Government of Western Australia
Department of Health

Effective from 14 June 2017

WA Clinical Alert (MedAlert) Policy

1. Purpose

The WA Clinical Alert (MedAlert) Policy (the Policy) mandates the implementation of a standardised process of communicating clinical alerts across the WA health system using the PAS (Patient Administration System) for example TOPAS, webPAS, or HCare.

The objective of this policy is to reduce the risk of patients experiencing an adverse event related to a previously identified serious anaesthetic condition, specified medical condition, or serious unexpected drug reaction, by improving communication of these risks to clinicians when patients present to hospital before the medical record is retrieved.

This Policy outlines the minimum requirements for the approval and documentation of clinical alerts within patient health records and the PAS throughout the WA health system to ensure consistent, safe and immediately available clinical alert information to clinicians.

This Policy supersedes the WA Clinical Alert (MedAlert) Policy OD 0511/14.

This Policy forms part of the Clinical Governance, Safety and Quality Policy Framework.

2. Applicability

This Policy applies to Health Service Providers (HSPs) and contracted health entities that provide publicly-funded inpatient care.

3. Policy Requirements

Each HSP must have its own local policy in place which includes governance arrangements, roles and responsibilities, and procedures to ensure the clinical alert process outlined below is followed and clinical alerts are entered into the PAS in a timely manner in all inpatient facilities.

Clinical Alerts

A Clinical Alert is a diagnosis which has the potential to be of critical importance to a patient's management during the first 24 hours of their admission to hospital and assumes that the patient is not always capable of communicating such information.

There are three classifications of clinical alerts; anaesthetic, medical and medication alerts.

Clinical Alert Process

The clinical alert process involves:

- Raising a clinical alert for a patient by completing MR ALERT 2 form (Appendix 1). This form is to be completed by a member of the treating medical team (for all alert categories) or pharmacist (for drug related clinical alerts only).
- Assessing adverse drug reactions to determine whether they classify as a clinical alert – (Appendix 2).
- Review and approval of the MR ALERT 2 form by the Clinical Alert Committee (CAC), or sole medical person/position at small facilities.
- If approved, entering the alert into the PAS in a timely manner.
- If a drug-related clinical alert occurs during hospitalisation a patient must be provided with the Adverse Drug Reaction Information Brochure for Consumers, or equivalent, that is completed by the treating medical team or pharmacist. (Appendix 5).
- Standardised documentation requirements for adverse drug reactions, which may, or may not, be elevated to serious drug reactions that require a clinical alert (as outlined in Appendix 3).
- Standardised documentation requirements for adverse drug reactions which occur during hospitalisation and require reporting to the Therapeutic Goods Administration (TGA) – Appendix 4).

All HSPs and contracted health entities with inpatient facilities are required to have a governance arrangements in place through their local policy, such as a Clinical Alert Committee (CAC):

- Larger facilities are required to have a site-based CAC.
- Smaller facilities may have a CAC managed at the regional/facility group level. In this situation there is a requirement to identify a sole medical person/position within each smaller facility responsible for reviewing and providing advice on clinical alerts.

Clinical Alert Committee

Membership

To provide appropriate and comprehensive governance of each HSP local policy the CAC membership must at a minimum include a:

- medical officer,
- pharmacist,
- health information manager, and
- clinical coding representative.

Role and Responsibilities

Each relevant CAC must be responsible for;

- Reviewing appropriateness and approving all clinical alerts raised on MR ALERT 2 forms to be entered into the PAS.
- Ensuring education is provided to all medical and pharmacy staff involved in raising clinical alerts ensuring a holistic understanding of what a clinical alert is, how to raise one for a patient and where to find the patient's clinical alert information when the patient is admitted to hospital.
- Managing the change requests for clinical alert categories and codes to be raised to the WA Clinical Alert Business User Group (Appendix 7).
- Monitoring compliance at their facility/ies with this policy.

The CAC must report regularly to the Clinical Governance Committee. Medication-related clinical alerts may also be tabled at the Drug and Therapeutics Committee/Medication Safety Committee as appropriate.

The PAS clinical alert system must <u>not</u> be used for:

- Other PAS Alerts including Micro Alerts and patient and/or family member Behaviour (Risk) Alerts. These are outside the scope of, and are not defined within, this Policy.
- MedicAlerts. The MedicAlert Foundation (who provides consumers with MedicAlert bracelets) has a registry to identify consumers with serious allergies or conditions and this is usually organised and authorised through the consumer's general practitioner. This system is outside the scope of this policy.

