Further Information Sources:

The Department of Education & Training, Student Wellbeing Branch
www.sofweb.vic.edu.au/wellbeing/support/anaphyl.htm

Anaphylaxis Australia Inc.
www.allergyfacts.org.au

The Allergy Department, Royal Children's Hospital
www.rch.org.au

The Australasian Society of Clinical Immunology and Allergy (ASCIA)
www.allergy.org.au

The Department of Human Services Children's Services Policy
www.office-for-children.vic.gov.au

The Victorian Government Schools Reference Guide
www.eduweb.vic.gov.au/referenceguide/

ASCIA Guidelines for the Prevention of Food Anaphylactic Reactions in Schools, Preschools and Childcare Centres:
www.allergy.org.au <http://www.allergy.org.au/

Safe Schools Are Effective Schools: A Resource for Developing Safe and Supportive School Environments:
www.sofweb.vic.edu.au/wellbeing/safeschools/bullying/index.htm

Appendix 1

Legislation Summary:

extracted from The Australian Journal of Emergency Management, Vol. 18 No 4. November 2003

Queensland - The Queensland legislation, originally enacted as the Voluntary Aid in Emergency Act 1973 and subsequently as the Law Reform (Miscellaneous Provisions) Act 1995 is the oldest but its operation is limited to doctors and nurses. For the protection to apply a doctor or nurse must be rendering assistance at or near the scene of the emergency or providing assistance whilst a person is being transported from the scene of the emergency to hospital or other 'adequate medical care'. They must act in good faith and without gross negligence and without 'fee or reward' or an expectation of receiving a 'fee or reward'. (Eburn 2000, 66).

New South Wales - The Civil Liability Act 2002 (NSW) provides that a Good Samaritan can incur no personal civil liability in respect, of their acts or omissions (s 57), if certain requirements are met. The relevant conditions that must be met before the Act will apply there must be 'an emergency'; the Good Samaritan must be 'assisting a person who is apparently injured or at risk of being injured' (s 57); and the Good Samaritan must be acting in good faith and without expectation of payment or other reward (s 56).

The protection afforded by the Act will not apply if the Good Samaritan causes the injury in the first place, so the driver of the motor vehicle that runs over a pedestrian cannot rely on the section for protection when they provide first aid to the person they have injured; nor can a Good Samaritan rely on the section if they are intoxicated or if they fraudulently impersonate a professional rescuer (s 58).

South Australia - The Wrongs Act 1936 (SA) protects any person who 'in good faith and without recklessness' comes to the aid of another who is in need or apparently in need of emergency assistance (s 38(2)). Emergency assistance is by definition, limited to medical assistance or other assistance to protect life and safety, not property (s 38(1)). The Act also protects a medically qualified person who, without expectation of payment, gives advice via telephone or other telecommunications device about the emergency treatment of a person (s 38(3)).

Victoria - The Wrongs Act 1958 (Vic) is similar to the legislation in South Australia. Some key differences are that the 'advice' provision can be relied upon by any person, not just a 'medically qualified person' as in South Australia (s 31B(2)). The 'Good Samaritan' needs to act in good faith, but unlike South Australia, there is no requirement that the action be 'without recklessness'(s 31B(2)). Unlike New South Wales, the 'Good Samaritan' can rely on the legislation even if they created the emergency or accident in the first place (s 31B(3)).

Appendix 2

Ministerial Order 706

On 14 July 2008, the Children's Services and Education Legislation Amendment (Anaphylaxis Management) Act 2008 came into effect amending the Children's Services Act 1996 and the Education and Training Reform Act 2006 requiring that all licensed children's services and schools have an anaphylaxis management policy in place.

All schools must review and update their existing policy and practices in managing students at risk of anaphylaxis to ensure they meet the legislative and policy requirements outlined below.

Any school that has enrolled a student or students at risk of anaphylaxis must by law have a School Anaphylaxis Management Policy in place that includes the following:

- a statement that the school will comply with Ministerial Order 706 and associated guidelines
- an Individual Anaphylaxis Management Plan (that includes an individual ASCIA Action Plan for Anaphylaxis) for each affected student, developed in consultation with the student's parents/carers and medical practitioner
- information and guidance in relation to the school's management of anaphylaxis, including:
    - prevention strategies to be used by the school to minimise the risk of an anaphylactic reaction for in-school and out-of-school settings
    - school management and emergency response procedures that can be followed when responding to an anaphylactic reaction
    - the purchase of spare or 'backup' adrenaline auto-injection devices(s) as part of the school first aid kit(s), for general use
    - development of a Communication Plan to raise staff, student and school community awareness about severe allergies and the School's Anaphylaxis Management Policy
    - regular training and updates for school staff in recognising and responding appropriately to an anaphylactic reaction, including competently administering an EpiPen/Anapen and
    - completion of an Annual Anaphylaxis Risk Management Checklist.

Codes of Practice

Codes of practice state ways to manage exposure to risks. These were known as Advisory Standards until November 2004.

