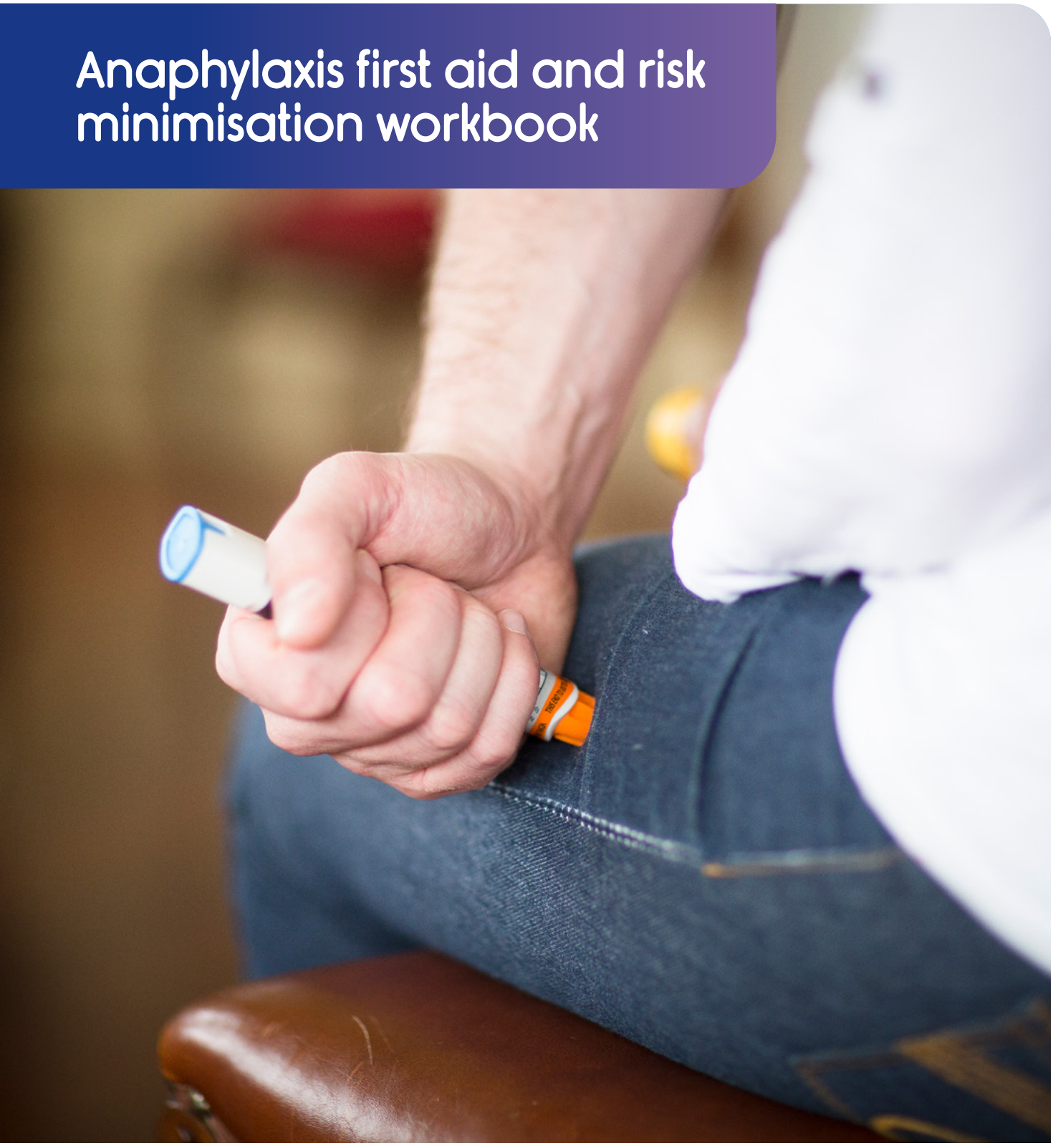
PREMIUMHealth
HEALTH CARE

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

Anaphylaxis first aid and risk minimisation workbook



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, present and emerging 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 reaction 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 on the face or can be all over the whole body as in a 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 mite, 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). About one in 100 adults will 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 20 minutes 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 ASCIA Action Plan for Anaphylaxis.
- 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.

SEVERE ALLERGIC REACTION – ANAPHYLAXIS

Anaphylaxis is a rapidly progressive 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 (EpiPen).

Respiratory

- difficulty breathing or
- noisy breathing
- swelling of 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

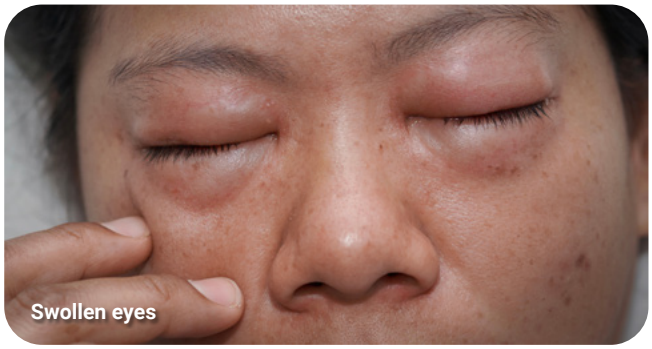
Management

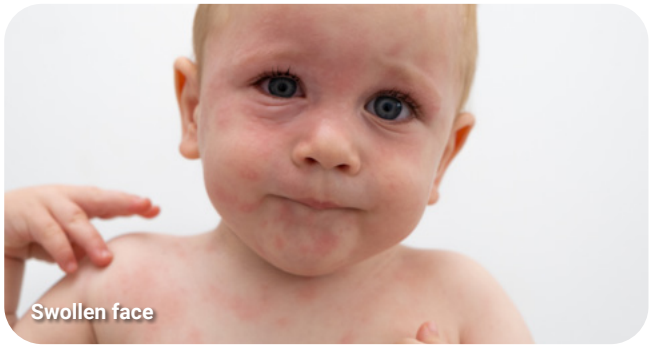
People with diagnosed allergies should avoid all triggers/ confirmed allergens and have a readily accessible Anaphylaxis action plan and medical alert device. The injection of adrenaline is the first line drug treatment in life threatening Anaphylaxis. If the casualty's signs and symptoms suggest Anaphylaxis,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

