Australian Commission on **Safety and Quality** in Health Care

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Australian Digital Health Agency

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Usability Guidance for Optimising My Health Record Viewing Platforms in Acute Care

Published by the Australian Commission on Safety and Quality in Health Care, Level 5, 255 Elizabeth Street, Sydney NSW 2000 and the Australian Digital Health Agency, Level 25, 175 Liverpool Street, Sydney NSW 2000
Phone: (02) 9126 3600

Email: **acsqhcdigitalhealth@safetyandquality.gov.au**
Website: **www.safetyandquality.gov.au**

Phone: 1300 901 001
Email: **help@digitalhealth.gov.au**
Website: **www.digitalhealth.gov.au**

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Contents

Summary

The *Usability Guidance for Optimising My Health Record Viewing Platforms in Acute Care* (the Guide) provides advice to software vendors and viewing platform owners on how to improve the user experience of viewing platforms that interface with My Health Record – Australia's national electronic health record platform.

The Guide was developed by the Australian Digital Health Agency (the Agency) and the Australian Commission on Safety and Quality in Health Care (the Commission) and includes best-practice recommendations in user experience design to enable the optimisation of viewing platforms integrated within clinical workflows.

This Guide identifies six areas of opportunity to improve the user experience of viewing platforms that interface with My Health Record and provides supporting recommendations on how to deliver these improvements under each opportunity area:

1. Best practice product design processes and standards
2. Transparency and visibility of record status and content
3. Intuitive navigation and wayfinding
4. User-centred information flow and display
5. Clear and consistent labelling and terminology
6. Usable and understandable emergency and restricted access controls

For use in all Australian health services

This Guide may be used by health service organisations procuring product design and development services to implement My Health Record into their software and to inform other procurement decisions and continuous quality improvement initiatives.

Clinicians, as end-users of viewing platforms, are encouraged to use this Guide to advocate for improvements in the design and usability of the viewing platform software available in their health service where it is not yet optimised.

While this Guide focuses on acute care, some of the recommendations are transferable to implementations of viewing platforms in other care settings in Australia.

My Health Record in Emergency Departments Report

The Guide was developed in response to recommendations put forward in the *My Health Record in Emergency Departments: Final report and adoption model* (MHR Report) published by the Commission in 2021. **(1)**

The MHR Report identified concerns with the usability of electronic medical record-based platforms used to access and view My Health Record in time-critical clinical environments. The MHR Report highlights the importance of a user-friendly viewing platform for routine clinician use and includes a range of recommendations, three of which are the focus of this Guide and are detailed in **Table 1**.

Table 1: Recommendations from MHR Report which are a focus of this Guide.

Theme	#	Finding	Recommendation
Usability	13	Many Emergency Department clinicians agreed that their My Health Record system viewing platform could be improved.	Usability improvements should be made to My Health Record viewing platforms, which will encourage clinicians to use the My Health Record system.
Usability	14	My Health Record system viewing platforms can have multiple pathways to the same content, which Emergency Department clinicians found time consuming and of low value.	Viewing platform system owners should continue to make access pathways to clinical documents as efficient as possible.
Usability	16	An improved and intuitive My Health Record system interface that enhances usability and on-screen presentation of content, guided by real-life case studies from health service organisations and their existing viewing platforms, would greatly improve Emergency Department clinicians' user experience.	A practical guide for viewing platforms, based on real-life case studies, could be a foundational document that outlines the high-value, user-friendly functions that encourage Emergency Department clinicians to use the My Health Record system regularly.

Background

Importance of national electronic health records

My Health Record is Australia's national, shared electronic health record designed to enable clinicians working anywhere in Australia to see important patient health information sourced from different clinical settings via local Clinical Information Systems (CISs). This includes hospital electronic medical records (eMRs) and software used by general practitioners (GPs) in their routine practice.

Patients in Australia receive health care in a range of settings including public and private hospitals, general practices, community health facilities and outpatient clinics. My Health Record enables each health service organisation to upload patient health information into My Health Record to support better clinical decision making and improved patient outcomes. Sharing patient information supports a patient's continuity of care within the Australian health system and reduces the risks associated with information being siloed to individual health services.

My Health Record in practice

Healthcare providers in Australia will be required to share, by default, key health information such as pathology reports and diagnostic imaging reports to My Health Record following the Health Legislation Amendment (Modernising My Health Record – Sharing by Default) Bill 2024. At the time of publication, the timeframes for when these changes will come into effect is not yet indicated. However, this expected increase in stored information available to patients and clinicians highlights the need to ensure My Health Record presents all stored information in easily accessible, curated and intuitive ways.

Clinicians typically access My Health Record through the embedded feature or viewer in their local CIS or eMR. Often, this is the single point of access for hospital clinicians who wish to access information within My Health Record. Local CIS or eMR viewers are either bespoke displays of My Health Record or utilise the Healthcare Information Provider Service (HIPS) Health Viewer, a freely available web application.

My Health Record can also be accessed through the **National Provider Portal** (NPP) which is a lightweight, browser-based alternative for providers who need quick or occasional access to My Health Record. The NPP provides similar functionally to the HIPS Health Viewer without being deeply integrated into local CIS or eMR systems and workflows.

It is important to note that while the modifications being recommended in this Guide will logically become enabled in the NPP and HIPS Health Viewer, additional effort will be required before the vendor specific CIS and eMR viewers are updated with these enhancements.

Australian Government leadership

This Guide was developed in partnership between the Agency and the Commission, both Australian Government organisations. The Agency is responsible for strengthening digital health arrangements in Australia which includes the operation of My Health Record, NPP and HIPS. The Commission is responsible for leading improvements in health care safety and quality at the national level. Together the organisations are expertly placed to provide best practice advice to organisations developing software for the Australian health system to support better and safer health care to enable quality patient outcomes.

Areas of focus in this Guide

This Guide responds to recommendations focused on the usability of viewing platforms used to access My Health Record put forward in the *My Health Record in Emergency Departments: Final report and adoption model* (MHR Report), published by the Commission in 2021. **(1)** The Guide also addresses challenges associated with the viewing platforms identified by clinicians during consultation for the development of this Guide. These areas of focus are summarised below.

Usability

Clinicians consistently reported during consultation that the interfaces of the various viewing platforms for My Health Record are unintuitive, confusing and inconsistent.

The MHR Report found that the design of the user interface and usability of viewing platforms impacted on clinicians' use of My Health Record by increasing their cognitive load through unnecessary pathways and clicks to determine how to access information. This led to clinicians being unwilling to engage with My Health Record as part of their routine clinical work.

This lack of engagement with My Health Record may create risks associated with medication errors, repeating tests unnecessarily and lack of awareness of the patient's medical history. **(13)**

Emergency access functionality

During consultation, clinicians regularly reported uncertainty about when to use the emergency access functionality (also called "Break Glass") in addition to inconsistency of this functionality across viewing platforms.

In circumstances where a patient has a restricted My Health Record, the emergency access function allows a clinician to access the record under situations considered an emergency - where a patient's life, health or safety is considered under serious threat. **(2)**

Some clinicians apply the emergency access functionality unknowingly under incorrect circumstances, while others do not enact this functionality when it would be appropriate and valuable for them to do so. Of specific concern, is that during consultation, clinicians noted confusion in the Emergency Department (ED) setting where some ED clinicians understood that the emergency access functionality is an ED clinician's routine way of accessing a patient's My Health Record. Of concern more generally, the penalties associated with the misuse of the emergency access functionality have reportedly deterred clinicians from using it.

Quantity and quality of information contained in My Health Record

During consultation clinicians consistently reported a lack of clarity about the quantity and quality of information that is contained in a patient's My Health Record. That is, while using the viewing platform, the value of spending time accessing a patient's record is not always immediately apparent to the end-user.

This uncertainty experienced by clinicians around whether to spend time accessing a patient's My Health Record for potentially no gain, adds to their cognitive burden in time-critical environments and increases the risks to the quality and appropriateness of patient care.

Variability in interface designs

Clinicians frequently reported during consultation that the variability in interface designs of viewing platforms can introduce inefficiencies in a clinician's workflow when a clinician works across multiple sites. This includes between separate health service organisations and between work sites of an individual health service organisation.

For a health service workforce comprised of permanent and locum staff, the variability in interface designs could further increase the cognitive load on a clinician in time sensitive situations. The time a clinician needs to overcome this learning curve may detract from the time available to care for patients.

Benefits to the health system of improved interfaces with the My Health Record

The application of best practice design principles and a more standardised user interface offers the potential to make the navigation of viewing platforms interfacing with My Health Record more efficient for all users. Improved interfaces with My Health Record are likely to increase the use of My Health Record by clinicians in acute settings, leading to the following benefits:

- Increased access to important health information in time-critical environments where decisions need to be made rapidly
- Improved understanding of a patient's significant clinical history
- Enhanced clinical decision making at the point of care
- Increased use of digital technologies to support the delivery of high-quality care.

Opportunities for improvement

This Guide identifies six areas of opportunity to improve the user experience of viewing platforms that interface with My Health Record. By embedding these opportunities in the design of the viewing platforms, software vendors and viewing platform owners can support the realisation of a range of benefits to patient and health system outcomes associated with the effective use of My Health Record.

The six areas of opportunity for improvement are:

- **Opportunity 1:** Best practice product design processes and standards
- **Opportunity 2:** Transparency and visibility of record status and content
- **Opportunity 3:** Intuitive navigation and wayfinding
- **Opportunity 4:** User-centred information flow and display
- **Opportunity 5:** Clear and consistent labelling and terminology
- **Opportunity 6:** Usable and understandable emergency and restricted access controls

Recommendations to guide the design of viewing platforms and how to deliver these opportunities for improvement are included under each opportunity area in this Guide.

