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NHS England

Professional guidance on the structure and content of ambulance records

December 2014

Produced by:

Royal College of Physicians

Organisations that endorsed the guidance

Association of Ambulance Chief Executives
Association of Directors of Children's Services
Association of Air Ambulances
British Association for Immediate Care (BASICS)
British Cardiovascular Society
British Heart Foundation
British Orthopaedic Association
British Red Cross
Care Provider Alliance
College of Emergency Medicine
College of Occupational Therapists
College of Paramedics
Independent Ambulance Association
National Ambulance Services Medical Directors Group
National Care Association
National Voices
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists
Royal National Lifeboat Institution
Royal Pharmaceutical Society
The Faculty of Pre-Hospital Care

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Foreword

Reliable recording of information is key to the successful treatment of people needing urgent or emergency care. Patients expect those looking after them to be able to access their clinical records, regardless of provider and location, where this is important to their clinical care. Additionally, the public expect the NHS to understand the quality of care provided in terms of effectiveness and safety. Integration of digital records will facilitate both of these aims, so the secretary of state for health has charged NHS England with ensuring that patients' records are digital and integrated within the next two years.

This report setting out national ambulance patient record guidance was commissioned by NHS England from the Health and Social Care Information Centre and contracted out to the Royal College of Physicians Health Informatics Unit. It is closely aligned with the standards for the structure and content of clinical records, which were published in July 2013. The aim is to create true digital integration from primary care, into the ambulance services and onto acute, community, mental health and other health and care provider organisations. This guidance will allow greater measurement and understanding of clinical care provided by the nation's ambulance services.

The guidance is an essential part of the Interoperability Architecture Framework being developed for health and social care, and will be implemented through commissioning and contracting arrangements.

Professor Sir Bruce Keogh
National Medical Director
NHS England

Guidelines for implementation

Personalised health and care 2020: a framework for action, published by the National Information Board, has set out a clear national direction for the use of standards in the health and care system. The national ambulance patient records content guidance will lead to development of interoperability and data standards for integration of ambulance systems with NHS 111, general practitioners and accident and emergency services. Implementation of this content guidance is not presently mandated nor centrally funded, however it is supported for implementation by a range of stakeholders – including the College of Paramedics and the Association of Ambulance Chief Executives. Funding for the implementation of this guidance and any future published information standards should form part of the specifications associated with the procurement or re-procurement of electronic patient records systems. Outside of these arrangements implementation may be funded via local contracting arrangements with clinical commissioners as part of local information integration plans where considered locally appropriate.

Introduction

This document describes the clinical professional guidance for the structure and content of ambulance patient records. The project to develop the guidance was sponsored by NHS England and commissioned by the Health and Social Care Information Centre (HSCIC). The guidance has been endorsed by 25 patient and professional representative groups, including the College of Paramedics, the Association of Ambulance Chief Executives and the College of Emergency Medicine. The guidance has been approved as a draft standard for trial use by the Professional Record Standards Body for Health and Social Care (PRSB) in July 2014.

The ability to integrate information from emergency ambulance services with hospital and primary care systems will have major benefits as the development and implementation of electronic health records gathers pace across the health service. The implementation of this guidance will allow information to be shared across settings to support patient care and be used in performance management, audit and commissioning, providing benefits for patients, the ambulance services, and the services with which they work.

Purpose of the guidance

The primary purpose of the guidance is to support paramedics and ambulance services in providing safe high-quality care for patients. Information recorded in a care record is the cornerstone of clinical care, underpinning safety and quality of care. Access to relevant information from a person's historical medical and social care records can be critically important for ambulance services' incident management. Ambulance crews need to accurately and efficiently record and transfer appropriate clinical information to another care service to support patient care. High-quality data can also be used for a number of important secondary purposes, including clinical audit, planning, policy, commissioning and research. For both primary and secondary purposes, electronic ambulance patient records should be patient focused and hold data recorded at the point of care using national standards and definitions.

