Leicestershire Partnership NHS Trust

Anaphylaxis and Drug Allergy Policy

This policy sets out the process for the response and management of anaphylaxis and allergy in our patients here at LPT.

Key words: Anaphylaxis, Adrenaline, Allergy, Drug, Epinephrine, Resuscitation

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Ratified By: Safety Forum

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Contents

Policy On A Page

SUMMARY & AIM

What is this policy for?

To provide guidance to support safe and consistent management of anaphylaxis and response to allergy by healthcare staff in accordance with current legislation, national, local guidance, and professional standards.

To define the responsibilities, competencies, training, and performance standards of healthcare staff regarding their role in recognising and managing anaphylaxis and allergy.

KEY REQUIREMENTS

What do I need to follow/understand?

The process for understanding the seriousness of timely and appropriate recognition of anaphylaxis and allergy to reduce the risk of harm to our patients.

Anaphylaxis can be caused by a broad range of triggers, but the most common allergens identified include food, drugs, and venom. There are clear age distributions for both hospitalisation and fatalities, that vary by trigger.

Food is the most common cause of anaphylaxis in young people. Pre-school-aged children have the highest rate of hospitalisation due to food anaphylaxis, but a disproportionately low rate of fatal outcomes.

The greatest risk from fatal food allergy appears to be in teenagers and adults up to age 30 years.4,5 In contrast, fatal anaphylaxis due to drugs is rare in children, and is highest in the elderly; this may be due to a combination of comorbid factors (e.g., cardiovascular disease, polypharmacy) in this age group, and concomitant use of antihypertensive drugs such as beta blockers and angiotensin-converting-enzyme (ACE) inhibitors.

Source: Resuscitation Council UK, Emergency treatment of anaphylaxis (May 2021). https://www.resus.org.uk/sites/default/files/2021-05/Emergency%20Treatment%20of%20Anaphylaxis%20May%202021_0.pdf

TARGET AUDIENCE:

Who is involved with this policy?

All clinical staff who undertake prescribing and administration of drugs and have responsibility for checking allergy status on admission including food allergy,

TRAINING

What training is there for this policy?

Online training via Ulearn

Anaphylaxis Level 1: basic understanding of anaphylaxis; including the causes, signs and initial treatments which should be given. (0.50hrs)

Anaphylaxis Level 2: to aid understanding of the recognition and management of anaphylaxis from any cause in community and hospital settings. It includes management of anaphylaxis in adults and children, further treatment in a hospital setting, blood tests and longer term follow up of those who experience anaphylaxis. (0.50hrs)

1.0 Quick look summary

This document will set out the relevant information regarding diagnosis and treatment of anaphylaxis within LPT which can be found in Appendix 1.

What you need to know:

This policy applies to all registered practitioners, including nursing staff, podiatrists, medical staff and additionally Assistant Practitioners, Student Nursing Associates, Nursing Associates, Physiotherapists in Advanced Practice roles and Medicines Administration Technicians.

All staff are expected to manage and treat an anaphylactic reaction within their clinical role in LPT within adult and children's services.

Key information

- Anaphylaxis is a severe, life-threatening reaction that can affect all ages and is always unexpected.
- Less severe allergic reactions are more common and will be treated in a different manner.
- Intramuscular injection of adrenaline is the first line treatment of an anaphylactic reaction.
- Early use of adrenaline is associated with improved outcomes for patients.

The recognition and treatment of anaphylaxis is based on the Resuscitation Council UK (2021) guidelines.

Allergic reactions can be avoided using straightforward steps:

- Always check the known allergy status of a patient prior to clinical interventions.
- Clearly document the known **allergy status** so that it is visible to other clinicians.
- Immediately prior to administering drugs recheck the allergy status of a patient.
- Patients and /or carers reporting allergies or intolerances should always be believed and the reaction reported documented appropriately in the patients electronic notes and on their electronic prescription.
- All inpatients with an identified allergy must have either a red identity band with black text on a white panel (Community Hospitals) or a white identity band with a red colour code. The nature of any allergy should not be recorded on the identity band. This highlights to staff that the patient has a recorded allergy/ sensitivity.

Where you can find information to support you to inform your clinical practice:

- Clinical guidance, Clinical features and treatment of Anaphylaxis is detailed in **Appendix 1**

- The nationally recognised 'Treatment Algorithm for Anaphylaxis' based on the Resuscitation Guidelines (2021) and the emergency response and medication management can be found in **Appendix 1.**

- Refractory Anaphylaxis Algorithm for advanced care and management is detailed in **Appendix 2** for those staff with advanced skills and those who consider themselves able to work at this level within their level of competence and training.

- Clinical guidance, process for identifying, confirming, and recording information for patients with allergy and responding when an allergy occurs is described in **Appendix 3.**

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
1	July 2012	• Harmonisation of former organisations policies. • Revised in line with NICE Guideline 134. • Updated references.
2	January 2015	• Revision onto new template. • Updated list of indicative staff who should carry/access adrenaline. • New reference made to Assistant Practitioners and Trainee Assistant Practitioners. • Inclusion of ULearn recording system.
3	November 2016	• Revision onto new template. • Updated reference list.
4	February 2017	• Addition of Allergy Advice as appendix.
5	December 2018	• Routine review. • Adding some information on non-Anaphylactic reactions.

Version number	Date	Comments (description change and amendments)
6	June 2021	• Routine review. • Addition of Resuscitation Council UK (2021) Anaphylaxis Algorithm. • Addition of Resuscitation Council UK (2021) Refractory Anaphylaxis Algorithm. • Addition of updated adrenaline dose for child less than 6 months. • Addition of antihistamine and steroid guidance. • New reference made to Medicines Administration Technicians and Nursing Associates
7	September 2024 – May 2025	• Routine review and update • Addition of auto injectors • Addition to staff list of who should carry adrenaline • Addition of process for management of expired auto-injectors (learning from a patient safety incident)

For Further Information Contact:

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LPT Resuscitation Officer.

