Australian Government
Australian Digital Health Agency

Clinical Documents
My Health Record Usability Recommendations

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Document information

Key information

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Product or document version history

Product or document version	Date	Release comments
1.0	24 Oct 2013	*Extracted from Clinical Usability Programme (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 Dec 2014	Revised version, incorporating usability recommendations from CUP R3 and minor editorial updates.
1.3	29 Jan 2016	Revised version, incorporating usability recommendations for recording adverse reactions and various miscellaneous items. Editorial updates to align with latest clinical document specifications, and renaming of PCEHR system to My Health Record system.
1.4	16 Jun 2017	Revised version, incorporating usability recommendations for assisted data import, miscellaneous updates to recommendations for additional clarity and usability in existing areas. Rebrand to Agency document.
1.4	13 May 2025	The document presentation has been enhanced to align with current branding guidelines, however the content has not been changed.

Transition of terms

Certain terms used within the context of this document have changed. The table provides a clear comparison of the historical terms used in text and their current equivalents for your reference.

Historical term	Current term
National eHealth Transition Authority (NEHTA)	The Australian Digital Health Agency (ADHA)
Personally controlled electronic health record (PCEHR)	My Health Record (MHR)

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1 Introduction

1.1 Purpose

It has been recognised that developers of software systems that access the My Health Record system[1] 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 My Health Record 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 My Health Record 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 Agency's Clinical Usability Programme (CUP) in consultation with general practice clinicians.

As the My Health Record system functionality increases and additional document types are added, 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 My Health Record 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 S*hared Health Summary PCEHR Usability Recommendations v1.22*[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;
- My Health Record system functions not related to the authoring and rendering of clinical documents and views exchanged with the My Health Record system; or

[1] Previously known as the personally controlled electronic health record (PCEHR) system.
[2] Links to this and other referenced documents are given in the References section at the end.

- 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 My Health Record 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 Agency 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*.

1.4 How to use this document

How you use this document depends on whether you have used either of the previous versions of this document, which incorporated CUP releases 1, 2 and 3:

- **Version 1.1** – incorporating CUP releases 1 and 2 (R1 and R2). CUP R1 recommendations focused on usability in the creation of a shared health summary document and the display of the My Health Record document list, while CUP R2 focused on the creation of an event summary document. Version 1.1 of this document should be read in conjunction with Shared *Health Summary PCEHR Usability Recommendations v1.1 and Event Summary PCEHR Usability Recommendations v1.0*
- **Version 1.2** – incorporating CUP release 3 (R3). These recommendations focused on the creation of a ‘home page’ when the user opens a patient’s digital health record and also on identifying and indicating new clinical documents in a patient’s digital health record to the user. Version 1.2 of this document should be read in conjunction with *Shared Health Summary PCEHR Usability Recommendations v1.2 and Event Summary PCEHR Usability Recommendations v1.1*

Vendors who have not implemented any CUP recommendations are advised to implement all recommendations listed in this document, to increase usability of their software.

Vendors who have implemented previous releases of CUP recommendations are advised to review the ‘status’ column of each recommendation to determine whether they will need to implement or not, based on the following guidelines:

- *No change from v1.1* – this status means that the recommendation was introduced in either R1 or R2 with no further amendments.
- *No change from v1.2* – this status means that the recommendation was introduced in R3 with no further amendments.
- *Revised for v1.2* – this status means that the recommendation was amended in v1.2 but remains unchanged in v1.3.
- *Revised for v1.3* – this status means the recommendation has been revised in v1.3, to make it clearer.
- *New for v1.3* – this status means the recommendation is new for v1.3.
- *Revised for v1.4* – this status means that the recommendations has been revised in v1.4, to make it clearer.
- **New for v1.4** – this status means the recommendation is new for v1.4.

For details of the changes made to recommendations between the various versions, refer to the *CUP Usability Recommendations – Complete Change Log v1.0*, available on request from the Agency Help Centre.

The shared health summary and event summary specifications have been updated to incorporate a number of CUP recommendations – these are noted throughout this document. If your software conforms to the updated specifications, then those CUP recommendations that have been incorporated are not applicable.

Some recommendations have had editorial changes, for example to change *PCEHR* to *digital health record*, and *PCEHR system* to *My Health Record system*. These changes do not alter the meaning of the recommendation, and are marked as ‘no change’.

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 My Health Record system CDATM 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 not applicable, in relation to Shared Health Summaries, if the system has passed conformance testing against the* Shared Health Summary – PCEHR Conformance Profile v1.6 *or later.* *This recommendation remains applicable for all other relevant clinical documents.*	*Mandatory*	*No change from v1.1*
CLD.137	The software **SHALL NOT** allow a user to record a "none known'' exclusion statement if either of the following scenarios apply: • There are items in the category, but all are un-ticked by a clinician; OR • All items in the category are confidential *Note: When either of the above scenarios apply, the only valid exclusion statements will be "none supplied".*	*Mandatory*	*No change from v1.3*
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 - My Health Record Usability Recommendations.	*Mandatory*	*No change from v1.1*

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	*No change from v1.1*

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*	*No change from v1.1*

ID	Recommendation	Obligation	Status
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*	*No change from v1.1*

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 CDA document's XDS.b metadata shall not be populated.*	*Mandatory*	*No change from v1.1*
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*	*No change from v1.1*

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 document's 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 is not applicable if the system has passed conformance testing against the* PCEHR Document Exchange Technical Service Specification v1.5 *or later*.	*Mandatory*	*No change from v1.1*
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 is not applicable if the system has passed conformance testing against the* PCEHR Document Exchange Technical Service Specification v1.5 *or later.*	*Mandatory*	*No change from v1.1*
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 is not applicable if the system has passed conformance testing against the* PCEHR Document Exchange Technical Service Specification v1.5 *or later*.	*Mandatory*	*No change from v1.1*
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 is not applicable if the system has passed conformance testing against the* PCEHR Document Exchange Technical Service Specification v1.5 *or later*.	*Mandatory*	*No change from v1.1*
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 is not applicable if the system has passed conformance testing against the* PCEHR Document Exchange Technical Service Specification v1.5 *or later*.	*Mandatory*	*No change from v1.1*

ID	Recommendation	Obligation	Status
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 is not applicable if the system has passed conformance testing against the* PCEHR Document Exchange Technical Service Specification v1.5 *or later*.	*Mandatory*	*No change from v1.1*
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 is not applicable if the system has passed conformance testing against the* PCEHR Document Exchange Technical Service Specification v1.5 *or later*.	*Conditional*	*No change from v1.1*
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*	*No change from v1.1*
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*	*No change from v1.1*

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 My Health Record 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 the Agency 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 v1.2*

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 My Health Record 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 v1.2*

CLD.19	*Merged with CLD.18*		*Removed in v1.2*
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 v1.2*

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 My Health Record system. However, providing a notification when a clinical document *has successfully* been uploaded to the My Health Record system 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 patient's digital health record. 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*	*No change from v1.2*

2.7 Prompt to upload to the My Health Record system

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*** (on the local health record) 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 digital health record; 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 dialogue 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*	*Revised for v1.3*
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*	*No change from v1.2*

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 My Health Record 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* My Health Records Act[3]*, 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*	*No change from v1.2*

[3] Previously called the Personally Controlled Electronic Health Records Act 2012 (Cth).

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 v1.2

<table>
<tr><th>ID</th><th>Recommendation</th><th>Obligation</th><th>Status</th></tr>
<tr><td>CLD.61</td><td>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.
This recommendation is not applicable for the following clinical documents if the software system has passed conformance testing against the following versions specified:
<table>
<tr><th>Clinical Document</th><th>Passed conformance testing against:</th></tr>
<tr><td>Shared Health Summary</td><td>Shared Health Summary – PCEHR Conformance Profile v1.6 or later</td></tr>
<tr><td>Event Summary</td><td>Event Summary – PCEHR Conformance Profile v1.4 or later</td></tr>
<tr><td>eHealth Dispense Record</td><td>eHealth Dispense Record – PCEHR Conformance Profile v1.3 or later</td></tr>
<tr><td>eHealth Prescription Record</td><td>eHealth Prescription Record – PCEHR Conformance Profile v1.3 or later</td></tr>
</table>
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. My Health Record system) or point-to-point (e.g. referral). This wider definition is to encourage consistent application and avoid misunderstandings.</td><td>Mandatory</td><td>Revised for v1.4</td></tr>
</table>

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.* *This recommendation is not applicable, in relation to shared health summaries, if the system has implemented against either* the Shared Health Summary Structured Content Specification v1.2 or later *OR* the Shared Health Summary CDA Implementation Guide v1.4 or later. *This recommendation is not applicable, in relation to event summaries, if the system has implemented against either the* Event Summary Structured Content Specification v1.2 or later *OR* the Event Summary CDA Implementation Guide v1.3 or *later*. *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. My Health Record system) or point-to-point (e.g. referral). This wider definition is to encourage consistent application and avoid misunderstandings.*	*Mandatory*	*Revised for v1.4*
CLD.22	*Replaced with CLD.63 and CLD.64.*		*Removed in v1.2*

<table>
<tr><th>ID</th><th>Recommendation</th><th>Obligation</th><th>Status</th></tr>
<tr><td>CLD.63</td><td>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.
This recommendation is not applicable for the following clinical documents if the software system has passed conformance testing against the following versions specified:
<table>
<tr><th>Clinical Document</th><th>Passed conformance testing against:</th></tr>
<tr><td>Shared Health Summary</td><td>Shared Health Summary – PCEHR Conformance Profile v1.6 or later</td></tr>
<tr><td>Event Summary</td><td>Event Summary – PCEHR Conformance Profile v1.4 or later</td></tr>
<tr><td>eHealth Dispense Record</td><td>eHealth Dispense Record – PCEHR Conformance Profile v1.3 or later</td></tr>
<tr><td>eHealth Prescription Record</td><td>eHealth Prescription Record – PCEHR Conformance Profile v1.3 or later</td></tr>
</table>
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. My Health Record system) or point-to-point (e.g. referral). This wider definition is to encourage consistent application and avoid misunderstandings.</td><td>Mandatory</td><td>Revised for v1.4</td></tr>
</table>

ID	*Recommendation*	Obligation	Status
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.* *This recommendation is not applicable, in relation to shared health summaries, if the system has implemented against either the* Shared Health Summary Structured Content Specification v1.2 or *later* OR the Shared Health Summary CDA Implementation Guide v1.4 or *later*. *This recommendation is not applicable, in relation to event summaries, if the system has implemented against either the* Event Summary Structured Content Specification v1.2 *or later OR the* Event Summary CDA Implementation Guide v1.3 *or later*. *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. My Health Record system) or point-to-point (e.g. referral). This wider definition is to encourage consistent application and avoid misunderstandings.*	*Mandatory*	*Revised for v1.4*

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 My Health Record 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”.

<table>
<tr><th>ID</th><th>Recommendation</th><th>Obligation</th><th>Status</th></tr>
<tr><td>CLD.23</td><td>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

<table><tr><th>Medicine</th><th>Directions</th></tr><tr><td>AMOXIL Capsule 250mg</td><td>1 ; 3 times daily</td></tr><tr><td>NEO-B12 Solution for Injection 1000 microgram/mL</td><td>1 ; every 3 months</td></tr><tr><td>AMOXIL Sugar Free Syrup 125mg/5mL</td><td>5mL ; 3 times a day</td></tr></table>
b) Appropriate dose-form text. For example:
1 injection every 3 months

<table><tr><th>Medicine</th><th>Directions</th></tr><tr><td>AMOXIL Capsule 250mg</td><td>1 capsule 3 times daily</td></tr><tr><td>NEO-B12 Solution for Injection 1000 microgram/mL</td><td>1 injection every 3 months</td></tr><tr><td>AMOXIL Sugar Free Syrup 125mg/5mL</td><td>5mL 3 times a day</td></tr></table>
c) Label parts with separating comma “,” with implied dose- form. For example:
Dose: 1, Instructions: every 3 months

<table><tr><th>Medicine</th><th>Directions</th></tr><tr><td>AMOXIL Capsule 250mg</td><td>Dose:1, Frequency: 3 times daily</td></tr><tr><td>NEO-B12 Solution for Injection 1000 microgram/mL</td><td>Dose:1, Instructions: every 3 months</td></tr><tr><td>AMOXIL Sugar Free Syrup 125mg/5mL</td><td>Dose: 5mL, Frequency: 3 times a day</td></tr></table>
The “Directions” data element may have an alternative name, depending on the type of clinical document.

