nehta

Procedure

Detailed Clinical Model Specification

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Document Information

Document owner

Document Owner
The National Clinical Terminology and Information Service

Change history

Version	Date	Comments
1.0	29 Jun 2007	Initial public release
1.1	29 Feb 2008	Minor typographical corrections and wording changes in Introduction
2.0	7 Sep 2009	Updated to incorporate changes made in the version 2.0 of the Discharge Summary Specification.
3.0	26 Aug 2011	New version created in accordance with the archetype from *NEHTA Clinical Knowledge Manager*[1].

Related documents

Name	Version/Release Date
NEHTA Acronyms, Abbreviations & Glossary of Terms	Version 1.2, Issued 25 May 2005
Participation Data Specification	Version 3.2, Issued 20 July 2011

[1] http://dcm.nehta.org.au/ckm

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- Standards Australia;
- Members of the Australian DataTypes Project;
- Australian Institute of Health & Welfare; and
- Ocean Informatics.

Table of Contents

1 Introduction

1.1 Purpose and Scope

This data group specification forms part of a suite of data specifications that NEHTA is developing for the Australian Health Informatics Community. The suite comprises specifications for a range of health topics (represented as “data groups”), which are generally agreed to be of high priority to standardise in order to achieve the benefits brought about by Level 4 (semantic) interoperability in the Australian health care setting.

NEHTA values your questions and comments about this document. Please direct your questions or feedback to *clinicalinformation@nehta.gov.au*.

1.2 Intended Audience

This document is intended to be read by jurisdictional ICT managers, clinicians involved in Clinical Information System specifications, software architects and developers, and implementers of Clinical Information Systems in various health care settings.

It is reasonably technical in nature and expects the audience to be familiar with the language of health data specification and have some familiarity with health information standards and specifications. Definitions and examples are provided to clarify relevant terminology usage and intent.

1.3 Background

There are several e-health priority areas to be addressed by NEHTA specifications. One area of priority is identification of the data to be communicated and its structure. NEHTA is addressing this through Data Specifications which detail the Data Elements (logically grouped), and their associated value domains.

Data Specifications need to be independent of messaging formats. They are concerned with providing an information framework in which to achieve semantic interoperability.

Data specifications have been developed:

- Based on jurisdiction and clinician identified priorities;
- Specifically to suit the Australian model for a shared EHR;
- To define collections of related information, e.g. event summaries, data groups, data elements;
- To allow for expansion and extension as electronic systems mature;
- So they are “human readable”, (with information enhanced by the hierarchical structure);
- Incorporating clinical examples of use to enhance utility and adoption; and
- To provide a set of clinical terminologies, specific to the requirements of the Australian healthcare system.

Whilst Personally Controlled Electronic Health Record (PCEHR) is referred to in these documents the implementation of the PCEHR is not dealt with here.

1.4 Terminology

NEHTA, through the National Clinical Terminology and Information Service (NCTIS), is defining a national approach to clinical terminology. Consistent and accurate articulation and interpretation of clinical terms is critical to the process of safe exchange.

The Systematised Nomenclature of Medicine - Clinical Terms® (SNOMED CT® [1]) has been recommended by NEHTA and endorsed by the Australian, State and Territory governments as the preferred clinical terminology for Australia, and is now freely available for e-health software developers to use in their Australian products under IHTSDO (International Health Terminology Standards Development Organisation) licensing arrangements.

While NEHTA's achievement of a national standard clinical terminology is based on SNOMED CT as the foundational resource, local variations and customisation of terms relevant to the Australian healthcare sector will be incorporated. SNOMED CT Australian Release (SNOMED CT-AU) is the Australian extension to SNOMED CT; the integrated national release of SNOMED CT for implementation in Australian deployed clinical IT systems. NEHTA is also developing the Australian Medicines Terminology (AMT) as the designated clinical terminology for medicines available in Australia. The AMT will provide a consistent approach to the identification and naming of medicines, to support medicines management and activity across the Australian healthcare domain. The AMT will be integrated with SNOMED CT-AU in the near future.

Reference sets listed as value domains within this document have been developed taking into account data element and data group definitions and how they align and complement the SNOMED CT concept model. For further information regarding terminology and the development of reference sets please visit *http://www.nehta.gov.au/connecting-australia/terminology-and-information* and direct your questions or feedback to *terminologies@nehta.gov.au*.

[1] SNOMED CT® is a registered trademark of the International Health Terminology Standards Development Organisation.

2 Procedure Data Group

2.1 Purpose

To record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion.

2.2 Use

Use to record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion. This is done by the recording of data against specific activities in the care pathway, which covers the entirety of steps required to effect this action, including booking, performing, etc.

The scope of this DCM encompasses activities for a broad range of clinical procedures performed for therapeutic, evaluative, investigative, screening or diagnostic purposes. Examples range from the relatively simple activities, such as insertion of an intravenous cannula, through to complex surgical operations.

Additional structured and detailed information about the procedure can be captured using purpose-specific data groups inserted into the 'Procedure detail' slot, where required.

Start date/time is included in the Protocol. If this is recorded against the Scheduled care pathway step, it captures the scheduled start time; if recorded against the Procedure performed step, then it captures the actual start time of the procedure.

End date/time has not been specifically modelled in this DCM as this is the date/time that is recorded (per the reference model) as each action or care pathway step is completed.

Within the context of an Operation Report, this DCM will be used to record only what was done during the procedure. Separate DCMs will be used to record the other required components of the Operation Report, including the taking of tissue specimen samples, use of imaging guidance, operation findings, post-operative instructions and plans for followup.

Within the context of a Problem list or summary, this DCM may be used to represent procedures that have been performed. The Problem Diagnosis DCM will be used to represent the patient's problems and diagnoses.

In practice, many procedures (for example, in ambulatory care) will occur once and not be ordered in advance. The pathway step, ‘Procedure completed’ (or ‘Failed attempt’, or ‘Procedure aborted’) will be recorded and the details added. In some cases a recurring procedure will be ordered, and in this situation data against the ‘Procedure undertaken’ step will be recorded on each occasion, leaving the instruction in the active state. When the last occurrence is recorded the ‘Procedure completed’ action is recorded showing that this order is now in the completed state.

In other situations, such as secondary care, there may be a formal order for a procedure using corresponding DCMs. This Procedure DCM can then be used to record the workflow of when and how the order has been carried out.

Recording information using this Procedure DCM indicates that some sort of activity has actually occurred; this will usually be the procedure itself but may be a failed attempt or another activity such as postponing the procedure. If there is a formal order for the procedure, the state of this order is represented by the Pathway step against which the data is recorded. For example, using this DCM the progressing state of a Gastroscopy order may be recorded through separate entries in the EHR progress notes at each 'Pathway' step:

- record the scheduled Start date/time for the gastroscopy (Procedure scheduled);
- record the gastroscopy was attempted but failed (Failed attempt); and
- record that the gastroscopy procedure has been completed, including information about the procedure details (Procedure completed).

