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Clinical Note Document Information Requirements

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1 Introduction

1.1 Purpose

During the development of the Aged Care Clinical Information System (ACCIS) Standards that were launched in August 2024, the project team identified a gap in how healthcare organisations transfer clinical information to and from an aged care CIS and another healthcare system where a standard format does not already exist. [AGENCY2024]

The goal of the clinical note document is to provide a consistent method of passing clinical information relevant to an aged care setting from one healthcare organisation to another in a safe and secure method using existing point-to-point transfer mechanisms.

The purpose of this document is to provide information requirements for the clinical note document. The information requirements are derived from the business requirements document and will also support the creation of an implementation guide to be published on the Agency developer portal.

1.2 Intended audience

This document is intended for:

- Software developers and healthcare providers that support the aged care sector
- Healthcare providers and software developers that work in primary care
- Commonwealth bodies, especially the Department of Health, Disability and Ageing (DHDA)
- State and territory governments
- Internal design teams that create logical and technical specifications and supporting documents.

1.3 Scope

This document is limited to information requirements for the clinical note document that will be communicated to and from an aged care Clinical Information System (CIS) and another healthcare system.

1.3.1 Out of scope

This document does not include:

- Requirements relating to clinical practices and workflows.
- Business practices and workflows relating to the operation of residential aged care homes (RACHs).
- Requirements unrelated to the aged care sector.
- All matters relating to compliance or policy.
- Resident/relative/carer-facing information channels.
- Solution or technical design.
- Point-to-point transport mechanisms.

1.4 Overview

The development of the clinical note document has emerged from the Aged Care Clinical Information Systems (ACCIS) Standards, which responded to recommendations 68 and 109 of the Royal Commission into Aged Care Quality and Safety.

The development of the ACCIS Standards identified a gap in how healthcare organisations transfer clinical information to and from an aged care clinical information system (CIS) and another clinical software system where a standard format does not already exist.

The development of the clinical note document supports and aligns with interoperability as a strategic priority in the Australian National Digital Health Strategy, as outlined in the National Healthcare Interoperability Plan 2023-2028 [AGENCY2023], which states that interoperability of clinical information is essential to high-quality, sustainable health care in which clinical information is collected in a prescribed manner and can be shared in real time with patients and their providers.

Specifically, *Action 3.5 in Priority Area 3 – Information Sharing* is to assess the current interoperability between GP and residential aged care facility systems, identifying issues, requirements and potential solutions to resolve issues.

The clinical note document also aligns with Outcome 3 of the Aged Care Data and Digital Strategy 2024-2029: Data is shared and reused securely to deliver a sustainable and continually improving aged care system.

Standards create consistency and compatibility, support a single source of truth, and enable interoperability. This document describes the scenarios and business requirements for the clinical note document, leveraging existing standards and infrastructure.

Efforts to standardise software systems align to the interoperability principles stated in the National Healthcare Interoperability Plan [AGENCY2023]. The sections in this document align to the following interoperability principles:

- health information is discoverable and accessible,
- national healthcare identifiers are used across the healthcare sector,
- national digital health standards and specifications are agreed and adopted,
- core national healthcare digital infrastructure is used across the sector, and
- collaboration and stakeholder engagement underpin interoperability.

The standardisation of software systems needs to reflect the above interoperability principles.

2 Context Requirements

2.1 Patient

This section describes the information requirements about the patient included in the clinical note document. The "patient" in this document might be a resident or a non-resident. The clinical note document must only include information relevant to an individual patient. This section corresponds to business requirement CN-080 Patient demographic, CN-085 Patient identifier and CN-090 Patient address.

Data item	Req. No.	Requirement statement	Rationale
Patient section (mandatory)	CN-IR-001	The clinical note document must contain a section about the patient.	This will provide identification details for the patient included in the clinical note document.

2.1.1 Individual Patient

Data item	Req. No.	Requirement statement	Rationale
Patient identifier (mandatory)	CN-IR-002	The clinical note document must contain patient identifiers. **Additional Notes** Nationally unique patient identifiers are preferred e.g. IHI, Medicare Card Numbers (with IRN), DVA numbers noting not all patients have such numbers. The patient identifier might be an IHI but it may be a local MRN or similar.	This will allow for the receiving healthcare organisation to match the patient to a patient record. Applying a nationally unique patient identifier (where possible) will also allow for patients who transfer to a different jurisdiction or who are engaging healthcare providers interstate. The RACH CIS may not be connected to the HI Service so the IHI must not be the only means of identifying an older person. Trace: CN-085 Patient identifier
Patient given name (mandatory)	CN-IR-003	The clinical note document must support an attribute for patient given name, and it must be called patient given name.	To enable consistent and correct identification of the patient. The definition for patient given name is the same described in the definition section of the NMDS. Trace: CN-080 Patient demographic
	CN-IR-004	The clinical note document should provide a means to indicate the patient has only one name (i.e. no given name).	An overt statement that a person has one name is better than a "blank", null, empty space or absence of any statement.
	CN-IR-005	The given name attribute must apply the METeOR ID 613340.	

