HEALTHGUARD FIRST AID TRAINING SERVICES

22578VIC

Course in First Aid Management of Anaphylaxis

LEARNER NOTES

First aid, not pretty aid!

Name:

Healthguard: Registered Training Organisation No. 21156

Established in 1993, Healthguard Training Services is a highly respected and experienced organisation that provides vocational First Aid, Fire Extinguisher and Fire Warden training to meet the needs of workplaces, schools, industry and local communities.

We currently deliver high quality training to over 300 schools in Victoria, as well as numerous organisations in the construction and manufacturing industry and the Emergency Services.

We offer affordable and professional training with courses tailored to suit your industry. We can also provide courses at a location of your choice at a time convenient to you.

Healthguard prides itself on offering current and practical information in an inclusive and comfortable learning environment. We believe learning should be enjoyable and encourage all participants to contribute to discussions.

CONTACT DETAILS

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www.healthguardfirstaid.com.au

ACKNOWLEDGEMENTS
Contributors: Darren Mannix, Kathryn Burke
Protocols: Australian Resuscitation Council Guidelines, Department of Education Victoria Anaphylaxis Guidelines
Images: Public domain clipart, 123rf, in house photography, Essential Parent, ASCIA

CONTENTS

LEARNER INFORMATION

Unit of Competency

Current units of competency:

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

Pre-requisites

There are no unit of competency pre-requisites for completing this course.

Delivery Mode

Pre-course work (self-paced ASCIA e-learning and Healthguard learner workbook)

Face to face – over approximately 1.5 hours (depending on previous experience).

Content Delivery

A combination of adult learning techniques is used to deliver the course content and assess your understanding. This includes completion of practical skills activities and assessment scenarios, group discussion and multiple choice assessment questions.

Our expectations of you

You are expected to treat all other participants in an ethical and responsible manner. Failure to do so may result in you being asked to leave the course.

To be able to successfully complete this course we expect you to be able to:

- Recognise a person experiencing an allergic/anaphylactic reaction
- Access and follow ASCIA management plans
- Demonstrate correct use of training adrenaline autoinjectors
- Develop an Individual Anaphylaxis Management Plan
- Develop risk minimisation strategies
- Develop a communication plan for anaphylaxis
- Complete any other relevant workplace documentation

Learner support

Our facilitators will promote an inclusive learning that respects the individuality, dignity and privacy of all participants.

If you have special needs for completing this training and assessment, please identify this during enrolment or before starting training. Your facilitator will help ensure any reasonable options are made available to help support you through the course.

Resources for this training and assessment

The following will be provided for your use at the face to face course:

- Appropriate PPE
- Adrenaline autoinjector training devices
- Copies of ASCIA allergy and anaphylaxis management plans
- First aid incident report form

Accreditation and award issued

Successful completion of all requirements for this course results in a nationally recognised training Statement of Attainment. This certificate will be issued to you after completing all requirements and paying all due course fees.

Maintaining currency

It is recommended that you refresh your knowledge and skills related to using an adrenaline autoinjector every 12 months, and renew this course in anaphylaxis every 2 years.

Recognition of prior learning

If you have evidence that you already have the knowledge and skills for this unit of competency, discuss the possibility of an 'assessment only' option. If you are found competent in all the requirements for this unit of competency then you may not need to complete the training. Please discuss this with your facilitator.

Complaints and appeals

If you are dissatisfied with the training provided, please discuss this with your facilitator on the day or contact the Healthguard Office on 1300 001 302. We are happy to discuss any issues or concerns.

If you disagree with the assessment decision or process there is an appeals process. Please contact our office to discuss this.

ALLERGIC REACTIONS

Allergy: An extra-sensitive response from the body's immune system to a certain substance that comes into contact with the body.

Allergen: Substance that causes the allergic reaction.

Substances that are allergens commonly include foods, pet dander, pollen, dust mites, bee venom or other insect bites.

People will react in different ways following contact with the allergen. Most people will only suffer with a **localised reaction**, where the reaction occur in one spot, such as a small localized skin rash where the bite occurred or allergen contacted the skin. It may also be a **systemic reaction** that involves a body system (such as skin or breathing).

If multiple body systems are involved then it is likely a life-threatening reaction (Anaphylaxis).

Anaphylaxis: The most severe and life-threatening form of an allergic reaction. It is often fast occurring and it affects multiple systems in the body.

The reaction makes the blood vessels in the body leaky. This results in swelling. The body thinks it is fighting an invader, which is why everything also becomes red and irritated. The severe allergic reaction usually occurs within 20 minutes of exposure to the trigger. Anaphylaxis may occur even without prior exposure to a trigger. It can affect any person at any age.

It is important to understand that mild/moderate signs and symptoms of an allergic reaction do not always precede anaphylaxis.

As outlined in the ***National Allergy Strategy*** for Australia, allergic diseases, particularly food allergy and drug allergy, are increasing in prevalence, complexity and severity:

- 1 in 10 infants now have a food allergy
- 1 in 20 children aged 10-14 years of age have a food allergy
- 2-4% of adults have a food allergy
- Fatalities from food-induced anaphylaxis increase by around 10% each year
- Hospital admissions for anaphylaxis have increased more than 4 to 5 times, especially for food related allergies.

CAUSES OF ALLERGIES

MAIN CAUSES

Food

Foods are the most common causes of anaphylaxis. Eight foods cause 95% of food allergic reactions in Australia. These are:

- Peanuts
- Tree nuts (hazelnuts, cashews, almonds, walnuts, pistachios, macadamias, brazil nuts, pecans, chestnuts and pine nuts)
- Eggs
- Cow's milk
- Wheat
- Soy
- Lupin
- Fish and shellfish (oysters, lobsters, clams, mussels, shrimps, crabs and prawns
- Sesame seeds

Bites and stings

Bee, wasp and jack jumper ant stings are the most common triggers of anaphylaxis to insect stings. Ticks, green ants and fire ants can also trigger anaphylaxis in susceptible individuals.

Medication

Medications, both over the counter and prescribed, can cause life threatening allergic reactions. Penicillin and aspirin are some common ones. Individuals can also have anaphylactic reactions to herbal or 'alternative' medicines.

Other triggers

Other triggers such as being cold, latex or exercise (with or without food) induced anaphylaxis are less common. Occasionally the trigger cannot be identified, despite investigations.

MANAGING REACTIONS DUE TO BITES AND STINGS

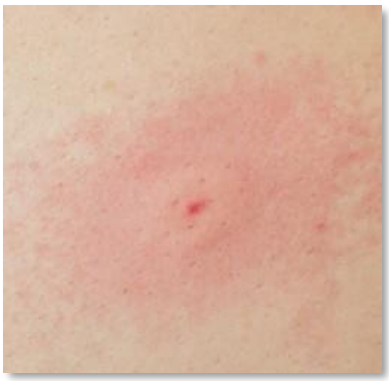
REMOVAL OF BEE STINGS

Bees usually leave their barbed sting in the skin and die. Flicking the sting out as soon as possible will reduce the amount of venom injected.

Use the edge of your fingernail, a car key or credit card. If possible, try not to squeeze the venom sac as this may increase the amount of venom injected.

WASP AND ANT STINGS

Wasps and ants do not leave a stinger in the skin.



REMOVAL OF TICKS

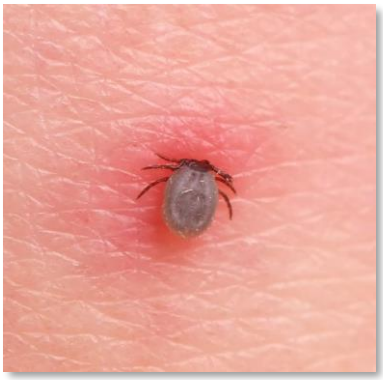
To reduce allergic reactions to ticks it is important that ticks are not forcibly removed or touched. Disturbing a tick may cause more allergen-containing saliva to be injected by the tick.

Published studies show that the safest way to remove a tick is to:

Freeze the tick, using a product that rapidly freezes and kills the tick. In most cases ether containing sprays will kill the tick within 5 minutes, and it will drop off the skin, OR,

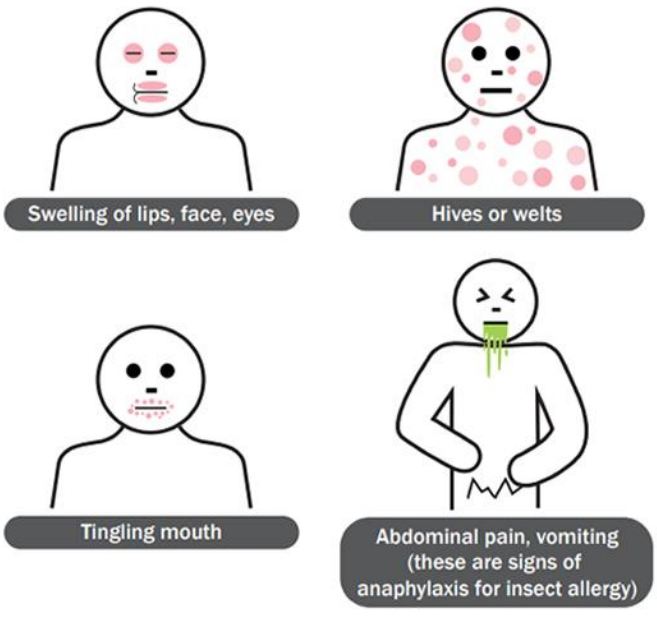
Leave the tick in place and seek medical assistance t o remove the tick.