2.3 Misuse

Not to be used to record details about related DCMs such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use specific DCMs for this purpose.

Not to be used to record a whole operation or procedure report.

2.4 PROCEDURE

Identification

Label	PROCEDURE
Metadata Type	Data Group
Identifier	DG-15514
OID	1.2.36.1.2001.1001.101.102.15514

Definition

Definition	A clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes.
Definition Source	NEHTA
Synonymous Names	Clinical Intervention

Usage

Misuse	Recording details about related activities such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use specific DCMs for these purposes. Recording a whole operation or procedure report. Recording an observation such as a pathology test result or an imaging test.

Data Hierarchy

	PROCEDURE				
	Procedure Name				0..1
	Description (Procedure Description)				0..1
	Reason (Procedure Reason)				0..*
	ANATOMICAL LOCATION				0..*
		SPECIFIC LOCATION			0..1
			Name of Location (Anatomical Location Name)		0..1
			Side		0..1

				Numerical Identifier	0..1
				Anatomical Plane	0..1
			RELATIVE LOCATION		0..*
				Identified Landmark	0..1
				Aspect (Anatomical Location Aspect)	0..1
				Distance From Landmark	0..1
			Description (Anatomical Location Description)		0..*
			Visual Markings/Orientation		0..*
			Image (Anatomical Location Image)		0..*
		Procedure Detail			0..*
		Duration (Procedure Duration)			0..1
		Multimedia			0..*
		Comment (Procedure Comment)			0..1
		Start Date/Time (DateTime Started)			0..1
		DEVICE			0..*
		INFORMATION PROVIDER			0..1
		SUBJECT			0..1

2.5 Procedure Name

Identification

Label	Procedure Name
Metadata Type	Data Element
Identifier	DE-15579
OID	1.2.36.1.2001.1001.101.103.15579

Definition

Definition	The name of the procedure (to be) performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	Procedure Foundation Reference Set

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..1	

2.6 Procedure Foundation Reference Set

Identification

Label	Procedure Foundation Reference Set
Metadata Type	Value Domain
Identifier	VD-16580
OID	1.2.36.1.2001.1001.101.104.16580
External Identifier	SNOMED CT-AU Concept Id: 32570141000036105

Definition

Definition	The Procedure foundation reference set provides the broadest possible terminology to support the recording of clinical interventions in Australian eHealth implementations.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
001011001	Procedure Name	1..1	

2.7 Procedure Description

Identification

Label	Description
Metadata Type	Data Element
Identifier	DE-16582
OID	1.2.36.1.2001.1001.101.103.16582

Definition

Definition	Narrative description about the activity or care pathway step for the identified procedure.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Examples include description about • the performance and findings from the procedure; or • the failed attempt or the cancellation of the procedure.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..1	

2.8 Procedure Reason

Identification

Label	Reason
Metadata Type	Data Element
Identifier	DE-16583
OID	1.2.36.1.2001.1001.101.103.16583

Definition

Definition	Reason that the activity or care pathway step for the identified procedure was carried out.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	1. The reason for the cancellation or suspension of the procedure.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..*	

2.9 ANATOMICAL LOCATION

Identification

Label	ANATOMICAL LOCATION
Metadata Type	Data Group
Identifier	DG-16150
OID	1.2.36.1.2001.1001.101.102.16150

Definition

Definition	Structured information about the specific anatomical location of the procedure.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..*	

Children

Data Type	Name	Occur-rences	Condi-tion
	SPECIFIC LOCATION	0..1	
	RELATIVE LOCATION	0..*	
	Description (Anatomical Location Description)	0..*	
	Visual Markings/Orientation	0..*	
	Image (Anatomical Location Image)	0..*	

2.10 SPECIFIC LOCATION

Identification

Label	SPECIFIC LOCATION
Metadata Type	Data Group
Identifier	DG-16151
OID	1.2.36.1.2001.1001.101.102.16151

Definition

Definition	Specific and identified anatomical location.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	ANATOMICAL LOCATION	0..1	

Children

Data Type	Name	Occur-rences	Condi-tion
	Name of Location (Anatomical Location Name)	0..1	
	Side	0..1	
	Numerical Identifier	0..1	
	Anatomical Plane	0..1	

2.11 Anatomical Location Name

Identification

Label	Name of Location
Metadata Type	Data Element
Identifier	DE-16153
OID	1.2.36.1.2001.1001.101.103.16153

Definition

Definition	The name of an anatomical location.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	Body Structure Foundation Reference Set

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	SPECIFIC LOCATION	0..1	

2.12 Body Structure Foundation Reference Set

Identification

Label	Body Structure Foundation Reference Set
Metadata Type	Value Domain
Identifier	VD-16152
OID	1.2.36.1.2001.1001.101.104.16152
External Identifier	SNOMED CT-AU Concept Id: 32570061000036105

Definition

Definition	The set of values for named anatomical locations.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
001011001	Name of Location (Anatomical Location Name)	1..1	

2.13 Side

Identification

Label	Side
Metadata Type	Data Element
Identifier	DE-16336
OID	1.2.36.1.2001.1001.101.103.16336

Definition

Definition	The laterality of an anatomical location.
Definition Source	NEHTA
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	1. Right. 2. Left. 3. Bilalteral.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	SPECIFIC LOCATION	0..1	

2.14 Laterality Reference Set

Identification

Label	Laterality Reference Set
Metadata Type	Value Domain
Identifier	VD-16312
OID	1.2.36.1.2001.1001.101.104.16312
External Identifier	SNOMED CT-AU Concept Id: 32570611000036103

Definition

Definition	The set of values for identifying laterality of an anatomical location.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Side	1..1	

2.15 Numerical Identifier

Identification

Label	Numerical Identifier
Metadata Type	Data Element
Identifier	DE-16338
OID	1.2.36.1.2001.1001.101.103.16338

Definition

Definition	Identify the specific anatomical site out of multiple sites.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Conditions of Use	This **SHALL** be an ordinal number between first and eighteenth.
Conditions of Use Source	NEHTA
Examples	1. First, as in 'first rib' 2. Second, as in 'second toe' 3. Third, as in 'third lumbar vertebra'

[1] http://www.hl7.org/oid/index.cfm

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	SPECIFIC LOCATION	0..1	

2.16 Anatomical Plane

Identification

Label	Anatomical Plane
Metadata Type	Data Element
Identifier	DE-16340
OID	1.2.36.1.2001.1001.101.103.16340

Definition

Definition	Line describing the position of a vertical anatomical plane in the body.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[2] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Midline. 2. Midclavicular. 3. Midaxillary. 4. Midscapular.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	SPECIFIC LOCATION	0..1	

