

### Purpose and Scope

To prevent patient exposure to known allergens and ensure that allergies/intolerances are documented in the patient chart and accessible to all disciplines involved in the patient's care.

### Policy

All patients will be assessed for allergies and intolerances to medication and food. Hospital personnel will identify, and document all known allergies/intolerances including the reaction if known.

### Procedure

**Definition:** Allergic reaction (to a medication or food): an immunologic hypersensitivity occurring as the result of unusual sensitivity to a drug (or food) (Best Practices for Health-System Pharmacy).

**Intolerance:** Patient has a reaction to the food/drug that precludes consumption.

#### A. Nursing Responsibilities:

1. Allergies/intolerances to known substances, medication, food, and insect bites must be documented on the following:
  - a. Medication order sheet(s) by the medication nurse
  - b. Nursing Assessment Sheet (Interdisciplinary Assessment) by the R.N. on the unit
  - c. Medication administration record and treatment record by the medication nurse.
  - d. Allergy/intolerance label affixed to the chart cover next to patient's name by the ward clerk.
2. If there are no allergies/intolerances, the initials NKA for "no known allergies" will be noted on the above documents.
3. Additional allergies/intolerances that have been identified by the treatment team must be added to the above as they become evident. The physician will write, date, and sign an order on the medication order sheet stating the new allergy/intolerance.
4. When it becomes evident that a patient is no longer allergic/intolerant to a stated medication/food, the allergy/intolerance is removed from

the above documents once the physician writes, dates and signs an order on the medication order sheet stating they are not allergic/intolerant.

#### B. Physician/Prescriber Responsibilities:

1. Upon admission, the physician/prescriber will list all food and drug allergies/intolerances on the medication reconciliation form, medication/ancillary order sheets and on the initial set of admission orders [Admission Order Sheet- Initial Plan of Care]. The nurse will list all food and drug allergies/intolerances on all subsequent medication order sheets.
2. The somatic physician/prescriber is responsible for documenting allergies/intolerances on the "Somatic Admission History and Physical" form.
3. When it becomes evident that the patient has developed a new allergy/intolerance, the physician/prescriber will write, date, and sign an order on the medication order sheet stating the new allergy/intolerance and describing the reaction.
4. In the event an allergy/intolerance is recorded, and it becomes evident that the patient is not allergic to the agent, the physician/prescriber will write, date, and sign an order on the medication order sheet stating that the patient is not allergic/intolerant to the agent.

#### C. Pharmacy Responsibilities:

1. The pharmacist will review all medication orders and medication reconciliation forms for allergy/intolerance information.
2. Medication allergy/intolerance information will be entered in the pharmacy computer system and used to screen medication orders.
3. The pharmacist will contact the physician/prescriber if an order is written for a medication that is listed in the allergy/intolerance section and request a clarification.

**References**

- Forms: Medication Order Sheet
- Non-Medication Order Sheet
- Ancillary Medication Order Sheet
- Dental Medication Order Sheet

**Approved by**



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Date



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