For the latest updates, please refer to this policy which is saved on the server.

Holy Eucharist Catholic Primary School

ANAPHYLAXIS MANAGEMENT POLICY (UPDATED 2020)

APPENDIX:

Holy Eucharist Catholic Primary School Commitment Statement to Child Safety

A safe and nurturing culture for all children and young people at our Catholic school

'The intention for this statement is to provide a central focus for child safety[1] at our Catholic school, built around a common understanding of the moral imperative and overarching commitments that underpin our drive for improvement and cultural change….

…Holy Eucharist Primary School together with the CECV will stay abreast of current legislation and will meet legislative duties to protect the safety and wellbeing of children and young people in our care, including the Victorian Child Safe Standards (Victorian Government 2016), mandatory reporting, grooming, failure to disclose and failure to protect requirements[2]'.

[1]As defined by the Victorian Government Special *Gazette* No. 2 (2016), 'children and young people' in this document refers to those children and young people enrolled as students in Catholic schools in Victoria.
[2]Holy Eucharist Catholic Primary School Commitment Statement to Child Safety

EVIDENCE OF THIS OCCURING AT HOLY EUCHARIST

This evidenced in this policy by:

Holy Eucharist Primary School, together with the guidance of the Catholic Education Commission of Victoria Ltd (CECV) holds the care, safety and wellbeing of children and young people when they are sick or injured regardless of their background or disability. Our utmost responsibility at Holy Eucharist is to create a child-safe school environment.

Introduction

Holy Eucharist Catholic Primary School is committed to providing, as far as is practicable, a safe, supportive environment, in which students at risk of anaphylaxis, can participate equally in all aspects of their education. The school is also committed to the provision of competent and prompt emergency care, to ensure the health and optimum outcome for all students who may experience an anaphylactic reaction, whether on or off the school's campus. The key prevention of anaphylaxis in school is the knowledge of students who are at risk, awareness of triggers (allergens) and prevention of exposure to these allergens.

This anaphylaxis policy and supporting guidelines are modelled on the Department of Education and Training's 'Anaphylaxis Guidelines', Victorian Government legislation, Ministerial Order 706 Anaphylaxis Management in Victorian Schools effective 22 April 2014 ***(See Appendix 1 and 2).***

Mission Statement as directed in Ministerial Order 706:

Holy Eucharist Catholic Primary School will comply with the order and guidelines on Anaphylaxis Management as directed by Ministerial Order 706, effective 22 April 2014.

In the event of an anaphylactic reaction, Holy Eucharist Catholic Primary School's first aid and emergency response procedures and the student's Individual Anaphylaxis Management Plan must be followed.

For the latest updates, please refer to this policy which is saved on the server.

Purpose

The purpose of the school's policy and supporting guidelines is to:

- Ensure that the school can assist parents in the management of their child's allergy;
- Encourage preventative measures to minimise the risk of and promote awareness of anaphylaxis
- Provide resources and training for staff in recognizing and responding appropriately to an anaphylactic reaction;
- Ensure an emergency response strategy is designed and implemented within the school.

Scope

These guidelines apply to all Holy Eucharist Catholic Primary School sites and to all staff members, non-teaching staff, casual relief teachers and contractors whilst performing duties on behalf of the school.

Background

Anaphylaxis is a severe, rapidly progressive allergic reaction that is potentially life threatening. The most common allergens in school-aged children are peanuts, eggs, tree nuts (e.g. cashews,) cow's milk, fish and shellfish, wheat, soy, sesame, latex, certain insect stings and medication.
The key to prevention of anaphylaxis in schools is knowledge of those students who have been diagnosed at risk, the awareness of triggers (allergens), and prevention of exposure to these triggers.

Adrenaline given through an EpiPen, auto-injector to the muscle of the outer mid-thigh is the most effective first aid treatment for anaphylaxis ***(See Appendix 3).***

Responsibilities of Parents and Guardians

Parents and guardians are responsible for ensuring that health information provided to the School is up to date and reviewed regularly to ensure that the accuracy of this information is maintained

Parents and guardians must notify the school upon enrolment or, as soon as they are aware, that their child has a severe allergy. A comprehensive Anaphylaxis Management Plan ***(See Appendix 4 and 5),*** completed by their attending medical practitioner or allergy specialist, must also be submitted upon enrolment or, as soon as they are aware, that their child has a severe allergy.

The Anaphylaxis Management Plan, must be in the regulation Australasian Society of Clinical Immunology and Allergy (ASCIA) colour and, must include an up-to-date photo of the student and clearly state what the child is allergic to and what medication should be administered if an anaphylactic reaction occurs (the Action Plan).

- Personal Use - ASCIA Action Plan for Anaphylaxis for use with EpiPen (Red);
- ASCIA Action Plan for Allergic Reactions (personal) for use when no adrenaline auto injector has been prescribed (Green).

The Anaphylaxis Management Plan must be completed by the attending doctor and supplied to the school by the parents and guardians:

- Annually, at the beginning of the school year;
- At any time the medical management of the allergy is changed;
- Immediately after a student has an anaphylactic reaction at school
- If a student is wishing to travel overseas or interstate as part of a school excursion or camp *(See **Appendix 6 and 7).***

Parents and guardians must ensure that a current photo of their child is attached to the Anaphylaxis Management Plans. The School will ensure that they are made aware that their child's Anaphylaxis Management Plan and accompanying photo will be displayed at various locations throughout the School for the sole purpose of informing all staff members of the allergy and to assist in an emergency response. A photo board will be displayed in the Office and First Aid Room to alert staff of all students

who have the severe allergy of Anaphylaxis.
Parents and guardians are responsible for providing to the school 1 x (in date) EpiPen auto-injector and any antihistamine that has been prescribed by the attending medical practitioner and described on the child's Anaphylaxis Management Plan. The school will also maintain an EpiPen auto-injector for general use.

Parents and guardians are responsible for supplying EpiPen with a pharmacy label particular to their child and used for that child only.

Parents and guardians are also responsible for supplying alternative food options for the student if necessary to eliminate any risk.

Parents and guardians must ensure that information about any changes to the student's Anaphylaxis Management and emergency contact details must be provided to the school as soon as they become aware of these.

Responsibilities of the School - Prevention Strategies

Members of the Leadership Team will ensure that an Anaphylaxis Management Plan for each student diagnosed with anaphylaxis or allergies, is developed in consultation with the student's parents or guardians and their attending medical practitioner.
A Communication Plan will be developed to ensure that all staff members, non-teaching staff and casual relief teachers are aware of every student with anaphylaxis and severe allergies and ensure that they understand the requirements of individual Management Plans of each of the students under their care.

Members of the Leadership Team will ensure that Anaphylaxis Management Plans are current and displayed at various locations throughout the School for the sole purpose of informing all staff members of the allergy and to assist in an emergency response.

Members of the Leadership Team will ensure that care and diligence applies at other times while the student is under the care or supervision of the school in the following settings:

- School excursions
- School camps
- School yard
- Special event days conducted or organised by the school
- Sport days.

Staff Training - Prevention Strategies and Training Requirements

From 2016 a new online model for anaphylaxis training is available to support Victorian schools to meet their training requirements and to improve schools' capacity to provide safe learning environments for young people with severe allergies.

Ministerial Order 706 has been amended to allow for the new online training model. Under this model it is recommended that **all Victorian school staff** undertake the new Australasian Society of Clinical Immunology and Allergy (ASCIA) e-training course and have their competency in using an autoinjector tested in person within 30 days of completing the course.

The online ASCIA e-training course is fully funded for all Victorian school staff. The course will take approximately one hour and can be accessed from the ASCIA site at: anaphylaxis e-training: Victorian Schools

Additionally every school is invited to nominate two staff members from each campus to undertake face-to-face training to skill them in providing competency checks to assess their colleagues' ability to use an auto-injector (e.g. EpiPen) and become School Anaphylaxis Supervisors.

Registration for the Course in Verifying the Correct Use of Adrenaline Autoinjector Devices 22303VIC can be accessed from the Asthma Foundation by phone 1300 314 806 or by visiting: www.asthma.org.au

Once your School Anaphylaxis Supervisors have completed their training your school can transition to the online model.

A School Anaphylaxis Supervisor Checklist has been developed to guide schools with the requirements of this role. Training agencies that have the Course in Verifying the Correct Use of Adrenaline Autoinjector Devices 22303VIC in their scope of practice are required to use this checklist to guide their training with Victorian schools.

Alternatively schools can opt to undertake fee-based face-to-face training in one of the accredited anaphylaxis training courses that meet the requirements of MO706:

- Course in First Aid Management of Anaphylaxis 22300VIC
- Course in Anaphylaxis Awareness 10313NAT.

