Healthier Communities, Outstanding Care

ALLERGY AND ANAPHYLAXIS IDENTIFICATION AND MANAGEMENT POLICY

POLICY

Reference	CPG-TW-AAAIMP		
Approving Body	Joint Drug and Therapeutics and Medicine Optimisation Committee		
Date Approved	16TH January 2026		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public**		
	YES	**NO**	**N/A**
	X		
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Summary of Changes from Previous Version	Policy amended to be inclusive for patients from Black, Asian and minority ethnic groups regarding assessment of skin tone changes in emergency/suspected anaphylaxis situations. Update/amends to associated documents.		
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Date of Completion of Equality Impact Assessment	1st October 2025		
Date of Environmental Impact Assessment (if applicable)	Not Applicable		
Legal and/or Accreditation Implications	Not Applicable		
Target Audience	All clinical staff who are employed by or on behalf of the Trust		
Review Date	March 2029		
Sponsor (Position)	Executive Medical Director		
Author (Position & Name)	Corporate Practice Development Team		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Corporate Training & Development/ Resuscitation Team		

Position of Person able to provide Further Guidance/Information	Corporate Practice Development Team Resuscitation Training Manager Assistant Chief Pharmacist

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
1. Adrenaline auto-injector counselling checklist	With policy/ intranet
2. Patient letter following a severe allergic reaction (anaphylaxis)	Current version on the intranet
3. NAP6 Anaesthetic Anaphylaxis Referral form and GP/Patient Information letter (**available from the Department of Anaesthetics only)**	With policy

CONTENTS

1.0 INTRODUCTION

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

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

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

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

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

Anaphylaxis may be an allergic response that is immunologically mediated, or a non-immunologically mediated response, or idiopathic. Certain foods, insect venoms, some medicines and latex are common precipitants of IgE mediated allergic anaphylaxis. Many medicines can also act through non-allergic mechanisms.

A significant proportion of anaphylaxis is classified as idiopathic, in which there are significant clinical effects but no readily identifiable cause. The relative likelihood of the reaction being allergic, non-allergic or idiopathic varies considerably with age.

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

2.0 POLICY STATEMENT

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

3.0 DEFINITIONS/ ABBREVIATIONS

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

4.0 ROLES AND RESPONSIBILITIES

Clinical Chairs and Divisional Directors of Nursing must:

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

Resuscitation Advisory Group must:

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

Line Managers must:

- Disseminate the policy to all their staff including agency staff.
- Ensure their staff adhere to all aspects of the policy.
- Facilitate staff access to relevant training.

- Ensure anaphylaxis events and severe allergic reactions are reported on DATIX®

Health Care Professionals (HCPs) must:

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

Non-Registered Healthcare Providers must:

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

Non-clinical staff must:

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

5.0 APPROVAL

Following consultation this policy has been approved by the Joint Drug and Therapeutics and Medicines Optimisation Committee

6.0 DOCUMENT REQUIREMENTS

6.1 Background:

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

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

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

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

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

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

6.2 Recognition & Diagnosis:

The clinical features of the reaction may vary in severity and progress. It is recommended that an

ABCDE clinical assessment format is used. Symptoms suggestive of the likelihood of a severe reaction may show one or several of the following signs:

Response Time	Sudden onset and rapid progression of symptoms following exposure to the trigger (more rarely several hours delay to onset of symptoms)
General Signs	Pallor, reduced level of consciousness, dyspnoea/apnoea, collapse leading to respiratory/cardiorespiratory arrest.
Airway	Angioedema - swelling of lips, face, neck, tongue, dysphagia, hoarseness and stridor.
Breathing	Chest tightness, tachypnoea, dyspnoea, bronchospasm with audible wheeze
Circulation	Profound hypotension in association with tachycardia and weak pulses. Slow capillary filling (>2 seconds).
Disability	Confusion, agitation, loss of consciousness
Exposure	**Skin** - Flushed or pale. For patients with darker skin tones check for palmer or conjunctival pallor and/ or centralised cyanosis. Cold and clammy skin. Itchy lips, palate, eyes, hands and feet. Widespread urticarial rash. (Note: 20% of cases have no skin reaction) **Gastrointestinal** - Nausea, vomiting, abdominal pain, diarrhoea, incontinence

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

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

- Remove the trigger substance if possible.

- Administer medication depending on severity of symptoms. Oral antihistamines may be sufficient for rash with no other symptoms.