Historically ambulance services in the UK have used stand-alone paper records and with widely varying adoption of electronic systems for recording information about patients. NHS England and the health secretary set challenging targets in 2013 for progress towards a paperless NHS by 2018. In order to realise this challenge, there must be standardised structure and content of the clinical information being captured in electronic systems to support safe, high-quality care of ambulance patients. The importance of these care record standards is reflected in the requirement set out in *Integrated digital care fund: achieving integrated health and care records* (www.england.nhs.uk) for applications to focus on solutions that incorporate the national record structure and content standards, and promote their use by clinical professions.

Development of the guidance

The Health and Social Care Information Centre (HSCIC) commissioned the Health Informatics Unit (HIU) of the RCP to develop standards for admission, handover, discharge, outpatient and referral records, published in July 2013. These standards were endorsed as fit for purpose by 50 clinical organisations, signed off by the Academy of Medical Royal Colleges and adopted by the Professional Records Standards Body for Health and Social Care (PRSB). NHS England and HSCIC required the ambulance patient record guidance to be based on and consistent with these existing clinical record standards (www.rcplondon.ac.uk/resources/standards-clinical-structure-and-content-patient-records). Work on the ambulance patient record guidance was led by paramedics with the support of the HIU.

The guidance was developed in consultation with patients, the ambulance services, the College of Paramedics, the Association of Ambulance Chief Executives and other relevant professional bodies, and was supported by the HIU of the RCP. We acknowledge and thank the organisations whose representatives and members contributed to the development of the ambulance patient record headings. A total of 33 organisations supported the development of the guidance and it has been endorsed by 25 organisations. The guidance was approved as a draft standard for trial use by the PRSB (www.theprsb.org.uk) in July 2014.

Development of the ambulance patient record guidance involved review of existing published evidence, the existing standards for the structure and content of clinical records, and the ambulance documentation currently used by the ambulance services of the UK. Extensive consultation was carried out with patients and professional bodies, both in multi-stakeholder project workshops and via an online survey which elicited 732 responses.

How to use the guidance in practice

This section summarises key points related to implementing the ambulance patient record guidance. More detailed implementation guidance is available in the implementation guidance section.

This is professional record guidance, which provides a standard structure for headings for the ambulance record which is meaningful to clinicians and patients. Each heading has a clinical description, which identifies the type of information to be recorded from a clinical perspective, so that a clinician will know what to record under each heading.

An ambulance electronic patient record system should include all of the headings. However, not all headings will need to be used in all circumstances, and should only be used when appropriate. All electronic systems should ensure that for every record entry, the date, time and the identity of the person making the entry is automatically recorded. The order in which the headings appear in applications, letters and communications can be agreed by end users and system suppliers.

Ambulance headings and subheadings

Incident details	
Subheadings	**Clinical description**
Source of call	Where the call originated from, eg 999, NHS 111, police, GP, hospital etc.
Caller details	The name and phone number of the person making the call and the relationship of the caller to the patient if known (especially if the patient is a child). Record if the caller is a child. Also whether the caller is with the patient.
Ambulance service	The ambulance service provider. This could be NHS, air ambulance, voluntary or private provider.
Incident number	The number that identifies the incident and is generated by the dispatcher in response to a call.
Incident date	The date of the incident.
Incident time	The time the incident occurred.
Time call received	The time that the call is connected to the ambulance control centre switchboard.
Incident details	Information about the incident recorded by the dispatcher.
Incident location	The location of the incident.
Normal place of residence?	Is this the patient's normal place of residence – yes/no?
Triage urgency code	The triage assessment by the dispatcher that determines the degree of urgency.
Dispatch time	The time the incident was allocated to the ambulance crew or individual responder.
Time mobile	The time the crew or individual responder is mobile following allocation of the incident.
Post-dispatch instructions	Additional information recorded and communicated by the dispatcher following allocation of the incident. This could include access instructions, such as key code.
Arrival time at incident	The time the crew or individual responder arrived at the scene of the incident.
Time at patient side	The moment of arrival at the patient's side.

