Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé	**REGIONAL** Applicable to all WRHA governed sites and facilities (including hospitals and personal care homes), and all funded hospitals and personal care homes. All other funded entities are excluded unless set out within a particular Service Purchase Agreement.		1
POLICY	Policy Name: **Allergy and Intolerance Documentation**	Policy Number: 110.000.420	Page: 1 of 8
	Approval Signature: *Original Signed by R. Cloutier*	Section: **CLINICAL / PROGRAM SERVICES**	
	Date: June 2018	Supercedes: NEW	

1.0 **PURPOSE:**

1.1 To reduce preventable harm to Patients due to a failure to inquire whether a Patient has known Allergies or Intolerances.

1.2 To promote standard documentation and communication by Health Care Providers of Patient Allergies and Intolerances including: medication, food, medical supplies, latex and environmental agents.

1.3 To promote staff and Patient/family awareness about Allergy and Intolerance documentation and communication practices in the WRHA.

1.4 To demonstrate regional consistency and compliance with Accreditation Canada requirements to provide staff and service providers with timely access to Patient information, including Allergies and Intolerances.

2.0 **DEFINITIONS:**

2.1 Allergen: The specific agent or medication causing the Allergy or Intolerance; e.g. amoxicillin, pollen, adhesive tape, wasp sting, shell fish, dyes, etc.

2.2 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.

2.3 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 causes tissue inflammation and/or organ dysfunction that can include symptoms such as: angioedema, urticaria, rash or anaphylaxis.

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

2.5 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.

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

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

2.8 Health Care Providers (HCP): Shall mean: physicians, residents, nurses, nurse practitioners, physician/clinical assistants, pharmacists, dietitians and other allied health professionals, as applicable.

2.9 Health Record: Personal health information compiled by individuals authorized to make entries on approved health record forms and maintained by facilities, sites or programs of the WRHA as the official record of health care provided to a Patient. Health Records, including electronic Health Records and paper-based Health Records are the physical property of a facility, site or program of the WRHA. For the purposes of this policy, Health Records include clinical records as defined in The Mental Health Act.

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

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

2.12 LTC Allergies and Intolerances Record: The Single Source of Truth used by the Long Term Care Program to manually record Allergy and Intolerance information for all Patients.

2.13 Onset Date: Date, if known, that Reaction was first noticed.

2.14 Patient: Shall mean Patient, client, individual or resident receiving healthcare from a WRHA facility, program or funded site.

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

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

2.17 Single Source of Truth for Allergies and Intolerances: The sole document used to record all Allergies and Intolerances (e.g. Clinical Circumstance Sheet, LTC Allergies and Intolerances Record, etc.). The Single Source of Truth for Allergies and Intolerances used will vary according to the type of Health Record used by a site, facility or community care provider.

2.18 Sites and Facilities: Any premises which are owned, operated or funded by the WRHA.

2.19 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.

3.0 **POLICY:**

3.1 The HCP shall ask the Patient about known Allergies and Intolerances prior to initiation of a medication, food, treatment or procedure.

3.2 Allergies and Intolerances shall be documented or updated on a Single Source of Truth for Allergies and Intolerances.

3.2.1 Sites and Facilities shall determine their own Single Source of Truth for Allergies and Intolerances.

Note: Documentation of health information in different sectors (acute care, community care, long term care) are at various stages in the transition from paper to electronic Health Records and are not integrated; electronically recorded Allergies and Intolerances are not shared at this time.

3.3 The HCP shall document all Allergy and Intolerance information provided, including: the Allergen, Reaction, Severity, Onset Date, Confidence Level and the Information Source.

3.3.1 Every effort shall be made to determine the exact Allergen that was responsible for known Reactions.
- General pharmacological classifications (e.g. opioids, vaccines, etc.) are to be avoided whenever possible.

3.3.2 If the Patient has no known Allergies or Intolerances, the HCP shall document "No Known Allergy" or NKA.

3.3.3 If information on Allergies and Intolerances cannot be obtained, the HCP shall document "Allergy Status Unknown" and provide the reason.

3.4 All Allergies, Intolerances, no known Allergy or Allergy status unknown entries shall be signed and dated on the Single Source of Truth for Allergies and Intolerances.

Note: Entries and modifications in the electronic Health Record are automatically time, date and signature stamped.

3.5 Sites, facilities and community care providers shall determine the location of the Single Source of Truth for Allergies and Intolerances for easy access by all HCPs while a Patient is under their care.

3.6 The Single Source of Truth for Allergies and Intolerances shall be faxed to pharmacy with the initial medication orders or medication reconciliation form and, if applicable, to Nutrition and Food Services.

3.6.1 All revisions to the Single Source of Truth for Allergies and Intolerances for admitted Patients shall be faxed to pharmacy and Nutrition and Food Services, if applicable.

