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Event Summary

PCEHR Usability Recommendations v1.0

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Document information

Key information

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Product version	Date	Release comments
1.0	5 May 2014	Initial release (part of Clinical Usability Program R2)

Table of contents

1 Introduction

1.1 Purpose

It has been recognised that developers of software systems that access the personally controlled electronic health record (PCEHR) system need usability recommendations to complement the software requirements provided by other eHealth specifications. These usability recommendations are designed to achieve greater consistency between software that accesses the PCEHR system, thereby improving clinical usability.

The usability recommendations are provided to all software developers interested in improving the usability of their software systems. They are *not* part of the set of software conformance requirements for clinical information systems accessing the PCEHR system; however, conformance to these usability recommendations is strongly encouraged by clinical system users. More information about conformance to the usability recommendations is provided in section 1.4.

These recommendations were prepared as part of NEHTA's Clinical Usability Program (CUP) in consultation with clinicians.

1.2 Intended audience

This document is intended for:

- healthcare providers;
- vendors and developers of eHealth systems; and
- software test laboratories.

1.3 Scope

This document provides usability recommendations for clinical information systems and contracted service provider systems authoring or rendering information contained in event summary documents exchanged with the PCEHR system.

It is focused on recommendations applicable to event summary documents. Additional usability recommendations for *all* types of clinical documents are published in the *Clinical Documents PCEHR Usability Recommendations v1.1* [NEHTA-1564:2014].

The usability recommendations in this document are chiefly intended for adoption by clinical software used by medical general practitioners. However, developers of software for other types of healthcare providers are also encouraged to adopt the usability recommendations.

This document does *not* provide usability recommendations for:

- document types other than event summary;
- PCEHR functions not related to the authoring and rendering of event summary documents exchanged with the PCEHR system; or
- display and management of clinical terminology.

1.4 Conformance

Software developers may want to claim that their software implements these usability recommendations. For such claims to be meaningful and for the healthcare community to have a shared understanding of these claims, the usability recommendations have been documented in the form of software conformance

requirements using the standard conformance verbs **SHALL**, **SHALL NOT**, **SHOULD**, **SHOULD NOT** and **MAY**.

Conformance to the recommendations in this document is not a prerequisite for software to be granted access to the PCEHR system. However, conformance to these usability recommendations is strongly encouraged by clinical software users. A software developer wanting to claim conformance to the clinical usability recommendations must have software that conforms to all mandatory and applicable conditional recommendations in this document. These are the recommendations using the verbs **SHALL** and **SHALL NOT**. Achievement of conformance to the mandatory and applicable conditional recommendations may be recognised by inclusion in the eHealth Register of Conformity operated by the National E-Health Transition Authority (NEHTA) on behalf of the Commonwealth Department of Health.

Software that implements the usability recommendations also needs to conform to the requirements listed in the *Event Summary PCEHR Conformance Profile v1.3* [NEHTA-1450-2013].

1.5 Context

The PCEHR event summary is a document intended for healthcare providers to record information relevant in the context of the PCEHR, where there is no existing communication exchange – such as a shared health summary, discharge summary or specialist letter.

The frequently cited use of an event summary is in conjunction with the assessment and treatment of itinerant patients. In this scenario, a patient visits a general practice or health clinic where a healthcare provider is not (and is unlikely to become) the patient's usual provider. Where the encounter is significant and the information is relevant to the patient's ongoing care, the healthcare provider would consider uploading an event summary.

2 Clinical synopsis authoring

Applies to: All systems authoring event summary clinical documents.

Event summary information requirements include a definition for event details – a "free-text" clinical synopsis where the document author may enter details about the event or encounter. This is an optional field that is populated when the event cannot be described in the other (structured) document sections outlined below. For example, if the event summary is a record of an immunisation administered, then population of the "Immunisations" section is sufficient to describe the event and a separate narrative is unnecessary.

When authoring event summaries, a consistent approach is needed to ensure suitable content can be appropriately entered, with rendering that is consistent with the original intent of the author.

ID	Recommendation	Status
EVS.01	The software **SHALL** by default initially present an empty entry field for Clinical Synopsis.	*Mandatory*
EVS.02	If progress or visit note entry is supported by the software, then there **SHALL** be a method to populate the Clinical Synopsis of the event summary with an import process of the progress or visit note for the current event (consultation). *Note: This might be implemented by an 'import progress notes' button. Any existing content in the Clinical Synopsis should not be overwritten by the imported data.*	*Conditional*
EVS.03	The software **SHALL** allow the user to edit the Clinical Synopsis content of an event summary. *Note: The Clinical Synopsis shall be editable regardless of whether it has been manually entered or imported from a progress or visit note.*	*Mandatory*
EVS.04	When a user imports the progress or visit note in the Clinical Synopsis, the software **SHALL** retain multi-line formatting of the source data. *Note: This can be achieved using the br and/or paragraph tags in the Clinical Synopsis narrative block.*	*Mandatory*
EVS.05	The software **SHALL** provide a complete import of the progress note or visit note when populating the Clinical Synopsis. *Note: The progress or visit note shall not be truncated or modified in any way that is not consistent with the original intent of the note.*	*Mandatory*
EVS.06	If the software allows the user to record a "Reason for visit" as a discrete data element in the patient notes, then there **SHOULD** be a method to populate the Clinical Synopsis of the event summary. *Note: This might be implemented by an 'import reason for visit' button. Caution needs to be exercised to avoid overwriting data already in the clinical synopsis. An option for a preface or appendix to existing content may be used.*	*Recommended*

ID	Recommendation	Status
EVS.07	The software **SHOULD** support layout formatting appropriately in the CDA narrative for Clinical Synopsis. This includes paragraphs, numbered list, bullet point list, italics, bold, underline, superscript, subscript and tables. *Note: This can be achieved by using CDA tags in the narrative part of the Clinical Synopsis – these include* paragraph, list (listType="unordered"), list (listType="ordered"), content (styleCode="Italics"), content (styleCode="Bold"), content (styleCode="Underline"), sup, sub, table, tbody, thead, tr, th, td. *See* Supplementary Notes for Implementers Relating to Clinical Document Presentation v1.0 *[NEHTA-1328:2013] for further rendering advice.*	*Recommended*

3 Event summary data selection

Applies to: All systems authoring event summary clinical documents.

