

Anaphylaxis and Drug Allergy Policy

This policy describes the process for the management of anaphylaxis and drug allergy within LPT

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	July 2012	<ul style="list-style-type: none"> • Harmonisation of former organisations policies. • Revised in line with NICE guidelines¹³⁴. Updated references.
2	January 2015	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Revision onto new template. • Updated reference list
4	February 2017	<ul style="list-style-type: none"> • Addition of Allergy Advice as appendix.
5	December 2018	<ul style="list-style-type: none"> • Routine review • Adding some information on non-anaphylactic reactions
6	June 2021	<ul style="list-style-type: none"> • 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 anti- histamine and steroid guidance • New reference made to Medicines Administration Technicians and Nursing Associates

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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.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

The Trusts commitment to equality means that this policy has been screened in relation to paying due regard to the Public Sector Equality Duty as set out in the Equality Act 2010 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

A due regard review found the activity outlined in the document to be equality neutral because the treatment of anaphylaxis is a life saving measure that does not impact on any protected characteristics. **(Appendix 7)**

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 a reaction the body has to a particular food or substance. Allergies are very common. They're thought to affect more than one in four people in the UK at some point in their lives.
Anaphylactic reaction	The life-threatening signs and symptoms caused by anaphylaxis
Anaphylactic shock	Poor perfusion of the body's vital organs caused by an anaphylaxis reaction
Anaphylaxis	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 compression	Pressure on the vena cava impeding venous return in pregnancy
CPR	Cardio Pulmonary Resuscitation
Due Regard	Having due regard for advancing equality involves: <ul style="list-style-type: none"> • 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
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

1.0. Purpose of the Policy

1.1 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.

2.0. Summary and Key Points

2.1 Anaphylaxis is a severe, life-threatening reaction that can affect all ages and is always unexpected.

2.2 Less severe allergic reactions are more common and will be treated in a different manner.

2.3 Intramuscular injection of adrenaline is the first line treatment of an anaphylactic reaction. Early use of adrenaline is associated with improved outcomes for patients.

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

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

2.6 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.

2.7 This document will set out the relevant information regarding allergies (**Appendix 3**).

3.0. Introduction

- 3.1 This policy applies to all registered practitioners, including nursing staff, podiatrists, medical staff and additionally Assistant Practitioners, Trainee Nursing Associates, Nursing Associates 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.
- 3.2 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.
- 3.3 There are approximately 20 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).
- 3.4 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) states the following:
- 3.5 **“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”**

4.0 Duties within the Organisation

- 4.1 **The Trust Board** has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.
- 4.2 **Trust Board Sub-committees** have the responsibility for ratifying policies and protocols.
- 4.3 **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.

4.4 **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.

4.5 **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
- Consider the use of antihistamines and/or steroids for non-anaphylactic allergic reactions and removal of the agent causing the reaction
- 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 may cause an anaphylactic reaction.
- 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 District Nursing)
 - Community Psychiatric Nurses (within 3 months of a depot medication being started)
 - Doctors (In-patient)
 - Community Childrens Nurse
 - (Diana) Immunisation Nurse FYPC)
 - Special school nurses
 - Health visitors and School Nurses when service requires them for mass immunisation programmes.
 - Podiatrists
 - Medicines Administration Technicians (MAT)
- 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.

5.0 Training needs

- 5.1 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)
- 5.2 The Ulearn system will identify: who the training applies to, delivery method, the update frequency, learning outcomes and prescribe the relevant E-Learning package.
- 5.3 A record of the event will be recorded on the Ulearn system.

6.0 Monitoring Compliance and Effectiveness - (See Appendix 6)

7.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
CQC Regulation 12 Provision of Safe Care and Treatment	Compliance evidenced by review of documentation when anaphylaxis has been treated. Monitoring of staff compliance with role essential training in the management of anaphylaxis within Ulearn.
NICE Clinical Guidance 134	Compliance evidenced within the Baseline Assessment Tool held by NICE lead.

8.0 References and Bibliography

Combined UHL/LPT/LLR Alliance Cardiopulmonary Resuscitation Policy (2020)
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Leicestershire Partnership NHS Trust (2021) *Management of Sharps and Exposure to Blood Borne 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 12/05/2021

NICE (2011 updated 2020) Anaphylaxis: Assessment and Referral after Emergency Treatment, London. National Institute for Clinical Excellence.
<https://www.nice.org.uk/Guidance/CG134> Accessed 08/04/2021.

NICE (2014) Drug allergy: Diagnosis and Management London. National Institute for Clinical Excellence. <https://www.nice.org.uk/guidance/cg183> Accessed 08/04/2021

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, weals, 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.