(continued overleaf)

Time left incident location	Time the crew or individual responder left the incident location.
Person accompanying patient	Person who has family, carer or other relationship who accompanies the patient.
Emergency driving exemption applies	Record of using blue lights travelling from the incident to handover destination.
Pre-alerts to receiving unit	Record of whether information has been transmitted to the expected handover destination prior to arrival (Y/N).
Patient demographics	
Subheadings	**Clinical description**
Patient name	The full name of the patient. Also patient-preferred name: the name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Patient sex	Sex at birth. Determines how the individual will be treated clinically.
Gender	As the patient wishes to portray themselves.
Ethnicity	The ethnicity of a person as specified by the person.
Religion	The religious affiliation as specified by the patient.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, eg Community Health Index (CHI) in Scotland.
Patient address	Patient's usual place of residence.
Patient telephone number	Telephone contact details of the person. To include, eg, mobile, work and home number if available.
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Name, relationship and contact details.
Communication preferences	Preferred contact method, eg sign language, letter, phone, etc. Also preferred written communication format, eg large print, braille.
Educational establishment	If the patient is a child, name and address of where the child attends, eg play group, nursery, school.

(continued overleaf)

Special requirements	
Subheadings	**Clinical description**
Special requirements	Special requirements that a patient has. Eg level of language (literacy); preferred language (interpreter required); bariatric ambulance required; support for any disability or impairment; any other special requirements.
Existing care plan and care management information	Record that there is a care plan or similar information held by the patient or held on other health or social care registers, eg Coordinate My Care, Hampshire Health Record, Summary Care Record, Special Patient Notes etc. Where the patient is a child this may include a 'child in need plan', 'child protection plan', 'looked after child plan', or may reference a particular adult care plan.
Participation in research	
Subheadings	**Clinical description**
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow-up, and contact number for adverse events or queries.
GP practice	
Subheadings	**Clinical description**
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.
GP practice identifier	National code which identifies the practice.
Health and care professional details	
Subheadings	**Clinical description**
Responsible health or care professional	The name, designation and/or personal identification number (if used) of the person with responsibility for the patient within this contact. Where multiple professionals have responsibility, provide details of the duration and extent of responsibility held. State whether identified professional was present, in communication, on call etc.

(continued overleaf)

Health or care professional(s) present	The name, designation and/or personal identification number (if used) of all other health or care professionals present.
Other agencies present	
Subheadings	**Clinical description**
Other agencies present	Identifier, name and/or designation of individuals from attending agencies, eg police, air ambulance, GP, community first responder, fire, coast guard, midwife, chemical hazards team, voluntary services etc.
Relevant clinical risk factors	
Subheadings	**Clinical description**
Relevant clinical risk factors	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/ differential diagnosis. Eg pregnancy, being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc.
Environmental risk factors	Factors in the patient's environment with immediate risk for the patient's health and wellbeing, eg loose carpets, steep stairs, damp etc.
Clinical risk assessment	Specific risk assessments required/undertaken, including thromboembolic risk assessment, spinal risk assessment etc.
Risk mitigation	Advice given or action taken to reduce the clinical risk, including action and date and time actioned.
Patient at high risk	This patient is at high risk of clinical deterioration if a specific existing condition is not recognised as being present. Eg Addison's disease, hard-to-control diabetes.
Presenting complaints or issues	
Subheadings	**Clinical description**
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow-up from admission, falls, a specific procedure, investigation or treatment.

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History	
Subheadings	**Clinical description**
History of each presenting complaint or issue	Information directly related to the development and characteristics of each presenting complaint (eg including travel history). Time of onset should be recorded when appropriate, eg stroke, cardiac arrest. Record whether the information is given by the patient or their carer.
Information brought by patient	Eg Patient Passport, diary data, pre-completed questionnaire, hand-held maternity record, personal child health record etc.
Relevant past medical, surgical and mental health history	The record of the patient's significant medical, surgical and mental health history (will include dental and obstetric history). Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc.
Management to date	Referrals, management, investigations and treatment that have already been undertaken, including patient managing their symptoms. Including: • Procedures conducted – procedures carried out (and the date) and procedure report.
Medications and medical devices	
Subheadings	**Clinical description**
Person authorising medication	The name and identification details of the person writing the prescription or authorising the medication.
Source of medication	Whether the medication is the patient's own or part of the ambulance stock.
Medication name	May be generic name or brand name (as appropriate).
Medication form	Eg capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc): may include method of administration (eg by infusion, via nebuliser, via NG tube) and/or site of use (eg 'to wound', 'to left eye', etc.).

