

## ALLERGY AND ANAPHYLAXIS IDENTIFICATION AND MANAGEMENT POLICY

		POLICY		
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	X			
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Author (Position & Name)	Corporate Practice Development Team			
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<b>Position of Person able to provide Further Guidance/Information</b>	Corporate Practice Development Team Resuscitation Training Manager Assistant Chief Pharmacist	
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<ol style="list-style-type: none"> <li>1. <a href="#">Adrenaline auto-injector counselling checklist</a></li> <li>2. <a href="#">Patient letter following a severe allergic reaction (anaphylaxis)</a></li> <li>3. NAP6 Anaesthetic Anaphylaxis Referral form and GP/Patient Information letter (<b>available from the Department of Anaesthetics only</b>)</li> </ol>	<p>With this policy (September 2021)</p> <p>With this policy (September 2021) (no changes to letter)</p> <p>Not reviewed – available only from the Department of Anaesthetics</p>	

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## 1.0 INTRODUCTION

An allergic reaction is hypersensitivity caused by exposure to a particular antigen (allergen) resulting in a marked increase in reactivity to that antigen on subsequent exposure, sometimes resulting in harmful reactions. The reaction may range from a mild attack of asthma or hay fever to severe dermatitis, gastroenteritis or shock that may cause death from breathing difficulties, circulatory collapse, and/or heart failure.

Allergic reactions are classified into four major types: type I (anaphylactic and IgE (Immunoglobulin E) dependent); type II (cytotoxic); type III (immune-complex mediated); type IV (cell mediated or delayed).

Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction. It is characterised by rapidly developing symptoms involving the airway (pharyngeal or laryngeal oedema) and/or breathing (bronchospasm with tachypnoea) and/or circulation (hypotension and/or tachycardia). In most cases there are associated skin and mucosal changes.

In emergency departments a person who presents with the signs and symptoms listed above may be classified as having a 'severe allergic' reaction rather than an 'anaphylactic' reaction. Throughout this guideline, anyone who presents with such signs and symptoms is classed as experiencing a 'suspected anaphylactic reaction', and should be diagnosed as having 'suspected anaphylaxis'.

People who have had a mild or moderate allergic reaction are at risk of, and may subsequently present with, suspected anaphylaxis. Certain groups may be at higher risk either because of an existing comorbidity (for example asthma) or because they are more likely to be exposed to the same allergen again (for example people with venom allergies or reactions to specific food triggers).

Anaphylaxis may be an allergic response that is immunologically mediated, or a non-immunologically mediated response, or idiopathic. Certain foods, insect venoms, some medicines and latex are common precipitants of IgE mediated allergic anaphylaxis. Many medicines can also act through non-allergic mechanisms. A significant proportion of anaphylaxis is classified as idiopathic, in which there are significant clinical effects but no readily identifiable cause. The relative likelihood of the reaction being allergic, non-allergic or idiopathic varies considerably with age.

The incidence of anaphylaxis is increasing. Recent UK data (Johansson et al, 2014) indicates that approximately 1:1333 of the English population have experienced anaphylaxis at some point in their lives. Guidelines produced for the treatment of anaphylaxis which will be referenced throughout this policy, are those of the Resuscitation Council UK (2021).

## 2.0 POLICY STATEMENT

The aim of this policy is to provide clear, current guidance for the recognition and treatment of an allergic reaction with or without anaphylaxis.

### 3.0 DEFINITIONS/ ABBREVIATIONS

<b>Allergic Reaction</b>	An allergic reaction occurs when the immune system overreacts to a harmless substance known as an allergen. This triggers the production of antibodies called Immunoglobulin E (IgE)
<b>Anaphylaxis</b>	A severe, life-threatening, generalised or systemic hypersensitivity reaction
<b>The Trust</b>	Sherwood Forest Hospitals NHS Foundation Trust
<b>Clinical Staff</b>	All employees of the Trust working in a clinical role, including those managed by a third party on behalf of the Trust
<b>HCP</b>	Health Care Professional for example Medical, Nursing and Allied Health staff groups
<b>PGD</b>	Patient Group Direction - A patient group direction (PGD) is a written direction that allows named health care professionals to supply and/or administer a named medicine in a specific clinical situation.
<b>Parenteral</b>	Medicine administration by injection, implantation or route other than the Alimentary canal – for the purposes of this policy <b>Intravenous or Intramuscular</b>
<b>ABCDE</b>	Patient clinical assessment process; Airway, Breathing, Circulation, Disability (neurological), Exposure
<b>Biphasic</b>	A further reoccurrence of symptoms
<b>IgE</b>	Immunoglobulin E
<b>RCUK</b>	Resuscitation Council (UK)
<b>ADR</b>	Adverse Drug Reaction.
<b>BNF</b>	British National Formulary
<b>NUH</b>	Nottingham University Hospitals
<b>AAGBI</b>	Association of Anaesthetists of Great Britain and Ireland
<b>Refractory anaphylaxis</b>	A situation that occurs where the patient has no improvement with respiratory or cardiovascular symptoms despite 2 appropriate doses of Intramuscular adrenaline.

### 4.0 ROLES AND RESPONSIBILITIES

#### Service Directors and Heads of Nursing must:

- Ensure the policy is disseminated to all relevant staff and that the policy is adhered to.

#### Resuscitation Advisory Group must:

- Support the author(s) to ensure the policy is reviewed and updated as necessary.

