LOS ANGELES GENERAL MEDICAL CENTER POLICY

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ALLERGIES AND ADVERSE DRUG REACTIONS: DOCUMENTATION	2/11/14	**927**
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Policy Owner(s): Patient Safety Officer
Executive Sponsor(s): Chief Quality Officer

Departments Consulted:	Reviewed & approved by:	Approved by:
Patient Safety Committee Pharmacy Nursing Services Office of Risk Management	Attending Staff Association Executive Committee Senior Executive Officer	(Signature on File) Chief Quality Officer (Signature on File) Chief Executive Officer

PURPOSE

To describe the process by which allergies and adverse drug reactions to medications are documented in the medical record.

POLICY

When a medication allergy or adverse drug reaction has been identified by a provider or staff, the name of the medication and type of reaction shall be documented as noted in the medical record. If a provider is able to confirm that a past history of allergy is incorrect, either because the patient's history clarifies that the reaction was not allergic (e.g., vomiting) or because the patient has been subsequently exposed to the drug or a close congener without adverse effect, the provider may update the EMR to remove or clarify the allergic reaction.

DEFINITIONS

Medication Allergy — An allergy is mediated by an immune response to a drug, resulting in tissue inflammation and/or organ dysfunction usually, but not always characterized by angioedema, rash, or anaphylaxis.

Adverse Drug Reaction — A reaction that is any unexpected, unintended, undesired, or excessive response to a medication in doses recognized in accepted medical practice.

Close congener — Drugs with similar chemical structure which has been shown in literature or through expert consensus that lack of allergic reaction to one will most likely result in lack of allergic reaction in the other.

PROCEDURE

1. Medication Allergy & Adverse Reaction Documentation

Medication allergy and adverse reactions must be obtained by healthcare providers, nurses and pharmacists prior to dispensing any medication to the patient whenever possible.

a. The allergy or reaction, if known, shall be recorded in the medical record under the allergy tab.

i. The documenting user is to ensure the correct category for the documentation is selected, i.e. Allergy, Side Effect, etc.
ii. In the event documentation requires the input of a product that is not automatically populated in the computer library, the nurse is to communicate with the pharmacist to have a free text documentation entered.
- Any free text documentation in the allergy or side effect field will require manual review by providers and pharmacists.

b. The provider shall act upon notification of a new allergy or new reaction by documentation in the medical record under the allergy tab.
c. To update or clarify a prior, incorrect allergy documented in the electronic medical record (EMR), the provider, pharmacist or nurse shall
i. Open the allergy tool / tab of the medical record
ii. Right click the allergy to be updated and select “Modify”
iii. Update or correct the reaction as appropriate. If the allergy was incorrectly entered, the status should be updated to “Canceled”.

2. Pharmacy Documentation

a. When processing an order that may potentially cause an allergic reaction, the pharmacist will contact the prescriber to clarify the order.

i. The pharmacist will discuss with the provider the order for medication in light of a documented allergy. If the provider was unaware of the allergy or agrees that there is a real risk of allergy, the pharmacist and provider will discuss available alternative therapies (if one exists) that is unlikely to cause a reaction.

ii. If the provider has evidence that the documented allergy is incorrect, the pharmacist will consider that evidence in light of new information, and a joint decision will be made about how to proceed: 1) prescribe an alternate medication; or 2) update the EMR to correct or clarify the documented allergy.

iii. If the provider and pharmacist are unable to agree on whether an allergic risk exists, and/or unable to jointly decide to take either of the above actions, the pharmacist will follow the the Pharmacy Impasse Procedure (Policy/Procedure #241), including:
- The pharmacist will place the medication order on hold and discuss the order with the supervising physician(s) by following the “chain of command”. The process will continue until an agreement is reached by both parties.
- Medical Officer of the Day (MOD) may be contacted when the supervising physician(s) are not available, or at any time needed.
- An order to override a recommendation of a pharmacist may only be made by an attending physician.

iv. After contacting the prescriber, the pharmacist will document the following information in the Cerner Drug Intervention module :

- Date of intervention
- Time of intervention
- The recommended alternative medication(s)
- The name of the prescriber
- The outcome of the intervention

3. Nursing Documentation

a. Upon obtaining a history of a medication allergy and reaction, the nursing staff shall review the medical record to determine if the allergy and reaction has been documented.

b. If the allergy or the reaction has not been previously documented, the nurse shall immediately notify the provider and shall document the allergy under the allergy tab

PROCEDURE DOCUMENTATION

Attending Staff Manual
Nursing Policies and Procedure Manual
Pharmacy Policies and Procedure Manual

REVISION DATES

February 11, 2014; August 13, 2018; April 26, 2019; April 7, 2024