eHealth Programme

(EH4001) CLINICAL DOCUMENT INDEXING STANDARDS

Version: 2.8

September 2015

Contents

1. Document Control

1.1 Summary information

Document Title	(eH4001) Clinical Document Indexing Standards
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Document status	Approved for publication
Date of last update	January 2015
Date of publication	September 2015
Compliance	Use of this standard is RECOMMENDED, PROSPECTIVELY, in all clinical systems, in particular those sharing information across Health Boards.
Owner	Clinical Change Leads Group (CCLG)
Change Control	Will be managed by NHS National Services Scotland Information Services Division and a Virtual Reference Group. Contact: mailto:NSS.isdDataStandards@nhs.net
Date for revalidation	A revalidation case will be sought from the standard owner in December 2014.

1.2 Version control

Date	Author	Version	Modifications
01/8/11	CC	V0.1	Initial Draft
16/1/12	CC	V0.2	Feedback from consultation period incorporated.
3/7/12	PW	V0.3	feedback from CCLG and NSS input
19/10/2012	CL	V0.4	eHealth A&D not suitable owner. CCLG accepted ownership. Section 2.5 amended to reflect this.
06/11/2012	CL	V0.5	Amendments requested by PET before sign-off
5/12/12	CL	V2.0	Version control / configuration data updated following approval to publish
15/04/13	AMW	V2.1	Modification – Duplicate code (CL12 – Operation Note) removed following Virtual Reference Group Meeting approval.
01/08/13	AMW	V2.2	Creating of new code LA20 - Genetics
22/11/13	CJA	V2.3	Remove ETT from description under code RP02. Creation of new codes; LA09 – Histocompatibility & Immunogenetics MI03 – Legacy Bulk Scanned Record CA06 – Anticipatory Care Plan (ELT) CA07 – Anticipatory Care Plan (ITG) AS34 – Risk Assessment RP34 – ETT RP35 – Ambulatory ECG monitoring report RP36 – Implant Device Maintenance report
07/03/2014	KH	V2.3	AS35 – Gait Analysis Assessment

24/03/2014	KH	V2.4	Creation of new codes: RP37 - Endoscopy Report – Upper GI RP38 – Endoscopy Report – Lower GI
15/07/2014	CJA	V2.5	AS35 – Gait Analysis Assessment Record
09/12/2014	CJA	V2.6	Updated document control by removing version number and modifications under document status. Amended order of codes under each document type so codes 99 are now at the end of each listing. IN09 - UVA / PUVA Treatment Record RP39 – Visual Field Reports RP40 – Nuclear Medicine Report IM03 – Nuclear Medicine Images
12/06/2015	KH	2.7	Creation of new code: RP41 Post Mortem/ Autopsy
04/09/2015	CJA	V2.8	Creation of new codes: RE01 Research Study Consent and Participant Information Sheet RE02 Research Study Visit Document RE03 Research Study Randomisation Documentations RE04 Research Study Adverse Event Documentation RE05 Research Study withdrawal/ Un-blinding RE99 Research Study Document – not otherwise specified

1.3 Strategic Objectives

Reviewer	Role/Department	Date signed off
Consortium Project Team	Workshop Participants/Reviewers	8th June 2011
eHealth Programme Executive Team	Approvers	5th November 2012
Clinical Change Leadership Team	Approvers	19th September 2012
eHealth Leads	Approvers	
eHealth Programme Executive Team	Approvers (Publication)	4th December 2012
Virtual Reference Group	Approvers	15th April 2013
	Design Review and Approval Panel representative	

2. Introduction

2.1 Purpose

This document describes proposed revisions to the NHS Scotland Clinical Document Indexing Standard v1.0 (2007).

This standard has been produced through a collaborative exercise led by NHS Greater Glasgow and Clyde on behalf of all Boards, and is for the use of NHS Scotland information systems (IS) and eHealth projects.

This is **version 2.8 (2015)** of the Standard, approved for publication.

