



**Clinical Documents**  
**Supplementary Guidance for Implementers**  
**v1.0**

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# Document information

## Key information

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## Product version history

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<b>Product version</b>	<b>Date</b>	<b>Release comments</b>
1.0	24 October 2013	Initial release

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# 1 Introduction

## 1.1 Purpose

This document is a supplement to NEHTA's specification bundle for clinical documents and provides implementation guidance on areas not covered in these specifications. It is intended to promote usability of software and greater consistency of information presentation to clinicians.

The guidance was prepared as part of NEHTA's Clinical Usability Program (CUP) in consultation with clinicians.

## 1.2 Intended audience

This document is intended for vendors implementing clinical documents.

## 1.3 Scope

This document provides guidance on the implementation of clinical documents.

It does not add, modify or remove requirements from clinical document specifications or conformance profiles.

Note that additional guidance relating to Shared Health Summary documents is covered in *Shared Health Summary – Supplementary Guidance for Implementers v1.0*.<sup>1</sup>

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<sup>1</sup> See: <http://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1478-2013/NEHTA-1474-2013>

## 2 Using exclusion statements appropriately

### 2.1 Applicability

Applies to all systems authoring documents that record exclusion statements.

### 2.2 Context

The proper clinical use of the three exclusion statement values – “none known”, “not asked”, and “none supplied” – is not sufficiently clear. There is inconsistency across software implementations, affecting clinician understanding and use of submitted PCEHR CDA documents. The use of a statement may be restricted for some clinical documents and vendors should refer to the appropriate individual specification and conformance requirements.

### 2.3 Recommendation

- 1 **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 from the user made prior to or during the document authoring process.
- 2 **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” is not a valid value to 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 from the user made before or during the document authoring process.
- 3 **None supplied** is a “catch all” value that is to be used when there are no items to list or all items are excluded and the user has not made one of the two explicit statements above. 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. When this is the value of the exclusion statement, the narrative representation should be “No [x] supplied in this document”, where the value of [x] depends on the particular section. 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.

## **3 Setting default values for document title**

### **3.1 Applicability**

Applies to all systems creating CDA documents.

### **3.2 Context**

The CDA implementation guides do not provide guidance on how to set the “document title” attribute in CDA documents. In the absence of this guidance, some vendors have designed their systems to allow users to edit the title, while others pre-populate with a fixed value.

### **3.3 Recommendation**

The CDA document title element should be set to the corresponding document type name (TypeCodeDisplayName) as defined in *Table 3 - XSDDocumentEntry Document Type and Class Code value set in the PCEHR Document Exchange Service Using the IHE XDS.b Platform: Technical Service Specification*.<sup>2</sup>

Other rules may be defined in the future for new document types, but no change is anticipated to the way titles are generated for document types described by CDA implementation guides that have already been published.

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<sup>2</sup> *PCEHR Document Exchange Service Using the IHE XDS.b Platform: Technical Service Specification v1.4*, available from <https://vendors.nehta.gov.au>

## **4 Creating and displaying administrative observations**

### **4.1 Applicability**

Applies to all systems creating CDA documents.

### **4.2 Context**

NEHTA CDA implementation guides specify a section "Administrative Observations". This contains document context information that could not be put into the header – mostly additional demographics and Medicare details. It is not of interest to the clinician.

### **4.3 Recommendation**

The Administrative Observations section is almost always present in CDA documents and is mostly required by the CDA implementation guides. In order that this section is not displayed in the document, it is recommended that the Administrative Observation section should not have a title or text element.

The Administrative Observations data elements that the CDA implementation guides define should NOT be presented in the document narrative (where these should be displayed, they will be displayed as part of the rendered header).

CDA authors who are using the Administrative Observations section for other information, such as distribution histories, should move this information into other specific sections where appropriate, and leave the Administrative Observations section title and text out.

If the Administrative Observations narrative is present, however, it should be displayed when rendering the document.