

CLINICAL GUIDELINE FOR DRUG ALLERGY AND THE TREATMENT OF MEDICAL EMERGENCIES

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CLINICAL GUIDELINE SUMMARY
<p>These clinical guidelines aim to ensure that staff are provided with current information and underpinning principles considered by the Trust to be essential regarding the treatment of medical emergencies and drug allergies.</p> <p>The principles contained within this clinical guideline and associated documents aim to ensure that open communication and respect are fundamental elements of the management of medical emergencies.</p> <p>It should be read in conjunction with the Trust’s procedural guidelines on CPR, Safe and Secure Handling of Medicines, Pharmacological Management of Acutely Disturbed Behaviour and Mandatory training.</p>
The Trust monitors the implementation of and compliance with this clinical guideline in the following ways;
These clinical guidelines will be monitored via the Datix incident reporting system.

SCOPE

Services	Applicable	Comments
Trustwide	✓	

The Director of responsible for monitoring the Clinical Guideline is the Executive Nurse

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**CLINICAL GUIDELINES FOR DRUG ALLERGY AND THE TREATMENT OF
MEDICAL EMERGENCIES**

1. INTRODUCTION

- 1.1. When medical emergencies arise it is essential that staff are familiar with the protocols and algorithms needed to guide their treatment. This clinical guideline covers medical emergencies including anaphylaxis, asthma and hypoglycaemia that are not included in other policies and guidelines within the Trust.
- 1.2. All drugs have the potential to cause side effects (adverse drug reactions), but not all are of an allergic nature. Drug allergy occurs when a reaction is caused by a drug with clinical features compatible with an immunological mechanism. Not all allergic drug reactions will involve anaphylaxis.
- 1.3. In order to prevent a patient being prescribed, dispensed or administered a drug to which they have had a previous allergy, suspected drug allergy needs to be properly documented and diagnosed.

2. SCOPE

- 2.1. All Registered Healthcare Professionals working within Essex Partnership University NHS Foundation Trust (EPUT) must be aware of the requirements regarding prompt recognition and treatment of a medical emergency and actions that should be taken following an instance of drug allergy.

4. RESPONSIBILITIES

- 3.1. Governance arrangements within the Trust will ensure that:
 - Appropriate systems are in place throughout the organisation to manage a medical emergency
 - Statistics will be collected and trends reported to the Executive Team by the Serious Incident Lead
- 3.2. Registered Healthcare Professionals:
 - Must ensure that they report all incidents of a medical emergency to their line manager and via the DATIX reporting system.
 - Must document all incidents of suspected drug allergy or other medical emergency in the patient's healthcare record
 - Must adhere to these clinical guidelines and make themselves available for the training in CPR, anaphylaxis and medicines management appropriate to their service.

5. RECOGNITION AND MANAGEMENT OF ANAPHYLAXIS

4.1. Introduction to Anaphylaxis

- 4.1.1. Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction, which requires prompt recognition and treatment. It is characterised by rapidly developing problems involving the airway and/or breathing and/or circulation. In most cases, there are associated skin and mucosal changes as well.
- 4.1.2. Outside the acute hospital setting, swift treatment of anaphylaxis with intra-muscular adrenaline (epinephrine) is the UK Resuscitation Council's treatment of choice and can save a life.
- 4.1.3. Regulation 238 of the Human Medicines Regulations 2012 allows Adrenaline 1:1000 (1mg in 1ml) for intramuscular injection to be administered by anyone, without the need for the directions of an appropriate practitioner (i.e. no prescription, PGD or direction is needed) for the purpose of saving life in an emergency.
- 4.1.4. Adverse effects are extremely rare when correct doses of adrenaline are injected intramuscularly (IM). Early intervention with IM adrenaline is associated with a better outcome.

4.2 Causes of Anaphylaxis

Anaphylaxis is an allergic response that may be immunologically mediated, a non-immunological response or idiopathic (i.e. no readily identifiable cause). People who have had a mild or moderate allergic reaction in the past are at risk of developing anaphylaxis. Certain groups may be at higher risk because of existing co-morbidity (for example asthma).

