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Residential Care Transfer Reason, Health Summary and Medication Chart
My Health Record Conformance Profile

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1 Introduction

1.1 Purpose

This document summarises the requirements for producing systems of residential care transfer reason (RTR), residential care health summary (RHS) and residential care medication chart (RMC) documents that connect to the My Health Record System.

This document lists the specific conformance requirements for RTR, RHS and RMC documents that are in addition to the Common Conformance Profile for Clinical Documents [AGENCY2017a]. Together, both documents represent the complete conformance requirements for the RTR, RHS and RMC documents.

1.2 Intended audience

The intended audience includes the following organisations:

- healthcare providers; and
- developers and software providers of digital health systems.

1.3 Scope

The scope of this conformance profile is the use of RTR, RHS and RMC, in the context of the My Health Record system.

1.4 Overview

The RTR, RHS and RMC document are three individual document types in the My Health Record system. They will be utilised when the healthcare individual (i.e. resident) is being transferred from their current residential aged care facility (RACF) to an acute care setting (hospital) for planned and unplanned transfer.

- Residential care transfer reason (RTR): A residential care transfer reason is generated by the originating residential care facility and contains the particulars of the transfer from a residential care setting including provider information, reason for transfer, and date of transfer.
- Residential care health summary (RHS): A residential care health summary contains information about a residential care individual's environment, health and care to support continuity of care.
- Residential care medication chart (RMC): A residential care medication chart is used as a record of orders and administration of prescription medicines, non-prescription medicines and nutritional supplements for individuals living in residential care facilities.

The producing systems of RTR, RHS, and RMC may or may not be integrated. There is no expectation that one producing system will generate all three document types. For example, the RMC document is often authored and generated by a separate medication management system that is different from the producing system of the RTR and RHS. Implementers are recommended to implement the document types relevant to the software systems.

1.5 Relevant specifications

Related specifications are listed below:

1. *Common Conformance Profile for Clinical Documents* [AGENCY2017a] - provides common Conformance Requirements which must be adhered to unless specifically overridden in this document.
2. *Core Level One Clinical Document Structured Content Specification* [AGENCY2018a] - specifies the data elements permissible in the clinical document at a logical level.
3. *Core Level One Clinical Document CDA Implementation Guide* [AGENCY2018b] - *specifies the mapping from the structured content specification into a clinical document using an HL7 CDA structure.*

The Core Level One Clinical Document Structured Content Specification [AGENCY2018a] and CDA Implementation Guide [AGENCY2018b] are generic, not specific to residential care transfer reason, health summary and medication chart, and not fit for purpose without additional implementation guidance.

2 Common Requirements for producing systems

The following requirements apply to all three clinical document types – residential care transfer reason (RTR), residential care health summary (RHS) and residential care medication chart (RMC).

Note to reader: the unique numbering of each requirement contained within this section of the profile is not intended to be sequential. Further, any gaps in numbering are intentional and inconsequential.

ACTS-01	**Capability to print the document** The producing system SHALL enable printing functionality of the document or enable the export of the document in a printable format.
Rationale	To enable the healthcare provider to print a copy of the clinical document from the producing system to accommodate various level of digital adoption and system maturity, and when an electronic document is not available or accessible in the My Health Record. For example, when the individual does not have a My Health Record or the healthcare provider has no access to the My Health Record.
Additional Notes	Conformance to this requirement can be demonstrated by showing print functionality has not been blocked.
	Type Conformance **Priority** Mandatory

ACTS-02	**Automatic re-upload of a document** The producing system SHOULD provide an automatic upload retry mechanism if the errors are detected and recoverable. For example, the My Health Record system is temporarily unavailable, or the network is unavailable.
Rationale	To enable the producing system to silently and unobtrusively re-upload the document to the My Health Record followed by recoverable errors.
Additional Notes	See requirement ACTS-03. One type of error message reported by the My Health Record system is that the system is temporarily unavailable for uploads and in this case the appropriate response would be for the producing system to retry the upload at a later point in time. An automatic upload retry mechanism will be enacted where document uploads have previously failed.
	Type Conformance **Priority** Recommended

ACTS-03 **Prompt to indicate unsuccessful document upload**

The producing system SHOULD prompt the user to indicate the document upload to the My Health Record system is unsuccessful.

Rationale To enable the producing system to alert user for the unsuccessful document upload, so that the user can take appropriate actions accordingly.

Additional Notes See requirement ACTS-02.

Type Conformance **Priority** Recommended

ACTS-04 **Upload of the document**

The producing system SHALL upload the document to the My Health Record system as soon as the document is authored and generated.

Rationale To prevent the producing system from uploading the document as part of the batch or overnight processing, so that there is no delay in accessing the documents during a transfer event.

Type Conformance **Priority** Mandatory

2.1 Objects of conformance

ACTS-05 **Allowed types of producing systems**

The RTR, RHS and RMC clinical documents SHALL only be produced by:

- clinical information systems (CIS); and
- contracted service provider (CSP) systems.

Rationale It is only appropriate for these producing systems to upload RTR, RHS and RMC documents until that risk profile for other producing systems are assessed and understood.

Consistent with other existing My Health Record documents.

Type Conformance **Priority** Mandatory

ACTS-06 **Disallowed types of producing systems**

The RTR, RHS and RMC SHALL NOT be produced by a:

- registered consumer portal
- registered repository
- registered portal operator (mobile gateway), or
- registered provider portal.

