

Summary of Changes

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1. Introduction

1.1. Focus

To describe the procedure related to assessing and documenting patient allergies in alignment with the Allergy Policy.

1.2. Health Organization Site Applicability

This procedure applied to all BC Cancer Physicians, regulated Health Care Professionals, and Designated Health Care Professionals

1.3. Definitions

Allergy: An adverse reaction to a drug or substance which is due to an immunological response.

Contraindications: A symptom or condition that makes a particular treatment or procedure inadvisable.

Intolerance: A non-immune reaction that is characterized by the inability to properly metabolize or absorb a substance or food in the digestive tract.

Side-effects: An untoward clinical response associated with exposure to, or use of, a substance.

Designated Health Care Professionals: Professionals regulated by regulatory colleges under the <u>Health Professions Act</u>, e.g. Physicians, Pharmacists, Nurses, and Dieticians. For complete list, see <u>BC Ministry of Health Professional Regulation</u>. Also includes approved Non-regulated Health Care Professionals, which are non-regulated professionals designated through the health organizations approval process (e.g. Radiation Therapist, Medical Imaging Technologists).

2. Procedure

2.1. Steps and Rationale

Prior to any initial medication or non-medication (i.e. latex, contrast media or food)
prescribing, a Designated Health Care Professional (DHCP) must assess and
document all allergies including drug, food, environmental and contrast allergies.
When allergy information is already documented it must be verified, and marked as
reviewed.

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- Verification and review of allergies should occur and recommended to be done prior to prescribing, preparing or administering medications, and recommended at minimum annually at the next scheduled appointment.
- 3. Allergy status should be verified by both:
 - a. Reviewing allergy information within the paper or electronic health record within the physician's narrative notes and/or dictation and/or allergy section of the Patient Reported Information and Symptom Measurement (PRISM) form.
 - b. Verbally confirming with patient.
- 4. Other allergy information (contraindication, intolerance and untoward side-effects) should be documented on the allergy form.
- 5. If patient develops new or suspected allergies then it is the Designated Health Care Professionals' responsibility to document this by updating the Allergy form.
- Once form is completed and if allergy identified, the clerk will affix the red allergy label to the form; and will fax to pharmacy if appropriate to local cancer centre policy.
- 7. A visual allergy cue must be used for all allergies/intolerances/contraindications/ side- effects to medications, latex, food, dye or tape for all inpatients and outpatients receiving procedural sedation or general anesthesia.'

Professional Practice decision is to use the **RED** armband to flag for visual allergy cue in the following areas:

- Inpatient
- Surgical (brachy included)
- Systemic treatment delivery
- Procedures requiring sedation administration (Includes Dental, conscious and procedural sedation)
- IV contrast procedures (CTSIM, Medical Imaging)
- Medical daycare appointments

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2.2. Documentation

The allergy form is to be placed at the front of the patient record (first page of every record)

Designated Health Care Professional ensures documentation of allergies on discharge prescriptions, discharge letters and inter-hospital transfer letters. Include allergy status on all other patient care documents (paper or electronic).

2.3. Patient/Client Education

Counsel patients who experience an allergic reaction or drug intolerance. They should have an understanding where possible, of their responsibilities to inform subsequent healthcare professionals of this reaction.

3. Related Documents and References

3.1. Related Documents

Allergy Documentation Policy (VCH, PHSA, PHC)

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