age should be entered in years for adults, and to the nearest three months (or less) for children aged less than two years.
1.4.2 Place of birth	Birthplace. If the person was born in Ireland, the county in which they were born. If the person was born outside of Ireland, the country in which they were born.	Required	0 … 1	Coded value	Examples of a county include; Galway, Roscommon. Examples of a country include Poland and China.
1.4.3 Sex	"Sex refers to the biological and physiological characteristics that define an individual to be either male or female." [CSO Data Standard for sex, 2024][(38)]	Mandatory	1 … 1	Coded value	The sex of the person assigned at birth. For example, male (M) or female (F) or unknown (U).
1.4.4 Gender (cluster)		Required	0 … 1		
1.4.4.1 Gender identity	"Gender is a social, psychological and cultural construct and it is developed in the process	Required	0 … 1	Coded value	Gender may refer to the gender of a person or the gender which a person expresses as the person's preferred gender or with which the person identifies and includes transgender

	of socialisation. Gender refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men and gender diverse people." [CSO Data Standard for Gender, 2024]) [39]				identities and a gender other than those of male and female. This includes individuals who see themselves as having no gender. The gender which a person identifies with may not match their sex recorded at birth. Coded values should include a value to capture 'other gender'. If 'other gender' is selected, 1.4.5 can be recorded.
1.4.4.2 Other Gender Identity	"Gender is a social, psychological and cultural construct and it is developed in the process of socialisation. Gender refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men and gender diverse people." (22)	Optional	0 … 1	Free text	If 'other gender' is selected in 1.4.4, the text provided by the person with choice of other gender can be recorded here.
1.4.5 Ethnicity	"Ethnicity is a measure of a close cultural connection, as opposed to 'race', nationality or citizenship. It involves sharing certain background	Optional	0 … *	Coded value	Multiple entries may be recorded. A person may identify with more than one ethnic background. Ethnicity may indicate higher risk profiles for some underlying clinical conditions. For example, sickle cell anaemia, galactosaemia.

	characteristics, such as a shared history, common ancestors, geographical origin, language, culture and religion. This provides people from an ethnic group with a distinct identity as seen by both themselves and others." (Executive 2024) [40,41]				
1.4.6 Preferred language	This is the language a person prefers to use to communicate.	Optional	0 … *	Coded value	Multiple entries may be recorded. An entry should represent a language spoken by and understood by the person. Record here if interpretive services are required to communicate with the patient.

Section 1.5 Communication Details

Section	**Description**				
1.5 Communication Details	This section identifies the contact details for the person. Contact details are the communication methods that can be used to communicate with the person. Examples of data elements in this section include mobile phone or email.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
1.5.1 Mobile Telephone Number	A unique combination of numbers used as input to a mobile phone for the	Required	0 … *	Numeric code. May include +symbol	A valid mobile phone number is provided in the following format: 08XXXXXXXX OR +3538XXXXXXXX OR 87XXXXXXXXX. For mobile phone numbers outside of Ireland, include the

	purpose of contacting the person.				country code using the format +XXX XXX XXX XXXX.
1.5.2 Email address	A unique combination of characters used as input to electronic telecommunication equipment for the purpose of emailing the person.	Required	0 … *	Alphanumeric character to include the @ symbol	A valid email address consists of an email prefix and an email domain separated by the @ symbol, for example MaryD@gmail.com
1.5.3 Other Communication details (cluster)		Optional	0 … *		
1.5.3.1 Communication details – Type	Other communication methods used by the person. For example landline telephone, pager, facsimile machine, messaging apps.	Optional	0 … *	Coded value	Indicates the type of communication method used by the person, other than a mobile phone and email.
1.5.3.2 Communication Details – Value	A unique combination of characters used as input to electronic telecommunication equipment for the purpose of contacting a person.	Optional	0 … *	Alpha-numeric	Where type of communication method is provided in 1.5.3.1, the corresponding value must be recorded here.
1.5.3.3 Preferred Communication Method	This indicates how the person would prefer to be contacted; by mobile/landline phone or email address, as	Required	0…1	Coded value	Select mobile or landline phone number or email address. Must be recorded if information is provided in 1.5.1, 1.5.2 or 1.5.3.

	described in 1.5.1, 1.5.2, and 1.5.3 above.				

Section 2. General Practitioner (GP) Details

Section	Description				
2 General Practitioner (GP) Details	This section provides name and contact details for the General Practitioner of the patient.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
2.1 GP Forename	The forename of the person's registered General Practitioner (GP). This is also referred to as the GP's given name or first name.	Required	0 … 1	Free text	The first name of the person's GP, as per the register of professional body- (e.g. Irish Medical Council)
2.2 GP Surname	The second part of the person's registered General Practitioner (GP) name which denotes their family or marital name. This is also referred to as family name or last name.	Required	0…1	Free text	The family or marital name of the person's GP as registered on the register of a professional body, for example the Irish Medical Council.

2.3 GP Practice Details (cluster)		Required	0 … 1		
2.3.1. GP Practice Name	The name of the person's GP practice.	Required	0 … *	Free text	This is the name of the practice and not the individual GP's name. The practice is typically made up of a group of doctors, nurses and staff who provide a primary care service.
2.3.2 GP Practice Address line(s)	This is an address field consisting of some but not all of; building complex subunit type abbreviation, building complex subunit number, address site name, house or property number, street name and type.	Required	0 … *	Free text	This field allows for collection of address information regarding building, house or apartment number and street. This can be more than one physical address line. It is any address information that goes before suburb/town/ townland/locality.
2.3.3 GP Practice Suburb/ Town/ Townland/ Locality	The full name of the locality describing the specific address of the GP practice.	Required	0 … *	Free text	This should identify where the GP practice is currently located. Intended to be used in conjunction with 5.2.3.2 Address line(s). For Dublin addresses only, the postal district number, for example Dublin 2 should be entered in this field and not the county field.
2.3.4 GP Practice District/ County	The full name of the county where the GP practice is located.	Required	0 … *	Coded Value	Intended to be used in conjunction with 5.2.3.2 Address line(s) and 5.2.3.3 Suburb/Town/Townland/

					Locality. For example, County Wexford or Lancashire (if outside of Ireland)
2.3.5 GP Practice Country	The full name of the country where the GP practice is located.	Required	0 … *	Coded Value	A code that specifies the country the GP practice is located in.
2.3.6 GP Practice Postcode	A code representing the address of the GP practice, for example Eircode in Ireland, Postcode in the United Kingdom or Zip Code in the USA.	Required	0 … *	Coded value	"Postcode" means a code consisting of numbers or other characters or both numbers and other characters that identifies the locality of an address and, where appropriate, the geographic location of an address.[19] An Eircode should be entered in this format XXX XXXX. For example, T12 Y2XT
2.4 GP communication details (cluster)		Required	0 … 1		
2.4.1 GP mobile phone number	A unique combination of numbers used as input to a mobile phone for the purpose of contacting the GP.	Required	0 … 1	Numeric and may include the + symbol	A valid mobile phone number is provided in the following format: 08XXXXXXX OR +3538XXXXXXX OR 87XXXXXXXX. For phone numbers outside of Ireland, include the country code using the format +XXX XXX XXX XXXX.
2.4.2 GP Landline phone number	A unique combination of numbers used as input to a landline telephone for	Required	0 … 1	Numeric and may include the + symbol	A valid landline telephone number is provided using the geographical area code first, followed by 5-7 digits in the following format: XX XXX XXXX OR +353XXXXXX OR 0XXXXXXX. For example, 01 XXX XXXX – Dublin area, 021 XXX

	the purpose of contacting the GP.				XXXX – Cork area. For landline telephone numbers outside of Ireland, include the country code using the format +XXX XXX XXX XXXX.
2.4.3 GP Email address	A unique combination of characters used as input to electronic telecommunication equipment for the purpose of emailing the GP.	Required	0 … 1	Alpha-numeric Character to include the @ symbol	A valid email address consists of an email prefix and an email domain separated by the @ symbol, for example MaryD@gmail.com

Section 3. Contact Person details

Section	**Description**				
3. Contact Person	This section identifies if a person has a contact person with whom a care provider can communicate, where appropriate to do so (such as an emergency contact, a legal guardian or a decision supporter). The details of this contact person are recorded for example, their name and communication contact details. It is important to update contact person details to ensure up-to-date information relating to the contact person is recorded at point of care. A person may have more than one contact person. As such, multiple contact person details may be recorded for this section. If a person has no contact person, this should be noted here.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
3.1 Forename of contact person	The contact person's legal identifying name. This is also referred to	Required	0 … 1	Free text	The first name of the contact person. This includes a double barrel name and this is a single record entry. For example, Mary.

	as given name or first name.				
3.2 Surname of contact person	The second part of the contact person's name which denotes their family or marital name. This is also referred to as family name or last name.	Required	0 … 1	Free text	This is the family or marital name of the contact person. For example, Daly.
3.3 Role of the contact person	Role of the contact person.	Required	0 … 1	Coded value	Indicates the role of the contact person. For example, legal guardian, nominated contact person, contact person in case of emergency, decision making assistant, enduring power of attorney.
3.4 Relationship	Relationship type with the person (for example, father, wife, daughter, neighbour, friend)	Required	0 … 1	Coded value	Indicates the relationship between the person and the named contact person. For example, father, wife, daughter, neighbour, friend, key support worker, service provider.
3.5 Communication details for contact person (cluster)		Required	0 … 1		

3.5.1 Mobile phone number of contact person	A unique combination of numbers used as input to a mobile phone for the purpose of contacting the named contact person.	Required	0 … 1	Numeric and may include the + symbol	A valid mobile phone number is provided in the following format: 08XXXXXXX OR +3538XXXXXXX OR 87XXXXXXXX. For phone numbers outside of Ireland, include the country code using the format +XXX XXX XXX XXXX.
3.5.2 Landline phone number of contact person	A unique combination of numbers used as input to a landline telephone for the purpose of contacting the named contact person.	Required	0 … 1	Numeric and may include the + symbol	A valid landline telephone number is provided using the geographical area code first, followed by 5-7 digits in the following format: XX XXX XXXX OR +353XXXXXXX OR 0XXXXXXX. For example, 01 XXX XXXX – Dublin area, 021 XXX XXXX – Cork area. For landline telephone numbers outside of Ireland, include the country code using the format +XXX XXX XXX XXXX.
3.5.3 Email address of contact person	A unique combination of characters used as input to electronic telecommunication equipment for the purpose of emailing a named contact person.	Required	0 … 1	Alpha-numeric Character to include @ symbol	A valid email address consists of an email prefix and an email domain separated by the @ symbol, for example MaryD@gmail.com

Section 4. Social Context

Section	Description				
4. Social Context	This section relates to the social setting in which the person lives, such as their household composition and other determinants of health.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
4.1 Living Situation	Describes conditions that affect the accessibility of the home or the stay in the home.	Required	0 … *	Free text	Conditions that affect the accessibility of the home or the stay in the home. Required if relevant to discharge, to describe household composition. For example, 'bed upstairs', 'can't walk upstairs', 'bathroom access', if patient is a carer or has a care need. Particularly relevant if baseline functionality has deteriorated during the hospital encounter.
4.2 Family Situation	This describes the patient's family situation and the form of cohabitation.	Required	0 … *	Free text	Record details of who lives with the patient, or what difficulties may arise from the patient's family situation. This may indicate if the patient has carer responsibilities in the home, or if the patient is living alone with no support.
4.3 Other Determinants of Health	This includes any life choices, which may affect the patient's health directly or indirectly.	Required	0 … *	Free text	Examples include tobacco, alcohol, drug use, social isolation.