Rationale The risk profile for these types of producing systems has not been assessed. It is not appropriate for these producing systems to upload RTR, RHS and RMC documents until that risk profile is understood.

Consistent with other existing My Health Record documents.

Type Conformance **Priority** Mandatory

2.2 Document author contact details

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. Inclusion of personal provider contact details is typically supported on an optional basis. However, some clinical information systems automatically populate the relevant fields with personal provider details already stored in the system.

While inclusion of personal provider details may in some cases be useful for documents exchanged point-to-point between providers, this is of concern as this information becomes visible to consumers once they are uploaded to their My Health Record.

Note: *Providers who have elected not to have their software automatically include any individual electronic contact details or address may still include these details where required in the narrative part of the document.*

ACTS-07	**Confirm author's personal electronic communication details to be included**
	If the producing system captures the personal electronic communication details (e.g. email address, phone number or fax number) of the document author, the individual electronic communication details SHALL NOT be automatically included unless stated otherwise.
Rationale	To prevent personal provider details become visible to the consumers for privacy and safety concerns. Consistent with other existing My Health Record documents.
Additional Notes	Software that doesn't provide this option can conform to this requirement by not automatically inserting individual's personal electronic communication details into the document as appropriate. The software can also demonstrate conformance by not capturing the individual's personal electronic communication details in the CIS.
	Type Conformance **Priority** Conditional

ACTS-08	**Confirm author's personal address to be included**
	If the producing system captures the personal address of the document author, the individual personal address SHALL NOT be automatically included unless stated otherwise.
Rationale	To prevent personal provider details become visible to the consumers for privacy and safety concerns. Consistent with other existing My Health Record documents.
Additional Notes	Software that doesn't provide this option can conform to this requirement by not automatically inserting individual's personal address details into the document as appropriate. The software can also demonstrate conformance by not capturing the individual's personal address details in the CIS.
	Type Conformance **Priority** Conditional

2.3 Application of Core Level One Clinical Document specifications

The Core Level One Clinical Document is an open specification that requires constraints to make the RTR, RHS and RMC fit for purpose. The requirements in this section constrain the Core Level One Clinical Document CDA Implementation Guide [AGENCY2018b] and should be considered during the software design stage.

The following requirements include their logical model path as derived from the 'Structured Content Specification (SCS) Data Component' values in the Core Level One Clinical Document CDA Implementation Guide [AGENCY2018b] (e.g. Subject of care > Participant).

The Xpath indicates the Clinical Document Architecture (CDA) schema element(s) to which conformance requirements are applied.

2.3.1 Cardinality

These requirements override the attribute cardinality specified in the Core Level One Clinical Document CDA Implementation Guide [AGENCY2018b].

2.3.1.1 Healthcare individual

The healthcare individual is sometimes called “subject of care”, “individual”, “consumer” or “patient”.

ACTS-09	**Healthcare individual identifier** The producing system SHALL instantiate an Individual Healthcare Identifier (IHI) of the healthcare individual. • Subject of care > Participant > Entity identifier
Rationale	To mandate the inclusion of the individual’s IHI to enable interoperability, eliminate ambiguity and support the indexing of clinical documents. If an IHI is not available, then the individual’s digital health record cannot be identified.
Additional Notes	The XPath is: ClinicalDocument/recordTarget/patientRole/patient/ext:asEntityIdentifier
	Type Technical **Priority** Mandatory

ACTS-10 **Healthcare individual address**

If instantiating the healthcare individual address:

- Subject of care > Participant > Address

The producing system SHALL contain:

- an address (of any type), OR
- a nullflavor (of any type), OR
- both,

BUT NOT

- an address (of any type) AND a MSK nullflavor.

Rationale

To enable consistent and correct identification of the individual.

To provide consistency with existing My Health Record clinical documents. The author is permitted to not include the individual's residential address due to privacy or safety concerns.

To enable the continuity of care and future research and public health/data analysis.

Additional Notes

The document author is permitted to suppress or not include the individual's residential address through the use of nullflavor. If the address is known, but not included in the document, then it is preferred the MSK nullflavor is used. The masking of the address may be used when there are patient privacy or safety concerns.

It is prohibited to include a MSK nullflavor AND an address because a masked address should not be available in the CDA/XML document.

Other nullflavors are also permitted.

The XPath is: ClinicalDocument/recordTarget/patientRole/addr

Type Technical **Priority** Conditional

2.3.1.2 Document author

ACTS-11 **Document author**

The producing system SHALL instantiate the document author as a person.

- ClinicalDocument > Participant > Person or Organisation or Device > Person

Rationale To specify the document author must be instantiated as a person.

To prohibit the document author as a device in the CDA implementation guide.

Additional Notes It is acknowledged that the document might be the result of collaboration between healthcare providers or the result of a shared healthcare event, but the My Health Record system requires each document to have one document author that is ultimately responsible for the clinical content that is uploaded to the My Health Record.

The XPath is: ClinicalDocument/author

Type Technical **Priority** Mandatory

ACTS-12 **Document author identifier**

The producing system SHALL instantiate a Healthcare Provider Identifier for Individual (HPI-I) of document author, otherwise it SHALL have a value that identifies the document author, and that value SHALL NOT be a nullflavor.

- Document author > Participant > Entity identifier

Rationale To mandate the inclusion of a HPI-I for authoring healthcare provider, or a value that identifies the document author to support existing organisations that are granted a temporary HPI-I exemption and do not provide a HPI-I of the document author.

