



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# Draft National Standard Demographic Dataset and Guidance for use in health and social care settings in Ireland

Public consultation document

February 2013

*Safer Better Care*

## About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive continuous improvement in Ireland's health and personal social care services, monitor the safety and quality of these services and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.
- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.
- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.
- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

## Overview of Health Information function

Health is information-intensive, generating huge volumes of data every day. It is estimated that up to 30% of the total health budget may be spent one way or another on handling information, collecting it, looking for it, and storing it. It is therefore imperative that information is managed in the most effective way possible in order to ensure a high quality, safe service.

Safe, reliable, healthcare depends on access to, and the use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. For example, when giving a patient a drug, a nurse needs to be sure that they are administering the appropriate dose of the correct drug to the right patient and that the patient is not allergic to it. Similarly, lack of up-to-date information can lead to the unnecessary duplication of tests – if critical diagnostic results are missing or overlooked, tests have to be repeated unnecessarily and, at best, appropriate treatment is delayed or at worst not given.

In addition, health information has a key role to play in healthcare planning decisions – where to locate a new service, whether or not to introduce a new national screening programme and decisions on best value for money in health and social care provision.

Under section (8)(1)(k) the Health Act 2007, the Health Information and Quality Authority (the Authority or HIQA) has responsibility for setting standards for all aspects of health information and monitoring compliance with those standards. In addition, under section 8(1)(j), the Authority is charged with evaluating the quality of the information available on health and social care and making recommendations in relation to improving the quality and filling in gaps where information is needed but is not currently available.

Information and communications technology (ICT) has a critical role to play in ensuring that information to drive quality and safety in health and social care settings is available when and where it is required. For example, it can generate alerts in the event that a patient is prescribed medication to which they are allergic. Further to this, it can support a much faster, more reliable and safer referral system between the patient's general practitioner (GP) and hospitals.

Although there are a number of examples of good practice, the current ICT infrastructure in Ireland's health and social care sector is highly fragmented with major gaps and silos of information which prevents the safe, effective, transfer of information. This results in service users being asked to provide the same information on multiple occasions.

Information can be lost, documentation is poor, and there is over-reliance on memory. Equally those responsible for planning our services experience great difficulty in bringing together information in order to make informed decisions. Variability in practice leads to variability in outcomes and cost of care. Furthermore, we are all being encouraged to take more responsibility for our own health and wellbeing, yet it can be very difficult to find consistent, understandable and trustworthy information on which to base our decisions.

As a result of these deficiencies, there is a clear and pressing need to develop a coherent and integrated approach to health information, based on standards and international best practice. A robust health information environment will allow all stakeholders – the general public, patients and service users, health professionals and policy makers – to make choices or decisions based on the best available information. This is a fundamental requirement for a high reliability healthcare system.

Through its health information function, the Authority is addressing these issues and working to ensure that high quality health and social care information is available to support the delivery, planning and monitoring of services. A key requirement is the ability to accurately and consistently identify service users. Hence, one of the areas currently being addressed through this work programme is the development of a national standardised demographic dataset and guidance for use in health and social care settings in Ireland.

## Table of Contents

About the Health Information and Quality Authority	ii
Overview of Health Information function	iii
Acknowledgements	2
2. Background	5
3. Consultation	6
4. Project Objectives	8
5. Methodology	8
6. Benefits of this work	9
7. Guidance for data entry for draft national standard demographic dataset	11
Draft National Standard Demographic Dataset and Guidance for use in health and social care settings in Ireland	13
8. Draft national standard demographic dataset and guidance	14
8.1 Subject of care identification	14
8.2 Subject of care biometric identification	17
8.3 Name components for subject of care	18
8.4 Address components for subject of care	31
8.5 Subject of care – Communication details	41
8.6 Additional demographic details for subject of care	45
9. Next Steps	50

## **Acknowledgements**

The draft national demographic dataset and guidance was developed following consultation with a number of key stakeholders.

In particular, the Authority would like to thank members of the General Practice Information Technology (GPIT) group, and Client Identity Services in the Department of Social Protection for their input and advice.

DRAFT

Table 1 provides definitions of the terminology used throughout the dataset.

**Table 1. Description of terminology used in the demographic dataset**

Term	Definition
<b>Biometric identification</b>	Biometric identifiers are part of the person; they are measurable biological characteristics, such as recording of a finger print or the shape of facial features.
<b>Healthcare organisation identifier (HOI)</b>	A healthcare organisation identifier is a unique, non-transferable number assigned to healthcare organisations in Ireland. It will allow the attaching of a dataset to identify its location, contact details and operational sites. <sup>(1)</sup>
<b>Healthcare practitioner identifier (HPI)</b>	A unique non-transferable lifetime number assigned to a healthcare practitioner. Its purpose is to identify the individual as one and the same person and to allow the 'attaching' of other information (such as name, address, contact details) to them. <sup>(1)</sup>
<b>Individual Health Identifier (IHI)</b>	An IHI is a unique, non-transferable lifetime number assigned to all individuals accessing health and social care in Ireland. Its purpose is to accurately identify the individual, enabling health and social care to be delivered to the right patient, in the right place and at the right time. <sup>(2)</sup>
<b>Optionality</b>	Refers to having options. In this case it indicates whether the data item is <i>required</i> i.e. that it is mandatory and must be completed; that the field is <i>optional</i> and need only be completed when appropriate, or that it is <i>conditional</i> , that is whether the data item needs to be completed or not depends on other conditions or data items.

Term	Definition
<b>Subject of care</b>	Any person who uses or is a potential user of a health or social care service, for example a patient, service user or resident.

DRAFT



## 1. Introduction

Safe and reliable health and social care depends on access to, and use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. The ability to uniquely identify individuals is imperative to provide quality and safe care. The Health Information and Quality Authority (the Authority or HIQA) has recognised the importance of being able to uniquely identify individuals and has recommended the introduction of an individual health identifier (IHI).<sup>(3)</sup> An IHI comprises of three main components: the number itself, the dataset associated with the number, and the system that supports the number and dataset. Therefore a national standard demographic dataset is one of the three key components of the IHI.

The scope of this project is to develop a national demographic dataset for health and social care services in Ireland, including hospitals, general practitioners, primary care centres, residential centres for older people, children's residential centres and allied health professionals. A demographic dataset is essential to provide core information about an individual. It comprises of a set of identifying data items about the subject of care, including, for example, the individual's name, address and date of birth.

The development of a national standard demographic dataset will help to consistently identify a subject of care and facilitate easier sharing of information within and between health and social care services. Unique and accurate identification of individuals will work towards reducing duplication in a number of areas including, for example, fewer duplicate records, appointments, testing and prescribing, resulting in time, administration and cost savings. A national standard demographic dataset will also work towards tracking and trending demographic data, hence enabling better planning of services and care provided. The accompanying guidance for demographic data entry presented in this document will provide support and assistance to the health and social care sector to meet the requirements of the draft national standard demographic dataset, and ensure consistency in the recording of the data.

## 2. Background

The Health Information and Quality Authority was established under the Health Act 2007<sup>(4)</sup> with the primary aim to promote patient safety and quality throughout healthcare. The Authority has a statutory remit to develop standards, evaluate information and make recommendations about deficiencies on health information as outlined in the Health Act 2007<sup>(4)</sup>. These statutory functions provide the basis for the Authority to have a central role in coordinating and

facilitating the improved collection, use and dissemination of health information by all stakeholders.