This recommendation is not applicable, in relation to shared health summaries, if the system has passed conformance testing against the Shared Health Summary – PCEHR Conformance Profile v1.6 or later.

This recommendation is not applicable, in relation to event summaries, if the system has passed conformance testing against the Event Summary – PCEHR Conformance Profile v1.4 or later.</td><td>Conditional</td><td>No change from v1.1</td></tr>
</table>

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 not applicable, in relation to shared health summaries, if the system has passed conformance testing against the* Shared Health Summary – PCEHR Conformance Profile v1.6 or later. *This recommendation is not applicable, in relation to event summaries, if the system has passed conformance testing against the* Event Summary – PCEHR Conformance Profile v1.4 *or later*.	*Conditional*	*No change from v1.1*

5 Immunisation sequence number

Applies to: All general practice clinical information systems recording immunisation and vaccination items.

Current GP software systems are not required to offer an immunisation sequence field for users to populate. However, the shared health summary can be populated with a sequence number, which some GP software systems are incorrectly populating with an automatically generated number.

The following recommendations help to ensure that the sequence number is either manually populated by the user or, if automatically generated, can be manually edited by the user.

ID	Recommendation	Obligation	Status
CLD.138	The software **SHALL** allow the user to enter and edit an immunisation sequence number when recording immunisations or vaccination details (or both). *Note: The immunisation sequence number field is optional; that is, the user may choose not to enter a number in the field.*	*Mandatory*	*No change from v1.3*
CLD.139	If an immunisation sequence number is entered, the software **SHALL** include the number when authoring a clinical document (where applicable). *Note: While a shared health summary clinical document includes a sequence number, an event summary does not.*	*Mandatory*	*No change from v1.3*

6 Rendering clinical documents

Applies to: General practice clinical information systems that display My Health Record documents.

6.1 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 My Health Record 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*	*No change from v1.2*

6.2 eHealth Prescription and Dispense View

As a significant number of prescription and dispense records are being uploaded to the My Health Record system, 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 digital health record.

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 My Health Record page.*	*Mandatory*	*Revised for v1.2*

6.3 Medicare Overview

As a significant number of Medicare-sourced records are being uploaded to the My Health Record system, 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 digital health record. 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 My Health Record page.*	*Mandatory*	*No change from v1.2*

6.4 Pathology and diagnostic imaging report views

Release 5 of the My Health Record system enabled pathology and diagnostic imaging organisations to commence the process of modifying their systems to upload pathology and diagnostic imaging reports to the My Health Record system. However, it is not until a significant number of these records are in fact being uploaded to the My Health Record system 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 digital health record. 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 digital health record. It is based on the contents of the consumer's diagnostic imaging report documents.

Both these views are available from Release 5 of the My Health Record system. When significant numbers of pathology and/or diagnostic view reports are being uploaded, the Agency will recommend (in a future version of this document) that these views **SHALL** be implemented. In the interim, the following recommendations apply to 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 conformance profile. *Note: Vendors may wish to consider including links to the Pathology Report View on the My Health Record page*.	*Optional*	*No change from v1.2*
CLD.68	The software **SHOULD** render the eHealth Diagnostic Imaging Report View according to the mandatory requirements in its conformance profile. *Note: Vendors may wish to consider including a link to the eHealth Diagnostic Imaging Report View on the My Health Record page.*	*Optional*	*No change from v1.2*

6.5 Configuration of My Health Record 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 My Health Record views that the Agency has recommended **SHALL** be implemented. *Note: User may choose to disable access to one or more My Health Record views (recommendation CLD.70).*	*Mandatory*	*No change from v1.2*
CLD.70	The software **SHALL** enable the user to disable access to one or more My Health Record views. The software **SHALL** indicate that the My Health Record view is disabled. *Note: Disabling access could be in the form of greying out and disabling the link to the My Health Record view.* *This should be an administrative task rather than part of the clinical workflow (e.g. under user administration settings).*	*Mandatory*	*No change from v1.2*
CLD.71	If a user chooses to disable access to a My Health Record view, the software **SHALL** provide advice (or contextual help) that the user can still see the documents from the document list on the My Health Record 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 My Health Record page, refer to section 10 My Health Record page*.	*Mandatory*	*No change from v1.2*

7 Recording adverse reactions

Applies to: General practice clinical information systems.

The intent of these guidelines is to better standardise the way adverse reactions are recorded and exchanged in clinical information systems through:

1 The definition of a minimum data set for adverse reaction records, including a 'reaction type' data element.

2 Consistent naming of data elements across clinical systems.

3 Use of standardised clinical terminology for recording 'reaction type', 'substance/agent' and 'clinical manifestation'. These terms are sourced from the Australian Medicines Terminology (AMT) and SNOMED CT-AU.

Throughout this document, the term 'adverse reactions' refers to both allergic and non-allergic reactions.

The majority of clinical information systems today support entry of adverse reactions in the patient record as structured information. However, currently there is a lack of standardisation and consistency across these systems in several important areas:

- **Naming of 'adverse reactions'**. For example, adverse reactions (both allergic and non-allergic) are referred to as 'allergies' in many clinical systems.
- **Information captured about an adverse reaction**. Clinical systems inconsistently support the attributes 'reaction type', 'clinical manifestation' (often confusingly referred to as 'reaction type'), 'severity', 'date of onset' (or the date an adverse drug event occurred) and 'date recorded'. There is also a lack of consistency in the naming of these elements from one clinical system to the next.
- **Adverse reactions terminology**. Software vendors have each developed their own terminologies, reference sets and lookup lists containing the clinical concepts displayed and available for selection when recording adverse reactions. This lack of consistency in clinical terminology is a significant barrier to machine interoperability of adverse reactions information exchanged between clinical systems.

Due to the clinical significance of adverse reactions, they are normally conspicuously displayed on the patient record and included in clinical correspondence. Furthermore, clinical document authoring tools typically include these details by default to streamline the authoring process. Structured and coded adverse reactions are evaluated by the active clinical decision support tools (i.e. contraindication checking) during the medication prescribing process.

The 'reaction type' data element is a member of the adverse reaction minimum data set, and is currently present in many (but not all) clinical systems today. 'Reaction type' is an important piece of clinical information – it is useful to be able to differentiate between different reaction types in order to aid clinical decision making. For example, if a clinician is aware that a patient suffers side effects with a specific medication rather than it causing an allergic reaction, then they may still administer that particular medication in a life-threatening situation.

'Reaction type' is present in the Agency's Discharge Summary specification and was incorporated in the Agency's Shared Health Summary and Event Summary specifications, revised in 2015. The Agency currently plans to incorporate 'reaction type' in other relevant clinical document types (i.e. eReferral and Specialist Letter) in the near future.

A standardised list of reaction types consistently applied in software systems will result in more complete information recorded about patient adverse reactions. More complete and consistent information will aid clinical comprehension and decision making, which, in turn, will result in positive patient safety outcomes. Use of a standardised list of reaction types will also facilitate simple data entry at an appropriate level of detail, whether it be a clinician, an allergy specialist or a registered nurse recording the adverse reaction.

The recommendations in this section also provide usability guidance on the implementation of SNOMED CT-AU reference sets for the recording of adverse reactions within the general practice clinical information system, and the creation of clinical documents with SNOMED CT-AU codes as appropriate for adverse reactions.

These recommendations apply to any general practice clinical information systems with the ability to record adverse reactions in the local record or in clinical documents that conform to Agency specifications.

7.1 Recording adverse reactions in local CIS

As most general practice clinical information systems (CIS) currently support recording of adverse reactions, the following recommendations are intended to standardise the minimum data set and clinical terminology used to record adverse reaction information.

ID	Recommendation	Obligation	Status
CLD.107	The software **SHALL** capture the following minimum data set in the local record for newly recorded adverse reactions: • Reaction type • Substance/agent • Clinical manifestation • Date of onset *Note: Substance/agent and clinical manifestation are already captured in the majority of clinical information systems today. The 'date of onset' is **not** the date when the user recorded the adverse reaction, but the date when the adverse reaction occurred.*	*Mandatory*	*No change from v1.3*
CLD.108	The software **SHALL** ensure that existing records of adverse reactions in the local record are unchanged and can still be displayed and edited. *Note: the minimum data set requirements (as set out in CLD.107) do not apply retrospectively to historical records, which remain viewable and editable within the software. Where there is no legacy data to be displayed for new field/s, the new field/s shall be left blank*.	*Mandatory*	*No change from v1.3*

ID	Recommendation	Obligation	Status
CLD.109	The software **SHALL** allow the 'date of onset' to be recorded as: • day, month and year; OR • month and year only; OR • year only; OR • not known.	*Mandatory*	*No change from v1.3*
CLD.110	The software **MAY** allow additional details (e.g. comments) to be recorded about an adverse reaction in the local CIS. *Note: Most clinical information systems already support entry of extra information beyond the minimum data requirements, as set out in CLD.107*.	*No obligation*	*No change from v1.3*
CLD.111	When there are no existing adverse reactions recorded on the patient's record, the software **SHALL** offer the option to indicate 'no known adverse reactions' in the local CIS. *Note: This is a positive statement by the user that the patient does not have any known adverse reactions. It correlates to the 'none known' exclusion statement in clinical documents. It is different to the state of 'unknown' which is supported in clinical documents by exclusion statements 'not asked' and 'none supplied'. Refer to recommendations in section 2.1 of this document on how exclusion statements are to be implemented.*	*Mandatory*	*No change from v1.3*
CLD.112	The software **SHALL** record the day, month and year when 'no known adverse reactions' has been indicated in the local CIS. This date is system generated.	*Mandatory*	*No change from v1.3*

7.1.1 Recording the substance/agent

Clinical information systems generally support the capture of a 'substance/agent' when adverse reactions are entered. The following recommendations are intended to standardise the clinical terminology used when recording 'substance/agent'.

ID	Recommendation	Obligation	Status
CLD.113	The software **SHOULD** use SNOMED CT-AU or AMT (or both) as the preferred terminology for recording a medicinal substance/agent. *Note: When the software obtains its 'substance/agent' terms from a medicines catalogue that forms part of an integrated clinical decision support system, then this decision support system may also need to support SNOMED CT-AU and AMT in order to support its interaction checking functionalities.* *It is anticipated that this recommendation will become mandatory in the future.*	*Optional*	*No change from v1.3*
CLD.114	The software **SHALL** use SNOMED CT-AU as the preferred terminology for recording a non-medicinal substance/agent.	*Mandatory*	*No change from v1.3*

ID	Recommendation	Obligation	Status
CLD.115	The software **SHOULD** search and display concepts from the *SNOMED CT-AU Non-medicinal adverse reaction agent reference set* when a user records a non-medicinal substance/agent. *Note: SNOMED CT-AU Non-medicinal adverse reaction agent reference set is a convenient and comprehensive (but not exhaustive) source of common non-medicinal agents. Less frequently encountered terms may be found elsewhere within the terminology that are not part of the reference set*.	*Optional*	*No change from v1.3*
CLD.116	When a user records a non-medicinal substance/agent that can be represented with a SNOMED CT-AU concept, the software **SHALL** store the SNOMED CT-AU concept's `preferredTerm` and its concept identifier in the local record. *Note: SNOMED CT-AU must be implemented as the interface terminology for recording non-medicinal substances.*	*Mandatory*	*No change from v1.3*
CLD.117	The software **MAY** allow the user to create user-defined non- medicinal substance/agent entries that appear for selection. *Note: Vendors may choose to continue supporting user-defined entries if the relevant SNOMED CT-AU concept cannot be readily identified.*	*No Obligation*	*No change from v1.3*
CLD.118	The software **SHALL NOT** allow users to directly enter free text in the substance/agent field when recording an adverse reaction. *Note: The intention is that, while users can set up predefined (but uncoded) substances/agents, they are prevented from entering free text directly. The objective is to prevent users from always entering free text, as this minimises the use of coded standardised data*.	*Mandatory*	*No change from v1.3*

7.1.2 Recording the reaction type

For many vendor systems, the 'reaction type' data element will be a new data element to capture when recording adverse reactions. The following recommendations are usability guidelines for implementing this data element.

