Government of **Western Australia**
Department of **Health**

WA CLINICAL ALERT – GLOSSARY

better health ▪ better care ▪ better value

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A clinical alert is designed to flag a patient's life-threatening issue/condition to the clinician before therapy is initiated, especially when the patient is unable to communicate with the treating team.

When the history of an alert is uncertain, but there is information to suggest an alert may be possible, the term 'unconfirmed' should be added to the free text information when submitting an alert rather than 'history of'.

There should be a process of prompting unconfirmed allergy related clinical alerts (angioedema/ anaphylaxis) to immunology for review to confirm allergy status. Issue with this is that some sites are not receiving feedback following immunology testing. It is advised to put alert on system and remove if confirmed not allergy related by immunology.

The WA Clinical Alert Business User Group is the governing body for all changes made to Clinical Alerts and relevant policy.

Any enquires for removal, modification or additional alerts must be directed to the secretariat of the WA Clinical Alert Business Group. (safetyandquality@health.wa.gov.au)

Clinical alerts entered into webPAS have a text field with the capacity for 200 character entry to provide the description of the alert.

1. Authorisation process

- The designated local committee / 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 anaesthetic, medical and drug alert queries in a timely manner, with the exclusion of anaesthetic and specified alerts.
- Some Clinical Alerts (specified alerts) can be entered without co-authorisation (i.e. organ transplant, heart valve replacements, pacemaker or other implanted devices when inserted during the admission being coded). Alerts that meet this criterion should be decided by the governing body within the hospital.

2. Data entry and file form in medical record

- Once the clinical alert has been approved for entry onto PAS, forward form with the medical record (if requested) to the position responsible for entering Alerts onto the system.

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 still requires 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.

Removal of alerts from PAS

- If an alert is entered in error or is no longer relevant it needs to be removed/ made inactive from the PAS to reduce the risk to the patient.
- 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.

Guide for assigning new clinical alert

When an alert is raised for a patient by a clinician that is not currently listed as a clinical alert, the following considerations need to be taken to determine if it is truly a clinical alert.

A clinical alert is designed to flag a patient's life-threatening issue/condition to the clinician before therapy is initiated, especially when the patient is unable to communicate with the treating team.

To be classified as a clinical alert the consequence of the clinician not knowing of the issue and the impact this would have on therapy decision must be significant. There is a need to take into account the impact factor to make sure clinical alert remains pertinent to the clinician.

Clinical Alerts should be of high/extreme risk, including those that are rare which would have a major/catastrophic outcome (1:10,000 incident before catastrophic would be considered high).

Multiply your assessed Consequence Level x Likelihood Level to find the Level of Risk Score (range 1 - 25).

Likelihood Descriptor (Refer to the Likelihood Assessment)		CONSEQUENCE *(refer Consequence Assessment)*				
		1	2	3	4	5
		Insignificant	Minor	Moderate	Major	Catastrophic
Rare	1	Low	Low	Low	Low	Moderate
Unlikely	2	Low	Low	Moderate	Moderate	High
Possible	3	Low	Moderate	Moderate	High	High
Likely	4	Low	Moderate	High	High	Extreme
Very Likely	5	Moderate	High	High	Extreme	Extreme

Assess the likelihood of an incident occurring, bearing in mind any existing controls in place and their effectiveness. Select the best fit on the 1 to 5 scale from the table below

LIKELIHOOD ASSESSMENT				
Likelihood Descriptor		Clinical	Corporate	
		Per separations/ Occasions of Service	Timescale for ongoing non-project activities or exposures	% Chance during life of project or financial year for budget risks
Rare	1	1 in 100,000 or more	Once in more than 10 years	Up to 5%
Unlikely	2	1 in 10,000	Once in 5 - 10 years	6 - 30%
Possible	3	1 in 1,000	Once in 3 - 5 years	31% - 60%
Likely	4	1 in 100	Once in1 to 3 years	61% - 90%
Very Likely	5	1 or more in 10	More than once a year	Over 90%

Before raising a new clinical alert for consideration to the WA Clinical Alert Business Advisory Group, a risk assessment must be undertaken, and justification provided for the alert.