It is unsafe to insert fine tweezers between the skin and the tick mouthpiece and lever the tick out.



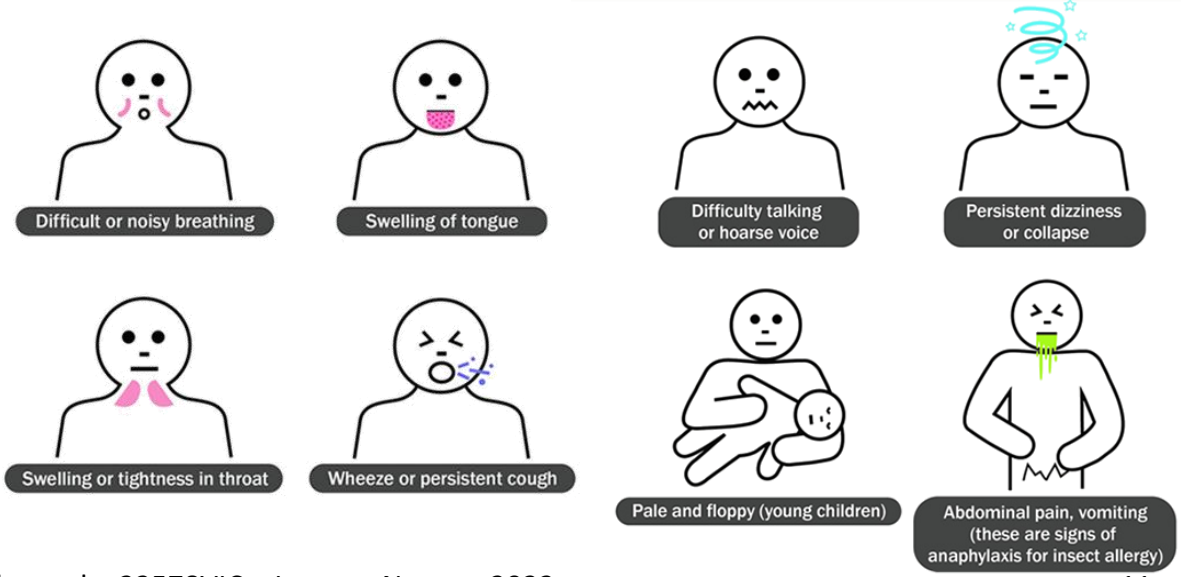
MANAGEMENT OF MILD TO MODERATE REACTIONS

SIGNS AND SYMPTOMS	MANAGEMENT
• History of exposure to allergen Localised: • Swelling • Hot and itchy red bump • Painful to touch Systemic: • If respiratory system may have watery eyes, runny nose, extra mucus, cough • If skin may have red itchy rash or hives including swelling to lips, eyes or face in general. Lips may tingle • If gastrointestinal may suffer from nausea, vomiting, abdominal pain or diarrhoea (Note – gastrointestinal signs for insect allergies is a sign of anaphylaxis) **Note:** reaction is not involving multiple body systems	Follow G.R.A.S.P. • Get help – if needed • Reassure the casualty • Apply cold compress to affected area • Some casualties may have antihistamines or other medications they take for known allergies to combat symptoms • Watch for signs of anaphylaxis



MANAGEMENT OF SEVERE (ANAPHYLACTIC) REACTIONS

SIGNS AND SYMPTOMS	MANAGEMENT
Signs and symptoms will differ between casualties. They do not need to have all symptoms or body systems affected for it to be anaphylaxis. • History/known allergy (but this may also be the first time) • Signs of shock • Nausea and/or vomiting and abdominal pain (for insect allergies) • Chest tightness • Difficulty/noisy breathing • Difficulty talking/hoarse voice • Persistent cough • Facial swelling • Swelling of tongue and throat • Itchy red rash • Hives • Pale and floppy (in young children) • Dizziness • Loss of consciousness.	If the casualty is conscious and is able to follow commands, follow G.R.A.S.P. • Get help – Call 000. This is life threatening • Reassure the casualty • Move the casualty away from trigger but do not let them stand or walk • Follow their Anaphylaxis action plan, if available • Assist with administration of any medication the casualty has, e.g. Adrenaline injector device, antihistamines, asthma puffer • Slacken any tight clothing • Monitor response to medications/ adrenaline Position **lying down** unless they need to sit up a little due to breathing difficulties. Follow D.R.S.A.B.C.D if the casualty is drowsy or unresponsive. Unconscious casualties should always be placed in the recovery position.



WHAT ABOUT…

ASTHMA AND ANAPHYLAXIS

If a person has asthma like symptoms, but there is also a risk that it may be an anaphylactic reaction, then treat anaphylaxis first.

Give the adrenaline injector first, followed by asthma reliever medication. Call an ambulance and continue following both the ASCIA Action Plan for Anaphylaxis and asthma first aid.

NO PREVIOUS HISTORY OR ALLERGY OR ANAPHYLAXIS

A person can experience anaphylaxis even though they may not have been diagnosed of being at risk of anaphylaxis, or have not been prescribed an adrenaline injector.

If the casualty is displaying signs and symptoms of anaphylaxis, use an adrenaline injector device.

ACTIONS TO AVOID

Under no circumstances should a person experiencing anaphylaxis **take a shower**, even if they think it will relieve symptoms, for the following reasons:

- Standing can cause a further drop in blood pressure
- Warm showers promote vasodilation (widening of the blood vessels), which can also lower blood pressure
- Bathroom floors are hard, so there is a greater risk of injury if the person faints and falls.

They should also avoid **eating and drinking anything**, as this can cause them to vomit, which may be inhaled (aspirated).

ASCIA ACTION PLANS

ASCIA Action Plans have been developed as an easy to follow, single page document to assist in treatment of allergies and anaphylaxis, including emergency actions.

There are different plans to cover allergic reactions of different severity (mild/moderate and severe), and also to consider emergency situations where a person may not know they have an allergy.

In education and care settings, a copy of a person's ASCIA Action Plan for Anaphylaxis (prepared by a medical or nurse practitioner), including an up-to-date photo of the person, must be obtained from the individual or parent/carer and held by the facility.

The individual or parent/carer is also required to provide any updates if the person's medical condition changes.

Scheduling and reviewing of the ASCIA Action Plans is the responsibility of the individual's treating doctor or nurse practitioner.

ASCIA Action Plans do not expire, and therefore the plan is still valid beyond the review date, which is a guide for patients to see their doctor.

Examples of ASCIA Action Plans are shown on the following pages.

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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.

Remember that a person may be told to use other medications to help manage an allergic reaction. You may need to assist in ensuring this medication is accessed and taken.

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www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For use with adrenaline (epinephrine) injectors

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:

Refer to the device label for instructions on how to give an adrenaline (epinephrine) injector.

Instructions are also on the ASCIA website www.allergy.org.au/anaphylaxis

Adrenaline injectors are prescribed 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, call for help and locate adrenaline injector
- 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**
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- **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
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 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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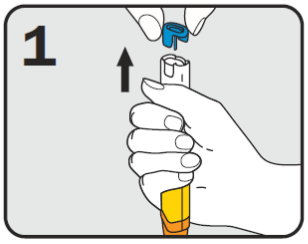
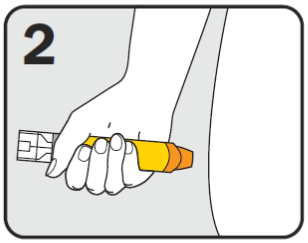
FIRST AID PLAN FOR Anaphylaxis

For use with EpiPen® adrenaline (epinephrine) autoinjectors

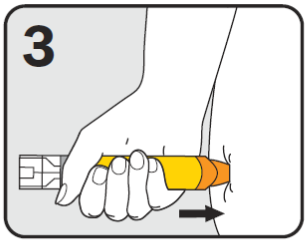
How to give EpiPen®



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.

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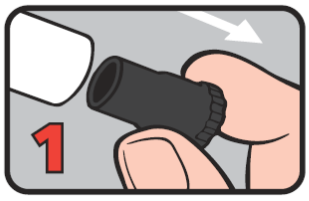
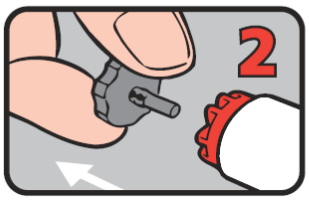
FIRST AID PLAN FOR Anaphylaxis

For use with AnaPen® adrenaline (epinephrine) autoinjectors

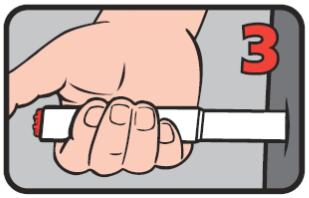
How to give AnaPen®



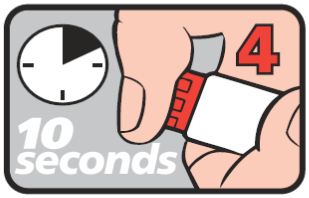
PULL OFF BLACK NEEDLE SHIELD



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
- 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.