1.2 Key individuals involved in developing and consulting on the reviewed document

Name	Designation
Julie Bell – Original policy	Clinical Trainer – now UHL
David Leeson	Clinical Education Lead LPT: now UHL
Anthony Oxley	Lead Pharmacist LPT
Elaine Liquorish	Clinical Education Lead CHS LPT

Circulated to the following individuals for comment

Name	Designation
Laura Browne	Physical Health Matron for Learning Disabilities and Autism Services

Joanne Charles	Lead Pharmacist - CHS
Rachel Calton	Lead Pharmacist – Education and Training
Tejas Khatau	Lead Pharmacist - FYPCLD
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Ged Swinton	LPT Resuscitation Officer
Sonia Thomson	Advanced Clinical Practitioner
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Lesley Weaving	Podiatry Team Lead
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1.3 Governance

Level 2 or 3 approving delivery group – Medicines Management Group

Level 1 Committee to ratify policy – Safety Forum

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.6 Definitions that apply to this policy.

ABCDE	Airway, Breathing, Circulation, Disability, Exposure
Adrenaline (epinephrine)	Injectable drug used for emergency treatment of severe allergic reaction, including anaphylaxis
Allergy	An allergy is the response of the body's immune system to normally harmless substances. Whilst in most people these substances (allergens) pose no problem, in allergic individuals their immune system identifies them as a 'threat' and produces an inappropriate response. Allergies are very common. They are thought to affect more than one in four people in the UK at some point in their lives.
Anaphylactic reaction **Anaphylactic shock** **Anaphylaxis**	The life-threatening signs and symptoms caused by anaphylaxis Poor perfusion of the body's vital organs caused by an anaphylaxis reaction Is the process which leads to an anaphylactic reaction- severe, life-threatening, generalised or systemic hypersensitivity reaction
Angioedema	Swelling in the deeper layer of the skin, often affecting eyelids, lips, mouth
Antibody	(also known as immunoglobulin) a protein manufactured by lymphocytes – a type of white blood cell, in response to the presence of an antigen, or foreign protein, in the body
Antigen	A substance, usually a protein that the body recognises as foreign and that can induce an immune response
BNF	British National Formulary
Caval **CPR**	Pressure on the vena cava impeding venous return in pregnancy Compression. Cardiopulmonary Resuscitation
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.

	• Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Iatrogenic	Relating to illness caused by medical examination or treatment.
Idiopathic	Self-originated; applied to a condition the cause of which is not known.
IgE	Immunoglobulin E
IM (Injection)	Intramuscular Injection
Immunoglobulin E	Antibody causing anaphylaxis
LPT	Leicestershire Partnership NHS Trust
MHRA	Medicines and Healthcare products Regulatory Agency
Positive patient identification 'red identity bands' for patients with known allergy	All inpatients with an identified allergy must have either a red identity band with black text on a white panel (Community Hospitals) or a white identity band with a red colour code. The nature of any allergy should not be recorded on the identity band.
Refractory Anaphylaxis	Anaphylaxis requiring ongoing treatment (due to persisting respiratory or cardiovascular symptoms) despite two appropriate doses of IM adrenaline.
Urticaria	Skin rash, notable for dark red, raised, itchy bumps
Yellow card scheme	UK system for collecting information on suspected adverse drug reactions to medicines. https://yellowcard.mhra.gov.uk/ The Yellow Card scheme is run by the Medicines and Healthcare products Regulatory Agency (MHRA), which safeguards medical products quality and efficacy in the United Kingdom.

Consent: a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision.
- have received sufficient information to take it and not be acting under duress.

Due Regard: Having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

2.0 Purpose and Introduction/Why we need this policy.

This document will set out the relevant information regarding diagnosis and treatment of anaphylaxis and drug related allergy within LPT (Appendix 1).

The policy aims to:

- Define the responsibilities, competencies, training and performance standards of healthcare staff with regard to their role in recognising and managing anaphylaxis.
- Provide guidance to support safe and consistent management of anaphylaxis by healthcare staff in accordance with current legislation, national and local guidance, and professional standards, and in particular to remain compliant with:
- NICE clinical guidelines 134 (updated 2020)
- CQC Regulation 12, Provide safe Care and Treatment.
- Resuscitation Council guidelines (2021) with links to NICE 134 (2011, updated 2020)
- Provide clinical guidance regarding allergies.

Summary and Key Points

Anaphylaxis

- Anaphylaxis is a severe, life-threatening reaction that can affect all ages and is always unexpected.
- Less severe allergic reactions are more common and will be treated in a different manner.
- Intramuscular injection of adrenaline is the first line treatment of an anaphylactic reaction. Early use of adrenaline is associated with improved outcomes for patients.
- The recognition and treatment of anaphylaxis is based on the Resuscitation Council UK (2021) guidelines.
- This document will set out the relevant information regarding diagnosis and treatment of anaphylaxis within LPT (Appendix 1).

Allergic reactions can be avoided using straightforward steps:

- Always check the known allergy status of the patient prior to interventions.
- Clearly document the known allergy status so that it is visible to other clinicians.
- Immediately prior to administering drugs recheck the allergy status of the patient.
- Patients and /or carers reporting allergies or intolerances should always be believed and the reaction reported documented appropriately in the patients notes and on their electronic prescription.

  All inpatients with an identified allergy must have either a red identity band with black text on a white panel (Community Hospitals) or a white identity band with a red colour code. The nature of any allergy should not be recorded on the identity band.
- It is important that they are aware of the importance of this as a means of additional communication for our staff and supports their safety.

3.0 Policy Requirements

Introduction

This policy applies to all registered practitioners, including nursing staff, podiatrists, medical staff and additionally Assistant Practitioners, Student Nursing Associates, Nursing Associates, Physiotherapists in Advanced Practice roles and Medicines Administration Technicians who are expected to manage and treat an anaphylactic reaction within their clinical role in LPT within adult and children's services.

Skilled unregistered clinical staff have a responsibility to be able to recognise the signs of possible anaphylaxis to enable them to:

- Summon help from other clinical staff and/or call 999 in the event of a person collapsing.
- This is to maximise the earliest possible response from the registered practitioner and/or ambulance service.

There are approximately 20 - 30 deaths from anaphylaxis reported each year in the UK, with around half the deaths being iatrogenic, although this may be an underestimate (NICE 2011). This policy is based on the Resuscitation Council (UK, 2021) guidelines for emergency treatment of anaphylactic reactions for healthcare providers together with NICE Clinical Guideline 134 (2011 updated 2021).

