

WHITING FORENSIC HOSPITAL
Nursing Policy and Procedure Manual

SECTION F: MEDICATION POLICIES & PROCEDURES
CHAPTER 23: MEDICATION MANAGEMENT

Policy and Procedure: 23.10 ALLERGY DOCUMENTATION

Standard of Practice:

The nurse will ensure that patients are assessed for known allergies and that this information is communicated and documented according to policy.

Standard of Care:

The patient can expect to have his/her known allergies communicated and documented in the patient's medical record.

Policy:

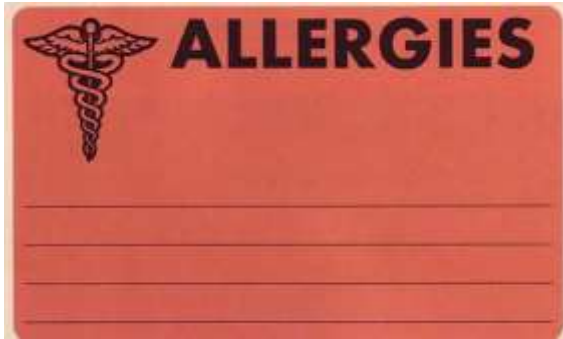
Assessments of patients identified allergic reaction(s) will be recorded on an allergy sticker and placed in the patient's medical record.

Procedure:

1. The nurse will inquire with the patient as to whether he/she has known allergies to medications and foods on admission.
2. The nurse will review the MD Order Sheet, any patient assessment information received and document identified allergy/allergies on the WFD identified allergy Sticker (see attached).
3. The nurse will document the patient's name, unit and allergenic agent on the allergy sticker.
4. The nurse will affix the completed allergy sticker in specified areas of the medical record:
 - Front cover center square of medical record binder
 - Inside front binder, top left corner
5. The nurse will also document identified allergy (allergies):
 - Medication Administration Record, in the Red Box: Allergic to
 - MD Order Sheet
 - Compare against PYXIS system
 - Transfer Note
 - Discharge Note
 - Interagency Referral Form
6. The nurse will notify the physician concerning all known allergies and whenever additional allergies are identified. Additional allergies shall be added to the patient's clinical folder in PYXIS.

7. All allergies will be documented as per the procedure identified above and new allergy stickers are to be utilized as necessary.

Item #: MAP486



"ALLERGIES" FL.Red 4" x 2-1/2" - 100/roll