Table 1: Glossary of definitions for clinical alerts

Anaesthetic Alerts		
Difficult Intubation/ Difficult Airway and Oxygenation	**Specify type including details of limited neck movement, describe grade of difficulty, device used and bag mask ventilation (BMV) status.**	A.Other1
Anaesthetic Drug Reaction	**Specify anaesthetic medication, reaction details and date that reaction occurred.** (Anaphylactic reaction to anaesthetic drug/s should be recorded under D02.03 Anaphylaxis – see alert below).	A02.01
Malignant Hyperthermia	**Specify anaesthetic agent involved and date of reaction.** Malignant hyperthermia (MH) manifests clinically as a hypermetabolic crisis when an MH-susceptible (MHS) individual is exposed to a volatile anaesthetic or suxamethonium.	A02.04
Sleep Apnoea	Sleep apnoea syndromes are characterized by the absence of airflow with or without ventilatory effort during sleep. Only report severe sleep obstructive sleep apnoea and those requiring Continuous Positive Airway Pressure (CPAP).	A03.01
Serious Drug/Dietary and Other Allergen (e.g. latex) Alerts		
Life-long Anticoagulant	**Specify anticoagulant and indication.** Not related to heart valve replacement (as this is identified as Heart Valve Replacement alert - M.Other1, see alert below)	D.Other1
Serious Drug Reactions	**Specify drug, reaction details and date that reaction occurred**. 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, or where adrenaline autoinjector (e.g. Epipen®) is required. <u>Allergic reactions for inclusion:</u> (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. <u>Other serious or life threatening reactions for inclusion:</u> • 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. • HIT - heparin induced thrombocytopenia • Other – must be deemed serious and life-threatening/causing significant harm. <u>Adverse drug reactions that are NOT deemed Clinical Alerts/Med Alerts:</u>	D.Other2

	• 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).	
Angioedema	**Specify drug or other allergen (e.g. latex) and date that reaction occurred.** Angioedema is self-limited, localised subcutaneous (or submucosal) swelling, which results from extravasation of fluid into interstitial tissues. Angioedema may occur in isolation, accompanied by urticaria, or as a component of anaphylaxis.	D02.02
Anaphylaxis	**Specify drug or other allergen (e.g. latex) and date that reaction occurred.** Anaphylaxis is an acute, potentially life-threatening, multisystem syndrome caused by the sudden release of mast cell mediators into the systemic circulation. Symptoms may include: • Respiratory compromise (e.g. dyspnoea, wheeze, persistent cough, difficult/noisy breathing, stridor, hypoxemia) • Reduced blood pressure or associated symptoms (e.g. persistent dizziness, collapse, hypotonia, syncope, incontinence) • Involvement of the skin-mucosal tissue (e.g, generalized hives, itch-flush, swollen lips-tongue-uvula). • Swelling/tightness in throat • Difficulty talking and/or hoarse voice • Persistent gastrointestinal symptoms and signs (e.g. crampy abdominal pain, vomiting). • Pale and floppy (young children)	D02.03
Anti-venom given	**Specify anti-venom given and date administered**	D05.01
Bleomycin	**Date prescribed and treating oncologist** Bleomycin-induced lung injury typically occurs insidiously during the first 6 months after starting treatment, but the potential for high-inspired fractions of oxygen to provoke pulmonary toxicity remains a life-long risk. There are particular concerns for patients who are undergoing surgery and who have been treated with bleomycin. Oxygen therapy can both induce and exacerbate bleomycin lung injury. A high concentration of inspired oxygen increases the risk of developing bleomycin-induced lung injury and a lower inspired oxygen concentration reduces the risk.	D12.01
Chronic Steroids	**Specify condition requiring chronic steroid treatment.** All patients on daily continuous steroid therapy.	D10.01

Clozapine	**Specify date patient initiated on clozapine therapy** Alert is to remain on system regardless of whether currently taking clozapine or not. Review clozapine monitoring system for current status. Contact pharmacy for further information.	D11.01
Serious Dietary/Food Reactions	**Specify Dietary/Food allergen and reaction.** **Specify if allergy requires adrenaline autoinjector (e.g. Epipen®)** Refer to Clinical Alert Policy (Appendix 6) 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 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. • If allergy requires adrenaline autoinjector (e.g. Epipen®)	D.Other10
Medical Conditions		
Heart Valve Replacement	**Specify site and type** (e.g. mechanical or porcine). Also add “Life Long Anticoagulant”	M.Other1
Implanted Devices	**Specify device and site** Devices include Permanent Pacemaker (PPM), VVT Ventricular Tachycardia PPM, neurostimulator, continuous subcutaneous insulin pumps, heart monitor or defibrillator, ventricular shunt, intrathecal pump, implanted hearing devices (e.g. Cochlear, BAHA implants)	M.Other3
Other Medical Conditions	**Specify condition** If medical condition not currently listed as an approved clinical alert. Must be related to a diagnosis which has the potential to be of critical, life-threatening 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. *This alert code must not be used as a ‘registry’ to identify patients that do NOT have life threatening conditions e.g. patient having cancer treatment or dialysis.* *These clinical alerts raised into the PAS will be reviewed by the Clinical Alert Committee of the organisation within which it was raised as well as the Clinical Alert Business User Group for consideration of a new clinical alert code.*	M.Other4
Streptokinase Therapy	**Specify site, hospital and date of administration** Usage in Respiratory medicine for complicated parapneumonic effusions and empyema generally administered by intercostal catheter. Anti-streptokinase antibodies remain elevated for up to 7.5 years after treatment, suggesting that a suboptimal response and an allergic reaction may occur with retreatment many years after the first exposure.	M.01.02

