Anaphylaxis Guidelines
<table>
<thead>
<tr>
<th>Version No.</th>
<th>Amendments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Change from Epinephrine (Adrenaline) to Adrenaline (Epinephrine) and paragraph on use of British approved name (BAN) v the recommended International Nonproprietary Name (rINN)</td>
</tr>
<tr>
<td>1.2</td>
<td>Updated 2014. The Resuscitation Council UK guidelines 2008 have not changed except that in 2012 they were annotated with links to NICE guidance. Minor amendments to this guideline include HSS Number changed to URN on Anaphylactic Reaction Report, references updated, training issues updated, unnecessary appendices removed A section on early intervention has been included.</td>
</tr>
</tbody>
</table>

Copy of this form to be given to Information Governance Officer
This document is largely based on the Resuscitation Council (UK) guidelines for the Emergency Treatment of Anaphylactic Reactions issued in January 2008 – annotated with links to NICE guidance 2012. It is recommended that all Registered Nurses working for Family Nursing and Home Care familiarise themselves with the most current Resuscitation Council (UK) guidance which is more extensive than these guidelines. Also, their guidance may change ahead of this document being updated.

Quality Assurance Framework (QAF) Standards
This guideline links to the following Quality Assurance Framework (QAF) quality standards:

1) Care and welfare of people who use the service
3) Management of medicines
5) Respecting and involving people who use the services
8) Co-operating with other providers
9) Requirements relating to workers
10) Assessing and monitoring the quality of service provision
11) Cleanliness and infection control
13) Safe, available and suitability of equipment
14) Consent to care and treatment
15) Records
16) Supporting workers
### 2014 Consultation:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Nursing and Children’s Community Nursing Teams</td>
<td>Oct 2014 - Prior to updating the guidelines</td>
</tr>
<tr>
<td>Rapid Response Team</td>
<td>Nov 2014</td>
</tr>
<tr>
<td>District Nursing Teams</td>
<td>Dec 2014</td>
</tr>
</tbody>
</table>
**Definition**

There is no universally agreed definition of anaphylaxis. However the following working definition has been proposed.

> "Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction." (Johansson et al. 2004)

Anaphylaxis is a rapidly developing life-threatening condition characterised by airway and/or breathing and/or circulatory problems usually accompanied by skin and/or mucosal changes (Resuscitation Council UK, 2008, p.9).

**What Happens During Anaphylaxis?**

When an allergen, to which the body is already sensitised, is encountered the immune system over-reacts stimulating mast cells to release large quantities of inflammatory mediators, such as histamine, into the bloodstream and tissues.

It is the rapid systemic release of these mediators that causes the clinical manifestations of an anaphylactic reaction.

This mechanism is extremely sensitive and can be triggered by even tiny amounts of the allergen (The Anaphylaxis Campaign, 2012)

**Incidence and Prevalence**

Anaphylaxis is not always recognised and as a result its incidence tends to be underestimated.

A study in 2006 concluded that the frequency of episodes of anaphylaxis is approximately 30-950 cases per 100,000 persons per year. (Lieberman et al. 2006).

Other figures suggest that 1 in every 1333 of the English population have experienced anaphylaxis at some point in their lives (Sheikh et al. 2008)

Between 1990 and 2004 there was a 700% increase in hospital admissions in England for anaphylaxis (Resuscitation Council UK, 2008, p.11).

What is important to be aware of is that the UK incidence of anaphylaxis is rising (Resuscitation Council UK, 2008, p.4).

**Mortality**

It is encouraging to note that the overall prognosis of anaphylaxis is good with most population studies reporting a case fatality ratio of < 1% (Resuscitation Council UK, 2008, p.11).

It is worth noting that pre-existing asthma, particularly if it is poorly controlled or there is non-compliance with treatment, does increase the risk of death as does delaying treatment with adrenaline (epinephrine) (Pumphrey, Gowland, 2007)

In the UK there are approximately 20 anaphylaxis deaths reported each year although there are concerns that this figure may be considerably underestimated (Resuscitation Council UK, 2008, p.11).

