WYE SCHOOL

ALLERGY AND ANAPHYLAXIS MANAGEMENT CODE OF PRACTICE

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United Learning
Allergy and Anaphylaxis Management Code of Practice

1. Scope

1.1 This Code of Practice forms part of the health and safety arrangements detailed in the 'United Learning Group Health and Safety Policy.' It provides further details on the measures required to meet statutory and group requirements in relation to allergy management.

1.2 The Code of Practice should be read in conjunction with the:

- Health and safety Policy -Here
- First Aid code of Practice - Here
- Supporting Pupils with Medical Needs and Children with Health Needs who cannot attend School Policy - Here
- Food Safety Policy - Here

2. Interpretation

2.1 The following definitions apply to this document:

- **Allergy** – An allergy is the response of the body's immune system to normally harmless substances. These do not cause any problems in most people, but in allergic individuals the immune system identifies them as 'allergens' and produces an inappropriate 'allergic' response. This can be relatively minor, such as localised itching, but it can also be much more serious, causing anaphylaxis which can lead to breathing problems and collapse.
- **Anaphylaxis** - Anaphylaxis is a severe, potentially life-threatening allergic reaction that can develop rapidly. It is also known as anaphylactic shock. It is caused by a sudden release of chemical substances including histamine, from cells into the blood and the tissues where they are stored. The release is triggered by the reaction between the allergic antibody (IgE) and the substance (allergen). This mechanism is so sensitive that minuet quantities of the allergen can cause a reaction. It should always be treated as a medical emergency.
- **Adrenaline Auto Injector** (AAI) – A device to administer an injection of adrenaline which should be given as soon as possible when anaphylaxis is suspected. People with known anaphylaxis will have an auto injector.
- **Onset** - The time of onset of the anaphylactic reaction is the time when symptoms were first noticed. It is important that this time is accurately recorded. A reaction can happen within minutes and almost invariably within 60 minutes.

3. Background

3.1 The UK has some of the highest prevalence rates of allergic conditions in the world with over 20% of the population affected by one or more allergic disorders.

3.2 Around 2-5% of children in the UK live with a food allergy, and most school classrooms will have at least 1 allergic pupil. These young people are at risk of anaphylaxis which requires an immediate emergency response.

3.3 20% of serious allergic reactions to food happen whilst a child is at school. It is therefore essential that staff recognise the signs of an allergic reaction and are able to manage it safely and effectively.

4. Duty of Care

4.1 Schools have a legal duty to support pupils with medical conditions, including allergy.

4.2 They must adhere to legislation and guidance on caring for pupils with medical conditions, including the administration of allergy medication and adrenaline auto- injectors. See references.

5. Allergy Action Plan

5.1 These plans have been designed to facilitate first aid treatment of anaphylaxis, to be delivered by people with or without any special medical training nor equipment, apart from access to adrenaline autoinjectors when trying to support people in a medical emergency.

5.2 The plans are medical documents and should be completed by the Child/ Young person's healthcare professional in partnership with parents and carers. The plans are designed to function as Individual Healthcare Plans for children and young people at risk of anaphylaxis.

5.3 The plan should include First Aid procedures for the administering of adrenaline. Allergy action plans include a consent for parents / legal guardians to sign, authorising the administration of AAIs in their child when required.

5.4 All leaders and any third-party providers should have access to emergency contact and emergency procedure details where appropriate to manage emergency situations related to allergies.

6. Individual Healthcare Plans

6.1 These plans are drawn up in partnership between the school, parents/carers, and relevant healthcare professional, e.g. school nurse, specialist or children's community nurse or paediatrician, who can best advice on the particular healthcare needs of a child/young person. Pupils should also be involved whenever appropriate.

6.2 The aim should be to capture the steps which a school should take to help the child/young person manage their specific condition and overcome any potential barriers to getting the most from their education.

6.3 Where a child/young person's health issues related only to their allergy, the Allergy Action Plan can function as their Individual Healthcare Plan.

7. Causes of anaphylaxis

7.1 The causes of anaphylaxis can be food, insect stings, medication, substances, and latex.

7.2 **Idiopathic anaphylaxis** is when there is no obvious trigger despite extensive testing.