2.2 Background

As Health Boards modernise and reorganise patient/client care there is a growing requirement for patients/clients to move across traditional geographical and care boundaries. This requirement, in turn, creates a need to have greater sharing of information across the boundaries - whilst maintaining patient/client safety and adhering to appropriate standards.

Over the past few years, Health Boards in Scotland have embarked on various initiatives to enhance the availability and use of electronic information and to increase the volume and scope of electronic clinical information and documents.

Provision of electronic solutions to support this increased electronic sharing relies on effective, efficient and consistent indexing across all NHS boards.

Feedback received from different health boards suggested that the initial NHS Scotland Clinical Document Indexing Standard, published in 2007, required review and possible amendment.

For these reasons three workshops were hosted by NHS Greater Glasgow and Clyde, supported by Scottish Government eHealth directorate. The first workshop concentrated on sharing experiences from document scanning projects in both primary and secondary care across NHS Scotland. The second and third workshops discussed the national speciality reference file and the NHS Scotland Clinical Document Indexing Standard, which includes a listing of document types and subtypes.

Feedback from the Boards, together with the outcomes of the workshops suggested that:

- The document indexing standard, and associated list of document types and subtypes, does not have any associated definitions
- The document indexing standard contains more options than are actually necessary and there appear to be some clinically relevant omissions
- Any amendments to the list should consider inclusion of non-medical specialties to ensure that nurse or therapy led service activity can be reported appropriately
- The costs associated with amending and implementing a new reference file, and the potential complexity of mapping existing document types and sub types to a new standard, need to be considered. There needs to be clear justification to amend the current document indexing standard.

2.3 Overview

This standard comprises of a list of clinical document indexes including document types and sub-types.

This list of index elements (metadata) is associated with a document and used for storage and future searching or sorting. One such element, the document 'Type' or category element demands a list of acceptable clinical document types that the NHS clinical community can approve as a standard list and would be fit for implementation in the various developments.

The current document standards have been in existence for a number of years. As a result, numerous changes to the standards were requested and added to the national reference file.

The indexing standards required to be considered and options assessed in light of the move towards electronic working and in the increased use of the standards. The 'do nothing' option was considered and rejected on the basis that current use of clinical documents was not reflected in the existing standards. This was discussed and agreed at the initial meeting of the group.

The revised indexing standards have made some small changes in indexing and classification of a few documents; this should not alter local storage of information and need not necessitate immediate change or cost to any board. Should a board wish to share information externally or to bring in external information from another board any subsequent project should detail the new mapping requirements and funding arrangements.

Updates to the files will be made by the custodians of the indexing standards and made available for NHS Boards for use. Where a review causes a change to the indexing used for any document consideration must be given to the historical content retained. The principle stated in the previous paragraph should be applied whenever possible.

A guidance document (**Document indexing guidance notes v2.3**) should be read alongside this standard. It dictates the set of metadata recommended to be stored and transmitted with a clinical document. It also illustrates the relationships between the various standards related to clinical document management.

2.4 References

A copy of the current document indexing standards can be found on the eHealth Standards Library web page and the ISD website .

The ISD national specialty list is to be used in document indexing, this is available as a reference file from ISD:- (http://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/National-Reference-Files/).

For background information on the clinical document Indexing Standards, please refer to the following paper written by Paul Woolman in 2007:-
eHealth WebSite - Document Indexing Paper 2007

Document Indexing Guidance Notes v2.3 (2014) published with this standard.

2.5 Ownership

Ownership of the Clinical Document Indexing Standards is with the Clinical Change Leadership Group (CCLG).

Ongoing maintenance of the standard, including a contact point for occasional additions or modifications will be provided by NHS Information Services (ISD) Data Management service. ISD will take a 'stewardship' role in respect of the standard and establish a Virtual Reference Group to that effect. The Virtual Reference Group should have representation from CCLG and NHS GGC, as the original authors, and will consider any requests for change.

NHS NSS will provide the following service:

1. ISD will maintain the clinical document type standard, as part of the funding it already receives for the Data Management, Data Advice Team.