Anaphylaxis is an abnormal antigen/antibody reaction in an individual exposed to a substance to which they are hypersensitive. A precise definition of anaphylaxis is not important for the emergency treatment of an anaphylactic reaction, however NICE

Clinical Guideline 134 (2011 updated 2021) and the 'The World Allergy Organisation Anaphylaxis Committee' defines anaphylaxis as:

'Anaphylaxis is a severe, life-threatening, generalised, or systemic hypersensitivity reaction. It is characterised by rapidly developing, life-threatening problems 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'.

Key points for staff for managing patient with anaphylaxis and allergy.

Drugs used for managing anaphylaxis.

Adrenaline is the first line treatment for severe allergic reactions (anaphylaxis) and is available by prescription in ampoules and in a pre-loaded injection device (known as an adrenaline auto-injector or AAI). Adrenaline is also known as epinephrine, which is its international name. They are the same drug.

How does adrenaline work?

Adrenaline acts quickly to open the airways, reduce their swelling, and raise the blood pressure. To work effectively, it must be given as soon as possible if there are any signs of a severe allergic reaction. With early treatment those more severe symptoms are easier to reverse.

Staff resources related to this policy

- Clinical guidance, Clinical features and treatment of Anaphylaxis is detailed in **Appendix 1**

- The nationally recognised 'Treatment Algorithm for Anaphylaxis' based on the Resuscitation Guidelines (2021) and the emergency response and medication management can be found in **Appendix 1.**

- Refractory Anaphylaxis Algorithm for advanced care and management is detailed in **Appendix 2** for those staff with advanced skills and those who consider themselves able to work at this level within their level of competence and training.

- Clinical guidance, process for identifying, confirming, and recording information for patients with allergy and responding when an allergy occurs is described in **Appendix 3.**

Obtaining and the Safe and Secure Handling of Adrenaline

Obtaining Adrenaline

Adrenaline ampoules or auto-injectors (where the use of this formulation has been agreed) can be ordered from the usual pharmacy provider for the service. Orders must only be made by registered clinicians and not administrative staff. Orders can be placed via email or by using the electronic Pharmacy eStock Request Form which will be sent electronically via email to lpt.pharmacyorders@nhs.net.
The following details will need to be included:

- Name of the individual placing the order
- Professional Number (i.e., NMC pin number)
- Delivery address
- Name of drug, formulation, strength, and quantity required,

A copy of the relevant form can be found on Staffnet or using the following link: https://staffnet.leicspart.nhs.uk/support-services/medicines-management/pharmacy-stock-order-form/

Access and Safe Storage of Adrenaline

Adrenaline is a 'Prescription Only Medicine' and therefore must be always stored securely.

Community Staff: Adrenaline must be stored in a locked medicines cabinet within the nursing hub. Access to the cabinet is via a key stored in a key safe. When staff are on duty, they must carry Adrenaline, or it must be easily accessible. Managerial staff must ensure that any booked bank or agency staff are aware of and are complying with this requirement.
When replenishing stock for nursing bags, staff should be signing the adrenaline pack logging sheet (see appendix) documenting how many ampoules they have taken together with batch numbers and expiry dates.
At the end of the shift, the adrenaline must be signed back in on the adrenaline pack logging sheet when not required to be carried again and stored at the individual's base. There are situations when at the end of the shift it is not feasible to go back to the base. In these situations, adrenaline can be taken to the individual's home.
Adrenaline should be checked for discoloration prior to commencing visits. Discoloration may happen if it has been subjected to extreme temperatures.

Nursing bags must not be left in the car overnight.

Outpatient/Clinic settings: If Adrenaline is being stored within these areas, it should be stored in a locked cupboard and clinicians must ensure it is readily accessible and available e.g., within wound care clinics or if administering local anaesthetic during podiatry procedures.

Inpatient Units – Adrenaline must be easily accessible in the appropriate designated place for universal access. All wards have a white Emergency Box containing adrenaline.

Spare stock adrenaline must be stored in its original packaging or the packaging that was provided by pharmacy to ensure that it is not exposed to light and is protected from physical damage.
Adrenaline must be stored at temperatures below 25°C but not allowed to freeze or be exposed to light.
Stock adrenaline must be stored in an appropriate medicines cupboard as set down in the Leicestershire Medicines Code. Every care must be taken to make sure that the adrenaline is stored securely and away from the reach and sight of children.
Due to the infrequency of adrenaline usage, it is vital that systems are in place to regularly check and record expiry dates and stock levels. Adrenaline should also be checked for discoloration as this may occur if it has been subjected to extreme temperatures.

Safe Transport of Adrenaline

During transport, adrenaline must be stored in a glove compartment or boot of the vehicle. Care must be taken to ensure that it is not subjected to high temperatures (over 25 degrees centigrade) or allowed to freeze.
Disposal of any sharps generated should be in line with relevant Trust policies.

Safe Disposal of Adrenaline

Ampoules which are intact are not considered sharps so can be placed in a medicines waste container (where one is available in an in-patient area) or returned to pharmacy. In other settings small quantities of adrenaline (i.e., 5 ampoules/auto-injectors or less at a time) that require disposal should be disposed of by dropping into a leak-resistant sharps bin.

Reporting of adverse reactions/patient safety incident

Adverse drug reactions that include an anaphylactic reaction should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) using the yellow card scheme https://yellowcard.mhra.gov.uk/

The British National Formulary (BNF) includes copies of the Yellow Card at the back of each edition.

All adverse reactions to medications, anaphylaxis and allergy affecting patients must be reported in accordance with the LPT Incident Reporting policy.

An Anaphylaxis Registry has been established in the UK. Healthcare professionals are encouraged to report all anaphylaxis events at anaphylaxie.net (to register, healthcare professionals should email anaphylaxis.registry@ic.ac.uk.

Use of Adrenaline Auto Injectors (AAIs)

With over 20% of the UK's population affected by at least one allergy, adrenaline auto-injectors (AAIs) are an important healthcare product used for those at risk of anaphylaxis and can save lives.