**Triggers**

Many things can trigger an anaphylactic reaction but the most common things include:

- Stings
- Nuts
- Food
- Drugs
- Contrast media
- Other e.g. latex, hair dye
Recognition of an Anaphylactic Reaction

The Resuscitation Council (UK) guidelines for healthcare providers dealing with the emergency treatment of anaphylactic reactions (2008, p.13) state that anaphylaxis is likely when all the following 3 criteria are met:

1. sudden onset and rapid progression of symptoms
2. life-threatening Airway and/or Breathing and/or Circulation problems
3. skin and/or mucosal changes (flushing, urticaria, angioedema)

Diagnosis is supported by exposure to a known allergen for the patient. However, The Resuscitation Council (UK) (2008) says the following should be noted:

- skin or mucosal changes alone are not a sign of an anaphylactic reaction
- skin and mucosal changes can be subtle or absent in up to 20% of reactions (some patients can have only a decrease in BP i.e. a circulation problem)
- There can also be gastrointestinal symptoms e.g. vomiting, abdominal pain, incontinence


**Airway problems:**

- Difficulty breathing and swallowing
- Feeling that the throat is closing up
- Hoarse voice
- Stridor

**Breathing problems:**

- Shortness of breath
- Increased respiratory rate
- Wheeze
- Patient becoming tired
- Confusion caused by hypoxia
- Cyanosis (usually a late sign)
- Respiratory arrest

<table>
<thead>
<tr>
<th>Normal adult respiratory rate 12-20 breaths per minute (bpm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
</tr>
<tr>
<td>&gt;1-2 years</td>
</tr>
<tr>
<td>&gt;2-5 years</td>
</tr>
<tr>
<td>5-12 years</td>
</tr>
<tr>
<td>&gt;12 years</td>
</tr>
</tbody>
</table>

**Circulation problems**

- Signs of shock – pale, clammy
- Tachycardia
- Hypotension – dizziness, feeling faint, collapse
- Decreased conscious level or loss of consciousness
- Cardiac arrest

<table>
<thead>
<tr>
<th>Normal heart rate by age (beats per minute):</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 months</td>
</tr>
<tr>
<td>&gt;3mths - 2years</td>
</tr>
<tr>
<td>&gt;2yrs – 10yrs</td>
</tr>
<tr>
<td>&gt;10years</td>
</tr>
<tr>
<td>Adults</td>
</tr>
</tbody>
</table>
Disability
- Confusion
- Agitation
- Loss of consciousness

Exposure
- Skin and/or mucosal changes
  - erythema – patchy or generalised red rash
  - urticaria
  - angioedema
- Often the first feature and present in over 80% of anaphylactic reactions
- Can be subtle or dramatic
- May be just skin, just mucosal or both

Differential Diagnosis

<table>
<thead>
<tr>
<th>Life-threatening Conditions</th>
<th>Non Life-threatening Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life-threatening asthma</td>
<td>Faint (vasovagal episode)</td>
</tr>
<tr>
<td>Low blood pressure with a</td>
<td>Panic attack</td>
</tr>
<tr>
<td>petechial or purpuric rash</td>
<td>Breath-holding episode in child</td>
</tr>
<tr>
<td>can be a sign of septic</td>
<td>Non-allergic urticaria or</td>
</tr>
<tr>
<td>shock</td>
<td>angioedema</td>
</tr>
</tbody>
</table>

(Resuscitation Council UK 2008, p.16)

Early Intervention
When a person presents with life-threatening features of anaphylaxis, the early use of intramuscular adrenaline is emphasised (Resuscitation Council UK 2008)
Treatment

The ABCDE approach is extended to the treatment of anaphylaxis.

Anaphylactic reaction?


Diagnosis - look for:
- Acute onset of illness
- Life-threatening Airway and/or Breathing and/or Circulation problems 1
- And usually skin changes

• Call for help
  - Lie patient flat
  - Raise patient’s legs

Adrenaline 2

When skills and equipment available:
- Establish airway
- High flow oxygen 3
- IV fluid challenge 4
- Chlorphenamine 4
- Hydrocortisone 5

Monitor:
- Pulse oximetry
- ECG
- Blood pressure

1 Life-threatening problems:
Airway: swelling, hoarseness, stridor
Breathing: rapid breathing, wheeze, fatigue, cyanosis, SpO₂ < 92%, confusion
Circulation: pale, clammy, low blood pressure, faintness, drowsy/coma

2 Adrenaline (give IM unless experienced with IV adrenaline) IM doses of 1:1000 adrenaline (repeat after 5 min if no better)
  - Adult: 500 micrograms IM (0.5 mL)
  - Child more than 12 years: 500 micrograms IM (0.5 mL)
  - Child 6 -12 years: 300 micrograms IM (0.3 mL)
  - Child less than 6 years: 150 micrograms IM (0.15 mL)

Adrenaline IV to be given only by experienced specialists
Titrate: Adults 50 micrograms, Children 1 microgram/kg

3 IV fluid challenge:
- Adult: 500 – 1000 mL
- Child: crystalloid 20 mL/kg

Stop IV colloid if this might be the cause of anaphylaxis

4 Chlorphenamine
  - (IM or slow IV)
  - Adult or child more than 12 years: 10 mg
  - Child 6 -12 years: 5 mg
  - Child 6 months to 6 years: 2.5 mg
  - Child less than 6 months: 250 micrograms/kg

5 Hydrocortisone
  - (IM or slow IV)
  - Adult: 200 mg
  - Child: 100 mg
  - Child: 50 mg
  - Child: 25 mg

(Resuscitation Council UK 2008, p.20)

NB. 3, 4 and 5 are not applicable to FN&HC staff working in the community environment.

An ambulance must be called for any patient/child who has had an anaphylactic reaction or a suspected reaction.
Adrenaline (Epinephrine)

Adrenaline (epinephrine) is the drug of choice for treating anaphylactic reactions and should be given to anyone with life-threatening features (Resuscitation Council UK 2008, p.21).

The Resuscitation Council (UK) emphasise the early use of intramuscular adrenaline (epinephrine) in this situation and they point out that it can fail to reverse the clinical manifestations of an anaphylactic reaction if its use is delayed (2008, p.24).

In some countries, the drug we know as ‘adrenaline’ is called ‘epinephrine’. However, according to the Medicines and Healthcare Regulatory Agency (MHRA) healthcare professionals in the UK should continue to use the name ‘adrenaline’ which is the British approved name (BAN) rather than the internationally approved name of ‘epinephrine’ (MHRA, 2006). This decision reflects the widespread familiarity with this name; however, manufacturers have been encouraged to use dual labelling on product packaging and product information literature (MHRA, 2013).

How It Works

Early adrenaline (epinephrine) administration has the following physiological benefits in the treatment of anaphylaxis:

- reverses peripheral vasodilation
- increases peripheral vascular resistance
- improves blood pressure and coronary perfusion
- decreases angio-oedema
- causes bronchodilation
- reduces the release of inflammatory mediators

Supply & Storage

Relevant Family Nursing and Home Care nursing staff carry 1:1000 adrenaline (epinephrine). In line with recommendations by the Resuscitation Council (UK) (2008) all clinical areas in which anaphylaxis could occur must have adrenaline (epinephrine) readily available.

Each clinical area must ensure that processes are in place for maintaining adequate supplies. Adrenaline (epinephrine) should be stored in a cool dark place (below 25°C but not in the refrigerator).

All adrenaline (epinephrine) must be replaced every October even if still in date. Staff should refer to the ‘Adrenaline Procedure’ regarding the annual renewal of their supply.

Administration

In the community setting, adrenaline (epinephrine) should only be given via the intramuscular route.

The best site for IM injection is the anterolateral aspect of the middle third of the thigh (Simons et al. 2001).

Whenever possible, consent should be obtained from the casualty or other appropriate person and documented.

Following administration of the appropriate age related dose of IM adrenaline (epinephrine) nurses should monitor the patient’s/child’s pulse, colour, respiratory rate and, if the equipment is available, blood pressure.

The casualty’s level of consciousness should also be observed using the AVPU approach.
These observations will help assess the response to the adrenaline (epinephrine).

If there is no improvement in the patient’s/child’s condition then a repeat IM dose can be given after 5 minutes.

Previously, FN&HC staff who carried adrenaline (epinephrine) could only administer a total of two age related doses of the drug however one further dose can now be given, if clinically indicated, about 5 minutes after the last dose.

The Resuscitation Council (UK) no longer supports giving half the dose of adrenaline (epinephrine) to patients in certain circumstances e.g. in those taking tricyclic antidepressants (2008, p.24)

**Side Effects**

- tachycardia and tremor
- dizziness
- anxiety
- headache
- arrhythmias
- dry mouth
- cold extremities

**Auto-injectors**

Approximately 1 in 12 people per year who have had an anaphylactic reaction will have a recurrence of this life-threatening condition (Gupta et al. 2004).