To find registered training organisations that deliver anaphylaxis training, go to the Australian Government Department of Education and Training site at: www.training.gov.au

In summary, school staff must complete one of the following options to meet the anaphylaxis training requirements of MO706:

Option 1

All school staff - ASCIA Anaphylaxis e-training for Victorian Schools followed by a competency check by the School Anaphylaxis Supervisor. This course is provided by ASCIA, is free for all Victorian schools and valid for 2 years.

AND

2 staff per school or per campus (School Anaphylaxis Supervisor) - Course in Verifying the Correct Use of Adrenaline Autoinjector Devices 22303VIC. This course is provided by the Asthma Foundation, is free to government schools and is valid for 3 years.

Option 2

School staff (as determined by the principal) - Course in First Aid Management of Anaphylaxis 22300 VIC (previously 22099VIC). This course is provided by an RTO that has this course in their scope of practice and is paid for by each school. The training is valid for 3 years.

Option 3

School staff (as determined by the principal) - Course in Anaphylaxis Awareness 10313NAT. This course is provided by any RTO that has this course in their scope of practice and is paid for by each school. The training is valid for 3 years.

For the latest updates, please refer to this policy which is saved on the server.

Please note: First aid training does **NOT** meet the requirements of anaphylaxis training requirements under MO706.

Twice-yearly anaphylaxis briefing requirements

All schools with a child or young person at risk of an anaphylactic reaction are required to undertake twice yearly briefings on anaphylaxis management under MO706.

A presentation has been developed to help schools ensure they are complying with the legislation. The briefing presentation incorporates information on how to administer an EpiPen and it is expected all staff will practice with the EpiPen trainer devices provided to your school. As part of the briefing, school staff should familiarise themselves with the children and young people in the school at risk of an anaphylactic reaction and their Individual Anaphylaxis Management Plans.

Any person who has completed Anaphylaxis Management Training in the last 2 years can lead the briefing. If your school has decided to choose the online option, your School Anaphylaxis Supervisor may be the most appropriate staff member for this role.

EpiPens

Holy Eucharist Catholic Primary School will provide an appropriate number of Generic EpiPen, in accordance with Ministerial Order 706, which should provide sufficient back up for students' prescribed with EpiPen in any anaphylaxis emergency.

These EpiPens are located in an unlocked cupboard (cool, dark place), within the office and SLA Staffroom so that they are readily accessible to all members of the Leadership Team, staff members and non-teaching staff at all times.

These EpiPen will be available for distribution to staff members instructing a sporting team or attending an excursion or for emergency use on School Camps as a back- up EpiPen.

Staff members are responsible for the safe transport and administration of EpiPens on excursions.

An EpiPen register is kept in the Office recording all students with EpiPen, its strength and expiry date.

The Office Assistant will regularly check the expiry date on all EpiPen and advise parents when their child's EpiPen is due to expire. A new EpiPen must be provided by the expiry date and if this does not occur and parents have been notified on a number of occasions, it may be necessary to exclude the child from attending school until current medication is supplied.

Emergency Response

Holy Eucharist Catholic Primary School has developed an emergency response procedure to ensure an immediate response in the case of a student suffering an anaphylactic or allergic reaction. This emergency response procedure is detailed within the school's emergency management plan and is displayed in the Staffroom, First Aid Room and Classrooms.

All staff members, non-teaching staff and casual relief teachers are made aware and reminded of the Emergency Response Procedures listed below bi-annually.

The emergency response procedure is as follows:

- Anaphylaxis Management Plans are displayed in prominent locations around the school. Staff members in the care of students with Anaphylaxis Management Plans are provided with copies and these are to be kept with the class roll or emergency response folder. Specialist teachers also maintain copies of Anaphylaxis Management Plans for all students in their care.
- Cards with the student's photo, allergy, name, class and emergency contact phone numbers are kept in students' anaphylaxis bags. These bags are given to staff members who conduct yard duty, specialist classes, sporting events and excursions.
- In the case of an anaphylactic or allergic reaction these cards are to be sent with a runner to the Staffroom (during recess) and the First Aid Room (during lunchtime) or Front Office (all other times). The attending staff member will access the affected student's pen and return with the runner to the incident site.
- **The student MUST NOT BE MOVED.**
- In the meantime, office staff should be alerted and instructed to phone for an ambulance. They should then wait at the front of the school to direct the ambulance. Ideally, the person administering the EpiPen should have a mobile phone with them to call the ambulance and then be able to give accurate information to the ambulance officers.
- Whoever administers the EpiPen must stay and monitor the child until the ambulance arrives.

The emergency response procedure for excursions, camps, sporting events or other 'off-site' activities is as follows:

- Staff members will administer the EpiPen or supervise the administration of the EpiPen by the student, if they are capable of self-administration.
- An ambulance must be phoned for immediately. If the area is remote, staff members are required to follow instructions from emergency services to ensure efficient access to the student;
- Contact must then be made with the parents/guardian to inform them of the event, the condition of their child and actions taken;
- A staff member must remain with the student at all times, until a parent or guardian arrives at the hospital;
- Staff members will inform other students in their care of the event, keeping them calm, whilst providing appropriate counselling and debriefing.

Communication Strategy

The following communication strategy has been developed to provide information to all staff members, students and parents about anaphylaxis and the school's anaphylaxis management. All staff members and non-teaching staff are to be provided with information on children who are at risk of anaphylactic or allergic reactions including a photographic summary of all students with an allergy.

All Casual Relief Teachers are made aware of any students in their care who may suffer from an anaphylactic or allergic reaction.

The communication strategy includes information about steps that will be taken to respond to an anaphylactic reaction by a student in the following school environments:

- School excursions
- School camps
- School yard
- Special event days conducted or organised by the school
- Sport days

All staff members, non-teaching staff and others who are responsible for the care of students such as sporting coaches, must maintain current Anaphylaxis Management accreditation, and must ensure that at all times, they know where the student's individual EpiPen and Anaphylaxis Management Plan is kept and have an emergency strategy in place to enact in the event of a anaphylactic or allergic reaction.

The communication strategy includes publication procedures, where all staff members and non-teaching staff are advised by members of the Leadership Team at a scheduled staff meeting and via e-mail of the students' individual Anaphylaxis Management Plans.

The communication strategy will also ensure that casual relief teachers and volunteers who are responsible for the students at risk of an anaphylactic or allergic reaction are adequately informed and understand their role in responding to an event by a student in their care.

All staff members and non-teaching staff will be made aware and reminded of the following at least twice a year:

- The school's Anaphylaxis Management Policy;
- The causes, symptoms and treatment of anaphylaxis;
- The identities of students diagnosed who are at risk of anaphylaxis and the location of their medication;
- How to use an adrenaline auto-injecting device, (EpiPen) including hands on practise with a trainer adrenaline auto-injecting device;
- The school's first aid and emergency response procedures.

In the event of an Anaphylactic Emergency, and in consideration for staff welfare, attending staff will be provided with appropriate post- emergency de-briefing, counselling and guidance as required and appropriate.

Risk Management Strategies

A review of individual student's Anaphylaxis Management Plans must be conducted annually in consultation with parents/guardian and their attending doctor. Additional Risk Management Strategies listed below will also be enacted:

- All attempts will be made to minimize the risk of an anaphylactic or allergic reaction by identifying offending allergens within the school environment;
- The school shall adopt a 'no share policy' for food in the classroom and school yard;
- Staff members should avoid the use of food treats in class or as rewards;
- During special occasions e.g. birthday parties, children with severe allergies should have their own supply of treats kept by the teacher in the classroom provided by the student's parents/guardian.
- Food preparation at school should include the use of separate utensils for students with a food allergy;
- Students should be encouraged to wash their hands and face regularly, especially before and after meals;
- Tables should be cleaned thoroughly after meals;
- Caution should be exercised in areas of high risk including the art and drama rooms;
- Avoid the use and reuse of boxes or cartons that have contained offending food products eg, nut based cereal boxes, egg cartons, milk cartons, play-dough.

