Safer Care Victoria

2017 May

Mandatory Reporting of Anaphylaxis

Discussion paper

VICTORIA State Government

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Safer Care Victoria

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Introduction

The purpose of this discussion paper is to seek input from relevant stakeholders, including health professionals, clinicians and members of the public, on the issue of collecting and reporting data relating to patients presenting to hospital due to anaphylaxis. In Victoria, food related anaphylaxis accounts for approximately 48 per cent of the total anaphylaxis presentations to Victorian emergency departments.[1] Hospital admissions due to anaphylaxis have been increasing at an accelerating rate since 1993.[2] Food induced anaphylaxis is most common in children with the majority of hospitalisations occurring in children under four years of age.[3]

In 2016, Coroner Jamieson made recommendations to the Minster for Health and the Secretary of the Department of Health and Human Services (the department) to establish a mandatory reporting system for children presenting to Victorian hospitals and emergency departments with anaphylaxis. The Minister and the Secretary accepted the Coroner's recommendations with the Secretary indicating the department would investigate, consult widely and formulate a program for mandatory reporting of anaphylaxis.

Responses to the questions within this paper will help policy makers to understand the different perspectives and often complex processes associated with mandatory reporting of anaphylaxis. These issues will need to be addressed when considering the legislative or regulatory framework required for this process to occur effectively.

The Australasian Society of Clinical Immunology and Allergy (ASCIA) defines anaphylaxis as an acute allergic reaction involving the widespread release of histamine and other mast cell mediators, resulting in clinical findings such as cardiorespiratory compromise (tachycardia, hypotension, stridor and wheeze) gastrointestinal muscle contraction (vomiting and or diarrhoea) and skin or mucosal findings (such as urticaria or angioedema). Anaphylaxis can occur from minutes to hours after exposure to the trigger and can rapidly become life threatening.

[1] Victorian Emergency Minimum Dataset, 2011-2016

[2] Ibid; Liew, W, Williamson, E and Tang, ML, 2009, *Anaphylaxis Fatalities and Admissions in Australia*, Journal of Allergy and Clinical Immunology, vol. 2, no. 123, pp 424-42; Mullins, R, Dear, K and Tang, M, 2015, *Time Trends in Australian Hospital Anaphylaxis Admissions in 1998-1999 to 2011-12,* Journal of Allergy and Clinical Immunology, vol. 136, no. 2, pp. 367-375.

[3] Mullins, R, Dear, K and Tang, M, 2015, *Time Trends in Australian Hospital Anaphylaxis Admissions in 1998-1999 to 2011-12,* Journal of Allergy and Clinical Immunology, vol. 136, no. 2, pp. 367-375.

Current anaphylaxis project work

The department has identified the need for a system wide review of the management of anaphylaxis in Victorian health services in line with implementing the recommendations of 2016 *Targeting Zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*. The department has been progressing a review of the management of anaphylaxis in the following ways;

1. The Victorian Paediatric Clinical Network (VPCN) has convened an expert advisory group to provide advice to the Chief Medical Officer on managing acute anaphylaxis in Victorian hospitals.

This work was undertaken to understand how anaphylaxis is currently managed in hospitals, retrieval services and general practice. Collaboration is progressing with ASCIA, the National Asthma Council Australia and the Statewide Paediatric Clinical Practice Guidelines Governance Group to align clinical practice guidelines for the treatment of anaphylaxis, as well as providing a standardised process for patients when discharged from hospital. Action plans for anaphylaxis and asthma will both include an alert that the presentation of asthma in someone with known allergies should first be treated with adrenaline followed by administration of the asthma reliever.

2. The Food Services Unit (FSU) is improving the ways health services manage food safety.

Local government is predominantly responsible for food regulation in Victoria through the administration of the Food Act 1984 and the Australia New Zealand Food Standards Code. The department's FSU is involved in food recalls, complaints relating to food allergens and responding to public health emergencies. The FSU has a significant role in developing regulations, policies and strategies that support a safe food system, informing and educating businesses and the community on food safety issues.

Management of food allergens has been recognised as a priority area for policy and resource development for the Food Safety Unit (FSU). The FSU has developed food allergen cards for the public which have been distributed via hospitals to encourage the reporting of packaged foods containing undeclared allergens.

3. Consideration is to be given to the practice of hospital staff holding and or managing patients' personal medication upon admission until discharge.

When patients are admitted to hospital, their own medications are required to be stored securely. Reasons for this include safe storage of dangerous medications, quality control and correct storage of medication. The review of the current practices of storage of patients' own medications in hospital is of particular interest, especially in relation to prompt access for the patient to time critical medications, such as adrenaline for people with severe allergies.