4.2.1 Anaphylaxis is most commonly caused by foods (especially peanut and tree nuts), insect stings, medicines and latex rubber. Food is a particularly common trigger in children, while medicines are a more common trigger in older people.

4.2.2 Medicines commonly causing anaphylaxis reactions include:

- Antibiotics (especially penicillins and cephalosporins).
- Aspirin and Non-Steroidal Anti-Inflammatory Drugs (NSAIDs e.g. ibuprofen)
- Vaccines
- Heparin
- Hyposensitising (allergen) preparations
- Neuromuscular blocking drugs
- Intravenous anaesthetic drugs
- Blood products
- Intravenous contrast media

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In the case of drugs, anaphylaxis is more likely after parenteral administration.

4.3 Signs and Symptoms of Anaphylaxis

4.3.1 The presentation of anaphylaxis varies between individuals. Its clinical course is unpredictable with variable severity within a range of clinical features. The combined presentation of multiple symptoms makes diagnosis of an anaphylactic reaction more likely. It should be noted however that not all symptoms of anaphylaxis will appear in all patients.

4.3.2 Onset and severity of symptoms may vary considerably between individuals even with exposure to the same allergen.

4.3.3 Presenting symptoms can include:

Skin

- Colour changes, flushed or pale
- Erythema – redness of the skin
- Pruritus – itchy skin
- Urticaria – a raised itchy rash

Airway

- Airway swelling – pharyngeal/laryngeal oedema
- Hoarse voice
- Stridor – high pitched ‘musical’ breathing sounds
- Swallowing difficulties and feeling of obstruction in the throat

Breathing

- Shortness of breath, difficulty breathing, tightness of the chest
- Wheeze
- Confusion-due to hypoxia
- Respiratory arrest

Circulation

- Signs of shock - pale, clammy
- Increased pulse rate and / or palpitations
- Hypotension (low blood pressure), potentially leading to collapse and loss of consciousness

Abdominal

- Abdominal cramps
- Vomiting
- Diarrhoea

Other

- Rhinitis – runny, stuffy nose caused by irritation/inflammation
- Conjunctivitis – inflammation and itching of the eye lid
- Swelling
- Sense of impending doom

- 4.3.4 Symptoms such as respiratory stridor, breathing difficulties, cyanosis, and/or pronounced tachycardia and imminent collapse should alert the healthcare professional to an anaphylactic reaction.
- 4.3.5 When anaphylaxis is fatal, death usually occurs very soon after contact with the trigger. From a case-series, fatal food reactions cause respiratory arrest typically after 30–35 minutes; insect stings cause collapse from shock after 10–15 minutes; and deaths caused by intravenous medication occur most commonly within five minutes.

4.4 Limiting the Risk of Anaphylactic Shock

- 4.4.1 Most anaphylactic reactions occur in people who have no risk factors. However, the following checks must be made to help assess the risk of anaphylaxis and impact on any subsequent treatment before administration of medicine particularly if new:
- Previous adverse/allergic reactions to medicines
 - Other known allergies
- 4.4.2 Where assessment identifies that there is a risk of anaphylaxis reference must be made to a medical practitioner to discuss the possible need to withhold the medicine or to give it within a controlled, medically-supervised environment. The potential risk must be discussed with the patient.
- 4.4.3 It is no longer recommended by the Green Book that practitioners keep patients to observe for reactions following the administration of vaccines. Due to the unpredictable nature of anaphylactic reactions it is not possible to define a particular time period over which all individuals should be observed to ensure they do not develop anaphylaxis.
- 4.4.4 The practitioner must have access to a phone or a means of calling for assistance in the event of a severe reaction.

4.5 Diagnosis of Anaphylaxis

- 4.5.1 Clinicians should be able to distinguish an anaphylactic reaction from fainting and panic attacks. Special attention should be paid to the condition of the skin, the pulse rate, the blood pressure and the upper airways. If in doubt anaphylaxis should be presumed.
- 4.5.2 Anaphylaxis is likely when all of the following 3 criteria are met:
- Sudden onset with rapid progression.
 - Life threatening airway and/or breathing and/or circulation problems.
 - Skin and mucosal changes.