If a code of practice exists for a risk at your workplace, you must:

- Do what the code says; or
- Adopt another way that identifies and manages exposure to the risk; and
- Take reasonable precautions and exercise due care. Date, time and location of the incident

Immediate action

Taking immediate action is the essential principle in first aid, as many illnesses and injuries are time-critical, such as anaphylaxis, stroke or a heart attack. A basic principle of first aid is that "any attempt is better than no attempt", which is not a licence to undertake dangerous or reckless actions, but rather to recognise that when basic first aid principles are followed in time sensitive situations, the result could be saving someone's life.

A casualty who is not breathing effectively, or is bleeding heavily, requires immediate aid. Prompt, effective first aid gives the casualty a much better chance of a good recovery.

It is also important not to panic – often taking a moment to survey the scene and think about what is going on and what is the best way to help can help avoid recklessly endangering the life of bystanders or even the first-aider. Try to remain calm and think your actions through. A calm and controlled first aider will give everyone confidence that the event is being handled efficiently and effectively. Remember the basic flowcharts, as these are designed to help in a chaotic situation.

Appendix 3

First Aid Legal and Ethical Issues

THE FOLLOWING DOES NOT CONSTITUTE LEGAL ADVICE. INDEPENDANT LEGAL ADVICE SHOULD BE SOUGHT BY INDIVIDUALS AND / OR ORGANISATIONS IF REQUIRED IN THEIR OWN JURISDICTION.

FAMILY ATTENDANCE DURING CPR

It is not necessary to remove family members during resuscitation. All studies to date on both adults and children have demonstrated no detrimental emotional or psychological impacts, with most studies actually finding that being present during resuscitation was associated with improved measures of coping and positive emotional outcomes.

STANDARD OF CARE

Lay persons or volunteers acting as "Good Samaritans" are under no legal obligation to assist a fellow person. However, the ARC encourages the provision of assistance to any person in need. Should a lay person choose to assist, a standard of care is expected appropriate to their training (or lack thereof). Generally speaking, this standard is low. All Australian States and Territories have enacted Statutes which provide some measure of protection for the Good Samaritan / volunteer. They are required to act with "good faith" and without recklessness. The law differs from state to state: In New South Wales and Queensland the Good Samaritan / volunteer is required to act with reasonable care and skill – a standard which is in fact no different from the common law standard which pre-dated the legislation. In the Northern Territory, persons are required by Statute law to render assistance to any other in need.

The standard of care required of a person who has a duty of care to respond, is higher. All must, like any other persons in our community who hold themselves out to have a skill, perform their tasks to a standard expected of a reasonably competent person with their training and experience. This does not mean a standard of care of the highest level. For example, medical practitioners and other allied health workers such as nurses and paramedics are expected to meet a standard of care appropriate to their relevant fields of work.

REFUSAL OF TREATMENT

Competent adults are legally entitled to refuse any treatment even if life-sustaining or their decisions are not for their own benefit. Substitute decision-makers, such as parents or guardians of minors, can likewise refuse treatment but only if in the "best interests" of their charge.

Several States/Territories have legislature which gives statutory force to the common law principle that competent persons may refuse treatment. A refusal of treatment certificate (or similar) is required to be completed by the person when competent (an advance directive) or by the legal agent or guardian (e.g. enduring power of attorney) of an incompetent person in conjunction with a medical practitioner. In health institutions/facilities, refusal of treatment orders, such as DNAR (Do-not-attempt-resuscitation) or NFR (not for resuscitation) should be documented in case notes and signed. Such decisions should be recorded on appropriate certification in jurisdictions where they exist. It has long been settled law that parents or guardians of minors, in conjunction with doctors, may make legal and ethical decisions on withholding and withdrawing life-sustaining treatment.

COMMUNICATION WITH CASUALTIES AND BYSTANDERS

Providing first aid can be a very stressful and daunting experience – both for the casualty and first aider as well as bystanders. The manner in which a first aider communicates with a casualty and bystanders is often at the bottom of their priority list, especially when confronted with a potentially serious situation. It is important to always communicate in a respectful and sensitive manner. This is not to say that it isn't necessary to sometimes be assertive, especially if the situation is critical; however this should be done in a respectful and considerate manner. Doing so can often assist to calm everyone down as well as to achieve cooperation from the casualty and bystanders.

It is also important to be culturally aware – for example, some cultures do not like men coming into physical contact with females who are not in their family, and may respond negatively if this is attempted. It may be possible to explain your intentions in a respectful manner. If not, alternatively it may be possible to talk a family member through the basic steps of first aid in order to achieve the same goal without compromising their cultural or religious beliefs.

Appendix 4

EDUCATION AND CARE SERVICES NATIONAL LAW (EXCERPTS)

Centre-based services - regulation 136(1)

The approved provider of a centre-based service must ensure that the following persons are in attendance at any place where children are being educated and cared for by the service, and immediately available in an emergency, at all times that children are being educated and cared for by the service:

a) at least one educator who holds a current approved first aid qualification
b) at least one educator who has undertaken current approved anaphylaxis management training
c) at least one educator who has undertaken current approved emergency asthma management training.

Services must have staff with current approved qualifications on duty at all times and immediately available in an emergency. One staff member may hold one or more of the qualifications.

Premises on school site - regulation 136(2)

If children are being educated and cared for at service premises on the site of a school, suitably qualified staff must be in attendance at the school site and immediately available in an emergency.

Services must have staff with current approved qualifications on duty at all times and immediately available in an emergency. One staff member may hold one or more of the qualifications.