#### Line Managers must:

- Disseminate the policy to all their staff including agency staff.
- Ensure their staff adhere to all aspects of the policy.
- Facilitate staff access to relevant training.
- Ensure anaphylaxis events and severe allergic reactions are reported on DATIX®

**Health Care Professionals (HCPs) must:**

- Practice within their code of professional conduct.
- Recognise the symptoms of anaphylaxis or suspected anaphylaxis and follow the Treatment Algorithm for the Emergency Management of Anaphylaxis ([Appendix A](#)), responding appropriately in accordance with their individual level of responsibility and training.
- Ensure they continue to update their knowledge and skills regarding anaphylaxis treatment protocols (this information is freely available at [www.resus.org.uk](http://www.resus.org.uk)).
- Counsel patients when they are newly started on adrenaline auto-injectors using ward / department-based counselling aids as required. Refer to the associated document: ([Appendix A](#)) Adrenaline Auto-injector Counselling Checklist – available to print from the intranet for use in practice.
- Ensure that all allergies are recorded in the patient’s care plan or health record and on the medication administration chart (if one is in circulation) or prescription.
- Assess the patient’s risk of developing an anaphylactic reaction prior to any treatment administration by checking allergy status.
- Ensure that no patient has medicines prescribed, supplied or administered unless allergy status has been obtained. The only exception is a life-threatening emergency.
  - Where there is a previous history of allergy to a particular medicine, the medicine should not be given, and the authorised prescriber should be contacted for advice on alternative treatments. If at this point the prescriber wishes to proceed with the treatment, this decision must be documented in the medical record. A discussion with the patient or their carer/representative must occur prior to treatment being administered wherever possible and this conversation also documented in the medical record.
  - If a medicine has been prescribed for which there is a documented history of allergy in a particular patient a DATIX® form must be completed. If the medicine is actually administered, then this is reported as an incident. If the routine checks prevent the medicine being given to the patient, then this should be reported as a near miss.
- Ensure all patients are discharged with a [Patient letter following a severe allergic reaction \(anaphylaxis\)](#) for their information – available to print from the intranet for use in practice. Any patients who experience anaphylaxis whilst under anaesthesia will be issued with a letter from the Anaesthetic Department, a letter will also be sent to their GP.
- The medical teams responsible for the care of the patient must ensure a referral to the appropriate allergy clinic is made prior to discharge following the guidance in this policy.

**Non-Registered Healthcare Providers must:**

- Alert the HCP immediately if patient distress/deterioration is observed

**Non-clinical staff must:**

- Summon assistance from a clinical member of staff and/or dial 2222 (999 for Mansfield Community Hospital & all other community care settings) to summon emergency medical assistance.

## 5.0 APPROVAL

Following consultation this policy has been approved by the Resuscitation Advisory Group

## 6.0 DOCUMENT REQUIREMENTS

### 6.1 Background:

Anaphylaxis can develop within a rapid time frame, and potentially with little or no warning for the victim or care provider. It is therefore essential that staff with a duty of care have the knowledge and skills to both recognise a potentially life-threatening situation and respond in a timely manner.

Examples of potential anaphylaxis triggers include:

- Foods - peanuts, fish/shellfish, eggs, milk.
- Medicines - antibiotics, vaccines, aspirin, anaesthetic agents, contrast media
- Venom - Bee/ Wasp stings.
- Blood
- Latex

Please note this is not an exhaustive list and allergic reactions and anaphylaxis can occur to many things and when given by different routes.

In cases where anaphylaxis is fatal, death usually occurs very soon after contact with the trigger. Those caused by intravenous medication have most commonly occurred within 5 minutes of injection. It is imperative that attending healthcare practitioners minimise the risk of anaphylaxis by taking a thorough history, assessing and documenting any previous reactions clearly within the patient's medical notes and on the medication and administration chart in accordance with the Trust

No medicines should be prescribed, administered or ordered, except in a life-threatening situation, unless the allergy status of the patient has been documented. If there are no allergies then 'NKDA' (no known drug allergies) should be recorded on the medicines administration chart. Adverse drug reactions are different and relate to side effects. These may be very severe and are just as important to avoid. If the reaction is not allergic in nature but a side effect or ADR, then document this clearly by writing 'ADR' next to the medicine and reaction.

Patients with a known allergy must be issued with a red handwritten patient identification band, which includes the words 'Allergy Alert' ([Policy & Procedure for the Positive Identification of Patients](#))

### 6.2 Recognition & Diagnosis:

The clinical features of the reaction may vary in severity and progress. It is recommended that an ABCDE clinical assessment format is used. Symptoms suggestive of the likelihood of a severe reaction may show one or several of the following signs:



<b>Response Time</b>	Sudden onset and rapid progression of symptoms following exposure to the trigger (more rarely several hours delay to onset of symptoms)
<b>General Signs</b>	Pallor, reduced level of consciousness, dyspnoea/apnoea, collapse leading to respiratory/cardiorespiratory arrest.
<b><u>A</u>irway</b>	Angioedema - swelling of lips, face, neck, tongue, dysphagia, hoarseness and stridor.
<b><u>B</u>reathing</b>	Chest tightness, tachypnoea, dyspnoea, bronchospasm with audible wheeze
<b><u>C</u>irculation</b>	Profound hypotension in association with tachycardia and weak pulses. Slow capillary filling (>2 seconds).
<b><u>D</u>isability</b>	Confusion, agitation, loss of consciousness
<b><u>E</u>xposure</b>	<b>Skin</b> - Flushed or pale. Cold & clammy. Itchy lips, palate, eyes, hands and feet. Widespread urticarial rash. (Note: 20% of cases have no skin reaction) <b>Gastrointestinal</b> - Nausea, vomiting, abdominal pain, diarrhoea, incontinence

**Caution:** Anaphylaxis may be confused with a panic attack, particularly in those patients who have previously experienced an anaphylactic reaction. The absence of rash, breathing difficulties, and swelling are useful distinguishing features, as is the slow pulse of a vasovagal (fainting) attack compared with the tachycardia present in a severe anaphylactic episode. A vasovagal episode will usually respond to lying the patient down and raising their legs, while ensuring a patent airway.