AAIs in the UK include Epipens, Emerade or Jext products, and are prescribed for those at risk of anaphylaxis.
Where an adrenaline auto-injector has been prescribed for a named person, the auto-injector can be administered by any person competent to do so, but only to the person for whom the auto-injector has been prescribed. You DO NOT need to wait for a written prescription if one does not currently exist.

The individual involved must be competent in being able to recognise anaphylaxis and administer adrenaline using an auto-injector. Resuscitation Council UK FAQ (2021) https://www.resus.org.uk/home/faqs/faqs-anaphylaxis

Safe disposal of out-of-date Adrenaline and AAIs

Adrenaline ampoules that go out of date for use must be safely disposed of in line with current LPT policy for safe disposal of medicines.

AAIs that go out of date must be safely disposed of in line with current LPT policy for safe disposal of medicines; they must not be used for visual demonstration of use by the resuscitation team. (learning from staff safety incident (without harm) where accidental injection during training demonstration occurred 2024).

4.0 Duties within the Organisation

Policy Author(s)

Have the responsibility to periodically review and update the policy as required or when new information is known that affects the clinical effectiveness if this policy.

Specialist Knowledge Leads (i.e., Resuscitation Leads and Chief Pharmacist)

Are responsible for ensuring that new evidence related to managing patient Anaphylaxis and allergy is shared to inform this policy and its staff guides.

Trust Board: Has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

Elected Trust Board Sub-committees: have the responsibility for ratifying policies, guidelines, and protocols.

Directorate Directors and Heads of Service are responsible for:

- Ensuring appropriate measures are put into place to ensure the delivery of clinical care is safe and effective.
- Delegate the responsibility to service leads for ensuring both unregistered and registered clinical practitioners are trained in the appropriate management of anaphylaxis within the organisation.
- Ensure appropriate mechanisms are in place to support service delivery, quality and continuity.

- Ensure that staff are appropriately trained in line with the requirements of this policy.
- Ensure there are appropriate resources provided within their service area to implement and adhere to the policy.
- Delegate the investigation of incidents associated with anaphylaxis appropriately and ensure that any learning from these is identified and that appropriate and effective system or practice changes are made.

Managers and Team leaders are responsible for:

- Ensure all staff in their service are aware of and adhere to this policy.
- Ensure that the anaphylaxis policy is adhered to and that there is a clear process for dissemination.
- Ensure that staff are released to meet their training needs.
- Ensure that line managers are supported in monitoring compliance with the anaphylaxis policy.

Clinical Staff:

All clinical staff who come into direct contact with patients should competently:

- Recognise the signs and symptoms of an allergic reaction/anaphylactic reaction, be able to distinguish between the two and to escalate care quickly for emergency support.
- Instigate early supportive management using the Resuscitation Council UK (2021) Guidelines and treatment of anaphylaxis algorithm. **Appendix 1.** Staff must always work within their clinical competence and role expectation and in line with training provided by LPT.
- Carry / have immediate access to adrenaline 1:1000 injection and associated equipment when administering any substance that carries a realistic risk of causing an anaphylactic reaction in the patient being treated.
- Comply with the contents of this policy, ensuring their competency is maintained in the management of anaphylaxis according to their role.
- Comply with the training requirements. (Appendix 4)
- Report incidents of all anaphylactic reactions in accordance with the LPT Incident Reporting policy and yellow card scheme.
- Ensure that they are aware of the location of adrenaline equipment and that it is easily accessible in an emergency. All other stocks of adrenaline should be stored in accordance with the Medicines policy and manufacturer's instructions.
- As adrenaline has a limited shelf-life, it is the responsibility of all clinical staff to ensure that the adrenaline available is in date and is kept in an environment that complies with the manufacturer's instructions.

Indicative staff who should carry/ have immediate access to and be able to use adrenaline would include:

- Registered Nurses, Assistant Practitioners and Nursing Associates (in-patient and Community Nursing).
- Any clinician administering a depot injection within 3 months of it being initiated. This includes community psychiatric nurses and community learning development nurses.
- Doctors (In-patient).
- Community Childrens Nurse.
- (Diana) Immunisation Nurse FYPCLDA.
- Special School Nurses.
- Health visitors and School Nurses when service requires them for mass immunisation programmes.
- Podiatrists.
- Physiotherapists in Advanced Practice roles
- Medicines Administration Technicians (MAT).

Training needs

- There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role specific training. (Appendix 4)
- The Ulearn system will identify who the training applies to, delivery method, the update frequency, learning outcomes and prescribe the relevant E-Learning package.
- Anaphylaxis Level 1: basic understanding of anaphylaxis; including the causes, signs and initial treatments which should be given. (0.50hrs)
- Anaphylaxis Level 2: to aid understanding of the recognition and management of anaphylaxis from any cause in community and hospital settings. It includes management of anaphylaxis in adults and children, further treatment in a hospital setting, blood tests and longer term follow up of those who experience anaphylaxis. (0.50hrs)
- A record of training undertaken will be recorded on the Ulearn system.

5.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

6.0 Monitoring Compliance and Effectiveness

Monitoring tools must be built into all procedural documents in order that compliance and effectiveness can be demonstrated.

Be realistic with the amount of monitoring you need to do and timescales.

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
Appendix 1	Compliance evidenced by review of documentation and incident when	Review of patient records and outcome Staff engagement post safety	Local Team Specialist staff.	Via local clinical team and governance process for

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
	anaphylaxis has been treated.	incident review.		managing incidents.
15	Monitoring of staff compliance with role essential training in the management of anaphylaxis within Ulearn.	Local Service Training Reports.	Directorate senior teams, Matrons, Ward Managers/Team Leaders.	Via Local governance processes & quality & safety meetings.
12	NICE Clinical Guidance 134	Reviewed at WAR meeting monthly.	Compliance evidenced within base line Assessment Tool held by NICE lead.	Monthly Trust alerts from NICE for changes – reviewed at WAR meeting monthly.

7.0 References and Bibliography

Combined UHL/LPT/LLR Alliance Cardiopulmonary Resuscitation Policy (2023)

https://secure.library.leicestershospitals.nhs.uk/PAGL/Shared%20Documents/Cardiopulmonary%20Resuscitation%20Policy%20UHL%20LLR%20Alliance%20LPT.pdf. Accessed 13/05/2025.

