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Clinical Note Document
Scenarios and business 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 a clinical information system (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 way using existing point-to-point transfer mechanisms.

This document describes scenarios and business requirements for the clinical note document that will capture clinical notes. This document will also support the creation of an information requirement document and an implementation guide to be published on the Agency developer portal.

1.2 Intended audience

This document is intended for:

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

1.3 Scope

This document is limited to discussing scenarios and business requirements for the clinical note document that will be communicated between a residential aged care home (RACH) 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 a RACH,
- requirements unrelated to the aged care sector,
- all matters relating to compliance or policy,
- resident/relative/carer-facing information channels,
- solution or technical design, and
- point-to-point transfer 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 a clinical information system (CIS) and another healthcare 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, 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 home 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.
- Collaboration and stakeholder engagement underpin interoperability.

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

2 Scenarios

This section describes some common scenarios that trigger and foster the creation of the clinical note document. This section is provided to offer context and background to readers so they can understand the purpose and use of clinical note documents and how they can be applied in the future.

This section is not exhaustive and does not include deviations or fringe examples but is provided to better position the reader on the potential application of clinical note documents.

2.1 Clinical note document created in the residential aged care home

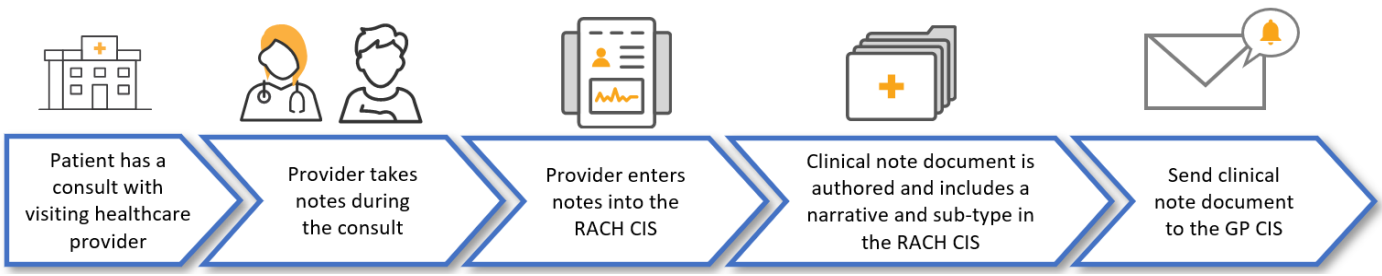
Dr Randal has an agreement to attend a RACH on a regular basis and consults with multiple residents there. On this occasion Dr Randal visits Mr Peterson for a routine consult. During the consultation, Dr Randal takes notes regarding Mr Peterson's weight and blood pressure.

After finishing her rounds, Dr Randal enters the notes from the consultation into Mr Peterson's electronic record in the RACH CIS.

Dr Randal needs to send the notes to her GP CIS. Dr Randal includes a narrative and selects an optional sub-type (e.g. summary note). Dr Randal then authors the clinical note document on the RACH CIS and sends the authored clinical note document to her GP CIS using existing point-to-point transfer mechanisms.

2.1.1 Structured Scenario

Step 1	Dr Randal completes a consultation with patient Mr Peterson.
Step 2	Dr Randal takes notes during the consult.
Step 3	Dr Randal enters the notes into the RACH CIS.
Step 4	Dr Randal selects an optional sub-type
Step 5	Dr Randal authors the clinical note document in the RACH CIS.
Step 6	Dr Randal sends the authored clinical note document to her GP CIS using existing point-to-point transfer mechanisms.



2.2 Author clinical note document with a PDF attachment in a GP CIS

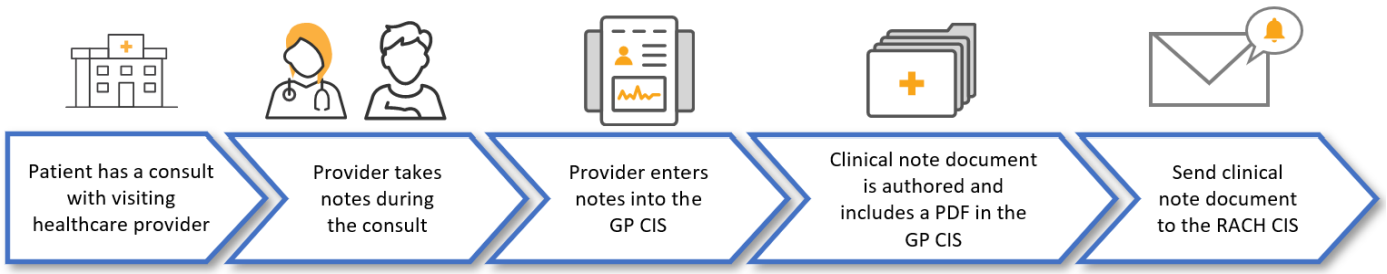
Dr Randal has an agreement to attend a RACH on a regular basis. Dr Randal consults with multiple residents and has a routine consultation with Mr Peterson. During the consultation, Dr Randal takes notes regarding Mr Peterson's weight and blood pressure.