### 6.3 Immediate Essential Management of an Allergic reaction without life threatening symptoms:

- Remove the trigger substance if possible.
- Administer medication depending on severity of symptoms. Oral antihistamines may be sufficient for rash with no other symptoms.
- It may be necessary to administer Chlorphenamine and Hydrocortisone injections immediately. These medications can be administered without a prescription for the purpose of saving life in an emergency situation by those competent to do so as described in the Medicines Policy.

	<b>Chlorphenamine</b> (slow intravenous or intramuscular)	<b>Hydrocortisone</b> (slow intravenous or intramuscular)
Adult or child over 12 years	10mg	200mg
Child 6-11 years	5mg	100mg
Child 6 months to 5 years	2.5mg	50mg
Child 1 month to 5 months	250 microgram/kg	25mg



- Call the doctor for Mansfield Community Hospital and all other community care settings as an allergic reaction can progress to anaphylaxis.

Refer to the BNF for further dose information as required. Link: [BNF](#)

After initial management, see section 6.5 for the ongoing care and monitoring of the patient.

#### 6.4 Immediate Essential Management of Anaphylaxis: with life threatening symptoms

- Summon emergency medical assistance if necessary. In the case of King's Mill Hospital and Newark sites do this by dialling 2222 (999 for Mansfield Community Hospital and all other community care settings).
- For anaphylaxis episodes in the operating theatres refer to AAGBI guidance at [QRH 3-1 Anaphylaxis v4.pdf \(anaesthetists.org\)](#)
- Remove the trigger substance if possible.
- Proceed in accordance with the Treatment Algorithm for the Emergency Management of Anaphylaxis ([Appendix B](#))
- **For management of refractory anaphylaxis see [appendix D](#).**
- In the event of the patient experiencing a cardiopulmonary arrest, the [Cardiopulmonary Resuscitation \(CPR\) Policy](#) must be followed and the [Resuscitation Council UK ADULT Life Support Algorithm](#) or the [Resuscitation Council UK PAEDIATRIC Advanced Life Support Algorithm](#) must be instigated.
- Adrenaline is regarded as the most important medicine for any severe anaphylactic reaction. It is most effective when administered early following anaphylaxis and via the **intramuscular (IM)** route. The preferred site for the injection is the anterolateral aspect of the midpoint of the thigh. Note: the adrenaline injection strength is 1:1000 (medication dosages for both adults and children are specified in the anaphylaxis treatment algorithm)
- Adrenaline is a prescription only medication. However, under the Human Medicines Regulations Schedule (2012) the administration of adrenaline is allowed without prescription for the purposes of saving life in an emergency anaphylaxis situation.

**When serious symptoms are present, clinical staff working within the Trust that have been trained in the administration of intramuscular injections are authorised to administer up to 2 doses of adrenaline 1:1000 without prescription, as per the RCUK anaphylaxis treatment algorithm guidelines, a minimum of 5 minutes apart via the intramuscular route**

- All resuscitation trolleys contain adrenaline for injection.
- Some outpatient areas have adrenaline auto-injectors.

- When assessing a person presenting with possible medicine allergy, take a history and undertake a clinical examination. Refer to Key priorities for implementation Drug allergy: diagnosis and management Guidance NICE 2014: ([Appendix C](#))

After initial management, see section 6.5 for the ongoing care and monitoring of the patient.

## 6.5 Further Management and Discharge Requirements:

In order to promote patient safety and additionally ensure compliance with the NICE 134 Guideline (2011), the following actions must be implemented:

- All anaphylaxis or allergic reaction events must be logged as a clinical incident on the DATIX® reporting system even if the allergic reaction was unexpected.
- For any patient presenting with an allergic reaction or anaphylaxis, staff must follow the [Emergency Department and Inpatient Care Pathway for Allergy and Anaphylaxis Identification and Management](#) – which can be printed from the intranet for use in practice.
- For any patient with suspected anaphylactic reactions associated with anaesthesia, the Anaesthetist in charge must complete a NAP6 Anaesthetic Anaphylaxis Referral Form and a letter for the patient and their GP. The patient will be referred to the Immunology Service at NUH and following clinic review the Anaesthetist may report the episode to the Medicines Health Regulatory Authority ([MHRA](#)) [via the yellow card scheme](#)
- Report none medication reactions to the Medicines and Healthcare Regulatory Agency ([MHRA](#)) [via the yellow card scheme](#)
- If the patient needs observing further and admission to hospital is not necessary they may be referred to the Same Day Emergency Care Unit (SDEC) using the [Emergency Department referral pathway to SDEC for Anaphylaxis / Suspected Anaphylaxis](#) – which can be printed from the intranet for use in practice.
- **In-hospital observation for a minimum period of 6-12 hours** is warranted for those patients whose presentation involves the following factors.
  - Displaying symptoms in one or more of the A, B, and C patient assessment criteria.
  - Reactions in patients with severe asthma, or with a severe asthmatic component.
  - Patients with a previous history of biphasic reaction

**Children** younger than 16 years who have had emergency treatment for suspected anaphylaxis should be admitted to hospital under the care of a paediatric medical team

- **Mast Cell Tryptase level blood sampling** is required to assist confirmation of diagnosis. Three samples are required if a reaction is suspected.
  - Sample 1 is taken during resuscitation or as soon as possible afterwards.
  - Sample 2 is then taken at 1-2 hours from onset of symptoms.