Family day care - regulation 136(3)

The approved provider of a family day care service must ensure that each family day care educator and family day care educator assistant engaged by or registered with the service:

a) holds a current approved first aid qualification; and
b) has undertaken current approved anaphylaxis management training; and
c) has undertaken current approved emergency asthma management training.

Each family day care services staff member, including educator assistants, must hold all three qualifications

Incidents, injury, trauma and illness

An approved service must have in place policies and procedures in the event that a child is injured, becomes ill, or suffers a trauma and should be followed. These must include the requirement that a parent be notified, as soon as possible and within 24 hours of an incident, injury, illness or trauma relating to their child (including the death of a child).

The National Regulations require that an incident, injury, trauma and illness record be kept and that the record be accurate and remain confidentially stored until the child is 25 years old. Information should be recorded as soon as possible, and within 24 hours after the incident, injury, trauma or illness. A sample 'Incident, injury, trauma and illness record" is included on page 161. This may be adapted for use by individual services, or providers may develop their own.

Serious incidents

The National Law requires the regulatory authority to be notified of any serious incident at an approved service. A serious incident means:

- the death of a child while attending a service, or following an incident while attending a service.
- any incident involving serious injury, trauma or illness of a child while being educated and cared for at an education and care service which a reasonable person would consider required urgent medical attention from a registered medical practitioner, or for which the child attended or ought reasonably to have attended a hospital. This might include, for example, whooping cough, a broken limb or an anaphylactic reaction.
- an incident at the service premises where the attendance of emergency services was sought, or should have been sought

First aid kits
A centre-based service must provide an appropriate number of suitable first aid kits that are easily recognisable and readily accessible to adults. The service must have policies and procedures about the administration of first aid to children being educated and cared for by the service.

A family day care educator must provide a suitable first aid kit at the residence or family day care venue that is easily recognisable and readily accessible to adults. First aid kits should also be taken when leaving the service premises for excursions, routine outings or emergency evacuations

When determining how many first aid kits are 'appropriate', the service should consider the number of children in attendance as well as the proximity of rooms to each other and the distances from outdoor spaces to the nearest first aid kit. For example, larger services may require a kit in each room or outside space, whereas a kit between two rooms might be appropriate in a smaller service with adjoining rooms.

Medical conditions
An approved service must have a policy for managing medical conditions which sets out practices in relation to the following:

- the management of medical conditions
- if a child enrolled has a specific health care need, allergy or relevant medical condition, procedures requiring parents to provide a medical management plan
- requiring the development of a risk minimisation plan in consultation with the child's parents
- requiring the development of a communications plan for staff members and parents.

Staff members and volunteers must be informed about the practices to be followed. If a child enrolled at the service has a specific health care need, allergy or other relevant medical condition, parents must be provided with a copy of the policy. Where a child has been diagnosed as at risk of anaphylaxis, a notice stating this must be displayed at the service

Administration of Medication
Medication (including prescription, over-the-counter and homeopathic medications) must not be administered to a child at a service without authorisation by a parent or person with the authority to consent to administration of medical attention to the child. In the case of an emergency, it is acceptable to obtain verbal consent from a parent, or a registered medical practitioner or medical emergency services if the child's parent cannot be contacted. In the case of an anaphylaxis or asthma emergency, medication may be administered to a child without authorisation. In this circumstance, the child's parent and emergency services must be contacted as soon as possible. The medication must be administered:

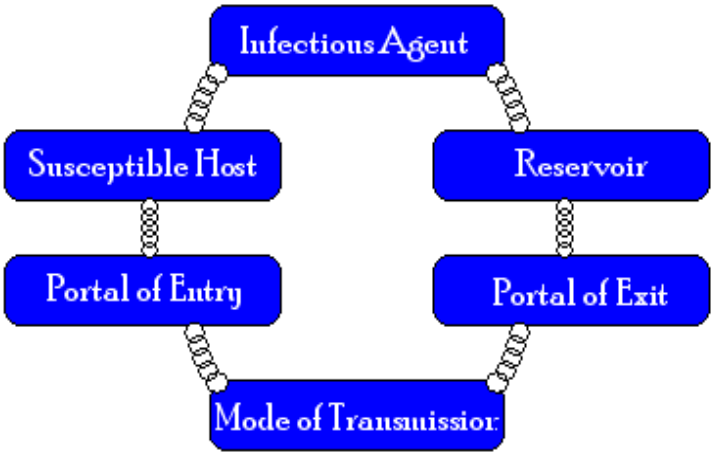
- from its original container before the expiry or use-by date
- in accordance with any instructions attached to the medication or provided by a registered medical practitioner
- for prescribed medications, from a container that bears the original label with the name of the child to whom it is prescribed
- with a second person checking the dosage of the medication and witnessing its administration
- details of the administration must be recorded in the medication record.

In the case of a family day care service, or a service that is permitted to have only one educator, a second person is not required to check the dosage and witness the administration of the medication.
The National Regulations set out requirements for confidentiality and the storage of medication records.

A child over preschool age may self-administer medication under the following circumstances:

- written authorisation is provided by a person with the authority to consent to the administration of medication
- the medical conditions policy of the service includes practices for self-administration of medication.