While this Guide focuses on acute care, the recommendations could be considered outside of acute care settings, but not all.

Scope of this Guide and the recommendations

The recommendations contained within this Guide are not a compliance requirement or considered mandatory for software developers and system owners working with My Health Record.

The recommendations are designed to avoid conflicting with current My Health Record conformance specifications and instead address current usability insights and feedback provided by clinicians to inform ongoing improvements and software design enhancements.

The recommendations contained within this Guide are technically feasible and can support design decisions in future implementations of My Health Record features.

This Guide does not identify or comment on existing implementations where many of the learnings have originated.

To inform ongoing evaluation and improvement, feedback on this Guide and the recommendations are welcome to **ExperienceDesign.Enquiries@digitalhealth.gov.au.**

Opportunity areas

Six areas of opportunity to improve the user experience of viewing platforms that interface with My Health Record.

Opportunity 1: Best practice product design processes and standards

The success of a digital service is dependent on high-quality user experience. High-quality user experience is driven by proven design best practices and processes and supported by design principles, standards, guidelines and frameworks. Embedding these methods and tools when designing and implementing viewing platforms to support the My Health Record can provide better outcomes for clinicians and therefore improved care to patients and efficiencies to the health service.

Embedding design processes that enable co-design, collaboration, user-testing and incorporate subject matter expertise such as clinical governance, ensure real needs are addressed and designs are fit for purpose. Additionally, the use of proven usability design principles and frameworks can provide a foundation for decision making and user centricity in design.

The following practices, tools and standards are recommended to support design and implementation processes to enhance the user experience of viewing platforms interfacing with My Health Record.

Recommendation 1.1 – Utilise human-centred design process models

Effective design process models are underpinned by human-centred design principles, and when applied in the health system, can improve the safety and quality of care provided to patients. **(3)**

Software designers and developers who are designing viewing platforms to support clinicians to seamlessly access My Health Record information should look to the International Organization for Standardization's (ISO) ISO 9241-210:2019 Ergonomics of human-system interaction — Part 210: Human-centred design for interactive systems**. (4)** This international standard is intended for use by those responsible for planning and managing projects that design and develop interactive systems and provides standards which embed human-centred design rigour, including co-design, testing and validation. **(4)** Usability testing with clinicians in the final development is recommended to ensure the local design quality expectations are met and viewing platforms are optimised for the end-user within their workflow.

Recommendation 1.2 – Embed validated product design principles and guidelines

Effective design practices, principles and guidelines support the creation of user-centred designs, provide teams with a structured approach to problem-solving, and ensure consistency, usability and accessibility throughout the process.

Software designers and developers should embed principles and guidelines relevant to the implementation of My Health Record into their product design to ensure the products are fit for purpose and deliver a high-quality user experience.

Table 2 lists the recommended guidelines and principles relevant to the implementation of My Health Record.

Table 2: Guidelines and Principles relevant to the implementation of My Health Record

Guidelines and Principles	Focus Area
10 Usability Heuristics for User Interface Design **(5)**	These heuristics are fundamental principles for designing user interfaces that are intuitive and user-friendly.
Nine Essential Principles of Software Usability for eMRs **(6)**	These principles focus on the usability of eMRs emphasising simplicity and consistency.
National Guidelines for On-Screen Display of Medicines Information **(7)**	The guidelines provide an evidence-based approach to the on-screen presentation of medicines information.
My Health Record Requirements and Guidelines for on-screen presentation guidance on mobile devices **(8)**	These requirements and guidelines offer an evidence-based approach for on-screen presentation guidance on mobile devices.

Recommendation 1.3 – Meet and exceed accessibility and inclusivity standards

My Health Record is Australia's national digital health record platform and must be accessible to all Australians, including the estimated 4.4 million Australian's who are living with disability. **(9)** The Australian Government is committed to providing information and services in a non-discriminatory, accessible manner and expects products, including digital products and services, to be developed in line with applicable legislation and recognised best practice.

It is therefore prudent that software designers embed accessibility and inclusivity from the outset of any build. This will lift the overall quality of the user experience, regardless of setting or workforce digital literacy, and the value of the product.

Relevant legislation and best practice guidelines available to inform software development includes:

- Australian Government, Disability Discrimination Act 1992
- Australian Government, Digital Transformation Agency, Digital Experience Policy **(10)**
- W3C Web Accessibility Initiative (WAI), Web Content Accessibility Guidelines (WCAG)

Opportunity 2: Transparency and visibility of record status and content

Better visibility of a patient's My Health Record status, available content and recent changes before and during access can surface the value of a record and support efficient workflows.

The current nature of many My Health Record implementations requires that they are accessed as an additional channel or add-on to the hospital eMR local environment. The access is often presented as a branded My Health Record button with minimal information that provides a view of the status of a patient's My Health Record.

Clinicians are often required to access a patient's My Health Record to determine if there are any clinical documents contained in the record. If there are documents present, the clinician must then open each clinical document in the various information categories within the record to determine the value, if any, of those documents. This task can be time consuming and result in minimal gain in terms of helpful patient information which can reduce a clinician's desire to engage with a patient's My Health Record altogether.

This challenge can be addressed through a digital design that provides transparency about the number and value of the clinical documents present or summary views in the various information categories of a patient's My Health Record.

The recommendations below offer techniques that can provide the record's status and improve the transparency of a record without impacting the appropriate controls or clinical workflows.

Recommendation 2.1 – Display the record's status at the My Health Record access point

To ensure clinicians have quick visibility of the status of a patient's record when they are accessing My Health Record through a single point in the eMR, a visual representation of the status should be available at the access point.

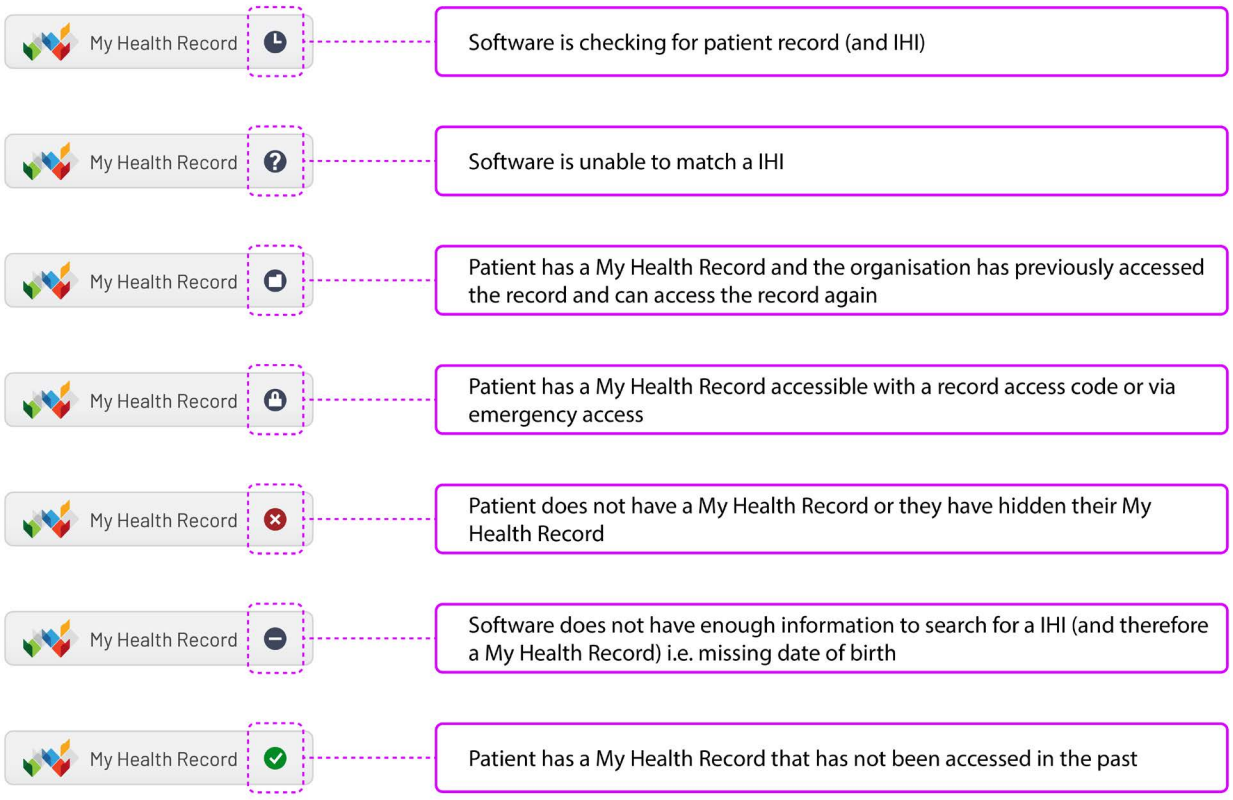
As a clinician typically accesses My Health Record via a button or a link through the health service's eMR, creating a visual cue such as an icon or text of the status of a patient's record will highlight the value of the record prior to a clinician accessing it.

Best practice user interface and user experience design principles recommend using an icon or text to create a visual cue and to avoid using colour as a visual cue on its own. It is important to note that accessibility requirements necessitate that alternate text appears when the mouse is hovered over the visual cue.

It is also recommended that a helpful instruction be included in any return messages to inform the user how they might be able to resolve the issue locally, rather than leaving the workflow and logging a job for later resolution. For example, if the viewing platform is unable to match the Individual Healthcare Identifier (IHI) associated with a record, the clinician may be able to verify the demographics of the patient and re-validate the IHI.