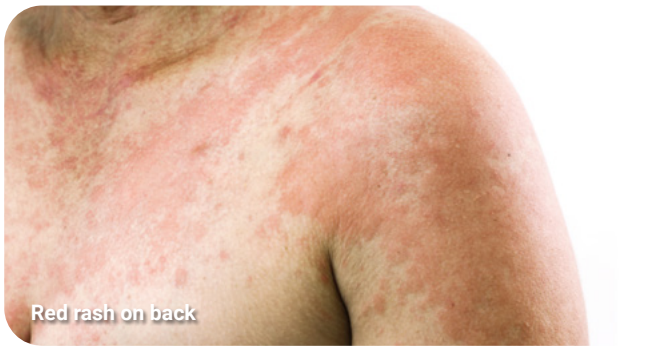
- Initiate the first aid priority action plan (DRSABCD) and include the following actions:
  - Lay casualty flat, do not stand or walk (if breathing is difficult, allow to sit).
  - When seated on the floor (not in chair) make sure the legs of the casualty are outstretched in front of them.
  - Hold an infant horizontally in arms.
  - 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.

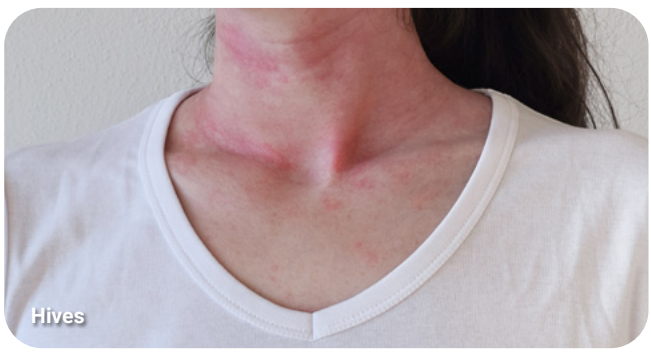
Implement casualty's ASCIA Action Plan for Anaphylaxis

- Administer adrenaline (bring medication to casualty, do not move them).
- Call an ambulance (triple zero 000) and monitor casualty continuously.
- Administer oxygen (if trained to administer) and/or asthma medication for respiratory symptoms. Further adrenaline should be given if 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 eyes


Swollen face


Red rash on back


Hives

A severe allergic reaction usually occurs within 20 minutes of exposure to the trigger.

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
- the majority of food allergic and anaphylactic reactions occur in pre-school age children. A South Australian survey in 2000 of over 4000 children indicated that 13 in 14 anaphylactic food reactions occurred in preschool age children and only 1in 14 occurred in a school-age child
- 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
- a Western Australian survey of schools and childcare services in 2008 indicated that 1 in 7 schools and 1 in 30 childcare services had at least 1 child who had a severe allergic reaction (anaphylaxis) in the 12 months prior to the survey date
- the risk of anaphylaxis in an individual case depends on several factors including the age of the child (the greater the age, the greater the risk of fatality), the particular food involved, the amount of the food ingested, if a food allergic child exercises soon after eating a specific food and the presence of asthma
- 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.
- while adverse reactions to medications are common, allergic reactions to medications are rare, and most often occur in hospitals

(Extract: *ASCIA Guidelines for prevention of anaphylaxis reactions in schools, pre-schools and childcare: 2012 Update*. Published in the Journal of Paediatrics and Child Health (JPCH) 49 (2013) 342-345, p 1.).

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

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 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.

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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.

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www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For use with EpiPen® 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):

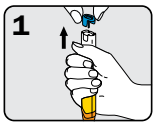
_____

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.

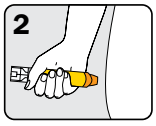
Whilst this plan does not expire, review is recommended by DD/MM/YY

Signed: _____
Date: _____

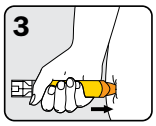
How to give EpiPen®



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**

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**
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ACTION FOR ANAPHYLAXIS

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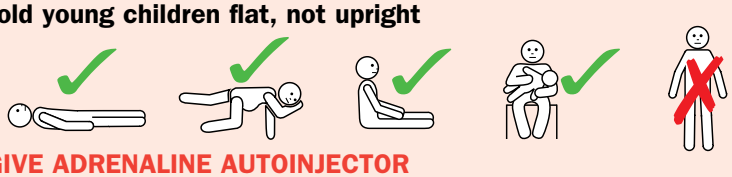

2 GIVE ADRENALINE AUTOINJECTOR
3 Phone ambulance - 000 (AU) or 111 (NZ)
4 Phone family/emergency contact
5 Further adrenaline may be given if no response after 5 minutes
6 Transfer person to hospital for at least 4 hours of observation

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.

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

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 permitted 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.

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 a 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. 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 auto-injector firmly with the orange tip pointed downwards (orange to the thigh, blue to the sky).
3	Place orange tip against mid outer thigh. **Do not inject into buttocks.**
4	Firmly push against mid outer thigh at a 90 degree angle until a click is heard **(Auto-injector is designed to work through clothing).**
5	Hold **firmly against thigh** for 3 seconds to deliver adrenaline. The injection is now complete.
6	Remove auto-injector from thigh (the orange needle cover will automatically extend to cover needle).
7	Call triple zero (000) and seek immediate medical attention.
8	Further adrenaline doses may be given if there is no improvement after 5 minutes or if instructed by the triple 000 operator.
9	Ensure used auto-injector is transported with casualty.

ADMINISTRATION OF INJECTABLE ADRENALINE

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.

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.

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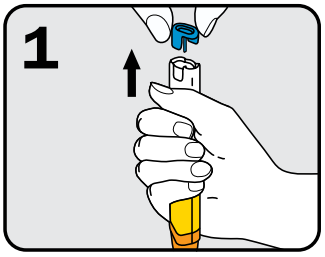
www.allergy.org.au

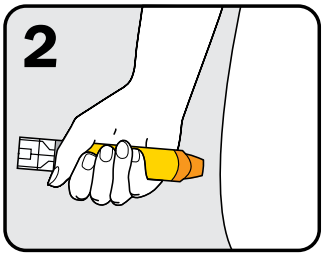
FIRST AID PLAN FOR Anaphylaxis

For use with EpiPen® adrenaline (epinephrine) autoinjectors

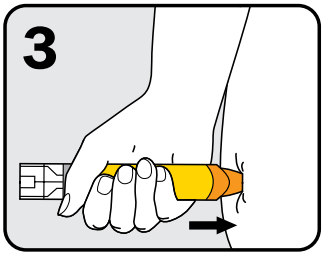
How to give EpiPen®



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 given as follows:

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

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
- 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

ALWAYS give adrenaline autoinjector FIRST, if someone has SEVERE AND SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice), even if there are no skin symptoms. THEN SEEK MEDICAL HELP.

