



Core Information Components

Discharge Summary Release 1.0

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Release

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Document Information

Change History

Version	Date	Contributor	Comments
0.01	2006-12	NEHTA	'National Discharge Summary - Data Content Specifications'
0.08	2009-02	Linda Bird	'Draft Core Discharge Summary Core Components' The essential components from the Data Content Specifications were extracted to create a first draft of the core. This draft was subsequently reviewed, amended and endorsed by NEHTA Clinical Leaders in preparation for broader external review.
0.16	2009-04	Linda Bird	Draft document distributed to external organisations for comment.
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Authorisation History

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0.01	2009-09	Draft for review.	Incorporating pre-release feedback to date.
0.34	2009-07-31	Release.	Approved.

Document Authorisation



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Preface

Document Purpose

This document presents the information components (also referred to as the 'core components') of the Discharge Summary Release 1.0 package, which have been recommended for use when exchanging discharge summaries in Australia. It is suggested that readers familiarise themselves with the Business Requirements Specification and Solution Design, also part of this package, before turning to this document.

Please note that the core discharge summary components are a logical set of data items for exchange and, as such, are independent of any particular platform, technology, exchange format or presentation format.

The discharge summary package describes the specifications and guidelines to be adopted by implementers when developing interoperable discharge summary solutions within the Australian healthcare community.

Updates to this document will be published on an annual basis, incorporating the additional package components as they are developed, and feedback from the industry sector.

Intended Audience

This document is intended for all interested stakeholders including:

- Early Adopter hospitals and health departments in the process of planning, implementing or upgrading discharge summary systems
- Software vendors developing discharge summary system products
- Early Adopter GP desktop software vendors
- Senior managers and policy makers, clinical experts, Health Information Managers, IT operations and support teams, and system integrators
- Technical and non-technical readers.

Document Map

The following diagram represents the relationship between this document and others within the discharge summary package.

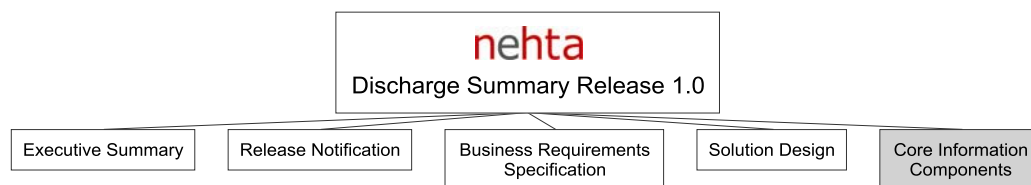


Figure 1 Discharge Summary Package Document Map

Document Status

This document is approved for release, and has been subject to internal/external consultation and review.

Definitions, Acronyms and Abbreviations

For a lists of abbreviations, acronyms and abbreviations, see the [Definitions section](#) at the end of the document, on page 35.

References and Related Documents

For a list of all referenced documents, see the [References](#) section at the end of the document, on page 38.

1 Introduction

1.1 Overview

The core discharge summary information components define the minimum set of data items that are recommended for implementation in any system that creates and transfers discharge summary information in Australia.

As this document defines the core components for these exchanges, it is anticipated that some discharge summaries will contain additional types of data to satisfy specific local requirements, or healthcare specialty requirements. It is expected that national extensions to the core discharge summary will be defined to support particular specialty areas (e.g. Aged Care, Oncology, Obstetrics, Cardiology, Community Nursing), and that a full set of discharge summary components will be maintained to capture all nationally-agreed data groups and elements for discharge summary exchange.

Please note that the core discharge summary components are a logical set of data items for exchange, and as such are independent of any particular platform, technology, exchange format or presentation format.

1.2 Discharge Summary

A discharge summary is currently defined as "A collection of information about events during care by a provider or organisation" [AS4700.6(Int)2007].

It comprises a document produced during a patient's stay in hospital as either an admitted or non-admitted patient, and issued when or after a patient leaves the care of the hospital.

Its primary function is to support the 'continuity of care' as the patient returns to the care of their community healthcare provider(s). The primary recipients of the Discharge Summary are healthcare providers who were providing the patient care prior to the hospital stay, including:

- The patient's usual GP (or primary health service such as an Aboriginal Community Controlled Health Service)
- The referring clinician (e.g. private specialist)
- Community Pharmacy
- Residential Aged Care Facility where the patient usually resides
- Other health professionals who will be involved in the patient's post-discharge care.

Within this primary function the purpose of the NEHTA discharge summary package is to:

- Assist and improve clinician-to-clinician communication
- Enable system-to-system communication of semantically interoperable data.

The secondary functions of the discharge summary include:

- Providing summary information regarding an earlier admission on the re-presentation of the patient to acute care
- Use by clinical coders when coding a patient record
- Providing the patient with a record of their hospital admission and care
- Inclusion in an Individual Electronic Health Record (IEHR), which could include a national IEHR or a local repository, for example to support coordinated care.

1.3 Purpose of the Core Components

The purpose of the core discharge summary components is to define the information requirements for a nationally-agreed discharge summary, suitable for exchange between healthcare providers in Australia, independent of exchange or presentation formats.

It is anticipated that these core components will:

- Promote a common understanding of the core components for consistent clinical interpretation when sharing discharge summaries between different clinical specialties, implementations and jurisdictions
- Support the semantic interoperability of core data components exchanged between different implementations and jurisdictions, irrespective of the exchange format being used
- Support cross-implementation and cross-jurisdictional querying over common Discharge summary components at the logical level, as may be required for Electronic Health Record implementations
- Provide a common framework upon which to define nationally-agreed, specialty-specific discharge summary components (e.g. for Aged Care)
- Provide a common framework for nationally-defined mappings to specific exchange formats
- Provide a common framework upon which to define national terminology sets that associate specific data items with valid values.