ID	Recommendation	Obligation	Status
CLD.119	An adverse reaction stored in the local record **SHALL** contain only one reaction type.	*Mandatory*	*No change from v1.3*
CLD.120	The software **SHALL** search and display concepts from the *SNOMED CT-AU Reaction type reference set* when a user records a reaction type. These concepts are listed in Appendix D. *Note: SNOMED CT-AU must be implemented as the interface terminology for recording reaction type*.	*Mandatory*	*No change from v1.3*

ID	Recommendation	Obligation	Status
CLD.121	When a user records a reaction type, the software **SHALL** store the SNOMED CT-AU concept's `preferredTerm` and its concept identifier in the local record. These concepts are listed in Appendix D. *Note: SNOMED CT-AU must be implemented as the interface terminology for recording reaction type.*	*Mandatory*	*No change from v1.3*
CLD.122	The software **SHALL** ensure that the following hierarchy of reaction types is clearly represented; that is, the more specialised reaction types are grouped within their parent level reaction type when displayed in a list. Adverse reaction Allergic reaction Hypersensitivity type I Hypersensitivity type II Hypersensitivity type III Hypersensitivity type IV Non-allergic reaction Drug interaction Drug interaction with drug Drug interaction with food Food intolerance Medication side-effect Toxicity *Note: The respective SNOMED CT-AU codes for each of the reaction type are available in Appendix D.* *The user is able to select any of the reaction types listed above.*	*Mandatory*	*No change from v1.3*
CLD.123	The software **SHALL** set the default Reaction Type to `Adverse reaction' when the user initiates the process for adding a new adverse reaction on the local CIS.	*Mandatory*	*No change from v1.3*

ID	Recommendation	Obligation	Status
CLD.124	The software **SHALL** ensure that illogical pairings of substance/agent and reaction type cannot be recorded as an adverse reaction event. For example, the following pairings are invalid: **Substance/agent type** / **Reaction Type** Medicinal / Food intolerance Non-medicinal / Drug interaction with drug Non-medicinal / Medication side-effect *Note: It is at the vendor's discretion to choose how to implement this recommendation. Options include disabling the item for selection or removing the item from the options altogether.* *Vendors may choose to allow the user to select the reaction type first and then modify the options available to the user when selecting substance/agent. For example, if the user selects 'Food intolerance', then the software should not allow the user to select a medicinal substance/agent.*	*Mandatory*	*No change from v1.3*

7.1.3 Recording the clinical manifestation

Current software already captures clinical manifestation when recording adverse reactions. The following recommendations are additional enhancements to the current workflow making use of clinical terminology to ensure consistency and to standardise the values that the 'clinical manifestation' field may contain.

ID	Recommendation	Obligation	Status
CLD.125	The software **SHALL** allow an adverse reaction to be recorded in the local record with a clinical manifestation of 'Not Recorded'.	*Mandatory*	*No change from v1.3*
CLD.126	The software **SHALL** search and display concepts from the *SNOMED CT-AU Clinical manifestation reference set* when a user records a clinical manifestation	*Mandatory*	*No change from v1.3*
CLD.127	When a user records a clinical manifestation, the software **SHALL** store the SNOMED CT-AU concept's `preferredTerm` and its concept identifier in the local record.	*Mandatory*	*No change from v1.3*
CLD.128	The software **SHALL** allow multiple clinical manifestations to be recorded against an adverse reaction.	*Mandatory*	*No change from v1.3*

7.2 Authoring adverse reactions on clinical documents

The following recommendations are usability guidelines on how adverse reactions should be incorporated into clinical documents, mainly to ensure that the 'reaction type' data element is included along with the 'substance/agent' and 'clinical manifestation' data elements.

ID	Recommendation	Obligation	Status
CLD.129	The software **SHALL** conform to the following requirement IDs in the *Clinical Terminology - Guidance for Use of Medicinal Nomenclatures in Information Exchange*: 020638, 020639, 020641, 020642, 020643, 022524, 022525	*Mandatory*	*No change from v1.3*
CLD.130	The software **SHALL** conform to the requirements for at least one of the use cases described in the Clinical Terminology - Guidance for Use in Healthcare Software.	*Mandatory*	*No change from v1.3*
CLD.131	If event summaries have been implemented, the software **SHALL** conform to version 1.4 or later of the *Event Summary PCEHR Conformance Profile*. *Note: version 1.4 and later of the Event Summary PCEHR Conformance Profile includes the data element 'reaction type' in the adverse reaction section of an Event Summary clinical document.*	*Conditional*	*No change from v1.3*
CLD.132	If shared health summaries have been implemented, the software **SHALL** conform to version 1.6 or later of the *Shared Heath Summary PCEHR Conformance Profile*. *Note: version 1.6 and later of the Shared Health Summary PCEHR Conformance Profile includes the data element 'reaction type' in the adverse reaction section of a Shared Health Summary clinical document.*	*Conditional*	*No change from v1.3*
CLD.133	When authoring clinical documents, the software **SHALL** include the 'reaction type' data element in the adverse reactions structured data section of the clinical document, *unless* a clinical manifestation is not recorded. *Note: Inclusion of reaction type is optional by default. The effect of this recommendation is to make the reaction type a mandatory data element.* *This recommendation currently only applies when authoring Shared Health Summary and Event Summary clinical documents as per recommendations CLD.131 and CLD.132.* *It is anticipated that the following clinical document content specifications will be updated in the future: eReferral, Specialist Letter, Discharge Summary.* *Adverse reactions that were recorded before the introduction of the reaction type as a mandatory data element may be uploaded to the clinical document with a blank reaction type.*	*Mandatory*	*Revised for v1.4*

ID	Recommendation	Obligation	Status
CLD.134	When authoring clinical documents, the software **SHALL** include all recorded data elements from the minimum adverse reaction data (as set out in recommendation CLD.107) in the adverse reaction narrative section of the clinical document. *Note: This recommendation applies to all applicable clinical document types that contain an adverse reaction section, including, but not limited to: Shared Health Summary, Event Summary, eReferral, Specialist Letter, Discharge Summary.*	*Mandatory*	*No change from v1.3*
CLD.135	When authoring clinical documents, the software **MAY** include additional adverse reaction data (captured in the local CIS) in the adverse reaction narrative section of the clinical document. *Note: This recommendation applies to all applicable clinical document types that contain an adverse reaction section, including, but not limited to: Shared Health Summary, Event Summary, eReferral, Specialist Letter, Discharge Summary*.	*No obligation*	*No change from v1.3*

7.3 Displaying adverse reactions

The following recommendations provide usability guidance on the display of adverse reactions in the general practice clinical information system.

ID	Recommendation	Obligation	Status
CLD.136	The software **SHALL** display one of the following section headings where adverse reactions are recorded and displayed in the local CIS: • Adverse reactions; OR • Allergies and adverse reactions *Note: Examples of headings that are not recommended include: Allergies, Allergic reactions.*	*Mandatory*	*No change from v1.3*

8 Assisted data import from a clinical document

Applies to: Any clinical information system that incorporates the Australian Medicines Terminology (AMT) and/or SNOMED CT-AU, and is capable of displaying clinical documents.

Purpose and Scope

The purpose of these guidelines is to improve and better standardise the method of transferring discrete information from clinical documents to local records.

The scope of these guidelines is limited to transfer of medicines and adverse reactions information as prioritised by the Clinical Usability Programme. This scope may be expanded in the future once it is determined how best to incorporate other clinical document content into local records.

Background

Clinical documents are routinely exchanged between healthcare providers to convey important medical information about patients. This exchange of clinical correspondence is an essential ingredient for effective 'continuity of care' when responsibility for patient care transfers between healthcare providers. For example, a clinician about to provide care to a patient may not have up-to-date medical records for the patient. An accompanying clinical note (e.g. referral, discharge summary, specialist letter) prepared by the patient's usual healthcare provider or referring clinician is therefore crucial to convey a proper understanding of, for example, the:

- medicines that the patient is currently taking, including medicines recently commenced or ceased;
- known adverse reactions to medicines and other substances;
- medical history including problems, procedures and diagnoses;
- recent investigations relevant to the encounter.

The usual practice at healthcare facilities using electronic medical record systems is to store clinical documents (in their entirety) as attachments to the local patient record. Clinical documents are stored directly, when received in electronic format, or as a scanned fax/hardcopy. A clinical document recorded in this manner appears within the "correspondence" section in the patient record where it is available for future reference. However, this action cannot update the key elements of the medical record (e.g. current medicines, known adverse reactions, medical history) that appear most prominently on the medical record, and are most frequently referred to when making treatment decisions.

Once a clinical document has been attached to the local patient record and reviewed, the clinician must decide what key information needs to be incorporated in the medical record. For example, a general practitioner reviews a discharge summary for one of their regular patients recently admitted to hospital, and notes their patient had been started on a new medicine during their stay, to continue post-discharge. The practitioner is in agreement with the treatment plan and decides to record the medicine in the 'current medicines' list within their local record so that a prescription can be printed. In clinical information systems today this seemingly simple action generally requires the manual transcription of

multiple discrete information elements from the clinical document to the relevant section(s) in the local record.

'Assisted data import' is software functionality designed to help clinicians streamline what is currently a cumbersome (and potentially error-prone) manual transcription process. It becomes practical when the clinical information systems used to exchange these documents implement common information standards including HL7 CDA clinical document formats, the Australian Medicines Terminology, and SNOMED CT-AU to describe medical concepts.

Assisted data import can be activated by a clinician following review of a clinical document if it meets minimum information standards relating to document structure. The clinician, having read the document, may activate an assisted data import option; for example assisted medicines or assisted adverse reactions import. When the assisted medicines import option is chosen, the clinician will be presented with side-by-side lists of the medicines contained in both the clinical document and the local record. From this screen visual comparisons can be readily made between the two lists, making apparent any changes to the patient's medicines regime, and what changes (if any) should be made in the local record to bring it up-to-date.

From an *assisted import screen*, a discrete entry in the local system may be directly edited in the same manner these entries could be edited from elsewhere in the clinical information system such as from the prescribing screen. Making this functionality available from the clinical document view can streamline the process of bringing together the relevant information onscreen in the one place.

Assisted import allows structured information to be 'imported' from a clinical document, replacing manual transcription with clicks or keystrokes. For example, when a clinician chooses to import a medicine through assisted data import, the software will take the structured/coded medicine information from the document entry and prepopulate the corresponding fields in the data entry screen used to record a new medicine in the local record (including preselection of the medicine from the local medication catalogue where linked to the Australian Medicines Terminology). Once the clinician has verified the information, entered any additional information, they may complete the process of adding the medicine to the local record or cancel the process.

These guidelines have been developed on the basis that:

- the decision to update medical information in the local record must only be made and acted on by a skilled clinician, not a computer;
- the presence of 'machine interpretable' information in a clinical document is dependent upon the capabilities of the clinical information system used by the clinician to produce the document;
- computers cannot reliably interpret information unless it is in a 'structured' format that meets minimum information standards. Software interpretation of unstructured or semi-structured documents is not wholly reliable, thus the conclusion must be that in order to safeguard the integrity of local records and patient safety, assisted data import can only be offered to clinicians when the clinical document meets minimum data quality and information standards; and
- a clinical document must conform to a structured template (conformance level 3A or 3B) recognised by the clinical information system performing assisted data import in order for it to be a suitable candidate for assisted data import.

8.1 Onscreen display of clinical document structured data

Onscreen display of clinical document structured data gives clinicians a facility to read (in a human readable format) the structured 'machine interpretable' data recorded in a clinical document that is usually hidden from display.

This view of the structured data is displayed alongside the clinical document narrative allowing side-by-side comparisons to be made. While the narrative component of a clinical document is seen/witnessed by the document author, the corresponding structured data is produced by the clinical information system and is not normally displayed to the author and there may be differences between the document narrative and structured data.[4]

A skilled clinician, through visual comparison of the structured data and document narrative, can satisfy themselves that they wish to proceed with assisted data import on the basis that he:

- has identified the structured data that is in reasonable or complete agreement with the document narrative; and
- is alert to information (if any) recorded in the document narrative that contradicts, provides supporting context, or more accurately describes that represented as structured data in the document.

ID	Recommendation	Obligation	Status
CLD.141	The software **SHALL** conform to the following requirements in the *Clinical Terminology – Guidance for Use of Medicinal Nomenclatures in Information Exchange*: • 020652; and • 020653.	*Mandatory*	***NEW for v1.4***
CLD.142	When a clinical document of conformance level 3A or 3B is displayed, and the clinical document contains structured data, the software **SHALL** provide the user with the option to view the structured data in a human readable format. *Note: This option could be provided through a button, expanding section, or similar user interface element.*	*Mandatory*	***NEW for v1.4***
CLD.143	When a clinical document is displayed that does NOT conform to level 3A or 3B template package, or the clinical document does NOT contain any structured data, the software **SHALL NOT** provide the user with the option to view the structured data.	*Mandatory*	***NEW for v1.4***
CLD.144	When structured data is displayed, it **SHALL** be arranged such that: a) Document narrative displayed on the left side; and b) Structured data displayed on the right side.	*Mandatory*	***NEW for v1.4***

[4] The policy that applies to certain clinical documents, including the eHealth Prescription Record and eHealth Dispense Record, is that the document narrative is derived entirely from the structured data and therefore the two representations are equivalent. While visual comparison is unnecessary in these cases, it will be readily apparent upon cursory review that the two datasets are indeed equivalent, and a consistent process that applies to all document types is preferable in order to simplify software design and workflow.