[2] http://www.hl7.org/oid/index.cfm

2.17 RELATIVE LOCATION

Identification

Label	RELATIVE LOCATION
Metadata Type	Data Group
Identifier	DG-16341
OID	1.2.36.1.2001.1001.101.102.16341

Definition

Definition	Qualifiers to identify non-specific location.
Definition Source	NEHTA
Synonymous Names	
Notes	An example is: 5cm (distance) inferior (aspect) to the tibial tuberosity (landmark). There may be more than one relative location required to provide a cross reference.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	ANATOMICAL LOCATION	0..*	

Children

Data Type	Name	Occur-rences	Condi-tion
	Identified Landmark	0..1	
	Aspect (Anatomical Location Aspect)	0..1	
	Distance From Landmark	0..1	

2.18 Identified Landmark

Identification

Label	Identified Landmark
Metadata Type	Data Element
Identifier	DE-16343
OID	1.2.36.1.2001.1001.101.103.16343

Definition

Definition	Identified anatomical landmark from which to specify relative anatomical location.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[3] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	RELATIVE LOCATION	0..1	

[3] http://www.hl7.org/oid/index.cfm

2.19 Anatomical Location Aspect

Identification

Label	Aspect
Metadata Type	Data Element
Identifier	DE-16345
OID	1.2.36.1.2001.1001.101.103.16345

Definition

Definition	Qualifier to identify which direction the anatomical location is in relation to the identified landmark.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[4] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Medial to: Relative location medial to the landmark. 2. Lateral to: Relative location lateral to the landmark. 3. Superior to: Relative location superior to the landmark. 4. Inferior to: Relative location inferior to the landmark. 5. Anterior to: Relative location anterior to the landmark. 6. Posterior to: Relative location posterior to the landmark. 7. Below: Relative location below the landmark. 8. Above: Relative location above the landmark. 9. Inferolateral to: Relative location inferior and medial to the landmark. 10. Superolateral to: Relative location superior and lateral to the landmark. 11. Inferomedial to: Relative location inferior and medial to the landmark.

[4] http://www.hl7.org/oid/index.cfm

12 Superomedial to: Relative location superior and medial to the landmark.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	RELATIVE LOCATION	0..1	

2.20 Distance From Landmark

Identification

Label	Distance From Landmark
Metadata Type	Data Element
Identifier	DE-16346
OID	1.2.36.1.2001.1001.101.103.16346

Definition

Definition	Distance of location from the identified landmark.
Definition Source	NEHTA
Synonymous Names	
Data Type	Quantity

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	RELATIVE LOCATION	0..1	

2.21 Anatomical Location Description

Identification

Label	Description
Metadata Type	Data Element
Identifier	DE-16319
OID	1.2.36.1.2001.1001.101.103.16319

Definition

Definition	Description of anatomical location.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	ANATOMICAL LOCATION	0..*	

2.22 Visual Markings/Orientation

Identification

Label	Visual Markings/Orientation
Metadata Type	Data Element
Identifier	DE-16407
OID	1.2.36.1.2001.1001.101.103.16407

Definition

Definition	Description of any visual markings used to orientate the viewer.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	1. External reference points. 2. Special sutures. 3. Ink markings.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	ANATOMICAL LOCATION	0..*	

2.23 Anatomical Location Image

Identification

Label	Image
Metadata Type	Data Element
Identifier	DE-16199
OID	1.2.36.1.2001.1001.101.103.16199

Definition

Definition	Image or images used to identify a location.
Definition Source	NEHTA
Synonymous Names	
Context	This element is intended to be an image, e.g. photo of the anatomical site such as a wound on the leg.
Context Source	NEHTA
Data Type	EncapsulatedData

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	ANATOMICAL LOCATION	0..*	

2.24 Procedure Detail

Identification

Label	Procedure Detail
Metadata Type	Data Element
Identifier	DE-16325
OID	1.2.36.1.2001.1001.101.102.16325

Definition

Definition	Further information about the procedure.
Definition Source	NEHTA
Synonymous Names	
Notes	Use to capture detailed, structured information about method & technique, equipment used & devices implanted and findings etc. This free text data element is currently a placeholder for further structured data that is as yet undefined. See Appendix A, *Known Issues* for further information.
Data Type	Text

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..*	

2.25 Procedure Duration

Identification

Label	Duration
Metadata Type	Data Element
Identifier	DE-16584
OID	1.2.36.1.2001.1001.101.103.16584

Definition

Definition	Duration of the procedure, especially for the “Procedure Performed” pathway step.
Definition Source	NEHTA
Synonymous Names	
Data Type	Duration

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..1	

2.26 Multimedia

Identification

Label	Multimedia
Metadata Type	Data Element
Identifier	DE-16376
OID	1.2.36.1.2001.1001.101.103.16376

Definition

Definition	Multimedia representation of the procedure undertaken.
Definition Source	NEHTA
Synonymous Names	
Notes	Inclusion of any multimedia file to support the recording of the reaction event.
Data Type	EncapsulatedData

Usage

Examples	1. A link to a video of the procedure performed. 2. A drawing of the wound/surgery.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..*	

2.27 Procedure Comment

Identification

Label	Comment
Metadata Type	Data Element
Identifier	DE-15595
OID	1.2.36.1.2001.1001.101.103.15595

Definition

Definition	Additional narrative about the procedure not captured in other fields.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..1	

2.28 DateTime Started

Identification

Label	Start Date/Time
Metadata Type	Data Element
Identifier	DE-15507
OID	1.2.36.1.2001.1001.101.103.15507

Definition

Definition	The start date and/or time for the procedure.
Definition Source	NEHTA
Synonymous Names	Date Started Start Date Start Date and Time
Data Type	DateTime

Usage

Conditions of Use	For a procedure which has not yet started, this is the planned date/time started. For a procedure which has started, this is the actual date/time started.
Conditions of Use Source	NEHTA
Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..1	

2.29 DEVICE

Identification

Label	DEVICE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Structured information about any device used during the procedure.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in *Appendix B*. • Participation Type **SHALL** have a fixed value of “Device”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a DEVICE.
Conditions of Use Source	*NEHTA*

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..*	

2.30 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Details pertinent to the identification of the source of the information about the procedure.
Definition Source	NEHTA
Synonymous Names	
Notes	This does not necessarily have to be a person and, in particular, not a healthcare provider. Types of sources include: • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software

Usage

Conditions of Use	This **SHALL NOT** be used unless the provider of the information is not the *Composer/Author* of the enclosing Structured Document. This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in *Appendix B*. • Participation Type **SHALL** have a fixed value of “Information Provider”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..1	

2.31 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	The individual upon whom the procedure is (to be) performed.
Definition Source	NEHTA
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, subject of the enclosing Structured Document is assumed.
Scope Source	NEHTA

Usage

Conditions of Use	This **SHALL NOT** be used unless the subject of the information is not the *Subject of Care* of the enclosing Structured Document. This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in *Appendix B*. • Participation Type **SHALL** have a fixed value of “Subject”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROCEDURE	0..1	

3 Exclusion Statement - Procedures Data Group

3.1 Purpose

To positively record the non-performance or exclusion of general groups of procedures (e.g. "never had a surgical procedure") or specific procedures ("no history of appendectomy") within the health record.