One key deficiency which has been identified by both the Authority and a number of stakeholders is the absence of a national standard demographic dataset across the Irish health and social care sector. Currently there is no standardisation or agreed guidance on the collection of demographic data, which can reduce the ability to accurately identify individuals and provide appropriate quality and safe care for all people using health and social care services in Ireland. As this dataset will be one of the three main components of an individual health identifier (IHI), it is important that it is in place in advance of the introduction of the identifier.

The lack of a national demographic dataset has resulted in each health and social care provider designing its own rules for the data items it wishes to collect on each individual. This results in varying approaches to the data items collected and the formats of same, with each data item having the possibility for many permutations and combinations. For example, the name McCarthy can be collected as McCarthy, Mc Carthy, MacCarthy and so forth, leading to a potential for duplication and / or misidentification. It is therefore crucial to have a single national standard for collection of such important demographic data in order to ensure standardised, accurate identification of each individual.

### **3. Consultation**

This consultation document presents for public consultation a draft national standard demographic dataset and associated guidance for data entry. The Authority is fully committed to stakeholder consultation and values all feedback provided as part of its development process.

This document is available for public consultation for an eight-week period. In this way, the public, service users and service providers have an opportunity to provide feedback and contribute to the development process. We invite all interested parties to submit their views on this document, which is outlined in detail in Section 8 of this document and summarised below.

The closing date for receipt of comments is **5pm on Friday 12 April 2013**.

### Summary of draft national standard demographic dataset

The Authority is proposing that for each individual that uses health or social care services, a standard set of data that uniquely identifies each individual is recorded. This is a national standard demographic dataset. The dataset is divided into five sections: health identifiers, name details, address details, communication details and other details.

- **Identifiers:** this section ensures that unique identification numbers are in place for every individual that uses health or social care services.
- **Name details:** this section focuses on the name details for each individual; it includes surname, first name and the name that they prefer to be called by.
- **Address details:** this section records residential and postage address for each individual. It includes street name, town and county.
- **Communication details:** communication details such as mobile phone number, landline number, and email address are recorded.
- **Other details:** this section records important demographic details, that do not fall under the other sections. There are four pieces of information requested, they are date of birth, gender, mother's birth surname, and person's religion.

### How to make a submission

A number of consultation questions have been prepared for your consideration when reviewing this document. Please note that these questions are not intended in any way to limit feedback, and all comments are welcome. There are several ways to tell us what you think.

Your comments can be submitted by completing the **online consultation feedback form** or alternatively downloading and completing the **consultation feedback form** both accessible from <http://www.hiqa.ie>. You can email your completed forms to [ehealth@hiqa.ie](mailto:ehealth@hiqa.ie) or print off a copy of the feedback form and post it to us at:

Health Information and Quality Authority  
National Standard Demographic Dataset and Guidance  
Health Information Directorate  
George's Court, George's Lane,  
Smithfield, Dublin 7

For further information or if you have any questions you can talk to the consultation team by calling (01) 8147684.

### How we will use your comments

Following the consultation, the Authority will analyse the submissions and amend the draft standard as appropriate. We wish to thank you in advance for taking the time to submit your comments.

## 4. Project Objectives

The objectives of this project are to:

1. Establish a national standard demographic dataset for health and social care providers in Ireland (including hospitals, general practitioners, primary care centres, residential centres for older people, children's residential centres and allied health professionals) based on international standards and best practice.
2. Develop supporting guidance for demographic data entry.

## 5. Methodology

The draft demographic dataset for consultation was developed by conducting a review of international standards in this area and by also assessing national practice through examining demographic data being collected by a number of national agencies both within the health arena and outside of it. Several national organisations were contacted and detailed discussions were also held with a number of key stakeholders.

The following international standards were reviewed:

- ISO/TS 22220:2011. Technical Specification. Health Informatics – Identification of subjects of healthcare<sup>(5)</sup>
- ISO/TS 27527:2010. Technical Specification. Health Informatics – Provider identification<sup>(6)</sup>
- Health Level Seven (HL7) version 2.4<sup>(7)</sup>
- AS 4846-2006. Australian Standard. Health Care Provider Identification.<sup>(8)</sup>

In addition, a review was conducted of demographic datasets associated with national patient identifiers in use in other countries, including the New Zealand National Health Index (NHI) number dataset<sup>(9)</sup> and the UK National Health Service (NHS) number dataset.<sup>(10)</sup>

## 6. Benefits of this work

### *Why standardise demographic data?*

One of the key requirements to ensure that high quality health and social care information is available to support the delivery, planning and monitoring of services, is the ability to accurately and consistently identify individuals. A national standard demographic dataset will identify a set of demographic data items that will be collected for each subject of care. The same data items will be collected for each subject of care in all health and social care providers throughout the nation.

Standardisation of demographic data will increase efficiencies, as there will be a clear understanding of what each data item means. This works towards greater accuracy in the collection and interpretation of the data, allowing for safer communication of each subject of care's demographic details. Standardised demographic data also limits the way data can be collected, interpreted and exchanged between different groups, resulting in time and cost savings<sup>(1)</sup>.

A wide range of stakeholders will benefit from having a standardised demographic dataset in place, including people who use our health and social services, healthcare practitioners, healthcare organisations and service planners. Some examples of these benefits are listed below.

### *What the standard demographic dataset will mean for people who use our health and social care services*

- safer, better care for patients from having accurate, complete demographic data for each subject of care
- removal of the need for repeated provision of demographic data on each visit to the health or social care service provider
- reduction in administration and costs as demographic data only collected once
- standardisation of the core demographic data enables more accurate analysis of demands and needs on the health or social care provider.

### *What the standard demographic dataset will mean for general practitioners*

- enable the collection of more accurate and consistent data and improve reliability of information
- assist in client/patient identification, therefore preventing duplication or misidentification errors, and less duplication of testing/prescribing
- allow information to be exchanged/transferred between information systems, therefore reducing administrative tasks

- cost-saving and time-saving benefits.

*What the standard demographic dataset will mean for hospitals*

- ensure more complete and accurate information on which to base potentially life-critical clinical decisions
- reduction in significant levels of duplication of administrative effort, less wastage of time and resources and hence greater efficiencies
- allow information to be exchanged/transferred between information systems
- accountability and improved communications.

*What the standard demographic dataset will mean for residential care services*

- demographic data collected once only reducing duplication of data collection and entry
- reduction in administration resulting in time and cost savings
- allow the residential care services to accurately identify the demographic needs of their services
- allow service planners to accurately identify age, gender and logistical requirements for residential care services.

## 7. Guidance for data entry for draft national standard demographic dataset

The national demographic dataset presents health and social care providers with a standard core set of data items to support the consistent, complete, and accurate identification of each subject of care.

This section outlines the draft national standard demographic dataset and provides guidance for data entry of the dataset. The draft national standard demographic dataset is made up of data items that establish accurate identification for each subject of care.

### Electronic messaging

In terms of electronic messaging, a detailed specification will be required to standardise data items within the demographic dataset for this purpose.