ID	Recommendation	Obligation	Status
CLD.145	When structured data is displayed, the software **SHALL** provide the user with the option to initiate assisted medicines import or *assisted adverse reactions import*. *Note: This could be implemented by displaying buttons labelled "Assisted medicines import" and "Assisted adverse reactions import" adjacent the structured medicines and structured adverse reactions lists, respectively.*	*Mandatory*	***NEW for v1.4***

8.2 Assisted medicines import

Assisted medicines import is designed to reduce amount of information that needs to be manually transcribed from a clinical document when the decision is made by a clinician to incorporate a medicine recorded in a document in their local record. The assisted medicines import screen will display a side-by-side view of the current medicines in the healthcare recipient's local record and medicines recorded in the clinical document.

Note: Assisted medicines import is only available when the source clinical document is a structured document that meets conformance level 3A or 3B and contains structured medicines information. This constraint ensures that source document is compliant with the associated Structured Document Template thus ensuring that a standards-compliant clinical information system providing assisted medicines import can safely and reliably interpret its structured information.

8.2.1 Assisted medicines import screen

ID	Recommendation	Obligation	Status
CLD.146	The software **SHALL** display an *assisted medicines import* screen with the following statement prominently displayed near the top of the screen: "This medicines list may not be a complete list of medicines included in the clinical document. Before importing medicines into your patient's local record, it is important to review the full clinical document for any information contradicting that shown here." Below this statement the following lists are displayed side-by- side: a) The list of current medicines from the local record on the left side (titled: 'local medicines list'); and b) The list of structured medicines from the clinical document on the right side (titled: 'clinical document medicines list'). *Note: Clinicians advised that side-by-side viewing of the lists of medicines from the healthcare recipient's local record and the clinical document is the most effective way to compare two lists when carrying out this reconciliation activity. It is preferable to display medicines lists on separate computer screens (where available) to maximise working area and minimise scrolling.*	*Mandatory*	***NEW for v1.4***

ID	Recommendation	Obligation	Status
CLD.147	The *local medicines list* **SHALL** include all medicines information (including column headings) displayed elsewhere in the software. *Note: Adopting a consistent local medicines list format across the system will aid comprehension by clinicians.*	*Mandatory*	***NEW for v1.4***
CLD.148	If horizontal scroll bars (or similar) are used to display information in the local medicines list, then the software **SHOULD** 'freeze' the first column (medicine name) when scrolling if doing so improves readability of the medicines list. *Note: It is expected that in many cases it will not be possible to display all columns onscreen simultaneously and that horizontal scroll bars will allow a user to view all of the information.*	*Optional*	***NEW for v1.4***
CLD.149	The software **SHALL** ensure that the first three columns displayed in the *local medicines list* contain the following information: a) Medicine name b) Directions c) Quantity dispensed (if captured by the local system) *Note: The above column headings are not prescriptive and the names chosen should be those used elsewhere in the software for consistency – see recommendation **CLD.151**.*	*Mandatory*	***NEW for v1.4***
CLD.150	The software **SHALL** ensure the remainder of the columns displayed in the *local medicines list* are maintained in the same display order as they appear in the medication chart or medicines list elsewhere in the software.	*Mandatory*	***NEW for v1.4***
CLD.151	The software **SHALL** ensure the *local medicines list* column headings match those in the medication chart or medicines list elsewhere in the local record.	*Mandatory*	***NEW for v1.4***
CLD.152	The software **SHALL** display items in the *local medicines list* in the same order as these items are normally listed elsewhere in the local record.	*Mandatory*	***NEW for v1.4***
CLD.153	The *clinical document medicines list* **SHALL** include a column for each structured medication attribute contained in the clinical document. *Note: Refer to Appendix 1 for the clinical document attributes (by document type) that are to be displayed in the clinical document medicines list.* *Vendors should refer to the relevant structured content specifications for further information about how medicines information is represented in each document types.* *A horizontal scroll bar may be needed to display all columns on the one screen.*	*Mandatory*	***NEW for v1.4***

ID	Recommendation	Obligation	Status
CLD.154	The software **SHALL** ensure that the first four columns displayed in the *clinical document medicines list* have the following headings: a) Medicine name b) Directions c) Quantity dispensed d) Clinical indication *Note: This applies regardless of whether or not there is content from the clinical document to populate each column. Refer to Appendix 1 to identify which data element in each clinical document corresponds to the above columns.*	*Mandatory*	***NEW for v1.4***
CLD.155	The software **SHALL** display the items in *the clinical document medicines list* in the same order as these items are recorded in the structured data section of the clinical document.	*Mandatory*	***NEW for v1.4***
CLD.156	The software **SHALL** populate the *clinical document medicines list* with the relevant structured data contained in the clinical document in accordance with requirement 020652 from the *Clinical Terminology – Guidance for Use of Medical Nomenclature in Information Exchange*.	*Mandatory*	***NEW for v1.4***
CLD.157	The software **SHALL** provide a facility to view the clinical document narrative and *clinical document medicines list* side- by-side within the *assisted medicines import* screen. *Note: This facility is to ensure that at all times a user may perform visual comparison of medicines information in the clinical document narrative with structured representations displayed in the clinical document medicines list. The clinical document narrative may contain qualifying information about the structured representation that the clinician should be informed about. It is also possible that the clinical document narrative could contain contradictory information and this poses a clinical safety risk if inaccurate information is relied upon. A facility to display both the clinical document and clinical document medicines list onscreen simultaneously permits the most direct visual comparison of medicines information.* *Assisted medicines import should only be performed on computers and mobile devices with sufficient screen size to display this required information.*	*Mandatory*	***NEW for v1.4***

8.2.2 Adding a medicine

ID	Recommendation	Obligation	Status
CLD.158	The software **SHALL NOT** allow a medicine to be imported through *assisted medicines import* unless the medicine is identified with an AMT version 3 concept. *Note: An AMT-enabled source system used to produce clinical documents may adopt an interface terminology (e.g. MIMS, AZdex, Multum-AU) with terms used to describe medicines with minor lexical differences to semantically equivalent terms in the AMT. The recommended practice for these so-called "mapped" AMT implementations is to represent the equivalent AMT concept in a CDA translation element. Medicines recorded in this manner are suitable for assisted import.*	*Mandatory*	***NEW for v1.4***
CLD.159	The software **SHALL** allow the user to select a medicine from the *clinical document medicines list* to import into the local record. *Note: An assisted medicine import could be initiated by double clicking on the medicine row or by providing a tick box for each medicine on the clinical document, etc.*	*Mandatory*	***NEW for v1.4***
CLD.160	Upon selecting a medicine to incorporate from the clinical document to the local record, the software **SHALL** commence the existing workflow for creating a new prescription or for recording a new medicine. *Note: The system will perform the usual checks and prompting, such as duplicate medication checking and adverse reaction alerting, as is usual when a new medicine or prescription is recorded*.	*Mandatory*	***NEW for v1.4***
CLD.161	When displaying the screen to record a new medicine or prescription, the software **SHALL** ensure that the details of the item selected from the *clinical document medicines list* are clearly visible. *Note: This is to ensure that the source medicine record (i.e. the highlighted item in the clinical document medicines list) can be referred to if the clinician modifies the prepopulated entries.*	*Mandatory*	***NEW for v1.4***
CLD.162	The software **SHALL** pre-populate the data entry screen with the details of the selected medicine. *Note: It is anticipated that the following data fields from the clinical documents can be used to pre-populate corresponding fields when creating a new prescription:* • *Medicine / Therapeutic Good ID* • *Directions / Dose Instruction* • *Clinical Indication / Reason for Therapeutic Good* • *Unit of Use Quantity Dispensed* *Refer to Appendix 1 – List of data elements in the medicines section of a clinical document to determine which data fields can be used to pre-populate corresponding fields for each clinical document type.*	*Mandatory*	***NEW for v1.4***

ID	Recommendation	Obligation	Status
CLD.163	When creating new prescription or new medication, if the selected medicine can be mapped to an item in the local medicine catalogue, the software **SHALL** pre-populate the medicine name field on the entry screen. *Note: Vendors should refer to both the Clinical Terminology – Use of Medical Nomenclatures in Information Exchange v1.0 and the Clinical Terminology – Guidance for Use in Healthcare Software v1.0 for further details on implementing AMT.*	*Conditional*	***NEW for v1.4***
CLD.164	The software **SHALL** clearly highlight any fields on the entry screen that have been pre-populated with information from the source clinical document.	*Mandatory*	***NEW for v1.4***
CLD.165	Any information about the selected medicine that cannot be transferred to the entry screen **SHALL** be clearly highlighted.	*Mandatory*	***NEW for v1.4***
CLD.166	The software **SHALL** allow the user to 'copy & paste' information from the selected medicine into the data entry fields.	*Mandatory*	***NEW for v1.4***
CLD.167	The software **SHALL** provide the option (through *assisted medicines import*) for a user to add a medicine to the local record without prescribing it. *Note: Many software systems currently implement this by allowing the user to deselect the option to print the prescription.*	*Mandatory*	***NEW for v1.4***
CLD.168	The software **SHOULD** provide the option (through assisted medicines import) for a user to indicate if the medicine is being prescribed elsewhere. *For example, the system may provide a 'prescribed elsewhere' indicator for the user to select.*	*Optional*	***NEW for v1.4***
CLD.169	If the software allows the user to record that the medicine is being prescribed elsewhere, the software **SHOULD** indicate this when the medicine is displayed in the local record. *For example, by providing an additional column displaying 'yes' if the medicine was 'prescribed elsewhere'*.	*Conditional*	***NEW for v1.4***
CLD.170	The software **SHALL** display an indicator adjacent to the clinical document medicines list item if it has been successfully imported into the local record during the current assisted import session. *Note: Appropriate visual indicators include use of icons or colour coded text.*	*Mandatory*	***NEW for v1.4***

8.2.3 Editing local medicine record

ID	Recommendation	Obligation	Status
CLD.171	The software **SHALL** allow the user to interact with the *local medicines list* to perform tasks that can be performed through the medication chart or medication list. These tasks might include edit, cease, re-prescribe, remove etc. *Note: Users should be able to access this functionality in the same manner they would normally, for example, right click to display a drop down menu with action items*.	*Mandatory*	***NEW for v1.4***
CLD.172	When the user chooses to modify an item in the *local medicines list*, the software **SHALL** ensure that items from the *clinical document medicines list* remain clearly displayed onscreen. For example, when a screen is displayed allowing the user to edit details of a medicine, this screen does not obscure the underlying clinical document medicines list. *Note: This is to assist the user if they wish to update an existing medicine in the local record with details from a medicine listed in the clinical document.*	*Mandatory*	***NEW for v1.4***

8.3 Assisted adverse reactions import

Assisted adverse reactions import is designed to reduce the amount of information that needs to be manually transcribed from a clinical document when the decision is made by a clinician to incorporate an adverse reaction recorded in a document into their local record. The assisted adverse reactions import screen will display a side- by-side view of the known adverse reactions in the healthcare recipient's local record and adverse reactions data recorded in the clinical document.

Note: *Assisted adverse reactions import* is only available when the source clinical document is a structured document that meets conformance level 3A or 3B and contains structured adverse reactions information. This constraint ensures that the source document is compliant with the associated Structured Document Template thus ensuring that a standards-compliant clinical information system providing *assisted adverse reactions import* can safely and reliably interpret its structured information.

