AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

November 2019
ACSQHC-0022-1.0

Clinical Scenario

Out of Hours

Joseph

Joseph presents to a busy emergency department at 8:45PM in the outer suburbs of Melbourne with dizziness, headaches and ongoing fatigue. Both he and his wife Gina are migrants from Portugal, with English being their second language. Gina has a difficult time trying to explain to the triage nurse about the nature of Joseph's recent doctor's appointment.

Joseph's GP recently uploaded a **shared health summary** to his My Health Record. Similarly, the pathology provider attached to the GP surgery is uploading **pathology reports**.

With no way to contact the GP until tomorrow, David (the R.N assessing Joseph) checked the My Health Record and saw Joseph's recent bloods and a summary of his current health problems.

Using My Health Record, David complements his clinical assessment by noting Joseph's history from the **shared health summary** and recent **pathology results.**

For more information:
www.myhealthrecord.gov.au or 1800 723 471

Australian Government
Australian Digital Health Agency

My Health Record

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Clinical Scenario

Medication Information

Lin

Lin arrives at an emergency department in Darwin after stepping on a dirty, rusty nail while gardening. Lin informs the triage nurse that she takes 9 different medications, but can't remember exact dosages and also can’t remember when she last had a tetanus booster. Lin further confirms she has diabetes, renal failure and thinks she may have had a previous reaction to antibiotics.

Lin recently updated her My Health Record **personal health summary** to reflect an antibiotic reaction. Her GP has also recently uploaded a new **shared health summary**.

Prescription and **dispense information** shows a number of medications recently prescribed by her GP and dispensed by her community pharmacist. The **medicines information view** displays a medication list and drug allergies that were extracted from the **shared health summary**.

Together with Lin, Jackie reviews information in the My Health Record to determine which medications Lin takes. They also discover that Lin has a penicillin allergy so Jackie opts for antibiotic cover using an alternative drug.

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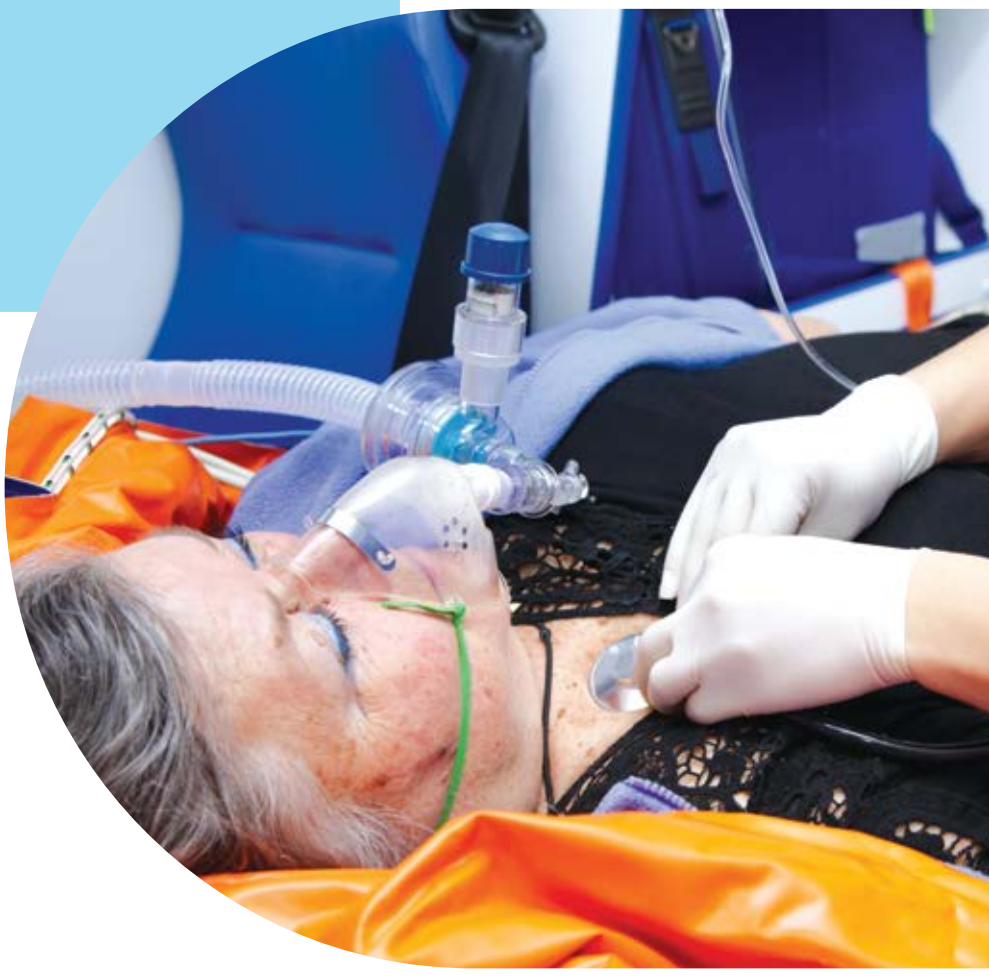
Clinical Scenario

Emergency Record Access



Jill

Jill was taken to an emergency department in Western Sydney following an MVA. She sustained significant injuries and could not communicate with ED staff. Using Jill's identifiers found in her belongings, the emergency physician was able to determine that Jill had a My Health Record. Jill had also set a Record Access Code (RAC) on her My Health Record. The physician utilised the Emergency Record Access (or "break glass") feature in order to view information in Jill's record.

The consultant finds a number of **event summaries** located in Jill's My Health Record. The ED team also discover she identifies as Jehovah's Witness and there is **advance care planning documents** in her record.

A previous **discharge summary** from a hospital admission documents a conversation with Jill and a clinician about her stance on receipt of blood and blood products and her wishes for end-of-life care.

Using this information in the My Health Record, the ED team can quickly make an informed decision about Jill's care that may not have been previously possible.

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