Additional Notes The relaxation of the mandatory requirement to include an HPI-I is only available to specific healthcare provider organisations, at the discretion of the My Health Record System Operator. HPI-I exemptions for a small number of organisations will continue to apply until the Agency reviews that policy.

The XPath is:

ClinicalDocument/author/assignedAuthor/assignedPerson/ext:asEntityIdentifier

Type Technical **Priority** Mandatory

ACTS-13 **Document author organisation name**

The producing system SHALL instantiate one and only one name of the organisation the document author is representing at the time of authoring the document.

- Document author > Participant > Person or Organisation or Device > Person > Employment Detail > Employer Organisation > Organisation > Organisation Name

Rationale To mandate the inclusion of the document author's organisation name.

Additional Notes The XPath is:

/ClinicalDocument/author/assignedAuthor/assignedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name

Type Technical **Priority** Mandatory

ACTS-14 **Document author organisation identifier**

The producing system SHALL instantiate one Healthcare Provider Identifier for Organisation (HPI-O) the document author is representing at the time of authoring the document.

- Document author > Participant > Person or Organisation or Device > Person > Employment Detail > Employer Organisation > Entity identifier

Rationale To mandate the inclusion of the HPI-O of the organisation the author is representing.

Additional Notes The XPath is:

/ClinicalDocument/author/assignedAuthor/assignedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/ext:asEntityIdentifier

Type Technical **Priority** Mandatory

ACTS-15 **Document author workplace address**

The producing system SHALL instantiate one and only one value for document author's workplace address and that address SHALL be an Australian address.

- Document author > Participant > Address

Rationale To mandate the inclusion of the author's workplace address. This requirement overrides the optional author's workplace address in the CDA implementation guide.

To restrict the document author's workplace address to be an Australian address and prohibits an international address.

Additional Notes The XPath is: ClinicalDocument/author/assignedAuthor/addr

The document may contain other non-workplace addresses. See requirement ACTS-08.

Type Technical **Priority** Mandatory

ACTS-16 **Document author workplace address type**

When instantiating the document author's workplace address:

- Document author > Participant > Address

The producing system SHALL instantiate one of the following document author's workplace address types:

- WP (Work Place)
- PST (Postal Address)
- TMP (Temporary Address)

Rationale To restrict the address use attributes of the workplace address in the CDA implementation guide.

Additional Notes The XPath is: ClinicalDocument/author/assignedAuthor/addr/@use

Type Technical **Priority** Mandatory

ACTS-17 **Document author workplace electronic communication details**

If instantiating the author's workplace electronic communication details:

- Document author > Participant > Electronic communication detail

The producing system SHALL instantiate one of the following document author's workplace electronic communication types:

- WP (Workplace)
- AS (Answering Service)
- EC (Emergency Contact)
- MC (Mobile Contact)

Rationale To restrict the telecom use attributes of the workplace electronic communication details in the CDA implementation guide.

Additional Notes The XPath is:

ClinicalDocument/author/assignedAuthor/telecom/@use

Type Technical **Priority** Conditional

2.3.1.3 Primary healthcare provider

The primary healthcare provider can only be instantiated as a person, represented as a "PARTICIPANT" in the Core Level One Clinical Document CDA Implementation Guide [AGENCY2018b] and Structured Content Specification [AGENCY2018a].

ACTS-18 **Primary healthcare provider**

The producing system SHALL instantiate one and only one primary healthcare provider as a personand this SHALL NOT contain a nullFlavor attribute.

- Participant

Rationale To mandate the inclusion of the primary healthcare provider of the healthcare individual and must not have more than one to avoid confusion. This requirement overrides the CDA implementation guide which allows the option of multiple primary care providers.

Additional Notes The XPath is: ClinicalDocument/participant

Type Technical **Priority** Mandatory

ACTS-19 **Primary healthcare provider code**

The producing system SHALL instantiate a typeCode of “PART” and a functionCode of “PCP” for the primary healthcare provider:

- ClinicalDocument/participant/@typeCode=“PART”
- ClinicalDocument/participant/functionCode/@code=“PCP”

Rationale To represent the primary healthcare provider participant and provide further guidance on the generic participant as a person provided in the CDA implementation guide.

Type Technical **Priority** Mandatory

ACTS-20 **Primary healthcare provider workplace address**

If instantiating the primary healthcare provider’s workplace:

- Participant > Participant > Address

The producing system SHALL instantiate at most one of the primary healthcare provider workplace address, and that workplace address SHALL contain one of the following workplace address types:

- WP (Work Place)
- PST (Postal Address)
- TMP (Temporary Address)

Rationale To restrict the inclusion of at most one primary healthcare provider’s workplace address and the use of workplace address types in the CDA implementation guide.

Additional Notes The XPath is:

ClinicalDocument/participant[part_person]/associatedEntity/addr/@use

Type Technical **Priority** Conditional

ACTS-21 **Primary healthcare provider workplace electronic communication details**

If instantiating the primary healthcare provider's workplace electronic communication details:

- Participant > Participant > Electronic communication detail

The producing system SHALL instantiate one of the following workplace electronic communication types:

- WP (Workplace)
- AS (Answering Service)
- EC (Emergency Contact)
- MC (Mobile Contact)

Rationale To restrict the telecom use attributes of the workplace electronic communication details in the CDA implementation guide.

