Guidance on the use of adrenaline auto-injectors (AAIs) in schools in Northern Ireland

An addendum to *Supporting Pupils with Medication Needs* (2008)

https://www.education-ni.gov.uk/sites/default/files/publications/de/supporting-pupils-with-medical-needs.pdf

Contents

1. Executive summary

Anaphylaxis is a severe and often sudden allergic reaction. It can occur when a susceptible person is exposed to an allergen (such as food or an insect sting). Reactions usually begin within minutes of exposure and progress rapidly, but can occur up to 2-3 hours later. It is potentially life threatening and always requires an immediate emergency response.

From 1 October 2017 the Human Medicines (Amendment) Regulations 2017 will allow all schools to buy adrenaline auto-injector (AAI) devices without a prescription, for emergency use in children who are at risk of anaphylaxis but whose own device is not available or not working.

The school's spare AAI should only be used on pupils:

- where both medical authorisation and written parental consent have been provided for the spare AAI to be used on them, and
- whose own prescribed AAI(s) cannot be administered correctly and without delay.

This change applies to all schools in the UK. Schools are not required to hold spare AAI(s) – this is a discretionary change enabling schools to do this if they wish. Only those institutions described in regulation 22 of the Human Medicines (No.2) Regulations 2014, which amends regulation 213 of the Human Medicines Regulations 2012, may legally hold spare AAIs.

Regulation 8 of the Human Medicines (Amendment) Regulations 2017 amends schedule 17 of the Human Medicines Regulations 2012, and sets out the principles of supply to schools.

This guidance is non-statutory. It has been developed by the Department of Health, England, with key stakeholders, and adapted for Northern Ireland by the Department of Health and the Department of Education, to capture the good practice which schools should observe in using spare AAIs. Schools may wish to use this as the basis of any protocol or policy. The principles of safe usage of AAI(s) in this guidance are universal and based on recognised good practice.

The guidance is designed to be read in conjunction with *Supporting Pupils with Medication Needs*[1] and every school's protocol or policy on use of the AAI should have regard to it.

Supporting Pupils with Medication Needs was produced in 2008 by the Department of Education (NI) and the Department of Health (NI) to assist schools to develop policies on managing medication in schools, including the administration of medicine and providing

[1] https://www.education-ni.gov.uk/sites/default/files/publications/de/supporting-pupils-with-medical-needs.pdf

effective support to individual pupils with medication needs. This includes specific advice on anaphylaxis.

Supporting Pupils with Medication Needs expects schools to:

- develop policies for supporting pupils with medication needs and review them regularly;
- have procedures in place on managing medicines on the premises;
- ensure that accurate records are maintained, and
- ensure that staff who volunteer, or are recruited for the purpose of supporting pupils with medication needs, are appropriately trained to support pupils with medical needs.

Any AAI(s) held by a school should be considered a spare / back-up device and not a replacement for a pupil's own AAI(s). Current guidance from the Medicines and Healthcare Products Regulatory Agency (MHRA) is that anyone prescribed an AAI should carry two of the devices at all times. This guidance does not supersede the advice from the MHRA[2], and any spare AAI(s) held by a school should be in addition to those already prescribed to a pupil.

Those facilities choosing to hold a spare AAI or spare AAIs may wish to establish a policy or protocol for their use in line with the guidance *Supporting Pupils with Medication Needs.*

An effective protocol should include the following, on which this guidance provides advice:

- arrangements for the supply, storage, care, and disposal of spare AAI(s) in line with *Supporting Pupils with Medication Needs*;
- a register of pupils who have been prescribed an AAI(s) (or where a doctor has provided a written plan recommending AAI(s) to be used in the event of anaphylaxis);
- written consent from the pupil's parent/legal guardian for use of the spare AAI(s), as part of a pupil's individual Medication Plan;
- ensuring that any spare AAI is used only in pupils where both medical authorisation and written parental/guardian consent have been provided;
- appropriate support and training for staff who volunteer or are recruited for the purpose of supporting pupils with medication needs, in the use of the AAI in line with the school's wider policy on supporting pupils with medication needs, and
- keeping a record of use of any AAI(s), as suggested by *Supporting Pupils with Medication Needs*, and informing parents or carers that their child has been administered an AAI and whether this was the school's spare AAI or the pupil's own device.

[2] https://www.gov.uk/drug-safety-update/adrenaline-auto-injector-advice-for-patients

This guidance supersedes the 2010 guidance *The Management of Anaphylaxis in Educational Establishments.*

The guidance in this document has been developed in conjunction with representatives of the following organisations:

- British Society for Allergy & Clinical Immunology (Paediatric Allergy Group)
- British Paediatric Allergy, Immunity and Infection Group
- Royal College of Paediatrics and Child Health
- Allergy UK
- Anaphylaxis Campaign
- Department of Health England
- Department of Education (Northern Ireland)
- Department of Health (Northern Ireland).

2. Introduction

Anaphylaxis is a severe and often sudden allergic reaction. It can occur when a susceptible person is exposed to an allergen (such as food or an insect sting). Reactions usually begin within minutes of exposure and progress rapidly, but can occur up to 2-3 hours later. It is potentially life threatening and always requires an immediate emergency response.

What can cause anaphylaxis?

Common allergens that can trigger anaphylaxis are:

- foods (e.g. peanuts, tree nuts, milk/dairy foods, egg, wheat, fish/seafood, sesame and soya);
- insect stings (e.g. bee, wasp);
- medications (e.g. antibiotics, pain relief such as ibuprofen), or
- latex (e.g. rubber gloves, balloons, swimming caps).

The severity of an allergic reaction can be influenced by a number of factors including minor illness (like a cold), asthma, and, in the case of food, the amount eaten. It is very unusual for someone with food allergies to experience anaphylaxis without actually eating the food: contact skin reactions to an allergen are very unlikely to trigger anaphylaxis.

The time from allergen exposure to severe life-threatening anaphylaxis and cardio-respiratory arrest varies, depending on the allergen.

- Food: While symptoms can begin immediately, severe symptoms often take 30+ minutes to occur. However, some severe reactions can occur within minutes, while others can occur over 1-2 hours after eating.[3] Severe reactions to dairy foods are often delayed, and may mimic a severe asthma attack without any other symptoms (e.g. skin rash) being present.
- Severe reactions to insect stings are often faster, occurring within 10-15 minutes.

Why does anaphylaxis occur?

An allergic reaction occurs because the body's immune system reacts inappropriately to a substance that it wrongly perceives as a threat. The reaction is due to an interaction between the substance ("allergen") and an antibody called Immunoglobulin E (IgE). This results in the release of chemicals such as histamine which cause the allergic reaction. In the skin, this causes an itchy rash, swelling and flushing. Many children (not just those with asthma) can develop breathing problems, similar to an asthma attack. The throat can tighten, causing swallowing difficulties and a high pitched sound (stridor) on breathing in.

[3]Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers. Resuscitation Council (UK). Available at: https://www.resus.org.uk/anaphylaxis/emergency-treatment-of-anaphylactic-reactions/

In severe cases, the allergic reaction can progress within minutes into a life-threatening reaction. Administration of adrenaline can be lifesaving, although severe reactions can require much more than a single dose of adrenaline. It is therefore vital to contact Emergency Services as early as possible**.** Delays in giving adrenaline are a common finding in fatal reactions.

Adrenaline should be administered immediately, at the first signs of anaphylaxis.

How common is anaphylaxis in schools?

Up to 8% of children in the UK have a food allergy.[4] However, the majority of allergic reactions to food are not anaphylaxis, even in children with previous anaphylaxis. Most reactions present with mild-moderate symptoms, and do not progress to anaphylaxis. Fatal allergic reactions are rare, but they are also very unpredictable. In the UK, 17% of fatal allergic reactions in school-aged children happen while at school.[5] Schools therefore need to consider how to reduce the risk of an allergic reaction, in line with *Supporting Pupils with Medication Needs*. Box 1 below provides a list of actions that schools and parents can take to reduce the risk of exposure to allergens.[6]

Box 1: Reducing the risk of allergen exposure in children with food allergy

- Bottles, other drinks and lunch boxes provided by parents for children with food allergies should be clearly labelled with the name of the child for whom they are intended.
- If food is purchased from the school canteen, through arrangement by the school, parents should consult with the catering service to agree upon a suitable menu and how it is prepared and provided. The child should be taught to also check with catering staff before purchasing.
- Where food is provided by the school, school staff involved in the preparation of food for pupils with allergens should receive the appropriate training in both identifying the allergens in food and the controls necessary to prevent cross-contamination during food preparation. Examples include: preparing food for children with food allergies first; careful cleaning (using warm soapy water) of food preparation areas and utensils.
- Food should not be given to food-allergic children in primary schools without parental engagement and permission (e.g. birthday parties, food treats).
- Schools should adopt policies to avoid trading and sharing of food, food utensils or food containers.
- Unlabelled food poses a potentially greater risk of allergen exposure than packaged food with precautionary allergen labelling suggesting a risk of contamination with allergen.

[4] Food Standards Agency. https://www.food.gov.uk/science/allergy-intolerance

[5] Turner PJ, Gowland MH, Sharma V et al. Increase in hospital admissions due to anaphylaxis but no increase in fatalities: an analysis of UK national anaphylaxis data, 1992–2012. J Allergy Clin Immunol 2015;135:956-63. Available at: http://www.jacionline.org/article/S0091-6749(14)01516-4/fulltext

[6] Vale S, Smith J, Said M, Mullins RJ, Loh R. ASCIA guidelines for prevention of anaphylaxis in schools, pre-schools and childcare: 2015 update. J Paediatric Child Health. 2015 Oct; 51(10):949-54.

- Use of food in crafts, cooking classes, science experiments and special events (e.g. fetes, assemblies, cultural events) needs to be considered and may need to be restricted depending on the allergies of particular children and their age.
- In arts/craft, an appropriate alternative ingredient can be substituted (e.g. wheat-free flour for play dough or cooking). Consider substituting non-food containers for egg cartons.
- When planning out-of-school activities such as sporting events, excursions (e.g. restaurants and food processing plants), school outings or camps, think early about the catering requirements of the food-allergic child and emergency planning (including access to emergency medication and medical care).

