



18 September 2013





About the Health Information and Quality Authority

The Health Information and Quality Authority (the Authority) 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) of the Health Act 2007, the Health Information and Quality Authority (the Authority) 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 standard demographic dataset and guidance for use in health and social care settings in Ireland.



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Table 1. Glossary of Terms

Term	Definition
Subject of care	Any person who uses or is a potential user of a health or social care service, for example a patient, service user or resident.
Individual Health Identifier (IHI)	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. The purpose of the IHI is to safely identify individuals accessing health and social care services in Ireland. The dataset associated with the IHI will contain data elements such as name, date of birth and address.
Biometric identification	Biometric identifiers are part of the person; they are measurable biological characteristics, such as a recording of a finger print or the shape of facial features.
Optionality	Refers to having options. In this case it indicates whether the data element is mandatory, mandatory where applicable or optional. Mandatory means that it is required, <i>Mandatory where applicable</i> means that if the data element applies to the subject of care it is required and must be completed; <i>Optional</i> means that it needs to be completed when appropriate.

^{*} The Health Identifiers Bill is expected to mandate for the introduction of individual health identifiers (IHI) in 2013.

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. A demographic dataset is essential to provide core information about an individual. A dataset consists of identifying elements about the subject of care, including, for example, the individual's date of birth, name and address as well as other items associated with an individual.

The purpose of the National Standard Demographic Dataset for Health and Social Care services in Ireland (hereafter referred to as the demographic dataset) is to remove the duplication and variation within and between service providers when collecting patients' and service users' demographic data. It will also assist all service providers, including primary care centres, general practitioners, hospitals, allied health professionals, children's residential centres and residential centres for older people to collect standard core data about patients and service users.

The development of a demographic dataset will help to standardise how demographics are recorded and facilitate easier sharing of information within and between health and social care services. This 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 standard demographic dataset will also work towards tracking and trending demographic data, hence enabling better planning of services and care provided.

The accompanying guidance will provide support and assistance to the health and social care sector to meet the requirements of the demographic dataset, and ensure consistency in the recording of the data.

1.1 Relationship with the Individual Health Identifier and Associated Dataset

The ability to uniquely identify individuals is imperative to provide quality and safe care. The Health Information and Quality Authority (the Authority) has recognised the importance of being able to uniquely identify individuals and has recommended the introduction of an individual health identifier (IHI)⁽¹⁾. 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. The purpose of the IHI is to safely identify individuals accessing health and social care services in Ireland. The dataset associated with the IHI will contain data elements such as name, date of birth and address.

The demographic dataset is a standard that sets out how healthcare providers should record demographic data about individuals accessing health and social care services. It includes all the data elements present in the IHI dataset with the exception of the Personal Public Service (PPS) number and signature.

It is important to note that it is intended that the Personal Public Service Number (PPS) is included in the IHI dataset purely for the purposes of searching for an Individual Health identifier and will not be downloadable or visible to users of the IHI system. Therefore, including the PPS number in the demographic dataset would be inappropriate. Importantly, the demographic dataset provides extensive guidance to providers regarding how data elements should be recorded.

When the IHI is implemented, service providers will have the ability to access the IHI system. Access to the IHI system could potentially be via the providers' IT systems. Using the same format for demographic elements will allow for quicker and more accurate searching of the IHI system. It could also potentially mean that service providers have the ability to download the appropriate data elements from the IHI dataset to their local systems.

2. Background

The Health Information and Quality Authority was established under the Health Act 2007⁽²⁾ 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 in health information as outlined in the Health Act 2007. 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 standardised or agreed guidance on the collection of demographic data. The lack of a national demographic dataset has resulted in each health and social care provider designing their own rules for the data elements they wish to collect on each individual. The result is that there are a variety of approaches to the data elements collected and the formats of same, with each data element having the possibility for many permutations and combinations. Examples include how to collect name details; for instance the name McCarthy can be collected as 'McCarthy', 'Mc Carthy', 'MacCarthy' and so forth, or date of birth can be collected as dd/mm/yy or dd/mm/yyyy or mm/dd/yy, leading to a potential for duplication of records. It is therefore crucial to have a single national standard to ensure consistency at a national and local level of such important demographic data.



3. Benefits of this work

Why standardise demographic data?

One of the key requirements to support the delivery, planning and monitoring of services, is the ability to have access to quality information about an individual. A national standard demographic dataset defines a set of demographic data elements that will be recorded for each subject of care. The same data elements should be recorded 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 element means. This works towards greater accuracy in the recording 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⁽³⁾.

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
- work towards removal of the need for repeated provision of demographic data on each visit to the health or social care service provider
- assist in reducing 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 recording 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.



