Lincolnshire Community Health Services NHS Trust

Anaphylactic Reaction, Procedure for Management

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Name of originator/author:	Lorna Adlington, Medicines Management Lead Nurse Helen Oliver Medicine Management Skills Facilitator
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Target audience:	All practitioners within Lincolnshire Community Health Services
Distributed via:	Web site and staff services Medicines Management

Version Control Sheet

Version	Section/Para /Appendix	Version/Description of Amendments	Date	Author/Amended by
1	5.5	New national guidance around recognition of anaphylaxis.	August 2008	Lorna Adlington
	5.7	New national guidance on treatment framework.		
	5.7.10	New national guidance on dose of adrenaline		
	Appendix One	Reflects new national guidance		
2	2.2	Clarifying the scope of the Document, Minor formatting	March 2009	Lorna Adlington, Anny Jones
3	Throughout	Update policy template and minor formatting	May 15	Lorna Adlington
	1.	Revised introduction in line with national guidance, reflecting organisational change.		
	5	Updated in line with national guidance		
	8 and 9	Minor updates in line with NICE guidance		
	10	Updated to reflect organisational changes		
	12	New section		
	13	Updated to reflect organisation change		
	15	Updated references		
	3	Change to mandatory update training		
	8	Addition of storage to all clinical areas		
	Appendix One	Updated to reflect all treatment options.		
	2	Clarification of scope of inclusion		
3.1		Extended	Sept 17	Corporate Assurance Team

4	6.1	Addition;Information regarding pre-existing asthma, poorly controlled or those asthmatics who fail to use, or delay treatment with, adrenaline	Jan 18	Helen Oliver
4	11	Updated reference and clarification on observations of the patient following vaccination	Jan 18	Helen Oliver
4	12.4	Addition: those who are suspected of having had an anaphylactic reaction should be encouraged to inform their General Practitioner for referral to a specialist in allergy	Jan 18	Helen Oliver
4	14.1	Deleted sentence regarding policy supporting training	Jan 18	Helen Oliver
4	15	Updated references	Jan 18	Helen Oliver

Contents

Policy Statement

Background The purpose of this guidance is to implement a co-ordinated and standardised approach to strategic, operational and clinical management of the procedure for management of anaphylactic reaction

Statement This policy offers 'best practice' advice and national guidance to ensure that anaphylactic reactions are managed safely and appropriately.

Responsibilities Compliance with the policy will be the responsibility of all Trust Staff, clinicians and practitioners.

Training It is the responsibility of operational managers and service **l**eads to ensure that appropriate mechanisms are in place to support the implementation of this policy, including appropriate training and maintenance of competency levels.

Dissemination Trust website, Intranet, Weekly Team Brief, Via Operational Managers and Service Leads, publicised through CCG forums, Senior Clinician meetings

Resource implication There are no identified additional resource implications, except time required to complete on-line learning packages

Consultation Where possible all interested parties were involved and included in this process.

1. Introduction

1.1 The UK incidence of anaphylactic reactions is increasing. Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction. It is characterised by rapidly developing, life threatening problems involving: the airway (pharyngeal or laryngeal oedema) and / or breathing (bronchospasm with tachypnoea) and / or circulation (hypotension and / or tachycardia). In most cases, there are associated skin and mucosal changes (Resuscitation Council 2008).

1.2 Anaphylaxis may be an allergic response that is immunologically mediated, or a non-immunologically mediated response, or idiopathic. Certain foods, insect venoms, some drugs and latex are common precipitants of immunoglobulin E (IgE) mediated allergic anaphylaxis. Many drugs can also act through non-allergic mechanisms. A significant proportion of anaphylaxis is classified as idiopathic, in which there are significant clinical effects but no readily identifiable cause. The relative likelihood of the reaction being allergic, non-allergic or iodiopathic varies considerably with age.

1.3 The aim of this procedure is to ensure that all practitioners are trained and equipped to recognise and respond effectively to anaphylaxis and offer an appropriate level of treatment for anaphylactic reaction where this is required.

2. Scope

2.1 This policy applies to all practitioners employed by Lincolnshire Community Health Services NHS Trust who have face to face contact with clients and patient's and are involved with high risk activities. This particularly involves those who carry out clinical procedures such as vaccination, steroid injections, acupuncture and local anaesthesia. It does not need to be carried by those practitioners who are not involved in any of these clinical activities.