1.4 Methodology

The following stakeholders were invited to comment on the core discharge summary information components:

- The AMA (Australian Medical Association)
- The RACGP (The Royal Australian College of General Practitioners)
- The AGPN (Australian General Practice Network)
- The Australian Commission on Safety and Quality in Healthcare
- The ACRRM (Australian College of Rural and Remote Medicine)
- RACP (The Royal Australasian College of Physicians)
- RACS (The Royal Australasian College of Surgeons)
- RCPA (The Royal College of Pathologists of Australasia)
- RANZCR (The Royal Australian and New Zealand College of Radiologists)
- RACMA (The Royal Australasian College of Medical Administrators)
- College of Emergency Medicine
- State Health Departments via jurisdictional CIO's
- Allied Health Professions Australia
- College of Nursing
- Consumer groups including some or all of:
 - Kidney Australia
 - Diabetes Australia
 - National Heart Foundation
 - National Stroke Foundation
 - Asthma Australia

- Society of Hospital Pharmacists Australia
- Australian Healthcare and Hospitals Association
- Aged Care Association Australia
- Aged and Community Services Australia
- Royal Australian and New Zealand College of Psychiatrists

The starting point for the discharge summary core information components was the National Discharge Summary Data Content Specification [NDSDCS2006] that was developed by NEHTA for exchange from an acute healthcare facility to a General Practitioner. From this, many of the optional data elements were removed to facilitate implementation, and the remaining data elements were summarised into the table shown in section 2.3.

As the core discharge summary components continue to evolve through consultation and feedback, it is intended that a full set of discharge summary components will be maintained as a superset of both the core information components and any specialty discharge summary components that are developed. For more details on NEHTA's full set of discharge summary components, please refer to [DS-SDT2009].

1.5 Exchange and Presentation Formats

The information included in these core discharge summary components is defined at the logical clinical level, and as such is independent of any particular platform, technology, exchange format or presentation format.

Consequently, the core components may be mapped to multiple different exchange formats. It is anticipated that such mappings will be defined and published following the endorsement of the core components.

Similarly, the requirement that a particular piece of data be exchanged in a discharge summary does not imply any particular requirement for the user interface. Some data elements (e.g. "Language") are intended purely for purposes of internal processes within the receiving system. Similarly, other data elements (e.g. "Date of Birth") have a number of different presentation options available (e.g. "Age", "Birth Day" + "Year of Birth" etc), which are not considered here. In addition to this, the names given to data components and data items are in many cases not appropriate to be used as field labels on a user interface. For example, "Encounter start datetime" may be more appropriately referred to as "Admission date" in a discharge summary system that supports only inpatient events.

Therefore, all component and item names are able to be labelled according to local requirements.

Please also note that the order in which the data items are listed in this document is not indicative of the order in which this data should be exchanged or presented to the user.

1.6 Adding Data

It is expected that the discharge summary author will use their clinical judgement to manually enter some of the data into the core discharge summary components (e.g. clinical synopsis). However, it is envisaged that Clinical Information Systems operating at the source healthcare facility (e.g. Patient Administration System, Medication Management System, etc.) should be available - whenever possible - to transfer relevant data into many of the core discharge summary components. This will minimise data entry and may reduce the issues of recording data redundantly in multiple data stores.

It is expected that, where feeder systems are used, the author's discretion is exercised by only including information that is relevant to the ongoing care of the patient in the discharge summary.

2 Core Components

2.1 Overview

The information components of the core discharge summary (as summarised in section 2.3) define the minimum set of data items that are recommended for implementation in a system that creates and exchanges Discharge Summaries within Australia.

The core discharge summary components are:

- Patient
- Nominated primary healthcare providers
- Facility
- Document author
- Document recipients
- Encounter details
- Problems/diagnoses (Principal, Complications, Co-Morbidities)
- Clinical synopsis
- Diagnostic
- Investigations
- Clinical interventions
- Current medications on discharge
- Ceased medications
- Allergies/adverse reactions
- Alerts
- Arranged services
- Recommendations
- Information provided to patient and/or relevant parties
- Document control
- Attachments.

2.2 Definition Description

The Core Components are defined below, using the following columns:

- *Component*: a high level section or group of data elements
- *Item*: an individual data element or data group. A data item may be a single unit of data (e.g. "Date of Birth"), or a set of data that has a standard structure (e.g. "Address")
- *Purpose*: the main purposes for exchanging this data, including:
 - C: Clinician to Clinician Communication
 - S: System to System Communication
 - D: Decision Support
 - E: Epidemiology and Statistics
 - Q: Safety and Quality
- *Type*: the type of data associated with the component or data item. Note that this may be a simple data type (e.g. text, date) requiring a

single field, or a predefined structure requiring a group of fields. For a full list of types used please refer to Section 3

- *Number of Values Allowed*: the number of times that the given component/item may be included in a Discharge Summary. For items, this is the number of times that the given item may be included, each time the component to which it belongs is included. The number of values may be either:
 - 0..1 (Zero or One) At most one data value
 - 1 (One) Exactly one data value
 - 0..Many (Zero to Many) Any number of data values
 - 1..Many (One to Many) At least one data value.
- *Notes*: Additional comments that clarify, explain or constrain the given data.

2.3 Definition

In the following table, component sections are shaded in yellow and component/items that require values in all discharge summaries are formatted in bold (i.e. for [1] and [1..Many]).

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
Patient		C, S, D, E, Q	Participation Person	1	The patient is the person about whom the healthcare event has been captured – that is, the subject of the information.	HEALTH EVENT CONTEXT.SUBJECT OF CARE
	Identifier	S, D, E, Q	Entity Identifier	1..Many	The unique identifier of the patient. This must include the patient's Individual Healthcare Identifier (IHI) when available. In the absence of an IHI, this must contain the sending facility's unique Medical Record Number (MRN) for the patient.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.ENTITY IDENTIFIER
	Name	C, S, Q	Person Name	1..Many	The patient's name, structured using a predefined type.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.PERSON.PERSON NAME
	Date of Birth	C, S, D, E, Q	Date Time	1	The patient's date of birth. If necessary, this may be an approximation, which includes only the year, or the month and year. An estimation flag may be used to indicate whether or not the date is an estimation.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.PERSON.PERSON ADDITIONAL DEMOGRAPHIC DATA.Date of Birth
	Sex	C, S, D,	Coded Text	1	The sex of the patient. Sex is the biological	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.PERSON.PERSON ADDITIONAL