Data item	Req. No.	Requirement statement	Rationale
Patient family name (mandatory)	CN-IR-006	The clinical note document must contain an attribute for patient family name, and it must be called patient family name	To enable consistent and correct identification of the patient. This is a required field when validating a IHI against the HI Service. The definition for patient family name is the same described in the definition section of the NMDS.
	CN-IR-007	The family name attribute must align with the METeOR ID 613331.	Trace: CN-080 Patient demographic
Patient's preferred name (s) (optional)	CN-IR-008	The clinical note document should support the preferred name of the patient.	Facilitates interactions with the individual and can assist in identifying the patient. Trace: CN-080 Patient demographic
Patient sex (mandatory)	CN-IR-009	The clinical note document must support an attribute for patient sex, and it must be called patient sex.	To support clinical use where appropriate.
	CN-IR-010	The sex attribute must apply the METeOR ID 741686.	Trace: CN-080 Patient demographic
Patient gender (mandatory)	CN-IR-011	The clinical note document must contain an attribute for gender, and it must be called gender.	Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents. Providing the patient's gender will assist in the correct identification of an individual. The definition for gender is the same described in the definition section of the NMDS.
	CN-IR-012	The gender attribute must apply the METeOR ID 741842	Trace: CN-080 Patient demographic
Patient date of birth (mandatory)	CN-IR-013	The clinical note document must contain an attribute for patient date of birth, and it must be called patient date of birth.	To enable consistent and correct identification of the individual. This is a required field when validating IHIs against the HI Service. The definition for patient date of birth is the same described in the definition section of the NMDS.
	CN-IR-014	The date of birth attribute must align with the METeOR ID 287007.	Trace: CN-080 Patient demographic
Date of birth accuracy indicator (optional)	CN-IR-015	The clinical note document should support the date of birth accuracy indicator.	To assist in the correct identification of the individual. It is important for clinicians to know when a provided date of birth is an approximation to assist in clinical decision making.

Data item	Req. No.	Requirement statement	Rationale
	CN-IR-016	The date of birth accuracy indicator must align with the METeOR ID 294429.	To enable consistent and correct identification of standard values. Trace: CN-080 Patient demographic
Patient Indigenous status (mandatory)	CN-IR-017	The clinical note document must contain an attribute for the patient's indigenous status, and it must be called patient indigenous status.	Provides information about whether persons identify as being of Aboriginal and/or Torres Strait Islander origin. This can be clinically relevant for some diagnosis and treatments. The definition for patient indigenous status is the same described in the definition section of the NMDS.
	CN-IR-018	The indigenous status attribute must apply the METeOR ID 602543.	Trace: CN-080 Patient demographic
Informal carer existence indicator (optional)	CN-IR-019	The clinical note document should support an attribute for the patient's informal carer existence indicator, and it must be called informal carer existence indicator.	An informal carer includes any person, such as a family member, friend or neighbour, who is giving regular, ongoing assistance to another person. This may provide healthcare providers with additional information on the patient's support system and identified contact person. The definition for the patient's informal carer existence indicator is the same described in the definition section of the NMDS.
	CN-IR-020	The patient's informal carer existence indicator attribute must apply the METeOR ID 787901.	Trace: CN-080 Patient demographic

2.2 Author

The author is the healthcare provider or responsible staff member (simply called “author” in this document) who provided the content to be included in the clinical note document. The healthcare provider or responsible staff member who provided the content can author the clinical note document in a RACH CIS and send to the GP CIS or from a GP CIS to a RACH CIS.