4. Scope of National Standard Demographic Dataset

The demographic dataset presents health and social care providers with a standard core set of data elements to support the consistent, complete, and accurate recording of information for each subject of care, which works towards the removal of duplication and improving the safety and quality of care provided. The objectives of the demographic dataset are to:

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

This dataset does not aim to specify the requirements for electronic transfer of demographic data.

In addition to the demographic dataset the Authority has developed a General Practice Messaging Standard⁽⁴⁾, a National Standard for Patient Referral Information⁽⁵⁾ and Standardising Patient Discharge Summary Information⁽⁶⁾, all of which can be found on http://www.higa.ie.

Outline of format for national standard demographic dataset and guidance

For ease of use the demographic dataset is divided into six sections. Each section has a brief overview, with a table identifying the relevant data elements, and guidance provided for each data element within the table.

The sections are broken down as follows:

- Subject of care identification: this section ensures that unique identification numbers are in place for every individual that uses health or social care services.
- Name components for subject of care: this section focuses on the name details for each individual; it includes first name, family name, and the name that the subject of care prefers to be called by.
- Additional demographic details for subject of care: these are additional data elements that are necessary to identify the subject of care but do not fall under the other categories, such as date of birth.
- Subject of care communication details: communication details such as mobile phone number, landline number, and email address are recorded.
- Address components for subject of care: this section records residential and postage address for each individual. It includes street name, town and county.
- Subject of care biometric identification: this section allows for technological advances, the intention of this section is to ensure that the dataset is future proofed, allowing for the capture of biometric data, such as voice recognition or iris scanning.

Each table is sub-divided into five columns. The order of the columns are:

- 1. Data element identification (ID) number
- Data element name
- 3. Data element definition
- 4. Optionality of each data element, i.e. whether the data element is required or optional
- 5. Example of the data element.

What's the difference between mandatory, mandatory where applicable and optional?

- **Mandatory** data elements should be included in all demographic datasets and these items should be recorded on each subject of care.
- **Mandatory where applicable** Mandatory where applicable are data elements that should be populated if the data element is relevant and applicable to the subject of care.
- Optional data elements may not apply to all subjects of care and therefore should be collected when appropriate.

The guidance provides more detailed information and explanations for each data element, it is presented in the following format:

Definition	A statement that provides an explanation of what is meant by the data element.		
Source standards	Details of the standards that recommend the use of the data element.		
Data type	Provides different representations of the data type. That is, if it is text, numeric, alphanumeric, coded list, date, time and so forth.		
Data codes and values	Lists the values or codes that are acceptable for representation of the data element. For example:		
	Code	Description	Alternative Code
	1	- Male	M
	2	Female	F
	3	Intersex or indeterminate	I
	9	Not stated/ inadequately	
		described	U
Guide for use	Provides additional guidance to inform the use of the data element.		
Verification rule	Quality control mechanisms that restrict the collection, storage or transferral of non-valid data.		
Collection method	Provides suggestions on how to capture data.		
Example	Provides an example of the data element*.		

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

6. Methodology

The standards were developed by conducting a review of national practice through examining the demographic data being collected by a number of national agencies both within and outside of health and social care. Relevant international standards were reviewed and detailed discussions were conducted with a number of key stakeholders. Throughout the development of the demographic dataset, the Authority consulted with members of the General Practice Information Technology Group (GPIT) and the Department of Social Protection, Client Identity Services (DSP/CIS).

The following international standards were reviewed:

- ISO/TS 22220:2011. Technical Specification. Health Informatics Identification of subjects of healthcare⁽⁷⁾
- ISO/TS 27527:2010. Technical Specification. Health Informatics Provider identification⁽⁸⁾
- ISO 3166-1:2006. Codes for the representation of names of countries and their subdivisions – Part 1: Country codes⁽⁹⁾
- AS 4846-2006. Australian Standard. Health Care Provider Identification⁽¹⁰⁾
- AS 4590-2006. Interchange of client information standard⁽¹¹⁾
- ASTM E1714-00. Guide for Properties of a Universal Health Care Identifier⁽¹²⁾
- ITU-T E.123. Notation for national and international telephone numbers, e-mail addresses and web addresses⁽¹³⁾
- European Convention on Nationality⁽¹⁴⁾.

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⁽¹⁵⁾, the UK National Health Service (NHS) number dataset⁽¹⁶⁾ and the proposed dataset associated with the Individual Health Identifier in Ireland.

An eight-week public consultation on the National Standard Demographic Dataset and Guidance for use in health and social care settings in Ireland took place from February 18, 2013 to April 12, 2013. The Authority welcomed all submissions and would like to thank all those who contributed. All submissions to the consultation were reviewed and informed the development of the final draft of the national standard demographic dataset.

7. National standard demographic dataset and guidance

The demographic dataset is broken down into six logical sections. Table 2 provides a summary of the sections and the data elements contained therein.

