Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

KEY EHEALTH TERMS

Contents

Background

HIQA develops standards, guidance and recommendations for health information to make healthcare safer.

The Sláintecare Implementation Plan (2018) introduces a number of key areas needed to modernise the health and social care system in Ireland:

- National electronic patient summary (summary care record)
- National shared care record
- National electronic health record
- National patient portal.

HIQA has produced this short booklet to explain these four terms which are described below including an example of a patient experience.

What is a national electronic patient summary?

Treating patients without access to their medical records is challenging. Many countries have developed a **national electronic patient summary**, (also known as a national summary care record) which makes an electronic snapshot of the patient's essential clinical information available to healthcare professionals treating patients in situations such as attendance at an out-of-hours clinic or in an emergency situation.

Internationally, a national electronic patient summary has been shown to support the sharing of a patient's information efficiently and appropriately across different organisations. This enables more timely and informed decisions regarding a patient's care, including a reduction in medicines errors, time savings during medicines reconciliation, and the choice of more appropriate care pathways for patients.

Irish context

In 2018, HIQA consulted with:

- **healthcare professionals**, including out-of-hours staff and emergency staff
- and **the public**

to define the kinds of clinical information that would be included in an Irish national electronic patient summary:

Subject of care	Patient's name, address, phone number, date of birth, and next of kin details.
Conditions	Any diagnosed, long-term health conditions – for example, diabetes.
Procedure	Any procedures the patient has had in the last six months.
Allergies	Any diagnosed allergies that the patient has.
Vaccinations	All vaccinations that that the patient has received.
Medications	All the medications the patient is currently prescribed.

Learn more

For further information outside of this booklet, you can watch this **animation**.

Example of patient experience

Aisha's national electronic patient summary

Aisha, aged 42, collapsed while shopping and was brought to the local emergency department. Aisha's blood pressure was very low.

Aisha's national electronic patient summary showed the emergency department doctor that Aisha was recently diagnosed with high blood pressure and had been prescribed medication.

While speaking with Aisha, the emergency department doctor realised that Aisha had accidentally taken a very high dosage and advised her on the correct dosage, before discharging her.

What is a national shared care record?

A **national shared care record** enables healthcare providers in different settings—for example, primary care and hospitals—to view patient records for direct patient care. It brings together information from various systems into a single place for care professionals to use to support the delivery of care. It provides more information than a national electronic patient summary and can be read and updated by authorised healthcare professionals from a number of healthcare settings.

Irish context

Within the context of the development of a national electronic health record for Ireland, a national shared care record will be created first, to combine patient data from individual organisation's IT systems into a single patient record.

Example of patient experience

Mary's national shared care record

Mary, aged 30, is a mother of two and has recently had a positive at home pregnancy test. She attends her local general practioners surgery and is confirmed pregnant. Her GP refers her to **the antenatal services which she has attended for her two previous pregnancies.**

During her pregnancy, Mary's healthcare records will be shared between the antenatal service and her GP. Both the antenatal service and her GP use computer systems which allow the recording and sharing of information gathered at each review, with each other.

At each review, be it in the GP practice or the antenatal clinic, the healthcare practitioners record and share information with each other on how Mary's pregnancy is progressing, including her vital signs, urinalysis, information on the foetus, a note of the visit and detail regarding the next scheduled visit in that setting, throughout the duration of Mary's pregnancy.

What is an national electronic health record?

A **national electronic health record (EHR)** is a complete digital record of a patient's journey, throughout their life, across all health and social care settings, for every citizen.

An EHR contains the information documented by healthcare professionals when they interact with that patient—for example, the patient's symptom history, past history of illnesses and operations, clinical observations made by the professional such as a blood pressure reading, blood and other test results, X-rays and scan results, prescriptions and other treatments, care advice, the course of the illness, preventive and public health activities such as immunisations, and activities undertaken by patients to stay healthy. An EHR system can support healthcare professionals by facilitating, for example, the use of checklists, alerts, and predictive tools, and embedding clinical guidelines, electronic prescribing and the ordering of tests.

Irish context

The national electronic health record will draw information from a wide range of healthcare organisations in Ireland – such as laboratories, specialists, medical imaging facilities, pharmacies, emergency facilities, primary, secondary, and tertiary care, public health, community care, and social care – to provide the most complete information available to the authorised healthcare professional caring for the patient.

The patient's national electronic health record will be a constantly updated and accurate source for all their care information.

Example of patient experience

Seamus's national electronic health record

Seamus, aged 85, was referred by his GP for a comprehensive health and social care assessment with care professionals including input from occupational therapy, physiotherapy, social work and public health. He was assigned a case manager, who developed a care plan with him, which included ongoing medication reviews between his GP and community pharmacists.

Following a fall at home, Seamus requires admission for treatment to a fracture hip. During his stay in hospital, further geriatric assessments took place with input from a multidisciplinary team led by a consultant geriatrician. The nurse clinical specialist liaises with Seamus's case manager in the community prior to his discharge advising on changes to the care plan.

With a national electronic health record in place, all of the health and social care professionals looking after Seamus will have immediate access to his key information. The assessments and his care plan devised in the community will be available to those treating Seamus in hospital.

Following discharge, his care professionals will be able to see the reason for him being in hospital, the investigations undertaken and procedures performed and changes to his care plan and medications.

Without a national electronic health record all this information will remain locked in paper format.

What is a national patient portal?

A patient portal is specially created to allow online access for individuals to their own healthcare information through apps on their smartphone or other devices, or using a website. In many countries, patients use a patient portal to access to their national electronic health record (EHR), where they can see their latest test results, clinical correspondence, request repeat medications and to request appointments. Some patient portals also enable patients to add their own health information, enabling them to maintain their own record of home monitoring for conditions such as diabetes. In another example, the EHR may provide a parent with the ability to add supplementary entries to an incomplete vaccination record for their child. The clinician reviewing the record can then review these and the original entries to gain a better understanding of the child's vaccination history.

Irish context

Part of the Shared Record Programme, the national patient portal is expected to provide a view of a patient's records from a wide variety of data sources, with a privacy audit trail and subject to legislative requirements and standards.

Find out more

For more information, contact HIQA's Technical Standards Team.

All our publications are available from **www.hiqa.ie**.

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See **HIQA's Privacy Notice**.

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