3.6.2 The Single Source of Truth for Allergies and Intolerances shall be dated, timed and initialed to indicate that the form was faxed.

Exception: Sites with fully implemented and integrated EPR and the community care providers.

3.7 Pharmacy shall enter and update the pharmacy information system with all Allergy and Intolerance information received.

3.7.1 Pharmacy shall not dispense a medication if the Single Source of Truth for Allergies and Intolerances has not been provided.

Exception: Medications required in emergent situations (e.g. resuscitation medications, STAT medications, etc.).

3.8 Nutrition and Food Services shall translate all food Allergies and Intolerances received into a diet order and process according to Nutrition and Food Services procedures.

3.8.1 Allergies and Intolerances that are communicated to Nutrition and Food Services from a source other than the Single Source of Truth shall be documented on the Single Source of Truth by a dietitian. If a dietitian is not available, Nutrition and Food Services will contact the HCP caring for the Patient to complete the Single Source of Truth.

Note: Details about operational procedures can be obtained by contacting Nutrition and Food Services at http://www.wrha.mb.ca/extranet/nutrition/ContactUs.php.

3.9 HCPs shall clarify any discrepancy between the documented Allergy or Intolerance and the prescribed medication, diet, treatment or procedure with the prescriber prior to administration.

3.10 The Single Source of Truth for Allergies and Intolerances shall accompany the Patient for all procedures, tests and treatments.

3.11 A copy of the Single Source of Truth for Allergies and Intolerances shall be provided to the next HCP when a Patient is transferred to another site or facility or when care is transferred to a community care provider (e.g. Home Care, etc.).

3.11.1 See Policy #110.000.410, Safe Patient Handover and Transfer Accountability (at http://home.wrha.mb.ca/corp/policy/files/110.000.410.pdf).

3.12 Visual cues (e.g. wrist bands, stickers on Patient record, etc.) may be used but shall not contain any specific Patient Allergy or Intolerance information. The visual cue may refer to the Single Source of Truth for Allergies and Intolerances.

Exception: Nutrition and Food Services may use recognized tools (e.g. food tray tickets, etc.) for translation of diet orders as required.
For Patients with confirmed latex Allergy (see below) follow Policy 110.000.390, Latex Safe Environment for Patients.

3.13 Known or suspected latex Allergies shall be documented on the Single Source of Truth for Allergies and Intolerances.

3.13.1 See Policy #110.000.390, Latex Safe Environment for Patients (at http://home.wrha.mb.ca/corp/policy/files/110.000.390.pdf) for complete information to protect the Patient with a known or suspected latex Allergy from contact with latex while receiving care.

4.0 PROCEDURE:

4.1 Patient Admitted to Sites with EPR-Access:

4.1.1 Sites with EPR-access shall use the CCS as the Single Source of Truth for Allergies and Intolerances. See sample in Appendix #1.

4.1.1.1 "See CCS" shall be written on all documents that prompt for documentation of Allergies (e.g. medication order sheet, medication administration record, etc.).

Exception: Sites with fully implemented and integrated EPR (e.g. St. Boniface Hospital) shall use the Allergies/Intolerances Summary View in the EPR as the Single Source of Truth for Allergies and Intolerances.

4.1.2 The admitting/registration clerk shall print a copy of the CCS and include it with the Patient's Health Record.

4.1.3 The HCP 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.

4.1.3.1 All Allergies, Intolerances, no known Allergy and Intolerance or Allergy and Intolerance status unknown entries on the CCS shall be signed and dated on the CCS to confirm review.

4.1.4 New Allergies and Intolerances or changes to existing information discovered while the Patient is admitted shall be hand-written on the CCS in the appropriate section AND entered into the Allergies/Intolerances Summary View in the EPR by the HCP discovering the new information.

4.1.4.1 When entering a new Allergy or Intolerance on the CCS, record as much information as possible, including the Type of Allergy or Intolerance and the Allergen, Reaction, Severity, Onset Date, Confidence Level and the Information Source.

4.1.4.2 HCP shall sign and date all new entries and changes to existing information on the CCS.

4.1.4.3 When entering an Allergy or Intolerance into the EPR, the HCP shall 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.

4.1.4.4 If a documented Allergy or Intolerance requires discontinuation, the HCP shall document the reason in the integrated progress notes and in the EPR.

4.1.4.5 See the Clinical EPR Allergies and Intolerances Reference Manual for complete information on entering Allergies and Intolerances into the EPR (see https://extranet.manitoba-ehealth.ca/PEARL/Articles/Allergies%20and%20Intolerances.aspx)

4.1.5 The CCS shall be stored in the Patient's Health Record, filed under the core divider agreed upon by the WRHA Medication Quality and Safety Committee.