Section 5. Legal Information

Section	Description				
5. Legal Information	This section relates to assisted decision-making and advanced healthcare directives relevant to the hospital encounter.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance Comments**
5.1 Assisted Decision-making (Record Entry)	A capacity assessment is carried out by a clinician to identify if a patient has capacity to make a specific decision at a specific time. The patient is assessed to identify whether they can understand information relevant to the decision, retain that information long enough to make a voluntary choice, weigh the information as part of the decision process, and communicate their decision in whatever way the patient communicates.	Required	0 … 1		Record whether a patient required assistance with decision-making during the hospital encounter. If this is not applicable to the particular patient, then "N/A" may be noted, and section not completed. An assessment of capacity during the period of admission should be recorded here if the outcome of the assessment is relevant to a specific decision about the person's treatment and care while an in-patient, or following discharge home. Record the reason for assessing capacity, the date of assessment and what decision-making support was arranged. Relevant national guidance and policy on assisted decision-making section should be followed. [18,36]
5.1.1 Date of Assisted Decision-	Record the date which decision-making	Required	0…1	Date	Complete in YYYY/MM/DD format.

making (Capacity Assessment)	(capacity) assessment was carried out.				
5.1.2 Reason for Assisted Decision-making (Capacity Assessment)	The reason for the capacity assessment to be carried out.	Required	0…1	Free text	Record the reason the assessment was required. For example, "patient did not appear to have good insight into the risks of returning home to live alone, with no support".
5.1.3 Type of Assisted Decision Support Agreed With Patient	Record the type of assisted decision-making support if this is required.	Required	0…1	Coded value	Types of decision-making assistance: • Decision-making assistant • Co-decision-making • Decision-making representative Power of attorney
5.2 Advanced Healthcare Directive (AHD) (Record Entry)	A record of an advance decision to accept or 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.	Required	0…1	Coded value/ Free text	**If AHD was recorded during the hospital stay, this section must be completed. If not, "No AHD" or "N/A" can be noted and the rest of section left blank.** An AHD must meet the requirements of the 2015 Act to be valid. It must be in writing, signed and witnessed. If the AHD includes the refusal of life-sustaining treatment, it must state specifically that the treatment is refused even if the person's life is at risk. If the AHD appoints a Designated Healthcare Representative (DHR), to make treatment decisions on the patient's behalf, this must be explicitly stated in the AHD. The DHR may then make treatment decisions on the patient's behalf within the terms of the AHD.[18]

5.2.1 Date and Time Advanced Healthcare Directive was completed	Date and time AHD was recorded.	Required	0…1	Date and time	Complete in YYYY/MM/DD and HH:MM format.
5.2.2 Type of Advanced Healthcare Directive	Type of AHD: Do not resuscitate, donor statement, refusal or request for life-saving treatment, appointment of designated healthcare representative.	Required	0…1	Coded text	Type of Advanced Healthcare Directive should be recorded. For example, DNR signed and witnessed. Copies of these documents must be sent to GP for records. GP may forward to other primary care professionals if relevant to their role.
5.2.3 Condition Relating to Advanced Healthcare Directive	The problem or disorder to which the Advanced Healthcare Directive applies.	Optional	0…*	Coded value /Free text	The problem or disorder to which the AHD applies.
5.2.4 Comments	Any further comments on advanced Healthcare Directive.	Optional	0…1	Free text	Any further comments about the Advanced Healthcare directive, which the GP should know about.

Section 6. Safeguarding Information

Section	Description				
6. Safeguarding Information	This section pertains to any matters relating to the welfare and protection of a child and the safeguarding of an adult at risk of abuse. If there is no risk, this should be stated, and this section should not be completed. If any concern exists, this section **must** be completed.[19,20,21] The clinician should be aware of the importance of confidentiality and the "need to know" principle when completing this section and sharing sensitive information.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
6.1 Safeguarding /Child Protection or Welfare Concerns	It should be recorded if there are safeguarding or child protection concerns.	Required	0 … *	Coded text	Document if any risks or concerns were identified by clinicians or healthcare professionals, if relevant to ongoing care after discharge. Any child protection or welfare concerns must be referred to Tusla or An Garda Síochána by the concerned clinician under legislation (mandated reporting). Any concerns for the safety of a vulnerable adult should be reported to the safeguarding and protection teams for their assessment.
6.2 Risks to Others	Risks to caring professionals or others.	Required	0… *	Free text	Must be reported to primary healthcare professionals if known risk to the safety of others. For example, violence, aggression, needles left on bed or floor after self-administration of non-prescribed drugs. Refer to HSE Policy and Guidance on Lone Working.[42]

6.3 Additional Information	Additional information which the Primary Healthcare professional needs to know about this issue.	Optional	0….*	Free text	Document actions taken during hospital encounter to address risk. For example, case referred to Tusla and or safeguarding team.

Section 7. Risks/Allergies/Adverse Events

Section	**Description**				
7. Risks/ Allergies/ Adverse Events	This section relates to clinical risks, allergies and or adverse events, which the patient has or is known to have, or developed during the hospital encounter, which may put the patient at risk, if exposure occurs again in the future. **Section 7.2 or Section 7.3 must be completed in every case.**				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
7.1 Clinical Risks	Document any clinical risks to the patient noted during the hospital encounter, which may continue into the post-discharge phase.	Required	0 … *	Free text	If relevant, record any clinical risks to the patient. For example, difficult intubation, falls or confusion episodes.
7.2 No Allergies/ Adverse Events Flag	Record if no allergies /adverse events known.	Required	0…1	Coded value	**If no known allergies, then this must be stated as NO KNOWN ALLERGIES**. Record if no known allergies or adverse events exist or occurred during hospital encounter. **Section 7.2 or 7.3 must be completed**
7.3 Allergies/ Adverse Events (Record Entry)	If an allergy occurred or was previously known, it must be recorded, and section completed.	Required	1 … 1		Must report to primary healthcare professional if allergy or adverse event occurred during the hospital encounter or existed previously.

7.3.1 Causative Agent	The name of the drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient.	Required	1 … *	Coded value/ Free text	List of causative agents. If no allergies or adverse reactions known, must document 'no known allergies'. This section may include food allergies, for example, peanut allergy.
7.3.2 Description of Reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient.	Optional	0 … 1	Coded value/Free text	Signs and symptoms of reaction experienced by the patient because of the reaction. For example, skin rash, swelling.
7.3.3 Date Recorded	The date that the reaction was clinically recorded/ asserted.	Required	0 … 1	Date	Complete in YYYY/MM/DD format. This will often equate to the date of onset of the reaction but this may not be wholly clear from source data.
7.3.4 Severity	A description of the severity of the reaction	Optional	0 … 1	Coded value/Free text	Severe, Moderate, Mild.
7.3.5 Certainty	A description of the certainty that the stated causative agent caused the allergic or adverse reaction.	Optional	0 … 1	Coded value/Free text	Description as to whether the adverse reaction was definitely caused by the named causative agent. For example, uncertain whether rash which developed after Nurofen administration was caused by medication or a viral rash?
7.3.6 Type of Reaction	The type of reaction experienced by the patient (allergic, intolerance).	Optional	0 … 1	Coded value/Free text	State whether this was an allergic response, or intolerance to a medicine, food product, or other allergen.
7.3.7 Evidence	Results of investigations that confirmed the certainty of the diagnosis.	Optional	0 … 1	Coded value/Free text	List of investigations and results demonstrating evidence of allergy. For example, skin-prick testing.

7.3.8 Date First Experienced	When the reaction was first experienced.	Optional	0 … 1	Date or Partial date or Free text	Date in YYYY/MM/DD format May be a date or partial date, for example, a given year. Or date may be recorded as free text, for example, during childhood.

Hospital Encounter Information

Section 8. Admission Details

Section	**Description**				
8. Admission Details	This section relates to details about the patient's admission to the hospital, including date, reason for admission, whether the patient was admitted electively, or as an emergency.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
8.1 Date and Time of Admission	Date and time patient admitted to the hospital.	Mandatory	1 … 1	Date and Time	Complete in YYYY/MM/DD and HH:MM format.
8.2 Reason for Admission	The health problems and issues experienced by the patient that prompted the decision to admit to hospital.	Mandatory	1 … 1	Coded value/Free text	Detail of the primary reason patient came to hospital for assessment/admission. For example, presented to emergency department with central chest pain.
8.3 Source of Admission	Where the patient was immediately prior to admission.	Required	0 … 1	Coded value/Free text	Detail of location of patient prior to admission. For example, admitted from home or transferred from another hospital or residential care.
8.4 Admission Urgency	Circumstances under which a patient was admitted to the hospital.	Required	0 … 1	Coded value	Detail of admission to hospital. For example, emergency, elective or transfer.

8.5 Referred by	This describes who made the decision to refer the patient to the hospital.	Required	0 … 1	Coded value/Free text	Complete if source of referral is known. For example, GP referral or self-referral or out-of-hours GP service.

Section 9. Discharge Details

Section	**Description**				
9. Discharge Details	This section describes details about the patient's discharge from the hospital, where, when and how they were discharged and the location to which they were discharged.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
9.1 Date and Time of Discharge	Actual date of discharge.	Mandatory	1 … 1	Date and Time	Complete in YYYY/MM/DD and HH:MM format.
9.2 Discharge Destination Address	The location to which the patient was discharged, if the patient was not discharged to the usual place of residence.	Required	0 … 1	Free text	Should only be completed if patient is not returning to normal place of residence after hospital discharge.
9.3 Discharge Type	Circumstances under which patient left the hospital.	Mandatory	1 … 1	Coded value/Free text	How the patient was discharged from the hospital, for example, with or against medical advice. This heading may be used to indicate that a patient was discharged on clinical advice or with clinical consent, or that a patient discharged him or herself against clinical advice or a carer or representative discharged the patient.
9.4 Discharging Consultant	The consultant responsible for the patient at time of discharge.	Mandatory	1 … 1	Free text	Name of consultant responsible for patient clinical care at time of discharge from hospital.

9.5 Discharging Specialty/ Department	The specialty or department responsible for the patient at the time of discharge.	Mandatory	1 … 1	Coded value/Free text	Specialty of the consultant whom the patient was under the care of at time of hospital discharge.
9.6 Discharged From (Location)	The ward or unit the patient resided in immediately prior to discharge.	Mandatory	1 … 1	Free text	Name of ward or unit where the patient resided prior to discharge. Important to document so primary healthcare professional can contact, if required.

Section 10. Section Synthesis/Narrative

Section	**Description**				
10. Narrative	This is a brief descriptive narrative, which may accompany the other sections in the group. It should "paint the picture" for the reader as to the patient's hospital journey. However, where appropriate and available, codes should be used.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
10.1 Narrative Text	A brief narrative of the section.	Optional	0 … 1	Free text	This section should include a brief narrative piece, which is relevant and appropriate to the section being described. The clinical narrative may include, for example, a brief record of the hospital stay, interpretation of findings and results, differential diagnosis and specific clinical decisions as a result, and specific actions taken during the hospital encounter.

Section 11. Patient History

Section	Description				
11. Patient History	This section includes current or past medical or family history, or travel history which may be related to the current hospital stay. This information is provided by the patient or carer at the time of admission, or comprises information obtained from referral letter, or from previous hospital records.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
11.1 Patient History	Narrative section of the patient's relevant health history.	0…*	Optional	Free text	This is information provided by the patient or carer about medical or health history relevant to this hospital encounter. For example, "Admitted with severe abdominal pain. Patient reported two previous admissions in 2024 with similar symptoms. Abdominal ultrasound (2025.05.15) showed multiple small gallstones. Treated conservatively at that time".
11.2 Patient Medical History	Medical history to date.	0…1	Required	Coded value/Free text	This is a list of conditions that the patient reported to have suffered in the past or still suffers. Medical history is not only a list of problems, but could contain broader description of the condition and its progress, details about treatment including medication and patient response to treatment. Past problem section should include only conditions that are important for continuity of care. This section, if provided, complements the diagnostic summary section of the discharge document.