7.3 **Food** that can cause an anaphylactic reaction:

- Eggs
- Fish
- Milk
- Crustaceans- for example crabs, lobster, crayfish, shrimp, and prawns.
- Molluscs- for example muscles, oysters, and squid.
- Peanuts
- Tree nuts - for example almonds, hazelnuts, walnuts, Brazil nuts, cashews, pecans pistachios and macadamia nuts.
- Sesame
- Cereals containing gluten – for example wheat, such as spelt, Khorasan wheat/ Kamut, rye, barley, oats, or their hybrid strains.
- Soybeans
- Celery and celeriac.
- Mustard
- Lupin
- Sulphur dioxide and sulphites (at concentrations of more than ten parts per million).

7.4 **The Food Information Regulations 2014** require all food businesses, including school caterers, to show allergen ingredients information for the food they serve. This makes it easier to identify the food that pupils with allergies can and cannot eat.

7.5 **The Food Information (Amendment) (England) Regulations 2022** cover the labelling requirements for prepacked food for direct sale (PPDS). It includes food that is packaged at the same place it is offered or sold to consumers and is in this packaging before it is ordered or selected. It can include food that consumers select themselves (e.g. from a display unit), as well as products kept behind a counter and some food sold at mobile or temporary outlets.

7.6 **Pharmaceutical products** that can cause anaphylaxis such as:

- Antibiotics – particularly penicillin like antibiotics.
- Muscle relaxants used in surgery.
- Non-steroidal anti-inflammatory drugs (NSAIDs).

7.7 **Substances** – such as hair dyes and latex. Not limited to.

8. Training

8.1 Designated first aiders will need to have specific training on anaphylaxis and understand their responsibilities in this regard.

8.2 The government has started consultation for new statutory guidance. Stronger protections for children with allergies in school - GOV.UK. The new statutory requirements will mean for the first time schools must provide allergy awareness training for all staff covering:

- Recognition of symptoms
- Emergency response and the use of adrenaline devices
- Alongside improved incident recording and lessons learnt processes

8.3 The use of the auto injectors is now in all accredited first aid at work courses and staff should demonstrate they can use a training auto injector as part of practical training.

8.4 It is good practice to have two named members of staff responsible for coordinating allergy management and updating local procedures. All staff should be trained on what to do in the event of an allergic reaction.

8.5 Training should be refreshed annually, and any new staff should be trained on induction. Acting fast is key in reducing the risk of a serious allergic reaction.

9. Medicines Management

9.1 Students should carry two AAIs with them at all times where safe to do so by risk assessment.

9.2 If the student is unable to carry AAI's themselves (e.g. primary) the medication should be stored safely, but easily accessible in an emergency.

9.3 It should be labelled for identification of each pupil i.e. their name and photograph and allergy action plan.

9.4 If it is stored away in an emergency, it should be brought to them, they must not be told to go to the room it is stored in for it to be administered.

9.5 It is the parents' responsibility to check expiry dates; however good practice is for schools to schedule their own checks of medication.

9.6 The dose of an AAI varies according to weight as a child grows the correct dose may change.

10. Risk of stigmatisation

10.1 It is important that allergic pupils are not stigmatised discriminated against, for example where safe to do so they should not be separated at meals times or excluded from class activities (unless specified in their allergy plan). Drawing attention to their allergy could result in bullying by other pupils, so inclusivity and overall awareness amongst pupils is vital.

11. Risk assessment

11.1 Staff should also identify activities where a child may be at risk, for example outdoors and food-based activities and ensure activities are properly planned and all medical needs are assessed and managed.

12. Staff with medical conditions relating to allergies.

12.1 Staff who have allergic conditions should be supported to ensure they can manage their condition safely and effectively and that first aid support would be available if required in a life-threatening emergency.

13. Spare Adrenaline Autoinjectors (AAI's) in schools

13.1 All schools must stock spare adrenaline autoinjectors for use in emergency situations.

13.2 Since 2017, schools have been legally able to directly purchase AAIs from a pharmaceutical supplier such as a local pharmacist for emergency use on children who are at risk of anaphylaxis, but whose own device is not available or not working.

13.3 A supplier e.g. pharmacist will need a request containing the name of the school, the purpose it is required for, the quantity and be signed by the head teacher.

13.4 Schools may administer their "spare" AAIs, obtained, without prescription, for use in emergencies, if available, to a pupil at risk of anaphylaxis, where both medical authorisation and written parental consent for use of the spare AAI has been provided.

13.5 Regulation 238 of the Human Medicines Regulations 2012 also allows for exceptional use in medical emergencies to save a life. AAI_HMR238_Clarification_Dr_P_Turner.pdf. This could be in a lifesaving situation where a child has an unrecognised allergy.

