MEDICAL SAFETY SERIES

M02

MANAGING ANAPHYLAXIS AND ALLERGIES

NOTE: This document complies with all relevant statutory requirements as at the version date. All settings where the Local Authority is the employer must comply with Local Authority requirements and should use this document for reference purposes only.

Version 4 – November 2015

REVIEW SHEET

The information in the table below details earlier versions of this document with a brief description of each review and how to distinguish amendments made since the previous version date (if any).

Version Number	Version Description	Date of Revision
1	Original	August 2011
2	Review only – no changes	August 2012
3	Review only – Minor amendments	July 2013
4	Reviewed with major amendments throughout regarding the statutory requirement to support pupils in school with medical conditions, the new IHCP format, expanded allergen information to include all 14 food allergens, storage, travel, record keeping, events and allergen information including where catering providers can get further information and resources to help them comply with the law on telling customers about allergens in food.	November 2015
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1 Introduction

This guide in the Medical Safety Series gives general advice on managing children and young people with severe allergies at risk of possibly life threatening anaphylactic shock in educational and care settings. It is based on information published by NHS Choices, the statutory DfE guidance document *Supporting Pupils at School with Medical Conditions (September 2014)* and information from *The Anaphylaxis Campaign* website at www.anaphylaxis.org.uk.

Reference should no longer be made to DfES document *Managing Medicines in Schools and Early Years Settings 2005* or to the Kym Allan Health & Safety Consultants Ltd. (KAHSC) Safety Series guidance M01 – Administering Medication which have been withdrawn by the respective authors.

1.1 Definitions

For the purposes of this guidance a child, pupil or student is referred to as a 'child' or 'young person' and usually means anyone under the age of 18 years (or 19 in a special educational setting). Reference is made to 'pupils' only in the sections which explain the statutory duties relating to children who are of statutory schooling age i.e. are aged 5-16 years.

Where the term 'parent' is used this includes any person with parental authority over the young person concerned e.g. carers, legal guardians etc.

Where the term 'manager' is used this includes head teachers, nursery managers and any other manager with a specific responsibility for the health, safety and wellbeing of young people.

Where the term 'setting' is used this refers to any kind of educational or care setting for children and young people e.g. maintained and independent nurseries, schools, colleges, Pupil Referral Units, childcare services, children's homes, university technical colleges etc. and will usually include wrap around care such as Out of School Clubs and Breakfast Clubs.

1.2 General

Around one third of the UK population will develop an allergy at some time in their lives. Allergies are becoming increasingly common and some allergy sufferers may be at risk of anaphylaxis. Research has shown that 1 in 70 children are allergic to peanuts but this figure may be as high as 1 in 50 if tree nuts are included e.g. walnuts, almonds, Brazils and hazelnuts etc. Occasionally other foods and substances are implicated including dyes, latex and some medicines. Sometimes the symptoms are severe and may even be life threatening. This is understandably alarming for parents, teachers, other staff and young people who witness it.

However, even the most severe allergic reaction is manageable. The vast majority of the young people affected are happily accommodated in mainstream facilities thanks to good communication and consensus between parents, staff, health professionals and education authorities. With sound precautionary measures and support from staff, their education may continue as normal for all concerned.

It is becoming essential that all staff have a basic awareness of allergens and the reactions they can induce in people because families will only know that a child has an allergy if they have been exposed to the allergen and suffered a reaction. The most likely serious but hidden allergy will be to wasp and bee stings because exposure is less likely to have been experienced already than exposure to a food allergen.

People can develop new allergies at any time, allergies can worsen significantly with each exposure and people can also overcome or "grow out of" allergies.

2 What is Anaphylaxis?

Anaphylaxis is a severe and potentially life-threatening allergic reaction at the extreme end of the allergic spectrum. Anaphylaxis may occur within seconds or minutes of exposure to the allergen, although sometimes it can take hours. It can be life-threatening if not treated quickly with adrenaline.

Any allergic reaction, including anaphylaxis, occurs because the body's immune system reacts inappropriately in response to the presence of a substance that it perceives as a threat. Anaphylaxis can be accompanied by shock (known anaphylactic shock): this is the most extreme form of an allergic reaction. The reaction causes substances to be released into the blood that dilate blood vessels and constrict air passages. Blood pressure falls dramatically, and breathing becomes difficult. Swelling of the face and neck (angio-oedema) increases the risk of suffocation.

Common triggers of anaphylaxis include:

- peanuts and tree nuts – peanut allergy and tree nut allergy frequently cause severe reactions and for that reason have received widespread publicity;
- other foods (e.g. dairy products, egg, fish, shellfish and soya);
- insect stings;
- latex;
- drugs.

When anaphylaxis causes the airways to be so constricted that the person cannot breathe and their blood pressure plummets reducing the flow of any oxygenated blood to the brain, it can start to suffer from oxygen deprivation. When oxygen levels are significantly low for four minutes or longer, brain cells begin to die and after five minutes permanent anoxic brain injury can occur.

On very rare occasions Idiopathic Anaphylaxis may be diagnosed where after extensive investigation, there may be no identifiable triggers.

3 What are the Symptoms?

Allergy doctors reserve the term Anaphylaxis for the most severe form of allergic reaction, when the blood pressure falls dramatically and the patient loses consciousness.

Other symptoms of an allergic reaction, whilst not strictly anaphylaxis, may also be life threatening. There may be swelling in the throat, which restricts air supply, severe asthma or a sudden feeling of weakness or floppiness. Any symptoms affecting the breathing are serious and emergency medical assistance must be sought immediately.

Symptoms commonly described as anaphylaxis are wide ranging. Any of the following may be present, although most young people with anaphylaxis would not necessarily experience all of these:

- generalised flushing of the skin anywhere on the body
- nettle rash (hives) anywhere on the body
- difficulty in swallowing or speaking
- swelling of throat and mouth
- alterations in heart rate
- severe asthma symptoms (see M04 – Management and Treatment of Asthma for more details)
- abdominal pain, nausea and vomiting
- sense of impending doom
- sudden feeling of weakness (due to a drop in blood pressure)
- collapse and unconsciousness.

Even where mild symptoms are present, the young person should be watched carefully. They may be heralding the start of a more serious reaction. The pictures overleaf describe severe examples of the range of observable reactions that may occur.

Nettle rash (hives)

Swelling of mouth

Nettle rash (hives)

Nettle rash (hives)

4 Common Allergens

In the case of allergy, the trigger is an allergen – a food or substance that the body's immune system wrongly perceives as a threat. The severity of a reaction caused by an allergen can vary and is dependent on a number of factors including:

- how much of the allergen has been taken into the body,
- the general level of health of the person affected, and
- whether or not the person's asthma symptoms are under control.

Not all allergens are in foodstuffs and not all allergens affect people through being consumed. Some cause problems through being inhaled or by contact with the skin.

To save lives and help the growing number of people who have a food-related allergy, the *Food Information Regulations (2014)* came into force throughout the UK. These regulations changed the way customers, including children in schools and care settings are provided with information about food allergens.

The Food Standards Agency provides supplementary information and resources for canteen services to use at food.gov.uk/science/allergy-intolerance/label/. The KAHSC *Catering Code of Practice (2015)* contains detailed information to support catering staff in meeting the requirements and is available to download at www.kymallanhsc.co.uk.

It is essential that young people with allergies and their parents advise in detail what allergens should be avoided and this should be part of their Individual Healthcare Plan (IHCP). It is also essential that staff have a general understanding of the kinds of things that can trigger anaphylaxis.

The best sources of advice and guidance on the causes, symptoms and treatment of allergic reactions which lead to anaphylaxis are from the *NHS Choices* webpages at:

www.nhs.uk/Conditions/Anaphylaxis/Pages/Causes.aspx and from the leading charity in the field *The Anaphylaxis Campaign* who have produced a number of factsheets to be found at: www.anaphylaxis.org.uk/our-factsheets as well as on the NHS Choices website.

For settings that offer statutory education i.e. for children aged between 5 and 16 years, in line with the DfE statutory guidance *Supporting Pupils at School with Medical Conditions (April 2014),* it is extremely important that all staff are given a general whole school awareness training or briefing session on the medical conditions that school is aware their pupils live with and their role in supporting those pupils. This briefing should always include anaphylaxis, whether there are identified young people at risk or not, because the outcomes for a young person who does not know they have an allergy could be extremely serious. In accordance with the unacceptable practice clearly stated in the DfE guidance, it is essential that all staff understand that they must never assume that every child with the same condition requires the same treatment.