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
		E, Q			distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.	DEMOGRAPHIC DATA.Sex
	Address	C, S, E, Q	Address	1..Many	The address of the patient, recorded in a structured format. Where the patient's address is not known, the address line can be populated with text entry of "patient has no known address." This may include "No fixed address" if appropriate.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.ADDRESS
	Communication Details	C, S	Electronic Communication Details	0..Many	The patient's preferred means of contact should be included to facilitate clinical follow-up. Each Contact Details data item includes the medium (e.g. telephone), usage (e.g. home) and details.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Nominated primary healthcare providers		C, S, E	Participation	0..Many	The healthcare provider(s) (person or organisation) nominated by the patient as being primarily responsible for their ongoing healthcare. It is expected that in many cases there will only be one nominated primary healthcare provider, and that this will be a General	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					Practitioner or General Practice. If the nominated primary healthcare provider is an individual, then Person Identifier and Name must be recorded. If the nominated primary healthcare provider is or has an organisation, then Organisation Identifier and Organisation Name must be recorded.	
	Role	C, S, E	Codeable Text	1	The role that the nominated primary healthcare provider plays in the patient's healthcare (e.g. "General Practitioner", "Community Nurse").	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.Healthcare Role
	Person Identifier	S, E, Q	Entity Identifier	0.. Many	This must include the Healthcare Provider Identifier for the individual (HPI-I) when available.	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ENTITY IDENTIFIER
	Person Name	C, Q	Person Name	0.. 1	The name of the nominated primary healthcare provider, recorded in a structured format.	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.PERSON.PERSON NAME
	Organisation Identifier	S, E, Q	Entity Identifier	0 .. Many	This must include the Healthcare Provider Identifier for the organisation (HPI-O) when available.	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ENTITY IDENTIFIER
	Organisation	C, Q	Organisation	0 .. 1	The name of the healthcare provider	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Name		Name		organisation at which the patient's nominated primary healthcare provider practices.	HEALTHCARE PROVIDER.PARTICIPANT.ORGANISATION.ORGANISATION NAME DETAIL
	Address	C	Address	1..Many	The address of the nominated primary healthcare provider, recorded in a structured format.	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ADDRESS
	Communication Details	C, S	Electronic Communication Details	1 .. Many	The nominated primary healthcare provider's preferred means of contact. Each Contact Details includes the medium (e.g. telephone), usage (e.g. work) and details.	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Facility		C, S, E, Q	Participation Organisation	1	The healthcare organisation involved in the delivery of the healthcare service to the patient, at the time of discharge.	HEALTH EVENT CONTEXT.FACILITY
	Identifier	S, D, E, Q	Entity Identifier	1..Many	This must include the Facility's HPI-O (Healthcare Provider Identifier – Organisation) when available.	HEALTH EVENT CONTEXT.FACILITY.PARTICIPANT.ENTITY IDENTIFIER
	Name	S, E, Q	Organisation Name	1	The name of the healthcare facility.	HEALTH EVENT CONTEXT.FACILITY.PARTICIPANT.ORGANISATION.ORGANISATION NAME DETAIL
	Address	C	Address	1..Many	The structured address(es) of the healthcare facility.	HEALTH EVENT CONTEXT.FACILITY.PARTICIPANT.ADDRESS

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Communication Details	C, Q	Electronic Communication Details	1..Many	The electronic contact details of the healthcare facility. This should include at least one method of communication (e.g. phone number).	HEALTH EVENT CONTEXT.FACILITY.PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Document author		C, S, E, Q	Participation HPI	1	The healthcare provider who was responsible for authoring the Discharge Summary document.	DOCUMENT CONTEXT.DOCUMENT AUTHOR
	Identifier	S, E, Q	Entity Identifier	1..Many	This must include the document author's HPI-I (Healthcare Provider Identifier – Individual) when available.	DOCUMENT CONTEXT.DOCUMENT AUTHOR.PARTICIPANT.ENTITY IDENTIFIER
	Name	C, Q	Person Name	1	The name of the document author, in a structured format.	DOCUMENT CONTEXT.DOCUMENT AUTHOR.PARTICIPANT.PERSON.PERSON NAME
	Communication Details	C, Q	Electronic Communication Details	0..Many	The contact details for the document author. This should include at least one method of communication (e.g. phone number).	DOCUMENT CONTEXT.DOCUMENT AUTHOR.PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Document recipients		C, S, E, Q	Participation	1..Many	The recipients of the document. Each recipient must be either an individual person, an organisation, or a person at an organisation. If the recipient is a person then Person Identifier and Person Name is required. If the recipient is an organisation then the Organisation	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					Identifier and Organisation Name is required.	
	Recipient Type	C, S, E, Q	Codeable Text	1	The type of this recipient. Valid values include "primary" and "cc". Each discharge summary should have at least one primary recipient. It is recommended that the Primary Recipient is the usual GP and the referring provider (where they are different).	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS.Document Recipient Type
	Organisation Identifier	S, E, Q	Entity Identifier	0..Many	The identifier of the organisational recipient. This must contain an Organisation Identifier when there is an Organisation Name.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS.PARTICIPANT.ENTITY IDENTIFIER
	Organisation Name	C, Q	Organisation Name	0..1	The name of the organisational recipient. This must contain an Organisation Name when there is an Organisation Identifier.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS.PARTICIPANT.ORGANISATION.ORGANISATION NAME DETAIL
	Person Identifier	S, E, Q	Entity Identifier	0..Many	Must contain the recipient's HPI-I (Healthcare Provider Identifier – Individual) when relevant (and when available). This must contain a Person Identifier when there is a Person Name.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS.PARTICIPANT.ENTITY IDENTIFIER
	Person Name	C, Q	Person Name	0.. 1	The name of the individual recipient (if	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS. PARTICIPANT.PERSON.PERSON

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					available), in a structured format. This must contain a Person Name when there is a Person Identifier.	NAME
	Relationship to Patient	C, S, Q	Codeable Text	1	The relationship that the recipient has with the patient – e.g. "General Practitioner", "Mother".	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS. PARTICIPANT.Relationship to Subject of Care
	Address	C	Address	0..Many	The structured address of the recipient.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS. PARTICIPANT.ADDRESS
	Communication details	C	Electronic Communication Details	0..Many	The contact details for the document recipient. This should include at least one method of communication (e.g. phone number).	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS. PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Encounter details		C, S, D, E, Q	Section	1	Encounter Details describes general details about the patient's stay in hospital as an admitted or non-admitted patient.	EVENT.ENCOUNTER
	Encounter DateTime Started	C, S, E, Q	Date Time	1	The date (and optionally time) that the encounter, to which this discharge summary refers, started. In the case of admitted patients, this is the date/time of their admission.	EVENT.ENCOUNTER.DateTime Encounter Started
	Encounter DateTime Ended	C, S, E, Q	Date Time	1	The date (and optionally time) that the encounter, to which this discharge summary refers, finished. In the case of admitted patients, this is	EVENT.ENCOUNTER. DateTime Encounter Ended

