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

Public Consultation Feedback Form

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services. HIQA has a responsibility to develop standards, recommendations and guidance to support the Irish digital health and health information landscape to ensure safer, better care for people using health and social care services.

HIQA is now in the process of revising the National Standard for Hospital Discharge Information. The National Standard for Hospital Discharge Information defines the core set of data elements required when a patient, whether adult or child, is discharged from an acute hospital back to the care of the Primary Care healthcare professional, to provide safe, high-quality care and support. Examples of data collected in a discharge document include admission details, clinical summary, medications on discharge and ongoing clinical care plan.

The consultation gives people the opportunity to provide feedback on the draft standard and become involved in the development process by submitting their views.

HIQA will carefully assess all feedback received and use it, along with other available evidence, to revise the National Standard for Hospital Discharge Information. Before you complete this consultation feedback form, please read the instructions for submitting feedback on the following pages.

The consultation closes at 5pm on Wednesday, 5 November 2025.

Data Protection and Freedom of Information (FOI)

This consultation is being conducted in accordance with data protection law, including the GDPR and Data Protection Act 2018.

HIQA will only collect and store personal information during this consultation for the purposes of verifying your feedback, or where you have indicated that you would like to be contacted to participate in future focus groups.

For further information on how HIQA uses personal information, please see our Privacy Notice available here. If you have any concerns regarding your personal information, please contact HIQA's Data Protection Officer on dpo@hiqa.ie.

Following the consultation, HIQA will publish a report summarising the responses received, which will include the names and types of organisations that submitted feedback. For that reason, it would be helpful if you could explain if you regard the information you have provided as being confidential or commercially sensitive.

Please note that HIQA is subject to the Freedom of Information (FOI) Act and the statutory Code of Practice for Public Bodies in relation to FOI. HIQA cannot give you an assurance that confidentiality can be maintained in all circumstances, due to the requirements of the FOI Act.

By submitting your feedback, you are agreeing to participate in this consultation.

Instructions for submitting feedback

- If you are commenting on behalf of a service or organisation, please combine all feedback from your organisation into one submission form and include the details of the service or organisation.
- Please do not paste other tables into the boxes already provided — type directly into the box as the box expands.
- If you are handwriting responses, please feel free to use additional paper.
- Please spell out any abbreviations that you use.
- Please specify the relevant section or data element number to help identify the feature to which the feedback relates.

1. About you

1.1 Are you providing feedback as:

☐ an individual

(If you would like to be contacted to participate in future stakeholder engagement, please provide your name and contact number below. Otherwise please skip.)

☒ on behalf of an organisation

(If you are responding on behalf of an organisation, please provide your organisation's name and contact details below for verification purposes.)

Irish Medical Organisation Vanessa Hetherington – Assistant Director, Policy and International Affairs vhetherington@imo.ie

1.2 Are you commenting:

☐ In a professional capacity?

(Please use the box below to specify your role in the organisation you currently work for.)

If yes, is this a clinical role? ☐ Yes ☐ No

If yes, please include clinical role details

☐As a member of the public/user of health and social care services?

(If you would like to provide any additional details, please share in the box below.)

2. Feedback on the draft standard

In this section, we would like to capture your opinion about the content of the hospital discharge information dataset. This section focuses on the data elements, their descriptions and associated conformance, cardinality and guidance. The questions in this section are not intended in any way to limit your feedback, and other comments relating to the draft standard are welcome.

2.1 Have all the appropriate data elements been included in the discharge information dataset?

☐ Yes

☐ No – if no, please specify the additional data elements that you think should be included and state why.

The IMO welcomes the use of standardised discharge information that supports the safe transfer of patients from the hospital to the GP or other community healthcare setting, however, in a busy healthcare environment it is vital that discharge summaries are concise and do not pose an unnecessary additional administrative burden on clinicians nor pose a risk to patient safety.
Quality of clinical information is paramount to the provision of safe, effective care. The key data elements including patient details, diagnosis, hospital tests and procedures, medication changes, follow up plan are included in the discharge information dataset however the excessive level of detail required in the document, even if pre-populated from the electronic health record, risks clogging the summary record with irrelevant information and the salient points will be lost with consequent risk to patient safety.
The reality is that the vast majority of hospitals in Ireland are still working off paper-based records and considerable backlogs in discharge summaries exists across many hospitals. In the absence of electronic patient records, a requirement to fill 180 data fields of a discharge summary is impractical and risks further delaying the safe discharge of patients to the community.

A key element that has been omitted, however, is a discharge summary for deceased patients. The absence of a patient discharge summary for deceased patients creates significant difficulties with diagnostic accuracy in the HIPE data and outcomes for those who die in hospital.
The National Audit of Hospital Mortality 2022 & 2023 recommended that *a discharge summary for deceased patients should be designed and added to the medical chart as a standard document, to be completed for all patients who die as an inpatient in the hospital. It should include all the necessary details to ensure proper coding of relevant*

2.2 Are there any data elements that you would remove from the discharge information dataset?

X Yes - if yes, please specify the data elements that you would remove below and state why. Please include the relevant data element number.

For example, "2.2 - Remove as this should not be required in a discharge information document due to ....."

☐ No

Section 1.3 - Health Identifiers

The PPS number and the Individual Health Identifier should be sufficient for identifying patients . All other identifiers in 1.3.3 should be removed.

1.5 – Communication details

The patients contact number - mobile phone number or landline and email should be mandatory. Other communication details 1.5.3 should be removed as they are unnecessary and presume widespread availability.

Section 5 – Legal

It should be sufficient to indicate on the summary discharge information record if the patient has a decision support or advanced healthcare directive in place. Other details in relation to capacity assessments (5.1.1 & 5.1.2) are not required in the summary discharge record.