The draft national standard demographic dataset is presented across a number of tables for ease of use. The tables are broken down as follows:

- subject of care identification
- subject of care biometric identification
- name components for subject of care
- address components for subject of care
- subject of care communication details
- additional demographic details for subject of care.

Each table is sub-divided into five columns. The first column assigns an identifier for each data item, the second column identifies the data items name, the next column provides the definition for the data item, while the fourth column outlines the optionality of each data item, i.e. whether the data item is required, optional, or conditional.

- **Required** fields should be included in all demographic datasets.
- **Optional** fields may be omitted if this information is not available or relevant at the time.
- **Conditional** fields have a dependency on where the subject of care is living. For instance if the subject of care does not have a street address, then the townland or locality is required, but if the subject of care does have a street address, then the street name is required, and the townland or locality is

optional.

The final column in the table provides an example of the data item. Please also note that the examples provided throughout are simply for illustrative purposes and are not intended to relate to real people, living or deceased.

The guidance provides similar explanations for each data item, which is presented in the following format:

<b>Definition</b>	A statement that provides an explanation of what is meant by the data item.															
<b>Source standards</b>	Details of the standards that recommend the use of the data item.															
<b>Data type</b>	Provides different representations of the data type that is, if it is text, numeric, alphanumeric, coded list, date, time and so forth.															
<b>Data domain</b>	Lists the values or codes that are acceptable for representation of the data element, for example: <table><thead><tr><th><i>Code</i></th><th><i>Descriptor</i></th><th><i>Alternative code</i></th></tr></thead><tbody><tr><td>1</td><td>Male</td><td>M</td></tr><tr><td>2</td><td>Female</td><td>F</td></tr><tr><td>3</td><td>Indeterminate</td><td>I</td></tr><tr><td>4</td><td>Not stated</td><td>N</td></tr></tbody></table>	<i>Code</i>	<i>Descriptor</i>	<i>Alternative code</i>	1	Male	M	2	Female	F	3	Indeterminate	I	4	Not stated	N
<i>Code</i>	<i>Descriptor</i>	<i>Alternative code</i>														
1	Male	M														
2	Female	F														
3	Indeterminate	I														
4	Not stated	N														
<b>Guide for use</b>	Provides additional guidance to inform the use of the data element.															
<b>Verification rules</b>	Quality control mechanisms that restrict the collection, storage or transferral of non-valid data.															
<b>Collection method</b>	Provides suggestions on how to capture data.															
<b>Example</b>	Provides an example of the data item. <sup>‡</sup>															

---

<sup>‡</sup> Please note that the examples provided throughout are simply for illustrative purposes and are not intended to relate to real people, living or deceased.



Draft National Standard  
Demographic Dataset and  
Guidance for use in health and  
social care settings in Ireland

## 8. Draft national standard demographic dataset and guidance

### 8.1 Subject of care identification

This section includes information relating to the identification of the subject of care.

**Table 2: Subject of care identification**

	Name	Definition	Optionality	Example
<b>8.1.1</b>	Individual Health Identifier(IHI)	An Individual Health Identifier can be defined as the designation permanently assigned to an individual for the purpose of identification to facilitate the provision of health and social care. <sup>(3)</sup>	Required	An IHI will support the unique identification of all individuals for health and social care purposes. It will be issued at a national level for the lifetime of the subject of care.
<b>8.1.2</b>	Health identifier (other)	An additional number or code assigned to a subject of care by a health or social care provider.	Optional	This number is specific to the service provider, for example, a hospital number, or number in a residential centre.
<b>8.1.3</b>	Issuer of subject of care identifier	The organisation or agency that allocates the subject of care identifier: this should be the healthcare practitioner identifier (HPI) or healthcare organisation identifier (HOI) when introduced.	Required	The Authority has recommended the introduction of unique identifiers for healthcare practitioners and organisations. When the HPI and HOI are introduced, these identifiers will identify the issuer of the subject of care identification.

### *Guidance for data entry for subject of care identification*

<b>8.1.1</b>	<b>Data item</b>	<b>Individual health identifier (IHI)</b>
	Definition	An Individual Health Identifier can be defined as the designation permanently assigned to an individual for the purpose of identification to facilitate the provision of health and social care.
	Source standards	ISO/TS 22220:2011, HL7-PID.
	Data type	Unique identifier.
	Guide for use	This identifier will be issued at a national level.
	Validation rules	Field may not be blank.
	Collection method	On introduction of the IHI the authority responsible for its issuance will determine the most appropriate means for health and social care providers to collect this health number.
	Example	To be determined.
<b>8.1.2</b>	<b>Data item</b>	<b>Health identifier (other)</b>
	Definition	An additional number or code assigned to a subject of care by a health or social care provider.
	Source standards	ISO/TS 22220:2011, ASTM E1714-00, Guide for Properties of a Universal Health Care Identifier.
	Data type	Unique identifier.
	Data domain	Not applicable.
	Guide for use	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or string coding systems.
	Validation rules	Dependent on the type of health identifier.

**Collection Method** This will be dependent on the type of health identifier.

**Example** Dependent on the format used by the issuer of the health identifier.

### **8.1.3 Data item Issuer of subject of care identifier**

**Definition** The organisation or agency that allocates the subject of care identifier. This should be the Healthcare Practitioner Identifier (HPI) or Healthcare Organisation Identifier (HOI) when issued.

**Source standards** ISO/TS 22220:2011

**Data type** Unique identifier.

**Data domain** Not applicable.

**Guide for use** An identifier that uniquely identifies the issuer of the subject of care identifier.

**Validations rules** Field may not be blank.

**Collection method** Provided by the issuer of the subject of care identifier.

**Example** To be determined.

## 8.2 Subject of care biometric identification

This section provides information relating to identifying a subject of care using a range of possible biometric identifiers.

**Table 3: Subject of care biometric identification**

	Name	Definition	Optionality	Example
8.2.1	Subject of care biometric identification	Voice recognition, iris scanning, retinal scanning, hand geometry, signature dynamics, keystroke dynamics, lip movement, thermal face image, thermal hand image, gait, blood type or DNA.	Optional	The coded text will list a range of possible biometric identifiers including finger print and voice recognition.

### *Guidance for data entry for biometric identification*

#### 8.2.1 Data item **Subject of care biometric identification**

**Definition** Biometric identification is created by devices that encrypt templates derived from 'live' images in order to confirm the identity of the subject of care. Biometric identifiers may be used in addition to conventional identification methods, as they can be faster and more reliable.

**Source standards** ISO/TS 22220:2011, ISO/TS 23527.

**Data type** Unique identifier.

**Data domain** Dependent on the type of biometric identification used.

**Guide for use** This is a stand-alone unique identifier.

**Validation rules** Dependent on the type of biometric identification used.

**Collection method** Dependent on the type of biometric identification used.

**Example** Fingerprint, retinal scan.

### 8.3 Name components for subject of care

This section provides information relating to the correct detailing of the name of the subject of care.