Data item	Req. No.	Requirement statement	Rationale
Document author section (mandatory)	CN-IR-021	The clinical note document must contain a section about the healthcare provider or responsible staff member who authored the clinical note document.	The document author section identifies the author. This information gives context to the recipient(s) and provides a means for the recipient to approach the author to clarify or correct the clinical notes document. Trace: CN-065 author healthcare organisation

2.2.1 Author Healthcare Organisation

This section describes the information requirements about the healthcare organisation where the clinical note document was authored. This section corresponds to business requirement CN-005 creation and author of a clinical note document, CN-065 author healthcare organisation, CN-070 healthcare organisation identifier and CN-075 healthcare organisation geographic location.

Data item	Req. No.	Requirement statement	Rationale
Healthcare organisation (mandatory)	CN-IR-022	The document must contain, at most, one healthcare organisation as the author of the clinical note document.	The healthcare provider organisation must always be provided. The healthcare provider (individual) might not be provided. Trace: CN-005 creation and author of a clinical note document
Healthcare organisation identifier (mandatory)	CN-IR-023	The clinical note document must contain the identifier of the healthcare organisation where the clinical note document was authored. **Additional Notes** An example of a healthcare organisation identifier is the HPI-O.	This will identify the healthcare organisation where the clinical note document originated. This information gives context about what healthcare organisation the document author is representing at the time. Trace: CN-070 healthcare organisation identifier
	CN-IR-024	The healthcare organisation identifier attribute must be of alphanumeric type of 19 characters long as specified in the METeOR ID 774972.	

Data item	Req. No.	Requirement statement	Rationale
Healthcare organisation address (optional)	CN-IR-025	The clinical note document should support the healthcare organisation workplace address where the clinical note document was authored	To enable consistent and correct identification of the healthcare organisation where the clinical note document was authored. Trace: CN-075 healthcare organisation geographic location.
	CN-IR-026	The healthcare organisation workplace address attribute should apply the METeOR ID 776938.	
Healthcare provider organisation name (mandatory)	CN-IR-027	The clinical note document must contain the name of the healthcare organisation that the healthcare provider is representing.	To enable consistent and correct identification of the healthcare provider organisation. This is a required field when validating HPI-Os against the Healthcare Identifiers Service. Trace: CN-065 author healthcare organisation

2.2.2 Author Healthcare Provider (individual)

This section describes the information requirements about the healthcare provider who provided the content to be included in the clinical note document. This section corresponds to business requirement CN-050 document author name, CN-055 document author identifier and CN-060 document author speciality.

Data item	Req. No.	Requirement statement	Rationale
Healthcare provider (mandatory)	CN-IR-028	The document must support, at most, one healthcare provider (individual) as the author of the clinical note document.	The healthcare provider organisation must always be provided. The healthcare provider (individual) might not be provided. Trace: CN-050 document author name

Data item	Req. No.	Requirement statement	Rationale
Healthcare provider identifier (conditional)	CN-IR-029	If the clinical note document includes a healthcare provider (individual) (see requirement CN-IR-27) then the document must contain an attribute for the healthcare provider identifier, and it must be called healthcare provider identifier. **Additional Notes** Examples of an identifier for healthcare providers are Medicare provider number, Aged Care provider number or Ahpra registration number. It is preferred but not required that the healthcare provider identifier attribute reflects the METeOR ID 774972	This will assist in the identification of the person who authored the clinical note document. Trace: CN-055 document author identifier
Healthcare provider given name (optional)	CN-IR-030	The clinical note document should support at least one given name for the healthcare provider.	To enable consistent and correct identification of the healthcare provider. Trace**:** CN-050 document author name
	CN-IR-031	The clinical note document should provide a means to indicate the provider has only one name (i.e. no given name).	An overt statement that a person has one name is better than a “blank”, null, empty space or absence of any statement.
Healthcare provider family name (mandatory)	CN-IR-032	The clinical note document must contain at least one family name for the healthcare provider.	To enable consistent and correct identification of the healthcare provider. This is a required field when validating HPI-Is against the Healthcare Identifiers Service. Trace**:** CN-050 document author name
Healthcare provider individual's workplace address (optional)	CN-IR-033	The clinical note document should support an attribute for the healthcare provider individual's workplace address, and it must be called healthcare provider individual's workplace address.	To enable consistent and correct identification of the healthcare provider. In an aged care setting, the workplace address will usually be the address of the residential aged care home but may be a clinic or other location.
	CN-IR-034	The providers individual workplace address attribute must apply the METeOR ID 776938.	The definition for healthcare provider individual's workplace address is the same described in the definition section of the NMDS.