13.6 AAIs can be used through clothes and should be injected into the upper outer thigh in line with the instructions provided by the manufacturer.

13.7 If someone appears to be having a severe allergic reaction (anaphylaxis), you MUST call 999 without delay and say anaphylaxis, even if they have already used their own AAI device, or a spare AAI.

13.8 In the event of a possible severe allergic reaction in a pupil who does not meet these criteria, emergency services (999) should be contacted and advice sought from them as to whether administration of the spare emergency AAI is appropriate.

14. Catering contractors

14.1 Staff should refer to their supplier's catering policy in relation to contractor due diligence, managing specific dietary needs, safe food options and preventing cross contamination.

15. Insects' stings and allergies

15.1 Insect stings (i.e. bees and wasps) can cause allergies in some children. Special care needs to be taken outdoors such as wearing shoes at all times and making sure any food and drink is properly covered. Staff supervising activities must ensure suitable medication including AAI's is always on hand for the management of anaphylaxis.

16. Monitoring

16.1 As with any other element of health and safety management, all support plans and first aids needs should be regularly reviewed and monitored.

17. Signs and Symptoms Anaphylaxis

17.1 Different people can have different symptoms, so it is very important staff are familiar with their specific action plan. A reaction can happen in minutes. The person may not necessarily experience all the symptoms below:

- **Upper airway** - swelling of the tongue and mouth, difficulty swallowing, Stridor (loud harsh high pitched respiratory sound), cough.
- **Lower airway** - respiratory wheeze, tight chest, shortness of breath
- **Circulation** - increased heart rate, irregular or abnormal heartbeat, loss of blood pressure
- **Skin** - itching, urticaria (hives, welts, or nettle rash), flushing, oedema (swelling due to fluid retention).
- **Gastrointestinal** - crampy abdominal pain, diarrhoea, nausea, or vomiting.
- **Central nervous system** - light headedness, loss of consciousness, confusion, headache, anxiety.
- **Pelvic area** - pelvic pain, loss of bladder control.
- **Other** - swelling of the conjunctiva, runny nose, a strange metallic taste in the mouth.

17.2 **The overriding concern must be protecting the airway.** Although the casualty is in shock, they may appear flushed.

18. First aid Anaphylaxis

18.1 The Government has provided a guidance document for the use of AAIs in schools - see references. It is however very important that staff are familiar with each individual child's triggers and response.

18.2 Some staff and pupils may carry their own medication that has been prescribed for them. If an individual needs to take their own prescribed medication, first aiders should support them and contact the emergency services as appropriate.

18.3 Anaphylaxis should always be treated as a medical emergency.

18.4 It is extremely important to gather as much information as possible when making an assessment of the casualty whether adult or student:

- Signs and symptoms - what you can see and what they feel.
- Allergies - what are they allergic to.
- Medication - what medication do they have if any.
- Previous history - has it happened before or is this the first time.
- Last oral intake - when and what did they last eat or drink.
- Event history - what happened – has the casualty deteriorated.

The 2025 Resus Guidelines have been updated:

https://www.resus.org.uk/professional-library/2025-resuscitation-guidelines/first-aid-guidelines#medical-emergencies

The new guidelines state to suspect anaphylaxis if someone has:

- Breathing difficulties that can range from noisy breathing (stridor) due to upper airway swelling to wheezing due to lower airway obstruction.
- Flushing, rash (hives), cold or clammy skin or feeling faint.
- Abdominal pain, vomiting, or diarrhoea.
- A recent exposure to known food allergens or insect stings.

If anaphylaxis is suspected guidelines state:

- Call 999.
- Ensure that the person is lying down unless there are breathing difficulties, in which case they may sit up with their legs extended.
- Remove the trigger if known and possible.
- Intramuscular adrenaline should be given (either self-administered or by trained individuals) as soon as possible via AAI into the outer thigh, which delivers the recommended dose.
- If symptoms persist five minutes after administration, give a second dose of adrenaline, ideally **in the opposite leg**.
- A second dose may also be required if the symptoms reoccur.
- ***** IF IN DOUBT, GIVE ADRENALINE *** Adrenaline is the GOLD standard in the treatment of anaphylaxis and its administration should not be delayed. When treating anaphylaxis, it should be noted that there are NO contraindications for the use of adrenaline.**
- It is very important that you tell the **999 operator - ANAPHYLAXIS** - This will make it a priority call. Call them even if the person feels better.
- When dialling 999, give clear and precise directions to the emergency operator, including the postcode of your location.
- If the pupil's condition deteriorates and a second dose adrenaline is administered after making the initial 999 call, make a second call to the emergency services to confirm that an ambulance has been dispatched.
- If they become unresponsive place them in the recovery position and be prepared to resuscitate them if they stop breathing normally.