2.2 All clinical practitioners are required to attend designated training in basic life support on an annual basis.

3. Competencies

3.1 All staff administering Adrenaline (Epinephrine) must be registered practitioners, working within the guidelines and Code of Conduct of their professional body.

3.2 All clinical staff will complete life support skills as part of the annual mandatory clinical updating programme.

3.3 All practitioners undertaking treatment of anaphylaxis should have competency in basic life support, having attended induction training and annual updating.

3.4 All individual practitioners have a professional responsibility to attend mandatory training.

3.5 It is the responsibility of the manager to ensure that all staff attend annual mandatory training, and every individual under their contract of employment comply with identified training needs.

4. Patients to whom this procedure refers

4.1 This procedure relates to all patients treated by, or in contact with clinicians in their working environment, who exhibit symptoms or signs of anaphylaxis or a

severe allergic reaction following administration of medication, local anaesthetic, vaccine, injection, acupuncture or history of exposure to other antigen.

5. Common causes of anaphylaxis

5.1 Anaphylaxis can be triggered by a wide range of triggers; however those most commonly identified include drugs, food groups and venom:

- Drugs including:
    - Vaccines and Immunisations
    - Antibiotics
    - Aspirin
    - Non-Steroidal anti – inflammatory drugs (NSAIDs) o Heparin
    - Blood and blood products o Anaesthetic drugs
    - Local anaesthetics – particularly Mepivacaine (brand name Scandonest), Lignocaine, Benzocaine, Procaine and Tetracaine.
    - Contrast media.
- Some foods such as shellfish, nuts, bananas, eggs.
- Peanuts and Tree Nuts
- Insect stings
- Latex products

This is not an exhaustive list.

5.2 Age is an important consideration. In children, food can be considered to be a particularly common trigger whilst medicinal products are much more common triggers in older people. However there are no guarantees and any food or medication can be implicated. In many cases no significant cause can be identified.

6. Recognition of anaphylaxis

6.1 An anaphylactic reaction is usually unexpected and likely to occur if a patient is exposed to a trigger. Usually within minutes of exposure the individual will develop a sudden illness characterised by rapidly progressing skin changes and / or life threatening airway / breathing and / or circulation problems.

6.2 There is no single set of criteria or symptoms to identify an anaphylactic reaction but a range of signs and symptoms, which in certain combinations, make a diagnosis more likely.

6.3 An ABCDE approach (See appendix one) must be followed when recognising and treating any acutely ill individuals:

Airway, **B**reathing, **C**irculation, **D**isability, **E**xposure.

6.4 **Anaphylaxis is likely when all of the following three criteria are met:** Sudden onset and rapid progression of symptoms
 Life threatening **A**irway and/or **B**reathing and/or **C**irculation problems

 Skin and/or mucosal changes (flushing, urticarial, angioedema).

6.5 Individuals may experience any combination of these A, B, C problems. The following signs and symptoms may help support diagnosis and treatment.

6.6 Life threatening **A**irway, **B**reathing and **C**irculation signs and symptoms include:

CRITERIA	SIGNS / SYMPTOMS
Airway obstruction	Angioedema (swelling of face, neck and tongue) Difficulty breathing, speaking and swallowing. Hoarse voice Stridor (high pitched inspiratory noise caused by upper airway obstruction)
Breathing difficulties	Shortness of breath. Increased respiratory rate. Bronchospasm – wheezing Tiredness Hypoxia – causing confusion Cyanosis – usually a late sign Respiratory arrest
Circulatory	Signs of shock – pale, clammy Tachycardia
	Hypotension Decreased levels of, or loss, of consciousness Cardiac arrest
Disability	Confusion Agitation Sense of impending doom Loss of consciousness Collapse
Exposure and Skin and Mucosal changes	Diffuse erythema Urticaria (itchy weals) – may be pale pink or red, different shapes and sizes. Alterations in skin colour (either flushed or pale) Cold and clammy

6.7 Skin and mucosal changes may be subtle or dramatic and are often the first distinguishing features. They are present in over 80% of anaphylactic reactions (Resuscitation Council UK 2008).