Table 2: Summary of data element structures

Data structures	Data elements
Subject of care identifier	Individual Health Identifier Health Identifier (Other)
Name components for subject of care	Name title Given name (first name) Given name (first name) sequence number Family name (last name) Family name (last name) sequence number Preferred name Name suffix Name usage classification
Additional demographic details for the subject of care	Date of birth Place of birth Sex Mother's birth family name Nationality Date of death Source of death notification
Communication details for the subject of care	Electronic communication medium Electronic communication detail Electronic contact preference code Electronic contact usage code

Address components for subject of care

Building/complex sub-unit type abbreviation

Building/complex sub-unit number

Address site name

Floor/level number

Street number

Street name

Locality/Townland

Town

County

Address type

Postal code

Country identifier

Subject of care biometric identification

Subject of care biometric identification

7.1 Subject of care identification

This section sets out the identifiers required to uniquely identify each subject of care, which will work towards improving the safety and quality of care provided to all subjects of care. These identifiers will be required throughout the public and private health and social care system.

In order to ensure that this dataset includes and accommodates future national initiatives*, this section sets out that the individual health identifier (IHI) is required. However, the Authority is fully aware that it must first be statutorily mandated by the forthcoming Health Identifiers Bill and subsequently developed and then implemented. Table 3 on the following page outlines the necessary identifiers for each subject of care. This is followed by more detailed guidance on each of the data elements.

^{*} The Health Identifiers Bill is expected to mandate for individual health identifiers (IHI) in 2013. When the IHI is implemented, it will then be mandatory in the demographic dataset.

Table 3: Subject of care identification

Data element name		Definition	Optionality	Example
7.1.1	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 ⁽¹⁾ .	Mandatory	
7.1.2	Health identifier (other)	An additional number or code assigned to a subject of care by a health or social care provider.	Mandatory where applicable	This number is specific to the service provider. For example, a hospital number, or number in a residential centre.

Further guidance for data entry for subject of care identification

7.1.1	Data element	Individual health identifier (IHI)
	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 in both public and private healthcare.
	Source standards	ISO/TS 22220:2011.
	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.

7.1.2	Data element	Health identifier (other)
	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 in both public and private healthcare.
	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.

7.2 Name components for subject of care

This section aims to sub-divide the components of a subject of care's name to ensure that each subject of care is accurately and uniquely identified, and to work towards the removal of duplication or mis-identification, leading to an improvement in safety and care provided.

In addition to recording the subject of care's current name, the dataset allows for the classification of names, which indicates if the name is a birth name, married name and so forth, allowing previous name(s) or different names to be recorded.

Names and order of names vary according to culture and place of birth. This demographic dataset sets about overcoming these differences. It requires that given name (first name) is recorded initially and family name (last name) is subsequently recorded.

The given name sequence number allows for several given names to be recorded. Therefore if the subject of care's name is Sarah Linda, Sarah is the first name, sequence number 1 and Linda is the first name, sequence number 2.

Family name is recorded after the given name. Several family names can be recorded. For example, if the subject of care's name is Allen-Smith, the family name sequence number allows for a clear distinction that Allen is the first family name and Smith is the second. Table 4 below outlines the name components for the subject of care. This is followed by more detailed guidance on each of the data elements.

Table 4: Name components for subject of care

Data eleme	ent name	Definition	Optionality	Example
7.2.1	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).
7.2.2	Given name	The subject of care's identifying name.	Mandatory	The name by which the subject of care is identified.
7.2.3	Given name sequence number	An indicator of the order of use for given names.	Mandatory	If subject of care given name is Sarah Linda, the first name is sequence number 1, 1.Sarah and the second name is sequence number 2, 2.Linda
7.2.4	Family name	The second part of the subject of care's name which denotes their family or marital name.	Mandatory	This is the family or marital name of the subject of care. For example Smith.

Data element name		Definition	Optionality	Example
7.2.5	Family name sequence number	An indicator of the order of use for family name(s).	Mandatory	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.
7.2.6	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. For example, Betty.
7.2.7	Name suffix	Additional term used following a person's name to identify a subject of care.	Mandatory where applicable	Identifies the subject of care's name suffix, for instance Senior (Sr) or Junior (Jr).
7.2.8	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.