Excursions, Camps, Sporting Events

Where students with identified anaphylaxis are required to attend excursions, camps, sporting events or other 'off-site' activities, staff members responsible for organising and attending the event, in consultation with members of the Leadership Team and other attending staff members will ensure the following:

- The student's EpiPen auto-injector, and a school's EpiPen, a copy of all student's individual Anaphylaxis Management Plans and an operational mobile phone must be taken on all excursions, camps, sporting events or other 'off-site' activities;
- Staff members with current Anaphylaxis Management accreditation and who are competent in administering an EpiPen must accompany the students on all excursions, camps, sporting events or other 'off-site' activities. All staff members attending all excursions, camps, sporting events or other 'off-site' activities need to be aware if there is a student at risk of anaphylaxis This should occur at a pre-event briefing, held in consultation with a member of the Leadership Team;
- Parents/guardians and attending staff members should discuss any alternate food that is required and provide food that is not able to be provided by the organiser of the excursion, camp, sporting event or other 'off-site' activity;
- Support for the student may include parents/guardians accompanying the student on the excursion, camp, sporting event or other 'off-site' activity where this is in the best interests of the student, taking into account the interests of the other participants;
- Camp and facility management, as well as other stakeholders must be informed, in advance, of any students at risk of an anaphylactic or allergic reaction;
- Food consumed on transport to the excursion, camp, sporting event or other 'off-site' activity will be carefully considered for the potential exposure to allergens;
- Staff members organising the excursion, camp, sporting event or other 'off-site' activity must take time to identify local emergency services and how to access them;
- EpiPen auto-injectors must remain in close proximity to individual students with identified anaphylaxis at all times during the excursion, camp, sporting event or other 'off-site' activity.
- Where appropriate, staff may give permission for a student to carry his/her own EpiPen.
- A second Generic EpiPen auto-injector will be carried by the responsible staff member and if it is deemed necessary or if location is remote, extra Generic EpiPens will be provided.
- Students with anaphylactic response to insects (i.e. bees) should always wear closed shoes and long-sleeved garments, apply appropriate protection and stay away from areas that may attract insects.

Annual Anaphylaxis Risk Management Checklists

In accordance with requirements of Ministerial Order 706, Holy Eucharist Catholic Primary School will conduct an annual Anaphylaxis Risk Management Checklist to ensure that all aspects of its Anaphylaxis Management policy and procedure have been implemented. Gaps identified as a result of completing the Anaphylaxis Risk Management Checklist *(See Appendix 8),* will be brought to the Leadership Team's attention immediately, where appropriate actions will be assigned and entered into the School's Compliance Register.

Information for Patients, Consumers and Carers (Frequently asked questions).

(See Appendix 3).

Acute Management of Anaphylaxis (For Medical Practitioners and Nurses).

(See Appendix 13).

Anaphylaxis Guidelines.

(See Appendix 14).

Ratified: February 2020

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 1: CHANGES TO ANAPHYLAXIS MANAGEMENT FOR ALL SCHOOLS

Department of Education and Early Childhood Development

Changes to Anaphylaxis Management for all Victorian Schools

Issued | February 2014

Ministerial Order 90 has been repealed and will be replaced by Ministerial Order 706 on 22 April 2014. The associated Guidelines in Anaphylaxis Management in schools have also been updated.

All schools (government, Catholic and independent) need to comply with Ministerial Order 706 and the associated Guidelines.

Ministerial Order 706: Anaphylaxis Management in Schools

Key changes to the Ministerial Order include:

- expanded definitions of 'anaphylaxis management training course' and 'school staff'
- a clearer outline of the matters a school's anaphylaxis management policy must contain (clause 6)
- new minimum requirements for all schools to:
  - make a statement in their anaphylaxis management policy that they will comply with the order and guidelines (clause 6, further detail outlined in the Guidelines)
  - develop prevention strategies (clause 8, further detail outlined in the guidelines)
  - the purchase of adrenaline autoinjectors for general use (clause 10)
  - conduct a twice-yearly briefing for relevant school staff on its anaphylaxis management policy and other specified anaphylaxis issues, and
  - complete an Annual Risk Management Checklist (clause 13).
- a new structure and headings
- removal of footnotes (these have been transferred to the updated revised guidelines)

Anaphylaxis Guidelines – A resource for managing severe allergies in Victorian Schools

Key changes to the Guidelines include:

- expanded and amended Glossary of Terms
- consistent language and structural chapter alignment with the Ministerial Order706
- strengthened legal obligations for schools and anaphylaxis management (chapter 4)
- a chapter on the contents of a School Anaphylaxis Management Policy (chapter 6)
- a new requirement for schools to provide a statement that they will comply with the order and guidelines in their policy (chapter 6)
- expanded prevention strategies for schools to consider and plan (chapter 8)
- new information and resource links for schools to access (chapter 11)
- greater clarity on staff training requirements (chapter 12)
- a new School Anaphylaxis Management Policy template (Appendix 2)
- a revised Individual Anaphylaxis Management Plan (Appendix 3)
- a revised Annual Risk Management Checklist (Appendix 4), and
- General updating throughout the document to ensure the guidelines align with the latest medical advice about anaphylaxis.

School Anaphylaxis Management Policy

All schools across Victoria, from 22 April 2014, must by law have an Anaphylaxis Management Policy if they have a student enrolled who has been diagnosed at risk of anaphylaxis. This policy must include procedures for:

- a statement that the School will comply with the Order and guidelines on anaphylaxis management

- a statement that in the event of an anaphylactic reaction, the school's first aid and emergency response procedures and the student's Individual Anaphylaxis Management Plan must be followed
- development and regular review of Individual Anaphylaxis Management Plans for affected students
- prevention strategies to be used by the school to minimise the risk of an anaphylactic reaction
- the purchase of Adrenaline Autoinjectors for General Use by schools
- the development of a Communication Plan
- the training of school staff on anaphylaxis management, and
- the completion of an annual Risk Management Checklist.

Additional Information

- Call the Royal Children's Hospital Anaphylaxis Advisory Line on 1300 725 911 for advice about implementing the requirements of Ministerial Order 706 for all Victorian schools.
- The Department of Education and Early Childhood Development website Anaphylaxis Management in Schools provides a range of support resources including:
  - a Questions and Answers Reference Sheet on school implementation
  - an updated School Anaphylaxis Management Policy template
  - a revised Individual Anaphylaxis Management Plan template
  - an updated Risk Management Checklist template, and
  - an updated PowerPoint presentation to assist schools deliver their twice yearly briefing sessions.

For further information visit:

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

APPENDIX 2: MINSTER FOR EDUCATION – MINISTERIAL ORDER 706

Minister for Education

2 Treasury Place
East Melbourne, Victoria 3002
Telephone: +61 3 9637 3196
Facsimile: +61 3 9637 2680

GPO BOX 4367
MELBOURNE VICTORIA 3001

School Principal

Dear Principal

The Victorian Government is committed to providing a safe and supportive environment in which children diagnosed at risk of anaphylaxis can participate equally in all aspects of schooling.

On 1 June 2012, the Coroner released findings into the death of a student who died from anaphylaxis after ingesting peanuts. The Department of Education and Early Childhood Development accepted the recommendations and has reviewed its anaphylaxis policy and guidelines.

As a result of this work, I am pleased to announce Ministerial Order 706: Anaphylaxis Management in Victorian schools, which comes into effect on 22 April 2014 and will repeal Ministerial Order 90.

Ministerial Order 706 sets out clearly the steps schools must take to ensure the safety of students at risk of anaphylaxis in their care. These requirements will form the basis of a minimum standard for school registration under Part IV of the Education and Training Reform Act.

All schools across Victoria, from 22 April 2014, must by law have an Anaphylaxis Management Policy if they have a student enrolled who has been diagnosed at risk of anaphylaxis. This policy must include:

- a statement that the school will comply with the Order and guidelines on anaphylaxis management
- a statement that in the event of an anaphylactic reaction, the school's first aid and emergency response procedures and the student's Individual Anaphylaxis Management Plan must be followed
- development and regular review of Individual Anaphylaxis Management Plans for affected students
- prevention strategies to be used by the school to minimise the risk of an anaphylactic reaction
- procedures for the purchase of back up Adrenaline Autoinjectors for General Use by schools
- the development of a Communication Plan
- the training of school staff on anaphylaxis management, and
- the completion of an annual Risk Management Checklist.

State Government Victoria

For the latest updates, please refer to this policy which is saved on the server.

To support the implementation of Ministerial Order 706, the Department has also revised its Anaphylaxis Guidelines to ensure consistent content and alignment.

To view Ministerial Order 706 and the revised Anaphylaxis Guidelines, please visit the Department's Anaphylaxis Management in Schools website:
www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx

For your reference, please find enclosed a Fact Sheet outlining the key changes to Ministerial Order 706 and the revised Anaphylaxis Guidelines.