6.8 Skin or mucosal changes alone are not a sign of an anaphylactic reaction. Skin changes without life threatening airway; breathing or circulatory signs do not signify an anaphylactic reaction.

6.9 Most anaphylactic reactions will occur over several minutes and may vary in severity. The patient will feel and look unwell, express anxieties and may experience a ‘sense of impending doom’.

6.10 The time of onset of a reaction may vary depending on the type of trigger (Resuscitation Council UK 2008). For example an intravenous trigger will cause a more rapid onset of reactions than stings.

6.11 The overall prognosis of anaphylaxis is good, with a case fatality ratio of less than 1% reported in most population-based studies. Risk of death is, however, increased in those with pre-existing asthma, particularly if the asthma is poorly controlled or in those asthmatics who fail to use, or delay treatment with Adrenaline (Epinephrine) (Resuscitation Council UK 2008).

7. Signs suggestive of a vasovagal or panic attack

7.1 General signs:

- Sweating, nausea, dizziness and weakness may precede the event.
- Choking and difficulty breathing may lead to hyperventilation and parasthesiae of the hands.

7.2 Cardiovascular:

- Bradycardia. The carotid pulse is slow and maintained in a vasovagal episode, but rapid and faint in an anaphylactic reaction.

7.3 All practitioners who treat anaphylaxis should be aware of the potential for confusion between anaphylaxis and a panic attack. Victims of previous anaphylaxis may be particularly prone to panic attacks if they think they have been re-exposed to the allergen. The sense of impending doom generalised urticarial and breathlessness leading to hyperventilation are symptoms that resemble anaphylaxis in some ways; however there is no indication of any life threatening features.

7.4 Problems can also arise with vasovagal attacks after immunisation procedures. However the absence of rash, breathing difficulties and swelling is a useful distinguishing feature, likewise the slow pulse of a vasovagal attack compared with the rapid pulse of an anaphylactic episode. Individuals who have fainted will usually respond to lying down and raising the legs.

7.5 Guidelines for the management of shock from anaphylaxis must therefore take into account the inevitability of some diagnostic errors, with an emphasis on the need for safety of any recommended measures. Practitioners should always follow an ABCDE approach to support diagnosis and treatment.

8. Treatment

8.1 Treatment of an anaphylactic reaction should be based on the general life support principle using the ABCDE approach to recognise symptoms and treat problems (Resuscitation Council UK 2008). See appendix one.

8.2 As soon as an anaphylaxis reaction is suspected the first priority is to dial 999 for paramedic assistance and transfer to an A&E department.

8.3 All suffers should recline in a position of comfort. Lying flat with or without leg elevation may be helpful for hypotension but unhelpful for breathing difficulties. These patients may prefer to sit up as this will make breathing easier. If the patient feels faint do not sit or stand up as this can cause cardiac arrest (Resuscitation Council UK 2008).

8.4 If available, oxygen should be administered at high flow rates (greater than 10 litres per minute). Cardiopulmonary resuscitation must be performed if the need arises.

8.5 Patients who are breathing but unconscious should be placed in the recovery position.

8.6 Pregnant ladies should lie on their left side to prevent caval compression (Resuscitation Council UK 2008).

8.7 If possible the trigger causing the anaphylactic reaction should be removed, for example stop any drug suspected of causing the reaction. However removing the trigger is not always possible. Do not delay treatment if removing the trigger is not feasible.

8.8 Adrenaline (Epinephrine) is generally regarded as the most important drug for any severe anaphylactic reaction. As an alpha-receptor agonist, it reverses peripheral vasodilation and reduces oedema. Its beta-receptor activity dilates the airways, increases the force of myocardial contraction, and suppresses histamine and leukotriene release. Adrenaline (Epinephrine) works best when given early after the onset of the reaction. Adverse effects are extremely rare with appropriate doses administered intramuscularly.

8.9 Adrenaline (Epinephrine) is generally the only drug available for use by community clinicians; however patients who have had this first line treatment will be transferred rapidly to hospital where any further necessary measures can be taken.

8.10 The recommendations for treatment are summarised in the algorithm shown in Appendix One. These should be followed as appropriate to the individual clinical area.