Further guidance for data entry for the name components of the subject of care

7.2.1	Data element	Name title		
	Definition	A prefix added to a subject of care's name in certain circumstances.		
	Source standards	ISO/TS 22220:2011.		
	Data type	Coded text		
	Data domain	The following is a non-exlused abbreviations. The f titles can be found in ISO	•	
		Name title Abbrevia	ation	
		Doctor Dr		
		Miss Ms Mister Mr		
		Missus Mrs		
		Professor Prof		
	Guide for use	If for instance the subject name title is Doctor, use	of care specifies that their the abbreviation Dr.	
	Verification rules	Titles of Ms, Mrs, Bean U Irish for Mrs) should only		
		Titles of Mr, Sir, and an tU into Irish for Mr) should o	Jasal (a direct translation nly be accepted for males.	
	Collection method	The following question format might assist with data collection:		
		What name title would younder?	ou like to be recorded	
		What is your preferred name title?		
	Example	Ms Murphy	Mr Murphy	
		Bean UíMhurchú	An tUasal ÓMurchú	

Data element	Given name
Definition	The subject of care's given name, first name or forename.
Source standards	ISO/TS 22220:2011.
Data type	Text
Data domain	Not applicable
Guide for use	Mixed case should be used. Given name should be recorded directly from the birth certificate or passport. The given name(s) should only include 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
Collection method	name or perhaps a nickname, this should be recorded under their preferred name. The following question format might assist with data collection: What is your first name(s)/given name(s) on your birth certificate?
Example	Mary: Mary is recorded as her first given name.
Registering an un-named newborn baby	An un-named baby is to be registered using the mother's family name (last name) in conjunction with the prefix 'Baby of'.
Registering un-named newborn twins	If the baby's mother's family name is Smith and a set of twins is to be registered, then 'Twin 1' is the given name in the field for the first baby (and Smith is the Family name) and 'Twin 2' is the given name of the second baby.
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 preferred name. Example: The subject's given name is Jennifer but she prefers to be called Amy. In this instance, record Amy as the preferred name and Jennifer as the

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 given name and a family 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 enter 'unknown' in the given name.

Data element	Order of given names	
Definition	Indicates the order of use for given names.	
Source standards	ISO/TS 22220:2011, AS 4846-2006.	
Data type	Numeric	
Data domain	The following is not an exhaustive list of the number of given names allowed for, the full listing can be found in ISO/TS 22220:2011 ⁽⁷⁾ .	
	First given name	1
	Second given name	2
	Third given name	3
Guide for use	Use with the given name.	
Collection method	The following question format might assist with data collection: What is your first name?	
Example	'Mary Georgina Smith' would have 'Mary' as a first name sequence number of 1 and 'Georgina' with a first name sequence number of 2.	

7.2.4	Data element	Preferred Name
	Definition	The preferred name or alias indicates the name by which the subject of care likes to be known.
	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? It should be highlighted 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.

Data element	Family name
Definition	The second part of the subject of care's name which denotes their family, surname, last name or marital name.
Source standards	ISO/TS 22220:2011.
Data type	Text
Data domain	Not applicable
Guide for use	Mixed case should be used.
	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 for their family name, each name should be registered as a family name within the group. For example, for the family name Hegarty-Smith, Hegarty should be entered as the first family name in the sequence and Smith as the second family name.
	Some people use more than one name: for example formal name, birth name, married or pre-marriage name (7.2.8 outlines the different classifications). This field should register their preferred family 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 family names begin with prefixes such as O', De, Mc or Mac etc. there should be no space between the prefix and rest of the family name, such as McHenry, O'Connell, DeBurke.
Verification rules	Not applicable.
Collection method	The following question format might assist with data collection: What is your family name(s)? Have you any other parts of your family name that you would like recorded?

Example	Seán ÓMurchadha Anna Dupont-Smith.	
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.	
Registering a pseudonym	A pseudonym is a fictitious or partial name instead of the full or actual name used. This process might be required in order to mask the identity of an individual, for example in the case of HIV testing where the subject of care want to remain anonymous. It is recommended that the subject be asked to record both the pseudonym in addition to a legally-known name. This requires local systems to be able to identify which name is to be used as the preferred name for the purposes 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. It is important to recognise that this is not total anonymity as there is a link to the usual identifiers of the individual. In a case where a subject of care is allowed full anonymity, to register a pseudonym against a true identity would be to breach the anonymity. Where anonymity is required or permitted, no link can be made.	
Registering unnamed multiple births	An unnamed (newborn) baby from a multiple birth should use their mother's family name plus a reference to the multiple birth. For example, if the baby's mother's family name is Quinn, use Twin 1 Quinn or Quad 1 Quinn, Quad 2 Quinn, etc When the babies are named, the actual names should be recorded as the preferred name.	
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 Umlaut ü	

Apostrophe	There should be no spaces before or after the apostrophe, i.e. in the example shown, between the O and the apostrophe or between the apostrophe and Brien. Example: O'Brien.
Full stop	There should be no space before a full stop, i.e. as in the example shown, between St and the full stop. Example: St.John.
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.
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.