The Department's website also has a variety of other resources including:

- a Questions and Answers Fact Sheet
- an updated School Anaphylaxis Management Policy template
- a revised Individual Anaphylaxis Management Plan template
- an updated Risk Management Checklist template
- a list of anaphylaxis training courses that comply with Ministerial Order 706, and
- an updated PowerPoint presentation to assist schools deliver their twice yearly briefing sessions.

Victorian schools are leading the way nationally in providing support to students with severe, life threatening allergies. Our schools are well prepared to support students who have been diagnosed at risk of anaphylaxis. Many schools have excellent strategies and procedures in place in line with the Anaphylaxis Guidelines. These changes will build on this good work.

The key to preventing an anaphylactic incident in schools is knowledge, awareness and planning. I encourage you to revisit the information and resources in the Anaphylaxis Guidelines which contain a range of strategies and advice on anaphylaxis management in schools. It is also important to continue to work in partnership with parents in order to minimise the risks associated with severe allergies.

If school staff require assistance with the implementation or interpretation of Ministerial Order 706 and the revised Anaphylaxis Guidelines, I encourage you to contact the Royal Children's Hospital Anaphylaxis Advisory Line on 1300 725 911.

Yours sincerely

The Hon. Martin Dixon,

MP Minister for Education Encl.

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

Information
FOR PATIENTS, CONSUMERS AND CARERS

ASCIA Action Plans - frequently asked questions (FAQ)

Q 1: How have the revised ASCIA Action Plans (2017) changed from the previous (2016) versions?

The following revised instructions for EpiPen® and EpiPen® Jr adrenaline (epinephrine) autoinjectors have been included in the 2017 versions of ASCIA Action Plans for Anaphylaxis:

- Reduced injection time from 10 to 3 seconds – this is based on research confirming efficacy and delivery of adrenaline through the 3 second delivery.
- Removal of the massage step after the injection – this has been found to reduce the risk of tissue irritation.

EpiPen®s with the 3 second label will start to enter pharmacies in Australia and New Zealand from 13 June 2017 onwards.

EpiPen®s with a 10 second label can continue to be used and should not be replaced unless they have been used, are just about to expire or have expired.

All EpiPen®s should now be held in place for 3 seconds, regardless of the instructions on the label. However, if they are held for 10 seconds it will not affect the way that the adrenaline works.

To access the 3 second EpiPen® training video, updated ASCIA Action Plans for Anaphylaxis and other resources go to www.allergy.org.au/anaphylaxis

Q 2: How many types of ASCIA Action Plans are there?

There are two types of ASCIA Action Plans for Anaphylaxis (General and Personal):

- The General version (orange) does not contain any personal information and can be used as a poster.
- The Personal version (red) is for individuals who have been prescribed adrenaline autoinjectors. This plan includes personal information and an area for a photo.

There is also an ASCIA Action Plan for Allergic Reactions (green), which is for individuals with medically confirmed mild to moderate allergies, who need to avoid certain allergens, but have not been prescribed adrenaline autoinjectors. This plan includes personal information and an area for a photo.

ASCIA Action Plans for Anaphylaxis and Allergic Reactions have text fields that can be directly typed into.

To save ASCIA Action Plans that have patient details typed into the text fields you need to "save as" and save the document with a new name (e.g. including the patient name). They can then be printed directly from the ASCIA website or the file that they have been saved to. To order hard copies email info@allergy.org.au

Q 3: Can the older versions (prior to 2015) of ASCIA Action Plans still be used?

No. These previous versions of ASCIA Action Plans should no longer be used.

Q 4: Can schools or parents complete an ASCIA Action Plan for Anaphylaxis (personal) or ASCIA Action Plan for Allergic Reactions for their students or children?

No. ASCIA Action Plans have been developed as medical documents and must be completed, signed and dated by the patient's medical doctor. If copies are required the original signed copy should be photocopied or scanned.

Q 5: Is it possible to obtain an electronic copy of the ASCIA Action Plans so that the child's information can be inserted by parents or school/childcare staff?

No. ASCIA Action Plans have been developed in a PDF format to ensure the documents are concise, consistent and easily understood. They now have fields that can be directly typed into by the treating doctor, but not by parents, or school/childcare staff, as they are medical documents.

Q 6: How often does an ASCIA Action Plan need to be updated?

ASCIA Action Plans should be reviewed when patients are reassessed by their doctor, and each time they obtain a new adrenaline autoinjector prescription, which is approximately every 12 to 18 months. If there are no changes in diagnosis or management the medical information on the ASCIA Action Plan may not need to be updated. However, if the patient is a child, the photo should be updated each time, so they can be easily identified.

Q 7: ASCIA Action Plans on the ASCIA website www.allergy.org.au are copyrighted. Can we still print them out and make copies?

Yes. ASCIA Action Plans can be printed off the website or photocopied without infringement of the copyright. ASCIA recommends that the Action Plans are printed in colour, if possible, as they are colour coded.

Q 8: What is the purpose of ASCIA Action Plans for Anaphylaxis?

ASCIA Action Plans for Anaphylaxis provide instructions for first aid treatment of anaphylaxis, to be delivered by people without any special medical training nor equipment, apart from access to an adrenaline autoinjector. All patients who have been prescribed an adrenaline autoinjector should also be provided with an ASCIA Action Plan for Anaphylaxis (personal).

Q 9: Is abdominal pain and/or vomiting without other symptoms a feature of anaphylaxis due to insect allergy?

Yes. The ASCIA Action Plan states that abdominal pain and/or vomiting is a symptom of a mild to moderate allergic reaction unless the individual has been stung or bitten by an insect in which case abdominal pain and/or vomiting is a symptom of anaphylaxis. Therefore, if someone experiences abdominal pain and/or vomiting to a food or medication, this is considered a mild to moderate symptom. However, if someone experiences abdominal pain and/or vomiting after being stung or bitten by an insect, this is a symptom of anaphylaxis and the adrenaline autoinjector should be administered.

It is important to watch for other signs and symptoms.

As stated on the ASCIA Action Plan, if in doubt as to whether the child or adult is experiencing anaphylaxis, give the adrenaline autoinjector and call an ambulance.

Q 10: Why does the ASCIA Action Plan for Anaphylaxis state that CPR should only be given if the person is unresponsive and not breathing normally AFTER giving adrenaline?

Adrenaline is life-saving and must be used promptly. Withholding or delaying the giving of adrenaline can result in deterioration and potentially death of the patient. This is why giving the adrenaline autoinjector is a priority on ASCIA Action Plans for Anaphylaxis, to prevent delays. If CPR is given before this step there is a possibility that adrenaline is delayed or not given. It is important to note that oxygen will usually be administered to the patient by ambulance staff.

Q 11: Who should have an ASCIA Action Plan for Allergic Reactions (green)?

The ASCIA Action Plan for Allergic Reactions has been developed for individuals (children or adults) with a confirmed food, insect or medication allergy, who have not been prescribed an adrenaline autoinjector, as they are not thought to be at risk of anaphylaxis. However, allergies to foods, insects or medications have the potential to result in severe allergic reactions (anaphylaxis) and the ASCIA Action Plan for Allergic Reactions provides guidance for carers on how to manage anaphylaxis if it occurs.

Q 12: Should an individual with allergic rhinitis (hay fever) have an ASCIA Action Plan for Allergic Reactions completed by their doctor?

No. Whilst allergic rhinitis can cause uncomfortable symptoms, these symptoms are not potentially life-threatening allergic reactions and hence an ASCIA Action Plan is not required.

However, if the allergic rhinitis affects an individual's asthma, their Asthma Action Plan should be followed.

Q 13: Is there an ASCIA Treatment Plan specifically designed for individuals with allergic rhinitis (hay fever)?

Yes. The ASCIA Treatment Plan for Allergic Rhinitis has been developed for individuals with allergy to environmental inhalant allergens such as grass pollen, dust mite, or mould, resulting in allergic rhinitis. This Treatment Plan is completed by the individual's medical practitioner and is meant for the individual or the parent and not for schools.

Most schools do not play a role in the treatment and management of allergic rhinitis. However, where medication administration is required at school, parents should liaise directly with the school.

Q 14: Can an organisation obtain an adrenaline autoinjector for general use (not prescribed for an individual) and do they require an Action Plan for Anaphylaxis?

Adrenaline autoinjectors for general use can be purchased without a prescription at full price from pharmacies. More information is available in the ASCIA document "Adrenaline Autoinjectors for General Use" which is available from the Anaphylaxis Resources section on the ASCIA website. The ASCIA Action Plan for Anaphylaxis (general) has been developed for use as a poster or as an instruction guide to include with an adrenaline autoinjector for general use.

Q 15: Where can we go to obtain further resources?