8.11 Adrenaline (Epinephrine) should be administered intramuscularly to treat anaphylactic reaction and will be rapidly absorbed.

8.12 Adrenaline (Epinephrine) can be given in an emergency situation without the necessity of a Patient Group Direction (PGD).

9. Adrenaline (Epinephrine) IM doses:

9.1 ADULTS:
A dose of 0.5mg adrenaline (0.5mL 1:1000 solution) should be administered intramuscularly and repeated after about 5 minutes in the absence of clinical improvement or if deterioration occurs after the initial treatment especially if consciousness becomes, or remains, impaired as a result of hypotension. In some cases several doses may be needed, particularly if improvement is transient.

9.2 CHILDREN:

The recommended doses of adrenaline are as follows:

AGE	DOSE	
< 6 months	150 micrograms IM	0.15 ml 1:1000 solution
6 months – 6 years	150 micrograms IM	0.15 ml 1:1000 solution
6 – 12 years	300 micrograms IM	0.3 ml 1:1000 solution
>12 years	500 micrograms IM	0.5 ml 1:1000 solution
Small or pre-pubertal child	300 micrograms IM	0.3 ml 1:1000 solution

9.3 These doses are based on what is considered safe and practical to draw up and inject in an emergency (Resuscitation Council UK 2008).

9.4 For IM injections, the needle needs to be long enough to ensure the drug is injected into the muscle:

- A 25mm (blue) needle is suitable for all ages.
- A 16mm (orange) needle is suitable in pre-term or very small infants.
- A 38mm (green) longer length needle may be required in some adults.

9.5 IM injections should be given at a 90` angle to the skin. The skin should be stretched, not bunched.

9.6 All doses may be repeated after 5 minutes if necessary. Further doses can be given at 5 minute intervals depending on response.

9.7 Adrenaline (Epinephrine) should not be repeated if the patient goes into cardio-respiratory arrest.

9.8 If patient carries their own prescribed pre-filled device, for example Epipen, anyone can assist the patient to take his or her medication.

9.9 A full record must be made in the clinical notes immediately following the event. It must include date, time and record of any medication given (including batch number) and must be signed by the practitioner.

9.10 Document the acute clinical features of the suspected anaphylactic reaction and record the time of the onset of reaction (NICE 2011). This is the time that symptoms are first noticed.

9.11 Record the circumstances immediately before the onset of symptoms to help identify any potential trigger.

9.12 The reaction should be reported to the MHRA (Medicines and Healthcare products Regulatory Agency) using the Yellow Card scheme. Yellow card reporting can be accessed via www.mhra.gov.uk or alternatively copies of the yellow card can be found at the back of each edition of the BNF (British National Formulary).

10. Equipment

10.1 For Community Teams:

10.1.1 Packs containing adrenaline (epinephrine) will be provided by the Community Team Lead / Service Leads. Packs are provided to all new members of staff following completion of internal training and recalled and replaced when expired.

10.1.2 The addition of syringes and needles to the adrenaline (epinephrine) will be the responsibility of each individual practitioner from within their own service stock. Adrenaline will be ordered centrally and supplied to the Community Team Lead / Service Leads.

10.1.3 All packs are sealed and marked with an expiry date and a central register of the location of packs will be held by each Team Lead.

10.1.4 Clinical staff should be familiar with the equipment and drugs they have available and should check them regularly.

10.1.5 Packs should be returned to the Community Team Lead / Service Leads for replacement if opened or damaged or the member of staff leaves the employment of the Trust.

10.1.6 It is the responsibility of all practitioners to be aware of the expiry date of their own pack and inform the Community Team Lead /Service Leads of any changes to their role or location. This will enable the tracking system for shock packs to be maintained effectively.

10.1.7 Adrenaline (epinephrine) should be kept in the original packaging should be made to ensure that it is not stored in hot places such as cars for prolonged periods or where it could be accessed by unauthorised persons.

10.2 For Clinical Areas – including Community Hospitals, Minor Injuries (MIU), Out Of Hours (OOH), Walk in Centres

10.2.1 All emergency drugs are supplied via the usual route of medicines supply for each individual clinical area ie usual stock order.

10.2.2 Reference should be made to the Safe and Secure Handling of medicines for the safe and secure storage of all emergency medicines (LCHS P-CIG-20).