7.2.6 Data element Orde		Order of family names
	Definition	Indicates the order of the family name, surname or last name.
	Source standards	ISO 22220:2011.
	Data type	Numeric
Data domain		The following is not an exhaustive list of the order of the family names allowed for, the full listing can be found in ISO/TS 22220:2011 ⁽⁷⁾ .
		First family name within a name set 1
		Second family name within a name set 2
		Third family name within a name set 3
		Fourth family name within a name set 4
	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	What is your family name? Can you please tell me the right order?
	Example	Smith Henry Jones, 1. Smith 2. Henry 3. Jones

Data element	Name suffix	
Definition	Additional term used following a person's name to identify a subject of care.	
Source standards	ISO/TS 22220:2011.	
Data type	Coded text	
Data domain	Name suffix should be abbreviated. The following are some examples of commonly used abbreviations. The full list of examples can be found in ISO/TS 22220:2011 ⁽⁷⁾ . Name Suffix Abbreviation Junior Jr	
	Senior Sr	
Guide for use	Mixed case should be used (rather than upper case only).	
Verification rule	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 Sr.	

Data element	Classifying names	
Definition	Clearly identifying how each name is used, for example is the name on the birth certificate, is it the pre-marriage (maiden) name.	
Source standards	ISO/TS 22220:2011.	
Data type	Coded text in some data. This code is obtained from ISO/TS 22220:2011 ⁽⁷⁾ .	
Data domain	The following are some examples of name uses. The listing from ISO/TS 22220:2011 ⁽⁷⁾ has been adapted for the Irish context in that birth certificate name has been included.	
	CodeDescriptionAlternative Code1Maiden nameM2Newborn nameN3Birth certificate nameB4Other nameO	
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.	
Maiden name	Maiden name (Pre-marriage name (M)) is the name used by the subject of care prior to marriage.	
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.	
Birth certificate name	The official name on the birth certificate. For example the birth certificate name could be Margaret, but the subject of care may actually be known as Sheila.	
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 maiden name, newborn name, registered name or under other name?	
Example	Mary Smith M Marianne Smith N	

7.3 Additional demographic details for the subject of care

This section is made up of data elements that qualify and ensure the accurate identification for the subject of care, as illustrated in Table 5. This is followed by more detailed guidance on each of the data elements.

Table 5: Additional demographic details for the subject of care

Date E	lement name	Definition	Optionality	Example
7.3.1	Date of birth	The date of birth of the subject of care.	Mandatory	The date of birth should follow the following format: dd/mm/yyyy.
7.3.2	Place of birth	Birthplace. If the subject of care is born in Ireland, the county in which they were born. If the subject of care was born outside of Ireland, the country in which they were born.	Optional	Examples of county include; Galway, Roscommon Examples of country include Poland, China
7.3.3	Sex	Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.	Mandatory	Examples of sex include male and female.

Date E	lement name	Definition	Optionality	Example
7.3.4	Mother's birth family name	The original family name of the subject of care's mother.	Optional	For example, Smith.
7.3.5	Nationality	The legal bond between a person and a State ⁽¹⁴⁾	Optional	Polish Chinese Irish
7.3.6	Date of death	The date that the subject of care dies.	Mandatory where applicable	The format for date of death should be dd/mm/yyyy.
7.3.7	Source of death notification	The source of information about the subject of care's death.	Optional	For example, Relative General Register Office.



Further guidance for data entry for additional demographic details of subject of care

7.3.1	Data element	Date of birth
	Definition	The date of birth of the subject of care as per the birth certificate.
	Source standards	ISO/TS 22220:2011.
	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 rule	Birth date should be less than or equal to date of death.
	Collection method	The following question format might assist with data collection:
		What is your date of birth?
	Example	12/11/1990.

7.3.2	Data element	Place of birth
	Definition	The county in which the subject of care was born, if born in Ireland. If born outside of Ireland the country in which the subject of care was born.
	Source standards	ISO/TS 22220:2011.
	Data type	Coded text
	Data domain	The Counties must be the same format as outlined in 5.9 The Countries must be a similar format as outlined in 5.11

Guide for use	Counties – please refer to 5.9 Countries – please refer to 5.11		
Verification rule	Birth date should be less than or equal to date of death.		
Collection method	The following question format might assist with data collection: Where were you born?		
Example	Cork CK Kildare KE Australia AU Canada CN		

Data element Sex **Definition** The sex of the subject of care. Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics. Source standards ISO/TS 22220:2011. Data type Coded text. This code is obtained from ISO/TS 22220:2011(7). **Data domain Alternative Code** Code **Description** Male 1 M 2 F Female 3 Intersex or indeterminate Not stated/ 9 inadequately U described

7.3.3

Guide for use

This data element indicates the sex of the person for administrative or general communication purposes and may be much less specific than the values used in clinical care.

Intersex or indeterminate

Code 3 'intersex or indeterminate', 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.

Verification rule

Accept only allowed values.

Field should not be blank.

Code 3, 'Intersex or indeterminate' should be confirmed if used for subjects aged over 90 days.

Collection method

The following format should be used for data collection:

What is your sex? ___Male ___Female

Please refer to 'guide for use' for codes 3 and 9 which should not be asked as part of the data collection process.

