Peninsula Health

PO Box 192
Mount Eliza, Victoria 3930 Australia
Telephone 03 9788 1200

2007
PREMIER'S AWARD
MOST OUTSTANDING
METROPOLITAN
HEALTH SERVICE

DEPARTMENT OF CLINICAL GOVERNANCE, QUALITY AND CUSTOMER SERVICES.

22 March 2010

Mr Iain West
Deputy State Coroner
State Coroner's Office
57- 83 Kavanagh St
Southbank
3006

Dear Mr West,

Regarding Julie Stephens Case number 5746/08

I write in response to the following recommendation arising from the investigation into the death of Julie Stephens.

That Frankston Hospital consider placing an allergy warning *sticker on the front cover of medical record for all patient's with known drug and food allergies.*

Peninsula Health has a policy 'Alerts and Adverse Reactions (3.1.37) '. A copy of this is attached.

Section 4.2 of this policy reads:

"Alert sheet

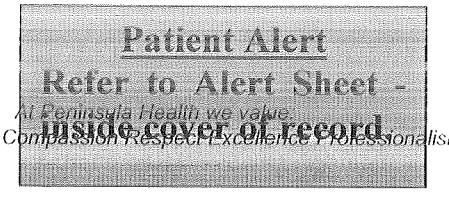
This sheet is designed to allow staff to record any patient alert in a single, easily identifiable, location. The Alert sheet (MR/000) is to be placed as the first sheet in any medical record volume when an alert is judged to be necessary. The Alert sheet is to be added to the medical record when the patient's first alert is identified by the clinical staff.

The Alert sheet includes the following sections

- Patient identification
- Potential Medical Record Volume locations
- Instructions for Use
- Adverse Drug Reactions or Drug Allergies
- Non Drug Alerts

If a patient presents to another campus and it is found that an alert is identified from the Patient Administration System or the Clinical Information System then this alert shall be added to the existing Alert sheet within the patient's medical record. If the record doesn't contain an Alert Sheet (MR/000) then this is to be added to the patient's record and the alert recorded accordingly. This will be the responsibility of the first treating clinician.

An Alert sticker is to be placed on the front cover of the patient's medical record".



Frankston Hospital

Rosebud Hospital

Psychiatric Services

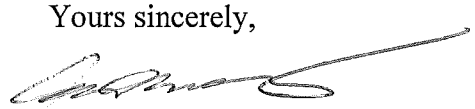
Aged Care, Rehabilitation & Palliative Care Services

Primary and Community Health

The current Peninsula Health policy regarding Alerts and Adverse reactions will be amended to include changes as a result of the Victorian Health Department's 'Cerner' project. This computerised system allows for electronic prescribing/ordering of medications, pathology and radiology. It will provide for allergies and alerts to be highlighted to staff when they are either prescribing or administering medications. The removal of the alerts stickers and alerts sheets from the paper based medical record is under consideration by Peninsula Health.

Should you require further information regarding this matter, please don't hesitate to contact us.

Yours sincerely,



Clive Wellington
MBBS FRACMA
Medical Director, Patient Safety Unit

3.1.37 ALERTS AND ADVERSE DRUG REACTIONS

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1. INTRODUCTION

Peninsula Health is committed to ensuring the best possible care is delivered to all its patients whilst maintaining a safe workplace for staff. The Alerts framework is a vital tool in assisting the staff of Peninsula Health to deliver this care in a safe and effective manner.

The Alerts framework will enable a pro-active approach to assist in the prevention of future incidents. The framework provides:

1) A consistent reporting policy and procedure to be followed in the event of potential harm or adverse events that occur to patients and/or staff. Compliance with the policy will also assist with the prevention of future incidents or potential harm to staff or patients.
2) Establishing and maintaining an accurate record of individual patient alerts that can be accessed by the appropriate staff via the medical record, Patient Administration System and Clinical Information System
3) A mechanism for corrective action or deletion of alerts when no longer deemed necessary
4) An integrated approach with the Incident Reporting Framework to maintain consistency of reporting and assist with the measurement of compliance.
5) A linkage with various internal Risk Assessment Tools that identify risk and associated alerts.

For the purposes of this policy, alerts can be categorized into:

- **Adverse Drug Reactions** or **Drug Allergies**

- **Non-Drug Alerts,** comprising -
  - *Infectious Risk*
  - *Special Needs &/or Preferences; e.g.:*
    - Complex Care Program Care Plan
    - Treat patient in accordance with care plan
  - *Safety & Security; e.g.:*
    - Aggression/Violence
    - Absconding Risk
    - Self Harm
    - Treat with staff chaperone
  - *Legal; e.g.:*
    - Power of Attorney Guardianship
    - Legal Custodian
    - Power of Attorney Medical Treatment
    - Privacy
    - Child at Risk
  - *Clinical/Medical; e.g.:*
    - Falls Risk (High/Extreme Risk Rated Patient)
    - Pressure Ulcers Risk (High/Extreme Risk Rated Patient)
    - Blood Transfusion Risk/Antibody Reaction

- *Administrative; e.g.:*
  - Duplicate Name
  - Overseas patient
- *Chemical; e.g.:*
  - Iodine
  - Sulphur
- *Food; e.g.:*
  - Egg
  - Nuts
- *Environment; e.g.:*
  - Latex
  - Dressings

2. RATIONALE / BACKGROUND

The systematic identification and recording of alerts is an essential part of Peninsula Health's efforts to continually improve the standard of patient care, ensuring staff safety and to minimize the occurrence of adverse events. An overall goal is to reduce the incidence and prevalence of sentinel events, adverse events, incidents and "near misses" or "close calls" that could be influenced by the recording of an alert.

The provision of care occurs at multiple sites and therefore it is essential that alerts are captured locally and then using the systems outlined below are made available for the information of other staff, regardless of their location.

Peninsula Health has a unique record numbering system that is centralised. Therefore regardless of where a patient is treated they will have the same single Unit Record (UR) number. However there are currently a number of medical record volumes, that all use the single patient UR number, but are located at different campuses. As at April 2007 the potential medical record volumes are:

- Frankston Acute (F)
- Psychiatry (P)
- Rosebud Acute (R)
- Community and Continuing Care (includes Chelsea CRC, Golf Links Rd Frankston, Jackson's Rd Mt Eliza, Eastborne Rd Rosebud, Jean Turner & Lotus Lodge (M)
- Community Health (C)

Medical record volumes can be transported around the Health Service in accordance with the Peninsula Health policy **7.1.20 Transfer of Peninsula Health Medical Records Between Campuses and Programs** to support the delivery of patient care via access to clinical information. Due to the logistic limitations of transferring physical records around the Health Service it is essential that a central electronic recording of alert information is also retained and available.

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3. DEFINITION

An **Alert** can be defined as any event or risk that has, or may, seriously affect the management of a patient or staff interaction with a patient. Staff must be vigilant in the identification of patient alerts and this judgment is to be made following a **factually based assessment** of the situation by any clinical staff member of Peninsula Health. Junior staff should consult more senior colleagues to ensure an alert is justified.

4. MEDICAL RECORD PROCEDURE

The first component of the alert framework is to ensure this information is captured locally. This is performed via the following mechanisms

4.1 Alert sheet

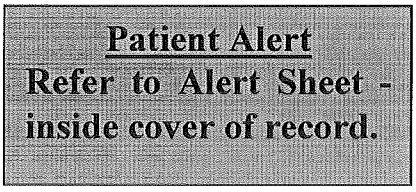
This sheet is designed to allow staff to record any patient alert in a single, easily identifiable, location. The Alert sheet (MR/000) is to be placed as the first sheet in any medical record volume when an alert is judged to be necessary. The Alert sheet is to be added to the medical record when the patient's first alert is identified by the clinical staff.

The Alert sheet includes the following sections

- Patient identification
- Potential Medical Record Volume locations
- Instructions for Use
- Adverse Drug Reactions or Drug Allergies
- Non Drug Alerts

If a patient presents to another campus and it is found that an alert is identified from the Patient Administration System or the Clinical Information System then this alert shall be added to the existing Alert sheet within the patient's medical record. If the record doesn't contain an Alert Sheet (MR/000) then this is to be added to the patient's record and the alert recorded accordingly. This will be the responsibility of the first treating clinician.

An Alert sticker is to be placed on the front cover of the patient's medical record.



When new volumes are created the staff of Health Information Services (HIS) will place the alert sheet in the current medical record volume. Copies of the Alert sheet will be placed in all other existing volumes for that patient.

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4.2 Adverse Drug Reactions or Allergies

Adverse Drug Reaction details shall be documented at the time of identification for each patient, client or resident of Peninsula Health.

It is the responsibility of all clinical staff (doctors, nurses and pharmacists) to ensure that the patients ADR / allergy information is correctly recorded on their drug chart(s), which included the drug(s) and the details of the patient's reaction(s) to them.

a) Guidelines for Allergy and Adverse Drug Reaction Documentation

- Specify the drug or class of drugs.
- Describe the reaction.
- Date and sign the entry and professional designation.
- If possible note when the reaction occurred e.g. 10 years ago or one week ago.
- Specify the route of administration if known eg oral, IV, IM etc.
- Specify when the reaction occurred in relation to the administration of the suspect drug e.g. was it immediate, or did it occur a week later.
- If the reaction is one that is an anticipated / known side effect of a drug specify the severity of the reaction e.g. nausea – mild, moderate or severe.

b) Allergy and Adverse Drug Reaction Documentation Protocol

- On admission, the Medical Admission and Nursing Admission documentation forms will prompt the first doctor or nurse to see the patient to ask about medication allergies and known adverse drug reactions and to record this information on the Drug Therapy Chart. If there are no allergies write NKA (No Known Allergy) or tick the no known allergies box on the Drug Chart to indicate that this has been checked.
- A patient's previous ADRs / allergies must be correctly documented on the drug chart before any medication is prescribed, administered or dispensed.
- The only exception to the above is in an emergency situation where medication must be given without delay and despite all reasonable attempts it has not been possible to obtain the patients previous ADR/ allergy history. In this situation the treating medical team should document in the patient's medial notes that 'medication was given despite being unable to obtain the patient's ADR/ allergy history' or words to that effect. The patient's ADR / allergy history should subsequently be obtained and documented on the drug chart as soon as possible.

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c) New Adverse Drug Reactions

- Any **new** Adverse Drug Reactions detected during the current admission must be documented as above, and also reported (preferably by a medical officer) on an Adverse Drug Reaction form, which is sent to Pharmacy (Frankston), then forwarded to ADRAC (Australian Drug Evaluation Committee in Canberra). (*See Guidelines for Allergy & Adverse Drug Recording – 4.2a*).

4.3 Non-Drug Alerts

4.3.1 Chemical Allergy

4.3.2 Food

4.3.3 Administrative

4.3.4 Clinical/Medical: As outlined previously there are many forms of medical alert. When it is judged as necessary to record such an alert, the reason for the alert shall be recorded on the Alert Sheet (MR/000) along with the name and designation of the reporting clinician and the date it was recorded.

4.3.5 Environment

4.3.6 Infectious Risk: With the increase in presentations of patients with multi-resistant organisms it is essential that the rapid identification of these patients and containment of these organisms occur. Therefore apart from the need to notify the Infection Prevention & Control Unit, it is essential that any factual infection risk is recorded on the Alert sheet (MR/000) with the following information –

- Organism identified
- Site
- Name, signature and designation of staff member reporting
- Date

4.3.7 Legal

4.3.8 Safety & Security

4.3.9 Special Needs &/or Preferences

Any allergic reaction, other than medicinal related, is to be recorded in this section of the Alert sheet (MR/000). As with other alerts it is important that the source is identified along with the staff member reporting and the date this was identified.

5. PATIENT ADMINISTRATION SYSTEM (iPM) PROCEDURE FOR NON-DRUG ALERTS

To ensure any alert information is available to the staff of other sites it is essential that this information is not only recorded on the patient's medical record but also on the Patient Administration System (PAS). The PAS is the central computer system that retains the electronic record of the patient's unit record (UR) number, demographic information and episode level activity. This system is the core for all other clinical systems utilized throughout the Health Service.

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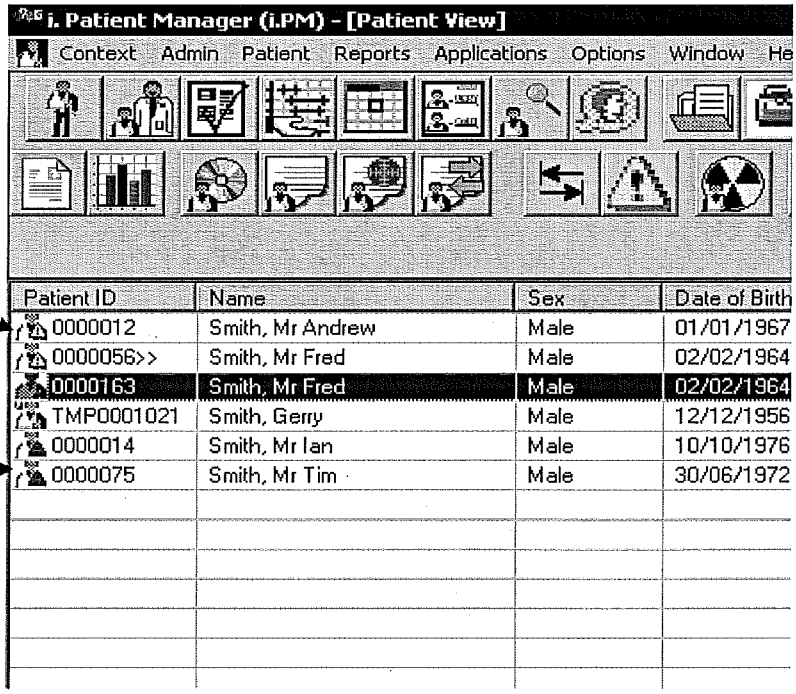
The current Patient Administration System used by Peninsula Health is iSOFT iPatient Manager (iPM).

5.1 Non-Drug Alert identification

From the Patient View Screen in iPM you can see which patients have a Non-Drug Alert registered.

The yellow triangle shows that the patient has either of the following alerts:
- Administrative
- Legal
- Safety & Security
- Special Needs &/or Preferences

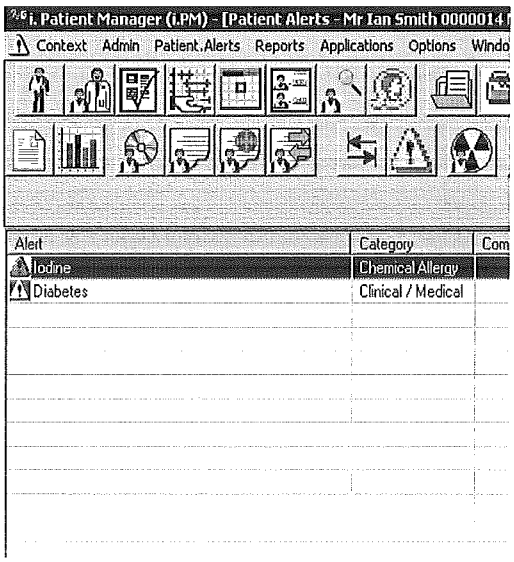
The red triangle shows that the patient has either of the following alerts:
- Chemical Allergy
- Food
- Clinical/Medical
- Environment
- Infectious Risk



5.2 Accessing Further Non-Drug Alert Information from within Patient Administration System (iPM)

Once it has been identified that a non-drug alert is present (see above) any user with the appropriate access privileges to seek further information can double click on the patient they want to access.

This patient is allergic to Iodine and has Diabetes.



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At this stage the specific alert can be identified and other information obtained if necessary from the patient's medical record.

5.3 Registering a new Non-Drug Alert

Once a new Non-Drug Alert is identified it shall be entered into the PAS by either –

a) Ward clerical staff (including Emergency Dept Reception staff) have permission to register Non-Drug Alerts and therefore provide broad coverage for urgent Non-Drug Alert registration

b) If the staff outlined above are not available contact the Health Information Services **Alert line** (extension 7627) for assistance, or

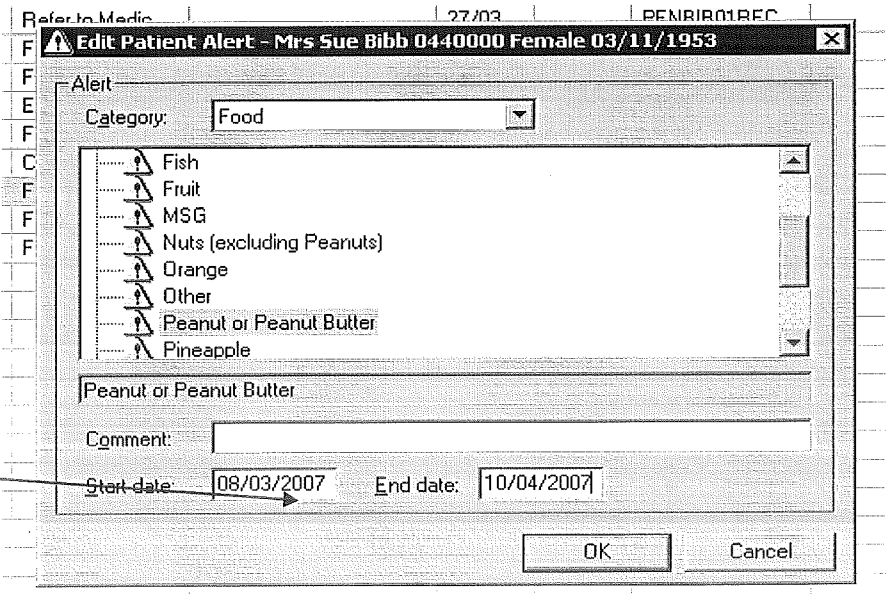
c) e-mail the Non-Drug Alert to **Alertline** via the internal e-mail system and address book. The nature of the alert, the UR number, name of staff member notifying and name of the patient must be provided.