And the following supports the diagnosis:

- Exposure to a known allergen for the patient

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4.5.3 Remember:

- 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 blood pressure, i.e., a circulation problem)
- There can also be gastrointestinal symptoms (e.g. vomiting, abdominal pain, incontinence)

4.5.4 Sudden onset and rapid progression of symptoms

- The patient will feel and look unwell.
- Most reactions occur over several minutes. Rarely, reactions may be slower in onset.
- The time of onset of an anaphylactic reaction depends on the type of trigger. An intravenous trigger will cause a more rapid onset of reaction than stings which, in turn, tend to cause a more rapid onset than orally ingested triggers.
- The patient is usually anxious and can experience a “sense of impending doom”.

4.5.5 The table below differentiates between anaphylaxis and fainting.

Signs and Symptoms	Anaphylaxis	Faint
Skin	<ul style="list-style-type: none"> • Skin itchiness • Pallor or flushing • Red or pale urticaria or angioedema 	<ul style="list-style-type: none"> • Generalised pallor • Cold clammy skin
Respiratory	<ul style="list-style-type: none"> • Cough • Wheeze • Stridor • Signs of respiratory distress – tachypnoea, cyanosis, rib recession 	<ul style="list-style-type: none"> • Normal Respiration (shallow, but not laboured)
Cardiovascular	<ul style="list-style-type: none"> • Tachycardia (generally) • Weak/absent central pulse • Sustained hypotension 	<ul style="list-style-type: none"> • Bradycardia • Strong central pulse • Transient hypotension which corrects in the supine position
Neurological	<ul style="list-style-type: none"> • Sense of severe anxiety and distress • Loss of consciousness with no improvement once supine or head down position 	<ul style="list-style-type: none"> • Sense of light headedness • Loss of consciousness, improves once supine or head down position • Transient jerking of the limbs and eye-rolling which may be confused with seizures

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4.5.6 Panic attacks may result in the following:

- Hyperventilation leading to paraesthesiae (tingling in the arms and legs).
- Erythematous rash associated with anxiety.

Hypotension, pallor, wheezing and urticarial rash / swelling will not be present.

4.6 Management of Anaphylaxis

4.6.1 An initial treatment algorithm is provided in Appendix 1 and summarised below:

- Where appropriate discontinue the suspected causative agent.
- Summon urgent assistance: If hospital based, call a medical emergency and an ambulance. If community based, call for an ambulance as soon as possible.
- Do not leave the patient alone. Monitor heart rate and respiration rate continuously. Check blood pressure every 1-2 minutes if you can.
- Lay the patient flat with the legs raised. However, if the person has breathing difficulties or respiratory distress increases when flat, sit in an upright position. Patients who are breathing and unconscious should be placed in the recovery position.
- If cardiac function or breathing stops administer Cardio Pulmonary Resuscitation (CPR)
- Administer IM adrenaline into the anterolateral aspect of the thigh
- Further doses of adrenaline can be given at about 5 minute intervals if there is no improvement in the patient's condition.

4.6.2 Adrenaline injection 1:1000 (1mg in 1ml) should be held by all in-patient units.

4.6.3 Anaphylaxis packs should be carried by all staff administering medicines in the community. These normally consist of 1ml ampoules of adrenaline 1:1000 (1mg in 1ml), 1ml syringes and 23g safety needles. Packs should be checked regularly to ensure the contents are within their expiry date. They should be stored securely below 25°C and not allowed to freeze.

4.6.4 Auto-injectors for self-administration of adrenaline should not be used as a substitute for a professional anaphylaxis pack. However, if a patient's own adrenaline auto-injector is the only available adrenaline preparation when treating anaphylaxis, healthcare professionals should use it.