(continued overleaf)

Dose	This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.
Medication frequency	Frequency of taking or administration of the therapeutic agent or medication.
Additional instructions	Allows for: • requirements for adherence support, eg compliance aids, prompts and packaging requirements • additional information about specific medicines, eg where specific brand required • patient requirements, eg unable to swallow tablets.
'Do not discontinue' warning	To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario.
Reason for medication	Reason for medication being prescribed, where known.
Medication recommendations	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Medication status	Whether or not a medication is being administered, eg started, stopped, suspended, reinstated. Record date for each change in status.
Medication change	Where a change is made to the medication, ie one drug stopped and another started or, eg, dose, frequency or route is changed.
Reason for medication change	Reason for change in medication, eg, sub-therapeutic dose, patient intolerant.
Medicine administered	Record of administration to the patient, including self-administration.
Reason for non-administration	Reason why drug not administered (eg patient refused, patient unavailable, drug not available).
Relevant previous medications	Record of relevant previous medications.
Medical devices	The record of dietary supplements, dressings and equipment that the patient is currently taking or using.
Medicine batch number	Record of the batch number of the medication.
Medicine expiry date	Record of the expiry date of the medication.

(continued overleaf)

Medicine effect	Record of the patient response to a given medication, eg pain score following analgesia.
Allergies and adverse reaction	
Subheadings	**Clinical description**
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient.
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: • manifestation, eg skin rash • type of reaction (allergic, adverse, intolerance) • severity of the reaction • certainty • evidence (eg results of investigations).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.
Date first experienced	When the reaction was first experienced. May be a date or partial date (eg, year) or text, eg during childhood.
Safety alerts	
Subheadings	**Clinical description**
Risks to self	Risks the patient poses to themselves, eg suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to care professional or third party.
Legal information	
Subheadings	**Clinical description**
Consent	Whether consent has been obtained and the situation the consent relates to, eg treatment, referral, information sharing, transfer etc. May include where record of consent is located or record of consent.
Record of refusal	The record of the objections made by the patient and the reasons for their objections. Also include the information given when patient refuses consent, including signature and designation of staff, and patient signature.

(continued overleaf)

Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when, and the outcome of the assessment. Also record best interests decision if patient lacks capacity.
Mental Health Act status	Record where a patient diagnosed with a mental disorder is formally detained under the Mental Health Act, including the section number.
Advance decision to refuse treatment (ADRT)	A record of an advance decision made by the patient to refuse a specific type of treatment at some time in the future. This may be verbal, but it must be in writing, signed and witnessed if it is the refusal of life-sustaining treatment. Also record if there has been a change in the decision.
Advance statement	Requests or preferences that have been stated by a patient conveying their wishes, beliefs and values regarding future care. This includes: • whether there is a written document • location of the document.
Lasting power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: • whether there is a person with lasting power of attorney for health and welfare, independent mental capacity advocate (IMCA), court appointed deputy. • name and contact details for person. Confirm that lasting or enduring power of attorney is not restricted to financial matters.
Consent relating to child	Consideration of age and competency, applying Gillick competency or Fraser guidelines. Record of person with parental responsibility or appointed guardian where child lacks competency. Record if there is disagreement between patient and parent.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg child protection plan, protection of vulnerable adult.
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.

(continued overleaf)

Social context	
Subheadings	**Clinical description**
Household composition	Eg lives alone, lives with family, lives with partner, etc. This may be free text.
Important patient relationships	Others present at the incident, or not present but with important relationships, eg dependants such as very young child. Record the name and the relationship with the patient where relevant.
Lives alone	Yes/no/don't know (Y/N/DK)
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and wellbeing, eg the record of the patient's physical activity level, pets, hobbies, sexual habits.
Smoking	Latest or current smoking observation.
Alcohol intake	Latest or current alcohol consumption observation.
Recreational substance use	Record of current or previous recreational substance use.
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history.
Social circumstances	The record of a patient's social background, network and personal circumstances, eg housing and religious, ethnic and spiritual needs, social concerns and whether the patient has dependants or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record.
Services and care	The description of services and care providing support for patient's health and social wellbeing.
Family history	
Subheadings	**Clinical description**
Family history	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc.

