AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

INFORMATION
for health service organisations

Acute Anaphylaxis

Clinical Care Standard

The Acute Anaphylaxis Clinical Care Standard aims to improve the recognition of anaphylaxis, and the provision of appropriate treatment and follow-up care.

The *Acute Anaphylaxis Clinical Care Standard* contains six quality statements relating to the care provided to adults, children and infants when they are experiencing anaphylaxis – from initial presentation to a healthcare setting or first clinical contact in the community, through to discharge and planning for follow-up care. It also applies to many patients who experience anaphylaxis while in a healthcare facility.

It includes a set of indicators to support health service organisations to monitor how well they are implementing the care recommended in this clinical care standard and to support local quality improvement activities.

The definitions required to collect and calculate indicator data are specified online at **meteor.aihw.gov.au/content/index.phtml/itemId/745144**

Monitoring the implementation of this clinical care standard will help organisations to meet some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition).

Relevant standards and actions include:

- Clinical Governance Standard: Actions 1.27b and 1.28
- Comprehensive Care Standard: Actions 5.02, 5.03, 5.05, 5.06, 5.10–5.14, 5.28.

1 Prompt recognition of anaphylaxis

A patient with acute-onset clinical deterioration with signs or symptoms of an allergic response is rapidly assessed for anaphylaxis, especially in the presence of an allergic trigger or a history of allergy.

Ensure that an anaphylaxis management protocol that outlines clinical criteria (consistent with the ASCIA *Acute Management of Anaphylaxis* guidelines) is available and used consistently by clinicians. Confirm that clinicians have the skills and competency to promptly recognise the signs and symptoms of allergic reactions, including anaphylaxis.

Ensure that systems are in place for the continuing assessment of the patient experiencing an allergic reaction, to monitor for the possible progression of symptoms to anaphylaxis. This may include drills to ensure proficiency of relevant staff in the anaphylaxis management protocol.

Reporting of incidents of delayed recognition of anaphylaxis or missed anaphylaxis as an adverse event should be included in the quality management program – for example, through incident reporting and management.

Indicator for local monitoring

Indicator 1a: Evidence of a locally approved anaphylaxis pathway. The pathway should include:

- An assessment protocol that outlines the clinical criteria to support prompt diagnosis of anaphylaxis
- Systems to ensure patients experiencing allergic reactions are monitored appropriately for possible progression of symptoms to anaphylaxis
- A process to ensure clinicians are competent in the anaphylaxis pathway
- A process to assess adherence to the pathway.

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2 Immediate injection of intramuscular adrenaline

A patient with anaphylaxis, or suspected anaphylaxis, is administered adrenaline intramuscularly without delay, before any other treatment including asthma medicines. Corticosteroids and antihistamines are not first-line treatments for anaphylaxis

Ensure that there is a protocol for the management of anaphylaxis in place that supports prompt administration of IM adrenaline by all relevant clinicians, including nurses. The use of protocols can significantly improve IM adrenaline injection rates for anaphylaxis.

Ensure that all clinical areas have access to adrenaline for the treatment of anaphylaxis, and specify access arrangements in the protocol for the management of anaphylaxis. This will ensure that adrenaline is readily accessible to any clinician who may administer it, including prn orders for IM adrenaline.

Ensure that clinicians have training in the management of anaphylaxis and are practised using adrenaline injector or pen devices. Ensure adrenaline injector practice devices are available; the closest adrenaline may be the patient's own injector device.

The use of 'anaphylaxis management' cards for an anaphylaxis event can serve as a cognitive aid when rehearsing the protocol for an event.

Consider providing access to adrenaline in readily identifiable anaphylaxis kits for emergency use, to reduce the time to administration of intramuscular adrenaline. The anaphylaxis kit may be placed on the resuscitation trolley and should be easily distinguished from the intravenous adrenaline for cardiac emergencies. An anaphylaxis kit also reduces the risk of an inadvertent IV overdose of adrenaline for anaphylaxis.

Indicator for local monitoring

Indicator 2a: Proportion of patients with anaphylaxis treated with intramuscular adrenaline.

3 Correct patient positioning

A patient experiencing anaphylaxis is laid flat, or allowed to sit with legs extended if breathing is difficult. An infant is held or laid horizontally. The patient is not allowed to stand or walk during, or immediately after, the event until they are assessed as safe to do so, even if they appear to have recovered.

Ensure acute anaphylaxis management protocols are in place to:

- Provide guidance on appropriate positioning for patients with anaphylaxis
- Specify that patients should not stand or walk until assessed as safe to do so after treatment with adrenaline.

4 Access to a personal adrenaline injector in all healthcare settings

A patient who has an adrenaline injector has access to it for self-administration during all healthcare encounters. This includes patients keeping their adrenaline injector safely at their bedside during a hospital admission.