4.1.6 The CCS shall be faxed to pharmacy and, if applicable, to Nutrition and Food Services with the initial medication orders or medication reconciliation form.

4.1.6.1 The CCS shall be faxed to pharmacy and to Nutrition and Food Services, if applicable, whenever it is updated.

4.1.6.2 The CCS shall be dated, timed and initialed at the bottom to indicate each time the form was faxed.

4.1.7 The CCS shall accompany the Patient for all procedures, tests and treatments.

4.1.8 A copy of the CCS shall be provided to the next HCP along with the Manitoba Information Transfer Referral Form when a Patient is transferred to another site or facility (see http://home.wrha.mb.ca/hinfo/chif/files/W-00147.pdf) or when care is transferred to a community care provider (e.g. Home Care, etc.).

4.1.9 A red identification (ID) wrist band shall be placed on all Patients with Allergies and Intolerances.

4.1.9.1 ID wrist bands shall not contain any specific information about the Allergy or Intolerance. ID wrist bands may state "see Clinical Circumstance Sheet" or "see CCS".

4.2 **Personal Care Homes (PCH) and Long Term Care (LTC) Facilities without Electronic Health Record Access:**

4.2.1 PCH and LTC sites shall use the LTC Allergies and Intolerances Record as the Single Source of Truth for Allergies and Intolerances.

4.2.1.1 "See LTC Allergies and Intolerances Record" shall be written on documents that prompt for documentation of Allergies (e.g. prescriber order sheet, medication reconciliation form, etc.).

Exception: For PCH and LTC sites with electronic Health Records, Allergies and Intolerances may be documented in the electronic Health Record.

4.2.2 The HCP admitting the Patient shall complete the LTC Allergies and Intolerances Record 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 or Intolerances.

4.2.2.1 If the Patient is transferred from another site or facility, the Single Source of Truth for Allergies and Intolerances shall be used as an information source.

4.2.2.2 When entering a new Allergy or Intolerance on the LTC Allergies and Intolerances Record, record as much information as possible, including the Allergen, Reaction, Severity, Information Source and comments.

4.2.2.3 All entries on the LTC Allergies and Intolerances Record shall be signed and dated.

4.2.3 New or changed Allergies and Intolerances discovered while the Patient is admitted shall be entered on the LTC Allergies and Intolerances Record by the HCP discovering the new information.

4.2.4 The admission and all updates to the LTC Allergies and Intolerances Records shall be faxed to pharmacy and Nutrition and Food Services.

4.2.4.1 For PCH and LTC sites with electronic Health Records, the Allergies and Intolerances shall be printed from the electronic Health Record and faxed to pharmacy and Nutrition and Food Services.

4.2.5 Visual cues (e.g. wrist bands, stickers on Patient record, etc.) may be used but shall only refer to the LTC Allergies and Intolerances Record.

Exception: Nutrition and Food Services may use recognized tools (e.g. food tray tickets, etc.) for translation of diet orders as required.

4.2.6 A copy of the LTC Allergies and Intolerances Record shall be sent with the Patient if they are transferred out of the PCH or LTC site (e.g. to emergency department, urgent care, appointments, tests, procedures, treatments, etc.).

4.2.6.1 For PCH and LTC sites with electronic Health Records, the Allergies and Intolerances shall be printed from the electronic Health Records and sent with the Patient.

4.3 **Community Programs with Electronic Health Record Access:**

4.3.1 All Allergies and Intolerances shall be reviewed and updated in the electronic Health Record prior to initiation of a medication, food, treatment or procedure in WRHA Community Programs (e.g. Home Care, Population Public Health, Mental Health, Primary Care, etc.)

4.3.1.1 Clinics and facilities shall develop consistent and sustainable procedures for Allergy and Intolerance documentation within the constraints of the electronic Health Record vendor in use.

4.4 **Community and other Facilities without Electronic Health Record Access:**

4.4.1 Facilities and clinics that do not have electronic Health Records shall use the Community Health Services Allergy and Intolerance Record form as the Single Source of Truth for Allergies and Intolerances (Form # WCC-00283). See sample in Appendix #2.

4.4.1.1 "See Community Allergy and Intolerance Record" shall be written on all documents that prompt for documentation of Allergies (e.g. medication order sheet, medication administration record, etc.).

Note: Single copies or small quantities of the form can be printed directly from the Community Health Information Forms page on Insite.
Larger quantities of the form should be ordered through WRHA Printing Services.
The form shall not be photocopied for the purpose of reproduction.

4.4.2 During the Patient visit the HCP shall review the Community Allergy and Intolerance Record 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.

4.4.2.1 All Allergies, Intolerances, no known Allergy and Intolerance or Allergy and Intolerance status unknown entries on the Community Allergy and Intolerance Record shall be signed and dated.