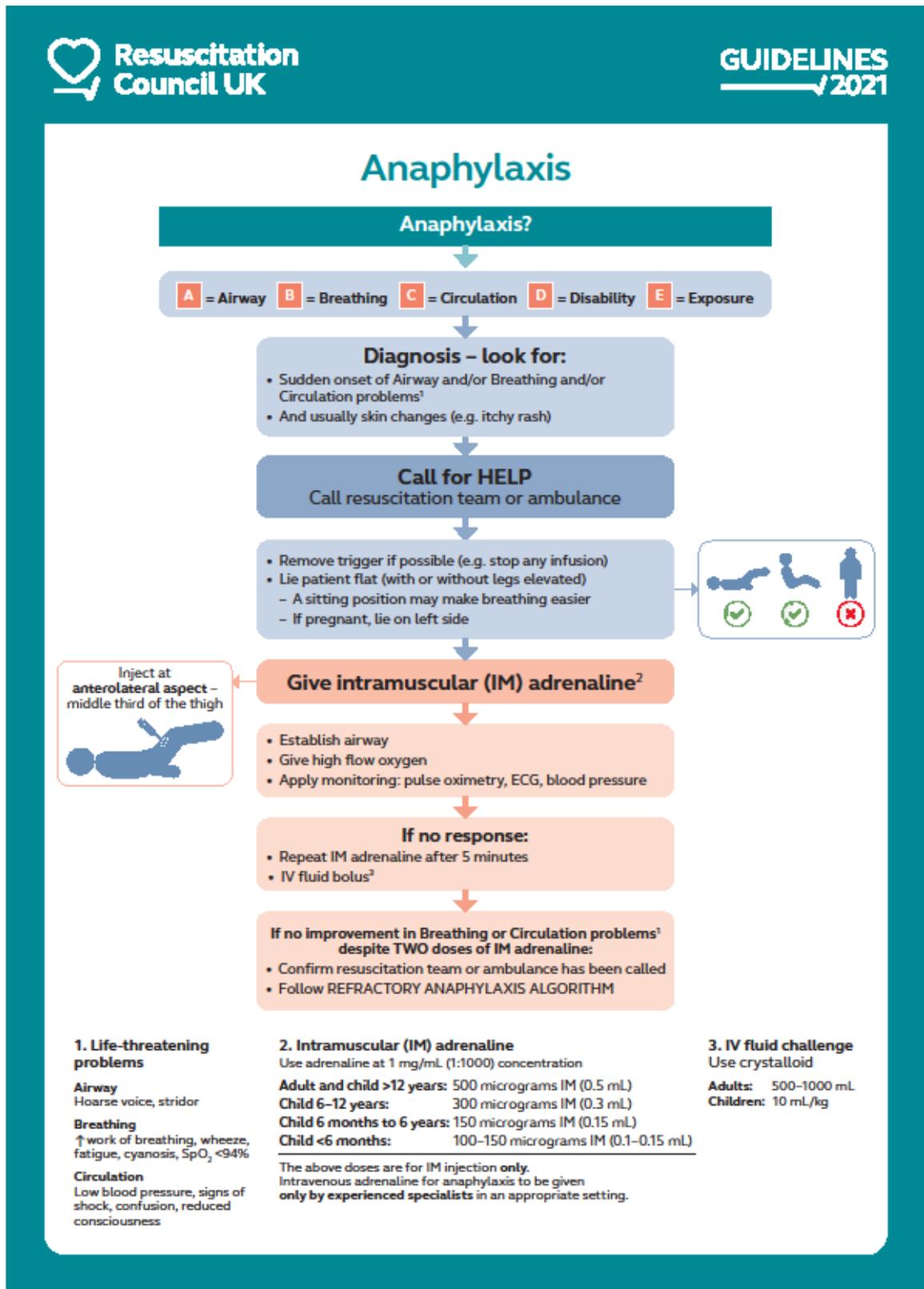
Antihistamines can be helpful in alleviating cutaneous symptoms (whether these are due to anaphylaxis or non-anaphylaxis allergic reactions), but must not be given in preference to adrenaline to treat anaphylaxis. In the presence of ongoing Airway/Breathing/ Circulation problems of anaphylaxis, give 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 dialing (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
ADULT	500 micrograms intramuscular (0.5ml)
CHILD MORE THAN 12 YEARS	500 micrograms intramuscular (0.5ml) (300 micrograms if child is small or prepubertal)
CHILD 6-12 YEARS	300 micrograms intramuscular (0.3ml)
CHILD 6 MONTHS to 6 YEARS	150 micrograms intramuscular (0.15ml)
CHILD LESS THAN 6 MONTHS	100-150 micrograms intramuscular (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 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 the 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 CPR immediately, according to the Combined UHL/LPT/LLR Alliance Cardiopulmonary Resuscitation Policy (2020)
- 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** Transfer to the acute sector for further monitoring in case of a biphasic reaction. Children under 16yrs of age must be admitted under the care of a paediatric medical team.