Example

Female: F

7.3.4

Data element	Mother's birth family name (maiden name)	
Definition	The original family name of the subject of care's mother.	
Source standards	ISO/TS 22220:2011.	
Data type	Text	
Data domain	Not applicable	
Guide for use	The mother's birth family name (maiden name) is her last name as it appears on her own birth certificate.	
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:	
	What is your mother's maiden name?	
Example	Smith Henry	

7.3.5	Data element	Nationality
	Definition	The legal bond between a person and a State ⁽¹⁴⁾ .
	Source standards	European Convention on Nationality.
	Data type	Text
	Data domain	A valid nationality
valid nationality (in the care holds two passpo		The passport that the subject of care holds is their valid nationality (in the event that the subject of care holds two passports, it is the subject of care's preference which one they choose to be recorded as their nationality).
	Verification rule	The nationality should relate to a valid country
collection:		The following question format might assist with data collection: What is your Nationality?
	Example	Irish Polish

7.3.6

Data element	Date of Death	
Definition	The date of death of the subject of care.	
Source standards	ISO/TS 22220:2011.	
Data type	Date	
Data domain	Valid dates	
Guide for use	Enter the full date of death using, day, month and year. Use leading zeros if necessary.	
Verification rule	Where date of birth is collected, date of death should be equal to or greater than the date of birth of the same person.	
Collection method	The following question format might assist with data collection: What date did the subject of care die?	
Example	18/07/2013	

7.3.7

Data element	Source of death notification		
Definition	This indicates the source of information about a subject of care's death. This field provides an indication of the certainty of the information.		
Source standards	ISO/TS 22220:2011		
Data type	Coded text. This code is obtained from ISO/TS 22220:2011 ⁽⁷⁾		
Data domain	Description Registry Health care provider Relative Other Unknown	Code 1 2 3 4 9	

Guide for use	Registry: Notification received from an official national registry office such as the General Registry office or the coroner. Health care provider: Death is notified directly by a health care provider, other than the person responsible for certification of death. Relative: A relative of the subject of care. Other: Death is identified through newspapers and other sources. Unknown: Source of information about the subject of care's death is not known.	
Verification rule	Valid codes or blank.	
Collection method	This data element should always be used in conjunction with date of death.	
Example	General Registry Office: 1	



7.4 Subject of care: Communication details

This section identifies the contact details for the subject of care and the preferred method of communication, for example, landline, phone or email. Each of the data elements that are listed in Table 6 is mandatory where applicable, as it is not expected that every subject of care will have an electronic communication medium and therefore the data elements set out in Table 6 will not apply to that subject of care. **However, where this information is available, it should be provided.** Table 6 is followed by more detailed guidance on each of the data elements.

Table 6: Communication details for the subject of care

Data e	lement name	Definition	Optionality	Example
7.4.1	Electronic Communication Medium	A code representing a type of communication mechanism used by a subject of care.	Mandatory where applicable	Examples include landline, mobile, virtual devices, email.
7.4.2	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.	Mandatory where applicable	National (0609) 123 4567 International +22 609 123 4567 ⁽¹⁷⁾ (086)0000000
7.4.3	Electronic contact preference code	An indication of the preferences for use of this contact type.	Mandatory where applicable	Examples include business hours or day time hours.
7.4.4	Electronic contact usage code	A code representing the manner of use that a person applies to an electronic communication medium.	Mandatory where applicable	The communication medium is used for business use only.

Further guidance for data entry for communication details of subject of care

Data element	Electronic communication medium		
Definition	A code representing a type of communication device used by a subject of care.		
Source standards	ISO/TS 22220:2011, AS 4846-2006.		
Data type	Coded text. This can be found in ISO/TS 22220:2011(7).		
Data domain	Code 1	Description Telephone (excluding mobile)	Alternative ⊤
	2 3 4 5	Mobile phone Email URL/web address Other	M E U O
	Definition Source standards Data type	Definition A code used by Source standards Data type Coded to 2 Data domain Code 1 2 3 4	Definition A code representing a type of communicused by a subject of care. Source standards ISO/TS 22220:2011, AS 4846-2006. Data type Coded text. This can be found in ISO/TS Data domain Code Description 1 Telephone (excluding mobile) 2 Mobile phone 3 Email 4 URL/web address

Guide for use

	communication medium and usage code assigned.	
Verification rules	Not applicable	
Collection method	The following question format might assist with data collection:	
	What is the best way to contact you? What is your preferred method of communication?	
Example	Mobile phone: M	

Each instance should have the appropriate electronic

7.4.2	Data element	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, AS 4846-2006, ITU-T E.123 Alphanumeric	
	Data type		
	Data domain A text string valid for a specific commu medium including spaces where applications.		
Guide for use		Record the full contact details. It may include multiple electronic communication details or addresses, for example multiple phone numbers and email addresses.	