19. Asthma

19.1 Given asthma attacks can be triggered by allergens we have included some key aspects of management in this code of practice.

19.2 Asthma triggers include common irritants and allergens, including respiratory infections (like colds and flu), pollen and dust mites, pet dander, air pollutants (including smoke), exercise, certain weather conditions (cold or dry air), and strong emotions or stress. Identifying and avoiding these personal triggers is crucial for managing asthma and preventing severe attacks.

19.3 From 1st October 2014 the Human Medicines (Amendment) (No. 2) Regulations 2014 allows schools to buy salbutamol inhalers, without a prescription, for use in emergencies.

19.4 The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.

19.5 The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty)

19.6 Keeping emergency inhalers has many benefits. It could prevent an unnecessary and traumatic trip to hospital for a child and potentially save their life. Parents are likely to have greater peace of mind about sending their child to school.

19.7 Having a protocol that sets out how and when the inhaler should be used will also protect staff by ensuring they know what to do in the event of a child having an asthma attack.

19.8 Children should have their own reliever inhaler at school to treat symptoms and for use in the event of an asthma attack. If they are able to manage their asthma themselves, they should keep their inhaler on them, and if not, it should be easily accessible to them.

19.9 Schools can buy inhalers and spacers (these are enclosed plastic vessels which make it easier to deliver asthma medicine to the lungs) from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions are observed.

19.10 A supplier will need a request signed by the principal or head teacher (ideally on appropriately headed paper) stating: the name of the school for which the product is required; the purpose for which that product is required, and the total quantity required.

19.11 Schools should consider keeping more than one emergency asthma kit, especially if covering more than one site, to ensure that all children within the school environment are close to a kit.

19.12 It is recommended that at least two named volunteers amongst school staff should have responsibility for ensuring all documentation and checks are in place

20. Signs and symptoms of an asthma attack

20.1 These include:

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Being unusually quiet
- The child complains of shortness of breath at rest, feeling tight in the chest (younger children may express this feeling as a tummy ache)
- Difficulty in breathing (fast and deep respiration)
- Nasal flaring
- Being unable to complete sentences
- Appearing exhausted
- A blue / white tinge around the lips
- Going blue

21. First Aid Asthma Attack

21.1 **CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD:**

- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

21.2 Responding to signs of an asthma attack:

- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward.
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with child while inhaler and spacer are brought to them
- Immediately help the child to take two separate puffs of the salbutamol via the spacer immediately
- If there is no immediate improvement, continue to give two puffs every two minutes up to a maximum of 10 puffs, or until their symptoms improve. The inhaler should be shaken between puffs.
- Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better.
- If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs, **CALL 999 FOR AN AMBULANCE**

- If an ambulance does not arrive in 10 minutes give another 10 puffs in the same way
- The child's parents or carers should be contacted after the ambulance has been called.
- A member of staff should always accompany a child taken to hospital by ambulance and stay with them until a parent or carer arrives.

Recording use of the inhaler and informing parents/carers:

21.3 Use of the emergency inhaler should be recorded. This should include where and when the attack took place (e.g. PE lesson, playground, classroom), how much medication was given, and by whom.

21.4 Supporting pupils requires written records to be kept of medicines administered to children. The child's parents must be informed in writing so that this information can also be passed onto the child's GP.

22. References

- *https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3*
- *https://www.gov.uk/government/publications/using-emergency-adrenaline-auto-injectors-in-schools*
- *https://www.food.gov.uk/business-guidance/allergen-guidance-for-food-businesses#allergens*
- *https://www.gov.uk/government/publications/school-food-standards-resources-for-schools/allergy-guidance-for-schools*
- *https://www.anaphylaxis.org.uk/education/about-safer-schools-programme/*
- *https://www.food.gov.uk/business-guidance/prepacked-for-direct-sale-ppds-allergen-labelling-changes-for-schools-colleges-and-nurseries*
- *https://www.food.gov.uk/business-guidance/introduction-to-allergen-labelling-changes-ppds*
- *https://www.gov.uk/government/publications/standards-for-school-food-in-england*
- *https://assets.publishing.service.gov.uk/media/5a74eb55ed915d3c7d528f98/emergency_inhalers_in_schools.pdf*

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