- Sample 3 is taken after 24 hours or longer in the recovery phase.

If the patient is discharged before the 24-hour sample this may be referred to the GP or allergy clinic.

- **All patients must be reviewed by a clinician prior to discharge**
- All patients must be discharged with a [Patient letter following a severe allergic reaction \(Anaphylaxis\)](#) which gives information on what to expect post discharge. This letter can be printed from the intranet for use in practice.
- All sufferers of anaphylaxis should be advised to carry/wear an alert device to inform bystanders should a future attack occur and be vigilant to avoid potential exposure to the trigger. The Allergy Clinic will provide this information once the diagnosis has been confirmed – see [Appendix E](#) for information on referral criteria to the allergy clinic. Prior to attendance at the clinic patients must show the [patient letter](#) issued at the point of discharge at any medical or dental appointments they go to prior to attendance at the allergy clinic.
- **All patients must be provided with two adrenaline auto-injector pens and instruction regarding administration prior to discharge**, as per the Adrenaline Auto-Injector Counselling Checklist ([Appendix A](#)) which can be printed from the intranet for use in practice. See section 6.5a for information on the supply of adrenaline auto-injectors. If the counselling occurs in pharmacy, then a copy of the checklist will be stapled to the prescription and filed alongside. If the counselling occurs at ward level, then this will be filed in the medical notes with the TTO paperwork. In the case of the Emergency Department, this checklist may be filed with the Emergency Department notes.
- All patients must be provided with advice regarding signs and symptoms of anaphylaxis and the importance of avoiding the trigger substance/action. This information is part of the Adrenaline Auto-Injector Counselling Checklist. If patients require further information, then they may be directed to [www.nhs.uk](http://www.nhs.uk) where there are several patient friendly leaflets on allergy and anaphylaxis. The Patient letter following a severe allergic reaction (anaphylaxis) given to patients will give information on what to expect in terms of referral and will give information on their potential allergens.
- Only new or unknown causes of severe allergy / anaphylaxis need to be referred to the Allergy clinic. Known triggers do not need routine referral, this will be at the discretion of the senior clinician.
- All patients who need a referral to a specialist allergy centre will be referred by the clinician.
- **Patients from ED/SDEC and all in-patient areas:** responsible clinician to refer via letter to the NUH allergy clinic and include a copy of the Emergency Department and Inpatient Pathway for the Allergy Identification and Management including Anaphylaxis. This may be posted to the address at the bottom of the pathway or faxed to the number provided.

- **Anaesthetics-** Please refer via letter or email as above to the allergy clinic and send a copy of the AAGBI Anaphylaxis Proforma and the anaesthetic record.
- **Paediatric patients** will be admitted onto the paediatric ward and referral made to the paediatric allergy clinic at Sherwood Forest Hospitals NHS Trust.
- See [Appendix E](#) for the indications for referral to the specialist allergy clinic. Further advice is also available from the specialist clinic should it be required prior to patient attendance.
- In the case of the Emergency Department, where the green notes may not be available at the point of discharge this information will be put onto SystemOne for the GP.
- The Emergency Department and Inpatient Pathway for the Allergy Identification and Management including Anaphylaxis document should be filed in the patients' medical notes behind the red alert divider.
- The GP must be informed of the event on discharge and any changes to the patient's allergy status. All information should be clearly documented on the communication paperwork and a copy of the Emergency Department and Inpatient Pathway for the Allergy Identification and Management including Anaphylaxis to be sent to the GP.

### 6.5a Supply of adrenaline auto-injectors.

All patients must be provided with two adrenaline auto-injector pens and instruction regarding administration prior to discharge, as per the Adrenaline Auto-Injector Counselling Checklist. ([Appendix A](#)) Instructions for administration can be found with each auto-injector.

During working hours, these may be supplied by the pharmacy department against either an outpatient or TTO prescription.

For adult patients out of hours, the Emergency Department will have prepacks which can be issued to patients as part of the [Procedure for the dispensing of pre-packed medication by nursing staff](#) against an outpatient prescription. These will be kept in the Medstation.

Paediatric patients presenting with severe allergy or anaphylaxis will be admitted for review by the Paediatric team so supply will be made on discharge via the pharmacy department during working hours.

All areas will have training packs available to assist with the counselling of patients at ward level. The responsibility for counselling will lie with ward staff if the patient is being discharged home from the in-patient setting and with Emergency Department staff for those treated and discharged from ED and pharmacy staff for those prescriptions dispensed as out patients via the dispensary.

If a patient with an existing allergy is admitted having used their supply of adrenaline auto-injector, then they must be discharged with a new supply.