Treatment

While “allergy” medicines such as antihistamines can be used for mild allergic reactions, they are ineffective in severe reactions – only adrenaline is recommended for severe reactions (anaphylaxis). The adrenaline treats both the symptoms of the reaction, and also stops the reaction and the further release of chemicals causing anaphylaxis. However, severe reactions may require more than one dose of adrenaline, and children can initially improve but then deteriorate later. It is therefore essential to always call for an ambulance to provide further medical attention, whenever anaphylaxis occurs. The use of adrenaline as an injection into the muscle is safe and can be life-saving.

Children and young people diagnosed with allergy to foods or insect stings are frequently prescribed AAI devices, to use in case of anaphylaxis. Adrenaline auto-injectors (current brands available in the UK are EpiPen®, Emerade®, Jext®) contain a single fixed dose of adrenaline, which can be administered by non-healthcare professionals such as family members, teachers and first-aid responders.

Children at risk of anaphylaxis should have their prescribed AAI(s) at school for use in an emergency. The MHRA recommends that those prescribed AAIs should carry two devices at all times, as some people can require more than one dose of adrenaline and the AAI device can be used wrongly or occasionally misfire.

Depending on their level of understanding and competence, children and particularly teenagers should carry their AAI(s) on their person at all times or they should be quickly and easily accessible at all times. If the AAI(s) are not carried by the pupil, then they should be kept in a central place in a box marked clearly with the pupil’s name but NOT locked in a cupboard or an office where access is restricted.

It is not uncommon for schools (often primary schools) to request a pupil’s AAI(s) are left in school to avoid the situation where a pupil or their family forgets to bring the AAI(s) to school each day. Where this occurs, the pupil must still have access to 2 AAIs when travelling to and from school.

Further information

There are a number of resources which provide information on allergies and anaphylaxis, and how they can be treated. Some of these are listed in section 7 together with contact details for support organisations. This guidance is not intended to be a detailed guide to the diagnosis or treatment of anaphylaxis in general. If any member of staff has reason to suspect a pupil has an allergy, they should notify the parents/guardians, so they can take their child to a doctor. Annex 3 gives advice on what to do in the event of an allergic reaction.

Incorporating into existing school policy

A school's medical needs policy may already cover elements of the AAI protocol, for example ensuring appropriate support and training for teachers. Policies will likely already cover elements such as arrangements for storage, care and disposal of medication, ensuring written consent for administration or supervision of administration of medication, keeping a record of administration of medication, and informing parents/guardians in relation to children's own inhalers, and could simply be expanded to cover the emergency AAI.

Roles and responsibilities

This guidance supersedes the 2010 guidance *The Management of Anaphylaxis in Educational Establishments.* Annex 2 sets out the roles and responsibilities of the school, the school meals service, parents/carers, the pupil, and the school health service.

3. Arrangements for the supply, storage, care and disposal of AAIs

Supply

From 1 October 2017, schools can purchase AAIs from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions is observed i.e. schools can buy AAIs in small quantities provided it is done on an occasional basis and the school does not intend to profit from it. 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.

A template letter which can be used for this purpose is provided at Annex 1, and can also be downloaded at: www.sparepensinschools.uk Please note that pharmacies are not required to provide AAIs free of charge to schools: the school must pay for them as a retail item.

A number of different brands of AAI are available in different doses depending on the manufacturer. It is up to the school to decide which brand(s) to purchase. Where all pupils in a single school/educational facility are prescribed the same device, it makes sense for that brand to be used for the spare AAI. If two or more brands are currently held by the school, the school may wish to purchase the brand most commonly prescribed to its pupils (this may avoid confusion and assist with training). However, the decision as to how many devices and brands to purchase will depend on local circumstances and is left to the discretion of the school.

AAIs are available in different doses, depending on the manufacturer. The Resuscitation Council (UK) recommends that healthcare professionals treat anaphylaxis using the age-based criteria, as follows.[7]

- For children age under 6 years: a dose of 150 microgram (0.15 milligram) of adrenaline is used (e.g. using an Epipen Junior (0.15mg), Emerade 150 or Jext 150 microgram device).
- For children age 6-12 years: a dose of 300 microgram (0.3 milligram) of adrenaline is used (e.g. using an Epipen (0.3mg), Emerade 300 or Jext 300 microgram device).
- For teenagers age 13+ years: a dose of 300 or 500 microgram (Emerade 500) can be used.

[7] Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers. Resuscitation Council (UK). Available at: https://www.resus.org.uk/anaphylaxis/emergency-treatment-of-anaphylactic-reactions/

In the context of supplying schools rather than individual pupils with AAIs for use in an emergency setting, using these same age-based criteria avoids the need for multiple devices/doses, thus reducing the potential for confusion in an emergency. Schools should consider the ages of their pupils at risk of anaphylaxis, when deciding which doses to obtain as the spare AAI.

