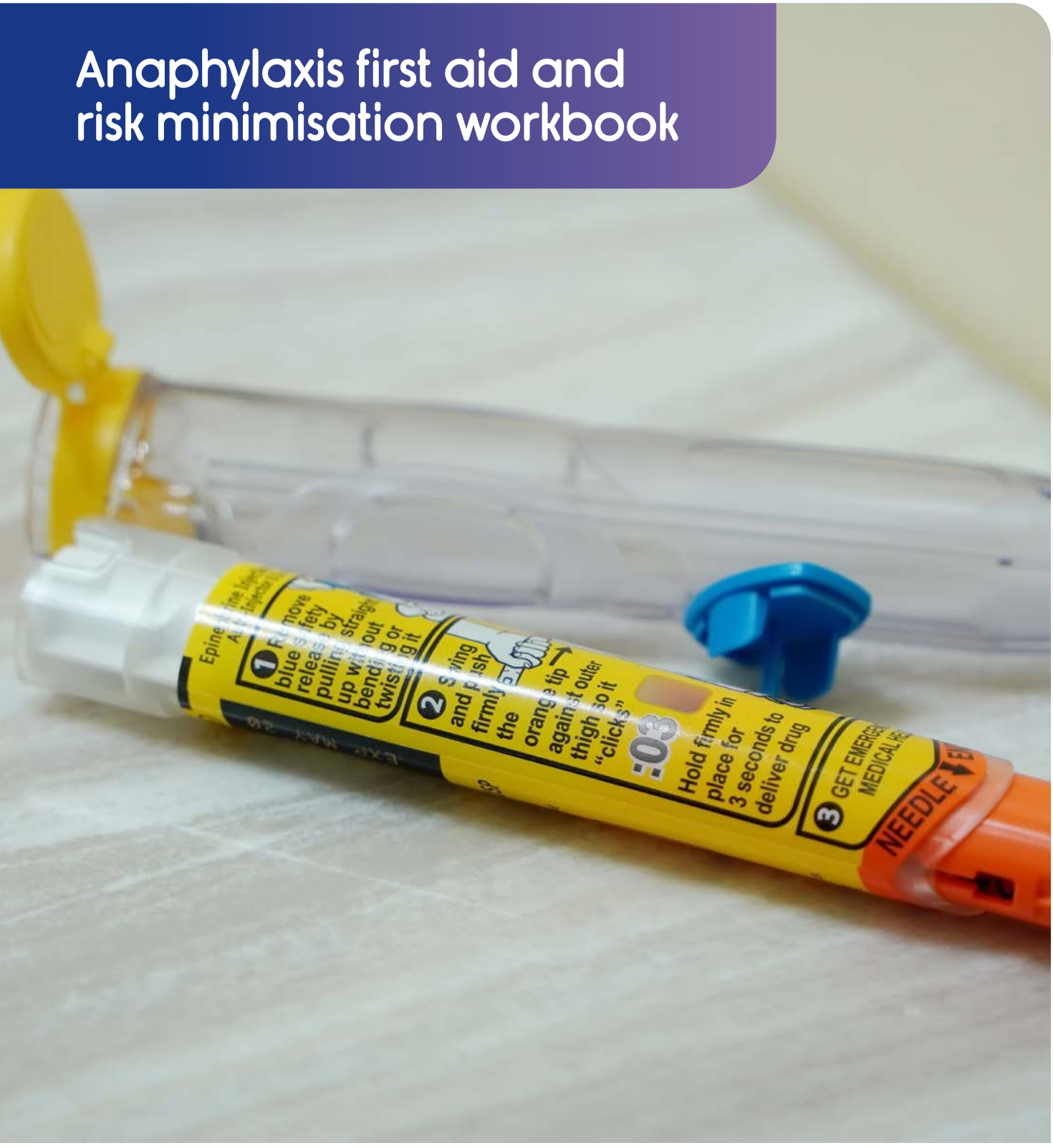
PREMIUMHealth
FIRST AID

Australia's premium first aid, mental health and health care training provider for over 35 years.

Anaphylaxis first aid and risk minimisation workbook



premiumhealth.com.au

1300 721 292

PREMIUMHealth

In the spirit of reconciliation Premium Health acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community. We pay our respects to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

OUR PROMISE

Premium Quality, without compromise. It's the Premium Health promise.

Phillipa Wilson
Founder & Managing Director of Premium Health

Our Trainers are Experienced Nurses and Paramedics	Passionate about sharing their experience
Premium Quality Programs	We pride ourselves on the depth of our course content and the quality of our training materials
Innovative Techniques, Empowering Outcomes	Methods remembered for years to come
Specialised Training, Contextualised to Your Workplace	Relevant and customised to workplaces

Welcome to your course and Premium Health.

The aim of this resource is to provide the essential knowledge and skills required in your training.

We select our Premium Health trainers and assessors carefully. All are either nurses or paramedics with appropriate training qualifications, technical expertise and experience.

ANAPHYLAXIS FIRST AID AND RISK MINIMISATION

WHAT YOU NEED TO KNOW ABOUT YOUR COURSE

Welcome

Welcome to your course and Premium Health. The aim of this resource is to provide the essential knowledge and details about the skills you require, firstly, to assist a person suffering an anaphylactic reaction until the arrival of medical assistance; and secondly, to develop risk minimisation and management strategies for allergic reactions and anaphylaxis.

Helping you to succeed in your course

We believe learning should be an enjoyable and challenging process and we understand that each learner is different. A variety of methods such as class participation, group discussion, scenarios, workbook exercises and opportunities for practice will help you to achieve competency.

We select our Premium Health trainers and assessors carefully. All are either registered nurses or paramedics with appropriate qualifications, technical expertise and experience in both education and emergency first aid care to enable them to provide you with training.

Course structure and award

The 22578VIC Course in First Aid Management of Anaphylaxis is a nationally recognised short course comprising two units:

- VU23090 Provide first aid management of anaphylaxis
- VU23091 Develop risk minimisation and risk management strategies for anaphylaxis

On 14 July 2008, the *Children's Services and Education Legislation Amendment (Anaphylaxis Management) Act 2008* came into effect amending the *Children's Services Act 1996* and the *Education and Training Reform Act 2006* requiring that all licensed children's services and schools have an anaphylaxis management policy in place. *Ministerial Order 706 - Anaphylaxis Management in Victorian Schools* outlines the requirements of a school Anaphylaxis Management Policy. Ministerial Order 706 comes into effect on 22 April 2014 and repeals Ministerial Order 90.

The contents of both units address the requirements of the Children's Services and Education legislation Amendment (Anaphylaxis Management) Act 2008, the Anaphylaxis Guidelines for Victorian Government Schools, Ministerial Order 706 (effective 22 April 2014) and Anaphylaxis Model Policy for Victorian Early Children's Services.

These two units may be undertaken separately.

Statement of Attainment and currency

A Statement of Attainment for the 22578VIC Course in First Aid Management of Anaphylaxis will be issued on successful completion of both units. The recommended best practice for refresher training of 22578VIC Course in First Aid Management of Anaphylaxis is that it occurs every 2 years.

Section 65 of the *Children's Services Regulations 2009* requires that all staff members on duty whenever children are being cared for or educated by the service to have undertaken training in administration of the adrenaline autoinjector device at least every 12 months.

Evaluation of the program

An evaluation form will be provided during the course. Your feedback is vitally important to us as we use this as part of our continuous improvement cycle. We especially value any personal comments you would like to make. Please complete the evaluation form at the end of your course.

Premium Health's customer service

We offer you an on-going service in relation to your course and invite you to call our office on 1300 721 292 or email us on customerservice@premiumhealth.com.au.

For more information about Premium Health and our health care, mental health and first aid courses, please access our website www.premiumhealth.com.au

Anaphylaxis management for licensed children's services

By 1 January 2012 each staff member employed, engaged, appointed or approved by the licensed children's services and all family day carers must complete first aid and anaphylaxis management training approved by the Secretary (Regulation 63 and 64). The Regulations clearly prescribe the elements that must be included in training.

The Regulations also continue to require that all staff on duty when there is a child diagnosed at risk of anaphylaxis and being cared for or educated in the service, must have undertaken anaphylaxis management training.

Annual training in administration of the adrenaline auto-injector device and CPR.

Annual training in the administration of the adrenaline auto-injector device is required for all staff members of licensed children's services whether or not there is a child diagnosed at risk of anaphylaxis.

A new requirement of the Children's Services Regulations 2009 is that staff having undertaken first aid training must undertake annual CPR training as well as the auto-injector device training and this training must be noted in staff records.

Monitoring of children's services

Authorised Officers of the Department of Education and Early Childhood Development (Children's Services Advisers) are required to inspect staff records as part of monitoring children's services, to ensure training has been undertaken.

The statement of attainment issued upon successful course completion by Premium Health, a registered training organisation, provides children's services and schools with the evidence training requirements have been met. For this reason, the RTO number and name, course code, title (and unit code and title if only one unit is undertaken), statement number and date of training should be recorded for each staff member so the information is available on request.

ANAPHYLAXIS AND ALLERGIC REACTIONS

WHAT IS AN ALLERGY?

An allergy is an abnormal response by the immune system to a substance that is usually harmless to most people. Allergies occur when the immune system produces antibodies against substances in the environment which are called allergens. Allergy or hypersensitivity reactions involve an inflammatory response that can affect the whole body or be localised. Symptoms of an allergic reaction includes skin rash, itchy eyes, lumps all over the body (such as rash-like hives). Most allergic reactions are mild like a rash or lump from a mosquito bite or sneezing from hay fever.

WHAT IS AN ALLERGEN?

An allergen is a substance that the immune system recognises as being a substance that may cause damage. The substance is usually ingested, injected, absorbed or inhaled by the body.

Ingested – Food and medicines are the most likely causes. Anaphylaxis can occur rapidly.

Injected – Stinging insects are the most common cause and includes insects such as bees.

Absorbed – Unlikely to cause anaphylaxis except in the form of latex used in gloves.

Inhaled – Pollens, dust mites, cat and dog dander and mould. Rarely causes anaphylaxis, but more often cause asthma and hay fever. These allergens stimulate a response from the immune system that presents itself in various ways, the most severe being anaphylaxis.

WHAT IS AN ALLERGIC REACTION?

Allergic reactions occur when the body's immune system reacts to a particular allergen. When these usually harmless substances cause an allergic reaction they are called allergens (or triggers). Common allergic triggers (allergens) include:

- food (peanuts, tree nuts, sesame, cow's milk, eggs, wheat, soybeans, fish and shellfish). Approximatively 10% of infants, 8% of children and 2% of adults in Australia have a food allergy
- insect stings (bees, ants and wasps) and tick bites
- medications including antibiotics (penicillin) and anaesthetic agents
- latex

In some people, other possibly unidentified allergens may trigger an allergic reaction and for others, exercise and alcohol are important co-factors. Any first aider or person attending an emergency should check if the casualty has a history of previous allergic reactions. The casualty may wear a MedicAlert or SOS bracelet or pendant. People who have a known allergy may carry prescribed medication in the form of tablets, syrup, a puffer or injection to use in case of a reaction. Once an allergy has developed, exposure to the particular allergen can result in symptoms from mild to life threatening. The most severe allergic reaction, anaphylaxis, is rare, but when it does occur it is life threatening and may be fatal. Typically anaphylaxis occurs within minutes. However it can be known to present several hours after contact with the allergen.

MILD – MODERATE ALLERGIC REACTIONS

A mild-moderate allergic reaction involves the skin and/or gastrointestinal tract without respiratory and/or cardiovascular involvement. This is not a life threatening reaction.

Skin

- generalised itchiness and/or redness
- raised, intensely itchy welts (red edges and pale centres) or hives
- tissue swelling (face, lips, eyes, not throat)
- in darker toned casualties, hives appear as raised lumps with reduced colour changes

Gastrointestinal

- abdominal pain
- vomiting
- loose bowel motions

Management

Initiate the first aid priority action plan (DRSABCD) and on recognition of a generalised allergic reaction:

- Implement casualty's Action Plan for generalised allergic reaction.
- Give first aid management appropriate to signs and symptoms present e.g. ice pack for itchiness and swelling.
- Do not leave casualty alone as reaction may progress to severe.
- Monitor the casualty continuously.
- If no signs of anaphylaxis, handover to parent/carer - communicate casualty's condition and treatment.
- Document incident as per workplace policies and procedures.

ACTION PLAN FOR ALLERGIC REACTIONS

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Allergic Reactions

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

1. _____

Mobile Ph: _____

2. _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises medications specified on this plan to be given according to the plan, as consented by the patient or parent/guardian, including use of adrenaline if available.

Whilst this plan does not expire, review is recommended by DD/MM/YY

Signed: _____

Date: _____

Note: This ASCIA Action Plan for Allergic Reactions is for people who have allergies but do not have a prescribed adrenaline (epinephrine) injector. For instructions refer to the device label or the ASCIA website www.allergy.org.au/anaphylaxis

Adrenaline injectors are given as follows:

- 150 mcg for children 7.5-20kg
- 300 mcg for children over 20kg and adults
- 300 mcg or 500 mcg for children and adults over 50kg

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person and call for help
- Give antihistamine (if prescribed) _____
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult or noisy breathing**
- **Swelling of tongue**
- **Swelling or tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- **If unconscious or pregnant, place in recovery position - on left side if pregnant, as shown below**
- **If breathing is difficult allow them to sit with legs outstretched**
- **Hold young children flat, not upright**

2 GIVE ADRENALINE INJECTOR IF AVAILABLE

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE INJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS GIVE ADRENALINE INJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

Note: If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

ACTION PLAN FOR ANAPHYLAXIS

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

Name: _____

Date of birth: _____

For use with EpiPen® adrenaline (epinephrine) autoinjectors

Confirmed allergens:

Family/emergency contact name(s):

1. _____

Mobile Ph: _____

2. _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises medications specified on this plan to be given according to the plan, as consented by the patient or parent/guardian.

Whilst this plan does not expire, review is recommended by DD/MM/YY

Signed: _____

Date: _____

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person, call for help and locate adrenaline autoinjector
- Give antihistamine (if prescribed) _____
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

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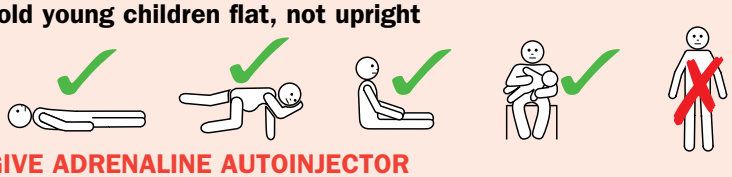
ACTION FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- **If unconscious or pregnant, place in recovery position - on left side if pregnant, as shown below**
- **If breathing is difficult allow them to sit with legs outstretched**
- **Hold young children flat, not upright**



2 GIVE ADRENALINE AUTOINJECTOR

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

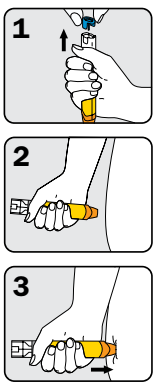
5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE AUTOINJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

How to give EpiPen®



1. Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE
2. Hold leg still and PLACE ORANGE END against outer mid-thigh (with or without clothing)
3. PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds REMOVE EpiPen®

EpiPen® is prescribed as follows:

- **EpiPen® Jr (150 mcg) for children 7.5-20kg**
- **EpiPen® (300 mcg) for children over 20kg and adults**

ALWAYS GIVE ADRENALINE AUTOINJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

Note: If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

SEVERE ALLERGIC REACTION – ANAPHYLAXIS

Anaphylaxis is a rapidly progressive and severe allergic reaction which affects several parts of the body at once. It is a life threatening condition. Anaphylaxis needs to be recognised as a medical emergency and responded to immediately. Anaphylaxis is characterised by respiratory and/or cardiovascular involvement. The only suitable treatment for Anaphylaxis is adrenaline which can be administered by the casualty or the first aider via an auto-injector. As mentioned, typically anaphylaxis occurs within minutes. However it can be known to present several hours after contact with the allergen.

Respiratory

- difficulty breathing or
- noisy breathing
- swelling, itchiness and tingling of the tongue
- swelling or tightness in the throat
- difficulty talking and/or a hoarse voice
- wheeze or persistent cough
- in crying infants and young children there may be a change in the character of the cry

Cardiovascular

- loss of consciousness
- collapse
- pale and floppy (in young children)

In some cases, anaphylaxis may be preceded by less dangerous allergic symptoms such as:

- hives or welts
- swelling of face, lips or eyes
- abdominal pain and vomiting

Causes

The common allergens triggering anaphylaxis include:

- food – peanuts, tree nuts (e.g. hazelnuts, cashews, almonds), sesame, egg, cow's milk, wheat, soy, seafood
- insect stings and tick bites particularly bees, ants and wasps
- medications including antibiotics (e.g. penicillin) and anaesthetic agents

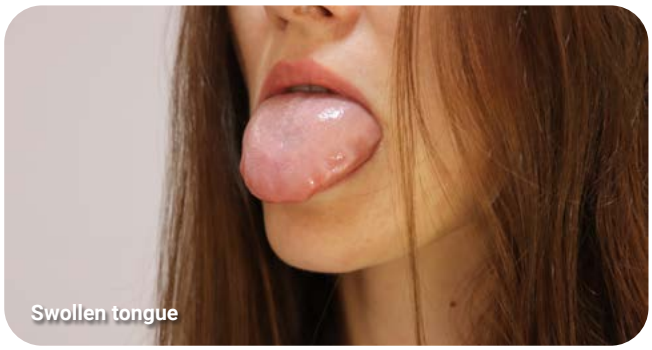
Management

People with diagnosed allergies should avoid all triggers/ confirmed allergens and have a readily accessible Anaphylaxis action plan and medical alert device. The injection of adrenaline is the first line drug treatment in life threatening Anaphylaxis. If the casualty's signs and symptoms suggest Anaphylaxis, the following steps should be followed:

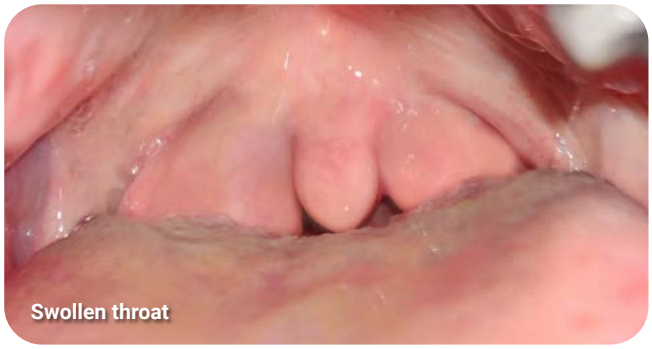
- Initiate the first aid priority action plan (DRSABCD) which may include the following actions if conscious or unconscious.
  - Allow casualty to sit on floor (especially if breathing is difficult) or lie down (do not stand or walk).
  - When seated or lying on the floor (not in chair) make sure the legs of the casualty are outstretched in front of them.
  - Hold an infant horizontally in arms or lie on a table.
  - The left side lying position is recommended for patients who are pregnant.
  - Prevent further exposure to the trigger if possible.
  - Stay with casualty and call for help.

Implement casualty's ASCIA Action Plan for Anaphylaxis

- Administer adrenaline via auto-injector (bring medication to casualty, do not move them).
- Call an ambulance (triple zero 000) and monitor the casualty continuously.
- Administer oxygen (if trained to administer) and/or asthma medication for respiratory symptoms. Further adrenaline should be given if there is no response after 5 minutes.
- Handover to relieving ambulance or medical personnel. Communicate casualty's condition and treatment.
- Document incident.
- If breathing stops, commence CPR.

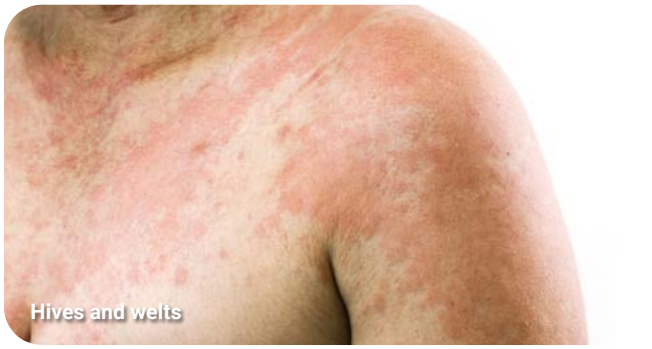

Swollen tongue

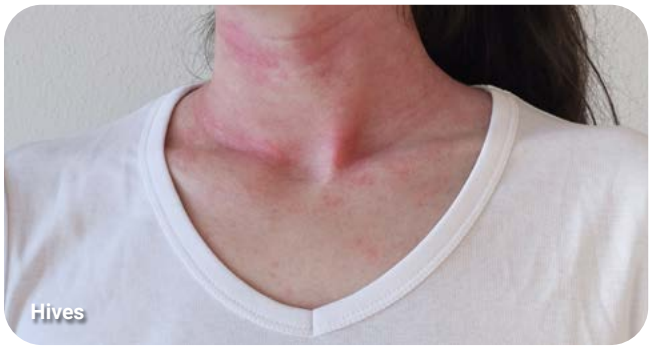

Swollen tongue


Swollen throat


Swollen eyes


Swollen face and lips


Hives and welts


Hives

FOOD AND ANAPHYLAXIS

Although allergic reactions to food are common in children, severe life-threatening reactions are uncommon and deaths are rare.

- the majority of food allergic reactions, even to highly allergenic foods such as peanuts, are not anaphylactic
- in Australia, the prevalence of food-induced anaphylaxis in pre-school age children was 1 in 170 and in school-age children was 1 in 1900
- a report from 2014 stated that 10% of infants in Australia suffer from food allergies,- one of the highest incidences in the world
- however, more than 9 in 10 fatal anaphylactic food reactions have occurred in children aged 5 years and older. This indicates the importance of food avoidance for those school-age children considered to be at risk of anaphylaxis
- Allergy and Anaphylaxis Australia in July 2021 suggests approximately 10% of infants, 6% of children and 2% of adults have a food allergy, including anaphylaxis
- while egg, peanut and milk are the most common food allergies, peanuts and tree nuts are the most likely foods to cause fatal anaphylaxis. As a result, schools, pre-schools and child-care services may implement specific risk-minimisation strategies for nut products, but not other allergens (e.g. removal of nut products from the school canteen)
- anaphylaxis is very unlikely to occur from skin contact to foods or exposure to food odours, however it is possible
- while adverse reactions to medications are common, allergic reactions to medications are rare, and most often occur in hospitals

EXERCISE AND ANAPHYLAXIS

School teachers and coaches supervising sporting activities need to be aware that a relationship between exercise and anaphylaxis may exist in some allergic “at risk” individuals:

Exercise-induced anaphylaxis typically affects young adults. Manifestations include itch, bronchospasm, urticaria/angioedema, sweating, syncope, gastrointestinal symptoms and nasal congestion. Some people experience symptoms with exercise alone, whilst others will only do so if allergenic foods are ingested around the same time.

The syndrome of food and exercise-induced anaphylaxis usually occurs during exercise. Less commonly, symptoms are triggered when the allergenic food is ingested following exercise.

- foods implicated in this syndrome include wheat and other cereals, celery, seafood, nuts, fruit and some vegetables
- the severity of symptoms is generally influenced by the amount of food ingested, the vigour of exercise and the time between the two. Thus severe symptoms are usually due to food eaten only a few hours earlier

(Extract: *Australian Society of Clinical Immunology and Allergy*).

DEALING WITH ANAPHYLAXIS

The steps in dealing with anaphylaxis are: identify, avoid and manage.

Identify – the trigger factor and remove it if possible and safe to do so

Avoid – the allergen. To assist in allergy avoidance, it’s best to develop a ‘Risk Minimisation Plan’

Manage – an anaphylactic reaction if it was to occur

TREATING ANAPHYLAXIS

Adrenaline is a natural hormone that is produced in the body but when we have anaphylaxis, we don't have enough adrenaline to reverse the signs and symptoms.

When injected, adrenaline rapidly reverses the effects of anaphylaxis by reducing throat swelling, opening the airways, and maintaining heart function and blood pressure.

Adrenaline is the most effective first aid treatment and should be given as soon as the signs and symptoms of anaphylaxis are recognised. It is given by injection into the muscle of the outer mid-thigh. Antihistamines will not treat a severe allergic reaction or prevent a severe allergic reaction from developing if given to someone once the reaction has started.

ADMINISTRATION OF INJECTABLE ADRENALINE

Adrenaline is given by injection into the muscle of the outer mid-thigh.

Adrenaline

The adrenaline used in controlled dose auto-injecting devices treats allergic emergencies.

Adrenaline is a medication which:

- narrows abnormally wide blood vessels
- makes the heart beat strongly

These effects help to improve the very low blood pressure and poor circulation that occurs in anaphylaxis.

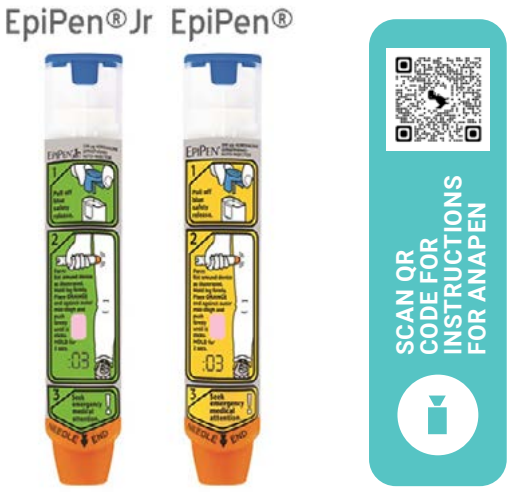
Adrenaline also:

- opens the air tubes in the lungs. This eases breathing and lessens wheezing
- helps stop swelling, for example, of the face and lips, skin rash and itching
- maintains blood pressure

EpiPen® adrenaline auto-injectors

Adrenaline auto-injectors are simple to operate, they:

- provide life-saving first aid medication
- may be self-administered or administered by a carer/ teacher/first aider
- automatically inject a pre-measured dose of adrenaline
- adrenaline in an auto-injector begins working in about 2 minutes
- are for single use only
- must be kept in a cool dry place where temperature stays below 25c (not to be refrigerated or frozen)
- should not be used if solution is cloudy, coloured or sediment is present or if beyond its expiry date or if the viewing window shows red (red means the adrenaline auto-injector has already “fired” and cannot be used again



IMPORTANT: if someone with known asthma and allergies has sudden breathing difficulties ALWAYS administer adrenaline first and then asthma reliever puffer second.

EpiPen®

The EpiPen® delivers one 0.3 mL dose of adrenaline (epinephrine). This dose provides 0.3 mg of adrenaline. Although these auto-injectors contain 2 mL of adrenaline 1:1,000 solution, the auto-injector cannot be re-used even though some adrenaline remains after injecting. This dosage is prescribed for children and adults weighing over 20 kg (ASCIA recommendation) or 30 kg (Pharmaceutical Benefits Scheme (PBS) recommendation). The dosage will be determined by the prescribing physician. The EpiPen® is yellow in colour.

EpiPen Jr®

EpiPen Jr® delivers one 0.3 mL dose of adrenaline (epinephrine). This dose provides 0.15 mg of adrenaline. Although these auto-injectors contain 2 mL of adrenaline 1:2,000 solution the auto-injector cannot be re-used even though some adrenaline remains after injecting. This dosage is prescribed for children weighing between 7.5 - 20 kg (ASCIA recommendation). The dosage will be determined by the prescribing physician. The EpiPen® Jr is green in colour.

Adrenaline side effects

There are no contra-indications to the use of adrenaline for anaphylaxis. The risk of NOT giving adrenaline far outweighs the potential risk of giving adrenaline. It is very rare for children to suffer any serious side effects from the administration of adrenaline via an auto-injector. The auto-injector contains adrenaline which is a naturally occurring hormone. Short-lived pallor is common due to the medicine acting on the blood vessels. Other symptoms which may occur include shaking, anxiety, palpitations, headache and nausea. These symptoms only last for a short time and are not serious.

Storage and accessibility

In children's services, for example at a child care centre or kindergarten, parents/carers are required to provide their "at risk" child with their own adrenaline auto-injector kit comprising an insulated container, for example, an insulated lunch pack containing:

- the child's in-date adrenaline auto-injecting device
- a copy of the child's ASCIA Action Plan for Anaphylaxis used in developing the centre or school's anaphylaxis management plan
- telephone contact details for the child's parents/ guardians, the doctor/medical service and the person to be notified in the event of a reaction if the parents/ guardian cannot be contacted
- any other medications such as an antihistamine if prescribed as per the ASCIA action plan

In schools, parents/carers are required to provide the student's in-date adrenaline auto-injecting device and an ASCIA Action Plan for Anaphylaxis completed by the doctor. The action plan is used along with other information to compile the student's anaphylaxis management. The adrenaline auto-injector is labelled with the student's name and stored along with their anaphylaxis management plan in an unlocked, easily accessible place and both are taken on all excursions and school camps. Schools are required to purchase generic adrenaline auto-injectors as backup to students' own injectors, and this should be done especially where there is no single, central, easily accessible location on the school site, multiple campuses, or for activities away from school, such as excursions and camps – see Anaphylaxis Guidelines: A resource for managing severe allergies in Victorian government schools 2016.

Giving an adrenaline auto-injector to a child

When giving an adrenaline auto-injector to a child it is important to hold them securely as they are likely to move or pull away. If the needle comes out of the child's leg before the full dose of adrenaline is administered it cannot be reinserted. Keep in mind that there is only one dose per auto-injector.

Disposal of an adrenaline auto-injector

Adrenaline auto-injectors cannot be reused even if some adrenaline remains inside the device. The used adrenaline auto-injector should be placed in a container, labelled clearly with the time it was given and then handed over to the ambulance. Do not throw the adrenaline auto-injector away. To dispose of an adrenaline auto-injector safely:

- carefully place the used EpiPen® orange tip first into the protective tube (puncture proof)
- place the tube in a container and write time adrenaline auto-injector was administered on the outside of the container. If no container available, write time on protective tube
- give the used adrenaline auto-injector to the ambulance officer or attending medical personnel to accompany the casualty to hospital for safe disposal

Expiry checking routine

The shelf life of adrenaline auto-injectors is normally around 12 – 18 months from date of manufacture. A checking routine should be put in place to ensure that all adrenaline auto-injectors are within their expiry date, wherever these are located - at home, within children's services organisations or schools. Marking the expiry date found on the side of each device on a calendar will assist in prompting replacement prior to the due date. Do not discard an expired auto-injector before a replacement auto-injector has been obtained

WHAT SHOULD YOU DO WHEN ANAPHYLAXIS OCCURS AND THE ADRENALINE AUTO-INJECTOR HAS EXPIRED?

Expired adrenaline auto-injectors are not as effective when used for treating anaphylaxis. However, a recently expired adrenaline auto-injector should be used in preference to not using one at all. An EpiPen® has a clear window near the tip where you can check the colour of the drug – if it is clear (not brown or cloudy or containing sediment) it should be safe to use.

EPIPEN® INSTRUCTIONS

To use auto-injector:

1	Check area prior to administration. Beware of items in pockets, seams of trousers, etc. which may be a barrier to administration.
2	Grasp with hand around the auto injector (make a fist) with the orange tip pointed downwards (orange to the thigh, blue to the sky).
3	Pull off blue cap (do not put thumb over end).
4	Place orange tip against mid outer thigh. **Do not inject into buttocks.**
5	Firmly push against mid outer thigh at a 90 degree angle until a click is heard **(Auto-injector is designed to work through clothing).**
6	Hold **firmly against thigh** for 3 seconds to deliver adrenaline. The injection is now complete.
7	Remove auto-injector from thigh (the orange needle cover will automatically extend to cover needle).
8	Call triple zero (000) and seek immediate medical attention.
9	Further adrenaline doses may be given if there is no improvement after 5 minutes or if instructed by the triple 000 operator.
10	Ensure used auto-injector is transported with casualty.

OTHER INJECTABLE ADRENALINE DEVICES (ANAPEN)

What is the Anapen?

Anapen® is a pre-filled syringe of adrenaline (epinephrine) contained in an auto-injection device for the immediate emergency treatment of severe allergic reaction (e.g.: anaphylaxis).

This medicine is for emergency use only and patients or carers should call emergency assistance on 000 after the Anapen® injection, even if symptoms appear to be improving.

You should always carry two Anapen® devices to ensure the recommended dose can be given. In the event one adrenaline dose is not enough to effectively treat the reaction, or the device doesn't function as intended, be prepared to administer a second dose.

It is important to do your best to keep your adrenaline autoinjector between 15 and 25°C in case of an allergic reaction. Obviously weather conditions in Australia are challenging but our aim is to minimise the amount of time the device is outside this temperature range. If you know you are going to be out in the sun for an extended time on a hot day (e.g. at the beach, camping or at a sporting event or when working outside) consider purchasing a MedActiv Easybag which can help maintain the adrenaline autoinjector device at the correct temperature for up to 5 days.

Anapen Dosages

Anapen Junior
150mcg Adrenaline (For children 7.5-20kg)

Anapen Child
300mcg Adrenaline (For children over 20kg and Adults)

Anapen Adult
500mcg Adrenaline (For children and Adults over 50kg)

ANAPEN INSTRUCTIONS

It is <u>NOT</u> the same as an EpiPen.

1. Remove the black needle shield by pulling hard in the direction of the arrow. This also removes the rigid protective needle shield.

2. Remove the grey safety cap from the red firing button by pulling as indicated by the arrow.

3. Hold the open end (needle end) of the Anapen® against the outer part of the thigh. If necessary, Anapen® can be used through light clothing, such as denim, cotton or polyester, avoiding any seam areas or pockets. *NB: Anapen® auto-injector is intended only for intramuscular use. Only administer into the outside of the thigh muscle, nowhere else.*

4. Press the red firing button so that it clicks. Keep holding the Anapen® auto-injector against the outer thigh for 3 seconds, then slowly remove it from the thigh.

5. The injection indicator will have turned red. This shows that the injection is complete. If the injection indicator is not red, injection must be repeated with a new Anapen®.

6. After the injection, the needle sticks out. To cover it, click the wide end of the black needle shield back on the open end (needle end) as indicated by the arrow.

7. Immediately after use, inform triple zero 000 that the casualty is suffering from anaphylaxis.". Advise the paramedic that an Anapen® has been administered into the thigh muscle and show them the product box for more information.

MANAGEMENT OF ALLERGIC REACTIONS AND ANAPHYLAXIS

A First Aid Priorities Action Plan should direct all actions taken in managing any life-threatening emergency. This means the actions associated with and the key steps relating to:

D	Assess for Danger
R	Assess casualty's Response and if unconscious
S	Send/call for help (triple zero 000) immediately
A	Assess Airway
B	Assess Breathing and if not breathing
C	Compressions should be applied and continued with 2 breaths (30:2 x 5 cycles per minute)
D	Defibrillator should be used immediately if available

When the incident scene is safe and anaphylaxis is immediately recognised, the instructions on the casualty's Action Plan for Anaphylaxis should be implemented – specifically adrenaline should be given and the ambulance called.

Recognising anaphylaxis is easier when a history of anaphylaxis is known and the signs and symptoms are obviously linked to a possible exposure to an allergen, such as ingesting a specific food or being stung by an insect.

ASCIA ACTION PLANS FOR ANAPHYLAXIS

Each person at risk should be provided with a written ASCIA action plan for anaphylaxis by their allergy specialist or doctor. The plan lists the person's known allergies, signs and symptoms and actions to be taken when exposed and anaphylaxis is present, such as giving an adrenaline auto-injector.

The Australian Society of Clinical Immunology and Allergy (ASCIA) provide personal Action plans for anaphylaxis, specific for the use of an EpiPen® or EpiPen® Jr.

ASCIA also provide an action plan for allergic reactions (for use when no adrenaline auto-injector has been prescribed).

Generic Action plans for Anaphylaxis which are useful for notice boards, staff room, first aid kits and rooms are also available on the ASCIA website - **www.allergy.org.au.**

ACTION PLAN FOR EPI-PEN

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

Name: _____

Date of birth: _____

For use with EpiPen® adrenaline (epinephrine) autoinjectors

Confirmed allergens:

Family/emergency contact name(s):

1. _____

Mobile Ph: _____

2. _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises medications specified on this plan to be given according to the plan, as consented by the patient or parent/guardian.

Whilst this plan does not expire, review is recommended by DD/MM/YY

Signed: _____

Date: _____

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person, call for help and locate adrenaline autoinjector
- Give antihistamine (if prescribed) _____
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

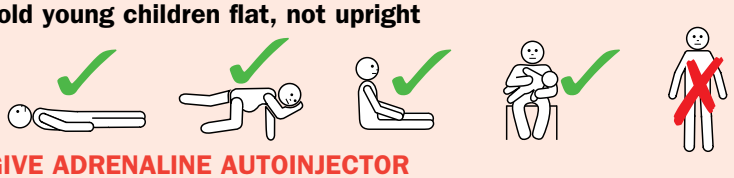
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult or noisy breathing**
- **Swelling of tongue**
- **Swelling or tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- **If unconscious or pregnant, place in recovery position - on left side if pregnant, as shown below**
- **If breathing is difficult allow them to sit with legs outstretched**
- **Hold young children flat, not upright**



2 GIVE ADRENALINE AUTOINJECTOR

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

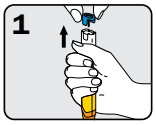
5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

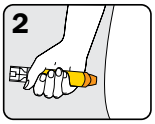
IF IN DOUBT GIVE ADRENALINE AUTOINJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

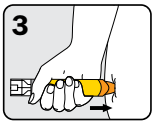
How to give EpiPen®



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



Hold leg still and PLACE ORANGE END against outer mid-thigh (with or without clothing)



PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds REMOVE EpiPen®

EpiPen® is prescribed as follows:

- **EpiPen® Jr (150 mcg) for children 7.5-20kg**
- **EpiPen® (300 mcg) for children over 20kg and adults**

ALWAYS GIVE ADRENALINE AUTOINJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

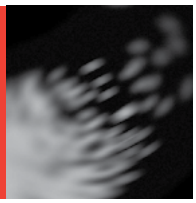
Asthma reliever medication prescribed: ☐ Y ☐ N

Note: If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

ACTION PLAN FOR ANAPEN

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis



For use with Anapen® adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

1. _____

Mobile Ph: _____

2. _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

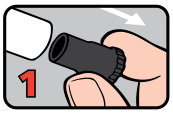
The treating doctor or np hereby authorises medications specified on this plan to be given according to the plan, as consented by the patient or parent/guardian.

Whilst this plan does not expire, review is recommended by DD/MM/YY

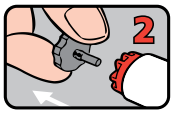
Signed: _____

Date: _____

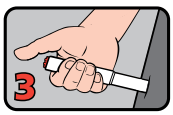
How to give Anapen®



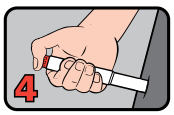
PULL OFF BLACK NEEDLE SHIELD



PULL OFF GREY SAFETY CAP from red button



PLACE NEEDLE END FIRMLY against outer mid-thigh at 90° angle (with or without clothing)



PRESS RED BUTTON so it clicks and hold for 3 seconds. REMOVE Anapen®

Anapen® is prescribed as follows:

- **Anapen® 150 Junior for children 7.5-20kg**
- **Anapen® 300 for children over 20kg and adults**
- **Anapen® 500 for children and adults over 50kg**

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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- Tingling mouth
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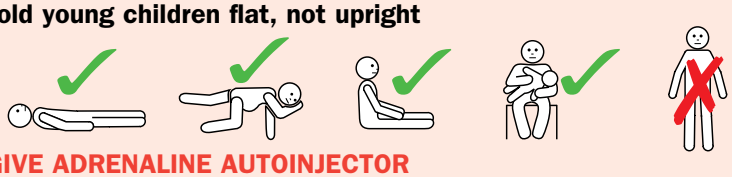


2 GIVE ADRENALINE AUTOINJECTOR

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE AUTOINJECTOR

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS GIVE ADRENALINE AUTOINJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

Note: If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre. Continue to follow this action plan for the person with the allergic reaction.

EMERGENCY FIRST AID CHECKLIST FOR ANAPHYLAXIS MANAGEMENT

1. Respond to the situation

The situation is assessed in a manner that recognises an urgent response is required and:

D: Manage DANGERS - Identify physical hazards and immediate risks to self, casualty and others, and minimise, remove or isolate identified hazards/ immediate risks using established first aid principles and procedures e.g.

- Where a sting is identified, check for presence of insects e.g. more bees.
- If sting is seen flick it out immediately – scrape sideways do not squeeze.
- Establish casualty's responsiveness whilst assessing casualty.
- Call for casualty's adrenaline auto-injector and ASCIA Action Plan for Anaphylaxis if risk known.
- Prepare to give auto-injector immediately when anaphylaxis signs are recognised.
- Do not move casualty unless in immediate danger (e.g. if situated near a beehive).
- Position on floor lying flat, may sit but do not allow to stand.

Assess the casualty

R: Determine casualty's RESPONSE - Assess conscious state.

- **Consciousness** - seek information about incident from casualty and/or from witnesses – check anaphylaxis status if not yet known.
- **Unconsciousness.**

S: Send call triple zero 000.

A: Assess AIRWAY – is it clear or obstructed, is the throat swollen?

B: Assess BREATHING - interpret signs and symptoms and either:

- **Breathing is satisfactory** - conclude mild-moderate allergic reaction where skin – gastrointestinal signs and symptoms exist and there is no history of an insect sting – follow ASCIA Plan, manage the situation, monitor casualty continuously, prepare for anaphylaxis.

or

- **Breathing is present and patient unconscious -** place casualty in recovery position on side, manage the situation, monitor casualty continuously.

or

- **Breathing is difficult** - conclude anaphylaxis – follow ASCIA plan, give adrenaline auto-injector immediately if available or administer as soon as it arrives on scene, call or direct someone to call ambulance, manage the situation, monitor casualty continuously.

or

- **Breathing is absent and other signs of collapse** - concludes anaphylaxis and cardiac arrest – follow ASCIA Plan - give adrenaline, call or direct someone to call ambulance, give CPR.

C: Assess CIRCULATION – check colour and warmth if conscious/other signs of life if not breathing.

2. Provide first aid treatment for anaphylactic reaction (follows ASCIA Plan for Anaphylaxis)

3.Communicate details of incident

- Direct someone to get casualty's adrenaline auto-injector and ASCIA Action Plan for Anaphylaxis from designated location if not already done OR use one from first aid kit if has one.
- **If not already done - give or assist casualty to give adrenaline auto-injector as soon as available** - note time of administration.
- Repeat adrenaline dose if no response after 5 minutes and another auto-injector is available.
- If a sting is seen **flick it out immediately** – scrape sideways do not squeeze (do not remove ticks) and apply an icepack from first aid kit if available.
- Monitor casualty continuously for further or worsening signs of anaphylaxis e.g. increased breathing difficulty, signs of shock, change in conscious state/ unconsciousness.
- Prepare to commence CPR.
- Hand casualty and auto-injector pen/s over to ambulance officer or attending medical personnel - communicate details of incident, casualty's condition and treatment given.
- Document incident in workplace incident record, as per workplace policies and guidelines.

4. Evaluate the first aid response to anaphylactic reaction after the event

- Assess the first aid treatment given against centre/ school's/organisation's procedures.
- Compare response to casualty's ASCIA Action Plan for Anaphylaxis.
- Assess response in relation to need to change the workplace's risk management strategies.
- Identify aspects for improvement and/or further development of skills and knowledge.

RISK MINIMISATION AND MANAGEMENT

SCHOOL ANAPHYLAXIS MANAGEMENT POLICY

If a school has an enrolled student at risk of anaphylaxis, it must have a school anaphylaxis management policy. The policy must contain all of the following matters:

- A statement that the school will comply with the Ministerial Order 706 and the guidelines on anaphylaxis management as published by the Department of Education.
- Information about the development, implementation, monitoring and regular review of Individual Anaphylaxis Management Plans for affected students, which include an individual ASCIA Action Plan for Anaphylaxis.
- Information and guidance in relation to the school's management of anaphylaxis, including:
  - prevention strategies to be used by the school to minimise the risk of an anaphylactic reaction
    - school management and emergency response procedures that can be followed when responding to an anaphylactic reaction
  - the circumstances under which Adrenaline Autoinjectors for general use must be purchased by the school
  - a communication plan that ensures that all school staff (including volunteers and casual staff), students and parents are provided with information about anaphylaxis and the school's anaphylaxis management policy
  - identification of school staff who must complete certain training, and the procedures for the training
    - completion of an annual risk management checklist

INDIVIDUAL ANAPHYLAXIS MANAGEMENT PLANS

The principal of the school is responsible for ensuring that an Individual anaphylaxis management plan is developed for each student who has been diagnosed by a Medical Practitioner as having a medical condition that relates to an allergy and the potential for anaphylactic reaction, where the school has been notified of that diagnosis. The plan is to be developed in consultation with the student's parents.

The plan must be in place as soon as practicable after the student enrols, and where possible, before the student's first day of school.

An individual anaphylaxis management plan must set out the following:

- Information about the student's medical condition that relates to allergy and the potential for anaphylactic reaction, including the type of allergy/allergies the student has (based on a written diagnosis from a Medical Practitioner).
- Strategies to minimise the risk of exposure to known and notified allergens while the student is under the care or supervision of school staff, for in-school and out-of-school settings including in the school yard, at camps and excursions, or at special events conducted, organised or attended by the school.
- The name of the person responsible for implementing the strategies.
- Information on where the student's medication will be stored.
- The student's emergency contact details, including doctor.
- An ASCIA action plan.

Each student's individual plan should be kept in various locations around the school that it is easily accessible by school staff in the event of an incident.

The school's anaphylaxis management policy requires the Principal to review an Individual anaphylaxis management plan in consultation with the students' parents in all the following circumstances:

- Annually.
- If the student's medical condition changes.
- As soon as practicable after the student has an anaphylactic reaction at school
- When the student is to participate in an off-site activity, such as camps and excursions, or at special events conducted, organised or attended by the school.

RISK MINIMISATION

Under the Ministerial Order 706, a school's anaphylaxis management policy must include prevention strategies used by the school to minimise the risk of an anaphylactic reaction.

The key to preventing anaphylaxis in childcare services, schools and workplaces lies:

- In knowing who is at risk.
- Being aware of their specific allergic triggers or allergens and
- Preventing exposure to these.
- Knowing and being able to give first aid to someone experiencing anaphylaxis.

In Victoria, the *Children's Services and Education Legislation Amendment Anaphylaxis Management Act 2008* came into effect in July 2008. This Act specifies the minimum safety standards to which children's services and schools must adhere to protect children and young people diagnosed at risk of anaphylaxis.

To minimise and manage the risk of anaphylaxis (under the Victorian legislation) schools, preschools, child care centres and other children's services are required to:

- Establish an Anaphylaxis Management Policy.
- Identify children/students at risk of anaphylaxis and ensure each has an Individual anaphylaxis management plan incorporating an ASCIA Action Plan for Anaphylaxis written by their doctor specifying allergic triggers and a medical management plan.
- The anaphylaxis management policy must include prevention strategies used by the school to minimise the risk of anaphylaxis.
- Implement the anaphylaxis prevention strategies specified in the plan.
- Train relevant staff to recognise and respond to anaphylaxis, including being able to give an adrenaline auto-injector.
- Implement a communication plan to raise anaphylaxis awareness within the centre, school and workplace community.

DEVELOPING A RISK MINIMISATION PLAN

Risk minimisation is the practice of reducing risks to a child, student, worker or individual at risk of anaphylaxis. This is done by assessing and rating the risks then minimising the risks by removing, as far as practicable, major sources of allergens from the particular environment and developing strategies to reduce the risk of and manage an anaphylactic reaction.

For individuals known to be at risk of anaphylaxis, it is important that the organisation conducts an assessment of the potential for accidental exposure to the allergen(s) and the level of risk specific to those individuals . This may be best done using a risk assessment matrix – see below. This assessment and the preparation of a risk management, minimisation plan should be carried out in consultation with parents/carers, child/at risk individuals and all other relevant stakeholders:

- workplace first aiders
- management
- unions
- students
- teachers
- casual staff
- specialist staff
- early childhood staff such as caterers, canteen staff
- school camp providers
- volunteers
- employers and the broader community

A risk management plan should be prepared for the whole of the organisation and the range of activities undertaken in in-school/children's services environments and out of school/children's services environment including:

- art, craft
- cooking
- science
- incursions
- canteens
- class parties
- special event days
- sports carnivals
- excursions
- camps etc.

COMMON ANAPHYLAXIS ALLERGEN CATEGORIES

Triggers of severe allergic reactions/anaphylaxis may be, however they are not limited to:

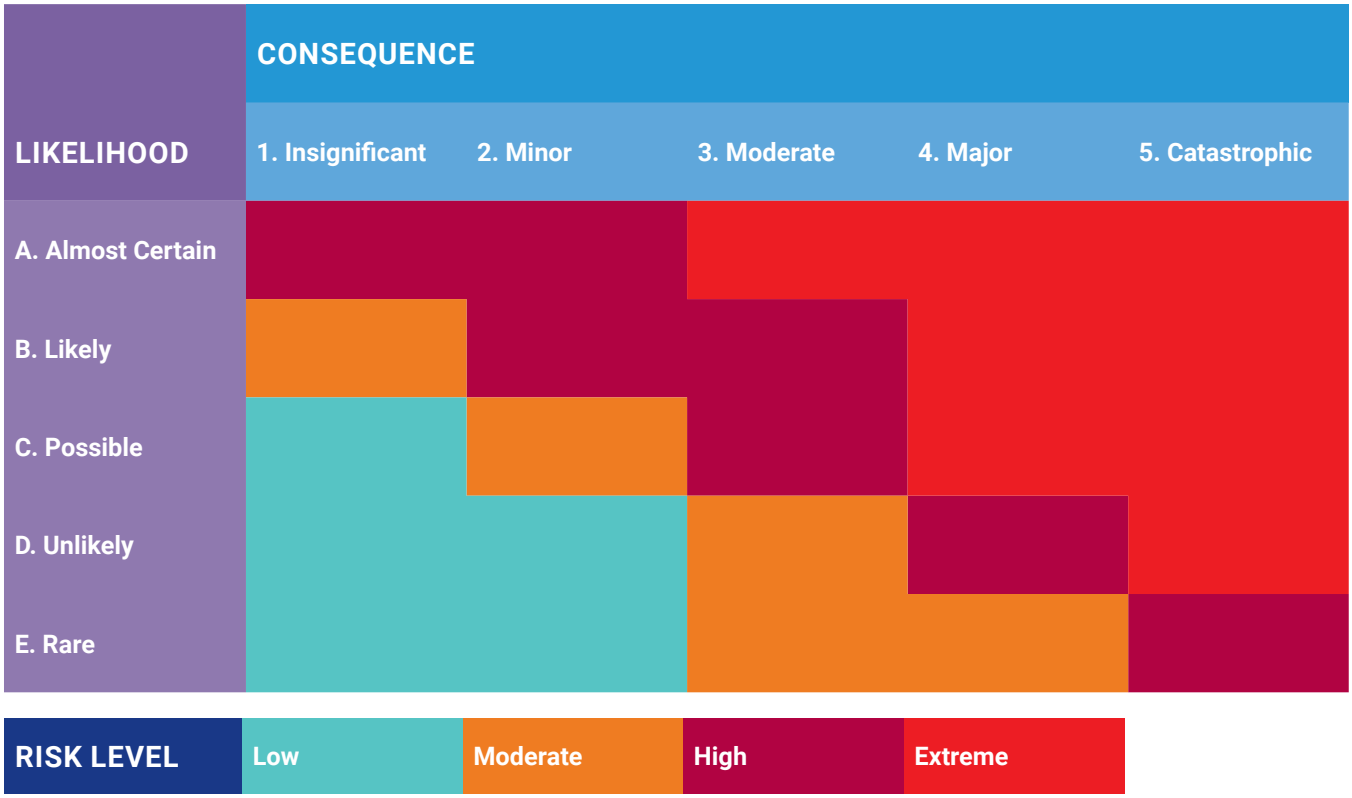
- foods including:
  - peanuts
  - tree nut
  - egg
  - cow's milk
  - wheat
  - soy
  - fish and shellfish
- insect bites
- medications, including antibiotics and anaesthetic agents

RISK ASSESSMENT MATRIX TOOL

CONSEQUENCE SCALE	
1. Insignificant	Only minor first aid treatment, no injury or a near miss incident
2. Minor	Medical treatment injury
3. Moderate	Serious but not permanent injury LTI
4. Major	Single fatality (death) or permanent disability
5. Catastrophic	Multiple fatalities (deaths), permanent disability or illness

LIKELIHOOD SCALE	
A. Almost Certain	Experience and data indicate the event has happened repeatedly which makes it highly likely the event will happen again
B. Likely	Experience/information suggest that the event has happened before and the event is likely to happen again
C. Possible	Information suggests that the event may occur
D. Unlikely	The event is foreseeable in theory only but has only occurred seldom
E. Rare	The event has never been known to occur

RISK ASSESSMENT MATRIX



The key questions which need to be asked when developing or reviewing a risk minimisation plan are:

- How well has the organisation planned for meeting the needs of allergic individual(s) at risk of anaphylaxis?
  - does the organisation have an Anaphylaxis management plan in place?
    - who are the "at risk" individuals?
    - what are they allergic to?
    - does everyone recognise the "at risk" individuals?
- Do families (parents/carers), the worker(s) and staff know how the organisation manages the risk of anaphylaxis?
- Do staff know how the organisation aims to minimise the risk of each individual being exposed to the specific allergen(s) to which he or she is allergic?
- Do staff know the strategies to be implemented that are identified in the risk minimisation plan?
- Do the relevant people know what actions to take if the individual has an anaphylactic reaction?
- How effective is the organisation's risk minimisation plan and is it reviewed and updated regularly?

RESOURCES FOR PREPARING A RISK MANAGEMENT PLAN

Further information concerning Children's Services Anaphylaxis Regulations is available at **https://www.education.vic.gov.au/childhood/providers/regulation/Pages/which.aspx**

ASCIA GUIDELINES FOR PREVENTION OF ANAPHYLAXIS

The four steps in the prevention of food anaphylactic reactions in children at risk in schools, preschools and child care centres presented in the ASCIA guidelines for prevention of anaphylaxis in schools, pre-schools and childcare:

2012 updates are:

- obtaining medical information about children at risk of anaphylaxis by the school, pre-school or childcare personnel
- staff training about how to recognise and respond to a mild, moderate or severe allergic reaction, including training in the use of adrenaline autoinjector devices
- implementation of practical strategies to avoid exposure to medically confirmed allergens
- age-appropriate education of children with severe allergies and their peers

With obvious modifications, these steps can be used by allergic adults.

Obtaining medical information about children at risk of anaphylaxis involves

- an ASCIA Action plan for Allergic Reactions or an ASCIA Action Plan for Anaphylaxis, completed and signed by a registered medical practitioner or authorised person
- the ASCIA Action Plan for Anaphylaxis including:
  - identification of the child (photo)
  - documentation of confirmed allergens
  - documentation of the first aid response including any prescribed medication
  - name and contact details of the medical practitioner or authorised person who has completed and signed the ASCIA Action Plan
  - contact details of the parents or guardians
- a signed Action Plan for Anaphylaxis containing photo identification of the child is considered sufficient medical confirmation for schools, pre-schools and childcare services
- updated information should be provided to schools by parents and it is important that schools, pre-schools or childcare services ensure that the medical information is updated
- staff should have a face-to-face meeting with the parents or guardians of each child at risk of anaphylaxis to discuss appropriate risk minimisation strategies. In high schools, this meeting may also include the allergic child, particularly in upper high school

(1) **Staff training and how to recognise and respond to an allergic reaction**

- Recognition of the risk and understanding the steps that can be taken to minimise allergens relating to anaphylaxis by all those responsible for the care of children in schools, pre-schools or childcare services, is the basis of prevention.
- Important topics that need to be addressed in the educational process include:
  - what is allergy?
  - what is anaphylaxis?
  - what are the common cause of allergic reactions and anaphylaxis?
  - how is anaphylaxis recognised?
  - how can an allergic reaction (including anaphylaxis) be prevented?
  - what should be done in the event of a child having a severe allergic reaction (anaphylaxis)?
  - instruction on how to use adrenaline autoinjectors (EpiPen or Anapen) using the child's ASCIA Action Plan for Anaphylaxis as the emergency guide

- If a child is known to be at risk of anaphylaxis and has asthma, it is important that asthma management is optimised.
- If the staff are unsure whether the child is experiencing anaphylaxis or severe asthma, they should be educated to administer the adrenaline autoinjector first, followed by asthma reliever medication and an ambulance should be called.
- Ideally, training of all staff on these topics should be provided by appropriately qualified professionals (e.g.
  - allergy nurse educators) and reinforced every 1 to 2 years

(2) **Implementation of practical strategies to avoid exposure to medically confirmed allergens**

- Avoidance of confirmed allergens is the basis of anaphylaxis prevention.
- Appropriate avoidance measures are critically dependant on education of the child, their peers and all school/ childcare staff.
- The appropriate measures will depend on the nature of the institution, the possible routes of exposure to known allergens and the age of the child.
- Blanket food bans are generally unnecessary and are not recommended in late primary or high school, although some childcare services, pre-schools and early primary schools implement such measures to reduce the risk of exposure in very young children.
- As a general principle it is not recommended that food allergic children in schools, pre-schools or childcare services are physically isolated from other children.

(3) **Age-appropriate education of children with severe allergies and their peers**

- While it is primarily the responsibility of parents to teach their allergic child to care for himself/herself, the school also has a role to implement a health-care plan and reinforce appropriate avoidance and management strategies.
- In childcare services and pre-schools, children are dependent on carers for providing a safe environment. As children mature they are able to take more responsibility for their own care.
- Education of the allergic individual and their peers is an important risk-minimisation strategy. It is important for all children to be educated about allergies and anaphylaxis and the risk-minimisation strategies applicable to them (e.g. hand washing after eating, not sharing food etc.)

ASCIA also provides a set of management principles for doctors and other health professionals that may be of interest (www.allergy.org.au).

ANAPHYLAXIS COMMUNICATION PLAN

The principal of a school is responsible for ensuring that a communication plan is developed to provide information to all school staff, students and parents about anaphylaxis and the school's anaphylaxis management policy.

The communication plan must include strategies for advising school staff, students and parents about how to respond to an anaphylactic reaction of a student in various environments including:

- during normal school activities including in the classroom, in the school yard, in all school buildings and sites including gymnasiums and halls
- during off-site or out of school activities, including on excursions, school camps and at special events conducted, organised or attended by the school

The communication plan must include procedures to inform volunteers and casual relief staff of students who are at risk of anaphylaxis and of their role in responding to an anaphylactic reaction experienced by a student in their care.

Raising staff awareness

The communication plan must include arrangements for relevant school staff to be briefed at least twice per year by a staff member who has current anaphylaxis management training (see Chapter 5 for further detail). However, it is best practice for a school to brief all school staff on a regular basis regarding anaphylaxis and the school's anaphylaxis management policy.

In addition, it is recommended that school anaphylaxis supervisor(s) or other designated staff member(s) be responsible for briefing all volunteers and casual relief staff, and new school staff (including administration and office staff, canteen staff, sessional teachers, and specialist teachers) on the above information and their role in responding to an anaphylactic reaction experienced by a student in their care.

Raising student awareness

Peer support is an important element of support for students at risk of anaphylaxis.

School staff can raise awareness in their school through fact sheets or posters displayed in hallways, canteens and classrooms. Class teachers can discuss the topic with students in class, with a few simple key messages such as the following:

Student messages about anaphylaxis

(1) Always take food allergies seriously — severe allergies are no joke.

(2) Don't share your food with friends who have food allergies.

(3) Wash your hands after eating.

(4) Know what your friends are allergic to.

(5) If a school friend becomes sick, get help from a teacher or parent immediately even if the friend does not want you to.

(6) Be respectful of a school friend's adrenaline autoinjector.

(7) Don't pressure your friends to eat food that they are allergic to.

It is important to be aware that a student at risk of anaphylaxis may not want to be singled out or be seen to be treated differently.

Work with parents

Schools should be aware that parents of a child who is at risk of anaphylaxis may experience considerable anxiety about sending their child to school. It is important to develop an open and cooperative relationship with them so that they can feel confident that appropriate management strategies are in place at school.

Aside from implementing practical risk minimisation strategies in schools, the anxiety that parents and students may feel can be considerably reduced by regular communication and increased education, awareness and support from the school community.

Raising school community awareness

Schools are encouraged to raise awareness about anaphylaxis in the school community so that there is an increased understanding of the condition. This can be done by providing information in the school newsletter, on the school website, at assemblies or parent information sessions. Information sheets can be sent out in school bulletins or even newsletters. These information sheets come from creditable resources such as, The Royal Children's Hospital, Allergies Australia and the ASCIA.

REFERENCES

Allergy & Anaphylaxis Australia

What is Anaphylaxis?
https://allergyfacts.org.au/allergy-anaphylaxis/what-is-anaphylaxis

Australasian Society of Clinical Immunology and Allergy

Allergy in Australia 2014. Page 4.
https://www.allergy.org.au/images/stories/reports/ASCIA_Allergy_in_Australia_2014_NHPA__Submission.pdf

Australian Commission on Safety and Quality in Health Care

Acute Anaphylaxis Clinical Care Standard
https://www.safetyandquality.gov.au/standards/clinical-care-standards/acute-anaphylaxis-clinical-care-standard

Education.vic.gov.au

Education and Care Services
https://www.education.vic.gov.au/childhood/providers/regulation/Pages/anaphylaxis.aspx#link87

Risk Management Plans
https://www.education.vic.gov.au/childhood/providers/regulation/Pages/anaphylaxis.aspx#link17

School Operations - Anaphylaxis
https://www2.education.vic.gov.au/pal/anaphylaxis/policy

Education and Training Reform Act 2006

https://www.education.vic.gov.au/Documents/school/teachers/health/Anaphylaxis_MinisterialOrder706.pdf

Victorian Schools Anaphylaxis Training

https://www2.education.vic.gov.au/pal/anaphylaxis/guidance/5-staff-training

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