- It may be necessary to administer Chlorphenamine and Hydrocortisone injections immediately. These medications can be administered without a prescription for the purpose of saving life in an emergency situation by those competent to do so as described in the Medicines Policy.

	Chlorphenamine (slow intravenous or intramuscular)	**Hydrocortisone** (slow intravenous or intramuscular)
Adult or child over 12 years	10mg	200mg
Child 6-11 years	5mg	100mg
Child 6 months to 5	2.5mg	50mg

years		
Child 1 month to 5 months	250 microgram/kg	25mg

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

Refer to the BNF for further dose information as required. BNF

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

6.4 Immediate Essential Management of Anaphylaxis: with life threatening symptoms

- Summon emergency medical assistance if necessary. In the case of King's Mill Hospital and Newark sites do this by dialling 2222 (999 for Mansfield Community Hospital and all other community care settings).

- For anaphylaxis episodes in the operating theatres refer to AAGBI guidance at QRH_3-1_Anaphylaxis_v4.pdf (anaesthetists.org)

- Remove the trigger substance if possible.

- Proceed in accordance with the Treatment Algorithm for the Emergency Management of Anaphylaxis (Appendix B)

- **For management of refractory anaphylaxis see Appendix D.**

- In the event of the patient experiencing a cardiopulmonary arrest, the Cardiopulmonary Resuscitation (CPR) Policy must be followed and the Resuscitation Council UK ADULT Life Support Algorithm or the Resuscitation Council UK PAEDIATRIC Advanced Life Support Algorithm must be instigated.

- Adrenaline is regarded as the most important medicine for any severe anaphylactic reaction. It is most effective when administered early following anaphylaxis and via the **intramuscular (IM)** route. The preferred site for the injection is the anterolateral aspect of the midpoint of the thigh. Note: the adrenaline injection strength is 1:1000 (medication dosages for both adults and children are specified in the anaphylaxis treatment algorithm)

- Adrenaline is a prescription only medication. However, under the Human Medicines Regulations Schedule (2012) the administration of adrenaline is allowed without prescription for the purposes of saving life in an emergency anaphylaxis situation.

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

- All resuscitation trolleys contain adrenaline for injection.

- Some outpatient areas have adrenaline auto-injectors.

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

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

6.5 Further Management and Discharge Requirements:

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

- All anaphylaxis or allergic reaction events must be logged as a clinical incident on the DATIX® reporting system even if the allergic reaction was unexpected.

- For any patient presenting with an allergic reaction or anaphylaxis, staff must follow the Emergency Department and Inpatient Care Pathway for Allergy and Anaphylaxis Identification and Management – which can be printed from the intranet for use in practice.

- For any patient with suspected anaphylactic reactions associated with anaesthesia, the Anaesthetist in charge must complete a NAP6 Anaesthetic Anaphylaxis Referral Form and a letter for the patient and their GP. The patient will be referred to the Immunology Service at NUH and following clinic review the Anaesthetist may report the episode to the Medicines Health Regulatory Authority (MHRA) via the yellow card scheme

- Report all serious medication reactions to the Medicines and Healthcare Regulatory Agency (MHRA) via the yellow card scheme

- If the patient needs observing further and admission to hospital is not necessary they may be referred to the Same Day Emergency Care Unit (SDEC) using the Emergency Department referral pathway to SDEC for Anaphylaxis / Suspected Anaphylaxis – which can be printed from the intranet for use in practice.

- **In-hospital observation for a minimum period of 6-12 hours** is warranted for those patients whose presentation involves the following factors.

  - Displaying symptoms in one or more of the A, B, and C patient assessment criteria.
  - Reactions in patients with severe asthma, or with a severe asthmatic component.
  - Patients with a previous history of biphasic reaction

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

- **Mast Cell Tryptase level blood sampling** is required to assist confirmation of diagnosis. Three samples are required if a reaction is suspected.

- Sample 1 is taken during resuscitation or as soon as possible afterwards.
- Sample 2 is then taken at 1-2 hours from onset of symptoms.
- Sample 3 is taken after 24 hours or longer in the recovery phase.

If the patient is discharged before the 24-hour sample they must asked to attend for this either to the Trust phlebotomy service in Clinic 3 of the KTC (check opening hours) or they may be referred to the GP subject to an available appointment being available. If the patient is to attend clinic 3 then they will need to be given a blood form prior to attending. The patient can then either attend, take a ticket and wait or pre-book an appointment via swift queue www.swiftqueue.co.uk

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Out of hours the patients must be asked to attend the SDEC department.