RESOURCES AND EQUIPMENT

In your workplace you should have the following resources available to help manage an allergic or anaphylactic event:

- ASCIA Action Plan for any staff/child who has a known allergy/anaphylactic reaction
- ASCIA First Aid Action Plan for any unexpected reactions
- The casualty's own adrenaline injector (where prescribed)
- Any additional medications prescribed to the casualty that have been identified in their ASCIA Action Plan
- A workplace's emergency first aid kit containing adrenaline injector for general use (how many of these to be available will need to be determined by the facility, taking into account the number of diagnosed children attending the facility and the likely availability of a backup device in various settings, including excursions and camps).
- Communication equipment or alarm system - to get help from other staff and/or to call for an ambulance

Note: Bring the resources, including medication, to the casualty rather than moving the casualty. Do not allow the casualty to walk, stand or sit up suddenly, even if they appear to have recovered.

IMPORTANCE OF POSITIONING

ASCIA Action Plans for Anaphylaxis include the following infographics that show the correct and incorrect positioning of a person having a severe allergic reaction (anaphylaxis).

Lay the casualty flat - do NOT allow them to stand, walk or be held upright, even if they appear to have recovered.

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

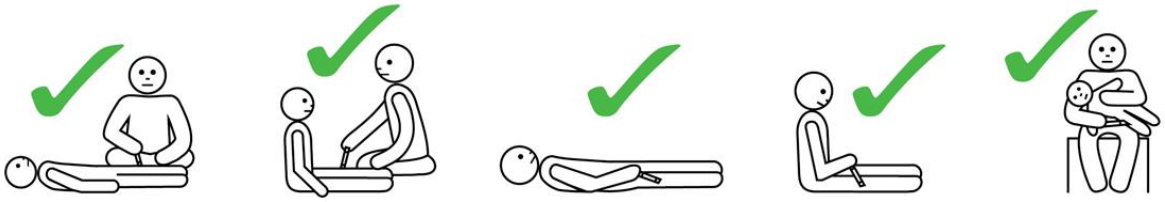
When a person has anaphylaxis their blood pressure can drop rapidly, which reduces blood flow to the heart. Laying the person flat will help blood flow to the heart which improves blood pressure, whilst standing can make anaphylaxis worse by causing blood pressure to drop.

USING ADRENALINE AUTO INJECTORS

ADRENALINE

Adrenaline is a naturally occurring substance in the body.

Adrenaline given as an injection into the muscle of the outer mid-thigh is the most effective first aid treatment for anaphylaxis. Using this large muscle means it is absorbed quickly and it makes it extremely unlikely that damage to nerves and tendons will occur, or that it will be accidentally be injected into an artery or vein. It is also the least painful part of the body to give an injection.



One of the actions of Adrenaline is to make blood vessels less leaky. Where swelling has occurred, this can help to reduce the swelling, open the airways and make breathing easier. Adrenaline also makes the heart beat harder and faster, which can help to increase blood pressure that becomes low when all the 'pipes' are leaking.

The adrenaline works within minutes and the effects last around 10 to 20 minutes.

Temporary side effects of adrenaline can include increased heart rate, trembling and paleness. Therefore, someone may still look unwell even after the adrenaline injector has been given.

INJECTOR DEVICES

Injector devices contain a single fixed dose of adrenaline. They are designed to be used by people who do not have medical training, such as a friend, teacher, children's education/care (CEC) centre worker, parent, passer-by, bystander or the person with anaphylaxis themselves (if they are well enough and old enough).

Instructions are shown on the label of each device and on the ASCIA Action Plan for Anaphylaxis.

The device can be used through a single layer of clothing (not thick jeans, seams or pockets).

There are two different brands of injector devices currently available in Australia – Epipens and Anapens. You should know how to use both.

USE THE INJECTOR EVEN IF YOU ARE UNSURE IF IT IS ANAPHYLAXIS

If in doubt, it is better to use an adrenaline injector than not use it. Under-treatment of anaphylaxis is more harmful (and potentially life threatening) than over-treatment of a mild or moderate allergic reaction.

Remember, you can use an adrenaline injector on a person who has not been diagnosed with anaphylaxis or who has not previously been prescribed an injector device. It is possible that this is their first anaphylactic reaction.

EPIPEN

While the medication inside the Epipen device is the same, there are 2 standard doses:

EPIPEN JUNIOR (Green)
Child (aged 1-5 years):
0.15mg
(half dose)

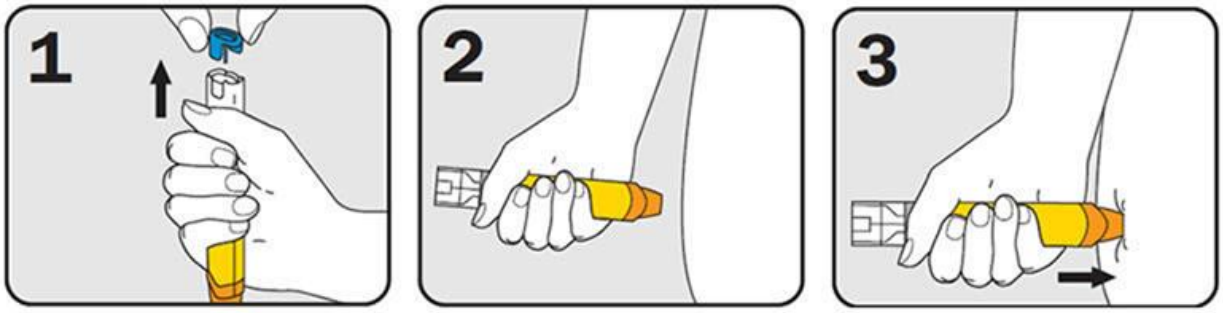
EPIPEN (Yellow)
Child (over 5 years) and Adults:
0.30mg

USING THE EPIPEN AUTO INJECTOR

1. Follow the instructions printed on the device itself or on the casualty's Action Plan
2. Remove the device from its protective container
3. Check the dose, expiration date and viewing window
4. Form fist around the Epipen
5. Remove blue safety cap by pulling straight up – do not bend or twist
6. Place the orange tip gently against the skin or through the clothes at the mid-thigh - **"Blue to the sky, orange to the thigh"**
7. Push the Auto Injecting Device until a loud "click" is heard (this can be quite loud). This means that the device has been activated
8. Hold in place for 3 seconds while the adrenaline is injected under pressure.

9. Remove the pen from the thigh. After injection, the orange cover automatically extends to ensure the needle is never exposed

10. Store the injector safely until arrival of Ambulance
11. Record the time that the Auto Injecting Device was given
12. There may be some slight bleeding at the injection site. Apply firm pressure with a cloth, tissue, clean handkerchief or bandage. You do not need to rub the area
13. You may need to repeat the process with a second auto injector if:
    - There is no improvement after 5 minutes
    - The person's condition gets better, but then worse again
    - If it seems the device didn't work or was accidently discharged before being injected into the person
14. Give used devices to the ambulance officer.



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®

ANAPEN

While the medication inside the Anapen device is the same, there are 3 standard doses:

ANAPEN JUNIOR (Green)
Child (1-5 years):
0.15mg

ANAPEN 300 (Orange)
Child (over 5 years) and Adults over 20kg:
0.30mg

ANAPEN 500 (Purple)
Child and Adult over 50kg
0.50mg

USING THE ANAPEN AUTO INJECTOR

1. Follow the instructions printed on the device itself or on the casualty's Action Plan
2. Remove the device from its container
3. Check the dose and expiration date
4. Form fist around the Anapen
5. Remove the needle cap (black boot) at the base of the device by pulling gently outwards and look inside the bottom of the device to make sure the grey needle sheath has come out.
6. Remove the black safety cap from the top of the device to expose the red firing button
7. Hold the Anapen with your thumb closest to the red button
8. Place the needle end gently against the skin or through the clothes at the mid-thigh
9. Press the red firing button. You will hear a click at the moment of injection. This means that the device has been activated
10. Hold in place for 10 seconds while the adrenaline is injected under pressure. The injection indicator will turn red to show the injection is complete.
11. Remove the pen from the thigh. After injection, the needle is exposed. You must press the needle down on a hard surface to avoid possible needlestick

injury. You can also place the needle into the wide end of the black needle shield or place it into a container

12. Store the injector safely until arrival of Ambulance
13. Record the time that the Auto Injecting Device was given
14. There may be some slight bleeding at the injection site. Apply firm pressure with a cloth, tissue, clean handkerchief or bandage. You do not need to rub the area
15. You may need to repeat the process with a second auto injector if:

- There is no improvement after 5 minutes
- The person's condition gets better, but then worse again
- If it seems the device didn't work or was accidently discharged before being injected into the person

15. Give used devices to the ambulance officer.

WHAT ABOUT…

USING OTHER PEOPLE'S ADRENALINE INJECTOR DEVICES

If a person requires an Adrenaline injector, however their own device is not available and a general use device is not available, another person's prescribed adrenaline injector can be used. This MUST be replaced as soon as possible, as it leaves the other person at higher risk.

USING DIFFERENT DOSES OF ADRENALINE INJECTORS

For children under 5: If only a higher dose device is available (containing 300 microgram of adrenaline) this should be used in preference to not using one at all.

For children over 5 and adults: If only a lower dose device is available (e.g. containing 150 micrograms of adrenaline) this should be used in preference to not using one at all. If 2 devices are available, they can be used together to give the 300 microgram adult dose.

USING EXPIRED/FUNNY COLOURED ADRENALINE

Injector devices with discoloured or expired adrenaline are not as effective when used for treating anaphylaxis and should therefore not be relied upon to treat anaphylaxis. However, the most recently expired adrenaline injector available should be used if no in-date device is available.