How can we better manage anaphylaxis in Victoria?

A report from the Victorian Paediatric Clinical Network Anaphylaxis Expert Group May 2017

Recommendations

- Early treatment of anaphylaxis in patients presenting with severe asthma where there is a history of anaphylaxis
- Compliance with latest evidence regarding posture and adrenaline escalation guidelines
- Provision of simplified adrenaline infusion and dose guidelines
- Provision of advice on discharge post anaphylaxis that includes completion of an ASCIA action plan, prescription for an adrenaline auto injector and referral to a specialist allergy clinic

Consultation

In 2016, Coroner Jamieson provided her findings with respect to the death of a child from complications of anaphylaxis after consuming mislabelled food and made recommendations to both the Minister for Health and the Secretary of the Department of Health and Human Services. The aims of these recommendations were;

- to protect and promote health in children with allergies and anaphylaxis
- to monitor, report and respond to circumstances that give rise to severe reactions in a timely and effective manner
- for the Secretary to investigate, consult and formulate a program of mandatory reporting for children presenting at hospitals and emergency departments with anaphylaxis
- to respond more agilely and reliably to incidents that trigger severe allergic or anaphylactic reactions through the interrogation of the sources of anaphylaxis and if it is apparent that a contributing factor involves packaged food or labelling of a packaged food, then a report be provided directly to the department's Food Safety Unit.

Response required

Given the recommendations from the Coroner, and thinking about your experience with anaphylaxis, we are interested in your response to the following areas. Your input and consideration of the issues will assist in shaping mandatory reporting of anaphylaxis.

1. Which cases of anaphylaxis should be considered for mandatory reporting?
2. What age group should be considered for mandatory reporting and why?
3. In what time frame should the case of anaphylaxis be reported?
4. Where does the responsibility lie for reporting cases of anaphylaxis?

This discussion paper provides an opportunity for health sector leaders and any interested clinician or member of the public, to put forward their ideas and provide feedback as to how they see mandatory reporting of anaphylaxis being structured.

Consideration 1: Cases of anaphylaxis

Which cases of anaphylaxis should be considered for mandatory reporting?

When thinking about cases of anaphylaxis, it is perhaps worthwhile considering the variability of triggers of anaphylaxis, which may not be immediately apparent in all cases. These may include, but not limited to; food, medications, latex and venoms. The Coroner requested that anaphylaxis in children who have consumed packaged food as the trigger is reported, but is there value in reporting other cases of anaphylaxis? In responding to this question think about the advantages and disadvantages in reporting different cases of anaphylaxis and how such reports can inform public health actions and policies.

- Should instances of anaphylaxis triggered by food be the only cases to be reported?
- Should all cases of anaphylaxis, independent of the trigger, be reported?
- Should cases where the trigger is unknown be reported?
- Should cases of any trigger, with that trigger specified, be reported?

Consideration 2: Age group to be reported

What age group should be considered for mandatory reporting and why?

Notwithstanding that the Coroner recommended mandatory reporting of cases involving children, are there benefits to be gained from collecting information and reporting a variety of age groups?

- Should all cases of anaphylaxis be reported regardless of age?
- Should all cases in children only (age 0-16 years) be reported?
- What is the rationale for your choice?

Consideration 3: Timing of reporting

In what time frame should the case of anaphylaxis be reported?

Given the aims of mandatory reporting, what would be considered a reasonable time frame to report a case of anaphylaxis to the department in order to reduce potential harm to others with allergies?

Consideration 4: Reporting responsibility

Where does the responsibility lie for reporting cases of anaphylaxis?

Reporting will need to be undertaken reliably and in a timely manner to meet the aims.

- Should the responsibility of mandatory reporting lie with the treating clinician?
- Should the responsibility of mandatory reporting lie with the health services? If so, who would be delegated to report?
- If anaphylaxis is managed in the primary health care setting, should the case be reported and who would be responsible for reporting?
- What would be the ideal mode of reporting (e.g. telephone, email, website or other)?
- What information should be reported?
- What would make reporting achievable?

Your response

The consultation time frame for this discussion paper will be from 9 June 2017 until 30 June 2017. Please respond to this paper via the to the following email address anaphylaxis@dhhs.vic.gov.au. Your response to the discussion paper will be considered confidential.

Your participation with this reform is greatly appreciated as Safer Care Victoria works toward improving safety for all Victorians.