Those at risk of anaphylaxis are often given adrenaline (epinephrine) auto-injectors for their own use.

The Resuscitation Council (UK) advocates that “healthcare professionals should be familiar with the use of the most commonly available auto-injector” and it should be used if it is the only adrenaline (epinephrine) preparation available (2008, p.24)

In situations where both an auto-injector and an adrenaline (epinephrine) supply are available the correct age related adrenaline (epinephrine) dose should be drawn up and administered rather than the auto-injector being used.

Adrenaline (epinephrine) auto-injectors are generally only available in 0.15mg and 0.3mg doses.

Several auto injector training devices are available within Family Nursing and Home Care (FNHC) for staff to practice the administration technique.

**Patient Group Direction**

The administration of adrenaline (epinephrine) is covered by a Patient Group Direction (PGD).

Whilst in the UK it is not necessary to have a patient specific direction for adrenaline (epinephrine) when it is to be used in an emergency situation, it is FNHC’s policy that all staff who may be required to administer adrenaline (epinephrine) in an emergency situation sign up to the Association’s PGD for Adrenaline (epinephrine).

All staff carrying this drug, or who may be required to administer it, must fulfil the requirements stipulated in the adrenaline PGD and sign up to this document every 2 years.

Relevant practitioners must also complete the PGD e.learning package every 3 years.

The PGD should be available whenever adrenaline (epinephrine) is being administered.

A copy of each version of the adrenaline (epinephrine) PGD will be retained by the Association for 10 years.
**Record Keeping**

Details of an anaphylactic reaction must be recorded in the patient's nursing record and, in the case of children, in the child’s records and in the parent held record (red book). The following information should be recorded:

- Description of the reaction with circumstances and timings
- Consent (if possible)
- Administered treatments - in the recording of adrenaline (epinephrine) administration the NMC guidelines for the Administration of Medicines must be followed
- Response to adrenaline (epinephrine) - before and after adrenaline (epinephrine) administration blood pressure, pulse, colour, respiratory rate and AVPU (as appropriate) should be recorded. Any adverse reaction to adrenaline (epinephrine) should also be documented.
- Time emergency services contacted, time of their arrival and time patient left for hospital
- Any advice or treatment declined by the patient or any person with responsibility for them
- Advice given about the risks involved should a patient or any person with responsibility for them decline hospital/medical treatment
- Advice/information given to patient/carer/parent (as appropriate)

Nursing staff should carry a copy of the ‘Anaphylactic Reaction Report’ (appendix 1) form in their work bags and it should be available in all clinics.

It should be completed (if available) and ideally sent to A&E with the patient, however, it is appreciated that as many FNHC clinical staff work alone there may not be time to do this.

Where it is not possible to send a completed ‘Anaphylactic Reaction Report’ to A&E with the casualty, as much information as possible should be given to the paramedics and the report faxed through as soon as it is practicable to do so.

A copy of the ‘Anaphylactic Reaction Report’ must also be sent to the patient’s GP.

The original copy of the ‘Anaphylactic Reaction Report’ must be filed in the client’s nursing records to document the incident.

As per FNHC protocol, an “Incident/Near Miss” form must also be completed.

**Reporting a Reaction**

It is important that the patient's GP is informed that an anaphylactic reaction/suspected reaction happened and full details should be passed on as soon as it is practicable to do so (see above).

Any anaphylactic reaction thought to be related to a drug or combination of drugs must be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) using the yellow card scheme. Copies of the yellow card can be found at the back of the British National Formulary (BNF) and at [www.mhra.gov.uk](http://www.mhra.gov.uk).

Line and Divisional Managers must also be made aware that an emergency situation has occurred and they will be required to complete and action the appropriate sections of the Incident/Accident/Near Miss form.

Provision must also be made to enable a debrief session for the clinician(s) involved and counselling/support must be arranged if required.
Training

All Nursing staff at Family Nursing and Home Care who may be required to administer adrenaline (epinephrine) must complete an **annual** mandatory update in anaphylaxis and **annual** basic life support (BLS) training.

BLS training sessions are organised by the Education and Development Department and are available throughout the year.

The anaphylaxis training/upDATES are available as an online package (see FNHC training prospectus for details).

E-learning training in the use of patient group directions must also be completed and repeated every **3 years**.

