Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Standardising Patient Discharge Summary Information: a Draft National Data Set for consultation

Consultation Feedback Form

November 2012

Your views are very important to us. We would like to hear what you think about the draft guidelines.

Your comments will be considered and will inform the development of the national data set for clinical discharge summaries. When commenting on a specific aspect of the draft dataset, it would help us if you tell us which element you are commenting on or the table number that you are commenting on.

The closing date for consultation is 5pm on Friday 11 January 2013

You can email or post a completed form to us. You can also complete and submit your feedback online on www.hiqa.ie.

About you

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Contact details	kwalsh@nmbi.ie 01 639-8502
Organisation* ***Please indicate if you are making your submission in a personal capacity only or on behalf of your organisation**	This submission is on behalf of the Nursing and Midwifery Board of Ireland
Date	03 January 2013

General feedback questions

You may provide us with feedback on the specific questions asked within the consultation document and repeated here (see questions that follow), or alternatively you can provide us with general comments.

Consultation Question 1

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

Please comment
The Nursing and Midwifery Board of Ireland believes there are definite benefits in having a standardised data set for clinical discharge summaries.

The main benefits include:

- enhancing the holistic care of individuals
- enhancing the systematic care of individuals
- a comprehensive and consistent approach, structure and process for health care professionals in producing discharge summaries
- ability of primary care practitioners to easily access pertinent information about the patient's hospitalisations within one document
- serves as a key tool for communication, care and treatment planning for and between the hospital and community/primary care interface.
- Contributes to improved patient safety and quality of care

Consultation Question 2

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

Please comment
It appears that the appropriate groupings of data items have been included in the data set. A suggestion that the document reference number (6.3.13) be placed at the front of the document for prominence and easy retrieval for filing/storing purposes.

Consultation Question 3

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

Please comment

It appears that the appropriate data items have been included in the data set. None of the data items listed should be left out. A suggested additional data item may be to include reference/listing of a primary carer (such as a family member) for such situations if the patient has impaired mental capacity and/or requires assistance from another person in relation to discharge needs/supports and care planning.

Consultation Question 4

Question 4: Do the definitions provided in Tables 1 – 7 of the consultation document adequately explain each of the data items? If not, please suggest improvements?

Please comment

Table 1 Patient Details – 6.1.1 Forename – It is possible that a patient may be using first name or given name which is not the same as the birth certificate. Does that require the health care professional to confirm the correct proper name as per the certificate? There may be variances to consider for this definition.

Table 3 Admission and discharge details

6.3.4 Hospital site – This could be confusing re the term "site". Is it possible there is more than one site within a hospital? Thus is the term site meant to define the actual hospital/organisation?

Consultation Question 5

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

Please comment

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

Table 4 Clinical Narrative
6.4.4 Clinical Alerts – the definition and its association with the usage is somewhat unclear. If it was a clinical alert would there be a reason why it not asked, or unknown? Is there the possibility of misinterpretation for this section?
6.4.5 Allergies – The question is posed as to whether the example of "not asked" should be included in the usage text, as best practice demonstrates that allergy history should always be part of the patient assessment.

Table 7 Person(s) completing discharge summary
6.7.5 Professional body registration number
The official term used by the Nursing and Midwifery Board of Ireland for this number is currently "the personal identification number".

General Comments

Please provide any general feedback you wish to give below.

Please comment

Is it envisaged that a registered nurse or registered midwife or alternatively an Advanced Nurse/Midwife Practitioner, may create the discharge summary for a patient as part of his/her employment responsibilities? This is unclear from the draft standards document.
This question is raised in relation to the completion of Table 5 Medication details. Does Table 5 serve as the medication prescriptions for the patient at time of discharge? If a nurse or midwife is responsible for the discharge summary does it extend to this medication prescription writing? This section should be clarified based on this interpretation.

The issue of a nurse or midwife transcribing from the medication prescription sheet/medication administration record used during the hospital stay to this discharge summary sheet should be considered in relation to safety and risk management. The Nursing and Midwifery Board of Ireland advocates for the

prescriber (i.e. medical doctor or registered nurse prescriber) to write the medication prescription if it forms part of the discharge summary.

Thank you for taking the time to give us your views.

Please return your form to us either by email or post:

ehealth@hiqa.ie

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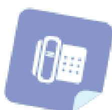

If you have any questions on the draft data set, you can contact the consultation team by calling (01) 8147685.

Please return your form to us either by email or post before 5pm on Friday 11 January 2013

Please note that the Authority is subject to the Freedom of Information Acts and the statutory Code of Practice regarding FOI.

For that reason, it would be helpful if you could explain to us if you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances.