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Common - Clinical Document
PCEHR Usability Recommendations v1.2

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National E-Health Transition Authority

National E-Health Transition Authority Ltd
Level 25, 56 Pitt Street
Sydney, NSW 2000
Australia
www.nehta.gov.au

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Regenstrief Institute (LOINC)

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Document information

Key information

Owner Head of Delivery

Contact for enquiries NEHTA Help Centre
t: 1300 901 001
e: help@nehta.gov.au

Product version history

Product version	Date	Release comments
1.0	24 Oct 2013	Extracted from Clinical Usability Program (CUP) R1 PCEHR Clinical Usability Software Requirements v1.0
1.1	5 May 2014	Revised version, incorporating usability recommendations from both CUP R1 and CUP R2
1.2	31 December 2014	Revised version, incorporating usability recommendations from CUP R3 and minor editorial updates.

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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 general practice software products that access the PCEHR system, thereby improving clinical usability.

While the usability recommendations are developed specifically for general practice software vendors, they 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 1.3.

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

As the PCEHR functionality increases and additional document types are added to the PCEHR, these usability recommendations will be updated.

1.2 Scope

1.2.1 In scope

This document provides usability recommendations for clinical information systems authoring or rendering information contained in clinical documents and views exchanged with the PCEHR system.

It is focused on recommendations applicable to *all* types of clinical documents. Additional usability recommendations for:

- Shared Health Summary clinical documents are published in the *Shared Health Summary PCEHR Usability Recommendations v1.2;* and
- Event Summary clinical documents are published in the *Event Summary PCEHR Usability Recommendations v1.1*.

1.2.2 Out of scope

This document does *not* provide usability recommendations for:

- specific types of clinical documents;
- PCEHR functions not related to the authoring and rendering of clinical documents and views exchanged with the PCEHR system; or
- display and management of clinical terminology.

1.3 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** and **SHOULD NOT**.

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 is recognised by mention on the table titled "eHealth Functions Available – General Practice Software Products" on the NEHTA website.

It is expected that the vendor's software will still meet (or has met) the requirements listed in the *Clinical Documents Common Conformance Profile v1.5*.

1.4 Use of this document

Recommendations from CUP releases 1 and 2 are pre-requisites for the implementation of CUP Release 3. For vendors who have implemented CUP releases 1 and 2, the key recommendations to read and implement are highlighted in the status column as:

- **Revised for CUP R3** – these are existing CUP Release 2 recommendations that have been amended or modified.
- **Removed for CUP R3** – these are existing CUP Release 2 recommendations that have been superseded by updated or new recommendations in CUP Release 3.
- **NEW in CUP R3** – these are new recommendations introduced in CUP Release 3. Some vendors may have taken the initiative and implemented some of these new recommendations already in their software, for example, recommendation CLD.57 (notification of successful upload to PCEHR).

For vendors who have not implemented CUP releases 1 and 2, it is advised that all recommendations listed in this document are implemented to increase usability of the software.

For further details on the changes made to existing recommendations between Release 2 and Release 3, refer to the *CUP Usability Recommendations – R3 Change Log v1.0* available from the NEHTA Help Centre.

The clinical document specifications are being updated for release February 2015. Some of the CUP recommendations listed in this document have been incorporated into the revisions. These are noted and referenced throughout this document.

2 Authoring clinical documents

The following usability recommendations have been defined, in consultation with general practice healthcare providers, to promote greater consistency between clinical documents and improve their usability.

2.1 Proper use of exclusion statement values

Applies to: General practice document authoring systems (any type of clinical document).

There has been inconsistency in the use of exclusion statements across software implementations, affecting clinician understanding and use of submitted PCEHR CDA documents.

This section provides recommendations for the proper clinical use of the three exclusion statement values "none known", "not asked" and "none supplied". It is consistent with Clinical Document Architecture (CDA) implementation guides and clarifies expected use. The use of an exclusion statement may be restricted for some clinical documents and vendors should refer to the appropriate individual specification and conformance requirements.

The exclusion statements are explained below, followed by specific usability recommendations.

None known

"None known" is only to be used when the user has made a positive statement that there are no known items. This is equivalent to the "no clinically significant items known" flag that appears in some applications. The mere absence of items in the list in the information system is not evidence that there are "none known", even if the expectation is that the user will record any existing items in the system. It is inappropriate for the software application to set this exclusion statement on the basis that there are no list items. It must be a positive statement based on an entry from a healthcare provider made before or during the document authoring process.

Not asked

"Not asked" is reserved as a positive statement from the user that they did not enquire concerning this aspect of the patient's health. Note that "not asked" shall not be used in the context of a shared health summary, as the author of the shared health summary is required to ask about each of the sections as part of the process of authoring the summary. It is inappropriate for the software application to set this exclusion statement on the basis that there are not any list items. It must be a positive statement based on an entry from a healthcare provider made before or during the document authoring process.

None supplied

"None supplied" is a value that is to be used when there are no items to list, and the user has not made one of the two above explicit statements. Users should not be led to understand that "none supplied" implies anything at all about whether there are items, or whether they are known, or why there are no items supplied. Except for shared health summaries, it is appropriate for the software application to set this exclusion statement automatically, in the absence of any list items, and

where the user has had the opportunity to specify a different exclusion statement but has not done so.

ID	Recommendation	Obligation	Status
CLD.01	The software **SHALL NOT** record a "none known" exclusion statement unless a healthcare provider has explicitly indicated so by making an entry either before or during the clinical document authoring process. *Note: This recommendation is identified for incorporation into the next publication of the* Shared Health Summary – PCEHR Conformance Profile v1.6.	*Mandatory*	*CUP R2 – no change*
CLD.02	The software **SHALL NOT** record a "not asked" exclusion statement unless there has been an explicit entry made indicating that there has been no enquiry concerning this aspect of the healthcare consumer's health before or during the clinical document authoring process. *Note: The exclusion statement "not asked" is not for use in shared health summaries as defined in the* Shared Health Summary PCEHR Usability Recommendations v1.2*.*	*Mandatory*	*CUP R2 – no change*

CLD.03	The software **SHALL** use the "none supplied" exclusion statement by default if:
	• the type of the clinical document is NOT a Shared Health Summary and
	• there is no explicit exclusion statement of
	  ○ "none known"; or
	  ○ "not asked"
	• and either
	  ○ no items are available for selection; or
	  ○ no items are selected for inclusion.
		Mandatory	*CUP R2 – no change*

CLD.04	If the document is a Shared Health Summary, the software **SHALL** use "none supplied" only if the user has explicitly selected the "none supplied" exclusion statement value.	*Mandatory*	*CUP R2 – no change*
CLD.05	If a "none supplied" exclusion statement is present, the software **SHALL** include a narrative statement with appropriate wording, depending on the entry type, in the form: "No [type] are supplied" Entry [type] includes: • procedures • problems/diagnoses • adverse reactions • medications • immunisations • recommendations	*Conditional*	*CUP R2 – no change*

2.2 Setting the document title and type

Applies to: General practice document authoring systems (any type of clinical document).

The following usability recommendations are defined to assist consistency and usability when setting the "title" for CDA documents and XDS.b metadata. The recommendations also address the setting of appropriate values for the document type display text "typeCodeDisplayName" for XDS.b metadata.

Note that the *PCEHR Document Exchange Service Using the IHE XDS.b Platform: Technical Service Specification v1.5* is referred to below as the *PCEHR Document Exchange Technical Service Specification*.

ID	Recommendation	Obligation	Status
CLD.06	The software **SHALL NOT** populate the "title" attribute in the document metadata (XDSDocumentEntry.title) when uploading a document. *Note: In the CDA document itself, the ClinicalDocument/title element may be set to any value, as appropriate, or be omitted. However, the "title" attribute in the PCEHR XDS.b metadata shall not be populated.*	*Mandatory*	*CUP R2 – no change*
CLD.07	The XDSDocumentEntry.typeCodeDisplayName in the XDS.b metadata of the CDA document **SHALL** be set to the document type name. The document type name **SHALL** be derived from the document type code (XDSDocumentEntry.typeCode) as per the *PCEHR Document Exchange Technical Service Specification*.	*Mandatory*	*CUP R2 – no change*

2.3 Managing date-times

Applies to: General practice document authoring systems (any type of clinical document).

The CDA implementation guides fix the values of the various date-times within clinical documents. The following recommendations define appropriate values for the XDS metadata, most of which are addressed in the *PCEHR Document Exchange Technical Service Specification*. Note that date/time values in the PCEHR document metadata are in UTC (Universal Time Coordinated) time zone. Software systems should convert local date/time values to UTC when populating document metadata and convert date/time values to local time when displaying them.

ID	Recommendation	Obligation	Status
CLD.08	For Shared Health Summary, eReferral and Specialist Letter document types, the software **SHALL** set the metadata Service Start Time (XDSDocumentEntry.serviceStartTime) to be the Document Creation Time (XDSDocumentEntry.creationTime). *Note: This recommendation has recently been incorporated into the latest version of the PCEHR Document Exchange Technical Service Specification (v1.5) and may therefore be removed in future releases of CUP.*	*Mandatory*	*CUP R2 – no change*

ID	Recommendation	Obligation	Status
CLD.09	For Shared Health Summary, eReferral and Specialist Letter document types, the software **SHALL** set the metadata Service Stop Time (XDSDocumentEntry.serviceStopTime) to be the Document Creation Time (XDSDocumentEntry.creationTime). *Note: This recommendation has recently been incorporated into the latest version of the PCEHR Document Exchange Technical Service Specification (v1.5) and may therefore be removed in future releases of CUP.*	*Mandatory*	*CUP R2 – no change*
CLD.10	For the Discharge Summary document type, the software **SHALL** set the metadata Service Start Time (XDSDocumentEntry.serviceStartTime) to be the admission date-time. *Note: This recommendation has recently been incorporated into the latest version of the PCEHR Document Exchange Technical Service Specification (v1.5) and may therefore be removed in future releases of CUP.*	*Mandatory*	*CUP R2 – no change*
CLD.11	For the Discharge Summary document type, the software **SHALL** set the metadata Service Stop Time (XDSDocumentEntry.serviceStopTime) to be the discharge date-time. *Note: This recommendation has recently been incorporated into the latest version of the PCEHR Document Exchange Technical Service Specification (v1.5) and may therefore be removed in future releases of CUP.*	*Mandatory*	*CUP R2 – no change*
CLD.12	For the Event Summary document type, the software **SHALL** set the metadata Service Start Time (XDSDocumentEntry.serviceStartTime) to be the encounter start date-time. *Note: This recommendation has recently been incorporated into the latest version of the PCEHR Document Exchange Technical Service Specification (v1.5) and may therefore be removed in future releases of CUP.*	*Mandatory*	*CUP R2 – no change*
CLD.13	For the Event Summary document type, the software **SHALL** set the metadata Service Stop Time (XDSDocumentEntry.serviceStopTime) to be the encounter end date-time. *Note: This recommendation has recently been incorporated into the latest version of the PCEHR Document Exchange Technical Service Specification (v1.5) and may therefore be removed in future releases of CUP.*	*Mandatory*	*CUP R2 – no change*

ID	Recommendation	Obligation	Status
CLD.14	If a date-time value is recorded within the XDS.b document metadata, the software **SHALL** record the date-time value as UTC. *Note: This means local date-time with timezone needs to be converted into UTC for inclusion in document metadata. Nominally this will be in the form YYYYMMDDhhmm or YYYYMMDDhhmmss* *This applies to XDSDocumentEntry metadata values* creationTime, serviceStartTime, serviceStopTime. *Note: This recommendation has recently been incorporated into the latest version of the PCEHR Document Exchange Technical Service Specification (v1.5) and may therefore be removed in future releases of CUP.*	*Conditional*	*CUP R2 – no change*
CLD.15	When a date-only value is recorded within the XDS.b document metadata, the software **SHALL** record the date as it is (local date), i.e. without conversion to UTC. *Note: This means local date will be stored as-is in document metadata.* *This applies to XDSDocumentEntry metadata values* creationTime, serviceStartTime, serviceStopTime.	*Conditional*	*CUP R2 – no change*
CLD.16	When a date-only value is recorded within the XDS.b document metadata, the software **SHALL NOT** increase precision by padding the time-out with zeroes. *Note: For example a date 20140201 is not to be padded to 20140201000000, which would increase precision of the date to date-time.* *This applies to XDSDocumentEntry metadata values* creationTime, serviceStartTime, serviceStopTime.	*Conditional*	*CUP R2 – no change*

2.4 Creating and displaying administrative observations

Applies to: General practice document authoring systems (any type of clinical document).