**Table 4: Name components for subject of care**

	Name	Definition	Optionality	Example
<b>8.3.1</b>	Name title	The title relevant to a specific family name for this subject of care.	Optional	Name title options include Doctor (Dr) and Mister (Mr).
<b>8.3.2</b>	Surname	The second part of the subject of care's name which denotes their family or marital name.	Required	This is the family or marital name of the subject of care, for example Smith.
<b>8.3.3</b>	Surname sequence number	An indicator of the order of use for family name(s).	Optional	The indicator will identify the order of use for the last name for instance Smith Hegarty; the first indicator will identify 1. Smith and the second identifier will identify 2. Hegarty.
<b>8.3.4</b>	Given name	The subject of care's identifying name.	Conditional	The name by which the subject of care is uniquely identified. This field is required unless there is no given name.
<b>8.3.5</b>	Given name sequence number	An indicator of the order of use for given names.	Optional	If subject of care given name is Mary Ann, the first name is sequence number 1, 1.Mary and the second name is sequence number 2, 2.Ann

	<b>Name</b>	<b>Definition</b>	<b>Optionality</b>	<b>Example</b>
<b>8.3.6</b>	Preferred name	Indicates the name by which the subject of care prefers to be identified. This is the name that will be displayed when the subject of care is referenced; it will be used on screens, reports, letters and data collections.	Optional	This name may be at variance from the birth name. It is the name by which the subject of care prefers to be addressed. Only one preferred name for any individual subject of care can be allocated.
<b>8.3.7</b>	Name suffix	Additional term used following a person's name to identify a subject of care.	Optional	Identifies the subject of care's name suffix, for instance Senior (Sr) or Junior (Jr).
<b>8.3.8</b>	Name usage classification	A classification that enables differentiation between the usage of names for a subject of care. An individual name may have many uses.	Optional	The subject of care may use a married name and pre-married name for different purposes.

### *Guidance for data entry for the name components of the subject of care*

<b>8.3.1. Data item</b>	<b>Name title</b>																								
Definition	An honorific form of address commencing a name, used when addressing a subject of care.																								
Source standards	ISO/TS 22220:2011, HL7 V2.4.																								
Data type	Coded text.																								
Data domain	The following is a non-exhaustive list of commonly used abbreviations. <table><thead><tr><th>Name title</th><th>Abbreviation</th></tr></thead><tbody><tr><td>Brother</td><td>Br</td></tr><tr><td>Doctor</td><td>Dr</td></tr><tr><td>Father</td><td>Fthr</td></tr><tr><td>Master</td><td>Mstr</td></tr><tr><td>Miss</td><td>Ms</td></tr><tr><td>Mister</td><td>Mr</td></tr><tr><td>Mrs</td><td>Mrs</td></tr><tr><td>Professor</td><td>Prof</td></tr><tr><td>Reverend</td><td>Rev</td></tr><tr><td>Sir</td><td>Sir</td></tr><tr><td>Sister</td><td>Sr</td></tr></tbody></table>	Name title	Abbreviation	Brother	Br	Doctor	Dr	Father	Fthr	Master	Mstr	Miss	Ms	Mister	Mr	Mrs	Mrs	Professor	Prof	Reverend	Rev	Sir	Sir	Sister	Sr
Name title	Abbreviation																								
Brother	Br																								
Doctor	Dr																								
Father	Fthr																								
Master	Mstr																								
Miss	Ms																								
Mister	Mr																								
Mrs	Mrs																								
Professor	Prof																								
Reverend	Rev																								
Sir	Sir																								
Sister	Sr																								
Guide for use	If for instance the subject of care specifies that their name title is Mister, use the abbreviation Mstr.																								
Verification rules	<p>Titles of Miss, Mrs, Bean Uí (Irish language, direct translation for Mrs.), Ms and Sr should only be accepted for females.</p> <p>Titles of Br, Mstr, Mr, An tUasal (Irish language direct translation for Mr.) and Sir should only be accepted for males.</p> <p>Title of Master should only be used for subjects less than 15 years of age.</p>																								



**Collection method** The following question format might assist with data collection:

*What name title would you like to be recorded under?*

*What is your preferred name title Mr or Sir?*

**Example** Ms Murphy  
Mr Murphy  
An tUasal Ó Murchú  
Bean Uí Mhurchú.

### 8.3.2 **Data item** **Surname**

**Definition** The second part of the subject of care's name which denotes their family or marital name. It can be referred to as surname, last name or family name.

**Source standards** ISO/TS 22220:2011, HL7 V2.4.

**Data type** Text.

**Data domain** Not applicable.

**Guide for use** Mixed case should be used.

#### *Surname*

The family name should be recorded in the format preferred by the subject. The format should be the same as that written by the subject on a registration form, or in the same format as that printed on an identification card, to ensure consistent collection of name data.

When a person uses two names as a surname, each name should be registered as a surname within the group. For example Smith-Jones, Smith should be entered as the first surname in the sequence and Jones as the second surname.

Some people use more than one name (formal name, birth name, married or pre-marriage name). This field should register their preferred name as it is more likely to be in common usage and more likely to be used on subsequent visits to the health or service care provider and will therefore make identification more accurate and easier.

When surnames commence with prefixes such as O' or De or Mc or Mac etc. there should be no space between the prefix and rest of the surname, such as McHenry, O'Connell, DeBurke

**Verification rules** Not applicable.

**Collection method** The following question format might assist with data collection:

*What is your surname(s)?*

*Have you any other surnames that you would like recorded?*

**Example** Seán ÓMurchadha  
Grégoire Dupont

#### Registering an unidentified subject of care

The default for unknown family name should be 'unknown' in all instances and the name recorded as the other name. A fictitious family name such as Doe shall not be created, as this is an actual family name. When the subject's name becomes known, it shall be recorded as the preferred name and the other name of 'unknown' shall not be overwritten.

#### Registering a pseudonym

A pseudonym is a fictitious or partial name in lieu of the full or actual name used. This process might be required in order to mask the identity of an individual e.g. in the case of HIV testing where the subject of care has the right of anonymity. It is recommended that the subject be asked to record both the pseudonym in addition to a legally known name e.g. to be used as the preferred name for the purpose of the test. This might require the temporary change of a name to preferred name, which is changed to another name after the pseudonym use is over.

#### Baby for adoption

The word 'adoption' should not be used as the family name, given name, or alias for a newborn baby. A newborn baby who is available or scheduled for adoption should be registered in the same way as other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the previous name should be marked as a usage type of name.

Linkage between the given name and usage name is forbidden by law. Systems should be built to ensure that this link is not used without authorisation.

### Punctuation

If special characters form part of the family name, they should be included, for example, hyphenated names should be entered with a hyphen. Other alphabetical characters to be aware of include:

Fada á	Eth ð
Tilde ñ	Grave ò
Acute ó	Circumflex ô

### Hyphen

There should be no spaces before or after a hyphen, i.e. between the last letter of 'Joyce' and the hyphen, or a space between the hyphen and the first letter of 'Browne'.

Example: Joyce-Browne.

### Apostrophe

In the prefixes of first names and surnames, there should be no spaces before or after the apostrophe and the prefix, i.e. between the **O'** and the apostrophe in the example shown, nor a space between the apostrophe and the first name, as in the example shown.

Example: O'Brien, D'Agostino.

### Full stop

There should be no space before a full stop, i.e. as in the example shown, between **St** and the full stop. As in the example shown, a space should be left between the full stop and 'John'.

Example: St. John, St. George.

### Space

If the subject has recorded their family name as more than one word, there should be no spaces between the words.