The following is the briefest of summaries about anaphylaxis triggers based on the extensive work of The Anaphylaxis Campaign. It may be helpful general information for staff about potential issues, but is not a substitute for a training/briefing session which identifies individual pupils, conditions and any specific actions required from staff.

4.1 Peanuts

It is fairly common for people with peanut allergy to react to tree nuts, and vice versa. Doctors often advise people with a peanut or nut allergy to be cautious and avoid all nuts. Peanuts are also known as groundnuts, earth nuts and monkey nuts. They are legumes rather than nuts, but it is probably unnecessary to eliminate other legumes (e.g. peas, beans and lentils) unless there is evidence that they cause problems.

Foods most likely to contain peanuts or tree nuts include: cakes, biscuits, confectionery, veggie burgers, salads and salad dressings, pesto sauce and Indian, Chinese, Thai or Indonesian dishes. Marzipan and praline are also both made with nuts. Salad dressings can also contain unrefined nut oil. A research team based in Southampton showed that refined peanut oil poses little or no risk for the vast majority of people with peanut allergy, in contrast to unrefined peanut oil, which is likely to retain its allergic properties.

4.2 Tree Nuts

Tree nuts and peanuts are by far the most common allergen to cause severe reactions. It is fairly common for someone with peanut allergy to react to tree nuts, and vice versa. Doctors often advise people with peanut or nut allergy to be cautious and avoid all nuts.

Tree nuts include almonds, Brazil nuts, cashews, hazelnuts, pistachios and walnuts. They are biologically distinct from peanuts, which are actually legumes.

Foods most likely to contain peanuts or tree nuts include cakes, biscuits, confectionery, veggie burgers, salads and salad dressings, pesto sauce and Indian, Chinese, Thai or Indonesian dishes. Marzipan and praline are both made with nuts.

There is no credible evidence that conkers pose a significant risk to anyone with a nut allergy although a few people have anecdotally reported that they have suffered a slight skin reaction when handling them. Anyone who has experienced a skin reaction to handling conkers should avoid them and they are poisonous to humans so nobody should be eating them, but these are not reasons to ban them from schools.

4.3 Sesame

People who are allergic to sesame must seek to avoid it completely, as even a tiny amount may trigger a severe reaction. The rise in sesame allergy is probably linked to its increased use in cooking: it is often used for flavouring and decorative purposes in foods.

Heating or cooking does not destroy the allergenic properties of sesame. Sesame oil should be regarded as extremely risky because it is almost certain that it will be unrefined and, therefore, contain the allergenic proteins that trigger allergic reactions.

Dishes containing sesame include tahini, gomashio (a Japanese flavouring), hummus and halvah (a sweet often made with sesame). Chinese stir fry oils sometimes contain sesame oil. It has also been found in the drink Aqua Libra. People have also reported allergic reactions to: veggie burgers, breadsticks, burger baps, cocktail biscuits, Middle Eastern foods, Chinese and Japanese foods, stir fry vegetables and health food snacks containing sesame. It may also be wise to avoid bread and other products bought from in-store bakeries because they may be contaminated by sesame seeds from other products

Other seeds known to provoke a reaction in very small numbers of people include pumpkin seeds and sunflower seeds. Considered a nut by most people, coconuts are actually a seed, albeit a very large one. The confusion is not helped by the fact that many people allergic to sesame are also allergic to tree nuts and legumes such as peanuts.

4.4 Wheat Containing Foods (Gluten)

Wheat is part of the grass family Triticeae. Many people report reactions to wheat, but not all reactions are true allergy. The most common reactions are:

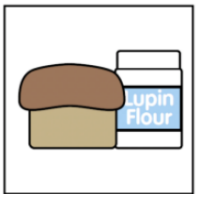
- Immediate type allergy to wheat i.e. immediate symptoms of an allergy to one or more of the 4 proteins in wheat,
- Delayed allergy reactions to wheat where symptoms can take 1-2 days to develop,
- Delayed type allergy to gluten, known as Coeliac Disease, which is a life-long and potentially fatal auto-immune disease rather than an allergy which attacks the gliaden wheat protein being digested and can cause serious damage to the intestinal tract or
- Intolerance to wheat.

Wheat intolerance differs from coeliac disease in that it is a poorly defined set of symptoms which vary considerably from one affected person to another. Symptoms tend to include abdominal discomfort, nausea, tiredness, bloating and altered bowel habit. It is not caused by an immune reaction like the other, and while the symptoms can be very unpleasant, it cannot cause life-threatening reactions or consequences unlike true wheat allergies.

People with wheat intolerance will still experience adverse symptoms from gluten free products, as the remaining part of the wheat will be affecting them. They may, or may not, be able to eat rye, barley and oats, that are part of the wheat family and, as with many other food intolerances, may be able to reintroduce wheat back into the diet after a period of elimination.

Products include wheat (such as spelt and Khorasan wheat/Kamut), rye, barley and oats. It is often found in foods containing flour, such as some baking powders, batter, breadcrumbs, bread, cakes, couscous, meat products, pasta, pastry, sauces, soups and foods dusted with flour.

4.5 Lupins



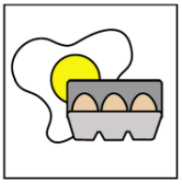
Although allergic reactions to lupin are not thought to be common in the UK, a link between a lupin and a peanut allergy has been established and both foods are legumes. A small but significant number of children with peanut allergy are allergic to lupin and medical opinion suggests that the chances of children with

peanut allergy also reacting to lupin are about 1 in 20. This includes lupin seeds and flour, and can be found in some types of bread, pastries and pasta.

4.6 Mustard

The mustard plant belongs to the Cruciferae (Brassicaceae) family. Allergic reactions appear to be triggered by very small amounts of mustard, such as from contaminated cooking utensils. The major allergens of mustard are heat-resistant and are not greatly affected by food processing, so cooking does not lessen the potential for an adverse reaction. This includes liquid mustard, mustard powder and mustard seeds. It is often found as an ingredient in breads, curries, marinades, meat products, salad dressing, sauces and soups.

4.7 Eggs



Most young people with egg allergy will only have mild symptoms, and some are able to tolerate some forms of cooked egg. But there are a few who experience severe, life-threatening reactions.

Read food labels carefully to check if products contain egg or albumen (an egg product). Some young people with egg allergy can eat well-cooked egg (e.g. in cake) without any ill effects but not raw or lightly cooked egg. Others are allergic even to egg that has been well cooked.

Mayonnaise often contains egg and this is sometimes raw egg. A lot of fresh pasta contains egg, but egg-free dried pasta is easy to find although there can be a very small risk of cross-contamination with egg based products. Individual manufacturers can identify which of their products are safe.

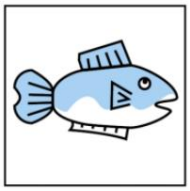
4.8 Milk and Dairy

Many young people with milk allergy will only have mild symptoms, and some are able to tolerate it in cooked foods. A few will experience severe, life-threatening reactions. In the most severe cases, even trace amounts can trigger symptoms.

Foods to be avoided include: milk, butter, or anything derived from butter (e.g. buttermilk, butter cream, butter icing), cheese, yoghurt, ghee (clarified butter used in South Asian cooking), curds and ice cream.

Other foods that may also contain milk or milk products include: cakes, biscuits, pies, breads, crisps and other snacks, processed meats, ready-made meals, most vegetable margarines, gravy mixes, and desserts. This list is not exhaustive – milk and milk products are used in many products. When reading food labels look out for 'whey' and 'casein' as these are milk proteins and should be avoided.

4.9 Fish

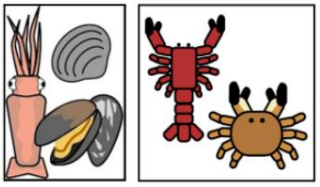


Most fish allergies – such as cod and other white fish – develop in childhood and are likely to be life-long. Young people who react to one type of fish are wise to eliminate all fish from their diet, as there is a high risk of cross-contamination (e.g. at market, on the fish counter etc.). Those with fish allergy may be able to eat shellfish, but the risk of cross-contamination is the same as for other fish.

Exposure to a minute amount of fish can cause a reaction. On rare occasions people have also been known to go into anaphylactic shock after inhaling airborne particles of the allergen when fish is cooked or at open markets.

Some ingredients to look out for and avoid include surimi (a seafood product present in some processed foods), Caesar salad dressing, Worcestershire sauce and caponata (all of which are likely to contain anchovies), and kedgeree (a rice and fish dish).

4.10 Shellfish



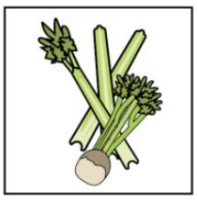
Allergic reactions to shellfish are rare in young children, and are usually not seen until the teenage years or adulthood. However, this may be simply because shellfish are not normally a part of the diet of young children. The universal symbols are for crustaceans (left) and molluscs (right).