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4.6.5 The recommended treatment doses of adrenaline are:

Age	Volume of Adrenaline (Epinephrine) 1 in 1000 (1mg in 1ml) Given by Intramuscular (IM) injection
Adults	0.5ml (500 micrograms)
> 12 years	0.5ml (500 micrograms)
6 – 12 years	0.3ml (300 micrograms)
Under 6 years	0.15ml (150 micrograms)

4.6.6 All patients who have experienced an anaphylactic reaction must be transferred to hospital for observation and follow-up treatment, even though they may appear to have made a full recovery.

4.6.7 Document the clinical features of the suspected anaphylactic reaction, the time of onset and the circumstances immediately before the onset of symptoms to help identify the possible trigger and ensure that this information is transferred to hospital with the patient

4.6.8 Discharge

Before discharge⁴, a healthcare professional with the appropriate skills and competencies should offer people (or, as appropriate, their parent and/or carer) the following:

- information about anaphylaxis, including the signs and symptoms of an anaphylactic reaction
- information about the risk of a biphasic reaction
- information on what to do if an anaphylactic reaction occurs (use the adrenaline injector and call emergency services)
- a demonstration of the correct use of the adrenaline injector and when to use it
- a prescription for 2 adrenaline injectors, with advice to carry the injectors with them at all times
- advice about how to avoid the suspected trigger (if known)
- information about the need for referral to a specialist allergy service and the referral process
- information about patient support groups.

9. MANAGEMENT OF HYPOGLYCAEMIA

(See also Mental Health & Learning Disability Formulary and Prescribing Guidelines Chapter 19)

5.1 Signs of Hypoglycaemia

Hypoglycaemia occurs when blood glucose levels fall below 4mmol/L (72mg/dL). Being aware of the early signs of hypoglycaemia will allow early treatment in order to bring blood glucose levels back into the normal range.

Symptoms of hypoglycaemia include:

- Sweating
- Fatigue
- Feeling dizzy
- Looking pale
- Feeling Weak
- Feeling Hungry
- Higher heart rate than usual
- Blurred vision
- Confusion
- Loss of consciousness
- Coma (extreme cases)

5.2 Causes of Hypoglycaemia

- Dose of insulin or oral hypoglycaemic agents too high
- Delayed meal or inadequate carbohydrate intake
- Exercise
- Alcohol

5.3 Treatment of Hypoglycaemia

- If the person is conscious and able to swallow administer 15g-20g fast acting glucose. (4-5 Glucotabs or 1 bottle of Glucojuice). Wait 10-15 minutes and recheck glucose levels, and record. If reading is still below 4 mmol/L, or if no physical improvement, repeat this procedure up to 3 times. If still no improvement after 45 minutes or 3 cycles of treatment call doctor. Consider Glucagon intramuscular injection (may be less effective if on sulphonylurea therapy)
- If the person is conscious and able to swallow, but in need of assistance squeeze 1-2 tubes of Glucogel inside cheeks and rub the outside of the cheeks to ensure good absorption. Ensure gag reflex is present. Wait 10-15 minutes and recheck glucose levels, and record. If reading is still below 4 mmol/L, or if no physical improvement, repeat STEP 1 up to 3 times. If still no improvement after 45 minutes or 3 cycles of treatment call doctor.

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Consider Glucagon intramuscular injection (may be less effective if on sulphonylurea therapy)

- If the person is unconscious and/or fitting check airways and place in recovery position administer 1mg glucagon IM. Call for emergency assistance. Once the patient is conscious give sips of Glucojuice. Check the glucose levels every 10-15 minutes to ensure that the glucose level returns to at least 4mmol/L.
- ALWAYS FOLLOW UP WITH A SLOWLY DIGESTED/ STARCHY CARBOHYDRATE. Check glucose level. Once it is at 4 mmol/L or over and person is recovered, give 20 g slowly digested/starchy carbohydrate. E.g.: 1 x slice/sandwich of low GI bread (ideally multigrain or granary); two digestive biscuits, 200-300 ml glass of milk, (not soya milk) small carton of fruit juice or next meal if due. Recheck glucose levels after 15 minutes. NOTE: Insulin should NEVER be omitted following an episode of low blood sugar.