Verification rules	The international prefix symbol should be + (plus) and should precede the country code in the international number. It serves to remind the subscriber to dial the international prefix, which differs from country to country, and also serves to identify the number following as the international telephone number ⁽¹⁷⁾ .	
	The symbol () (parentheses) should be used to indicate that the digits within the () are not always dialled, e.g. (091) 524523.	
Collection method	The following question format might assist with data collection: What is your mobile number? What is your email address?	
Example	(091)520000, +22 609 123 4567, subjectofcare@home.ie	

7.4.3

Data element	Electronic contact preference code		
Definition	An indication of the preferences for use of this contact type.		
Source standards	ISO/TS 22220:2011.		
Data type	Coded text		
Data domain	Description Business hours Day time hours Weekend hours At all times Evening/night hours	Code B D W A E	
Guide for use	Indication of the most appropriate times in the day to use that method of communication.		
Verification rules	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

Data element 7.4.4 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** Alternative code Code **Description** 1 **Business** В Ρ 2 Personal 3 Both business and personal use Α **Guide for use** This data element allows multiple electronic contact usage 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: Is your email address for personal or business use? Is your mobile phone for business or personal purposes? **Example** Business: B

7.5 Address components for subject of care

This section provides information relating to the address for the subject of care. It provides the facility to record various types of addresses, for example home, business or postal address. Table 7 outlines the address components for the subject of care. This is followed by more detailed guidance on each of the data elements.

Table 7: Address components for the subject of care

Data ele	ement name	Optionality	Definition	Example
7.5.1	Building/ complex sub-unit type abbreviation	Mandatory where applicable	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.
7.5.2	Building/ complex sub- unit number	Mandatory where applicable	The specification of the number or iden- tifier of a building/ complex to clearly distinguish it from another.	The building or complex sub- unit number, for example Apt No 6.
7.5.3	Address site name	Mandatory where applicable	The full name used to identify the physical building or property as part of its location.	An example is 'Hazelwood Apartment Complex'.
7.5.4	Floor/level number	Mandatory where applicable	Identify the floor or level of a multi-storey building/complex.	Identification of the floor or level number, e.g. floor 3, level A.
7.5.5	Street number	Mandatory where applicable	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.

Data ele	ement name	Optionality	Definition	Example
7.5.6	Street name	Mandatory where applicable	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'.
7.5.7	Locality/ Townland	Mandatory where applicable	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'.
7.5.8	Town	Mandatory	Identifies the town the subject of care resides in.	Town names include Ballinasloe, or An Daingean.
7.5.9	County	Mandatory	Identifies the county the subject of care resides in.	Counties include Galway or Cork.
7.5.10	Postal Code	Mandatory where applicable*	The code for the postal delivery area.	At the time of writing examples are 6 (for Dublin 6) and 8 (for Dublin 8).
7.5.11	Country identifier	Mandatory	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.
7.5.12	Address type	Mandatory where applicable	A code representing a type of address, i.e. postal address or residential address.	Postal address: P

^{*} At the time of writing this document only a number of areas in Dublin have a postcode. It is expected that a national postcode system will be introduced in 2015, the format of the postcode will change and this data element will then become Mandatory for all addresses.

Further guidance for data entry for address components of subject of care

7.5.1	Data element	Building/complex sub-unit type abbreviation		
	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 22220:20	11.	
	Data type	Coded text		
	Data domain	The data domain is from ISO/TS 22220 ⁽⁷⁾ , the list includes but is not restricted to the below. Please see ISO/TS 22220 for the full listing:		
		Description Apartment Duplex Marine Berth Room Townhouse Warehouse Cottage Flat Penthouse Studio Unit	Code APT DUP MB RM TNHS WE CTGE F PTHS STU U	
	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 d collection: How would you categorise the building in which y reside?		
	Example	APT, CTGE		

Data element	Building/complex sub-unit number	
Definition	The specification of the number of identifier of a building/complex to clearly distinguish it from another.	
Source standards	ISO/TS 22220:2011.	
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: What is the number of the building/complex in which you live?	
Example	APT 6	

7.5.3 **Data element** Address site name **Definition** The full name used to identify the physical building or property as part of its location. ISO/TS 22220:2011. Source standards 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.