11.3 Patient Family History	Family history of medical conditions as informed by patient/carer.	0…1	Optional	Free text	This is a list of conditions, which are known by the patient or carer to exist within the family. For example, family history of cystic fibrosis, galactasaemia, coeliac disease.
11.4 Epidemiological History (Record Entry)	This includes any travel history and infectious contacts the patient may have had prior to (and relevant to hospital admission).	0…1	Required		Relevant notes on travel and stay relating to potential exposure to infectious agent should be shared with the primary healthcare professional.
11.4.1 Country Visited	Name of the country visited.	1…1	Mandatory	Coded value/Free text	Country in which the person was potentially exposed to an infectious agent.
11.4.2 Time Period	Dates patient spent in the country visited.	0…1	Required	Alpha-numeric Code	Dates of visit to country must be entered if known, in YYYY/MM/DD format. If actual dates unknown, approximate time visited and date last there in days or weeks should be recorded. For example, "Returned from Malawi three weeks ago".
11.4.3 Infectious Agent	Suspected infectious agent(s) to which the patient was exposed.	0…*	Optional	Coded value/Free text	Any information about the suspected agent the patient may have been exposed to.
11.4.4 Proximity	Proximity of patient to infectious agent during exposure.	0…*	Optional	Coded value/Free text	Proximity to the source and or carrier of the infectious agent during exposure. Proximity could be expressed by text, code (direct, indirect) or value specifying distance from the infectious agent carrier.
11.4.5 Additional Information	Any additional information relating to infectious contact.	0…1	Optional	Free text	Any additional information identified about the infectious agent, symptoms, or treatment

					identified during the hospital stay should be forwarded to the GP for follow-up reference.

Section 12. Clinical Evaluation

Section	**Description**				
12. Clinical Evaluation	This section includes observations, vital signs and clinical findings, as carried out by medical team at admission and throughout the course of the hospital stay. It may include functional assessment at the time of the examination if completed.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
12.1 Date and Time	Date and time of clinical evaluation, if relevant to diagnosis or ongoing clinical care of the patient.	0…*	Required	Date and time	Complete in YYYY/MM/DD and HH:MM format.
12.2 Observations	Record what the clinician observed during the clinical evaluation. This should be recorded if relevant to the patient condition.	0…*	Optional	Coded value/Free text	This denotes what the healthcare professional observed during clinical evaluation. For example, "patient noted to be cold and clammy", "extremities oedematous", "central cyanosis noted".
12.3 Examination Findings	Record findings as identified by examining doctor.	0…*	Optional	Coded value/Free text	Record findings during clinical examination. For example, "poor capillary refill", "crepitations noted in both lungs on auscultation".
12.4 Vital Signs	These are clinical measurements taken at regular intervals during patient hospitalisation, depending on condition.	0…..*	Optional	Coded value/Free text	Vital signs may be recorded in discharge document, if relevant to ongoing patient care. Examples include but are not restricted to temperature, pulse, respirations, blood pressure, and oxygen saturation.

					For example, "patient oxygen saturation levels remain below 90% on room air".
12.5 Anthropometric Measurements	These are measurements which indicate physical properties of the body; including height, weight, head circumference, abdominal girth, body circumference.	0…*	Optional	Coded value/Free text	These should be recorded if relevant to the condition or post-discharge care of the patient. For example, the discharging doctor may record the patient's weight, or arm circumference if the patient was admitted for investigations of weight loss or eating disorders – to show baseline measurement, and improvement or deterioration of condition.

Section 13. Investigation/Results

Section	**Description**				
13. Investigation Results	This section identifies clinical investigations requested and or performed to confirm provisional diagnosis or clinical impression. It includes investigations carried out during the hospital encounter, which will be relevant to the ongoing clinical care of the patient after discharge back to the care of the primary healthcare professional. This will help to avoid duplication of investigations.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
13.1 Investigations (Record Entry)	Investigations and results which are carried out to inform provisional or primary diagnosis. Only investigations or results which are relevant to support diagnosis or to ongoing care should be	Required	0 … *		Discharging clinician is responsible for deciding which investigations and or results are to be included in the discharge document. Only investigation results relevant to the ongoing care of the patient on discharge should be included.

	recorded in discharge document.				
13.1.1 Investigation Requested	The requested investigation. The investigation may refer to an individual test or a group of related tests or broader investigation required.	Mandatory	1 … 1	Coded value/Free text	Detail of investigation requested, for example, bloods, radiology investigations. **One entry per investigation**, for example, full blood count, urea and electrolytes, CT scan of thorax.
13.1.2 Status	The status of the investigation requested.	Required	0 … 1	Coded value/Free text	Examples of value may include but are not limited to terms such as: "requested", "active", "suspended", "completed" or "cancelled".
13.1.3 Result	For each investigation, the date and result of the investigation (this includes the result value, with unit of observation and reference interval, if applicable).	Required	0 … 1	Coded value/Free text	If possible, this should include only results that are important or relevant to communicate to the GP or primary healthcare professionals involved in the ongoing patient care. Consequently, health results of investigations should include date of results, value units and references, where available. Discharging health professional may need to select the results. This will help to avoid duplication of investigations after discharge from hospital. Only one entry per result should be recorded.
13.1.4 Date of Result	Date the result of the investigation was issued.	Required	0 … 1	Date	Completed in YYYY/MM/DD format.

Section 14. Diagnosis

Section	Description				
14. Diagnosis	This section relates to principal diagnoses identified which resulted in the patient's hospital admission. Principal diagnosis is the main reason the patient was admitted to the hospital on this occasion, and must be documented in the hospital discharge document. Additional diagnoses or co-existing conditions relevant to this hospital encounter should also be documented, including any relevant co-morbidity that could have contributed to or be affected by the principal diagnosis. For example, hypertension in a patient admitted for stroke.				
Data Element	**Description**	**Cardinality**	**Conformance**	**Values**	**Guidance**
14.1 Diagnosis (Record Entry)	Diagnosis of condition for which patient was admitted, or previous diagnosis if relevant to the hospital encounter, or ongoing patient care following hospital discharge.	Required	0 … 1		Record primary or secondary diagnosis for the current hospital encounter, or previous diagnosis if relevant to ongoing clinical care following discharge. For example, a patient diagnosed with left stroke and past diagnosis of hypertension. Only one diagnosis per entry.
14.1.1 Diagnosis Name	Identification of the condition or diagnosis.	Mandatory	1 … 1	Coded value/Free text	Only one entry per diagnosis completed.
14.1.2 Date of Diagnosis	Estimated or actual date the diagnosis made.	Required	0 … 1	Date	Complete in YYYY/MM/DD format.
14.1.3 Severity	Assessment of the severity of the diagnosis, as evaluated by the healthcare practitioner.	Required	0 … 1	Coded value/Free text	Document the severity of the diagnosis. For example, comminuted fracture of left ulna, or simple non-displaced fracture of left ulna.
14.1.4 Anatomical location	Anatomical location relating to the diagnosis.	Required	0 … 1	Coded value/Free text	Document where in the body the diagnosis relates to, for example fractured left ulna. Anatomical location to be fully spelled. No abbreviations.

14.1.5 Status	The status of the diagnosis.	Required	0 … 1	Coded value/Free text	Value may include but not be confined to terms such as: "provisional", "confirmed" or "refuted".
14.1.6 Clinical Stage/Grade	TNM (Tumour, Node, Metastases) staging for cancer.	Required	0 … 1	Coded value/Free text	Tumour, Node, Metastases (TNM) is an attribute of diagnosis. Will assist GP in identifying patient prognosis.
14.1.7 Comments	Supporting free text may be included to provide additional clarity on diagnosis.	Required	0 … 1	Free text	Document any additional comments to support the diagnosis.

Section 15. Procedures/Operations/Treatment

Section	**Description**				
15. Procedures	This section relates to procedures, operations or treatments performed for definitive treatment, diagnostic or exploratory purposes. These may be radiological, physical or medication. This includes both psychological and medical therapies and procedures for example, cognitive behaviour therapy, or follow-up interventions resulting from physical health checks. The discharging clinician is responsible for recording all procedures carried out or requested during the hospital encounter, relevant to the ongoing clinical care of the patient after discharge from hospital.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
15.1 Procedures/ Operations/ Treatment (Record Entry)	Procedures and or operations and or treatments carried out during hospital encounter.	Required	1… *		If no procedure or treatment was carried out, this must be documented, and rest of section left blank. If procedure or operation or treatment was carried out, this section must be completed.
15.1.1 Procedure Name	Identification of the operation or procedure.	Required	0 … 1	Coded value/Free text	Name all operations or procedures or treatments carried out on the patient during the hospital encounter. Multiple single entries per procedure or treatment may be dated and documented.

15.1.2 Status	The status of the procedure requested.	Required	0 … 1	Coded value/Free text	Value may include "requested", "completed", "cancelled", "postponed".
15.1.3 Date	The date the procedure was performed.	Required	0 … 1	Date	Complete in YYYY/MM/DD format.
15.1.4 Anatomical Location	The site of the procedure.	Required	0 … 1	Coded value/Free text	The site on the body where the procedure was performed. For example, bilateral grommets inserted in ears.
15.1.5 Laterality	Laterality of the procedure.	Required	0 …1	Coded value/Free text	The side of the body where the procedure was carried out, if relevant. Full detail of side of the body should be included, for example, left dynamic hip screw implanted).
15.1.6 Complications Relating to Procedure/ Operation	Details of any intra-operative complications encountered during the procedure, arising during the patient's stay in the recovery unit or directly attributable to the procedure.	Required	0 … 1	Coded value/Free text	Document any complication encountered during the procedure or operation while the patient was an inpatient. For example, post-operative bleeding, wound dehiscence.
15.1.7 Additional Comments	Any further comments that clarify outcome or findings of a procedure or operation relevant to the patient's care.	Required	0 … 1	Free text	Any further comment to provide clarification about the procedure or operation. This comment may indicate outcome of the procedure. For example, "Gastroscopy identified small area of inflammation in fundus of stomach. Clo test sample taken", "Will require repeat procedure following treatment".

Section 16. Infection Control Status

Section	Description				
16. Infection Control Status	This section identifies any acquired or persisting infection, identified during the hospital encounter. It is important for the primary healthcare professional to be aware of the patient's infection status on discharge from hospital.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
16.1 Infection Control Status	This should detail information relating to the prevention, investigation, monitoring and treatment of infections.	Required	0 … *	Coded value/Free text	Document the presence of healthcare-associated infection such as MRSA, C-Difficile or other infections which occurred or have continued during the hospital encounter. For example, "wound swab identified MRSA 2025/04/23".
16.2 Management of Infection Identified	Document any management plan for infection identified	Required	0…*	Coded value/Free text	Document any treatment for ongoing infection required on discharge. For example, "pseudomonas infection continues in left leg wound, to continue on silver nitrate dressing daily and ciproflaxin p.o. for 10 days post discharge". "For repeat wound swab 4 weeks after discharge".

Section 17. Functional Status

Section	Description				
17. Functional Status	This section identifies the patient's level of functionality in relation to independent activities of daily living (IADLs). It is important for the primary healthcare professional to be informed whether the patient has the ability to manage independently after discharge from hospital, to identify if further home support is required.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**

17.1 Functional Assessment (Record Entry)	Patient's level of functionality in relation to independent activities of daily living (IADLs).	Required	0 … *		If a functional assessment is carried out, result must be reported and this section completed. Multiple functional assessments may be carried out on the same patient.
17.1.2 Date Functional Assessment carried out	Date the functional assessment was carried out.	Mandatory	1…1	Date	Completed in YYYY/MM/DD format.
17.1.1 Functional Assessment type	Functional assessment or clinical assessment scales used to assist diagnosis.	Mandatory	1 … 1	Coded value/Free text	Any assessment screening score must be documented if relevant to ongoing patient care. History of falls should be provided. Examples of functional assessment may include but are not to limited to: • Barthel Index for Activities of daily living • Waterlow Pressure Ulceration Risk Assessment, • Rockwood Frailty Scale, • Malnutrition Universal Screening Tool • Falls Risk Screening. Indicators of independence levels include but are not exclusive to "Independent", "Support required"; Assistance of 1, Assistance of 2, "Wheelchair bound", "Requires assistance with all ADLs".
17.1.2 Functional Assessment result	Outcome and or result of functional assessment undertaken.	Required	0 … *	Coded value/Free text	Detail of results of functional assessment, for example, "Waterlow score =15". "MUST score =2".