1.5 Safe and Secure Handling of Adrenaline

1.5.1 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 can be placed via email or by using the electronic Pharmacy eStock Request Form which will be sent electronically via email to

Pharmacyorder@leicspart.nhs.uk The following details will need to be included:

- Name of the individual placing the order
- Professional Number (ie 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/wp-content/uploads/staff-directory/Pharmacy-eStock-Request-Form-Misc-location-v2.pdf>

1.5.2 Access and Safe Storage of Adrenaline

Adrenaline is a Prescription Only Medicine and therefore must be stored securely at all times.

Community Staff - 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 a record documenting how many ampoules they have taken together with batch numbers and expiry dates. At the end of the shift, the adrenaline must be 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. Nursing bags must not be left in the car overnight.

Adrenaline should be checked for discoloration prior to commencing visits. Discoloration may happen if it has been subjected to extreme temperatures.

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 eg 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.

1.5.3 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.

1.5.4 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.

1.6 Reporting of adverse reactions

1.6.1 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 (www.mhra.gov.uk). The British National Formulary (BNF) includes copies of the Yellow Card at the back of each edition.

1.6.2 All adverse reactions 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

Refractory anaphylaxis algorithm

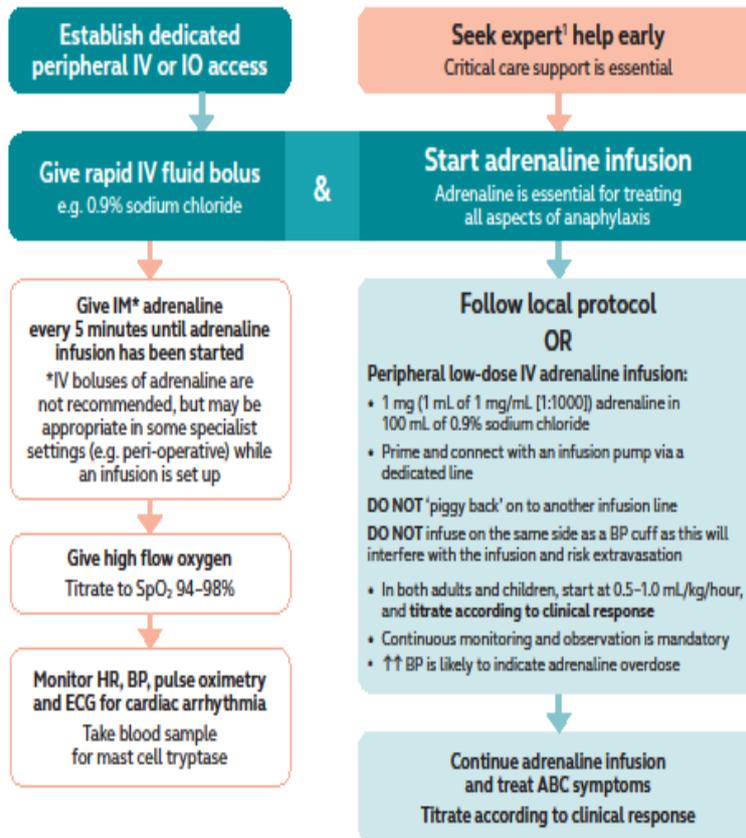
NOTE: Clinicians must only work within their level of competence and training



GUIDELINES
2021

Refractory anaphylaxis

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



¹Intravenous 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

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 a number of 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. 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 System One and Rio. Patients with a confirmed Drug Allergy must have a red alert sticker placed on the external cover of their medical notes.

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 (eg if unconscious or confused etc) every attempt must be made to establish whether an allergy exists eg 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 18 year 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. The allergy should be recorded on an alert notice which should be placed at the front of the medical notes and a red alert sticker stuck to the external front cover of the medical notes.