Infection Control



Chain of Infection

Whether or not infection happens will depend on a number of things. This is best explained by looking at the chain of infection.

The Six links to the Chain of Infection

In order for infection to occur, the six links to the Chain of Infection must occur.

Infectious Agent: any disease causing micro-organism (pathogen) i.e. bacteria, virus.

Reservoir: Where the pathogen is located (i.e. blood, saliva)

Portal of Exit: The route of escape of the pathogen from the reservoir (i.e. saliva via coughing, blood via cut in skin)

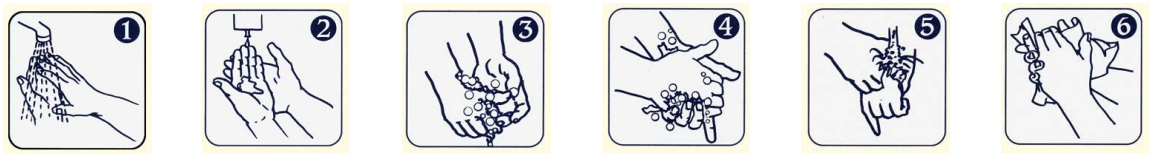
Mode of Transmission: How the pathogen gets from the reservoir to its new host (i.e. propelled through air, direct contact)

Portal of Entry: The route in which the pathogen enters the new host (breaks in skin (cuts, wounds), inhalation, ingestion, sexual contact)

Susceptible Host: The organism that accepts the pathogen (you or the casualty)

How to break the Chain of Infection

Correct Hand Washing: Appropriate hand washing by the First Aider remains the most important factor in preventing the spread of micro-organisms. Good hand-washing techniques include



1	2	3	4	5	6
Start with warm or hot water	**Use soap and make a lather**	**Rub & Scrub thoroughly for at least 20 seconds**	**Scrub palms, backs of hands, wrists, between fingers and under fingernails**	**Rinse well and use a disposable towel to turn off tap**	**Dry hands completely with a clean or disposable towel**

BARRIERS

Use barrier equipment whenever possible (gloves, masks, face shields, eye protection, aprons and tongs). Barriers will dramatically decrease the chance of infection spreading, both to the casualty and to you!





Needle Stick Injuries

Needle stick injuries are an opportunity for a pathogen to penetrate directly into the blood stream of another person if not handled carefully. HIV (AIDS) and Hepatitis B are just a few of the possible blood borne viruses that can be communicated from one person to another. The risk of actual infection depends on a number of factors, including firstly what pathogens are on the needle stick, and also how long it has been outside of the body for. Viruses such as HIV generally only survive outside the body for several minutes, but can survive hours if conditions are right. If injured by a used needle stick, one should always contact medical assistance so that testing and preventative measures can be done to decrease the risk of infection.

Ways to reduce the risk of needle stick injuries:

- It is generally recommended that workers who may come in contact with blood or body fluids should receive Hepatitis B vaccinations
- Follow all safety procedures in the workplace
- Latex or nitrile gloves will not protect you against needle stick injuries
- **Never** bend or snap used needles
- **Never** re-cap a needle
- Always place used needles into a clearly labelled and puncture-proof sharps approved container

If you do become contaminated by a sharp you should follow the following steps

- Penetration of skin - wash the blood / body fluid away with water
- Contamination of the eye – rinse with water or saline with the eye open
- Blood in mouth – spit out blood, and repeatedly wash with water
- Seek professional medical assistance from your doctor or hospital

First Aider Characteristics

As a First Aider, you could be dealing with difficult, life threatening situations. People around you may be screaming, moaning, or in a panic. A proficient First Aider will be:

Calm & Collected – As you approach an emergency – take a few deep breaths. This will help you slow down your racing heart, and encourage you to take a moment to collect your thoughts. By taking a few moments you will be able to absorb what is happening around you - what dangers are present, what injuries has the casualty sustained. By collecting your thoughts you will be able to logically approach the situation and remember your training. Concentrate on what you are doing, and try not to get distracted or flustered.

Reassuring – Many conditions can be exacerbated if a casualty becomes overly anxious and distressed. The casualty may be in shock, confused, or concerned. Talk to your casualty as a person, and reassure them that things are under control. If other people are present that are trying to help but are also finding the situation distressing, it helps to reassure them that you know what you are doing and the situation is in hand. This will encourage them to follow your instructions and help them to stay focused.

Assertive – There is a big difference between assertion and aggression. You need to be bold in your statements, and confident in your instructions. People will be relying on you to direct them. If you present yourself as someone who is confident in your own abilities, people will more readily take instructions from you. If you are the only First Aider on site, take control and provide assertive instructions to people with short explanations as to why those tasks are useful. If people understand what they are doing and know that you have things in control they will more readily assist you in what needs to be done to assist the casualty and keep everyone safe. If the casualty is anxious or going into shock, sometimes assertive instructions may be necessary to prevent them from moving or doing something that may exacerbate their condition.

Sensitive – It is important to be sensitive to a casualty's needs and the fact they are likely very stressed / anxious. It is likewise important to be culturally aware. There are many cultures with specific beliefs and attitudes which may cause people to respond negatively if a first aider forces themselves into a situation without considering the ramifications first. Good communication will often resolve any potential conflicts and enable a first aider to assist in a positive and helpful manner. Remember, you are much more likely to receive respect and cooperation from people if you are respectful to them!