4. Compliance, measurement and evaluation

HSPs are responsible for carrying out regular audits and evaluating compliance with the Policy.

Each HSP Board must provide an annual statement of compliance assurance against all policy requirements to the safetyandquality@health.wa.gov.au mailbox by 31 September for the preceding financial year.

HSPs must make available the following indicators to the System Manager on request:

- Percentage (%) (including numerator/denominator information) of alerts that were reviewed as appropriate to be entered onto PAS.
- Percentage (%) (including numerator/denominator information) of medical, pharmacy and clerical staff who have received education on clinical alerts.

Evaluations to review the quality and appropriateness of information entered onto the PAS clinical alert system will be undertaken by the Clinical Alert Business User Group (within the Department of Health) on behalf of the System Manager. Feedback will be provided to the HSPs to review and rectify as required to ensure compliance.

Non-mandatory suggested qualitative indicators for HSPs to monitor their compliance with this policy include:

- Average time for alerts to be uploaded onto PAS, i.e. number of days from date of generating MR ALERT 2 form (filled out to date entered onto PAS).
- Percentage (%) of patient medical records with MR ALERT 2 form that have been entered onto PAS from a 50 percentage sample.
- Percentage (%) of patients with a clinical alert that has not been notified (e.g. patient has had an anaphylactic reaction to medication which has been documented in medical record (admission notes or medication chart) but has not be raised as a clinical alert on an MR ALERT 2 form).

5. Related documents

The following documents are required to give affect to this policy (i.e. the documents included are mandatory):

- Appendix 1 – MRALERT 2 Form for raising clinical alerts for PAS entry
- Appendix 2 - Serious Adverse Drug Reactions for Inclusion on the PAS
- Appendix 3 - Documentation of Adverse Drug Reactions (ADRs)
- Appendix 4 - Adverse Drug Reactions occurring during hospital admission

6. Supporting information

The following documents inform this policy (i.e. documents that are not mandatory to the implementation of this policy but may support the implementation of the policy):

- Appendix 5 – Consumer Adverse Drug Reaction Brochure
- Appendix 6 – Dietary Allergy / Food Allergy
- Appendix 7 - Raising a New Clinical Alert
- Appendix 8 - Patient Alert Form
- Appendix 9 - Recommended Process for Medical Condition (M) and Drug-Related (D) Clinical Alerts
- Appendix 10 - Advance Health Directives

7. Definitions

Adverse Drug Reaction	A harmful or undesirable effect associated with the exposure to a medication/drug at therapeutic or sub-therapeutic doses.
Clinical handover	Refers to any situation in which responsibility and accountability for some or all aspects of a patients care is passed from one clinician, or group of clinicians, to another.
Clinical Alert	A diagnosis which has the potential to be of critical importance to patients' management during the first 24 hours of their admission to hospital and assumes that the patient is not always capable of communicating such information. There are three classifications of clinical alerts; anaesthetic, medical and drug alerts. By raising a Clinical Alert (also known as MedAlert) for approval to be entered onto the PAS (patient administration system –e.g. TOPAS/webPAS/HCare), critical clinical information can be immediately flagged from the PAS for notification to clinicians before the medical record is retrieved.
Clinician	Clinicians include doctors, nurses, pharmacists and allied health professionals.
PAS	Patient Administration System (i.e. TOPAS – The Open Patient Administration System, webPAS, The Web based Patient Administration System, HCare – Health Care and Related Systems).
Patient medical record	The complete electronic or paper file associated with each patient.
Protocol	Refers to a site-specific operating guidance document based on this document
Serious Drug Reaction	A serious adverse drug reaction is defined reaction that may lead to a life-threatening event and has an absolute or relative contraindication to repeat administration of the drug.

8. Policy owner

Assistant Director General, Clinical Services and Research

Refer queries to the Secretariat of Clinical Alert Business User Group by email.

Clinical Alert Business User Group
Division: Patient Safety and Clinical Quality

Enquiries relating to this mandatory policy may be directed to:
QICM@health.wa.gov.au.

9. Review

This mandatory policy will be reviewed and evaluated as required to ensure it is relevant and recent. At a minimum it will be reviewed within 3 years after first issue and at least every 3 years thereafter.

Version	Effective from	Review date	Amendment(s)
MP 0053/17	14 June 2017	June 2020	Original version

The review table indicates previous versions of the mandatory document and any significant changes.

10. Approval

This mandatory policy has been approved and issued by the Director General of the Department of Health.

Approval by	Dr David Russell-Weisz, Director General, Department of Health
Approval date	23 May 2017
Published date	14 June 2017
RMR#	F-AA-15932

APPENDIX 1 – Clinical Alert (MedAlert) FORM _ MR ALERT 2 FORM

Front Page

HEALTH DEPARTMENT OF WESTERN AUSTRALIA

_____HOSPITAL

MED ALERT / CLINICAL ALERT NOTIFICATION

Application for adding, removing or modifying a Med Alert. This is **only** for conditions which are of a life-threatening nature and likely to be recurrent.

Please use I.D. label or block print

SURNAME	URN
GIVEN NAMES	
D.O.B.	SEX

XY000080

Please send the completed form to your Clinical Coding Department

REQUEST TYPE: ☐ ADD ☐ UPDATE ☐ DELETE **DATE:** / /

CONDITION (see over):

Clinical Alert code:_____ Condition:_____

Please name the condition if not listed:

_____

CLINICAL-ALER FREE TEXT (200 characters)

_____

_____

_____

_____

_____

_____

_____

Example only

APPLICANT

Clinicians Name:_____ Signature:_____

Unit / Department:_____

Office Use Only

Clinical Alert Request Received *Date:___/___/____*

☐ *Request Approved*

☐ Not Approved Requestor Notified: ☐ Yes ☐ No

Name:_____ Signature:_____

Computer Entry

Name:_____ Signature:_____

DO NOT WRITE IN BINDING MARGIN

HDMRALERT2 12/16

CLINICAL ALERT NOTIFICATION

MR ALERT 2

Valid at the time of print

APPENDIX 1 (continued) –Clinical Alert (MedAlert) Form /MR ALERT 2 Form

Current clinical alert codes are printed on the back of the Clinical Alert (MedAlert) Form (MR Alert 2). They are broken down in the anaethetic alerts, drug/dietary reaction alerts and medical condition alerts. These alerts are reviewed periodically for relevance and use.

Please refer to Safety and Quality website for most current version of this form.

http://ww2.health.wa.gov.au/Health-for/Health-professionals/Safety-and-quality - Managing Clinical Risk.

APPENDIX 2 - Serious Adverse Drug Reactions for Inclusion on the PAS

Only serious life threatening reactions are to be documented on the PAS.

Both the drug implicated and the reaction which occurred MUST be specified.

A serious adverse drug reaction is defined as an absolute or relative contraindication to repeat administration of the drug. There is a need to differentiate between serious and severe reactions -"severe" is often used to describe the intensity of a medical event. Other cases require further clarification.

Medications /drugs of concern are those likely to be given without verbal consultation with the patient (i.e. when the patient is too unwell). Examples include antibiotics, anaesthetics, and analgesics.

Allergic reactions for inclusion:

(Drug and Non Drug Allergies e.g. Latex, Intravenous Contrasts, Chlorhexidine):

- Rash – if thought to be serious or severe, or accompanied by swelling of the whole body (not localised).
- Anaphylaxis or Anaphylactoid reactions.
- Serum Sickness.
- Angioedema - swelling of face, throat, neck, tongue.
- Bronchospasm, asthma, other breathing difficulties.

Other serious or life threatening reactions for inclusion:

- Agranulocytosis (e.g. clozapine).
- Extrapyramidal side effects (severe dystonia / laryngospasm) to antipsychotics.
- Stevens Johnson Syndrome.
- Toxic epidermal necrolysis.
- Malignant hyperthermia.
- Scoline apnea or cholinesterase problem.
- Neuroleptic Malignant Syndrome.
- Hepatitis or Nephritis.
- Other – must be deemed serious and life-threatening/causing significant harm.

Adverse drug reactions that are NOT deemed Clinical Alerts/Med Alerts:

- Non-dose Related Reactions – Unpredictable and uncommon side-effects not related to pharmacological action, with a low mortality rate (e.g. Timolol causing depression, Lithium induced neutropenia).
- Time-related Reactions – Uncommon reactions which are usually dose-related, and occur sometime after the use of the drug (e.g. Tardive dyskinesia secondary to antipsychotic drugs).
- Dose Related Reactions – Predictable side-effects related to pharmacological action of drugs (e.g. moderate extrapyramidal side-effects to antipsychotic drugs, excessive nausea and vomiting with opioids, vancomycin causing Red Man Syndrome).
- Mild to moderate side-effects or unknown reactions are not to be recorded as a clinical alert but should be documented in the medical record. Examples of these include:
  - mild diarrhoea, nausea and mild vomiting, itch, hayfever / blocked nose, local swelling or pain.
  - Non-serious adverse reactions to non-drug allergens (e.g. bee stings, grasses).

Appendix 3 - Documentation of Adverse Drug Reactions (ADRs)

Before new medications/drugs are prescribed, dispensed or administered for a patient it is important that the patient's ADR documentation is reviewed to prevent patient re exposure to a drug which may lead to an adverse event.

On first hospital encounter with the patient (i.e. admission to hospital or outpatient clinic) the patient should be interviewed to determine whether the patient has experienced any previous adverse drug reaction or allergic responses when taking medications /drugs in the past.

The treating clinician is responsible for determining whether an ADR is clinically important. For each adverse drug reaction identified the following information must be documented in the medical record, on all National Inpatient Medication Charts (NIMCs), and in the patient's discharge summary:

- The generic name of the medication/drug implicated.
- The reaction which occurred.
- The date of the reaction (if known).
- The person documenting the ADR must sign and date the record.

In the case of ADRs involving hypersensitivity reactions or clinically important side effects the following actions are required:

- If the ADR occurs during the current admission, follow the actions below and refer to Appendix 5.
- Document details on MR ALERT 1 – Patient Alert Form. An "ALERT" sticker should be placed next to the text and on the front cover.
- Document details on every National Inpatient Medication Chart (NIMC) in the red Adverse Drug Reaction box. Attach an "ADVERSE DRUG REACTION" sticker on the red "Attach ADR Sticker" box and on the back page.

Adverse Drug Reaction

- ADR details must be transferred to all new medication charts that are commenced.
- Patients with a known allergy, or suspected clinically important ADR or other known risk should be issued with a RED patient identification band. No other coloured patient identification band is to be used.
- If an allergy is identified subsequent to admission the standard white identification band will be replaced by a RED identification band by nursing/midwifery staff caring for the patient.

Whether or not a reaction is deemed a drug-related clinical alert requires clarification by either a medical officer or senior pharmacist.

If the ADR meets the criteria as a clinical alert outlined in Appendix 2, initiate the clinical alert process. (Recommended process outlined in Appendix 9. Information in this section is provided as a recommended example of how the process may function within a hospital site. Sites may vary process to meet individual circumstances).

Rechallenge of Drug

If a drug has been prescribed and there is documentation to state a previous adverse drug reaction has occurred (e.g. NIMC, medical record, triage records), the nurse/midwife must check with the prescriber that the medication is safe to administer.

If a previous adverse drug reaction has been identified and documented appropriately, and there is a clinical need to rechallenge the patient due to no other therapeutic option being available and/or lack of clarification of the reaction, the adverse drug reaction must be acknowledged by the medical officer and reasons for rechallenge must be documented in the medical record.

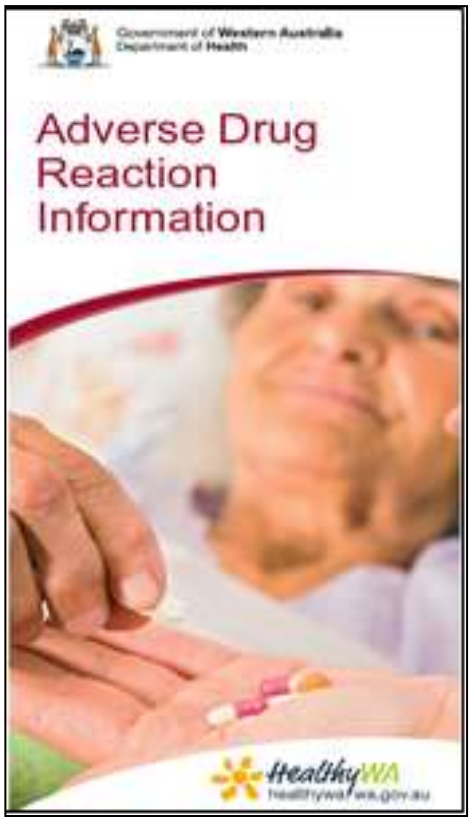
If the reaction is a serious adverse drug reaction (e.g. anaphylaxis, angioedema, bronchospasm, rash etc. refer to Appendix 2) the team consultant must review the order and document in the medical record if the drug is required to be administered.