Schools may wish to discuss these guidelines with their community pharmacist, when deciding which AAI device(s) are most appropriate for a particular school.

The emergency anaphylaxis kit

It is good practice for schools holding spare AAIs to store these as part of an emergency anaphylaxis kit which should include:

- 1 or more AAI(s);
- instructions on how to use the device(s);
- instructions on storage of the AAI device(s);
- manufacturer's information;
- a checklist of injectors, identified by their batch number and expiry date with monthly checks recorded;
- a note of the arrangements for replacing the injectors;
- a list of pupils to whom the AAI can be administered, and
- an administration record.

Schools might like to keep the emergency kit together with an "emergency asthma inhaler kit" (containing a salbutamol inhaler device and spacer).[8] Many food-allergic children also have asthma, and asthma is a common symptom during food-induced anaphylaxis.

Severe anaphylaxis is an extremely time-critical situation: delays in administering adrenaline have been associated with fatal outcomes. Schools should ensure that all AAI devices – including those belonging to a younger child, and any spare AAI in the Emergency kit – are kept in a safe and suitably central location**:** for example, the school office or staffroom to which all staff have access at all times, but in which the AAI is out of the reach and sight of children. They must not be locked away in a cupboard or an office where access is restricted. Schools should ensure that AAIs are accessible and available for use at all times, and not located more than 5 minutes away from where they may be needed. In larger schools, it may be prudent to locate a

[8] https://www.gov.uk/government/publications/emergency-asthma-inhalers-for-use-in-schools

kit near the main dining area and another near the playground; more than one kit may be needed.

Any spare AAI devices held in the Emergency Kit should be kept separate from any pupil's own prescribed AAI which might be stored nearby. The spare AAI should be clearly labelled to avoid confusion with that prescribed to a named pupil.

Storage and care of the AAI

A school's allergy/anaphylaxis policy should include staff responsibilities for maintaining the spare anaphylaxis kit. It is recommended that at least two named volunteers amongst school staff should have responsibility for ensuring that:

- on a monthly basis the AAIs are present and in date, and
- that replacement AAIs are obtained when expiry dates approach. This can be facilitated by signing up to the AAI expiry alerts through the relevant AAI manufacturer.

The AAI devices should be stored at room temperature (in line with manufacturer's guidelines), protected from direct sunlight and extremes of temperature.

Schools may wish to require parents/guardians to take their pupil's own prescribed AAIs home before school holidays (including half-term breaks) to ensure that their own AAIs remain in date and have not expired.

Disposal

Once an AAI has been used it cannot be re-used and must be disposed of according to manufacturer's guidelines. Used AAIs can be given to the ambulance paramedics on arrival or can be disposed of in a pre-ordered sharps bin for collection by the local council.

School trips including sporting activities

Schools should conduct a risk-assessment for any pupil at risk of anaphylaxis taking part in a school trip off school premises, in line with the *Supporting Pupils with Medication Needs* guidance on educational trips. Pupils at risk of anaphylaxis should have their AAIs with them, and there should be staff trained to administer AAI in an emergency. Schools may wish to consider whether it may be appropriate, under some circumstances, to take spare AAIs obtained for emergency use on some trips.

4. Children to whom a spare AAI can be administered

The spare AAI in the Emergency Kit should only be used in a pupil:

- where both medical authorisation and written parental/guardian consent have been provided for the spare AAI to be used on them, and
- where the pupil's own AAI(s) cannot be administered correctly and without delay.

This information should be recorded in a pupil's individual Medication Plan. Where a pupil has no other healthcare needs other than a risk of anaphylaxis, schools may wish to consider using the British Society for Allergy and Clinical Immunology's (BSACI) Allergy Action Plan[9]. All children with a diagnosis of an allergy and at risk of anaphylaxis should have a written Individual Medication Plan

There should already be procedures in place to ensure that schools are notified of pupils who have additional health needs and this information will enable them to compile an allergy register. Some schools may already have such a register as part of their medication needs policies.

The register could include:

- known allergens and risk factors for anaphylaxis;
- whether a pupil has been prescribed AAI(s) (and if so what type and dose);
- where a pupil has been prescribed an AAI whether parental consent has been given for use of the spare AAI which may be different to the personal AAI prescribed for the pupil, and
- a photograph of each pupil to allow a visual check to be made (this will require parental/guardian consent).

The register is crucial as in larger schools (and secondary schools in particular), it may not be feasible for individual members of staff to be aware of which pupils have been prescribed AAIs. Consequently, schools should ensure that the register is easy to access and easy to read. Schools will also need to ensure they have a proportionate and flexible approach to checking the register. Delays in administering adrenaline have been associated with death. Allowing

[9] http://www.sparepensinschools.uk/plans or http://www.bsaci.org/about/pag-allergy-action-plans-for-children

pupils to keep their AAIs with them will reduce delays, and allows for confirmation of consent without the need to check the register.

Schools will want to consider when consent for use of the AAI is best obtained but the most appropriate time would be as part of the introduction or development of the individual medication plan. Consent should be updated regularly – ideally annually – to take account of changes to a pupil's condition.