3.2 Use

Use to record the positive non-performance or exclusion of general groups of procedures (e.g. "never had a surgical procedure") or specific procedures ("no history of appendectomy") within the health record. This detailed clinical model avoids the need to use terminology to express negation about any item within the health record.

3.3 EXCLUSION STATEMENT - PROCEDURES

Identification

Label	EXCLUSION STATEMENT - PROCEDURES
Metadata Type	Data Group
Identifier	DG-16134
OID	1.2.36.1.2001.1001.101.102.16134

Definition

Definition	Statements to positively assert that certain procedure has not been performed on the patient.
Definition Source	NEHTA
Synonymous Names	

Data Hierarchy

	EXCLUSION STATEMENT - PROCEDURES		
		Global Statement	0..*
		No Previous History of	0..1
		INFORMATION PROVIDER	0..1
		SUBJECT	0..1

3.4 Global Statement

Identification

Label	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition

Definition	The statement about the absence or exclusion of procedure performed on the patient.
Definition Source	openEHR Foundation
Synonymous Names	
Context	Use to capture any information that is needed to be explicitly recorded as being absent or excluded within the record.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EXCLUSION STATEMENT - PROCEDURES	0..*	

3.5 Global Statement Values

Identification

Label	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition

Definition	The set of values for the statement about the absence or exclusion.
Definition Source	openEHR Foundation

Value Domain

Source	NEHTA	
Permissible Values	*Not asked*	No information about past procedures is available because the patient was not asked or not able to be asked
	None known	No information about past procedures is known
	None supplied	No information about past procedures is supplied
	No significant medical history	No significant medical history of any undertaken procedures
	No significant surgical history	No significant surgical history of any undertaken procedures
	No relevant medical history	No relevant medical history of any undertaken procedures
	No relevant surgical history	No relevant surgical history of any undertaken procedures
	No significant past history	No significant past history of any undertaken procedures
	No relevant past history	No relevant past history of any undertaken procedures
	Please see Appendix A, *Known Issues*	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Global Statement	1..1	

3.6 No Previous History of

Identification

Label	No Previous History of
Metadata Type	Data Element
Identifier	DE-16303
OID	1.2.36.1.2001.1001.101.103.16303

Definition

Definition	Positive statements about procedure that are explicitly known to have not been identified at the time of recording.
Definition Source	openEHR Foundation
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EXCLUSION STATEMENT - PROCEDURES	0..1	

[1] http://www.hl7.org/oid/index.cfm

3.7 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Details pertinent to the identification of the source of the information about the procedure.
Definition Source	NEHTA
Synonymous Names	
Notes	This does not necessarily have to be a person and, in particular, not a healthcare provider. Types of sources include: • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software

Usage

Conditions of Use	This **SHALL NOT** be used unless the provider of the information is not the *Composer/Author* of the enclosing Structured Document. This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in *Appendix B*. • Participation Type **SHALL** have a fixed value of “Information Provider”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EXCLUSION STATEMENT - PROCEDURES	0..1	

3.8 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	The individual upon whom the procedure is (to be) performed.
Definition Source	NEHTA
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, subject of the enclosing Structured Document is assumed.
Scope Source	*NEHTA*

Usage

Conditions of Use	This **SHALL NOT** be used unless the subject of the information is not the *Subject of Care* of the enclosing Structured Document. This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in *Appendix B*. • Participation Type **SHALL** have a fixed value of “Subject”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.
Conditions of Use Source	NEHTA