Appendix 4 - Adverse Drug Reactions occurring during hospital admission

A new adverse drug reaction (ADR) occurring during a hospital episode requires:

- Documentation of the adverse drug reaction details (culprit drug [generic name], reaction observed and date of reaction) in the medical notes, on the medication chart, on the PAS if appropriate, and in the discharge summary.
- Supply patient with red patient identification band.
- The patient is to be given an Adverse Drug Reaction Information Brochure if an adverse drug reaction has occurred during hospitalisation. (Refer to Appendix 2)
- Information detailing a new ADR must be communicated to the general practitioner or receiving hospital in the discharge summary.
- An Advisory Committee on the Safety of Medicines (ACSOM) form may need to be completed and forwarded to the Pharmacy Department and the Therapeutic Goods Administration (TGA) http://www.tga.gov.au/safety/medicines-statistics-2010.htm#report.
- Alternatively online reporting can be done through the TGA website.
- Reports of suspected adverse drug reactions can be made:
- Online at 'Report a Problem' (http://www.tga.gov.au/safety/medicines-statistics-2010.htm#report.)
- Using a 'Blue Card' available from the TGA's Office of Product Review (1800 044 114 or adr.reports@tga.gov.au) or downloaded from the TGA website at 'Blue Card' adverse reaction reporting form, or MIMS Online. (https://www.mimsonline.com.au)
- Adverse drug reactions meeting status of serious adverse drug reaction in this policy should be reported to the TGA - Advisory Committee of the Safety of Medicines (ACSOM).
- In event of an adverse drug reaction where agent is not clearly identified, clarification from Immunology (where available) and documentation of all drugs the patient is prescribed must be reported to the TGA - Advisory Committee of the Safety of Medicines (ACSOM).

APPENDIX 5 - Adverse Drug Reaction Information Brochure for Consumers



A print ready version can be found on the Safety and Quality website - Managing Clinical Risk

http://ww2.health.wa.gov.au/Health-for/Health-professionals/Safety-and-quality

Appendix 6 – Dietary Allergy / Food Allergy

Dietary (Food) allergy is deemed a clinical alert (which must be differentiated from a food intolerance which is not a clinical alert).

A **food allergy** is an abnormal immune mediated reaction to ingested food, resulting in clinical symptoms. Reactions can occur after eating a small amount of food. Food allergy affects 10% of infants <1 year, 4-8% of children <5 years and up to 2% of the adult population in Australia. It is the responsibility of the treating medical team to ensure a clinical alert is recorded for patients with a food allergy.

A **food intolerance** does not involve the immune system and does not cause severe life-threatening allergic reactions (known as anaphylaxis) and should not be listed as a clinical alert (see clinical alert definition). Food intolerance reactions are dose related and are often delayed. Symptoms may include headaches or gastrointestinal symptoms after eating.

Food Allergies to be reported as a clinical alert include:

- Anaphylaxis or anaphylactoid reaction
- Swelling of face, lips, eyes, tongue or throat
- Flushing or hives/welts on the skin
- Tingling mouth
- Severe abdominal pain, severe vomiting, severe diarrhoea
- Difficult /noisy breathing
- Difficulty talking and / or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness and/or collapse
- Pale and floppy (in young children)
- Acute onset of hypotension, severe breathing difficulty, bronchospasm or upper airway obstruction where anaphylaxis is considered possible.

There are nine common allergens in Australia specified by the Australasian Society of Clinical Immunology and Allergy (ASCIA).

These are wheat, egg, soy, cow's milk (diary), peanuts, tree nuts, fish, shell fish (Crustacean), and sesame.

These foods cause around 90% of food allergic reactions in Australia. Food labels are required by law to declare if the food or beverage contains any of these common nine allergens. (Note: The legislation identifies gluten, not wheat). Outside of the nine common food allergens, any other food can cause an allergic reaction.

A food allergy clinical alert (DOther10), must include in the comments field the words either 'unconfirmed' or 'confirmed' depending on what follow up has been completed in determining the association between the allergy symptoms and the suspected food allergen.