Data element	Floor/level number		
Definition	Descriptor used to identify the floor or level of a multi-storey building/complex.		
Source standards	ISO/TS 22220.		
Data type	Coded text and free text.		
Data domain	The following is not an exhaustive list of the types of floor/levels, the full listing can be found in ISO/TS 22220:2011 ⁽⁷⁾ . Description Floor Level Code FL		
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		

Data element	Street number	
Definition	The numeric or string reference number of a house or property that is unique within a street name, suburb.	
Source standards	ISO/TS 22220:2011.	
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: What is the number of your residence?	
Example	1 4	

7.5.6	Data element	Street name including street type		ing street type
	Definition	The name that identifies a public thoroughfare and differentiates it from others in the same locality. ISO/TS 22220:2011. Text The following is not an exhaustive list of street type, the full listing can be found in ISO/TS 22220:2011 ⁽⁷⁾ .		'
	Source standards			
	Data type			
	Data domain			
		Avenue Close	Court Square	Park Terrace
		Junction Alley Street 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. Not applicable		
	Guide for use			potential confusion in the
	Verification rule			

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.

Townland/locality 7.5.7 **Data element Definition** The full name of the general locality containing the specific address of a subject of care. Source standards ISO/TS 22220:2011, 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 must be located in Ireland. It should 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: What is the name of the locality or townland where you currently reside? **Example** Blackrock (Co Dublin), Drumshanbo North (Co Leitrim).

7.5.8	Data element	Town		
	Definition	The full name of the town where the subject of care resides.		
	Source standards	ISO/TS 22220:2011.		
	Data type	Text		
	Data domain	The list below provides some examples of towns in Ireland.		
		DescriptionNew Inn(Cork)Drumcondra(Dublin)Enniskerry(Wicklow)Slealy(Laois)		
	Guide for use	The town identifies commonly-used location names.		
	Verification rule	The town must be in Ireland. This can be confirmed by cross checking with An Post GeoDirectory Ltd's list of towns ⁽¹⁸⁾ . It should 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 a collection: What town do you currently live in?				
	Example	Templemore Dungarvan.		

7.5.9	Data element	County	
	Definition	The full name of the county where the subject of resides.	
	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

Guide for use	Record the county as identified by the subject of care.	
Verification rule	The county must be in Ireland.	
Collection method The following question format might assist wi collection: What county do you currently reside in?		
Example	Wexford.	

7.5.10	Data element	Postal code		
Definition		A code representing the address of the subject of care, as defined by the postal service.		
	Source standards	ISO/TS 22220:2011.		
	Data type	Alphanumeric		
	Data domain	At the time of writing this demographic dataset, the data domain includes only Dublin addresses ranging from Dublin 1 to Dublin 24 (inclusive), examples include:		
		Description	Code	
		Dublin 1	Dublin 6	
		Dublin 2 Dublin 9		
		However, it is subject to change, as it expected that a new postal code systewill be introduced in 2015.		
Guide for use This code iden		This code identifies the location	dentifies the location of each address.	
	Verification rule	It must meet the criteria set out by the Department o Communications, Energy and Natural Resources.		
Collection method The following question format might collection:		night assist with data		
		What is your postal code?		
Example Dublin 8, Dublin 10.		Dublin 8, Dublin 10.		

Data element	Country identifier		
Definition	A code representing the country component of a subject of care's address.		
Source standards	ISO 3166-1:2006, ISO/TS 22220:2011.		
Data type	Text		
Data domain	The data domain includes, but is not restricted to the below. The full listing can be obtained from ISO 3166-1:2006 ⁽¹⁹⁾ .		
	Description United States of America France Australia	Code US FR AU	
Guide for use	This code identifies the country of location for each address.		
Verification rule	It must meet the criteria set out by International Standards Organisation (ISO alpha-2).		
Collection method	The following question format might assist with data collection: What country do you currently live in?		
Example	Denmark: DK.		

7.5.12	Data element	Address type	
	Definition	The address of the subjec	t of care.
	Source standards	ISO/TS 22220:2011.	
	Data type	Coded Text	
	Data domain	The list below indicates the code options, the full listing can be found in ISO/TS 22220:2011:	
		Description	Code
		Place of residence	R
		Postal address	Р

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

7.6 Subject of care biometric identification

This section provides information relating to identifying a subject of care using a range of possible biometric identifiers. Biometric identifiers are optional as they may not be suitable for many service providers to collect, and at the time of writing this document the vast majority of service providers do not have the capacity or capability to collect them. However, they have been included in the demographic dataset to ensure that the dataset allows for and facilitates advances in information collection. Table 8 identifies a number of biometric indicators. This is followed by more detailed guidance on each of the data elements.

Table 8: Subject of care biometric identification

Data element name		Definition	Optionality	Example
7.6.1	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.

Further guidance for data entry for biometric identification

7.6.1	Data element	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	Dependent on the type of biometric identification used.		
	Data type	Dependent on the type of biometric identification used.		
	Data domain	Dependent on the type of biometric identification used.		
	Guide for use	Dependent on the type of biometric identification used.		
	Verification rule	Dependent on the type of biometric identification used.		
	Collection method	Dependent on the type of biometric identification used.		
	Example	Fingerprint, retinal scan.		

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Published by The Health Information and Quality Authority

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