5. Responding to the symptoms of an allergic reaction

AAIs are intended for use in emergency situations when a food-allergic individual is having a reaction consistent with anaphylaxis, as a measure that is taken until an ambulance arrives. Therefore, unless directed otherwise by a healthcare professional, the spare AAI should only be used in pupils:

- where both medical authorisation and written parental consent have been provided to administer the spare AAI, and
- whose own AAI(s) cannot be administered correctly and without delay.

Please see Annex 3 for recognition and management of an allergic reaction/anaphylaxis.

This information should be recorded in a pupil's individual medication plan which should be signed by a healthcare professional and kept in the schools medical register.

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.

It is recommended the school allergy policy includes general information on how to recognise and respond to an allergic reaction, and what to do in emergency situations. Some schools will already have this information in an allergy policy or medical conditions policy. Staff should be aware of the difficulties younger children may have in explaining how they feel.

Further information and film clips showing adrenaline being administered can be found at: http://www.sparepensinschools.uk

Recording use of the AAI and informing parents/carers

In line with *Supporting Pupils with Medication Needs*, use of any AAI device should be recorded. This should include:

- where and when the reaction took place (e.g. PE lesson, playground, classroom);
- how much medication was given, and by whom, and
- any person who has been given an AAI must be transferred to hospital for further monitoring. The pupil's parents/guardians should be contacted at the earliest opportunity. The hospital discharge documentation will be sent to the pupil's GP informing them of the reaction.

6. Staff

Any member of staff may volunteer to take on the responsibilities set out in this guidance, but they cannot be required to do so. These staff may already have wider responsibilities for administering medication and/or supporting pupils with medical conditions.

Severe anaphylaxis is an extremely time critical situation. Delays in administering adrenaline have been associated with death**.** It is therefore appropriate for as many staff as possible to be trained in how to administer AAI.

In the following advice, the term 'designated members of staff' refers to any member of staff who has responsibility for helping to administer a spare AAI, e.g. they have volunteered to help a pupil use the emergency AAI, and been trained to do this, and are identified in the school's medication needs policy as someone to whom all members of staff may have recourse in an emergency.

Schools will want to ensure there are a reasonable number of designated members of staff to provide sufficient coverage, including when staff are on leave. In many schools, it would be appropriate for there to be multiple designated members of staff who can administer an AAI to avoid any delay in treatment.

Schools should ensure staff have appropriate training and support, relevant to their level of responsibility. *Supporting Pupils with Medication Needs* states that once staff who have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services.

It would be reasonable for all staff to:

- be trained to recognise the range of signs and symptoms of an allergic reaction;
- understand the rapidity with which anaphylaxis can progress to a life-threatening reaction, and that anaphylaxis may occur with prior mild (e.g. skin) symptoms;
- appreciate the need to administer adrenaline without delay as soon as anaphylaxis occurs, before the patient might reach a state of collapse (after which it may be too late for the adrenaline to be effective);
- be aware of the anaphylaxis policy;
- be aware of how to check if a pupil is on the register;
- be aware of how to access the AAI, and
- be aware of who the designated members of staff are, and the policy on how to access their help.

Schools must arrange specialist anaphylaxis training, provided by local health services, for staff where a pupil in the school has been diagnosed as being at risk of anaphylaxis. The specialist training should include practical instruction in how to use the different AAI devices available. Online resources and introductory e-learning modules can be found at http://www.sparepensinschools.uk. This is not a substitute for face-to-face training.

As part of the medication needs policy, the school should have agreed arrangements in place for all members of staff to summon the assistance of a designated member of staff, to help administer an AAI, as well as for collecting the spare AAI in the emergency kit. These should be proportionate and flexible – and can include phone calls being made to another member of staff or responsible secondary school-aged children asking for the assistance of another member of staff and/or collecting the AAI (but not checking the register), and procedures for supporting a designated staff member's class while they are helping to administer an AAI.

Thought should be given to where delays could occur (for example, a phone call is made to summon help but there is no answer, etc.).

The school's policy should include a procedure for allowing a quick check of the register as part of initiating the emergency response. This does not necessarily need to be undertaken by a designated member of staff, but there may be value in a copy of the register being held by at least each designated member. If the register is relatively succinct, it could be held in every classroom. Alternatively, allowing pupils to keep their AAI(s) with them will reduce delays, and allows for confirmation of consent without the need to check the register.

Designated members of staff should be trained in:

- recognising the range of signs and symptoms of severe allergic reactions;
- responding appropriately to a request for help from another member of staff;
- recognising when emergency action is necessary;
- administering AAIs according to the manufacturer's instructions, and
- making appropriate records of allergic reactions.

Training material

It is recommended that schools should also ensure that:

- a named individual is responsible for overseeing the protocol for use of the spare AAI, and monitoring its implementation and for maintaining the allergy register, and
- at least two individuals are responsible for the supply, storage, care and disposal of the AAI.