A 'confirmed' food allergy must been diagnosed by an immunology or allergy specialist. When a food allergy challenge has been completed, the hospital (or HSP for smaller sites) must have a system in place to document de-labelling of a food allergy including removal of a food allergy clinical alert.

Appendix 7 – Changes or additions to Clinical Alert categories, codes or definitions

The WA Clinical Alert Business User Group is established through the Patient Safety and Clinical Quality Directorate, Clinical Services and Research Division, Department of Health.

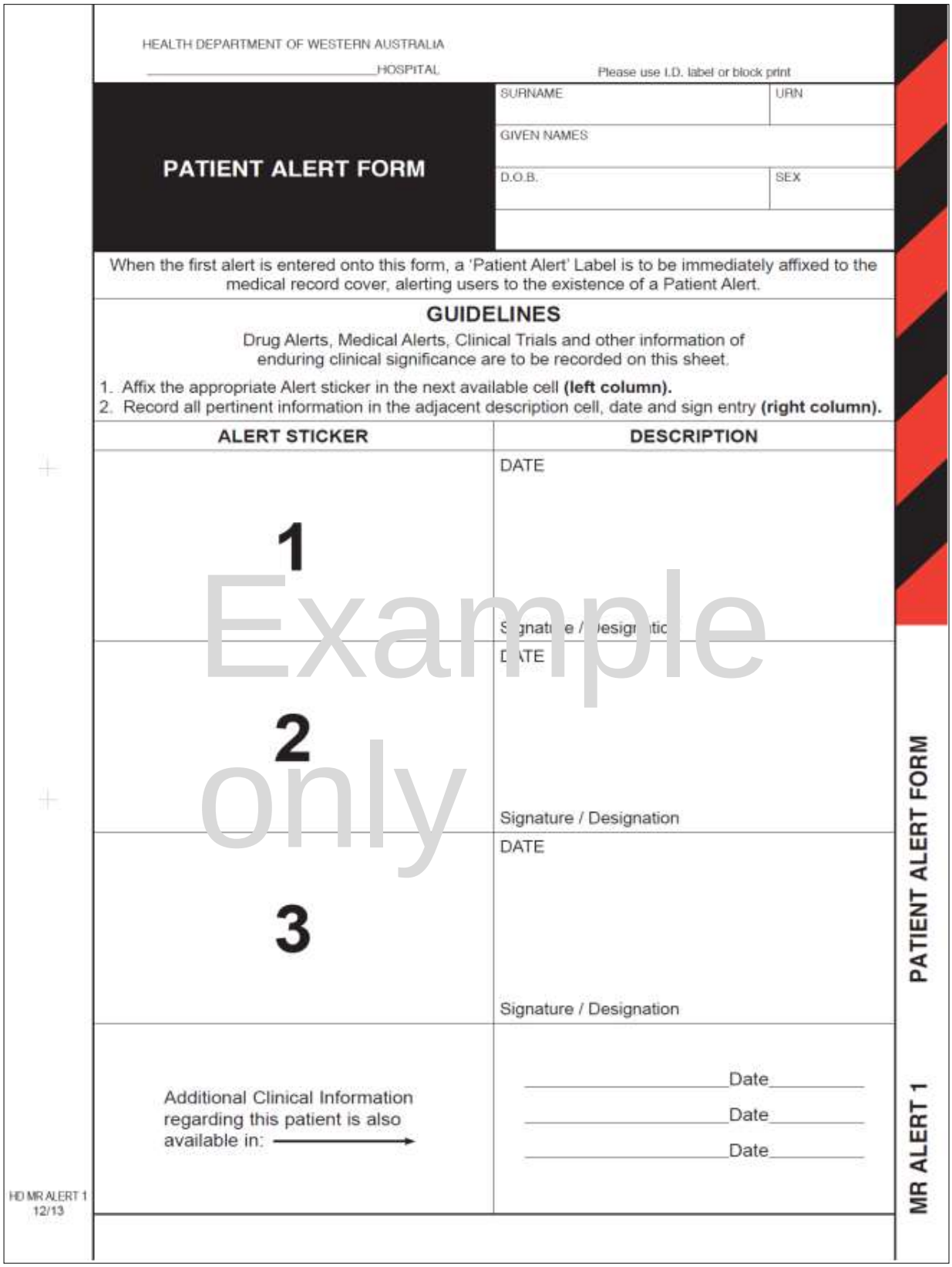
Responsibilities of this group include:

- assessment of existing Clinical Alert code definitions to be used on the PAS;
- assessment of any proposed changes made on TOPAS/WebPAS; and
- provision of guidance on standardisation of documentation of adverse drug reactions (and serious non drug allergies e.g. Latex, Intravenous Contrasts, Chlorhexidine) which may, or may not, be elevated to serious drug reactions that require a clinical alert.