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

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

Avnapen 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)

TO USE ANAPEN

It is NOT 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. *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 10 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, call 000 and ask for an ambulance and say "anaphylaxis". Advise the paramedic that an Anapen® has been administered into the thigh muscle and show them the product box for more information.

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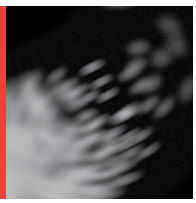
ACTION PLAN FOR Anaphylaxis



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):

_____

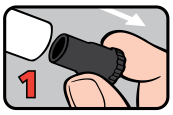
The treating doctor or np hereby authorises medications specified on this plan to be given according to the plan, as consented by the patient or parent/guardian.

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

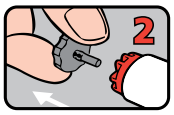
Signed: _____

Date: _____

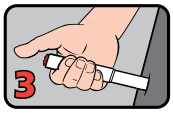
How to give Anapen®



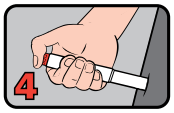
PULL OFF BLACK NEEDLE SHIELD



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 10 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

- 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

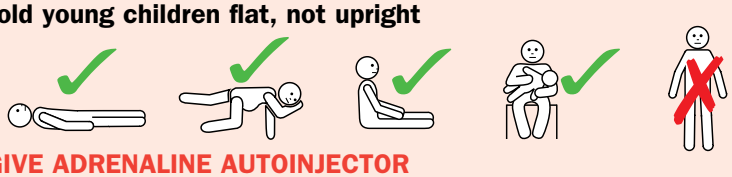
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **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

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.

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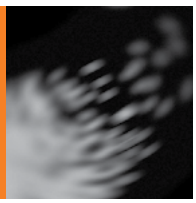
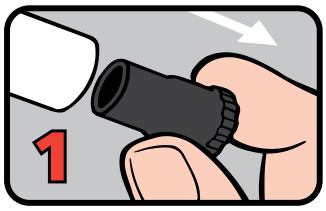
FIRST AID PLAN FOR Anaphylaxis



For use with AnaPen® adrenaline (epinephrine) autoinjectors

How to give AnaPen®



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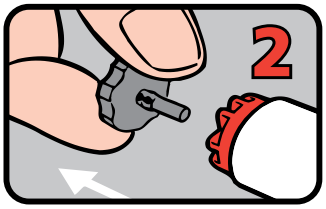

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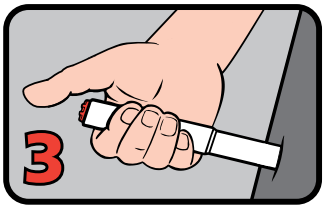

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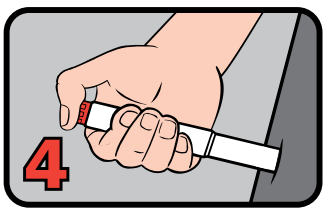

PRESS RED BUTTON so it clicks and hold for 10 seconds.
REMOVE Anapen®

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SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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- 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
- Phone family/emergency contact

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

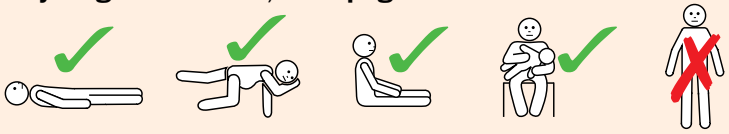
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **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

ALWAYS give adrenaline autoinjector FIRST, if someone has SEVERE AND SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice), even if there are no skin symptoms. THEN SEEK MEDICAL HELP.

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

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 (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 immediately anaphylaxis is recognised, the casualty's Action Plan for Anaphylaxis should be implemented – specifically adrenaline should be given and the ambulance called.

Recognising anaphylaxis is easier when the incident history is communicated immediately and the signs and symptoms are obviously linked to a possible allergic cause such as the eating of food or following a sting by an insect allergen.

An immediate response putting the casualty's Action Plan for Anaphylaxis into action correctly and effectively is the first aid management irrespective of the final outcome for the individual suffering the anaphylaxis.

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 a 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.**

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 health and safety of self, casualty, others 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.
- Initiate interim response activities while 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 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 for help.

A: Assess AIRWAY – is it clear or obstructed, is the throat is 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 uses 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 over to ambulance officer or attending medical personnel - communicate details of incident, casualty's condition and treatment given.
- Document incident in workplace incident record.

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 for change in 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.
- 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 and 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.

ANAPHYLAXIS ALLERGEN CATEGORIES

Triggers of severe allergic reactions/anaphylaxis may be:

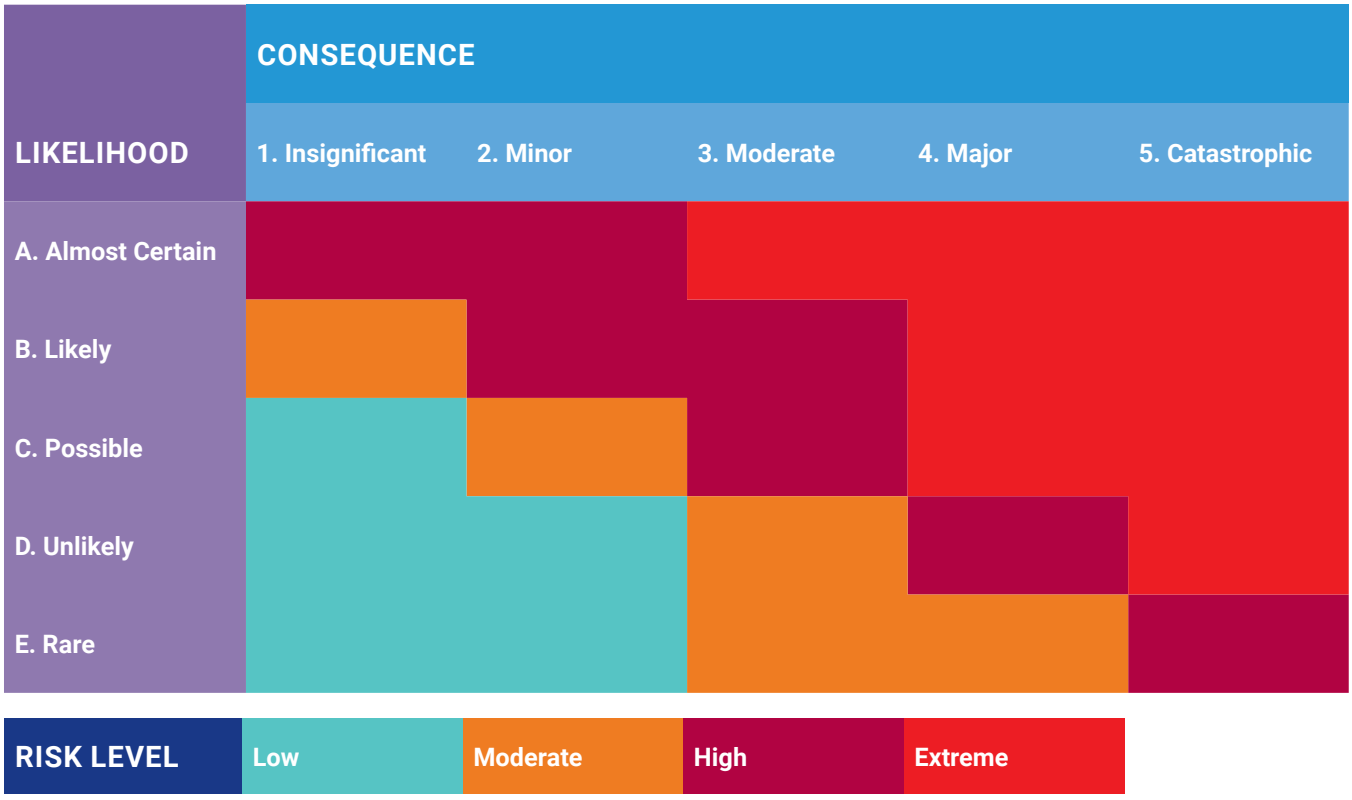
- foods including:
  - peanuts
  - tree nut
  - egg
  - cow's milk
  - wheat
  - soy
  - fish and shellfish
- insect bites
- medications, including antibiotics and anaesthetic agents

RISK ASSESSMENT MATRIX TOOL

CONSEQUENCE SCALE	
1. Insignificant	Minor First Aid treatment or no injury
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 that make it highly likely to the event will likely happen again
B. Likely	Experience/information suggest that the event has happened before and the event will likely 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 **www.education.vic.gov.au/childhood/providers/health/pages/anaphylaxis.aspx#1**

School resources to assist with the preparation of schools' anaphylaxis management/risk minimisation plans are provided in Appendix 1 and 2 and further information about anaphylaxis and school responsibilities is available at **www.education.vic.gov.au/school/parents/health/pages/anaphylaxis.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 update 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.

(1) **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
- the ASCIA Action Plan for Anaphylaxis included:
  - identification of the child (photo) o Documentation of confirmed allergens
  - documentation of the first aid response including any prescribed medication
  - name and contact details of the medical practitioner 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

(2) **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 food 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

(3) **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.

(4) 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.)

(See Appendix 3 for the ASCIA guidelines for prevention of anaphylaxis in schools, pre-schools and childcare: 2012 update)

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 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.

APPENDIX 1: DEECD SAMPLE ANAPHYLAXIS MANAGEMENT POLICY

SAMPLE ANAPHYLAXIS MANAGEMENT POLICY

Ministerial Order 706 – Anaphylaxis Management in Schools

School Name

Note: this is only a sample. Your School must develop/update its own anaphylaxis management policy. Schools should read the Anaphylaxis Guidelines for Victorian Schools when developing/updating their anaphylaxis management policies.

School Statement

A statement that the school will fully comply with Ministerial Order 706 and the associated Guidelines published and amended by the Department from time to time.

Note: this statement will acknowledge the School's responsibility to develop and maintain an Anaphylaxis Management Policy.

Individual Anaphylaxis Management Plans

Note: A template of an Individual Anaphylaxis Management Plan can be found in Appendix 3 of the Anaphylaxis Guidelines for Victorian Schools or the Department's website:

http://www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx

The Principal will ensure that an Individual Anaphylaxis Management Plan is developed, in consultation with the student's Parents, for any student who has been diagnosed by a Medical Practitioner as being at risk of anaphylaxis.

The Individual Anaphylaxis Management Plan will be in place as soon as practicable after the student enrols, and where possible before their first day of school.

The Individual Anaphylaxis Management Plan will 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(s) responsible for implementing the strategies;
- information on where the student's medication will be stored;
- the student's emergency contact details; and
- an ASCIA Action Plan

Note: The red and blue 'ASCIA Action Plan for Anaphylaxis' is the recognised form for emergency procedure plans that is provided by Medical Practitioners to Parents when a child is diagnosed as being at risk of anaphylaxis. An example can be found in Appendix 3 of the Anaphylaxis Guidelines or downloaded from **http://www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx**

School Staff will then implement and monitor the student's Individual Anaphylaxis Management Plan.

The student's Individual Anaphylaxis Management Plan will be reviewed, in consultation with the student's Parents in all of the following circumstances:

annually;

if the student's medical condition, insofar as it relates to allergy and the potential for anaphylactic reaction, changes;

as soon as practicable after the student has an anaphylactic reaction at School; and

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 (eg. class parties, elective subjects, cultural days, fetes, incursions).

The School's Anaphylaxis Management Policy must state that it is the responsibility of the Parents to:

- provide the ASCIA Action Plan;
- inform the School in writing if their child's medical condition, insofar as it relates to allergy and the potential for anaphylactic reaction, changes and if relevant, provide an updated ASCIA Action Plan;
- provide an up to date photo for the ASCIA Action Plan when that Plan is provided to the School and when it is reviewed; and
- provide the School with an Adrenaline Autoinjector that is current and not expired for their child.

Prevention Strategies

Note: Chapter 8 of the Anaphylaxis Guidelines for Victorian Schools contains advice about a range of Prevention Strategies that can be put in place.

This section should detail the Risk Minimisation and Prevention Strategies that your School will put in place for all relevant in-school and out-of-school settings which include (but are not limited to) the following:

- during classroom activities (including class rotations, specialist and elective classes);
- between classes and other breaks;
- in canteens;
- during recess and lunchtimes; • before and after school; and
- special events including incursions, sports, cultural days, fetes or class parties, excursions and camps

School Management and Emergency Response

Note: Chapter 9 of the Anaphylaxis Guidelines for Victorian Schools contains advice about procedures for School management and emergency response for anaphylactic reactions.

The School's Anaphylaxis Management Policy must include procedures for emergency response to anaphylactic reactions. The procedures should include the following:

- a complete and up to date list of students identified as having a medical condition that relates to allergy and the potential for anaphylactic reaction;
- details of Individual Anaphylaxis Management Plans and ASCIA Action Plans and where these can be located:
  - in a classroom;
  - in the school yard;
  - in all school buildings and sites including gymnasiums and halls;
  - on school excursions; o on school camps; and
  - at special events conducted, organised or attended by the school
- Information about the storage and accessibility of Adrenaline Autoinjectors;
- how communication with School Staff, students and Parents is to occur in in accordance with a communications plan

Adrenaline Autoinjectors for General Use

The Principal will purchase Adrenaline Autoinjector(s) for General Use (purchased by the School) and as a back up to those supplied by Parents.

The Principal will determine the number of additional Adrenaline Autoinjector(s) required. In doing so, the Principal will take into account the following relevant considerations:

- the number of students enrolled at the School who have been diagnosed as being at risk of anaphylaxis;
- the accessibility of Adrenaline Autoinjectors that have been provided by Parents of students who have been diagnosed as being at risk of anaphylaxis;
- the availability and sufficient supply of Adrenaline Autoinjectors for General Use in specified locations at the School, including
- in the school yard, and at excursions, camps and special events conducted or organised by the School; and
- the Adrenaline Autoinjectors for General Use have a limited life, usually expiring within 12-18 months, and will need to be replaced at the School's expense, either at the time of use or expiry, whichever is first

Note: Adrenaline Autoinjectors for General Use are available for purchase at any chemist. No prescriptions are necessary.

Communication Plan

Note: Chapter 11 of the Anaphylaxis Guidelines for Victorian government Schools has advice about strategies to raise staff and student awareness, working with Parents and engaging the broader school community.

This section should set out a Communication Plan 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 by 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; and
- during off-site or out of school activities, including on excursions, school camps and at special events conducted or organised by the School.

The Communication Plan must include procedures to inform volunteers and casual relief staff of students with a medical condition that relates to allergy and the potential for anaphylactic reaction and their role in responding to an anaphylactic reaction by a student in their care.

It is the responsibility of the Principal of the School to ensure that relevant School Staff are:

- trained; and
- briefed at least twice per calendar year

Staff Training

The following School Staff will be appropriately trained:

- School Staff who conduct classes that students with a medical condition that relates to allergy and the potential for anaphylactic reaction; and
- Any further School Staff that are determined by the Principal

The identified School Staff will undertake the following training:

- an Anaphylaxis Management Training Course in the three years prior; and
- participate in a briefing, to occur twice per calendar year (with the first briefing to be held at the beginning of the school year) on:
  - the School's Anaphylaxis Management Policy; o the causes, symptoms and treatment of anaphylaxis;
  - the identities of the students with a medical condition that relates to an allergy and the potential for anaphylactic reaction, and where their medication is located;
  - how to use an Adrenaline Autoinjector, including hands on practise with a trainer Adrenaline
  - Autoinjector device:
    - the School's general first aid and emergency response procedures; and
    - the location of, and access to, Adrenaline Autoinjector that have been provided by Parents or purchased by the School for general use

The briefing must be conducted by a member of School Staff who has successfully completed an Anaphylaxis Management Training Course in the last 12 months.

In the event that the relevant training and briefing has not occurred, the Principal will develop an interim Individual Anaphylaxis Management Plan in consultation with the Parents of any affected student with a medical condition that relates to allergy and the potential for anaphylactic reaction. Training will be provided to relevant School Staff as soon as practicable after the student enrols, and preferably before the student's first day at School.

The Principal will ensure that while the student is under the care or supervision of the School, including excursions, yard duty, camps and special event days, there is a sufficient number of School Staff present who have successfully completed an Anaphylaxis Management Training Course in the three years prior.

Note: A video has been developed and can be viewed from **http://www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx**

Annual Risk Management Checklist

The Principal will complete an annual Risk Management Checklist as published by the Department of Education and Early Childhood Development to monitor compliance with their obligations.

Note: A template of the Risk Management Checklist can be found at Appendix 4 of the Anaphylaxis Guidelines for Victorian Schools or the Department's website: **http://www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx**

APPENDIX 2: DEECD ANAPHYLAXIS GUIDELINES, FEBRUARY 2014

ENVIRONMENT

To be completed by principal or nominee. Please consider each environment/area (on and off school site) the student will be in for the term, e.g. classroom, canteen, food tech room, sports oval, excursions and camps etc.

Name of environment/area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**

ASCIA ACTION PLAN FOR ANAPHYLAXIS

(Attach a copy of this plan here, which parents/carers are to supply (signed by the student's medical practitioner, with an up-to-date photo of the child).

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

ACTION PLAN FOR Anaphylaxis

for use with EpiPen® or Epipen® Jr adrenaline autoinjectors (with blue safety release and orange needle end)

Name:

Date of birth:

Photo

Confirmed allergens:

Family/emergency contact name(s):

Work Ph:

Home Ph:

Mobile Ph:

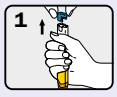
Plan prepared by:

Dr

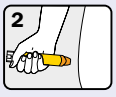
Signed

Date:

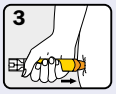
How to give EpiPen® or EpiPen® Jr



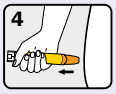
Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE.



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 10 seconds.



REMOVE EpiPen®. Massage injection site for 10 seconds.

MILD TO MODERATE ALLERGIC REACTION

- swelling of lips, face, eyes
- hives or welts
- tingling mouth
- abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

ACTION

- **For insect allergy, flick out sting if visible. Do not remove ticks**
- Stay with person and call for help
- Give medications (if prescribed) .....
  Dose: .....
- Locate EpiPen® or EpiPen® Jr
- Contact family/emergency contact

Watch for any one of the following signs of Anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- difficult/noisy breathing
- swelling of tongue
- swelling/tightness in throat
- difficulty talking and/or hoarse voice
- wheeze or persistent cough
- persistent dizziness or collapse
- pale and floppy (young children)

ACTION

1. **Lay person flat, do not stand or walk. If breathing is difficult allow to sit**
2. **Give EpiPen® or EpiPen® Jr**
3. **Phone ambulance*- 000 (AU), 111 (NZ), 112 (mobile)**
4. **Contact family/emergency contact**
5. **Further adrenaline doses may be given if no response after 5 minutes (if another adrenaline autoinjector is available)**

If in doubt, give EpiPen® or EpiPen® Jr

EpiPen® Jr is generally prescribed for children aged 1-5 years.
*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

Additional information

<table>
<tr><td colspan="2">This Individual Anaphylaxis Management Plan will be reviewed on any of the following occurrences (whichever happen earlier):
• Not more than 12 months since the development of this plan (insert date)
• Immediately after an anaphylactic reaction occurs whilst the student is in the care of school staff
• Any changes in student's medical condition.
I have been consulted in the development of this Individual Anaphylaxis Management Plan.
I consent to the risk minimisation strategies proposed.
Risk minimisation strategies
Refer to Appendix 2 – prevention strategies</td></tr>
<tr><td>Signature of parent/ carer:</td><td></td></tr>
<tr><td>Date:</td><td></td></tr>
<tr><td colspan="2">I have consulted to the parent/carers of the students and the relevant staff who will be involved in the implementation of this Individual Anaphylaxis Management Plan.</td></tr>
<tr><td>Signature of principal (or nominee):</td><td></td></tr>
<tr><td>Date:</td><td></td></tr>
</table>

Appendix 2: Prevention Strategies

In-school settings

Classrooms	
1.	Keep a copy of the student's Individual Anaphylaxis in the classroom.
2.	Liaise with parents/carers about food-related activities ahead of time.
3.	Use non-food treats where possible, but if food treats are used in class it is recommended that parents/carers of anaphylactic students provide a treat box with alternative treats. Treat boxes should be clearly labelled and only handled by the student.
4.	Never give food from outside sources to a student who is at risk of anaphylaxis.
5.	Treats for the other students in the class must not contain the substance to which the student is allergic. It is recommended to use non-food treats where possible.
6.	Products labelled 'may contain traces of nuts' should not be served to students allergic to nuts.
7.	Be aware of the possibility of hidden allergens in cooking, food technology, science and art classes (e.g. egg or milk cartons). Note: that year level/specialist teachers must consider the risk-minimisation strategies of the student diagnosed at risk of anaphylaxis, even if that student is not in their class.
8.	Have regular discussions with students about the importance of washing hands, eating their own food and not sharing food.
9.	A designated staff member should inform casual relief teachers and specialist teachers and volunteers of: • the school's Anaphylaxis Management Policy • the causes, symptoms and treatment of anaphylaxis • identity of students diagnosed at risk of anaphylaxis and where their Individual Anaphylaxis Management Plan and adrenaline autoinjector are located their role in responding to an anaphylaxis student in their care preventative strategies in place to minimise the risk of anaphylaxis reaction.

Canteens	
1.	Canteen staff (whether internal or external) should be able to demonstrate satisfactory training in the food allergen management and its implications on food-handling practices, including knowledge of the major food allergens triggering anaphylaxis, cross-contamination issues specific to food allergy, label reading, etc.
2.	Refer to http://www.allergyfacts.org.au/component/virtuemart/ to and Refer to 'Safe Food Handling' in the School Policy and Advisory Guide, available at http://www.education.vic.gov.au/management/governance/spag/governance/safetymgt/foodhandling.htm
3.	Canteen staff, including volunteers, should be briefed about students at risk of anaphylaxis and have up to date training in an accredited anaphylaxis management training course as soon as practical after a student enrols. See http://www.health.vic.gov.au/foodsafety/downloads/allergen_intolerance_biz.pdf
4.	Products labelled 'may contain traces of nuts' should not be served to students allergic to nuts.
5.	Canteens should provide a range of healthy meals/ products that are designed to exclude any traces of peanut or other nut products.
6.	Physical isolation of students at risk of anaphylaxis is not recommended.
7.	Make sure that tables and surfaces are wiped down regularly.

Yard	
1.	If a school has a student who is at risk of anaphylaxis, sufficient staff on yard duty must be trained in the administration of the adrenaline autoinjector (i.e. EpiPen®/ Anapen®) to be able to respond quickly to an anaphylactic reaction if needed.
2.	The adrenaline autoinjector and individual Anaphylaxis Management Plan for each student at risk of anaphylaxis be easily accessible from the yard, and staff should be aware of its exact location. **(Remember that an anaphylactic reaction can occur in as little as five minutes.)**
3.	Yard duty staff must also be able to identify those students at risk of anaphylaxis.
4.	Yard duty staff must direct another person to bring the adrenaline autoinjector to them and should never leave a student who is experiencing an anaphylactic reaction unattended.
5.	A student experiencing an anaphylactic reaction should not be moved.
6.	Students with anaphylactic responses to insects should be encouraged to stay away from water or flowering plants. Schools should liaise with parents/carers to encourage students to wear light or dark rather than bright colours, as well as closed shoes and long-sleeved garments when outdoors.
7.	Keep lawns and clover mowed and outdoor bins covered.
8.	The student should keep drinks and food covered while outdoors.

Special events (e.g. sporting events, incursions, class parties, etc.)	
1.	If a school has a student at risk of anaphylaxis, sufficient staff supervising the special event must be trained in the administration of an adrenaline autoinjector to be able to respond quickly to be able to respond quickly to and anaphylaxis reaction if required.
2.	Staff should avoid using food in activities or games, including as rewards. The adrenaline autoinjector and individual Anaphylaxis Management Plan for each student at risk of Anaphylaxis should be easily accessible and staff should be aware of the exact location.
3.	For special occasions, class teachers should consult parents/carers in advance to either develop an alternative food menu or request the parents/carers to send a meal for the student.
4.	Parents/carers of other students should be informed in advance about foods that may cause allergic reactions in students at risk of anaphylaxis and request that they avoid providing students with treats whilst they are at school or at a special school event.
5.	Party balloons should not be used if any student is allergic to latex.
6.	Swimming caps should not be used for a student who is allergic to latex.

APPENDIX 3: INDIVIDUAL ANAPHYLAXIS MANAGEMENT PLAN

Department of Education and Early Childhood Development

The Royal Children's Hospital Melbourne

Appendix 3: Anaphylaxis Risk Management Checklist

School Name:	
Primary / Secondary (Please tick):	Primary ☐ Secondary ☐
Date of Review:	Time:
School Contract Person: Name: (Who provided information collected)	
Position:	
Review given to: Name: (if different from above)	
Position:	
Comments:	
1. How many current students have been prescribed (and carry) an adrenaline auto injector?	
2. Have any students ever had an allergic reaction requiring medical intervention at school? If Yes, how many times?	Yes ☐ No ☐
If Yes, how many students?	
3. Have any students ever had an Anaphylactic reaction at school? If Yes, how many time?	Yes ☐ No ☐
If Yes, how many students?	
4. Has a staff member been required to administer an adrenaline auto injector to a student? If Yes, how many times?	Yes ☐ No ☐

SECTION 1: Individual Anaphylaxis Management Plans and ASCIA Action Plan for Anaphylaxis

1. Does every student who carries an adrenaline auto injector (either for allergic reaction or anaphylaxis) have an Individual Anaphylaxis Management Plan and ASCIA Action Plan for Anaphylaxis (Emergency Action Plan for individual at risk of anaphylaxis, completed and signed by a prescribed medical practitioner).	Yes ☐ No ☐
2. Are all Individual Anaphylaxis Management Plan reviewed regularly with parents (at least annually)?	Yes ☐ No ☐
3. Do the Anaphylaxis Management Plans set out strategies to minimise the risk of exposure to allergens for in-school and out of class settings?	
During classroom activities, including elective classes	Yes ☐ No ☐
In canteens or during lunch or snack times	Yes ☐ No ☐
Before and after school, in the school yard and during breaks	Yes ☐ No ☐
For special events, such as sports days, class parties and extra-curricular activities	Yes ☐ No ☐
For excursions and camps	Yes ☐ No ☐
Other	

4. Do all students who have been prescribed an adrenaline auto injector have a copy of their ASCIA Emergency Action Plan for Anaphylaxis kept at school (provided by the parent)? Yes ☐ No ☐

Where are they kept?

5. Does the ASCIA Emergency Action Plan for Anaphylaxis have a recent photo of the student with them? Yes ☐ No ☐

SECTION 2: Storage and Accessibility of adrenaline auto injectors

1. Where are the students adrenaline auto injectors stored?

2. Do all staff know where the school's general autoinjectors are stored. Are the adrenaline auto injectors stored at room temperature?

3. Is the storage safe (not refrigerated)? Yes ☐ No ☐

Is the storage unlocked and accessible to staff at all times? Yes ☐ No ☐

Comments

Are the adrenaline auto injectors easy to find? Yes ☐ No ☐

Comments

4. Is a copy of students' ASCIA Emergency Action Plan for Anaphylaxis kept together with their student's adrenaline auto injector? Yes ☐ No ☐

Comments

5. Are the adrenaline auto injectors and ASCIA Emergency Action Plans for Anaphylaxis clearly labelled with students' names? Yes ☐ No ☐

Comments

6. Has someone been designated to check the adrenaline auto injector expiry dates on a regular basis? Who? Yes ☐ No ☐

Comments

7. Has the school signed up to EpiClub or Ana-alert (free reminder services)? Yes ☐ No ☐

8. Do all staff know where the adrenaline auto injector and ASCIA Emergency Action Plan for Anaphylaxis are stored? Yes ☐ No ☐

Comments

9. Is there an adrenaline auto injector for general use in the school's first aid kit? Yes ☐ No ☐

If Yes, where is it located?

10. Is this device clearly labelled as the 'General Use' adrenaline auto injector? Yes ☐ No ☐

SECTION 3: Prevention Strategies

1. Have you done a risk assessment to identify potential accidental exposure to allergens for a student with anaphylaxis? Yes ☐ No ☐

2. Have you implemented any of the prevention strategies (in Appendix 2 of the Guidelines)? Yes ☐ No ☐

3. Are there always sufficient staff members on yard duty with current training in anaphylaxis emergency management? Yes ☐ No ☐

SECTION 4: School's First Aid and Emergency Response Procedures for when an allergic reaction occurs

1. Is the school's Communication Plan for when an allergic reaction occurs for all in-school and all out-of-school scenarios clearly documented in the School's Communication Plan and distributed to all staff? Have all staff responsible for students with anaphylaxis received training and a twice yearly briefing? Yes ☐ No ☐

2. Do staff know when their training needs to be renewed? Have you developed an School's First Aid and Emergency Response Procedures for when an allergic reaction occurs?

In the class room? Yes ☐ No ☐

In the school yard? Yes ☐ No ☐

At school camps and excursions? Yes ☐ No ☐

On special event days, such as sports days? Yes ☐ No ☐

Does your plan include who will call the Ambulance? Yes ☐ No ☐

3. Is there a designated person who will be sent to collect the student's adrenaline auto injector and ASCIA Emergency Action Plan for Anaphylaxis? Yes ☐ No ☐

4. Have you checked how long it will take to get to the adrenaline auto injector and ASCIA Emergency Action Plan for Anaphylaxis to a student from various areas of the school including: Yes ☐ No ☐

The class room? Yes ☐ No ☐

The school yard? Yes ☐ No ☐

The sports field? Yes ☐ No ☐

5. On excursions or other out of school events is there a plan for who is responsible for ensuring the adrenaline auto injector(s) are correctly stored and available for use? Yes ☐ No ☐

Who will do this on excursions?

Who will do this on camps?

Who will do this on sporting activities?

6. Is there a process for post incident support in place?	Yes ☐ No ☐
Comments	
7. Have all staff been briefed on:	
The school's Anaphylaxis Management Policy?	Yes ☐ No ☐
The causes, symptoms and treatment of anaphylaxis?	Yes ☐ No ☐
The identities of students who have been prescribed an adrenaline auto injector and where their medication is located?	Yes ☐ No ☐
How to use an adrenaline auto injector device, including hands on practice with a training adrenaline auto injector device?	Yes ☐ No ☐
School's First Aid and Emergency Response Procedures for all in-school and out-of-school environments?	Yes ☐ No ☐
Where the adrenaline auto injector for general use is kept?	Yes ☐ No ☐
Where a student's medication is located including if they carry it on their person?	Yes ☐ No ☐

SECTION 5: Communicating with Staff, students and parents/carers

1. Is there a communication plan in place to provide information about anaphylaxis and the school's policies?	Yes ☐ No ☐
To staff?	
To students?	
To parents/carers?	
2. Are the School's First Aid and Emergency Response Procedures for when an allergic reaction occurs for all in-school and out-of-school scenarios documented in the school's Communication plan and distributed to all staff?	Yes ☐ No ☐
Comments	
3. Do all staff know which students scarry an autoinjector and is there a process for distributing this information to all staff?	Yes ☐ No ☐
Comments	
4. How is this information kept up to date?	Yes ☐ No ☐
Comments	
5. Are there strategies in place to increase awareness about severe allergies among students for all in-school and out-of school environments?	Yes ☐ No ☐
Comments	

APPENDIX 4: ANNUAL RISK MANAGEMENT CHECKLIST

Adrenaline (Epinephrine) Injectors for General Use

Adrenaline (epinephrine) injectors (e.g. EpiPen® or Anapen®) are approved for use in Australia and New Zealand for the emergency treatment of anaphylaxis, the most severe form of allergic reaction.

ASCIA cannot dictate policy regarding the use of adrenaline injectors for general use that are not prescribed for an individual. Advice from the local education and/or health authorities should be sought regarding authorisation to include adrenaline injectors for general use in first aid kits, and whether these can be administered in an emergency.

Having an adrenaline injector for general use (e.g. in first aid kits) should be considered as being additional to the prescribed adrenaline injectors for individuals. They should NOT be a substitute for individuals at high risk of anaphylaxis having their own prescribed adrenaline injector/s.

Adrenaline injectors for general use are most likely to be used when:

- An individual who is known to be at risk of anaphylaxis does not have their own device immediately accessible, or the device is out of date.
- A second dose of adrenaline is required before an ambulance has arrived.
- An individual's device has misfired or accidentally been discharged.
- A previously diagnosed individual with mild allergy who was not prescribed an adrenaline injector has their first episode of anaphylaxis.
- An undiagnosed individual is having their first episode of anaphylaxis, and was not previously known to be at risk (e.g. a child having their first reaction at school). This is dependent on (a) local policies that allow administration under those circumstances, and (b) education of caregivers about the recognition of anaphylaxis and training in adrenaline injector administration.

Using another person's adrenaline injector device

ASCIA does not have published information or guidelines on using another person's adrenaline injector in an anaphylaxis emergency. It is unlikely that these can be developed whilst there is still inconsistency in the regulations regarding giving non-prescribed adrenaline injectors in Australia and New Zealand.

The following is general advice, not an official ASCIA Guideline:

- If another individual's adrenaline injector is used in an anaphylaxis emergency, when there is no adrenaline injector for general use available, it would be essential that the device is immediately replaced by the institution, purchasing the same brand of adrenaline injector at a local pharmacy.
- If the individual whose adrenaline injector has been used has anaphylaxis before their adrenaline injector is replaced, they should be taken immediately to hospital by ambulance. If the individual is not insured for the ambulance cost, this expense should be covered by the institution.

Availability

- Adrenaline injectors are available from pharmacies without a prescription at full price.
- In Australia, the Pharmaceutical Benefits Scheme (PBS) listing for adrenaline injectors allows for authority prescriptions of a maximum quantity of two adrenaline injectors (EpiPen® or Anapen®) for children or adults (no repeats). They are available at a subsidised cost when prescribed by doctors for individuals considered to be at high risk of anaphylaxis.
- In New Zealand, adrenaline injectors are not currently subsidised by Pharmac.

- All adrenaline injectors, whether they are prescribed or for general use, can only be used once and should be replaced by the expiry date, or immediately after they are used.

Administration

- It is reasonable for a person without specific first aid training in anaphylaxis to administer an adrenaline injector in an emergency if there is no other person nearby who has had basic training in the use of an adrenaline injector.
- The person administering first aid should have reasonable grounds for believing that the individual is having an acute allergic reaction. Symptoms and signs of anaphylaxis are shown on the ASCIA Action Plan for Anaphylaxis (general), which should be stored with an adrenaline injector for general use.
- Instructions for giving an adrenaline injector are shown on the barrel of the device, package insert and the device specific ASCIA Action Plan for Anaphylaxis.
- If a person is in doubt, an adrenaline injector should be given, as outlined on the ASCIA Action Plan for Anaphylaxis.

Precautions

- An adrenaline injector should be administered into the outer mid-thigh, as shown in the diagrams on the barrel of the device, the package insert, and the ASCIA Action Plan for Anaphylaxis.
- An ambulance should be called **immediately** after giving an adrenaline injector to take the individual to hospital, so they can remain under medical observation until symptoms have resolved.
- A copy of the device specific ASCIA Action Plan for Anaphylaxis (general) should always be kept with an adrenaline injector for general use, and in the first aid kit if that is where it is stored.
- There are no absolute contraindications (factors which make it unwise to give treatment) for use of an adrenaline injector in an individual who is experiencing anaphylaxis.
- Transient (temporary) side effects of adrenaline such as increased heart rate, trembling and paleness are to be expected.
- There are no published reports of death or serious injury resulting from use of adrenaline injectors.
- No serious or permanent harm is likely to occur from mistakenly administering adrenaline, using an adrenaline injector, to an individual who is not experiencing anaphylaxis.

Further Information

Further information is available on the ASCIA website www.allergy.org.au/anaphylaxis

Patient information and support is available from the following national patient support groups for Australia and New Zealand:

- Allergy & Anaphylaxis Australia: www.allergyfacts.org.au
- Allergy New Zealand: www.allergy.org.nz

NOTES

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- Diabetes training for support workers
- Dysphagia for support workers
- End of life care
- Epilepsy training for support workers
- Epilepsy training and midazolam administration via intranasal and buccal routes
- Food safety awareness for support workers
- Infection control
- Managing behaviours with positive support
- Manual handling
- Nebuliser training for asthma
- Ostomy and stoma care for support workers
- Positive behaviour support
- Pressure injury – prevention and care for support workers
- Providing personal care with dignity and respect
- Shallow suctioning
- Tube feeding management
- Urinary catheter care
- Wound care awareness for support workers

FIRST AID TRAINING

- Cardiopulmonary resuscitation (CPR)
- Provide first aid
- Asthma and anaphylaxis
- Advanced first aid

MENTAL HEALTH

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