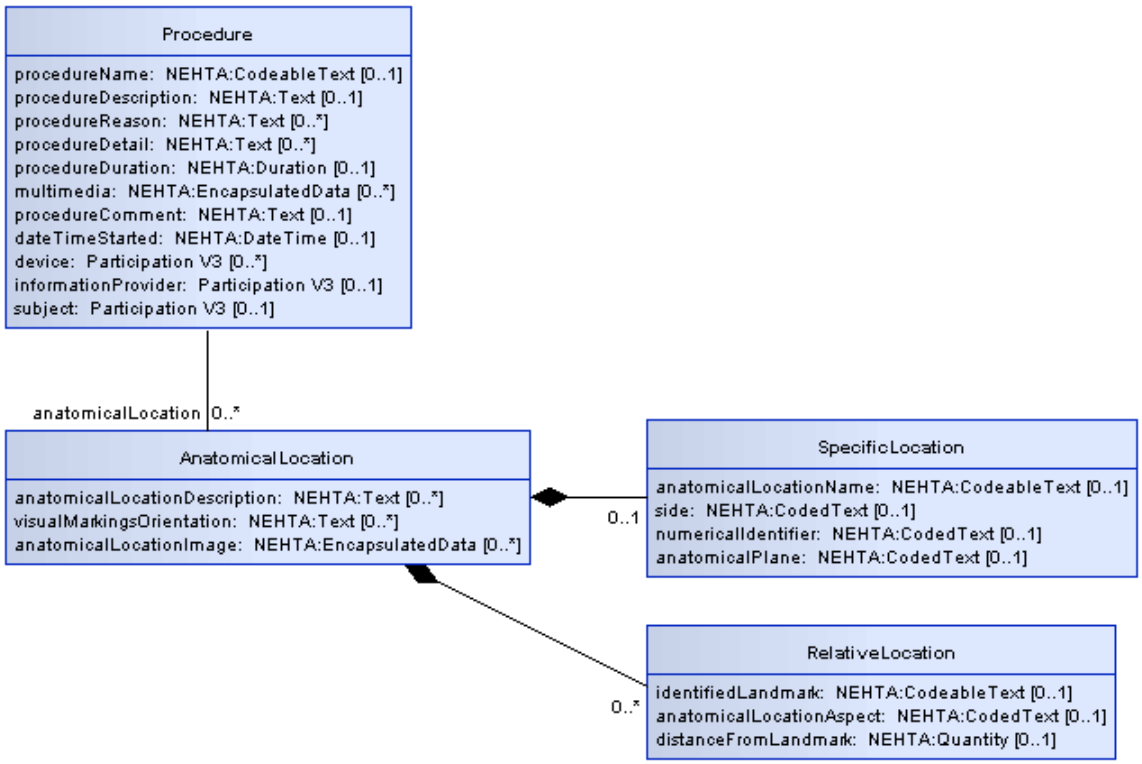
Relationships

Parents

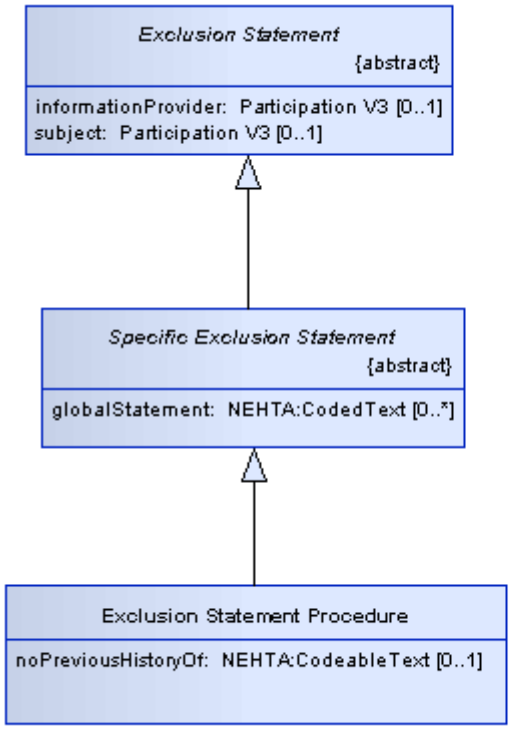
Data Type	Name	Occur-rences	Condi-tion
	EXCLUSION STATEMENT - PROCEDURES	0..1	

4 UML Class Diagram

The following figure presents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes. Data groups are displayed as classes, their names are represented as association role names. Association role names are only displayed if they differ from the associated class name. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.



UML class diagram of the Procedure data hierarchy.



UML class diagram of the Exclusion Statement for Procedure data hierarchy.

Reference List

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http://www.nehta.gov.au/component/docman/doc_download/8-clinical-information-glossary-v12

[NEHT2010c] National E-Health Transition Authority, September 2010, *Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification*, Version 1.0, accessed 13 September 2010.
http://www.nehta.gov.au/component/docman/doc_download/1121-data-types-in-nehta-specifications-v10

[NEHT2011v] National E-Health Transition Authority, 20 July 2011, *Participation Data Specification*, Version 3.2, accessed 22 July 2011.
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[RFC1521] Network Working Group, 1993, *RFC1521 - MIME (Multipurpose Internet Mail Extensions) Part One*, accessed 7 June 2010.
http://www.faqs.org/rfcs/rfc1521.html

[RFC2119] Network Working Group, 1997, *RFC2119 - Key words for use in RFCs to Indicate Requirement Levels*, accessed 13 April 2010.
http://www.faqs.org/rfcs/rfc2119.html

[SA2006a] Standards Australia, 2006, *AS 4846 (2006) – Healthcare Provider Identification*, accessed 12 November 2009.
http://infostore.saiglobal.com/store/Details.aspx?ProductID=318554

[SA2006b] Standards Australia, 2006, *AS 5017 (2006) – Healthcare Client Identification*, accessed 12 November 2009.
http://infostore.saiglobal.com/store/Details.aspx?ProductID=320426

Appendix A. Known Issues

This appendix lists known issues with this specification at the time of publishing. NEHTA are working on solutions to these issues, but we encourage and invite comments to further assist the development of these solutions.

Reference	Description
Data Hierarchy	This detailed clinical model has not yet been fully mapped to HL7 CDA. Mapping to CDA may reveal inconsistencies in the data hierarchy requiring normative change.
'End Date/Time' Data Element	This detailed clinical model does not include 'End Date/Time' (of a procedure) data element that needs to be added in the next round.
'Global Statement Values' Data Element	The list of permissible values is a sample set to initiate discussion and collaboration to develop the correct set of values.
'Performer' Data Element	It has been identified that this detailed clinical model requires a 'Performer' participation, i.e. the Person who carried out the Procedure. This is currently under review and should be included in the next release.
Exclusion Statement	The Exclusion Statement detailed clinical model is the subject of on-going development and review and may well change in the future.
Undefined Value Domains	The following data elements lack a defined value domain: 'Numerical Identifier', 'Anatomical Plane' and 'Anatomical Location Aspect'. NEHTA is in the process of developing national code sets for these items. In the meantime, you are free to use your own code set(s) providing any code set used SHALL be registered, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available. Note that when national standard code set(s) do become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Appendix B. Specification Guide for Use

B.1 Overview

Each Detailed Clinical Model (DCM) and Structured Content Specification (SCS) is designed to be a shared basis for data interpretation. It specifies rigorous business and technical definitions of data which systems may need to share. It is intended to be a logical specification of the data to be persisted within or communicated between systems. It is also the foundation for conformance, compliance and accreditation testing of implemented systems. NEHTA's CDA implementation guides are guides to the implementation of HL7 CDA R2 messages based upon these DCMs and SCSs.

Each DCM specifies all of the data components required for any use of a clinical concept, for instance an entry in a medical record such as a procedure or an imaging test. As such they are maximal data sets. DCMs are building blocks which are trimmed to size for use in construction SCSs.

Each SCS specifies the data for a single type of clinical document or information exchange, such as a discharge summary. It is assembled using DCMs which have been constrained to eliminate data components not relevant to the particular context. For example, procedure in a discharge summary uses only some of the data components required by procedure in a specialist report.

B.2 The Structured Content Specification Metamodel

The NEHTA Structured Content Metamodel (see Figure 1) is used to specify the overall structure of a Structured Content Specification.

A DCM can be considered as a Data Group with no parent.