Figure 1 provides examples of My Health Record status buttons with recommended icon positioning and their meanings.

Figure 1: Example of My Health Record buttons with icon positioning.



Examples of status information available to surface prior to a record being accessed:

- Software is checking for the patient's My Health Record and Individual Healthcare Identifier.
- Software is unable to match an IHI.
- Patient has a My Health Record and the organisation has previously accessed the record and can access the record again.
- Patient has a My Health Record. You can access the record with a record access code provided by the patient or their authorised representative or via Emergency Access.
- Patient does not have a My Health Record.
- Software does not have enough information to search for an IHI and therefore a My Health Record. This is likely because of missing data in the search parameters, for example, date of birth. Please review the data and try again.
- Patient has a My Health Record which you can access now. The organisation has not accessed this record in the past.
- Provide access to an explanation on the meaning of the status message as shown in Figure 1 (legend, tooltip etc.).

Recommendation 2.2 – Surface priority patient information once a record has been accessed

Surfacing priority clinical and administrative health data in My Health Record will enable a clinician to quickly identify priority patient and clinically relevant information which can support clinical workflows.

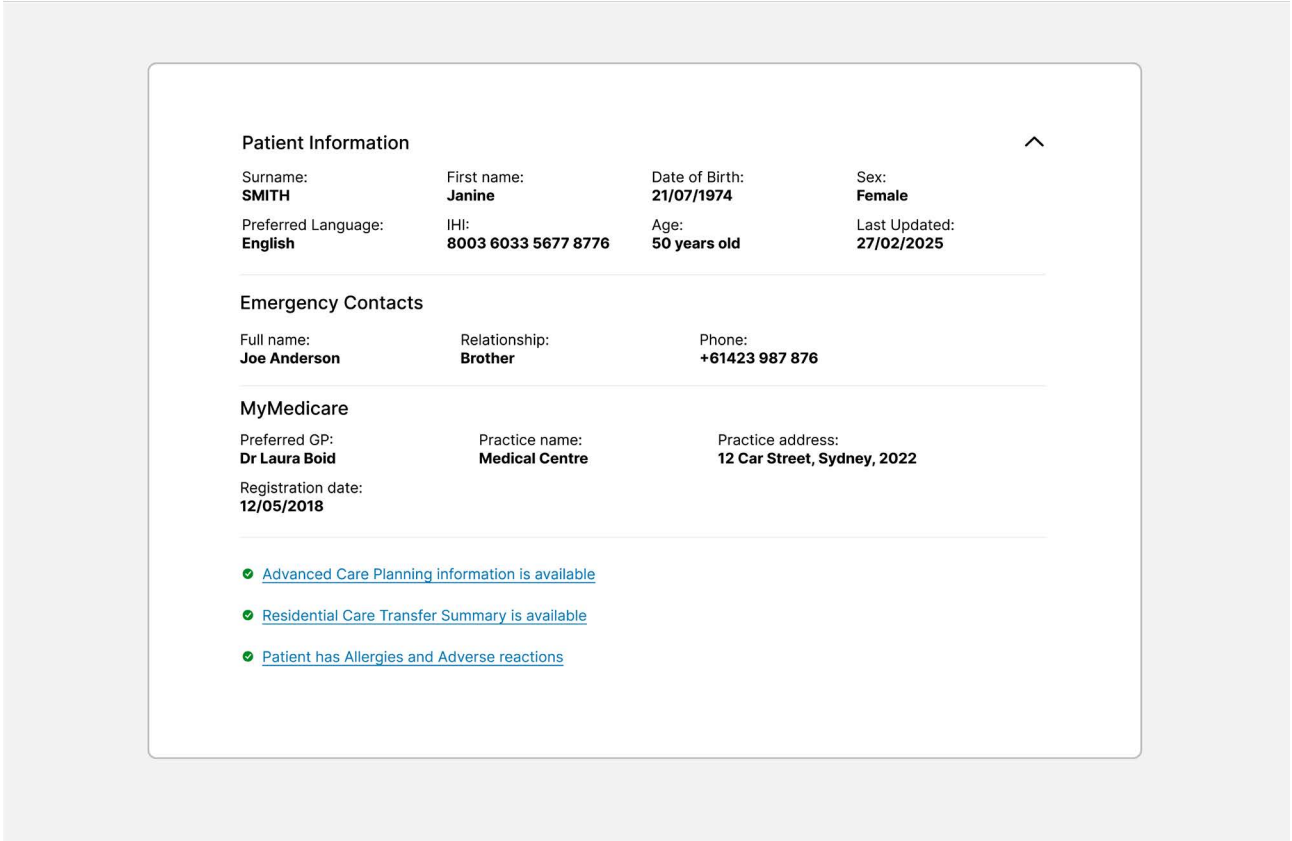
Priority patient information to display could include:

- Patient Identifier Information
- Emergency Contact details
- MyMedicare and/or General Practitioner (GP) details
- Allergies and adverse reactions (if any)
- Advance Care Planning documents (if available)
- Transfer & Residential Care documents (if available)
- Preferred language spoken and/or interpreter if required (if available in the local environment)

Include the date each piece of priority information was last updated to aid with connecting the value and importance of the information.

Figure 2 displays an example of techniques which surface critical information about a patient in the My Health Record.

Figure 2: Techniques which surface critical information about a patient



Please refer to **Recommendation 4.1 – Prominently visualise patient identifier information that is consistent with standard clinical practice** for advice pertaining to priority ordering of “Patient identifier information”.

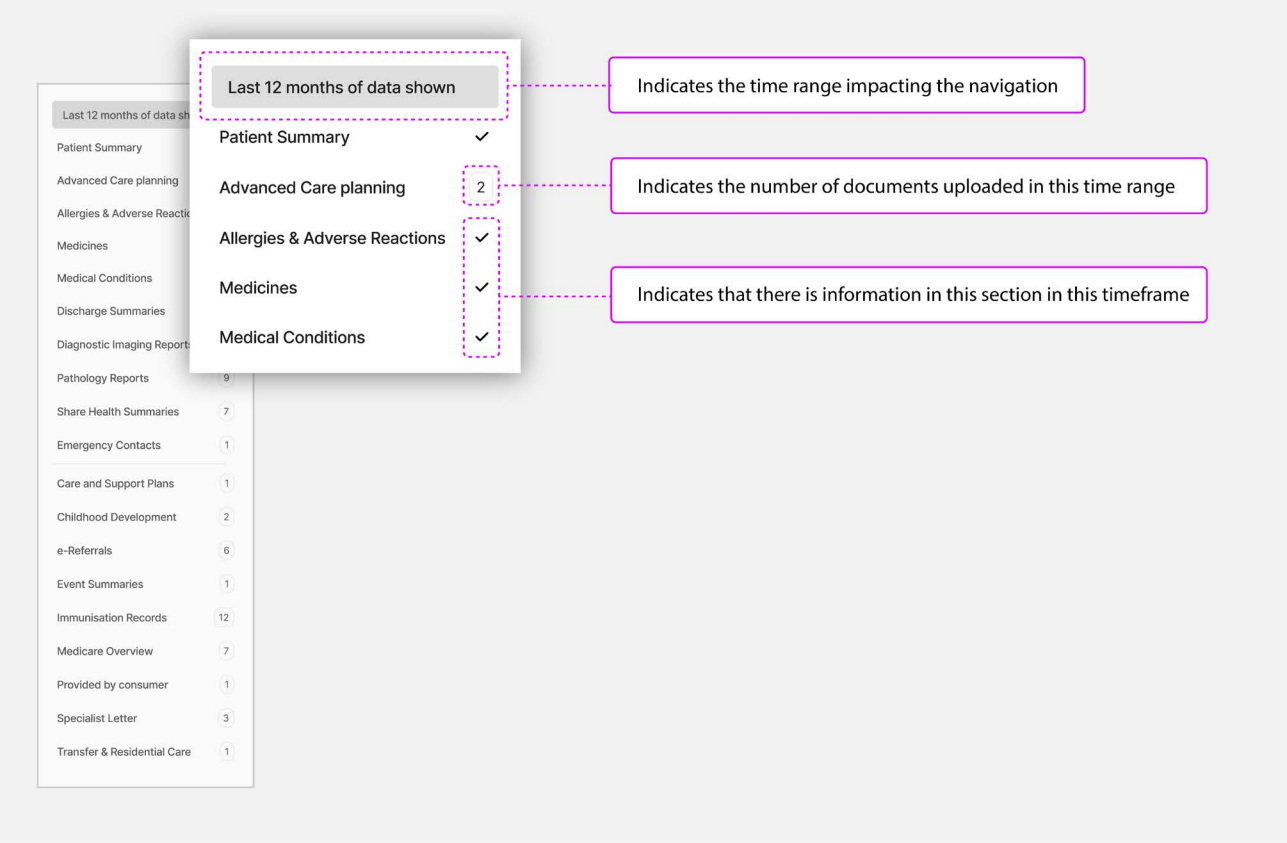
Recommendation 2.3 – Visually indicate the presence of recent information

Visual indications of the presence of recent information contained within the various sections of the My Health Record should be included to convey the value of a patient's record to a clinician. A visual indication provides transparency that can facilitate workflow efficiency and reduce the time involved in identifying clinically relevant information.

Figure 3 provides an example of how a My Health Record sidebar navigation panel could be used to present the number of documents contained within a tab. The use of a sidebar can minimise a user's mouse clicks and reduce time wasted navigating to somewhere that contains no information.