Leicestershire Partnership NHS Trust (2023) Management of Sharps and Exposure to Blood Born Viruses Policy. Leicestershire Partnership NHS Trust.

Nursing and Midwifery Council (2018) The Code – Professional standards of practice and behaviour for nurses and midwives and nursing associates, London. Nursing and Midwifery Council

Resuscitation Council UK (2021) Emergency treatment of anaphylactic reactions:

Guidelines for healthcare providers. Working Group of Resuscitation Council UK London. Resuscitation Council UK, https://www.resus.org.uk/library/additional-guidance/guidance-anaphylaxis/emergency-treatment. Accessed 12/05/2025.

NICE (2011 updated 2020) Anaphylaxis: Assessment and Referral after Emergency Treatment, London. National Institute for Clinical Excellence. https://www.nice.org.uk/Guidance/CG134 https://www.nice.org.uk/guidance/cg134. Accessed 13/05/2025.

NICE (2014) Drug allergy: Diagnosis and Management London. National Institute for Clinical Excellence. https://www.nice.org.uk/guidance/cg183 Accessed 13/05/2025.

https://www.anaphylaxis.org.uk/healthcare-professionals/nice-quality-standards/anaphylaxis-nice-guideline/?gad_source=1&gad_campaignid=22520885699&gclid=EAIaIQobChMItIznIlOjjQMVKpZQBh0YBRZmEAAYASAAEgLG_vD_BwE.

https://www.leicspart.nhs.uk/wp-content/uploads/2023/10/Positive-Patient-Identification-Policy-Exp-April-2027.pdf

Additional Staff Resources available at: https://www.anaphylaxis.org.uk/healthcare-professionals/ (accessed 15/05/2025)

8.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Clinical Guidance

1. ANAPHYLAXIS

1.1 Recognition of anaphylaxis

1.1.1 ABCDE approach for recognition of anaphylaxis

1.1.2 Airway problems

Throat and tongue swelling, difficulty swallowing and breathing, hoarse voice, stridor.

1.1.3 Breathing problems

Shortness of breath, increased respiratory rate, wheeze, confusion caused by hypoxia, cyanosis (usually a late sign), and respiratory arrest.

1.1.4 Circulation problems

Signs of shock (pale, clammy), tachycardia, hypotension (feeling faint, dizziness, collapse), decreased or loss of consciousness, cardiac arrest.

1.1.5 Disability problems

Altered neurological status due to decreased brain perfusion. May be confusion, agitation, feeling of impending doom and loss of consciousness. May have abdominal pain, incontinence, vomiting.

1.1.6 Exposure

Skin and/or mucosal changes, urticaria (hives, nettle rash, weal's, welts), erythema, angioedema (commonly eyelids, lips and sometimes mouth and throat). **N.B. Skin changes alone do not signify an anaphylactic reaction.**

- **Infants and some other vulnerable individuals may not themselves be able to describe subjective symptoms e.g., feeling of warmth, weakness, anxiety, fright. Signs of persistent crying may be difficult to interpret.**

1.2 Differential diagnosis

1.2.1 Following the ABCDE approach will help with treating the differential diagnosis.

1.2.2 Non-life-threatening conditions that respond to simple measures:

- Faint (vasovagal episode).
- Panic attack.
- Breath holding episode in child.
- Idiopathic (non-allergic) urticaria or angioedema.

1.3 Life-threatening conditions

- Sometimes an anaphylactic reaction can present with signs and symptoms that are very similar to life-threatening asthma – this is commonest in children.
- A low blood pressure (or normal in children) with a petechial or purpuric rash can be a sign of septic shock.
- If in any doubt about the diagnosis give adrenaline and call (9)999 / seek medical help if available. **Staff working within the Bradgate Mental Health Unit and Bennion Centre must also put out a 2222 call.**

1.4 Treatment guidelines

- These treatment guidelines are based on the recommendations of the Resuscitation Council (UK) (2021).
- As the diagnosis of anaphylaxis is not always obvious, all those who treat anaphylaxis must have a systematic approach.
- In general, the clinical signs of critical illness are similar whatever the underlying process because they reflect failing respiratory cardiovascular and neurological systems i.e., ABCDE problems.
- Use an ABCDE approach to recognise and treat an anaphylactic reaction. The basic principles of treatment are the same for all age groups.