- **All patients must be reviewed by a clinician prior to discharge**

- All patients must be discharged with a Patient letter following a severe allergic reaction (Anaphylaxis) which gives information on what to expect post discharge. This letter can be printed from the intranet for use in practice.

- All sufferers of anaphylaxis should be advised to carry/wear an alert device to inform bystanders should a future attack occur and be vigilant to avoid potential exposure to the trigger. The Allergy Clinic will provide this information once the diagnosis has been confirmed – see Appendix E for information on referral criteria to the allergy clinic. Prior to attendance at the clinic patients must show the patient letter issued at the point of discharge at any medical or dental appointments they go to prior to attendance at the allergy clinic.

- **All patients must be provided with two adrenaline auto-injector pens and instruction regarding administration prior to discharge**, as per the Adrenaline Auto-Injector Counselling Checklist (Appendix A) which can be printed from the intranet for use in practice. See section 6.5a for information on the supply of adrenaline auto-injectors. If the counselling occurs in pharmacy, then a copy of the checklist will be stapled to the prescription and filed alongside. If the counselling occurs at ward level, then this will be filed in the medical notes with the TTO paperwork. In the case of the Emergency Department, this checklist may be filed with the Emergency Department notes.

- All patients must be provided with advice regarding signs and symptoms of anaphylaxis and the importance of avoiding the trigger substance/action. This information is part of the Adrenaline Auto-Injector Counselling Checklist. If patients require further information, then they may be directed to www.nhs.uk where there are several patient friendly leaflets on allergy and anaphylaxis. The Patient letter following a severe allergic reaction (anaphylaxis) given to patients will give information on what to expect in terms of referral and will give information on their potential allergens.

- Only new or unknown causes of severe allergy / anaphylaxis need to be referred to the Allergy clinic. Known triggers do not need routine referral, this will be at the discretion of the senior clinician.

- All patients who need a referral to a specialist allergy centre will be referred by the clinician.

  - **Patients from ED/SDEC and all in-patient areas:** responsible clinician to refer via letter to the NUH allergy clinic and include a copy of the Emergency Department and Inpatient Pathway for the Allergy Identification and Management including Anaphylaxis. This may be emailed to the NUH allergy clinic nuhnt.allergyandimmadmin@nhs.net

  - **Anaesthetics-** Please refer via letter or email as above to the allergy clinic and send a copy of the AAGBI Anaphylaxis Proforma and the anaesthetic record. Perioperative anaphylaxis referrals have specific requirements regarding the information required for a referral to be considered. This is detailed here: The Allergy Service | NUH
    Perioperative anaphylaxis referrals can be sent electronically with the required documentation here: nuhnt.anaestheticallergy@nhs.net

  - **Paediatric patients** will be admitted onto the paediatric ward and referral made to the paediatric allergy clinic at Sherwood Forest Hospitals NHS Trust.

- See Appendix E for the indications for referral to the specialist allergy clinic. Further advice is also available from the specialist clinic should it be required prior to patient attendance.

- In the case of the Emergency Department, where the green notes may not be available at the point of discharge this information will be put onto SystemOne for the GP.

- The Emergency Department and Inpatient Pathway for the Allergy Identification and Management including Anaphylaxis document should be filed in the patients' medical notes behind the red alert divider.

- The GP must be informed of the event on discharge and any changes to the patient's allergy status. All information should be clearly documented on the communication paperwork and a copy of the Emergency Department and Inpatient Pathway for the Allergy Identification and Management including Anaphylaxis to be sent to the GP.

6.5a Supply of adrenaline auto-injectors.

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

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

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

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

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

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

6.6 Maintaining and sharing medicines allergy information

- Prescriptions (paper or electronic) issued in any healthcare setting should record information on which medicines or medicine classes to avoid in order to reduce risk of medicine allergy.

- Documentation of a medicine allergy requires the following information as a minimum:

  - the medicine name
  - the signs, symptoms and severity of the reaction
  - the Medication and Administration record (in-patient medicine chart) also requires the person documenting to sign and date the entry.

- The medicine allergy should be documented separately from adverse reactions and be clearly visible to all health care professionals who are prescribing medications. This is not physically possible with the current medication chart and so the letters 'ADR' should be documented to denote a side effect or adverse drug reaction as opposed to an allergy.