Patient information and anaphylaxis training is available from ASCIA, the peak professional body for clinical immunology and allergy in Australia and New Zealand: www.allergy.org.au/patients

ASCIA INFORMATION FOR PATIENTS, CONSUMERS AND CARERS

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

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

ASCIA is the peak professional body of clinical immunology/allergy specialists in Australia and New Zealand

Website: www.allergy.org.au
Email: info@allergy.org.au
Postal address: PO Box 450 Balgowlah NSW 2093 Australia

Disclaimer
This document has been developed and peer reviewed by ASCIA members and is based on expert opinion and the available published literature at the time of review. Information contained in this document is not intended to replace medical advice and any questions regarding a medical diagnosis or treatment should be directed to a medical practitioner. Development of this document is not funded by any commercial sources and is not influenced by commercial organisations.

Content updated 2017

For the latest updates, please refer to this policy which is saved on the server.

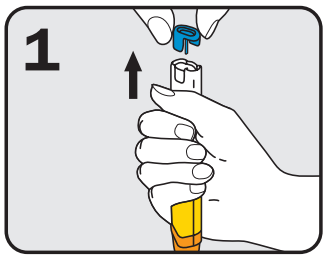
APPENDIX 4: FIRST AID PLAN FOR ANAPHYLAXIS – For use with EpiPen Adrenaline Autoinjectors

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

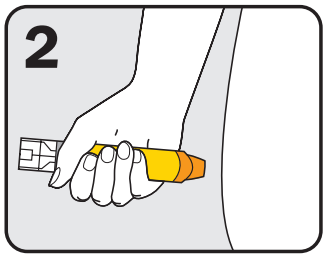
FIRST AID PLAN FOR Anaphylaxis

For use with EpiPen® adrenaline (epinephrine) autoinjectors

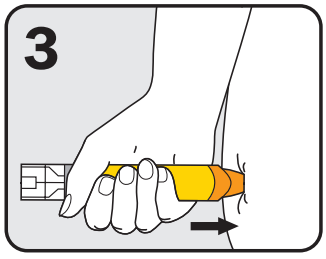
How to give EpiPen® adrenaline (epinephrine) autoinjectors



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



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



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

REMOVE EpiPen®

EpiPen® is prescribed for children over 20kg and adults. EpiPen®Jr is prescribed for children 7.5-20kg.

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
- Locate adrenaline autoinjector
- Phone family/emergency contact

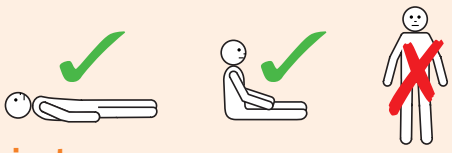
Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

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

- **Difficult/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 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, 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.

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

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 5: FIRST AID PLAN FOR ANAPHYLAXIS – For use with Generic Adrenaline Autoinjectors

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

FIRST AID PLAN FOR Anaphylaxis

For use with adrenaline (epinephrine) autoinjectors - refer to the device label for instructions

Translated versions of this document are on the ASCIA website www.allergy.org.au/anaphylaxis#ta5

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
- Locate adrenaline autoinjector
- Phone family/emergency contact

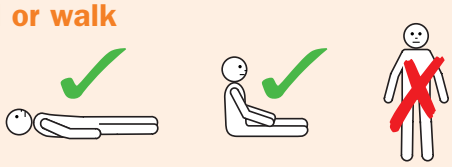
Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

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

- **Difficult/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 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, 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.

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

Adrenaline autoinjectors (300 mcg) are prescribed for children over 20kg and adults. Adrenaline autoinjectors (150 mcg) are prescribed for children 7.5-20kg.

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 6:
INDIVIDUAL ANAPHYLAXIS MANAGEMENT PLAN – To be completed together with the Anaphylaxis Action Plan

Holy Eucharist Catholic Primary School

1A Oleander Drive, St Albans South, VIC 3021

PH 8312 0900

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 Parents' 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: HOLY EUCHARIST SCHOOL	**Student's Name**
Student Date of Birth	**Student Year Level**
Medicare No:	**Health Insurance No**
Ambulance Cover: ☐ Yes ☐ No	**Ambulance Membership No**
Severely allergic to:	
Other health conditions	
Medication at school	

EMERGENCY CONTACT DETAILS (PARENT)

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

Medical practitioner contact	**Name**	
	Address	**Phone:**
Emergency care to be provided at school		
Storage for Adrenaline Autoinjector (device specific) (EpiPen)		

For the latest updates, please refer to this policy which is saved on the server.

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?

AUTHORISATION

Name of Medical/ Health Practitioner:

Professional Role:

Medical Health Practitioner's Signature:

Date:

Contact Details:

Name of Parent/ Guardian/Mature Minor:

Signature:

Date:

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 7:

ACTION PLAN FOR ANAPHYLAXIS – For EpiPen Adrenaline Autoinjectors *(Plan prepared by Doctor or Nurse Practitioner*

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

ACTION PLAN FOR Anaphylaxis

For use with EpiPen® adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Photo

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises:

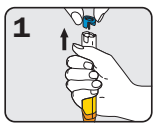
- **Medications specified on this plan to be administered according to the plan.**
- **Prescription of 2 adrenaline autoinjectors.**
- **Review of this plan is due by the date below.**

Date: _____

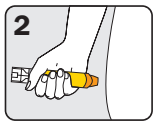
Signed: _____

Date: _____

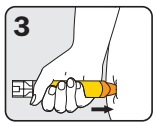
How to give EpiPen® adrenaline (epinephrine) autoinjectors



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



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



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

REMOVE EpiPen®

EpiPen® is prescribed for children over 20kg and adults. EpiPen®Jr is prescribed for children 7.5-20kg.

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
- Locate 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

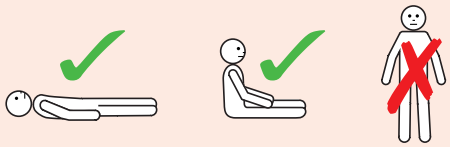
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **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 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

- *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.*

For the latest updates, please refer to this policy which is saved on the server.

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

annually;

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

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

when the student is to participate in an off-site activity, such as camps and excursions, or at special events conducted, organised or attended by the School (eg. class parties, elective subjects, cultural days, fetes, incursions).

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 - Prevention Strategies of the Anaphylaxis Guidelines

Signature of parent:	
Date:	

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 8: ACTION PLAN FOR ANAPHYLAXIS – For Generic Adrenaline Autoinjectors *(Plan prepared by Doctor or Nurse)*

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

ACTION PLAN FOR Anaphylaxis

For use with adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Photo

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises:

- **Medications specified on this plan to be administered according to the plan.**
- **Prescription of 2 adrenaline autoinjectors.**
- **Review of this plan is due by the date below.**

Date: _____

Signed: _____

Date: _____

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

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

Adrenaline autoinjectors (300 mcg) are prescribed for children over 20kg and adults. Adrenaline autoinjectors (150 mcg) are prescribed for children 7.5-20kg.

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
- Locate 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

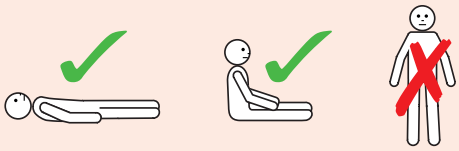
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **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 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

- *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.*

For the latest updates, please refer to this policy which is saved on the server.

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

annually;

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

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

when the student is to participate in an off-site activity, such as camps and excursions, or at special events conducted, organised or attended by the School (eg. class parties, elective subjects, cultural days, fetes, incursions).

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 - Prevention Strategies of the Anaphylaxis Guidelines

Signature of parent:	
Date:	

APPENDIX 9: FAST FACTS - ANAPHYLAXIS

Fast Facts

Anaphylaxis

1 Anaphylaxis is a potentially life threatening, severe allergic reaction, that should always be treated as a medical emergency. It occurs after exposure to an allergen (usually to foods, insects or medicines), to which a person is allergic. Not all people with allergies are at risk of anaphylaxis.

2 Anaphylaxis symptoms include one or more of the following:

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

3 In some cases, anaphylaxis is preceded by a mild to moderate allergic reaction, with symptoms such as swelling of face, lips and/or eyes, hives or welts and stomach (abdominal) pain and vomiting.

4 Anaphylaxis requires immediate treatment with adrenaline (epinephrine), injected into the outer mid-thigh. It works rapidly to reverse the effects of anaphylaxis.

5 Adrenaline autoinjectors contain a single, fixed dose of adrenaline, and have been designed to be given by non-medical people, including the patient themselves (if they are well enough).

