Tuesday Talks with John

ALLERGY DOCUMENTATION IN THE MEDICAL RECORD

Early in my career, I was given some great advice... "*Document, document, document".* Correct and complete documentation is essential to delivering patient care in a safe environment. But sometimes it becomes difficult to keep track of *everything* that you're supposed to be documenting!

An important component of documentation are drug allergies. Patient drug allergies **and** associated reactions must be documented in the medical record and can not be overlooked. CMS Conditions for coverage section 416.47(b) requires documentation of drug allergies AND their reactions. Section 416.52(a)(1) states that drug allergies and reactions must be included in the patient's history & physical.

In addition to the H&P, the patient's pre-surgical assessment must include documented known drug allergies and reactions (416.47(a)(2)). This pre-surgical assessment, including information about drug allergies, must be

repeated for each separate admission/ procedure, even if the answer is "NKDA".

The Joint Commission and AAAHC both require centers to place known drug allergies and their reactions in a "highly visible location in the patient's chart", which is commonly interpreted as the front of the chart. *Be sure to include drug reactions* as well as the designation for known drug allergy.

Reference these documents to learn more:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_l_ambulatory.pdf

https://www.jointcommission.org/assets/1/18/SEA_35.PDF

https://www.beckersasc.com/asc-accreditation-and-patient-safety/10-of-the-most-challenging-aaahc-a-medicare-standards.html

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[609-313-7572] [JOHN@JDJCONSULTING.NET] [www.JDJConsulting.net]