Additional Notes The XPath is:

ClinicalDocument/participant[part_person]/associatedEntity/telecom/@use

Type Technical **Priority** Conditional

ACTS-22 **Primary healthcare provider identifier**

If instantiating the primary healthcare provider identifier:

- Participant > Participant > Entity identifier

The producing system SHOULD instantiate a Healthcare Provider Identifier for Individual (HPI-I) of the primary healthcare provider.

Rationale To encourage the inclusion of Healthcare Provider Identifier-Individual (HPI-I) of the primary healthcare provider as a person.

Additional Notes The XPath is
ClinicalDocument/participant[part_person]/associatedEntity/associatedPerson/ext:asEntityIdentifier

Type Technical **Priority** Recommended

ACTS-23 **Primary healthcare provider organisation name**

When instantiating the primary healthcare provider as a person, the producing system SHALL instantiate the name of the organisation the primary healthcare provider is representing.

- Participant > Participant > Person or Organisation or Device > Person > Employment Detail > Employer Organisation > Organisation > Organisation Name

Rationale To mandate the name of the organisation the primary healthcare provider is representing.

Additional Notes The XPath is either:

/ClinicalDocument/participant[part_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name

Type Technical **Priority** Mandatory

ACTS-24 **Primary healthcare provider organisation identifier**

If instantiating the primary healthcare provider, the producing system SHOULD instantiate a Healthcare Provider Identifier for Organisation (HPI-O) the primary health provider is representing at the time of authoring the document.

- Participant > Participant > Person or Organisation or Device > Person > Employment Detail > Employer Organisation > Entity Identifier

Rationale To encourage the inclusion of Healthcare Provider Identifier-Organisation (HPI-O) of the organisation the primary healthcare provider is representing for the My Health Record system.

Additional Notes The XPath is either:

/ClinicalDocument/participant/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/ext:asEntityIdentifier

Type Technical **Priority** Recommended

2.3.1.4 Document metadata

ACTS-25 **Document version number**

The producing system SHALL instantiate the My Health Record system CDA document version number:

- ClinicalDocument/versionNumber

Rationale This requirement overrides the CDA implementation guide by mandating the inclusion of the document version number recognised by the My Health Record system.

Consistent with other existing My Health Record documents.

Type Technical **Priority** Mandatory

2.3.2 Value sets

These requirements override the value sets specified in the Core Level One Clinical Document CDA Implementation Guide [AGENCY2018b], or specify a value set where none was provided.

ACTS-26 **Individual indigenous status**

The indigenous status value SHALL be one of the values from Australian Indigenous Status value set and the code system OID SHALL be: 1.2.36.1.2001.1004.200.10012.

- Subject of care > Participant > Person or Organisation or Device > Person > Demographic data > Indigenous status

Rationale This requirement overrides the deprecated and historical METeOR indigenous status value set in the CDA implementation guide.

Additional Notes The Australian Indigenous Status value set can be found here: https://www.healthterminologies.gov.au/integration/R4/fhir/ValueSet/australian-indigenous-status-1

The XPath is: /ClinicalDocument/recordTarget/patientRole/patient/ethnicGroupCode

Type Technical **Priority** Mandatory

ACTS-27 **Healthcare provider role**

The healthcare provider role value SHOULD be one of the values from the Practitioner Role value set,

Or this MAY be a nullFlavor attribute.

- Document author > Role, or
- Participant > Role

Rationale This requirement overrides the ANZSCO - Australian and New Zealand Standard Classification of Occupations value set in the CDA implementation guide.

This requirement aligns with HL7 AU standard for practitioner role terminology (https://build.fhir.org/ig/hl7au/au-fhir-base/StructureDefinition-au-practitionerrole.html).

Additional Notes The Practitioner Role value set can be found here: https://healthterminologies.gov.au/fhir/ValueSet/practitioner-role-1

The XPath is:

- ClinicalDocument/author/assignedAuthor/code
- ClinicalDocument/participant[part_person]/associatedEntity/code

Type Technical **Priority** Recommended

3 Requirements for residential care transfer reason (RTR) producing systems

The following requirements apply to the generation of a residential care transfer reason for the My Health Record system, in addition to the common requirements in section 2.

RTR-01 **Document conformance level**

The document SHALL conform to the requirements for conformance level 1B as defined in the Common Conformance Profile for clinical documents [AGENCY2017a].

Rationale To ensure the document meets the requirements of the document conformance level.

Consistent with other existing My Health Record documents.

Type Conformance **Priority** Mandatory

RTR-02 **Mandatory content for the residential care transfer reason document**

The producing system SHALL have the capability to include the following information in the narrative section of document:

- Transfer date, and
- Primary reason for transfer.

Rationale To inform the receiving healthcare provider the primary reason for transferring the individual and the transfer date to assist in the provision of healthcare for the individual.

To mitigate the risk of missing critical health information in the residential care transfer reason document.

Type Conformance **Priority** Mandatory

RTR-03 **Recommended content for the residential care transfer reason document**

The producing system SHOULD include the action taken to treat the presenting condition for the individual in the document.

Rationale To inform the receiving healthcare provider about the individual's health situation and the action taken prior to the transfer to assist in the provision of healthcare for the individual.

Type Conformance **Priority** Recommended

RTR-04 **Prohibit PDF attachment**

The producing system SHALL NOT contain a PDF attachment.

Rationale Disallowing PDF attachment reduces the risk of the upload of non-RTR information. The clinical information of the RTR is expected to be in the document narrative.

Additional Notes See requirement RTR-02.

