OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS

Allergic Reaction/Anaphylactic Emergency

Subjective Data: Allergies: __________________________
Chief complaint: _____________________________________________________________________

Type of reaction:
☐ Itching
☐ Skin redness (rash/hives)
☐ Known allergen exposure

Describe:_________________________________

Current medication(s): ______________________________________________________________________________

Objective Data: (clinically indicated VS)
BP _________ Pulse _________ Resp. ________ Temp. ________ Wt._______O2 sats._________ FSBS: ___________

Respiration
☐ Even
☐ Uneven
☐ Labored
☐ Unlabored
☐ Shallow
☐ Deep
☐ Use of accessory muscles

Lung Sounds
☐ Clear
☐ Rhonchi
☐ Wheezes
☐ Diminished
☐ Rales

Skin
☐ Warm
☐ Pink
☐ Cool
☐ Pale
☐ Cyanotic
☐ Mottled
☐ Diaphoretic

LOC
☐ Awake
☐ Alert
☐ Oriented X___
☐ Confused
☐ Lethargic
☐ Comatose

Swelling
☐ Tongue
☐ Throat
☐ Facial
☐ Extremities
☐ Generalized

Appearance
☐ No distress
☐ Mild distress
☐ Moderate distress
☐ Severe distress

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IN ALL CASES OF ALLERGIC REACTION/ANAPHYLACTIC EMERGENCY: Health care provider must be called if not on site or if after clinic hours.

Anticipate health care providers need for the following: Intubation/airway management, IV access .9% normal saline, Epinephrine 1:1000 SC, CPR, Notify emergency department.

Emergency department notification time: __________ Transport time: _______ Transported by: ___________
Health Care Provider: ________________ Time Notified: _______ Orders Received for Treatment: ☐ Yes ☐ No

Plan: Interventions: (check all that apply)
☐ Check in assessment only for health care providers visit.
☐ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
☐ Give Benadryl 50 mg p.o. or IM as soon as possible (this will require an order from the health care provider)
☐ Provide IV access (if clinically indicated) (this will require an order from the health care provider)
☐ Encourage increase fluids.
☐ Re-evaluate frequently for at least the next 4 hours.
☐ Record ER assessment/treatment, copy and send to emergency department with patient.
☐ VS every 5 –10 minutes until transported:
Time: _________ BP _________ Pulse: __________ Resp: __________ Temp: ________ O2 Sats: __________
Time: _________ BP _________ Pulse: __________ Resp: __________ Temp: ________ O2 Sats: __________
Time: _________ BP _________ Pulse: __________ Resp: __________ Temp: ________ O2 Sats: __________

☐ Education/Intervention: Instructed on treatment provided, patient to wear allergy bracelet, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: ___________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Health Care Provider Signature/Credentials: ________________ Date: __________ Time: _________
RN/LPN Signature/Credentials: __________________________ Date: __________ Time: _________

Inmate Name __________________________ (Last, First) DOC #