Section 18. Medication Details

Section	Description				
18. Medication Details	Primary care health professionals require timely and accurate information about the patient's medication during the hospital encounter, including the complete list of medications that the patient is prescribed on discharge, or changes made to medication, during the hospital encounter. If no prescription is completed, "NO medications prescribed" must be recorded. Vaccinations administered to the patient during the inpatient stay must be recorded in the medication section.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
18.1 Medication (Record Entry)	Any medications which were prescribed for the patient on discharge from hospital.	Mandatory	1…*		**If no medications/vaccinations are prescribed, then "No Medications Prescribed" must be entered**; the rest of the section left blank. Details of and instructions for medications sections completed, only when relevant. Only one entry per medication. If a prescription is completed for the patient on discharge from hospital, optionality and or conformance must be adhered to.
18.1.1 Medication Name	Medications prescribed for patient. May be generic name or brand name as appropriate: for example "Citalopram", "Trimethoprim".	Required	0 … *	Coded value/Free text	Name of medication prescribed for patient, or vaccination if given to the patient during the hospital encounter. Only one entry per medication. However, multiple medication entries permitted.
18.1.2 Start Date/Time	The date and or time that the medication course should begin.	Required	0 … 1	Date and time	Complete in YYYY/MM/DD and HH:MM format.

18.1.3 Form	Form of the medicinal substance, for example, capsules, tablets, liquid.	Required	0 … 1	Coded value/Free text	Form of medication prescribed - tablets, injection or liquid. Required if a specific form has been prescribed, for example, "Modified Release Capsules" or suspension.
18.1.4 Route	Medication administration description (oral, IM, IV, etc.)	Required	0 … 1	Coded value/Free text	Whether medication is to be administered by intramuscular, subcutaneous, intravenous injection, orally, or instillation (drops). May include method of administration, for example, by infusion, nebuliser, NG tube.
18.1.5 Site	The anatomical site at which the medication is to be administered. Comment, for example, "left eye".	Required	0 … 1	Coded value/Free text	This is to identify the site of medication administration. For example, '2 drops to be instilled into LEFT eye three times daily'. Anatomical site must be fully spelled.
18.1.6 Dose	A plain free text description of medication single dose amount, for example, "30 mg" or "2 tabs".	Required	0 … 1	Coded value/Free text	Dose of medication prescribed, for example, paracetamol 1 gram or paracetamol 500mg X 2 tablets.
18.1.7 Frequency	A plain free text description of medication dose frequency, for example, "twice a day", "at 8am, 2pm and 10pm".	Required	0… 1	Coded value/Free text	State specific times if required, for example, '8am and 6pm' or 'three times daily' if evenly spaced through the day, and medication is to be taken three times a day.
18.1.8 Duration	Record the time period for which the medication should be continued, including direction not to discontinue.	Required	0 … 1	Coded value/Free text	For example, to continue on medication for 14 days from discharge, prescribed analgesia three times daily, for 5 days only.

18.1.9 Additional Instructions	Additional administration instructions as plain free text. This may include guidance to the prescriber, patient or person administering the medication.	Required	0… *	Coded value/Free text	Any further instructions to be given relating to the medication, for example, "Warfarin levels to be repeated weekly and doses altered according to INR results". In some settings, specific administration instructions may be re-labelled as "patient advice" or "dispensing instruction" to capture the nature of the instruction. For example, "omit morning dose on day of procedure", "for pain or fever", "dispense weekly".
18.1.10 End Date/Time	The date and or time that the medication course should finish.	Required	0…1	Date and time	Complete in YYYY/MM/DD format and HH:MM format.
18.1.11 Indication	Reason for medication being prescribed, where known.	Required	0…1	Coded value/Free text	Reason for medication if prescribed during the hospital encounter.
18.2 Medication Changes/ Discontinuation (Record Entry)	Any changes or discontinuation to existing prescription must be recorded in the discharge document.	Required	0…1		Document if there is a change and or discontinuation of medication and reason for same recorded.
18.2.1 Name of Discontinued /Changed Medication	The name of the medication being discontinued and or changed.	Required	0 … 1	Coded value/Free text	Document any medication, which was stopped, for example, Amoxicillin stopped. Cefotaxime commenced 2025/04/24. 1 dose of hydrocortisone 10mg IV given for rash.
18.2.2 Nature of a Change to the Medication	Where a change is made to the medication, such as one drug stopped and another	Required	0 … *	Coded value/Free text	Changes in medication list, for example, patient's dose increased, decreased, changed from one

	started (for example, dose, frequency or route is changed).				medication to another – such as amoxicillin changed to Cefotaxime.
18.2.3 Reason for Change /Discontinuation of Medication	Reason for change and or discontinuation of medication, for example sub-therapeutic dose, patient intolerant.	Required	0 … 1	Coded value/Free text	Rationale for changing and or discontinuing medication, for example, patient developed severe rash to amoxicillin. Same stopped 2025/04/24. Commenced on Erythromycin p.o.
18.2.4 Date of Latest Change/ Discontinuation of Medication	The date of the medication changed and or discontinuation.	Required	0 … 1	Date and time	Complete in YYYY/MM/DD format and HH:MM format.
18.2.5 Additional Comments	Any additional comment about the medication change and or discontinuation.	Optional	0 … *	Free text	Any further instructions to be given relating to the medication, for example, Warfarin levels to be repeated weekly and doses amended, according to INR results.
18.3 Aids to Compliance (Record Entry)	Describe any aids to compliance.	Optional	0 … *	Free text	Good indicator of patient compliance and functional ability. For example, requires support with medications, easy open containers, medication chart, and medication support via carer, medication blister packs or aids.

Section 19. Medical Devices /Implants

Section	Description
19. Medical Devices/ Implants	Implants and medical devices used that affected or may affect the provision of health services (diagnosis and treatment). In addition, medical devices explanted, or if use of device(s) was stopped during hospitalisation.

Data Element	Description	Conformance	Cardinality	Values	Guidance
19.1 Implants or Devices (Record Entry)	Record if medical device or implants were implanted or explanted.	Required	0…1		Describes the patient's implanted and external medical devices and equipment, upon which their health status depends. Includes devices such as cardiac pacemakers, implantable defibrillator, prosthesis, ferromagnetic bone implants, and so on, of which the HP needs to be aware.
19.1.1 Device	Details of the device used: name, type, make, model of implant or device, manufacturer of device, serial number of device.	Required	0 … 1	Coded value/Free text	Must report to primary healthcare professional if an implant or medical device was implemented during the hospital encounter. **If not, this must be stated as "No Devices/ Implants. If yes, conformance must be adhered to**.
19.1.2 Implant/ Device Commencement Date	Implant or device date commenced.	Required	0…*	Date	Complete in YYYY/MM/DD format.
19.1.3 Date of Device/ Implant Discontinuation	Date when the implant was explanted or device discontinued.	Required	0…1	Date	Complete in YYYY/MM/DD format.
19.1.4 Body Site	Anatomical location of the device. May include laterality.	Required	0…1	Coded value/Free text	Location on the body where device/implant is situated. For example, "Libre glucose monitor positioned on left lateral deltoid area. To be changed every 14 days. Areas to be alternated".
19.1.5 Reason for Device/Implant	The reason the device was commenced or implant inserted.	Required	0…1	Code value/Free text	The reason the device implant was commenced or ceased. For example, "Negative pressure wound therapy pump discontinued after 3 weeks, on 2025.07.17, as wound healed to subcuticular

Insertion or Removal					level. Continues on alternate day dressings. Healing by secondary intention".
19.1.6 Additional Comments	Additional comments relating to the device or implant in- situ.	Reason	0…1	Free text	For example, "Dexcom glucose monitor inserted to right upper deltoid area. Patient educated how to reposition to alternating sites every fortnight".

Section 20. Future Management and or Care Plan

Section	**Description**				
20. Actions for Healthcare Providers	This section includes follow-up care of the patient after discharge from hospital. It also includes actions which the hospital plans to undertake, actions for the primary healthcare professionals, along with actions and advice discussed and agreed with the patient and or their carer.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
20.1 Hospital Actions	Record if there are actions for the hospital following the patient's discharge. The discharging professional should state these actions have been discussed with, understood and agreed by the patient and or carer.	Required	0…1	Free text	This should include any outstanding tests, appointments or investigations, which will require the patient to return to the hospital setting after discharge. For example, "Patient to return for outpatient MRI of chest and abdomen- appointment date to be sent out to patient".
20.2 GP Actions	Actions that are requested of the general practitioner, including any advice, recommendations or actions	Required	0…1	Free text	If there are future management actions to be followed up by GP, actions should be listed. For example, repeat blood tests, 24-hour blood

	that were requested by the acute hospital setting. Discharging professional should state actions have been discussed with, understood and agreed with patient and or carer.				pressure monitoring, smoking cessation programme.
20.3 Actions for Others, Including Nursing and or Health and Social Care Professionals	Actions that are requested of health and social care professionals and nursing teams, by the acute hospital setting. Discharging professional should state actions have been discussed with, understood and agreed with patient and or carer.	Required	0… *	Free text	Actions for which others, including nursing and or health and social care professionals will be responsible for after the patient has been discharged, including planned investigations, procedures and treatment for a patient's identified conditions and priorities. For example, daily dressings, occupational therapy review, or community physiotherapy. Discharging clinician must identify that the plan of care on discharge has been understood by and agreed with patient or carer.
20.4 Education, Advice and Recommendations for Patient	Include any education, advice, recommendations or actions requested by healthcare professionals that the patient has been advised to undertake.	Required	0 … *	Free text	Document any advice, recommendations or actions requested by another healthcare professional during the hospital encounter, or health promotion activities the patient has been advised to undertake. For example, patient seen by respiratory team 2025/04/24. Patient advised to engage with smoking cessation programme.

20.5 Patient and or Carer Concerns, Expectations and Wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Where the person lacks capacity, this may include their representative's concerns, expectations or wishes.	Required	0 … *	Free text	Especially useful in the case of complex case discharges. Record who has expressed these (patient or carer or representative on behalf of the patient). Document if any family or patient representative identified relevant concerns and patient needs, so that supports can be put in place for patient discharge. For example, "patient expressed wish to return home, however family stated they cannot stay with their mother 24/7 and she is at high risk of falls".

Document Information

Section 21. Person Completing Hospital Discharge Document

Section	**Description**				
21. Person Completing Hospital Discharge Document	This section identifies the name, role and professional identification of the person completing the discharge document. This is the person who the recipient of the document will contact should there be any queries regarding the patient clinical care and plan following discharge.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
21.1 Full Name	The title, forename and surname of the person completing the document,	Mandatory	1 … 1	Free text	Full name of professional completing the discharge document in the form Title, First name, Surname. For example, Dr Michael Murphy.

	preferably in a structured format.				
21.2 Grade/Role/ Job Title	Job title or grade or role of the person completing the discharge document.	Mandatory	1 … 1	Free text	Role of person completing the discharge document. For example senior house officer, advanced nurse practitioner.
21.3 Professional Body Registration Number	Professional registration number of the person completing the discharge document.	Required	0 … 1	Alpha-numeric	Name must be the same name as registered with professional body number, such as IMC or NMBI and so on. For example, Dr Mary Brown Medical Council Number: 123456.
21.4 Organisation Name	The organisation by which the person completing the discharge document is employed.	Mandatory	1 … 1	Free text	Name of the organisation where the professional completing the discharge document is employed. For example, St. James's Hospital, Dublin 8.
21.5 Contact Telephone Number	Provides the number to contact the person completing the discharge document. For example, +353 86 6234541 or 021-45612.	Required	0 … 1	Numeric	A unique combination of numbers used as input to a landline phone or mobile phone for contacting the person completing the discharge document. Detail is important for follow-on questions, which the primary healthcare professional may have on receipt of the document.
21.6 Contact Email Address	Provides the email address to contact the person completing the discharge document.	Required	0 … 1	Alpha-numeric	A unique combination of characters used as input to electronic telecommunication equipment for emailing the person completing the discharge document. Contact details are important for follow-on questions, which the primary healthcare professional may have on receipt of the document.

21.7 Signature	Signature of person completing the discharge document.	Mandatory	1 … 1	Free text	Electronic discharge identifies date, time and data input author. Digital signature to be provided if document completed digitally.
21.8 Date and Time of Completion of Discharge Document	Date and time discharge document was completed.	Mandatory	1 … 1	Date and time	Complete in YYYY/MM/DD and HH:MM format.

Section 22. Hospital Discharge Document Sign-Off

Section	**Description**				
22. Discharge Document Sign-Off	If completed discharge document requires additional sign off, this should be recorded.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
22.1 Person's Full Name	The title, forename and surname of the person signing off the discharge document.	Required	0 … 1	Free text	If the person completing the discharge document is also responsible for the clinical care of the patient, this should be noted and rest of section left blank. Full name of professional signing off the discharge document in the form: Title, First name, Surname. For example, Dr Michael Murphy or Mr John Brown.