The design execution could include showing the number of documents contained within a section or a "tick" to visually indicate that information has been added to that section within the last 12 months.

Figure 3: Examples of a My Health Record navigation with visual indicators



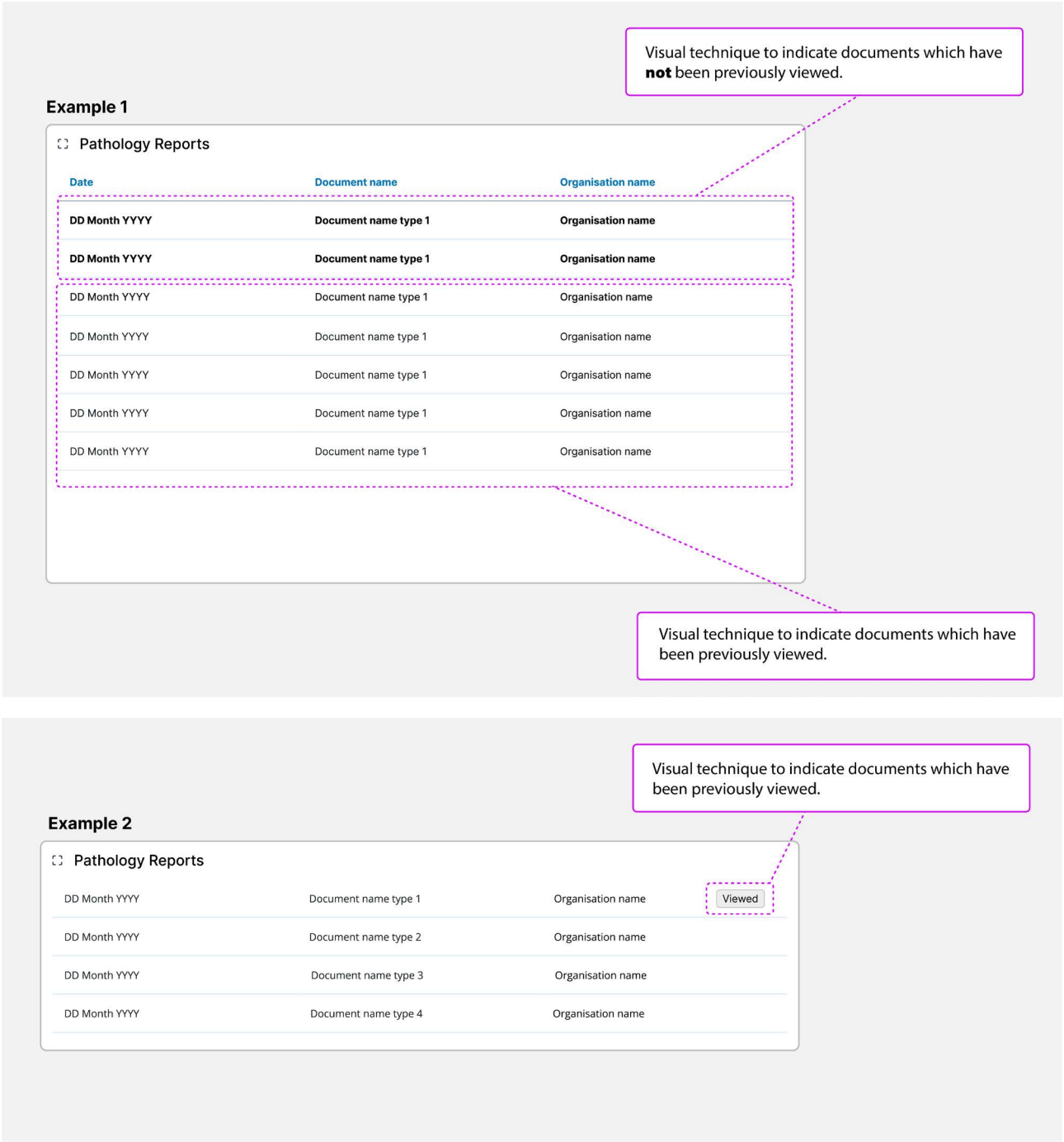
Recommendation 2.4 – Visually differentiate documents that the clinician has previously viewed

Visually differentiating documents that the clinician has and has not previously viewed within that session should be a key design feature when displaying a document type list available in My Health Record. Ideally, the feature should persist across the user's every session within the viewing platform.

Visually differentiating documents facilitates timely and efficient navigation of clinical information by the user and avoids duplication.

Figure 4 provides two examples of how the visualisation of viewed documents could be presented in My Health Record.

Figure 4: Examples of a list of documents with a visualisation of viewed documents



Opportunity 3: Intuitive navigation and wayfinding

Providing intuitive pathways to critical information in My Health Record viewing platforms, along with relevant filtering, control and findability, can improve timely accessibility to information by clinicians and enhance clinical workflows.

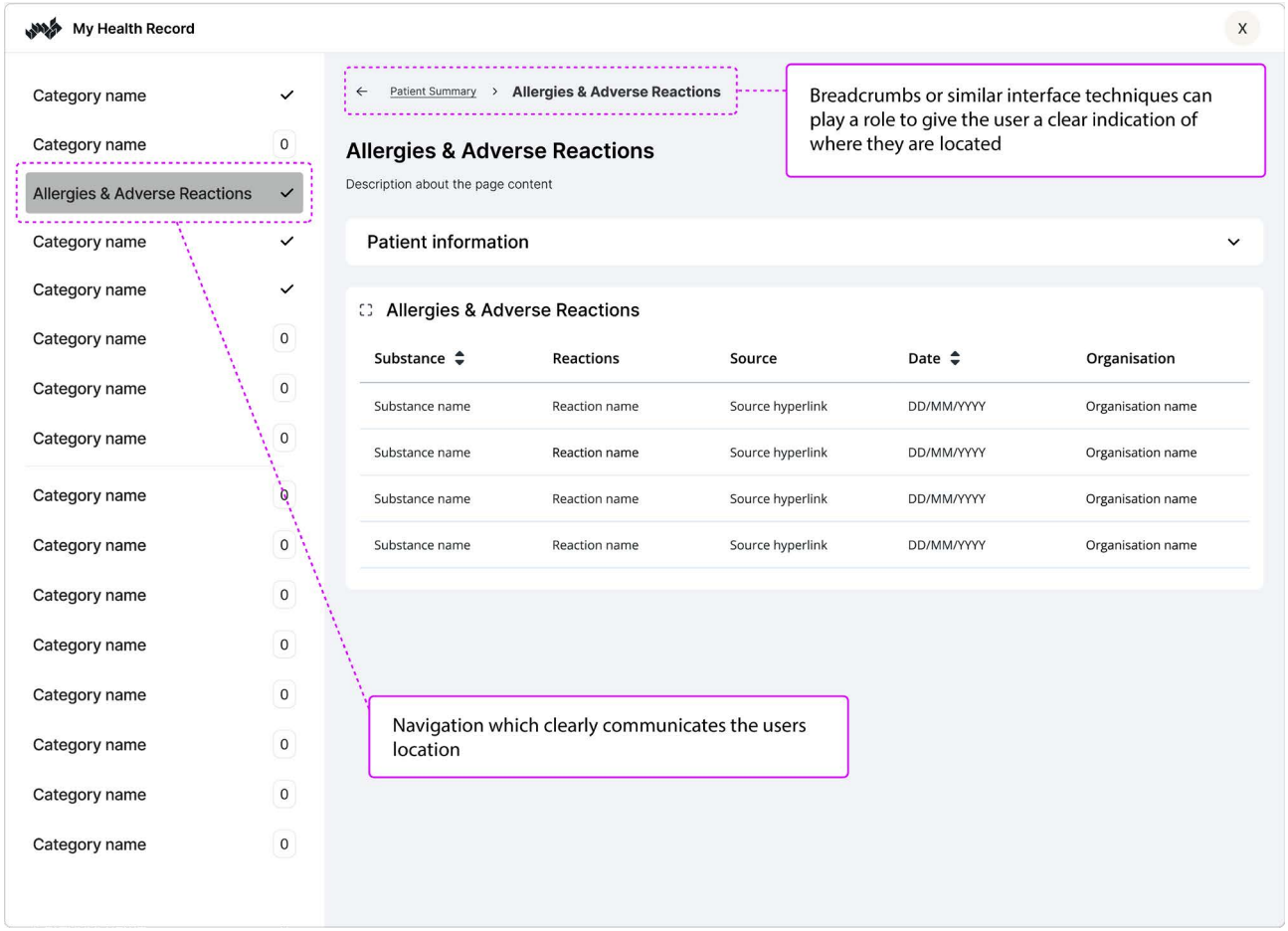
Recommendation 3.1 – Present a user's location in My Health Record consistently

Consistently presenting a user's location within the My Health Record system to the user while they are working in the system will orientate the user to where they are in the system, improve their navigation and enhance their workflow.

Using breadcrumbs such as location-based, attribute-based and path-based is a best practice in clinical software design to enhance user navigation and help users understand where they are within the system.

Figure 5 provides examples of techniques which can be used to orientate a user in the My Health Record system.

Figure 5: Examples of techniques used to orientate a user in the system



Recommendation 3.2 – Provide intuitive filtering of document lists

Providing intuitive filtering when displaying a document type list in My Health Record can enhance clinical decision making by enabling clinicians to access the most relevant and contemporary patient information in a timely and efficient manner.

A patient's My Health Record can contain large quantities of documents, and when presented in a list, can be challenging for clinicians to navigate and find information that is relevant to support their clinical decision making. Filtering by document type and date range should be incorporated into viewing platforms to support user-friendly implementation.