10.2.3 Checking of emergency drugs should be included in local processes to check expiry date, maintenance of seal and appropriate storage. Reference should be made to the Safe and Secure Handling of medicines policy (LCHS P-CG-20).

10.3 Where possible all supplies should be latex free.

11. Observation of patient's after Immunisation / Injection

11.1 While anaphylaxis after immunisation is rare (Resuscitation Council 2008), fainting and panic attacks associated with Immunisations are not. Practitioners involved in vaccination programmes must be able to deal with these and recognise the difference between anaphylaxis and fainting.

11.2 The risk of severe life-threatening reactions after immunisation is extremely small. The rate in the UK is approximately one per million vaccine doses (DH 2014)

. Onset of anaphylaxis can be rapid, typically within minutes, and its clinical course is unpredictable with variable severity and clinical features.

11.3 Due to the unpredictable nature of anaphylactic reactions it is not possible to define a particular time period over which all individuals should be observed following immunisation to ensure they do not develop anaphylaxis (Resuscitation Council 2008). It is therefore considered that by the time practitioners have checked the site for bleeding, the patient has replaced clothing and the patient's records have been completed that any immediate problems should have become apparent and if the patient has been assessed to be feeling well, that this is to be considered an adequate observation period (Vaccine Task Force 2001)

11.4 There is no evidence to support the practice of keeping patients under longer observation than 5-10 minutes (Resuscitation Council 2008), unless stated in the Summary of Characteristics for a particular vaccine (Royal College of Nursing)

11.5 It is further recommended that patient's be given instructions, preferably written (ie Patient Information Leaflet included with the vaccine), regarding observation for the post vaccination possible side effects and after care. This is particularly important in patients who have received ingested vaccines such as cholera, polio and oral typhoid when reactions could occur up to 72 hours post vaccination.

11.6 The same advice and considerations should be given to all patients undergoing a local anaesthetic or receiving antibiotic cover.

11.7 Consideration should be given to ensure prevention where possible. Emphasis should be given to the checking and recording of an adequate and thorough medical history particularly allergies.

12. Observation of patients after emergency treatment for anaphylaxis

12.1 NICE (2011) advise that all adults and young people aged 16 years or older who have had emergency treatment for suspected anaphylaxis should be observed for 6 – 12 hours from the onset of symptoms.

12.2 In individuals with reactions that are controlled promptly and easily a shorter observation period may be considered provided they receive the appropriate advice prior to discharge.

12.3 In addition NICE (2011) also advise that children younger than 16 years old who have received emergency treatment for suspected anaphylaxis should be admitted to hospital under the care of a paediatric medical team.

12.4. The patient should be encouraged to inform their General Practitioner of their suspected / confirmed anaphylactic reaction so they have the opportunity to be reviewed by a specialist in allergies (Resuscitation Council 2008)

13. Audit / Monitoring

13.1 Following any incident practitioners must report and record the episode in accordance with the Trusts Incident Reporting Policy.

13.2 Compliance with mandatory training and evidence of competency will be monitored through the staff development review process. Records are maintained as part of ESR.

13.3 Records should be held by CommunityTeam Lead /Service Leads of all staff who have been issued with and carry adrenaline (epinephrine).

13.4 Clinical leads should consider auditing the use of these guidelines to measure implementation.

13.5 Audit of training and annual update will be set against a benchmark of 100%.

14. Implementation Strategy

14.1. After approval the policy will be made available on the Trust website.

15. References

- LCHS Safe and Secure Handling of Medicines policy (P-CIG-20).
- National Institute for Health and Clinical Excellence (2011) *Anaphylaxis: assessment to confirm an anaphylactic episode and the decision to refer after emergency treatment for a suspected anaphylactic episode.*
- DH (2014) Immunisation against infectious disease (The Green Book) accessed via
- https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book [Accessed 19.01.18]
- NMC (2007) Standards for Medicines Management. https://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/ [Accessed 19.01.18]
- Resuscitation Council UK (2008) Emergency treatment of anaphylactic reactions. Guidelines for healthcare providers accessed via www.resus.org.uk [Accessed 19.01.18]
- Royal College of Nursing (1999) accessed via www.rcn.org/get help/rcn-advice/immunisation#anaphlaxsisandadverseevents [Accessed 19.01.18]
- Vaccination Administration Task Force (2001) UK Guidance on Best Practice in Vaccine Administration. http://www.wales.nhs.uk/sitesplus/documents/861/UK%20best%20practice%20guidance%20vacc%20admin%202001.pdf [Accessed 19.01.18]