REUSING THE DEVICE IF IT WAS PULLED OUT TOO QUICKLY

Each adrenaline injector only releases a single, fixed dose of adrenaline once the device is triggered. The adrenaline is expelled quickly once the device is activated, which can only be done once. You cannot reuse the device.

ACCIDENTLY INJECTING MYSELF WITH THE ADRENALINE INJECTOR DEVICE

Most accidental injections (an estimated 94%) occur when a casualty or someone trying to help them accidentally jabs their finger or thumb.

An accidental injection to the hands or feet can impair blood flow to these areas and can potentially cause tissue death. This however, is the worst-case scenario.

Symptoms of an accidental injection are not usually so severe and may include:

- temporary numbness or tingling
- pain and swelling at the injection site
- elevated heart rate and/or heart palpations.

Regardless, you should always seek medical attention in the event of an accidental injection. Better safe than sorry!

Call the Poisons Information line on 13 11 26 for further advice.

LOOKING AFTER ADRENALINE INJECTOR DEVICES

STORAGE

Adrenaline injector devices should be stored:

- In a cool dark place at room temperature, between 15-25°C, but not refrigerated, as temperatures below 15°C may damage the injector mechanism.
- Where they are readily available and not in a locked cupboard.
- With a **RED** ASCIA Action Plan for Anaphylaxis, clearly labelled with the name of the person who has been prescribed the device, including if the device is carried by the person.
- With an **ORANGE** ASCIA First Aid Plan for Anaphylaxis if they are for general use (not prescribed for a person).

CARRYING ADRENALINE INJECTORS

People who are at risk of anaphylaxis should have an adrenaline injector with them, either carried themselves (if they are old enough), or by their parent/carer.

Note: The decision as to whether a child can carry their own adrenaline injector should be made when developing the student's anaphylaxis management plan, in consultation with the student, their parents/guardians and their medical practitioner. This decision is generally based on a combination of factors, including age, maturity and ability to use the device.

If a child carries their own adrenaline injector device they:

- May not physically be able to self-administer due to the effects of anaphylaxis.
- Should be educated that if they self-administer, they should immediately alert a staff member and an ambulance must be called.
- Need to have a second adrenaline injector (provided by the parent/guardian) kept on site at the facility in an easily accessible, unlocked location that is known to all staff.
- Should use an insulated wallet if carrying a device outside for an extended time in the heat (such as hiking or at the beach).

Note: If adrenaline autoinjectors are stored with asthma inhalers (reliever or preventer puffer) in a person's first aid kit, they should not be separated. Asthma inhalers should be stored below 30°C but do not need to be refrigerated, and should not be left in cars.

EXPIRY

The shelf life of adrenaline injectors is normally 1-2 years from date of manufacture.

The expiry date on the side of the device needs to be marked on a calendar and the device must be replaced prior to this date.

Expired adrenaline injectors are not as effective when used for treating anaphylaxis. However, if no other adrenaline injector is available, a recently expired adrenaline injector should be used in preference to not using one at all.

EpiPen autoinjectors contain a clear window near the tip where you can check if the adrenaline is discoloured or contains sediment. If this is the case, the device should be replaced as the adrenaline may be less effective.

DISPOSAL

After using an adrenaline injector device:

- An ambulance should be called immediately to take the person to hospital, so they can be given further treatment and remain under observation for at least 4 hours.
- The used device needs to be clearly labelled with the time it was given and then handed over to the ambulance.

Note: Adrenaline autoinjectors are single use devices and **cannot** be reused, even if some adrenaline remains inside the device.

REPLACEMENT

The adrenaline injector device will need to be replaced by the individual/parent or carer:

- after use
- if the device is faulty or misfired (for return to manufacturer)
- when the device is expired

Note: A reviewed/updated and signed ASCIA Plan for the individual is also needed every time their Adrenaline injector device is replaced.

STRESS AND POST-INCIDENT SUPPORT

Emergencies are stressful and emotionally draining. Depending on the circumstances it is also psychologically traumatic for everyone involved, including the casualty, others witnessing the anaphylactic reaction, and parents/carers.

If steps are not taken to look after yourself and anyone else at the scene, there is a risk of developing post-traumatic stress.

SUPPORT OPTIONS

In the event of an anaphylactic reaction, children and staff may benefit from post-incident support. Options could include:

- Debriefing conducted by skilled professional (e.g. critical incident counsellor)
- Peer support program (e.g. 250k)
- Professional psychological support
- Employee Assistance Programs (EAP)
- Lifeline
- Beyond Blue
- Youth Supports (e.g. Kids Helpline or Headspace)
- Allergy & Anaphylaxis Australia (A&AA)

SELF-CARE

If you are feeling distressed after the incident, even if you don't feel like it, try to do some of the things suggested below. They might help you to come to terms with the traumatic event you experienced.

- Recognise that you have been through a stressful event and that you will have an emotional reaction to it. Give yourself permission to feel bad, but also remember your strengths –it's tough, but you can deal with it.
- Get rest and eat well. Physical and mental health are closely linked.
- Cut back on tea, coffee, chocolate, soft drink, and cigarettes. Your body is already 'hyped up' enough, and these substances will only add to this.
- Resume your normal routine as soon as possible, but take it easy.
- Try not to bottle up your feelings or block them out. Recurring thoughts, dreams, and flashbacks are unpleasant, but they will decrease with time.

- Spend time with people you care about, even if you don’t want to talk about your experience. Sometimes you will want to be alone, and that’s OK too, but try not to become too isolated.

POST-INCIDENT ACTIONS

FOLLOW UP TASKS

- Ensure that replacement adrenaline injector devices are being organised.
- An interim Individual Anaphylaxis Management Plan should be put in place, to manage any other anaphylactic reactions that occur prior to the replacement Adrenaline Autoinjector being provided (either for the individual or for the General Use device).
- The person's Individual Anaphylaxis Management Plan should be reviewed, in consultation with the individual or parents/carers as appropriate.

INCIDENT REVIEW

After an anaphylaxis emergency your workplace's response to the incident needs to be reviewed.

Any identified areas for improvement should be recognised and recommendations made to improve future emergency responses.

This may involve:

- updating your organisation's anaphylaxis policy and procedures
- communicating any changes to other staff, children and parents/carers

LEGAL OBLIGATIONS FOR SCHOOLS

EDUCATION AND TRAINING REFORM ACT 2006

Section 4.3.1(6)(c) of the Act requires a school which has enrolled a student in circumstances where the school knows, or ought reasonably to know, that the student has been diagnosed as being at risk of anaphylaxis, to develop an anaphylaxis management policy which contains all of the matters required.

MINISTERIAL ORDER 706 – ANAPHYLAXIS MANAGEMENT FOR ALL VICTORIAN SCHOOLS

The purpose of the Order is to specify the matters that schools applying for registration and Registered Schools must contain in their anaphylaxis management policy for the purposes of s 4.3.1(6)(c) of the Act.

OUTSIDE SCHOOL HOURS CARE PROGRAMS

The Order does NOT apply to outside school hours care (OSHC) programs, whether run by the school or an external provider. The Education and Care Services National Law Act 2010 (Vic) specifies that an 'outside school hours service' is an 'education and care service', and the requirements relating to the management of anaphylaxis are contained in Regulation 90(1)(a) of the Education and Care Services National Regulations.

LEGAL OBLIGATIONS FOR CARE PROVIDERS

CHILDREN'S SERVICES ACT 1996 (AMENDED 2008)

section 26A of the Victorian Act requires all children's services to have an anaphylaxis management policy in place. This requirement applies whether or not you have a child enrolled who has been diagnosed as at risk of anaphylaxis.

CHILDREN'S SERVICES REGULATIONS 2009

The Victorian Regulations prescribe requirements, and in particular training requirements, related to anaphylaxis.

What must be included in the anaphylaxis management policy are listed in the Regulations. This includes:

- Ensuring that all staff members complete first aid training and anaphylaxis management training every 3 years
- Services regulated under the National Quality Framework and the Education and Care Services Supplementary Provisions legislation are required to have at least one educator who has undertaken current approved anaphylaxis management training to be in attendance at all times children are present
- If a child who has been diagnosed as at risk of anaphylaxis, then all staff members on duty must have undertaken approved anaphylaxis management training whenever caring for or educating the child
- All staff members on duty must have undertaken training in the administration of the adrenaline auto injection device at least every 12 months
- It is recommended that all staff members practise using the adrenaline auto injection device quarterly, whether or not a child with anaphylaxis is enrolled and attending the service. This should be recorded in the staff record
- A current anaphylaxis management action plan for the child (prepared and signed by the child's medical practitioner) must be recorded as part of the child's health information and kept in the child's enrolment record
- A risk minimisation plan must be developed in consultation with the child's parents/guardians
- Staff members must be able to identify where the adrenaline auto injection device is located for each child
- An authorisation form signed by a person authorised to consent to the administration of medication must be completed and attached to the child's enrolment record

OTHER LEGISLATION

DUTY OF CARE

All schools and care services have a legal duty to take reasonable steps to protect their children from reasonably foreseeable risks of injury.

In some circumstances, volunteers engaged in activities also have a duty of care to children, e.g. where volunteers have a direct supervision role with a student at risk of anaphylaxis, and where there are no staff present.

The organisation and its staff have a duty to take reasonable steps to inform themselves as to whether an enrolled child is at risk of anaphylaxis.