8.3.1 Assisted adverse reactions import screen

ID	Recommendation	Obligation	Status
CLD.173	The software SHALL display an assisted adverse reactions import screen with the following statement prominently displayed near the top of the screen: "This adverse reactions list may not be a complete list of adverse reactions included in the clinical document Before importing adverse reactions into your patient's local record, it is important to review the full clinical document for any information contradicting that shown here." Below this statement, the following lists are displayed side-by-side: a) The list of adverse reactions from the local record on the left side (titled: 'local adverse reactions list'); and b) The list of adverse reactions from the clinical document on the right side (titled: 'clinical document adverse reactions list'). *Note: Clinicians advised that side-by-side viewing of the lists of adverse reactions from the healthcare recipient's record and the clinical document is the most effective way to compare two lists when carrying out this reconciliation activity. It is preferable to display these lists on separate computer screens (where available) to maximise working area and minimise scrolling.*	*Mandatory*	***NEW for v1.4***
CLD.174	The local adverse reactions list SHALL include all adverse reactions information (including column headings) displayed elsewhere in the software. Note: Adopting a consistent local adverse reactions list format across the system will aid comprehension by clinicians.	*Mandatory*	***NEW for v1.4***
CLD.175	The software SHALL ensure that the first three columns displayed in the local adverse reactions list contain the following information: a) Substance/agent b) Manifestation/s c) Reaction type *Note: The above column headings are not prescriptive and the names chosen should be those used elsewhere in the software for consistency – see recommendation **CLD_177**.*	*Mandatory*	***NEW for v1.4***
CLD.176	The software SHALL ensure the remainder of the columns displayed in the *local adverse reactions list* are maintained in the same display order as they appear elsewhere in the software.	*Mandatory*	***NEW for v1.4***
CLD.177	The software SHAL**L** ensure the *local adverse reactions list* column headings match those listed elsewhere in the software.	*Mandatory*	***NEW for v1.4***
CLD.178	The software SHALL display items in the *local adverse reactions list* in the same order as these items are normally listed elsewhere in the local record.	*Mandatory*	***NEW for v1.4***

ID	Recommendation	Obligation	Status
CLD.179	The *clinical document adverse reactions list* SHALL include a column for each structured adverse reaction attribute contained in the clinical document. *Note: Refer to Appendix 2 for the clinical document attributes (by document type) that are to be displayed in the clinical document adverse reactions list.* *Vendors should refer to the relevant structured content specifications for further information about how adverse reactions information is represented in each document types.*	*Mandatory*	***NEW for v1.4***
CLD.180	The software SHALL ensure the first three columns displayed in the *clinical document adverse reactions list* have the following headings: a) Substance/agent b) Manifestation/s c) Reaction type *Note: This applies regardless of whether or not there is content from the clinical document to populate each column. Refer to Appendix 2 to identify which data element in each clinical document corresponds to the above columns*.	*Mandatory*	***NEW for v1.4***
CLD.181	The software SHALL display the items in the *clinical document adverse reactions list* in the same order as these items are recorded in the structured data section of the clinical document.	*Mandatory*	***NEW for v1.4***
CLD.182	The software SHALL populate the *clinical document adverse reactions list* with the relevant structured data contained in the clinical document in accordance with requirement 020652 from the *Clinical Terminology – Guidance for Use of Medical Nomenclature in Information Exchange*.	*Mandatory*	***NEW for v1.4***
CLD.183	The software SHALL provide a facility to view the clinical document narrative and *clinical document adverse reactions list* side-by-side within the *assisted adverse reactions import screen*. *Note: This facility is to ensure that at all times a user may perform visual comparison of adverse reactions information in the clinical document narrative with structured representations clinical document adverse reactions list. The clinical document narrative may contain qualifying information about the structured representation that the clinician should be informed about. It is also possible that the clinical document narrative could contain contradictory and this poses a clinical safety risk if inaccurate information is relied upon.* *A facility to display both the clinical document narrative and clinical document adverse reactions list onscreen simultaneously permits the most direct comparison of adverse reactions information. Assisted medicines import should be performed on computers and mobile devices with sufficient screen size to display this required information.*	*Mandatory*	***NEW for v1.4***

8.3.2 Adding an adverse reaction

ID	Recommendation	Obligation	Status
CLD.184	The software SHALL NOT allow an adverse reaction to be imported through *assisted adverse reactions import* unless the substance/agent is identified with either an AMT version 3 or SNOMED CT-AU concept. *Note: An AMT-enabled source system used to produce clinical documents may adopt an interface terminology (e.g. MIMS, AZdex, Multum-AU) with terms used to describe medicinal adverse reactions with minor lexical differences to semantically equivalent terms in the AMT. The recommended practice for these so-called "mapped" AMT implementations is to represent the equivalent AMT concept in a CDA translation element.* *Adverse reactions recorded in this manner are suitable for assisted import. Adverse reaction records containing the nullFlavor="OTH" attribute are suitable for assisted import, provided the corresponding concept is a SNOMED CT-AU concept recognised by the software.*	*Mandatory*	***NEW for v1.4***
CLD.185	If an adverse reaction in a clinical document is recorded in the local record, the software SHALL indicate this in the *clinical document adverse reactions list*. *Note: Adverse reactions in the clinical document and local record are deemed to be equivalent if the substance/agent have matching AMT or SNOMED CT-AU concept identifiers. This indicator could take the form of a message 'Already on record' or an icon with descriptive 'tooltip'.*	*Mandatory*	***NEW for v1.4***
CLD.186	The software SHALL allow the user to select an item from the *clinical document adverse reactions list* to be imported into the local record. *Note: An assisted adverse reactions import could be initiated by double clicking on the row item or by providing a tick box for each list item etc.*	*Mandatory*	***NEW for v1.4***
CLD.187	Upon selecting an adverse reaction to incorporate from the clinical document to the local record, the software SHALL commence the existing workflow for recording a new adverse reaction. *Note: The system will continue to prompt and prevent duplicate records per the normal processes for recording a new adverse reaction.*	*Mandatory*	***NEW for v1.4***
CLD.188	When displaying the screen to record a new adverse reaction, the software SHALL ensure that the details of the item selected from the *clinical document adverse reactions list* are clearly visible. Note: This is to ensure that the source record (i.e. the highlighted item in the clinical document adverse reactions list) may be referred to if the clinician modifies the prepopulated entries.	*Mandatory*	***NEW for v1.4***
CLD.189	The software SHALL pre-populate the data entry screen with the details of the selected adverse reaction. *Note: The following data elements in the source document are candidates for pre-population:* • *Substance/agent* • *Reaction type* • *Manifestation/s*	*Mandatory*	***NEW for v1.4***

ID	Recommendation	Obligation	Status
CLD.190	The software SHALL clearly highlight any fields on the entry screen that have been pre-populated with information from the source clinical document.	*Mandatory*	***NEW for v1.4***
CLD.191	Any information about the selected adverse reaction that cannot be transferred to the entry screen SHALL be clearly highlighted.	*Mandatory*	***NEW for v1.4***
CLD.192	The software SHALL allow the user to 'copy & paste' information from the selected adverse reaction into the data entry fields.	*Mandatory*	***NEW for v1.4***
CLD.193	The software SHALL display an indicator adjacent to the *clinical document adverse reactions list* item if it has been successfully imported into the local record during the current assisted import session. *Note: Appropriate visual indicators include use of icons or colour-coded text.*	*Mandatory*	***NEW for v1.4***

8.3.3 Editing an adverse reaction record

ID	Recommendation	Obligation	Status
CLD.194	The software SHALL allow the user to interact with the *local adverse reactions list* to perform tasks that can be performed through the known adverse reactions list that appears elsewhere in the local record. *Note: Users should be able to access this functionality in the same manner they would normally. For example, right click to display a drop down menu with action items.*	*Mandatory*	***NEW for v1.4***
CLD.195	When the user chooses to modify an item in the *local adverse reactions list*, the software SHALL ensure that items in the *clinical document adverse reactions* list remain clearly displayed onscreen. For example, when a screen is displayed allowing the user to edit details of an adverse reaction, this screen does not obscure the underlying clinical document adverse reactions list. *Note: This is to assist the user if they wish to update an existing adverse reaction in the local record with details from an adverse reaction listed in the clinical document.*	*Mandatory*	***NEW for v1.4***

9 Identifying new clinical documents from the My Health Record system

Applies to: General practice clinical information systems that access the My Health Record system.

A central concept for CUP Release 3 (version 1.2 of this document) 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 digital health record without having to open the digital health record. They have requested that, alongside the indicator of whether a patient is registered or not with the My Health Record system, a count of the number of new clinical documents from the patient's digital health record 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 My Health Record system clinical documents that a user wants to include in lists of documents recently added to a patient's digital health record. They introduce the concept of a "new clinical document" and how this concept should be applied when rendering the My Health Record 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*	*No change from v1.2*
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 digital health record: 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).* *It is anticipated that timing preferences are set via the user's administration settings only.*	*Mandatory*	*Revised for v1.3*
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*	*No change from v1.2*

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 My Health Record page (see recommendation CLD.84).* *This recommendation ensures that any new clinical document type that is introduced to the My Health Record system 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).* *It is anticipated that the user defines a subset of new clinical documents via the user’s administration settings only.*	*Mandatory*	*Revised for v1.3*
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; and* • *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*	*No change from v1.2*

10 Locating and accessing My Health Record system functions

Applies to: General practice clinical information systems accessing the My Health Record system.

Healthcare providers have raised issues about the ease of access to My Health Record system–related functions. Some healthcare providers find it difficult to locate either the healthcare recipient's current digital health record status or the mechanism to launch My Health Record system functions, due to the different My Health Record system access methods used by software developers.

The usability recommendations below will result in more consistent behaviours to support healthcare providers' use of the My Health Record system.

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 digital health status when displaying the consumer's local health record. *Note: The patient's digital health record 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:* • *Digital health record exists (access code may or may not be required)* • *Digital health record may not exist (i.e."doesPCEHRExist" operation returns false)* • *Operation cannot complete (e.g. no patient IHI on file or cannot connect to My Health Record system due to network connectivity failure or system outage)*	*Mandatory*	*No change from v1.1*

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 My Health Record (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 My Health Record (0)*	*Mandatory*	*No change from v1.2*
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*	*No change from v1.2*
CLD.27	The My Health Record entry point **SHALL** allow navigation to all supported My Health Record clinical activities, including: 1. Open the My Health Record 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 v1.2*
CLD.28	The software **MAY** allow access to My Health Record 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.*	*No obligation*	*Revised for v1.3*

ID	Recommendation	Obligation	Status
CLD.29	An entry point to My Health Record system 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 digital health recordstatus indicator or via a separate window tab, drop-down menu, button, etc*.	*Mandatory*	*No change from v1.1*
CLD.30	Healthcare identifier (HI) checks and digital health record 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 patient's digital health record 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 v1.2*

11 My Health Record page

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

Vendors may have already implemented the foundations of the health record overview in CUP releases 1 or 2 (version 1.1 of this document). The concept of a My Health Record page is therefore an expansion of the document list functionality outlined in version 1.1 of the CUP recommendations.

In CUP Release 3 (version 1.2 of this document), 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 digital health 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 My Health Record page will also include a way of navigating to (or displaying) the most recent shared health summary uploaded to the My Health Record system (if applicable), provide links to My Health Record views (optional) and, for a new patient, provide an additional document list of historic shared health summaries.

By implementing version 1.2 of the CUP recommendations, users will be able to have an overview of the patient's digital health record in a structured display. They will have easy access to new clinical documentation only or all clinical documentation.

11.1 Overall layout of the My Health Record page

The following recommendations assume that the patient's digital health record exists and is accessible. These recommendations provide an overall layout of the My Health Record page with further specific details in sections 10.2 and 10.3. The My Health Record page is displayed automatically whenever the user accesses the patient's digital health 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 ('My Health Record 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 My Health Record 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 My Health Record views.*	*Mandatory*	*No change from v1.2*
CLD.80	The software **SHALL** provide a screen ('My Health Record 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 My Health Record 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 6 for recommendations regarding My Health Record views.*	*Mandatory*	*No change from v1.2*

ID	Recommendation	Obligation	Status
CLD.81	The software **SHALL** allow the user to easily switch between the patient's local health record, the My Health Record page and other My Health Record system clinical activities, such as authoring and uploading a shared health summary or event summary. *Note: While the My Health Record page is intended to be the primary means of accessing My Health Record system information, users may wish to access other My Health Record system clinical activities directly, or go back the patient's local health record.*	*Mandatory*	*No change from v1.2*
CLD.82	The My Health Record 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*	*No change from v1.2*

11.2 Default display of the documents list on the My Health Record page

The following recommendations outline how the document list on the My Health Record 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 My Health Record 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 digital health record 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 My Health Record page for any new patient.*	*Mandatory*	*No change from v1.2*

ID	Recommendation	Obligation	Status
CLD.84	For existing patients, the document list on the My Health Record 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 My Health Record page for any existing patient.*	*Mandatory*	*No change from v1.2*
CLD.85	For existing patients, the My Health Record 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*	*No change from v1.2*

ID	Recommendation	Obligation	Status
CLD.86	If the document list on the My Health Record 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*	*No change from v1.2*
CLD.87	If there are no documents to be listed, the software **SHALL** display an empty document list on the My Health Record 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*	*No change from v1.2*

11.3 Shared health summary display on My Health Record page

ID	Recommendation	Obligation	Status
CLD.88	The My Health Record 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 digital health record does not have a shared health summary to be displayed.*	*Mandatory*	*No change from v1.2*
CLD.89	The My Health Record 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*	*No change from v1.2*

ID	Recommendation	Obligation	Status
CLD.90	Where no shared health summary exists, the My Health Record 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*	*No change from v1.2*

12 My Health Record document lists – general functionality

Applies to: General practice clinical information systems that display My Health Record system documents.

