Key Words: Adverse Reaction, Medication, Allergy

Policy Applies to: To all staff who administer medications at Mercy Hospital

Related Standards:

- **EQuIP Standard** 1.5 Safety, Criterion 1.5.1 - Medications are managed to ensure safe and effective practices

Rationale: The Adverse Medication Reaction policy is an adjunct to both the Medicines Management and Patient Assessment policies and supports the identification and notification and treatment of adverse reaction to a medicine.

Definitions:

**Medication allergy** is often a common term used to depict any unexpected and unwanted event or effect that occurs when an individual is taking a specific medication or therapeutic agent. A better, overall term to describe these circumstances would be an adverse reaction to a medication.
Hypersensitivity and allergic reactions to medication is an unpredictable immune-mediated response to an agent manifesting most frequently in various skin reactions, bronchoconstriction and oedema. Medications which more commonly are known to induce an allergic reaction; sulpha antibiotics, penicillin, acetylsalicylic acid, allopurinol, anti-seizure medications, anti-arrhythmic. About 1 in 6 adverse drug reactions represents drug hypersensitivity, and are allergic or non-immune mediated reactions.

Anaphylaxis is a severe systemic allergic reaction and should be considered if skin signs co-exist with bronchospasm or hypotension. Muscle relaxants are the most common trigger of anaphylaxis during anaesthesia in Australasia. Antibiotics are also common triggers with anaphylaxis to chlorhexidine becoming an emerging concern. True allergy to medications however accounts for only 6-10% of all adverse medication effects.

Side effects of medication are usually nonimmunologic effect of the agent and are predictable. An example of this type of reaction is gastrointestinal effects and ulceration from NSAIDs.

Medication intolerance is another type of reaction where a patient has a lower threshold to the normal pharmacological action of a medication, such as tinnitus after a single average dose of aspirin.

Objectives

- To outline the management for the prevention and detection of an adverse reaction to a medication
- Ensure staff are aware of the appropriate interventions for an adverse reaction to a medication.
- To enable staff to differentiate the types of adverse reactions to a medication.

Implementation

Via staff awareness of policy

Evaluation

Via Incident Reports
# Adverse Reaction to Medication

**MERCY HOSPITAL DUNEDIN**

*Clinical Services Policy Manual*

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## References

**External**

- Anaphylaxis flow diagram NZRC
- Anaphylaxis Management Guidelines ANZAAG-ANZCA Version 1.1 June 2013
- “Adverse Medication Reactions: Types and Treatment Options” Marc. A. Riedl, M.D., and Adrian M. Casillas, M.D. University of California, Los Angeles, David Geffen School of Medicine, Los Angeles, California

**Internal**

- [Medicines Management Policy](#), Clinical Services Policy Manual
- [Patient Assessment Policy](#), Clinical Services Policy Manual
- [Clinical Records Management Policy](#), Hospital Policy and Information Manual
- Cardiac Arrest / Patient Emergency Process, Clinical Services Work Manual
- Anaphylaxis Box documentation - Theatre & McAuley Ward
PROCESS

Prevention

Prevention of adverse reactions to medications (where known) begins prior to admission via patient assessment. Where an adverse reaction is noted it must be recorded as per The Clinical Records Management Policy.

Detection

Clinical features of an adverse medication reaction - the signs and symptoms depend on the part of the immune system that is reacting.

The most common allergic reaction to a medication is a measles-like rash (without hives), which typically occurs after several days to two weeks of treatment. This is most likely caused by specific immune cells in the skin, which react to the medication. In most cases, only the skin is affected and the rash usually clears once the medication is discontinued. However, the reaction may be quite/more severe and include wheezing, facial swelling, angioedema (localized oedema of deeper skin layers) and abnormalities of coagulation and fibrinolysis.

The most severe reaction is anaphylaxis and occurs when a person’s immune system produces the antibody IgE in response to a drug. On repeat exposure, the drug binds to IgE antibodies on mast cells, resulting in massive/significant release of histamine and other potent chemicals as most cells degranulate. This triggers symptoms and signs of an anaphylactic reaction which include:

- Cutaneous - sense of warmth, flushing, hives, urticaria
- Respiratory - swelling of the throat/stridor/wheeze/ due to angio- neurotic oedema and laryngeal spasm leading to respiratory distress and or arrest
- Nausea or vomiting
- Cardiovascular Hypotension, rapid thready pulse, circulatory collapse
- Sense of impending doom.

These symptoms require emergency attention including an immediate injection of adrenaline. If the reaction is not immediately treated, anaphylaxis can result in death.
Most anaphylactic reaction occurs within one hour after the patient takes the medication. In 5-20% of cases, a recurrence of the anaphylactic reaction may occur up to several hours later. This is more common in patients who had a severe initial reaction. Elevated serum tryptase level is supportive of anaphylaxis. The peak level is usually 15-120 minutes after onset of the reaction and declines slowly within 3-6 hours. The return to baseline level can generally be verified 24hrs after the reaction.

**Intervention**

For complete flow diagram of anaphylaxis treatments please refer to Appendix 1 and 2. To be used in conjunction with the Australia and New Zealand Anaesthetic allergy group (ANZAAG) guidelines on Anaphylaxis management found in the Anaphylaxis box in Theatre & McAuley Ward.

**Treatment**

In the event of a patient having an adverse/allergic reaction to a medication the process followed will be dependent upon the severity of the patient response.

The most important and effective therapeutic measure in managing medication adverse reactions however is the discontinuation of the offending medication, if possible.

- If the reaction to the medication does not compromise the patient’s haemodynamic status and the patient is not at immediate risk, stop the medication if able, stay with the patient, call for assistance, notify the patient’s consultant and follow orders given.

- If the allergy leads to an anaphylactic response for the patient please refer to the anaphylaxis flow diagram – refer Appendix 1 and 2. Adrenaline can be administered intramuscularly and intravenously. If severe anaphylaxis IV adrenaline should be diluted (1:100,000) and infused at a controlled rate.

- In addition access the Anaphylaxis boxes kept in McAuley Ward and Theatre. In these boxes are the:
  - Australia and New Zealand Anaesthetic allergy group (ANZAAG) guidelines on Anaphylaxis management
• Request forms and 4 plain serum tubes for collection of tryptase specimens. *Serum tryptase specimens must be sent to the laboratory urgently for processing as tryptase levels are not stable in whole blood. Delayed processing may result in false negative results.*

• Patient form letters
• Patient information brochure
• Testing referral forms

• As is stated in the Mercy Hospital ‘Cardiac arrest / Patient Emergency’ Policy it is the expectation of Mercy Hospital that staff trained at Level 6 WILL commence CPR, defibrillate shockable rhythms and administer medications e.g. adrenaline, as indicated in the algorithms and as per their level of NZRC training.