FNHC staff who undertake training of staff in schools/nurseries should ensure that they are confident in how to administer adrenaline via the most commonly used auto-injector devices. Indeed, all staff should be familiar with how to use such devices (The Resuscitation Council 2008). Auto-injector devices are available for training purposes.

Competence

Registered Nurses have a duty to maintain their competence in recognising and treating anaphylactic reaction.

A competency framework (appendix 2) is available and it is recommended that Nurses use it to demonstrate that they remain competent in this area.

Where training needs are identified appropriate educational support must be sought.

Audit

Annually the Governance and Performance Division will audit (appendix 3) adherence to:

1. the internal process for staff renewing their adrenaline (epinephrine) supply
2. the criteria for PGD use
References


Lieberman P et.al. (2006) Epidemiology of anaphylaxis: findings of the American College of Allergy, Asthma and Immunology, Epidemiology of Anaphylaxis Working Group, Allergy, Asthma, Immunology 97(5):596-602


MHRA (2006)
http://www.mhra.gov.uk/Howweregulate/Medicines/Namingofmedicines/ChangestomedicinesnamesBANstordINNs/Frequentlyaskedquestions/index.htm (last accessed 10.07.14)

MHRA (2013)
http://www.mhra.gov.uk/Howweregulate/Medicines/Namingofmedicines/ChangestomedicinesnamesBANstordINNs/index.htm (last accessed 10.07.14)

Simons FE et al. (2001), Epinephrine absorption in adults: intramuscular versus subcutaneous injection, Journal of Allergy and Clinical Immunology; 108(5):871-3

Anaphylactic Reaction Report

Date and Time of Reaction Onset: .................................................................

Description of Reaction:
e.g. ABCDE, onset/signs/symptoms/location of patient etc

Suspected Trigger: (tick as appropriate)       Details
Sting          □ ................................................   Nut          □ ................................................   Food          □ ................................................   Drug          □ ................................................   Other          □ ................................................

Observations:

<table>
<thead>
<tr>
<th>Pulse</th>
<th>Respiratory Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Colour</td>
</tr>
<tr>
<td>Level of Consciousness (AVPU)</td>
<td>A – alert  □   V – responds to vocal command □   P – responds only to pain □   U - unconscious □</td>
</tr>
</tbody>
</table>

Time Ambulance Called: .................................................................

Treatment: (tick as appropriate)       comments
Positioning (ideally lying flat with legs elevated) □ ..............................................
Information about adrenaline (including side effects) given □ ..............................................
Verbal consent obtained (specify from whom) ..............................................
Adrenaline (Epinephrine) 1:1000 – IM □ ..............................................
High Dose Oxygen Therapy □ ..............................................
Cardio-Pulmonary Resuscitation □ ..............................................
Adrenaline (Epinephrine) Administration:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Dosage</th>
<th>Route</th>
<th>Site</th>
<th>Manufacturer</th>
<th>Batch Number</th>
<th>Expiry Date</th>
<th>Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>IM</td>
<td></td>
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<td>3</td>
<td></td>
<td></td>
<td>IM</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Response Following Adrenaline (Epinephrine):

*Initial Dose*

<table>
<thead>
<tr>
<th>Pulse</th>
<th>Respiratory Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Colour</td>
</tr>
<tr>
<td>Level of Consciousness (AVPU)</td>
<td>A – alert</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*1st Repeat Dose*

<table>
<thead>
<tr>
<th>Pulse</th>
<th>Respiratory Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Colour</td>
</tr>
<tr>
<td>Level of Consciousness (AVPU)</td>
<td>A – alert</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*2nd Repeat Dose*

<table>
<thead>
<tr>
<th>Pulse</th>
<th>Respiratory Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Colour</td>
</tr>
<tr>
<td>Level of Consciousness (AVPU)</td>
<td>A – alert</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Details of any adverse reaction to Adrenaline (Epinephrine) ………………………………………

Ambulance Arrival Time: …………………… Patient Departure Time: …………………

Print Name of Nurse: ………………………………………………………………………

Signature: …………………………………………………………………………………

Date/Time: …………………………………………………………………………………

Please fax as soon as possible to A&E. A copy to be sent to the patient’s GP and the original to be retained in their FNHC records. (Updated July 2014)
## Self Assessment Competency Framework for Anaphylaxis

Date of last anaphylaxis update: ..............................................................