Shellfish are biologically distinct from fish and can be divided into 4 main groups:

- crustaceans (e.g. crab, lobster, crayfish, shrimp, prawn);
- bivalves (e.g. molluscs, mussels, oysters, scallops, clams);
- gastropods (e.g. snails);
- cephalopods (e.g. squid, cuttlefish, octopus).

Those who are allergic to one type of shellfish are often advised to avoid all shellfish due to the risk of cross-contamination in the same ways as fish above which usually leads to avoidance of all fish also.

4.11 Celery

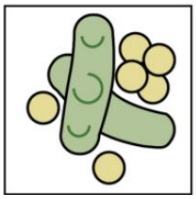


This allergy can be triggered by celery stalks, leaves and seeds and celeriac (the root). It is often found in celery salt, salads, some meat products, soups and stock cubes which can make it difficult for some people to avoid.

Celery and celeriac allergy is not nearly as common in the UK as in other parts of Europe. Allergy to celeriac is highly associated with birch and mugwort pollen sensitisation. Allergy to celeriac (the celery root) is more common than to the celery stick, although both can cause severe reactions. Symptoms vary from mild ones, such as oral allergy syndrome, to anaphylactic shock.

Heating or cooking does not destroy the allergenic properties of celery, according to reports. For some people allergic reactions to cooked celery will take place, even after high temperatures are used. Particular proteins may be responsible for serious systemic reactions rather than simply oral ones.

4.12 Soya



The soya bean belongs to the legume family, which includes fresh and dried peas, beans, carob, liquorice and peanut, but research has shown that a symptomatic reaction to more than one member of the legume family is rare. It is therefore in most cases not necessary to avoid all foods from this plant family.

Soya is widely used in foods and can be present in as much as 60% of all manufactured foods. Soya can be found in beancurd, edamame beans, miso paste, textured soya protein, soya flour or tofu. It is often used in some desserts, ice cream, meat products, sauces and vegetarian products. Avoidance of all these products would make the diet very restricted. However, as with many other allergies, the level of avoidance required will depend on each individual case. Some people may need to avoid all these forms of soya, whereas others may be able to tolerate, for example, soy sauce and soya lecithin.

4.13 Sulphur Dioxide

It is rare for someone to be allergic to sulphites, but they can cause allergy-like symptoms in people with underlying asthma and allergic rhinitis. The most common reaction is wheezing, tight chest and cough. The incidence of sulphite sensitivity in the general population is thought to be less than 2%, but this rises to between 5 and 13% in asthmatics.

Severe reactions to sulphites (anaphylaxis) have been reported but are very rare. Some people with urticaria, a type of skin rash, can also experience worsening of symptoms after eating sulphites.

Sulphites are often used as a preservative in dried fruit such as raisins, dried apricots and prunes. It can also be found in meat products, soft drinks, pickles, condiments and vegetables as well as in wine and beer.

4.14 Wasp and Bee Stings

Most people known to be at risk of a severe allergic reaction to an insect sting find the prospect of being stung very frightening. Fortunately, the risks of this happening are minimal if sensible precautions are taken.

Young people need to take special care outdoors wearing shoes at all times and ensuring any food or drink is covered and kept in sight. The chances of a sting proving life-threatening are reduced considerably if a young person has suitable medicine on hand at all times.

4.15 Latex

There are two types of latex allergy known as 'type-1' and 'type-4' reactions.

Type-1 latex allergy

This is potentially life-threatening. Those affected are sensitive to the natural proteins in latex. Young people diagnosed with this allergy may suffer from nasal irritations, rashes, asthma and anaphylaxis. Latex allergy is serious but it can be managed and controlled. There are numerous everyday items to be avoided including rubber gloves, balloons, pencil erasers, rubber bands, rubber balls, and tubes and stoppers used for science experiments.

Condoms usually contain latex – this may need to mentioned in sex education classes. Even if a young person only has a mild allergy to latex they should try, as much as possible, to avoid contact with it. This is because with each contact, the allergic reaction may increase in severity and symptoms may get worse.

Young people with a severe allergy should not use any latex products and they may also have a food allergy to sweet chestnut and also other fruits such as banana, kiwi and avocado.

Type-4 latex allergy

This is a non-life threatening dermatitis, which occurs when latex comes into contact with the skin. Chemicals used when processing the rubber cause the allergic skin reaction. Symptoms include reddening, itching and swelling of the skin, which develop one or two days after contact.

4.16 Medicines

Medicines known to cause anaphylaxis in a very small number of people include:

- antibiotics, particularly penicillin,
- muscle relaxants e.g. non-steroidal anti-inflammatory drugs (NSAIDs) such as painkillers containing ibuprofen, aspirin and general anaesthesia,
- opiates such as codeine, morphine etc.

This is usually only critical knowledge for education settings when they are caring for young people on residential experiences where a painkiller might be more likely to be administered.

4.17 Dyes

Allergic reactions to dyes are not limited to when they are contact the body in sprays, hair and skin dyes. Any contact with a dye or dyed material, including dyed clothing can provoke contact dermatitis, the reaction in the skin. Symptoms can range from very mild irritation to severe burn-like injuries, but rarely anaphylaxis. Black henna is not a natural henna and is never considered safe to use on skin.

5 Treatments

Diagnosis is usually made by the young person's GP or Consultant. Sometimes skin tests can further confirm the diagnosis.

Treatment is **urgent** and **essential** to prevent progression of a severe anaphylactic reaction.

If a young person develops asthma-like symptoms, e.g. shortness of breath, wheeziness etc.; floppiness or weakness; steady deterioration or loss of consciousness, the adrenalin must be administered without delay.

Two main types of medicine are available for treatment of a severe allergic reaction:

- Antihistamines (Piriton, Zirtec etc.)
- Preloaded Adrenalin injection ('pen' or injector branded EpiPen, Emerade or Jext).

5.1 Anti-histamines

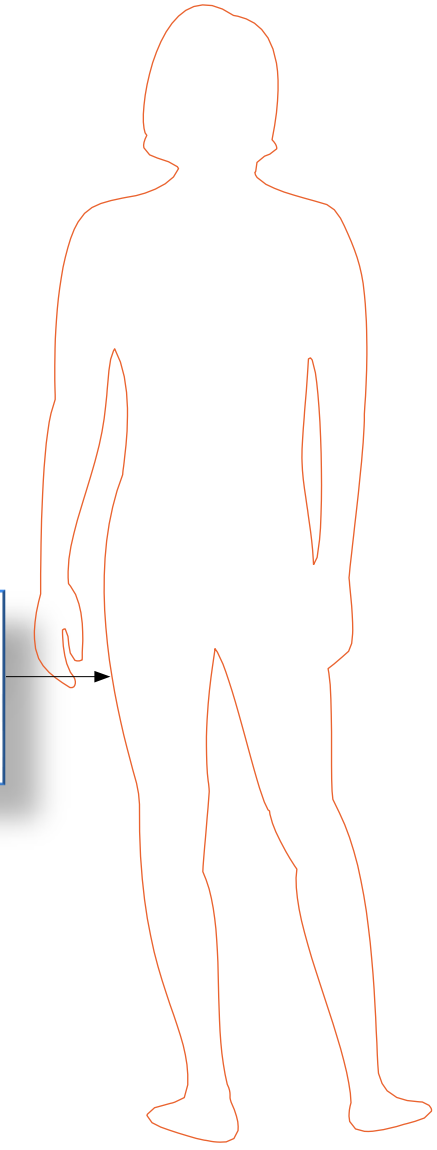
Some young people with severe allergies will be prescribed anti-histamines for use to relieve mild symptoms or as part of their emergency procedure for a severe reaction, or both. If they do need them they will come in either liquid or tablet form.

Directions on when to give anti-histamines should be taken from the young person's doctor and recorded in the IHCP, but directions may vary from one young person to another even when the same product is being administered. If anti-histamines are prescribed as part of the emergency procedure they should be kept together with the young person's adrenaline.

5.2 Injectable Adrenaline

Every young person at risk of anaphylaxis should be prescribed an adrenaline injector and the instructions from their doctor for its use should be part of their IHCP. It should only be administered by staff or volunteers who have received training from a healthcare professional.

Adrenaline is also called epinephrine and is a well-understood, safe drug. It causes the 'flight or fight' reaction which prepares the body for any stressful physical activity, by speeding up the heart and increasing the flow of blood to the muscles. Adrenaline helps to reverse the effects of severe anaphylaxis by constricting blood vessels, stimulating the heart, reducing skin reactions and relieving swelling around the face or lips. There should be no serious side effects even if it is given a second time or if the allergic reaction is misdiagnosed. If the injector is given by mistake when no reaction is being suffered the child should still go to hospital for ongoing assessment.



