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Clinical Manual **CLN - A - 36**

POLICY
Allergy Documentation Policy - Joint GRH & SMGH

Purpose

This policy outlines the expectations for assessing, documenting and reviewing allergy information (i.e. allergy, contraindication, intolerance and side-effects) in the electronic health record (EHR).

Policy

The **Allergy Control** is the source of truth for a patient's allergy information. When the Allergy Control is not available, designated downtime forms will be used to temporarily document allergy information.

All staff members who are Regulated Health Care Professionals (RHCP) as defined by the Regulated Health Professions Act, and trained in electronic allergy entry may collect, input, validate and amend allergy information in the Electronic Health Record (EHR).

A RHCP must assess and document allergy information. When allergy information is already documented it must be verified, and marked as reviewed prior to any initial medication or non-medication (i.e. latex, contrast media or food) prescribing.

SCOPE

This policy applies to all regulated health care professionals working across GRH and SMGH.

Inclusion Criteria

- Allergy collection and documentation will occur for all registered patients both inpatient and outpatient encounters at the time the patient is assessed.

Exclusion Criteria

- Newborns are exempt from this process as allergy status cannot be determined.
- In medical imaging, allergy reconciliation will be incomplete as allergy

documentation is limited to medical imaging exposures.

Definitions

Allergy: An adverse reaction to a drug or substance which is due to an immunologic response to an allergen, including medications, contrast media, food, environment, latex, or other substances as identified by the patient/client/resident. This immune response results in symptoms such as urticaria, difficulty breathing, and/or anaphylaxis. The allergen in non-sensitive persons will produce no effect in similar amounts. An example is severe shortness of breath and swelling with exposure to penicillin.

Allergy Control: is a feature in the electronic health record that allows for documenting and tracking a patient's existing and new allergy conditions. The Allergy Control includes known allergies and other details such as category type, reaction indication, onset, severity, with codified entry for drug allergy cross checking.

Intolerance: A lower threshold to the normal pharmacologic actions of a drug. Sensitivity to a particular substance resulting in undesirable, unpleasant side effect or toxicity for the individual exposed to the substance. This reaction does lead to an immune response. This response may include but is not limited to drowsiness, respiratory depression, nausea or bradycardia. E.g. excessive drowsiness when administered dimenhydrinate at recommended doses.

Side effects: An undesirable response to a drug, which occurs at normally, used doses. This response is associated with exposure to, or use of, a substance and does not lead to an immune response. Side effects may include but are not limited to lab abnormalities, drowsiness, nausea, hallucinations, or tachycardia. E.g. Heparin induced thrombocytopenia history from previous exposure to unfractionated heparin.

Procedure

RHCPs are responsible for:

- Assessing and adding allergy information as per their scope and education
- RHCPs are required to determine and act on any discrepancy between the documented allergy and the prescribed medication with the prescriber.
- Consulting with the Most Responsible Provider (MRP) when modifying or cancelling existing allergy information. RHCPs are required to act on any new information or discrepancy between the documented allergy information and the prescribed order. If a discrepancy is found between the allergy information documented in the former medical record and new electronic information system, the pharmacist (or nurse) will reconcile the allergy/adverse drug reaction information with the patient or substitute decision maker and contact the prescriber to clarify the allergy or if indicated, recommend a therapeutic alternative.

At a minimum, Assessment and Documentation must occur:

- On admission and at least annually for Inpatient/Residential Care patients/clients
- On each transition of care
- On clinic intake and at least annually (at the next scheduled appointment) for outpatients/clients
- To be considered a complete allergy history, all three allergen categories (drug, food and environmental) must be reviewed. Reactions must be documented with every substance identified by the patient and documented as an allergy, side-effect or intolerance.
- Any severe allergy, intolerance, or side effect to a drug, food or environmental trigger that is significant enough that the patient should not be re-exposed to that substance, should be designated as an "allergy" to ensure appropriate allergy screening and alerting in the system.
- The source of information will also be included. Appropriate sources of information are:
    - Patient
    - Family member
    - Guardian
    - Friend
    - Medical alert (i.e. bracelet, necklace)
    - Community Pharmacy
    - Previous patient record
- Substances and reactions should be selected from the provided common lists. Once this information is entered it will be marked as reviewed to update the EHR.
- If a substance (ie. medication, food, environmental agent), is not available in Cerner as a selection option, a Pharmacist must enter the allergy information using free-text.

Emergent Situations

- An accurate and complete allergy information history must be present and verified prior to prescribing, dispensing or administering any medications or non-medications (i.e. latex, contrast media or food) except in emergent situations when history is designated as "unable to obtain." If the patient is unable to give an allergy history, and no-one is present to speak on the patient's behalf, then "unable to obtain allergies" should be added to the record, and leave all present information intact. This should be clarified as soon as possible and "unable to obtain" cancelled.
- A verbal order may be obtained from a Provider to administer "stat" medications without a completed allergy information history when this information is unobtainable. The order must be transcribed into the health record and co-signed by the Provider within 24 hours.

Visual Allergy Cue

- A red Identification band will be the visual allergy cue for all patients with

allergies/intolerances to medications, latex, contrast, and/or food. Any other allergies/sensitivities/intolerances must be documented but do not require the application of a red identification band (i.e. dust, cat hair, hay fever, etc).
- If an allergy is identified after admission/encounter, the RHCP who became aware of the change in allergy status shall update the Allergy Control Powerchart and ensure that a red allergy band is applied to the patient's limb.
- Provide education to patients/families regarding reporting allergy/intolerance history, the visual allergy cues (red arm band) and methods of preventing allergen exposure while receiving health care within GRH & SMGH.

Clinical Decision Support

- Medication Clinical Decision Support is available for linked medications/allergies. The clinical decision support will alert the practitioner doing Computer Provider Order Entry (CPOE) that there is an allergy alert. The provider will need to determine the risk/benefit of ordering the medication in relation to the patient allergy.
- The EHR will also provide clinical decision support if allergies are not yet documented, prompting documentation of patient allergies before signing of orders. This clinical decision support does not replace clinical skill, knowledge and judgement.

Downtime

- For both planned and unplanned electronic health record down time, all allergy information documentation will take place on appropriate downtime form.
- It is the responsibility of a Regulated Health Care Professional to ensure the electronic health record is updated accordingly when the system is restored.

Communication

- All others who become aware of new allergy information should communicate with a regulated health care professional RHCP responsible for the patient's care
- Notify any other departments or units which require allergy intolerance information and document that notification to:
    - Environmental Services staff regarding any client allergies in relation to cleaning substances in use
    - Nutrition and Food Services regarding new client food allergies.

Client Transfer to External Facility

- A patient allergy summary will be printed as part of the patient transfer package for transfer to external organizations
- The transferring RHCP will review the Allergy Record during handover report with the receiving RHCP.

Educational Requirements

Allergy documentation policy and procedures will be part of clinical hospital orientation.

Quality Monitoring Process

The management of this policy including monitoring and implementation is the responsibility of Clinical Managers in partnership with Professional Practice.

Related Documents

1. Downtime policy

References

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