2. ISD will as required convene a national stakeholder group drawing on previous specialist knowledge to include representatives of the clinical portal, SCI Store, boards, etc. This could function virtually depending on the discussion required.

3. Interim revisions required will be agreed by the Virtual Reference Group. If a change endorsed by the Virtual Reference Group is significant and its implementation would result in additional cost or implementation activity, it will be escalated to the full CCLG for approval. On approval ISD will make the required changes to the source file and publish on the web

In addition to the ongoing maintenance 'custodianship' provided by NSS, SG eHealth will instigate periodic reviews of the standard, likely to be on a two or three year period as with all other eHealth standards.

2.6 Contents

The remainder of this document is presented in the following sections:

Section 3 describes the scope of the standard i.e. which type of project the standard may apply to, and the associated timescales;

Section 3.4 contains the detail of the standard;

Section 4 describes the sign off process for the standard.

3. Scope

3.1 Overview

The scope recognises this as a National requirement and includes all NHS Scotland Boards. Input was sought directly from:

- NHS Greater Glasgow and Clyde (Lead Board)
- NHS Dumfries and Galloway
- NHS Forth Valley
- NHS Grampian
- NHS Tayside
- SCIMP
- NHS National Services Scotland
- Scottish Government – eHealth Division

3.2 Applicable systems

All clinical systems in particular those sharing information across Health Boards for example:-

- Clinical Portals
- SCI Store
- Letters Systems

- Clinical Systems
- GP Systems (EMIS & INPS)
- TrakCare

3.3 Timescales

The standard should to be implemented in accordance with eHealth and local Health Board strategies.

3.4 Contents of standard

Following on from workshops held, consultations and reviews, the current standards have been updated to reflect the discussion points and agreement reached with the stakeholders.

The proposed document type standards are as follows:-

REVISED DOCUMENT INDEXING STANDARDS (September 2015)		
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**
AL	**Alerts & Risks**	
AL01	Allergies and Adverse Reactions	Any allergy or adverse reaction noted at a point in time
AL02	Alerts	Any alert noted at a point in time
AS	**Assessments**	
AS01	Nursing assessment tool	Any tool used by nursing staff for recording an assessment.
AS02	AHP Assessment	Any assessment completed by an AHP
AS03	CAF assessment	Common Assessment Framework - a standard approach to conducting assessments of children's additional needs.
AS04	(SSA) assessment	Single Shared Assessment - person-centred and more streamlined approach led by a single professional with other specialist involvement where appropriate.
AS05	CPA assessment	Care Programme Approach.
AS07	Multidisciplinary assessment	Any assessment completed by various clinical staff groups
AS08	Scored Assessment	Any completed scored assessment.
AS10	Pre-admission assessment	Any assessment completed prior to any admission.
AS11	Self-assessment form	Any assessment completed by a patient
AS12	Medical assessment	Any assessment completed by medical staff
AS13	Theatre Patient Checklist	Intervention/Procedure check prior to theatre
AS14	Social Services Assessment.	Any assessment completed for or by social services
AS15	Pre Op Assessment	Any assessment completed prior to an intervention/ procedure
AS16	Nursing Profile	Any profile used by nursing staff to assess a patient.
AS34	Risk Assessment	Self-explanatory
AS35	Gait Analysis Assessment Record	This is a structured assessment of an individual's gait which may include graphs and