- The medicine allergy status should be confirmed, as per the Medicine Policy guidance, with the patient or family members or carers as appropriate before prescribing, dispensing or administering any medicines. Unless the situation is life threatening, none of the aforementioned tasks should be undertaken until information on the patient's allergy status can be obtained.

- The information regarding allergy status should be updated and included in all GP referrals and hospital discharge letters.

- Medicines reconciliation for people admitted to hospital should be carried out in line with medicine policy and include the confirmation of allergy status.

- Patients admitted to hospital who have a medicine allergy must wear a red wrist band to identify and alert staff to the fact that they have an allergy, as stated in the Policy & Procedure for the Positive Identification of Patients.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Audit the usability at ward level of the resus trolleys	Resus Committee	Visual checks	Annual	• Resus Committee
All allergy related medication incidents reported on DATIX® are reviewed by the Medication Safety Officer (MSO) and all harms are discussed at the Medicines Safety Group	Medication Safety Officer	Monthly review As the incident occurs	Monthly	• Medicines Safety Group
Ensure all pts with known allergy have a red wrist band in place.	Practice Development Nurse – Medicines Management	Monthly metrics Annual - specific audit.	Monthly – metrics Annual - audit	• Nursing & Midwifery Board

8.0 TRAINING AND IMPLEMENTATION

8.1 All Cardiac arrest team leaders will have a valid Advanced Life Support (ALS) provider certificate. Advanced Paediatric Life Support (APLS) or European Paediatric Advanced Life Support (EPALS) certificate for the paediatric team leaders (Course syllabus incorporates knowledge around the emergency management of anaphylaxis).

8.2 Anaphylaxis training is incorporated in the Immediate Life Support (ILS) and Paediatric Life Support (PILS) courses as recommended for staff in the **CPR Training Policy**

8.3 Emergency Treatment of Anaphylactic Reactions (sherwood-eacademy.co.uk) is available on the Trusts intranet site.

8.4 Midwives access anaphylaxis training as part of their annual mandatory Emergency Skills Training Day.

8.5 All non-medical clinical staff undertake anaphylaxis e-learning as part of their annual mandatory update training.

8.6 All medical staff, registered nurses, midwives and allied health professionals will be responsible for ensuring they remain up to date with current, related guidelines Emergency treatment for anaphylaxis guidelines (Resus Council UK)

8.7 Anaphylaxis Algorithm posters should be displayed in the clean utility area of all clinical wards/departments and are also contained, as laminates, within the Adult and Paediatric Resuscitation Trollies.

8.8 Epi-Pen training will be provided on a 'train the trainer' basis and counselling aids will be available on all wards and departments to assist with patients counselling. The training checklist will also act as an aide memoire for those counselling patients. Alternative adrenaline auto-injectors are available when needed.

9.0 IMPACT ASSESSMENTS

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

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

Evidence Base:

Human Medicines Regulations 2012 (SI 1916). Regulation 238, schedule19. [online]. Available from: https://www.legislation.gov.uk/uksi/2012/1916/regulation/238/made [Accessed 6th March 2025].

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

Mukwende. M, Tamony. P, Turner. M. (2019/20) Mind the Gap: A handbook of clinical signs in Black and Brown skin. Available at https://www.blackandbrownskin.co.uk/mindthegap [Accessed 19th March 2025]

National Institute for Health & Clinical Excellence (2011) Anaphylaxis: assessment and referral after emergency treatment [CG 134]. [online]. Available from: Overview | Anaphylaxis: assessment and referral after emergency treatment | Guidance | NICE [Accessed 6th March 2025]

National Institute for Health & Clinical Excellence Guideline (2014) Drug allergy: diagnosis and management [CG183]. [online]. Available from: Overview | Drug allergy: diagnosis and management | Guidance | NICE [Accessed 6th March 2025].

National Institute for Health & Clinical Excellence (2015) Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes [NG 5]. [online]. Available from: https://www.nice.org.uk/guidance/ng5/resources/medicines-optimisation-the-safe-and-effective-use-of-medicines-to-enable-the-best-possible-outcomes-pdf-51041805253 [Accessed 6th March 2025].

Resuscitation Council UK (2021) Emergency treatment of anaphylaxis: guidelines for healthcare providers. [online]. Available from: https://www.resus.org.uk/sites/default/files/2021-05/Emergency%20Treatment%20of%20Anaphylaxis%20May%202021_0.pdf [Accessed 6th March 2025].

