

## **Allergies Documentation in CRIS**

In CRIS, there are two steps for Nurses to document the patient's allergy:

1. The first step is to document the Clinician's allergy discussion with the patient, as per JCAHO requirement, in the Admission Assessment Note. The clinician will document that they have actually asked the patient about their allergy status as required per Unit's policy.
  2. The second step is to document the actual allergy in the **Patient Info** tab. The Patient Info tab is equivalent to the late *General* Information in MIS. The data entered in here will go across visits and will be viewed and shared by all member of the interdisciplinary team. For example, Pharmacy, Nutrition, Radiology, etc will be looking in this Tab to verify patient's allergies.
- *Both steps need to be done for the patient's initial and each recurrent visit.*

When Documenting an Allergy there are three bolded mandatory fields in the Allergy Form that must be entered:

- a. **Type**
- b. **Allergen**
- c. **Reaction**

**NOTE:** The most serious reaction needs to be entered in the Reaction field. This field allows only one entry. Any further reaction noted, must be entered in the Comments field.

### **Needs Allergy Assessment**

All patients migrated from MIS will need their Allergy entered in CRIS. The default in their allergy information tab displays "**Needs Allergy Assessment**". This was added to the patient's record during data migration and needs to be updated the first time a patient is seen after CRIS is live. On the first patient encounter, the **Needs Allergy Assessment** allergy should be discontinued and the actual patient's allergies added.

### **Mark Allergies Reviewed**

Once allergies have been discussed with the patient, they can be marked as reviewed. The "**Unreviewed allergies**" will display until the "**Mark as reviewed**" button on the Allergy Summary View pane is clicked off. The red message will then disappear from the patient's Header. Whenever the patient's visit closes and a new visit is opened, the **red** message will display again for that new visit. The same will occur to every new patient entered in the CRIS.

## ***Maintain Allergy Information***

You can add patient allergies by clicking the **Allergy** data entry option under the Patient Info tab. For example, if you've been informed that a patient has a penicillin allergy, you would **first check** to see if the allergy has been entered by looking at the **Allergies/Comments** in the **Summary View**.

### **On the Admission Assessment Notes:**

- 1- Select Patient on the **Patient List**
- 2- Select the **Enter Document** Icon
- 3- From the **Start of the Browser**, click on the **plus** sign next to **Nursing**
- 4- Select **Admission** from the list
- 5- High light the **Admission Assessment Note** on the right side and click **Open**. The admission assessment note document will display
- 6- Under the **Allergy History** address the allergy assessment questions:
  - a. Patient reports allergies to Med/Food/Environment
    - Yes
    - No
  - b. Allergy band applied on Patient
    - Yes
    - No
    - No Known Allergy
  - c. Note: "Document Patient Allergies in the Patient Information Tab"
- 7- **Save** and **close** once finished entering the admission assessment Note
- 8- With the same assigned patient, select the **Patient Info** tab

### **Patient Info Tab:**

#### **To add an allergy**

1. Under the **Patient Info** tab select Allergy under the **Data Entry** list,.. The **Allergy (Adding New)** dialog box opens.
2. Select a **Type** from the drop-down list.
3. Select an **Allergen** from the drop-down list.
4. Select a **Reaction** from the drop-down list.
5. If desired, enter a **Description** of the allergy.
6. If desired, select a **Confidence Level** from the drop-down list.
7. If desired, select an **Information Source** from the drop-down list.

8. If desired, enter the name of the person who confirmed the allergy in the **Confirmed By** field.
9. Click **OK**.

### To edit an allergy

1. Under the **Patient Info** tab, **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Make the desired edits. Note that you cannot edit the **Type** or **Allergen**.
4. Click **OK**.

The screenshot shows a software dialog box titled "Allergy (Adding New)". At the top, there are two dropdown menus: "Type" set to "Environmental" and "Status" set to "Active". Below these are several input fields: "Allergen" with a dropdown menu showing "Latex or rubber", "Reaction" with a dropdown menu showing "Rash", "Description" with a large empty text area, "Confidence Level" with a dropdown menu showing "Observed", "Information Source" with a dropdown menu showing "Caregiver", and "Confirmed By" with an empty text field. To the right of the "Information Source" and "Confirmed By" fields are two buttons: "Add New" and "Apply". At the bottom of the dialog, there are two text boxes labeled "Entered:" and "Last Modified:". Below these are five buttons: "OK", "Cancel", "Discontinue", "Delete", and "Help".

### To discontinue an allergy

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Click **Discontinue**.
4. Click **OK**. The status of the allergy changes to **Inactive**.

**To delete an allergy (Training Note: Delete only if allergy entered on an incorrect patient)**

1. Under the **Patient Info** tab, **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Click **Delete**. A confirmation message displays.
4. Click **OK**.

## Needs Allergy Assessment

To discontinue the Needs Allergy Assessment allergy

1. Under the **Patient Info** tab **Summary Views** list, select **Allergies/Comments**.

Double-click the Needs Allergy Assessment allergy and click **Details**. The **Allergy Details** dialog box opens

The screenshot shows the 'Allergy Details' dialog box. At the top, there is a title bar with the text 'Allergy Details' and a close button. Below the title bar, there are two fields: 'Type:' with a dropdown menu set to 'Other' and 'Status:' with a dropdown menu set to 'Active'. The main area of the dialog contains several fields: 'Allergen:' with a dropdown menu set to 'Needs Allergy Assessment', 'Reaction:' with a dropdown menu set to 'Unknown', 'Description:' with a text area containing 'Other', 'Confidence Level:' with a dropdown menu, 'Information Source:' with a dropdown menu, and 'Confirmed By:' with a text field. To the right of these fields are two buttons: 'Add New' and 'Apply'. At the bottom of the dialog, there are two fields: 'Entered:' and 'Last Modified:', both containing the text 'Bove, Lisa (MD) 5/26/2004 08:11'. At the very bottom, there are five buttons: 'OK', 'Cancel', 'Discontinue', 'Delete', and 'Help'.

