Team Name: Pharmacy & Therapeutics Team Lead: Director - Pharmacy Approved by: Regional Lead - Medical Services & Chief Medical Officer	Reference Number: CLI.6010.PL.047 Program Area: Pharmacy & Therapeutics Policy Section: General
Issue Date: April 14, 2021 Review Date: Revision Date: August 11, 2022	Subject: Medication Allergy Identification and Reaction Recording

Use of pre-printed documents: Users are to refer to the electronic version of this document located on the Southern Health-Santé Sud Health Provider Site to ensure the most current document is consulted.

POLICY SUBJECT:
Medication Allergy Identification and Reaction Recording

PURPOSE:
To define the procedure for recording medication allergies on a patient/client's profile.

BOARD POLICY REFERENCE:
Executive Limitation (EL-2) Treatment of Clients

POLICY:
Accurate information about a patient/client's medication allergies are an important element in medication safety and an integral component of the medication profile.

DEFINITIONS:
Allergen: The specific agent or medication causing the Allergy and Intolerance i.e. amoxicillin, etc

Allergies/Intolerances Summary View: The window in the EPR where details about Allergies and Intolerances for a selected Patient can be added, reviewed, marked as reviewed, modified or discontinued. It can be accessed from Clinical EPR, EPR-ADT, Emergency Department Information System (EDIS) and Scheduling EPR; based on the user security role.

Allergy: An immune-mediated response to an Allergen which results in the body producing antibodies and the subsequent release of histamine and other mediators. This response caused tissue inflammation and/or organ dysfunction that can include symptoms such as: angioedema, urticarial, rash or anaphylaxis.

Clinical Circumstances Sheet (CCS): The document printed from the EPR that displays the Allergy and Intolerance information on file in the EPR.

Clinical EPR: The clinical component of the EPR that is used primarily by physicians, nurses and other allied health professionals. It can contain laboratory results, orders, clinical documentation and information about Allergies and Intolerances.

Confidence Level: A description of the validity of the Allergy or Intolerance; confirmed or suspected. NOTE: Entering the Confidence Level is optional.

Electronic Patient Record (EPR): A computer-based profile of a Patient's visit to a hospital compiling demographics, scheduling, clinical and emergency department information.

Information Source: Source of the information concerning the Allergy or Intolerance; Patient, spouse or other family member, parent, guardian, Health Record, nurse, pharmacist, physician, other.

Intolerance: A usually predictable or dose dependent adverse or unpleasant effect from a medication, food,latex or environmental agent (i.e. nausea from antibiotics)

Onset Date: Date, if know, that Reaction was first noticed.

Reaction: A description of the symptoms the Patient experienced when exposed to the Allergen; i.e. anaphylaxis, shortness of breath, eczema, facial swelling, cramps, etc.

Severity: A description of the degree to which the Patient experienced the Reaction; mild, moderate or severe

Type: A classification of the Allergy or Intolerance; airborne, drug, drug category, food, skin contact or stings/bites. Note: type does not need to be indicated when recording Allergies and Intolerances manually

PROCEDURE:

All Direct Care Providers (DCP) e.g. nurses, prescribers, respiratory therapists:

- Ask the Patient about known Allergies and Intolerance prior to initiation of a medication.
- Allergy information should be included on all admission orders sent to pharmacy including Best Possible Medication History (BPMH), Transfer Med Rec form and Discharge Med Rec form.
- The name of the medication and description of the reaction should be included.
- Allergies are confirmed by a prescriber.
- If the Patient has no known Allergies, document "No Known Allergy" or NKA.
- If information on Allergies cannot be obtained, document "Allergy Status Unknown" and provide the reason.
- Document confirmed allergies and reaction on the following (as applicable by service or care area):

- Clinical Circumstances Sheet (CCS) (CLI.6010.PL.047.SD.01)
  NOTE: sites with EPR-access write "see CCS" on all documents that prompt for documentation of allergies.
- Admission history (e.g. prescriber, nursing, pre-operative questionnaire)
- Allergy Armband (red)
- Prescriber Order Sheet CLI.4510.PR.002.FORM.06
- Resident Information for Integrated Care Plan Form CLI.6410.PL.002.FORM.02
- Medication Administration Records (MARs)
- Medication Reconciliation Forms (BPMH, Transfer, Discharge)
- Care Maps/Standard Orders
- Nursing Service Request
- Nursing History
- Front of Nursing Chart
- Medication sheets

- The admitting/registration clerk shall print a copy of the CCS and include it with the Patient's Health Record
- The DCP first seeing or admitting a Patient shall review the CCS with the Patient or family/caregiver to ensure that all known Allergies and Intolerances are documented or to verify that the Patient has no known Allergies and Intolerances.
  - ALL allergies, intolerances, no know allergies, or unknown allergies documented on CCS shall be signed and dated to confirm review
- NEW allergies or intolerances or CHANGES to existing information discovered while the **Patient is admitted** shall be hand-written on the CCS in the appropriate section (except in Emergency Department where nurses have EPR access and can enter updated allergy information)
  - Record as much information as possible, including the Type, Reaction, Severity, Onset Date, Confidence Level and Information Source
  - DCP shall sign and date all new entries and changes to existing information on the CCS
  - If a documented allergy or intolerance requires discontinuation, the DCP shall document the reason in the IPN and CCS
- The CCS shall be faxed to pharmacy whenever it is updated
  - The CCS shall be dated, timed and initialed at the bottom to indicate each time the form was faxed

Pharmacy:

- Where allergy and reaction information is not included on admission orders, the pharmacist or pharmacy technician/assistant will acquire this information on each admission to the hospital, health centre or personal care home.
- Medications ordered for patients should be checked against their allergy profile before dispensing.

- Enter any NEW or CHANGES to allergies and intolerances into the EPR
    - Select the appropriate Type, Allergen, Reaction, Severity, Onset Date, Confidence Level and Information Source from the EPR drop down menus in the Allergies/Intolerances Summary View
    - See the Clinical EPR Allergies and Intolerances Reference Manual for complete information on entering Allergies and Intolerances into the EPR (https://extranet.manitoba-ehealth.ca/PEARL/Articles/Allergies%20and%20Intolerances.aspx)
- For sites that do not have EPR enter NEW or CHANGES to allergies and intolerances into BDM Mov.

SUPPORTING DOCUMENT:

CLI.6010.PL.047.SD.01 Clinical Circumstances Sheet

REFERENCES:

Prescriber Order Sheet CLI.4510.PR.002.FORM.06
Resident Information for Integrated Care Plan Form CLI.6410.PL.002.FORM.02