This requirement overwrites requirement 23741 in the Common Conformance Profile for clinical documents [AGENCY2017a]. Other forms of attachments as stated in the Common Conformance Profile (e.g. .jpg, .png) are allowed except PDF attachment (.pdf).

Type Conformance **Priority** Mandatory

RTR-05 **Prompt to upload a RHS and RMC**

When a RTR is generated, the producing system SHALL prompt the author to upload a RHS and RMC with up-to-date information.

Rationale To remind authors of the upload of RHS and RMC together with a RTR to support the provision of healthcare for the individual. This requirement mitigates the risk that RHS and RMC may not be during the transfer.

Additional Notes Automated reminders encourage document authors to contribute meaningful, up-to-date and relevant clinical information to the healthcare providers and MHR.

Type Conformance **Priority** Mandatory

3.1 Application of Core Level One Clinical Document specifications

RTR-06 **RTR Document type**

The producing system SHALL use:

- the code “100.32044” in the code attribute of the code element of the clinical document;
- the OID in the codeSystem attribute of the code element of the clinical document SHALL be “1.2.36.1.2001.1001.101”.

Rationale To specify the document type code and code system for the residential care transfer reason document type.

Additional Notes The XPath is: ClinicalDocument/code

Type Technical **Priority** Mandatory

RTR-07 **RTR Document type display name**

The producing system SHOULD include the value “Residential Care Transfer Reason” in the displayName attribute of the code element of the clinical document.

Rationale To support future proofing of the document type display name as terminology may change over time.

Additional Notes The XPath is: ClinicalDocument/code

Type Technical **Priority** Recommended

RTR-08 **RTR Document title**

The producing system SHALL instantiate one and only one document title, and the title element value of the clinical document SHALL be “Residential Care Transfer Reason”.

Rationale To specify the document title for the RTR document type, and ensure the consistent rendering of the document title in the My Health Record system.

Additional Notes The XPath is: ClinicalDocument/title

Type Technical **Priority** Mandatory

RTR-09	**Clinical document template identifier**
	The producing system SHALL ensure that one instance of the clinical document: • the root attribute of the templateId element SHALL be "1.2.36.1.2001.1001.100.1002.32044"; and • the extension attribute of the templateId element SHALL be "1.0".
Rationale	To specify the document template for the RTR document type. This templateId is used for document conformance and validation purposes.
Additional Notes	This is in addition to the template ID specified in the Core Level One Clinical Document CDA Implementation Guide.
	Type Technical **Priority** Mandatory

4 Requirements for residential care health summary (RHS) producing systems

The following requirements apply to the generation of a residential care health summary for the My Health Record system, in addition to the common requirements in section 2.

RHS-01 **Document conformance level**

The document SHALL conform to the requirements for conformance level 1A as defined in the Common Conformance Profile for clinical documents [AGENCY2017a].

Rationale To ensure the document meets the requirements of the document conformance level.

Consistent with other existing My Health Record documents.

Type Conformance **Priority** Mandatory

RHS-02 **Inclusion of PDF attachment of RHS**

The document SHALL contain one and only one PDF attachment of the residential care health summary document.

Rationale To enable the receiving healthcare provider to access and view the attachment to support the provision of healthcare for the individual.

Until the document can be represented with structured data it should only be made available in the My Health Record system in PDF format to ensure that the presentation and rendering of the data is as expected by the authoring healthcare provider.

Additional Notes The PDF file is expected to be viewable by the healthcare individual and any healthcare provider that is a My Health Record participant. For example, the residential care health summary document PDF files should not have any of these features:

- encryption
- password protection
- printing or copying restriction
- embedded fonts (as not all PDF viewers support them).

Type Conformance **Priority** Mandatory

RHS-03 **Prohibit an advance care information attachment**

The document SHALL NOT contain any attachments about advance care information when uploading to the My Health Record, including a PDF attachment of the Advance Care Planning (ACP) document.

Rationale To be compliant with the Copyright Act 1968, for uploading information to the My Health Record without infringing copyright.

To enable discoverability and currency of advance care information within the My Health Record as a separate document type (i.e. advance care planning document).

To ensure other healthcare providers and organisations can access all ACP information shared independently to the My Health Record. To enable consistent user experience to access existing advance care information.

Type Conformance **Priority** Mandatory

RHS-04 **Demographic details of the healthcare individual**

The producing system SHALL include the demographic details of the healthcare individual on each page of the PDF attachment.

Rationale To ensure the correct individual's residential care health summary PDF document is correctly attached and uploaded to the My Health Record system. This requirement mitigates the risk of individual identification errors.

Additional Notes The demographic details of the healthcare individual include the first name (if applicable), family name, date of birth and sex.

Type Conformance **Priority** Mandatory

RHS-05 **Mandatory content for the residential care health summary**

The producing system SHALL include the following information in the PDF attachment:

- Allergies and adverse reactions
- Medical history
- Vital signs
- Emergency contact details
- Weight
- Diet and fluid

Rationale To inform the receiving healthcare provider about the individual's health situation, and sufficient health information are provided to assist in the provision of healthcare for the individual.

Additional Notes This requirement implies the information is either displayed in the PDF attachment or indicates that no information is displayed (i.e. exclusion statement) in the sections of a PDF attachment.

The emergency contact can be a family member, next of kin, Enduring Power of Attorney (EPOA), carer or guardian of the healthcare individual.

