

Allergy Report: A Hallmark of Safe prescribing

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ABSTRACT

Documenting allergy is an important element of patient safety and quality clinical practice. Proper entries of allergy to drugs and unfavourable reactions will lessen the possible harm that can be avoided, improper prescriptions, and severe anaphylaxis incidents. Incomplete/unclear documentation of allergy is a persistent issue in healthcare systems across the globe in spite of its significance in the system. Drug charts and clinical notes too often do not differentiate between the real allergy reaction and the non-allergic adverse reaction causing confusion among the prescribers and nurses. This is not only a breach of patient safety, but can also make unnecessary restrictions on the utilization of necessary drugs. There is an urgent need of standardized method to document unfamiliarity of allergy ratings, and indicating clearly the name of drug, type of response, severity, and date of onset. More so, the health workers need to be trained to understand the dissimilarity between intolerance and allergy, and to document the same information throughout medical records. When implemented in combination with diligent bedside practices, modern electronic prescribing systems can equip an organization with the means of decreasing ambiguity levels and facilitate inter-team communication accuracy. Finally, documenting allergies is a bureaucratic undertaking which is a lifesaving practice. A culture where a clear, precise and up to date recording of allergy is given importance would mean that the patient receives safe effective and personalized care.

KEY WORDS: Documentation about allergies, drug allergy, patient safety, drug charts on prescriptions, drug errors, adverse drug reactions

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INTRODUCTION :

Harm in healthcare due to drug allergies is a huge element of negative effects that are avoidable. Documentation of allergies correctly and in a timely and accurate fashion is thus one of the foundations of safe prescribing and patient-centered care. Yet even in the context of the further development of electronic health systems and clinical governance, cases of failure in the detection of allergies have been reported. These multiple mistakes are usually associated with missing entries, imprecise descriptions, or an inability to add information to the records in case of the discovery of new allergies[1-3].

Most hospitals store allergy records in a variety of locations: drug violations, electronic prescriber, and medical records. However, changes in agreement in these records have continued to be an issue. As an illustration, the patient drug record may show allergy to penicillin with no description of the reaction, whereas the clinical note may be penicillin rash. These misinterpretations can be confusing to clinicians and can lead to careless re-exposure to a harmful drug or unjustified avoidance of an effective and safe drug. The two situations jeopardize safety and the outcome of treatment[4].

Flowchart: Steps in Allergy Documentation

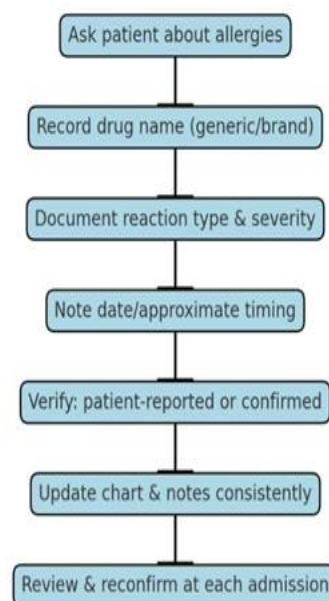


Fig 1:Steps in allergy Documentation

Documenting allergy should not be performed by just typing the name of a drug. Clinicians should define what kind of reactions is present (e.g., rash, anaphylaxis, gastrointestinal intolerance), how severe it was, and whether confirmed or suspected. This difference is truly crucial, since most patients who were considered to be allergic to antibiotics, especially penicillin are not really allergic, but suffered side effects. The wrong termination of the patients causes a broad spectrum antibiotic to be used, put away antimicrobial resistance and raising healthcare expenditure[5, 6].

These challenges need training, frequent audits, and creation of awareness conducted by multiple disciplines. The bottom line is that the process of allergy documentation is not supposed to be a clerical responsibility but instead, it is the fundamental role on

clinical practice integration- essential to patient safety and a means of ensuring desirable therapy results[7].

Highlights:

- Documentation of allergy lessens avoidable mishandling and prescription mistakes.
- Handwriting in documentation should be clear, specific and the same.
- There is need to distinguish between an allergy and intolerance.
- Unhealthy written guidelines cause a wasteful evasion of safe medications.
- Systems of training and audit enhance accuracy and compliance.

Major Heading: The Need for Precision in Allergy Documentation

Only when it comes to recording allergy preciseness is not a choice but a tenet. It is not sufficient to record drug name in Alergies, because it will not give a situation concerning clinical decision making. One such difference is the distinction between mild rash and anaphylaxis, which is life altering, but in most drug charts the distinction is not outlined. Likewise, the communicative signal of opioid allergy, although with no details, would not allow a patient to get the necessary analgesia in case of the scarcity of alternatives[8].

Formal strategy should thus be taken. Any allergies record must contain:

1. Drug name (generic and brand if relevant).
2. Type of reaction (rash, anaphylaxis, gastrointestinal upset).
3. Severity (mild, moderate, severe, life-threatening).
4. Date/approximate timing of reaction.
5. Verification (patient-reported, confirmed clinically, or documented previously).

This accuracy eradicates uncertainty, enhances interprofessional communication, and the patient will not be subject to avoidable risk. Inclusion of this framework in paper and electronic systems is necessary in order to achieve a safer area of health care.

CONCLUSION:

Allergy documentation is an easy but a very significant part of patient safety. Effective documentation is based on clarity, precision and consistency and this should be taken by healthcare professionals very seriously. When healthcare systems are structured with records, multidisciplinary training and continuous audit, the decreasing factor of preventable harm is considerably achieved. After all, an allergy documentation is not only a paper but a security device that guarantees patients receive the appropriate treatment when and where it is most needed without taking unnecessary risks in the process[9, 10].

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