Treatment for any severe allergic reaction requires intramuscular adrenaline – an injection of adrenaline – usually into the upper aspect of the muscle in the side of the thigh as in the diagram (right). The young person may be prescribed one of the three most common adrenaline injectors; the EpiPen; the Emerade or the Jext. These devices are preloaded with a single dose and are surprisingly simple to administer. They all claim to safely and

reliably puncture into the thigh muscle through clothing including denim. The needle is not seen until after it has been withdrawn from the leg and usually the device will automatically drop a needle shield over the sharp at that point. Once the injection is given, signs of improvement should be seen fairly rapidly. If there is no improvement or symptoms are getting worse a second injection, where available, may be administered after 5–10 minutes.

When symptoms are those of anaphylactic shock the position of the young person is very important because anaphylactic shock involves a fall in blood pressure.

- If the young person is feeling faint or weak, looking pale, or beginning to go floppy, lay them down with their legs raised. They should not stand up.
- If there are also signs of vomiting, lay them on their side to avoid choking.
- If they are having difficulty breathing caused by asthma symptoms and/or by swelling of the airways, they are likely to feel more comfortable sitting up.

An injector should be used immediately to treat a severe reaction in accordance with the young person's IHCP. If in any doubt about the severity of an allergy reaction, the injector should be used anyway. After use the injector should be made safe by following the manufacturer's instructions, placing it in a rigid container and then handing it to the paramedic or ambulance crew to be taken with the young person to the hospital, both for their information and for safe disposal. If adrenaline has been given, an ambulance must be called and the young person taken to hospital in every case because relapse of a severe allergic reaction is possible after apparent recovery.

It is important that there are at least two injectors for each affected young person. One may misfire or fail to operate properly or a second dose may be required whilst awaiting medical assistance. Where there are a number of young people who have been prescribed adrenaline, only three or four pens need to be kept on the premises at any one time. Staff should, however, check that the pre-loaded dose is correct for the individual on whom it is being used before administering it.

It is normal for children as young as 5 - 11 years to require an adult dose because its need is based on their body weight. At 25+kg an adult dose is required.

6 Parental Responsibilities

The following is a checklist of ways in which families can help their allergic child at nursery, school or college, or in a childcare setting.

Parents should:

- Notify the setting of their child's allergies and ensure they communicate clearly.
- Work with the setting to develop a plan that accommodates the child's needs throughout the day including in the class or playroom, in dining areas, in after-school programmes, during setting sponsored activities and on home-to-school transport.
- Provide written medical documentation, instructions and medicines as directed by a doctor.
- Replace medicines after use or upon expiry. Parents should ask to check their child's emergency kit(s) kept on site termly (3 times a year) to ensure they are stored correctly, still in date, and ready for use.
- Educate their child in allergy self-management, including what foods or substances are safe and unsafe, strategies for avoiding allergens, how to spot early symptoms of an allergic reaction, how and when to tell an adult of any reaction, and how to read food labels.
- Agree with education and care providers whether their child is capable of self-administration (when they are not too ill) and agree to the procedures to enable and support it wherever possible e.g. carrying their own emergency medicine on their person at all times.
- Provide a "stash" of safe snacks for special events (to be stored at the setting) and periodically check its supply and freshness.

- Review policies and procedures with the staff, the school nurse (if appropriate), the child's doctor and the child (where appropriate) after a reaction has occurred.

7 Children's Responsibilities

All children should have as much responsibility for their own health and wellbeing as they are capable of managing at the youngest possible age, especially when they are learning to live with serious and life-long health conditions. All aspects of self-management from choosing their own foods to self-medication should be enabled as soon as they are capable by agreement with parents and in some cases as agreed with a healthcare professional as well. In the youngest of children and those with learning difficulties this will require careful monitoring by and support from well-informed staff.

In line with DfE statutory guidance *Supporting Pupils…*, statutory school age pupils should carry their emergency medicines on their person as soon as they are old enough to do so responsibly. There is no set age when this should be considered because it will depend on the severity of the child's condition, how well they control it and how capable they are of recognising when they are having a reaction and of taking the appropriate emergency action. Whereabouts on them that a child normally carries their medicine should be recorded on their IHCP so that if they are unable to administer it themselves, staff know where to look for the injector while at the same time sending for the one held on-site.

Children and young people need to:

- Be sure not to exchange food or some types of equipment with others e.g. objects with latex in them etc.;
- Avoid eating anything with unknown ingredients;
- Be proactive in the care and management of their own allergies and reactions (based on their age and capability);
- Check regularly that their emergency medicine is in-date and ready to use (and practice self-administration with a training pen as appropriate);
- Notify an adult immediately if they eat something they believe may contain the food to which they are allergic or if they come into contact with the substance they are allergic to;
- Notify an adult immediately if they believe they are having a reaction, even if the cause is unknown;
- Always wear their medical alert bracelet or some other form of medical identification.

8 The Role of Staff

Staff have a professional duty to safeguard the health and safety of young people in their care. This does not, however, imply a duty upon them to administer medicine unless they are contractually obliged as part of the terms and conditions of their employment. Staff may voluntarily undertake this duty and must receive training enabling them to do so.

Staff indemnity when performing such functions is provided by the Employer's Liability Insurance. All staff administering medicines will be covered by that insurance policy in the event of a claim for negligence as long as they have acted reasonably in accordance with their training and within the scope of their employment.

Education settings providing statutory education to children aged 5 to 16 years also have a statutory duty to support pupils at school with medical conditions. The DfE statutory guidance *Supporting Pupils at School with Medical Conditions (September 2014)* is clear that medicines **must** be administered to pupils when failure to do so would harm either their health or their education. Both the Head teacher and the Governing Body or other employer should support staff in their decision to volunteer to administer adrenaline, but the statutory duty to pupils means that schools **must** have arrangements in place to administer medicines when such harm might occur. Where

young people have conditions that may require rapid and potentially life-saving intervention, **all** staff should be able to recognise the onset of the condition and take appropriate action, although not all may be expected (and be specially trained) to administer injections.

In all cases, training in the use of injectors must be delivered by a healthcare professional. They could be the young person's GP; a community nurse, the school nursing service, an allergy specialist nurse etc. The training should cover the identification of symptoms, the administration of the medicine and details of the emergency treatment plan for the individual concerned. The training must also be done using the brand of injector that the young person has been prescribed because they are all slightly different.

Occasionally, parents will offer to train staff and although this may seem reasonable, it should be avoided. If there is any unreasonable but unavoidable delay in getting appropriate training from a healthcare professional, there are links to manufacturer training videos for administering adrenaline using Jext and Emerade injectors on the NHS Choices webpages at www.nhs.uk/Conditions/Anaphylaxis/Pages/Treatment.aspx and for administering the EpiPen on their own webpages at www.epipen.co.uk/patients/. It is better to use a manufacturer's training video with or without input from parents than to do nothing or take advice only from a parent while waiting for appropriate training from a healthcare professional. If there is any doubt about the appropriate steps to take, the school or community or specialist nurse should be consulted before a decision is made.

The Medicines and Healthcare Products Regulatory Agency (MHRA) have produced a two-page guide for patients *Adrenaline Auto-Injectors: Advice on Use (May 2014)* available at: https://assets.digital.cabinet-office.gov.uk/media/54730805ed915d1380000045/con418524.pdf which staff may find helpful. It contains the kind of minimal information that all staff should be made aware of in the whole staff awareness training/briefing session (which should only cover the conditions the setting is aware that they need to deal with as well as anaphylaxis where the outcomes for a young person who does not know they have an allergy could be extremely serious). Staff should also be provided with access to the manufacturer's instructional videos aimed at patients and carers on how to administer their brand of injector so that they can refresh their training as frequently as they wish.

As a matter of routine, there must be a clear procedure for summoning an ambulance in an emergency. The person making that call must give the **exact location** of the patient, advise 999 that they are having an **anaphylactic reaction** and **what** they are reacting to where possible. In the event of a severe allergic reaction occurring, immediate adrenaline treatment will be necessary while waiting for the ambulance to arrive.

The person suffering the allergic reaction should always go to hospital if they have used their injector.

