

Manitoba Health, Healthy Living & Seniors (MHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Communication and Documentation of Allergies

Summary:

A patient was sent home from hospital with a prescription for a medication to which they had a documented allergy in the chart.

The patient brought their prescription to the community pharmacy to have it filled. The pharmacy called the prescribing doctor's clinic because a documented allergy to the prescribed medication was noted on the written prescription. The doctor and the pharmacist in the clinic had decided that this was not a true allergy, as the patient did not react when on the same medication the year before. They shared this information with the community pharmacy. The prescription was filled for the patient.

Two days later, the patient came to an Urgent Care Clinic after having developed a rash. The doctor at the urgent care clinic knew the patient previously. He felt that the rash was a reaction to the medication prescribed two days earlier. A few months earlier, the patient reacted to another medication. At that time, there was a more severe deterioration in their condition.

As a result of this, the doctor called an emergency medical code, a "medical 25" just in case their condition deteriorated further. A "medical 25" is called when there is an emergency situation that requires immediate medical care. As a result, the patient was sent to the nearest hospital emergency department where they were observed for a period of time and discharged later that day. .

Keywords: Allergy, Documentation

Type of Analysis: single event

Topic: Clinical Administration/Documentation

Findings of the Review:

- The patient's electronic health record at the outpatient clinic contained an allergy flag even though it was decided that a true medication allergy did not exist.
- There was a progress note written regarding the discussion with the community pharmacy which again stated the indicated medication allergy was not a true allergy.
- There were a number of written notes in the chart documenting suspected medication reactions over a two year period. There were at least six different medications identified in these notes.
- An allergy to the medication in question was documented in the hospital chart in several places. .
- An allergy to the medication was documented on the prescription given to the community pharmacy. This prescription was created using the outpatient clinic's electronic chart. There is no allergy alert system in the electronic chart. .
- The patient had seen an allergist who determined that the patient did not have an allergy to the medication ordered. There was agreement that the patient does react to some medications.
- A letter was sent by the clinic to the infection Control Department seeking their recommendations about what medications to prescribe for the patient if similar issues occur in the future.
- There were many gaps in the communication processes discovered with the chart. Written allergies are not always recorded in the appropriate chart location.
- Among the medical staff, there were varying interpretations regarding when to call a "medical 25" at the urgent care clinic. The "medical 25" policy had been updated, however still remained in draft form.

System Learning:

A formalized process enter, modify and delete allergies in the electronic health record should be established. Documentation of the allergy should include the type of reaction, the severity and whether the allergy has been medically proven. In addition, the process should delineate the roles and responsibilities of care providers for allergy documentation.

Patient care policies that reference a medical emergency must be finalized and implemented in a timely fashion. Communication of the policy change should include education and training with respect to the policy.

Automated allergy checks should be implemented within the electronic health record.

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