A default filter view for the clinician user and the ability for a user to save their preferred filter view across their sessions in My Health Record would be highly beneficial to a busy clinician in a time critical environment. Design execution filtering options for the clinician user could include:

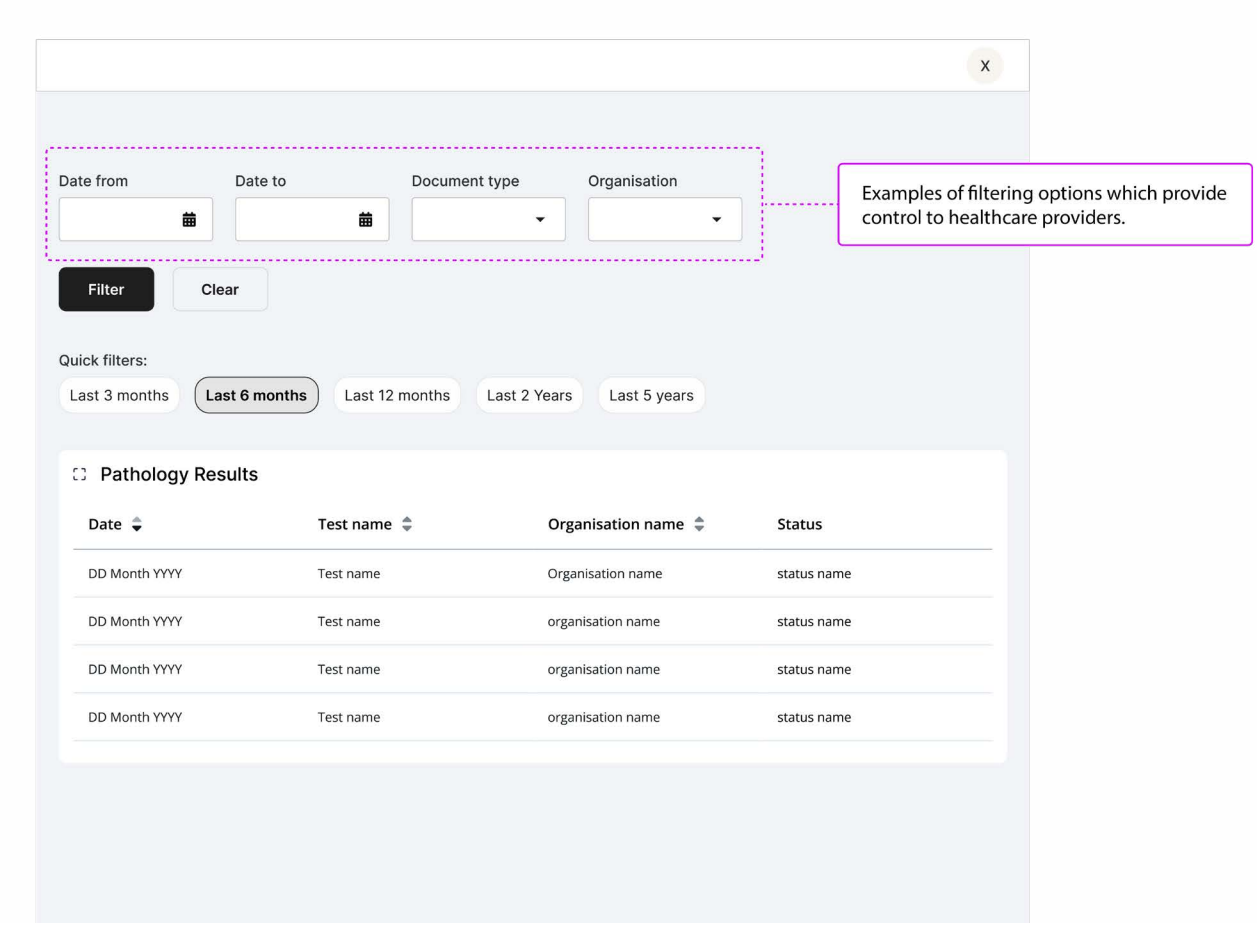
- Specific date ranges
- Option for pre-defined ranges, for example in the last 3 months, 6 months, 12 months, 2 years, 5 years
- A specific column heading within the list of documents, for example Test Name, whereby a dropdown list for filtering should be presented that is limited to the test names available within that record
- Document Type

Free text searching

If the software design provides an option for clinicians to filter a document type list by free text searching, best practice recommends only returning and displaying the document results that exactly meet the search criteria with the most recent documents at the top of the list.

Figure 6 provides an example of intuitive document filtering options relevant to My Health Record.

Figure 6: Example of filtering techniques relevant to the My Health Record System



Recommendation 3.3 – Provide intuitive sorting of document lists

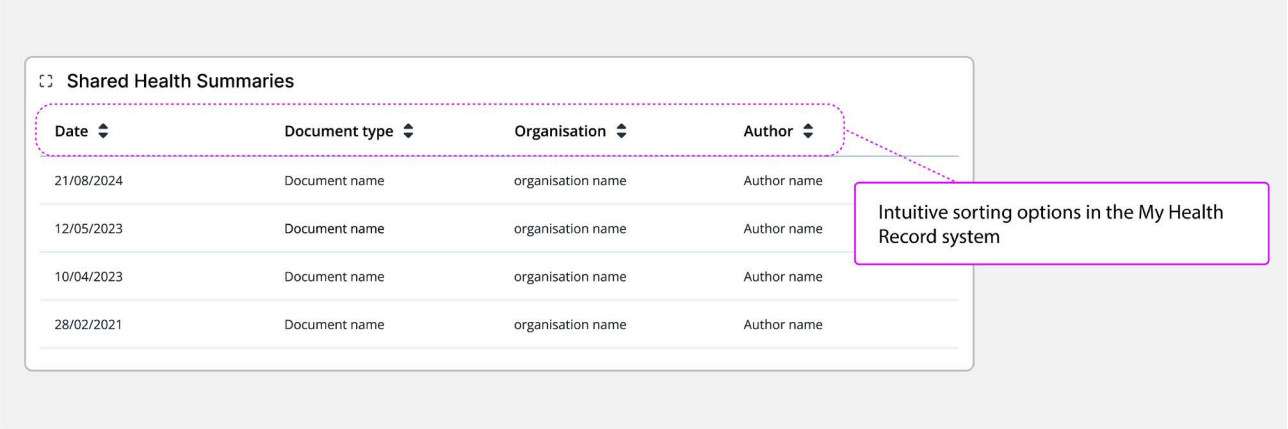
Similar to intuitive filtering at Recommendation 3.2, providing intuitive sorting options when displaying a document list in the My Health Record system can surface valuable information more efficiently and can support effective clinical decision making.

Intuitive sorting options can include:

- Ensuring that reverse chronological order is the standard initial presentation of documents displayed in a list.
- Option to sort column data alphabetically, where appropriate.

Figure 7 provides an example of intuitive sorting options in the My Health Record system.

Figure 7: Intuitive sorting options in the My Health Record system



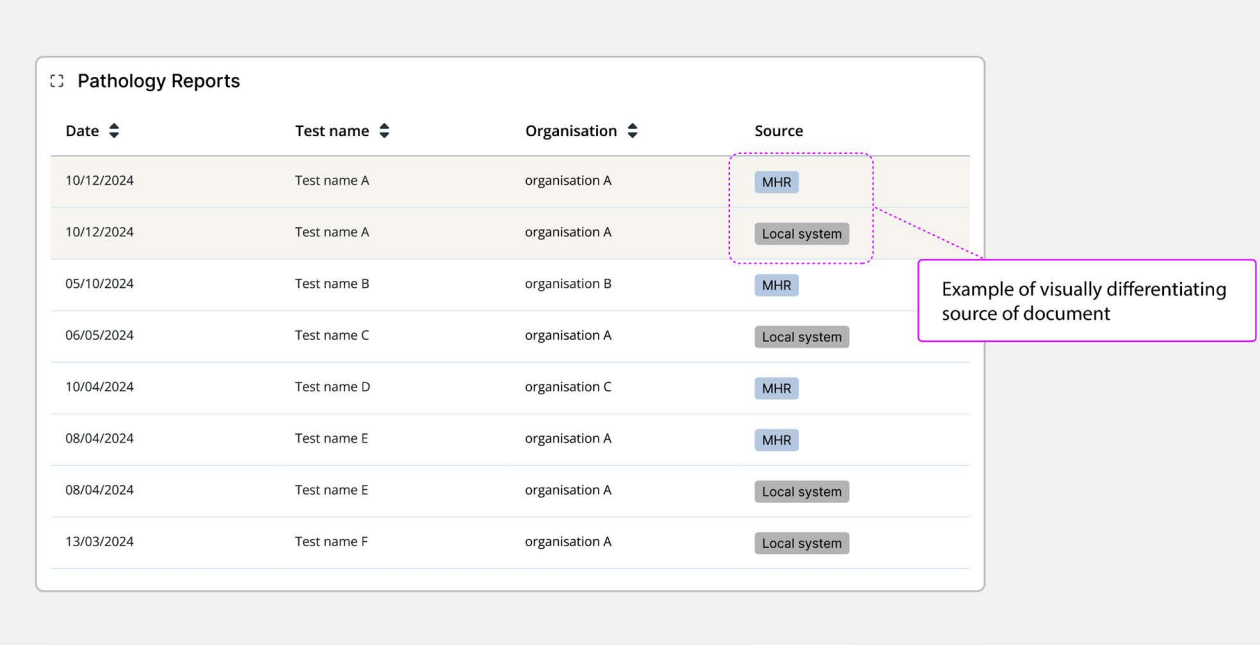
Recommendation 3.4 – Distinguish locally available content from My Health Record content

A key reason a clinician will engage with My Health Record is to find information about their patient that is not already available on the local eMR. Making it easy for the user to differentiate between information sources in My Health Record and information authored by the health service organisation will create workflow efficiencies.