Data item	Req. No.	Requirement statement	Rationale
Healthcare provider individual's workplace electronic communication details (optional)	CN-IR-035	The clinical note document should support at least one set of electronic communication details for the workplace of the individual. For example, telephone numbers, mobile phone numbers, email addresses etc. **Additional Notes** A healthcare provider may work for more than one organisation. These are the workplace communication details of the individual's workplace, not the organisation.	To enable electronic communication with the healthcare provider.
Healthcare provider profession (mandatory)	CN-IR-036	The clinical note document must support the healthcare provider profession.	Describing the professional role that a healthcare provider is performing can provide context and assist in interactions between healthcare providers to the patient. It will be optional for the author to provide this information. Trace: CN-060 document author speciality

2.3 Intended Recipient

The intended recipient is the healthcare provider or healthcare organisation that will receive the clinical note document. The author must include details for the receiving healthcare organisation. It is optional to include additional information for the healthcare provider.

Data item	Req. No.	Requirement statement	Rationale
Intended recipient section (mandatory)	CN-IR-037	The clinical note document must contain a section about the intended recipient healthcare organisation.	The clinical note must contain the healthcare organisation details. The healthcare provider details are optional. This allows the author to send the clinical note document to the healthcare organisation without knowing the individual provider.
	CN-IR-038	The clinical note document should contain details for the intended individual healthcare provider recipient.	
Intended recipient (mandatory)	CN-IR-039	The clinical note document must contain the intended recipient healthcare organisation identifier and might contain the intended recipient healthcare provider individual identifier.	This will allow for the identification of the recipient of the clinical note document.

2.3.1 Intended Recipient – Healthcare Organisation

This section describes the information requirements for the receiving healthcare organisation.

Data item	Req. No.	Requirement statement	Rationale
Intended recipient healthcare organisation (mandatory)	CN-IR-040	The clinical note document must contain a minimum of one intended recipient healthcare organisation.	The clinical note document must have at least one healthcare organisation as the intended recipient. The author may choose to send the clinical note document to more than one healthcare organisation.
	CN-IR-040a	The clinical note document should support more than one intended recipient healthcare organisation.	The author may choose to send the clinical note document to more than one healthcare organisation.
Intended recipient healthcare organisation identifier (mandatory)	CN-IR-041	The clinical note document must contain identification details for the intended recipient healthcare organisation. **Additional Notes** An example of a healthcare organisation identifier is the HPI-O or facility name.	The clinical note must contain the intended recipient's organisation details. This allows the author to send the clinical note document to the healthcare organisation without specifying the individual provider.

Data item	Req. No.	Requirement statement	Rationale
Intended recipient healthcare organisation department / unit (optional)	CN-IR-042	The clinical note document should support the name of the department or unit within a larger organisation.	In the case of a larger organisation providing the department/unit this ensures that the relevant area in the organisation is clear.
Intended recipient healthcare organisation address (optional)	CN-IR-043	The clinical note document should support the address of the recipient healthcare organisation.	This allows the recipient and supporting healthcare providers to understand who the original intended recipient was.

2.3.2 Intended Recipient – Healthcare Provider (individual)

This section describes the information requirements for the recipient of the clinical note document.

Data item	Req. No.	Requirement statement	Rationale
Intended recipient healthcare provider individual (optional)	CN-IR-044	The clinical note document should have a minimum of one intended recipient healthcare provider.	The clinical note document should have at least one healthcare provider organisation as the intended recipient. The author may choose to send the clinical note document to more than one healthcare provider.
Intended recipient healthcare provider identifier (optional)	CN-IR-045	The clinical note document should support an attribute for the intended recipient healthcare provider identifier, and it must be called the intended recipient healthcare provider. **Additional Notes** Examples of an identifier for healthcare providers are the Medicare provider number, Aged Care provider number or Ahpra registration number.	The clinical note must contain the healthcare organisation details; the healthcare provider details are optional. This allows the author to send the clinical note document to the healthcare organisation without knowing the provider. The definition for intended recipient healthcare provider is the same described in the definition section of the NMDS.
	CN-IR-046	The intended recipient healthcare provider identifier attribute should apply the METeOR ID 774972.	
Intended recipient healthcare provider given name (optional)	CN-IR-047	The clinical note document should support at least one given name for the healthcare provider.	To enable consistent and correct identification of the healthcare provider. If the provider has only one name this field will be blank.
	CN-IR-048	The clinical note document should provide a means to indicate the intended recipient has only one name (i.e. no given name).	An overt statement that a person has one name is an improvement over a “blank”, null, empty space or absence of any statement.