6 ASCIA Action Plans for Anaphylaxis include infographics to illustrate the first steps of 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 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.

More information: www.allergy.org.au/anaphylaxis

Other Fast Facts: www.allergy.org.au/patients/fast-facts

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

Information
FOR PATIENTS, CONSUMERS AND CARERS

Travelling with allergy, asthma and anaphylaxis: Checklist

Plan ahead

You may need to request the following from your doctor:

- ☐ Prescriptions to cover your trip.
- ☐ Doctor's letter about the medications you need to take.
- ☐ Special vaccinations.
- ☐ Updated ASCIA Action Plan for Anaphylaxis and ASCIA Travel Plan if you are carrying an adrenaline (epinephrine) autoinjector (e.g. EpiPen). You may wish to photograph these onto your mobile phone together with your prescriptions).
- ☐ Medical report for your travel insurance policy, if required.

Medication

- ☐ Take enough for your trip, plus some spare in case you get delayed, lose it or need a higher dose because of illness (e.g. asthma medicines).
- ☐ Make sure medicines have not expired or will not expire whilst you are travelling.
- ☐ If you have been prescribed an adrenaline autoinjector, you should always carry the devices with you, including when travelling. Factors to be considered when deciding to have more than your usual supply of adrenaline autoinjector devices might include flight duration, destination (e.g. interstate or overseas), and other destination related factors (e.g. English speaking country or not; ability to access medical care; ability to replace the adrenaline autoinjector if used as they are not available in every country; ability to prepare own food or not). Severity related factors should also be considered and all of these issues should be discussed with your doctor, noting that only 2 devices are subsidised by the Australian PBS scheme and that additional devices would have to be purchased at full cost. In New Zealand, adrenaline autoinjectors are not subsidised by Pharmac.
- ☐ Take medication in original packaging. This minimises the risk of having problems with Customs when leaving Australia or New Zealand (there are regulations about exporting government subsidised medicines) or Customs when entering other countries.
- ☐ Carry essential medicines in your hand luggage. Adrenaline autoinjectors should not be packed into checked-in luggage or in overhead lockers. They must be easily accessible at all times.

Vaccination

- ☐ Respiratory infections can worsen asthma. Consider influenza vaccination. If egg allergic, the influenza vaccine can usually be given safely. For more information, go to the health professional information section on the ASCIA website www.allergy.org.au. If you need other egg-containing vaccines, you will need specialist advice.

Travel Plan for Anaphylaxis

- ☐ Download an ASCIA Travel Plan for Anaphylaxis and have it completed by your doctor:

www.allergy.org.au/health-professionals/anaphylaxis-resources/ascia-travel-plan-anaphylaxis

This helps when carrying adrenaline autoinjectors in hand luggage and through Customs.

Notify travel agent and airline/s about food allergy

- ☐ Contact the airline/s to determine their food allergy policies well in advance of travel and before you book tickets.
- ☐ Tell your travel agent and airline/s about your food allergy in advance.

ASCIA INFORMATION FOR PATIENTS, CONSUMERS AND CARERS

Insurance

- Have adequate travel insurance.
- Ensure the policy covers your medical condition. Special approval may be required.
- Check if there are any special conditions (e.g. doctor's report required, an additional fee to cover anaphylaxis).

Hospital and other medical facilities

- At your travel destination/s determine the location and contact details of emergency facilities and have these details available in case they are needed.
- Ensure that you have a way of contacting emergency services (e.g. switch your mobile phone to international roaming or purchase local or international SIM cards and check that they work).

Accommodation

- For food allergy, consider self-catering accommodation, which gives you the option of safely preparing food for yourself.
- When booking, enquire about relevant inhalant allergen risk (e.g. pets) if you have significant asthma or allergic rhinitis (hay fever) symptoms.
- Speak with your doctor if you often become unwell when away from home. Some people have medications increased or commenced for the time of the travel.

When boarding (airline, ship)

- Notify ship or airline attendants when you board about your allergies and indicate the location of your ASCIA Action Plan and adrenaline autoinjector (if prescribed).
- If an allergic reaction occurs while travelling, follow your ASCIA Action Plan and notify travel attendants so they can assist if needed.
- You may also wish to notify passengers around you, particularly to reduce the likelihood that food may be offered to young children with food allergy.
- Consider taking your own supply of food, bearing in mind restrictions on liquids for international flights. This is particularly important when considering the bottle size of antihistamine liquid or baby formula.
- Consider wiping down tables and armrests to remove possible residual food allergens (contact can sometimes trigger mild allergic symptoms).
- While fumes or dust from inhaled food allergen might cause allergic rhinitis (hay fever) or mild asthma symptoms, the risks of serious reactions is very low unless the food is actually eaten.
- Some airlines offer "exclusion zones" (not serving allergenic food within a few rows of the allergic person). While this can be requested, availability cannot be guaranteed. Since the effectiveness of 'exclusion zones' has not yet been researched, it is unknown whether this is an effective strategy to reduce the risk of allergen exposure.
- Keep emergency medication with you in hand luggage. If you are travelling with adrenaline autoinjectors, keep these with you or under the seat in front of you and NOT in the overhead locker. You need to be able to access your adrenaline autoinjectors with your seatbelt fastened.

Language cards

- If travelling to non-English speaking countries and eating out, consider purchasing foreign language travel cards that warn about your allergy to show to food service staff.
- Examples include: www.selectwisely.com and www.dietarycard.com

Patient support organisations

You may wish to contact your local patient support organisation for further information and/or resources about travelling with allergies, particularly food allergies. These organisations include:

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

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www.allergy.org.au

Travel Plan

FOR PEOPLE AT RISK OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

Name: *(as shown on passport)*

Date of birth:

Confirmed allergens:

For other details refer to the attached ASCIA Action Plan for Anaphylaxis

Travel plan prepared by medical or nurse practitioner:

Signed:

Date:

Additional information:

This person is highly allergic and is at risk of a severe, life threatening allergic reaction (anaphylaxis) if accidentally exposed to the trigger/s which causes their allergic reaction/s.

Because of the potential for anaphylaxis, one or more adrenaline (epinephrine) autoinjectors and a copy of their ASCIA Action Plan for Anaphylaxis should be available and easily accessible at all times for this person while travelling, together with a safe supply of food and liquids appropriate for the travel period.

Administration of an adrenaline autoinjector is the first line treatment for anaphylaxis.

Adrenaline autoinjectors contain a single, fixed dose of adrenaline. In an emergency a person at risk of anaphylaxis requires immediate administration of adrenaline, which can be lifesaving. This treatment should be give according to the attached ASCIA Action Plan for Anaphylaxis.

Adrenaline autoinjectors must be carried on all airline flights in hand luggage or on the person.

The luggage hold of an aircraft is NOT an appropriate place for this emergency medication to be stored, due to the reasons listed below.

Adrenaline autoinjector devices:

- need to be readily available, if required during the flight.
- can be broken with rough handling.
- may be lost if luggage goes astray.
- should not be subjected to temperature fluctuations.

APPENDIX 12: ANNUAL RISK MANAGEMENT CHECKLIST

Holy Eucharist Catholic Primary School

1A Oleander Drive St Albans South
PH 8312 0900

Annual Risk Management Checklist

(To be completed at the start of each year - Revised 2020)

School Information	
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

For the latest updates, please refer to this policy which is saved on the server.

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 classroom?	☐ Yes ☐ No
b. In the schoolyard?	☐ 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 classroom?	☐ 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?	

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www.allergy.org.au

Guidelines

Acute Management of Anaphylaxis

These guidelines are intended for medical practitioners and nurses providing first responder emergency care. The appendix includes additional information for emergency department staff, ambulance staff, rural or remote medical practitioners and nurses providing emergency care.

Anaphylaxis definitions

- Any **acute onset illness** with **typical skin features** (urticarial rash or erythema/flushing, and/or angioedema), **PLUS** involvement of **respiratory** and/or **cardiovascular** and/or persistent severe **gastrointestinal** symptoms; or
- Any **acute onset** of **hypotension** or **bronchospasm** or **upper airway obstruction** where anaphylaxis is considered possible**, even if typical skin features are not present**.

The most common triggers of anaphylaxis (severe allergic reaction) are foods, insect stings and drugs (medications).

Signs and symptoms of allergic reactions

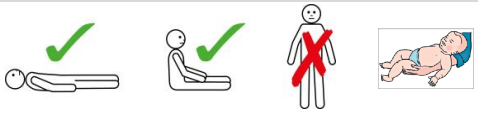
Mild or moderate reactions

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect sting or injected drug (medication) allergy

Anaphylaxis – Indicated by <u>any one</u> of the following signs:

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or sudden persistent cough*
- Persistent dizziness or collapse
- Pale and floppy (young children)
- Abdominal pain, vomiting (for insect sting or injected drug (medication) allergy).