Type Conformance **Priority** Mandatory

RHS-06 **Recommended content for the residential care health summary**

The producing system SHOULD include the following information in the PDF attachment:

- Pain
- Resident history
- Behavioural profile
- Cognitive impairment
- Clinical frailty
- Activities of daily living or pre-morbid condition
- Implants and devices
- Falls and fractures
- Wound management
- Pressure injuries
- Care needs summary

Rationale To inform the receiving healthcare provider about the individual's health situation, and sufficient health information are provided to assist in the provision of healthcare for the individual.

Type Conformance **Priority** Recommended

RHS-07 **Document preview prior to upload**

The producing system SHALL provide an automatic preview of the document prior to the upload.

Rationale To enable the document author to view and update the document, and ensure the document is appropriate, readable, complete (i.e. no missing pages/information), rendered correctly and for the correct individual prior to the document upload.

To mitigate the risk of having an incorrect, incomplete and inappropriate information, that may lead to misinterpretation and clinical safety concerns.

Type Conformance **Priority** Mandatory

4.1 Application of Core Level One Clinical Document specifications

RHS-08 **RHS Document type**

The producing system SHALL use:

- the code “100.32049” in the code attribute of the code element of the clinical document;
- the OID in the codeSystem attribute of the code element of the clinical document SHALL be “1.2.36.1.2001.1001.101”.

Rationale To specify the document type code and code system for the residential care transfer reason document type.

Additional Notes The XPath is: ClinicalDocument/code

Type Technical **Priority** Mandatory

RHS-09 **RHS Document type display name**

The producing system SHOULD include the value “Residential Care Health Summary” in the displayName attribute of the code element of the clinical document.

Rationale To support future proofing of the document type display name as terminology may change over time.

Additional Notes The XPath is: ClinicalDocument/code

Type Technical **Priority** Recommended

RHS-10 **RHS Document title**

The producing system SHALL instantiate one and only one document title, and the title element value of the clinical document SHALL be “Residential Care Health Summary”.

Rationale To specify the document title for the RHS document type, and ensure the consistent rendering of the document title in the My Health Record system.

Additional Notes The XPath is: ClinicalDocument/title

Type Technical **Priority** Mandatory

RHS-11 **Clinical document template identifier**

The producing system SHALL ensure that one instance of the clinical document:

- the root attribute of the templateId element SHALL be "1.2.36.1.2001.1001.100.1002.32049"; and
- the extension attribute of the templateId element SHALL be "1.0".

Rationale To specify the document template for the document type.

This templateId is used for document conformance and validation purposes.

Additional Notes This is in addition to the template ID specified in the Core Level One Clinical Document CDA implementation guide.

Type Technical **Priority** Mandatory

RHS-12 **Referencing residential care health summary PDF attachment**

The document SHALL contain the PDF (see requirement RHS-02) in ENCAPSULATED DATA with:
"templateID/@root="1.2.36.1.2001.1001.101.102.16883"
under section with
"templateID/@root="1.2.36.1.2001.1001.101.101.16886".

Rationale To uniquely identify the inclusion of the attachment.

Additional Notes The document may contain other attachments (e.g. logos) that do not contain a residential care health summary or any other residential clinical information.
This requirement applies only to attachments that include residential information.

Type Technical **Priority** Mandatory

RHS-13 **PDF attachment MIME type**

The MIME type of the PDF attachment SHALL be of .pdf application/pdf MIME type.

Rationale To specify the MIME type of the document to be a PDF attachment.

Additional Notes This requirement overrides Requirement 023741 in the Common Conformance Profile for clinical documents [AGENCY2017a].

Type Technical **Priority** Mandatory

5 Requirements for residential care medication chart (RMC) producing systems

The following requirements apply to the generation of a residential care medication chart for the My Health Record system, in addition to the common requirements in section 2.

RMC-01 **Document conformance level**

The document SHALL conform to the requirements for conformance level 1A as defined in the Common Conformance Profile for clinical documents [AGENCY2017a].

Rationale To ensure the document meets the requirements of the document conformance level.

Consistent with other existing My Health Record documents.

Type Conformance **Priority** Mandatory

RMC-02 **Inclusion of PDF attachment of RMC**

The document SHALL contain one and only one PDF attachment of the current medication chart of the healthcare individual.

Rationale To enable the producing system to provide the list of recorded medicines on the medication chart as an attachment will ease change and adoption barriers.

Until the document can be represented with structured data it should only be made available in the My Health Record system in PDF format to ensure that the presentation and rendering of the data is as expected by the authoring healthcare provider.

Additional Notes A medication chart can be a scanned copy of a paper chart or an electronic medication chart.

The PDF file is expected to be viewable by the healthcare individual and any healthcare provider that is a My Health Record participant. For example, the residential care medication chart document PDF files should not have any of these features:

- encryption
- password protection
- printing or copying restriction
- embedded fonts (as not all PDF viewers support them).

Type Conformance **Priority** Mandatory

RMC-03 **Prohibit an advance care information attachment**

The document SHALL NOT contain any attachments about advance care information when uploading to the My Health Record, including a PDF attachment of the Advance Care Planning (ACP) document.

Rationale To be compliant with the Copyright Act 1968, for uploading information to the My Health Record without infringing copyright.

To enable discoverability and currency of advance care information within the My Health Record as a separate document type (i.e. advance care planning document).

To ensure other healthcare providers and organisations can access all ACP information shared independently to the My Health Record. To enable consistent user experience to access existing advance care information.

Type Conformance **Priority** Mandatory

RMC-04 **Completeness of the residential care medication chart**

The producing system SHALL have the capability to include a list of medicines and administration events recorded in the medication chart.