REVISED DOCUMENT INDEXING STANDARDS (September 2015)		
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**
		charts, images of the objective findings.
AS99	Assessment	Not Specified or for bulk scanning
CA	**Care Plans**	
CA03	Clinical Care Plan	Any care plan involving clinicians and/or social services which may or may not be integrated. Also includes Care Pathway.
CA04	MDT Plan	Any care plan involving multi disciplinary staff groups for example Lung MDT Plan
CA05	Discharge Plan	Any care plan used for discharge planning including nursing
CA06	Anticipatory Care Plan (ELT)	End of Life Treatment decisions
CA07	Anticipatory Care Plan (ITG)	Individualised Treatment Guidelines for a patient with an unusual condition or difficulty treating a condition
CA99	Care Plan	Not Specified or for bulk scanning
CH	**Observations**	
CH03	Fluid Balance Chart	Any chart, form or document used to record fluid balance
CH04	Fundal height chart	Any chart, form or document used to record fundal height
CH05	Growth Chart	Any chart, form or document used to record growth
CH06	ITU & ICU chart	Any chart, form or document used to record intensive care or intensive therapy observations
CH07	Partogram	A graphical record of key data (maternal and fetal) during labour for example Cervical Dilatation
CH08	Temperature Chart	Any chart, form or document used to record temperature
CH09	Patient Safety Checklist	Any chart, form or document used for this purpose
CH10	Vital Signs Chart	Any chart, form or document used to vital signs
CH11	Weight Chart	Any chart, form or document used to record weight
CH99	Observation	Not specified or for bulk scanning
CL	**Clinical Notes**	
CL03	Inpatient medical note	Any inpatient information recorded by medical staff
CL04	Inpatient nursing note	Any inpatient information recorded by nursing staff
CL05	Medical note	Any information recorded by medical staff
CL06	Multidisciplinary note	Any information recorded by multiple staff groups
CL07	Nursing note	Any information recorded by nursing staff including community notes
CL08	OOH note	Any information recorded by Out of Hours service

REVISED DOCUMENT INDEXING STANDARDS (September 2015)		
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**
CL09	Outpatient nursing note	Any outpatient information recorded by nursing staff
CL10	Outpatient medical note	Any outpatient information recorded by medical staff
CL11	AHP note	Any information recorded by an AHP e.g.. Dietetic Record Card
CL13	Telephone Consultation	Any clinical information pertaining to a telephone consultation
CL14	Video Consultation	Any clinical information pertaining to a video consultation
CL15	Summary record	Any clinical summary noted at a point in time
CL16	ED Card	Emergency department clinical note e.g.. AE Card
CL99	Clinical note	Not Specified or for bulk scanning and remote notes including patient contacts by telephone and email.
CO	**Correspondence**	
CO02	Outpatient Letter	Created as a result of an out patient clinic attendance e.g.. clinic letter
CO03	Clinical letter	Containing clinical information, not a clinic attendance or discharge
CO04	Discharge letter	Created as a result of discharge from care
CO06	Inpatient Final Discharge letter	Final inpatient discharge letter Includes day case
CO08	Immediate Inpatient Discharge letter	Immediate inpatient discharge letter includes day case
CO09	Letter from patient	Letter received from a patient
CO10	Letter to patient	Clinical letter sent to a patient
CO14	Referral letter	Referral from any source about the patient
CO15	Social service letter	Letter from social services
CO16	Transfer letter	Transfer of care letter
CO17	Administrative Letter	Administrative letters sent to patient e.g.. Invitation letter, Admission letter and Recall letter
CO18	Did not Attend Letter	Letter sent to patient and/or GP advising of non-attendance and subsequent action.
CO19	Unscheduled Care	Unplanned/unscheduled contact e.g.. AE letters, NHS24 letters, OOH
CO20	MDT Letter	Multi-Disciplinary Letter
CO99	Correspondence	Not Specified or for Bulk Scanning
IM	**Images**	
IM01	Radiology	Images which are sourced from else where and not available on other electronic systems e.g. PACS.
IM02	Medical Photograph	Photographic images related to patient management
IM03	Nuclear Medicine Images	Images sourced from nuclear medicine investigations