Employers of persons working in education and care services will generally be legally liable for the acts or omissions of their employees at work which result in a breach of the duty of care to a child attending an education and care service. This is called the principle of vicarious liability.

It essentially means that employers are legally responsible for what their staff do as part of their work. The exception is where the actions of an employee amount to serious and wilful misconduct. Carelessness, inadvertence or a simple mistake do not amount to serious and wilful misconduct.

EMPLOYEES LIABILITY ACT 1991

The Act is an additional protection for employees. It is aimed at ensuring that employers have no recourse against their employees in relation to liability claims. Again the exception is where there has been serious and wilful misconduct.

WORK HEALTH AND SAFETY ACT 2011

The Act provides that a person conducting a business or undertaking must ensure as far as is reasonably practicable that the health and safety of persons at the workplace are not put at risk.

A worker must:

- take reasonable care that what they do (or don't do) does not adversely affect the health and safety of others
- follow as best as able, any reasonable instruction that is given by their employer
- follow any policies and procedures set in place by their employer to keep people safe

DISABILITY DISCRIMINATION LEGISLATION

Anaphylaxis falls within the definition of disability for the purposes of both the Equal Opportunity Act 2010 (Vic) and the Disability Discrimination Act 1992 (Cth). This means that schools and care services must ensure that they do not unlawfully discriminate, either directly or indirectly, against children with anaphylaxis.

Direct discrimination could occur when a student is treated unfavourably because of their anaphylaxis, e.g. not being allowed to attend a camp because they have anaphylaxis, or being refused enrolment due to their condition.

Indirect discrimination may occur where a school has imposed a requirement on all students which disadvantages anaphylactic students. E.g., setting an assessment task which requires all students in a food technology class to prepare the same meal, where that meal contains a particular allergen.

STAFF TRAINING

The Ministerial Order 706 sets out the minimum requirements for anaphylaxis management training in schools and the Guidelines provide further detail on training requirements.

Under the Order school staff must undertake training in anaphylaxis management if they:

- conduct classes attended by students with a medical condition relating to allergy and the potential for anaphylactic reaction, or
- are specifically identified and requested to do so by the school principal, based on the principal's assessment of the risk of an anaphylactic reaction occurring while a student is under that staff member's care, authority or supervision.

Schools are encouraged to consider whether volunteers at the school and regular casual relief teachers should also undertake training.

The Order states that these school staff must:

- successfully complete an anaphylaxis management training course (either online in the last 2 years or face-to-face in the last 3 years) and
- participate in the school's twice yearly briefings conducted by the school anaphylaxis supervisor or another member of staff nominated by the principal who has completed an approved anaphylaxis management training course in the past 2 years.

Training must cover all available adrenaline injector devices currently on the market in Australia.

First aid training such as *HLTAID011 Apply First Aid* or *HLTAID012 Apply First Aid in an Education and Care Setting* alone does not sufficiently meet the training requirements of the Order.

Note: The DET, who authorised the 22578VIC course state that best practice is to complete refresher training in this course every 2 years.

OPTION TO USE THE ASCIA E-LEARNING COURSE AND IN-SCHOOL ASSESSMENT

It is recommended that all staff undertake the free Australasian Society of Clinical Immunology and Allergy (ASCIA) e-training course which has been developed by ASCIA in conjunction with the Department for all school staff, to increase the quality and consistency of training. The online course can be accessed on ASCIA's website.

To successfully complete this training staff will also be required to show that they are able to use an adrenaline auto-injector. This capability must be tested within 30 days of completion of the online training course.

Staff that complete the online training course will be required to repeat that training and the adrenaline auto-injector competency assessment every 2 years.

Schools should nominate 2 staff members from each campus to become school anaphylaxis supervisors who undertake competency checks on all staff that have successfully completed the online training course.

Note: To become a school anaphylaxis supervisor and undertake these competency checks, nominated staff must complete the accredited course *22579VIC Training in Verifying the Correct Use of Adrenaline Injector Devices*.

TWICE-YEARLY ANAPHYLAXIS BRIEFING REQUIREMENTS

In addition to the training above, an in-house anaphylaxis school briefing must be conducted twice a year. It is recommended that all staff attend this briefing.

This briefing should preferably be led by the school anaphylaxis supervisor or another member of staff who has current anaphylaxis training. The person leading the twice-yearly anaphylaxis school briefing should have successfully completed an anaphylaxis management training course in the previous 2 years.

A presentation for the briefing has been developed by the Department for schools use. Information covered needs to include:

- The Anaphylaxis Management Policy
- Identities of people diagnosed at risk of anaphylaxis (noting that information regarding children and including teenagers can only be shared with relevant staff, not the broader community)
- Risk identification and strategies to minimise the risk of an individual's exposure to known triggers/allergens
- Triggers of allergic reactions including anaphylaxis
- Signs and symptoms of allergic reactions, including anaphylaxis
- Roles and responsibilities of individuals in responding to allergic reactions
- First aid and emergency response procedures for various scenarios
- Location of all adrenaline injectors and their accompanying ASCIA Action Plans (noting these should always be kept/stored together)
- Correct storage of adrenaline injectors, including the required temperature and protection from direct light
- Use of Adrenaline injector devices

SCHOOL ANAPHYLAXIS MANAGEMENT POLICY

If a school has enrolled a student at risk of anaphylaxis, it must have a school anaphylaxis management policy. Schools without a student currently enrolled who is at risk of anaphylaxis are encouraged to also have a policy in place.

This policy should be reviewed annually and updated according to any change in individual school circumstances.

An Anaphylaxis Policy Template that meets these requirements is available for school use on the School Policy Templates Portal.

The Anaphylaxis Management Policy must contain all of the following matters:

- a statement that the school will comply with the Order and Guidelines on anaphylaxis management
- identification of the school staff who must complete anaphylaxis training and the procedures for the training
- information about the development, implementation, monitoring and regular review of individual anaphylaxis management plans for affected students, which includes 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 identify anaphylactic risks and minimise the risk of an anaphylactic reaction
    - school management and emergency response procedures for responding to an anaphylactic reaction
    - clear articulation of 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 adequate information about anaphylaxis and the school's anaphylaxis management policy
    - completion of an annual risk management checklist

An example policy is provided on the following page.

Sample Anaphylaxis Management Policy

School Name

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. This will acknowledge the School's responsibility to develop and maintain an Anaphylaxis Management Policy.

Individual Anaphylaxis Management Plans

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.

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;
- when the adrenaline auto-injector is replaced, 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 (e.g. 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.

Prevention Strategies

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

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;
  - 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.

Communication Plan

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;
    - 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.

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.

INDIVIDUAL ANAPHYLAXIS MANAGEMENT PLANS

An individual anaphylaxis management plan must be developed for each person who has been diagnosed by a medical practitioner as being at risk of anaphylaxis, where the facility has been notified of that diagnosis. The plan is to be developed in consultation with the individual or parents/carers.

The plan must be in place as soon as practicable after the individual commences school/care/work, and where possible, before the first day attending the facility.

An Individual Anaphylaxis Management Plan Template that meets requirements is available from https://www.education.vic.gov.au/PAL/anaphylaxis-individual-management-plan.docx

A copy is provided on the following pages.

As specified in the template, the plan must include:

- information about the person's allergy related medical condition, the potential for anaphylactic reaction (including signs and symptoms)
- strategies to minimise the risk of exposure to known allergens while the individual is at work/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 risk minimisation strategies which have been identified in the Plan
- information on where the person's medication will be stored
- the person's emergency contact details
- an up-to-date ASCIA Action Plan for Anaphylaxis completed by the person's medical practitioner

A copy of each individual anaphylaxis management plan should be stored with the person's ASCIA Action Plan for Anaphylaxis and the person's adrenaline autoinjector. Copies should be kept in various locations around the facility so that the Plan is easily accessible by staff in the event of an incident.

The plan should be reviewed on any of the following occurrences:

- annually (e.g. at the start of the year)
- if the person's medical condition (relating to allergy and the potential for anaphylactic reaction) changes
- when the adrenaline auto-injector is replaced

- as soon as practicable after an anaphylactic reaction at the facility
- when the person is to participate in an off-site activity.

Sample Individual Anaphylaxis Management Plan

This plan is to be completed by the principal or nominee on the basis of information from the student's medical practitioner (**ASCIA Action Plan for Anaphylaxis**) provided by the parent. It is the parent's responsibility to provide the school with a copy of the student's ASCIA Action Plan for Anaphylaxis containing the emergency procedures plan (signed by the student's medical practitioner) and an up-to-date photo of the student - to be appended to this plan; and to inform the school if their child's medical condition changes.			
School		**Phone**	
Student			
DOB		**Year level**	
Severely allergic to:			
Other health conditions			
Medication at school			
EMERGENCY CONTACT DETAILS (PARENT/CARER)			
Name		**Name**	
Relationship		**Relationship**	
Home phone		**Home phone**	
Work phone		**Work phone**	
Mobile		**Mobile**	
Address		**Address**	
EMERGENCY CONTACT DETAILS (ALTERNATE)			
Name		**Name**	
Relationship		**Relationship**	
Home phone		**Home phone**	
Work phone		**Work phone**	
Mobile		**Mobile**	
Address		**Address**	
Medical practitioner contact	**Name**		
	Phone		
Emergency care to be provided at school			
Storage location for adrenaline			

autoinjector (device specific)	

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 year, 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

www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For EpiPen® adrenaline (epinephrine) autoinjectors

Name:

Date of birth:

Confirmed allergens:

Family/emergency contact name(s):

Work Ph:

Home Ph:

Mobile Ph:

Plan prepared by medical or nurse practitioner:

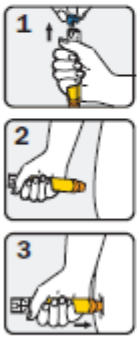
I hereby authorise medications specified on this plan to be administered according to the plan

Signed:

Date:

Action Plan due for review:

How to give EpiPen®



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

All EpiPen®s should be held in place for 3 seconds regardless of instructions on device label

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 - freeze dry tick and allow to drop off
- Stay with person and call for help
- Locate EpiPen® or EpiPen® Jr adrenaline autoinjector
- Give other medications (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/noisy breathing**
- **Swelling of tongue**
- **Swelling/tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking and/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, place in recovery position
- If breathing is difficult allow them to sit

2 Give EpiPen® or EpiPen® Jr adrenaline autoinjector

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

4 Phone family/emergency contact

5 Further adrenaline doses 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

Parents and guardians (via their medical practitioner) can access the ASCIA Action Plan from: http://www.allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis

This Individual Anaphylaxis Management Plan will be reviewed on any of the following occurrences (whichever happen earlier):

- annually (ideally start of school year for school-aged children)
- 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
- 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).

I have been consulted in the development of this Individual Anaphylaxis Management Plan.

I consent to the risk minimisation strategies proposed.

Risk minimisation strategies are available at Chapter 8 – Risk Minimisation Strategies of the Anaphylaxis Guidelines

Signature of parent:	
Date:	
I have consulted the parents of the students and the relevant school staff who will be involved in the implementation of this Individual Anaphylaxis Management Plan.	
Signature of principal (or nominee):	
Date:	

RISK MINIMISATION

An anaphylaxis management policy must include prevention strategies to be used to minimise the risk of a person suffering an anaphylactic reaction, for both in and out of school settings.

It is important to remember that minimisation of the risk of anaphylaxis is everyone's responsibility including staff, children and families.

A number of suggested risk minimisation strategies are from Allergy and Anaphylaxis Australia:
https://allergyfacts.org.au/images/pdf/Riskminimisation3.pdf

Some examples include:

- Having appropriate policy and emergency response procedures in place for a variety of scenarios both on site and off site
- Ensuring all staff complete relevant training
- Sending out information sheets to families about certain events/activities
- List ingredients in food when for sale
- Do not use food rewards
- Cover rubbish bins that attract bees/ants/wasps
- Specify outdoor areas that are lower risk of bees
- Ensure non-latex gloves are available

Staff will need to determine which strategies are appropriate after consideration of all relevant factors including the age of the person at risk, the facilities and activities available at the facility, the likelihood of that person's exposure to the relevant allergen/s whilst at the facility, and the general environment.

Prevention strategies must be reviewed at least annually, and as soon as possible following an anaphylaxis incident.

NUT AWARE, NOT NUT FREE

Nuts are the most common trigger for an anaphylactic reaction or fatality due to food-induced anaphylaxis. To minimise the risk of a person's exposure and reaction, facilities should not use nuts during in-school and out-of-school activities. It is also recommended that activities don't place pressure on individuals to try foods, whether they contain a known allergen or not.

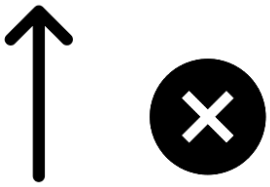
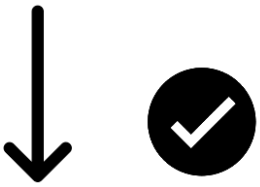
Blanket banning of nuts or other foods associated with anaphylaxis and allergies is not recommended because:

- it can create complacency amongst staff and students

- it cannot eliminate the presence of all allergens

RISK ASSESSMENT PROCESS

Below is an example of the risk assessment process for one allergy scenario.

	**1. Identify potential hazards (what could cause an allergic reaction?)** *Wasp nest often growing on side of building – 2 children at facility are allergic to wasp stings*
	**2. Assess the risk (how likely is it to happen? How severe would consequences be if it did happen?)** *Nests appear near area where balls often used for sport. Food bins also in area. Children with allergies play in area every day. LIKELY someone could be stung. Both individuals have anaphylactic reactions to the stings. SEVERE consequences. HIGH risk.*
	**3. Identify strategies to prevent or control the hazard** *Put lid on food bin. Warn children about nest and need to keep bin lid on. Get professional to remove any nests out of hours. Organise inspections every 6 months.*
	**4. Evaluate if the level of risk is reduced to an acceptable level** *Without nest risk is eliminated. Inspections every 6 months should keep risk LOW. This is acceptable.*
	**5. Monitor and review the effectiveness of your strategies** *Review with pest controller every 6 months or if anyone reports sighting of wasps in play area. Also update annually as part of risk minimisation strategies review.*

A risk minimisation checklist for anaphylaxis is shown on the following page, including a chart to document risk minimisation strategies for a scenario.

Risk Minimisation Plan for Anaphylaxis - Checklist

How well has the organisation planned for meeting the needs of individuals with allergies who are at risk of anaphylaxis?	
1. Who are the individuals?	• List names and room locations of each person at risk
2. What are they allergic to?	• List all of the known allergens for each person at risk • List potential sources of exposure to each known allergen and strategies to minimise the risk of exposure. This will include requesting that certain foods/items not be brought to the site.
3. Does everyone recognise the individuals at risk?	• List the strategies for ensuring that all staff, including relief staff and cooks, recognise each of the people at risk • Confirm where each person's ASCIA Action Plan (including photograph) will be displayed
4. Do families and staff know how the facility manages the risk of anaphylaxis?	• Record when each individual or parent/carer of an at risk person is provided a copy of the Anaphylaxis management policy
	• Record when each individual or parent/carer provides an Adrenaline Injector Device
	• Test that all staff, including relief staff, know where the Adrenaline injecting device is kept for each person at risk
	• Regular checks of the expiry date of each Adrenaline injecting device are undertaken by a nominated staff member and the individual or parent/carer
	• Organisation writes to all families requesting that specific procedures be followed to minimise the risk of exposure to a known allergen. This may include requesting the following are not sent to the site: ○ Food containing the major sources of allergens, or foods where transfer from one person to another is likely, e.g. peanut, nut products, whole egg, chocolate ○ Food packaging of risk foods, e.g. cereal boxes, egg cartons and so on
	• A new written request is sent to families if the food allergens change
	• Ensure all families are aware of the policy that no individual who has been prescribed an Auto Injecting Device is permitted to attend the site without that Auto Injecting Device
	• The organisation displays the ASCIA Emergency Action Plan for anaphylaxis, in a key location and locates a completed ambulance 'how to call' card by the telephone/s
	• The Adrenaline Injecting Device and the ASCIA Action Plan is taken on all off site events attended by the at risk person

5. Has a communication plan been developed which includes procedures to ensure that everyone is informed, changes are communicated, and staff are updated?	• List names and room locations of each person at risk • All individuals or parents/carers are provided with a copy of the Anaphylaxis Policy prior to commencing at service • A copy of this policy is displayed in a prominent location at the site • Staff will meet with individuals or parents/carers of a child diagnosed as at risk of anaphylaxis prior to commencement and will develop an individual communication plan for that family. • An induction process for all staff and volunteers includes information regarding the management of anaphylaxis at the service including the location of adrenaline auto-injector kits, anaphylaxis medical management action plans, risk minimisation plans and procedures, and identification of children at risk.

Do all staff know how the service aims to minimise the risk of a person being exposed to an allergen?

Think about times when the person at risk could potentially be exposed to allergens and develop appropriate strategies including identifying the person responsible for implementing them.

- Hygiene procedures and practices are followed to minimise the risk of cross-contamination of surfaces, food utensils or containers by food allergens
- Consider the safest place for the at-risk person to be served and to consume food, while ensuring they are not discriminated against or socially excluded from activities.
- Develop procedures for ensuring that each at-risk person only consumes food prepared specifically for them.
- Ensure everyone washes hands before and after eating.
- Employ teaching strategies to raise the awareness for everyone about anaphylaxis and the importance of no food sharing
- Ensure drinks and food for the at-risk person are clearly labelled with the name

Do relevant people know what action to take if a child has an anaphylactic episode?

- Know what each person's anaphylaxis action plan contains and implement the procedures.
- Know who will do each task in an emergency, including:
  - administer the adrenaline and stay with the child
  - getting help/calling 000
  - communicate with family
  - ensure the supervision of other children at the service
  - let the ambulance officers into the service and take them to the child.
- Ensure all staff have undertaken approved anaphylaxis management training and participate in regular practise sessions.
- Ensure a completed Ambulance Victoria AV How to Call Card is located next to all telephone/s.

How effective is the service's risk minimisation strategies?
Review the risk minimisation plan of each child diagnosed as at risk of anaphylaxis with parents/guardians at least annually, but always on enrolment and after any incident or accidental exposure to allergens.

Example scenario and risk minimisation strategies:

Scenario	Strategy	Responsibility
Protection for individuals with insect bite allergies	Ensure the person diagnosed as at risk of anaphylaxis wears shoes at all times they are outdoors.	Educators/care providers
	Respond promptly to any instance of insect infestation. It may be appropriate to request exclusion of the person diagnosed as at risk during the period required to eradicate the insects	Approved Provider/ Nominated Supervisor
	Specify outdoor areas that are lowest risk to the person diagnosed as at risk and encourage them to use that area.	Educators/care providers
	Decrease the number of plants that attract bees or other biting insects.	Approved Provider

ANAPHYLAXIS EMERGENCY RESPONSE PROCEDURES

The anaphylaxis management policy must include details of how the policy integrates with general first aid and emergency response procedures.