5.4 Cancellation of Non Drug Alerts

If it is clinically determined by a senior doctor, Nurse Unit Manager or relevant Department Head that a Non-Drug Alert is no longer necessary then the Alert shall be removed from the Patient Administration System (Ward Clerk) and the patient's medical record volumes (Clinician). The reason for removal will be recorded along with the staff member responsible for determining that the alert is no longer required.

Infection alerts shall only be removed following the documented approval of the Infection Prevention and Control staff in consultation with either the Clinical Microbiologist or Infectious Diseases Physician.

To Cancel a Non Drug Alert on iPM, right click on the alert in the alerts screen and select "Edit Alert" which will show this screen.
Enter the end date which will end the alert.



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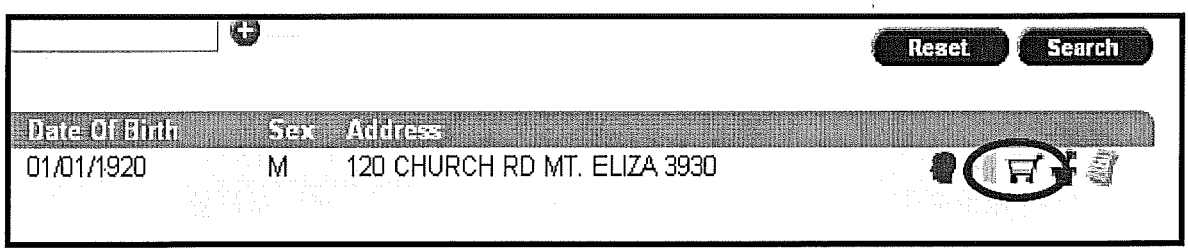
6. ADVERSE DRUG REACTIONS

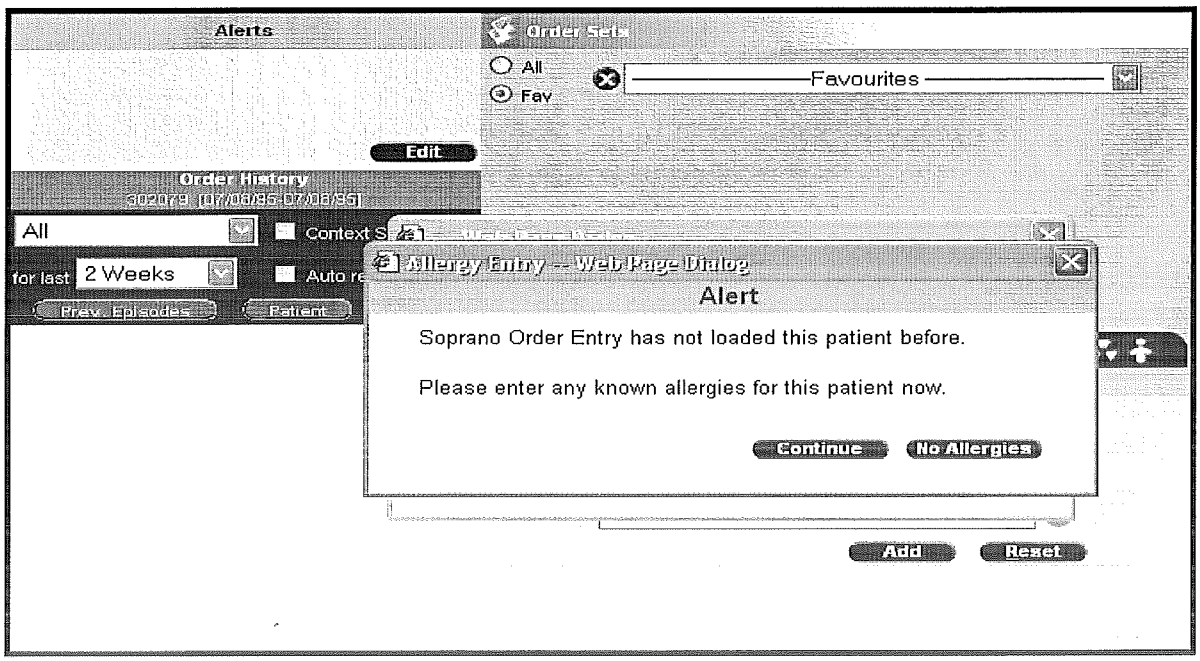
To ensure that information about known adverse drug reactions and drug allergies is available to staff at other sites and in future presentations, medical staff are responsible for recording drug reactions in the e-Prescribing component of the Clinical Information System software, CONCERTO.

6.1 Registering a new Drug Reaction

Accessing the Alerts screen in CONCERTO is done via the Discharge Medications link in the e-Discharge Summary template, or directly by selecting the 'shopping trolley' or 'mortar & pestle' icons.



If the patient has not previously had an Alert entered, an 'Allergy Entry' dialog box (illustrated below) will be presented to the clinician.



Step 1: Alter the search type to generic drug. CONCERTO does not currently support searching by drug class, therefore the generic drug should always be entered.

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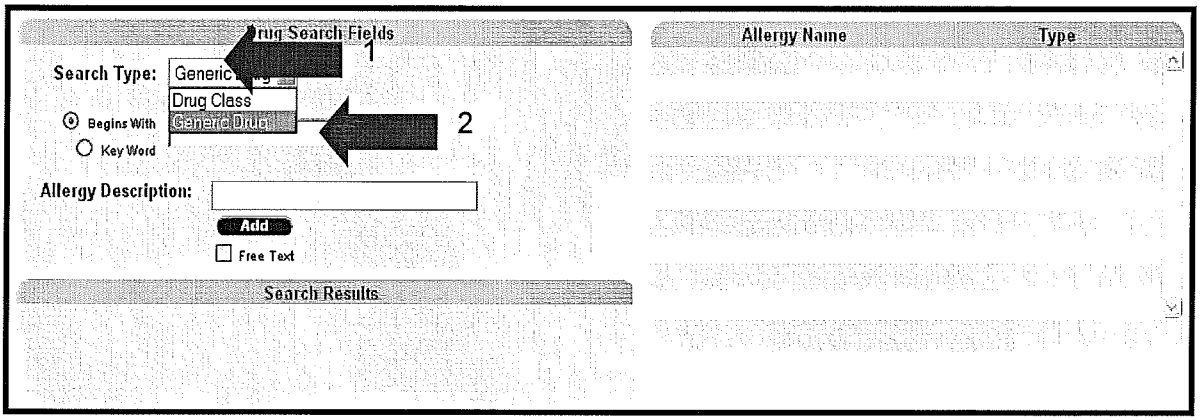
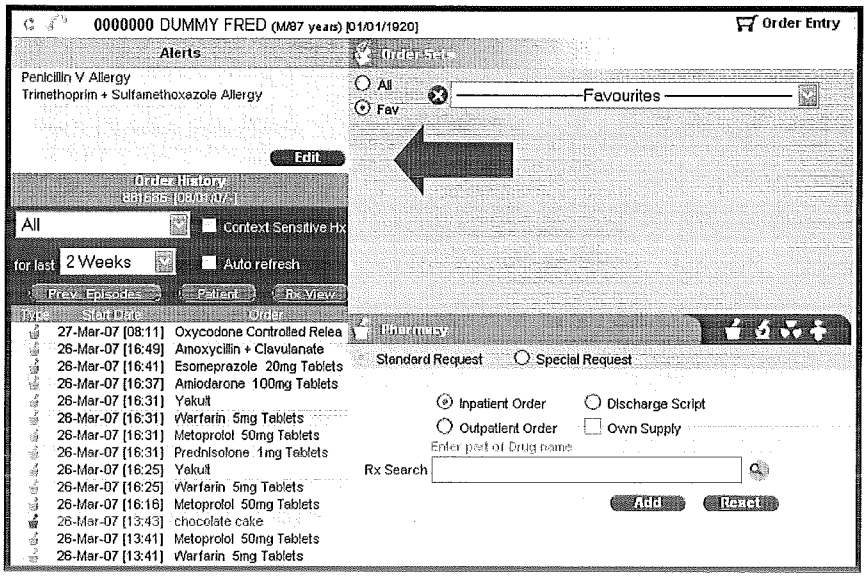
Step 2: Type the first few letters of the drug and press enter. Select the appropriate drug from search results, and click ADD.



Step 3: Occasionally, it may not be possible to search for the appropriate drug. If this occurs, check the 'Free text' box, and click ADD. **Caution: Medical staff must be aware that drug reactions recorded using free text are not subject to automatic interaction checking, and so can be prescribed again without an automated warning.**

6.2 Accessing the Drug Reaction History in CONCERTO

When accessing either the Order Entry or Medication View applications all previously recorded drug reactions will appear in the top left of the screen (as illustrated below).



