Allergy Alert! Evaluation Of The Communication Of New Allergies Post-Discharge

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BACKGROUND

Comprehensive allergy documentation is crucial in protecting patients from medication-related harm. If patients have a new, confirmed, medication allergy during their hospital admission, Northern Health reports the event to the Therapeutic Goods Administration and updates the patient's allergy documentation in line with the National Safety and Quality Health Service (NSQHS) Standards (4.07, 4.08, 4.09).

Additionally, Northern Health provides follow-up documentation to the patient in the form of a letter (detailing the reaction that occurred) and an allergy alert card. The patient's nominated General Practitioner (GP) also receives a letter to assist in updating their medical records with the patient's new, confirmed medication allergy. Currently, the documentation is prepared by the Medication Safety Pharmacist.

AIM

To determine the proportion of patients, post-discharge, who received the follow-up documentation after developing a new, confirmed, medication allergy during their hospital admission

Furthermore, the secondary objectives were to determine the proportion of patients that:

- Were re-exposed to the allergen.
- Were satisfied with information provided about their new medication allergy.
- Had updated GP medical records and shared My Health Record (MHR) allergy documentation.
- Had complete allergy documentation within Northern Health's records.

METHOD

A retrospective audit was conducted for all patients admitted to Northern Health from July 2022 to March 2023 that had a new, confirmed medication allergy event reported (via VHIMS) during their admission. Patients were screened for eligibility as shown in *Figure 1*.

Patients and their GPs were contacted via phone call and surveyed to confirm if the allergy documentation had been received. Patients were asked to rate their satisfaction with the information provided using the Likert scale. GP clinics were asked to confirm if patient medical records were updated accordingly. Patients' shared My Health Record was viewed to confirm if the new medication allergy was documented.