CDA implementation guides specify a section known as "Administrative observations", which contains document context information such as additional demographic information and Medicare details. Since all these details are not of clinical relevance, it is recommended that the contents are not included when authoring the CDA document.

ID	Recommendation	Obligation	Status
CLD.17	If the software sends documents to the PCEHR system using an appropriate template package, the software **SHALL NOT** include any narrative content when authoring the Administrative Observations section in clinical document instances. *Note: Conforming to this recommendation can only be achieved by using template packages published for PCEHR Release 4 (October 2013) and later. Template packages published before PCEHR Release 4 report an error when the Administrative Observations narrative is not present. The mandatory requirement for Administrative Observations narrative has been relaxed and newer versions of the template packages do not report an error when the narrative is omitted. Contact NEHTA for a list of the template packages that allow the Administrative Observations to be omitted.* *Specifications for Shared Health Summary (and other document types) will be revisited with a view to removing the Administrative Observations section.*	*Mandatory*	*Revised for CUP R3*

2.5 Setting healthcare facility type code

Applies to: General practice document authoring systems (any type of clinical document containing healthCareFacility code).

The CDA implementation guides do not state the preferred values for healthCareFacility code in clinical documents. These are stated in the recommendations below, so that the values of healthCareFacility code are consistent with the requirements for the "healthcare facility type" code in the clinical document metadata sent to the PCEHR system (defined in the *PCEHR Document Exchange Service: Logical Service Specification)*.

The types of clinical documents that currently contain healthCareFacility code are Discharge Summary, eHealth Prescription Record and eHealth Dispense Record.

ID	Recommendation	Obligation	Status

CLD.18	If the software creates a clinical document with a healthCareFacility `code`, then the software **SHOULD** set the `code` and `displayName` to the values specified in the *1292.0 - Australian and New Zealand Standard Industrial Classification 2006 [ANZSIC2006]* unless specified otherwise in a CDA implementation guide.
	Note: Where possible, vendors should be using ANZSIC codes to align with the document's XDS.b metadata.
	For example:
	`<healthCareFacility>`
	…
	`<code code="8534" codeSystem="1.2.36.1.2001.1005.47" codeSystemName="ANSZIC 2006" displayName="Chiropractic and Osteopathic Services" />`
	…
	`</healthCareFacility>`
		Conditional	*Revised for CUP R3*

CLD.19	*Merged with CLD.18*		*Removed in CUP R3*
CLD.20	If the software creates a clinical document with a healthCareFacility code using the *1292.0 – Australian and New Zealand Standard Industrial Classification 2006 [ANZSIC2006] (as noted in CLD.18)*, then the software **SHOULD** set the `codeSystem` to 1.2.36.1.2001.1005.47 and the `codeSystemName` to ANZSIC 2006.	*Conditional*	*Revised for CUP R3*

2.6 Successful upload of clinical document

Applies to: General practice document authoring systems (any type of clinical document).

Many general practice systems provide an error message if the document is not successfully uploaded onto the PCEHR system. However, providing a notification when a clinical document *has successfully* been uploaded to the PCEHR enhances usability since it confirms that the system is working. Care is required to ensure this notification is not intrusive and does not interrupt clinical workflow.

ID	Recommendation	Obligation	Status
CLD.57	The software **SHALL** provide notification on successful upload of a clinical document to the PCEHR. The notification **SHALL NOT** require any action from the user (e.g. user does not need to click an OK button). The notification **SHALL** be unobtrusive (e.g. temporarily displayed). *Note: Some vendors may have taken the initiative and implemented this recommendation already in their software.*	*Mandatory*	***NEW in CUP R3***

2.7 Prompt to upload to the PCEHR

Applies to: General practice document authoring systems.

General practice users have suggested that a reminder or prompt to upload a shared health summary or event summary at the end of a patient's clinical appointment would be helpful, until it becomes a natural part of the clinical workflow. At that point, a user should be able to turn off the reminder or prompt.

ID	Recommendation	Obligation	Status
CLD.58	The software **SHALL** prompt the user to upload either a shared health summary or event summary when *all* the following conditions are met: 1. ***Additions*** or ***changes*** to the patient's medical history, medications, allergies and adverse reactions, and/or immunisations have been made; AND 2. The user has not already uploaded either a shared health summary or event summary during the current clinical appointment; AND 3. The patient has a PCEHR; AND 4. The prompt has not been turned off by the user. *Note: Vendors may wish to consider what changes to medications would necessitate a prompt to upload a shared health summary or event summary. For example, when the only change is a repeat prescription of a current medication, then a prompt may not be required.* *Vendors need to allow users to ignore the prompt without being required to upload a shared health summary or event summary.* *For example, the software may display a dialog box when a user is exiting the patient's local health record and provide the following options to the user:* • *Upload a shared health summary* • *Upload an event summary* • *Close patient's record without upload* *Recommendation CLD.59 enables a user to turn off the display of this prompt.*	*Mandatory*	***NEW in CUP R3***
CLD.59	The software **SHALL** allow the user to switch off the prompt to upload either a shared health summary or event summary. The default setting is to display the prompt. *Note: Turning off this prompt should be an administrative task rather than part of the clinical workflow (e.g. under user administration settings).* *Refer to recommendation CLD.58 for further details regarding the prompt.*	*Mandatory*	***NEW in CUP R3***

2.8 Clinical document author role

Applies to: General practice document authoring systems (all clinical documents).

Some general practice software systems have incorrectly hardcoded the author roles onto clinical documents uploaded onto the PCEHR system.

This recommendation addresses this by encouraging the appropriate role to be attached to the author of the clinical document.

ID	Recommendation	Obligation	Status
CLD.60	When authoring a clinical document, the software **SHALL** ensure the user's role is correctly reflected in the appropriate CDA entry in the clinical document. *Note: Correctly recording the author role is important for audit purposes and for clarity of clinical provenance.* *The user login must be set up with a role that is appropriate for recording in the clinical document.* *In particular, according to the* PCEHR Act*, the author of a shared health summary must be a medical practitioner, registered nurse or an Aboriginal and Torres Strait Islander health worker. The user must therefore be set up with a role that is appropriate for uploading shared health summaries.*	*Mandatory*	***NEW in CUP R3***

3 Excluding individual provider contact information

Applies to: All general practice systems authoring clinical documents.

Clinical documents can support telecommunication and address details for participating healthcare providers. These commonly support entry of address, mobile phone, home phone, pager, fax and email address details as part of the system's healthcare provider record. The current CDA implementation guides specify that at least one individual communication and address detail is mandatory, while organisation communication and address details are optional. Revised CDA implementation guides will state that at least one organisation communication and address detail is mandatory, while individual communication and address details are optional in all clinical documents.

The recommendations below enable the user to choose whether to include their individual communication or address details in clinical documents. By default, these details should be excluded. These details are in addition to the organisation communication and address details that are included in clinical documents by default.

ID	Recommendation	Obligation	Status
CLD.21	*Replaced by CLD.61 and CLD.62.*		*Removed in CUP R3*
CLD.61	The software **SHOULD** allow users to select which (if any) of their individual electronic communication details (e.g. email address, phone number or fax number) may be automatically included in clinical correspondence. By default, all individual communication details **SHALL** be excluded. *Note: An individual communication detail is currently mandatory in the CDA implementation guides but will be changed to optional in future versions.* *Vendors may wish to provide a capability for providers who have chosen not to automatically include their individual communication details to include them for specific clinical documents.* *Clinical correspondence includes all clinical documents, whether transmitted electronically or printed and sent point-to-share (e.g. PCEHR) or point-to-point (e.g. referral). This wider definition is to encourage consistent application and avoid misunderstandings.*	*Mandatory*	***NEW in CUP R3***

ID	Recommendation	Obligation	Status
CLD.62	The software **SHALL** include at least ONE electronic communication detail for the authoring organisation in all clinical correspondence. *Note: An organisation's communication detail is currently optional in the CDA implementation guides but will be changed to mandatory in future versions.* *Vendors may wish to provide a capability for providers who have chosen not to automatically include their individual communication details to include them for specific clinical documents. This is in addition to the authoring organisation's communication detail that is automatically included.* *Clinical correspondence includes all clinical documents, whether transmitted electronically or printed and sent point-to-share (e.g. PCEHR) or point-to-point (e.g. referral). This wider definition is to encourage consistent application and avoid misunderstandings.*	*Mandatory*	***NEW in CUP R3***
CLD.22	*Replaced with CLD.63 and CLD.64.*		*Removed in CUP R3*
CLD.63	The software **SHOULD** allow users to select which (if any) of their individual addresses may be automatically included in clinical correspondence. By default, all individual addresses **SHALL** be excluded. *Note: An individual's address is currently mandatory in the CDA implementation guides but will be changed to optional in future versions.* *Vendors may wish to provide a capability for providers who have chosen not to automatically include their individual address details to include them for specific clinical documents.* *Clinical correspondence includes all clinical documents, whether transmitted electronically or printed and sent point-to-share (e.g. PCEHR) or point-to-point (e.g. referral). This wider definition is to encourage consistent application and avoid misunderstandings.*	*Mandatory*	***NEW in CUP R3***
CLD.64	The software **SHALL** include at least ONE address for the authoring organisation in all clinical correspondence. *Note: An organisation's address is currently optional in the CDA implementation guides but will be changed to mandatory in future versions.* *Vendors may wish to provide a capability for providers who have chosen not to automatically include their individual address details to include them for specific clinical documents. This is in addition to the authoring organisation's address that is automatically included.* *Clinical correspondence includes all clinical documents whether transmitted electronically or printed and sent point-to-share (e.g. PCEHR) or point-to-point (e.g. referral). This wider definition is to encourage consistent application and avoid misunderstandings.*	*Mandatory*	***NEW in CUP R3***

4 Displaying medicine instructions appropriately

Applies to: All general practice clinical information systems authoring clinical document containing medicine items.

In systems that create medicine items, there is a need to ensure appropriate and consistent presentation when these entries are viewed in the PCEHR system or downloaded and displayed in other clinical information systems. To address identified safety and usability issues, a number of interim usability recommendations have been defined in this section. This guidance should be viewed in light of the current project by the Australian Commission on Safety and Quality in Healthcare [ACSQHC2013], which will create guidelines for safe and appropriate on-screen display of medicines information.

The CDA implementation guides define a "Directions" data element that concatenates dose, frequency and instructions content as part of a medicine item.

Australian prescribing systems currently use a variety of data entry fields to capture "dose", "frequency" and "instructions" when entering medicine items into the patient record. In some cases "frequency" is not entered (for example, the pick list does not contain the desired frequency) and the "instructions" field is used instead to capture all frequency and other instructions as text.

A current real-life example is:
Product: "NEO B-12 Solution for Injection"
Dose: "1"
Frequency: (Null or field does not exist)
Instructions: "2 monthly"

When combined into a single "Directions" data element, this may appear as:

"NEO B-12 Solution for Injection 1 2 monthly"

when presented as a narrative, in a CDA document or elsewhere. The proximity of digits "1" and "2" may lead to confusion and potential misinterpretation of the medicine instructions. For example, does the above mean *one (injection) 2 monthly* or *12 (injections) each month*?

Systems are able to identify *2 times a month* but some are unable to create *every 2 months*. If software could include "every" it would be clear that the above means *one injection every 2 months* as opposed to *one injection 2 times a month*.

The situation is mitigated in some systems where medicine items may include a "Dosage Form" which may also be the administrable dose unit (for example, capsule, tablet, and injection). This, when used explicitly with the dose, clarifies the meaning. For example: "1 2 monthly" becomes "1 injection every 2 months" and "1 in the morning" becomes "1 tablet in the morning". Some drug forms, however, imply the administrable form syrup, liquid – for example "30mL daily".

ID	Recommendation	Obligation	Status
CLD.23	If the software allows the user to select dose, frequency, and instructions for using medicine (e.g. via pull down menus) rather than entering the information in a free text field, then a visual separator **SHALL** be used in the "Directions" data element to avoid combining combined dose, frequency or instruction values with adjacent numeric digits. *Note: Acceptable methods include:* *a) A spaced semi-colon " ; " with implied dose-form. For example:* *1 ; every 3 months* **Medicine** / **Directions** AMOXIL Capsule 250mg / 1 ; 3 times daily NEO-B12 Solution for Injection 1000 microgram/mL / 1 ; every 3 months AMOXIL Sugar Free Syrup 125mg/5mL / 5mL ; 3 times a day *b) Appropriate dose-form text. For example:* *1 injection every 3 months* **Medicine** / **Directions** AMOXIL Capsule 250mg / 1 capsule 3 times daily NEO-B12 Solution for Injection 1000 microgram/mL / 1 injection every 3 months AMOXIL Sugar Free Syrup 125mg/5mL / 5mL 3 times a day *c) Label parts with separating comma "," with implied dose-form. For example:* *Dose: 1, Instructions: every 3 months* **Medicine** / **Directions** AMOXIL Capsule 250mg / Dose:1, Frequency: 3 times daily NEO-B12 Solution for Injection 1000 microgram/mL / Dose:1, Instructions: every 3 months AMOXIL Sugar Free Syrup 125mg/5mL / Dose: 5mL, Frequency: 3 times a day *The "Directions" data element may have an alternative name, depending on the type of clinical document.* *This recommendation is identified for incorporation into the next publication of the* Shared Health Summary – PCEHR Conformance Profile (v1.6) *and the* Event Summary – PCEHR Conformance Profile (v1.4).	*Conditional*	*CUP R2 – no change*

ID	Recommendation	Obligation	Status
CLD.24	If the software allows medicine entries when authoring clinical documents, then it **SHALL** ensure that a "dose-form" is included in the entry. *Note: Acceptable methods include:* *a) Drug/product descriptions that include a form that is the dose-form e.g. 'Paracetamol 500mg tablet – 2 times daily'* *b) Drug form and dose/directions imply dose-form e.g. 'Benadryl (30mg; 100mg/5mL) Syrup – 30mL daily as required'* c) *Through an explicit statement of dose-form in the dose/directions e.g. 'Genteal 0.3% Eye Drops – 3 drops daily'* *This recommendation is identified for incorporation into the next publication of the* Shared Health Summary – PCEHR Conformance Profile (v1.6) *and the* Event Summary – PCEHR Conformance Profile (v1.4).	*Conditional*	*CUP R2 – no change*

5 Rendering clinical documents

Applies to: General practice clinical information systems that display PCEHR documents.

5.1 Navigating to the next or previous CDA document

General practice systems should offer their users a quick and easy way to review the content of multiple PCEHR documents displayed in a document list. This includes the ability for general practice users to display the previous or next document in the document list without having to return to the document list first.

ID	Recommendation	Obligation	Status
CLD.65	When a CDA document is opened from a document list, the software **SHOULD** allow the user to navigate to the next or previous document in the document list and/or views. For example, vendors may choose to display NEXT and PREVIOUS buttons. *Note: Enhances usability by enabling the next or previous document in the document list or view to be opened without the user having to close the CDA document and then select the next or previous document.*	*Optional*	***NEW in CUP R3***

5.2 eHealth Prescription and Dispense View

As a significant number of prescription and dispense records are being uploaded to the PCEHR, general practice users require an effective means of aggregating and managing the display of this information.

The eHealth Prescription and Dispense View provides users with an effective means of aggregating the display of the prescription records and dispense records in a healthcare consumer's PCEHR.

An eHealth Prescription and Dispense View has information in two forms: a narrative form and a structured form. If the view is rendered according to the *CDA Rendering Specification v1.0*, then the narrative information is presented. If the view is rendered according to the *eHealth Prescription and Dispense View Presentation Guide v1.0*, then the structured data is presented. This latter view is the more usable form as it provides advanced usability features, such as grouping by specific fields, expandable and collapsible groups, and linking to underlying source documents.

ID	Recommendation	Obligation	Status
CLD.25	The software **SHALL** implement the eHealth Prescription and Dispense View and render according to the mandatory requirements in the *eHealth Prescription and Dispense View Presentation Guide*. *Note: Vendors may wish to consider including a link to the eHealth Prescription and Dispense View on the PCEHR page.*	*Mandatory*	*Revised for CUP R3*

5.3 Medicare Overview

As a significant number of Medicare-sourced records are being uploaded to the PCEHR, general practice users require an effective means of aggregating and managing the display of this information.

The Medicare Overview provides a summary of Medicare-sourced information stored in an individual's PCEHR. It allows providers and individuals to view a summary of Medicare information in a single view rather than through multiple documents. In particular, the Medicare Benefits Scheme (MBS) and Department of Veteran's Affairs (DVA) claims data and the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) claims data is summarised giving an overview and history at a glance, rather than users needing to view multiple documents. This overview makes it easier to find and display patient information during a clinical appointment.

ID	Recommendation	Obligation	Status
CLD.66	The software **SHALL** implement the Medicare Overview and render according to the mandatory requirements in the *Medicare Overview – PCEHR Conformance Profile* and the *PCEHR View Service – Technical Service Specification*. *Note: Vendors may wish to consider including a link to the Medicare Overview on the PCEHR page.*	*Mandatory*	***NEW in CUP R3***

5.4 Pathology and diagnostic imaging report views

Release 5 of the PCEHR enables pathology and diagnostic imaging organisations to commence the process of modifying their systems to upload pathology and diagnostic imaging reports to the PCEHR. However, it is not until a significant number of these records are in fact being uploaded to the PCEHR that general practice users require an effective means of aggregating and managing the display of this information.

The eHealth Pathology Report View provides an electronic summary of the pathology report information contained in a consumer's PCEHR. It is based on the contents of the consumer's pathology report documents.

The eHealth Diagnostic Imaging Report View provides an electronic summary of the diagnostic imaging report information contained in a consumer's PCEHR. It is based on the contents of the consumer's diagnostic imaging report documents.

Both these views are available from PCEHR Release 5. When significant numbers of pathology and/or diagnostic view reports are being uploaded, NEHTA will recommend (in a future CUP release) that these views SHALL be implemented. In the interim, the following recommendations apply to those vendors who choose to implement these views.

ID	Recommendation	Obligation	Status
CLD.67	The software **SHOULD** render the eHealth Pathology Report View according to the mandatory requirements in its PCEHR conformance profile when available in PCEHR Release 5. *Note: Vendors may wish to consider including links to the Pathology Report View on the PCEHR page.*	*Optional*	***NEW in CUP R3***

CLD.68	The software **SHOULD** render the eHealth Diagnostic Imaging Report View according to the mandatory requirements in its PCEHR conformance profile when available in PCEHR Release 5. *Note: Vendors may wish to consider including a link to the eHealth Diagnostic Imaging Report View on the PCEHR page.*	*Optional*	***NEW in CUP R3***

5.5 Configuration of PCEHR views

It is noted that the above recommendations regarding the implementation of specific views are made on the basis of information about document uploading that is occurring on a national basis. However, general practice users have noted that these national trends may not apply to their particular patient cohort – so, for example, while there might be significant volumes of prescription and dispense records being uploaded on a national basis which would warrant vendors to build the Prescription and Dispense View, an individual user may not find a significant volume of these records for a significant proportion of their patients. Therefore, users require that these views can be disabled or enabled according to their individual needs.

ID	Recommendation	Obligation	Status
CLD.69	By default, the software **SHALL** display those PCEHR views that NEHTA has recommended **SHALL** be implemented. *Note: User may choose to disable access to one or more PCEHR views (recommendation CLD.70).*	*Mandatory*	***NEW in CUP R3***
CLD.70	The software **SHALL** enable the user to disable access to one or more PCEHR views. The software **SHALL** indicate that the PCEHR view is disabled. *Note: Disabling access could be in the form of greying out and disabling the link to the PCEHR view.* *This should be an administrative task rather than part of the clinical workflow (e.g. under user administration settings).*	*Mandatory*	***NEW in CUP R3***
CLD.71	If a user chooses to disable access to a PCEHR view, the software **SHALL** provide advice (or contextual help) that the user can still see the documents from the document list on the PCEHR page. *Note: Vendors may wish to include a message or warning if the document types covered by the view that is being disabled are not displayed by default on the document list.* *For further details regarding the PCEHR page, refer to section 8.*	*Mandatory*	***NEW in CUP R3***

6 Identifying new clinical documents from the PCEHR

Applies to: General practice clinical information systems that access the PCEHR system.

A central concept for CUP Release 3 is that of a new clinical document for an existing patient. General practice users want to easily identify when new clinical documents that they did not author are available on their patient's PCEHR without having to open the PCEHR record. They have requested that, alongside the indicator of whether a patient is registered or not with PCEHR, a count of the number of new clinical documents from the patient's PCEHR is included.

In addition, general practice users also want to be able to exclude specific clinical document types from being counted and listed as a new clinical document for an existing patient.

The following recommendations provide guidance about identifying those PCEHR clinical documents that a user wants to include in lists of documents recently added to a patient's PCEHR. They introduce the concept of a "new clinical document" and how this concept should be applied when rendering the PCEHR page. These recommendations apply to existing patients only, since the concept of a new clinical document is not meaningful for new patients.

An existing patient is one who has attended at least one clinical appointment and whose patient record has not been archived by the software system or healthcare provider.

Refer to Appendix C.1 for an example mock-up of recommendations CLD.73 and CLD.75.

ID	Recommendation	Obligation	Status
CLD.72	The software **SHALL** identify a clinical document as new if all the following conditions are met: 1. The document is authored by a HPI-O (i.e. document is authored by a clinical organisation as opposed to one authored by a consumer or administrative organisation such as DHS (Medicare)); AND 2. The document is authored by a different organisation (i.e. different HPI-O) OR by a different clinician within the same organisation (i.e. same HPI-O, different HPI-I); AND 3. The document was authored within the timing preferences set by the user. *Note: A user is able to select a timing preference for identifying new clinical documents – for example, clinical documents that have been authored since the patient's last visit. Refer to recommendations CLD.73 and CLD.74 for further details.* *This recommendation affects the number in the new clinical documents notification (see recommendation CLD.77).* *At times, an HPI-I may not be present in the document list. Vendors will need to be aware of this and handle accordingly. If the software cannot determine the author, then the document should be identified as new (provided the other two conditions have been met).*	*Mandatory*	***NEW in CUP R3***
CLD.73	The software **SHALL** allow the user to select one of the following timing preferences for identifying new clinical documents from the patient's PCEHR: 1. Since the patient's last clinical appointment attended at the practice (default); OR 2. Since the last shared health summary authored by a healthcare provider from the ***same*** organisation; OR 3. Within a user defined time period e.g. 3 months. *Note: This recommendation affects the number in the new clinical documents notification (see recommendation CLD.77).* *For new patients, all clinical documents are displayed (refer to CLD.83).*	*Mandatory*	***NEW in CUP R3***
CLD.74	The software **SHALL** use the Document Date (XDS.DocumentEntry.creationTime) to evaluate the timing requirement for new clinical documents (refer to recommendation CLD.72).	*Mandatory*	***NEW in CUP R3***

ID	Recommendation	Obligation	Status
CLD.75	The software **SHALL** allow the user to define a subset of new clinical documents (e.g. "your new clinical documents") by *excluding* one or more clinical document types. *Note: This recommendation affects the number in the new clinical documents notification (see recommendation CLD.77).* *This recommendation also affects which new clinical documents are included in the document list display on the PCEHR page (see recommendation CLD.84).* *This recommendation ensures that any new clinical document type that is introduced to the PCEHR is automatically included in the new clinical documents notification and displayed on the document list.* *For new patients, all clinical documents are displayed (refer to CLD.83).*	*Mandatory*	***NEW in CUP R3***
CLD.76	The software **SHALL** apply the user's preferences across all existing patients. *Note: This includes* • *setting the timing preference for the identification of new clinical documents* • *excluding document types i.e. creating a subset of new clinical documents* • *turning off the display of the new clinical documents notification on the patient's local health record* *Some practices may wish to enforce preferences across the organisation rather than at the individual user level. Vendors should cater for this if applicable.*	*Mandatory*	***NEW in CUP R3***

7 Locating and accessing PCEHR functions

Applies to: General practice clinical information systems accessing the PCEHR system.

Healthcare providers have raised issues about the ease of access to PCEHR-related functions. Some healthcare providers find it difficult to locate both the current PCEHR status and the mechanism to launch PCEHR functions, due to the different PCEHR access methods used by software developers.

The usability recommendations below will result in more consistent behaviours to support healthcare providers' use of the PCEHR.

Refer to Appendix C.2 for an example mock-up of recommendations CLD.26 and CLD.77. Refer to Appendix C.1 for an example mock-up of recommendation CLD.78.

ID	Recommendation	Obligation	Status
CLD.26	The software **SHALL** prominently display an indicator of the patient's PCEHR status when displaying the consumer's local health record. *Note: The PCEHR status is determined by the "doesPCEHRExist" operation [NEHTA-1120:2012]. The indicator can use any combination of words, colours and icons appropriate to the layout of the clinical system. The record statuses that the indicator needs to handle are:* • *PCEHR exists (access code may or may not be required)* • *PCEHR may not exist (i.e."doesPCEHRExist" operation returns false)* • *Operation cannot complete (e.g. no patient IHI on file or cannot connect to PCEHR due to network connectivity failure or system outage)*	*Mandatory*	*CUP R2 – no change*

ID	Recommendation	Obligation	Status
CLD.77	When displaying a patient's local health record, the software **SHALL** display a new clinical documents notification if the following conditions are met: 1. The patient is an existing patient; AND 2. The setting for the display of this notification is 'on' The notification **SHALL** include the number of clinical documents identified as new (with the exception of document types that have been specifically excluded in user preferences). For example, 5 new clinical documents OR PCEHR (5) *Note: The new clinical documents notification is determined by the software executing the "findDocuments" operation [NEHTA-1971:2014]. A list of documents is returned and the software will need to count only the new clinical documents in the list. The definition of a new clinical document is described in recommendation CLD.72.* *Users are also able to set preferences to exclude one or more clinical document types from being counted. For example, if a user has set preferences to exclude eHealth dispense records, then the number displayed will not include any new eHealth dispense records. See recommendation CLD.75 for further details.* *This activity is to be carried out in the background in order to eliminate unnecessary delay in opening the patient's local health record.* *If no new clinical documents are identified, then the number 0 is used. For example,* *0 new clinical documents OR PCEHR (0)*	*Mandatory*	***NEW in CUP R3***
CLD.78	Users **SHALL** be able to set whether to display the new clinical documents notification. The default is to display the notification. *Note: If the display is switched off, both the count and label (if one exists) of the new clinical documents notification are not displayed.*	*Mandatory*	***NEW in CUP R3***
CLD.27	The PCEHR entry point **SHALL** allow navigation to all supported PCEHR clinical activities, including: 1. Open the PCEHR page. 2. Author and upload a shared health summary. 3. Author and upload an event summary. *Note: This may be by direct access to the function or by navigation to a suitable screen where all functions are accessible.*	*Mandatory*	*Revised for CUP R3*
CLD.28	The software **SHOULD** allow access to PCEHR activities from other areas in the software, as deemed appropriate. *Note: Examples include the ability to author shared health summaries and event summaries from the letter writing module.*	*Optional*	*Revised for CUP R3*

ID	Recommendation	Obligation	Status
CLD.29	An entry point to PCEHR functionality **SHALL** be prominently displayed and accessible from the patient's local health record. *Note: This may be combined with the user controls associated with the PCEHR status indicator or via a separate window tab, drop-down menu, button, etc.*	*Mandatory*	*CUP R2 – no change*
CLD.30	Healthcare identifier (HI) checks and PCEHR status checks **SHOULD** be performed in the background where possible to improve system responsiveness and eliminate unnecessary delay when opening the patient's local health record. *Note: The PCEHR status is determined by the "doesPCEHRExist" operation [NEHTA-1120:2012]. It is recommended that background web service lookups are performed whenever an external service is invoked, as this will prevent the user interface from locking or becoming unresponsive when network performance at the health service is degraded or the external service is otherwise non-responsive or inaccessible.*	*Optional*	*Revised for CUP R3*

8 PCEHR page

Applies to: General practice clinical information systems that connect to the PCEHR system and display PCEHR documents.

Vendors may have already implemented the foundations of the health record overview in CUP releases 1 or 2. The concept of a PCEHR page is therefore an expansion of the document list functionality implemented in CUP releases 1 and 2.

In CUP Release 3, the document list will be filtered to display only new clinical documents for existing patients. For new patients, all clinical documents are displayed from the patient's PCEHR record (with the exception of shared health summaries, as these will be available on a separate document list).

In addition to the document list, the PCEHR page will also include a way of navigating to (or displaying) the most recent shared health summary uploaded onto the PCEHR (if applicable), provide links to PCEHR views (optional) and, if it is a new patient, provide an additional document list of historic shared health summaries.

By implementing CUP Release 3 recommendations, users will be able to have an overview of the patient's record in a structured display. They will have easy access to new clinical documentation only or all clinical documentation.

8.1 Overall layout of the PCEHR page

The following recommendations assume that the patient's PCEHR exists and is accessible. These recommendations provide an overall layout of the PCEHR page with further specific details in sections 8.2 and 8.3. The PCEHR page is displayed automatically whenever the user accesses the patient's PCEHR record.

Note that, where specified, an existing patient is one who has attended at least one clinical appointment and whose patient record has not been archived by the software system or practice.

Refer to Appendix C.3 for an example mock-up of recommendation CLD.79. Refer to Appendix C.4 for an example mock-up of recommendation CLD.80.

ID	Recommendation	Obligation	Status
CLD.79	The software **SHALL** provide a screen ('PCEHR page') that displays the following main items, as a minimum, **for an existing patient**: 1 A document list filtered to show **new** clinical documents only (omitting any document types specifically excluded by the user in their preference settings). *Note: An empty document list is displayed if there are no new clinical documents to be listed.* 2 A way of navigating to (or display of) the following items: a The contents of the most recent shared health summary (if available) *Note: If a shared health summary is not available, the user is notified.* b Links to specific PCEHR views (this is optional) *Note: Refer to recommendations CLD.84, CLD.85, CLD.86 and CLD.87 for further details regarding the presentation of the document list.* *Refer to recommendations CLD.88, CLD.89 and CLD.90 regarding the presentation of the shared health summary.* *Refer to section 5 for recommendations regarding PCEHR views.*	*Mandatory*	***NEW in CUP R3***
CLD.80	The software **SHALL** provide a screen ('PCEHR page') that displays the following main items, as a minimum, **for a new patient**: 1. A document list filtered to show **all** clinical documents except shared health summaries. *Note: An empty document list is displayed if there are no new clinical documents to be listed.* 2. A way of navigating to (or displaying) the following items: *a.* The contents of the most recent shared health summary (if available). *Note: If a shared health summary is not available, the user is notified.* b. Links to specific PCEHR views (this is optional). *c.* An additional document list showing all historic shared health summaries, grouped by organisation (name) and in reverse chronological order by document date *Note: The current shared health summary is not included in this document list as it is being displayed as per point 2a of this recommendation.* *Note: Refer to recommendations CLD.83 and CLD.87 for further details regarding the presentation of the document list.* *Refer to recommendations CLD.88, CLD.89 and CLD.90 regarding the presentation of the shared health summary.* *Refer to section 5 for recommendations regarding PCEHR views.*	*Mandatory*	***NEW in CUP R3***

ID	Recommendation	Obligation	Status
CLD.81	The software **SHALL** allow the user to easily switch between the patient's local health record, the PCEHR page and other PCEHR clinical activities, such as authoring and uploading a shared health summary or event summary. *Note: While the PCEHR page is intended to be the primary means of accessing PCEHR information, users may wish to access other PCEHR clinical activities directly, or go back the patient's local health record.*	*Mandatory*	***NEW in CUP R3***
CLD.82	The PCEHR page **SHALL** *always* display the following statement to users: This is not a complete view of the individual's health information. For more information about the individual's health record or data, please consult the individual or other healthcare professionals as needed. *Note: This is consistent with the disclaimer displayed in the health record overview.*	*Mandatory*	***NEW in CUP R3***

8.2 Default display of the documents list on the PCEHR page

The following recommendations outline how the document list on the PCEHR page is to be displayed initially.

Note that, where specified, an existing patient is one who has attended at least one clinical appointment and whose patient record has not been archived by the software system or practice.

Refer to Appendix C.5 for an example mock-up of recommendations CLD.84, CLD.85 and CLD.86. Refer to Appendix C.6 for an example mock-up of recommendation CLD.83.

