Recording of Allergies and Adverse Reactions

Note that under the *RACGP Standards*, practices must keep a record of known allergies for at least 90% of their active patient health records (Criterion QI2.1 – Health Summaries reads: "*Our active patient health records contain a record of each patient's known allergies.*") If a patient has no known allergies, a practitioner must verify this with the patient and then record 'no known allergies'. **RACGP Allergy guidelines**

Opportunities for recording and maintaining updated information regarding allergies:

- New patient form and entered into clinical software by GP at first consult
- Social & Lifestyle template completed annually or following a period of absence
- Prior to prescribing any medication or issuing a repeat prescription
- Prior to administering any medication in practice (e.g. vaccines, local anaesthetic)
- Before applying any topical treatment or dressing product (e.g. query latex, adhesive)
- Before uploading a shared health summary to My Health Record
- Annually during Health Assessments
- When performing a GP Management Plan or Team Care Arrangement
- During medication reviews
- On becoming aware that the patient's allergy or adverse reaction status has changed. For example, patient self reported or noted in a discharge summary from another healthcare provider

Allergy recording is the responsibility of every member of the practice team. Allied Health providers contributing to the patient's clinical records should also update allergy status within their scope of practice.

Why is correct clinical coding important?

If allergies and adverse reactions are not captured as structured data within your clinical information system, you may miss contraindications if you are prescribing, and important information about the severity of a reaction. To improve the data on allergies and adverse reactions, you should first differentiate between the two when you enter the patient's information in your clinical information system. Second, you should code the severity of the reaction and the nature of the reaction. **RACGP Allergy guidelines**

The primary purpose of improving the data in health records is to provide safe and high-quality healthcare for individuals and practice populations.

However, there are a range of other benefits for improving the quality of data within health records:

- It can improve communication between healthcare professionals
- It makes it easier for patients to understand their healthcare information
- It allows for efficient management of recalls and reminders
- It may be helpful for defending medico-legal claims
- It gives general practices a better understanding of their patient cohort.

Data quality is also linked to accreditation under the *RACGP Standards for general practices, 5th edition.* **RACGP benefits of improving health record data**