Good communicator – You need to be clear in your instructions, as to not create confusion. A clear instruction meets 3 criteria:

- Observable – you must be able to see the person undertake your task
- Measurable – to what extent must the person do it
- Clear – easy to understand and specific

"I need you to call 000 for help, ask for an ambulance, and tell the operator the casualty is unconscious and breathing"

- This is observable, because you can see the person call 000
- This is measurable – because the person has been told what to say
- This is clear – as it is not ambiguous.

Safe Manual Handling

Manual handling includes pulling, pushing, lifting, moving, carrying, restraining or holding any person or object.

Safe manual handling involves:

Assessing the situation

- Can you move the person yourself, or is help required
- How far will you have to move the person
- Is the pathway clear or cluttered
- Are there any manual handling aids available (sheets / lifting equipment etc)

Sizing up the load

- Test the weight by lifting the corners, or tilting the object
- Ask for help if it is too heavy
- Use counter weight to assist in movement
- Ensure that the weight is within your capacity to safely lift

Use good lifting techniques

- Use good body mechanics - maintain a straight back, bend your legs and use equipment when available
- Maintain a large base of support. (Stabilising using your feet)
- Don't move a casualty on your own.
- Lift only as a last resort (the best lift is NO lift - unless life threatening)
- Keep the object close to your body.

Refer to Recovery Position for techniques for moving a casualty.

Basic Life Support Chart

Casualty who is NOT breathing and NOT conscious.

The Australian Resuscitation Council recommends using the following acronym when caring for the unconscious – **D R S A B C D**

D Check for **Danger**

Hazards / Risks / Safety?

R **Responsive? (Unconscious?)**

S **Call for Help (000)**

A Open **Airway**

B Check for normal breathing

C Start CPR (30:2)
Give 30 chest **Compressions**
(almost 2 compressions / second)
followed by 2 breaths
If you are unwilling or unable to perform rescue breaths, continue with chest compressions only

D Attach **AED** as soon as available and follow its prompts

Continue **CPR** until qualified personnel arrive or signs of life return.

As you will see, this process is very similar to providing care to Caring for the unconscious. Infact, you will find that the some of the words are the same

- **Danger**
- **Response**
- **Send for Help**
- **Airway**

same for breathing and non-breathing casualties

Anaphylaxis Personal Plan Template

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

ACTION PLAN FOR Allergic Reactions

Name: _____

Date of birth: _____

Photo

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by:

Dr: _____

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

Signed:

_____

Date: _____

Date of next review: _____

Note: The ASCIA Action Plan for Allergic Reactions is for people with mild to moderate allergies, who need to avoid certain allergens.

For people with severe allergies (and at risk of anaphylaxis) there are ASCIA Action Plans for Anaphylaxis, which include adrenaline autoinjector instructions.

Instructions are also on the device label and at:
www.allergy.org.au/anaphylaxis

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. Do not remove ticks.
- Stay with person and call for help.
- Give other medications (if prescribed).....
- Phone family/emergency contact.

Mild to moderate allergic reactions may not always occur before anaphylaxis

Watch for ANY ONE of the following signs of anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

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

ACTION FOR ANAPHYLAXIS

1 **Lay person flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.**
2 **Give adrenaline autoinjector if available.**
3 **Phone ambulance*: 000 (AU) or 111 (NZ).**
4 **Phone family/emergency contact.**

Commence CPR at any time if person is unresponsive and not breathing normally.
*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

IF UNCERTAIN WHETHER IT IS ANAPHYLAXIS OR ASTHMA

- Give adrenaline autoinjector FIRST, then asthma reliever.
- If someone with known food or insect allergy suddenly develops severe asthma like symptoms, give adrenaline autoinjector FIRST, then asthma reliever.

Asthma: Y ☐ N ☐ Medication: _____

Anaphylaxis Personal Plan – Example completed

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

ACTION PLAN FOR Allergic Reactions

Name: Chloe Light
Date of birth: 03 / 01 / 2007

Confirmed allergens:
Peanuts

Family/emergency contact name(s):
Francis Smart

Work Ph: 9236 6482
Home Ph: 9778 1264
Mobile Ph: 0146 004 004

Plan prepared by:
Dr: Ken Wu

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

Signed:

Date: 10 January 2016
Date of next review: 10 January 2017

Note: The ASCIA Action Plan for Allergic Reactions is for people with mild to moderate allergies, who need to avoid certain allergens.

For people with severe allergies (and at risk of anaphylaxis) there are ASCIA Action Plans for Anaphylaxis, which include adrenaline autoinjector instructions.

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MILD TO MODERATE ALLERGIC REACTION

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- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy, flick out sting if visible. Do not remove ticks.
- Stay with person and call for help.
- Give other medications (if prescribed) Zyrtec 10ml
- Phone family/emergency contact.