Rationale To provide the healthcare providers with information about the medicines that have been administered to the individual prior to transfer will assist in the provision of care for the healthcare individual. It is important to include the list of medicines as complete as possible.

Additional Notes The current medication chart is a list of current medicines and their administration events (i.e. date and time of administration) recorded in the medication chart with at least one month of last administration events is preferred. However, it does not prevent medicines beyond the one-month timeframe to be included if the author chooses to do so.

Type Conformance **Priority** Mandatory

RMC-05 **National residential medication chart**

If the producing system generates a National Residential Medication Chart (NRMC), the producing system SHALL ensure the medication chart meets the medicine information, structure and presentation described in NRMC.

Rationale This requirement aligns with the National Residential Medication Chart produced by the Australian Commission on Safety and Quality in Health Care [ACSQHC2021a].

To inform the receiving healthcare provider about the individual's health situation and current medicines to assist in the provision of healthcare.

Additional Notes See requirement RMC-04.

Type Conformance **Priority** Conditional

RMC-06 **Demographic details of the healthcare individual**

The producing system SHALL include the demographic details of the healthcare individual of the PDF attachment.

Rationale To ensure the correct individual's residential care medication chart PDF document is correctly attached and uploaded to the My Health Record system. This requirement mitigates the risk of individual identification errors.

Additional Notes The demographic details of the healthcare individual include the first name (if applicable), family name, date of birth and sex.

Type Conformance **Priority** Mandatory

RMC-07 **Mandatory content for the residential care medication chart**

If the producing system generates a medication chart that is not National Residential Medication Chart (NRMC), the producing system SHALL include the following information in the PDF attachment:

- Allergies and adverse reactions
- Current medicines
- Ceased medicines (if applicable)
- Withheld (equivalent to suspended) medicines (if applicable)
- Functional status for medicines administration
- Weight

Rationale To inform the receiving healthcare provider about the individual's health situation and current medicines to assist in the provision of healthcare.

Additional Notes See requirement RMC-04.

Medicines that are ceased in the last 3 months are recommended. Author needs to consider the relevance and importance of the medicine given the situation in which the document was constructed. This requirement does not prevent medicines beyond the three-month timeframe to be included if the author chooses to do so.

The functional status for medicines administration includes an indication of swallowing difficulties, cognitive impairment, dexterity difficulties, resistant to medicine, nil by mouth and self-administers.

Type Conformance **Priority** Conditional

RMC-08 **Recommended content for the residential care medication chart**

If the producing system generates a medication chart that is not National Residential Medication Chart (NRMC), the producing system SHOULD include the following information in the PDF attachment:

- Pharmacy organisation details
- Prescriber details
- Nutritional supplement

Rationale To inform the receiving healthcare provider about the individual's health situation, and enable sufficient health information are provided to assist in the provision of healthcare for the individual.

Type Conformance **Priority** Recommended

RMC-09 **Ceased medicines**

If the RMC includes any ceased medicines of the healthcare individual, the ceased medicines SHOULD be visually differentiated from the current medicines.

Rationale To reduce the confusion between the current and ceased medicines by the readers.

This requirement reflects a recommendation by the Australian Commission on Safety and Quality in Healthcare care – Electronic National Residential Medication Chart Medication Management Systems [ACSQHC2021].

Additional Notes For example, ceased medicines are presented in a separate or distinct section below the current medicines section, or clearly indicated on the paper medication chart that a medicine is ceased.

Type Conformance **Priority** Recommended

RMC-10 **Document preview prior to upload**

If the document contains a scanned copy of a paper medication chart, the producing system SHALL provide an automatic preview of the document prior to the upload.

Rationale To allow the document author to view the information that are included in the attachment that is appropriate, readable, complete (i.e. no missing pages), rendered correctly and for the correct individual prior to the MHR upload.

To mitigate the risk of having an incorrect, incomplete and inappropriate information that may lead to misinterpretation and clinical safety concerns.

Additional Notes This requirement applies to a scanned copy of medication chart that requires manual scanning or uploading to the producing system.

Type Conformance **Priority** Conditional

5.1 Application of Core Level One Clinical Document specifications

RMC-11 **RMC Document type**

The producing system SHALL use:

- the code “100.32046” in the code attribute of the code element of the clinical document;
- the OID in the codeSystem attribute of the code element of the clinical document SHALL be “1.2.36.1.2001.1001.101”.

Rationale To specify the document type code and code system for the residential care transfer reason document type.

Additional Notes The XPath is: ClinicalDocument/code

Type Technical **Priority** Mandatory

RMC-12 **RMC Document type display name**

The producing system SHOULD include the value “Residential Care Medication Chart” in the displayName attribute of the code element of the clinical document.

Rationale To support future proofing of the document type display name as terminology may change over time.

Additional Notes The XPath is: ClinicalDocument/code

Type Technical **Priority** Recommended

RMC-13 **RMC Document title**

The producing system SHALL instantiate one and only one document title, and the title element value of the clinical document SHALL be “Residential Care Medication Chart”.

Rationale To specify the document title for the RMC document type, and ensure the consistent rendering of the document title in the My Health Record system.

Additional Notes The XPath is: ClinicalDocument/title

Type Technical **Priority** Mandatory

RMC-14 **Clinical document template identifier**

The producing system SHALL ensure that one instance of the clinical document:

- the root attribute of the templateId element SHALL be "1.2.36.1.2001.1001.100.1002.32046"; and
- the extension attribute of the templateId element SHALL be "1.0".

