Anaphylaxis Guidelines
(including procedure for the management of an anaphylactic reaction)

August 2019
**Document Ratification Form**

<table>
<thead>
<tr>
<th><strong>Type</strong></th>
<th>Guideline and procedure</th>
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</thead>
<tbody>
<tr>
<td>i.e. Strategy, Policy, Education Package etc.</td>
<td>Guideline and procedure</td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td>Anaphylaxis Guidelines (including procedure for the management of an anaphylactic reaction)</td>
</tr>
<tr>
<td><strong>Category</strong></td>
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<tr>
<td>i.e. organisational, clinical, Corporate, Finance etc</td>
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</tr>
<tr>
<td><strong>Version</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>Author</strong></td>
<td>Elspeth Snowie (Clinical Effectiveness Facilitator)</td>
</tr>
<tr>
<td><strong>Approved by</strong></td>
<td>Organisational Governance Approval Group</td>
</tr>
<tr>
<td><strong>Date Approved</strong></td>
<td>7 August 2019</td>
</tr>
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<td><strong>Review Date</strong></td>
<td>7 August 2022</td>
</tr>
<tr>
<td><strong>Person responsible for review</strong></td>
<td>Clinical Effectiveness Facilitator</td>
</tr>
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</table>
## Version Control/Amendments

<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 Non-proprietary 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>
<tr>
<td>2.0 (2019)</td>
<td>Includes minor rewording, layout and formatting changes for clarity and consistency with other FNHC guidelines. Quality Assurance Framework (QAF) Standards removed. Section numbering added. <strong>Section 3</strong> (numbering on old guidelines document) Prevalence removed. <strong>Section 10</strong> (numbering on old guidelines document) Paragraph regarding the use of the name adrenaline rather than epinephrine has been removed as now unable to find references which dated back to 2006. <strong>Section 1</strong> Rationale (1.1) Scope (1.2) and Principles (1.3) added. <strong>Section 2.10.2</strong> Link to the Annual Replacement of Adrenaline Standard Operating Procedure in the Medicines Policy has been added. <strong>Section 2.10.3</strong> Total number of age-related doses that staff can administer has been added. Added – not to sit/stand the casualty up too early. <strong>Section 2.11</strong> use of a Patient Group Direction is no longer required to administer adrenaline to save a life. Link to the electronic medicines compendium site added. <strong>Section 2.12</strong> the NMC standards for the Administration of Medicines have been withdrawn from use – staff should record the administration of adrenaline in line with Family Nursing &amp; Home Care (FNHC) Medicines Policy. Emergency Department (ED) used in place of Accident and Emergency (A&amp;E). The use of electronic patient records is reflected. <strong>Section 2.14</strong> the requirement to undertake PGD training has been removed. <strong>Appendix 1</strong> the use of a paper based incident reporting system has been removed - all incidences of anaphylaxis should be reported via Assure. References updated – where it has not been possible to easily locate old references or find equivalent newer references the information has been removed. <strong>Appendix 1</strong> A&amp;E changed to ED. Caution added – ‘do not sit/stand casualty up too early’</td>
</tr>
<tr>
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<td>Amendments</td>
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<td></td>
<td><strong>Appendix 3</strong></td>
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<td></td>
<td>new simplified audit tool added in place of previous tool</td>
</tr>
</tbody>
</table>
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Appendices
Appendix 1 – Anaphylactic Reaction Report
Appendix 2 – Competency Record
Appendix 3 – Adrenaline Users Audit Tool
It is recommended that all Registered Nurses working for/on behalf of Family Nursing & Home Care familiarise themselves with the most current Resuscitation Council (UK) guidelines for the Emergency Treatment of Anaphylactic Reactions which is more extensive than these guidelines. Also, their guidance may change ahead of this document being updated.
1. Introduction

1.1 Rationale

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).

The incidence of anaphylaxis is increasing (Resuscitation Council UK, 2008), therefore it is important that staff are aware of how to recognise and manage this clinical emergency.

1.2 Scope

These clinical guidelines apply to all Registered Nurses working for or on behalf of Family Nursing & Home Care. It may also be of interest to non-registrants working in clinical areas.