If My Health Record documents are mixed in with local eMR documents, visually differentiating the two types of documents will make it possible for clinicians to identify the document's source. Viewing platforms could use either the My Health Record icon or My Health Record text to visually indicate a document's source.

Figure 8 includes an example of how to visually differentiate the source of a document in My Health Record.

Figure 8: Example of visually differentiating the source of a document in My Health Record



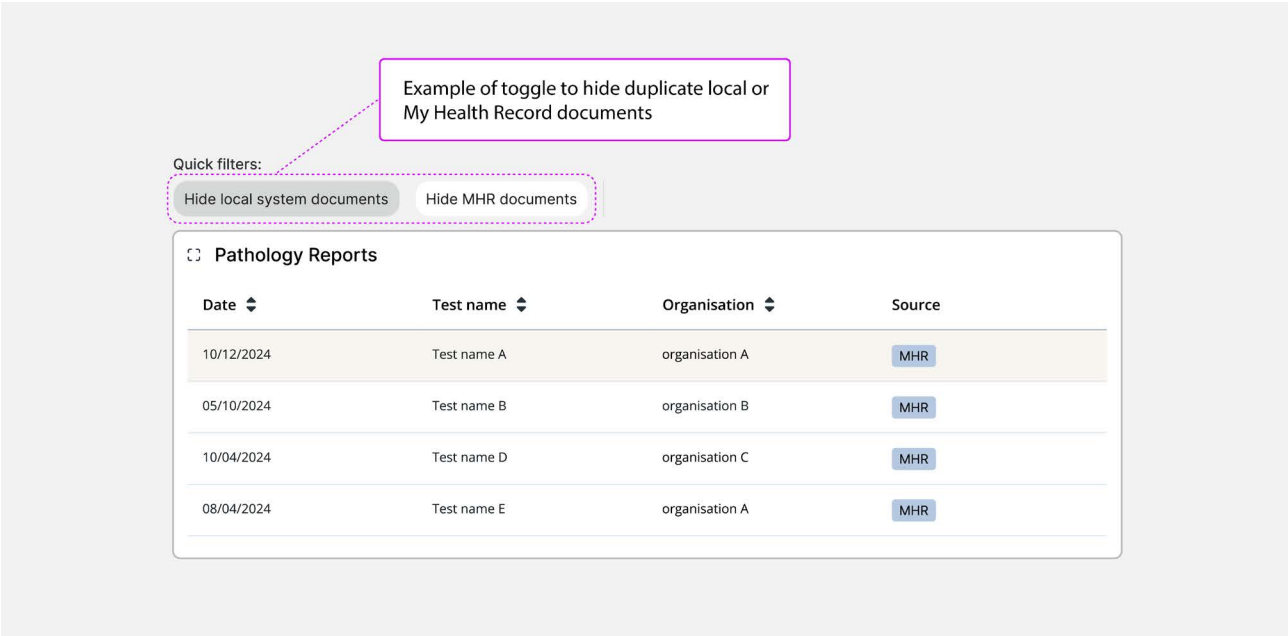
Recommendation 3.5 - Detect and manage duplicate documents in the system

Related to **Recommendation 3.4**, a viewing platform that detects and manages duplicate documents will enable the clinician to identify the most relevant information in My Health Record to understand a patient's history.

A user-initiated toggle applied to document lists in the viewing platform that "hides" or visually highlights content that is sourced from the local eMR and My Health Record will help the user identify and potentially "hide" duplicate documents so they can find the most relevant information more efficiently.

Figure 9 provides an example of a user-initiated toggle to view/hide duplicate documents in My Health Record.

Figure 9: Example of toggle to hide duplicate local or My Health Record



Recommendation 3.6 – Incorporate components which aid interpretation, navigation and wayfinding

Effective interpretation, navigation and wayfinding components can create a seamless and logical user experience and improve timely clinician access to important information.

Table 3 provides examples of important software components that can enhance interpretation, navigation and wayfinding in My Health Record.

Table 3: Examples of components which enhance wayfinding

Component	Purpose	Example in Australian CIS Context
Consistent Icons & Labels	Helps users quickly identify functions and data types	Use of SNOMED-CT AU terms for clinical conditions and procedures
Breadcrumb Navigation	Shows users their location within the system	“Patient Records > Cardiology > ECG Results”
Colour Coding & Visual Cues	Differentiates data types or urgency levels	Red for critical alerts, green or completed tasks and text with the inclusion of tags that factor in accessibility e.g. colour blindness
Search & Filter Tools	Enables quick access to specific patient data	Filtering lab results by date or test type, consider including ability to save filters and set defaults for the user
Dashboard Summaries	Provide at-a-glance patient overviews	Summary cards for allergies, medications and vitals
Contextual Help & Tooltips	Supports interpretation of complex data	Hovering over a lab value shows reference ranges
Logical Grouping of Information	Reduces cognitive load by clustering related data	Grouped all cardiovascular data under one tab
Mobile-Friendly Interfaces	Supports navigation on tablets and phones used in wards	Responsive design for My Health Record access on mobile devices
Reduction of Clicks for the User	Reduces the amount of clicks the user will make to access information they need	Directly opening the PDF attachment when selecting the document instead of the CDA first

Recommendation 3.7 – Display the source of the clinical data

The presentation of data provenance in My Health Record would improve the utility of different documents, improve transparency and trust in the information in My Health Record and allow for quicker retrieval of relevant information in time critical situations.

Data provenance specific to My Health Record to support clinical workflows and improve decision making could include:

- Author
- Specialty
- Organisation

Opportunity 4: User-centred information flow and display

My Health Record contains a range of documents and information with specific purposes. Consistency in the onscreen presentation of this information, including document lists, tables and views, is critical to the effectiveness of My Health Record and its use across Australia.

Informed prioritisation and presentation of onscreen information, along with thoughtful component implementation, can ensure information aligns with the critical needs of clinicians and their workflows and supports timely access to critical patient data. Optimising screen layout can also reduce unnecessary navigation and cognitive load, enhance usability, streamline decision making and improve patient care.

Structured data standards are becoming more established in the My Health Record system as user-centred flow and component prioritisation and presentation are improved. Information about current My Health Record structured data standards is available on the Agency website - **Digital Health Standards Catalogue.**

Recommendation 4.1 – Prominently display patient identifier information in a format consistent with standard clinical practice

Presenting patient identifier information to clinicians in a way that is consistent with standard clinical practice supports the accurate interpretation of the information and reduces the cognitive load on the user.

Standard clinical practice uses the following patient identifier information:

- Displaying patient name: LAST Name, First Name
- Displaying patient date of birth (age): DD/MM/YYYY (XX years old)
- Displaying patient sex and gender: Male/Female/(Non-Binary)
- Preferred Language
- Individual Healthcare Identifier (IHI)

To enhance usability and prevent errors, “Patient identifier information” should be pinned to the top of the view in My Health Record.

Please see **Recommendation 2.2 – Surface priority patient information once a record has been accessed** for suggested design execution.

Figure 10: Example of prominently displaying patient identifying information

Recommendation 4.2 – Provide a "Summary" page to preview recently updated information

Presenting high-value patient information in a consolidated or "summary" view of available My Health Record data reduces the number of clicks required by a user to find and access key clinical information.

A "Summary" page succinctly presents relevant clinical information by previewing the most recently available content within a navigation item. This allows clinicians to quickly assess the recency of the information and efficiently determine if further exploration is required.

Including a patient's preferred language on the "Summary" page would aid in the timely engagement of appropriate interpreters.

By displaying a few pieces of content for a navigation item with a visual indication such as a "Show more" button, clinicians can be directed to where all the available content is found.

Recommendation 4.3 – Prioritise the order of navigation lists

Presenting clinically important and relevant information contained within a patient's My Health Record onscreen in a consistent and logical order will enable clinicians to access the information in a timely and efficient manner and make informed clinical decisions. This is particularly critical for clinicians in an emergency department.

List 1 shows a proposed ordering of information which can be split into two sections for a navigation list contained within a My Health Record. This ordering is based on feedback from clinicians working regularly with My Health Record.

List 1: Proposed priority order for information in a navigation list

- Patient Summary
- Emergency Contacts
- Advance Care Planning
- Allergies & Adverse Reactions
- Medicines
- Discharge Summaries
- Pathology Reports
- Diagnostic Imaging Reports
- Shared Health Summaries
- Care and Support Plans
- Childhood development
- e-Referrals
- Event Summaries
- Immunisation Records
- Medicare Overview
- Provided by consumer
- Specialist Letter
- Transfer & Residential Care

Recommendation 4.4 – Group similar clinical information together

Clinically important and relevant My Health Record information could be presented in logical groupings to assist clinicians in navigating and accessing critical patient data in an efficient way. Grouping items may be beneficial in specific clinical settings or to accommodate varying clinician preferences and priorities.

List 2 provides an example of how My Health Record information could be grouped to inform navigation lists or interface categories in a viewing platform.