Mild to moderate allergic reactions may not always occur before anaphylaxis

Watch for ANY ONE of the following signs of anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
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- 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 breathing is difficult allow them to sit.**
2 **Give adrenaline autoinjector if available.**
3 **Phone ambulance*: 000 (AU) or 111 (NZ).**
4 **Phone family/emergency contact.**

Commence CPR at any time if person is unresponsive and not breathing normally.
*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

IF UNCERTAIN WHETHER IT IS ANAPHYLAXIS OR ASTHMA

- Give adrenaline autoinjector FIRST, then asthma reliever.
- If someone with known food or insect allergy suddenly develops severe asthma like symptoms, give adrenaline autoinjector FIRST, then asthma reliever.

Asthma: Y ☐ N ☑ Medication: Nil

Appendix 11

Anaphylaxis Management Checklist example

☐	**Proactively seek information about severe allergies from parents/carers.**
☐	**If a student has been diagnosed as being at risk of anaphylaxis, meet with parents/carers to obtain information about student's allergies and prevention strategies.**
☐	**Conduct risk assessment.**
☐	**Develop individual anaphylaxis management plan.**
☐	**Parents to provide copies of ASCIA Action Plan with up to date photo.**
☐	**Parents to provide the student's EpiPen® or other medication.**
☐	**Develop communication plan for staff, students and parents/ carers to raise awareness about severe allergies and the school's policies.**
☐	**Implement preventative strategies in management plan.**
☐	**Arrange staff training.**
☐	**Make sure EpiPen® is correctly stored, that staff know where it is and can access it quickly (under 5 minutes).**
☐	**Regularly check EpiPen® to make sure it is not cloudy or out of date.**
☐	**Ensure EpiPens® and Action Plans are taken whenever the student participates in off-site activities (e.g. camps, excursions, field trips, sport days).**
☐	**Regularly review school management strategies and practise scenarios for responding to an emergency.**
☐	**Review student's anaphylaxis management plan annually or if the student's situation changes.**

Appendix 12

Anaphylaxis Management in Schools

Anaphylaxis is a severe and sudden allergic reaction when a person is exposed to an allergen. The most common allergens in children are eggs, peanuts, tree nuts (e.g. cashews), cow's milk, fish and shellfish, wheat, soy, certain insect stings and medications.

On 14 July 2008, *the Children's Services and Education Legislation Amendment (Anaphylaxis Management) Act 2008* came into effect amending the *Children's Services Act 1996* and the *Education and Training Reform Act 2006* requiring that all licensed children's services and schools have an anaphylaxis management policy in place.

Ministerial Order 706 (effective from 22 April 2014)

All schools must review and update their existing policy and practices in managing students at risk of anaphylaxis to ensure they meet the legislative and policy requirements outlined below.
Any school that has enrolled a student or students at risk of anaphylaxis must by law have a School Anaphylaxis Management Policy in place that includes the following:

- a statement that the school will comply with Ministerial Order 706 and associated guidelines
- an Individual Anaphylaxis Management Plan (that includes an individual ASCIA Action Plan for Anaphylaxis) for each affected student, developed in consultation with the student's parents/carers and medical practitioner
- information and guidance in relation to the school's management of anaphylaxis, including:
    - prevention strategies to be used by the school to minimise the risk of an anaphylactic reaction for in-school and out-of-school settings
    - school management and emergency response procedures that can be followed when responding to an anaphylactic reaction
    - the purchase of spare or 'backup' adrenaline auto-injection devices(s) as part of the school first aid kit(s), for general use
    - development of a Communication Plan to raise staff, student and school community awareness about severe allergies and the School's Anaphylaxis Management Policy
    - regular training and updates for school staff in recognising and responding appropriately to an anaphylactic reaction, including competently administering an EpiPen/Anapen and
    - completion of an Annual Anaphylaxis Risk Management Checklist.

Important excerpts from Ministerial Order 706:

PART C: MANAGEMENT OF STUDENTS DIAGNOSED AS AT RISK OF ANAPHYLAXIS

7. Individual Management Plans

7.1. A school's anaphylaxis management policy must state the following in relation to Individual Anaphylaxis Management Plans for each student diagnosed with a medical condition that relates to allergy and the potential for anaphylactic reaction:

7.1.1. that the principal of the school is responsible for ensuring 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 having a medical condition that relates to allergy and the potential for anaphylactic reaction, where the school has been notified of that diagnosis;

7.1.2. that the Individual Anaphylaxis Management Plan must be in place as soon as practicable after the student enrols, and where possible before the student's first day of attendance at that school;

7.2. that the Individual Anaphylaxis Management Plan must include the following:

(a) information about the medical condition that relates to allergy and the potential for anaphylactic reaction, including the type of allergy or allergies the student has (based on a written diagnosis from a medical practitioner);

(b) 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;

(c) the name of the person/s responsible for implementing the strategies;

(d) information on where the student's medication will be stored;

(e) the student's emergency contact details; and

(f) an action plan in a format approved by the Australasian Society of Clinical Immunology and Allergy (hereafter referred to as an ASCIA Action Plan), provided by the parent.

7.3. A school's anaphylaxis management policy must require the school to review the student's Individual Anaphylaxis Management Plan in consultation with the student's parents in all of the following circumstances:

7.3.1. annually;

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

7.3.3. as soon as is practicable after a student has an anaphylactic reaction at school; and

7.3.4. when a 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.

7.4. A school's anaphylaxis management policy must state that it is the responsibility of the parent to:

7.4.1. provide the ASCIA Action Plan referred to in clause 7.2(f);

7.4.2. 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;

7.4.3. 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

7.4.4. provide the school with an adrenaline auto-injector that is current and not expired for their child.