Section 7 – Risks/Allergies/Adverse events

All new clinical risks/allergies/adverse events as well as the causative agent and severity are required. However the details of the event (7.3.2 to 7.3.8) are not required in the summary discharge record.

Section 11.1 - Patient history

A brief narrative of the patients relevant history should be required. All other information in relation to the patient's medical history including family history and previous exposure to infectious agents are not required in the summary discharge record.

2.3 Do the descriptions provided for each data element clearly explain the data elements?

☐ Yes

☐ No – if no, please suggest improvements. Please include the relevant data element number.

For example, "2.3.1 - change description to include information on ....."

1.4.6 Preferred language Rather than flagging the preferred language it would be more appropriate to flag if an **interpreter is required** and for what language. 19.1 Implants or Devices (Record Entry) Only new medical devices or implants that were implanted or explanted **during the hospital stay** should be included. This detail should be included with the procedures list for the hospital stay, not separately. Section 20 – Future Management and or Care Plan 20.2 – GP Actions The description should be changed to include agreement with the GP on future actions. - Actions that are requested of **and agreed with** the General Practitioner

2.4 Do you agree with the conformance for each data element?

Conformance indicates whether the data element is mandatory, required or optional.

a) Mandatory: The information must be included.
b) Required: If it exists, the information should be included.
c) Optional: A local decision is made as to whether the information is included.

☐ Yes

☐ No – if no, state why. Please include the relevant data element number.

For example, "5.1.2 - change the conformance of this data element from required to optional because ....."

1.2.1 – Address - The Patient's address should be mandatory with an option to include no fixed abode.

1.4.4 Gender Identity - Gender identity is social construct and should be optional and provided by the patient on admission.

21.3 Professional Body Registration Number – This should be mandatory as it is already a mandatory requirement of the HSE.

2.5 Do you agree with the cardinality for each data element?

Cardinality refers to how many entries can be made for a data element. Some data elements may require a zero, one or many entries.

☐ Yes

☐ No – if no, state why. Please include the relevant data element number.

For example, "5.2.4 - due to ..... the cardinality of this data element should be changed from 0...1 to 0...*"

Section 14 - Diagnosis

All primary and secondary diagnosis should be listed. It is unclear from the cardinality how all diagnosis will be entered.

Section 15 – Procedures/Operations/Treatment

All investigations/procedures/operations/ treatments carried out during the hospital stay should be listed

2.6 Do you agree with the value for each element?

Value refers to how the information should be recorded, such as; free text, coded value, alpha-numeric value, numeric, date, or multimedia in a coded format.

☐ Yes

☐ No – if no, state why. Please include the relevant data element number.

For example, "6.2 - change the value of this data element from free text to coded because ....."

1.4.5 Ethnicity – Processing data in relation to race or ethnicity is important for measuring and addressing inequalities in health. – An agreed set of health equity stratifiers is required for health datasets. These should be coded and selected from a drop down menu and populated from the electronic health record.

2.7 Is the guidance provided throughout the document clear and easy to understand?

Guidance for each data element is provided at a high level in the dataset.

☐ Yes

☐ No – if no, please suggest improvements. Please include the relevant data element number.

For example, "8.4 - include ..... in the guidance for this data element to provide better clarity to the end user"

6.2 Risk to others – Guidance should highlight previous violence and aggression. Not all patients with a drug addiction pose a risk to others.

20.2 – GP Actions

The guidance should refer to paragraph 33.8 of the Guide to Professional Conduct & Ethics for Registered Medical Practitioners (9th Ed)

When discharging care to the patient's GP, the doctor who orders diagnostic tests or investigations must follow up on the results to ensure these investigations have taken place, results are followed up and appropriate action taken, including communication to the GP.

3. General feedback

3.1 Do you think the language used in the draft standard is clear, easy to follow and easy to understand?

☐ Yes

☐ No – if no, please suggest improvements, including the relevant data element number, if appropriate.

3.2 Do you think the content and structure of the draft standard is clear, easy to follow and easy to understand?

☐ Yes

☒ No – if no, please suggest improvements.

The content and structure of the document of the draft standard is difficult to understand. In particular the cardinality poses difficulties where for example an item such as any child protection concerns or allergies should be mandatory, but for the purpose of this document are only required as they may not exist.

A significant piece is missing from the draft standard explain the purpose of the discharge summary form which is a tool to support the safe transfer of patients from the hospital to the GP or community setting.

In relation to the examples provided in Appendix 3 the tick box highlighting what data fields should be completed gives priority to all data fields with no emphasis on the salient information required by the GP.

As a general comment, the structure, language and design of this standard format is very inaccessible and unlikely to be read by most of those for whom it is relevant.

3.3 Are there any general comments you wish to make in relation to the draft standard?

As above, the IMO has grave concerns that the level of information required in this document is excessive and potentially poses a risk to patient safety even if pre-populated from electronic patient records. It should be possible to capture the required information in one or two pages.

4. Use of the standard in practice

4.1 What will help to support the implementation of this standard in the service that you use or work in? (For example, additional guidance, tools or educational material.)

It is important that the use of information technology in healthcare acts as a tool to support patient care and does not impose an additional administrative burden, reducing clinical time spent with patients. The IMO advises that before adoption, any revised standard discharge form should be trialled in the hospital setting to ensure it is fit for purpose in a busy clinical environment.

Discharge letters generate a significant amount of work for doctors in Irish hospitals, especially for teams with a high turnover of patients. Often less experienced NCHDs can be charged with preparing the discharge letters and can spend a significant part of their working day writing these documents. The HSE and HIQA needs to acknowledge this increased workload and will need to audit and monitor how NCHDs are spending their clinical time.

Thank you for your input. We will carefully assess all information received and use it, along with other evidence, to inform the revision of the draft standard.