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Review of systems	
Subheadings	**Clinical description**
Review of systems	The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties, mood/anxiety, etc.
Patient's and carer's concerns, expectations and wishes	
Subheadings	**Clinical description**
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent, or the parent of a young child.
Examination findings	
Subheadings	**Clinical description**
General appearance	The record of a clinician's 'first impression' assessment including general clinical examination finding, eg clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight, etc.
Vital signs	The record of essential physiological measurements, eg heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of Early Warning Score (which may be computed) chart where appropriate.
Mobility	Patient's mobility, eg requirement for walking aid, wheel chair, etc.
Mental state	Formal mental state examination or general description. Eg depression, anxiety, confusion, delirium, dementia.
Cardiovascular system	The record of findings from the cardiovascular system examination.
Respiratory system	The record of findings from the respiratory system examination.
Abdomen	The record of findings from the abdominal examination.
Musculoskeletal system	The record of findings from the musculoskeletal system examination.

(continued overleaf)

Skin	The record of findings from examination of the skin.
Nervous system	The record of findings from the nervous system examination.
Genitourinary	The record of findings from the genitourinary examination.
Head and neck examination	The record of findings from the head and neck examination.
Oral examination	The record of findings from oral examination.
Assessment scales	
Subheadings	**Clinical description**
Assessment scales	Assessment scales used, eg Glasgow Coma scale, AVPU (alert, voice, pain, unresponsive) scale, Wong Baker Pain scale, etc.
Problems and issues	
Subheadings	**Clinical description**
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance, yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation.
Diagnosis	
Subheadings	**Clinical description**
Clinical impression	The clinical impression the clinician has made based on available evidence.
Differential diagnosis	The determination of which one of several conditions may be producing the symptoms.
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.
Procedures	
Subheadings	**Clinical description**
Procedure	The therapeutic procedure performed. This could include site and must include laterality where applicable.

(continued overleaf)

Complications related to procedure	Details of any complications during the procedure or associated with the procedure.
Specific anaesthesia issues	Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.
Treatments and interventions	
Subheadings	**Clinical description**
Treatments and interventions	Record here any specific treatments and interventions that should be identified. All medications should be recorded under the medications heading.
Clinical summary	
Subheadings	**Clinical description**
Clinical summary	Narrative summary of the episode. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'. In mental health and psychiatry, this may be the place for formulation.
Investigations and results	
Subheadings	**Clinical description**
Investigations requested	This includes a name or description of the investigation requested and the date requested.
Investigations results	The result of the investigation (including the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results.
Plan and requested actions	
Subheadings	**Clinical description**
Actions	Including planned investigations, procedures, and treatment, for a patient's identified conditions and priorities: a) person responsible – name and designation/department/hospital/patient etc – of person responsible for carrying out the proposed action, and where action should take place

(continued overleaf)

	b) action – requested planned or completed c) when action requested for – requested date, time, or period – as relevant d) suggested strategies – suggested strategies for potential problems, eg telephone contact for advice.
Escalation plan	Who needs to be contacted in the event of significant problems or patient deterioration.
Agreed with patient or legitimate patient representative	(Y/N/NA) Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments if any. Also if agreement cannot be obtained and reason for this.
Aims and limitations of treatment and special instructions	The current aim of treatment including limitations to treatment and communication issues.
Do not attempt cardio-pulmonary resuscitation (DNACPR)	Whether a decision has been made, the decision, the date of decision, date for review and location of documentation.
Information and advice given	
Subheadings	**Clinical description**
Information and advice given	This includes: • what information • to whom it was given. The oral or written information or advice given to the patient, carer, other authorised representative care professional or other third party. Also the preferred format for information. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment.
Disposition details	
Subheadings	**Clinical description**
Disposition type	The type of disposition including handover (eg to A&E; from community first responder to ambulance crew), referral (to other service), discharge (eg, home or self-discharge).

