Event summaries: A guide for clinical immunology/allergy specialists using conformant software

What is an event summary?

An event summary is a clinical document you can upload to:

- provide information about a significant healthcare event (e.g. a new food allergy is confirmed); or

- indicate a change to their health status or condition (e.g. patient confirmed not allergic following a food or drug challenge).

In April 2020, there are already more than 1.6 million event summaries in My Health Record.

The information contained in an event summary should be in a format that can be understood by healthcare providers outside of your own organisation or practice. It should describe:

- the presentation of the event
- the assessment made
- the action taken

Who can upload an event summary?

An event summary is completed by healthcare providers who are not the patient's regular GP. A healthcare provider can upload an event summary to an individual's My Health Record using conformant clinical software (e.g. Genie).

The image below shows how allergies and adverse reactions entered into an event summary appear in a patient's My Health Record in the Medicines View. The source document can be clicked to open.

How to upload an event summary

The following steps assume that:

1) Your organisation (HPI-O) is registered to the My Health Record system
2) Your healthcare provider identifier (HPI-I) is linked into the organisation's system
3) Your software is connected to the My Health Record system
4) The patient's Individual Healthcare Identifier (IHI) has been validated in your system
5) The patient has a My Health Record.

The way an event summary is created depends on your clinical information system. However, document layout and fields are consistent across systems. The following views are taken from **Genie** software.

Step 1 – Open the My Health Record tab

Open the patient's local medical record and enter the clinical information/notes for the consultation.
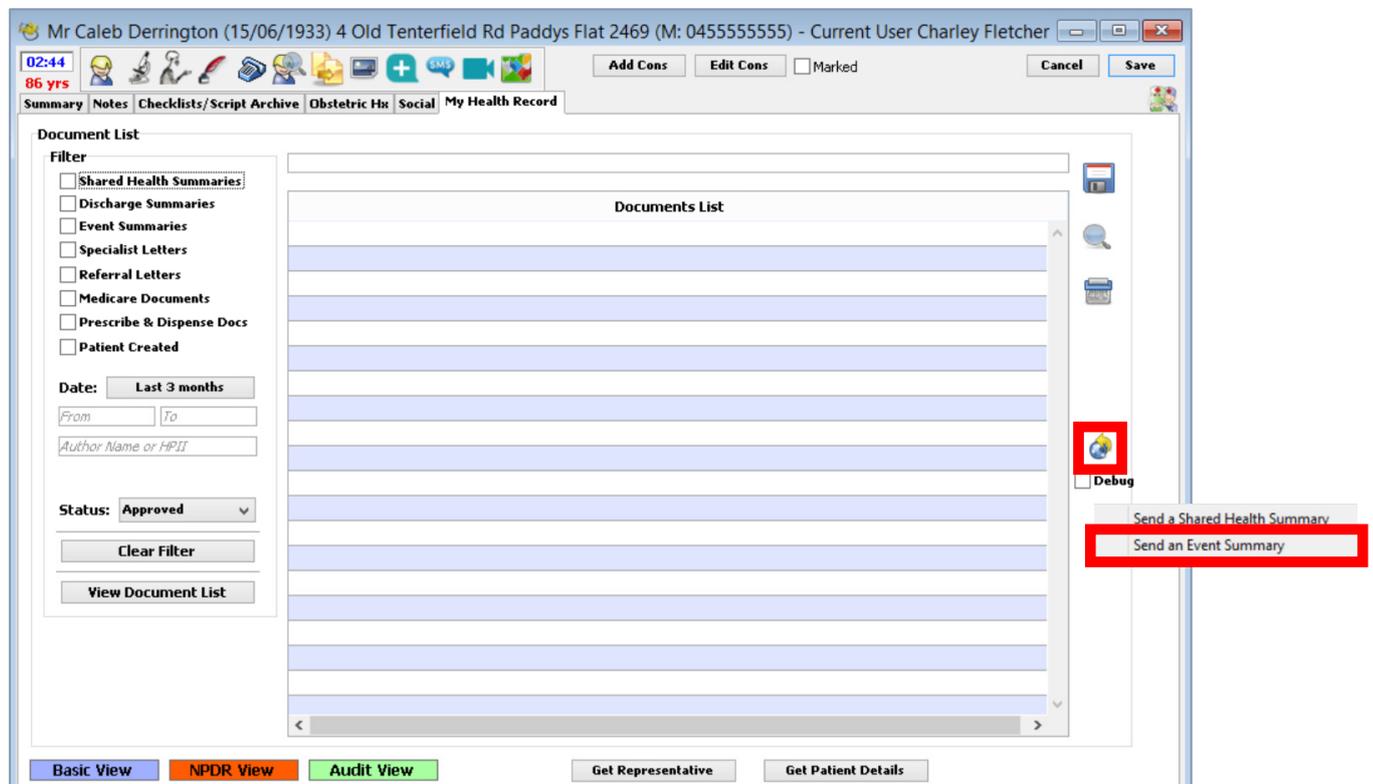
Select the **My Health Record** icon to access the patient's My Health Record, then select the **My Health Record** tab.