After finishing her rounds, Dr Randal returns to her GP clinic and enters the notes from Mr Peterson's consultation into her GP CIS.

Dr Randal needs to send the notes to the RACH CIS at Mr Peterson's RACH. Dr Randal authors the clinical note document on the GP CIS, attaches a PDF, and then, using existing point-to-point transfer mechanisms, sends the authored clinical note document to the RACH CIS.

2.2.1 Structured Scenario

Step 1	Dr Randal completes a consultation with patient Mr Peterson.
Step 2	Dr Randal takes notes during the consultation.
Step 3	Dr Randal enters the notes into her GP CIS.
Step 4	Dr Randal authors the clinical note document in her GP CIS.
Step 5	Dr Randal attaches a PDF to the clinical note document.
Step 6	Dr Randal sends the authored clinical note document (with PDF attachment) to the RACH CIS using existing point-to-point transfer mechanisms.



2.3 Clinical note document created and sent to multiple providers

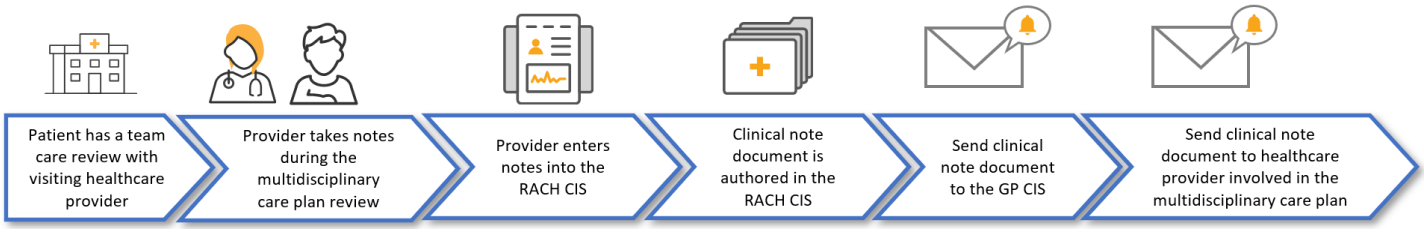
Dr Randal visits the RACH and attends to Mr Peterson as part of a multidisciplinary care plan review. During the consultation, Dr Randal takes notes regarding Mr Peterson's weight and blood pressure.

Dr Randal then enters the notes from Mr Peterson's consultation into the RACH CIS.

Dr Randal needs to send the notes to her GP CIS and to Dr Smith as part of a multidisciplinary care plan. Dr Randal authors the clinical note document on the RACH CIS. Then, using existing point-to-point transfer mechanisms, sends the authored clinical note document to Dr Smith and her own GP CIS.

2.3.1 Structured Scenario

Step 1	Dr Randal completes a multidisciplinary care plan review with patient Mr Peterson.
Step 2	Dr Randal takes notes during the consultation.
Step 3	Dr Randal enters the notes into the RACH CIS.
Step 4	Dr Randal authors the clinical note document in the RACH CIS.
Step 5	Dr Randal sends the authored clinical note document to her clinic using existing point-to-point transfer mechanisms.
Step 6	Dr Randal sends the authored clinical note document to Dr Smith's clinic using existing point-to-point transfer mechanisms.