## 6.6 Maintaining and sharing medicines allergy information

- Prescriptions (paper or electronic) issued in any healthcare setting should record information on which medicines or medicine classes to avoid in order to reduce risk of medicine allergy.
- Documentation of a medicine allergy requires the following information as a minimum:
  - the medicine name
  - the signs, symptoms and severity of the reaction
  - the current Medication and Administration record (in-patient medicine chart) also requires the person documenting to sign and date the entry.
- The medicine allergy should be documented separately from adverse reactions and be clearly visible to all health care professionals who are prescribing medications. This is not physically possible with the current medication chart and so the letters 'ADR' should be documented to denote a side effect or adverse drug reaction as opposed to an allergy.
- The medicine allergy status should be confirmed with the patient or family members or carers as appropriate before prescribing, dispensing or administering any medicines. Unless the situation is life threatening, none of the aforementioned tasks should be undertaken until information on the patient's allergy status can be obtained.
- The information regarding allergy status should be updated and included in all GP referrals and hospital discharge letters.
- Medicines reconciliation for people admitted to hospital should be carried out in line with local policy and include the confirmation of allergy status.
- Patients admitted to hospital who have a medicine allergy must wear a red wrist band to identify and alert staff to the fact that they have an allergy, as stated in the [Policy & Procedure for the Positive Identification of Patients](#).

## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored  (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual  (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit  (HOW – will this element be monitored (method used))	Frequency of Monitoring  (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results  (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Audit the usability at ward level of the resus trolleys	Medication Safety Officer	Medication Safe Storage and Security Audit	Annual	<ul style="list-style-type: none"> <li>Medicines Safety Group</li> </ul>
All allergy related medication incidents reported on DATIX® are reviewed by the Medication Safety Officer (MSO) and all harms are discussed at the Medicines Safety Group	Medication Safety Officer	Monthly review As the incident occurs	Monthly	<ul style="list-style-type: none"> <li>Medicines Safety Group</li> </ul>
Ensure all pts with known allergy have a red wrist band in place.	Practice Development Nurse – Medicines Management	Monthly metrics Annual - specific audit.	Monthly – metrics Annual - audit	<ul style="list-style-type: none"> <li>Nursing &amp; Midwifery Board</li> <li>Medicines Safety Group</li> </ul>

## 8.0 TRAINING AND IMPLEMENTATION

- 8.1 All Cardiac arrest team leaders will have a valid Advanced Life Support (ALS) provider certificate. Advanced Paediatric Life Support (APLS) or European Paediatric Advanced Life Support (EPALS) certificate for the paediatric team leaders (Course syllabus incorporates knowledge around the emergency management of anaphylaxis).
- 8.2 Anaphylaxis training is incorporated in the Immediate Life Support (ILS) and Paediatric Life Support (PILS) courses as recommended for staff in the **CPR Training Policy**
- 8.3 [Emergency Treatment of Anaphylactic Reactions \(sherwood-eacademy.co.uk\)](https://www.sherwood-eacademy.co.uk) is available on the Trusts intranet site.
- 8.4 Midwives access anaphylaxis training as part of their annual mandatory Emergency Skills Training Day.
- 8.5 All non-medical clinical staff undertake anaphylaxis e-learning as part of their annual mandatory update training.
- 8.6 All medical staff, registered nurses, midwives and allied health professionals will be responsible for ensuring they remain up to date with current, related guidelines [Emergency treatment for anaphylaxis guidelines \(Resus Council UK\)](#)
- 8.7 Anaphylaxis Algorithm posters should be displayed in the clean utility area of all clinical wards/departments and are also contained, as laminates, within the Adult and Paediatric Resuscitation Trolleys.
- 8.8 Epi-Pen training will be provided on a 'train the trainer' basis and counselling aids will be available on all wards and departments to assist with patients counselling. The training checklist will also act as an aide memoire for those counselling patients. Alternative adrenaline auto-injectors are available when needed.

## 9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix F](#).
- This document is not subject to an Environmental Impact Assessment

## 10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

### Evidence Base:

Human Medicines Regulations 2012 (SI 1916). Regulation 238, schedule 19. [online]. Available from: <https://www.legislation.gov.uk/ukSI/2012/1916/regulation/238/made> [Accessed 27th August 2021].

Johansson SG, Bieber T, Dahl R, Friedmann PS, Lanier BQ, Lockey RF et al. (2004) Revised nomenclature for allergy for global use: Report of the Nomenclature Review Committee of the World Allergy Organisation 2003. J Allergy Clin Immunol, 113(5): 832-6.



National Institute for Health & Clinical Excellence (2011) Anaphylaxis: assessment and referral after emergency treatment [CG 134]. [online]. Available from: <https://www.nice.org.uk/guidance/cg134/resources/anaphylaxis-assessment-and-referral-after-emergency-treatment-pdf-35109510368965> [Accessed 27th August 2021].

National Institute for Health & Clinical Excellence Guideline (2014) Drug allergy: diagnosis and management [CG183]. [online]. Available from: <https://www.nice.org.uk/guidance/cg183/resources/drug-allergy-diagnosis-and-management-pdf-35109811022821> [Accessed 27th August 2021].