Royal College of Anaesthetists (2018) Anaesthesia, surgery and life threatening reactions: Reports and finding of the Royal College of Anaesthetists. 6th national audit project: perioperative anaphylaxis. [online]. Available from: https://www.rcoa.ac.uk/sites/default/files/documents/2019-09/NAP6-REPORT-2018-STD.pdf [Accessed 6th March 2025].

Related SFHFT Documents:

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

11.0 KEYWORDS

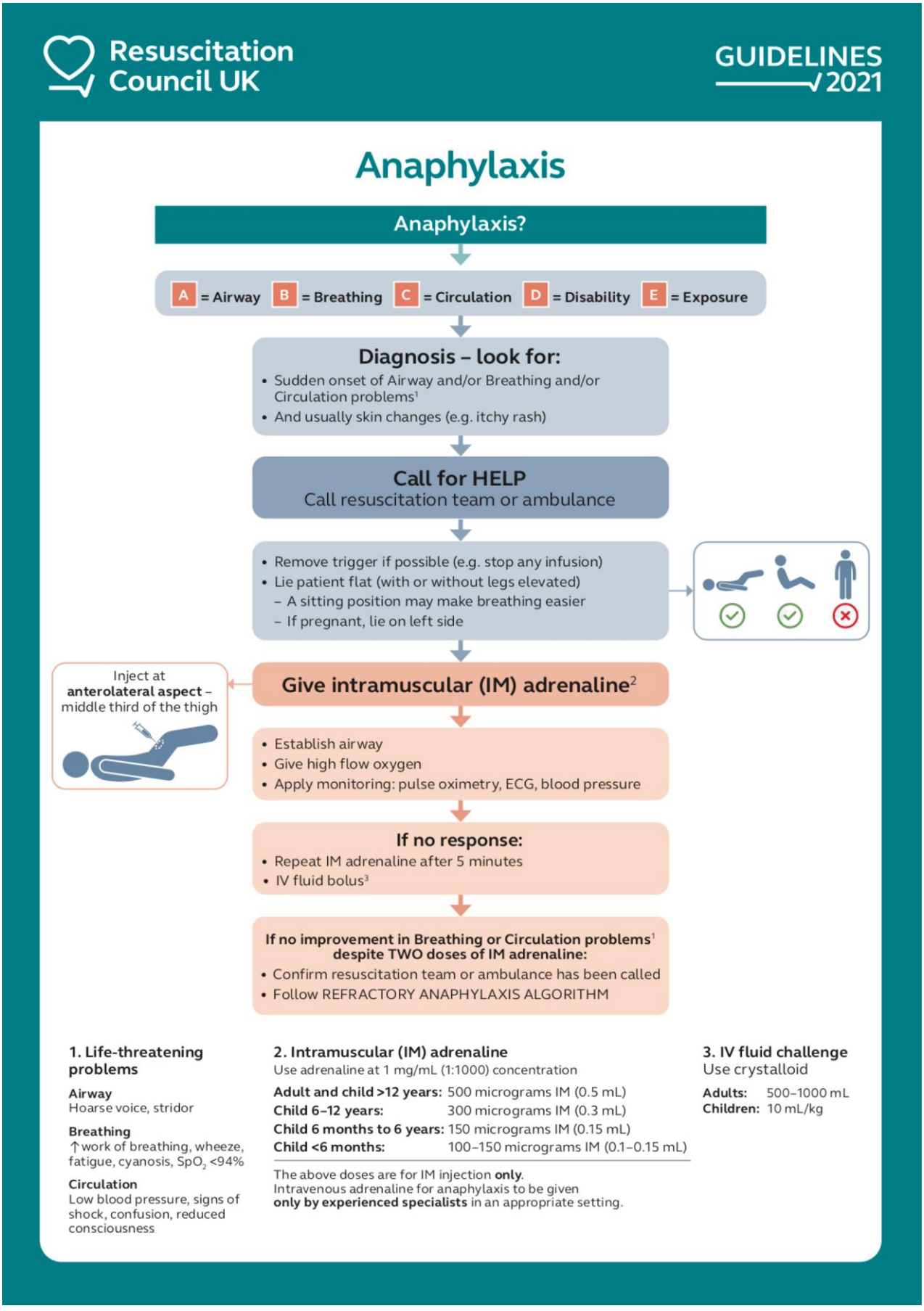
- Adverse drug reaction; ADR; anaphylactic; allergic; allergen; hypersensitivity; adrenaline; shock; pen; rash; urticaria;