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					the date/time of their discharge.	
	Separation Mode	C, E	Coded Text	1	The status of the patient at separation (e.g. discharge/ transfer/ death) and/or place to which the person is released (e.g. home).	EVENT.ENCOUNTER.Separation Mode
	Location of Discharge	C	Text	1	The number or identifier of the physical location from which the patient was discharged. In the case of admitted patients, this should be the ward in which they were located at the time of discharge. For non-admitted patients, this may be the department (e.g. "Emergency Department") in which the encounter occurred.	EVENT.ENCOUNTER.Location of Discharge
	Specialties	C, E	Codeable Text	0..Many	A reverse chronological list of the clinical specialties under which the patient was treated during the encounter (i.e. the last specialty appears first). Each specialty should only appear once in the list, in its first (i.e. most recent) position.	EVENT.ENCOUNTER.Specialty
	Responsible Health Professional	C, E, Q	Participation HPI	1	The healthcare provider who was responsible for the care given to the patient, at the time of discharge.	EVENT.ENCOUNTER.RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Other Participants	C, E, Q	Participation Person/HPI	0.. Many	Other healthcare providers who were involved in the encounter, or individuals associated with the patient at the time of the encounter, and the role that they played – e.g. registrar, referred specialist, referring clinician, emergency contact. Only those participants who are considered to be relevant to the ongoing care of the patient should be included.	EVENT.ENCOUNTER.OTHER PARTICIPANTS
Problems / diagnoses		C, S, D, E, Q	Section	1..Many	Describes the diagnostic labels or problem statements assigned by the healthcare provider to describe the diagnoses and health/medical problems pertaining to the patient during the encounter. This must include at least one problem/diagnosis whose type is "Principal". Only past history relevant to the patient's encounter should be included.	EVENT.PROBLEMS/DIAGNOSES THIS VISIT.PROBLEM/DIAGNOSIS
	Problem / Diagnosis Type	C, S, D, E, Q	Coded Text	1	The type used to categorise the problem/diagnosis. The supported Problem/Diagnosis Types include "Principal", "Complication" and "Co-	EVENT.PROBLEMS/DIAGNOSES THIS VISIT.PROBLEM/DIAGNOSIS.Problem/Diagnosis Type

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					morbidity".	
	Problem / Diagnosis Description	C, S, D, E, Q	Codeable Text	1	A description of the problem/diagnosis, which may or may not be coded.	EVENT.PROBLEMS/DIAGNOSES THIS VISIT.PROBLEM/DIAGNOSIS.Problem/Diagnosis Description
Clinical synopsis		C	Section	1	The clinical synopsis contains summary information or comments about the clinical management of the patient, and the prognosis of diagnoses/problems identified during the healthcare encounter. It may also include health related information pertinent to the patient, and a clinical interpretation of relevant investigations and observations performed on the patient (including pathology and diagnostic imaging). Please note that pathology and diagnostic imaging reports referred to in the clinical synopsis should be included in full as an attachment to the Discharge Summary. These attached investigation reports should be referenced and listed in the Investigation results section.	EVENT.CLINICAL SYNOPSIS
	Clinical Synopsis	C	Text	1	The clinical synopsis, in free text.	EVENT.CLINICAL SYNOPSIS.Clinical Synopsis Description

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Description					
Diagnostic Investigations		C, S, D, E, Q	Section	0..Many	Describes the important diagnostic investigations performed on the patient during the healthcare event, that are considered to be relevant to the patient's ongoing care This allows the results to be included as an attached report, or as a reference (i.e. link) to where the results are located. Pending results can be indicated using a Result Status of "pending".	EVENT.DIAGNOSTIC INVESTIGATIONS
	Investigation Type	C, S, D, E, Q	Codeable Text	1	The type or category of investigation performed on the patient – e.g. "Pathology", "Diagnostic Imaging".	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.Diagnostic Investigation Type
	Investigation Name	C, S, D, E, Q	Codeable Text	1	The name of the investigation performed on the patient – e.g. "INR".	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.Diagnostic Investigation Name
	Investigation Date	C, S, D, E, Q	DateTime	1	The date and/or datetime that the diagnostic investigation was performed (in the case of diagnostic imaging investigations), or the specimen was taken (in the case of pathology investigations).	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.DateTime of Diagnostic Investigation
	Result Status	C, S, Q	Codeable	1	The status of the investigation result –	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
			Text		e.g. "pending", "interim", "final".	INVESTIGATION.Result Status
	Document Control	C, S, E, Q	Document Control	0..1	Information about the attached results or pending result (such as the version number, identifiers, document type, status and date attested) that will assist in the processing and document management of the attachment.	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.REPORT ATTACHMENT.DOCUMENT CONTROL
	EITHER					
	Link	C, S, E, Q	Link	0..1	A reference to an external repository where the investigation results are stored.	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.REPORT ATTACHMENT.Link or Data
	OR					
	Data	C, S, E, Q	Encapsulated Data	0..1	The actual content of the investigation report. The report may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text, or XML using a NEHTA-defined template.	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.REPORT ATTACHMENT.Link or Data
Clinical interventions		C, S, E	Section	0..Many	Describes the clinical interventions (including operations and procedures) performed on the patient during the healthcare encounter.	EVENT.CLINICAL INTERVENTIONS PERFORMED THIS VISIT.CLINICAL INTERVENTION
	Clinical Intervention	C, S, E	Codeable	1	A separate description should be included for	EVENT.CLINICAL INTERVENTIONS PERFORMED THIS VISIT.CLINICAL

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Description		Text		each Clinical Intervention performed. Information pertaining to a related complication may also be included.	INTERVENTION.Clinical Intervention Description
Current medications on discharge		C, S, D, E, Q	Item Detail	1..Many	Medications that the patient will continue or commence on discharge.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE
	Discharge Medications Indicator	C, S, E, Q	Coded Text	1	Indicates whether or not the patient is known to be taking any medications on discharge. For example "Known" or "None known"	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.KNOWN MEDICATIONS
					IF Known THEN	If MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.KNOWN MEDICATIONS.Known Medications Type = "Current Medications on Discharge" and MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.KNOWN MEDICATIONS.Known Medications Value = "Known" THEN
	Status	C, S, Q	Coded Text	1	The status of the medication item at the time of discharge (e.g. "New", "Unchanged", "Dose increased", "Dose decreased", "Withheld").	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Item Status
	Item Description	C, S, D, E, Q	Codeable Text	1	The details that fully describe a medication, including the name of the medication (active ingredients or brand name), strength and	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.ITEM.Item Description