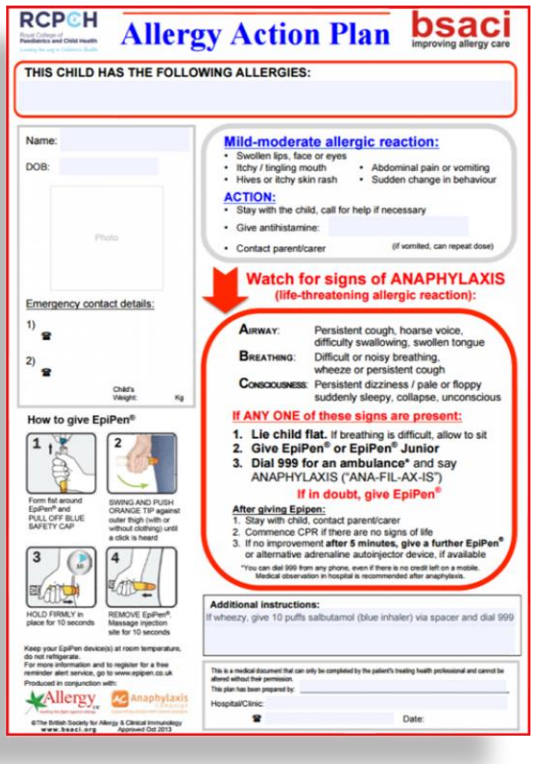
9 Individual Healthcare Plans (IHCP)

Any individual with such a potentially serious medical condition must have an IHCP drawn up in conjunction with relevant staff, parents, healthcare professionals and wherever possible the young person themselves.

An essential part of the IHCP is an established treatment plan and accompanying emergency procedures. Some young people will already have a one page *Allergy Action Plan* (AAP) relevant to the brand of injector they have been prescribed which has been completed for them by their clinician (EpiPen brand AAP pictured overleaf).

With pictorial adrenalin administration instructions these Action Plans by the *British Society for Allergy and Clinical Immunology (BSACI)* are very helpful, but they cannot be the whole of the education or care setting IHCP because they are meant to be completed by a clinician only and they have no space on them to consider, well in advance, what adjustments to the curriculum or

activities need to be made or the important differences between executing the plan on-site, off-site and away on residential experiences.


RCPCH Allergy Action Plan bsaci improving allergy care

THIS CHILD HAS THE FOLLOWING ALLERGIES:

Name:
DOB:
Photo
Emergency contact details:
1)
2)
Child's Weight: Kg

Mild-moderate allergic reaction:
- Swollen lips, face or eyes
- Itchy / tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

ACTION:
- Stay with the child, call for help if necessary
- Give antihistamine:
- Contact parent/carer (if vomited, can repeat dose)

Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction):

AIRWAY: Persistent cough, hoarse voice, difficulty swallowing, swollen tongue
BREATHING: Difficult or noisy breathing, wheeze or persistent cough
CONSCIOUSNESS: Persistent dizziness / pale or floppy suddenly sleepy, collapse, unconscious

If ANY ONE of these signs are present:
1. **Lie child flat.** If breathing is difficult, allow to sit
2. **Give EpiPen® or EpiPen® Junior**
3. **Dial 999 for an ambulance*** and say ANAPHYLAXIS ("ANA-FIL-AX-IS")

If in doubt, give EpiPen®

After giving Epipen:
1. Stay with child, contact parent/carer
2. Commence CPR if there are no signs of life
3. If no improvement **after 5 minutes, give a further EpiPen®** or alternative adrenaline autoinjector device, if available

*You can dial 999 from any phone, even if there is no credit left on a mobile. Medical observation in hospital is recommended after anaphylaxis.

How to give EpiPen®

1 Form fist around EpiPen® and PULL OFF BLUE SAFETY CAP
2 SWING AND PUSH ORANGE TIP against outer thigh (with or without clothing) until a click is heard
3 HOLD FIRMLY in place for 10 seconds
4 REMOVE EpiPen®. Massage injection site for 10 seconds

Keep your EpiPen device(s) at room temperature, do not refrigerate.
For more information and to register for a free reminder alert service, go to www.epipen.co.uk
Produced in conjunction with:
Allergy UK Anaphylaxis Campaign
©The British Society for Allergy & Clinical Immunology
www.bsaci.org Approved Oct 2013

Additional instructions:
If wheezy, give 10 puffs salbutamol (blue inhaler) via spacer and dial 999

This is a medical document that can only be completed by the patient's treating health professional and cannot be altered without their permission.
This plan has been prepared by:
Hospital/Clinic:
Date:

It is important that all staff, particularly those on temporary or supply contracts can easily recognise young people at risk of anaphylactic reaction. One way of achieving this with due regard to the dignity of those affected is to code or highlight the name of any young people with serious medical conditions on any register.

A sample IHCP covering those kinds of additional planning needs is attached at **Appendix A**. It will be necessary to arrange for periodic reviews of the IHCP to allow for any changing health needs and where incidents are rare, can also be a useful reminder to monitor the expiry date on medicines held on site.

Contingency plans must also be in place in case for any reason the normal routine for treatment breaks down, e.g. the trained staff are absent. This should be included in the IHCP and is likely to include calling for an ambulance.

To make best use of the IHCP it has been formulated as a table in a Word document. To keep it as easy to read and as short as possible it should be typed up and the size of the boxes reduced to fit the text along the way by clicking on the bottom border of the box and moving it upwards or by changing the height of that row on the Table Layout tab. It only has boxes as big as they are so that parents can handwrite one and send it in if they can't make the IHCP meeting and to give staff a template to structure the meeting around and space for notes of what the IHCP needs to say when it is finished.

Settings often feel that the IHCP should be signed by all parties involved. Designed as a Word table, it is simple to insert rows and cells can be added to the template IHCP if desired, although the DfE template did not provide space for signatures and it did provide space for the names of individuals involved to be recorded on the IHCP as well as the names of all those the plan has been distributed to. It is not recommended that settings can expect a healthcare professional to sign off IHCPs because they are unlikely to have the capacity to and they should already be completing for their patient, a BSACI Allergy Action Plan for those whose anaphylaxis is life-threatening.

9.1 Procedures Following a Reaction

If it is directly relevant to the successful implementation of a young person's IHCP, elements of the following information should be recorded in the relevant emergency action section of the IHCP agreed in consultation with the young person, parents and healthcare professionals as appropriate. A shorter instructional version is reproduced on the reverse of the IHCP in Appendix A. Alternatively, when a young person has an AAP as described above that should be attached to the IHCP.

If adrenaline is administered an ambulance should still be called because symptoms may return after a short period and more than one injection may be required to control the reaction.

If any symptoms of a reaction become apparent:

1. Help will be sought immediately from staff trained in anaphylaxis emergency procedures;

2. The Head teacher/manager will be informed;
3. On instruction of the trained staff the parents/carers will be informed, usually by the Head teacher/manager, in the priority order as above.

An adult will remain with the young person at all times.

1. The trained staff will assess the situation;
2. Decide whether to summon an ambulance and arrange for it to be done if necessary;
3. Send for any medicine including the emergency adrenaline 'pen' and check the expiry date;
4. Follow the personal emergency procedure as laid down by the young person's healthcare professional below administering appropriate medicine in line with perceived symptoms.

The area will be cleared of unnecessary personnel including other young people as necessary:

If the symptoms appear life-threatening:

1. **Help the young person into the position which is comfortable and assists their breathing.**
2. The **adrenaline injector will be administered** in accordance with training and the injector made safe to give to the ambulance crew;
    a). Remove any needle safety cap and keep safe;
    b). Remove any injector button cap and keep safe;
    c). Jab or place pen to upper aspect of outer thigh according to manufacturer's instructions on top of any clothing not easily moved;
    d). Press injector button firmly;
    e). Hold 'pen' in place for at least 10 seconds;
    f). Withdraw 'pen' and replace all caps making it safe for the ambulance crew.
3. The **exact time of the adrenaline dose will be noted** in case a second dose no less than 5 minutes after the first is required and also to notify the ambulance crew.
4. Continuous **assessment of the condition** of the young person will be carried out positioning them in accordance with their symptoms e.g.
    a). faint/weak/pale/floppy – laid down with legs raised to increase blood flow;
    b). nausea/vomiting – laid down on their side to avoid choking;
    c). Asthma symptoms/wheezing/difficulty breathing – sat up to ease breathing.
5. **On the arrival of the paramedics or ambulance crew** the trained staff will inform them of the time and type of medicines given and hand over all used adrenaline injectors.

The person calling for the ambulance must state:

1. Name and age of young person;
2. That you believe them to be suffering from anaphylaxis;
3. The cause or trigger (if known);
4. The name, address and telephone number of the site;

After the emergency:

1. Details of all medicines administered with date and time will be recorded on the individual's record card;
2. Completed record card replaced along with this HCP in the individual's 'Orange box' (any suitable rigid plastic container).
3. Debriefing of all staff involved will take place;
4. Emergency plans will be reviewed according to any issues which arose;
5. Arrangements to replace used medicines and/or 'pens' will be made.

This text is reproduced in instructional format as a back page reminder of general procedures on the IHCP of an anaphylactic person. When a young person has an AAP, a copy of that should be attached to the IHCP and the emergency action sections overleaf can be made smaller and just refer to the attachment.

10 Managing Exposure

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are typical children in every respect – except that if they come into contact with a certain food or substance, they may become extremely unwell. It is important that these children are allowed to develop in the normal way and are not stigmatised or made to feel different. All efforts should be made to ensure that the allergic child has the opportunity to participate in all of the activities available to their peers.

Day-to-day measures are needed for risk management including:

- an awareness of the young person's needs in relation to the lunch menu, individual meal requirements and snacks;
- assessment of the risks presented by foodstuffs not belonging to or being consumed by the individual;
- assessment of the risks in the curriculum or play activities such as food technology, science etc.;
- assessment of the risks outdoors or off-site through PE, play and on trips;
- checks at reasonable intervals (usually at least termly by parents) that adrenaline kept on the premises or taken out on visits is in date. **Out of date injectors may not work**.

10.1 Meals and Snacks

There must be a system in place to ensure that information about the dietary requirements of young people with allergies is shared with kitchen staff, especially when the allergies are severe. Where kitchen staff are not employed by the setting i.e. contracted kitchen staff, it is important that a robust system exists to keep them informed.

The introduction of mandatory allergen information provision to customers under the *Food Information Regulations (2014)* should mean that everyone working with food knows the 14 food allergens legislated for and that producers of food will have labelled their products appropriately so that kitchen staff who are serving food know what information they must share with customers. The Food Standards Agency has produced a host of information and resources to support canteen services at food.gov.uk/science/allergy-intolerance/label/. The KAHSC *Catering Code of Practice (2015)* contains detailed information to support catering staff in meeting the requirements and is available to download at www.kymallanhsc.co.uk.

It is recommended that children with severe food allergies be supplied with a home packed lunch. This is particularly so in the case of nursery and infant school age children and sometimes those with special educational needs when they are less likely to be aware of what they can and cannot eat.

The Anaphylaxis Campaign does not necessarily support 'peanut bans'. Settings do however, have a clear duty of care to all young people and so need to have procedures in place to minimise the risk of a reaction occurring in a food-allergic child. Some children are hypersensitive to their allergens where contact with a door handle recently touched by somebody else who had been handling their allergen can trigger severe anaphylaxis in the allergic child. Settings may wish to write to parents asking for their cooperation in making life safer for allergic children, but bans should be reserved for the most extreme of cases where the risk assessment shows that no other controls can reduce the risks to the allergic child to a tolerable enough level. *The Anaphylaxis Campaign* offers help and advice on doing this to anyone calling their helpline on 01252 542029.

10.2 Outdoor Activities, Visits Off-site and Travel

For young people who are allergic to insect stings, a little planning may be necessary to keep them safe outdoors. This could be as simple as ensuring that they wear shoes on their feet at all times, they understand how to behave near stinging insects to reduce the chances of being stung, an injector-trained person is available in the vicinity when they are outside and that their injector is

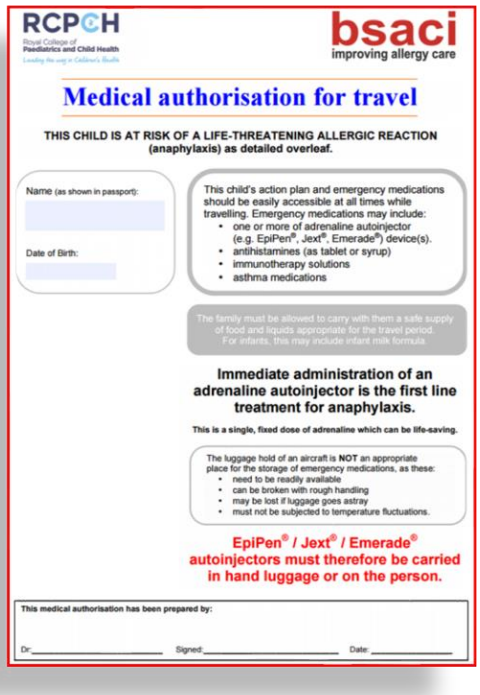
carried by them or a designated member of staff or is suitably close by in the nearest building. Ultimately all schools and care facilities should be working towards self-sufficiency and independence for young people with anaphylaxis which, for most sufferers is a life-long condition. It is essential that children grow up enabled to take control of their condition and save their own life should they ever suffer a severe reaction whilst they are alone.

Trips may need a little extra advance preparation. Children with allergies should have every opportunity to attend sports trips to other settings and most other settings should, by now, have had experience of dealing with at least one child with a food or insect sting allergy. The PE teacher or sports coach should be fully aware of the contents of the child's IHCP and *may* need to notify the places being visited that a member of the team has an allergy when arranging fixtures. A member of staff trained in administering adrenaline should accompany the team and where the other setting feels that they are not equipped to cater for a particular food-allergic child, the setting the child is from should arrange for the child to take their own food.

Arrangements for outdoor activities and off-site visits should be discussed with the young person and parents in advance. A risk assessment should be undertaken and a meeting should be arranged with the parents and the child if appropriate, to ensure they are satisfied with plans. This often happens in a single meeting initially when the child's whole IHCP is developed and the entire range of outdoor and off-site activities available are discussed. The IHCP is a risk assessment to be read alongside the ordinary trip risk assessments which may make additional references e.g. to checks with hotel kitchens on arrival to ensure they are aware of the allergy information provided beforehand. There should not necessarily be an expectation that all parties will meet before every trip off-site, although it is more likely to become necessary for a residential experience. At least one person trained in administering adrenaline must accompany off-site visits. For the purposes of equality, it is not advisable for a parent to accompany their own child on school trips in the capacity of carer, although in some cases this may be unavoidable.

When travelling using any kind of transportation, injectors must be carried on the person or packed in hand luggage so that they are easily accessible during the journey. This is especially true of flying where access to the hold is not possible en-route unlike on a coach or ferry where special arrangements to stop and retrieve them may be difficult but are not physically impossible.

When passing through international border controls, the injectors must be taken out of the hand luggage and presented for screening and inspection, together with supporting documentary proof of authenticity such as a prescription or doctor's letter because they are both liquid and sharp. BSACI have designed a *Medical Authorisation for Travel* document (pictured right) which is meant to be printed on the reverse of an individual's *Allergy Action Plan*.


RCPCH Royal College of Paediatrics and Child Health

bsaci improving allergy care

Medical authorisation for travel

THIS CHILD IS AT RISK OF A LIFE-THREATENING ALLERGIC REACTION (anaphylaxis) as detailed overleaf.

Name (as shown in passport):

Date of Birth:

This child's action plan and emergency medications should be easily accessible at all times while travelling. Emergency medications may include:
- one or more of adrenaline autoinjector (e.g. EpiPen®, Jext®, Emerade®) device(s).
- antihistamines (as tablet or syrup)
- immunotherapy solutions
- asthma medications

The family must be allowed to carry with them a safe supply of food and liquids appropriate for the travel period. For infants, this may include infant milk formula.

Immediate administration of an adrenaline autoinjector is the first line treatment for anaphylaxis.

This is a single, fixed dose of adrenaline which can be life-saving.

The luggage hold of an aircraft is **NOT** an appropriate place for the storage of emergency medications, as these:
- need to be readily available
- can be broken with rough handling
- may be lost if luggage goes astray
- must not be subjected to temperature fluctuations.

EpiPen® / Jext® / Emerade® autoinjectors must therefore be carried in hand luggage or on the person.

This medical authorisation has been prepared by:

Dr:_____ Signed:_____ Date:_____

Tips on Flying

The *International Food Allergy Alliance* advises that visit leaders should ensure that:

- Parents have sought and shared appropriate advice about flying from their child's doctor. Some airlines may request written medical evidence of the allergy and visit leaders must be prepared. An AAP (as above) is written by a clinician and is designed to fulfil this need.
- If the allergy sufferer has a medical alert bracelet or similar identification marker, they wear it at all times when away from home.

- Allergy needs are communicated to all relevant parties e.g. the travel agent and airline staff. Leaders should communicate directly with the airline's customer services/in-flight services and try to get any verification in writing.
- The airline being dealt with is the one actually operating the flight. Some are franchised out to different airlines which may not have the same policy or may not be advised of special arrangements. When communicating with airlines well in advance of travel, some will make special efforts to ensure the flight is 'peanut friendly'.
- When needs are outlined, the potential problems which may occur are explained calmly and without making aggressive demands. Airlines are very focused on the problems caused by peanuts, but the steam from some cooked fish and shellfish can also trigger reactions, so the meal choices of passengers close by may cause a problem. Leaders should avoid using the phrase 'nut free flight' because airlines have no control over passengers bringing their own packets of nuts on board. The Cabin Crew can certainly ask for the cooperation of all passengers though. British Airways and Virgin Atlantic are among those airlines that have removed peanut snacks from certain classes of flight, but leaders should always check that is still their policy at the time of booking.
- When successful in securing special arrangements, these are in place for all connecting and return flights and copies of any airline letters or emails are carried.
- When checking in, that the arrangements which have been promised are in fact in place. Check again at the gate on boarding the plane.
- Where necessary, wet wipes (preferably alcohol-based) are available to clean surfaces such as the fold-down tray. Ask at the gate to pre-board the plane to clean the seat, arms and tray.
- The allergic person does not use the airline blanket or pillow which may not have been washed between users.
- The injector is carried on the allergic person or on the person of a supervisor or in the seat pocket in front of the allergic person and never in the overhead locker. Leaders should understand that, even when they travel with an airline that trains their cabin crew to recognise the symptoms of anaphylaxis and administer treatment, the crew will expect the leader or a group supervisor to treat the allergic person first.
- There is scope within plans and supervision ratios to manage an emergency or last minute change to travel plans such as the allergy sufferer having to travel on another flight.

CASE STUDY: The mother of fish and fish vapour allergic child says:

"Problems arise when hot fish meals are served on flights so we adopt the following approach:
Before booking, we ask what type of meal is usually served in economy on that route. If fish is served, the concentration of fish vapour is obviously much greater, as is the likelihood of sitting next to a passenger eating fish. In those circumstances, we find another flight.
A few days before departure we call to find out what the airline is planning to serve because menus change constantly.
At check-in we ask about meals again.
On boarding the plane we ask again as last minute substitutions can happen.

We have had to change flights in the past at each of the above stages, including at the gate, where a last minute salmon meal was introduced.
I think short haul flights on budget airlines, where meal preparation and service are kept to a minimum, offer the best option for fish allergy sufferers. It is obviously very difficult to plan longer trips where timing is crucial (we have missed part of a family celebration)."
Read more at:
www.anaphylaxis.org.uk/living-with-anaphylaxis/travelling/peanut-snacks/

- The visit insurer is notified of the presence on the trip of an anaphylactic child and that the leader and parents understand the cost and insurance implications for any necessary last minute visit changes caused by risks associated with the condition.

10.3 Food Technology and Science Activities

No child can be excluded from any curricular activities that they are entitled to access and the *Equality Act (2010)* requires employers and service providers to make reasonable adjustments to work or to the services they provide to ensure equal access for those with disabilities or anyone with a protected characteristic such as gender, religion, pregnancy etc.

Experiments with food or certain chemicals may present difficulties and appropriate control measures to reduce the risk of an anaphylactic reaction should be identified in advance as part of the general risk assessment process. Suitable alternatives should be agreed.

In food technology lessons care is needed with foods that any child is allergic to. Risks can be minimised by cleaning the cooking area thoroughly before use and ensuring that recipes are thought through carefully.

Some settings have effectively introduced a nut-free environment but this can be difficult to achieve or enforce and can result in stigma, children hiding banned foods making risks unknown and bullying. It must also be accepted by everyone concerned that while staff will endeavour to ensure that a child does not come into contact with a particular allergen; this cannot ever be guaranteed no matter how careful the controls are.

Those allergic to animal hair may encounter difficulties handling historical objects made or stuffed with animal fibres such as horse hair. The severity of the potential reaction should guide staff on the enquiries they need to make of venues or workshop providers where young people can come into contact with their allergen in a way that they may not be expecting.

10.4 Pets and Animal Contact

Some people are allergic to different types of animal hair from cats and dogs to horses and other animals. Managing this will always be a case of careful forethought and discussion with an allergic young person and/or their parents.

This will particularly affect preparation for visits off-site involving planned contact with animals at farms and other visitor attractions, as well as the opportunities for unplanned contact with animals such as dogs off their leads in parks.

It will also need careful consideration when bringing animals into settings permanently as pets or temporarily for ‘show and tell’ style activities. Parents should always be notified at least 24 hours before children take part in activities involving contact with animals or other potential allergens such as henna tattooing. This is so they can withdraw their consent if they are not happy for their child to have that experience, but also to prompt families to disclose allergies which they may not have thought to tell the setting about because they didn’t think it was a risk in that environment.

10.5 Events

Open days, fetes, fayres, cheese and wine evenings, plays and performances, bring-and-buy sales and other events and sponsored activities are all ways in which education and care settings engage with their local community, raise their public profile and raise money to fund fantastic opportunities for the children and young people they serve.

The *Food Information Regulations (2014),* which apply to the sale of foodstuffs by commercial organisations regarding food allergen labelling or information provision, do not apply to non-commercial activities such as those outlined above. If, however, the foods are made in the setting by staff and/or children with ingredients purchased by the setting, for the purpose of raising money, then settings should be aware that it *could* be argued that the food is being made

commercially and for profit (staff were being paid at the time they made the food and it is being sold for more than it cost to make).

When parents and other members of the community, including staff provide foodstuffs that they have prepared and donated to an event to help fundraise, it is clear that **the Regulations do not apply** and food does not have to be labelled with allergen information. Settings that ask their community to help out with events in this way should try to use it as an opportunity to raise awareness about allergies and anaphylaxis throughout their community. It would be best practice to tell people who will donate homemade foodstuffs what the 14 food allergens are and ask them to label any donated food that contains any of the allergens and which ones they contain. The Food Standards Agency has produced a very simple poster explaining what the 14 allergens are and what foods they might be found in which might be helpful to those who communicate via email. **There is no requirement for foodstuffs sold non-commercially to be labelled.** It would just be a fantastic learning opportunity for children, young people and their entire community.

When a setting engages a commercial provider to make food available to people attending an event e.g. a burger van, **the commercial provider will be subject to the Regulations** and they must label the food they sell or have a sign up instructing customers to ask the vendor, who must then be able to tell them verbally which foods do or do not contain a particular food allergen. Before confirming arrangements with such a provider it is advisable to check that they are aware of their responsibilities and will be complying with them.

11 Storage and Access to Medicines

Emergency medicines should never be locked away unless they are a controlled drug and the risk assessment indicates that leaving them unsecured is too great a risk to too many people. Medicines should be kept out of the reach of children generally, including the child they are for if the child is not competent to look after it themselves and to self-administer without support.

No medicines of any kind should ever be stored in a first aid kit because they are not part of first aid. On excursions, staff may choose to carry medicines or injectors inside a travel first aid kit as a safe and easily recognisable place to keep them on a trip off-site where the child/ren might need them. They must be clearly marked as belonging to the young person who it belongs to.

In the setting, adrenaline/epinephrine should be stored in an easily identifiable container which should be kept separate from the storage of first aid equipment. In the past, the Local Authority may have supplied 'orange boxes' similar to the type pictured right. They were the same size and shape as a traditional green first aid box without the cross markings and coloured bright orange instead. This service has ceased and the large solid orange boxes are difficult to source now because they are generally viewed as impractical in most situations.

Suitable containers are available to purchase from any good medical supplies retailer. The tough but soft packs pictured right have replaced orange boxes as the preferred emergency medicines storage container and they come in different sizes. The brand pictured is Medpac (other brands are available). There are no set specifications for what such a container must look like. It needs to be sturdy enough for where it will be kept and how it will be used and big enough to hold the medicine, dispensers (and any manufacturer's instructions), protective equipment (gloves, wipes etc. if needed for administration), administration record, information about and photograph of the child (IHCP) and for it not to be confusable with first aid supplies.

The number of emergency medicines and storage containers one child needs will depend on:

- the likelihood of a reaction and how well the individual manages their potential exposure,
- the severity of a reaction; mainly how quickly their condition becomes life-threatening which will determine how far away it can be stored (brain cells are extremely sensitive to a

lack of oxygen: some start to die less than 5 minutes after their oxygen supply is cut off and brain damage or death can result from low blood pressure or from airway constriction),

- where medicines are normally kept day-to-day i.e. whether the young person carries them on their person or whether it is in their class or playroom,
- where and when the individual is likely not to be carrying any emergency medicine on their person i.e. during water, sporting, messy and some play activities,
- the size of the site in relation to the severity of a reaction and where it might be experienced i.e. medicine should not be kept in a place more than a 3 minute return trip away from where a severe reaction may be suffered.