12.0 APPENDICES

Appendix A	Adrenaline Auto-injector Counselling Checklist (via intranet)
Appendix B	Treatment Algorithm for the Emergency Management of Anaphylaxis (as

	displayed in all clinical areas)
Appendix C	Signs and allergic patterns of suspected medicine allergy with timing of onset
Appendix D	Refractory anaphylaxis - for use in specialist areas
Appendix E	Indications for referral for the Specialist Allergy Clinic
Appendix F	Equality Impact Assessment

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



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

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

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

Box 1 Immediate, rapidly evolving reactions

Anaphylaxis – a severe multi-system reaction characterised by: • erythema, urticaria or angioedema **and** • hypotension and/or bronchospasm	Onset usually less than 1 hour after medicine exposure (previous exposure not always confirmed)
Urticaria or angioedema without systemic features	
Exacerbation of asthma (for example, with non-steroidal anti-inflammatory drugs [NSAIDs])	

Box 2 Non-immediate reactions without systemic involvement

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

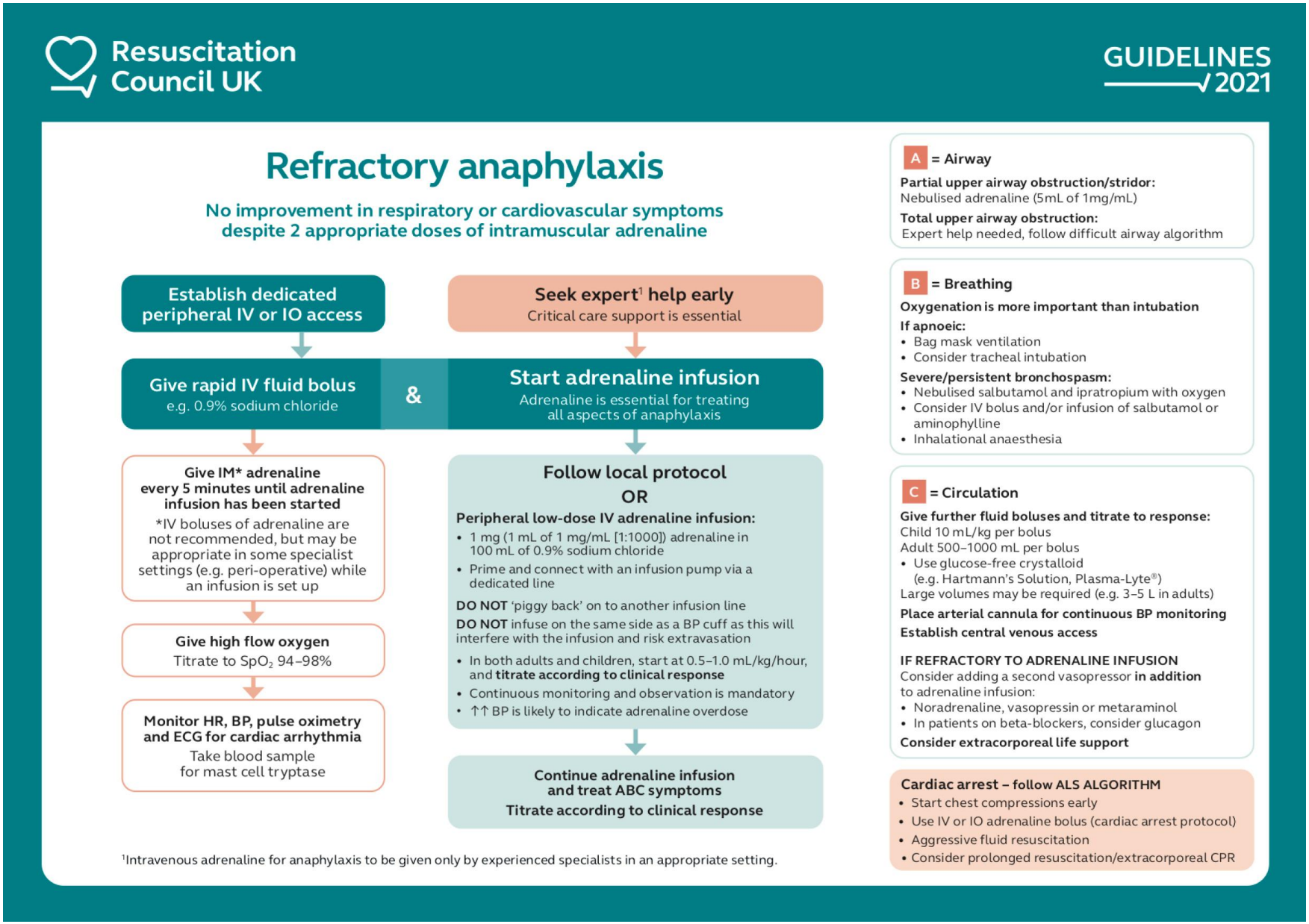
Box 3 Non-immediate reactions with systemic involvement