Bleeding Disorder	**Specify condition** **Clinician to indicate classification of bleeding disorder that requires clinical alert notification.** (e.g. Haemophilia, von Willebrand disease, Christmas Disease).	M.01.03
Sickle Cell Anaemia	Sickle cell disease (SCD) refers to any one of the syndromes in which the sickle mutation is co-inherited with a mutation at the other beta globin allele that reduces or abolishes normal beta globin production. Sickle cell anaemia (homozygous sickle mutation) produces a chronic, compensated haemolytic anaemia that may be punctuated with episodes of acute worsening.	M01.04
Severe Arrhythmia	**Specify type of arrhythmia and treatment** including; • Ventricular tachycardia • Supraventricular tachycardia • Ventricular fibrillation • Wolff Parkinson White Syndrome	M02.02
Hypopituitary	Hypopituitarism is defined as deficient secretion of one or more pituitary hormones because of pituitary or hypothalamic disease (e.g. corticotrophin (ACTH), thyrotropin, gonadotropin, growth hormone, or prolactin)	M03.07
Addison's Disease	Primary adrenal insufficiency – may result in adrenal crisis/shock due to mineralocorticoid and glucocorticoid deficiency.	M03.08
Porphyria	**Specify class/type** The porphyrias are metabolic disorders caused by altered activities of enzymes within the haeme-biosynthetic pathway. Porphyrias can be classified as either acute or cutaneous, reflecting the primary clinical manifestations. The porphyrias are also classified as hepatic or erythropoietic, depending on whether the site of initial production and accumulation of pathway intermediates is the liver or the bone marrow. Acute porphyrias — The acute porphyrias (ie, those with neurovisceral manifestations) include the following: • ALA dehydratase porphyria (ADP) • Acute intermittent porphyria (AIP) • Hereditary coproporphyria (HCP) • Variegate porphyria (VP)	M04.01
Neuroleptic Malignant Syndrome	**Specify neuroleptic agent involved and date reaction occurred** Neuroleptic malignant syndrome (NMS) is a life-threatening neurologic emergency associated with the use of neuroleptic agents and characterized by a distinctive clinical syndrome of mental status change, rigidity, fever, and dysautonomia.	M04.04
G6PD Deficiency	Glucose-6-phosphate dehydrogenase (G6PD) deficiency is an inherited disorder caused by a genetic defect in the red blood cell (RBC) enzyme G6PD, which generates nicotinamide adenine dinucleotide phosphate (NADPH) and protects RBCs from oxidative injury. G6PD deficiency is the most common enzymatic disorder of RBCs.	M04.05
Thalassaemia	Thalassemia is a group of disorders in which the normal ratio of alpha globin to beta globin production is disrupted due to a disease-causing variant in one or more of the globin genes. This can cause destruction of red blood cell precursors in the bone marrow (ineffective erythropoiesis) and circulation (haemolysis). As a result, affected individuals have variable degrees of anaemia and extramedullary haematopoiesis, which in turn can cause bone changes, impaired growth, and iron overload.	M04.06
Severe Epilepsy	Only report when diagnosis documented as intractable / recurrent seizures.	M05.01

Myaesthenia Gravis	Myasthenia gravis is a disorder of neuromuscular transmission involving a fluctuating degree and variable combination of weakness in ocular, bulbar, limb, and respiratory muscles.	M.05.02
Fabricated Illness	Fabricated illness (or factitious disorder imposed on self) is characterized by falsified general medical or psychiatric symptoms. Patients deceptively misrepresent, simulate, or cause symptoms of an illness and/or injury in themselves, even in the absence of obvious external rewards. May also include 'Munchausen's by Proxy'.	M06.01
Difficult X-Match	**Antibody cross match –** to be confirmed by PathWest/Haematology. Haematology documentation required.	M09.01
Organ Transplant	**Specify organ transplanted, and hospital and date if available.**	M10.06
Advance Health Directive (AHD)	**Specify "AHD exists" only** It is expected that if this flag is raised to the clinician will review the patient's medical record to determine if the AHD was raised at the hospital of admission and/or initiate a discussion with patient/carer as to where the AHD was filed and the currency of the content. Refer to Appendix 10 of Clinical Alert Policy	M11.01
Asplenia	**Specify whether hyposplenia (spleen intact but not functioning) or, partial or complete removal of spleen, and immunisation status where available**.	M12.01

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