Example: McDonald, NiShuilleabháin, LeBrun, MacCarthy

### Other prefixes

In the event that a family name contains a prefix, the prefix should be entered before the family name field. For example, when Hungarian women become widowed, some add the prefix 'Ozvegy' (the abbreviation is 'Ozy') before their

married family name. So 'Mrs. Szabo' would become 'Mrs. Ozy Szabo'. In this instance, 'Mrs. Szabo' becomes other name and 'Mrs. Ozy Szabo' becomes the preferred name.

#### Misspelled family name

If the subject's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as another name in the name usage field with conditional use indicating that the name was a misspelling. Recording misspelled names is important for filing and identifying documents that might be issued with previous versions of the subject's name and for future identification of the subject, should they contact the health system again and have the same problem with spelling. Discretion should be used regarding the degree of recording that is maintained.

<b>8.3.3</b>	<b>Data item</b>	<b>Surname sequence number</b>
	Definition	An indicator of the order of use for surname / last name.
	Source standards	ISO 22220:2011, HL7 V2.4.
	Data type	Numeric.
	Data domain	<ol style="list-style-type: none"><li>1. First family name within a name set.</li><li>2. Second family name within a name set.</li><li>3. Third family name within a name set.</li><li>4. Fourth family name within a name set.</li></ol>
	Guide for use	Multiple family names may be recorded for a given name. Each family name should have a family name sequence number recorded.
	Verification rule	Not applicable.
	Collection method	<i>In what order do you use your surname / last name?</i>
	Example	Mary Henry Smith, Surname: 1. Henry 2. Smith

### 8.3.4 Data item Given name

**Definition** The subject of care's identifying name.

**Source standard** ISO/TS 22220:2011, HL7 V2.4.

**Data type** Text.

**Data domain** Not applicable.

**Guide for use** Mixed case should be used.

Given names should be recorded directly from the birth certificate or passport. The given name should only include the first name, middle name, forename, second name and other given names that are on the subject of care's birth certificate or passport.

If the subject of care prefers to be called by a different name, a shortened version of their own name or perhaps a nickname, this should be recorded under preferred name.

**Collection method** The following question format might assist with data collection:

*What is your official first name as per your birth certificate / passport?*

*Are there any other names that are on your birth certificate / passport? If so what are they?*

**Example** Mary Georgina Smith: Mary is recorded as her first given name. Georgina is recorded as the second given name.

#### *Registering an un-named newborn baby*

An un-named baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'.

#### *Registering un-named newborn twins*

If the baby's mother's given name is Fiona and a set of twins is to be registered, then 'Twin 1 of Fiona' is the given name in the field for the first baby and 'Twin 2 of Fiona' is the given name of the second baby.

### *Registering unnamed multiple births*

An un-named (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple birth. For example, if the baby's mother's given name is Fiona, use Quad 1 of Fiona, Quad 2 of Fiona; or Quin 1 of Fiona, sext 1 of Fiona etc..

When the babies are named, the actual names should be recorded as the preferred name.

### *Shortened or alternate first given name*

If the subject of care uses a shortened or alternate version of their first given name, record this as the usage name.

Example: The subject's given name is Jennifer but she prefers to be called Jenny. In this instance, record Jenny as the preferred name and Jennifer as the given name.

### *Punctuation*

If special characters form part of the given name, they should be included.

Example: Ann-marie, Grégoire, Seán, Áine.

### *Registering an un-identified subject of care*

If the subject of care's given name is not known, record 'unknown' in the given name field.

### *Use of first initial*

If the subject's given name is not known, but the first letter (initial) in the name is known, record the first letter in the given name field. A full stop shall not follow after the initial.

Example: J

### *Subjects of care with only one name*

In extremely rare circumstances, a subject of care may not have a family name and a given name: they have only one name by which they are known. If the subject has only one name, record it in the family name and leave the given name field blank.

<b>8.3.5</b>	<b>Data item</b>	<b>Given name sequence number</b>
	Definition	An indicator of the order of use for given names.
	Source standards	ISO/TS 22220:2011, HL7 V2.4, AS 4846-2006.
	Data type	Numeric.
	Data domain	1 First given name 2 Second given name 3 Third given name
	Guide for use	To be used in conjunction with given name.
	Collection method	The following question format might assist with data collection:  <i>In what order are your given names recorded on your birth certificate?</i>
	Example	'Mary Georgina Smith' would have 'Mary' as a given name sequence number of 1 and 'Georgina' with a given name sequence number of 2.
<b>8.3.6</b>	<b>Data item</b>	<b>Preferred Name</b>
	Definition	Indicates the name by which the subject of care prefers to be identified.
	Source standards	ISO/TS 22220:2011.
	Data type	Text.
	Data domain	Not applicable.
	Guide for use	This is the name that will be displayed when the subject of care is referenced. It is to be used on screens, reports, letters and data collections. The subject of care should be able to provide documentation that verifies that their 'preferred name' is in fact used.

**Verification rules** Only one name for any individual subject of care can be allocated as the preferred name at any point in time.

**Collection method** The following question format might assist with data collection:

*What is your preferred name?*

Highlighting that this will be the name used in correspondence, healthcare records and so forth.

**Example** The subject of care's given name is Jonathan, but Jack is his preferred name.

### 8.3.7 **Data item** **Name suffix**

**Definition** Additional term used following a person's name to identify a subject of care.

**Source standard** ISO/TS 22220:2011, HL7 V2.4.

**Data type** Coded text.

**Data domain** Name suffix should be abbreviated. The following are some examples of commonly used abbreviations

<i>Name Suffix</i>	<i>Abbreviation</i>
Junior	Jr
Senior	Sr
First	I
Second	II

**Guide for use** Mixed case should be used (rather than upper case only).

**Validation rules** Not applicable.

**Collection method** The following question format might assist with data collection:

*Do you have a suffix that you would like to use as part of your name?*



**Example** John Smith Jr. or Daniel Lyons III.

### 8.3.8 **Data item** **Name usage classification**

**Definition** A classification that enables differentiation between the usage of names for a subject of care. An individual name may have many name uses.

**Source standard** ISO/TS 22220:2011, HL7 V2.4, AS 4590-2006.

**Data type** Coded text.

**Data domain** The following are some examples of name uses.

<i>Code</i>	<i>Description</i>	<i>Alternative Code</i>
1	Pre-marriage name	M
2	Newborn name	N
3	Registered name	L
4	Other name	O

**Guide for use** More than one name can be recorded for a subject of care and each of these names may have more than one usage at any given point in time.

#### **Pre-marriage name**

Pre-marriage name (M) is the name used by the subject of care prior to marriage, often referred to as maiden name.

#### **Newborn name**

Newborn name (N) type is reserved for the identification of unnamed newborn babies. It acts as a preferred name until an actual name is available at which time it is no longer used.

#### **Other name**

Other name (O) is any other name that a subject is also known by, or has been known by in the past; that is, all other names. This includes misspelled names, or name variations that are to be retained as they have been used to identify this subject. More than one other name may be recorded for a subject.

**Validation rules** Not applicable.

**Collection method** The following question format might assist with data collection:

*Is this the name that you always use or would you like to categorise it, for instance as your pre-marriage name, newborn name, registered name or under other name?*

<b>Example</b>	Mary Smith	M
	Marianne Smith	N

DRAFT

## 8.4 Address components for subject of care

This section provides information relating to the correct detailing of the address of the subject of care.