The policy must include emergency response procedures relating to anaphylactic reactions including:

- a complete and up to date list of persons identified as being at risk of anaphylaxis
- details of individual anaphylaxis management plans and ASCIA Action Plans, where these are located during on site and off site events
- an outline of the storage and accessibility of adrenaline injector devices, including those for general use
- how appropriate communication with school staff, students and parents is to occur in accordance with the communication plan
- how it is ensured that there are a sufficient number of school staff present who have been trained in anaphylaxis management

There needs to be clear roles and responsibilities for:

- Principals
- Staff
- Anaphylaxis supervisors
- Parents/carers

It is important that emergency response procedures allow staff to react quickly if an anaphylactic reaction occurs, regardless of the setting. Drills to test the effectiveness of these procedures should be undertaken regularly.

Some key points to consider for procedures include:

- How will Adrenaline injector devices be tracked as “in” or “out” from the main storage area, e.g. when offsite activities are occurring?
- Who will be nominated to remain with a person having an anaphylactic reaction?
- Who will be nominated to raise the alarm/call for help?
- Who will be nominated to wait for the ambulance and direct them to the casualty?
- How will a second Adrenaline injector device be sent to the location of the casualty in case it is needed?
- What will the procedure be during an off-site event?

COMMUNICATION PLAN

The school Anaphylaxis Management Policy must include a communication plan, which is to be reviewed at least annually.

The plan must provide information to all school staff, students and parents (and volunteers and casual relief staff) about anaphylaxis and the school's anaphylaxis management policy.

This includes listing the strategies for advising school staff and students about how to respond to an anaphylactic reaction of a student in various environments, including during normal school activities and during off-site or out of school activities.

RAISING STAFF AWARENESS

The communication plan must include arrangements for relevant staff to be briefed at least twice per year.

In addition, it is recommended that a 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, specialist teachers) of the above information and their role in responding to an anaphylactic reaction 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 School through fact sheets or posters displayed in hallways, canteens and classrooms. Teachers can discuss the topic with students in class, with a few simple key messages, outlined in the following:

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 to
6. Be respectful of a school friend’s Adrenaline injector device
7. Don’t pressure your friends to eat food 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. Also be aware that bullying of students at risk of anaphylaxis can occur in the form of teasing, tricking a student into eating a particular food or threatening a student with the substance that they are allergic to, such as peanuts.

Talk to the students involved so that they are aware of the seriousness of an anaphylactic reaction. Any attempt to harm a student diagnosed at risk of anaphylaxis must be treated as a serious and dangerous incident and dealt with in line with the School's anti-bullying policy.

COMMUNICATION WITH PARENTS/CARERS

Schools should be aware that parents/carers 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.

Aside from implementing practical prevention 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.

An example of a communication plan is provided on the following page.

Sample School Anaphylaxis Communication Plan

The Communication Plan provides information to all ***school name*** staff, students and parents about anaphylaxis and the school's Anaphylaxis Management Policy.

Raising Staff Awareness

All school staff are briefed twice yearly by the school anaphylaxis supervisor regarding the students with anaphylaxis, recognising the symptoms and staff's role in responding to anaphylactic reactions. All staff will complete ASCIA Anaphylaxis e-training every 2 years and be verified by the school anaphylaxis supervisor. All volunteers and Casual Relief teachers will be informed of students diagnosed with anaphylaxis and there role in responding to an anaphylactic reaction.

Raising Student Awareness

Teachers will discuss anaphylaxis with their students with a few key messages, including:

- the seriousness of food allergies
- eating their own lunch and not sharing food
- hand washing
- knowing what students in the class are allergic to
- seeking immediate help if another student becomes unwell.

Working with Parents

The school will develop an open and cooperative relationship with parents so that they can feel confident that appropriate management strategies are in place. The school anaphylaxis Supervisor will:

- inform parents/carers in writing one month prior to the EpiPen and plan expiry date
- work with parents to develop an Individual Anaphylaxis Management Plan to be reviewed yearly or after an anaphylactic reaction.

Parents will:

- inform the school at enrolment or when diagnosed of a student's allergies
- provide an ASCIA Action Plan to the school yearly that is signed by the students medical practitioner
- provide an EpiPen/EpiPen Jnr and any other medications required e.g. antihistamines and replace by expiry
- work with the anaphylaxis supervisor to develop an Individual Management Plan and review it yearly or after an anaphylactic reaction

- keep the school updated with any changes to the student's allergies.

Raising School Community Awareness

Information will be provided to the school community via school newsletters and through the school's communication portal Compass. Relevant posters raising anaphylaxis awareness and increasing understanding of the condition are displayed around the school.

Emergency Response Procedures

Responding to an anaphylactic reaction in the school during normal school activities

This includes in the classroom, in the schoolyard and all school buildings:

- Lay the student flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit, or if vomiting place in recovery position
- For an insect allergy, flick out sting if visible
- Stay with the child and send for immediate assistance using the emergency card system if outside, via phone if inside. Contact Office
- If in school yard, a staff member will bring the student's emergency pack to you
- Administer EpiPen
- Call 000 or have another person call for you
- Record time EpiPen was administered
- Phone parents/ carers or emergency contacts
- If there is no improvement after 5 minutes, administer further dose of school general use EpiPen
- Commence CPR if person is unresponsive and not breathing normally
- If you are unsure if it is anaphylaxis or asthma also give asthma medication.

Students' emergency packs containing individual EpiPens are located in the First Aid room in clearly labelled bags along with their ASCIA Action Plans. Students' ASCIA Action Plans are also clearly displayed on the wall of the First Aid room and in the students' classroom.

Emergency school EpiPen/EpiPen Jr are stored in clearly marked bags in the First Aid room.

Responding to an anaphylactic reaction during off-site or out of school activities

This includes on excursions, school camps and at special events conducted, organised or attended by the school:

- Lay the student flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit, or if vomiting place in recovery position
- For an insect allergy, flick out sting if visible

- Administer EpiPen

- Call 000 or have another person call for you
- Record time EpiPen was administered
- Phone parents/ carers or emergency contacts
- If there is no improvement after 5 minutes, administer further dose of school general use EpiPen
- Commence CPR at any time if person is unresponsive and not breathing normally
- If you are unsure if it is anaphylaxis or asthma also give asthma medication.

All staff responsible for a group/class/team of students should be aware of any serious medical conditions of students in their groups.

The staff in charge of the person at risk of anaphylaxis is responsible for carrying the Epipen with them at all times and ensuring that in the event of an anaphylactic reaction, the ASCIA Action Plan is followed and the EpiPen is administered promptly.

In the event of an anaphylactic reaction, staff members must follow the ASCIA Action Plan for anaphylaxis.

ANNUAL RISK MANAGEMENT CHECKLIST

Under the School Anaphylaxis Management Policy, the Principal must complete an annual anaphylaxis Risk Management Checklist to monitor their compliance with Ministerial Order 706, Department of Education Anaphylaxis Guidelines and their legal obligations.

It is recommended that the School's annual Risk Management Checklist for anaphylaxis contain questions relating to the following:

- Background information about the school and students identified at risk of anaphylaxis
- Details of Individual Anaphylaxis Management Plans and ASCIA Action Plans
- Storage and accessibility of Adrenaline injector devices
- Prevention strategies used by the school to minimise the risk of an anaphylactic reaction
- General first aid and emergency response procedures for when an allergic reaction occurs at all on-site and off-site activities
- Communication with School staff, students and parents.

An example is provided on the following pages.

Sample Annual Risk Management Checklist

(to be completed at the start of each year)

School name:	
Date of review:	
Who completed this checklist?	Name: Position:
Review given to:	Name Position
Comments:	

General information	
1. How many current students have been diagnosed as being at risk of anaphylaxis, and have been prescribed an adrenaline autoinjector?	
2. How many of these students carry their adrenaline autoinjector on their person?	
3. Have any students ever had an allergic reaction requiring medical intervention at school?	☐ Yes ☐ No
a. If Yes, how many times?	
4. Have any students ever had an anaphylactic reaction at school?	☐ Yes ☐ No
a. If Yes, how many students?	
b. If Yes, how many times	
5. Has a staff member been required to administer an adrenaline autoinjector to a student?	☐ Yes ☐ No
a. If Yes, how many times?	
6. If your school is a government school, was every incident in which a student suffered an anaphylactic reaction reported via the Incident Reporting and Information System (IRIS)?	☐ Yes ☐ No

SECTION 1: Training	
7. Have all school staff who conduct classes with students who are at risk of anaphylaxis successfully completed an approved anaphylaxis management training course, either: • online training (ASCIA anaphylaxis e-training) within the last 2 years, or • accredited face to face training (22300VIC or 10313NAT) within the last 3 years?	☐ Yes ☐ No
8. Does your school conduct twice yearly briefings annually? If no, please explain why not, as this is a requirement for school registration.	☐ Yes ☐ No
9. Do all school staff participate in a twice yearly anaphylaxis briefing? If no, please explain why not, as this is a requirement for school registration.	☐ Yes ☐ No
10. If you are intending to use the ASCIA Anaphylaxis e-training for Victorian Schools: a. Has your school trained a minimum of 2 school staff (School Anaphylaxis Supervisors) to conduct competency checks of adrenaline autoinjectors (EpiPen®)?	☐ Yes ☐ No
b. b. Are your school staff being assessed for their competency in using adrenaline autoinjectors (EpiPen®) within 30 days of completing the ASCIA Anaphylaxis e-training for Victorian Schools?	☐ Yes ☐ No
SECTION 2: Individual Anaphylaxis Management Plans	
11. Does every student who has been diagnosed as being at risk of anaphylaxis and prescribed an adrenaline autoinjector have an Individual Anaphylaxis Management Plan which includes an ASCIA Action Plan for Anaphylaxis completed and signed by a prescribed medical practitioner?	☐ Yes ☐ No
12. Are all Individual Anaphylaxis Management Plans reviewed regularly with parents (at least annually)?	☐ Yes ☐ No
13. Do the Individual Anaphylaxis Management Plans set out strategies to minimise the risk of exposure to allergens for the following in-school and out of class settings?	
a. During classroom activities, including elective classes	☐ Yes ☐ No
b. In canteens or during lunch or snack times	☐ Yes ☐ No
c. Before and after school, in the school yard and during breaks	☐ Yes ☐ No
d. For special events, such as sports days, class parties and extra-curricular activities	☐ Yes ☐ No
e. For excursions and camps	☐ Yes ☐ No

f. Other	☐ Yes ☐ No
14. Do all students who carry an adrenaline autoinjector on their person have a copy of their ASCIA Action Plan for Anaphylaxis kept at the school (provided by the parent)?	☐ Yes ☐ No
a. Where are the Action Plans kept?	

15. Does the ASCIA Action Plan for Anaphylaxis include a recent photo of the student?	☐ Yes ☐ No
16. Are Individual Management Plans (for students at risk of anaphylaxis) reviewed prior to any off site activities (such as sport, camps or special events), and in consultation with the student's parent/s?	☐ Yes ☐ No
SECTION 3: Storage and accessibility of adrenaline autoinjectors	
17. Where are the student(s) adrenaline autoinjectors stored?	
18. Do all school staff know where the school's adrenaline autoinjectors for general use are stored?	☐ Yes ☐ No
19. Are the adrenaline autoinjectors stored at room temperature (not refrigerated) and out of direct sunlight?	☐ Yes ☐ No
20. Is the storage safe?	☐ Yes ☐ No
21. Is the storage unlocked and accessible to school staff at all times? Comments:	☐ Yes ☐ No
22. Are the adrenaline autoinjectors easy to find? Comments:	☐ Yes ☐ No
23. Is a copy of student's individual ASCIA Action Plan for Anaphylaxis kept together with the student's adrenaline autoinjector?	☐ Yes ☐ No
24. Are the adrenaline autoinjectors and Individual Anaphylaxis Management Plans (including the ASCIA Action Plan for Anaphylaxis) clearly labelled with the student's names?	☐ Yes ☐ No
25. Has someone been designated to check the adrenaline autoinjector expiry dates on a regular basis? Who? ……	☐ Yes ☐ No
26. Are there adrenaline autoinjectors which are currently in the possession of the school which have expired?	☐ Yes ☐ No
27. Has the school signed up to EpiClub (optional free reminder services)?	☐ Yes ☐ No
28. Do all school staff know where the adrenaline autoinjectors, the ASCIA Action Plans for Anaphylaxis and the Individual Anaphylaxis Management Plans are stored?	☐ Yes ☐ No
29. Has the school purchased adrenaline autoinjector(s) for general use, and have they been placed in the school's first aid kit(s)?	☐ Yes ☐ No

30. Where are these first aid kits located? Do staff know where they are located?	☐ Yes ☐ No
31. Is the adrenaline autoinjector for general use clearly labelled as the 'General Use' adrenaline autoinjector?	☐ Yes ☐ No
32. Is there a register for signing adrenaline autoinjectors in and out when taken for excursions, camps etc?	☐ Yes ☐ No
SECTION 4: Risk Minimisation strategies	
33. Have you done a risk assessment to identify potential accidental exposure to allergens for all students who have been diagnosed as being at risk of anaphylaxis?	☐ Yes ☐ No
34. Have you implemented any of the risk minimisation strategies in the Anaphylaxis Guidelines? If yes, list these in the space provided below. If no please explain why not as this is a requirement for school registration.	☐ Yes ☐ No
35. Are there always sufficient school staff members on yard duty who have current Anaphylaxis Management Training?	☐ Yes ☐ No
SECTION 5: School management and emergency response	
36. Does the school have procedures for emergency responses to anaphylactic reactions? Are they clearly documented and communicated to all staff?	☐ Yes ☐ No
37. Do school staff know when their training needs to be renewed?	☐ Yes ☐ No
38. Have you developed emergency response procedures for when an allergic reaction occurs?	☐ Yes ☐ No
a. In the class room?	☐ Yes ☐ No
b. In the school yard?	☐ Yes ☐ No
c. In all school buildings and sites, including gymnasiums and halls?	☐ Yes ☐ No
d. At school camps and excursions?	☐ Yes ☐ No
e. On special event days (such as sports days) conducted, organised or attended by the school?	☐ Yes ☐ No
39. Does your plan include who will call the ambulance?	☐ Yes ☐ No
40. Is there a designated person who will be sent to collect the student's adrenaline autoinjector and individual ASCIA Action Plan for Anaphylaxis?	☐ Yes ☐ No
41. Have you checked how long it takes to get an individual's adrenaline autoinjector and corresponding individual ASCIA Action Plan for Anaphylaxis to a student experiencing an anaphylactic reaction from various areas of the school including:	☐ Yes ☐ No

a. The class room?	☐ Yes ☐ No
b. The school yard?	☐ Yes ☐ No
c. The sports field?	☐ Yes ☐ No
d. The school canteen?	☐ Yes ☐ No
42. On excursions or other out of school events is there a plan for who is responsible for ensuring the adrenaline autoinjector(s) and Individual Anaphylaxis Management Plans (including the ASCIA Action Plan) and the adrenaline autoinjector for general use are correctly stored and available for use?	☐ Yes ☐ No
43. Who will make these arrangements during excursions? ……..	
44. Who will make these arrangements during camps? ……..	
45. Who will make these arrangements during sporting activities? ……..	
46. Is there a process for post-incident support in place?	☐ Yes ☐ No
47. Have all school staff who conduct classes attended by students at risk of anaphylaxis, and any other staff identified by the principal, been briefed by someone familiar with the school and who has completed an approved anaphylaxis management course in the last 2 years on:	
a. The school's Anaphylaxis Management Policy?	☐ Yes ☐ No
b. The causes, symptoms and treatment of anaphylaxis?	☐ Yes ☐ No
c. The identities of students at risk of anaphylaxis, and who are prescribed an adrenaline autoinjector, including where their medication is located?	☐ Yes ☐ No
d. How to use an adrenaline autoinjector, including hands on practice with a trainer adrenaline autoinjector?	☐ Yes ☐ No
e. The school's general first aid and emergency response procedures for all in-school and out-of-school environments?	☐ Yes ☐ No
f. Where the adrenaline autoinjector(s) for general use is kept?	☐ Yes ☐ No
g. Where the adrenaline autoinjectors for individual students are located including if they carry it on their person?	☐ Yes ☐ No
SECTION 6: Communication Plan	
48. Is there a Communication Plan in place to provide information about anaphylaxis and the school's policies?	
a. To school staff?	☐ Yes ☐ No

b. To students?	☐ Yes ☐ No
c. To parents?	☐ Yes ☐ No
d. To volunteers?	☐ Yes ☐ No
e. To casual relief staff?	☐ Yes ☐ No
49. Is there a process for distributing this information to the relevant school staff?	☐ Yes ☐ No
a. What is it?	
50. How will this information kept up to date?	
51. Are there strategies in place to increase awareness about severe allergies among students for all in-school and out-of-school environments?	☐ Yes ☐ No
52. What are they?	

FURTHER INFORMATION

For further information about allergies, anaphylaxis and requirements for your workplace, please refer to the following sources of relevant and current information and guidelines:

Australasian Society of Clinical Immunology and Allergy (ASCIA)
https://www.allergy.org.au/

- Anaphylaxis e-training
- World allergy week
- ASCIA Action Plans
- Anaphylaxis management guidelines
- Anaphylaxis risk minimisation strategies for schools and education/care
- Anaphylaxis resources https://www.allergy.org.au/anaphylaxis

Allergy & Anaphylaxis Australia
https://allergyfacts.org.au/

- Allergy and anaphylaxis information
- Food allergies
- Other allergens
- Curriculum resources for use with students/children

National Allergy Strategy
https://nationalallergystrategy.org.au/

- Copy of strategy
- All about Allergens e-learning for food services

250K - A hub for the 250,000 young Australians living with severe allergy
https://250k.org.au

- 250K Youth project resources (are you allergy aware?)

Victorian Registration and Qualifications Authority
https://www.vrqa.vic.gov.au/schools/Pages/anaphylaxis-management.aspx

- Link to relevant legislation, ministerial orders, policy guidelines and checklists
- Children's Services and Education Legislation Amendment (Anaphylaxis Management) Act 2008 (VIC)
- Ministerial Order 706 (Updated December 2015)

Australian Children's Education and Care Quality Authority
https://www.acecqa.gov.au/qualifications/requirements/first-aid-qualifications-training

- Approved anaphylaxis management training