This section contains software recommendations for the presentation of lists of My Health Record system documents.

It is recommended that information retrieved from a patient's digital health record 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.

12.1 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 v1.2*
CLD.32	Lists displayed by default to clinical users **SHOULD NOT** include columns other than the required columns of Document Date, Service Date, 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 v1.2*
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 v1.2*

ID	Recommendation	Obligation	Status
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 v1.2*
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*	*No change from v1.1*
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*	*No change from v1.1*
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*	*No change from v1.1*
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*	*No change from v1.1*
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*	*No change from v1.1*

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 v1.2*
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 v1.2*
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*	*No change from v1.1*
CLD.43	The software **SHALL** display all date-time columns using the local time zone of the user. *Note: Date-time values in a clinical document's 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*	*No change from v1.1*
CLD.91	When listing documents from the patient's digital health record, 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*	*No change from v1.2*

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*	*No change from v1.2*
CLD.93	Clinical documents **SHALL** be identified as new within any document list retrieved from the patient's digital health record. *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*	*No change from v1.2*
CLD.94	The user **SHOULD** be able to view the clinical synopsis field of an event summary in the documents list on the My Health Record 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*	*No change from v1.2*
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*	*No change from v1.2*

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 My Health Record 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*	*No change from v1.2*

12.2 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 My Health Record page (as identified in section 9).

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*	*No change from v1.1*
CLD.45	The software **SHOULD** allow a user to sort on any additional column, in ascending or descending order.	*Optional*	*Revised for v1.2*
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*	*No change from v1.2*
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*	*No change from v1.1*
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*	*No change from v1.1*
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 v1.2*

ID	Recommendation	Obligation	Status
CLD.49	If the software offers grouping functionality, the following **SHALL** all be applied: • Grouping can be applied to any column at the discretion of the vendor. • If a column is grouped, then groups are in sorted order (or in reverse order). • Grouping can be cancelled. *Note: This recommendation ensures that the group headings are based on sorted column. It also means that any expanded group items can be in sorted order of another column. For example, the table below shows the document listed grouped by document type (which is sorted alphabetically) with each group sorted in reverse on document date.*	*Conditional*	*Revised for v1.3*

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

12.3 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 My Health Record page (as identified in section 10).

ID	Recommendation	Obligation	Status
CLD.50[5]	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 v1.2*

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

ID	Recommendation	Obligation	Status
CLD.51[6]	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 v1.2*
CLD.98	The software **SHOULD** allow the user to exclude all My Health Record system document types from the document list if the software has implemented a My Health Record 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*	*No change from v1.2*
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 My Health Record 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*	*No change from v1.2*
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	No change from v1.2
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 My Health Record view, enabling users to exclude groups of document types with one selection. Recommendations relating to My Health Record 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 My Health Record page.*	*Mandatory*	*Revised for v1.2*

[6] 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.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 v1.2*
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 v1.2*
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 My Health Record page.	*Mandatory*	*No change from v1.2*
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*	*No change from v1.1*
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*	*No change from v1.2*
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*	*No change from v1.2*

13 General

Applies to: General practice clinical information systems that connect to the My Health Record system.

13.1 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 My Health Record system service is currently unavailable. Please try again later. *Note: Providing user with some insight about why an error has occurred and what actions the user can take to rectify the error will enhance system usability.*	*Mandatory*	*No change from v1.2*

13.2 Indicators for administration staff

13.2.1 'Patient not registered with My Health Record' indicator

While the digital health record status indicator recommended in CLD.26 provides the general practice user with information about the patient's enrolment status with the My Health Record system, similar information should be provided to administration staff who may not have access to the patient's clinical record. For example, in many cases, it is the front desk staff who are responsible for performing assisted registration services. A My Health Record system indicator for administration staff would help them identify patients who may require such enrolment support.

ID	Recommendation	Obligation	Status
CLD.104	If the software provides a separate interface to administrative staff (e.g. front desk), then the software **SHALL** provide an indicator if a patient is not registered with the My Health Record system. *Note: The wording of the indicator should recognise that assisted registration is voluntary and requires patient consent.* *The digital health record status indicator (as defined in CLD.26) is currently only available from the patient's clinical record, to which administrators may not have access. The implementation of this recommendation will provide administration staff with information on whether a patient is registered for a digital health record.*	*Conditional*	*No change v1.2*
CLD.105	If the software provides an indicator to administration staff when a patient is not registered with the My Health Record system, then the software **SHALL** allow administration staff users to turn off this indicator. The default setting is to display the indicator. *Note: The indicator is specific to the user. Once switched off, the indicator will not be displayed for any patient. Further details about this indicator are in recommendation CLD.104.*	*Conditional*	*No change from v1.2*

13.2.2 'IHI non match' indicator

Since a small proportion of IHI searches do not return a match, there is a need to improve the quality of demographics data held within general practice. The following recommendations will enable an indicator or prompt to encourage administration staff (e.g. front desk) 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 a separate interface to administration staff (e.g. front desk), then the software **SHALL** provide an indicator if an IHI search fails to return a match. *Note: The wording of the indicator should prompt the user 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 the user should direct the patient to check the information held by Medicare.*	*Conditional*	*No change from v1.2*

ID	Recommendation	Obligation	Status
CLD.140	If the software provides an indicator to administration staff when an IHI search fails to return a match, then the software **SHALL** allow the user to print out the following patient details on one sheet as recorded on the clinical information system: • Patient's full name • Patient's Medicare number • Patient's date of birth • Patient's address *Note: This recommendation allows the user to provide a printed copy of the patient's demographic details stored in the local system to the patient. It these details are accurate, the patient may choose to contact Medicare to advise that information is not up-to-date.*	*Conditional*	*No change from v1.3*

Appendix A CDA mapping to XDSDocumentEntry fields

This table includes CDA data components that may contain representative content for the columns in a My Health Record 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	healthcareFacilityTypeCode Dis playName	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 My Health Record system 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 Client sample code:

```
// 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();
```

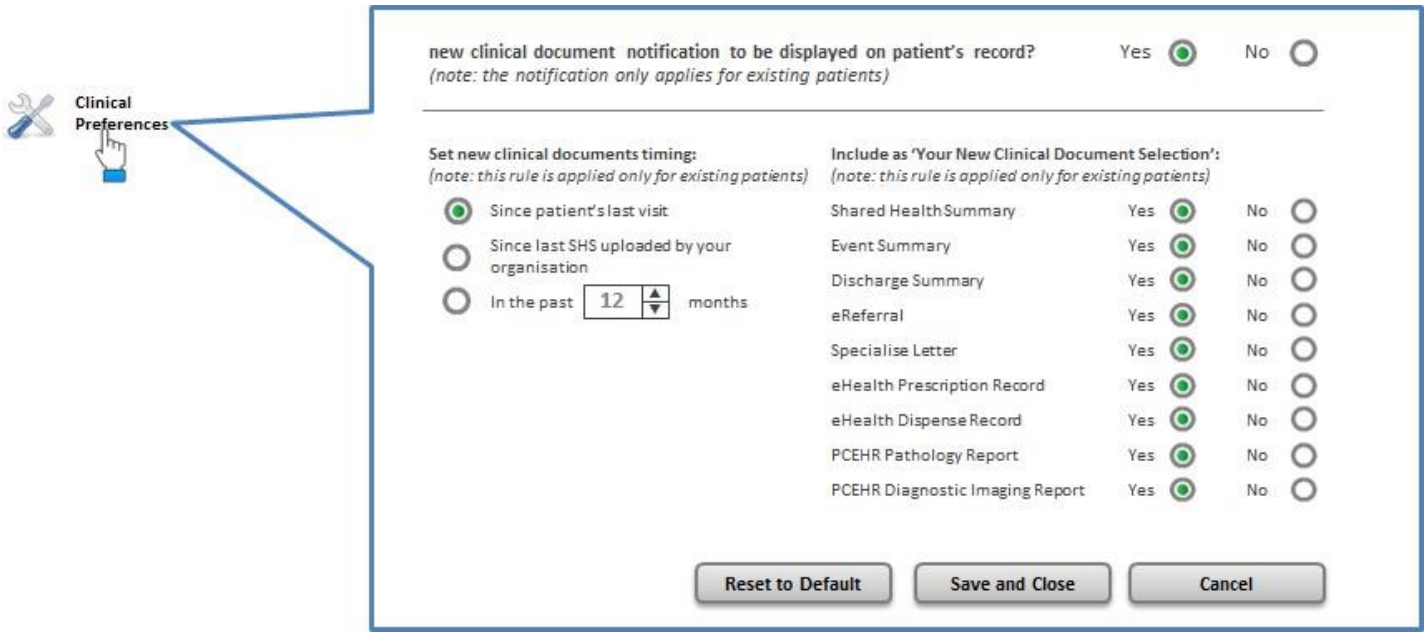
Appendix C Example mock-ups

C.1 New clinical document configuration options

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 8 *Identifying new clinical documents from the My Health Record system* and CLD.78 in section 9 *Locating and accessing My Health Record system functions*

This mock-up demonstrates how:

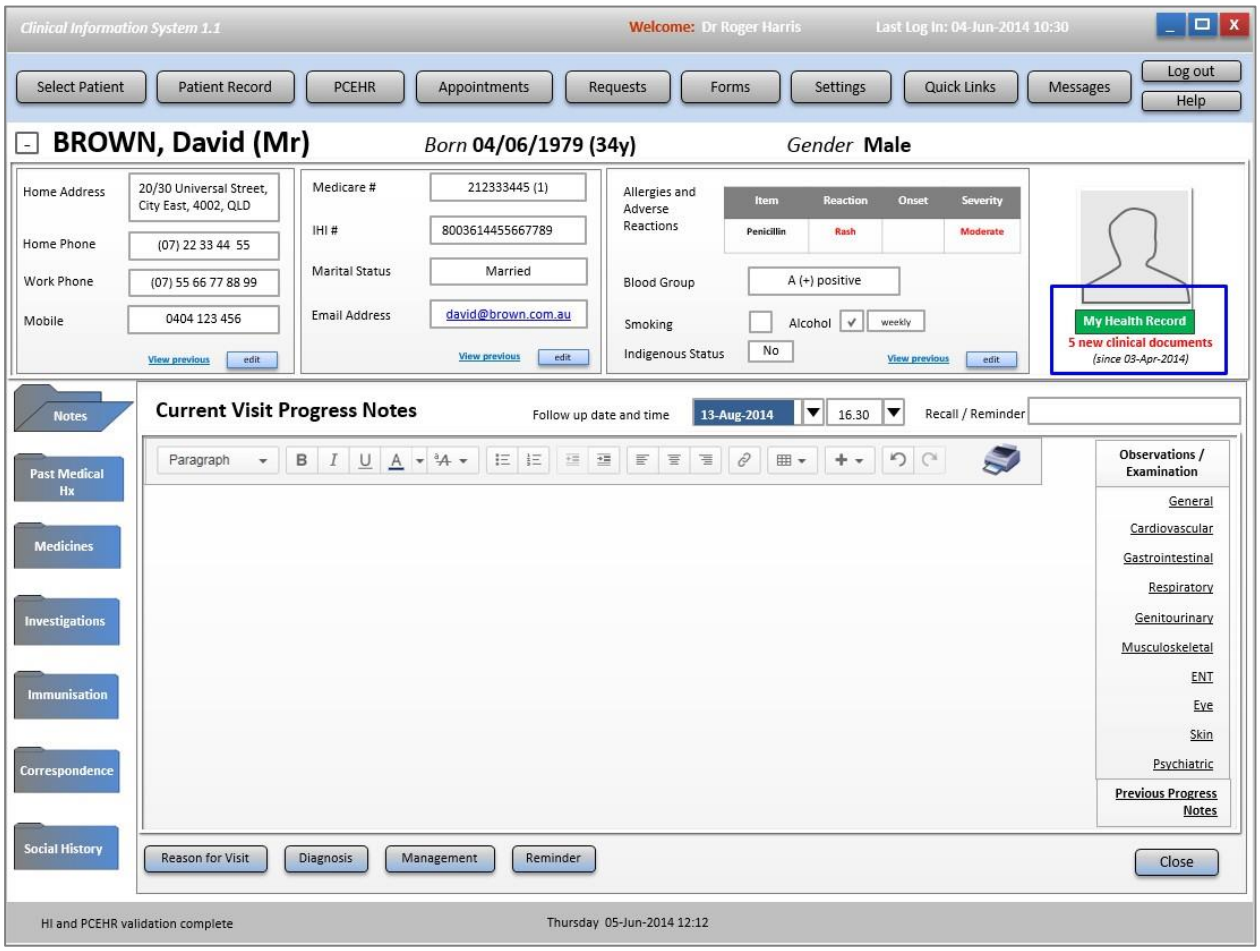
- Users may choose to switch off the display of the 'new_clinical_documents count', which also turns off the display of the note that the user has excluded clinical documents.
- Users may choose the timing option for identifying new clinical documents.
- Users may choose to exclude one or more document 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.