**Table 5: Address components for the subject of care**

	<b>Name</b>	<b>Optionality</b>	<b>Definition</b>	<b>Example</b>
<b>8.4.1</b>	Building/complex sub-unit type abbreviation	Optional	The specification of the type of a separately identifiable portion within a building/complex to clearly distinguish it from another.	Building type includes APT for Apartment and F for flat.
<b>8.4.2</b>	Building/complex sub-unit number	Optional	The specification of the number of identifier of a building/complex. To clearly distinguish it from another.	The building or complex sub-unit number, for example Apt No 6.
<b>8.4.3</b>	Address site name	Optional	The full name used to identify the physical building or property as part of its location.	An example is 'Hazelwood Apartment Complex'.
<b>8.4.4</b>	Floor/level number	Optional	Identify the floor or level of a multi-storey building/complex.	Identification of the floor or level number, floor 3, level A.
<b>8.4.5</b>	Street number	Conditional	The numeric or string reference number of a house or property that is unique within a street name or suburb.	Identification of the house number, for example 44.

	<b>Name</b>	<b>Optionality</b>	<b>Definition</b>	<b>Example</b>
<b>8.4.6</b>	Street name	Conditional	The name that identifies a public thoroughfare and differentiates it from others in the same suburb/town. The street name is required, if it is part of the subject of care's address.	The street name includes names of streets, estates and so forth, e.g. 'Lissadel Drive'.
<b>8.4.7</b>	Locality/ Townland	Conditional	The full name of the general locality containing the specific address of a subject of care. If there is no street name the locality or townland is required.	Names of a locality or townland e.g. 'Kilclooney'.
<b>8.4.8</b>	Town	Required	Identifies the town the subject of care resides in.	Town names include Ballinasloe, Bandon or An Daingean.
<b>8.4.9</b>	County	Required	Identifies the county the subject of care resides in.	Counties include Galway or Cork.
<b>8.4.10</b>	Address type	Optional	A code representing a type of address i.e. postal address or residential address.	Example: postal address: P
<b>8.4.11</b>	Postal Code	Optional	The code for the postal delivery area.	This is a listing of the postal codes in Ireland, for example 6 (for Dublin 6) and 8 (for Dublin 8).

	Name	Optionality	Definition	Example
<b>8.4.12</b>	Country identifier	Required	A code representing the country component of the subject of care's address.	A coded list will include all countries such as Ireland, Poland etc..

*Guidance for data entry for address components of subject of care*

<b>8.4.1</b>	<b>Data item</b>	<b>Building/complex sub-unit type abbreviation</b>										
	Definition	The specification of the type of a separately identifiable portion within a building or complex, to clearly distinguish it from another.										
	Source standards	ISO/TS 22220:2011, HL7 V2.4.										
	Data type	Coded text.										
	Data domain	The data domain includes, but is not restricted to: <table border="1" data-bbox="523 1160 874 1346"> <thead> <tr> <th>Description</th> <th>Code</th> </tr> </thead> <tbody> <tr> <td>Apartment</td> <td>APT</td> </tr> <tr> <td>Cottage</td> <td>CTGE</td> </tr> <tr> <td>Duplex</td> <td>DUP</td> </tr> <tr> <td>Flat</td> <td>F</td> </tr> </tbody> </table>	Description	Code	Apartment	APT	Cottage	CTGE	Duplex	DUP	Flat	F
Description	Code											
Apartment	APT											
Cottage	CTGE											
Duplex	DUP											
Flat	F											
	Guide for use	This code identifies the type of building where the subject of care is contactable.										
	Verification rule	Not applicable.										
	Collection method	The following question format might assist with data collection:  <i>How would you categorise the building in which you reside?</i>										
	Example	APT, CTGE										

<b>8.4.2</b>	<b>Data item</b>	<b>Building/complex sub-unit number</b>
	Definition	The specification of the number of identifier of a building/complex to clearly distinguish it from another.
	Source standards	ISO/TS 22220:2011, HL7 V2.4.
	Data type	Alphanumeric.
	Data domain	Not applicable.
	Guide for use	The building/complex sub-unit should be recorded with its corresponding building/complex sub-unit type abbreviation.
	Verification rule	Not applicable.
	Collection method	The following question format might assist with data collection:  <i>What is the number of the building/complex in which you live?</i>
	Example	APT 6
<b>8.4.3</b>	<b>Data item</b>	<b>Address site name</b>
	Definition	The full name used to identify the physical building or property as part of its location.
	Source standards	ISO/TS 22220, HL7 V2.4.
	Data type	Text.
	Data domain	Not applicable.
	Guide for use	This information is not usually abbreviated. It should include any reference to a wing or other components of a building complex. A comma is to be used to separate the wing reference from the rest of the building name.
	Verification rule	Not applicable.

**Collection method** The following question format might assist with data collection:

*Does the building/complex that you reside in have a specific name?*

**Example** Hazelwood apartment complex.

#### 8.4.4 **Data type** **Floor/level number**

**Definition** Descriptor used to identify the floor or level of a multi-storey building/complex.

**Source standards** ISO/TS 22220, HL7 V2.4.

**Data type** Coded text and free text.

**Data domain** Some examples are listed below, it is not an exhaustive list:

Description	Code
Floor	FL
Level	L

**Guide for use** The floor/level number should be recorded with the corresponding floor/level type.

**Verification rule** Not applicable.

**Collection method** The following question format might assist with data collection:

*What floor do you currently reside on?*  
*What is the name and number of the floor or level that you currently reside on?*

**Example** (Floor 1a) FL 1a, (Level 3) L3

#### 8.4.5 Data type Street number

Definition	The numeric or string reference number of a house or property that is unique within a street name, suburb.
Source standard	ISO/TS 22220, HL7 V2.4.
Data type	Alphanumeric.
Data domain	Not applicable.
Guide for use	Generally only one street number is used, occasionally it is alphanumerical.
Verification rule	Not applicable.
Collection method	The following question format might assist with data collection:  <i>What is the number of your residence?</i>
Example	1 4 5a

#### 8.4.6 Data item Street name including street type

Definition	The name that identifies a public thoroughfare and differentiates it from others in the same locality.
Source standards	ISO/TS 22220:2011, HL7 V2.4.
Data type	Text.
Data domain	The full street type name should be written, the list below provides certain examples, but is not a comprehensive schedule:  Avenue      Court      Park Close      Square      Terrace Junction      Alley      Street



**Guide for use** Street types should be written in full where space permits in order to avoid potential confusion in the case of an emergency and to improve the quality of street type information.

**Verification rule** Not applicable.

**Collection method** The following question format might assist with data collection:

*Can I ask you the full name of your street of residence?*

**Example** Lissadel Close

#### 8.4.7 **Data item** **Townland/locality**

**Definition** The full name of the general locality containing the specific address of a subject of care.

**Source standards** ISO/TS 22220:2011, HL7 V2.4, AS 4590-2006.

**Data type** Text.

**Data domain** Suburb, locality or townland.

**Guide for use** This should identify the area that the subject of care currently resides in.

**Verification rule** The townland or locality name must meet official names as per the Department of the Environment, Community and Local Government. It should also be confirmed that the townland or locality is located in the county specified by the subject of care as their area of residence.