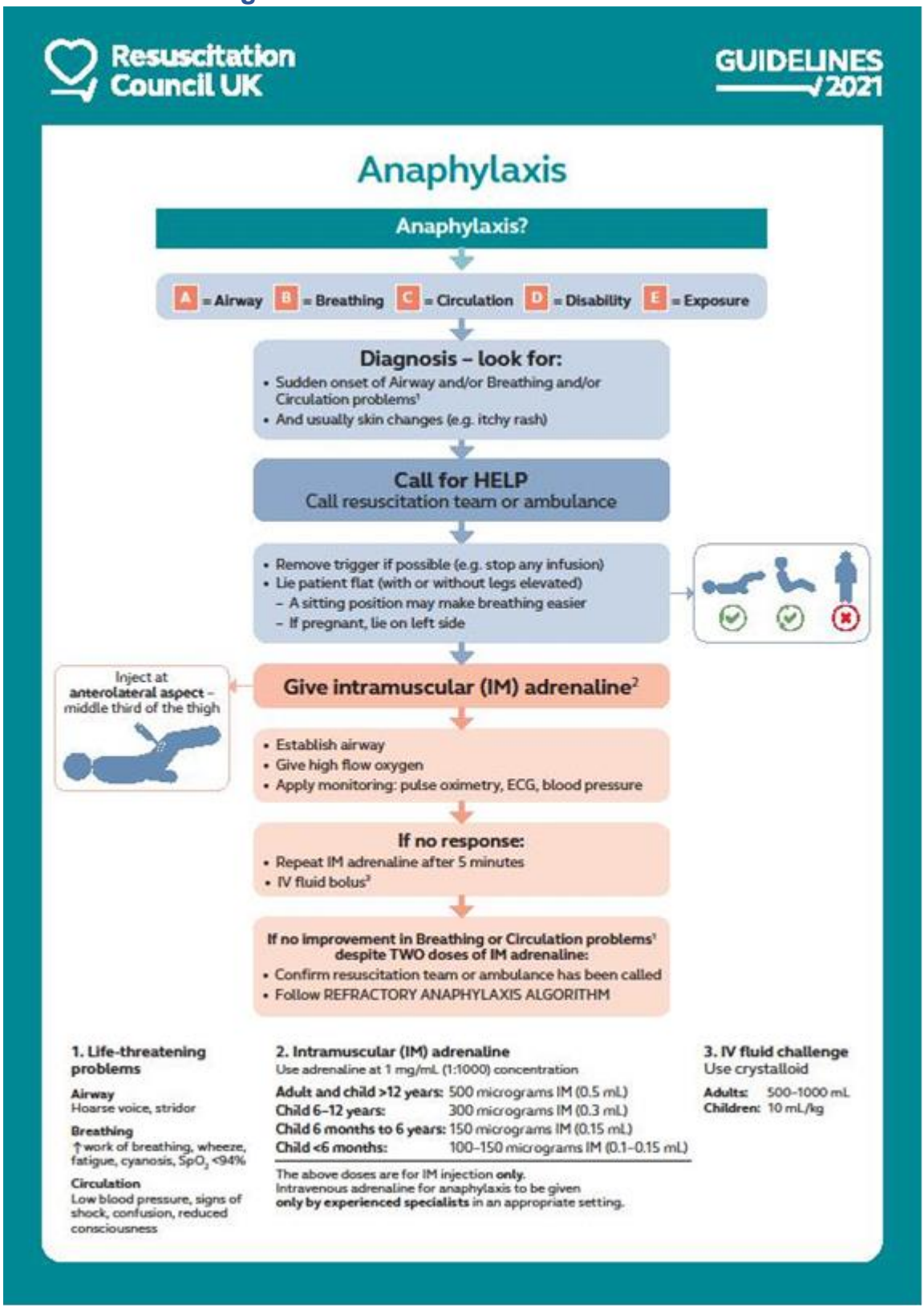
1.4.1 Antihistamines

- Antihistamines are **not recommended** as part of the initial emergency treatment for anaphylaxis. Antihistamines have no role in treating respiratory or cardiovascular symptoms of anaphylaxis. Antihistamines can be used to treat skin symptoms that often occur as part of allergic reactions including anaphylaxis.
- Antihistamines can be helpful in alleviating cutaneous symptoms (whether these are due to anaphylaxis or non-anaphylaxis allergic reactions) but must not be given in preference to adrenaline to treat anaphylaxis. In the presence of ongoing Airway/Breathing/ Circulation problems of anaphylaxis, give further IM adrenaline and seek expert advice.
- Once a patient has been stabilised, use a non-sedating oral antihistamine (e.g., cetirizine) in preference to chlorphenamine which causes sedation. (Resuscitation Council UK 2021 p32)

1.4.2 Steroids

The routine use of corticosteroids to treat anaphylaxis is not advised. Consider giving steroids after initial resuscitation for refractory reactions or ongoing asthma/shock. Steroids must not be given preferentially to adrenaline. (Resuscitation Council UK 2021 p33)

1.4.3 Treatment Algorithm



1.4.4 As soon as anaphylaxis is recognised **call for help.** Remove trigger if possible. Lie patient flat. A sitting position may make breathing easier. If pregnant, lie patient on left side. Administer the required amount of adrenaline in line with the table below and instruct the helper to dial (9)999 stating anaphylactic shock. If you are on your own administer the adrenaline prior to dialling (9)999. If the person affected is a child state this clearly to the ambulance service.

1.4.5 The following IM dose of adrenaline should be administered without delay. Inject adrenaline IM into the anterolateral of middle third of the thigh. (NOTE: the volume shown in brackets refers to adrenaline ampoule 1:1000 strength (1mg/ml)). Some clinicians such as those working in paediatrics may have been issued with auto-injectors or ampoules and should be trained in the safe use of both.

MEDICAL MANAGEMENT	DOSE OF ADRENALINE (1:1000 strength (1mg/ml)
ADULT + CHILD OVER 12	500 micrograms intramuscular (IM) (0.5ml)
CHILD 6-12 YEARS	300 micrograms IM (0.3ml)
CHILD 6 MONTHS to 6 YEARS	150 micrograms IM (0.15ml)
CHILD LESS THAN 6 MONTHS	100-150 micrograms IM (0.1- 0.15ml)

Repeat clinical assessment of patient and monitor condition.

The above doses can be repeated as necessary at five-minute intervals, based on the clinical assessment of the patient (in the absence of improvement or actual deterioration between doses)

NOTE: there is no upper limit to the number of doses that can be administered

Never leave patient unless to seek help.

Additional Responses

Clinicians with additional relevant skills and training who respond to an anaphylaxis incident can instigate treatment using the 'Refractory Anaphylaxis Treatment Algorithm' shown in Appendix 2. Staff must only work within their level of competence, training and following LPT Policies.

1.4.6 After the administration of adrenaline, establish airway and if available give high flow oxygen.

If trained, start monitoring physical health vital signs as soon as possible:

- Pulse oximetry, respiration rate, heart rate, blood pressure, ECG, level of consciousness and complete NEWS2.
- Patients who are breathing and unconscious should be placed in the recovery position. If trained, establish Intravenous (IV) access, and

prepare an IV fluid bolus of 500mls 0.9% Sodium Chloride. If not trained to do this urgently contact someone who is and can do this for your patient.

- If your patient is pregnant, she should be placed in the recovery position on her left side to prevent 'caval compression'.

1.4.7 If cardio-respiratory arrest occurs after an anaphylactic reaction, start Cardiopulmonary Resuscitation (CPR) immediately, according to the Combined UHL/LPT/LLR Alliance Cardiopulmonary Resuscitation Policy (2023)

1.4.8 Adrenaline must only be given by IM route in the emergency treatment of anaphylactic reactions within LPT.

1.4.9 Record the time of the onset of the anaphylactic reaction and the time of administration of the causal agent of the anaphylactic reaction (if known). Document the time of the initial dose of adrenaline and the rationale for administering any further doses of adrenaline at five-minute intervals.