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#### Related SFHFT Documents:

- [Medicines Policy](#)
- [Transfusion Policy, Procedures and Guidelines](#)
- [Cardiopulmonary Resuscitation \(CPR\) Policy](#)
- [Policy & Procedure for the Positive Identification of Patients](#)
- [Procedure for the dispensing of pre-packed medication by nursing staff](#)
- [Emergency Department and Inpatient Care Pathway for Allergy and Anaphylaxis Identification and Management](#)
- [Emergency Department to SDEC Care Pathway for Anaphylaxis/ Suspected Anaphylaxis \(previously AECU\)](#)

#### 11.0 KEYWORDS

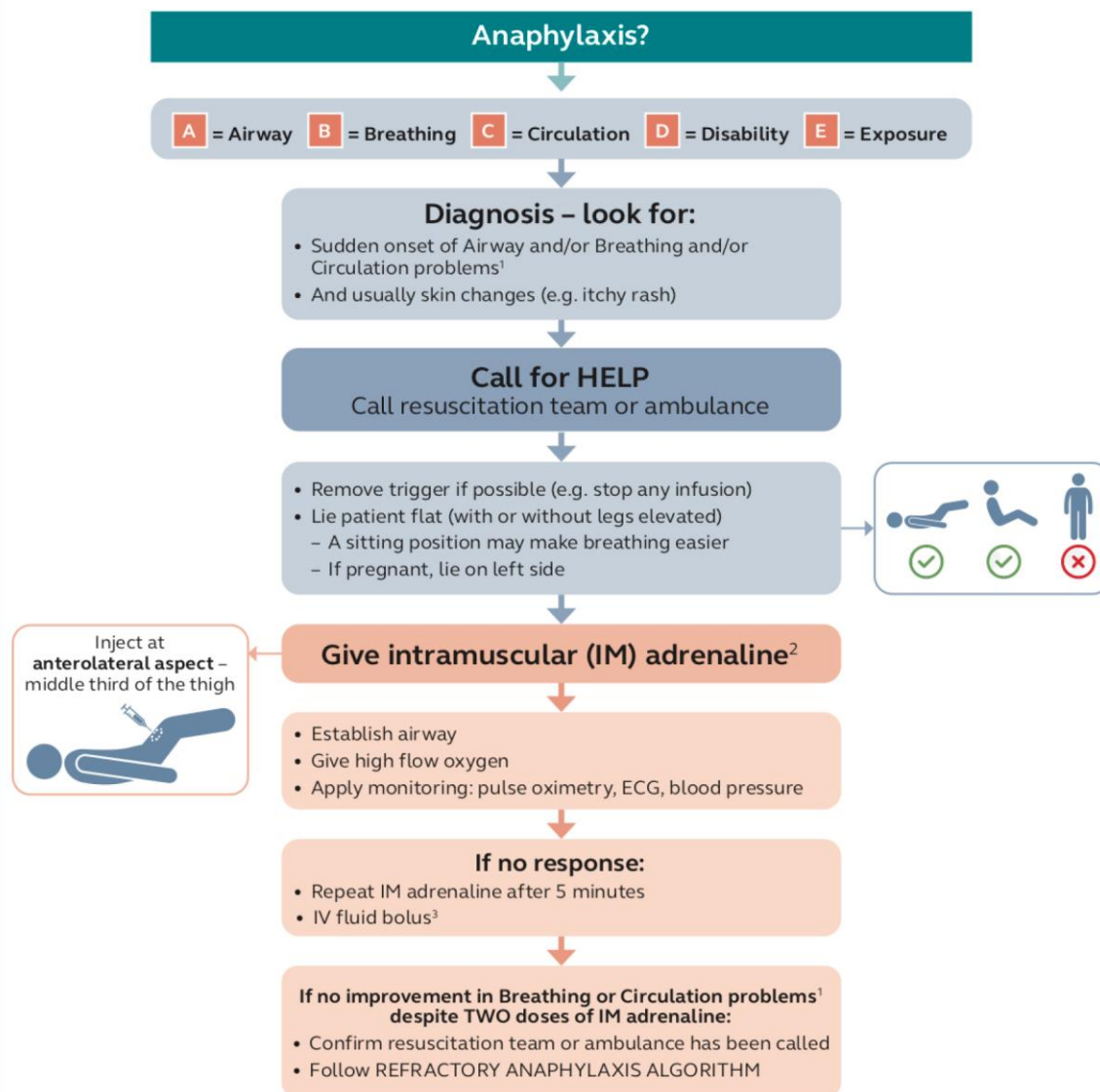
- Adverse drug reaction; ADR; anaphylactic; allergic; allergen; hypersensitivity; adrenaline; shock; pen; rash; urticaria;

#### 12.0 APPENDICES

<a href="#">Appendix A</a>	<a href="#">Adrenaline Auto-injector Counselling Checklist</a>
<a href="#">Appendix B</a>	Treatment Algorithm for the Emergency Management of Anaphylaxis (as displayed in all clinical areas)
<a href="#">Appendix C</a>	Signs and allergic patterns of suspected medicine allergy with timing of onset
<a href="#">Appendix D</a>	Refractory anaphylaxis - for use in specialist areas
<a href="#">Appendix E</a>	Indications for referral for the Specialist Allergy Clinic
<a href="#">Appendix F</a>	Equality Impact Assessment

**Appendix B: Treatment Algorithm for the Emergency Management of Anaphylaxis**  
(Resuscitation Council UK: Guidelines 2021)

## Anaphylaxis



**1. Life-threatening problems**

**Airway**  
Hoarse voice, stridor

**Breathing**  
↑ work of breathing, wheeze, fatigue, cyanosis, SpO<sub>2</sub> <94%

**Circulation**  
Low blood pressure, signs of shock, confusion, reduced consciousness

**2. Intramuscular (IM) adrenaline**

Use adrenaline at 1 mg/mL (1:1000) concentration

**Adult and child >12 years:** 500 micrograms IM (0.5 mL)  
**Child 6–12 years:** 300 micrograms IM (0.3 mL)  
**Child 6 months to 6 years:** 150 micrograms IM (0.15 mL)  
**Child <6 months:** 100–150 micrograms IM (0.1–0.15 mL)

The above doses are for IM injection **only**.  
 Intravenous adrenaline for anaphylaxis to be given **only by experienced specialists** in an appropriate setting.