Immediate actions



1. **Remove allergen** (if still present).
2. **Call for assistance**.
3. **Lay patient flat. Do not allow them to stand or walk. Do not hold infants upright.**
   If breathing is difficult, allow the patient to sit.
4. **Give INTRAMUSCULAR INJECTION (IMI) ADRENALINE (epinephrine) into outer mid thigh** without delay using an adrenaline autoinjector if available OR adrenaline ampoule and syringe.
5. **Give oxygen** (if available).
6. **Call ambulance** to transport patient if not already in a hospital setting.

ALWAYS give adrenaline FIRST, then asthma reliever 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.

*Unlike the cough in asthma, the onset of coughing during anaphylaxis is usually sudden.

- If required at any time, commence cardiopulmonary resuscitation (CPR).

To access ASCIA Action Plans and other anaphylaxis resources go to www.allergy.org.au/anaphylaxis

Adrenaline administration and dosages

Adrenaline (epinephrine) is the first line treatment of anaphylaxis and acts to reduce airway mucosal oedema, induce brochodilation, induce vasoconstriction and increase strength of cardiac contraction**.**

Give INTRAMUSCULAR INJECTION (IMI) OF ADRENALINE (1:1000) into outer mid thigh (0.01mg per kg up to 0.5mg per dose) without delay using an adrenaline autoinjector if available OR adrenaline ampoule and syringe, as follows.

Adrenaline (epinephrine) dosages chart			
Age (years)	**Weight (kg)**	**Vol. adrenaline 1:1000**	**Adrenaline autoinjector**
~<1	<7.5kg	0.1 mL	Not available
~1-2	10	0.1 mL	7.5*-20 kg (~<5yrs) 0.15mg device (e.g. EpiPen Jr)
~2-3	15	0.15 mL	
~4-6	20	0.2 mL	
~7-10	30	0.3 mL	>20kg (~>5yrs) 0.3mg device (e.g. EpiPen)
~10-12	40	0.4 mL	
~>12 and adults	>50	0.5 mL	

* Whilst 10-20kg was the previous weight guide for a 0.15mg adrenaline autoinjector device, a 0.15mg device may now also be prescribed for an infant weighting 7.5-10kg by health professionals who have made a considered assessment. Use of a 0.15mg device for treatment of infants weighing 7.5kg or more poses less risk, particularly when used without medical training, than use of an adrenaline ampoule and syringe.

Infants with anaphylaxis may retain pallor despite 2-3 doses of adrenaline, and this can resolve without further doses. More than 2-3 doses of adrenaline in infants may cause hypertension and tachycardia.

Pregnant women experiencing anaphylaxis need to be treated without delay and there are no absolute contraindications to adrenaline use in anaphylaxis. If clinical judgement deems that there is a risk of maternal death or foetal compromise due to inadequately treated anaphylaxis, then in pregnant women weighing > 50kg, consider giving 500 mcg IM adrenaline.

Note:

- If multiple doses are required for severe reactions (e.g. 2-3 doses administered at 5 minutes intervals), consider adrenaline infusion if skills and equipment are available.
- For emergency treatment of anaphylaxis, ampoules of adrenaline 1:1000 should be used for both IM doses and infusion if required (adrenaline 1:10 000 should not be used).

Positioning of patients

- Laying the patient flat will improve venous blood return to the heart.
- By contrast, placing the patient in an upright position, including holding infants upright over a shoulder, can impair blood returning to the heart, resulting in insufficient blood for the heart to circulate and low blood pressure.
- The left lateral position is recommended for patients who are pregnant to reduce the risk of compression of the inferior vena cava by the pregnant uterus and thus impairing venous return to the heart.
- Fatality can occur within minutes if a patient stands or sits suddenly.

- For mainly respiratory reactions, the patient may prefer to sit and this may help support breathing and improve ventilation. BEWARE that even sitting may trigger hypotension. Monitor closely. Immediately lay the patient flat again, if there is any alteration in conscious state or drop in blood pressure.
- If vomiting, lay the patient on their side (recovery position).
- Patients must **not** be walked to/from the ambulance, even if they appear to have recovered.
- Infographics (see page 1) are included in ASCIA Action Plans to reinforce correct positioning.

Supportive management - when skills and equipment are available

- Check pulse, blood pressure, ECG, pulse oximetry, conscious state.
- Give high flow oxygen if available and airway support if needed.
- Obtain IV access in adults and hypotensive children.
- If hypotensive, give IV normal saline 20mL/kg rapidly and consider additional wide bore IV access.

See Appendix for additional information.

Additional measures - IV adrenaline infusion in clinical setting

If inadequate response after 2-3 adrenaline doses, or deterioration of patient, start IV adrenaline infusion, given by staff trained in its use or in liaison with an emergency/critical care specialist. IV adrenaline infusions should be used with a dedicated line, infusion pump and anti-reflux valves wherever possible.

CAUTION: IV boluses of adrenaline are NOT recommended without specialised training as they may increase the risk of cardiac arrhythmia.

See Appendix for additional information.

Additional measures to consider if IV adrenaline infusion is ineffective

For Upper airway obstruction	• Nebulised adrenaline (5mL i.e. 5 ampoules of 1:1000). • Consider need for advanced airway management if skills and equipment are available.
For persistent hypotension/ shock	• Give normal saline (maximum of 50mL/kg in first 30 minutes). • Glucagon • In adults, selective vasoconstrictors only after advice from an emergency medicine/critical care specialist. See Appendix for dosage and additional information.
For persistent wheeze	Bronchodilators: Salbutamol 8 - 12 puffs of 100µg using a spacer OR 5mg salbutamol by nebuliser. **Note: Bronchodilators do not prevent or relieve upper airway obstruction, hypotension or shock.** Corticosteroids: Oral prednisolone 1 mg/kg (maximum of 50 mg) or intravenous hydrocortisone 5 mg/kg (maximum of 200 mg). **Note: Steroids must not be used as a first line medication in place of adrenaline.**

Antihistamines and corticosteroids

Antihistamines:

- Antihistamines have no role in treating or preventing respiratory or cardiovascular symptoms of anaphylaxis.
- Do not use oral sedating antihistamines as side effects (drowsiness or lethargy) may mimic some signs of anaphylaxis.
- **Injectable promethazine should not be used** in anaphylaxis as it can worsen hypotension and cause muscle necrosis.

Corticosteroids:

- The benefit of corticosteroids in anaphylaxis is unproven.

Observe patient for at least 4 hours after last dose of adrenaline

Relapse, protracted and/or biphasic reactions may occur. Patients require overnight observation if they:

- Had a severe or protracted anaphylaxis (e.g. required repeated doses of adrenaline or IV fluid resuscitation), OR
- Have a history of asthma or severe/protracted anaphylaxis, OR
- Have other concomitant illness (e.g. asthma, history or arrhythmia), OR
- Live alone or are remote from medical care, OR
- Present for medical care late in the evening.

True biphasic reactions are estimated to occur following 3-20% of anaphylactic reactions.

Follow up treatment including advice for hospital discharge

Adrenaline autoinjector

- If there is a risk of re-exposure (e.g. stings, foods, unknown cause) then prescribe an adrenaline autoinjector before discharge, pending specialist review.
- Teach the patient how to use the adrenaline autoinjector using a trainer device and provide them with an ASCIA Action Plan for Anaphylaxis - see ASCIA website www.allergy.org.au/anaphylaxis

Allergy specialist referral

- Refer ALL patients who present with anaphylaxis for specialist review
- The allergy specialist will:
  - Identify/confirm cause.
  - Educate regarding avoidance/prevention strategies, management of comorbidities.
  - Provide ASCIA Action Plan for Anaphylaxis - preparation for future reactions.
  - Initiate immunotherapy where available (some insect venoms).

Documentation of episodes

Patients should be advised to document the circumstances of episodes of anaphylaxis to facilitate identification of avoidable causes (e.g. food, medication, herbal remedies, bites and stings, co-factors like exercise) in the 6-8 hours preceding the onset of symptoms.
The ASCIA allergic reactions event record form can be used to collect and document this information.
https://allergy.org.au/hp/anaphylaxis/anaphylaxis-event-record/

Preparation: Equipment required for acute management of anaphylaxis

The equipment on your emergency trolley should include:

- Adrenaline 1:1000 (consider adrenaline autoinjector availability, particularly in rural locations, for initial administration by nursing staff)
- 1mL syringes; 21-gauge needles

- Oxygen
- Airway equipment, including nebuliser and suction
- Defibrillator
- Manual blood pressure cuff
- IV access equipment (including large bore cannulae)
- At least 3 litres of normal saline
- A hands-free phone in resuscitation room, to allow health care providers in remote locations to receive instructions by phone whilst keeping hands free for resuscitation.