Data item	Req. No.	Requirement statement	Rationale
Intended recipient healthcare provider family name (optional)	CN-IR-049	The clinical note document must contain at least one family name for the healthcare provider.	To enable consistent and correct identification of the healthcare provider. This is a required field when validating HPI-Is against the Healthcare Identifiers Service.

2.4 Clinical Note Document Identification

Healthcare providers and healthcare organisations may receive multiple clinical note documents in a short period of time; identification data can assist healthcare providers and healthcare organisations in identifying clinical note documents. This section corresponds to business requirement CN-095 clinical note document unique identifier.

Data item	Req. No.	Requirement statement	Rationale
Identification section (mandatory)	CN-IR-050	The clinical note document must contain a section to identify the clinical note document.	In cases where healthcare providers receive multiple clinical note documents the identification information would allow the healthcare provider to identify the most current clinical note document while also providing a history of ones previously received.

2.4.1 Identification

This section includes information requirements that provide an individual identification for each clinical note document.

Data item	Req. No.	Requirement statement	Rationale
Clinical note document unique identifier (mandatory)	CN-IR-051	The clinical note document must have a unique identifier for each document authored.	This will allow for healthcare providers to identify a clinical note document by a unique identifier. Trace: CN-095 clinical note document unique identifier
Clinical note document authored date (mandatory)	CN-IR-052	The clinical note document must include the date of authoring.	This will provide a better user experience as the provider will be able to identify the date the clinical note document was authored.
Clinical note document authored time (mandatory)	CN-IR-053	The clinical note document must include the time and time zone of authoring.	In cases where more than one clinical note document is authored in a day, including a time of authoring will assist the provider to identify the current version. This will provide a better user experience.
Clinical note document version number (optional)	CN-IR-054	The clinical note document should support a version number of the authored document.	If an additional iteration of the authored clinical note document is required, then a version number will assist providers in identifying the most current information.

2.5 Sub-Type

The sub-type allows the document author to describe the type or nature of the clinical note document. The sub-types have yet to be defined and will be included in the technical specifications. This section corresponds to business requirement CN-115 sub-type.

Data item	Req. No.	Requirement statement	Rationale
Clinical note document sub-type (optional)	CN-IR-055	The clinical note document should support a sub-type. **Additional Notes** This might be similar to the way My Health record does sub-types for Event Summaries.	This will allow for healthcare providers to identify a clinical note document by a sub-type. Trace: Business requirement CN-115.

3 Content Requirements

3.1 Narrative

A healthcare provider may utilise the narrative text to detail relevant clinical data for the identified patient. The narrative text is optional for the author to provide and may or may not reflect the optional attachments. This section corresponds to business requirement CN-100 narrative text.

Data item	Req. No.	Requirement statement	Rationale
Narrative (mandatory)	CN-IR-056	The clinical note document must support a narrative to be included in the clinical note document.	The narrative text is optional for the author to provide and may or may not reflect the optional attachments. Trace: CN-100 narrative text

3.2 Attachment

The author may wish to attach one or more files to the clinical note document as supporting clinical information such as pathology reports and medication charts. Including an attachment is optional and not mandatory. This attachment might be a PDF or image or other file type. This section corresponds to business requirement CN-105 attachments.

Data item	Req. No.	Requirement statement	Rationale
Attachment (mandatory)	CN-IR-057	The clinical note document must support at least one attachment to be attached to the clinical note document.	The author may wish to attach one or more files to the clinical note document as supporting clinical information, such as pathology reports and medication charts. Including an attachment is optional and not mandatory. This attachment might be a PDF or image or other file type. Trace: CN-105 attachments

3.3 Terminology

This section describes terminology for the clinical note document.

Data item	Req. No.	Requirement statement	Rationale
NMDS (mandatory)	CN-IR-058	The clinical note document must utilise the AIHW NMDS code sets for "person" attributes described in this document.	The identified patient demographics information requirements have referenced the AIHW NMDS in this document. Trace: CN-130 National Minimum Data Set (NMDS) patient demographics
Terminology (mandatory)	CN-IR-059	The clinical note document must utilise SNOMED code sets where clinically appropriate, subject to requirement CN-IR-054.	Ensuring clinical note documents utilise freely available and clinically appropriate terminology code sets such as SNOMED increases the chance of data interoperability. In some contexts, the use of SNOMED is not clinically advisable or technically possible.