22.2 Grade/Role/Job title	Job title or grade or role of the person signing off the discharge document.	Required	0 … 1	Free text	Role of person signing off the discharge document. For example, consultant colorectal surgeon, senior house officer, registrar, advanced nurse practitioner, diabetes nurse specialist.
22.3 Professional Body Registration Number	Professional registration number of the person signing the discharge document. For example, Irish medical Council registration number or NMBI registration number.	Required	0 … 1	Numeric code	Name must be the same name as registered with professional body number such as IMC or NMBI and so on. For example, Dr Mary Brown, Medical Council Number: 123456.
22.4 Organisation name	The organisation by which the person signing off the discharge document is employed.	Mandatory	1 … 1	Free text	Name of the organisation where the professional signing off the discharge document is employed. For example, St. James's Hospital, Dublin 8.
22.5 Contact Details	Contact details of the person signing off the discharge document. For example, a phone number or email address.	Mandatory	1 … *	Free text	Contact details of the person signing off the discharge document are important for follow-on questions, which the primary healthcare professional may need to ask on reading of the document.
22.6 Signature	Signature of person signing off the discharge document.	Mandatory	1 … 1	Free text	Electronic discharge identifies date, time and data input author. Digital signature to be provided if document completed digitally.

Section 23. Distribution List

Section	Description				
23. Distribution List	The section identifies who will receive a copy of the hospital discharge document, and their role in the patient's ongoing clinical care.				
Data Element	**Description**	**Conformance**	**Cardinality**	**Values**	**Guidance**
23.1 Full Name	If the document is being sent to a named individual, this is the name of the recipient, preferably in a structured format, including title, first name, and surname.	Required	0 … 1	Free text	Name should be legal name, including title, first name, and surname.
23.2 Role	If the document is being sent either to a named individual, or to a non-named person with a specific role, then this is the role of the recipient. For example, GP or Referring doctor.	Required	0… 1	Free text	Name of primary healthcare professional role. For example, general practitioner, referring doctor, public health nurse.
23.3 Organisation Name	The name of the organisation the recipient is representing or the organisation named as the receiving organisation.	Required	0… 1	Free text	Name of practice where primary healthcare professional is employed. For example, Hillview Medical Centre, Celbridge, Co. Kildare.

Appendix 1
National Health Information Standards to date

2013
- National Standard for Patient Discharge Summary Information
- National Standard for a Demographic Dataset and Guidance

2015
- Data model for an electronic medicinal product reference catalogue – a National Standard.
- ePrescription dataset and clinical document architecture standard

2016
- National Standard for a Demographic Dataset and Guidance for Use in Health and social care settings in Ireland
- National standard diagnosis dataset and clinical document architecture (CDA) template
- National standard adverse reaction dataset and clinical document architecture (CDA) template

2017
- National Standard for a Procedure Dataset including a Clinical Document Architecture specification
- National Standard for a Dispensing Note including a Clinical Document Architecture specification
- General Practice Messaging Standard

2018
- National Standard on information requirements for national community-based ePrescribing

2019
- National Standard on information requirements for a national electronic patient summary

2024
- National Standards for Information Management in Health and Social Care

Appendix 2
Standards Working Group Membership

Name	Role	Organisation
Anne Coleman	Head of Quality Risk and Accreditation at Blackrock Health Hermitage Clinic	Private Hospitals Association
David Hanlon	National Clinical Advisor for Primary Care	HSE
David McConaghy	General Practitioner	Irish College of General Practitioners
Don Forde	Quality Management Support and Assurance Division	Central Statistics Office (CSO)
Eamonn Coyne	eHealth and Health Information Systems Unit	Department of Health
Fionnuala Donohue	National Director of Public Health Medicine, Health Intelligence	Health Service Executive (HSE)
Helen Conroy	Health Information Policy Unit	Department of Health
Karen Wynne	Technical Integration Manager, Chief Technology Transformation Office (CTTO)	HSE
Katey Tolan	Policy and Researcher Manager in Standards and Quality Assurance Division	Mental Health Commission
Linda Hendy	Standards Development Manager	National Standards Authority of Ireland (NSAI)
Loretto Grogan	National Chief Nursing and Midwifery Information Officer	HSE
Mandy Daly	Service User Representative	IPPOSI
Mark Conroy	Data and Analytics (ICT Data Manager)	Tusla
Neil O'Hare	Chief Information Officer	Children's Health Ireland, HSE
Niall Halliday	Chief HSCP Information Officer	HSE

Sandra Lawler	Health Identifier Management Services, CTTO	HSE
Theresa Barry	Clinical Terminology Architecture Lead, CTTO	HSE
Tiberius Pereira	Service User Representative	Patients for Patient Safety
Vincent Jordan	Technology and Transformation Director	HSE

Project Team, HIQA

Deirdre Connolly Linda Weir	Acting Deputy Director of Health Information Standards, HIQA (October 2024 to June 2025) Deputy Director of Health Information Standards, HIQA (June 2025 – present)
Ruth Benson	Programme Manager, HIQA
Edel Cahalin	Senior Business Analyst, HIQA
Nora Donnelly	Senior Business Analyst, HIQA (October 2024 to June 2025)
Shane Kelly	Health Systems Engineer, HIQA (June 2025 to present)
Julia Johansson	Research Officer, HIQA (October 2024 to March 2025)
Ailbhe O'Rourke	Research Officer, HIQA (March 2025 to present)

Appendix 3

Use Case 1: Simple Case (John)

This use case scenario illustrates how the Draft National Standard for Hospital Discharge Information can map to a "live-case scenario". In this simple clinical scenario, an overview of the clinical case is provided. Mapping to the sections in the draft standard is completed, to demonstrate what a hospital discharge document in semi-structure and discharge letter format might look like. The first table sets out which sections in the standard require completion in this case, and a second more detailed table identifies which sub-sections and elements within the datasets are required.

Scenario: A Case of Acute Appendicitis in a Young Adult

John, a 28-year-old male presented to the emergency department with a 12-hour history of abdominal pain. The pain began as a diffuse central discomfort and progressively moved to the right lower quadrant (RLQ). Associated symptoms included loss of appetite, nausea, and a single episode of vomiting.

On examination, his temperature was normal, heart rate was raised (HR 98 bpm). Abdominal examination revealed localised tenderness in the RLQ with guarding and rebound tenderness at McBurney's point. Rovsing's and psoas signs were positive. Bowel sounds were present but reduced.

Initial blood tests showed raised while cell count (WBC 13.5 x 10^9/L, neutrophils 85%) and elevated C-reactive protein (CRP 48 mg/L). Kidney and liver function tests were within normal limits. No abnormalities were found on analysis of his urine.

An abdominal ultrasound was undertaken. The appendix appeared enlarged and inflamed. It measured 8mm in diameter and did not compress with pressure. There is some surrounding tissue swelling, which suggests inflammation.

John was admitted under the general surgery team and commenced on intravenous fluids and antibiotics (cefuroxime and metronidazole). He underwent a laparoscopic appendicectomy later that evening. Findings during surgery confirmed an inflamed, non-perforated appendix. There was no evidence of abscess or peritonitis. The procedure was completed without complications.

Post-operatively, the patient recovered well. John was mobile within 12 hours, tolerated oral intake by the following morning, and he experienced minimal pain managed with oral analgesia. He was discharged home on post-operative day one with instructions for wound care, analgesia, and outpatient follow-up.

Histopathological examination confirmed acute appendicitis. No malignancy or perforation was identified.

Table 2. Sections in Standard requiring completion: John's use case (simple)

Sections in standard to be completed	Include
Patient Information	
Patient Demographics	✓
GP Details	✓
Personal Contacts	
Social Context	
Legal Information	
Safeguarding	
Clinical Risk/Allergies/Adverse Events	✓
Hospital Encounter	
Admission Details	✓
Discharge Details	✓
Narrative	
Patient History	✓
Clinical Evaluation	✓
Investigations/Results	✓
Diagnosis	✓
Procedures/Treatments	✓
Infection Control Status	
Functional Status	✓
Medication Details	✓
Medical Devices/ Implants	
Future Management /Care Plan	✓

Discharge Document data	
Person Completing Discharge	✓
Discharge Document Sign-Off	✓
Distribution List	

Hospital Discharge Information – Semi structured (Generated)

Patient Demographics

- **Name:** John O'Connor
- **Age:** 28
- **Sex:** Male
- **Address:** 27 Main Street, Chapelizod, Dublin 7, D07CL23
- **PPSN:** 4G7637832
- **DOB:** 1997/10/10

GP Details

- **GP Name:** Maria O'Brien
- **Practice Address:** Infirmary Road Practice, 12 Old Infirmary Road, Inchichore, Dublin 7, D01 D007

Admission Details

- **Date of Admission:** 2025/06/06
- **Reason for Admission:** Suspected acute appendicitis
- **Referring Source:** Self-presented to Emergency Department

Discharge Details

- **Date of Discharge:** 2025/06/08
- **Discharge Destination:** Home
- **Mode of Discharge:** Ambulatory, self-care

Patient History

- Complained of pain in central abdomen which moved to right lower abdomen which commenced the previous evening. Felt nauseous, no appetite, vomited once.

Clinical Risks/Allergies/Alerts

- No known drug allergies

Clinical Evaluation

- **Examination Findings:** RLQ tenderness, guarding, rebound tenderness, positive Rovsing's and psoas signs
- **Vitals:** T 38.2°C, HR 98 bpm, BP 124/78 mmHg, RR 18, SpO_2 98% RA

Investigations/Results

- **Bloods:** WBC 13.5 x 10^9/L, CRP 48 mg/L
- **Imaging:** Ultrasound confirmed acute appendicitis

Procedure/Treatments

- **Management:** IV fluids, IV antibiotics (cefuroxime + metronidazole), laparoscopic appendicectomy
- **Intraoperative findings:** Inflamed, non-perforated appendix
- **Histology:** Acute suppurative appendicitis

Diagnosis

- Acute suppurative appendicitis

Functional Status

- Post-op: Mobilised within 12 hours, tolerated oral intake, no complications
- Stable post-operatively
- No signs of infection or complications
- Independent in all activities of daily living
- Mobilising without assistance
- Discharged in good condition

Medication Details

- IV cefuroxime
- IV metronidazole
- Paracetamol
- Ibuprofen

Medications on Discharge

- Paracetamol 1g PO QID PRN

- Ibuprofen 400 mg PO TID PRN with food
- Oral antibiotics

Future Management / Care Plan

Hospital Actions

- Follow-up in surgical outpatient clinic in 7–10 days

GP Actions

- Review wound site if concerns arise
- Reinforce post-operative care advice
- Monitor for any delayed complications

Patient Advice and Recommendations

- Take medications as prescribed
- Maintain hydration and light diet
- Avoid heavy lifting or strenuous activity
- Seek medical attention if fever, increasing pain, or wound issues occur

Person Completing Discharge Document

- 2025.06.10
- Dr Grainne Smith,
- Consultant GI Surgeon, Southern University Hospital, Dublin 8.
- Medical council registration number: 17854
- 01 – 8175643
- surgeryGI-SUHospital@hse.ie

Hospital Discharge Information – Narrative (Letter format)

To: Dr Maria O'Brien, Infirmary Road Practice, 12 Old Infirmary Road, Inchichore, Dublin 7, D01 D007 *[GP Details]*
Re: John O'Connor; Address: 27 Main Street, Chapelizod, Dublin 7, D07CL23; DOB:1997/10/10; PPSN: 4G7637832 *[Patient Demographics]*
Date: 2025/06/08 *[Discharge document Data]*

Dear Dr O'Brien,

John was admitted on June 6th *[Admission Details]* with a 12-hour history of abdominal pain migrating to the right lower quadrant, associated with nausea and loss of appetite. *[Patient History]*

On examination, his temperature was raised (38.2°C). Examination on his abdomen revealed localised tenderness, guarding, and positive Rovsing's and psoas signs. *[Clinical Evaluation]*

Blood tests showed a raised white cell count of WBC 13.5 x 10^9/L and raised C - reactive protein at 48 mg/L. Ultrasound confirmed an inflamed appendix measuring 8 mm, with surrounding fat stranding confirming inflamed appendix. *[Investigation Results]*

John, who had no known allergies *[Clinical Risk/Allergies/Adverse Events]*, was treated with IV fluids and antibiotics (cefuroxime and metronidazole) *[Medication Details]* and underwent an uncomplicated laparoscopic appendicectomy *[Procedure]*. Intraoperative findings confirmed an inflamed, non-perforated appendix. *[Diagnosis]*

Following surgery, John was mobilised and tolerated oral intake within 24 hours *[Functional Status*] and was discharged on June 8th. *[Discharge Details]*

Histology confirmed acute suppurative appendicitis. *[Investigation/Results][Diagnosis]*.