1.3 Principles

Clinical staff will have the knowledge and skills to promptly identify and safely manage anaphylaxis in the community setting.

An ABCDE approach will be used for the recognition and management of anaphylaxis.

2. Guidance

2.1 Definition

There is no universally agreed definition of anaphylaxis. However the European Academy of Allergy and Clinical Immunology suggest that anaphylaxis is a “severe, potentially life-threatening systemic hypersensitivity reaction.” (Murano, A et al 2014, p.1026).

2.2 What Happens During Anaphylaxis?

When an allergen is encountered, to which the body is already sensitised, the immune system over-reacts. This stimulates mast cells to release large quantities of inflammatory mediators, such as histamine, into the blood stream and tissues. It is the rapid systemic release of these mediators that cause the clinical manifestations of an anaphylactic reaction. This mechanism is extremely sensitive and can be triggered by even tiny amounts of the allergen (Anaphylaxis Campaign, 2019)

2.3 Incidence of Anaphylaxis

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

Studies from the UK have indicated that over the last 20 years there has been an increase in hospital admissions with anaphylaxis (Anagnostou, K, Turner, P. 2018)

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

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). However, it is encouraging to note that the overall prognosis of anaphylaxis is good. Fortunately fatal anaphylaxis is a rare event (Anagnostou, K, Turner, P. 2018)

Studies have shown that there is an increased risk of death when treatment with adrenaline (epinephrine) is delayed (Anagnostou, K, Turner, P. 2018).

2.5 Triggers

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

- Stings
- Drugs
- Nuts
- Contrast media
- Food
- Other e.g. latex, hair dye

2.6 Recognition of an Anaphylactic Reaction

The Resuscitation Council (UK) guidelines for healthcare providers dealing with the emergency treatment of anaphylactic reactions 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)

(The Resuscitation Council (UK), 2008, p.13)

Diagnosis is supported by exposure to a known allergen for the patient. However, The Resuscitation Council (UK) (2008, p.13) 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

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

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
2.7 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 petechial or purpuric rash can be a sign of septic shock</td>
<td>Panic attack</td>
</tr>
<tr>
<td></td>
<td>Breath-holding episode in child</td>
</tr>
<tr>
<td></td>
<td>Non-allergic urticaria or angioedema</td>
</tr>
</tbody>
</table>

(Resuscitation Council UK 2008, p.16)

2.8 Early Intervention

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

The ABCDE approach is extended to the treatment of anaphylaxis.

![Diagram of the ABCDE approach extended to anaphylaxis treatment]

**Anaphylactic reaction?**

**Airway, Breathing, Circulation, Disability, Exposure**

**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
- IV fluid challenge[^3]
- 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)

<table>
<thead>
<tr>
<th>IM doses of 1:1000 adrenaline (repeat after 5 min if no better)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult</strong></td>
</tr>
<tr>
<td><strong>Child more than 12 years</strong></td>
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<tr>
<td><strong>Child 6-12 years</strong></td>
</tr>
<tr>
<td><strong>Child less than 6 years</strong></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Dose</th>
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<tbody>
<tr>
<td><strong>Adult or child more than 12 years</strong></td>
</tr>
<tr>
<td><strong>Child 6 - 12 years</strong></td>
</tr>
<tr>
<td><strong>Child 6 months to 6 years</strong></td>
</tr>
<tr>
<td><strong>Child less than 6 months</strong></td>
</tr>
</tbody>
</table>

[^5]: Hydrocortisone (IM or slow IV)

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</table>

(Resuscitation Council UK 2008, p.20)

NB. 3, 4 and 5 are not applicable to Family Nursing & Home Care 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*
2.10 Adrenaline (Epinephrine)

Adrenaline 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) (2008) emphasise the early use of intramuscular adrenaline in this situation and they point out that it can fail to reverse an anaphylactic reaction if its use is delayed.

2.10.1 How It Works

Early adrenaline 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

2.10.2 Supply & Storage

Relevant Family Nursing & Home Care nursing staff carry 2 ampoules of 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 readily available. Each clinical area must ensure that processes are in place for maintaining adequate supplies.