Ensure a policy, and the necessary protocols, are in place to allow a patient who has a personal adrenaline injector to maintain easy access to it at all times in a manner that is safe to others. The policy should describe steps for:

- Checking the expiry date of the adrenaline injector
- Checking the device to make sure the solution is clear, does not appear to have been used, and has been stored appropriately
- Obtaining a replacement device if there are doubts about the integrity of the patient's injector
- Assessing the patient's capacity to administer the injector safely during their hospital admission
- Involving the parent, guardian or carer, if appropriate
- Identifying a readily accessible location
- Ensuring that access does not compromise the safety of others.

Ensure clinical communication processes are in place for alerting staff to the patient's allergy and anaphylaxis risk (for example, via EMR and patient records) at clinical handover and during transitions of care, and of the need to ensure the patient has access to the adrenaline injector for self-administration at all times, including while in the hospital. In addition, the policy should ensure that nurses are aware the patient has their own adrenaline injector device and that hospital staff can administer the device in an emergency, if this is the closest available adrenaline.

Indicator for local monitoring

Indicator 4a: Evidence of a locally approved policy to ensure patients maintain access to their personal adrenaline injectors. The policy should specify the:

- Organisation's protocol to identify patients admitted to hospital who carry adrenaline injectors
- Organisation's protocol for patients to maintain access to their adrenaline injectors for self-administration throughout their hospital stay
- Process to ensure all staff are informed of the patients who are at risk of anaphylaxis and must have their adrenaline injectors personally available for self-administration at all times while admitted to hospital.

5 Observation time following anaphylaxis

A patient treated for anaphylaxis remains under clinical observation for at least four hours after their last dose of adrenaline, or overnight as appropriate according to the Australasian Society of Clinical Immunology and Allergy *Acute Management of Anaphylaxis* guidelines. Observation timeframes are determined based on assessment and risk appraisal after initial treatment.

Ensure protocols align with ASCIA guidelines and that systems and processes are in place for patients to undergo clinical observation for the appropriate length of time.

6 Discharge management and documentation

Before a patient leaves a healthcare facility after having anaphylaxis, they are advised about the suspected allergen, allergen avoidance strategies and post-discharge care. The discharge care plan is tailored to the allergen and includes details of the suspected allergen, the appropriate ASCIA Action Plan, and the need for prompt follow-up with a general practitioner and clinical immunology/ allergy specialist review. Where there is a risk of re-exposure, the patient is prescribed a personal adrenaline injector and is trained in its use. Details of the allergen, the anaphylactic reaction and discharge care arrangements are documented in the patient's healthcare record.

Ensure systems, policies and protocols are in place for clinicians to tailor discharge requirements to the patient's needs and provide relevant documentation, as appropriate to the local setting. Consider how to incorporate the tools, templates and resources described in this standard into policies, procedures and guidelines. This should include the ability to:

- Provide information on anaphylaxis and allergy management, including appropriate written patient information such as the Commission Anaphylaxis Discharge Checklist and Discussion Guide, and patient information from ASCIA and Allergy & Anaphylaxis Australia (**allergyfacts.org.au**).
- Provide tailored action plans including the ASCIA **Action Plan for Anaphylaxis** and/or ASCIA **Action Plan for Drug (Medication) Allergy**.
- Document the allergic reaction and provide a record to the patient – for medicines allergies, use the ASCIA **Record for Drug (Medication) Allergy** or local electronic equivalent.
- Supply a personal adrenaline injector at discharge – or provide a prescription where this can be dispensed immediately upon leaving the facility – for patients at risk of re-exposure to the allergen (note: where eligible, up to two injectors may be prescribed with a PBS Authority prescription). Arranging supply of an adrenaline injector after hours may be required in some local settings.
- Provide training to patients and carers on the use of the adrenaline injector when supplied or prescribed, from staff competent to provide this training using an appropriate training device.

Ensure processes are in place for appropriate documentation of the details of the suspected allergen and the allergen exposure in the patient's record. For medicine allergies processes for documenting and reporting details of the adverse reaction should be adhered to, including accurate documentation in the healthcare record and the discharge plan provided to the GP and other clinicians providing ongoing care. Ensure processes are in place for documenting the anaphylaxis event and their allergy status in the patient's My Health Record, when local health service arrangements allow.

Indicators for local monitoring

Indicator 6a: Evidence of local arrangements that ensure patients treated for anaphylaxis receive tailored discharge planning prior to separation from hospital. The local arrangements should specify the:

- Patient education resources, referrals and discharge documents to be provided to patients
- Process to provide patients with personal adrenaline injectors, if indicated
- Information that must be documented in the patient's medical record after treatment for anaphylaxis
- Organisation's process to assess adherence to the local arrangements.

Indicator 6b: Proportion of patients treated for anaphylaxis separated from hospital with a completed ASCIA Action Plan for Anaphylaxis or ASCIA Action Plan for Drug (Medication) Allergy.

Indicator 6c: Proportion of patients treated for anaphylaxis who require adrenaline injectors who are supplied or prescribed an adrenaline injector prior to separation from hospital.

Questions?

Further information about the clinical care standard is available from: **safetyandquality.gov.au/anaphylaxis-ccs**.

You can contact the Clinical Care Standards program team at: **ccs@safetyandquality.gov.au**.