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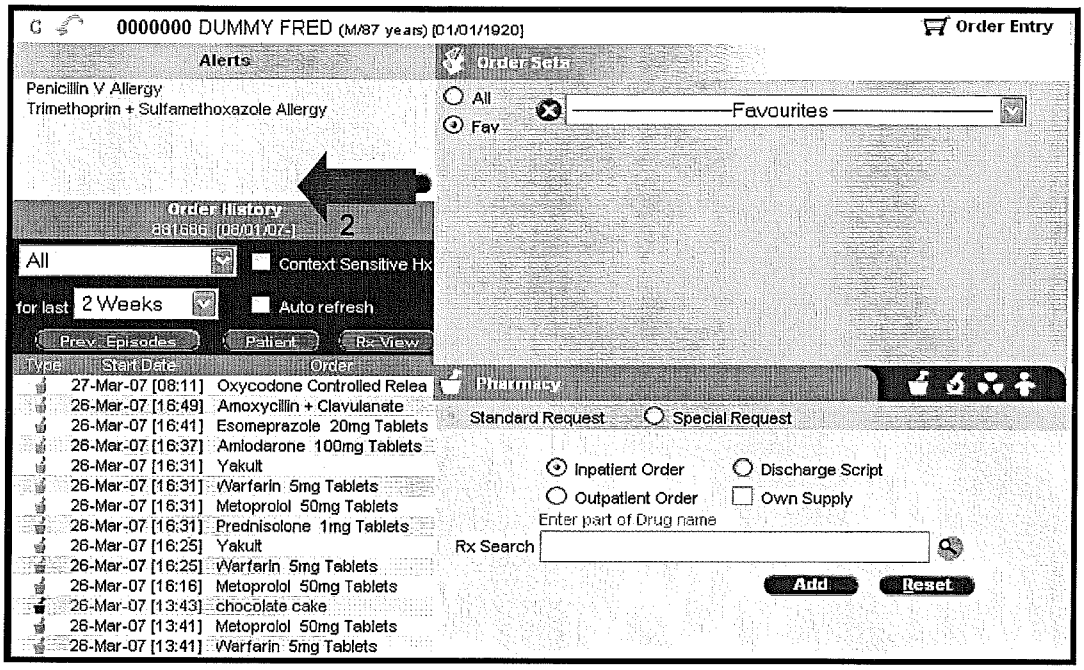
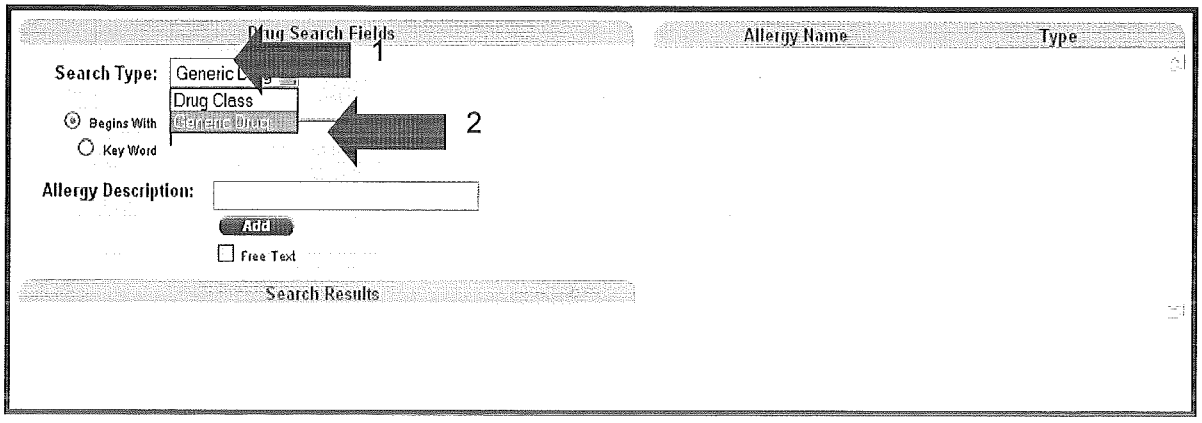


6.3 Registering an additional Drug Reaction

To register an additional drug reaction, click EDIT (illustrated above) to view the drug reaction screen.

Alter the search type to generic drug. CONCERTO does not currently support searching by drug class, therefore the generic drug should always be entered.