1.4.10 After a suspected anaphylactic reaction in **adults or young people aged 16 years or older**, timed blood samples for mast cell tryptase should be taken using a '**BROWN TOP SERUM GEL'** bottle if the sample is to be sent to the pathology laboratory at UHL. (Note that circumstances may dictate that this cannot happen within LPT):

- A sample as soon as possible after emergency treatment has started.
- A second sample ideally within 1-2 hours (but no later than 4 hours) from the onset of symptoms

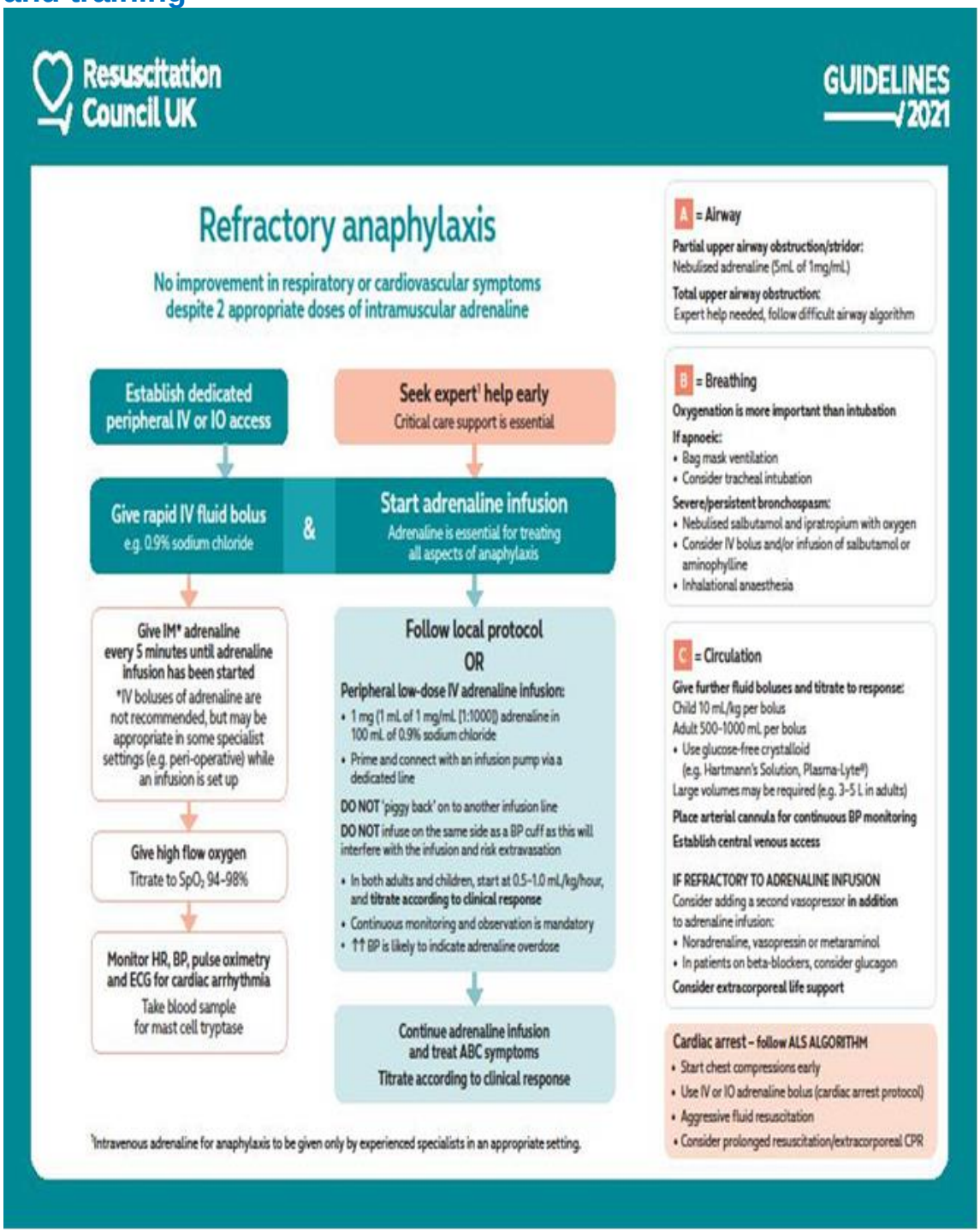
1.4.11 After a suspected anaphylactic reaction in **children younger than 16 years,** consider taking blood samples for mast cell tryptase testing using a BROWN TOP SERUM GEL bottle if the sample is to be sent to the pathology laboratory as UHL if the cause is thought to be venom related, drug related or idiopathic – (Note that circumstances may dictate that this cannot happen within LPT):

- A sample as soon as possible after emergency treatment has started.
- A second sample ideally within 1-2 hours (but no later than 4 hours) from the onset of symptoms

1.4.12 All patients who have experienced an anaphylactic episode will require assessment and monitoring in an emergency department. Children under 16yrs of age must be admitted under the care of a paediatric medical team.

Appendix 2: Refractory anaphylaxis algorithm

***NOTE*: Clinicians must only work within their level of competence and training**



Appendix 3: Clinical Guidance

1.0 ALLERGIES

1.1 It is a mandatory requirement that the allergy status of patients is available at the point of prescribing, dispensing and medicine administration.

2.0 Confirming allergies.

2.1 Assessment of whether patients have any identified medication allergies must be carried out as part of their initial assessment. The question “Have you had any bad reactions after taking medicines? “is key to determining a patient’s. allergy status.

2.2 Allergy status may be obtained from several sources. The patient is the ideal source, but other sources include the next of kin, carer, GP, care home, hospital notes or previous hospital discharge letter (TTO).

3.0 Documentation of allergies.

3.1 The Drug Allergy section on the electronic prescription chart is a compulsory section that must be completed. **All Allergies** must also be documented in the clerking notes when a patient is admitted, on any paper record held by the patient or other electronic patient documentation recording system such as SystmOne and Wellsky.

All inpatients with an identified allergy must have either a red identity band with black text on a white panel (Community Hospitals) or a white identity band with a red colour code. The nature of any allergy should not be recorded on the identity band. This highlights to staff that the patient has a recorded allergy/ sensitivity.