<table>
<thead>
<tr>
<th>Following training and self study I can:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give a working definition of anaphylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State the incidence of anaphylactic shock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>List the common triggers for anaphylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State who may be at increased risk of anaphylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use the ABCDE approach to recognise anaphylactic reaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss differential diagnoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain the importance of calling for an ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain what to do in the event of anaphylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State the adult dose of adrenaline (epinephrine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State the dose of adrenaline (epinephrine) required for children of different ages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State the preferred site for administering IM adrenaline (epinephrine) into</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain how to use an adrenaline (epinephrine) auto injector device</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe what adrenaline (epinephrine) does to the body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>List the side effects of adrenaline (epinephrine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have read and understood the most current version of the Anaphylaxis Guidelines for Family Nursing and Home Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have read and understood the most current version of the Resuscitation Council (UK) Emergency Treatment for Anaphylactic Reactions – guidelines for healthcare providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel that I have the necessary knowledge and skills to safely deal with an anaphylactic reaction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have answered ‘no’ to any of the above statements please reassess your competence following further training/study.

<table>
<thead>
<tr>
<th>Name of Nurse</th>
<th>Signature of Nurse</th>
<th>Date(s) of Self Assessment/Reassessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please retain this document in your PREPP portfolio.
Anaphylaxis Audit

This audit should be undertaken in January of each year using data for the previous year as it stands on the 31st December (with the exception of the adrenaline supply information).

Information will be located in the following places:

♦ The ‘live’ Adrenaline Register – located in ‘Central Filing’
♦ The ‘hard copy’ record of staff collecting their replacement adrenaline supply.

The standards to be audited are:

- 100% of staff on the Adrenaline (epinephrine) Register will routinely replace their adrenaline (epinephrine) supply by the end of October every year.
- 100% of staff on the anaphylaxis training register will complete Anaphylaxis training annually.
- 100% of staff on the anaphylaxis training register will complete approved Adult Basic Life Support training annually.
- 100% of Paediatric, School Nursing and Health Visiting staff on the anaphylaxis training register will complete approved Paediatric Basic Life Support training annually.
- 100% of staff on anaphylaxis training register will complete the approved online e.learning course on PGDs.
- 100% of staff on anaphylaxis training register will have signed up to the latest version of the adrenaline PGD.

Name of Auditor: …………………………………………..Date of Audit: ………………………

Adrenaline (epinephrine) Supply

number of staff who have collected new adrenaline (epinephrine) supply by the end October
number of staff on the adrenaline (holders) register x100 = % compliant with adrenaline supply policy

Mandatory Training

Anaphylaxis

number of staff on the anaphylaxis training register who have completed anaphylaxis training in the previous year
number of staff on the anaphylaxis training register X 100 = % compliant

Basic Life Support

Adult

number of staff on the adrenaline (epinephrine) register who have completed BLS training within the last year
number of staff on the anaphylaxis training register X 100 = % compliant

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Paediatric (School Nurses, Paediatric Nurses and Health Visitors only)

\[ \text{number of staff above on the anaphylaxis training register who have completed Paediatric BLS training within the last year} \times 100 = \% \text{ compliant} \]

Patient Group Direction

\[ \text{number of staff on the anaphylaxis training register who have completed the PGD e-learning package} \times 100 = \% \text{ compliant} \]

\[ \text{number of staff on the anaphylaxis training register who have signed up to the latest version of the adrenaline PGD} \times 100 = \% \text{ compliant} \]

Audit Report

Outcomes

During ………… there were ………… people on the Adrenaline (holders) Register. ………… of those people had collected their Adrenaline (epinephrine) supply which represents a …………% compliance rate with local policy.

………..% of staff on the Anaphylaxis Training Register had completed Anaphylaxis training in the previous year.

………..% of staff on the Anaphylaxis Register had completed adult basic life support training in the previous year and …………% of relevant staff on the Anaphylaxis Training Register had completed paediatric basic life support training.

……….. staff successfully completed the approved on line training course for Patient Group Directions. This represents ………….% of staff on the Anaphylaxis training Register who have completed this training.

………..% of staff on the Anaphylaxis Training Register have signed the Patient Group Direction for Adrenaline (epinephrine).

Recommendations & Actions

Conclusion

In line with the agreed audit plan the standards for Anaphylaxis will be re-audited in one year.

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