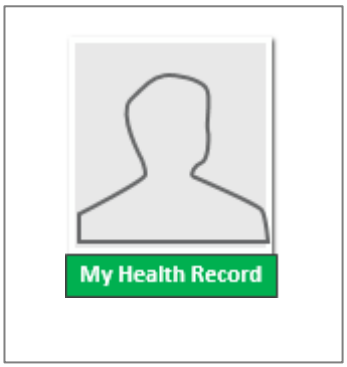
C.2 Enhanced My Health Record system indicator including new clinical documents notification

The below is an example of how the My Health Record system 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 9 *Locating and accessing My Health Record system functions*.



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

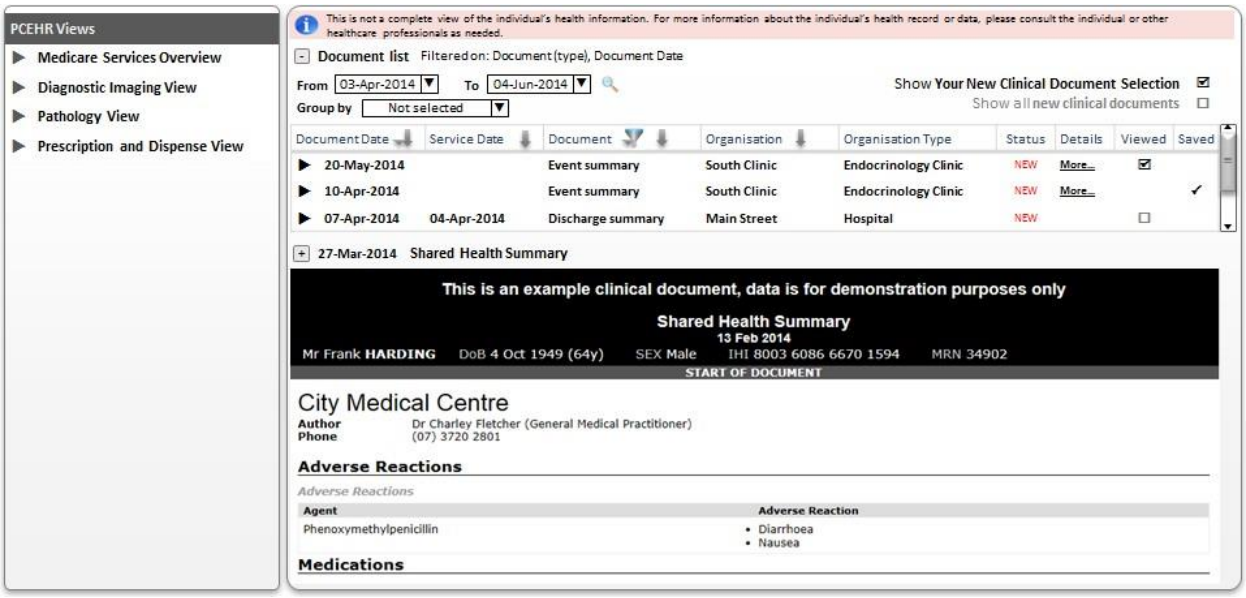


C.3 My Health Record page display for an existing patient

The example below shows how the My Health Record page could look for an existing patient. This mock-up relates to recommendation CLD.79 in section 10.1 *Overall layout of the My Health Record page*.

There are three main items to be included:

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

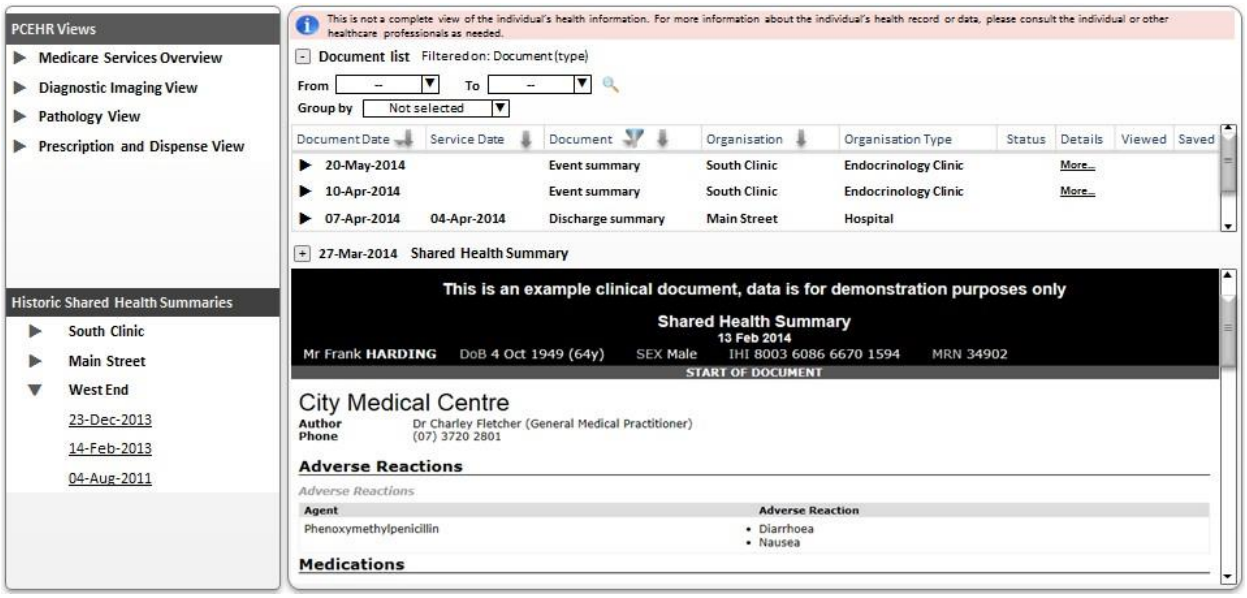


C.4 My Health Record page display for a new patient

The example below shows how the My Health Record page could look for a new patient. This mock-up relates to recommendation CLD.80 in section 10.1 *Overall layout of the My Health Record 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 digital health record.
- Links to My Health Record 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 My Health Record page.



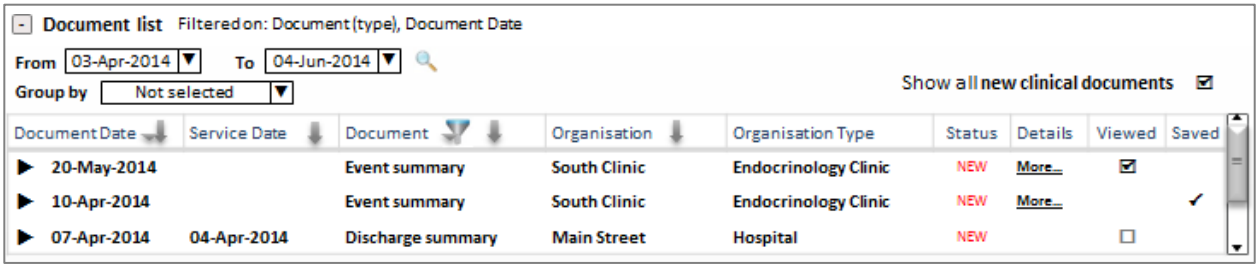
C.5 Default document list displayed on My Health Record page for an existing patient

The example below shows how a document list could be displayed on the My Health Record page for an existing patient. These mock-ups relate to recommendations CLD.84, CLD.85 and CLD.86 in section 10.2 *Default display of the documents list on the My Health Record 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 My Health Record page for a new patient

The below is an example of how a document list could be displayed on the My Health Record page for a new patient. This mock-up relates to recommendation CLD.83 in section 10.2 *Default display of the documents list on the My Health Record page*.

This mock-up demonstrates how:

- 'From' and 'To' dates are not set – all clinical documents are listed from the patient's digital health record.
- '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.

Appendix D SNOMED CT-AU Adverse reaction type reference set

SCTID	Preferred Term
281647001	Adverse reaction
419076005	Allergic reaction
12263007	Hypersensitivity reaction type I
90092004	Hypersensitivity reaction type II
83699005	Hypersensitivity reaction type III
28031001	Hypersensitivity reaction type IV
609406000	Non-allergic reaction
79899007	Drug interaction
404204005	Drug interaction with drug
95907004	Drug interaction with food
235719002	Food intolerance
401207004	Medication side-effect
75478009	Toxicity

Appendix E List of data elements in the medicines section of clinical documents

The following table lists the relevant data concepts to be displayed on the *clinical document medicines* list for each clinical document type. For each clinical document type:

- First column identifies the clinical document type
- Second column shows the data component from the Detailed Clinical Model specification
- Third column shows the CDA Scheme Data Element from the clinical document's CDA Implementation Guide
- Fourth column shows the column heading under which the representative content from the data element will be displayed on the *clinical document medicines list* (recommendation *R4-103*)

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
Shared Health Summary		ClinicalDocument/component/structuredBody/component[meds]/section/	
	Known Medication (MEDICATION INSTRUCTION) > Therapeutic Good Identification	entry[med_inst]/substanceAdministration/consumable/manufacturedProduct/ manufacturedMaterial/code	Medicine name
	Known Medication (MEDICATION INSTRUCTION) > Directions	entry[med_inst]/substanceAdminstration/text:ST	Directions
	Known Medication (MEDICATION INSTRUCTION) > Clinical Indication	entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/text:ST	Clinical indication
	Known Medication (MEDICATION INSTRUCTION) > Medication Instruction Comment	entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/text:ST	Comment

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
Event Summary		ClinicalDocument/component/structuredBody/component[meds]/section/	
	Known Medication (MEDICATION INSTRUCTION) > Therapeutic Good Identification	entry[med_inst]/substanceAdministration/consumable/manufacturedProduct/ manufacturedMaterial/code	Medicine name
	Known Medication (MEDICATION INSTRUCTION) > Directions	entry[med_inst]/substanceAdminstration/text:ST	Directions
	Known Medication (MEDICATION INSTRUCTION) > Clinical Indication	entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/text:ST	Clinical indication
	Known Medication (MEDICATION INSTRUCTION) > Medication Instruction Comment	entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/text:ST	Comment
	Known Medication (MEDICATION INSTRUCTION) > Change Type	entry[med_inst]/substanceAdministration/entryRelationship[change]/observation/value:CD	N/A
	Known Medication (MEDICATION INSTRUCTION) > Change Status	entry[med_inst]/substanceAdministration/entryRelationship[change]/observation/ entryRelationship[made]/observation/value:CD	N/A
	Known Medication (MEDICATION INSTRUCTION) > Change Description	entry[med_inst]/substanceAdministration/entryRelationship[change]/observation/text:ST	N/A
	Known Medication (MEDICATION INSTRUCTION) > Change or Recommendation Reason	entry[med_inst]/substanceAdministration/entryRelationship[change]/observation/ entryRelationship[change_rsn]/act/text	N/A

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
Discharge Summary		*Current Medications on Discharge:* ClinicalDocument/component/structuredBody/component[meds]/section/component[current]/section/	
	Therapeutic Good > Therapeutic Good Identification	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code	Medicine name
	Therapeutic Good > Dosage > Dose Instruction	entry[sbadm]/substanceAdministration/text:ST	Directions
	Therapeutic Good > Dosage > Unit of Use Quantity Dispensed	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/text:ST	Quantity dispensed
	Therapeutic Good > Reason for Therapeutic Good	entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/text:ST	Clinical indication
	Therapeutic Good > Additional Comments	entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/text:ST	Comment
	Therapeutic Good > Medication History > Item Status	entry[sbadm]/substanceAdministration/entryRelationship[item_status]/observation/code	N/A
	Therapeutic Good > Medication History > Change Detail > Changes Made	entry[sbadm]/substanceAdministration/entryRelationship[change_detail]/observation/code	N/A
	Therapeutic Good > Medication History > Change Detail > Reason for Change	entry[sbadm]/substanceAdministration/entryRelationship[change_detail]/observation/entryRelationship[rsn_for_change]/act/text:ST	N/A