Adrenaline should be stored in a cool dark place (below 25°C but not in the refrigerator).

All adrenaline must be replaced every October even if still in date. Staff should refer to the Standard Operating Procedure ‘Annual Replacement of Adrenaline’ in the Medicines Policy https://www.fnhc.org.je/media/42933/medicines-policy-2016-updated-december-2017-4418.pdf

2.10.3 Administration

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

Intramuscular adrenaline should, preferably, be injected into the anterolateral aspect of the middle third of the thigh (National Institute for Health and Care Excellence – BNF, 2019)

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, nurses should monitor the casualty’s pulse, colour, respiratory rate and blood pressure (if the equipment is available).

The casualty’s level of consciousness should also be observed using the AVPU approach.

These observations will help assess the response to the adrenaline.
If there is no improvement in the patient's/child's condition then a repeat IM dose can be given after 5 minutes. One further age-related dose can be given, if clinically indicated, about 5 minutes after the last dose. The administration of a maximum of 3 age-related doses is permitted by Family Nursing & Home Care staff.

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

Care should be taken not to sit/stand the casualty up too early.

2.10.4 Side Effects

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

2.10.5 Auto-injectors

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

"Healthcare professionals should be familiar with the use of the most commonly available auto-injector" (Resuscitation Council (UK) 2008, p.24) and it should be used if it is the only adrenaline preparation available (Resuscitation Council (UK) 2008).

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

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

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

2.11 Patient Group Direction

The administration of adrenaline was covered by a Patient Group Direction (PGD) until October 2018 when it was withdrawn from use. The reason for this being that there is no legal requirement for a PGD when adrenaline is administered to save life.

For further information about adrenaline, see https://www.medicines.org.uk/emc/ for the summary of product characteristics and patient information.

2.12 Record Keeping

Details of an anaphylactic reaction should be recorded in the patient’s nursing record and in the case of children 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 - the recording of adrenaline administration should be in line with the organisation’s medicines policy
- response to adrenaline - before and after adrenaline administration, blood
pressure, pulse, colour, respiratory rate and AVPU (as appropriate) should be recorded - any adverse reaction to adrenaline 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 ED (Emergency Department) 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 ED 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’ should also be sent to the patient’s GP.

The ‘Anaphylactic Reaction Report’ should be scanned into the patient’s electronic nursing records to document the event.

All incidences of anaphylaxis should be reported via Assure.

2.13 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.

Line Managers should also be made aware that an emergency situation has occurred and should investigate to identify if there is learning from the event.

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

2.14 Training

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

Basic Life Support training sessions are organised by the Education and Development Department and are available throughout the year.

The anaphylaxis training/updates are available as on online package (see FNHC training prospectus for details)

Family Nursing & Home Care staff who train 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.

2.15 Competence

Registered Nurses have a duty to maintain their competence in recognising and treating an 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 should be sought.

2.16 Audit

The Adrenaline Users Process Audit (appendix 3) will be undertaken annually by the Quality and Governance Division. All areas where adrenaline is used will be included in the audit.

This policy has been updated taking into account current guidance from Resuscitation Council (U.K.). Also, see section 5 for the full list of reference documents used.

3. Development and Consultation

3.1 Development

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. At the time of updating this Family Nursing & Home Care clinical guideline, an updated Resuscitation Council guideline is awaited.

3.2 Consultation Schedule (for updating of policy)

Not sent out for separate consultation as no significant changes and the staff it would have been sent to are on the Organisational Governance Approval Group anyway.

4. Ratification Process

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<th>Date of Committee/Group</th>
<th>Outcome</th>
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<td>Agreed with minor change suggested (which has been made)</td>
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<td>Approval Group</td>
<td></td>
<td></td>
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<tr>
<td>Chief Executive Officer</td>
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5. Dissemination and Implementation

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<th>Planned Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email to all staff</td>
<td>Education and Development Administrator</td>
<td>Within 2 weeks following ratification</td>
</tr>
<tr>
<td>Policy to be placed on the Procedural Document Library</td>
<td>Education and Development Administrator</td>
<td>Within 2 weeks following ratification</td>
</tr>
</tbody>
</table>
6. References