Proposed changes to clinical alerts categories, codes or definitions must be requested through the WA Clinical Alert Business User Group via the hospital's local committee (CAC) or representative.

CA representatives or equivalent may refer queries and proposals for such changes to the WA Clinical Alert BUG Secretariat via QICM@health.wa.gov.au

Appendix 8 - Patient Alert Form



HEALTH DEPARTMENT OF WESTERN AUSTRALIA

_____HOSPITAL

Please use I.D. label or block print

PATIENT ALERT FORM

SURNAME	URN
GIVEN NAMES	
D.O.B.	SEX

When the first alert is entered onto this form, a 'Patient Alert' Label is to be immediately affixed to the medical record cover, alerting users to the existence of a Patient Alert.

GUIDELINES

Drug Alerts, Medical Alerts, Clinical Trials and other information of enduring clinical significance are to be recorded on this sheet.

1. Affix the appropriate Alert sticker in the next available cell **(left column).**
2. Record all pertinent information in the adjacent description cell, date and sign entry **(right column).**

ALERT STICKER	DESCRIPTION
1	DATE Signature / Designation
2	DATE Signature / Designation
3	DATE Signature / Designation
Additional Clinical Information regarding this patient is also available in: ⟶	_____Date_____ _____Date_____ _____Date_____

PATIENT ALERT FORM

MR ALERT 1

HD MR ALERT 1
12/13

Appendix 9 - Recommended Process for Medical Condition (M) and Drug-Related (D) Clinical Alerts

Information in this section is provided as a recommended example of how the process may function within a hospital site. Sites may vary process to meet individual circumstances.

It is up to the individual health service provider to assign authorisation to the appropriate position/s to enter the alerts onto the PAS. Positions responsible for entering alerts must have undertaken training on clinical alerts and use of the PAS.

1. Identification of alert and completion of Clinical Alert / Med Alert Notification (MR ALERT 2) form

- During the patient's admission it is the responsibility of the medical officer to report clinical alerts in accordance with specified medical, anaesthetic or drug-related alerts and specific detailing as per Clinical Alert / Med Alert Notification (MR ALERT 2) form. This form must be forwarded to clinical coding to enter onto the PAS. The form is then to be filed at the front of the medical record.
- During the patient's admission it is the responsibility of the clinical pharmacist to report adverse drug reactions in accordance with specified clinical guidelines and specific detailing as per Clinical Alert / Med Alert Notification (MR ALERT 2) form. This form must be forwarded to clinical coding to enter onto the PAS. The form is then to be filed at the front of the medical record.
- Clinical coding staff are to identify records with new *Med Alert/Clinical Alert Notification (MR ALERT 2) form/s for medical, anaesthetic or drug alerts. Initiate Patient Alert Form (MR ALERT 1) if alert identified during coding.

2. Authorisation process

- The designated Clinical Alert Committee (CAC) / dedicated position (depending on size of institution - ideally a medical officer or clinical pharmacist (if drug related)) responsible for governance of clinical alerts for each site will review all medical alerts and drug alert queries in a timely manner, with the exclusion of anaesthetic and specified alerts.
- Some clinical alerts can be entered by clinical coding staff without co-authorisation (including, but is not exclusive to organ transplant, heart valve replacements, pacemaker or other implanted devices when inserted during the admission being coded, asplenia and Advance Health Directive). Alerts that meet this criterion should be decided by the governing body within the hospital.

3. Data entry and file form in medical record

- Once the clinical alert has been approved by the CAC/dedicated position, the alert must be entered into the PAS clinical alert system. This must be undertaken by persons authorised to enter patient data onto the PAS clinical alert system. This role may be allocated to a clinician (doctor) or pharmacist (for drug-related alerts) if trained

sufficiently to do so. If no authorised person is available in the clinical area the MR ALERT 2 form should be forwarded with the medical record (if requested) to medical records/ clinical coding to be entered onto the system.