Step 2 – Open the Event Summary screen

The **Documents List** is displayed.

Select the **Create and Upload a New Document** icon, then select **Send an Event Summary**.

Step 3 – Add your notes

Select **Import Last Consultation Notes** to populate the Event Details box with the consultation notes from the patient's local medical record. You can also add or edit the Event Details manually.

ASCIA recommends that allergy information is coded into the clinical software, rather than being added as free text in the notes section.

You can record current substances/agents that the patient is confirmed allergic to. You can also record an allergy that the patient has been confirmed NOT ALLERGIC to. For example, when the patient has passed a food or drug challenge. The correct standardised wording for this is shown in the example below.

Newly Identified Adverse Reactions	Manifestation
Penicillin – confirmed NOT ALLERGIC	Passed challenge test 27 May 2020 by Dr First name Surname

Tick/untick the items to include/not include in the event summary. Then click **OK**.

Step 4 – Check the information and send to My Health Record

Verify that the information in the event summary is correct. Then click **Send**.

The Event Summary will appear as a new upload in the patient's My Health Record. The allergy information is displayed in the Medicines View of the Allergies and Adverse Reactions section. An event summary cannot be edited once it is uploaded to the My Health Record system; however, it can be superseded by a new version that replaces the original.

Using standardised wording

To help improve identification of a patient's current allergy status, ASCIA recommends the use of standardised wording particularly to confirm that a patient has been challenged and is no longer allergic to a substance (e.g. a food or medication).

To confirm a patient **is allergic**, use the following:

Substance	Manifestation
Name of allergen (e.g. egg) – confirmed ALLERGIC	Type of reaction (e.g. anaphylaxis)

To confirm a patient **is no longer allergic**, use the following:

Substance	Manifestation
Name of allergen (e.g. penicillin) – confirmed NOT ALLERGIC	Passed challenge test (date and specialist name)

Additional information to consider including in your specialist letters

A shared health summary is another type of clinical document authored by a GP that may be available in a patient's My Health Record. Depending on when it was authored, it may contain out-of-date allergy information. You can alert the GP to the potential conflicting information when you write your specialist letter.

If the GP is the author of an old shared health summary with out-of-date information about the patient's allergy status relating to the patient's allergy information in your letter, you could also encourage the GP to delete the out-of-date shared health summary, which will remove the conflicting allergy information for that particular allergen.

ASCIA recommends you use this, or similar wording, to communicate this information in your letter:

This patient has been confirmed as ALLERGIC to X,Y and confirmed NOT ALLERGIC to Z. Please update your local clinical records accordingly. If you use My Health Record for your patients, please consider uploading an updated shared health summary for this patient to ensure allergy information is accurate. Where there is an old shared health summary with conflicting allergy information to that stated in this letter, you may wish to delete that document if you are the author.

Further information and support

There are a range of clinical software demonstrations and summary sheets available on the My Health Record website that show how to create and upload an event summary in different clinical software products.

For general enquiries about registering or using My Health Record, contact the My Health Record Helpline on **1800 723 471** and select option 2.

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australasian society of clinical immunology and allergy