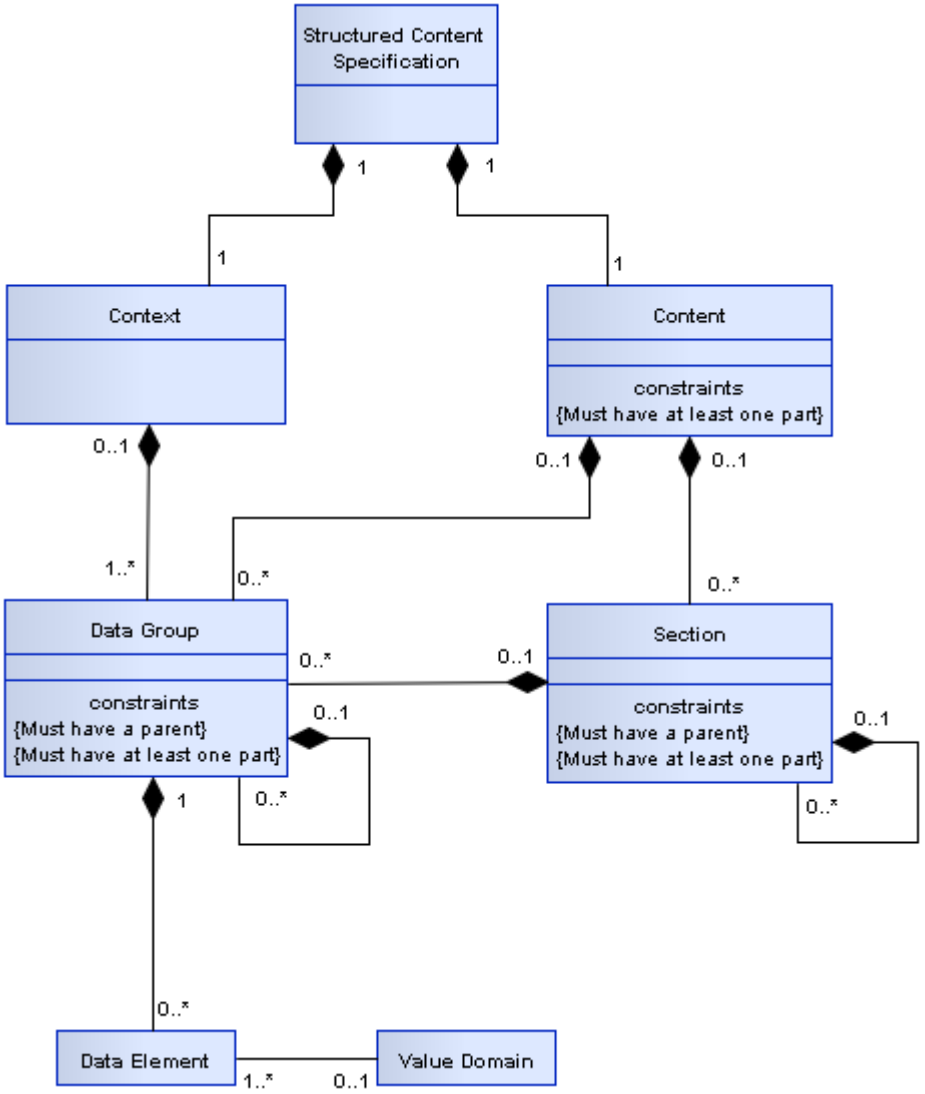

Figure 1: SCS Metamodel

There are two main components used to organise information within a Structured Content Specification (SCS) as follows:

Context: This contains information related to the overall context of the document.

Content: This contains information, which changes between different SCSs, but is always structured as shown, and consists of the following components:

- Section
- Data Group
- Data Element
- Value Domain

These components are described in more detail below.

Context

The purpose of the Context is to identify and classify the document and to provide subjects of care and involved healthcare providers with the information related to the relevant healthcare events.

Content

The Content contains a collection of health information pertinent to a subject of care which is derived from the healthcare event described in the document. The detail **MAY** be organised into one or more sections, each of which contains one or more data groups and/or possible data elements.

Section

The contents of the structured document Content **MAY** be subdivided into one or more sections. A section is an organising container that gives a reader a clue as to the expected content. The primary purpose of a section is to organise information in the manner that is suitable for the primary purpose for which it is collected, and that provides a way to navigate through the data components within the document, thereby enabling more efficient querying. It **SHOULD** also support safe re-use for secondary purposes, e.g. clinical coding or inclusion in a summarised form in an electronic health record. A section is context-specific to the document in which it resides.

Data Group

Each data group is used to represent one concept. A data group consists of other data groups and/or data elements. Some data groups are reused across detailed clinical models.

Participation

Participation is a special case of a data group that is based on a data group template, which is reused throughout the detailed clinical models (DCMs) and SCSs. Participations are an amalgam of the Actors (see below) operating within a defined healthcare domain and the Roles that they are playing within that domain.

A Participant has been defined to align with the concepts of the NEHTA interoperability framework. It equates to an *Entity* that is related to the action described in an SCS as an *Actor*. A participant can be a human, an organisation or an IT system.

[NEHT2011v] defines the full Participation specification.

Choice

Choice represents a decision to be made at run-time between a disjunctive mandatory set of data groups defined at design-time, i.e. one and only one member of the set **SHALL** be chosen.

For example, at design time a Healthcare Provider provides a service but it is not until run-time that a decision can be made as to whether the provider is a person or an organisation. Hence when a Healthcare Provider Participant is instantiated, it **SHALL** be done with the choice of either the *Person* data group or the *Organisation* data group.

Data Element

A data element is the smallest named unit of information in the model that can be assigned a value. For example, 'DateTime of Observation' and 'Observation Note'. Data elements are bound to data types (see Data Types Legend). Some data elements are reused in different data groups.

Whilst all data elements are constrained by their data type, some data elements are further constrained by value domains (see Value Domain below).

Value Domain

A value domain constrains the permissible values for a data element. The values **MAY** be a subset of values based on a generic data type.

Value domains are reusable components and therefore, the same value domain can be referred to by different data elements in different contexts. Value domains are often specified as a reference set. A reference set (or a subset) is a constrained list of SNOMED CT-AU, AMT or LOINC concepts that are appropriate to a particular context. It **SHOULD**be noted that many of these reference sets have been developed specifically for the context in which they appear. An assessment of fitness for purpose **SHOULD** therefore be undertaken before using any of the reference sets in another context.

Value domains constrain by either specifying a lower and/or upper bound on the range of permissible values or else by specifying a finite set of prescribed values. Such a set of prescribed values can be specified directly within the definition of the data element, or in a separate but associated specification or else by reference to one or more vocabulary/terminology reference sets. The table below provides some examples of value domains.

<table>
<tr><th>Data Element</th><th>Data Type</th><th>Example of Value Domain</th></tr>
<tr><td>Sex</td><td>CodedText</td><td>[SA2006a] and [SA2006b] derive their values from METeOR 270263 which includes values such as:
<table><tr><th>Value</th><th>Meaning</th></tr><tr><td>1</td><td>Male</td></tr><tr><td>2</td><td>Female</td></tr><tr><td>3</td><td>Intersex or Indeterminate</td></tr><tr><td>9</td><td>Not Stated/Inadequately Described</td></tr></table></td></tr>
<tr><td>Diagnosis</td><td>CodeableText</td><td>A SNOMED CT-AU reference set which references concepts such as 'Bronchitis' (Concept ID: 32398004)</td></tr>
<tr><td>Therapeutic Good Identification</td><td>CodeableText</td><td>An AMT reference set which references concepts such as 'Ibuprofen Blue (Herron) (ibuprofen 200 mg) tablet: film-coated, 1 tablet' (Concept ID: 54363011000036107)</td></tr>
<tr><td>To Be Advised</td><td>CodeableText</td><td>A LOINC subset which references concepts such as 'Cholesterol [Moles/volume] in Serum or Plasma' (ID: 14647-2)</td></tr>
</table>

Table 1: Value Domain Examples

B.3 Icon Legend

These legends describe all icons that are used within the various NEHTA information specifications.

Metadata Types Legend

The following table explains each of the icons used to represent the metadata types within DCMs and SCSs.