3.4 Medication Statement

This section details the information requirements for the clinical note document to send a medication statement between organisations. A medication statement is a statement of current and/or past medications taken by the patient. This is not a prescription or a legally recognised medicine chart. This section corresponds to business requirement CN-040 medication statement.

Data item	Req. No.	Requirement statement	Rationale
Medication statement (mandatory)	CN-IR-060	The clinical note document must have the capability to include a medication statement or details about current or past medications in a structured format.	The clinical note document can be used to send a medication statement between organisations. Note: a medication statement is not the actual prescription or a legally recognised medicine chart. Trace: CN-040 medication statement.

3.4.1 Medication

This section includes information requirements for the medication statement in the clinical note document. These information requirements are derived from the AU Base Medication Statement - AU Base Implementation Guide v5.0.0.

Data item	Req. No.	Requirement statement	Rationale
Active ingredient (mandatory)	CN-IR-061	The clinical note document must support the active ingredient in the medication.	The Active ingredient prescribing (AIP) government initiative requires that the active ingredient of the medication must be provided on scripts; the brand name can be included but must be listed after the active ingredient. [DHDA2024] Private scripts are not subject to the AIP (though considered best practice) so the author may not provide an active ingredient in every case. Trace: CN-040 Prescription records.
Prescriber details (mandatory)	CN-IR-062	The clinical note document must support the prescriber's details to be included in the clinical note document. **Additional Notes** The author may not include prescriber details, and some medications may not have a prescriber e.g. over-the-counter medication.	This will assist in the identification of the healthcare provider who prescribed the medication. Trace: CN-040 medication statement.
Therapeutic Good Name (mandatory)	CN-IR-063	The clinical note document must support the medication name.	Healthcare providers can provide a specific medication brand name or the generic medication name. Trace: CN-040 medication statement.
Therapeutic Good Strength (mandatory)	CN-IR-064	The clinical note document must support the strength of the medication.	This will provide healthcare providers with details of the good strength of medication prescribed. Trace: CN-040 medication statement.
Directions (mandatory)	CN-IR-065	The clinical note document must support directions for administration of the medication.	Directions can include frequency and time of day. Trace: CN-040 medication statement.
Formula (optional)	CN-IR-066	The clinical note document should support formulas for compound medications.	Medications can be requested as compound formulas, providing the details of what was included in the compound formula script will allow for a healthcare provider to have an accurate record of medication. Trace: CN-040 medication statement.

Data item	Req. No.	Requirement statement	Rationale
Clinical indication (mandatory)	CN-IR-067	The clinical note document must support multiple clinical indications to be provided for each medicine.	The clinical indication is the justification for prescribing the medication. This has synergy with Electronic Prescribing. Each medicine might have more than one clinical indication. Trace: CN-040 medication statement.

Acronyms

Acronym	Description
ACCIS	Aged Care Clinical Information System
AIHW	Australian Institute of Health and Welfare
AIP	Active ingredient prescribing
CIS	Clinical Information System
DHDA	Department of Health, Disability and Aging
EMM	Electronic Medication Management
FHIR	Fast Health Information Resource
HPI-I	Healthcare Provider Identifier – Individual
HPI-O	Healthcare Provider Identifier – Organisation
IHI	Individual Healthcare Identifier
NMDS	National Minimum Data Set
RACH	Residential Aged Care Home
SNOMED	Systematised Nomenclature of Medicine

Glossary

Term	Meaning
Clinical Information System	A system that deals with the collection, storage, retrieval, communication and optimal use of health-related data, information, and knowledge. A clinical information system may provide access to information contained in an electronic health record, but it may also provide other functions such as workflow, order entry, and results reporting. A CIS may also serve the role, or have similar features to, an electronic medicines management system.
Electronic Medicines Management System	The utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration and supply of a medicine through knowledge and decision support and providing a robust audit trail for the entire medicines use process. See also Clinical Information System.
Minimum Dataset	A specified minimum dataset that will include mandatory items that a CIS must support.
Standard	Standards referred to in this document are documents that set out recommended specifications, procedures and guidelines that aim to ensure products, services, and systems are safe, consistent, and reliable.

References

AGENCY2023	*National Healthcare Interoperability Plan 2023-2028*, Australian Digital Health Agency, 2023
AGENCY2024	*Aged Care Clinical Information System Standards v1.0*, Australian Digital Health Agency, 2024
DHDA2024	*Active ingredient prescribing initiative*, Department of Health, Disability and Ageing, 2024