Liability and indemnity

Supporting Pupils with Medication Needs advises that if a member of staff administers medication to a pupil, or undertakes a medical procedure to support a pupil and, as a result, expenses, liability, loss, claim or proceedings arise, the employer will indemnify the member of staff provided all of the following conditions apply.

a. The member of staff is a direct employee.

b. The medication/procedure is administered by the member of staff in the course of, or ancillary to, their employment.

c. The member of staff follows:

- the procedures set out in this guidance;
- the school's policy, and
- the procedures outlined in the individual pupil's Medication Plan, or written permission from parents and directions received through training in the appropriate procedures.

d. Except as set out in the Note below, the expenses, liability, loss, claim or proceedings are not directly or indirectly caused by and do not arise from fraud, dishonesty or a criminal offence committed by the member of staff.

Note: Condition d. does not apply in the case of a criminal offence under Health and Safety legislation.

7. Useful Links

- Spare Pens in Schools: http://www.sparepensinschools.uk
- Official guidance relating to supporting pupils with medication needs in schools in NI: Supporting Pupils with Medication Needs, (Department of Education, Department of Health, Social Services and Public Safety Northern Ireland, 2008):

  https://www.education-ni.gov.uk/articles/support-pupils-medication-needs
- Allergy UK : https://www.allergyuk.org/
- Whole school allergy and awareness management (Allergy UK) :https://www.allergyuk.org/schools/whole-school-allergy-awareness-and-management
- Anaphylaxis Campaign: https://www.anaphylaxis.org.uk
- AllergyWise training for schools:

  https://www.anaphylaxis.org.uk/information-training/allergywise-training/for-schools/
- AllergyWise training for school nurses (Anaphylaxis Campaign): http://www.anaphylaxis.org.uk/information-resources/allergywise-training/for-healthcare-professionals/
- Education for Health: http://www.educationforhealth.org
- Food allergy quality standards (The National Institute for Health and Care Excellence, March 2016):https://www.nice.org.uk/guidance/qs118
- Anaphylaxis: assessment and referral after emergency treatment (The National Institute for Health and Care Excellence, 2011): https://www.nice.org.uk/guidance/cg134?unlid=22904150420167115834

Annex 1

Letter template to pharmacy to obtain an AAI

Schools must provide a written letter when ordering “spare” back-up adrenaline auto-injector devices.

A sample letter is provided below, which should be printed on the school’s headed paper and then signed by the principal or head teacher at the school and should state:

- the name of the school for which the adrenaline auto-injector devices are required,
- the purpose for which devices are required, and
- the total quantity required for each device.

[To be completed on headed school paper]

[Date]

We wish to purchase emergency Adrenaline Auto-injector devices for use in our school/college.

The adrenaline auto-injectors will be used in line with the manufacturer’s instructions, for the emergency treatment of anaphylaxis in accordance with the Human Medicines (Amendment) Regulations 2017. This allows schools to purchase “spare” back-up adrenaline auto-injectors for the emergency treatment of anaphylaxis.

Please supply the following devices:

Brand name*		Dose* (state milligrams or micrograms)	Quantity required
	Adrenaline auto-injector device		
	Adrenaline auto-injector device		

Signed:

_____ Date: _____

Print name:
Head Teacher/Principal

*AAIs are available in different doses and devices. Schools may wish to purchase the brand most commonly prescribed to its pupils (to reduce confusion and assist with training). Guidance from the Department of Health to schools recommends:

For children age under 6 years:	For children age 6-12 years:	For teenagers age 13+ years:
• Epipen Junior (0.15mg) **or** • Emerade 150 microgram **or** • Jext 150 microgram	• Epipen (0.3 milligrams) **or** • Emerade 300 microgram **or** • Jext 300 microgram	• Epipen (0.3 milligrams) **or** • Emerade 300 microgram **or** • Emerade 500 microgram **or** • Jext 300 microgram

Further information can be found at http://www.sparepensinschools.uk

Annex 2

Roles and responsibilities

The school

1.1 The school principal (or other designated teacher) will notify the school nurse/doctor on becoming aware of a child requiring adrenaline/epinephrine in school. Dealing with medical conditions and medication needs must take into account the risks which arise from these and should aim to minimise probability of anything more serious happening to the child. Action should be taken to optimise opportunities to minimise risk – risk assessment.

1.2 The principal (or other designated teacher) will make staff aware of the pupil's allergic condition, the arrangements in this protocol and who the trained staff are. (N.B. - not forgetting temporary and substitute teachers).

1.3 The principal (or other designated teacher) should discuss details of the Medication Plan and child's condition with his/her parents/guardians. The implications of the pupil's allergy on their full and active participation in school life should also be discussed. The principal/designated teacher will seek volunteers from existing staff to be trained in the treatment of anaphylaxis, including administration of adrenaline/epinephrine. Appropriate training will need to be provided by local health services.

1.4 The principal/designated teacher should inform staff of activities, which could put the child at risk. Medical advice should be sought in relation to this matter and the situation fully discussed with parents/guardians.

1.5 The principal/designated teacher, catering representative and parents/guardians should agree appropriate food provision in school to avoid any allergic reaction. This should be supported by any medical evidence.