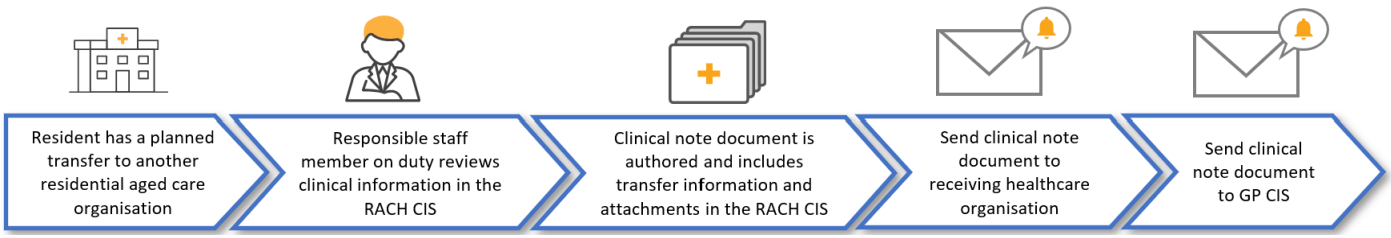
2.4 Clinical note document created for a patient transfer

Mr Peterson has a planned transfer from his current RACH to another RACH closer to where his daughter lives. Bill is a nurse at the RACH and is the responsible staff member on duty. He reviews the clinical information in the RACH CIS to send to Mr Peterson's new RACH. Bill includes Mr Peterson's recent clinical information and his strict dietary needs.

Bill authors the clinical note document on the RACH CIS and attaches any relevant information associated with the transfer e.g. dietary requirements, medication charts and recent blood test results. Bill uses existing point-to-point transfer mechanisms to send the clinical note document to the receiving RACH system. Bill also sends the authored clinical note document to Mr Peterson's usual GP.

2.4.1 Structured Scenario

Step 1	Mr Peterson has a planned transfer to another residential aged care organisation.
Step 2	Bill, the responsible staff member on duty, reviews clinical information in the RACH CIS.
Step 3	Bill authors the clinical note document and includes relevant information and attaches documents associated with the transfer.
Step 4	Bill sends the authored clinical note document and attachments to the receiving RACH CIS using existing point-to-point transfer mechanisms.
Step 5	Bill sends the authored clinical note document and attachments to Mr Peterson's usual GP using existing point-to-point transfer mechanisms.



2.5 Clinical note document created for a telehealth consultation

Mr Peterson requires an after-hours consultation with a GP. The responsible staff member on duty facilitates a phone call with Dr George, an after-hours GP that Mr Peterson has not seen before. Mr Peterson attends a telehealth consultation with Dr George. During the consult, Dr George takes notes regarding Mr Peterson's health.

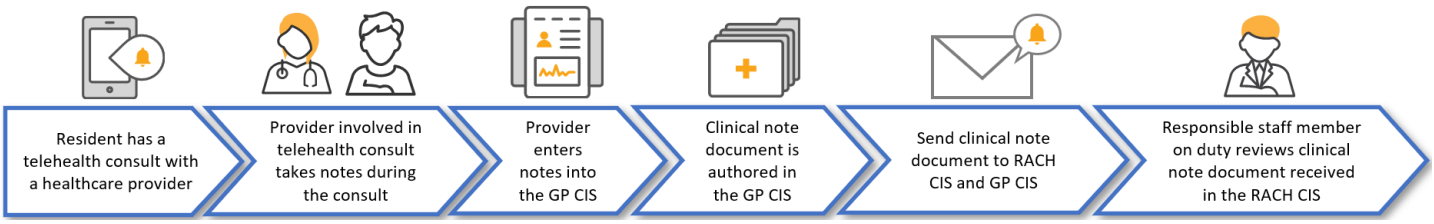
Dr George enters the notes from Mr Peterson's telehealth consultation into his GP CIS.

Dr George needs to send his notes to the RACH CIS and to Mr Peterson's usual GP. Dr George authors the clinical note document on the GP CIS then, using existing point-to-point transfer mechanisms, sends the authored clinical note document to the RACH CIS and to Mr Peterson's usual GP.

Bill is the responsible staff member on duty at the RACH and reviews the clinical note document received from Dr George and feels confident in actioning documented instructions discussed in the telehealth consultation.

2.5.1 Structured Scenario

Step 1	Dr George completes an after-hours phone consultation with Mr Peterson.
Step 2	Dr George takes notes during the consultation.
Step 3	Dr George enters the notes into his GP CIS.
Step 4	Dr George authors the clinical note document in his GP CIS.
Step 5	Dr George sends the authored clinical note document to the RACH CIS and Mr Peterson's usual GP using existing point-to-point transfer mechanisms.
Step 6	Bill, the responsible staff member on duty at the RACH, reviews and actions the clinical note document received.



3 Business requirements

This section describes the business requirements for implementation of clinical note document. The requirements are applicable to CIS and EMM systems.

Agency design documents have traditionally used terms such as “consumer”, “patient”, “individual”, “healthcare recipient”, “resident”, and “healthcare individual” to refer to the person receiving health care. For simplicity, this document uses the generic term “patient”, whilst acknowledging that in some circumstances other terms like “resident” are more appropriate, especially in a residential aged-care home setting.