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					dose form, where appropriate.	
	Dose Instructions	C, Q	Text	1	A description of how a particular product is being taken by the patient as at the date of discharge, or is intended to be taken immediately following discharge. This must include the route, dose quantity, frequency and any additional instructions required to safely describe the appropriate dosage. This should also include the administration schedule. In discharge summary systems, which support atomic dosage instructions, this item only needs to be populated when the atomic dosage items are not.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.DOSAGE.Dose Instruction
	Reason for Medication	C, D, E, Q	Codeable Text	0..1	The clinical justification (e.g. specific therapeutic effect intended) for the use of the medication. For inpatient discharge summaries, this should be recorded.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Reason for Medication
	Duration	C, S, E	Time Interval and Coded Text	0..1	The time period (optionally including start date, end date and length of time) that the patient has taken or will take the prescribed medication. If no end	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Medications Duration

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					date is supplied, then the medication is ongoing. If the length of time post discharge is required, then this can be derived for display.	
	Changes Made	C, Q	Codeable Text	0..1	A description of any change made during the healthcare encounter, where the change is intended to continue after discharge.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.CHANGE DETAILS.Changes Made
	Reason for Change	C, Q	Text	0..1	The justification for the stated change in medication.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.CHANGE DETAILS.Reason for Change
	Quantity Supplied	C, S, Q	Text	0..1	The quantity of medication supplied by the facility to the patient, with which the patient is discharged.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Unit of Use Quantity Dispensed
	Additional Comments	C, Q	Text	0..1	Any additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management – e.g. "Patient requires an administration aid", "Patient will require new script in 3 days of discharge", "Dosage to be reviewed in 10 days", "Target INR for warfarin management", or "Recommence post-discharge" (for medications with status	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Additional Comments.

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					of "Withheld".	
	Medication Item Authoriser	C, S, Q	Participation HPI	1	The healthcare provider who authorized for this item to be added to the Current Medications on Discharge list for the purpose of medication reconciliation, and the role they played in the patient's healthcare (e.g. "Pharmacist").	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.MEDICATION ITEM AUTHORISER
Ceased medications		C, S, D, E, Q	Item Detail	1..Many	Medications that the patient was taking at the start of the healthcare encounter (e.g. on admission), that have been stopped during the encounter or on discharge, and that are not expected to be recommenced.	MEDICATIONS.CEASED MEDICATIONS
	Ceased Medications Indicator	C, S, E, Q	Coded Text	1	Indicates whether or not the patient has any known ceased medications during the healthcare encounter or on discharge. For example "Known", "None known".	MEDICATIONS.CEASED MEDICATIONS.KNOWN MEDICATIONS
					IF Known THEN	If MEDICATIONS.CEASED MEDICATIONS.KNOWN MEDICATIONS.Known Medications Type = "Ceased Medications" and MEDICATIONS.CEASED MEDICATIONS.KNOWN MEDICATIONS.Known Medications Value = "Known"

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
						THEN
	Item Description	C, S, D, E, Q	Codeable Text	1	The name of the medication, as described by the prescriber or pharmacist. This description should include the active ingredient names, brand name, strength and dose form of the medication, where appropriate.	MEDICATIONS.CEASED MEDICATIONS.ITEM DETAIL.ITEM.Item Description
	Reason for Ceasing	C, Q	Text	1	The reason that the medication was ceased.	MEDICATIONS.CEASED MEDICATIONS.ITEM DETAIL.CHANGES MADE
Allergies / Adverse reactions		C, S, D, E, Q	Adverse Reaction	1..Many	Describes the known adverse reactions for the patient (including allergies and intolerances), and any relevant reaction details.	HEALTH PROFILE.ADVVERSE REACTIONS
	Adverse Reactions Indicator	C, S, E, Q	Coded Text	1	Indicates the status of knowledge about the patient's Adverse Reactions. For example "Known", "None known", "Unknown", "Not asked".	HEALTH PROFILE.ADVVERSE REACTIONS.Known Adverse Reactions Value
					IF Known THEN	IF HEALTH PROFILE.ADVVERSE REACTIONS.Known Adverse Reactions Value = "Known" THEN
	Agent Description	C, S, D, E, Q	Codeable Text	1	The agent/substance causing the adverse reaction experienced by the patient.	HEALTH PROFILE.ADVVERSE REACTIONS.ADVVERSE REACTION.Agent Description
	Reaction Description	C, S, D, E, Q	Codeable Text	0..Many	The signs and/or symptoms experienced	HEALTH PROFILE.ADVVERSE REACTIONS.ADVVERSE REACTION.REACTION

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					or exhibited by the patient as a consequence of the adverse reaction to the specific agent/substance. The severity of the reaction and certainty may be included in this description, where appropriate.	DETAIL.Reaction Description
Alerts		C, Q	Alert	0..Many	Describes alerts pertaining to the patient that may require special consideration or action by the recipients.	HEALTH PROFILE.ALERTS
	Alert Type	C, S, Q	Codeable Text	1	The type of alert (e.g. infection risk, special needs, clinical, discharge circumstances, vulnerable families, psychosocial alerts etc).	HEALTH PROFILE.ALERTS.ALERT.Alert Type
	Alert Description	C, S, Q	Codeable Text	1	Describes the nature of the alert.	HEALTH PROFILE.ALERTS.ALERT.Alert Description
Arranged services		C, S, E, Q	Requested Service	0..Many	Describes clinical services that have been provided for or arranged for the patient. This can include appointments related to clinical follow up. If the service provision has not been confirmed then, the service date and/or provider may not be recorded.	PLAN.ARRANGED SERVICES
	Service Description	C, S, E, Q	Codeable Text	1	A description of the arranged service.	PLAN.ARRANGED SERVICES.ARRANGED SERVICE.Arranged Service Description

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Service Date	C, S, Q	DateTime or Time Interval	0..1	The datetime or date range at/during which the arranged service is scheduled to be provided to the patient.	PLAN.ARRANGED SERVICES.ARRANGED SERVICE.Service Commencement Window
	Service Provider	C, S, E, Q	Participation	0..1	The provider (individual or organisation) that has been requested to provide the service. This may include their role, identifiers, name, address and contact details.	PLAN.ARRANGED SERVICES.ARRANGED SERVICE.SERVICE PROVIDER
	Service Booking Status	C, S, Q	Codeable Text	1	An indication of the booking status of the arranged service – e.g. "requested", "tentative", "confirmed".	PLAN.ARRANGED SERVICES.ARRANGED SERVICE.Service Booking Status
Recommendations		C, S, E	Recommendation	1..Many	Recommendations to a recipient healthcare provider and/or patient that are relevant to the continuity of care and management of the patient after discharge.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.RECOMMENDATIONS PROVIDED
	Recommendation To	C, S, E	Participation	1	The individual or organisation, who will be receiving a copy of the discharge summary, and to which the recommendation is directed.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.RECOMMENDATIONS PROVIDED.RECOMMENDATION RECIPIENT
	Recommendation Note	C	Text	1	Details of the recommendation given by the healthcare provider from the facility.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.RECOMMENDATIONS PROVIDED.Recommendation Note