PART D: SCHOOL MANAGEMENT OF ANAPHYLAXIS

8. Prevention Strategies

8.1. A school's anaphylaxis management policy must include prevention strategies used by the school to minimise the risk of an anaphylactic reaction.

9. School management and emergency response

9.1. A school's anaphylaxis management policy must include details of how the policy integrates with the school's general first aid and emergency response procedures.

9.2. The school's anaphylaxis management policy must include procedures for emergency response to anaphylactic reactions including:

9.2.1. 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;

9.2.2. details of Individual Anaphylaxis Management Plans and ACSIA Action Plans and where these can be located:

(a) during normal school activities including in the classroom, in the school yard, in all school buildings and sites including gymnasiums and halls; and

(b) during off-site or out of school activities, including on excursions, school camps and at special events conducted, organised or attended by the school;

9.2.3. information about storage and accessibility of adrenaline auto-injectors including those for general use; and

9.2.4. how communication with school staff, students and parents is to occur in accordance with a communications plan that complies with clause 11.

9.3. The school's anaphylaxis management policy must state that when a student with a medical condition that relates to allergy and the potential for anaphylactic reaction is under the care or supervision of the school outside of normal class activities, including in the school yard, at camps and excursions, or at special events conducted, organised or attended by the school, the principal must ensure that there is a sufficient number of school staff present who have been trained in accordance with clause 12.

9.4. The school's anaphylaxis management policy must state that in the event of an anaphylactic reaction, the emergency response procedures in its policy must be followed, together with the school's general first aid and emergency response procedures and the student's ASCIA Action Plan.

10. Adrenaline Auto-injectors for General Use

10.1. A school's anaphylaxis management policy must prescribe the purchase of adrenaline auto-injectors for general use as follows:

10.1.1. the principal is responsible for arranging for the purchase of additional adrenaline auto-injector(s) for general use and as a back up to those supplied by parents;

10.1.2. the principal will determine the number and type of adrenaline auto-injector(s) for general use to purchase and in doing so consider all of the following:

(a) the number of students enrolled at the school that have been diagnosed with a medical condition that relates to allergy and the potential for anaphylactic reaction;

(b) the accessibility of adrenaline auto-injectors that have been provided by parents;

(c) the availability of a sufficient supply of adrenaline auto-injectors for general use in specified locations at the school, including in the school yard, and at excursions, camps and special events conducted, organised or attended by the school; and

(d) that adrenaline auto-injectors have a limited life, usually expire 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.

11. Communication Plan

11.1. A school's anaphylaxis management policy must contain a communication plan that includes the following information:

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

11.1.2. strategies for advising school staff, students and parents about how to respond to an anaphylactic reaction:

(a) during normal school activities including in the classroom, in the school yard, in all school buildings and sites including gymnasiums and halls; and

(b) during off-site or out of school activities, including on excursions, school camps and at special events conducted, organised or attended by the school;

11.1.3. 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 of a student in their care; and

11.1.4. that the principal of a school is responsible for ensuring that the school staff identified in clause 12.1 are:

(a) trained; and

(b) briefed at least twice per calendar year

in accordance with clause 12.

12. Staff Training

12.1. A school's anaphylaxis management policy must state that the following school staff must be trained in accordance with this clause:

12.1.1. school staff who conduct classes that students with a medical condition that relates to allergy and the potential for anaphylactic reaction attend; and

12.1.2. any further school staff that the principal identifies, based on an assessment of the risk of an anaphylactic reaction occurring while a student is under the care or supervision of the school.

12.2. A school's anaphylaxis management policy must state that school staff who are subject to training requirements in accordance with clause 12.1 must:

12.2.1. have successfully completed an anaphylaxis management training course in the three years prior; and

12.2.2. participate in a briefing, to occur twice per calendar year with the first one to be held at the beginning of the school year, by a member of school staff who has successfully completed an anaphylaxis management training course in the 12 months prior, on:

(c) the school's anaphylaxis management policy;

(d) the causes, symptoms and treatment of anaphylaxis;

(e) the identities of students with a medical condition that relates to allergy and the potential for anaphylactic reaction, and where their medication is located;

(f) how to use an adrenaline auto-injector, including hands on practise with a trainer adrenaline auto-injector;

(g) the school's general first aid and emergency response procedures; and

(h) the location of, and access to, adrenaline auto-injectors that have been provided by parents or purchased by the school for general use.

12.3. If for any reason training and briefing has not yet occurred in accordance with clauses 12.2.1 and 12.2.2, the principal must develop an interim plan in consultation with the parents of any affected student with a medical condition that relates to allergy and the potential for anaphylactic reaction, and training must occur as soon as possible thereafter.