1.6 The school staff will endeavour to ensure that other pupils are aware of the dangers of anaphylaxis.

1.7 The principal/designated teacher will ensure that the parental consent form is signed. He/she will discuss with parent(s)/guardian(s) agreement to display child's photo on the individual Medication Plan.

1.8 The principal/designated teacher will ensure safe storage of and easy access to the AAIs and medication, together with the individual Medication Plan. All trained staff must be aware of where these are stored.

1.9 School trips. The school should make arrangements for the safe handling and transportation of emergency medication and relevant Medication Plans. Where trips involve other schools, their staff also need to be aware of the possible risk of anaphylaxis and informed whom to contact in an emergency. It may be useful to notify them in writing.

1.10 It is the duty of parents/guardians to check the expiry date of the AAIs, however, in some schools it has been found useful to use a manufacturer's expiry date alert service.

1.11 The school will enlist the help of all other parents/guardians in minimising the risk of nut/allergen exposure perhaps by issuing a letter to all parents/guardians requesting assistance with exclusion of nuts. The school may wish to consider making school premises a nut-free/allergen-free zone.

1.12 Following an anaphylactic incident, a review/debrief involving relevant staff and community paediatrician/school nurse should be arranged within a week if possible.

The school meals service

2.1 The school meals service will prepare food for children with an allergy in a way which avoids cross-contamination at all stages of preparation. Any limitations must be discussed with the parents/guardians.

2.2 In accordance with the Food Information Regulations 2014, caterers are required to ensure accurate information is available for all food served in relation to allergens. [10] [11]

The parents/carers

3.1 The parents/carers will ensure that the school and GP community paediatrician/school nurse are fully informed about the child's allergy including the situation where a child is no longer allergic to particular foods.

3.2 The parents/carers have a duty to check the expiry date of the AAI. They have a responsibility for maintaining, and replacing in school, two up to date auto-injectors, inhalers if asthmatic and oral antihistamine medication with a measuring spoon.

If the child has been prescribed an auto-injector device that the school has little or no experience of using, the community paediatrician/school nurse and school need to be immediately informed as administration differs and may cause confusion.

3.3 The parents/carers will ensure that the pupil's General Practitioner (GP) is aware of the protocol and agreeable to being contacted in an emergency, particularly where the GP is likely to be able to reach the school before an ambulance. (The community paediatrician/ school nurse will forward a copy of the Medication Plan to the child's GP).

3.4 The parents/carers will discuss with school the arrangements for lunch and snacks.

3.5 The parents/carers will regularly remind their child of the need to refuse any food items offered by others, especially pupils.

3.6 The parents/carers will ensure that the teacher knows which foods are suitable for rewards, if this is the teacher's practice.

3.7 The parents/carers will encourage the pupil to wear a medical identification device (e.g. SOS® or Medicalert®) at all times.

3.8 The parents/carers will ensure that siblings and other family members are made fully aware

[10] (https://www.food.gov.uk/sites/default/files/fir-guidance2014.pdf,

[11] https://www.food.gov.uk/sites/default/files/multimedia/pdfs/publication/loosefoodsleaflet.pdf)

of the arrangements that are in place.

The pupil

4.1 The pupil is responsible for wearing their medical identification device at all times. (This may require guidance from parents/teachers).

4.2 The pupil will act sensibly regarding food sharing.

4.3 Secondary level pupils may be responsible for carrying their own auto-injector and ensuring that it is with them at all times, especially when away from the main school buildings e.g. at sports fields.

The school health service

4.4 The school health service aims to promote the physical, emotional and mental health of all children and young people during their time at school. The services offered will help to identify health and developmental problems and enable appropriate action to be taken.

4.5 The school health service is available to all schools. The key members of the team are the school nurses and as part of the health service they are in a position to liaise and work with GPs and their hospital colleagues as well as with Consultant Community Paediatricians, nurses and therapists, etc. from Health and Social Care (HSC) Trusts.

5.1 The school health service will assist in organising appropriate training, and can provide advice and support for school staff.

5.2 The school health service will ensure that training includes the recognition and treatment of anaphylaxis and administration of auto-injectors using injection techniques. (Training devices are held by community paediatricians/school nurses).