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
Information provided to patient and/or relevant parties		C, Q	Section	0..1	Details of the information and education that has been provided to and discussed with the patient, their family, carer and/or other relevant parties, including awareness or lack of awareness of diagnosed conditions, and relevant health management. An indication of whether or not the patient or carer has understood the information or instructions provided may also be relevant.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.INFORMATION PROVIDED.
	Information Provided Description	C, Q	Text	1	A description of the information that has (or has not been) been provided to the patient.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.INFORMATION PROVIDED.Information Provided to Subject of Care and/or Relevant Parties
Document control		C, S, E, Q	Document Control	1	Versioning and other document control information associated with the Discharge Summary document. These details are required for the technical exchange of the document and do not necessarily need to be displayed to the user. However, there may be value in displaying some items (e.g. Version Number, Date Attested, Document Status, etc.).	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Document Instance Identifier	S, Q	Unique Identifier	1	The universally unique identifier of this instance of the Discharge Summary document.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Instance Identifier
	Document Set Identifier	S, Q	Unique Identifier	1	The universally unique identifier of the set of documents related to the same healthcare encounter, of which the Discharge Summary document is a versioned instance.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Set Identifier
	Version Number	C, S, Q	Integer	1	The version number of the Discharge Summary document instance.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Version Number
	Document Originating System Identifier	S, E, Q	Unique Identifier	1	A universally unique identifier of the system used to create the Discharge Summary document.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Originating System Identifier
	Document Type	C, S, Q	Coded Text	1	The name of the Discharge Summary document type used – e.g. "Discharge Summary"	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Type
	Document Type Version Number	S, Q	Integer	1	The version number of the Discharge Summary document type used to create the Discharge Summary.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Type Version Number
	Confidentiality Indicator	S, Q	Coded Text	1	The degree to how sensitive information might be and the extent to which the information can be shared. This is currently reserved for	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Confidentiality Indicator

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					future application and values have not been assigned to this indicator.	
	DateTime Attested	C, S, Q	Date Time	1	The date/time when the Discharge Summary document was attested (or finalised, or signed off) by the document authoriser.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.DateTime Attested
	Document Status	C, S, Q	Coded Text	1	The status of the document (e.g. "Interim", "Final", "Amended")	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Status
	Language	S, Q	Coded Text	1	The language primarily used within the document (e.g. "en-AU")	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Language
Attachments		C, S, E, Q	Attachment	0..Many	Documents that have been attached to the Discharge Summary (as a link or as data), because they are relevant to the ongoing care of the patient. For example a care plan, or a health assessment.	ATTACHMENTS
	Document Name	C	Text	1	The name of the attached document, to be used when referencing the attachment (e.g. "Care Plan")	ATTACHMENTS.ATTACHMENT.Document Name
	Document Control	C, S, E, Q	Document Control	0..1	Information about the attachment (such as the version number, identifiers, document type and date attested)	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					that will assist in the processing and document management of the attachment.	
	Section Reference	C,S	Codeable Text	0..Many	The section in the Discharge Summary from which the attachment should be referenced – e.g. Pathology, Physical Assessment. This information may be used to organise references to the attachments into appropriate groups.	ATTACHMENTS.ATTACHMENT.Section Reference
	EITHER					
	Link	C, S, E, Q	Link	0..1	A reference to an external repository where the attachment is stored.	ATTACHMENTS.ATTACHMENT.Link or Data
	OR					
	Data	C, S, E, Q	Encapsulated Data	0..1	The actual content of the attachment. The attachment may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text or XML structured using a NEHTA-defined template.	ATTACHMENTS.ATTACHMENT.Link or Data

Table 1 Core Component Definition

3 Component and Item Types

3.1 Component Types

The following component types are referred to in the Core Discharge Summary definition. For more details, please refer to [DS-SDT2009].

3.1.1 Adverse Reaction

Describes the known adverse reactions experienced by the patient and any relevant reaction details.

3.1.2 Alert

Describes information pertaining to a patient that may:

- Need special consideration by a healthcare provider before making a decision to avert an unfavourable healthcare event
- Need consideration and/or action by a healthcare provider or facility in relation to the care and safety of the patient, staff and/or other individuals
- Notify the healthcare provider of special circumstances that may be relevant in delivering care and/or interacting with the patient.

3.1.3 Attachment

Documents that have been attached to the Discharge Summary (either as a link or as data), because they are relevant to the ongoing care of the patient. For example, the original referral, relevant pathology reports, relevant diagnostic imaging reports, referral letters, a care plan, and assessments.

3.1.4 Document Control

Holds versioning information about the document instance that belongs to the same logical document set, i.e. that are related to the same healthcare event/encounter/clinical interaction.

3.1.5 Item Detail

Describes a single unique medication product.

3.1.6 Participation

Refers to the individuals, organisations and IT systems operating within a defined healthcare domain, and the roles that these entities play within that domain.

3.1.7 Participation Organisation

Refers to an organisation operating within a defined healthcare domain, and the roles that it plays within that domain.

3.1.8 Participation Person

Refers to an individual within a defined healthcare domain, and the roles that he or she plays within that domain.

3.1.9 Participation HPI

Refers to a Healthcare Provider Individual operating within a defined healthcare domain, and the roles that he or she plays within that domain.

3.1.10 Recommendation

Recommendations to a recipient healthcare provider and/or patient that are relevant to the continuity of care and management of the patient after discharge.

3.1.11 Requested Service

Describes a clinical referral or a service requested for, planned for, or provided to the patient.

3.1.12 Section

Groups related information together and provides a way to navigate through the data items within the document.

3.2 Item Types

This section briefly describes the item types referred to in the Core Discharge Summary definition. For more details, please refer to [DS-SDT2009].