2. Click **Discontinue**.
3. Click **OK**. The status changes to **Inactive**.
4. Add patient allergies as needed.

## Mark Allergies Reviewed

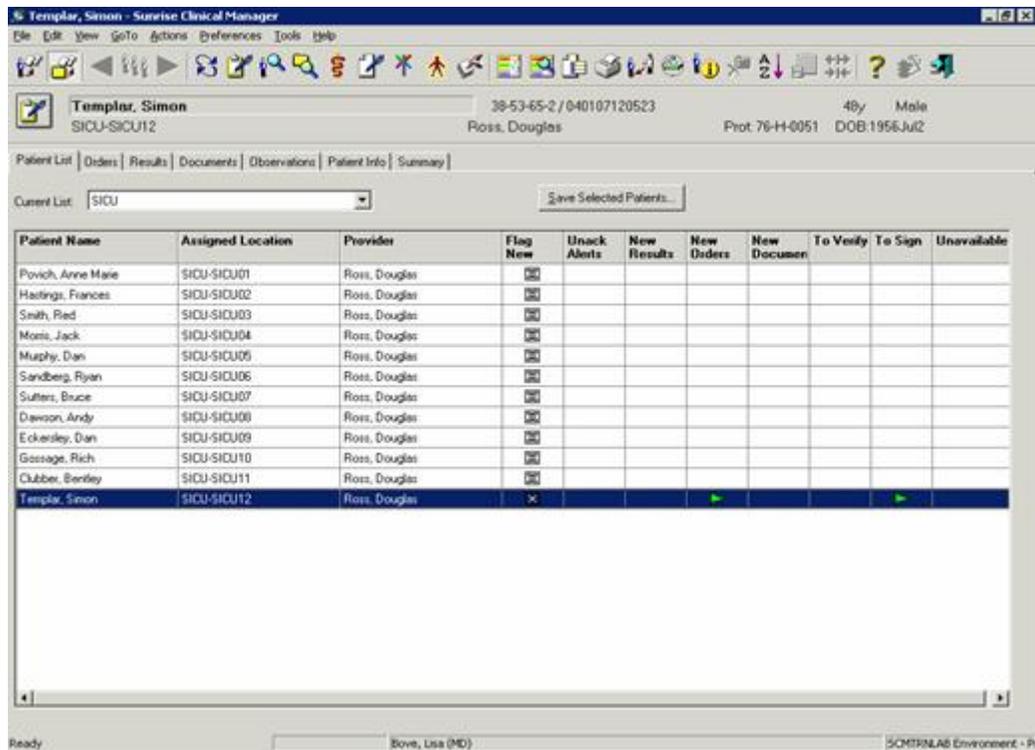
Once allergies have been discussed with the patient, they can be marked as reviewed.

### To mark all new allergies as reviewed

Do one of the following:

1. **Under the Patient Info tab** section **Summary Views** list, select **Allergies/Comments**, and click **Mark as Reviewed**.
2. In the **Allergies Summary** dialog box, click **Mark as Reviewed**.

Once an allergy is reviewed, the patient header changes.



The screenshot displays the Sunrise Clinical Manager interface for patient Simon Templar. The patient's information is shown at the top: 38-53-65-2 / 040107120523, 48y Male, Prot: 76-H-0051, DOB: 1956Jul2. The interface includes a menu bar, a toolbar, and a patient list table. The table has columns for Patient Name, Assigned Location, Provider, Flag New, Unack Alerts, New Results, New Orders, New Documents, To Verify, To Sign, and Unavailable. The patient Simon Templar is highlighted in blue, indicating he is the current patient.

Patient Name	Assigned Location	Provider	Flag New	Unack Alerts	New Results	New Orders	New Documents	To Verify	To Sign	Unavailable
Povich, Anne Marie	SICU-SICU01	Ross, Douglas	<input type="checkbox"/>							
Hastings, Frances	SICU-SICU02	Ross, Douglas	<input type="checkbox"/>							
Smith, Ried	SICU-SICU03	Ross, Douglas	<input type="checkbox"/>							
Morris, Jack	SICU-SICU04	Ross, Douglas	<input type="checkbox"/>							
Murphy, Dan	SICU-SICU05	Ross, Douglas	<input type="checkbox"/>							
Sandberg, Ryan	SICU-SICU06	Ross, Douglas	<input type="checkbox"/>							
Statters, Bruce	SICU-SICU07	Ross, Douglas	<input type="checkbox"/>							
Dawson, Andy	SICU-SICU08	Ross, Douglas	<input type="checkbox"/>							
Eckersley, Dan	SICU-SICU09	Ross, Douglas	<input type="checkbox"/>							
Gossage, Rich	SICU-SICU10	Ross, Douglas	<input type="checkbox"/>							
Clubber, Bentley	SICU-SICU11	Ross, Douglas	<input type="checkbox"/>							
Templar, Simon	SICU-SICU12	Ross, Douglas	<input checked="" type="checkbox"/>							