**3. IV fluid challenge**

Use crystalloid

**Adults:** 500–1000 mL  
**Children:** 10 mL/kg

## **Appendix C – ref: NICE 2014: Signs and allergic patterns of suspected medicine allergy with timing of onset**

Use the following boxes as a guide when deciding whether to suspect medicine allergy.

Boxes 1–3 Signs and allergic patterns of suspected medicine allergy with timing of onset

### **Box 1 Immediate, rapidly evolving reactions**

<p>Anaphylaxis – a severe multi-system reaction characterised by:</p> <ul style="list-style-type: none"> <li>erythema, urticaria or angioedema <b>and</b></li> <li>hypotension and/or bronchospasm</li> </ul>	<p>Onset usually less than 1 hour after medicine exposure (previous exposure not always confirmed)</p>
<p>Urticaria or angioedema without systemic features</p>	
<p>Exacerbation of asthma (for example, with non-steroidal anti-inflammatory drugs [NSAIDs])</p>	

### **Box 2 Non-immediate reactions without systemic involvement**

<p>Widespread red macules or papules (exanthema-like)</p>	<p>Onset usually 6–10 days after first exposure or within 3 days of second exposure</p>
<p>Fixed eruption (localised inflamed skin)</p>	

### **Box 3 Non-immediate reactions with systemic involvement**

<p>Drug reaction with eosinophilia and systemic symptoms (DRESS) or medicine hypersensitivity syndrome (DHS) characterised by:</p> <ul style="list-style-type: none"> <li>widespread red macules, papules or erythroderma</li> <li>fever</li> <li>lymphadenopathy</li> <li>liver dysfunction</li> <li>eosinophilia</li> </ul>	<p>Onset usually 2–6 weeks after first exposure or within 3 days of second exposure</p>
<p>Toxic epidermal necrolysis or Stevens–Johnson syndrome characterised by:</p> <ul style="list-style-type: none"> <li>painful rash and fever (often early signs)</li> <li>mucosal or cutaneous erosions</li> <li>vesicles, blistering or epidermal detachment</li> <li>red purpuric macules or erythema multiforme</li> </ul>	<p>Onset usually 7–14 days after first exposure or within 3 days of second exposure</p>
<p>Acute generalised exanthematous pustulosis (AGEP)</p>	<p>Onset usually 3–5 days after</p>

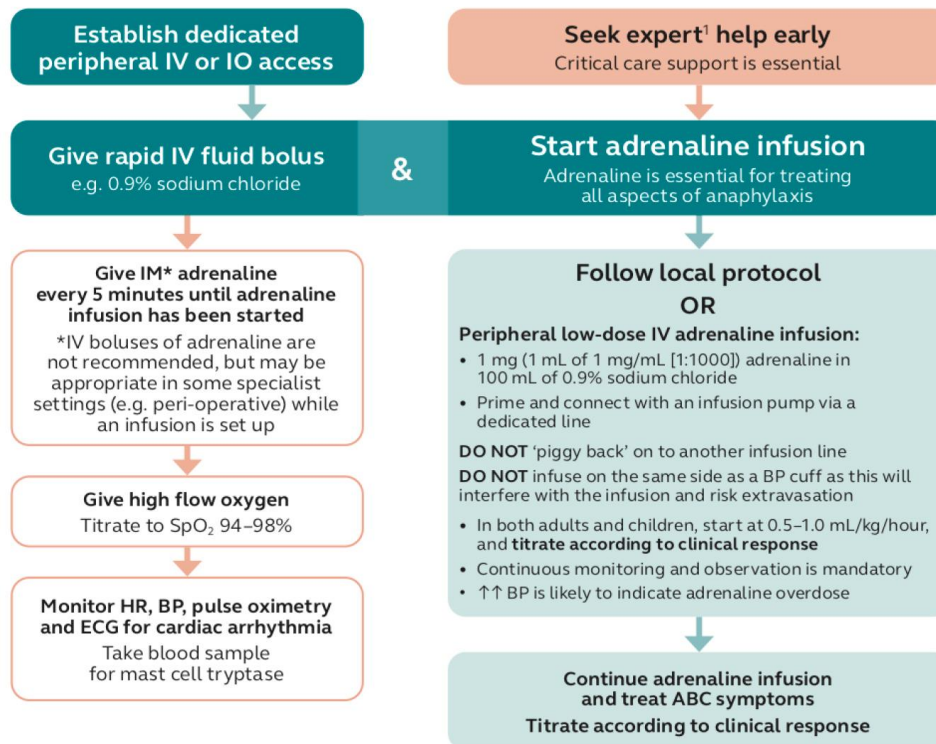
characterised by: <ul style="list-style-type: none"> <li>• widespread pustules</li> <li>• fever</li> <li>• neutrophilia</li> </ul>	first exposure
Common disorders caused, rarely, by medicines allergy: <ul style="list-style-type: none"> <li>• eczema</li> <li>• hepatitis</li> <li>• nephritis</li> <li>• photosensitivity</li> <li>• vasculitis</li> </ul>	Time of onset variable