See the glossary for the meaning of the terms “mandatory” and “recommended” in the context of this document.

3.1 Clinical note document creation

This section describes the creation of the clinical note document.

CN-005	**Creation and author of a clinical note document**
	The clinical note document must be able to be authored within the CIS using relevant information from the local patient record for a single nominated patient.
Priority:	Mandatory
Notes:	Some content in the clinical note document is sourced from the local patient record, e.g. resident name and date of birth.

CN-007	**Authoring clinical note document in a RACH CIS**
	The clinical note document must be able to be authored in the RACH CIS prior to sending.
Priority:	Mandatory
Notes:	GPs or other RACH staff may want to author a clinical note document in the RACH CIS and send that to a GP or other healthcare provider.

CN-010	**Authoring clinical note document in a GP CIS**
	The clinical note document should be able to be authored in the GP CIS prior to sending.
Priority:	Recommended

Notes: GPs may want to author a clinical note document in their practice/clinic CIS and send that to a RACH or other healthcare provider.

CN-015 **Point-to-point transfer**

The clinical note document must be able to be transferred point-to-point from one healthcare organisation to another using existing point-to-point transfer mechanisms.

Priority: Mandatory

Notes: Utilising existing point-to-point transfer mechanisms allows for interoperability by using existing infrastructure. This document does not discuss the method and technology for that point-to-point transfer.

CN-020 **Non-clinical correspondence**

The clinical note document must not be used for correspondence that is non-clinical between healthcare providers and organisations.

Priority: Mandatory

Notes: Correspondence between healthcare providers and organisations does not meet the definition of clinical note document. Examples of correspondence are referrals, specialist letters and requests for priority appointments. Correspondence of this nature must not be sent as a clinical note document. The permissible content for the clinical note document will be defined in the information requirements.

CN-025 **Use of clinical note document**

The clinical note document must not be used when an existing technical specification already exists.

Priority: Mandatory

Notes: For example, a My Health Record advance care plan needs to use the My Health Record advance care plan specification where possible and appropriate.

CN-030 **Agency Developer portal**

The clinical note document specification must be uploaded to and made available to software developers via the Agency developer portal.

Priority: Mandatory

Notes:	This will support software developers in implementing the clinical note document.

CN-035	**Time critical information**
	The clinical note document must not be the only method used to exchange time critical information. Providers must use existing methods to exchange time critical information, and the clinical note document may be used to supplement this.
Priority:	Mandatory
Notes:	Providers must use existing methods to exchange time critical information.

CN-040	**Medication Statement**
	The clinical note document must allow the author to include a medication statement or details about current or past medications in a structured format.
Priority:	Mandatory
Notes:	The clinical note document can be used to send a medication statement between organisations. Note: a medication statement is not a prescription or a legally recognised medicine chart.

3.2 Clinical note document composition

This section describes the composition and structure of the clinical note document.

CN-045	**Minimum data set**
	The clinical note document must contain a specified minimum data set.
Priority:	Mandatory
Notes:	The minimum data set will encompass important information required for every clinical note document. The minimum data set will be outlined in the information requirements.

CN-050	**Document author name**
	The clinical note document must contain the name of the document author.
Priority:	Mandatory
Notes:	First name can be optional but last name is mandatory for providers with only one name.

CN-055	**Document author identifier**
	The clinical note document should contain the identifier of the document author.
Priority:	Recommended
Notes:	The author identifier may be the HPI-I, provider number or AHPRA registration number or some other identifier.

CN-060	**Document author speciality**
	The clinical note document should contain the speciality of the document author.
Priority:	Recommended
Notes:	The author speciality, sometimes called ‘occupation’, is the role the author is assuming at the time of authoring the document.

CN-065	**Author healthcare organisation**
	The clinical note document must contain details of the organisation the document author is representing at the time of authoring.
Priority:	Mandatory
Notes:	When the clinical note document is authored, it must be clear what healthcare organisation the document author is representing at the time. For example, a visiting GP would be representing the GP clinic they work for.

CN-070	**Healthcare organisation identifier**
	The clinical note document should contain the identifier for the healthcare organisation the document author is representing at the time of authoring.
Priority:	Recommended
Notes:	The healthcare organisation could be identified by the Healthcare Provider Identifier – Organisation (HPI-O) or another identifier that uniquely identifies the organisation.