As in Step 2 of 6.1 (above), type the first few letters of the drug and press enter. Select the appropriate drug from search results, and click ADD.



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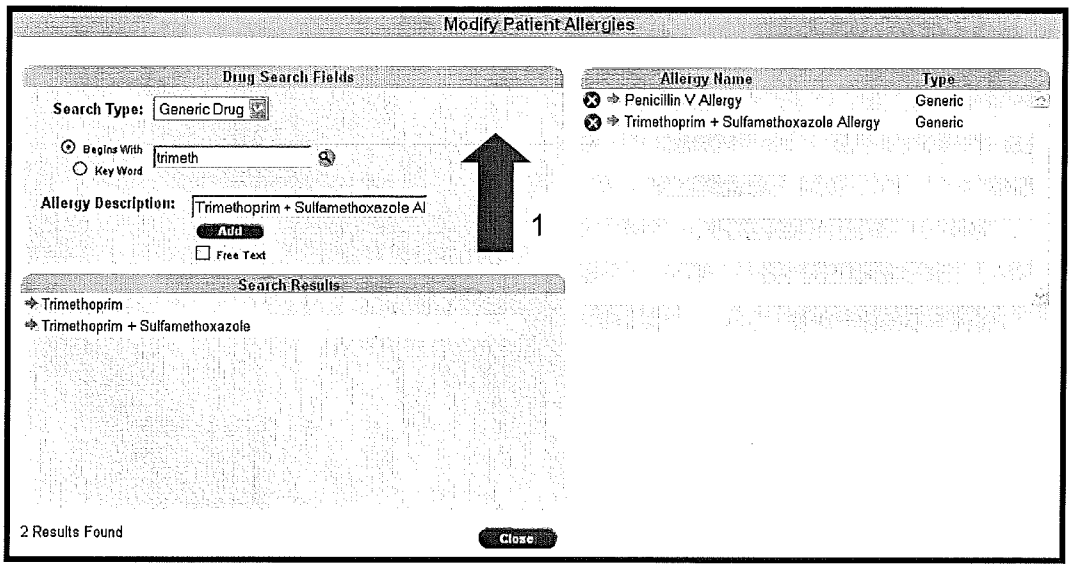
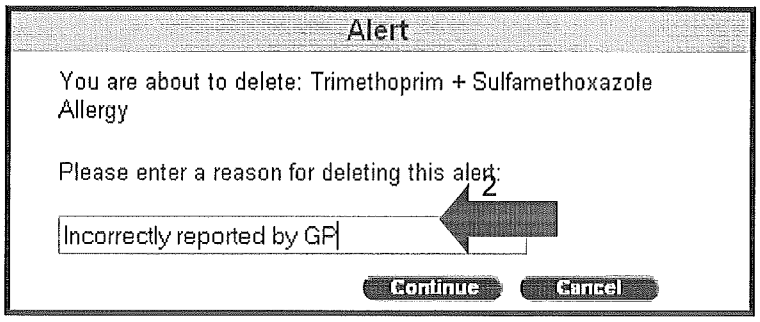
6.4 Cancellation of Adverse Drug Reactions

If it is clinically determined that a known adverse drug reaction or allergy warning is no longer necessary or has been incorrectly recorded, it should be removed from CONCERTO, and from the patient's medical record. To do this, first access the patient allergy screen as in section 6.1, then;

Click on the red cross adjacent to the allergy being removed (as in 1 below).



Type in the reason for removing the allergy record (as in 2 below) and press continue.



7. EVALUATION OF ALERTS PROCESS

In order to monitor compliance, Health Information Services shall provide a quarterly report to the Information Management Evaluation and Patient Safety Management Committees, regarding the number of alerts added to the Patient Administration System.

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As part of the Incident Reporting Framework, a question requesting staff to indicate if a patient alert was recorded that related to the incident being reported. If, following review by the Patient Safety Unit, Clinical or Operations Director, it is determined that a patient alert should be recorded or amended, the details of the incident will be forwarded to the Alertline staff in Health Information Services – Frankston. The HIS staff member will review the Patient Administration System and make the necessary changes. The relevant medical record volumes will also be reviewed and amended as appropriate. These instances will also be recorded for reporting to the Information Management Evaluation and Patient Safety Committees.

8. REFERENCES

- Transfer of Clinical Records between Peninsula Health Service Sites and Peninsula Health Programs (policy 7.1.20)
- Incident Reporting (policy 3.1.29)
- Replaces Drug Alert Documentation Policy (7.1.25)
- Medication Management Policy (6.1.04)