**Collection method** The following question format might assist with data collection:

*Can I ask you the name of the locality or townland where you currently reside?*

**Example** Blackrock (Co Dublin), Drumshanbo North (Co Leitrim).

#### 8.4.8 Data item **Town**

**Definition** The full name of the town where the subject of care resides.

**Source standards** ISO/TS 22220:2011, HL7 V2.4.

**Data type** Text.

**Data domain** The list below provides some examples of towns in Ireland.

##### **Description**

New Inn (Cork)  
Drumcondra (Dublin)  
Enniskerry (Wicklow)  
Slealy (Laois)  
Glenties (Donegal)

**Guide for use** The town identifies commonly used location names.

**Verification rules** The location name must meet official names as per the Department of the Environment, Community and Local Government. It should also be confirmed that the town is located in the county specified by the subject of care as their area of residence.

**Collection method** The following question format might assist with data collection:

*What is the name of your town of residence?*

*What town do you currently live in?*

**Example** Templemore  
Dungarvan.

**8.4.9 Data item County**

**Definition** The full name of the county where the subject of care resides.

**Source standards** An Post/Geodirectory.

**Data type** Text.

**Data domain** The list below is indicative and is not exhaustive of the counties in Ireland:

Description	Code
Cork	CK
Kildare	KE
Kilkenny	KK
Laois	LS
Mayo	MO

**Guide for use** Record the county as identified by the subject of care.

**Verification rules** The county must match the listing of counties in Ireland as per the Department of the Environment, Community and Local Government.

**Collection method** The following question format might assist with data collection:

*What county do you currently reside in?*

**Example** Wexford.

**8.4.10 Definition Address type**

**Source standards** A code representing a type of address.

**Data type** Coded Text.

**Data domain** The list below indicates the code options

Description	Code
-------------	------

Place of residence R  
Postal address P

**Guide for use** Multiple addresses may be recorded as required. Each address should have an associated address type code. There should only be one current home address and one current postal address.

**Verification rules** Not applicable.

**Collection method** The following question format might assist with data collection:

*Is that address your place of residence and /or your postal address?*

**Example** Place of residence: R

#### **C/o (in care of)**

It should be noted that the subject of care may indicate that c/o (in care of) needs to be included with the address. If this is the case, please put c/o in front of the postal address.

## 8.5 Subject of care – Communication details

This section provides information relating to the correct detailing of the contact details of the subject of care.

**Table 6: Communication details for the subject of care**

	Name	Definition	Optionality	Example
<b>8.5.1</b>	Electronic Communication Medium	A code representing a type of communication mechanism used by a subject of care	Optional	Examples include, landline, mobile, virtual devices, email.
<b>8.5.2</b>	Electronic communication detail-	A unique combination of characters used as input to electronic telecommunication for the purpose of contacting the subject of care. This combination should include the country code where applicable, the area code in brackets ( ), and the main contact number.	Optional	National (0609) 123 4567  International +22 609 123 4567 <sup>(12)</sup>  (086)0000000
<b>8.5.3</b>	Electronic contact preference code	An indication of the preferences for use of this contact type.	Optional	Examples include business hours or day time hours.
<b>8.5.4</b>	Electronic contact usage code	A code representing the manner of use that a person applies to an electronic communication medium.	Optional	The communication medium is used for business use only.

### *Guidance for data entry for communication details of subject of care*

#### **8.5.1 Data item Electronic communication medium**

Definition	A code representing a type of communication mechanism used by a subject of care.		
Source standards	ISO/TS 22220:2011, HL7 V2.4, AS 4846-2006, HNBC 98-10.		
Data type	Coded text.		
Data domain	<b>Code</b>	<b>Description</b>	<b>Alternative</b>
	1	Telephone (excluding mobile)	T
	2	Mobile phone	M
	3	Email	E
	4	URL/web address	U
	5	Other	O
Guide for use	Each instance should have the appropriate electronic communication medium and usage code assigned.		
Verification rules	Not applicable.		
Collection method	Questions that might help collection of data include: <i>What is the best way to contact you?</i> <i>What is your preferred method of communication?</i>		
Example	Mobile phone: M.		

#### **8.5.2 Data item Electronic communication details**

Definition	A unique combination of characters used as input to electronic telecommunication equipment for the purpose of contacting a subject of care.
Source standards	ISO/TS 22220:2011, HL7 V2.4, AS 4846-2006.
Data type	Alphanumeric.

<b>Data domain</b>	A text string valid for a specific communication medium including spaces where applicable.
<b>Guide for use</b>	Record the full phone number (including any prefixes)  Multiple electronic communication details or addresses, for example multiple phone numbers, Viber numbers and email addresses. Each instance should have an appropriate electronic communication medium and type assigned.
<b>Verification rules</b>	Not applicable.
<b>Collection method</b>	The following question format might assist with data collection:  <i>What is your contact number?</i> <i>What is your contact email address?</i>
<b>Example</b>	(091)520000, +22 609 123 4567 <sup>(12)</sup> , <a href="mailto:subjectofcare@home.ie">subjectofcare@home.ie</a>

### 8.5.3 **Data item** **Electronic contact preference code**

<b>Definition</b>	An indication of the preferences for use of this contact type.	
<b>Source standards</b>	ISO/TS 22220:2011.	
<b>Data type</b>	Coded text.	
<b>Data domain</b>	The below provides examples, but is not an exhaustive list of possibilities:	
	<b>Description</b>	<b>Code</b>
	Business hours	B
	Day time hours	D
	Weekend hours	W
	At all times	A
	Evening/night hours	E
<b>Guide for use</b>	Indication of the most appropriate times in the day to use that method of communication.	
<b>Verification rules</b>	Not applicable.	

**Collection method** The following question format might assist with data collection:

*What is the most suitable time to contact you at this number?*  
*When is the most appropriate time to contact you on your mobile phone?*

**Example** At all times: A

#### 8.5.4 **Data item** **Electronic contact usage code**

**Definition** A code representing the manner of use that a person applies to an electronic communication medium.

**Source standards** ISO/TS 22220:2011, AS 4846-2006.

**Data type** Coded text.

Data domain	Code	Description	Alternative code
	1	Business	B
	2	Personal	P
	3	Both business and personal use	A

**Guide for use** This data item allows multiple electronic contact usages codes to be recorded. Each instance should have an appropriate electronic communication medium and usage code assigned.

**Verification rules** Not applicable.

**Collection Method** The following question format might assist with data collection:

*Can I ask you is your email address for personal or business use?*

*Is your mobile phone for business or personal purposes?*

**Example:** Business: B



## 8.6 Additional demographic details for subject of care

This section provides information relating to additional demographic details of the subject of care.

**Table 7: Additional demographic details for the subject of care**

	Name	Definition	Optionality	Example
<b>8.6.1</b>	Date of birth	The date of birth of the subject of care.	Required	The data of birth should follow the following format: dd/mm/yyyy.
<b>8.6.2</b>	Gender	Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behaviour and other aspects of a person's life.	Required	Examples of gender include male and female.
<b>8.6.3</b>	Mother's birth surname	The original family name of the subject of care's mother.	Optional	For example, Smith.
<b>8.6.4</b>	Religion	Stated religion of the subject of care.	Optional	Example Roman Catholic.