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
	Therapeutic Good > Medication History > Change Detail > Medication Duration	entry[sbadm]/substanceAdministration/effectiveTime:IVL_TS	N/A
		Ceased Medications on Discharge: ClinicalDocument/component/structuredBody/component[meds]/section/ component[ceased]/section/	
	Therapeutic Good > Therapeutic Good Identification	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/ manufacturedMaterial/code	Medicine name
	Therapeutic Good > Medication History > Item Status	entry[sbadm]/substanceAdministration/entryRelationship[item_status]/observation/code	N/A
	Therapeutic Good > Medication History > Change Detail > Changes Made	entry[sbadm]/substanceAdministration/entryRelationship[change_detail]/observation/code	N/A
	Therapeutic Good > Medication History > Change Detail > Reason for Change	entry[sbadm]/substanceAdministration/entryRelationship[change_detail]/observation/ entryRelationship[rsn_for_change]/act/text:ST	N/A
eReferral		ClinicalDocument/component/structuredBody/component[meds]/section/	
	Medication Instruction > Medicine	entry[med_inst]/substanceAdministration/consumable/manufacturedProduct/ manufacturedMaterial/code	Medicine name
	Medication Instruction > Directions	entry[med_inst]/substanceAdminstration/text:ST	Directions

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
Specialist Letter		ClinicalDocument/component/structuredBody/component[meds]/section/	
	Medication > Medicine	entry[med_inst]/substanceAdministration/consumable/manufacturedProduct/ manufacturedMaterial/code	Medicine name
	Medication > Directions	entry[med_inst]/substanceAdminstration/text:ST	Directions
	Medication > Clinical Indication	entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/text:ST	Clinical indication
	Medication > Comment	entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/text:ST	Comment
	Medication > Change Type	entry[med_inst]/substanceAdministration/entryRelationship[change]/observation/value:CD	N/A
	Medication > Change or Recommendation	entry[med_inst]/substanceAdministration/entryRelationship[change]/observation/ entryRelationship[made]/observation/value:CD	N/A
	Medication > Change Description	entry[med_inst]/substanceAdministration/entryRelationship[change]/observation/text:ST	N/A
	Medication > Change Reason	entry[med_inst]/substanceAdministration/entryRelationship[change]/observation/ entryRelationship[change_rsn]/act/text	N/A
eHealth Prescription Record		ClinicalDocument/component/structuredBody/component[pres_item]/section/	
	Prescription Item (MEDICATION INSTRUCTION) > Therapeutic Good Identification	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/ manufacturedMaterial/code	Medicine name
	Prescription Item (MEDICATION INSTRUCTION) > Therapeutic Good Strength (Additional Therapeutic Good Detail)	entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/text	N/A

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
	Prescription Item (MEDICATION INSTRUCTION) > Therapeutic Good Generic Name (Additional Therapeutic Good Detail)	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/ manufacturedMaterial/name	N/A
	Prescription Item (MEDICATION INSTRUCTION) > Directions	entry[sbadm]/substanceAdministration/text	Directions
	Prescription Item (MEDICATION INSTRUCTION) > Formula	entry[sbadm]/substanceAdministration/entryRelationship[form]/act/text	N/A
	Prescription Item (MEDICATION INSTRUCTION) > Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION) > Form	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/ manufacturedMaterial/ext:formCode	N/A
	Prescription Item (MEDICATION INSTRUCTION) > Clinical Indication	entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/text	Clinical Indication
	Prescription Item (MEDICATION INSTRUCTION) > Administration Details (MEDICATION ADMINISTRATION) > Route	entry[sbadm]/substanceAdministration/routeCode	N/A
	Prescription Item (MEDICATION INSTRUCTION) > Comment (Medication Instruction Comment)	entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/text	N/A

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
	Prescription Item (MEDICATION INSTRUCTION) > DISPENSING > Quantity to Dispense (AMOUNT OF MEDICATION) > Quantity Description	entry[sbadm]/substanceAdministration/entryRelationship[sply]/ entryRelationship[qty_desc]/act/text	N/A
	Prescription Item (MEDICATION INSTRUCTION) > DISPENSING > Maximum Number of Repeats (Number of Repeats)	entry[sbadm]/substanceAdministration/repeatNumber/high/@value	N/A
	Prescription Item (MEDICATION INSTRUCTION) > DISPENSING > Minimum Interval Between Repeats	entry[sbadm]/substanceAdministration/entryRelationship[sply]supply/ effectiveTime/period/@value	N/A
	Prescription Item (MEDICATION INSTRUCTION) > Brand Substitution Permitted	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ ext:subjectOf2/ext:substitutionPermission/ext:code	N/A
	Prescription Item (MEDICATION INSTRUCTION) > PBS Manufacturer Code (Administrative Manufacturer Code)	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/ manufacturerOrganization/id	N/A
	Prescription Item (MEDICATION INSTRUCTION) > DateTime Prescription Expires	entry[expiry]/observation/effectiveTime/@value	N/A
		ClinicalDocument/component/structuredBody/component[disp_item]/section/	

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
eHealth Dispense Record	Dispense Item > Therapeutic Good Identification	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/manufacturedMaterial/code	Medicine name
	Dispense Item > Therapeutic Good Strength (Additional Therapeutic Good Detail)	entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/text	N/A
	Dispense Item > Therapeutic Good Generic Name (Additional Therapeutic Good Detail)	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/manufacturedMaterial/name	N/A
	Dispense Item> Additional Dispensed Item Description (Additional Therapeutic Good Detail)	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/manufacturedMaterial/ext:desc	N/A
	Dispense Item > Label Instruction (Medication Action Instructions)	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/text:ST	Directions
	Dispense Item > Formula	entry[sbadm]/substanceAdministration/entryRelationship[form]/act/text	N/A
	Dispense Item > Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION) > Form	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/manufacturedMaterial/ext:formCode	N/A
	Dispense Item > Quantity Dispensed (AMOUNT OF MEDICATION) > Quantity Description	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/text	Quantity dispensed

Document type	SCS Data Component	CDA Schema Data Element Bold items denote those data elements that could be used for pre-population when creating a new prescription of new medicine record via the assisted medicines import screen (recommendation R4-025).	Column heading on the *clinical document adverse reactions list*
	Dispense Item > Comment (Medication Instruction Comment)	entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/text	N/A
	Dispense Item > Brand Substitution Occurred	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ entryRelationship[brand]/observation/value:BL	N/A
	Dispense Item > Number of this Dispense	entry[sbadm]/substanceAdministration/entryRelationship[sply]/sequenceNumber/@value	N/A
	Dispense Item > Maximum Number of Repeats (Number of Repeats)	entry[sbadm]/substanceAdministration/repeatNumber/high/@value	N/A
	Dispense Item > PBS Manufacturer Code (Administrative Manufacturer Code)	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/ manufacturedProduct/manufacturedOrganization/id	N/A
	Dispense Item > Unique Pharmacy Prescription Number (Administrative System Identifier)	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ entryRelationship[pharm_pres_num]/act/text	N/A
	Dispense Item > DateTime of Dispense Event (Medication Action DateTime)	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/effectiveTime	N/A

Appendix F List of data elements in the adverse reactions section of clinical documents

The following table lists the relevant data concepts to be displayed on the clinical document adverse reactions list for each clinical document type. For each clinical document type:

- First column identifies the clinical document type
- Second column shows the data component from the Detailed Clinical Model specification
- Third column shows the CDA Scheme Data Element from the clinical document's CDA Implementation Guide
- Fourth column shows the column heading under which the representative content from the data element will be displayed on the *clinical document medicines list* (recommendation *R4-045*)

Document type	**SCS Data Component**	**CDA Schema Data Element** **Bold** items denote those data elements that could be used for pre-population when creating a new adverse reaction record via the *assisted adverse reactions import* screen (recommendation R4-025).	**Column heading on the *clinical document adverse reactions list***
Shared Health Summary		ClinicalDocument/component/structuredBody/component[adv_reacts]/section/	
	ADVERSE REACTION > Substance/Agent	**entry[adv_react]/act/participant/participantRole/playingEntity/code**	Substance/Agent
	ADVERSE REACTION > REACTION EVENT > Manifestation	**entry[adv_react]/act/entryRelationship[rct_evnt]/observation/ entryRelationship[mfst]/observation/code**	Manifestation
	ADVERSE REACTION > REACTION EVENT > Reaction Type	**entry[adv_react]/act/entryRelationship[rct_evnt]/observation/value:CD**	Reaction Type

Document type	**SCS Data Component**	**CDA Schema Data Element** **Bold** items denote those data elements that could be used for pre-population when creating a new adverse reaction record via the *assisted adverse reactions import* screen (recommendation R4-025).	**Column heading on the *clinical document adverse reactions list***
Event Summary		ClinicalDocument/component/structuredBody/component[adv_reacts]/section/	
	ADVERSE REACTION > Substance/Agent	**entry[adv_react]/act/participant/participantRole/playingEntity/code**	Substance/Agent
	ADVERSE REACTION > REACTION EVENT > Manifestation	**entry[adv_react]/act/entryRelationship[rct_evnt]/observation/ entryRelationship[mfst]/observation/code**	Manifestation
	ADVERSE REACTION > REACTION EVENT > Reaction Type	**entry[adv_react]/act/entryRelationship[rct_evnt]/observation/value:CD**	Reaction Type
Discharge Summary		ClinicalDocument/component/structuredBody/component[health]/section/ component[adverse]/section	
	Adverse Reaction > Agent Description	**entry/observation/participant/participantRole/playingEntity/code**	Substance/Agent
	Adverse Reaction > Adverse Reaction Type	**entry/observation/value:CD**	Reaction Type
	Adverse Reaction > Reaction Detail > Reaction Description	**entry[adv_reac]/observation/entryRelationship/observation/code**	Manifestation

Document type	**SCS Data Component**	**CDA Schema Data Element** **Bold** items denote those data elements that could be used for pre-population when creating a new adverse reaction record via the *assisted adverse reactions import* screen (recommendation R4-025).	**Column heading on the *clinical document adverse reactions list***
eReferral		ClinicalDocument/component/structuredBody/component[adv_react]/section/	
	Adverse Reaction > Substance/Agent	**entry/observation/participant/participantRole/playingEntity/code**	Substance/Agent
	Adverse Reaction > Reaction Event > Manifestation	**entry[adv_react]/act/entryRelationship[rct_evnt]/observation/ entryRelationship[mfst]/observation/code**	Manifestation
Specialist Letter		ClinicalDocument/component/structuredBody/component[adv_react]/section/	
	Adverse Reaction > Substance/Agent	**entry/observation/participant/participantRole/playingEntity/code**	Substance/Agent
	Adverse Reaction > Reaction Event > Manifestation	**entry[adv_react]/act/entryRelationship[rct_evnt]/observation/ entryRelationship[mfst]/observation/code**	Manifestation

Glossary

Term or abbreviation	Description
Australian Medicines Terminology (AMT)	A national terminology that delivers unique codes to unambiguously identify originator and generic brands of medicines commonly used in Australia. It also provides standard naming conventions and terminology to accurately describe medications.
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 My Health Record 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 My Health Record system; or b) health information management services relating to the My Health Record system (section 5 *My 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.
My Health Record system	National eHealth infrastructure for managing records in eHealth. This was previously called the personally controlled electronic health record system (eHealth record system).
Systematised Nomenclature of Human Medicine Clinical Terminology (SNOMED CT)	A comprehensive multilingual clinical healthcare terminology providing a standardised way to represent clinical phrases captured by the clinician. SNOMED CT Australian Release (SNOMED CT-AU) is the Australian extension to SNOMED CT, providing local variations and customisations of terms relevant to the Australian healthcare community.

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NEHTA-1786:2014 *Clinical Terminology Guidance for Use in Healthcare Software v1.0,* 12 Aug 2014

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NEHTA-1922:2014 *Shared Health Summary PCEHR Usability Recommendations v1.2*, 31 December 2014

Other references

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

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AS5021	*AS 5021:2005 - The language of health concept representation*, Standards Australia, 2005.
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IHE2011b	*IHE IT Infrastructure Technical Framework Volume 2a (ITI TF-2a) Transactions Part A –Sections 3.1 – 3.28.*