CN-075	**Healthcare organisation geographic location**
	The clinical note document should contain the geographic location of the healthcare organisation the author is representing at the time of authoring.
Priority:	Recommended
Notes:	The healthcare organisation geographic location may be the address or suburb.

CN-080	**Patient demographic**
	The clinical note document must contain sufficient patient demographics to uniquely identify the patient.
Priority:	Mandatory
Notes:	The clinical note document must contain patient demographics that can be used to uniquely identify a patient, such as name and date of birth for the receiving healthcare organisation to identify the correct patient.

CN-085	**Patient identifier**
	The clinical note document must contain a unique patient identifier.
Priority:	Mandatory
Notes:	The unique patient identifier may be the patient IHI. 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.

CN-090	**Patient address**
	The clinical note document must allow the provisioning of the patient's residential address.
Priority:	Mandatory
Notes:	An older person in a RACH will often have the same residential address as the RACH. Some older persons that are in short-stays and temporary respite may have a residential address that is not the RACH address. The clinical notes document is not a My Health Record document and does not need to conform to My Health Record policy regarding the suppression of patient addresses.

CN-095	**Document unique identifier**
	The clinical note document must include details to uniquely identify each clinical note document.
Priority:	Mandatory
Notes:	The unique identifier can include a numeric value, time and date of authoring.

CN-100	**Narrative text**
	The clinical note document must allow narrative text to be included.
Priority:	Mandatory
Notes:	The narrative text is optional for the author to provide and may or may not reflect the optional attachments (see CN-105).

CN-105	**Attachments**
	The clinical note document must allow for at least one attachment to be attached to the clinical note document.
Priority:	Mandatory
Notes:	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.

CN-110	**Clinical note document composition**
	The clinical note document must include either an attachment, narrative text, or both.
Priority:	Mandatory
Notes:	The clinical note document must at minimum include an attachment or narrative text. It can include both.

CN-115	**Sub-type**
	The clinical note document should include a sub-type that allows the document author to describe the nature of the clinical note document. The sub-type will be optional for the document author to provide.
Priority:	Recommended
Notes:	Sub-types will be a way for document authors to describe the type or nature of clinical document.

CN-120	**Data exchange standard**
	The clinical note document should utilise freely available industry recognised data exchange standards.
Priority:	Mandatory
Notes:	Ensuring clinical note documents utilise freely available data exchange standards such as Health Level Seven Clinical Document Architecture (HL7 CDA) and Fast Healthcare Interoperability Resources (FHIR) increases the chance of data interoperability.

CN-125	**My Health Record compatible**
	The clinical note document information model should be compatible with My Health Record infrastructure as much as possible.
Priority:	Recommended
Notes:	Where possible, the clinical note document information model should be compatible with the My Health Record system as much as possible but exact alignment is not expected. Designing in as much compatibility as possible will make the inclusion of the clinical note document into My Health Record a technical possibility in the future. Other mandatory requirements are a higher priority than this recommendation.

CN-130	**National Minimum Data Set (NMDS) patient demographics**
	The clinical note document must align with or incorporate patient demographics included in the NMDS.
Priority:	Mandatory
Notes:	The AIHW have published the NMDS. Aged Care National Minimum Data Set 2025

3.3 Standards for future development

This section describes business requirements that may be in-scope in the future.

CN-135	**National Minimum Data Set (NMDS) clinical information** The clinical note document may align with or incorporate clinical information specified in a future release of the NMDS.
Priority:	N/A
Notes:	The AIHW will provide future releases of the NMDS. One of those future releases may contain clinical information appropriate for the aged care sector.

Acronyms

Acronym	Description
ACCIS	Aged Care Clinical Information System
AHPRA	Australian Health Practitioner Regulation Agency
CIS	Clinical Information System
EMM	Electronic Medication Management
FHIR	Fast Healthcare Interoperability Resource
GP	General Practitioner
HI Service	Healthcare Identifier Service
HL7 CDA	Health Level Seven Clinical Document Architecture
HPI-O	Healthcare Provider Identifier – Organisation
HPI-I	Healthcare Provider Identifier – Individual
IHI	Individual Healthcare Identifier
NMDS	National Minimum Data Set
RACH	Residential Aged Care Home
SNOMED	Systematized 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 of, 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.
Mandatory	The solution design is expected to enable, support or make the stated requirement technically possible.
Minimum Data Set	A specified minimum data set that will include mandatory items that a CIS must support.
Recommended	It is desirable for the solution design to enable, support or make the stated requirement technically possible.
Referral	Referral is the communication, with the intention of initiating care transfer, from the provider making the referral to the receiver.
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