Accessible Information Standard

Recording information and communication needs

The second step in the successful implementation of the Accessible Information Standard is based on the recording of needs:

- Consistent and routine recording of patients', service users', carers' and parents' information and communication needs, where they relate to a disability, impairment or sensory loss, as part of patient / service user records and clinical management / patient administration systems;

- Use of defined clinical terminology, set out in four subsets, to record such needs, where Read v2, CTV3 or SNOMED CT® codes are used in electronic systems;

- Use of defined English definitions indicating needs, where systems are not compatible with either of the three clinical terminologies or where paper based systems / records are used;

- Recording of needs in such a way that they are 'highly visible'.

Overview of requirements – recording of needs

Where individuals have information and / or communication needs relating to or caused by a disability, impairment or sensory loss:

- Such information MUST be recorded as part of the individual's first or next interaction with the service.

- In electronic systems which use SNOMED CT, Read v2 or CTV3 codes, such information MUST be recorded using the coded data items associated with the subsets defined by this standard.

- In electronic systems which use other coding systems or terminologies, or where paper records are used, such information MUST be recorded in line with the human readable definitions / categories associated with the data items.

The codes associated with the four subsets of the Accessible Information Standard have been included as part of the **inclusion dataset** (SCR v2.1) for Summary Care Records (as of March 2016).

Note that additional codes / data items have been requested across the three terminologies, and will be made available and associated with the existing subsets in line with the next scheduled biannual release (01 October 2015).

Further additional codes / data items may be requested and, if appropriate released, in future, as outlined in the Maintenance Plan. It is the responsibility of the IT systems supplier or lead organisation to ensure that the coding used in patient record and administration systems is current and up-to-date.

Systems and documentation MUST be formatted so as to make any record of information or communication needs 'highly visible' (see section 9).

Organisations MUST ensure that information recorded about individuals' information and communication support needs is accurate. Systems for edit checking and quality assurance of data SHOULD be put in place, including establishment of alerts or mechanisms to prevent or discourage the recording of mutually incompatible data in related fields (see section 8.2).

In addition, the Specification makes clear that, "Where online systems enable patients or service users to access their own records, and subject to **Data Protection Act 1998** safeguards, such systems:

• MUST enable an individual to review the data recorded about their communication and information needs and request changes if necessary; and, where necessary functionality exists,

• SHOULD enable an individual to record their own communication and information needs using this system where appropriate." Organisations may wish to review information and guidance associated with the **Patient Online** programme in this regard.

Guidance for recording of needs

Some of the types or categories of information and communication support included in the Standard's subsets are mutually incompatible, i.e. it would not be possible for one individual to need some types of support in combination with one or more others. For example, someone who needs information in braille will not require support to lipread (because the former implies significant visual loss and the latter relies on sight). Conversely, some combinations of recorded needs are highly likely to occur, for example, 'does use hearing aid' and / or 'does lipread' plus 'requires contact by short message service text message' or 'requires contact by email'. Staff should consider both of these aspects when recording individuals' needs and when prompting patients, service users, parents and carers to identify their needs.

Data items may be deliberately used in combination and / or with appropriate additional free text to support clarity, where appropriate and where supported by relevant local policies. For example the combination of 'uses British Sign Language' and 'requires information on digital versatile disc' to indicate that the individual requires information presenting as a British Sign Language (BSL) video saved (and sent to them) on a DVD.

Information recorded about patients', service users' , carers' and parents' information and communication support needs must be based on information from the individual themselves or, where they are unable to provide this information, on information from their main informal carer or parent. The individual patient, service user, carer or parent should be aware of the information recorded about their information and communication support needs, including to verify accuracy.