He was discharged to home *[Discharge Details]* on paracetamol and ibuprofen *[Medication on Discharge].*

Follow-up appointment arranged in the surgical clinic on June 18th @ 3.30 pm. Wound care advice was given and John was advised to avoid strenuous activity for two weeks. *[Future Management/Care Plan]*

Kind regards,

Dr Grainne Smith, Consultant GI Surgeon, Southern University Hospital.
Medical council registration number: 17854
Phone: 01 – 8175643
Email: surgeryGI-SUHospital@hse.ie *[Person completing Discharge document], [Organisation name], [Discharge Document Sign Off]*

Table 3. Subsections/elements in standard requiring completion: John's use case (simple)

Subsections/elements to be completed.	Include
Patient Information	
1. Patient Demographics	
Title	✓
Forename	✓
Surname	✓
Preferred name	
Address	✓
Health Identifier: PPS/IHI	✓
Date of Birth	✓
Sex	✓
Gender	✓
Nationality	✓
Ethnicity	
Date of Death	
Communication Details	✓
2. GP details	
Name	✓
Practice Details	✓
3. Personal Contacts	
Name	
Role	
Relationship	
Contact Details	
4. Social Context	

Living Situation	
Family Situation	
Other Determinants of Health	
5. Legal Information	
Assisted Decision-making	
Advanced Healthcare Directive	
6. Safeguarding	
7. Clinical Risk/Allergies/Adverse Events	
Clinical Risks	
Allergies/Adverse Events	✓
Hospital Encounter Information	
8. Admission Details	
Date/Time	✓
Reason	✓
Source	✓
Urgency	✓
Referred by	✓
9. Discharge Details	
Date/Time	✓
Discharge Destination Address	✓
Discharge Type	✓
Discharging Consultant	✓
Discharging Specialty/Dept.	✓
Discharged from: Ward/Unit Name	✓
10. Narrative	
11. Patient History	

Patient History	
Past Medical History	
Family History	
Epidemiological History	
12. Clinical Evaluation	
Date/Time of evaluation	✓
Observations	
Examination Findings	✓
Vital Signs	✓
Anthropometric Measurements	
13. Investigations/Results	
Investigation Requested	✓
Date of Result	✓
Result	✓
Status	
14. Diagnosis	
Diagnosis Name	✓
Date of Diagnosis	✓
Severity	✓
Anatomical Location	✓
Status	✓
Clinical Stage/Grade	✓
Additional Comments	
15. Procedures/Treatments	
Name	✓
Date	✓

Status	✓
Anatomical location	✓
Laterality	✓
Complications Relating to Procedure/Treatment	✓
Additional Comments	
16. Infection Control Status	
Presence of Identified Infection	
Management of Identified Infection	
17. Functional status	
Date of Assessment	
Type of functional Assessment	
Result	
18. Medication Details	
Medication Name	✓
Start Date	✓
Form	✓
Route	✓
Site	✓
Dose	✓
Frequency	✓
Duration	✓
Additional Instructions	
Medication End Date/Time	✓
Date of Changes/Discontinuation of Medication	
Indication	
Medication Name Changes/Discontinuation	

Nature of Change	
Reason for Medication Change/Discontinuation	
Additional Comments	
Aids to Compliance	
19. Medical Devices/Implants	
Device/Implant Details	
Commencement Date	
Discontinuation/Explanation of Device/Implant	
Body Site	
Reason for Device/Implant Insertion or Removal	
Additional Comments	
20. Future Management/Care plan	
Hospital Actions	
GP Actions	✓
Actions for Others (Nursing /HSCPs)	
Education, Advice and Recommendations for Patient	✓
Patient/Carer Concerns, Expectations and Wishes	
Document Information	
21. Person Completing Discharge Document	
Full Name	✓
Grade/Role/Job Title	✓
Professional Body Registration Number	✓
Organisation Where the Professional Completing is Employed	✓
Contact Details	✓
Signature	✓
Date and Time of Completion of Discharge Document	✓
22. Discharge Document Sign-Off	

Full Name	✓
Grade/Role/Job Title	✓
Professional Body Registration Number	✓
Organisation Name	✓
Contact Details	✓
Signature	✓
23. Distribution List	
Full Name	
Role of Recipients	
Organisation Name	

Appendix 4
Use-Case 2: Complex Case (Peggy)

This use case scenario illustrates how the Draft National Standard for Hospital Discharge Information can map to a "live–case scenario". In this complex clinical scenario, an overview of the clinical case is provided. Mapping to the sections in the draft standard is completed, to demonstrate what a hospital discharge document in semi-structure and discharge letter format might look like. The first table sets out which sections in the standard require completion in this case. A second more detailed table, identifies which sub-sections and elements within the datasets are required.

Scenario 2: Case of Complex Hospital Discharge

Peggy, an 80-year-old female, presented to the emergency department via ambulance on 2025/05/10, following a collapse at home. On admission, Peggy was awake and alert, but weak, with breathlessness on speech. She complained of nausea and pain in lower right leg.

On examination, temperature was 37.8 degrees centigrade, heart rate raised (HR102/min). Respirations: 18/min. Blood pressure was low at 135/78. Oxygen saturation 86% on 2L/O_2/min. Examination revealed bilateral lower lobe crepitations, and both legs noted to be very oedematous, with pitting oedema present to knee area. Upper arms were also oedematous, but central cyanosis not present. Leg ulcer present in lower right leg. Red, hot and offensive odour, with simple dressing adhered to wound.

Initial blood tests showed raised while cell count (WBC 17x10^9/L, neutrophils 85%) and elevated C-reactive protein (CRP 35 mg/L). Haemoglobin B was low at 8.8 g/dL. CXR showed bilateral lower lobe infiltrates, with pulmonary oedema and cardiomegaly. Wound swab showed pseudomonas infection of right leg ulcer. ABPI pressures identified venous ulceration.

Peggy was admitted under the care of the Geriatrician Team for treatment of pneumonia, heart failure, infected leg ulcer and fluid overload. Oxygen therapy, fluid restriction, IV antibiotic treatment for pneumonia and leg wound infection. Despite this, O_2 levels remained low, and echocardiogram showed ejection fraction of 32%. Previous echo in September 2024, showed Ejection Fraction of 42%.

On 15 May, during the hospital encounter, Peggy fell and sustained right fractured neck of femur. Right dynamic hip screw inserted on 16 May. Peggy mobilising short distances, with aid of physio and walking frame since 17 May. Now requires assistance of one person with most daily activities. Peggy will require primary care physiotherapy, occupational therapy home assessment and PHN assessment for

home support and wound dressings. Peggy will require home oxygen therapy on discharge.

Peggy responded well to clinical treatment. However, in discussion with Peggy regarding discharge plan, and recommending a period of convalescence, Peggy stated she wishes to return home from hospital and revealed she is the sole carer for her husband Jack, 85 years, with Alzheimer's dementia (Jack is currently staying with Peggy's niece while she is in hospital, but he has not settled there). The couple currently do not have home support, and Peggy has not had wound assessment in the past, dressing the wound herself at home. Peggy is unsure if she will be able to continue caring for Jack, while on oxygen therapy and needing to use a walking frame herself. Peggy has three adult children, all living abroad.

MDT meeting held on 29 May to plan for Peggy's discharge home. The team agreed that Peggy is clinically ready for discharge, despite requiring 24-hour home oxygen therapy. Social worker has applied for homecare package to support Peggy to look after her husband in their home, as is her wish. Peggy will require assistance of one, and walking frame to mobilise, for at least six to eight weeks. Peggy is eager to return home and has declined medical advice to wait for the homecare package to be in situ before discharge. Peggy has lost 2.5 kg since admission (3 weeks), nausea continues. This may be due to diuresis or heart failure or stress. Peggy will require community dietetics assessment.

Table 4. Sections in standard requiring completion: Peggy's use case (complex)

Sections in standard to be completed	Include
Patient Information	
Patient Details	✓
GP Details	✓
Personal Contacts	✓
Social Context	✓
Legal Information	
Safeguarding	
Clinical Risk/Allergies/Adverse Events	✓
Hospital Encounter	
Admission Details	✓
Discharge Details	✓
Narrative	✓
Patient History	✓
Clinical Evaluation	✓
Investigations/Results	✓
Diagnosis	✓
Procedures/Treatments	✓
Infection Control Status	✓
Functional Status	✓
Medication Details	✓
Medical devices/implants	
Future Management/Care Plan	✓
Document Information	

Person Completing Discharge	✓
Discharge Document Sign-Off	✓
Distribution List	✓

Hospital Discharge Information– Semi structured (Generated)

Patient Details

- **Name:** Mrs. Margaret Byrne (Peggy)
- **Age:** 80
- **Sex:** Female
- **Address:** 27 Main Street, Chapelizod, Dublin 7, D07CL23
- **PPSN:** 4G7637832
- **Medical Card:** Yes
- **DOB:** 1945/10/10

GP Details

- **GP Name:** Maria O'Brien
- **Practice Address:** Infirmary Road Practice, 12 Old Infirmary Road, Inchicore, Dublin 7, D01 D007

Person Contact Details

- Anna Mulhall (Daughter/Emergency contact).
- 4 Oxbridge Lane, Chertsey, Surrey, England.
- 0044 1932 1234567

Social Context:

- Lives in two-storey house with bathroom upstairs. No downstairs toilet.
- Peggy is main carer for husband Jack (Dementia)
- Has three adult children all living abroad.
- No home support in-situ
- Ex-smoker x 40 years (stopped in 2005)

Admission Details

- **Date/Time of Admission:** 2025.05.10: 11:30
- **Reason for Admission:** Collapse at home
- **Referring Source:** emergency ambulance call

Discharge Details

- Date/Time of Discharge: 2025.05.31:10:30 by Prof Gallagher, Geriatrician.

- Discharge Destination**:** Home
- Mode of Discharge**:** Ambulatory with assistance of one
- Type: With consultant advice
- Discharged from: St. Michael's Ward

Narrative:

Peggy was admitted following collapse. Admitted for treatment of heart failure, pneumonia, and leg wound infection. She fell six days after admission (2025.05.15), and sustained fractured neck of right femur. Surgical insertion of right dynamic hip screw on 2025.05.16, under spinal anaesthesia. Uneventful surgical recovery. Pneumonia resolved with I/V antibiotic therapy, diuretics and fluid restriction. CXR on 2025.05.28 shows lungs improving. However, echocardiogram on 2025.05.14, identified deterioration of heart failure condition; with EF of 32% and worsening cardiomegaly.

Post-op: Mobilised within 24 hours, tolerated oral intake, no surgical complications or femoral wound infection noted.

Lower right leg ulcer: continues on ciprofloxacin 250mg b.d. for 14 days p.o.

Going home on O_2 therapy. Leg ulcer wound swab showed pseudomonas aeruginosa infection, which persists. S/B vascular team; ABPI testing identified venous insufficiency causing the ulcer. Compression bandaging commenced. For vascular review in Sept 2023.

Patient History

Collapse at home, breathless, swelling of extremities. Known patient. Multiple previous hospitalisations for heart failure. MI in 2005.

Past Medical History

- Myocardial infarction: August, 2005. Had stenting of posterior coronary artery.
- COPD diagnosed in 2003.
- Hysterectomy: 2001 for prolapsed uterus.
- Cholecystectomy: 1993 for gallstones.

Clinical Risks/Allergies/Alerts

- **No known drug allergies**
- **Falls risk.** Had fall in hospital on 2025.05.15- sustained fractured neck of right femur. Right dynamic hip screw inserted on 2025.05.16
- **Pressure ulceration risk:** Waterlow score 21.