Icon	Metadata Types
	Structured Document
	Section
	Data Group
	Participation
	Choice

Table 2: Metadata Types Legend

Data Types Legend

The following table explains each of the icons used to represent the data types bound to each data element in the SCSs. These data types are a profile of the **ISO 21090-2011** data types as specified in [NEHT2010c].

Icon	Data type	Explanation
	Boolean (ISO 21090: BL)	A primitive data type, sometimes called the logical data type, having one of two values: *true* and *false*. Many systems represent true as *non-zero* (often 1, or -1) and false as *zero*. **Usage/Examples** • An actual value entered by a user might be 'yes' or could be chosen by a mouse click on an icon such as ☑.

CodeableText

(ISO 21090: CD)

Coded text *with* exceptions; flexible data type to support various ways of holding text, both free text and coded text. Commonly used to support compliance for early adopters of the Structured Content Specifications. Whilst it is recommended that the values in this data type come from the bound value domain, it allows other value domains to also be used (with or without translations to the bound value domain) or free text alternatives. This is a recognition that it **MAY** not be possible to define an entire value domain for a complex concept (e.g. *Diagnosis*) or that there **MAY** be competing code sets in existence. Note that within exchange specifications and/or message profiles this data type **MAY** be constrained to mandate compliance with the bound value domain.

Usage/Examples

- AIHW Separation Mode specifies the status at separation of a person from an organisation. An early adopter **MAY** have a similar concept (coded or otherwise) that maps to this data element but does not strictly comply with the AIHW values.
- A SNOMED CT-AU coded/complex expression that embodies single or multiple concepts. The SNOMED CT-AU concepts behind these CodeableText components are specified in the Structured Content Specification value domains.

CodedText

(ISO 21090: CD)

Coded text *without* exceptions; text with code mappings. Values in this data type **SHALL** come from the bound value domain, with no exceptions. Often used for reference sets with only a small number of applicable values, e.g. Gender and Document Status.

Usage/Examples

[SA2006b] specifies the following value domain representing a type of address:

Value	Meaning
1	Business
2	Mailing or Postal
3	Temporary Accommodation
4	Residential (permanent)
9	Not Stated/Unknown/Inadequately Described

DateTime

(ISO 21090: TS)

Used for specifying a single date and/or time. Has the ability to indicate a level of precision, but not whether the date/time is estimated. String representations of known dates **SHALL** conform to the nonextended format within the **ISO 21090-2011** standard, i.e. YYYYMMDDHHMMSS.UUUU[+]-ZZzz.

Usage/Examples

- Partial dates: 2008, 20081001.
- To indicate 1:20 pm on May the 31st, 1999 for a time zone which is 5 hours behind Coordinated Universal Time (UTC): 19990531132000-0500.

	Duration (ISO 21090: PQ.TIME)	The period of time during which something continues. Consists of a value and a unit which represents the time value, e.g. hours, months. Compound durations are not allowed, e.g. 10 days 3 weeks 5 hours. **Usage/Examples** • 3 hours • 6 months • 1 year
	Any (ISO 21090: ANY)	Represents a data element where the data type to be used is conditional upon another data component. The values that can be required will vary considerably depending on the context. Note that this is an abstract data type that is the basis for all data types and **SHOULD NOT** be used in an actual implementation.
	EncapsulatedData (ISO 21090: ED)	Data that is primarily intended for human interpretation or for further machine processing outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g., XML signatures). **Usage/Examples** • JPEG images • HTML documents • [RFC1521] MIME types
	Integer (ISO 21090: INT)	The mathematical data type comprising the exact integral values (according to [NEHT2010c]). **Usage/Examples** • 1 • -50 • 125
	Link (ISO 21090: TEL)	This is a general link, reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system. **Usage/Examples** • URL (Uniform Resource Locator) – the World Wide Web address of a site on the internet, such as the URL for the Google internet search engine – *'http://www.google.com'*. • An absolute or relative path within a file/directory structure – e.g. in the Windows® operating system, the "link" or absolute path to a particular letter could be *C:\Documents and Settings\GuestUser\MyDocuments\letter.doc*

 Quantity (ISO 21090: PQ)	Used for recording many real world measurements and observations. Includes the magnitude value and the units. **Usage/Examples** • 100 centimetres • 25.5 grams
 QuantityRatio (ISO 21090: RTO)	The relative magnitudes of two *Quantity* values (usually expressed as a quotient). **Usage/Examples** • 25 mg/500 ml • 200 mmol per litre
 QuantityRange (ISO 21090: IVL)	Two *Quantity* values that define the minimum and maximum values, i.e. lower and upper bounds. This is typically used for defining the valid range of values for a particular measurement or observation. Unbounded quantity ranges can be defined by not including a minimum and/or a maximum quantity value. **Usage/Examples** • -20 to 100 Celsius • 30-50 mg • >10 kg
 RealNumber (ISO 21090: REAL)	A computational approximation to the standard mathematical concept of real numbers. These are often called floating point numbers. **Usage/Examples** • 1.075 • -325.1 • 3.14157
 Text (ISO 21090: ST)	Character strings (with optional language). Unless otherwise constrained by an implementation, can be any combination of alpha, numeric or symbols from the Unicode character set. Sometimes referred to as free text. **Usage/Examples** “The patient is a 37 year old man who was referred for cardiac evaluation after complaining of occasional palpitations, racing heart beats and occasional dizziness.”
 TimeInterval (ISO 21090:TS)	An interval in time, with (optionally) a start date/time and (optionally) an end date/time and/or a duration/width. **Usage/Examples** • 01/01/2008 – 31/12/2008 • 1:30 a.m. – 6:00 p.m., duration/width = 16.5 hours

	UniqueIdentifier (ISO 21090: II)	A general unique value to identify a physical or virtual object or concept. In using this data type, the attributes of the UniqueIdentifier data type **SHOULD** be populated from the identifiers as defined in AS 4846 (2006) [SA2006a] and AS 5017 (2006) [SA2006b] as follows: *root*: a globally unique object identifier that identifies the combination of geographic area, issuer and type. If no such globally unique object identifier exists, it **SHALL** be created. *extension*: a unique identifier within the scope of the root that is directly equivalent to the identifier designation element. *identifierName*: a human readable name for the namespace represented by the root that is populated with the issuer or identifier type values, or a concatenation of both as appropriate. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such. *identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such. Also, the following constraints apply on the UniqueIdentifier data type: The *root* attribute **SHALL** be used. For an entity identifier the *root* attribute **SHALL** be an OID that consists of a node in a hierarchically-assigned namespace, formally defined using the ITU-T's ASN.1 standard. For an entity identifier the *root* attribute **SHALL NOT** be a UUID. The *extension* attribute **SHALL** be used. **Usage/Examples** IHIs, HPI-Is, HPI-Os and patient hospital medical record numbers are examples of identifiers that **MAY** be carried by this data type.

Table 3: Data Types Legend

Keywords Legend

Where used in this document and in DCMs and SCSs, the keywords **SHALL, SHOULD, MAY, SHALL NOT** and **SHOULD NOT** are to be interpreted as described in [RFC2119].

The following table defines these keywords

Keyword	Interpretation
SHALL	This word, or the terms ‘required’ or ‘must’, means that the definition is an absolute requirement of the specification.
SHOULD	This word, or the adjective ‘recommended’, means that there **MAY** exist valid reasons in particular circumstances to ignore a particular component, but the full implications **SHALL** be understood and carefully weighed before choosing a different course.

MAY	This word, or the adjective 'optional', means that a component is truly optional. One implementer **MAY** choose to include the component because a particular implementation requires it, or because the implementer determines that it enhances the implementation while another implementer **MAY** omit the same component. An implementation which does not include a particular option **SHALL** be prepared to interoperate with another implementation which does include the option, perhaps with reduced functionality. In the same vein, an implementation which does include a particular option **SHALL** be prepared to interoperate with another implementation which does not include the option (except of course, for the feature the option provides).
SHALL NOT	This phrase, or the phrase 'must not' means that the definition is an absolute prohibition of the specification.
SHOULD NOT	This phrase, or the phrase 'not recommended' means that there **MAY** exist valid reasons in particular circumstances when the particular behaviour is acceptable or even useful, but the full implications **SHOULD** be understood and the case carefully weighed before implementing any behaviour described with this label.

Table 4: Keywords Legend

B.4 Information Model Specification Parts Legends

This section illustrates the format and parts used to define each Section, Data Group and Data Element within NEHTA's information model specifications and identifies when each part is applicable.

Data Hierarchy

The top-level component contains a data hierarchy. Each row contains information about a single data component. The entries are nested to represent inclusion of one component in another. Each entry contains three occupied cells. One contains an icon to indicate its data type. One contains the label and description of the component (if the label is different from the name, the name is displayed in brackets after the label). One contains the multiplicity range for the data component.

In a SCS a component may be prohibited, that is it occurs in the referenced DCM but it **SHALL** not be included in documents created according to the SCS. This is represented by a multiplicity range of 0..0, the text of the entry is also in a ~~strike through~~ font and it has a grey background.

Chapter Name

Each section, data group, data element, value domain or choice has its own eponymous chapter. The chapter name is used in all data hierarchies.

Identification Section Legend

The following table illustrates the layout of the Identification section and describes the various parts of the section.

Label	A suggested display name for the component. (Source NEHTA.)

Metadata Type	The metadata type of the component, e.g. section, data group or data element. (Source NEHTA.)
Identifier	A NEHTA assigned internal identifier of the concept represented by the component. (Source NEHTA.)
OID	An object identifier that uniquely identifies the concept represented by the data component. (Source NEHTA.)
External Identifier	An identifier of the concept represented by the data component which is assigned by an organisation other than NEHTA. (Source NEHTA.)

Table 6: Identification Section Legend

Definition Section Legend

The following table illustrates the layout of the Definition section and describes the various parts of the section.

Definition	The meaning, description and/or explanation of the data component. (Source NEHTA.) For data groups used in a particular context the definition **MAY** be a refinement of the generic data group definition.
Definition Source	The authoritative source for the Definition statement.
Synonymous Names	A list of any names the data component **MAY** also be known as. (Source NEHTA.) Implementers **MAY** prefer to use synonymous names to refer to the component in specific contexts.
Scope	Situations in which the data component may be used, i.e. the extent and capacity within which this data component may be used, including the circumstances under which the collection of specified data are required or recommended. For example, Medication Instruction (data group) has a scope which includes all prescribable therapeutic goods, both medicines and non-medicines. This attribute is not relevant to data elements or value domains. (Source NEHTA.)
Scope Source	The authoritative source for the Scope statement.
Context	The environment in which the data component is meaningful, i.e. the circumstance, purpose and perspective under which this data component is defined or used. For example, Street Name has a context of Address. (Source NEHTA.)
Assumptions	Suppositions and notions used in defining the data component. (Source NEHTA.)
Assumptions Source	The authoritative source for the Assumptions statement.
Notes	Informative text that further describes the data component, or assists in the understanding of how the data component can be used. (Source NEHTA.)
Notes Source	The authoritative source for the Notes statement.
Data Type	The data type of the data element, e.g. DateTime or Text. (Source NEHTA.)

	The Data type is applicable only to data elements. The valid data types are specified in the Data Types Legend.
Value Domain	The name and identifier of the terminologies, code sets and classifications to define the data element value range, or a statement describing what values to use in the absence of a defined value domain for the related data element. In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. (Source NEHTA.) The Value Domain is applicable only to CodedText and CodeableText data elements.

Table 7: Definition Section Legend

Value Domain Section Legend

The following table illustrates the layout of the Value Domain section and describes the various parts of the section.

Source	The name of the terminology or vocabulary from which the value domain's permissible values are sourced, e.g. SNOMED CT-AU, LOINC.
Version Number	Version number of the value domain source.
Permissible Values	List of permissible values in the value domain.

Table 8: Value Domain Section Legend

Usage Section Legend

The following table illustrates the layout of the Usage section and describes the various parts of the section.

Examples	One or more demonstrations of the data that is catered for by the data element. (Source NEHTA.) Where a data element has an associated value domain examples representative of that domain are used where possible. Where the value domain is yet to be determined an indicative example is provided. Implementation guides **MAY** contain specific examples for how data elements **SHALL** be populated and how they relate to each other. The Value Domain is applicable only to CodedText and CodeableText data elements.
Conditions of Use	Prerequisites, provisos and/or restrictions for use of the component. (Source NEHTA.)

Conditions of Use Source	The authoritative source for the Conditions of Use statement.
Misuse	Incorrect, inappropriate and/or wrong uses of the component. (Source NEHTA.)
Default Value	A common denomination, or at least a usable denomination, from the Value Domain where available and/or applicable, typically assigned at the creation of an instance of the component. (Source NEHTA.)

Table 9: Usage Section Legend

Relationships Section Legend

The Relationships section specifies the cardinality and conditionality between parent and child data components.

The following table illustrates the layout of the Children relationships table.

Data Type	Name	Occurrences	Condition
Icon illustrating the Metadata type or Data type	Component Name	The maximum and minimum number of instances of this child component that **SHALL** occur.	The conditions that **SHALL** be met to include this child data element. Only applicable for elements with a Conditional obligation.

Table 10: Children Legend

The following table illustrates the layout of the Parent relationships table. Note that the relationships described by this table are from the parent to the child component.

Data Type	Name	Occurrences	Condition
Icon illustrating the Metadata or Data type	Component Name	The maximum and minimum number of instances of the component described on this page that **SHALL** occur.	The conditions that **SHALL** be met to include the data element. Only applicable for elements with a Conditional obligation.

Table 11: Parent Legend

Index

R

S

V