MEMORANDUM

To: Harvard Pilgrim Primary Care Physicians

From: Roberta Herman, MD 
Chief Medical Officer and Senior Vice President for Health Services

Date: November 15, 2005

Re: Opportunity to improve documentation of drug allergies and adverse reactions

Since the release of the landmark Institute of Medicine report, “To Err is Human,” in late 1999, which focused on preventable inpatient medication errors, much attention has been paid to improving the safety of medication prescribing. At Harvard Pilgrim Health Care, we have focused our patient safety efforts over the last number of years on Reducing Outpatient Medication Errors (ROME). We have put in place a multi-faceted ROME program that addresses anticoagulation monitoring and medication reconciliation after hospitalization. We have also been working for several years to improve the documentation of drug allergies and side effects in ambulatory care, and I am again writing to ask for your help with this important matter.

**Issue Identified**  – As you are well aware, the complete and current documentation of medication allergies and adverse reactions in a patient’s medical record is one of the basic ways to reduce the likelihood that a patient will experience medication problems that can lead to significant complications or to patient non-compliance with appropriate treatment. Yet in Harvard Pilgrim’s most recent random chart audits, performed to assess compliance with its medical record documentation standards, only 76% of patient charts included prominent documentation of the presence or absence of patient allergies and adverse reactions. Since Harvard Pilgrim began conducting chart audits in the 1990’s, performance on this important safety measure has consistently fallen below Harvard Pilgrim’s compliance target of 80% or better. It should not be surprising that failure to document the absence of drug allergies and adverse reactions using an “NKA” notation, is a major contributing cause of these low rates. Our audit results are much lower than those of a recent study published in the January 2005 issue of Medical Care that found “Allergies prominently noted” in 90.3% of the nearly 3,500 charts reviewed during an assessment of medical records in primary care practices in Ohio. Although there has been improvement on this standard over the years that Harvard Pilgrim has been measuring, more needs to be done.

**Research on Adverse Drug Events in Ambulatory Care** – Although the most serious medication errors generally occur during inpatient hospital stays and much research has focused there, drug-related problems are common in the outpatient setting. They are also, increasingly, a basis for outpatient malpractice allegations, with nearly 10% of office-based liability cases being drug-related. An article, published in 2000 in the Journal of General Internal Medicine, based on research done largely by the Division of General Medicine at Brigham and Women’s Hospital, found that reported drug complications were common among the outpatients surveyed, but that most were not documented in the medical record. There were clearly preventable errors among those studied – 13% of the drug complications affected patients for whom there was a prior allergic or other reaction to the prescribed drug already documented in the medical record. Among those reporting a drug complication, 35% reported that their medication had not been changed following the occurrence of the problem and 20% indicated that their symptoms...
continued for more than three months. A follow-up study by the same research team, published in the *New England Journal of Medicine* in April 2003, found a 25% prevalence of adverse drug events, many preventable or ameliorable, among patients of adult medicine practices in Boston.

**Impact on patients** – A finding from the first Boston study was that a third of the patients experiencing drug complications reported interference with work, leisure or activities of daily living (35%), and about half sought medical attention and experienced worry or discomfort (48% and 49%, respectively). The researchers suggest that physicians may take for granted the types of complications reported by most patients in the study (classified generally as “significant,” not severe or life-threatening), and may underestimate the effect these drug complications have on patients’ quality of life, health care utilization and overall satisfaction with care. The second study found that 63% of ameliorable drug events were attributable to the physician’s failure to respond to medication-related symptoms reported by patients, with the other 37% attributable to patients’ failure to report drug-related symptoms to their physicians. The study recommended the development and use of better methods to identify, monitor and document drug side effects in order to reduce the incidence of these events that can have serious consequences.

**Use of allergy stickers** - For practices using paper records, the routine use of brightly-colored allergy stickers, placed on patient records so that they are not obscured by other objects, is a good way to address allergy documentation. Stickers must be readily available in each exam room in order to be widely used. Including an “NKA” (No Known Allergies) option on these stickers is the best way to increase documentation of the absence of allergies and adverse reactions.

**Keep information up-to-date** - Allergy information is only useful if entries are dated and updated regularly, something that the office staff can do as part of the patient check-in process. By asking patients *“Is there any drug that we shouldn’t give you for any reason?”* office staff can efficiently elicit both drug allergy and side effect information from patients in a way that eliminates confusion about whether a given reaction is really an allergy, or a side effect. The key point is that either should be documented in the record because both are important to patient care.

**Educating our members** - In addition to communicating with primary care physicians in our network about this issue, we will also be reminding our members of the role they play in facilitating the safe delivery of their own care. An upcoming issue of our member newsletter will reinforce how members can work more actively with their physicians to increase the safety and effectiveness of their care, and we trust you will welcome your patients’ interest and involvement. Among other things, we are:

- urging our members to be sure that all their doctors know about all the medicines they are taking, and whether they’ve experienced any allergic reactions or side effects from any of them, including all prescription and over-the-counter drugs and dietary supplements,
- urging patients to ask their doctors about how, when and how long to take their medicines – and what side effects to look for – in terms they can understand and will remember easily.

**Collaborating for improvement** - We look forward to continued collaboration work with our physician network to address allergy documentation and hope our members will be encouraged to discuss any drug allergies or side effects with you. We’d like to hear about any “best practice” that you would like to share related to drug allergy documentation. You can contact us with best practice information or other feedback at the Web address or phone number listed below.

**For more information** - For more about the ROME project or links to the articles cited, log onto our Provider Web site at [www.harvardpilgrim.org/providers](http://www.harvardpilgrim.org/providers). Click on Medical Management; select Medical Records Quality (articles) or Patient Safety (ROME). For a paper copy of any of the above, please call 617-509-7564. Harvard Pilgrim Health Care’s Medical Record Standards are enclosed for your review. They can also be found on our Web site and in our Provider Manual.