Clinical Evaluation

- Examination Findings on admission: Breathless on speaking. Bilateral leg oedema and upper arms. Crepitations in both lower lobes of lungs. Right leg wound: red, purulent discharge, malodorous.
- Vitals: T 37.8°C, HR 102 bpm, BP 135/78 mmHg, RR 18, SpO_2: 86% RA

Investigations/Results

- Bloods: 2025.05.10; WBC 17.0 x 10^9/L, CRP 35mg/L, HB 8.8
- Imaging: Chest X-ray; 2025.05.10; confirmed bilateral lower lobe pneumonia
- Wound swab: taken on 2025.05.10: showed pseudomonas infection of right lower leg ulcer.
- Echocardiogram: (2025.05.14) identified ejection fraction of 32%, cardiomegaly.
- ABPI pressures (2025.05.14): diagnosed venous insufficiency leg ulcer.
- X Ray of Right Hip and pelvis 202505.15: Fractured neck of right femur.

Diagnosis

2025.05.10

- Pneumonia
- Heart failure.
- Infected leg ulcer: pseudomonas aeruginosa
- Fluid overload

2025.05.15

- Fractured neck of right femur

Procedure/ Operations/ Treatments

- Insertion of right dynamic hip screw to fractured neck of right femur 2025.05.16 under spinal anaesthesia.

- Wound dressing: clean with chlorosept, Actilite Manuka honey non-adherent dressing, and compression bandage to right lower leg. Changed every 48 hours.

Functional Status

- Requires oxygen therapy; 2L/Min
- Requires assistance of one person, with most activities of daily living: Barthel score = 6/20
- Waterlow Score = 21, at high risk of pressure ulcer development.
- Mobilising with assistance of one person and walking frame

- Will require support at home.

Medications on Discharge; Prescription sent to pharmacy.

- Ciprofloxacin 250mg bd po x 14 days
- Paracetamol 1G QDS prn po.
- Oxygen 2L/min via nasal prongs, (home oxygen convertor machine)
- Diuretics: Frumil 40mg bd po.
- Adalat retard 20mg mane po

Changes to Medications:

Frumil changed to 40mg bd morning and noon to support diuresis.

Future Management/Care Plan

Hospital Actions

- Follow up in orthopaedic outpatient clinic in 4 weeks
- Follow up in Prof Gallagher's OPD in 6 weeks
- To return for cardiology review. Appointment to be sent.
- Appointment with Vascular outpatients' clinic made for 2025.09.16 (appointment given to Peggy).

GP Actions

- Review wound site if concerns arise
- Follow-up re: oxygen therapy
- Needs repeat wound swab in 4 weeks
- For monitoring re-oedema, fluid restriction, for repeat U&E in 3-4 weeks.
- Monitor for any delayed complications

Actions for Other H&SCPs

- **PHN:** Wound dressing and compression bandaging three times weekly
- **PHN:** Follow up on homecare package application to support Peggy to look after husband in their home
- **Physiotherapy:** Review
- **Occupational Therapy:** assessment for appliances, bed downstairs
- **Dietician**: assessment for high protein nutritious diet to prevent further weight loss following discharge
- **Social Work:** if required, to further support care of husband in the home.

Patient Education/Advice and Recommendations

- Take medications as prescribed.
- Maintain hydration while on fluid restriction, and protein-rich diet.
- Regular oral care for mouth dryness or soreness, caused by oxygen therapy.
- Regular passive exercise while in the chair. Stand to walk with assistance of one for the moment, until strength regained in legs.
- Avoid strenuous activity.
- Seek medical attention if fever, increasing pain, or wound issues occur.
- Consider accessing more help in the home to manage situation.

Patient Concerns/Expectations

- Peggy wishes to go home before HCP is processed. This may require support and further assessment regarding home situation. Peggy is reluctant to accept help with caring for husband and this will need some support.

Person Completing Discharge Document

- Date of discharge document (2025.05.31)
- Dr Grainne Smith,
- SHO to Prof Gallagher, Consultant Geriatrician.
- Southern University Hospital, Dublin 8.
- Medical council registration number: 17854
- 01 – 8175643
- olderpersons@SUHospital@hse.ie
- Signature: _____

Consultant Sign-Off

- Prof J Gallagher
- Consultant Geriatrician
- Southern University Hospital, Dublin 8.
- Medical council registration number 12345
- 01-8175643
- olderpersons@SUHospital@hse.ie
- Signature _____

Distribution List

Dr Maria O Brien	General Practitioner	Infirmary Road General Practice
Sonya Biarritz	Physiotherapist	Inchicore Primary Care Centre
Anna Murphy	PHN	Inchicore Primary Care Centre
John Brown	Occupational Therapist	Inchicore Primary Care Centre
Dimiti Malek	Dietician	Inchicore Primary Care Centre
Aine Ní Bhriain	Social Worker	Inchicore Primary Care Centre

Hospital Discharge Information – Narrative (letter format)

To: Dr Maria O'Brien, Infirmary Road Practice, 12 Old Infirmary Road, Inchichore, Dublin 7, D01 D007 *[GP Details]*
Re: Mrs. Peggy Byrne; Address: 27 Main Street, Chapelizod, Dublin 7, D07CL23; DOB: 1945/10/10; PPSN: 4G7637832 *[Patient Demographics]*
Date: 202505/31 *[Discharge Document Data]*

Dear Dr O'Brien,

Peggy, who is well known to us both, was admitted on May 10 *[Admission Details]* following collapse at home. *[Patient History]*

On examination, her temperature was slightly raised (37.8°C). She was tachypnoeic, with difficulty speaking. Oxygen saturation was 86% on admission. Examination revealed bilateral lower lobe crepitations, pitting oedema in both legs, with an infected leg ulcer on right lower leg. *[Clinical Evaluation]*

Initial blood tests showed raised white cell count of WBC 17 x 10^9/L and raised C-reactive protein at 23 mg/L, with a Haemoglobin of 8.8g/dL. Chest X-ray showed bilateral lower lobe infiltrates with pulmonary oedema and cardiomegaly. Echocardiogram on 2025.05.14 showed Stage III heart failure with ejection fraction of 32% (down from 42%, in Sept 2024). *[Diagnosis]*.

Wound swab taken on 2025.05.10 from lower leg wound identified pseudomonas aeruginosa infection. ABPI assessment identified venous insufficiency ulceration. *[Investigation results]*

Peggy, who had no known allergies *[Clinical Risk/Allergies/Adverse Events]*, was treated with IV fluid restriction to 1500ml/24 hours, antibiotics (intravenous ciprofloxacin for 14 days). She was initially catheterised for output measurement, and Lasix 40mg bolus dose given IV, with good effect. *[Medication Details]* However, on 15 May, Peggy sustained a fall in the ward, and subsequent X-ray identified fractured neck of right femur. She underwent an uncomplicated insertion of right dynamic hip screw under spinal anaesthetic on 2025.05.16. *[Procedure]*

Following surgery, Peggy was mobilised by physiotherapist using walking frame. However, she now requires 24-hour oxygen therapy at 2L/min (home oxygen supply arranged), the assistance of one for most ADLs. Barthel score 6/20, Waterlow score

21. *[Functional Status].* Weight loss of 3.5kg noted since admission. MDT held on 2025.05.29. Peggy clinically ready for discharge. She was seen by vascular team for review of leg ulcer, and ABPIs carried out. Venous ulceration diagnosed [*Diagnosis].* Compression bandaging carried out every 48 hours. Peggy may require bed to be moved downstairs.

As you know Peggy cares for her husband, Jack, who has moderate dementia, but is clinically well. She is eager to get home to care for Jack but is aware of her own new lower activity baseline. She will require support to remain at home. *[Discharge Details, Social context]*She was discharged home today by Prof Gallagher, Consultant Geriatrician. *[Discharge Sign-off details]* on fluid restriction of 1500mls/24 hours, O_2 therapy, and Frumil 40mg bd., (changed from previous dose of 20mg po mane). po. and Adalat retard 20mg mane for blood pressure maintenance, ciprofloxacin 250mg bd. Po x 14 days. Same to finish on 2025.06.13. Also prescribed Paracetamol 1G QID prn po. *[Medication on discharge].*

Follow-up appointments arranged in the hospital, as follows:

- Orthopaedic clinic in 4-6 weeks (date tbc),
- Prof Gallagher's OPD in 6 weeks (date tbc),
- Vascular clinic on 2025.09.16 and
- Cardiology outpatients (confirmed appointment to be sent). *[Future Management/Care Plan]*

Peggy will require PHN assessment for home support for herself and Jack to support them to continue to live at home, which is Peggy's intention. She may require hospital bed or bed downstairs if Peggy cannot manage stairs at home. Alternate day Manuka honey dressing and profore light compression bandaging should continue until vascular clinic in September. Continuous oxygen therapy required in the home. Order sent for oxygen conversion machine, tubing and oxygen cylinders - sent to the home this morning. Peggy will require wound swab in 4 weeks, U&E levels and review of oedema in 3-4 weeks, and Primary Care OT, Physio, Dietician, Social Worker review.

Kind regards,

Dr Grainne Smith, SHO to Prof Gallagher, Consultant Geriatrician, Southern University Hospital, Dublin 8.
IMC registration number: 17854
Phone: 01 – 8175643: email olderpersons.SUHospital@hse.ie *[Person completing Discharge document],[Organisation name] , [Discharge document Sign Off]*

Table 5: Subsections/elements in standard requiring completion: Peggy's use case (complex)

Subsections/elements in standard to be completed	Include
Patient Information	
1. Patient Demographics	
Title	✓
Forename	✓
Surname	✓
Preferred Name	✓
Address	✓
Health Identifier: PPS/IHI/Medical Card	✓
Date of Birth	✓
Sex	✓
Gender	
Nationality	
Ethnicity	
Date of Death	
Communication Details	✓
2. GP details	
Name	✓
Practice Details	✓
3. Personal Contacts	
Name	✓
Role	✓
Relationship	✓
Contact Details	✓
4. Social Context	
Living Situation	✓
Family Situation	✓
Other Determinants of Health	
5. Legal Information	
Assisted Decision-making	
Advanced Healthcare Directive	
6. Safeguarding	
7. Clinical Risk/Allergies/Adverse Events	
Clinical Risks	✓

Allergies/Adverse Events	✓
Hospital Encounter Information	
8. Admission Details	
Date/Time	✓
Reason	✓
Source	✓
Urgency	✓
Referred by	✓
9. Discharge Details	
Date/Time	✓
Discharge Destination Address	✓
Discharge Type	✓
Discharging Consultant	✓
Discharging Specialty/Dept.	✓
Discharged From: Ward/Unit Name	✓
10. Narrative	✓
11. Patient History	
Patient History	✓
Past Medical History	✓
Family History	✓
Epidemiological History	
12. Clinical Evaluation	
Date/Time of Evaluation	✓
Observations	✓
Examination Findings	✓
Vital Signs	✓
Anthropometric Measurements	
13. Investigations/ Results	

Investigation Requested	✓
Date of Result	✓
Result	✓
Status	
14. Diagnosis	
Diagnosis Name	✓
Date of Diagnosis	✓
Severity	✓
Anatomical Location	✓
Status	✓
Clinical Stage/Grade	✓
Additional Comments	✓
15. Procedures/Operations/Treatments	
Name	✓
Date	✓
Status	✓
Anatomical Location	✓
Laterality	✓
Complications Relating to Procedure/Treatment	✓
Additional Comments	✓
16. Infection Control Status	
Presence of Identified Infection	✓
Management of Identified Infection	✓
17. Functional Status	
Date of Assessment	✓
Type of Functional Assessment	✓
Result	✓

18. Medication Details	
Medication Name	✓
Start Date	✓
Form	✓
Route	✓
Site	✓
Dose	✓
Frequency	✓
Duration	✓
Additional Instructions	✓
Medication End Date/Time	✓
Date of Changes/Discontinuation of Medication	✓
Indication	✓
Medication Name Changes/Discontinuation	✓
Nature of Change	✓
Reason for Medication Change/Discontinuation	✓
Additional Comments	✓
Aids to Compliance	✓
19. Medical devices/Implants	
Device/Implant Details	
Commencement Date	
Discontinuation/Explanation of Device/Implant	
Body Site	
Reason for Device/Implant Insertion or Removal	
Additional Comments	
20. Future Management /Care Plan	
Hospital Actions	✓
GP Actions	✓

Actions for Others (Nursing /HSCPs)	✓
Education, Advice and Recommendations for Patient	✓
Patient/Carer Concerns, Expectations and Wishes	✓
Document Information	
21. Person Completing Discharge	
Full Name	✓
Grade/Role/job title	✓
Professional Body Registration Number	✓
Organisation Name	✓
Contact Details	✓
Signature	✓
Date and Time of Completion of Discharge Document	✓
22.Discharge Document Sign-Off	
Full Name	✓
Grade/role/Job Title	✓
Professional Body Registration Number	✓
Organisation Name	✓
Contact Details	✓
Signature	✓
23. Distribution List	
Full Name	✓
Role of Recipients	✓
Organisation Name	✓

References:

1. Government of Ireland. *Health Act 2007 (as amended)*. ONLINE: Government of Ireland. 2007. Available from: https://www.irishstatutebook.ie/eli/2007/act/23/section/1/enacted/en/index.html. Accessed on: 24th January 2025.