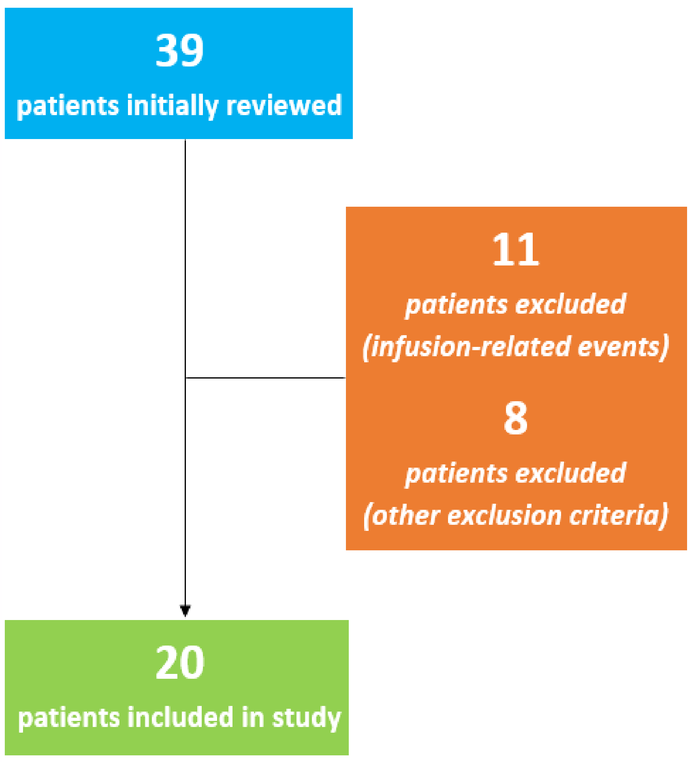


Figure 1: Patient inclusion criteria flow diagram

RESULTS

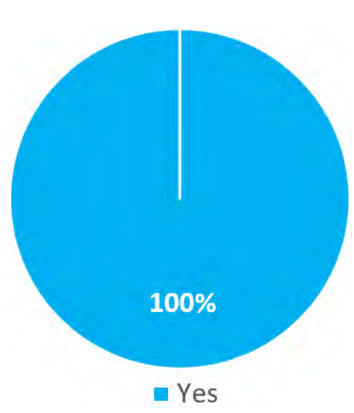


Chart 1: Proportion of new allergies reported to TGA by Northern Health

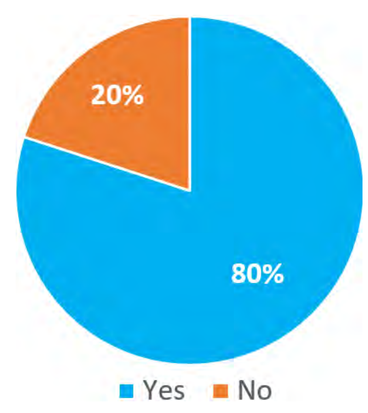


Chart 2: Proportion of patients that received the required documentation

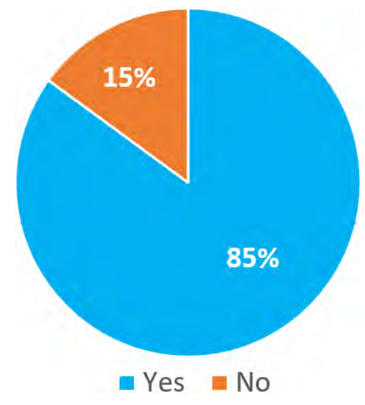
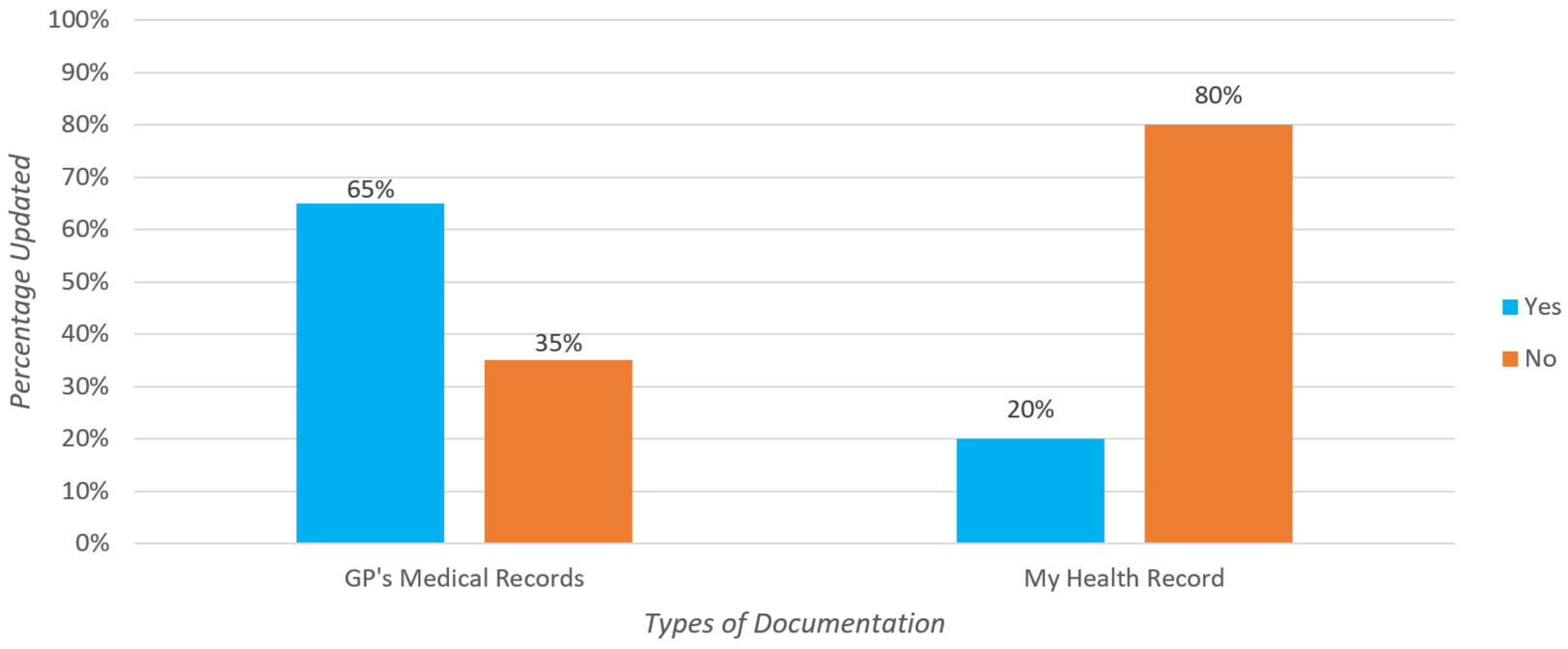


Chart 3: Proportion of GPs that received the required documentation

Figure 2: Patient satisfaction with the allergy documentation provided by Northern Health



Graph 1: Proportion of GPs that updated the patient's medical record to reflect the new medication allergy

DISCUSSION

The audit comprised of 20 patients. 100% of new, confirmed, allergy events were reported to the TGA *(Chart 1)*. In accordance with the NSQHS, the allergen (100%), reaction description (100%) and date of reaction (90%) were documented in patients' medical records. While only 10% of patients had reaction severity documented, this is expected to improve with the implementation of Electronic Medical Records (EMR) at Northern Health, as severity assessment will be built as a mandatory field.

A total of 16 patients received the allergy letter and alert card *(Chart 2).* Using the Likert scale, 100% of patients reported being 'Satisfied' or 'Highly Satisfied' with the documentation provided *(Figure 2).* 17 GP clinics received the allergy letter *(Chart 3)*. The mean duration between allergy event and documentation received by the GP was 63 days (range 14, 110).

A total of 65% of patients' GP medical records were updated before the first phone call *(Graph 1)*, which increased to 88% after a second phone call. While this is not current practice, additional verbal correspondence could be considered as part of the process for communicating new patient allergies. Recording of the new medication allergies on the shared MHR was low (20%), which is likely due the lack of integration between GP medical record software and MHR, as well as patient control functionality.

No patients recalled being re-exposed to their allergen. Only 20% of patients recalled having further allergy testing, however this is performed by an external organisation that does not notify Northern Health of any further allergy testing. Establishing an allergy clinic at Northern Health would help improve this current gap in practice.

LIMITING FACTORS

- Voluntary reporting of new medication allergies via VHIMS by staff.
- Patient recall – patients in the audit were contacted at the same time regardless of when their allergy occurred.

CONCLUSION

Current processes of providing patients and GPs with allergy documentation is mostly effective in ensuring allergy information is updated post-discharge from hospital. Implementation of an allergy clinic at Northern Health would assist in refining the quality of allergy documentation in both the hospital's, and GP's records, beyond a patient's hospital admission.

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