### *Guidance for data entry for additional demographic details of subject of care*

<b>8.6.1</b>	<b>Data item</b>	<b>Date of birth</b>
	Definition	The date of birth of the subject of care.
	Source standards	ISO/TS 22220:2011, HL7 V2.4.
	Data type	Date.

Data domain	Valid dates.
Guide for use	The date format is dd/mm/yyyy. Enter the full date of birth using day, month and year. Use leading zeros if necessary, for example 01/01/2001. Where date of birth is not accurately known, an approximate date should be used to derive age, for example, if the subject of care estimates that they are 30, then in 2013 date of birth should be recorded as 00/00/1983
Verification rules	Birth date should be less than or equal to date of death.
Collection method	The following question format might assist with data collection:  <i>What is your date of birth?</i>
Example	12/11/1990.

## 8.6.2

<b>Data item</b>	<b>Gender</b>															
Definition	The sex of a subject.  Gender is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, gender is based on anatomical characteristics.															
Source standards	ISO/TS 22220:2011, HL7 V2.4.															
Data type	Coded text.															
Data domain	<table border="0"> <thead> <tr> <th style="text-align: left;">Code</th> <th style="text-align: left;">Descriptor</th> <th style="text-align: left;">Alternative code</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Male</td> <td>M</td> </tr> <tr> <td>2</td> <td>Female</td> <td>F</td> </tr> <tr> <td>3</td> <td>Intersex or indeterminate</td> <td>I</td> </tr> <tr> <td>4</td> <td>Not stated/inadequately described</td> <td>U</td> </tr> </tbody> </table>	Code	Descriptor	Alternative code	1	Male	M	2	Female	F	3	Intersex or indeterminate	I	4	Not stated/inadequately described	U
Code	Descriptor	Alternative code														
1	Male	M														
2	Female	F														
3	Intersex or indeterminate	I														
4	Not stated/inadequately described	U														
Guide for use	Gender indicates the sex of the subject of care.															

### Intersex or indeterminate

Code 3 'intersex or indeterminate', is generally used for babies. It refers to a person who, because of a genetic condition was born with reproductive organs or sex chromosomes that are not exclusively male or female, or whose sex has not yet been determined for whatever reason.

For reasons of sensitivity, this question should not be asked, or used on data collection forms; it should only be used if the respondent volunteers the information or if it becomes clear during data collection.

### Not stated/inadequately described

Code 9, 'Not stated/inadequately described', should only be used if the data is not collected at the point of subject of care contact, or circumstances dictate that the data are not able to be collected. It should not be used on primary collection forms.

#### Verification rules

Accept only allowed values.

Field should not be blank.

#### Collection method

The following format should be used for data collection:

*What is your gender? \_\_\_Male \_\_\_Female*

Please refer to 'guide for use' for **codes 3 and 4**, which should **not be asked** as part of the data collection process.

#### Example

Female.

### 8.6.3

<b>Data item</b>	<b>Mother's birth surname</b>
Definition	The original surname of the subject of care's mother.
Source standards	ISO/TS 22220:2011, HL7 V2.4.
Data type	Text.
Data domain	Not applicable.
Guide for use	Further confirmation of the identity of the subject of care.
Verification rules	All letters of the alphabet and additional characters as identified in family name.
Collection method	The following question format might assist with data collection:  <i>What is your mother's birth surname?</i>
Example	Smith Henry

### 8.6.4

<b>Data item</b>	<b>Religion</b>										
Definition	Stated religion of the subject of care.										
Source standards	HL7-PID.										
Data type	Coded text.										
Data domain	Below is an indicative list of religions, it is not exhaustive:  <table><thead><tr><th>Code</th><th>Description</th></tr></thead><tbody><tr><td>1</td><td>Apostolic/Pentecostal</td></tr><tr><td>2</td><td>Church of Ireland</td></tr><tr><td>3</td><td>Methodist</td></tr><tr><td>4</td><td>None</td></tr></tbody></table>	Code	Description	1	Apostolic/Pentecostal	2	Church of Ireland	3	Methodist	4	None
Code	Description										
1	Apostolic/Pentecostal										
2	Church of Ireland										
3	Methodist										
4	None										
Guide for use	Enter the appropriate religion from the coded list.										

**Verification rules** Not applicable.

**Collection method** The following question format might assist with data collection:

*Would you like your religion to be recorded?*

**Example** Baptist  
Catholic

DRAFT

## 9. Next Steps

Following the public consultation, the Authority will examine all submissions received and amend the draft dataset and guidance as appropriate.

The Authority will recommend that the final version of the national standard demographic dataset is the dataset attached to the IHI.

In addition, the finalised national demographic dataset and guidance will be published on the HIQA website, [www.hiqa.ie](http://www.hiqa.ie).

DRAFT

## 10. References

- (1) Health Information and Quality Authority. *Recommendations for Health Identifiers for Healthcare Practitioners and Organisations*. 2011. Available online from: [http://www.hiqa.ie/publications?page=1&topic=All&type=All&date\[value\]\[year\]=2011](http://www.hiqa.ie/publications?page=1&topic=All&type=All&date[value][year]=2011).
- (2) Health Information and Quality Authority. *Unique Identifiers* [Online]. Available from: <http://www.hiqa.ie/>.
- (3) Health Information and Quality Authority. *Recommendations for a Unique Health Identifier in Ireland for individuals*. 2009. Available online from: <http://www.hiqa.ie/content/recommendations-unique-health-identifier-individuals-ireland>.
- (4) The Health Act 2007. Dublin: The Stationery Office; 2007. Available online from: <http://www.irishstatutebook.ie/2007/en/act/pub/0023/index.html>.
- (5) International Organization for Standardization (ISO). *ISO/TS 22220:2011. Technical Specification. Health Informatics – Identification of subjects of health care*. 2011.
- (6) International Organization for Standardization (ISO). *ISO/TS 27527:2010. Technical Specification. Health Informatics - Provider identification*. 2010.
- (7) Health Level Seven International. *Health Level Seven (HL7)* [Online]. Available from: <http://www.hl7.org/>.
- (8) Standards Australia. *Australian Standard AS 4846-2006. Health Care Provider Identification*. 2006.
- (9) Ministry of Health NZ. *National Health Index number, New Zealand*. [Online]. Available from: <http://www.health.govt.nz/our-work/health-identity/national-health-index>.
- (10) National Health Service U. *NHS Number* [Online]. Available from: <http://www.nhs.uk/NHSEngland/thenhs/records/Pages/thenhsnumber.aspx>.
- (11) Australian Institute of Health and Welfare. *A guide to data development*. Canberra: AIHW; Report No.: HWI 94. 2007. Available online from: <http://www.aihw.gov.au/search/?q=a+guide+to+data+development>.

- (12) Irish Telecommunications Union. *Notation for national and international telephone numbers, e-mail addresses and Web addresses* . 2001. Available online from: <http://www.itu.int/rec/T-REC-E.123-200102-I/en>.

DRAFT



Published by the Health Information and Quality Authority.

For further information please contact:

Health Information and Quality Authority  
Dublin Regional Office  
George's Court  
George's Lane  
Smithfield  
Dublin 7

Phone: +353 (0) 1 814 7400  
URL: [www.hiqa.ie](http://www.hiqa.ie)

© Health Information and Quality Authority 2013