Rationale To specify the document template for the document type.

This templateId is used for document conformance and validation purposes.

Additional Notes This is in addition to the template ID specified in the Core Level One Clinical Document CDA Implementation Guide.

Type Technical **Priority** Mandatory

RMC-15 **Referencing residential care medication chart PDF attachment**

The document SHALL contain the PDF (see requirement RMC-02**)** in ENCAPSULATED DATA with:

"templateID/@root="1.2.36.1.2001.1001.101.102.16883"
under section with
"templateID/@root="1.2.36.1.2001.1001.101.101.16886".

Rationale To uniquely identify the inclusion of the attachment.

Additional Notes The document may contain other attachments (e.g. logos) that do not contain a residential care medication chart or any other residential clinical information.
This requirement applies only to attachments that include residential information.

Type Technical **Priority** Mandatory

RMC-16 **PDF attachment MIME type**

The MIME type of the PDF attachment SHALL be of .pdf application/pdf MIME type.

Rationale To specify the MIME type of the document to be a PDF attachment.

Additional Notes This requirement overrides Requirement 023741 in the Common Conformance Profile for clinical documents [AGENCY2017a].

Type Technical **Priority** Mandatory

Acronyms

Acronym	Description
ACP	Advance Care Planning
CIS	Clinical Information System
CSP	Contracted Service Provider
CDA	Clinical Document Architecture
HPI-I	Healthcare provider identifier - individual
HPI-O	Healthcare provider identifier - organisation
IHI	Individual healthcare identifier
NRMC	National Residential Medication Chart
RACF	Residential Aged Care Facility
RTR	Residential Care Transfer Reason
RHS	Residential Care Heath Summary
RMC	Residential Care Medication Chart

Glossary

Term	Meaning
clinical information system (CIS)	A system that deals with the collection, storage, retrieval, communication and optimal use of health-related data, information, and knowledge. A clinical information system may provide access to information contained in an electronic health record, but it may also provide other functions such as workflow, order entry, and results reporting.
conformance	A measurement (by testing) of the adherence of an implementation to a specification or standard.
conditional	Conditional priority is mandatory requirement where implementation is subject to the specified condition being met.
healthcare provider identifier - individual (HPI-I)	A unique 16-digit number used to identify providers who deliver healthcare in the Australian healthcare setting.
healthcare provider identifier - organisation (HPI-O)	A unique 16-digit number used to identify organisations who deliver care in the Australian healthcare setting.
healthcare individual	An individual who is, or could be, the subject of care in the context of a healthcare event.
individual healthcare identifier (IHI)	A 16-digit unique number used to identify individuals who receive care in the Australian healthcare system.
producing system	A software system that has the role of generating and issuing conformant clinical documents suitable for use by other digital health participants.
registered consumer portal	A third-party portal used by consumers to access information on the My Health Record system that is registered with the My Health Record system as a registered portal operator.
registered provider portal	A third-party portal used by healthcare providers to access information on the My Health Record system that is registered with the My Health Record system as a registered portal operator.
registered repository	A third-party repository used to store clinical documents and other clinical data that connects to the My Health Record system. A repository may store clinical documents in either a proprietary format or a CDA format.
Residential care transfer reason	A residential care transfer reason is generated by the originating residential care facility and contains the particulars of the transfer from a residential care setting including provider information, reason for transfer, and date of transfer.
Residential care health summary	A residential care health summary contains information about a residential care individual's environment, health and care to support continuity of care.
Residential care medication chart	A residential care medication chart is used as a record of orders and administration of prescription medicines, non-prescription medicines and nutritional supplements for individuals living in residential care facilities.

Term	Meaning
SHALL	This word, or the term REQUIRED or Mandatory, means that the statement is an absolute requirement of the specification. *Source: Network Working Group, 1997, RFC2119 - Key words for use in RFCs to Indicate Requirement Levels.*
SHALL NOT	This phrase means that the statement is an absolute prohibition of the specification. *Source: Network Working Group, 1997, RFC2119 - Key words for use in RFCs to Indicate Requirement Levels.*
SHOULD	This word, or the term RECOMMENDED, means that there may exist valid reasons in particular circumstances to ignore a particular item, but the full implications must be understood and carefully weighed before choosing a different course. *Source: Network Working Group, 1997, RFC2119 - Key words for use in RFCs to Indicate Requirement Levels.*
subject of care	One or more persons scheduled to receive, receiving, or having received a health service [ISO/TC 215:2005].
template package	The set of files that describe the structure, validation and rendering for a template, along with supporting documentation.

References

[AGENCY2017a] *Common Conformance Profile for Clinical Documents*, v1.7, Australian Digital Health Agency, 2017

[AGENCY2012a] *My Health Record Connecting Systems Conformance Requirements Document*, v1.5, Australian Digital Health Agency, 2012

[AGENCY2018a] *Core Level One Clinical Document Structured Content Specification*, v1.1, Australian Digital Health Agency, 2018

[AGENCY2018b] *Core Level One Clinical Document CDA Implementation Guide,* v1.1, Australian Digital Health Agency, 2018

[OPC2012] *National Health (Residential Medication Chart) Determination 2012,* Office of Parliamentary Counsel, 2012

[ACSQHC2021] *Electronic National Residential Medication Chart Medication Management Systems,* Australian Commission on Safety and Quality in Healthcare care, 2021