REVISED DOCUMENT INDEXING STANDARDS (September 2015)		
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**
IM99	Images	Not specified or for bulk scanning
IN	**Interventions/Procedures**	
IN01	Anaesthetic record	Record of Anaesthesia
IN03	Nutritional record	Diet intake, enteral and parenteral feeding
IN04	Endoscopy record	Record of endoscopic intervention
IN05	Interventional radiology record	Record of radiotherapy treatment for cancer
IN06	AHP therapy record	Record of AHP therapy
IN07	Operation note	Record of surgical intervention
IN08	Radiotherapy record	Record of radiotherapy treatment
IN09	UVA / PUVA Treatment Record	Intervention involving ultraviolet light therapy, often as an outpatient treatment
IN99	Intervention	Not specified or for bulk scanning
LA	**Labs**	
LA01	Biochemistry	Any result from a test performed in a Biochemistry lab
LA02	Labs summary	A summarised view of location/patient results
LA03	Haematology	Any result from a test performed in a haematology lab
LA04	Cellular Pathology	Any result from a test performed in a celluar pathology lab, Includes Histopathology & Cytology
LA05	Virology	Any result from a test performed in a virology lab
LA06	Immunology	Any result from a test performed in an immunology lab
LA07	Microbiology	Any result from a test performed in a microbiology lab, including MSSU, MRSA Screening
LA08	Blood transfusion	Any result from a test performed in a blood transfusion lab
LA09	Histocompatibility & Immunogenetics	Renal, Cardiac, Stem Cell transplant H&I investigations and HLA disease associations
LA20	Genetics	Any results from genetic investigations are to be filed here. Examples include: cytogenetics, clinical genetics, biochemical and molecular.
LA99	Labs	Not specified or for bulk scanning
ME	**Medication**	
ME01	Controlled drugs dispensing	Any chart, form or document recording the dispensing of controlled drugs e.g., Morphine, Diamorphine
ME03	Drug administration chart	Any record of the administration of medicine for example Insulin or Warfarin
ME07	Medication record	Any medication record including Prescription record, repeat prescriptions & Med Reconciliation form
ME08	Prescription and administration record	Any record for the prescribing and administration of medicine, for example Kardex as used in some Health Boards.

REVISED DOCUMENT INDEXING STANDARDS (September 2015)		
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**
ME09	Chemotherapy record	Record of chemotherapy treatment for cancer
ME99	Medication	Not specified or for bulk scanning
MI	**Miscellaneous**	
MI01	Miscellaneous	Non defined document within this section
MI02	Front sheet	Patient Master Index Sheet. For Bulk Scanning.
MI03	Legacy Bulk Scanned Record	Bulk scanned whole patient case record
NO	**Notification & Legal Documents**	
NO01	Fiscal Autopsy report	Formal Autopsy report from Fiscal office.
NO02	Child protection documentation	Record of child protection case conference, child safety action plan, summary of investigation.
NO03	Consent form	Document advising consent has been obtained
NO04	Death certificate	Certificate of death
NO05	Exemption form	Any record that relates to patient exemptions
NO06	Infectious disease notification	Notification of infectious disease for example to Public Health
NO07	Legal notice	Any legal notice
NO08	Mental Health Act notice	Emergency Detention Certificate, Short Term Detention Certificate, Compulsory Treatment Order, Revocation.
NO09	Refusal Form	Notice that patient has refused treatment
NO10	Employment report	Self-explanatory
NO11	Housing report	Self-explanatory
NO12	War Pensions report	Self-explanatory
NO13	Disabled driver badge report	Self-explanatory
NO14	Driving licence fitness report	Self-explanatory
NO15	DSS RMO RM2 report	Self-explanatory
NO16	Insurance (life) report	Self-explanatory
NO17	RM10-DHSS DMO report	Self-explanatory
NO18	DLA 370 report	Self-explanatory
NO19	DS 1500 report	Self-explanatory
NO20	Adoption Report	Self-explanatory
NO21	Adult Incapacity Report	Self-explanatory
NO22	Power of attorney/Legal Guardianship	Self-explanatory
NO99	Notification & Legal Document	Not specified or for bulk scanning
PH	**Patient held records**	
PH01	Patient held record	Any record held by the patient
PA	**Patient Preferences/Instructions**	
PA01	DNAR order	Any patient instruction regarding resuscitation
PA02	Living Wills & Advance directives	Any patient instruction regarding treatment/care
PA03	Organ donor card	Any patient instruction regarding organ donation
PA99	Patient Preferences/Instruction	Not Specified or for bulk scanning