4. If the proposed clinical alert is not approved for entry onto PAS

- If the alert is not deemed to be a clinical alert (i.e. serious/life threatening issue) but is still required to be captured in the patient's medical record (such as mild to moderate side-effects to a drug), the position responsible for approval of alerts should ensure the alert (medical, anaesthetic or drug alert information) is documented on inside cover of the health record, the Patient Alert Form (MR ALERT1) or in the digital medical record if not already documented.
- Cross the Clinical Alert/ Med Alert Notification forms through with two diagonal lines and state the reason why not approved. The MR ALERT 2 form should still be filed as a record of proposed Clinical Alert with reason why it was not approved.

5. Removal of alerts from PAS

- If an alert is entered in error it needs to be removed from the PAS to reduce the risk to the patient.
- If an alert is no longer active, or is no longer relevant, the alert should be inactivated so they do not automatically be displayed.
- When the alert codes are being reviewed and need to be updated (new ones added or obsolete ones removed) then a change request is raised by the committee to update the PAS, and the relevant communications sent to stakeholders regarding the change.

6. Recommended process for alert queries within hospitals

- The designated local committee / dedicated person (depending on size of institution) responsible for governance of clinical alerts for each site will review all medical alerts and drug alert queries, with the exclusion of anaesthetic and specified alerts.
- Chair, Clinical Alert Committee will:
- Review medical records / Clinical Alert / Med Alert Notification (MR ALERT 2) form/s flagged as containing new alerts.
- Approve/not approve Clinical Alert/Med Alert Notification forms and adjust wording as needed.

If Clinical Alert is approved:

- Document the clinical alert information as per section 6.4.
- Record your name, designation and date of entry.
- Place alert labels on the outside of the health record.
- Forward Clinical Alert/Med Alert Notification form (MR ALERT 2) and health record to Clinical Coding for addition onto the PAS.

If Clinical Alert Not Approved:

- Cross the Clinical Alert/Med Alert Notification form (MR ALERT 2) through with two diagonal lines and state the reason why not approved. Ensure relevant alert information is documented on inside cover of the health record and the Patient Alert Form (MR ALERT1).
- Return records/Clinical Alert/MedAlert Notification (MR ALERT 2) form to medical records.

Where a clinical alert for a patient does not fit within one of the specified categories the Medical Other (M.Other.4) or Drug Other (Drug.Other.3) category may be used.

The M.Other 4 /Drug.Other.3 alerts must only be used for clinical alerts that are potentially life-threatening conditions that are crucial for treating physicians to be alerted to immediately on patient presentation to hospital. D.Other3 alerts must have the specific drug and the reaction documented before being submitted for input to the PAS. The use of these codes will be reviewed periodically by the Clinical Alert Business User Group to determine if new codes are required.

Appendix 10 - Advance Health Directives

If a patient has an Advance Health Directive (ADH) a clinical alert should be raised for the patient.

An Advanced Health Directive (AHD) is a document that contains the patient's decisions about future treatment. Treatment includes medical, surgical and dental treatment and other health care. An AHD can either provide consent, or refuse consent, to future treatment.

An AHD comes into effect only if the patient is unable to make reasonable judgments about a treatment decision at the time that the treatment is required. In these circumstances, the AHD acts as your 'voice'.

When a patient presents to hospital (whether as an emergency presentation or a direct admission) it is important to identify if the patient has an AHD and ensure the presence of the patient's AHD is recorded as a clinical alert and filed within the patient's medical record.

Completing a clinical alert and filing a copy of the patient's AHD within their medical record will raise awareness of advance care planning (ACP) and also improve access to an AHD at point of care.

The presence of an AHD alert (M11.02) on the PAS provides a flag that identifies that an AHD exists for the patient. The details of the AHD are not stored on the PAS. On identifying an AHD alert the doctor must discuss the AHD with the patient or the family/carer to determine the content and currency of the AHD.

It is important that the treating team be familiar with the patient's AHD and their treatment wishes. As soon as possible an ACP discussion should be held with the patient to clarify if they remain comfortable with their choice of preferred treatment decision(s).

Please refer to the Advance Care Planning website for further information.

www.health.wa.gov.au/advancecareplanning

This document can be made available in alternative formats on request for a person with a disability.

Valid at the time of print