List 2: Proposed groupings for items in My Health Record navigation lists

Patient Information

- Summary
- Emergency Contacts
- Advance Care Planning
- Medicare Overview

Medical History

- Allergies & Adverse Reactions
- Medicines
- Medical Conditions
- Immunisation Records

Care Plans & Summaries

- Discharge Summaries
- Shared Health Summaries
- Transfer & Residential Care
- Care and Support Plans
- Event Summaries
- Specialist Letters
- e-Referrals

Clinical Documents

- Pathology Reports
- Diagnostic Imaging Reports

Provided by consumer

Recommendation 4.5 – Ensure consistent presentation of document lists

Presenting information in a consistent and accessible format will enhance the user experience and inform the effectiveness of the clinical information available in My Health Record.

When presenting a mixed document type list in My Health Record, the document metadata displayed in the list should include at a minimum:

- Date
- Document type name
- Organisation
- Author

In line with best practice, a document list should be presented in reverse chronological order. That is with the most recent document appearing at the top of the list.

Recommendation 4.6 - Ensure consistent table display and column ordering

Establishing a consistent approach to the presentation of important My Health Record information in onscreen tables, including column display and prioritising the ordering of column headings, will support clinicians to understand and interpret information more efficiently and effectively.

When creating table views to display specific information in My Health Record, for example, Pathology, Allergies and Adverse Reactions or Medicines, the order of the columns in the table should reflect the priority of the information. For example, “Date” and “Document Name” should be before the ‘Author’ and ‘Organisation’.

> Please see **Recommendation 3.3 - Provide intuitive sorting of document lists** for advice regarding intuitive table sorting.

Opportunity 5: Clear and consistent labelling and terminology

The use of clear and consistent labelling and terminology in the design and implementation of viewing platforms interfacing with My Health Record can support efficient clinical workflows, improve accessibility to clinical information and minimise the risk of errors.

Inconsistencies and variability in the visual design and in the labels and terminologies currently used in viewing platforms in place across Australia often lead to trial-and-error exploration in the system by the user, reducing efficiency and resulting in clinician frustration.

Recommendation 5.1 - Use standardised labels

Use standardised labels and refer to documents using exact category names listed in the taxonomy to ensure correct mapping to the right document.

Standardised labels refer to uniform terminologies, codes and formats used to represent clinical concepts, procedures, diagnoses and outcomes in electronic health records (such as the My Health Record system) and other clinical information systems. Standardised labels for clinical data in clinical information systems are essential for ensuring interoperability, data consistency and quality across healthcare settings. **(11)**

Recommendation 5.2 – Use standardised clinical language

Embed the use of clinical language in the design of every user facing element of the viewing platform to ensure it aligns with standard healthcare terminology and the user understands the information at first glance.

Table 4 provides a list of recommended terminology for use in My Health Record and relevant examples of terminology to avoid using. For example, use “Pathology Reports” instead of “Test Results”.

Table 4: Recommended terminology for use in My Health Record

Recommended Nomenclature	Examples of Inconsistent Nomenclature
Pharmacist Shared Medicines Lists	Meds List
Discharge Summaries	Discharge Docs
Pathology Reports	Blood Test Results, Test Results
Diagnostic Image Reports	X-rays Reports, Imaging Results
e-Referrals	Referral document
Event Summaries	Patient History
Goals of Care Documents	Treatment Preferences
Immunisations	Vaccination Record
Shared Health Summaries	Doctor's notes
Prescription and Dispense Record	Rx Records
Transfer & Residential Care Documents	Hospital Transfer Forms
Specialist Letters	Consultation Letters

Opportunity 6: Usable and understandable emergency and restricted access controls

The My Health Record system has an emergency access function which allows a clinician to access a patient's restricted record in emergency situations where a patient's life, health or safety is considered under serious threat. **(2)**

It is important that My Health Record users are supported by clear and intuitive workflows, consistent terminology and consistent functionality in the use of the emergency access function across viewing platforms interfacing with My Health Record.

The appropriate use of the emergency access function will enable clinicians to access restricted records and support timely clinical decision making in emergency situations.

Recommendation 6.1 – Simplify how a user requests access to a restricted record

When a clinician is seeking to access a restricted My Health Record, users should be presented with a single page displaying the option to either provide a record access code or request Emergency Access.

If a patient's My Health Record is restricted, a clinician can obtain a record access code from the patient or the patient's authorised representative to access the patient's My Health Record.

If the clinician cannot reasonably obtain a record access code, the clinician can request Emergency Access (or "Breaking Glass") which will grant them and their organisation short-term (5-day) access to the patient's My Health Record. After 5 days, the clinician's access reverts to the original settings and further access requires the clinician to obtain a record access code or request another Emergency Access.

Improving transparency around the requirements necessary to obtain access to a restricted My Health Record is important to support emergency clinical workflows and decision making through timely access to information.

Recommendation 6.2 – Provide users with the option to explain the reasons for requesting Emergency Access

On requesting Emergency Access to a patient's My Health Record, users should be asked to choose at least one of the following two options for requesting the Emergency Access:

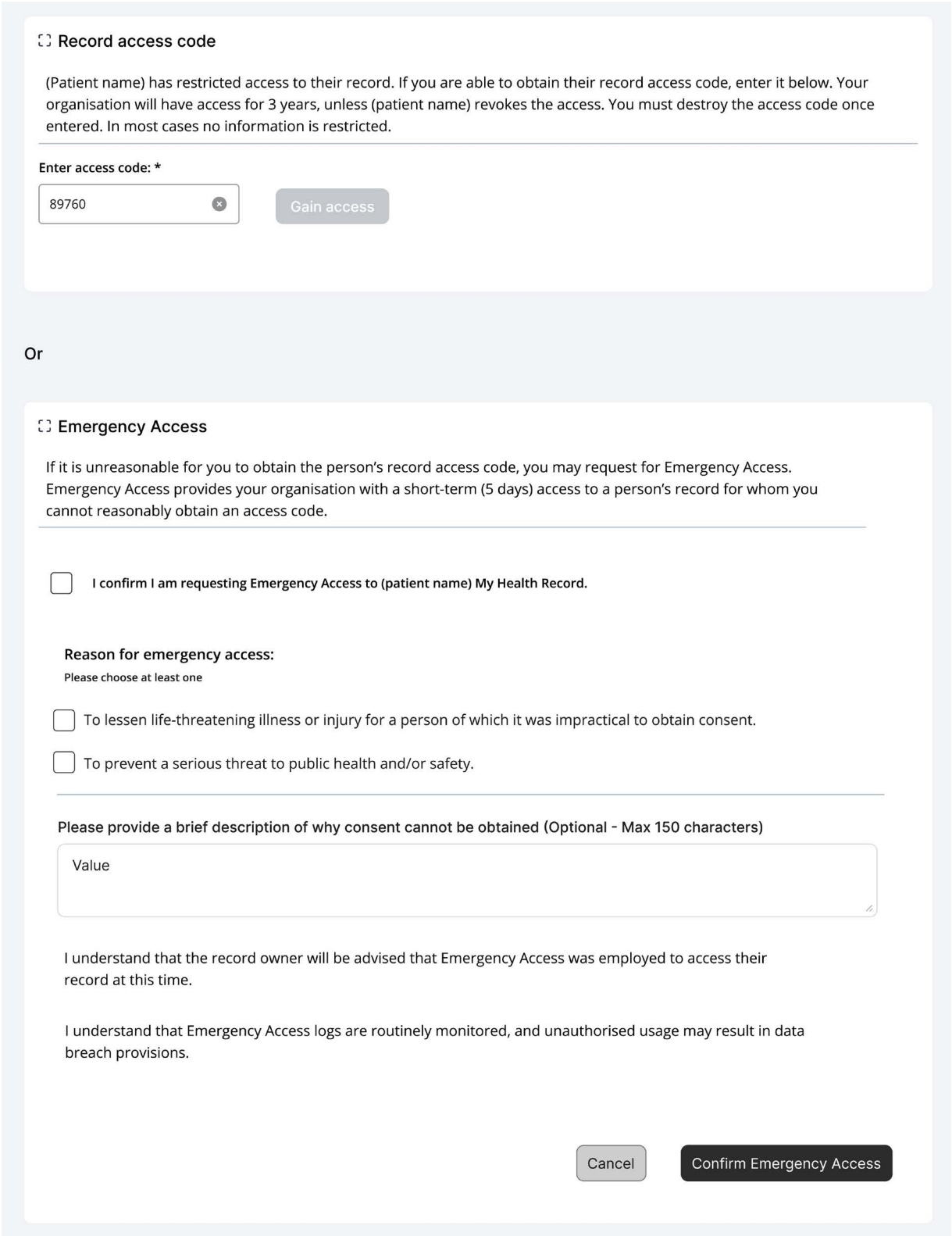
- To lessen life-threatening illness or injury for a person of which it was impractical to obtain consent; and/or
- To prevent a serious threat to public health and/or safety.

To streamline local reporting, a free text field of up to 150 characters could also be available for users to provide a brief description of why consent from the patient could not be obtained to access the patient's My Health Record.

This information can be used to support health service organisations in the maintenance of Emergency Access request logs in line with their obligations to implement practices, procedures and systems that ensure the Emergency Access function of My Health Record is used appropriately and conforms with the **My Health Records Act 2012** and **Privacy Act 1988**.

Figure 11 provides a suggested flow for the implementation of the Emergency Access function of My Health Record. Figure 11 Example of suggested flow for implementation of the Emergency Access function of My Health Record.