NICE CG183 (Sept 2014) Drug allergy: diagnosis and management – [Key priorities for implementation | Drug allergy: diagnosis and management | Guidance | NICE](#)

## Appendix D – Refractory anaphylaxis – for use in specialist areas (Resuscitation Council UK: Guidelines 2021)

### Refractory anaphylaxis

No improvement in respiratory or cardiovascular symptoms despite 2 appropriate doses of intramuscular adrenaline



<sup>1</sup>Intravenous adrenaline for anaphylaxis to be given only by experienced specialists in an appropriate setting.

**A = Airway**

**Partial upper airway obstruction/stridor:**  
 Nebulised adrenaline (5mL of 1mg/mL)

**Total upper airway obstruction:**

Expert help needed, follow difficult airway algorithm

**B = Breathing**

**Oxygenation is more important than intubation**

**If apnoeic:**

- Bag mask ventilation
- Consider tracheal intubation

**Severe/persistent bronchospasm:**

- Nebulised salbutamol and ipratropium with oxygen
- Consider IV bolus and/or infusion of salbutamol or aminophylline
- Inhalational anaesthesia

**C = Circulation**

**Give further fluid boluses and titrate to response:**

Child 10 mL/kg per bolus  
 Adult 500–1000 mL per bolus

- Use glucose-free crystalloid (e.g. Hartmann's Solution, Plasma-Lyte®)

Large volumes may be required (e.g. 3–5 L in adults)

**Place arterial cannula for continuous BP monitoring**

**Establish central venous access**

**IF REFRACTORY TO ADRENALINE INFUSION**

Consider adding a second vasopressor **in addition** to adrenaline infusion:

- Noradrenaline, vasopressin or metaraminol
- In patients on beta-blockers, consider glucagon

**Consider extracorporeal life support**

**Cardiac arrest – follow ALS ALGORITHM**

- Start chest compressions early
- Use IV or IO adrenaline bolus (cardiac arrest protocol)
- Aggressive fluid resuscitation
- Consider prolonged resuscitation/extracorporeal CPR

## Appendix E:

### Indications for referral for the Specialist Allergy Clinic

1. Any severe reaction or anaphylaxis or suspected anaphylaxis which is new or has an unknown source.
2. Suspected venom allergy- refer for possible immunotherapy
3. Severe non immediate cutaneous reaction with eosinophilia ie: Stevens Johnson Syndrome
4. Refer people who need treatment with an NSAID to a specialist medication allergy service if they have had a suspected allergic reaction to an NSAID with symptoms such as anaphylaxis, severe angioedema or an asthmatic. These patients should **NOT** be offered a selective COX-2 inhibitor in a non-specialist setting.
5. People with beta-lactam suspected allergy should be referred to a specialist centre if they have a condition which requires or may require this treatment in the future. Consider referring people to a specialist medication allergy service if they are not able to take beta-lactam antibiotics and at least one other class of antibiotic because of suspected allergy to these antibiotics.
6. Refer people with a suspected allergy to local anaesthetics to a specialist medication allergy service if they need a procedure involving a local anaesthetic
7. General anaesthesia- Refer people to a specialist medication allergy service if they have had anaphylaxis or another suspected allergic reaction during or immediately after general anaesthesia.



## **APPENDIX F – EQUALITY IMPACT ASSESSMENT FORM (EQIA)**

<b>Name of service/policy/procedure being reviewed:</b> Allergy and Anaphylaxis Identification and Management Policy)			
<b>New or existing service/policy/procedure:</b> Existing - updated			
<b>Date of Assessment:</b> 21/12/2021			
<b>For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)</b>			
<b>Protected Characteristic</b>	<b>a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?</b>	<b>b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?</b>	<b>c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality</b>
<b>The area of policy or its implementation being assessed:</b>			
<b>Race and Ethnicity</b>	NA	NA	NA
<b>Gender</b>	NA	NA	NA
<b>Age</b>	NA	NA	NA
<b>Religion</b>	NA	NA	NA
<b>Disability</b>	NA	NA	NA
<b>Sexuality</b>	NA	NA	NA
<b>Pregnancy and Maternity</b>	NA	NA	NA
<b>Gender Reassignment</b>	NA	NA	NA
<b>Marriage and Civil Partnership</b>	NA	NA	NA



<b>Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)</b>	NA	NA	NA
<b>What consultation with protected characteristic groups including patient groups have you carried out?</b> <ul style="list-style-type: none"> <li>None required</li> </ul>			
<b>What data or information did you use in support of this EqIA?</b> <ul style="list-style-type: none"> <li>Policy content</li> </ul>			
<b>As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?</b> <ul style="list-style-type: none"> <li>No</li> </ul>			
<b>Level of impact</b>  From the information provided above and following EQIA guidance document Guidance on how to complete an EIA ( <a href="#">click here</a> ), please indicate the perceived level of impact:  <b>Low Level of Impact</b>  For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.			
<b>Name of Responsible Person undertaking this assessment:</b>			
<b>Signature: Alison Davidson</b>			
<b>Date: 21/12/2021</b>			