4.4.3 New Allergies and Intolerances or changes to existing information discovered during the Patient visit shall be entered on the Community Allergy and Intolerance Record by the HCP discovering the new information.

4.4.3.1 When entering a new Allergy or Intolerance on the Community Allergy and Intolerance Record, record as much information as possible, including the Allergen, Reaction, Severity, Onset Date, Confidence Level and the Information Source.

4.4.3.2 HCP shall sign and date all new entries and changes to existing information on the Community Allergy and Intolerance Record.

5.0 **REFERENCES**:

5.1 Medication Management Standards; Standard 5.1; Accreditation Canada. 2017. Available from: http://www.accreditation.ca or http://home.wrha.mb.ca/quality/documents/10.pdf

5.2 Never Events for Hospital Care in Canada - Safer Care for Patients, Canadian Patient Safety Institute, September 2015 Available from: http://www.patientsafetyinstitute.ca/english/toolsresources/neverevents/pages/default.aspx

5.3 Allergy Never Events, ISMP Canada Safety Bulletin, 16 (10), December 20, 2016.

5.4 Manitoba eHealth Clinical EPR Allergies and Intolerances Reference Manual Version 15.3.1. July 2016. Available from: https://extranet.manitoba-ehealth.ca/PEARL/Articles/Allergies%20and%20Intolerances.aspx

Policy Contact: Dr. Fred Aoki, WRHA Medication Quality and Safety Committee Co-Chair
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Appendix # 1

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé

VICTORIA GENERAL HOSPITAL

Clinical Circumstances Sheet

Test, Patient	**26y (23-Jan-1987)** **Female**	**MRN: 580125**	
ED-03-01	Attending MD: **Emergency Provider**	**Visit: 50080158**	**ADM**
PHIN: **MB-111222333**	MB Reg: **123123**	Series:	
Language: **English**	Interpreter: **No**		
MRSA and VRE and ESBL Suspect	Admit Date & Time: **13-Feb-2013 11:54**	**Emergency**	

Admission Assessment for Risk of ARO:

Risk of ARO: Risk Present

Entry was made in a Risk of ARO comment based on the registration ARO Risk screening question "In the past 6 months, have you been hospitalized or in Emergency for more than 24 hours in an acute care hospital?"

Please refer to the region's Infection Prevention and Control Manual. Admission Screening of patients for Antibiotic Resistant Organisms.

Infection Control Health Issue:

MRSA and VRE and ESBL Suspect - Exposed to Methicillin-Resistant Staphylococcus aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE) and Extended Spectrum Beta Lactamase (ESBL) requires cultures to determine status.

Patient may require Additional Precautions. Please refer to the region's Infection Prevention and Control Manual. Screen as per guidelines.

Clinical Considerations:

Transplant Protocol **Bariatric Patient** **Obstructive Sleep Apnea**

Documented Allergies

Type	Allergen	Reaction (Severity)	Entered Date	Status	Source	Verified By	Date
Drug	penicillin	Chest Tightness; Erythema; Hives	15-Feb-2013	Active	Patient		
Food	Chocolate	Abdominal Pain; Cramps; Edema	15-Feb-2013	Active	Nurse		

Documented Intolerances

Type	Allergen	Reaction (Severity)	Entered Date	Status	Source	Verified By	Date
Food	Eggs	Abdominal Pain	15-Feb-2013	Active			
Skin Contact	Detergents	Itching	15-Feb-2013	Active			

New Allergies/Intolerances

Type	Allergen	Reaction (Severity)	Source	Initials	Date

FORM COMPLETED AND FAXED TO PHARMACY/FOOD SERVICES (MUST be done after each revision)

Date/Time	Initials	Date/Time	Initials	Date/Time	Initials

Confidential Patient Information
Victoria General Hospital

End of Report
1 of 1

Feb 15 2013 12:53PM RegClerkVGH01, Tester

Appendix # 2

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

Community Health Services
Allergy and Intolerance Record

	Recorded by (initials):	Date (DD/MMM/YYYY)
❑ **No known allergies or intolerances**		
❑ **Allergy status unknown** Reason: _____		

Allergy	Intolerance	Allergen	Reaction						Severity				Source				Comments include Confidence Level, if necessary and Onset Date, if known	Recorded by initials	Date DD/MMM/YYYY
			Anaphylaxis	Short of breath	Hives or Rash	Swelling (specify in Comments)	Gastrointestinal specify in Comments	Other (specify in Comments)	Severe	Moderate	Mild	Unknown	Individual	Family, Care Giver or Guardian	Health Record	Health Professional			

FILE PERMANENTLY IN HEALTH RECORD

See Back of Form for Instructions for Use