Appendix One

ANAPHYLAXIS ALGORITHM
TREATMENT OF ANAPHYLACTIC REACTION

(adaptedfromResuscitationCouncilUK 2008)

AnaphylacticReaction

↓

Check:
Airway, **B**reathing, **C**irculation, **D**isabilityand **E**xposure

↓

Diagnosis.Lookfor:
- Acuteonsetofillness
- Lifethreateningairwayorbreathingcomplications(Box1)
- Skinchanges.

↓

Immediately call for paramedic help

↓

Lay the patient down flat

↓

Raise the patient's legs (if breathing not impaired)

↓

Administer Intramuscular Adrenaline (Epinephrine):

IM doses of adrenaline 1:1000
- Adult 500 micrograms IM (0.5ml)
- Child (12 and above) 500 micrograms IM (0.5ml)
- Child (6 – 12 years) 300 micrograms IM (0.3ml)
- Child (less than 6 years)150 micrograms IM (0.15ml) Repeat after 5 minutes if there is no improvement.

BOX 1 - **Life threatening complications**
- **Airway** – swelling, hoarseness, stridor
- **Breathing** – rapid breathing, wheezing, fatigue, cyanosis, Sp02 <92%, confusion.
- **Circulation** – pale, clammy, low blood pressure, faintness, drowsy / coma.

BOX 2 - IV FLUID CHALLENGE

Adult - 500 – 1000 mL
Child - crystalloid 20 mL/kg

Stop IV colloid if this is potential cause of anaphylaxis

When appropriate skills and equipment is available:
- Establish airway
- High flow oxygen **Monitor**:
- IV fluid challenge (Box 2) • Pulse oximetry
- Chlorphenamine (Box 3) • ECG
- Hydrocortisone (Box 3) • Blood pressure

Please note any drug given from box 2 or 3 will require a prescription

BOX 3

	Chlorphenamine	**Hydrocortisone** (IM or slow IV)
Adult or child more than 12 years	10mg	200mg
Child 6 – 12 years	5mg	100mg
Child 6 months to 6 years	2.5mg	50mg
Child less than 6 months	250micrograms / kg	25mg

Equality Analysis

Appendix Two

Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help LCHS staff members to comply with the general duty.

Please complete the template by following the instructions in each box. Should you have any queries or suggestions on this template, please contact Rachel Higgins Equality and Diverssity Lead.

Name of Policy/Procedure/Function*
Anaphylactic reaction, procedure for management
Equality Analysis Carried out by: Helen Oliver Date: 24.01.18
Equality & Human Rights Lead: Rachel Higgins
Director\General Manager:

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	The purpose of this guidance is to implement a coordinated and standardised approach to strategic, operational and clinical administration of emergency adrenalin for anaphylaxis.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	All staff and service users who have face to face contact with patients, particularly those involved with clinical procedures such as vaccinations, etc.		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No.		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?			
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		X	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Helen Oliver		
Date:		24.01.18		

Appendix Three

Human Rights Assessment Tool

The Human Rights Act, which came into force in October 2000, incorporates into domestic lase the
European Convention on Human Rights to which the UK has been committed since 1951. Section 6 of the Human Rights Act makes it unlawful for a public authority to act in a way that is compatible with a Convention right. The underlying intention of the Act is to create a Human rights culture in public services.

To be completed and attached to any policy document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1	Will it affect a person's right to life?	**No**	
2	Will someone be deprived of their liberty or have their security threatened?	**No**	
3	Could this result in a person being treated in a degrading or inhuman manner?	**No**	
4	Is there a possibility that a person will be prevented from exercising their beliefs?	**No**	
5	Will anyone's private and family life be interfered with?	**No**	

If the answer is "yes" to any of the questions on the proforma can the policy be amended to avoid impacting on Human Rights? If not, please refer it to the Director of Corporate Affairs to enable legal advice to be sought before proceeding.