3.2.1 Address

An Address is a structured description of a physical or postal location, which includes the following sub-elements:

- No Fixed Address Indicator (Boolean)
- Address Line (Text)
- Suburb/Town/Locality (Codeable Text)
- State/Territory/Province (Codeable Text)
- Postcode (Codeable Text)
- Country (Codeable Text)
- Australian Delivery Point Identifier (Identifier)
- Address Purpose (Coded Text)
- Address Purpose Date Range (Time Interval).

3.2.2 Any

This item type is used where the data type may vary considerably depending on the context – e.g. free text, numeric values, or data structures.

3.2.3 Boolean

A simple datatype, which has one of two values: true and false.

3.2.4 Codeable Text

Codeable Text is a flexible datatype used to hold either free text or coded text. Codeable Text includes the following sub-elements:

- Display Name (Text)
- Original Text (Text)

- Translation (Coded Text)
- Code (Text)
- Code System (UUID)
- Code System Name (Text)
- Code System Version (Text)
- Value Set (Text)
- Value Set Version (Text).

3.2.5 Coded Text

Coded Text is used to hold both a text description and code mappings. Coded Text includes the following sub-elements:

- Display Name (Text)
- Original Text (Text)
- Translation (Coded Text)
- Code (Text)
- Code System (UUID)
- Code System Name (Text)
- Code System Version (Text)
- Value Set (Text)
- Value Set Version (Text).

3.2.6 Date Time

Data Time is used to specify a single date and/or time. It has the ability to indicate a level of precision, and define estimated or partial dates. An estimation flag may be used to indicate whether or not the date is an estimate. String representations of known dates should conform to the non-extended format within [ISO21090-2008] – that is “YYYYMMDDHHMMSS.UUUU[+|-ZZzz]”.

3.2.7 Document Control

Versioning and other document control information associated with the Discharge Summary document. These details are required for the technical exchange of the document and do not necessarily need to be displayed to the user. However, there may be value in displaying some items (e.g. Version Number, Date Attested, Document Status, etc.).

3.2.8 Electronic Communication Details

Electronic Communication Details is used to describe methods for electronically contacting a person or organisation, including telephone numbers, fax numbers, pager numbers, email addresses and URLs. Electronic Communication Details include the following sub-elements:

- Electronic Communication Medium (Coded Text)
- Electronic Communication Usage Code (Coded Text)
- Electronic Communication Details (Text).

3.2.9 Encapsulated Data

Data that is primarily intended for human interpretation or for further machine processing, outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g. XML-signatures).

3.2.10 Entity Identifier

Entity Identifiers are used to uniquely identify a person or organisation, and includes the following sub-elements:

- Identifier Designation (Text)
- Identifier Geographic Area (Coded Text)
- Identifier Issuer (Text)
- Identifier Type (Text).

3.2.11 Episode

An episode identifies a single healthcare event, encounter or interaction or a series of these, defined and grouped according to a particular healthcare process. Episodes are determined by a healthcare provider, and can cover one or more illnesses, and can involve one or more providers. Episodes include the following sub-elements:

- Episode Identifier (Identifier)
- DateTime Episode Started (Date Time).

3.2.12 Integer

The mathematical datatype comprising the exact integral values [ISO11404-2007].

3.2.13 Link

A link is a reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system (e.g. URL or path).

3.2.14 Organisation Name

The name by which an organisation is known, which includes the following sub-elements:

- Organisation Name (Text)
- Department/Unit (Text)
- Organisation Name Usage (Coded Text)
- Organisation Name Usage Date Range (Time Interval).

3.2.15 Participation Organisation

Participation Organisation refers to an organisation operating within a defined healthcare domain, and the roles that it plays within this domain. It includes the following sub-elements:

- Role Name (Codeable Text)
- Participation DateTime Range (Codeable Text)
- Relationship to Patient (Coded Text)
- Entity Identifier (Entity Identifier)

- Address (Address)
- Electronic Communication (Electronic Communication Details)
- Organisation Name (Organisation Name).

3.2.16 Participation Person

Participation Person refers to an individual within a defined healthcare domain, and the roles that he or she plays within this domain. It includes the following sub-elements:

- Role Name (Codeable Text)
- Participation DateTime Range (Codeable Text)
- Relationship to Patient (Codeable Text)
- Entity Identifier (Entity Identifier)
- Address (Address)
- Electronic Communication (Electronic Communication Details)
- Person Name (Person Name)
- Additional Demographics (Person Additional Demographic Data).

3.2.17 Participation HPI

Participation HPI refers to a Healthcare Provider Individual operating within a defined healthcare domain, and the roles that he or she plays within this domain. It includes the same sub-elements as Participation Person, in addition to the following:

- Employer Organisation (Employer Organisation Detail)
- Healthcare Provider Practice (Healthcare Provider Practice Detail).

3.2.18 Participation

A participation (person or organisation) playing a particular role within a particular healthcare domain. It may include the sub-elements of either Participation Person, Participation Organisation or Participation HPI.

3.2.19 Person Name

Person Name captures the name details of a person. A person may have more than one name recorded. It includes the following sub-elements:

- Name Title (List of Text)
- Family Name (Text)
- Given Name (List of Text)
- Name Suffix (List of Coded Text)
- Preferred Name Indicator (Boolean)
- Name Conditional Use Flag (Coded Text)
- Person Name Usage
- Person Name Usage Date Range.

3.2.20 Quantity

Used for recording real world measurements and observations. It includes the magnitude value and the units, and may also include its precision.

3.2.21 Quantity Range

Two Quantity values that define the minimum and maximum values (i.e. lower and upper bounds). This is typically used for defining the valid range of values for a particular measurement or observation. Unbounded quantity ranges can be defined by not including a minimum and/or a maximum Quantity value.

3.2.22 Text

Text refers to a character string (with optional language indicator). Unless otherwise constrained by an implementation, it can be any combination of alphanumeric characters or symbols from the Unicode character set. This is sometimes referred to as free text.

3.2.23 Time Interval

A time interval is a period of time, which may have a Start DateTime, an End Date Time and/or a Duration/Width.

3.2.24 Unique Identifier

A general type of identifier which uniquely identifies a physical or virtual object of concept within a defined domain. In many cases, it is recommended to use a Universally Unique Identifier (UUID).

Definitions

This section explains the specialised terminology used in this document.

Shortened Terms

This table lists abbreviations and acronyms in alphabetical order.