An event summary can hold structured clinical information, sourced from a local record. These structured items are presented to the document author in separate lists, with each list corresponding to the section. The author may then select list items for inclusion in the document.

These sections are:

- **Newly identified adverse reactions** – including the substance/agent and clinical manifestation.
- **Medications** – including newly added medication name, directions of use and the clinical indication.
- **Diagnosis/interventions** – list of medical history items including problems, diagnosis and procedures. In addition to the history item name, the date of onset (or procedure date/time started) and free-text comments are recorded in the event summary.
- **Immunisations** – including medication name and medication action date/time.
- **Diagnostic investigations** – pathology and diagnostic imaging requested services and reports.

Note: These sections are taken from the Event Summary CDA Implementation Guide v1.2 *[NEHTA-0989-2012].*

An event summary is a record of a specific event and should contain information relevant to that event only. In a general practice context, an event of interest typically occurs in a consultation or visit; therefore the data entered or updated in the consultation is most likely to be relevant for the event summary.

ID	Recommendation	Status
EVS.08	The software **SHALL** present the following statement when an event summary is being authored: "An event summary is used to capture key health information about a clinically significant healthcare event that could be relevant to the ongoing care of an individual. It is not a complete health summary and should not be wholly relied upon, nor should it replace direct communication between healthcare providers."	*Mandatory*

ID	Recommendation	Status
EVS.09	The software **SHALL** initially present for selection only entries that have been created or updated *during the event* (consultation) for supported entry types: • Newly Identified Adverse Reactions; • Medications; • Diagnosis/Interventions; • Immunisations; and • Diagnostic Investigations – Requested Service The list headings **SHALL** be as given above. Each item in the lists **SHALL** contain the data elements listed in the *Event Summary Structured Content Specification v1.1* [NEHTA-0995:2011] as a mandatory element.	*Mandatory*
EVS.10	The software **SHALL** initially present for selection only diagnostic investigation results that have been reviewed *during the event* (consultation) for supported entry types: • Pathology Test Results; and • Imaging Examination Results	*Mandatory*
EVS.11	The software **SHALL NOT** select any entries for inclusion in the event summary by default for all entry types: • Newly Identified Adverse Reactions; • Medications; • Diagnoses/Interventions; • Immunisations; and • Diagnostic Investigations (requests and results)	*Mandatory*
EVS.12	The software **SHALL** provide a method to optionally, if desired by the author, expand the items available to also show historical entries for all of Newly Identified Adverse Reactions, Medications, Diagnosis/Interventions, Immunisations, and Diagnostic Investigations (requests and results) which can be selected for inclusion in the event summary. *Note: Historical entries are those that have been created or updated before the event (consultation). This recommendation could be implemented with a single 'More' button associated with the event summary.*	*Mandatory*

Abbreviations and terminology

Term or abbreviation	Description
CDA	Clinical Document Architecture (CDA) is an XML-based mark-up standard intended to specify the encoding, structure and semantics of clinical documents exchanged between health software systems. Specifications for clinical documents are based on Clinical Document Architecture, Release 2 [HL72005].
clinical document	A digital file containing personal health information about an individual, containing unstructured (narrative) information and optionally structured (atomic) information.
contracted service provider (CSP)	An entity that may offer health software as a service, and support access to the PCEHR system on behalf of healthcare organisations. A CSP provides under a contract with the healthcare provider organisation: a) information technology services relating to the PCEHR system; or b) health information management services relating to the PCEHR system (Section 5 *Personally Controlled Electronic Health Records Act 2012* [COM2012]).
PCEHR system	Personally controlled electronic health record system (eHealth record system). National eHealth infrastructure for managing records in eHealth. The eHealth record system includes the PCEHR repository, and the National Prescription and Dispense Repository.

References

NEHTA references

The references below are published on www.nehta.gov.au.

If viewing this as a printed document, use the NEHTA-XXXX:YYYY identifier to search for the exact reference online.

NEHTA-0989-2012 *Event Summary CDA Implementation Guide v1.2,* 7 March 2012.

NEHTA-0995:2011 *Event Summary Structured Content Specification v1.1*, 30 November 2011.

NEHTA-1328:2013 *Supplementary Notes for Implementers Relating to Clinical Document Presentation v1.0,* 10 May 2013.

NEHTA-1450-2013 *Event Summary PCEHR Conformance Profile v1.3*, 9 October 2013.

NEHTA-1564:2014 *Clinical Documents PCEHR Usability Recommendations v1.1,* 5 May 2014.

Other references

At the time of publication, the versions listed below were valid. However, as all documents are subject to revision, readers are encouraged to use the most recent versions of these documents.

AS5021 *AS 5021:2005 - The language of health concept representation*, Standards Australia, 2005.

COM2012 *Personally Controlled Electronic Health Records Act 2012*, Australian Government ComLaw, 2012.

HL72005 *Clinical Document Architecture, Release 2*, ISO/HL7 27932:2008, 21 April 2005.