2. Government of Ireland. Health Information Bill 2024 [Online]. Available from https://www.oireachtas.ie/en/bills/bill/2024/61/ Accessed 8th August, 2025.

3. European Commission. European Health Data Space Regulation 2025 [Online]. Available from https://eur-lex.europa.eu/eli/reg/2025/327 Accessed on: 10/03/2025.

4. European Commission. General Data Protection Regulation 2018 [Online]. Available from https://gdpr-info.eu/. Accessed on:10/03/2025

5. Irish Statute Book. (2018). Data Protection Act, No. 7/2018. Dublin, Irish Statute Book. Available from https://www.irishstatutebook.ie/eli/2018/act/7/enacted/en/html. Accessed on 27/01/2025

6. Ireland, G. o. (2025). "The Path to Universal Healthcare – Sláintecare & Programme for Government 2025+." Retrieved 26/05/2025, from https://www.gov.ie/en/department-of-health/publications/path-to-universal-healthcare-sl%c3%a1intecare-programme-for-government-2025/

7. Government of Ireland. Health Identifiers Act 2014 [Online]. Available from https://www.irishstatutebook.ie/eli/2014/act/15/. Accessed on: 10/03/2025

8. Government of Ireland. *Digital for Care: A Digital Health Framework for Ireland 2024-2030*. ONLINE: Government of Ireland. 2024. Available from: https://www.gov.ie/en/press-release/3ad02-minister-for-health-publishes-digital-for-care-a-digital-health-framework-for-ireland-2024-2030/. Accessed on: 28th January 2025.

9. Health Service Executive. *HSE Digital Health Strategic Implementation Roadmap* ONLINE: 2024. Available from:

https://about.hse.ie/publications/digital-for-care/. Accessed on: 28th January 2025.

10. Health Information and Quality Authority. National Standards for Information Management in Health and Social Care. ONLINE: Health Information and Quality Authority, 2024. Available from: https://www.hiqa.ie/sites/default/files/2024-06/National-Standards-for-Information-Management-2024.pdf. Accessed on: 28th January 2025.

11. Health Information and Quality Authority. *National Standard for Patient Discharge Summary Information*. ONLINE: Health Information and Quality Authority. 2013. Available from: https://www.hiqa.ie/sites/default/files/2017-01/National-Standard-Patient-Discharge-Summary.pdf. Accessed on: 27th January 2025.

12. eHealth Network. *Guideline on the electronic exchange of health data under Cross-Border Directive 2011/24/EU: Hospital Discharge Report.* ONLINE: eHealth Network; 2024. Available from ehn_hdr_guidelines_en.pdf. Accessed 27th January, 2025.

13. XtEHR@dataspace. Available from Xt-ehr.eu Accessed 20.08.2025

14. National E-Health Transition Authority. *e-Discharge Summary Core Information components V1.6.,* [Online]*.* Available from https://developer.digitalhealth.gov.au/resources/discharge-summary-v1-6. Accessed on: 23rd January 2025

15. Government of Ireland. (2018). Slaintecare Implementation Strategy. Online, Government of Ireland.,.Available from https://www.gov.ie/en/department-of-health/publications/sl%c3%a1intecare-implementation-strategy/. Accessed on 29th January 2025.

16. Government of Ireland. *Sláintecare Action Plan 2023*. ONLINE: Government of Ireland. 2023. Available from: https://about.hse.ie/our-work/slaintecare-our-strategy-for-improving-irelands-healthcare-system/. Accessed on: 29th January 2025.

17. Government of Ireland. *Patient Safety (Notifiable Incidents and Open Disclosures) Act 2023*. ONLINE: Irish Statute Book, 2023. Available from: https://www.irishstatutebook.ie/eli/2023/act/10/enacted/en/html Accessed on

15th May, 2025.

18. Government of Ireland. *Assisted Decision-Making (Capacity) 2015 (as amended)*. ONLINE: Government of Ireland. 2023. Available from: https://www.irishstatutebook.ie/eli/isbc/2022_46.html Accessed on: 3rd April 2025.

19. Department of Health and Children. Childrens First: summary: National Guidelines for the protection and Welfare of children. ONLINE: TUSLA, 2020. Available from: https://www.tusla.ie/children-first/children-first-guidance-and-legislation/

20. Health Services Executive Social Care Division. *Safeguarding vulnerable Persons at Risk of Abuse national Policy and Procedures*. ONLINE: Health Service Executive, 2014. Available from: https://www2.healthservice.hse.ie/organisation/national-pppgs/safeguarding-vulnerable-persons-at-risk-of-abuse-2014-national-policy-procedures/ Accessed on 15th May, 2025.

21. Health Information and Quality Authority & Mental Health Commission. National Standards for Adult Safeguarding. Dublin. HIQA. (2019). Available from https://www.hiqa.ie/reports-and-publications/standard/national-standards-adult-safeguarding. Accessed 15th May, 2025.

22. MedCom.DK. *The good XML printing epicrisis Discharge letter*. ONLINE Medcom.DK. 2020. Available from: https://svn.medcom.dk/svn/releases/Standarder/Den%20gode%20epikrise/XML/XDIS01/Dokumentation/. Accessed on: 27th January 2025.

23. Professional Record Standards Body (PRSB). *e-Discharge Summary Standard*. ONLINE: PRSB. 2021. Available from: https://theprsb.org/standards/edischargesummary/. Accessed on: 22nd January 2025.

24. Australian Commission on Safety and Quality in Health Care. *National Guidelines for On-Screen Presentation of Discharge Summaries*. ONLINE: Australian Commission on Safety and Quality in Health Care. 2017. Available from: https://www.safetyandquality.gov.au/sites/default/files/2019-

06/National-guidelines-for-on-screen-presentation-of-discharge-summaries-Sep-2017.pdf Accessed on: 27th January 2025.

25. XpanDH. *XpanDH Hospital Discharge Report*. ONLINE: XpanDH. 2025. Available from: https://build.fhir.org/ig/hl7-eu/xpandh-hdr/downloads.html. Accessed on: 28th January 2025.

26. Iakes Goenaga, Xabier Lahuerta, Aitziber Atutxa, Koldo Gojenola. A section identification tool: Towards HL7 CDA/CCR standardization in Spanish discharge summaries. *Journal of Biomedical Informatics*. 2021; 121:[N.PAG-N.PAG pp.]. Available from: https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=152273209&site=ehost-live. Accessed on: 20th January 2025.

27. Chong Song, Masaharu Nakayama. Implementation of a Patient Summary Web Application According to the International Patient Summary and Validation in Common Use Cases in Japan. *Journal of Medical Systems*. 2023; 47(1):[1-9 pp.]. Available from: https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=172971125&site=ehost-live. Accessed on: 20th January 2025.

28. Alexander Dimitrov, Georg Duftschmid. Generation of FHIR-Based International Patient Summaries from ELGA Data...16th Annual Conference on Health Informatics meets Digital Health (dHealth 2022), May 24–25, 2022, Vienna, Austria. *Studies in Health Technology & Informatics*. 2022; 293:[1-8 pp.]. Available from: https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=157082989&site=ehost-live. Accessed on: 20th January 2025.

29. Christopher J. Smith, Micah Beachy, Andrew Vasey, Trek Langenhan, Jason Shiffermiller. Evaluation of an Enhanced Discharge Summary Template: Building a Better Handoff Document. *Journal of Clinical Outcomes Management*. 2017; 24(12):[542-50 pp.]. Available from: https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=127096811&site=ehost-live. Accessed on: 20th January 2025.

30. Farrant Hiroshi Sakaguchi. Improving the Discharge Summary. Utah: The University of Utah; 2016.

31. Anthony Nya. *Quality and extent of adherence on internal medicine discharge letters in a regional hospital in South Africa to prescribed guidelines. A retrospective audit.* 2019.

32. M. Salim Al-Damluji, K. Dzara, B. Hodshon, N. Punnanithinont, H. M. Krumholz, S. I. Chaudhry, et al. Association of discharge summary quality with readmission risk for patients hospitalized with heart failure exacerbation. *Circulation Cardiovascular quality and outcomes*. 2015; 8(1):[109-11 pp.]. Available from: https://www.cochranelibrary.com/central/doi/10.1002/central/CN-01111096/full. Accessed on: 20th January 2025.

33. C. M. Schwarz, M. Hoffmann, C. Smolle, A. Borenich, S. Fürst, A. C. Tuca, et al. Patient-centered discharge summaries to support safety and individual health literacy: a double-blind randomized controlled trial in Austria. *BMC health services research*. 2024; 24(1):[789 p.]. Available from: https://www.cochranelibrary.com/central/doi/10.1002/central/CN-02725064/full. Accessed on: 20th January 2025.

34. C. M. Schwarz, M. Hoffmann, C. Smolle, M. Eiber, B. Stoiser, G. Pregartner, et al. Structure, content, unsafe abbreviations, and completeness of discharge summaries: a retrospective analysis in a University Hospital in Austria. *Journal of evaluation in clinical practice*. 2021; 27(6):[1243-51 pp.]. Available from: https://www.cochranelibrary.com/central/doi/10.1002/central/CN-02232422/full. Accessed on: 23rd January 2025.

35. Council, I. M. (2024). Guide to Professional Conduct & Ethics for Registered Medical Practitioners. Continuity of Care. Dublin Medical Council**:** 36-38. Authority, H. I. Q. (2024). "National Standards for Information Management in Health and Social Care."

36. Decision Support Service. Decision-making assistance agreement 2025 [Online]. Available from https://decisionsupportservice.ie/. Accessed on: 31/05/2025.

37. Communications Regulation (Postal Services) Act 2011 [Online]. Ireland. Available from; https://www.irishstatutebook.ie/eli/2011/act/21/enacted/en/html. Accessed on: Accessed on 31/05/2025.

38. Central Statistics Office. CSO Data Standard for Sex. Ireland: Central Statistics Office; 2024. Available from : https://www.cso.ie/en/methods/classifications/csodatastandardsandclassifications/csodatastandards/csodatastandardforsex/

39. Central Statistics Office. CSO Data Standard for Gender. Ireland: Central Statistics Office; 2024. Available from: so.ie/en/methods/classifications/csodatastandardsandclassifications/csodatastandards/csodatastandardforgender/#:~:text=This%20harmonised%20standard%20presents%20guidance,certain%20health%20and%20demographic%20indicators.

40. Central Statistics Office. CSO Data Standard for Ethnicity [Online]. Available from https://www.cso.ie/en/methods/classifications/csodatastandardsandclassifications/csodatastandards/csodatastandardforethnicity/. Accessed on: 09/05/2025

41. Health Service Executive. Ethnic Equality Monitoring, (2024). Available from: https://www.hse.ie/eng/about/who/primarycare/socialinclusion/intercultural-health/ethnic-equality-monitoring/. Accessed on: 31/05/2025

42. Health Service Executive. HSE policy and Guidance on Lone Working. (2022). Available from https://healthservice.hse.ie/staff/health-and-safety/lone-working/ Accessed 20th August, 2025.

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