3.2 Document confirmed allergies using approved (generic) medication names, not abbreviated in any way as indicated in the Leicestershire Medicines code. (Patients may also have an allergy to a constituent present in medicines). **N.B.** If documenting a new allergy, include the strength and formulation of the drug and date the allergy first occurred.

3.3 The type of reaction must also be stated e.g., rash, swelling. This can indicate whether the patient has intolerance or a true allergy. **N.B**. electronic prescriptions allow you to select ‘drug allergy’ or ‘drug intolerance’ as appropriate and this should be done accurately to distinguish side effects from allergic reactions.

3.4 If there are no allergies this must be stated within the allergy box as ‘None Known’.

3.5 In all situations, even where there is no allergy, the box must be signed and dated by the healthcare professional completing the information. **N.B.** This is done automatically on the electronic prescribing system.

3.6 Where the patient is unable to provide any information (e.g., if unconscious or confused etc.) every attempt must be made to establish whether an allergy exists e.g., from next of kin, carer, GP/patient records. If the allergy status cannot be established the allergy box must be completed as 'unable to establish allergy status' with the reason why. The box must be signed and dated by the healthcare professional completing the information.

3.7 Where the allergy status cannot be established the prescriber responsible for the patient's care should be contacted to confirm that the medication can be administered to the patient, and this should be recorded in the patient's records.

3.8 Allergy information must be documented on discharge prescriptions and on the electronic discharge letter, ensuring that all new allergies are highlighted to the patients GP. Information must be transcribed in full e.g., include reaction details.

4.0 If an allergy occurs.

4.1 If a new allergic reaction occurs whilst a patient in LPT that is suspected to be a result of medication then practitioners must consider the following:

- Adverse drug reactions that include any black triangle medicines (intensively monitored medicines)
- Adverse reactions in under 18year old patients (whether minor or serious)
- Serious reaction in established or herbal medicines in adults

All above reactions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) using the yellow card scheme (www.mhra.gov.uk). The allergy should be discussed with the patient.

4.2 Any patients with suspected or confirmed anaphylactic reaction, or severe non–immediate cutaneous reaction (e.g., Stevens Johnson Syndrome, toxic epidermal necrolysis) to a drug should be referred to the specialist drug allergy service.

4.3 Any other drug allergy queries should be directed to the Clinical Immunology and Allergy service either at the LRI or GGH sites. Patients should undergo assessment of their allergies within a clinic situation if necessary.

Appendix 4 Training Needs Analysis

Training topic:	**Anaphylaxis Level 1**: basic understanding of anaphylaxis; including the causes, signs and initial treatments which should be given. (0.50hrs) **Anaphylaxis Level 2**: to aid understanding of the recognition and management of anaphylaxis from any cause in community and hospital settings. It includes management of anaphylaxis in adults and children, further treatment in a hospital setting, blood tests and longer term follow up of those who experience anaphylaxis. (0.50hrs)
Type of training: (see study leave policy)	Mandatory (must be on mandatory training register) * Role Essential (must be on the role essential training register) *
Directorate to which the training is applicable:	Adult Mental Health* Community Health Services * Enabling Services * Families Young People Children / Learning Disability/ Autism Services Hosted Services *
Staff groups who require the training:	Clinicians who carry out administration of medication or invasive procedures on patients. Such clinicians would include Registered Nurses, Nursing Associates, Assistant Practitioners, Health Visitors, School Nurses, Podiatrists, Medicines Administration Technicians, those working in Learning Disabilities, Immunisation Services and Mental Health and Health Care Support Workers
Regularity of Update requirement:	Two Yearly Update
Who is responsible for delivery of this training?	This is now an eLearning package and accessed via Ulearn
Have resources been identified?	Yes
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	ULearn *

How is this training going to be monitored?	As part of the appraisal process and via the Ulearn system and Directorate Training Reports	
Signed by Learning and Development Approval name and date	Alison O Donnell	Date: 14/05/2025

Appendix 5 – Adrenaline Stock Log Sheet

Opening Balance / Balance Transfer: [ ] ampoules. Staff 1 signature: …… Staff 2 signature: ……

Stock Removed					Stock Returned				
Date	Time	Qty	Signature 1	Signature 2 (optional)	Date	Time	Qty	Signature 1	Signature 2 (optional)
01/01/2025	09:15	2	*Nurse 1*	*Staff 2*	01/01/2025	14:25	2	*Nurse 1*	*Doctor 2*

Appendix 6 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers Answer yes to all

Respond to different needs of different sectors of the population yes

Work continuously to improve quality services and to minimise errors yes

Support and value its staff yes

Work together with others to ensure a seamless service for patients yes

Help keep people healthy and work to reduce health inequalities yes

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance yes

Appendix 7 Due Regard Screening Template

Section 1	
Name of activity/proposal	Emergency recognition and treatment of anaphylaxis and drug allergy in the clinical setting
Date Screening commenced	14/05/2025
Directorate / Service carrying out the assessment	Enabling/Pharmacy
Name and role of person undertaking this Due Regard (Equality Analysis)	Anthony Oxley – Head of Pharmacy
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: Updating of the Policy that prescribes the standards for recognising and treating anaphylaxis and allergy in the clinical setting.	
OBJECTIVES: To ensure that any episode of anaphylaxis is treated in accordance with the latest national guidelines.	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	No impact
Disability	No impact
Gender reassignment	No impact
Marriage & Civil Partnership	No impact
Pregnancy & Maternity	No impact
Race	No impact
Religion and Belief	No impact
Sex	No impact
Sexual Orientation	No impact
Other equality groups?	No impact

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4. √

Section 4
If this proposal is low risk please give evidence or justification for how you reached this decision:

Signed by reviewer/assessor	A. Oxley	Date	14/05/2025
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	A Oxley	Date	14/05/2025

Appendix 8 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.			
Name of Document:	**Anaphylaxis and Allergy Policy**		
Completed by:	**Anthony Oxley**		
Job title	**Head of Pharmacy**		**Date 14/05/2025**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	

7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.		
Data Privacy approval name:		
Date of approval		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust