SESLHD GUIDELINE COVER SHEET

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EXECUTIVE SPONSOR	Director Clinical Governance and Medical Services
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POSITION RESPONSIBLE FOR DOCUMENT	SESLHD Deteriorating Patient Committee
FUNCTIONAL GROUP(S)	Clinical Governance
KEY TERMS	Anaphylaxis, Clinical deterioration; escalation; adrenaline, Adrenaline/ Epinephrine, deteriorating patient
SUMMARY	This guideline outlines the recommended response to anaphylaxis management to allow a standardised approach to recognising and managing this patient group.

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Health
South Eastern Sydney
Local Health District

Acute Anaphylaxis Management

Section 1 – Background

Anaphylaxis is the most severe form of allergic reaction and is potentially life threatening. It must be treated as a medical emergency, requiring immediate treatment and urgent medical attention. Anaphylaxis often occurs as an acute and inappropriate inflammatory reaction to an allergy which can result in life threatening consequences to the patient within minutes to hours.

Over four million Australians live with allergies. Food allergy, for example, occurs in around 5-10% of children and 2-4% of adults in Australia and New Zealand (Australasian Society of Clinical Immunology and Allergy (ASCIA) 2023).

While not everyone with an allergy is at risk, recent studies show increasing incidence of all-cause anaphylaxis in Australia, the United Kingdom and the United States. In Australia, in the five years to 2019-20

- Anaphylaxis presentations to emergency departments in public hospitals grew by 51% - to more than 11,594 in 2019-20.
- Anaphylaxis hospital admissions increased by 35% - from 9,042 in 2015-16 to 12,179 in 2019-20 (Australian Commission on Safety and Quality in Health Care. (2021) *Acute Anaphylaxis Clinical Care Standard).*

This guideline has been established to standardised Anaphylaxis managements across South Eastern Sydney Local Health District (SESLHD) in both inpatient, outpatient and community settings.

Section 2 – Principles

- This guideline is aligned with the ASCIA Guidelines – Acute Management of Anaphylaxis (ASCIA, 2024).
- The guideline should be read in conjunction with Acute Anaphylaxis Clinical Care Standard - Implementation guide for NSW Health Facilities

Section 3 – Definitions

Anaphylaxis:

- Any acute onset illness with typical skin features (urticarial rash or erythema/flushing, and/or angioedema), plus involvement of respiratory and/or cardiovascular and/or persistent severe gastrointestinal symptoms; or
- Any acute onset of hypotension or bronchospasm or upper airway obstruction where anaphylaxis is considered possible, even if typical skin features are not present.

Allergic Reaction:

- Allergy occurs when a person's immune system reacts to substances in the environment that are harmless to most people. These substances are known as allergens and are found in dust mites, pets, pollen, insects, ticks, moulds, foods, and drugs (medications).

Adrenaline Auto Injector:

- Often known by their brand name as an EpiPen® (EpiPen Junior 150, Epipen 300) and Anapen® (Anapen 150, Anapen 500), auto injectors are used to treat severe allergic reactions. They contain a single, fixed dose of adrenaline and are designed to be used by anyone, including people with no medical training. i.e. Anapen 500 (Anapen 150 and 300)

ASCIA Action Plan:

- Australasian Society of Clinical Immunology and Allergy (ASCIA) Action Plan for Anaphylaxis (red) or an ASCIA Action Plan for Allergic Reactions (green) or an ASCIA First Aid Plan Anaphylaxis (orange) or an ASCIA Action Plan for Drug (Medication) Allergy.

Section 4 – Responsibilities

Clinical Governance Unit

- Communicate with stakeholders, including patients, families, carers, clinicians and the Clinical Excellence Commission (CEC), to provide feedback on the performance and effectiveness of the Deteriorating Patient Safety Net System.

Clinical Nurse Consultant - Clinical Emergency Response Systems

- Provide leadership and management of recognising and responding to the deteriorating patient via the SESLHD Deteriorating Patient Programs (DPP) Committee
- Provide local guidance and directives on the Clinical Emergency Response System (CERS) to ensure consistency in management of anaphylaxis/suspected anaphylaxis across local sites
- Provide guidance on reporting requirements for local facilities

Nurse Unit Managers / Clinical Nurse Consultants / Midwife Consultants and Educators

- Support staff education, as appropriate to position, for example: identifying practice and knowledge gaps
- Provide leadership and clinical support to staff in the recognition, escalation and management on acute anaphylaxis
- Provide education guided by the NSW Health Deteriorating Patient Education Strategy
- Encourage staff to complete online education provided by Health Education and Training (HETI) on how to safely care for patients with anaphylaxis from admission to discharge. *Course Code: 576522987.*
- Enable all patients who have their own adrenaline injector to have immediate access to it. This is to avoid harm resulting from delayed administration of adrenaline for a known allergy causing anaphylaxis.

Medical staff

- Complete mandatory Deteriorating Patient education as per NSW Health Deteriorating Patient Education Strategy.
- Prompt recognition, escalation and management of acute anaphylaxis

- Comprehensive information of the anaphylactic episode must be documented in the patient's healthcare record after treatment for anaphylaxis, using the appropriate documentation template, where available and as appropriate.
- Ensure patients treated for anaphylaxis receive tailored discharge planning prior to separation from hospital.
- Patient education resources, referrals and discharge documents to be provided to patients
- Any patient who has experienced an anaphylaxis episode must have a documented medical management plan that includes the frequency of observations
- Monitor a full set of vital signs hourly, at a minimum, for 4 hours is recommended after last dose of adrenaline.
- 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 education to patients and carers on recognition, management of escalation of anaphylaxis management

Clinical Staff

- Complete mandatory Deteriorating Patient education as per NSW Health Deteriorating Patient Education Strategy.
- Prompt recognition and escalation of those experiencing signs and symptoms of acute anaphylaxis
- Monitor a full set of vital signs hourly, at a minimum, for 4 hours after last dose of adrenaline.
- Provide education to patients and carers on recognition, management and escalation in line with medical management plan
- To administer intramuscular (IM) adrenaline (epinephrine) via autoinjector or syringe, according to NSW Health Policy Directive PD2022_032 - Medication Handling
- If the patient would like to have access to their personal adrenaline injector the Registered/Enrolled Nurse/Midwife must assess and check the expiry date, ensure there is a clear 'window' to check it hasn't been used and apply a patient sticker.

- Competency must be assessed by asking the patient the symptoms of anaphylaxis, how to administer their adrenaline autoinjector, consideration of physical and cognitive ability and informing the patient they must immediately notify clinicians if they use their own device.

Pharmacy staff

- Process to provide patients with personal adrenaline injectors
- Education and training to patients and carers on use of personal adrenaline injectors, if required.
- Responsible for stock control and supply for inpatient settings

Education and Training

All clinical staff are highly encouraged to complete online education provided by Health Education and Training (HETI) on how to safely care for patients with anaphylaxis from admission to discharge.

- Acute Anaphylaxis and the safe use of adrenaline (epinephrine) Code: 576522987

Section 5 – Recognition and assessment

5.1 Anaphylaxis is highly likely when any one of the following two criteria are fulfilled:

Criteria One

Acute onset of an illness (minutes to several hours) with simultaneous involvement of the skin, mucosal tissue, or both (e.g. generalized urticaria (hives), pruritus or flushing, swollen lips-tongue-uvula), and at least one of the following:

a) Respiratory compromise (e.g. dyspnoea, wheeze-bronchospasm, stridor, hypoxemia).
b) Reduced blood pressure or associated symptoms of end-organ dysfunction (e.g. hypotonia [collapse], syncope, incontinence).
c) Severe gastrointestinal symptoms (e.g. severe abdominal pain, vomiting), especially after exposure to non-food allergens.

Criteria Two

Acute onset of hypotension or bronchospasm or laryngeal involvement after exposure to a known or highly probable allergen for that patient (minutes to several hours), even in the absence of typical skin involvement

5.2 Signs and symptoms of allergic reactions

Mild or moderate reactions (may not always occur before anaphylaxis):

- Swelling of lips, face, eyes
- Urticaria (Hives or welts)
- Tingling mouth
- Abdominal pain, vomiting - these are signs of anaphylaxis for insect sting or injected drug (medication) allergy

5.3 Anaphylaxis – Indicated by any one of the following signs:

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Difficulty talking or hoarse voice
- Wheeze and/or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)

- Abdominal pain, vomiting - for insect stings or injected drug (medication) allergy

5.4 Signs and symptoms of anaphylaxis in maternal patients

Additional signs and symptoms include:

- Persistent hypotension - may be the predominant feature.
- Intense vulvar and vaginal itching (particularly if allergic reaction/IgE-mediated reaction to latex).
- Low back pain
- Uterine cramps
- Foetal distress

5.4 Assessment

Assessment of a patient needs to, at a minimum, include a systematic A-G assessment (or equivalent) and be documented in the patient's health care record, as per the requirements outlined in NSW Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating

Section 6 – Escalation

6.1 Escalation – Inpatient / Outpatient

All cases of anaphylaxis (confirmed or suspected) must be escalated as per local hospitals CERS process in line with relevant SESLHD policies:

- Management of the Deteriorating ADULT inpatient
- Management of the Deteriorating MATERNITY woman
- Management of deteriorating PAEDIATRIC inpatient
- Management of the Deteriorating NEONATAL inpatient

6.2 SESLHD Hospital Specific Flow Chart

- St George Hospital Inpatient Flowchart – Appendix B
- St George Hospital Outpatient Flowchart – Appendix C
- St George Hospital - Hospital in The Home (HiTH) – Appendix D
- Prince of Wales Hospital - Hospital in The Home (HiTH) - Appendix E
- The Sutherland Hospital & St George Hospital Community Flowchart – Appendix F

6.3 Emergency Departments

Emergency Departments may follow the Emergency Care Assessment and Treatment (ECAT) protocols in the management of Anaphylaxis or Allergic Reactions Adult- Anaphylaxis or allergic reactions and Paediatric- Anaphylaxis

Section 7 – Treatment for anaphyalxis

Adrenaline is the first line treatment for anaphylaxis and acts to reduce airway mucosal oedema, induce bronchodilation, induce vasoconstriction and increase strength of cardiac contraction.

Refer to the Anaphylaxis Flow Chart in Appendix A.

7.1 Inpatient Setting: Immediate actions in the treatment of anaphylaxis

- Remove allergen (if still present)
- Activate local CERS via switchboard on 2222
- Lay patient flat. Do not allow them to stand or walk.
    - If unconscious or pregnant, place in recovery position - on left side if pregnant
    - If breathing is difficult allow them to sit with legs outstretched
    - Hold young children flat, not upright
- If patient's own adrenaline auto injector is available, encourage patient use.
- If adrenaline auto injector not readily available, immediately administer INTRAMUSCULAR INJECTION (IMI) OF ADRENALINE **(1:1,000)** into mid anterolateral thigh (0.01 mg/kg up to 0.5 mg per dose). Refer to Adrenaline (epinephrine) – Administration for the management of anaphylaxis to adults 16 years and over for administration without an immediate medical order.
  For adrenaline dosages for patients < 50 kg, refer to ASCIA Guidelines: Appendix A- Advanced Acute Management of Anaphylaxis.
- Administer high flow oxygen (15 L/min) and airway support as required.
- Continuously monitor for response to treatment, including vital signs, as further adrenaline may need to be given if little or no response/improvement after 5 minutes.
- Commence CPR at any time if person is unresponsive and not breathing normally until help arrives.

7.1.1 Considerations

- If multiple doses are required to treat anaphylaxis (2 to 3 doses administered at 5-minute intervals), consider adrenaline infusion and transfer to higher level of care where skills and monitoring equipment are available. This should include cardiac monitoring, pulse oximetry and blood pressure monitoring (Australian Medicines Handbook (AMH), 2025).

- Always give adrenaline FIRST, then asthma reliever if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.
- IV adrenaline infusions should be used with a dedicated line, infusion pump and anti-reflux valves wherever possible.
- IV boluses of adrenaline are NOT recommended without specialised training as they may increase the risk of cardiac arrhythmia.
- The prompt administration of adrenaline (epinephrine) is the cornerstone of anaphylaxis management in both the pregnant and non-pregnant population. A dose of 0.5 mg adrenaline intramuscularly (IM) can be given for treatment of anaphylaxis in pregnancy.
- Antihistamines have no role in treating or preventing respiratory or cardiovascular symptoms of anaphylaxis. Do not use oral sedating antihistamines as side effects (drowsiness or lethargy) may mimic some signs of anaphylaxis. Injectable promethazine should not be used in anaphylaxis as it can worsen hypotension and cause muscle necrosis.
- Refer to Clinical Practice Guidelines: Anaphylaxis - The Royal Children's Hospital Melbourne or for further guidance on paediatric anaphylaxis management.

7.2 Supportive management and additional measures

- A comprehensive re-assessment (A-G or equivalent) including a full set of vital signs is required as per local CERS policies.
- Administer high flow oxygen (15 L/min) and airway support as required.
- Obtain IV access in adults and tachycardic and/or hypotensive children. The first sign of cardiovascular compromise in children is ongoing tachycardia. Hypotension can occur. later, when it can then be difficult to get IV access, resulting in a significantly prolonged recovery process.
- Consider if hypotensive, give IV normal saline 20 mL/kg rapidly and consider additional wide bore intravenous access for paediatric and adult populations. The response to the initial bolus should be reassessed before administering additional fluids.
- Specialised areas such as operating theatres should refer to their regulatory bodies such as the Australian and New Zealand College of Anaesthetics & Faculty of Pain Medicine (ANZCA).

- For guidance on additional measures if an IV adrenaline infusion is ineffective or advanced acute management of anaphylaxis for those that provide emergency care, refer to ASCIA Guidelines: Appendix A- Advanced Acute Management of Anaphylaxis

7.3 Outpatient and Community settings

Refer to SESLHD Standing Order for administration of adrenaline for episodes of anaphylaxis Adrenaline (epinephrine) – Administration for the management of anaphylaxis in adult patients / clients in the outpatient or community setting

7.3.1 Outpatient Setting: Immediate actions in the treatment of anaphylaxis

- Remove allergen (if still present)
- Stay with patient and call for help as per your local CERS process
- Lay patient flat. Do not allow them to stand or walk.
    - If unconscious or pregnant, place in recovery position - on left side if pregnant
    - If breathing is difficult allow them to sit with legs outstretched
    - Hold young children flat, not upright
- If patient's own adrenaline auto injector is available, encourage patient use.
- If adrenaline auto injector not readily available, immediately administer INTRAMUSCULAR INJECTION (IMI) OF ADRENALINE **(1:1,000)** into mid anterolateral thigh (0.01 mg/kg up to 0.5 mg per dose). Refer to Adrenaline (epinephrine) – Administration for the management of anaphylaxis in adult patients / clients in the outpatient or community setting for administration without an immediate medical order. For adrenaline dosages for patients < 50 kg, refer to ASCIA Guidelines: Appendix A- Advanced Acute Management of Anaphylaxis.
- Administer high flow oxygen (15 L/min) and airway support as required.
- Continuously monitor for response to treatment, including vital signs, as further adrenaline may need to be given if little or no response/improvement after 5 minutes.
- Commence CPR at any time if person is unresponsive and not breathing normally until help arrives.
- Continue to monitor and stay with patient until local clinical emergency response or NSW Ambulance arrives and provide ISBAR handover.
- Once patient has been stabilised, transfer person to the emergency department or hospital for at least 4 hours of observation.

7.3.2 Community Setting: Immediate actions in the treatment of anaphylaxis

- Remove allergen (if still present)
- Stay with patient and call NSW Ambulance on 000
- Lay patient flat. Do not allow them to stand or walk.
    - If unconscious or pregnant, place in recovery position - on left side if pregnant
    - If breathing is difficult allow them to sit with legs outstretched
    - Hold young children flat, not upright
- If patient's own adrenaline auto injector is available, encourage patient use.
- If adrenaline auto injector not readily available, immediately administer INTRAMUSCULAR INJECTION (IMI) OF ADRENALINE **(1:1,000)** into mid anterolateral thigh (0.01 mg/kg up to 0.5 mg per dose). Refer to Adrenaline (epinephrine) – Administration for the management of anaphylaxis in adult patients / clients in the outpatient or community setting for administration without an immediate medical order. For adrenaline dosages for patients < 50 kg, refer to ASCIA Guidelines: Appendix A- Advanced Acute Management of Anaphylaxis.
- Administer high flow oxygen (15 L/min) (if available)
- Continuously monitor for response to treatment, as further adrenaline may need to be given if little or no response/improvement after 5 minutes.
- Commence CPR at any time if person is unresponsive and not breathing normally until help arrives.
- Stay with patient until NSW Ambulance arrives and provide ISBAR handover.
- Transfer person to hospital for at least 4 hours of observation.

7.4 Access to personal adrenaline auto injector in healthcare settings

- All patients who have their own adrenaline auto injector must be allowed to have immediate access to it. This is to avoid harm resulting from delayed administration of adrenaline for a known allergy causing anaphylaxis. A risk assessment may be undertaken in circumstances where potential harm or risk to self or others has been deemed.

  For example, for mental health consumers, the consumer's acuity and the acuity of the mental health unit should be considered. Refer to SESLHDGL/082 Clinical Risk Assessment and Management - Mental Health and SESLHDBR/080 Search to maintain safety in SESLHD Mental Health Inpatient facilities

- The Registered/Enrolled Nurse or Midwife is responsible for checking the expiry date, ensure there is a clear 'window' to check it hasn't been used and apply a patient sticker.
- The patient's unit or ward must be assessed to ensure the safe storage of an adrenaline (epinephrine) autoinjector. This assessment must be completed and documented in the patient's health care record.
- If the adrenaline auto injector is expired or there is any doubt about the integrity, obtain replacement through pharmacy.
- Assessment of the patient's capacity to administer the injection safely is essential. Involvement of a parent, guardian or carer may be required.
- Identify a safe space ready for patient use unless requested by the patient to be locked up ensuring safety of other patients and staff members are not compromised.
- The adrenaline auto injector should be kept with the patients ASCIA (Australasian Society of Clinical Immunology and Allergy) Action Plan for Anaphylaxis.

7.5 Anaphylaxis Kits

- Anaphylaxis kits provide the necessary equipment to effectively manage first-line anaphylaxis.
- Local facilities are responsible for determining appropriate storage locations and access procedures for anaphylaxis kits in inpatient, outpatient, and community settings.
- In inpatient areas, where applicable, kits may be stored in designated emergency trolleys, with contents checked regularly to ensure medications are within expiry and equipment is functional.
- In outpatient and community areas, where kits are not stored in a locked trolley or bag, daily checks when the service is open should be conducted to verify the integrity and expiry of medications, alongside emergency equipment assessments.
- The use of anaphylaxis kits is not mandatory; each hospital or service should determine their necessity based on local requirements and risk assessment.

Section 8 – Monitoring and post-anaphylaxis management

8.1 Monitoring

- A minimum of hourly observations for 4 hours is recommended after last dose of adrenaline. Adrenaline/ Epinephrine has a short duration, and occasionally biphasic anaphylaxis can occur requiring further treatment. True biphasic reactions are estimated to occur following 3-20% of anaphylactic reactions.
- Relapse, protracted and/or biphasic reactions may occur and overnight observation is strongly recommended for patients if they:
    - had severe or protracted anaphylaxis (e.g. required repeated adrenaline doses or IV fluid resuscitation), OR
    - have a history of severe or protracted anaphylaxis, OR
    - have concomitant illness (e.g. severe asthma, history of arrhythmia, systemic mastocytosis) OR
    - live alone or are remote from medical care, OR
    - present for medical care late in the evening.
- Observation timeframes are determined based on assessment and risk appraisal after initial treatment.
- Any patient post anaphylaxis episode is required to have a documented medical management plan including frequency of observations.

Section 9 – Discharge management and documentation

- If anaphylaxis is recognised in a patient with the causative or suspected agent identified, the allergy is to be documented in the eMR with the severity of reaction listed as 'severe'.
- If anaphylaxis occurred as inpatient after treatment has occurred, completion of an IMS+ is required.
- Document a systematic A-G assessment (or equivalent), reason for escalation, treatment and outcome in the patient's health care record.
- Provide information on anaphylaxis and allergy management, including appropriate written patient information such as the Commission's Anaphylaxis Discharge Checklist and Discussion Guide, and patient information from ASCIA and Allergy & Anaphylaxis Australia (allergyfacts.org.au)
- Document the allergic reaction in the electronic medical record (eMR) and provide a record to the patient – for medication allergies, use the ASCIA Record for Drug (Medication) Allergy or local electronic equivalent
- Provide tailored action plans including the ASCIA Action Plan for Anaphylaxis and/or ASCIA Action Plan for Drug (Medication) Allergy
- Supply a personal adrenaline auto injector at discharge – or provide a prescription where this can be dispensed immediately upon leaving the facility if not available from pharmacy (note: where eligible, up to two injectors may be prescribed with a PBS Authority prescription); arranging supply of an adrenaline auto injector after hours may be required in some local settings.
- Provide training to patients and carers on the use of the adrenaline auto injector when supplied or prescribed, using an appropriate training device
- Tailor the patient's discharge care to the suspected allergen and risk of re-exposure to ensure adequate follow-up and preventive measures.

  In some cases, this will include:

  - An ASCIA Action Plan
  - Advice about follow-up visits with their GP and a clinical immunology/allergy specialist
  - The ACSQHC Anaphylaxis Discharge Checklist and Discussion Guide

- Patients should be referred to patient/consumer support organisations for information on daily management and support whilst they await clinical immunology/allergy specialist review: Allergy & Anaphylaxis Australia www.allergyfacts.org.au
- Refer to Discharge advice & actions following anaphylaxis flowchart
- Pharmacy will replace a patient's own adrenaline auto-injector if used within an inpatient facility

9.1 Discharge advice & actions following anaphylaxis flowchart

Figure 2: Discharge advice and actions following anaphylaxis – food, insect venom or other non-medicine allergy with a risk of re-exposure

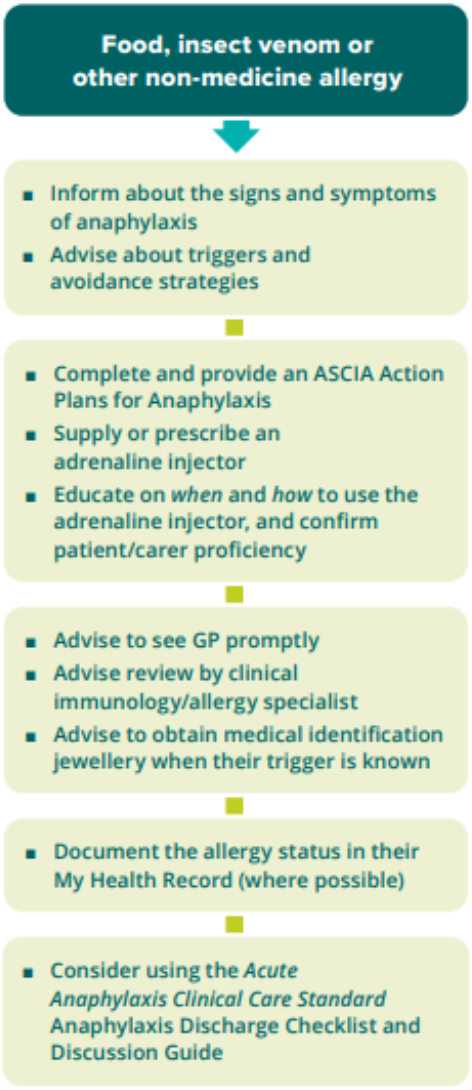
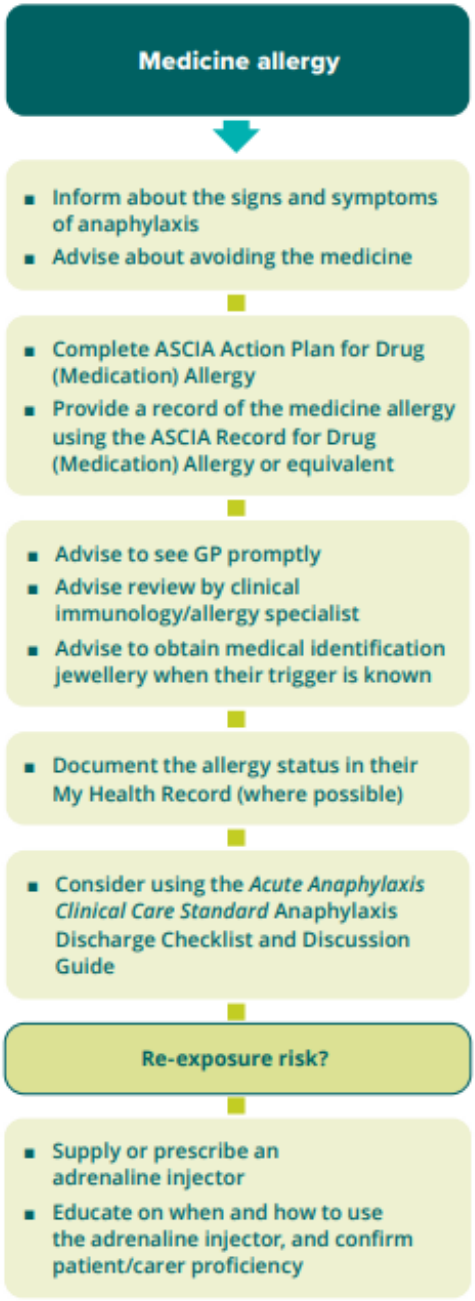


Figure 3: Discharge advice and actions following anaphylaxis caused by a medicine



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Flowchart reproduced with permission from the *Acute Anaphylaxis Clinical Care Standard* developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC). ACSQHC: Sydney (2021)

Section 10 –

References

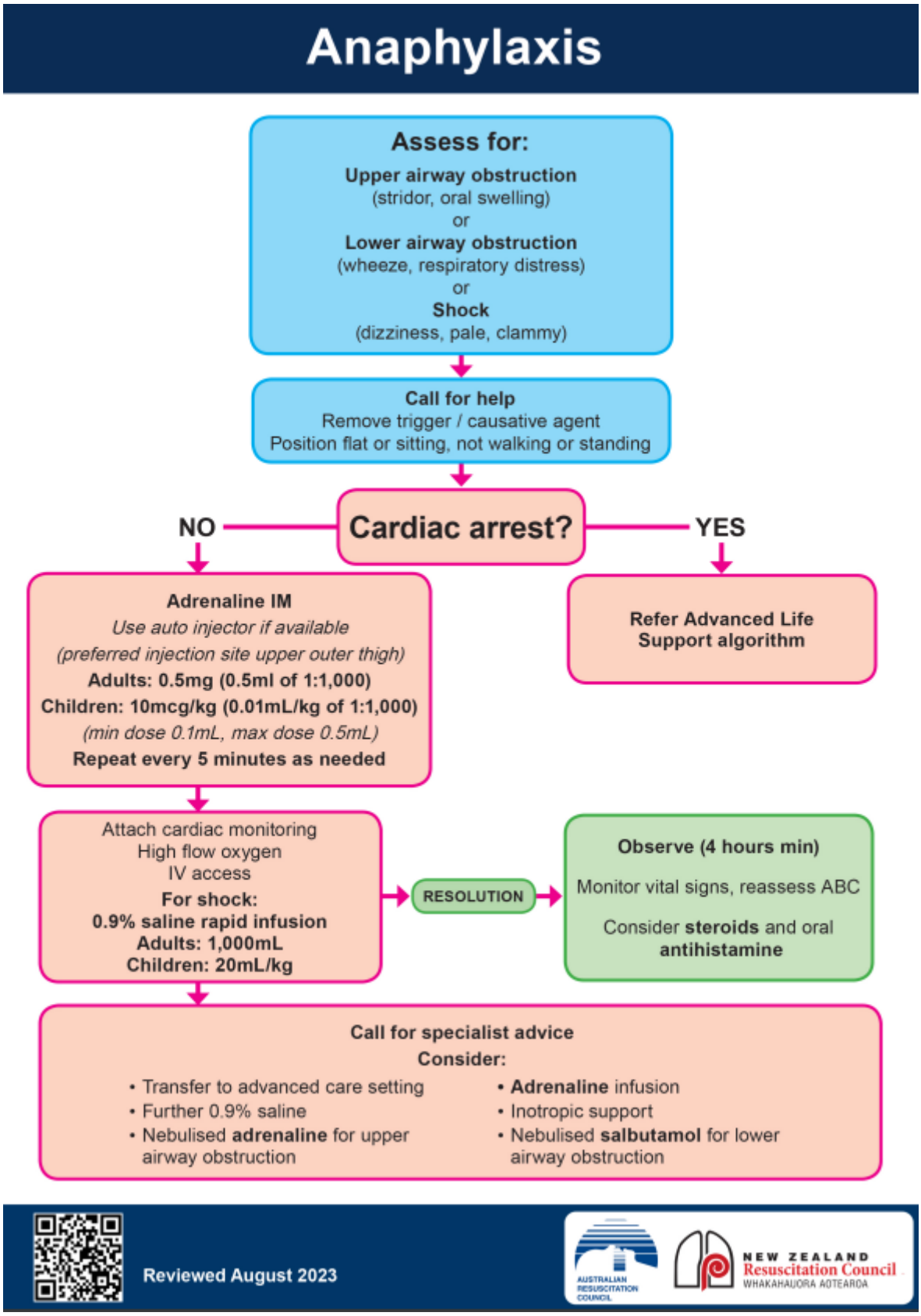
Cross References	▪ Australian Commission on Safety and Quality in Health Care. Acute Anaphylaxis Clinical Care Standard. Sydney: ACSQHC; 2021 ACSQHC ▪ Acute Anaphylaxis Clinical Care Standard - Implementation guide for NSW Health Facilities ▪ ACSQHC Acute Anaphylaxis Clinical Care Standard resources (Anaphylaxis discharge checklist) ▪ NSW Health Policy Directive PD2022_032 - Medication Handling ▪ NSW Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating ▪ SESLHD/679 Management of the Deteriorating ADULT inpatient (excluding maternity) ▪ SESLHD/705 Management of the deteriorating MATERNITY woman ▪ NSW Health PD 2022_032 - Medication Handling ▪ SESLHDGL/082 Clinical Risk Assessment and Management - Mental Health ▪ SESLHDBR/080 Search to maintain safety in SESLHD Mental Health Inpatient facilities ▪ My Health Learning: Acute anaphylaxis and the safe use of adrenaline (epinephrine). Course Code:
External References	▪ ANZCOR ANZCOR Anaphylaxis Flow Chart (August 2023) ▪ ASCIA www.allergy.org.au Current clinical guidelines from the Australasian Society of Clinical Immunology and Allergy (ASCIA), including Acute Management of Anaphylaxis (July 2024) ▪ ASCIA Action Plan ▪ Anaphylaxis: emergency management for health professionals. Australian Prescriber 2018; 41:54 https://doi.org/10.18773/austprescr.2018.014 ▪ ANZAAG www.anzaag.com & ANZCA anzca.edu.au perioperative anaphylaxis

	▪ Home - Allergy & Anaphylaxis Australia (allergyfacts.org.au) ▪ ASCIA: Acute Management of Anaphylaxis in Pregnancy ▪ ASCIA: Allergy and Anaphylaxis ▪ Clinical Practice Guidelines: Anaphylaxis - The Royal Children's Hospital Melbourne ▪ Australasian Society of Clinical Immunology and Allergy (ASCIA). (2023). *Food Allergy - Fast Facts*. ▪ Australian Medicines Handbook (AMH) Adrenaline (epinephrine) (anaphylaxis) ▪ Australian and New Zealand College of Anaesthetics & Faculty of Pain Medicine (ANZCA),2022. Perioperative Anaphylaxis Management Guidelines ▪ Emergency Care Institute. Anaphylaxis 2024. Clinical Tools: Anaphylaxis ▪ The Sydney Children's Hospital Network, Anaphylaxis and Generalised Allergic Reaction (GAR) Practice Guideline, 2020. ▪ The Royal Children's Melbourne Hospital, Clinical Practice Guidelines, 2021. Anaphylaxis

Version and approval history

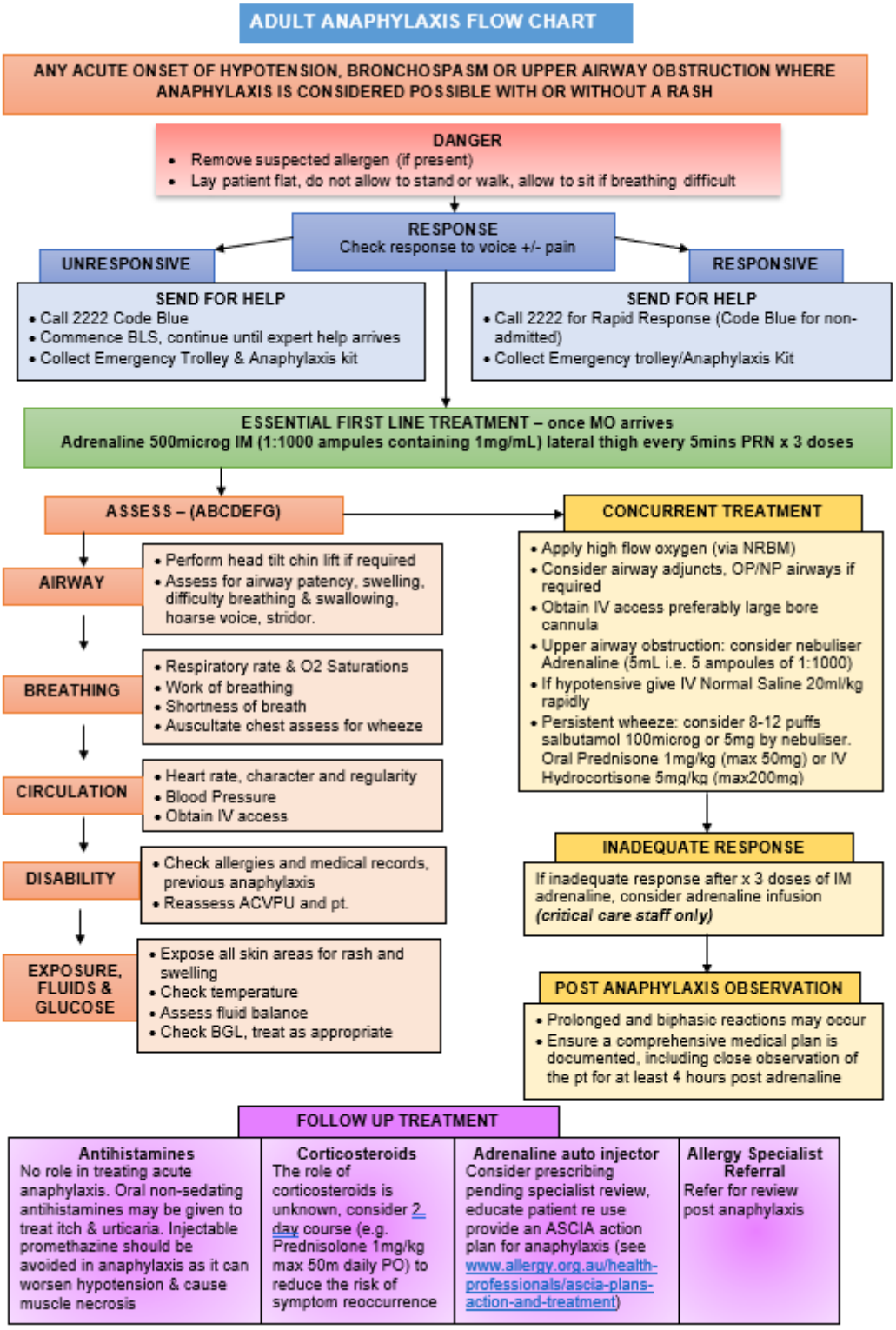
Date	Version	Version and approval notes
4 April 2025	1.0	New Guideline developed by SESLHD Deteriorating Patient Committee to meet requirements of the Anaphylaxis Clinical Care Standard. Replaces SGH BR 520 - Anaphylaxis - Acute, Management of in the Adult Patient – SGH, TSH BR 784 - Anaphylaxis Acute - Management Of In The Adult And Maternity Patient TSH and SGH BR 560 - Acute Anaphylaxis - Management of the HiTH patient SGH, Approved by SESLHD Drug and Therapeutics Committee, SESLHD Patient Safety and Quality Committee and CE.

Appendix A – ARC: Anaphylaxis Flow Chart

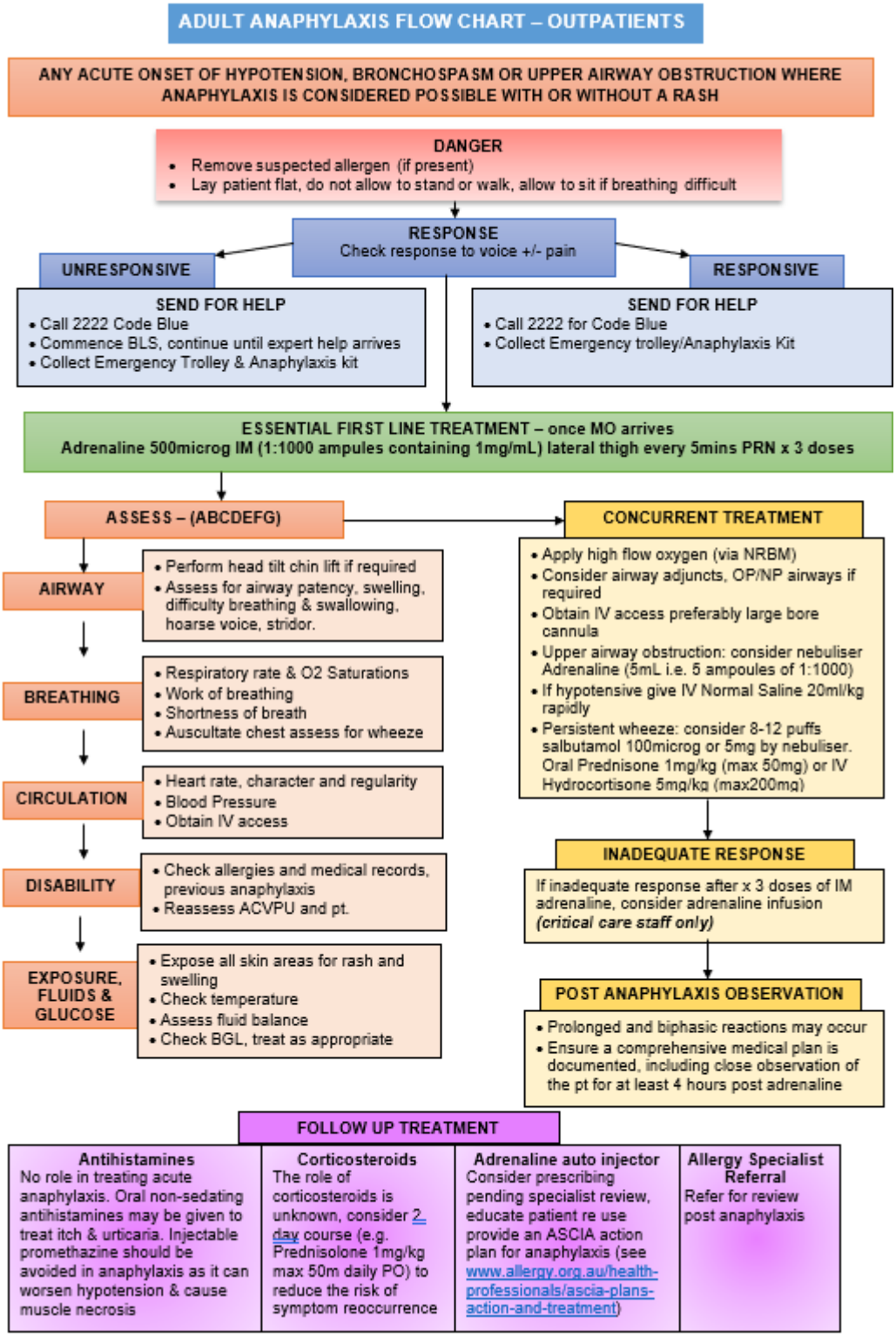


Source: Australian and New Zealand Committee on Resuscitation (2023)

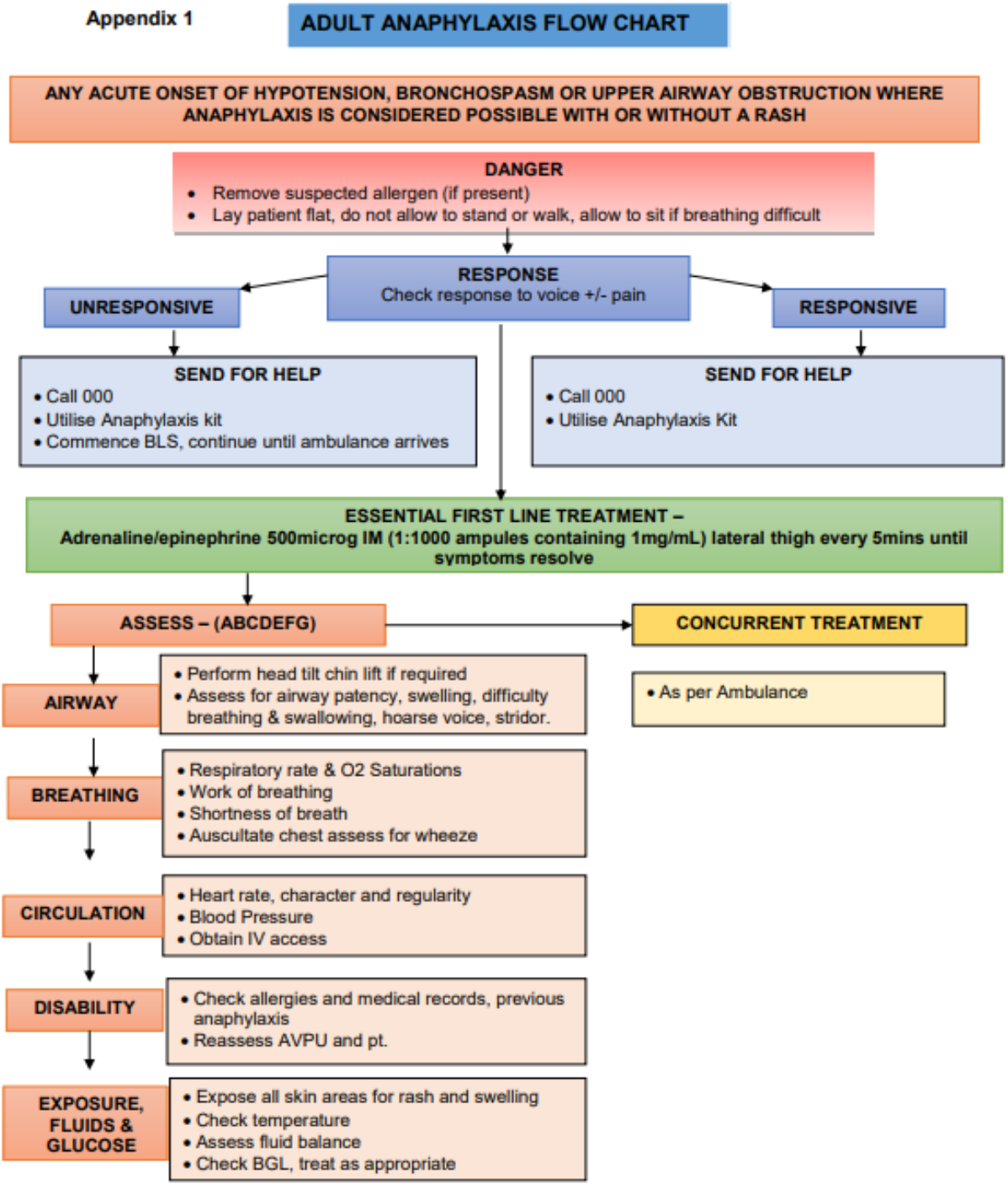
Appendix B – SGH Inpatient: Anaphylaxis Flow Chart



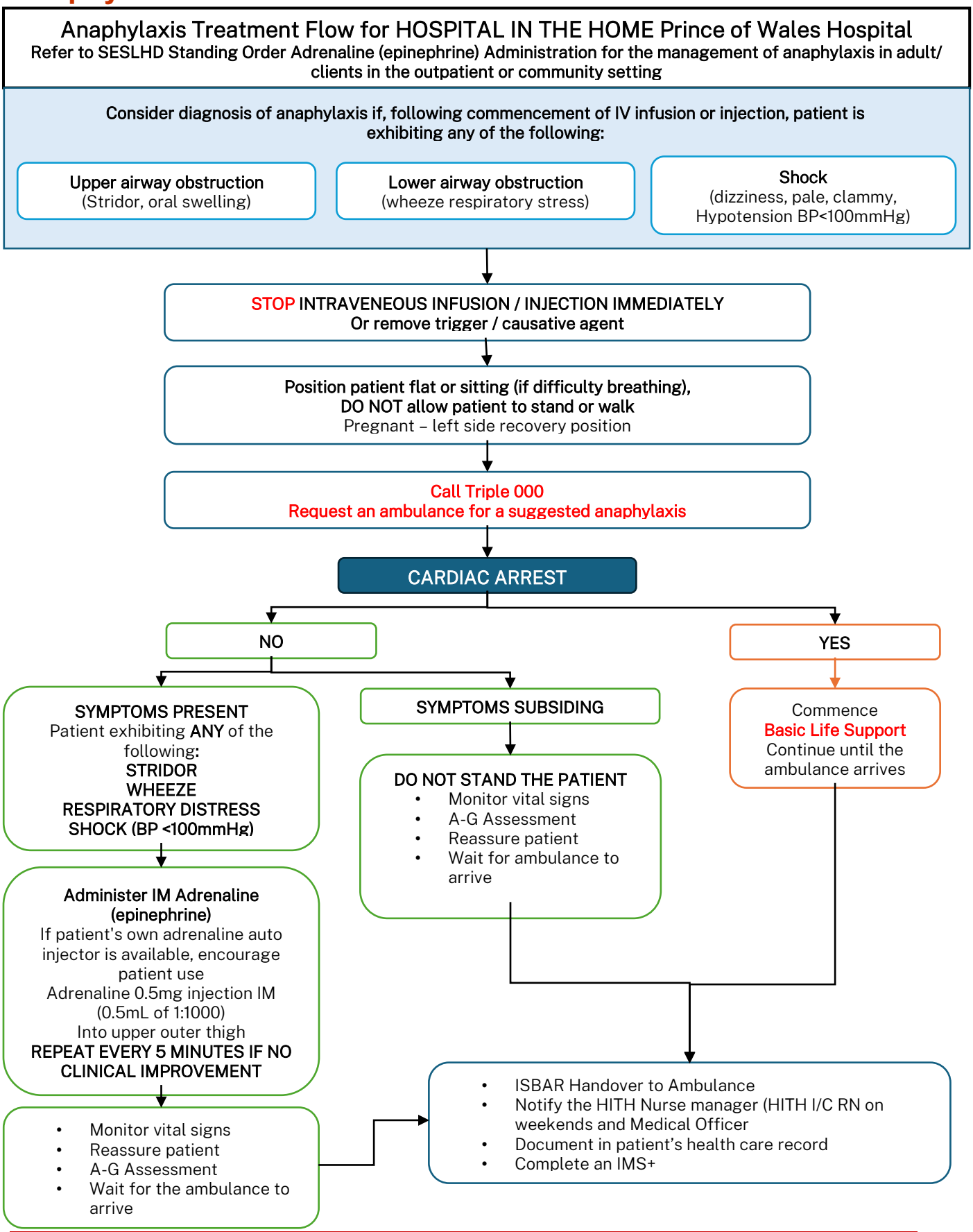
Appendix C – SGH Outpatients: Anaphylaxis Flowchart



Appendix D – SGH: Hospital in The Home (HiTH) Flow Chart



Appendix E – POWH: Hospital in The Home (HiTH) – Anaphylaxis Treatment Flow



Appendix F – SGH & TSH Community Adult Anaphylaxis Flow Chart