Anagnostou, K; Turner, P (2018) Myths, facts and controversies in the diagnosis and management of anaphylaxis; Archives of Disease in Childhood 2019; 104:83-90 available at https://adc.bmj.com/content/104/1/83 (last accessed 04/10/19)


Murano, A et al. (2014) Anaphylaxis: guidelines from the European Academy of Allergy and Clinical Immunology; Allergy – European Journal of Allergy and Clinical Immunology; 69; 1026-1045


Appendix 1

Anaphylactic Reaction Report

Name ............................................................
Date of Birth ...................................................
URN ..............................................................

attach patient label

For hospital staff only
If patient no longer in the Emergency Department (ED), please forward this document to the appropriate ward or file in the patient’s medical records.

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

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

Suspected Trigger: (tick as appropriate)
Sting  ☐
Nut  ☐
Food  ☐
Drug  ☐
Other  ☐ please give details……………………………………………………………

Tick if “Yellow Card” completed  ☐

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></td>
</tr>
<tr>
<td>A – alert</td>
<td>☐</td>
</tr>
<tr>
<td>V – responds to vocal command</td>
<td>☐</td>
</tr>
<tr>
<td>P – responds only to pain</td>
<td>☐</td>
</tr>
<tr>
<td>U – unconscious</td>
<td>☐</td>
</tr>
</tbody>
</table>

Time ambulance called: ..............................................................................

Treatment: (tick as appropriate)
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  ☐

Please fax as soon as possible to ED. A copy to be sent to the patient’s GP. (updated May 2019)
Patient's Name: …………………. DOB: ……………… URN: ………………

**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>
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<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>IM</td>
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</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>Caution: Do not sit/stand casualty up too early</td>
</tr>
<tr>
<td>A – alert</td>
<td>❑</td>
</tr>
<tr>
<td>V – responds to vocal command</td>
<td>❑</td>
</tr>
<tr>
<td>P – responds only to pain</td>
<td>❑</td>
</tr>
<tr>
<td>U - unconscious</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>Caution: Do not sit/stand casualty up too early</td>
</tr>
<tr>
<td>A – alert</td>
<td>❑</td>
</tr>
<tr>
<td>V – responds to vocal command</td>
<td>❑</td>
</tr>
<tr>
<td>P – responds only to pain</td>
<td>❑</td>
</tr>
<tr>
<td>U - unconscious</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>Caution: Do not sit/stand casualty up too early</td>
</tr>
<tr>
<td>A – alert</td>
<td>❑</td>
</tr>
<tr>
<td>V – responds to vocal command</td>
<td>❑</td>
</tr>
<tr>
<td>P – responds only to pain</td>
<td>❑</td>
</tr>
<tr>
<td>U - unconscious</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 ED. A copy to be sent to the patient's GP. (updated May 2019)
Appendix 2

Self-assessment Competency Framework (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 required for children of different ages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State the preferred site for administering IM adrenaline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain how to use an adrenaline auto injector device</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe what adrenaline does to the body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>List the side effects of adrenaline</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have read and understood the most current version of the Anaphylaxis Guidelines for Family Nursing & Home Care

I have read and understood the most current version of the Resuscitation Council (UK) Emergency Treatment for Anaphylactic Reactions – guidelines for healthcare providers

I feel that I have the necessary knowledge and skills to safely deal with an anaphylactic reaction

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Nurse</td>
<td></td>
</tr>
<tr>
<td>Date(s) of Self Assessment/Reassessment</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

Adrenaline Users Process Audit Tool

<table>
<thead>
<tr>
<th>Date of Audit:</th>
<th>Name of Auditor:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Service/Team:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Guidance:**

This audit should be undertaken in January using the data for the previous year as it stands on the 31st December (with the exception of the collection of the adrenaline supply information). Information will be located in the ‘live’ adrenaline register on ‘central filing’.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>No. of YES</th>
<th>No. of NO</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who carry adrenaline have replaced their adrenaline supply by the end of October</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff have completed annual anaphylaxis training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff have completed annual Adult Basic Life Support training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Nursing, Children’s Community Nursing and Health Visiting staff have completed annual Paediatric Basic Life Support training</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% compliance