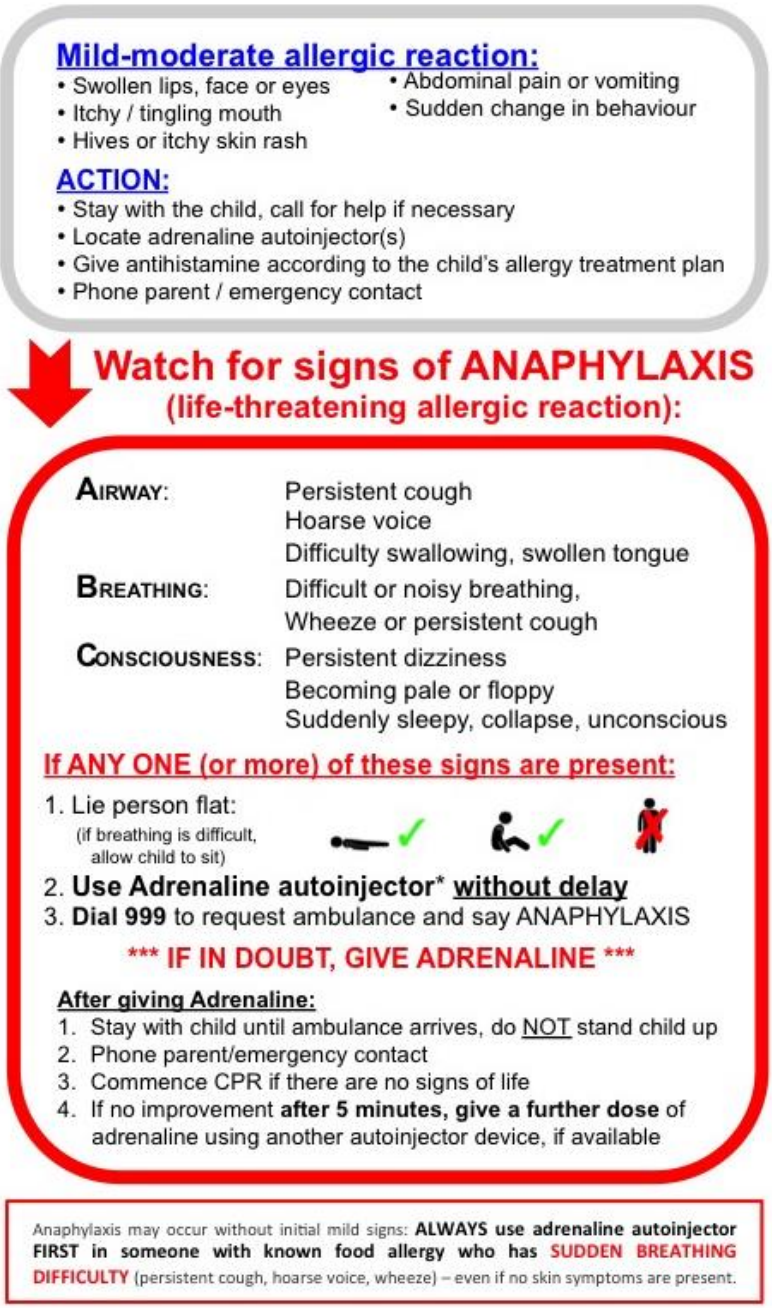
5.3 The school health service will ensure training on safe disposal of the sharps box in accordance with Trust waste disposal procedures.

5.4 The school health service will participate in any debriefing sessions.

5.5 The school health service will send a copy of the Medication Plan to the GP, parents and school.

Annex 3

Recognition and management of an allergic reaction/anaphylaxis



Mild-moderate symptoms are usually responsive to an antihistamine. The pupil does not normally need to be sent home from school, or require urgent medical attention. However, mild

reactions can develop into anaphylaxis: children having a mild-moderate (non-anaphylactic) reaction should therefore be monitored for any progression in symptoms.

What to do if any symptoms of anaphylaxis are present

You should administer the pupil's own AAI if available, if not use the spare AAI. The AAI can be administered through clothes and should be injected into the upper outer thigh in line with the instructions issued for each brand of injector. If in doubt, give adrenaline.

After giving adrenaline, do not move the pupil. Standing someone up with anaphylaxis has triggered cardiac arrest. Provide reassurance and keep the pupil lying down or sitting up with their legs raised slightly. In a young pregnant person, the advice is to lie the person on their left side.

If someone appears to be having a severe allergic reaction, it is vital to call the emergency services without delay - even if they have already self-administered their own adrenaline injection and this has made them better. A person receiving an adrenaline injection should always be taken to hospital for monitoring afterwards.

Always dial 999 and request an ambulance if an AAI is used.

Practical points

- Try to ensure that a person suffering an allergic reaction remains as still as possible, and does not get up or rush around. Bring the AAI to the pupil, not the other way round.
- When dialling 999, say that the person is suffering from anaphylaxis ("ANA-FIL-AX-IS").
- Give clear and precise directions to the emergency operator, including the postcode of your location.
- If the pupil's condition does not improve 5 to 10 minutes after the initial injection you should administer a second dose. If this is done, make a second call to the emergency services to confirm that an ambulance has been dispatched.
- Send someone outside to direct the ambulance paramedics when they arrive.
- Arrange to phone parents/carer.
- Tell the paramedics:
    - if the child is known to have an allergy;
    - what might have caused this reaction e.g. recent food, and
    - the time the AAI was given.

Recording use of the AAI and informing parents/carers

In line with *Supporting Pupils with Medication Needs*, use of any AAI device should be recorded. This should include:

- where and when the reaction took place (e.g. PE lesson, playground, classroom), and
- how much medication was given, and by whom.

Any person who has been given an AAI must be transferred to hospital for further monitoring. The pupil's parents/guardians should be contacted at the earliest opportunity. The hospital discharge documentation will be sent to the pupil's GP informing them of the reaction.