Acknowledgements

The information in these guidelines is consistent with the Australian Prescriber Anaphylaxis Management wall chart www.australianprescriber.com

These guidelines are based on the following international guidelines:

- International Liaison Committee on Resuscitation (ILCOR) and Australian and New Zealand Committee on Resuscitation (ANZCOR) guidelines
- American Academy of Allergy, Asthma and Immunology (AAAAI) anaphylaxis parameter
- World Allergy Organisation (WAO) anaphylaxis guidelines

The appendix includes information on advanced acute management of anaphylaxis for emergency department staff, ambulance staff, rural or remote medical practitioners and nurses providing emergency care. This additional information was previously in a separate document titled ASCIA Guidelines for advanced acute management of anaphylaxis.

Appendix: Advanced Acute Management of Anaphylaxis

This additional information is intended for health professionals working in emergency departments, ambulance staff, and rural or remote medical practitioners and nurses providing emergency care.

Supportive management (when skills and equipment are available)

- Monitor pulse, blood pressure, respiratory rate, pulse oximetry, conscious state.
- Give high flow oxygen (6-8 L/min) and airway support if needed.
- Supplemental oxygen should be given to all patients with respiratory distress, reduced conscious level and those requiring repeated doses of adrenaline.
- Supplemental oxygen should be considered in patients who have asthma, other chronic respiratory disease, or cardiovascular disease.
- Obtain intravenous (IV) access in adults and in hypotensive children.
- If hypotensive:
  - Give intravenous normal saline (20 mL/kg rapidly under pressure), and repeat bolus if hypotension persists.
  - Consider additional wide bore (14 or 16 gauge for adults) intravenous access.

During severe anaphylaxis with hypotension, marked fluid extravasation into the tissues can occur: DO NOT FORGET FLUID RESUSCITATION.

Assess circulation to reduce risk of overtreatment

- Monitor for signs of overtreatment (especially if respiratory distress or hypotension were absent initially) – including pulmonary oedema, hypertension.
- In this setting (anaphylaxis) it is recommended that if possible a simple palpable systolic blood pressure (SBP) should be measured:
  - Attach a manual BP cuff of an appropriate size and find the brachial or radial pulse.
  - Determine the pressure at which this pulse disappears/reappears (the "palpable" systolic BP).
  - This is a reliable measure of initial severity and response to treatment
  - Measurement of palpable SBP may be more difficult in children.

Note: If a patient is nauseous, shaky, vomiting, or tachycardic but has a normal or elevated SBP, this may be adrenaline toxicity (side effects) rather than worsening anaphylaxis.

Additional measures - IV adrenaline infusion

IV adrenaline infusions should only be given by, or in liaison with, an emergency medicine/critical care specialist.

If your centre has a protocol for IV adrenaline infusion for critical care, this should be utilised and titrated to response with close cardio-respiratory monitoring.

If there is not an established protocol for your centre, two protocols for IV adrenaline infusion are provided, one for pre-hospital settings and a second for emergency departments/tertiary hospital settings only.

It is important to note that the two infusion protocols have *different* concentrations and *different* rates of IV fluid infusion, resulting in the same initial rate of adrenaline infusion.

It is vital that IV adrenaline infusions should be used with the following equipment wherever possible:

- Dedicated line,
- Infusion pump,
- Anti-reflux valves in intravenous line.

Additional measures - IV adrenaline infusion for pre-hospital settings

If there is inadequate response to IMI adrenaline or deterioration, start an intravenous adrenaline infusion. IV adrenaline infusions should only be given by, or in liaison with, an emergency medicine/critical care specialist. Infusions can be given with or without using an infusion pump.

The protocol for 1000 mL normal saline is as follows:

- Mix 1 mL of 1:1000 adrenaline in **1000 mL** of normal saline.
- Start infusion at **~5 mL/kg/hour** (~0.1 microgram/kg/minute).
- If you do not have an infusion pump, a standard giving set administers ~20 drops per mL, therefore, start at ~2 drops per second for an adult.
- Titrate rate up or down according to response and side effects.
- Monitor continuously – ECG and pulse oximetry and frequent non-invasive blood pressure measurements as a minimum to maximise benefit and minimise risk of overtreatment and adrenaline toxicity.

Note:

- This protocol is intended for temporary use, when no infusion pump is available.
- Most anaphylactic reactions settle with only 1 mg adrenaline in 1 litre.
- Indefinite continuation of low concentration infusion increases risk of fluid overload.
- **Caution - Intravenous boluses of adrenaline are NOT recommended due to risk of cardiac ischaemia or arrhythmia UNLESS the patient is in cardiac arrest.**

Additional measures: IV adrenaline infusion for emergency departments/tertiary hospitals only

This infusion will facilitate a more rapid delivery through a peripheral line and **should only be used in emergency departments and tertiary hospital settings.**

The protocol for 100 mL normal saline is as follows:

- Mix 1 mL of 1:1000 adrenaline in **100 mL** normal saline.
  - Initial rate adjusted accordingly to **0.5 mL/kg/hour** (~0.1 microgram/kg/minute).
  - Should *only* be given by infusion pump.
- Monitor continuously – ECG and pulse oximetry and frequent non-invasive blood pressure measurements as a minimum to maximise benefit and minimise risk of overtreatment and adrenaline toxicity.

Additional measures to consider if IV adrenaline infusion is ineffective

For persistent hypotension/shock	• Give normal saline (maximum of 50mL/kg in first 30 minutes). • In patients with cardiogenic shock (especially if taking beta blockers) consider an intravenous glucagon bolus of: – 1-2mg in adults – 20-30 microgram/kg up to 1mg in children This may be repeated or followed by an infusion of 1-2mg/hour in adults. • In adults, selective vasoconstrictors metaraminol (2-10mg) or vasopressin (10-40 units) only after advice from an emergency medicine/critical care specialist. Beware of side effects including arrhythmias, severe hypotension and pulmonary oedema. • In children, metaraminol 10 micrograms/kg/dose can be used. Noradrenaline infusion may be used in the critical care setting only with invasive blood pressure monitoring.

Advanced airway management

- Oxygenation is more important than intubation *per se.*
- Always call for help from the most experienced person available.
- If airway support is required, first use the skills you are most familiar with (e.g. jaw thrust, Guedel or nasopharyngeal airway, bag-valve-mask with high flow oxygen attached). This will save most patients, even those with apparent airway swelling (these patients have often stopped breathing due to circulatory collapse rather than airway obstruction and can be adequately ventilated with basic life support procedures).
- DO NOT make prolonged attempts at intubation - remember the patient is not getting any oxygen while you are intubating.

If unable to maintain an airway and the patient's oxygen saturations are falling further approaches to the airway (e.g. cricothyrotomy) should be considered in accordance with established difficult airway management protocols. Specific training is required to perform these procedures.

Special situation: Overwhelming anaphylaxis (cardiac arrest)

Key points:

- Massive vasodilatation and fluid extravasation.
- Unlikely that IMI adrenaline will be absorbed in this situation due to poor peripheral circulation.
- Even if absorbed, IMI adrenaline on its own may be insufficient to overcome vasodilatation and extravasation.
- Need both IV adrenaline bolus (cardiac arrest protocol, 1 mg every 2-3 minutes) AND aggressive fluid resuscitation in addition to CPR (Normal Saline 20mL/kg stat, through a large bore IV under pressure, repeat if no response).
- Do not give up too soon - this is a situation when prolonged CPR should be considered, because the patient arrested rapidly with previously normal tissue oxygenation, and has a potentially reversible cause. Consider extracorporeal membrane oxygenation (ECMO) if resource is available.

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 14: ANAPHYLAXIS GUIDELINES – SAVED ON THE SERVER

VICTORIA State Government | Education and Training

*****PLEASE FIND ANAPHALAXIS GUIDELINES (82 PAGES) SAVED ON THE SCHOOL SERVER**

*****ALTERNATIVELY YOU CAN VISIT THE 'VICTORIAN STATE GOVERNMENT - EDUCATION AND TRAINING' WEBSITE AT:**
https://www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx

Anaphylaxis Guidelines

A resource for managing severe allergies in Victorian schools

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