Drug reaction with eosinophilia and systemic symptoms (DRESS) or medicine hypersensitivity syndrome (DHS) characterised by: • widespread red macules, papules or erythroderma • fever • lymphadenopathy • liver dysfunction • eosinophilia	Onset usually 2–6 weeks after first exposure or within 3 days of second exposure
Toxic epidermal necrolysis or Stevens–Johnson syndrome characterised by: • painful rash and fever (often early signs) • mucosal or cutaneous erosions • vesicles, blistering or epidermal detachment • red purpuric macules or erythema multiforme	Onset usually 7–14 days after first exposure or within 3 days of second exposure

Acute generalised exanthematous pustulosis (AGEP) characterised by: • widespread pustules • fever • neutrophilia	Onset usually 3–5 days after first exposure
Common disorders caused, rarely, by medicines allergy: • eczema • hepatitis • nephritis • photosensitivity • vasculitis	Time of onset variable

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

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



Appendix E:

Indications for referral for the Specialist Allergy Clinic at NUH

ALL referrals should be made via the Emergency Department secretaries or the patients GP, requested by the reviewing clinician via their hospital discharge letter

There is a summary of the service, and information relating to referrals processes, on the allergy clinic internet site, here: Clinical immunology and allergy | NUH

Referrals to the clinic can be made for:

1. Any severe reaction or anaphylaxis or suspected anaphylaxis which is new or has an unknown source.

2. Suspected venom allergy- refer for possible immunotherapy

3. Severe non immediate cutaneous reaction with eosinophilia ie: Stevens Johnson Syndrome

4. Refer people who need treatment with an NSAID to a specialist medication allergy service if they have had a suspected allergic reaction to an NSAID with symptoms such as anaphylaxis, severe angioedema or an asthmatic. These patients should **NOT** be offered a selective COX-2 inhibitor in a non-specialist setting.

5. People with beta-lactam suspected allergy should be referred to a specialist centre if they have a condition which requires or may require this treatment in the future. Consider referring people to a specialist medication allergy service if they are not able to take beta-lactam antibiotics and at least one other class of antibiotic because of suspected allergy to these antibiotics.

6. Refer people with a suspected allergy to local anaesthetics to a specialist medication allergy service if they need a procedure involving a local anaesthetic

7. General anaesthesia- Refer people to a specialist medication allergy service if they have had anaphylaxis or another suspected allergic reaction during or immediately after general anaesthesia.

Perioperative anaphylaxis referrals can be sent electronically with the required documentation here: nuhnt.anaestheticallergy@nhs.net

Note that the clinic has specific NOTTS Area Prescribing Committee (NOTTS APC) referral criteria which need to be met prior to referral for allergic rhinitis and chronic spontaneous urticaria.

Urticaria-primary-care-pathway.pdfAllergic-rhinitis-primary-care-pathway.pdf

APPENDIX F – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Allergy and Anaphylaxis Identification and Management Policy*)*			
New or existing service/policy/procedure: Existing - updated			
Date of Assessment: 20/03/2025			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	Policy needs to be inclusive of the different skin tones representative of BAME patient groups	Policy amended to be inclusive of darker skin tones representative of the wider population	Circulation of the amended policy
Gender	None	N/A	None
Age	None	N/A	None
Religion	None	N/A	None
Disability	None	N/A	None
Sexuality	None	N/A	None
Pregnancy and Maternity	None	N/A	None
Gender Reassignment	None	N/A	None
Marriage and Civil Partnership	None	N/A	None

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	N/A	None

What consultation with protected characteristic groups including patient groups have you carried out?

- **None required**

What data or information did you use in support of this EqIA?

- **Policy content**

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- **No**

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Alison Davidson

Signature: Alison Davidson

Date: 1st October 2025