6. TREATMENT OF ASTHMA (Adults)

6.1. Acute asthma can be fatal and must be treated promptly and energetically. It should be treated with oxygen and inhaled salbutamol via a large volume spacer device. Emergency services must be called.

6.2. Recognising Symptoms:

- Cannot complete sentences in one breath
- Pulse more than 100 beats per minute
- Respiration more than 25 breaths per minute
- Peak flow 35-50% of best.

6.3. Management

- Call for urgent medical assistance
- Support the patient to sit upright, leaning forward to assist ventilation
- Use a face mask to administer oxygen and adjust rates as necessary to achieve the target oxygen saturation.
- Attach a pulse oximeter and monitor oxygen saturation levels. The arterial oxygen saturation target is 94-98%.
- Check peak flow. This should read more than 50% of best.
- Administer 4-10 puffs of salbutamol inhaler (1 puff = 100 microgram) via a spacer device.
- Call 999 if the condition does not resolve immediately
- Repeat salbutamol inhalation as above if necessary in 10 – 20 minutes
- Where indicated prescribe a systemic corticosteroid.

7. GENERAL MANAGEMENT OF DRUG ALLERGY

7.1 Diagnosis

7.1.1 A reaction is more likely to have been caused by allergy to a drug if it occurred during or immediately after use of the drug, and the drug is known to cause that type of reaction or the patient has previously had a similar reaction to that drug or drug class.

Reactions may take several patterns (see table below)

Immediate, rapidly evolving reactions	Anaphylaxis (see sections 4 & 5)	Onset usually less than 1 hours after drug exposure (previous exposure not always confirmed)
	Urticaria or angioedema without systemic features	
	Exacerbation of asthma (for example with NSAIDs)	
Non-immediate reactions without systemic involvement	Widespread red macules or papules (exanthema-like)	Onset usually 6-10 days after first drug exposure or within 3 days of second exposure
	Fixed drug eruption (localised inflamed skin)	
Non-immediate reactions with systemic involvement	Drug reaction with eosinophilia and systemic symptoms or drug hypersensitivity syndrome characterised by: <ul style="list-style-type: none"> • Widespread red macules, papules or erythroderma • Fever • Lymphadenopathy • Liver dysfunction • Eosinophilia 	Onset usually 2-6 weeks after first drug exposure or within 3 days of second exposure
	Toxic epidermal necrolysis or Stevens-Johnson syndrome characterised by: <ul style="list-style-type: none"> • Painful rash and fever (often early signs) • Mucosal or cutaneous erosions • Vesicles, blistering or epidermal detachment • Red purpuric macules of erythema multiforme 	Onset usually 7-14 days after first drug exposure or within 3 days of second exposure
	Acute generalised exanthematous pustulosis characterised by: <ul style="list-style-type: none"> • Widespread pustules • Fever • neutrophilia 	Onset usually 3-5 days after first drug exposure

7.1.2 A reaction is more likely to be caused by drug allergy if it occurred during or after use of the drug.

7.1.3 A reaction is less likely to be caused by drug allergy if there is a possible non-drug cause (e.g. the patient has had similar symptoms when not taking the drug), or the patient only has gastro-intestinal symptoms.

7.2 Treatment

7.2.1 If a drug allergy is suspected:

- consider stopping the suspected drug if possible, or reduce the dose if not

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- treat the symptoms of the acute reaction as appropriate – this may involve the use of antihistamines, corticosteroids, beta₂-agonists
- Identify safe alternative medication if possible

7.2.2 Severe reactions will need to be treated in an acute hospital setting.

7.3 Documentation of a suspected allergic reaction

7.3.1 The occurrence of a suspected drug allergy should be documented in the patient's healthcare record so that all of the following information is included:

- The generic and brand name of the drug or drugs suspected of causing the reaction, including the strength, formulation
- The route of administration
- The indication for which the drug was being taken
- A description of the reaction
- The date and time of the reaction
- The number of doses or days the drug has been taken before the onset of the reaction
- Drugs or classes of drugs to be avoided in the future

7.3.2 Ensure that details of a suspected drug allergy are included in the patient's discharge letter.

7.3.3 Details of all suspected drug allergies should be included on the medicines prescription and administration chart (drug chart). If the patient has more than one drug chart these details must be completed on all charts.