This could mean that two or more containers with medicine in, stored in different locations around the site are necessary to effectively manage one young person with severe anaphylaxis. There is no requirement that each child should have their own personal containers, but it will eliminate the chances of administering the wrong medicine to the wrong child in an emergency situation if they are kept separately. Adrenaline or epinephrine is only administered in two different doses based on the body mass of the individual and a child will move onto the adult dose at any age between 5 and 11 years old. This means that the negative outcome of making a mistake and administering the wrong child's medicine will be negligible provided that all of the children sharing a container are on the same medicine at the same dose.

It is unlikely that an education or care setting will need a sharps box for the safe disposal of needles purely to manage young people with anaphylaxis because the needle is integral to the injector and, if used, it must be made safe according to the manufacturer's instructions and given to the paramedics when the child goes to hospital. It will be disposed of safely by the hospital who will want to see it first.

12 Record Keeping

Any young person who has an allergy that may require treatment will need an IHCP, although what is recorded there and the detail will depend on the severity of potential outcomes for them from exposure and the complexity of the arrangements required. It should be kept as short and as user friendly as possible.

Any young person who has anaphylaxis and requires emergency adrenaline to relieve life-threatening symptoms, should get from their clinician a completed and signed BSACI *Allergy Action Plan* with pictorial guide to administration. The clinician might be the GP, a hospital consultant etc. They can also get a BSACI *Medical Authorisation for Travel* which can be required for air travel and international border crossings.

The parents of any young person who may require medicine to be administered by staff will need to provide their written parental consent to do so.

The setting will require at least one spare injector (preferably two, even if the young person carries their own as well) and the storage container it is kept in needs to include an administration record as well as a copy of the IHCP with any manufacturer's instructions. It is **not** the case that two responsible adults need to sign when adrenaline is administered. It is a prescription drug, but it is not a controlled drug under the *Misuse of Drugs Act (1971)* like stimulants such as methylphenidate (Ritalin) are.

All record forms, plans and parental consent templates can be found as appendices to the KAHSC *Model Supporting Pupils with Medial Conditions Policy* available at www.kymallanhsc.co.uk.

13 References and Sources of Further Information

The work of other people that has been used to create this guidance and sources of further information and support referred to throughout include:

Documents:

- DfE, *Supporting Pupils at School with Medical Conditions,* Crown Copyright, (September 2014)
- MHRA, *Adrenaline Auto-Injectors: Advice on Use,* Crown Copyright (May 2014)
- KAHSC, Model Supporting Pupils with Medical Conditions Policy, (regularly updated)

Websites

- www.nhs.uk/Conditions/Anaphylaxis - the NHS Choices website which summarises the causes, symptoms and treatments of and living with anaphylaxis.
- www.anaphylaxis.org.uk – a leading UK charity working on behalf of anaphylaxis sufferers.
- food.gov.uk/science/allergy-intolerance/label – the Food Standards Agency website where kitchens and others who work with or handle food can download resources to help them manage the exposure of people to allergens that trigger a reaction or anaphylaxis in them.
- www.kymallanhsc.co.uk – the Kym Allan Health and Safety Consultants Ltd. website.
- www.epipen.co.uk/patients/epipen-user-guide/ - manufacturer instruction videos on administering their brand of injector.
- www.jext.co.uk/jext-video-demonstrations.aspx - manufacturer instruction videos on administering their brand of injector.
- www.emerade.com/instruction-video - manufacturer instruction videos on administering their brand of injector.
- www.bsaci.org/about/pag-allergy-action-plans-for-children - a leading UK education, training and research organisation for improving allergy care.
- www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency – the Medicines and Healthcare Products Regulatory Agency website.
- www.foodallergyalliance.org/ - an alliance of patient education groups around the world whose mission is to unite organisations working in food allergy and anaphylaxis to exchange information and advance key issues to those with food allergy and anaphylaxis.

For further information about this guide, please contact Kym Allan Health & Safety Consultants Ltd., 3-4 Citadel Row, CARLISLE, CA3 8SQ, Telephone: 01228 210152.

Individual Healthcare Plan (IHCP)

School/Setting:				**PHOTO**
Name of Child:				
Date of Birth:				
Address of Child:				
Gender:	MALE / FEMALE	**Class/Form:**		
Date:		**Review Date:**		

Who is responsible for providing support in school?	

Medical Diagnosis or Condition

EMERGENCY CONTACT INFORMATION			
Family Contact 1		**Family Contact 2**	
Name:		**Name:**	
Relationship to Child:		**Relationship to Child:**	
Work Tel. No:		**Work Tel. No:**	
Home Tel. No:		**Home Tel. No:**	
Mobile Tel. No:		**Mobile Tel. No:**	
Clinic or Hospital Contact		**GP Contact**	
Name:		**Name:**	
Contact No:		**Contact No:**	

Describe the child's medical needs (e.g. details of any symptoms, triggers, signs, treatments, facilities, equipment/devices, environmental issues etc.)

Please note: Some or all of this information may be shared on a *confidential* and *strictly need to know basis*, with adults other than school staff who may be working with children and young people in a paid or voluntary capacity. **Such adults are bound by the school's code of conduct on confidentiality.**

Medicine details (e.g. name of medicine, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision, whether carried by the child and how carried etc.)
Agreed procedure in the event that medicine or procedures are refused by the child
Daily care requirements (e.g. before sports activities, at lunchtime etc.)
Specific support in place for any educational, social and emotional needs (include re-integration and any partnership working following absences e.g. Local Authority hospital/home tuition services etc. and sensitive management of re-integration after serious or embarrassing incidents at school.
Arrangements for educational visits or other activities outside the normal timetable
Other Information

Describe what constitutes an emergency and the action to take if this occurs

Permission held to administer **salbutamol** in an asthma emergency. YES NO N/A

Describe any follow-up care required

Who is responsible in an emergency? (Please state if different for different activities e.g. off-site etc.):

Staff training needs identified or already undertaken (e.g. names of staff trained, what training they have received and when, along with any plans to train others and when)

Plan developed with (e.g. the child, named parents, staff, healthcare professionals and any others)

Form copied to (Please state who holds copies of this information and where)**:**

Emergency Actions: Generic Summary

(Delete this information and attach a copy of the child's AAP instead if they have one)

If any symptoms of a reaction become apparent:

1. Seek help from staff trained in anaphylaxis emergency procedures;
2. Inform the Head teacher/manager;
3. Inform parents only when trained staff.

An adult will remain with the young person at all times.

1. Trained staff will assess the situation;
2. Decide whether to summon an ambulance and arrange for it to be done;
3. Send for any medicine including the emergency adrenaline 'pen' and check the expiry date;
4. Follow the personal emergency procedure described in the IHCP administering appropriate medicine in line with perceived symptoms.
5. Clear the area of unnecessary personnel including other young people.

If the symptoms appear life-threatening:

1. **Help the young person into the position which is comfortable and assists their breathing.**
2. **Administer the adrenaline injector** in accordance with training and make the injector made safe to give to the ambulance crew as follows;
    a). Remove any needle safety cap and keep safe;
    b). Remove any injector button cap and keep safe;
    c). Jab or place pen to upper aspect of outer thigh according to manufacturer's instructions on top of any clothing not easily moved;
    d). Press injector button firmly;
    e). Hold 'pen' in place for at least 10 seconds;
    f). Withdraw 'pen' and replace all caps making it safe for the ambulance crew.
5. **Note the exact time of the adrenaline dose** in case a second dose no less than 5 minutes after the first is required and also to notify the ambulance crew.
6. **Continuously assess their condition** positioning them in accordance with their symptoms e.g.
    a). faint/weak/pale/floppy – laid down with legs raised to increase blood flow;
    b). nausea/vomiting – laid down on their side to avoid choking;
    c). Asthma symptoms/wheezing/difficulty breathing – sat up to ease breathing.
6. **On the arrival of the paramedics or ambulance crew** inform them of the time and type of medicines given and hand over all used adrenaline injectors.

The person calling for the ambulance must state:

1. Name and age of young person;
2. That you believe them to be suffering from anaphylaxis;
3. The cause or trigger (if known);
4. The name, address and telephone number of the site and that they will be met on arrival.

After the emergency:

1. Record details of all medicines administered with date and time on the individual's record card;
2. Replace completed record card along with this HCP in the individual's 'Orange box' (any suitable rigid plastic container).
3. Debrief all staff involved (and if necessary young people as well);
4. Review emergency plans addressing any issues which arose;
5. Arrange to replace used medicines and/or 'pens'.