REVISED DOCUMENT INDEXING STANDARDS (September 2015)		
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**
RE	**Research/ Research Study**	
RE01	Research Study Consent and Participant Information Sheet	Signed Consent Form and associated Participant Information Sheet. From a practical and governance perspective, it is important that the correct, matching-paired versions of PIS and Consent are always stored together. Additionally, it is often the case that these are supplied as single, combined documents. It is therefore best to categorise these as the same document sub-type.
RE02	Research Study Visit document	Documents used by Clinical Trials Staff, Research Nurses or Investigators to collect study data during patient visits – examples include Source Data Worksheets, Study Data Capture Forms, Clinical Sheets
RE03	Research Study Randomisation documentation	Any documentation detailing randomisation
RE04	Research Study Adverse Event documentation	Details of any participant adverse events. This category would only be used where details of the Adverse Event are not recorded elsewhere – e.g. within a Study Visit Document. Sponsors' SAE / SUSAR Forms, etc., are stored in the CRF rather than the medical notes.
RE05	Research Study withdrawal / un-blinding	Any study document completed as a result of withdrawal or un-blinding of a study participant
RE99	Research Study Document – not otherwise specified	Any other study-specific document that does not fit into any of the above categories or for bulk scanning
RP	**Reports**	
RP02	ECG	For example ECG
RP05	Pulmonary Investigation	For example, PFT, Sleep tests
RP08	Vascular Investigation	For example, Carotid, DVT
RP09	Gastro Investigation	For example, Breath tests, PH studies
RP11	Cardiac Investigation	All other Cardiac tests except those in sub-types ECG & Echos e.g. Ambulatory BP
RP12	Urodynamics	For example, Urethral function test, Cystometry
RP13	Neuro Investigation	For example, Carpal tunnel, EEG & nerve conduction studies
RP29	Ambulance Patient Report Form	For example ePRF (Electronic Patient Report Form)
RP30	Radiology	For example, X-ray, CT
RP31	Echo	For example, Echocardiogram
RP32	Audiology Investigation	For example, Hearing Aids, Tinnitus
RP33	AHP Investigation	For example, balance test, swallowing tests
RP34	ETT	Exercise Tolerance Test report
RP35	Ambulatory ECG monitoring report	For example 24 hour ECG

REVISED DOCUMENT INDEXING STANDARDS (September 2015)		
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**
RP36	Implanted Device Maintenance Report	For example maintenance can include device check, replacement of leads, reprogramming, repositioning, testing etc
RP37	Endoscopy Report – Upper GI	Self-explanatory
RP38	Endoscopy Report – Lower GI	Self-explanatory
RP39	Visual Field Report	A report detailing a plot of patient's visual fields and any associated defects.
RP40	Nuclear Medicine Report	A report on nuclear medicine imaging, 2D scintigraphy, 3D SPECT and PET scan reports e.g. bone scan, myocardial perfusion, V/Q scan, PET.
RP41	Post Mortem/ Autopsy	Report of a post mortem examination / autopsy not carried out under the auspices of the procurator fiscal's office.
RP99	Report	Not specified or for bulk scanning
TH	**Third party documents**	
TH01	Non-Statutory provider document	Any document from a non-statutory organisation for example, local authority information
TH02	Private provider note	Any document from private health care provision
TH99	Third party document	Not specified or for bulk scanning
Document Types = 17 & Document Sub Types = 155		

Guidance Notes have been produced which provide further clarity when applying the indexing standards to documents and act as a quick reference to ensure there is an agreed and consistent approach for storing and retrieving electronic clinical documentation.

3.5 Data items

Data items are not applicable as this is a document management standard.

4. Document approval and sign-off

4.1 Current status

This standard is currently at **version 2.8**. It has been issued for final approval by the eHealth Programmes Executive Team.

4.2 Final sign off

This standard will be completed according to the standard review and authoring process as defined in relevant e-Health process document and the standard will be reviewed and signed off as described in section 4.1.