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

4.4 Any cases of fatal anaphylactic reaction require discussion following Trust procedures with the coroner.

Training Requirements

Training Required	YES	
Training topic:	Anaphylaxis	
Type of training: (see study leave policy)	<input type="checkbox"/> Mandatory (must be on mandatory training register) <input checked="" type="checkbox"/> Clinical Mandatory <input type="checkbox"/> Personal development	
Division(s) to which the training is applicable:	<input checked="" type="checkbox"/> Mental Health Directorate <input checked="" type="checkbox"/> Community Health Services <input type="checkbox"/> Enabling Services <input checked="" type="checkbox"/> Families Young People & Children and Learning Disabilities Services <input type="checkbox"/> 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 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 produced by the Clinical Education Team and accessed via Ulearn	
Have resources been identified?	Yes	
Has a training plan been agreed?	Yes	
Where will completion of this training be recorded?	<input checked="" type="checkbox"/> ULearn <input type="checkbox"/> Other (please specify)	
How is this training going to be monitored?	As part of the appraisal process and via the Ulearn system	

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	✓
Respond to different needs of different sectors of the population	
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	
Help keep people healthy and work to reduce health inequalities	
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Process for Monitoring Compliance and Effectiveness

Appendix 6

Page Ref	Minimum Requirements	Self-Assessment Evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
9, 16	Ensure that staff attend training to deliver the care as described in Appendix 3 of this policy.	Sections 6.0	Review by team managers of records of training that is recorded on the Ulearn system	Community Managers/ Ward Matrons/ Podiatry Managers	Quarterly
11-15	Ensure that staff are competent to deliver the care as described in Appendix 1 of this policy.	Section 6.0	Discussion at appraisal between line manager and staff member as part of review of training.	Community Managers/ Ward Matrons/ Podiatry Managers	Annual
9	Review of episodes of reported anaphylaxis on the Ulysses system.	Section 4.5	Individual case by case review of patients notes when anaphylaxis has been reported/treated.	Locality Action Group reporting to PSEG	Reported as required and as exception.
9	Ensure that the appropriate clinicians carry usable adrenaline.	Section 4.5	Spot checks by team managers and Clinical Education Team as part of clinical monitoring.	Line managers and Clinical Education Team	Ongoing

Section 1			
Name of activity/proposal	Emergency recognition and treatment of anaphylaxis and drug allergy in the clinical setting		
Date Screening commenced	14 th June 2021		
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 drug 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 <u>tick</u> 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:			
Carrying out this life saving treatment does not impact on any protected characteristics.			
Signed by reviewer/assessor	A. Oxley	Date	14 th June 2021
<i>Sign off that this proposal is low risk and does not require a full Equality Analysis</i>			
Head of Service Signed		Date	14 th June 2021

Appendix 8

DATA PRIVACY IMPACT ASSESSMENT SCREENING

<p>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.</p> <p>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.</p>		
Name of Document:	Anaphylaxis Policy	
Completed by:	Anthony Oxley	
Job title	Head of Pharmacy	Date 14th June 2021
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	
<p>If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk</p> <p>In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.</p>		
Data Privacy approval name:		
Date of approval		

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

Data Privacy Impact Screening Guidance Notes

The following guidance notes should provide an explanation of the context for the screening questions and therefore assist you in determining your responses.

Question 1: Some policies will support underpinning processes and procedures. This question asks the policy author to consider whether through the implementation of the policy/procedure, will introduce the need to collect information that would not have previously been collected.

Question 2: This question asks the policy author if as part of the implementation of the policy/procedure, the process involves service users/staff providing information about them, over and above what we would normally collect

Question 3: This questions asks the policy author if the process or procedure underpinning the policy includes the need to share information with other organisations or groups of staff, who would not previously have received or had access to this information.

Question 4: This question asks the author to consider whether the underpinning processes and procedures involve using information that is collected and used, in ways that changes the purpose for the collection e.g. not for direct care purposes, but for research or planning

Question 5: This question asks the author to consider whether the underpinning processes or procedures involve the use of technology to either collect or use the information. This does not need to be a new technology, but whether a particular technology is being used to process the information e.g. use of email for communicating with service users as a primary means of contact

Question 6: This question asks the author to consider whether any underpinning processes or procedures outlined in the document support a decision making process that may lead to certain actions being taken in relation to the service user/staff member, which may have a significant privacy impact on them

Question 7: This question asks the author to consider whether any of the underpinning processes set out how information about service users/staff members may intrude on their privacy rights e.g. does the process involve the using specific types of special category data (previously known as sensitive personal data)

Question 8: This question asks the author to consider whether any part of the underpinning process(es) involves the need to contact service users/staff in ways that they may find intrusive e.g. using an application based communication such as WhatsApp

If you have any further questions about how to answer any specific questions on the screening tool, please contact the Data Privacy Team via LPT-DataPrivacy@leicspart.secure.nhs.uk