ID	Recommendation	Obligation	Status
CLD.83	For new patients, the document list on the PCEHR page **SHALL** initially display: • all clinical documents (i.e. authored by any HPI-O); • sorted by document date in reverse chronological order; • with no grouping applied. *Note: As the patient is new to the healthcare organisation, all clinical documents on the patient's PCEHR will have been uploaded by a different organisation and will therefore be of interest to the user.* *Shared health summaries are not included as there is a separate document list to display these (see recommendation CLD.80).* *This is the default display of the document list when the user accesses the PCEHR page for any new patient.*	*Mandatory*	***NEW in CUP R3***

ID	Recommendation	Obligation	Status
CLD.84	For existing patients, the document list on the PCEHR page **SHALL** initially display: • all new clinical documents (with the exception of document types that have been specifically excluded in user preferences); • sorted by document date in reverse chronological order; • with no grouping applied. *Note: The definition of a new clinical document is described in recommendation CLD.72.* *Users are able to set preferences to exclude one or more clinical document types from the new clinical documents set. For example, if a user has set preferences to exclude eHealth dispense records, then the document list displayed will not include any new eHealth dispense records. See recommendation CLD.75 for further details.* *The number of documents displayed in this document list is the same as the number in the display of the new clinical documents notification (see CLD.77).* *This is the default display of the document list when the user accesses the PCEHR page for any existing patient.*	*Mandatory*	***NEW in CUP R3***
CLD.85	For existing patients, the PCEHR page **SHALL** provide clear indication that only *new* clinical documents are being displayed. The indication **SHALL** also identify if there are any exclusions by document type as set out in the user's preferences. *For example, if a user has set preferences to exclude one or more document types, a caption could be displayed as:* Show **your selection of new clinical documents** ☑ *If a user has not set preferences to exclude any document types, a caption could be displayed as:* Show **all new clinical documents** ☑ *Note: Users are able to set preferences to exclude one or more clinical document types from the new clinical documents set. For example, if the user has set preferences to exclude eHealth dispense records, then the document list displayed will not include any new eHealth dispense records. See recommendation CLD.75 for further details.* *In the example above, the checkbox is ticked to indicate that the document list has been filtered.* *This recommendation does not apply to new patients.*	*Mandatory*	***NEW in CUP R3***

ID	Recommendation	Obligation	Status
CLD.86	If the document list on the PCEHR page is displaying a subset of new clinical documents, the software **SHALL** allow the user to select and display *all* new clinical documents. *For example, the following captions above the document list could be displayed:* Show **your selection of new clinical documents** ☑ Show **all new clinical documents** ☐ *Note: In the example above, the checkbox allows the user to select and therefore display all new clinical documents. Refer to recommendation CLD.72 for a definition of a new clinical document.* *Users are able to set preferences to exclude one or more clinical document types from the new clinical documents set. For example, if the user has set preferences to exclude eHealth dispense records, then the document list displayed will not include any new eHealth dispense records. See recommendation CLD.75 for further details.* *This recommendation does not apply to new patients.*	*Mandatory*	***NEW in CUP R3***
CLD.87	If there are no documents to be listed, the software **SHALL** display an empty document list on the PCEHR page. The software **SHALL** indicate that there are no documents to be displayed. *For example, the following caption could be displayed:* There are no documents to be listed	*Mandatory*	***NEW in CUP R3***

8.3 Shared health summary display on PCEHR page

ID	Recommendation	Obligation	Status
CLD.88	The PCEHR page **SHALL** enable the user to view, with no more than one action, the most recent shared health summary (if available), (e.g. click on a link to open the shared health summary OR open a tab that is displaying the shared health summary). *Note: Refer to recommendation CLD.90 if the patient's PCEHR record does not have a shared health summary to be displayed.*	*Mandatory*	***NEW in CUP R3***
CLD.89	The PCEHR page **SHALL** indicate if the most recent shared health summary is new (e.g. highlighting the link that opens the shared health summary or displaying a 'new' icon next to the tab that displays the shared health summary etc.). *Note: The shared health summary would be identified as new if it meets the criteria of a new clinical document as defined in recommendation CLD.72.*	*Mandatory*	***NEW in CUP R3***

ID	Recommendation	Obligation	Status
CLD.90	Where no shared health summary exists, the PCEHR page **SHALL NOT** provide the navigation means to display the most recent shared health summary (e.g. disable the link to open or remove tab displaying the shared health summary). *Note: Vendors may wish to consider whether to include an additional note to encourage users to upload a shared health summary.*	*Mandatory*	***NEW in CUP R3***

9 PCEHR document lists – general functionality

Applies to: General practice clinical information systems that display PCEHR documents.

This section contains software recommendations for the presentation of lists of PCEHR documents.

It is recommended that information retrieved from a PCEHR is displayed in the columns defined in this section. Software developers may choose to provide administrator or debug views with additional columns to help with troubleshooting, etc. These alternative views should not be the default option for normal use.

The recommendations regarding sorting, grouping and filtering outlined in this section relate to real-time customisation that lets the user manipulate what is displayed and how the information is displayed in a document list.

9.1 Columns and content

ID	Recommendation	Obligation	Status
CLD.31	Lists displayed by default to clinical users **SHALL** be displayed in columns and **SHALL** include columns with the following headings: Document Date Service Date Document Organisation Organisation Type *Note: The columns are used to provide the following information:* • *Document Date: The date the document was created* • *Service Date: The date and time the health service was provided* • *Document: The type of document (e.g. shared health summary)* • *Organisation: The name of the organisation that authored the document* • *Organisation Type: The type of organisation that authored the document.* *Note: CLD.33 identifies how to obtain the content for each of these columns for a document.*	*Mandatory*	*Revised for CUP R3*
CLD.32	Lists displayed by default to clinical users **SHOULD NOT** include columns other than the required columns of Document Date, Service Data, Document, Organisation, Organisation type. *Note: Exceptions to this recommendation will depend on how vendors choose to implement recommendations CLD.41, CLD.91, CLD.92, CLD.93, CLD.94 and CLD.95.*	*Optional*	*Revised for CUP R3*

ID	Recommendation	Obligation	Status
CLD.33	Information displayed in the columns (as identified in CLD.31) **SHALL** be obtained from document metadata, or from the clinical document if the document metadata is not available. *Note: Refer to Appendix A for mapping between document metadata and CDA data components.*	*Mandatory*	*Revised for CUP R3*
CLD.34	The format for all dates displayed in the Document Date and Service Date columns **SHOULD** conform to one of the date formats stated in the *CDA Rendering Specification*.	*Optional*	*Revised for CUP R3*
CLD.35	The display dates in the Document Date and Service Date columns **SHALL NOT** include time or timezone. *Note: The user can find the time and timezone when viewing a document.*	*Mandatory*	*CUP R2 – no change*
CLD.36	A Service Date **SHALL NOT** be displayed if the service date is identical to the document date. *Note: A recommendation about displaying the service date when sorting is stated in CLD.46.*	*Mandatory*	*CUP R2 – no change*
CLD.37	The Document column **SHALL** display the document type name. The document title **SHALL NOT** be displayed in the Document column. *Note: The document type name can be obtained from the document metadata attribute XDSDocumentEntry.typeCodeDisplayName. Alternatively, if metadata is not available, the document type name is to be derived from the clinical document data element ClinicalDocument/code/@code as described in Appendix A.*	*Mandatory*	*CUP R2 – no change*
CLD.38	Names listed in the Organisation column **SHALL** be organisation names only. *Note: Organisation data is obtained from either the document metadata (the "organisation name" element in XDSDocumentEntry.authorInstitution) or from the clinical document itself, when metadata is not available. Refer to Appendix A for mapping between document metadata and CDA data components.*	*Mandatory*	*CUP R2 – no change*
CLD.39	If the clinical information system uses clinical documents to display information in the Organisation column, then the name of the organisation **SHALL** be one of (in order of priority): • the healthcare facility (if present) • the authoring person's employing organisation (if present) • the custodian organisation (if present). If none of the above is available, then a name **SHALL NOT** be present in the Organisation column *Note: The data element providing the name of the healthcare facility is a mandatory element of Discharge Summary, PCEHR Prescription Record and PCEHR Dispense Record. The data element for the authoring person's employing organisation is a mandatory element of Shared Health Summary, Event Summary, Specialist Letter and Discharge Summary.*	*Conditional*	*CUP R2 – no change*

ID	Recommendation	Obligation	Status
CLD.40	If the software uses clinical document content to display information in the Organisation Type column, this **SHALL** be obtained from: • the value stored in the `originalText` attribute (if present); otherwise • the value stored in the `displayName` attribute (if present); otherwise • left blank. The value of the facility code attribute **SHALL NOT** be used. *Note: This recommendation is only applicable where the software does not have access to a clinical document's XDS.b metadata for extracting the Organisation Type to fill in the Organisation Type column in a document list display. This only applies for clinical document types containing facility details i.e. Discharge Summary, eHealth Prescription Record and eHealth Dispense Record.*	*Conditional*	*Revised for CUP R3*
CLD.41	If the software supports query for removed or superseded documents, the display **SHALL** make it clear to the healthcare provider whether a document has been removed or superseded on the documents list. *Note: This could be implemented in various ways, such as indicating the status in an additional column or using alternative colours. Removed and superseded documents are highlighted on the document list so that users are aware that those documents are not current. Removed documents are only available for display when the accessing organisation is the same as the document authoring organisation.*	*Conditional*	*Revised for CUP R3*
CLD.42	If an additional column is used to indicate that documents have been removed or superseded, a value **SHALL** only be displayed if a document has been removed or superseded. *Note: For example, do not repeat "approved" for every document as this results in clutter that detracts from readability.*	*Conditional*	*CUP R2 – no change*
CLD.43	The software **SHALL** display all date-time columns using the local time zone of the user. *Note: Date-time values in PCEHR XDS.b metadata are recorded as UTC (Universal Time Coordinated) so must be converted to local time for display. When date-only values are recorded these should be shown as-is in document lists. (See Section 2.3 "*Managing date-times*")*	*Mandatory*	*CUP R2 – no change*
CLD.91	When listing documents from the PCEHR, the software **SHOULD** include an indicator on the document list identifying whether a document has been viewed by the user. The software **SHOULD** allow the user to reset the indicator. *Note: The indicator enables a user to quickly see whether they have viewed a document or not. It is specific to the individual user.* *For example, the indicator may be set to TRUE automatically once the user has viewed the document, but the user may choose to set it back to FALSE.*	*Optional*	***NEW in CUP R3***

ID	Recommendation	Obligation	Status
CLD.92	If the software is capable of storing clinical documents in the patient's local health record, the software **SHALL** include an indicator on the document list identifying whether a document has been saved to the patient's record in the software. *Note: The indicator enables a user to quickly and visually identify whether a document has already been saved to the patient's record in the local health system and is specific to the organisation.* *For example, the indicator may be set to TRUE automatically once the document has been saved to the patient's record.*	*Conditional*	***NEW in CUP R3***
CLD.93	Clinical documents **SHALL** be identified as new within any document list retrieved from the PCEHR. *Note: The definition of a new clinical document is described in recommendation CLD.72.* *The new indicator includes all new clinical documents i.e. even those document types that have been excluded in user preferences will be identified as 'new' on the document list if listed.*	*Mandatory*	***NEW in CUP R3***
CLD.94	The user **SHOULD** be able to view the clinical synopsis field of an event summary in the documents list on the PCEHR page without viewing the entire event summary document. *Note: Vendors should be aware that:* • *In order to satisfy this recommendation, it is expected that vendors will augment the document list with the clinical synopsis field retrieved from the Recent Documents section of the Health Record Overview;* • *However, the Recent Documents section of the Health Record Overview contains only 12 months' worth of data;* • *If the clinical synopsis is not available for display (i.e. for event summaries that are older than 12 months), the software will need to indicate this technical limitation i.e. differentiate between unable to display from a valid 'empty' clinical synopsis field.* *Vendors are required to include a parameter that identifies how many characters to retrieve from the clinical synopsis field when the system makes a Health Record Overview service call. It is suggested that a minimum of 150 characters should be extracted from the clinical synopsis.*	*Optional*	***NEW in CUP R3***
CLD.95	If the clinical synopsis field is available to be viewed from the document list, the software **SHALL** minimise the number of actions required by the user to view the clinical synopsis field. *Note: Vendors are encouraged to minimise the number of clicks a user makes to view the clinical synopsis field – for example, the field could be displayed when the user's mouse hovers over the event summary row on the document list.*	*Conditional*	***NEW in CUP R3***

ID	Recommendation	Obligation	Status
CLD.96	If there are too many documents to be displayed on the document list, the software **SHOULD** provide a visual indication that there are more documents then those currently on display and allow the user to access these. *Note: There may be more documents available than can be shown on the document list when the PCEHR page is opened. By including, for example, a MORE button or a scroll bar, this provides a visual indication to the user that there are additional documents on the document list.*	*Optional*	***NEW in CUP R3***

9.2 Sorting and grouping

Refer to recommendations CLD.83 and CLD.84 for default sorting to be applied when the document list is displayed on the PCEHR page (as identified in section 7).

ID	Recommendation	Obligation	Status
CLD.44	The software **SHALL** allow a user to be able to sort on the Document Date, Service Date, and Document columns, in ascending or descending order.	*Mandatory*	*CUP R2 – no change*
CLD.45	The software **SHOULD** allow a user to sort on any additional column, in ascending or descending order.	*Optional*	*Revised for CUP R3*
CLD.97	The software **SHALL** clearly indicate to the user when the document list has been sorted. *For example, a downward arrow may appear next to a sorting icon in the column heading to indicate that column has been sorted in descending order.*	*Mandatory*	***NEW in CUP R3***
CLD.46	When the user sorts on Service Date, the sort **SHALL** be by the service date and not the date displayed in the Service Date column. *Note: The reason for this recommendation is that the displayed date is not displayed in the Service Date column when the service date is equal to the document date. In this case, the document's position in the document list would be determined by its document date; i.e. documents with a blank display date do not necessarily all appear at the top or bottom of the list.*	*Mandatory*	*CUP R2 – no change*
CLD.47	When sorting by Service Date, the service date (day, month and year) **SHALL** be displayed. Documents that have no service date **SHALL** be sorted by document date.	*Mandatory*	*CUP R2 – no change*
CLD.48	The software **SHOULD** provide grouping/collapsing. *Note: Grouping/collapsing refers to the ability for the user to aggregate like entries for chosen list column. These grouped entries can be expanded and collapsed to aid navigation of the document list.*	*Optional*	*Revised for CUP R3*

ID	Recommendation	Obligation	Status
CLD.49	If the software offers grouping functionality, this **SHALL** be applied only to the current sort column. *Note: Allowing grouping only by sorted column ensures that the group headings are based on sorted column. This means any expanded group items are still shown in primary sort order.*	*Conditional*	*CUP R2 – no change*

Document	Document Date	Service Date	Organisation	Organisation Type
Event Summary				
Event Summary	13-Feb-2013		Northern Clinic	General Practice
Event Summary	01-Jan-2013		Main St Clinic	General Practice
Shared Health Summary				
Shared Health Summary	30-Apr-2013		Main St Clinic	General Practice
Shared Health Summary	12-Feb-2013		Northern Clinic	General Practice
Specialist Letter				
Specialist Letter	03-Jan-2013	02-Jan-2013	Western Clinic	Physiotherapy Services

9.3 Filtering

Filtering may be applied as a parameter to the document list service call (server-side filtering) or locally (client-side) by filtering the document list returned by the service call.

Refer to Appendix B for more information on server-side filtering.

Refer to recommendations CLD.83 and CLD.84 for default filters to be applied when the document list is displayed on the PCEHR page (as identified in section 7).

ID	Recommendation	Obligation	Status
CLD.50[1]	The software **SHALL** allow the user to exclude all Medicare documents from the document list. *Note: The Medicare documents are Pharmaceutical Benefits Report, Australian Childhood Immunisation Register, Medicare/DVA Benefits Report and Australian Organ Donor Register.* *Users are encouraged to use the Medicare Overview (if available) to view information from these documents – refer to recommendation CLD.66.*	*Mandatory*	*Revised for CUP R3*
CLD.51[2]	The software **SHALL** allow the user to exclude all eHealth prescription records and eHealth dispense records from the document list. *Note: Users are encouraged to use the eHealth Prescription and Dispense View to view information from these documents – refer to recommendation CLD.25.*	*Mandatory*	*Revised for CUP R3*

[1] CLD.50 is superseded by the more general recommendation CLD.98 and may be removed in future releases of CUP.
[2] CLD.51 is superseded by the more general recommendation CLD.98 and may be removed in future releases of CUP.

ID	Recommendation	Obligation	Status
CLD.98	The software **SHOULD** allow the user to exclude all PCEHR document types from the document list if the software has implemented a PCEHR view that uses these document types. *For example, a user may be able to choose to exclude eHealth prescription records and eHealth dispense records with one selection rather than having to select each document type individually.*	*Optional*	***NEW in CUP R3***
CLD.99	The software **SHALL** allow the user to filter the document list by document date. *Note: This date filter for the document list is automatically set for an existing patient when the user accesses the PCEHR page based on the timing preferences set by the user.* *For example, the vendor may choose to provide a* From *and* To *date for users to complete.*	*Mandatory*	***NEW in CUP R3***
CLD.52	The software **SHALL** allow the user to only include documents from the last three months. *Note: This date filter allows the user to view only the most recent documents.* *For example, the vendor may choose to provide a button allowing the user to select 'last 3 months'.*	*Mandatory*	*Revised for CUP R3*
CLD.53	The software **SHALL** allow the user to filter by one or more document types. *Note: Document type is defined as the value in the document metadata (XDSDocumentEntry.typeCode) or the clinical document (ClinicalDocument/code/@code) itself.* *Vendors are encouraged to group document types that have or will have a corresponding PCEHR view, enabling users to exclude groups of document types with one selection. Recommendations relating to PCEHR views are described in section 5.* *This does not prevent individual document types within these groups from being selected for exclusion independently (e.g. the user may wish to only exclude eHealth prescription records – and keep eHealth dispense records displayed – on the document list).* *Refer to recommendations CLD.83 and CLD.84 for default filters to be applied to the document list when the user opens the PCEHR page.*	*Mandatory*	*Revised for CUP R3*
CLD.54	If the software supports query for removed or superseded documents, then the software **SHALL** allow the user to include or exclude all removed or superseded documents from being displayed in the document list.	*Conditional*	*Revised for CUP R3*

ID	Recommendation	Obligation	Status
CLD.55	The software **SHALL** clearly indicate to the user when document filters have been applied. The software **SHALL** enable the user to identify what has been filtered in the document list. For example, the document type column may show a filter icon that is highlighted to indicate that the filter is 'on'. The user could then click on the icon to determine what document types have been included and excluded from the document list. *Note: Making the user aware that the displayed list is a partial document list will help mitigate clinical safety risk. Prominently displaying the current filter settings is an adequate indication.*	*Mandatory*	*Revised for CUP R3*
CLD.100	The software **SHALL** allow the user to remove any or all document filters that have been applied to the document list on the PCEHR page.	*Mandatory*	***NEW in CUP R3***
CLD.56	If the software supports filtering of the document list based on date, then this **SHALL** be based on date-time converted to local time from the UTC date-time recorded in metadata fields.	*Conditional*	*CUP R2 – no change*
CLD.101	If the software displays a viewed indicator on the document list, then the software **SHALL** allow the user to filter for 'viewed' or 'not viewed' documents. *Note: Refer to recommendation CLD.91 for further details regarding the 'viewed' indicator.*	*Conditional*	***NEW in CUP R3***
CLD.102	If the software is capable of storing clinical documents in the patient's local health record, then the software **SHALL** allow the user to filter for 'saved' or 'not saved' documents. *Note: Refer to recommendation CLD.92 for further details regarding the 'saved' indicator.*	*Conditional*	***NEW in CUP R3***

10 General

Applies to: General practice clinical information systems that connect to the PCEHR system.

10.1 Error message display

In order to be useful, error messages displayed to general practice users need to be easy to understand and provide clear guidance about actions to take to resolve the error.

ID	Recommendation	Obligation	Status
CLD.103	The software **SHALL** ensure that all error messages provided to the user include a clear explanation of the error and the action the user should take next. *Examples include:* Your NASH certificate is not configured correctly or has expired. Please contact your system administrator. Your HPI-O has not been set up. Please contact your practice administrator. Your HPI-I has not been set up. Please contact your practice administrator. The PCEHR service is currently unavailable. Please try again later. *Note: Providing user with some insight to why an error has occurred and what actions the user can take to rectify the error will enhance system usability.*	*Mandatory*	***NEW in CUP R3***

10.2 Indicators for front desk staff

10.2.1 'Patient not registered with PCEHR' indicator

While the PCEHR indicator recommended in CLD.26 provides the general practice user with information about the patient's enrolment status with the PCEHR system, similar information should be provided to front desk staff. In many cases, it is the front desk staff who are responsible for performing assisted registration services. A PCEHR indicator for front desk staff would help them identify patients who may require such enrolment support.

ID	Recommendation	Obligation	Status
CLD.104	If the software provides an interface to front desk staff, then the software **SHALL** provide an indicator to front desk staff if a patient is not registered with the PCEHR system. *Note: The wording of the indicator should be mindful that assisted registration is voluntary and requires patient consent.* *The PCEHR indicator (as defined in CLD.26) is currently only available from the patient's clinical record, to which the front desk staff may not have access. The implementation of this recommendation will provide front desk staff with information on whether a patient is registered for a PCEHR.*	*Conditional*	***NEW in CUP R3***
CLD.105	If the software provides an indicator to front desk staff when a patient is not registered with the PCEHR system, then the software **SHALL** enable front desk staff users to turn off this indicator. The default setting is to display the indicator. *Note: The indicator is specific to the front desk user. Once switched off, the indicator will not be displayed for any patient. Further details about this indicator are in recommendation CLD.104.*	*Conditional*	***NEW in CUP R3***

10.2.2 'IHI non match' indicator

It is known that a small proportion of IHI searches do not return a match, and therefore it is recognised there is a need to improve the quality of demographics data held within general practice. The following recommendation will enable an indicator or prompt to encourage front desk staff to check and correct demographic details if an IHI search fails to return a match.

ID	Recommendation	Obligation	Status
CLD.106	If the software provides an interface to front desk staff, then the software **SHALL** provide an indicator to front desk staff if an IHI search fails to return a match. *Note: The wording of the indicator should prompt front desk staff to check the following patient's details:* *a. Correct spelling of the patient's full name* *b. Patient's current Medicare number* *c. Patient's date of birth* *d. Patient's address* *Vendors are encouraged to include a note that if the above action fails to resolve the matter, then front desk staff should direct the patient to check the information held by Medicare.*	*Conditional*	***NEW in CUP R3***

Appendix A CDA mapping to XDSDocumentEntry fields

This table includes CDA data components that may contain representative content for the columns in a PCEHR document list when the specified metadata (XDSDocumentEntry) is not available. The XDSDocumentEntry metadata is specified in the *PCEHR Document Exchange Technical Service Specification*.

Column	XDSDocumentEntry	CDA data component
Document Date	creationTime	ClinicalDocument/effectiveTime
Service Date	serviceStopTime	ClinicalDocument/componentOf/encompassingEncounter/effectiveTime Note: The clinical document data element "ClinicalDocument/componentOf/encompassingEncounter/effectiveTime" is not present in all types of clinical documents.
Document	typeCodeDisplayName	ClinicalDocument/code/@code (See note 1)
Organisation	authorInstitution (see note 2)	ClinicalDocument/author/assignedAuthor/ assignedPerson/ext:asEmployment/ ext:employerOrganization/ ext:asOrganizationPartOf/wholeOrganization/ext:name *Note: Some types of documents do not have an assignedAuthor and some other types of documents have an assignedAuthor but no employerOrganization.* *This CDA data component is for Shared Health Summary, Event Summary, Specialist Letter, eReferral and Discharge Summary.* *For PCEHR Prescription Record and PCEHR Dispense Record the CDA data component is ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/serviceProviderOrganization/asOrganizationPartOf/wholeOrganization/name* *For some types of documents (i.e. Medicare/DVA Benefits Report, Australian Organ Donor Register, Australian Childhood Immunisation Register and Pharmaceutical Benefits Report) the author is software, rather than a person, and there is no employerOrganization listed.*
Organisation Type	healthcareFacilityTypeCodeDisplayName	ClinicalDocument/componentOf/encompassingEncounter/location/healthCareFacility/code (see note 3)

Notes to table

1 The document name is obtained by using a mapping table per Table 3 of the *PCEHR Document Exchange Technical Service Specification*. The clinical document code (ClinicalDocument/code/@code) is mapped to TypeCodeClassCode in the mapping table, with the corresponding TypeCodeDisplayName text displayed in the Document column.

2 Organisation is obtained from XDSDocumentEntry.authorInstitution described in HL7 V2 field XON.1– Organization Name [IHE2011a].

3 This CDA element is present in Discharge Summary, eHealth Prescription Record and eHealth Dispense Record documents. It is not present in Shared Health Summary, Specialist Letter, Event Summary, eReferral documents, consumer entered information documents (e.g. Advance Care Directive Custodian Record and Personal Health Summary) and or Medicare documents.

Appendix B Server-side document list filtering

This section describes how to limit items in the document list to include only the document types of primary interest to users. In the example below, the default list is limited to display of health summaries, event summaries and discharge summaries.

When invoking the "GetDocumentList" web service, an XDS.b Registry Stored Query findDocuments query is performed. This query supports searching by any of the parameters supported by that Registry Stored Query.

The supported parameters can be found in section 3.18.4.1.2.3.7.1 of *IHE IT Infrastructure Technical Framework Volume 2a* [IHE2011b].

Table 3 in the *PCEHR Document Exchange Technical Service Specification* provides the list of TypeCodes and ClassCodes required to be used for PCEHR documents when registered. These codes can be used in the query for the $XDSDocumentEntryClassCode (coded according to the definition in section 3.18.4.1.2.3.4 of the IHE Volume 2a document referenced above).

Multiple identifiers for different document types may be specified, and the query will return documents which match any of the supplied values (OR logic).

Selecting the appropriate ClassCodes will result in only documents of those types being returned.

Ignoring the rest of the query (the "default" empty structure), the values required to return only shared health summaries, event summaries, discharge summaries and specialist letters would look something this:

```
<Slot name="$XDSDocumentEntryClassCode ">
   <ValueList>
      <Value>('60591-5^^LOINC')</Value>
      <Value>('34133-9^^LOINC')</Value>
      <Value>('18842-5^^LOINC')</Value>
      <Value>('51852-2^^LOINC')</Value>
   </ValueList>
</Slot>
```

The following sample code demonstrates document filtering in conjunction with the PCEHR Client sample code (available from www.nehta.gov.au):

```
// Create a query
AdhocQueryBuilderadhocQueryBuilder = new
AdhocQueryBuilder("800360xxxxxxxxxx", new[] {
DocumentStatus.Approved });
if(!chkShowallDocs.Checked)
   adhocQueryBuilder.ClassCode = new[] {
      ClassCodes.DischargeSummary,
      ClassCodes.EventSummary,
      ClassCodes.SpecialistLetter,
      ClassCodes.SharedHealthSummary };
// Combo box allows user to define date period in months - default
is 12 months
```

```
DateTimestartDate =
DateTime.Now.AddMonths(cboMonthRange.SelectedText);
DateTimeendDate = DateTime.Now;
adhocQueryBuilder.CreationTimeFrom = new
ISO8601DateTime(startDate);
adhocQueryBuilder.CreationTimeTo = new ISO8601DateTime(endDate);
// Create the request using the query
AdhocQueryRequestqueryRequest = adhocQueryBuilder.BuildRequest();
```

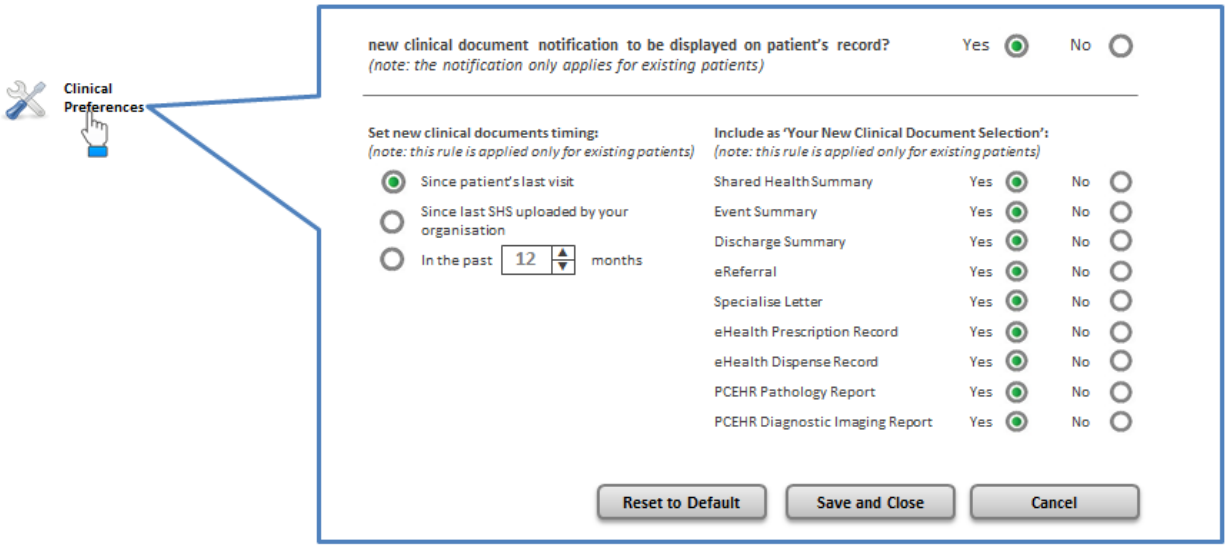
Appendix C Example mock-ups

C.1 New clinical document configuration options

The below is an example of how the new clinical document configuration options could be made available to the user. This mock-up relates to recommendations CLD.73 and CLD.75 in section 6 *Identifying new clinical documents from the PCEHR* and CLD.78 in section 7 *Locating and accessing PCEHR functions*.

This mock-up demonstrates how:

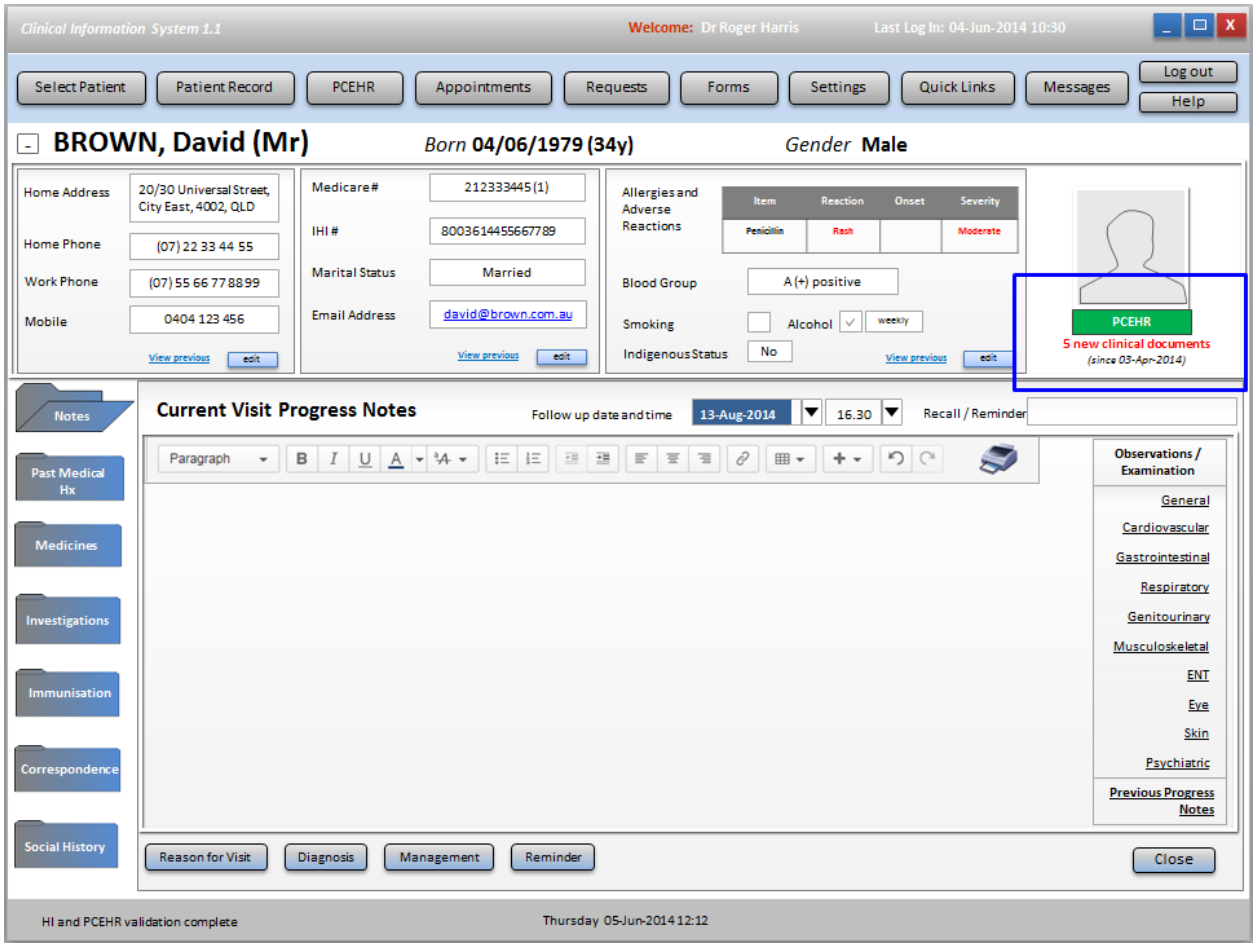
- Users may choose to switch off the display of the 'new_clinical_documents count', which also turns off the display of the note that the user has excluded clinical documents.
- Users may choose the timing option for identifying new clinical documents.
- Users may choose to exclude one or more document types, thus creating a subset of new clinical documents ('your selection of new clinical documents').
- Default settings are:
    - The new clinical documents notification is displayed.
    - Timing option set to 'Since patient's last visit'.
    - All clinical documents are included i.e. none are selected for exclusion.



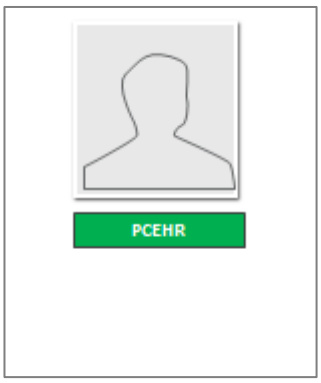
C.2 Enhanced PCEHR indicator including new clinical documents notification

The below is an example of how the PCEHR indicator and the new clinical documents notification could be displayed on a patient's local health record.

These mock-ups relate to recommendations CLD.26 and CLD.77 in section 7 *Locating and accessing PCEHR functions*.



For a new patient, the new clinical documents notification does not apply and therefore nothing is displayed:

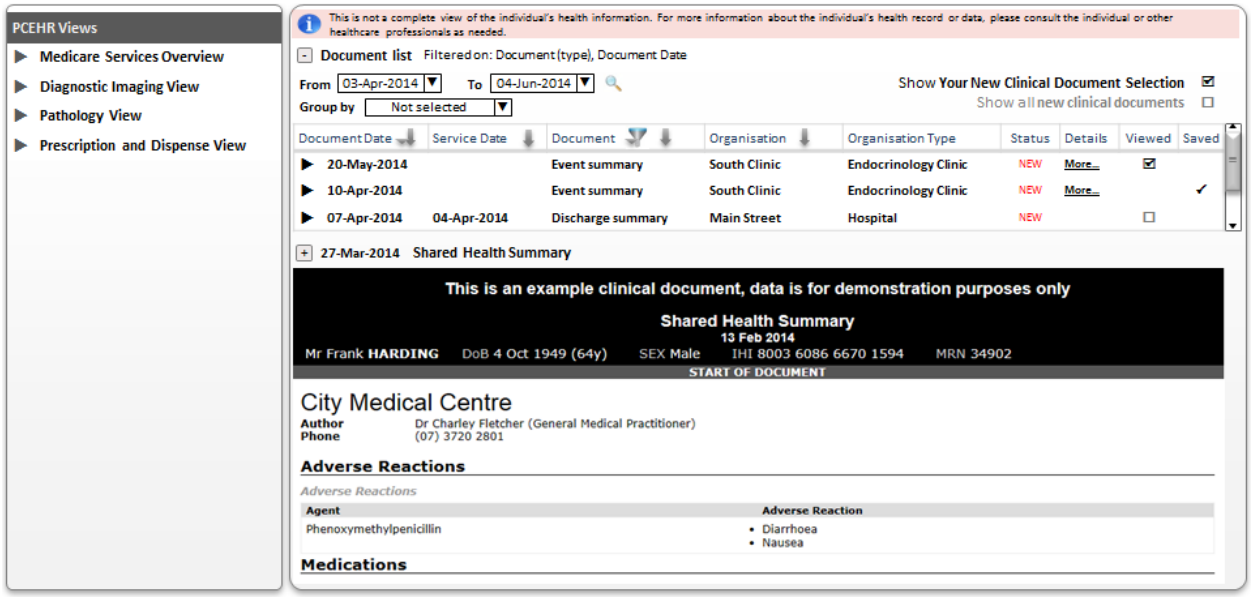


C.3 PCEHR page display for an existing patient

The example below shows how the PCEHR page could look for an existing patient. This mock-up relates to recommendation CLD.79 in section 8.1 *Overall layout of the PCEHR page.*

There are three main items to be included:

- A document list displaying new clinical documents.
- Most recent shared health summary from patient's PCEHR.
- Links to PCEHR views (optional).
- All three items do not necessarily have to be on the same screen but are all part of the PCEHR page.

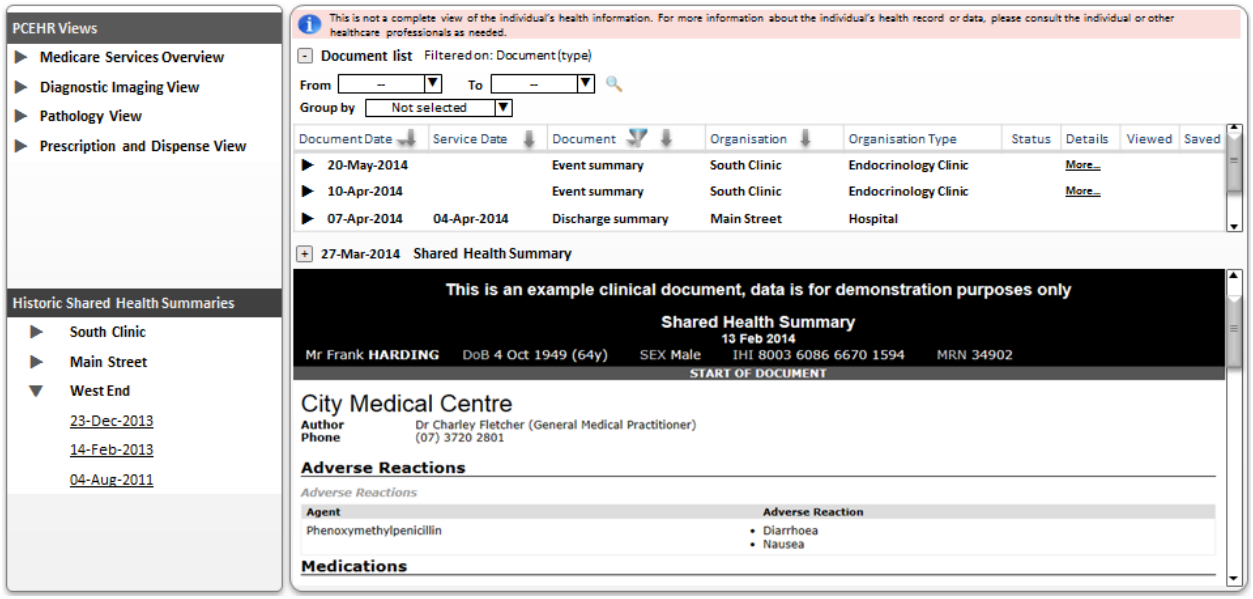


C.4 PCEHR page display for a new patient

The example below shows how the PCEHR page could look for a new patient. This mock-up relates to recommendation CLD.80 in section 8.1 *Overall layout of the PCEHR page*.

There are four main items to be included:

- A document list displaying new clinical documents.
- Most recent shared health summary from the patient's PCEHR.
- Links to PCEHR views (optional).
- An additional document list for displaying historic shared health summaries (note: the most recent one is not included in this list).
- All four items do not necessarily have to be on the same screen but are all part of the PCEHR page.

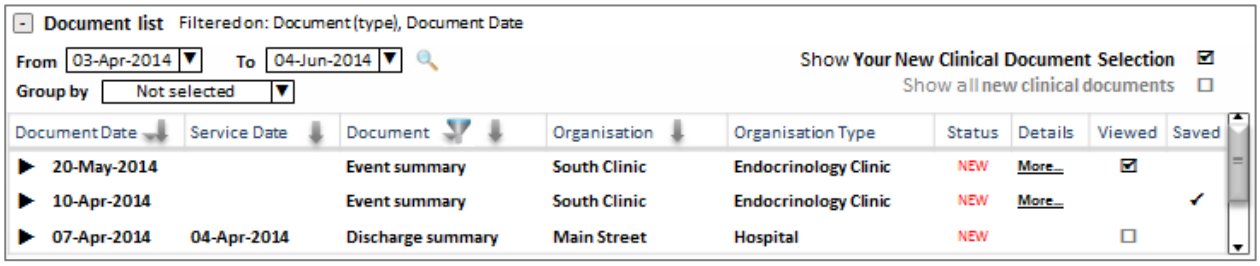


C.5 Default document list displayed on PCEHR page for an existing patient

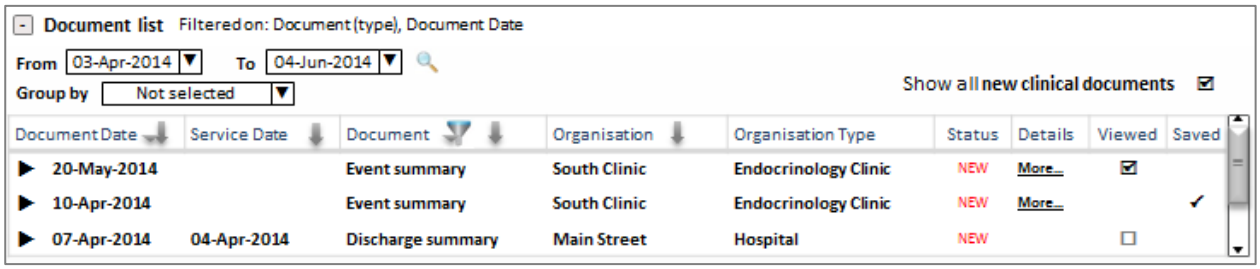
The example below shows how a document list could be displayed on the PCEHR page for an existing patient. These mock-ups relate to recommendations CLD.84, CLD.85 and CLD.86 in section 8.2 *Default display of the documents list on the PCEHR page*.

This mock-up demonstrates how:

- 'From' and 'To' dates are based on the user's timing preferences – for example: 'To' would be the current date while 'From' could be the date of the patient's last visit (if that is the timing preference that has been set by the user).
- 'Group by' is not set.
- The list is sorted by the column Document Date in reverse chronological order.
- The filter icon next to the Document column shows that a filter has been applied (or caption above document list indicating what filters are applied).
- There are two captions above the document list:
  - One shows that the current filter is set to display a subset of the new clinical documents (i.e. all new documents with the exception of those document types that have been specifically excluded by the user);
  - The other allows the user to select and display all new clinical documents.



If the patient has not excluded any clinical document types from being identified as a new clinical document, the caption 'Show Your New Clinical Document Selection' is not displayed:

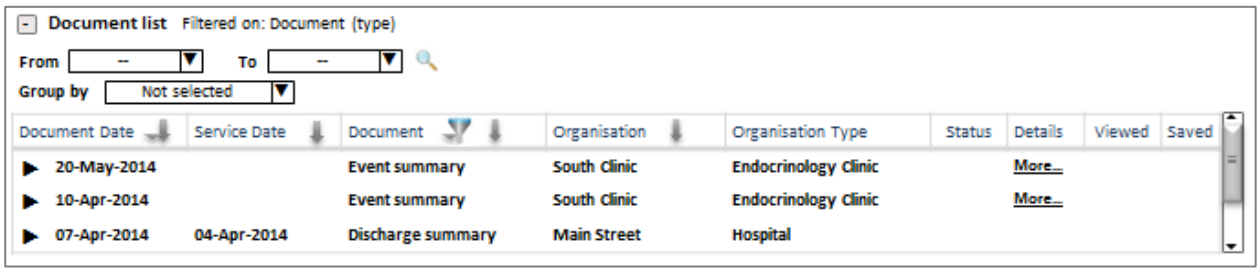


C.6 Default document list displayed on PCEHR page for a new patient

The below is an example of how a document list could be displayed on the PCEHR page for a new patient. This mock-up relates to recommendation CLD.83 in section 8.2 *Default display of the documents list on the PCEHR page*.

This mock-up demonstrates how:

- 'From' and 'To' dates are not set – all clinical documents are listed from the patient's PCEHR.
- 'Group by' is not set.
- The list is sorted by the column Document Date in reverse chronological order.
- The filter icon next to the Document column shows that a filter has been applied (note: users clicking on this filter will be able to see that all clinical document types are selected, while the remaining document types are not selected).
- There are no captions required for a document list for a new patient.



Glossary

Term or abbreviation	Description
Clinical Document Architecture (CDA)	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 CDA Release 2 [HL72005].
clinical document	A digital file containing personal health information about an individual, containing unstructured (narrative) information and optionally structured (atomic) information.
clinical information system	A system that deals with the collection, storage, retrieval, communication, and use of health related data, information and knowledge pertaining to subjects of care [AS5021]. The system may comprise one or more applications or components.
contracted service provider	An entity that may offer health software as a service, and support access to the PCEHR system on behalf of healthcare organisations. A contracted service provider 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]).
existing patient	An existing patient is a healthcare consumer who has attended at least one clinical appointment (at that healthcare provider organisation) and whose patient record has not been archived by the software system or health provider.
healthcare consumer	A person who is the subject of care.
new patient	A new patient is a healthcare consumer who has not attended a clinical appointment (at that healthcare provider organization) OR is a consumer whose patient records have been archived by the software system or health provider.
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 reference online.

NEHTA-1970:2014 *PCEHR Document Exchange Service: Logical Service Specification v1.3.1*, December 2014.

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