Figure 11: Example of the suggested flow for implementation of the Emergency Access function



Recommendation 6.3 - Provide users with transparent privacy and access information

In requesting Emergency Access to a patient's My Health Record, a clinician should be provided with an Emergency Access Declaration to accept and agree to statements that outline the following, prior to accessing the patient's record:

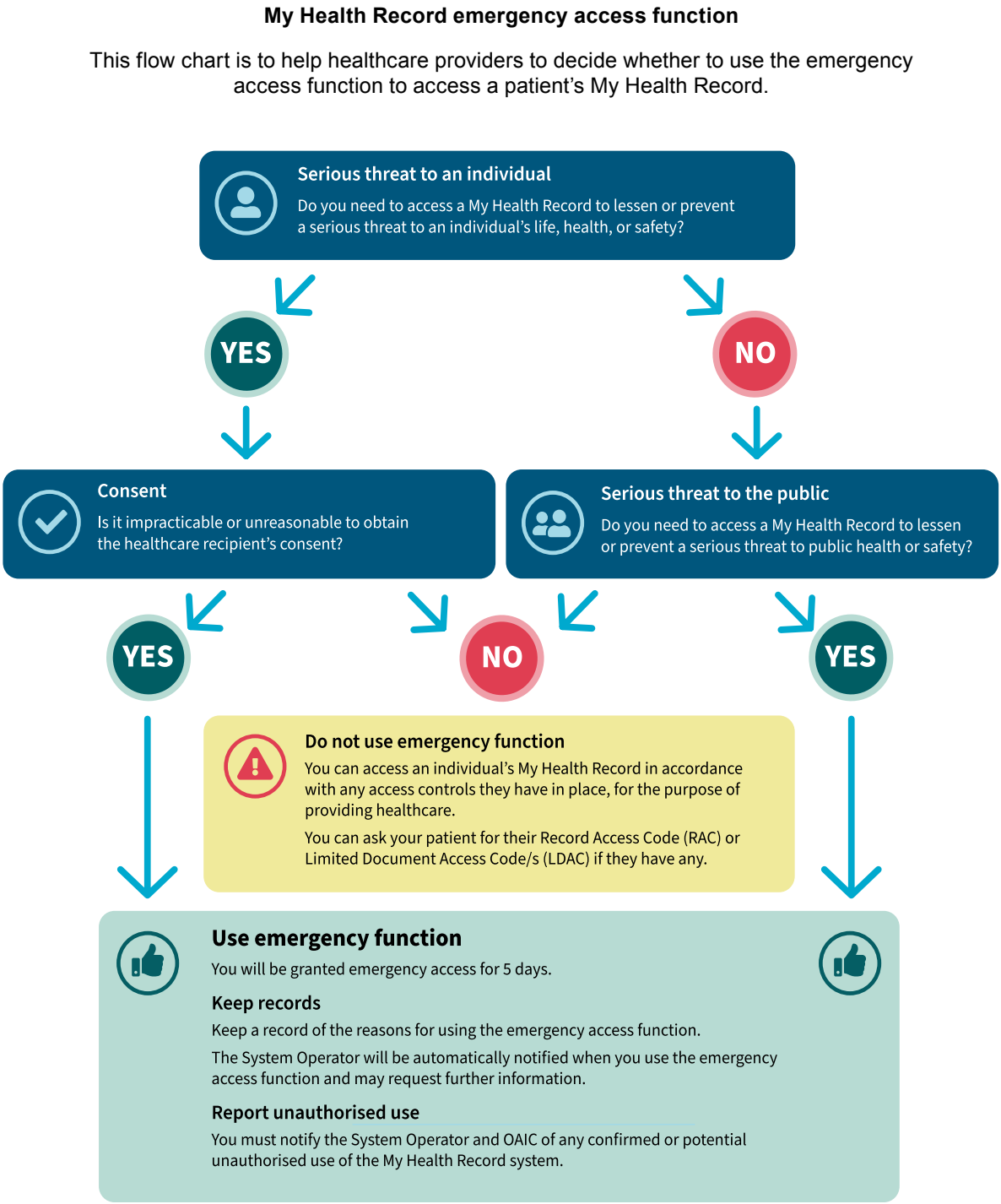
- Users confirm they are requesting Emergency Access for that patient.
- Users understand that the patient will be notified that Emergency Access to their record was obtained.
- Users acknowledge that requests for Emergency Access are recorded and unauthorised access may result in data breach provisions and/or penalties.

Recommendation 6.4 – Embed the Emergency Access Flow Chart in the workflow

The Emergency Access Flow Chart (**Figure 12**) has been created to help healthcare providers decide whether to use the Emergency Access function to access a patient's My Health Record.

The Flow Chart should be embedded into the My Health Record Emergency Access workflow to support users in appropriately requesting Emergency Access in My Health Record.

Figure 12: Emergency Access Flow Chart ***(Source: Office of the Australian Information Commissioner (12))***



Recommendation 6.5 – At the My Health Record access point, display the record's status as being a restricted record

In line with **Recommendation 2.1 – Display the record's status at the My Health Record access point**, a patient whose My Health Record is only accessible with a record access code or via Emergency Access should be visually indicated on the My Health Record button.

The use of a consistent visual indicator to clearly flag that the patient record is only accessible using the Emergency Access feature would support the appropriate use of the feature.

Appendix 1

Acronyms & definitions

Component	Definition
CIS	Clinical Information System is a software solution that stores and manages information collected directly from equipment and clinician inputs. Examples include patient administration systems, laboratory information systems, picture archive and communication systems, electronic medical records and electronic healthcare records.
Clinician	A medical practitioner who is involved in the diagnosis and/or treatment of patients, including recommending preventative action. In this Guide, a medical practitioner who engages in clinical practice in any job, including medical specialists, nurses and allied health professionals providing care in an acute care setting, are classified as a clinician. In this Guide, a clinician is also the My Health Record system user.
Development team	Working with viewing platform owners and software vendors, development teams work to improve and maintain the software relevant to viewing platforms in this context.
ED	Emergency Department
EHR	Electronic health records are secure digital systems built to store health information.
eMR	Electronic medical records, a system utilised day to day by clinicians and staff to gather, manage and consult patient information and data to inform and record patient care delivery in real time.
GP	General Practitioner
Health service Organisation	An organisation that delivers health care to patients in a systematic and safe way. Settings can include hospitals, community settings, general practice, clinics and pharmacies.
HIPS	Healthcare Information Provider Service is a standalone middleware solution which integrates directly with a hospital's clinical information system.
IHI	Individual Healthcare Identifier is a unique number used to identify an individual for health care purposes. It helps ensure health professionals are confident that the right information is associated with the right individual at the point of care.

Component	Definition
MHR	My Health Record is Australia's national electronic health record system. It is a summary of a consumer's health information that is sourced from a variety of providers across the healthcare system, which consumers and clinicians can access. An individual patient's record is referred to as their My Health Record.
NPP	National Provider Portal allows healthcare providers to access the My Health Record System without conformant clinical software.
UI	User Interface: How the series of screens, pages and visual elements (e.g., icons and buttons) enable users to interact with the My Health Record system, which contributes to the overall user experience.
UX	User Experience: What influences a person's perception towards every aspect of the My Health Record system when they use it.
Viewing Platform	Software used to present the My Health Record system to users; typically interfaces with the local CIS.
Viewing platform owner	Person or team responsible for the implementation, maintenance and user-experience of a viewing platform.
WCAG	Web Content Accessibility Guidelines are the international standard which explains how to make web content more accessible to people with disabilities.
Workflow	The steps a clinician takes to provide clinical care to a patient.

Appendix 2

How this Guide was developed

This Guide is supported by accumulated design research and insights generated through the Agency's design processes and practices. These insights inform the design and delivery of many My Health Record features and considerations relevant to conformant software implementations in acute care settings, providing an opportunity to expand their value beyond practice.

The purpose and scope of this advice is not intended to prescribe how My Health Record should be implemented in conformant software, recognising the possible constraints in the existing design of the software. Instead, the Guide offers advice on the challenges the Agency and users of My Health Record have encountered and techniques to address them.

The recommendations are not a compliance requirement or mandatory (to avoid conflicting with current My Health Record conformance specifications) but rather address current usability insights and feedback provided by clinicians.

The recommendations are technically feasible and can support design decisions in future implementations of My Health Record features.

This Guide does not identify or comment on existing implementations where many of the learnings have originated.

The audience for this advice includes teams or organisations procuring product design and development services to implement My Health Record into their software.

Guide development process

Stage 1 – Consolidation & Analysis

To inform the Guide, existing literature, design research and reports which provided the most recent insights and findings on the use of My Health Record in acute care settings were analysed and synthesised into a set of common problem statements. This framed the issues for future consultation and validation with project stakeholders.

Stage 2 – Consultation with platform owners

Consultation with jurisdictional platform owners, as nominated by the Agency's Digitally Enabled Care Advisory Committee, was undertaken to understand existing My Health Record implementations and recent improvements or learnings which support the findings from Stage 1.

Stage 3 – Clinician and Subject Matter Expert Engagement

The Guide's authors then consulted with clinicians and the Agency's Digital Health Advisors using My Health Record to present the developed problem statements and underlying issues for validation and solution exploration.

Stage 4 – Guide development and validation

Through the consultation and development process six opportunity areas were identified which overarch the recommendations. Stage 4 validated these through consultations with clinicians and subject matter experts to inform the development of this Guide.

For this Guide, the actual names of the clinical documents as displayed in the My Health Record are not included in the examples.

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Australian Commission on **Safety and Quality** in Health Care

Australian Government
Australian Digital Health Agency

Australian
Commission on
Safety and Quality
in Health Care

T. +61 2 9393 0117
Level 5, 255 Elizabeth St
Sydney NSW 2000 Australia

safetyandquality.gov.au