**Use Case Title**

No known allergy/intolerance

**Use Case Description**

The purpose of this use case is to support the documentation of the assertion by patient or his/her guardian that there, to the best of his/her knowledge there is no known history of allergy or intolerance and adverse reaction to medications or substance.

The information is then captured in hospital clinical information systems/EHRS; and to support the generation and exchange of such information in a hospital discharge summary.

**Conditions**

A patient involved in a minor motor vehicle accident (MVA) presented at the Emergency Department for treatment and is assessed for history of allergy/intolerance to any medications, foods and environmental agents as part of medical history assessment and examination procedures.

**Exclusions**

Patient with positive history of allergy/intolerance or adverse reaction to one or more medication(s) or substance(s).

**Preconditions**

Patient presented to hospital with for care/treatment.

The hospital uses electronic medical record systems supporting the documentation of the adverse reaction event, management and revision of allergy/intolerance list

Hospital electronic clinical information system/EHRS capable of generating and transmitting electronic discharge summary

**Sequence of Steps**

Patient presenting to ED

Patient was assessed with full medical history taking and physical examination by attending physician

History of allergy/intolerance to any medications, foods and environmental agents is assessed as part of the medical history taking

Patient condition was diagnosed, treatment was given

Documentation of presenting problem, medical history, medication history, treatment and outcomes with creation/update of allergy/intolerance lists in hospital clinical information system or EHRS

Discharge summary generated using hospital clinical information system or EHRS

**Post Conditions**

Updated EHRS record with “no known allergy/intolerance” entry to allergy/intolerance list

Hospital discharge summary includes “no known allergy/intolerance and adverse reaction” information

Patient also offered the option of updating his PHR with “no known allergy/intolerance and adverse reaction” information

**Use Case Scenarios**

A 45-year retired male footballer had a minor collision with a taxi while riding his bicycle into an intersection of a road and suffered from minor concussion. He was taken to the ED of a local hospital by an ambulance.

This was the patient’s first encounter at the hospital ED.

His *presenting complaints* include:

Momentary loss of consciousness for approximately 1-2 minutes immediately after collision

Mild headache with no nausea, no vomiting

Bruises to left shoulder, left upper arm and antero-lateral aspect of left lower chest

Skin abrasions on anterio-lateral aspect of left leg with moderate to severe pain

*Medical History*:

Bilateral secondary osteoarthritic knee (sports injuries related)

Otherwise relatively healthy male with regular exercises.

Patient was asked the following questions on any allergy/intolerance and adverse reaction details:

Had the patient ever experienced any [allergic/intolerance] bad reaction(s) to the following agents?

* Any medications – prescribed, over-the-counter, naturopathy/herbal substances
* Any foods or food ingredients
* Any environmental agents such as animal hair/fur or dander

If the patient had never experienced any allergic/intolerance reactions to the above substances/agent, had the patient ever been told, e.g. by parents/guardians that he previously had suffered any such allergic/intolerance reactions or known to have the condition?

Patient answered no to the above questions. And it was concluded that patient had denied **any known history of allergy or intolerance** to any medication or substance

Denied any relevant family medical history.

*Medications*:

Glucosamine sulphate: 1500mg per day

Chondroitin sulphate: 800mg per day

Fish oil 4000mg two times per day

Panadeine Forte (paracetamol 500mg + codeine phosphate 30mg) 2 tablets 6 hourly whenever necessary for knee pain relief

*Physical Examinations*:

Blood pressure: 145/85 mmHg (likely to be stressed related)

Heart: rate = 92/min, no murmur, no added HS, ECG = sinus rhythm, no ischaemia

Neurological:

Minimal concussive amnesia

Moderate headache

No convulsion

No photophobia

No muscle weakness

No sensory loss

No nausea, no vomiting

Pupils: R+L = approx. 4mm, equal and briskly reactive to light

Neck: no bruise, no haematoma, skin intact, no tenderness, no limitation to range of motion

Left shoulder, upper arm and chest revealed bruises

Shoulder joints, elbow joints, wrist joints, hip joints, knee joints, ankle joints: no swelling, no tenderness, no limitation to range of motion

Left leg: skin abrasion measuring 5cm X 12cm with uneven depth of dermal loss consistent of abrading injury

Respiratory, CNS, Abdomen/GI, Genito-urinary: NAD

*X-Rays*:

Skull – reviewed no bony injury

Chest – reviewed no bony injury

Left shoulder, upper and lower arms and hand – reviewed no bony injury

Left femur; tibia and fibula – reviewed no bony injury

*Diagnosis*:

Motor vehicle accident induced injuries including:

Mild concessional injury

Abrading injury to skin of left anterio-lateral aspect of left leg.

*Treatment*:

Hourly neurological observations for 4-6 hours

Paracetamol 1000mg 6 hourly

Surgical toilet and dressing to abrading skin injury

Discharge to care of General Practitioner after completion of neurological observations confirming no adverse neurological consequence

*Outcomes*:

Surgical toilet and dressing given to skin wound.

The allergy/intolerance list was updated with entry of “no known allergy/intolerance to medication or substance.

Patient discharged home with non-narcotic analgesic (e.g. paracetamol)

Hospital EHRS on this patient is updated with “no known allergy/intolerance to medication or substance” information

Discharge summary sent to GP including “no known allergy/intolerance to medication or substance” information.

Patient was offered the opportunity for his PHR to be updated with the latest medical history including the “no known allergy/intolerance and adverse reaction” details