Appendix 13

Stakeholder Roles and responsibilities

Various stakeholders have important roles and responsibilities as defined by the Victorian Government. The following are some examples of such responsibilities:

Principles

- Actively seek information to identify students with severe life threatening allergies at enrolment
- Conduct a risk assessment of the potential for accidental exposure to allergens while the student is in the care of the school.
- Meet with parents/carers to develop an Anaphylaxis Management Plan for the student. This includes documenting practical strategies for in-school and out-of-school settings to minimise the risk of exposure to allergens, and nominating staff who are responsible for their implementation
- Request that parents provide an ASCIA (Australasian Society of Clinical Immunology and Allergy) Action Plan that has been signed by the student's medical practitioner and has an up to date photograph of the student
- Ensure that staff obtain training in how to recognise and respond to an anaphylactic reaction, including administering an EpiPen®.
- Develop a communication plan to raise student, staff and parent awareness about severe allergies and the school's policies.
- Provide information to all staff (including specialist staff, new staff, sessional staff, canteen staff and office staff) so that they are aware of students who are at risk of anaphylaxis, the student's allergies, the school's management strategies and first aid procedures. This can include providing copies or displaying the student's ASCIA Action Plan in canteens, classrooms and staff rooms
- Ensure that there are procedures in place for informing casual relief teachers of students at risk of anaphylaxis and the steps required for prevention and emergency response.
- If schools use an external canteen provider, ensure that the provider can demonstrate satisfactory training in the area of anaphylaxis and its implications on food handling practices.
- Allocate time, such as during staff meetings, to discuss, practise and review the school's management strategies for students at risk of anaphylaxis. Practise using the trainer EpiPen® regularly.
- fostering a school environment that is safe and supportive for their peers

First aid coordinators / school nurses

- Keep an up to date register of students at risk of anaphylaxis.
- Ensure that students' emergency contact details are up to date.
- Obtain training in how to recognise and respond to an anaphylactic reaction, including administering an EpiPen®.
- Check that the EpiPen® is not cloudy or out of date regularly, e.g. at the beginning or end of each term.
- Inform parents/carers a month prior in writing if the EpiPen® needs to be replaced.
- Ensure that the EpiPen® is stored correctly (at room temperature and away from light) in an unlocked, easily accessible place, and that it is appropriately labelled.
- Provide or arrange post-incident support (e.g. counselling) to students and staff, if appropriate.
- Work with staff to conduct regular reviews of prevention and management strategies.
- Work with staff to develop strategies to raise school staff, student and community awareness about severe allergies

Parents/carers of a student at risk of anaphylaxis

- Inform the school, either at enrolment or diagnosis, of the student's allergies, and whether the student has been diagnosed as being at risk of anaphylaxis.
- Obtain information from the student's medical practitioner about their condition and any medications to be administered. Inform school staff of all relevant information and concerns relating to the health of the student.
- Meet with the school to develop the student's Anaphylaxis Management Plan.
- Provide an ASCIA Action Plan, or copies of the plan to the school that is signed by the student's medical practitioner and has an up to date photograph.
- Provide the EpiPen® and any other medications to the school.
- Replace the EpiPen® before it expires.
- Assist school staff in planning and preparation for the student prior to school camps, field trips, incursions, excursions or special events such as class parties or sport days.
- Supply alternative food options for the student when needed.
- Inform staff of any changes to the student's emergency contact details.
- Participate in reviews of the student's Anaphylaxis Management Plan, e.g. when there is a change to the student's condition or at an annual review

School staff who are responsible for the care of students at risk of anaphylaxis

- Know the identity of students who are at risk of anaphylaxis.
- Understand the causes, symptoms, and treatment of anaphylaxis.
- Obtain training in how to recognise and respond to an anaphylactic reaction, including administering an EpiPen®.
- Know the school's first aid emergency procedures and what your role is in relation to responding to an anaphylactic reaction.
- Keep a copy of the student's ASCIA Action Plan (or know where to find one quickly) and follow it in the event of an allergic reaction.
- Know where the student's EpiPen® is kept. Remember that the EpiPen® is designed so that anyone can administer it in an emergency.
- Know and follow the prevention strategies in the student's Anaphylaxis Management Plan.
- Plan ahead for special class activities or special occasions such as excursions, incursions, sport days, camps and parties.
- Work with parents/carers to provide appropriate food for the student.
- Avoid the use of food treats in class or as rewards, as these may contain hidden allergens.
- Be aware of the possibility of hidden allergens in foods and of traces of allergens when using items such as egg or milk cartons in art or cooking classes.
- Be careful of the risk of cross-contamination when preparing, handling and displaying food.
- Make sure that tables and surfaces are wiped down regularly and that students wash their hands after handling food.

Appendix 14

Template: Strategies to avoid allergens

Student's Name:		
Date of Birth:	Year Level:	
Severe Allergy to:		
Other known allergies:		
Risk	Strategy	Who is responsible

Appendix 15

Template Anaphylaxis Management Plan

School:		
Phone:		
Student's Name:		
Date of Birth:	Year Level:	
Severe Allergy to:		
Other Health Conditions:		
Medication at School:		
Parent / Carer Contact:	Parent Carer (1) Name: Relationship: Home Ph: Work Ph: Mobile: Address:	Parent Carer (2) Name: Relationship: Home Ph: Work Ph: Mobile: Address:
Additional Emergency Contact:		
Medical practitioner details:		
Emergency care to be provided at school:		
The following Anaphylaxis Management Plan has been developed with my knowledge and input and will be reviewed on:		
Date of proposed review:		
Signature of parent / guardian (1):	Date:	
Signature of parent / guardian (2):	Date:	