SOP · ALR-SOP-001 · Version 1.0 · Approved by the ASF Expert Committee

Supports: 53.1

At a glance

- Every patient has an allergy history taken and recorded before any drug, product or allergen is given (ALR-FRM-001).
- The history records the agent, the reaction and its severity, and the date.
- The record is checked and updated at each new prescription and each change of condition.
- A patient with no known allergy is recorded as such, with the date checked.
- Stop and get help straight away if: a drug, product or allergen is given to a patient whose allergy history is not recorded.

1. Purpose

To make sure every patient’s allergies are known and recorded before anything that could trigger a reaction is given (53.1).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of the facility
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions

Term	Meaning
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background

To make sure every patient’s allergies are known and recorded before anything that could trigger a reaction is given (53.1).

5. Responsibilities

Role	Responsibility	Competence
Treating clinician	Takes and records the allergy history	Clinical lead
Nurse	Checks the record before each administration	Treating clinician

6. Materials and equipment

Item	Requirement	Condition
Records and forms named in this document	Current version	Checked before use

7. Safety

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Step 1. Ask.

- Ask about allergies to drugs, products, foods and other agents, and about past reactions.

Key point: Asked.

Step 2. Record.

- Record each allergy with the agent, the reaction, its severity and the date (ALR-FRM-001).

Key point: Recorded.

Step 3. Check.

- Check the record before each new drug or product is given, and update it at each change.

Key point: Checked.

10. Decision points

- No decision points in this procedure.

11. Special situations

Situation	Action
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

12. Escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

13. Monitoring

Measure	Target	Frequency	Owner	If not met
Patients with an allergy history recorded before first administration	100%	Monthly	Clinical lead	Escalate to the hospital director
Records checked at each new prescription	100%	Monthly	Clinical lead	Review the record before the next dose

14. Records

Record	Kept in	Retention
Record named in this document	Patient record or the area file	the period set by the facility’s records policy years

15. Training

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

16. Related documents

ID	Title	Use
ALR-FRM-001	Allergy history record	Record
HOS-POL-001	Medicines management policy (existing, reused)	Policy

17. Evidence

Reference	Note
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

18. Change history

Version	Date	What changed	Approval
1.0	the date of approval	First version	set Expert Committee approval

E-learning for this document

- **Allergy & Immunotherapy Safety Endorsement** (AMB-18)

References

- Accréditation Sans Frontières (2026). ASF Policy Framework v1.2. (E-006)
- Accréditation Sans Frontières (2026). ASF Expert Committee consensus on Standard 1. (E-009)

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