**The grey subheadings on pages 24 and 25 are different types of patient disposition.* *(continued overleaf)*

Handover	
Handover destination	Details of the hospital or other location where handover occurs. This may also include team or department.
Additional handover information	Eg list of items such as personal belongings and other information relevant to the handover.
Date of arrival at handover destination	The date the ambulance parks at the handover destination.
Time of arrival at handover destination	The time the ambulance parks at the handover destination (eg A&E, clinic, etc).
Time of notification of arrival	The time of the notification to the receiving team that the ambulance has arrived.
Time of handover	The time the patient was handed over to the receiving care professional.
Time of leaving handover destination	The time taken by ambulance crews to complete any reports and to prepare their vehicle for the next call and to call 'clear' with the ambulance control room.
Person receiving handover	
Name	
Personal identification number	
Designation or role	
Grade	
Specialty	
Contact details	
Referral	
Referral to	Name, designation and organisation. If not an individual, this could be a service, eg GP surgery, department, specialty, subspecialty, educational institution, mental health, social services etc.
Reason for referral	A clear statement of the purpose of the person making the referral, eg diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient, (eg palliative care), provide referrer with advice/guidance. This may include referral because of carers' concerns.
Referral date	The date the referral was made.

(continued overleaf)

Referral time	The time the referral was made.
Person to attend with patient	Identify others who will/may accompany the patient, eg relative, carer, chaperone. Includes: • name • relationship (friend, relative, etc.) • role (patient advocate, chaperone etc.) • attendee's special requirements.
Attachments	Documents included as attachments which accompany the communication.
Referral criteria	Records whether specific criteria required for referral, to a particular service, have been met (may be nationally or locally determined).
Expectation of referral	A clear statement of the expectations of the person making the referral as to the management of the patient, eg advice only, diagnosis, treatment, etc.
Discharge	
Discharge date	
Discharge time	
Discharge reason	Reason for discharge of patient, eg completion of treatment, treatment advised, refusal of treatment, no treatment required, life extinct etc.
Discharge destination	The destination of the patient on discharge from hospital or other healthcare provider.
Discharged into care of	Record of individual or organisation taking responsibility for patient upon discharge, eg carer, relative, care home, supported living environment, GP, police etc.
Discharge address	Address to which patient discharged. Only completed where this is not the usual place of residence.
Recognition of life extinct	
Evidence for decision	The evidence used in coming to the decision that the patient's life is extinct.
Date and time life extinct confirmed	The date and time at which the decision that life is extinct is made
Person making decision	Name, personal identification number, and/or designation.

(continued overleaf)

Person completing record	
Subheadings	**Clinical description**
Name	
Designation or role	
Grade	
Specialty	
Contact details	
Date completed	
Distribution list	
Subheadings	**Clinical description**
Distribution list	Other individuals to receive copies of this communication/referral letter.

Implementation guidance

Implementing the ambulance record guidance into electronic patient records will:

- provide a common structure which, if adopted universally, will make it easier for both patients and clinicians to navigate around an electronic health record where information is drawn from different care settings

- enable the context and hence the meaning of information to be preserved when communicating between different care settings and information systems, thus enabling information reuse.

Explanation of record guidance

This is professional record guidance, rather than information or technical standards. As such, it provides a standard structure of headings for the ambulance record that is meaningful to clinicians and patients. Each heading has a clinical description, which identifies the type of information to be recorded from a clinical perspective, such that a clinician would know what to record under each heading.

The document does not specify the data content precisely, eg data type, code lists, etc. Further work is needed to develop such specifications and it is expected that standards for structured content will be developed over time, based on evidence and national consensus.

The top-level headings, such as 'social context', (which includes 'household composition', 'lifestyle', 'alcohol intake', etc) are intended to support navigation around the record and are clinical groupings of related subheadings, rather than having any semantic meaning.

The subheadings that fall under a heading may vary between care setting or document type (eg ambulance record, discharge summary, referral). In other words, a specific subheading may appear under different headings in different contexts.

The majority, but not all, of the subheadings are record entries (eg patient 'date of birth', 'usual address', etc). An exception is 'medication and medical devices', which has been broken down into components or elements within a record entry, eg medication 'dose', 'frequency' etc.

It is possible that some subheadings may be broken down further in the future, creating additional, more detailed headings. For example, it is already recognised that investigation results may need additional subheadings to enable structured information to be captured on individual investigations.

Scope of record guidance

The focus of the guidance work has been on the ambulance patient report form and communication with the hospital and GP.