Term	Description
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AMA	Australian Medical Association
CC	Core Connectivity
CI	Clinical Information
CIO	Chief Information Officer
CT	Clinical Terminology
EHR	Electronic Health Record
GP	General Practitioner
HPI	Healthcare Provider Identifier
ICT	Information and Communication Technology
IEHR	Individual Electronic Health Record
INR	International Normalisation Ratio
IT	Information Technology
NASH	National Authentication Service for Health
NEHTA	National E-Health Transition Authority
RACGP	The Royal Australian College of General Practitioners
RACMA	The Royal Australasian College of Medical Administrators
RACP	The Royal Australasian College of Physicians
RACS	The Royal Australasian College of Surgeons
RANZCR	The Royal Australian and New Zealand College of Radiologists
RCPA	The Royal College of Pathologists of Australasia
SDT	Structured Document Template
SIL	Service Instance Locator
SNOMED CT	Systemised Nomenclature of Medicine, Clinical Terminology
UHI	Unique Healthcare identifiers
UUID	Universally Unique Identifier

Glossary

This table lists specialised terminology in alphabetical order.

Term	Description
Admitting doctor	The clinician, with the appropriate delegated authority, who decides that a patient should be admitted to the hospital.
Author	The medical officer chiefly responsible for completing the discharge summary.
Authoriser	The clinician responsible for authorising the release and distribution of the discharge summary.
Business Architect	A Business Architect is anyone looks at the way work is being directed and accomplished, and then identifies, designs and oversees the implementation of improvements that are harmonious with the nature and strategy of the organisation. Source: http://www.businessarchitects.org
Contributor	Other clinical staff who can complete specific sections of the Discharge Summary.
Development Team	The Developer writes the code for the specifications that the Development leads provide. Source: http://www.developer.com
Discharge summary administrator	Responsible for the non-technical administration of the discharge summary system and processes.
Distribution list	List of all planned unambiguously recipients of a discharge summary instance.
Distributor	Can distribute discharge summaries that have already been finalised and distributed. Typically this would be Medical Records staff who receive requests from GPs.
Electronic Signature	An electronic signature refers to a form of authentication for the web services and includes signed certificates.
Endpoint	Where a web service connects to the network. Source: http://www.looselycoupled.com/glossary/endpoint
Exception list	List of discharge summaries received by a Practice that have anomalies that need to be resolved through human intervention.
Interim discharge summary	A discharge summary released to provide information to recipients with the understanding that the information contained may not be complete and is subject to change/amendment.
Interoperability	The ability of software and hardware on multiple machines from multiple vendors to communicate. Source: http://foldoc.org/interoperability
Non-admitted Patient	Patients who are admitted for dialysis, same day radiotherapy and other procedures involving repetitive one day admissions would not normally require a discharge summary are referred to as non-admitted patients.
Persistent Data	Persistent Data denotes information that is infrequently accessed and not likely to be modified. It out lasts the execution of a particular program.
Solutions Architect	The Solutions Architect is typically responsible for matching technologies to the problem being solved. Source: http://www.developer.com
Summary Health Profile	A standard specification of demographic and health/clinical data contents used to capture information about the health status of a patient at a specific point-in-time. It is intended to provide crucial health status information to facilitate the delivery of safe, quality care to the patient, especially in unplanned/emergency

Term	Description
	situations.
Technical Architect	The technical architect is responsible for transforming the requirements into a set of architecture and design documents that can be used by the rest of the team to actually create the solution. Source: http://www.developer.com
Treating doctor	The clinician responsible chiefly responsible for the care of the patient during an inpatient episode.
Worklist	List of discharge summaries currently assigned to a particular clinician.

References

At the time of publication, the document versions indicated are valid. However, as all documents listed below are subject to revision, readers are encouraged to also seek out the most recent versions of these documents.

Package Documents

The documents listed below are part of the suite delivered in the discharge summary package.

Discharge Summary Package Documents			
[REF]	Document Name	Publisher	Link
[DS-ES2009]	Discharge Summary Release 1.0 – Executive Summary v0.45	NEHTA 2009	http://www.nehta.gov.au/e-communications-in-practice/edischarge-summaries Open menu: e-Discharge Summary Package
[DS-RN2009]	Discharge Summary Release 1.0 – Release Notification v0.05		
[DS-BRS2009]	Discharge Summary Release 1.0 – Business Requirements Specification v0.14		
[DS-SD2009]	Discharge Summary Release 1.0 – Solution Design v0.18		
[DS-CIC2009]	Discharge Summary Release 1.0 – Core Information Components v0.34		

References

The documents listed below are non-package documents that have been cited in this document.

Reference Documents			
[REF]	Document Name	Publisher	Link
[AIHW-AHS2006]	'Australian hospital statistics 2006-07', 2008, Health Services Series, No. 31, Cat. no. HSE 55. Canberra.	Aust Inst of Health & Welfare 2008	http://www.aihw.gov.au/publications/index.cfm/title/10587
[AS4700.6(Int)2007]	Interim Australian Standard, Implementation of Health Level Seven (HL7) Version 2.5, Part 6: Referral, discharge and health record messaging	Standards Australia 2007	http://infostore.saiglobal.com/store/ Search "AS 4700.6(Int)-2007".
[DS-SDT2009]	Discharge Summary - Core, Structured Document Template (20090807) (v2.0)	NEHTA 2009	http://www.nehta.gov.au/clinical-information-mi Open menus at bottom of web page.
[ISO11404-2007]	ISO/IEC 11404:2007 Information technology - General-Purpose Datatypes (GPD)	ISO 2007	http://www.iso.org Search "11404:2007".
[ISO21090-2008]	ISO/DIS 21090 Health Informatics - Harmonized data types for information interchange	ISO 2008	http://www.iso.org Search "21090" using 'Standards under development'.
[NDSDCS2006]	National Discharge Summary Data Content Specifications v1.0	NEHTA 2006	http://www.nehta.gov.au/ Search "discharge content".

Related Reading

The documents listed below may provide further information about the topics discussed in this document.

Related Documents			
[REF]	Document Name	Publisher	Link
[IF2007]	Interoperability Framework v2.0	NEHTA 2008	http://www.nehta.gov.au/ Search "interoperability 2.0".
[WSP2008]	Web Services Profile v3.0	NEHTA 2008	http://www.nehta.gov.au/ Search "web services profile" using 'Exact Phrase' filter.
[NEHTAWEB]	NEHTA Web Site	NEHTA 2008	http://www.nehta.gov.au/

Key Contacts

Persons listed below may be contacted to provide further information about the topics discussed in this document.

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