7.4 Documentation on Admission

7.4.1 A patient's drug allergy status should be confirmed before prescribing, dispensing or administering medicines, and should form part of medicines reconciliation at admission.

7.4.2 Care needs to be taken to try and differentiate between patients' perceived allergy (e.g. GI symptoms with antibiotics) and true allergic reactions, by asking about the actual symptoms experienced. Many patients who present with a history of penicillin allergy for example have not had an immunological reaction to penicillin. The questions in the following table can be used to obtain a more accurate allergy history:

Information required for an allergy history	
Detailed description of the reaction, including symptoms, severity, duration	History of other antibiotics taken since the reaction and outcome
Route of drug administration and duration of therapy	Presence of a medical alert bracelet
Interval between initiation of therapy and reaction (timing of onset)	Whether skin testing has ever been performed (and if so, the results)

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What happened when the antibiotic was stopped; did the reaction require treatment?	Consideration of possible causes of the reaction (antibiotic, other drugs, disease)
How long ago the reaction occurred (patient's age at time of reaction)	

7.4.3 Details of all suspected drug allergies should be included on the medicines prescription and administration chart (drug chart). If the patient has more than one drug chart these details must be completed on all charts.

7.5 Referral to specialist allergy services

7.5.1 Patients who have experienced a suspected anaphylactic reaction or a severe non-immediate cutaneous reaction (e.g. reaction with eosinophilia and systemic symptoms, Steven-Johnson Syndrome, toxic epidermal necrolysis) should be referred to a specialist drug allergy service. As the patient is likely to have been transferred to an acute setting this is likely to occur as part of the management of the event or, depending on the circumstances, via the patient's general practitioner.

8. TREATMENT OF VASOVAGAL SYNCOPE IN INTRAUTERINE CONTRACEPTIVE INSERTION

- 8.1 Inadequate oxygenation and blood flow to the brain results in loss of consciousness. This may occur with a low blood pressure caused by vagal over activity (a vasovagal attack, simple faint, or syncope) which slows the heart rate significantly (bradycardia). This can follow emotional stress, pain or specifically after cervical dilatation and instrumentation of the uterus. Some patients are more prone to this and have a history of repeated faints.
- 8.2 Loss of consciousness associated with inadequate cerebral perfusion can be associated with a transient period of twitching or a brief seizure. This is invariably self-limiting and resolves as the bradycardia resolves. Such seizures are not epilepsy and should not be treated as such.
- 8.3 Bradycardia is defined as a heart rate of less than 60 per minute. Most people do not get symptoms until the heart rate is less than 40 per minute. Refer to CPR procedural guidelines.

Symptomatic bradycardia should be treated with IV/IM Atropine in accordance with FSRH Service Standards for Resuscitation

9. MONITORING

These clinical guidelines will be monitored by the Resuscitation and Deteriorating Patient Group and Medicines Management Groups to ensure that the latest guidance is referenced in this procedure. The Trust should annually audit of the frequency of use of this procedure which should include the number of times patients have been treated with adrenaline as a result of an anaphylactic reaction. All instances of anaphylaxis should be reported via Datix.

10. TRAINING

Training in anaphylaxis is given on the enhanced emergency skills courses for Mental Health staff and is attended by all qualified inpatient service staff. Community staff receive basic anaphylaxis training as part of their basic CPR and Defibrillator Training, or through e-learning.

10.1 The training includes:

- A basic understanding of the reaction and causes
- Recognition of the presenting signs and symptoms
- The assessment and appropriate intervention for a patient suffering from anaphylactic reactions including general and specific treatment especially the dosages and correct administration of adrenaline.

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