It has not been possible in the project timescales to consider supplementary information recorded by the ambulance service, where national standardisation would also be of value. The following documents were identified specifically by the steering group:

- *Recognition of life extinct*. Currently there are different forms in place across ambulance trusts and the four nations. Standardisation of this documentation would need consultation with the body representing coroners.

- *Major incident report*. This is a multi-patient report form used to record summary information in major incidents and to transfer this information on to the hospital. The principle would be to use appropriate headings in the report, but this project has defined neither what these headings should be, nor what or how information should be communicated to other agencies.

The guidance has been developed with widespread consultation, but piloting it in live operation was excluded from scope of the project. Hence it has not yet been 'road tested' in an ambulance electronic patient record. This is a vital prerequisite to the guidance being finalized as 'fit for purpose'.

Implementation in electronic patient records

The headings can be implemented in an ambulance electronic patient record (EPR) through inclusion of a requirement for the headings in an EPR procurement and configuration during implementation.

1 Recording against headings

A full electronic patient record should include all the headings listed in this document. However, it is not intended that all the data will be recorded for all patients. Data will only be recorded against a heading in an individual patient's record when there is a clinical need to do so. In the pre-hospital environment, it will be vital to capture necessary relevant information concerning the patient in a timely manner and the design of the IT system must accommodate this requirement.

2 Information obtained from elsewhere

Not all the information in the ambulance EPR will be recorded by the ambulance crew. Relevant information that has been recorded by NHS 111 or in the control room should be available to the paramedic and displayed under appropriate headings in the record. Patient demographic information should be obtained from the Personal Demographics Service (PDS). Relevant timings may be recorded automatically by computer-aided dispatch (CAD) in the vehicle.

3 Sequence

The sequence in which the headings are presented in this document is not prescriptive. Within an EPR, the information will be displayed for data recording, reviewing and communicating in an order that enables effective clinical practice.

4 Content

The information under each heading can be either free text or coded. At present, much of the coded information will be local. However the recommendation will be to use NHS-mandated standards, eg SNOMED CT, DM+D etc. In some instances, eg source of call, there is a need to agree a national set of appropriate options to support analysis at a national level.

Many ambulance patient report forms include a 'homunculus' or diagram of a body to use to record site of injuries, IV sites, etc. This could be included under the 'Examination findings' heading, but this would be an implementation decision for users.

5 Format

The information can be displayed in any format as designed by the end user and supplier. The ambulance guidance provides a common structure to the record, not a style guide. Different IT systems can display the same message in different ways, but the content will remain the same. Where there is a heading and a subheading with the same name, eg 'family history', there is no need to display the heading as well as the subheading.

6 Date, time and author

One of the generic medical record-keeping standards is that each record entry must have the date and time recorded and the signature of the person making the record. This information should be recorded in an electronic record automatically, by date and time stamping each record and associating it with the personal identification of the individual recording it.

7 Source of information

Information recorded may be provided by other people and agencies, eg police, midwife, GP, patient's relative. Where this is the case, the source should be recorded.

Implementation in electronic communications

The ambulance guidance has been based on the Clinical Documentation and Generic Record Standards (CDGRS) so that it is consistent with the headings to enable information sharing between ambulance and hospital/primary care.

Information from the ambulance record will only be communicated according to clinical need. This means that:

- *not all headings in the ambulance record need to appear in ambulance discharge or referral communications. For some headings, only those against which information has been recorded will need to be communicated, but for others, eg allergies and adverse reactions, headings will need to be communicated even where there is no content.*

- *some of the information (eg provided by the dispatch) is intended to inform the ambulance crew rather than for onward communication.*

- *the content of the communication will differ according to the type of recipient. For example, social care may not need the clinical detail needed by healthcare services.*

- *users, in consultation with their suppliers, can define clinical communications and decide which of the headings are appropriate to include in them, the sequence of the headings in the communication and the format of the communication.*

- *additional information would need to be carried in the electronic communication, such as details of the sender and recipient, document type etc. These are not specified in the ambulance headings, but would be included in a technical message specification.*

PRSB
Professional Record Standards Body
for health and social care

The Professional Records Standards Body for Health and Social Care (PRSB) has approved this guidance as a draft standard for trial use.

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