Anaphylaxis and allergies procedure

This is a mandated procedure under the operational policy framework. Any edits to this procedure must follow the process outlined on the creating, updating and deleting operational policies page.

Overview

This procedure is for all staff working in education and care to support children and young people with allergies and anaphylaxis.

This procedure must be read along with the Department for Education health support planning processes.

Scope

This procedure applies to educators, early childhood development specialists, principals, directors and education support staff working in education and care.

It describes:

- proactive and reactive strategies for children and young people with allergies and anaphylaxis
- signs and symptoms of mild to moderate allergic reactions and anaphylaxis
- the emergency response for anaphylaxis
- the requirement for general use adrenaline (epinephrine) autoinjectors
- education and training for anaphylaxis
- risk minimisation strategies for children and young people with allergies to prevent anaphylaxis.

This procedure applies from the time a child or young person is enrolled until they leave the education and care service.

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Detail

Anaphylaxis and allergies background

Allergic reaction

An allergic reaction happens when the immune system reacts to substances in the environment that are harmless to most people. These are known as allergens. They are found in foods, insects, pollen, mould, dust mites and some medications.

Most allergic reactions are mild and don't involve the airways or circulation.

Anaphylaxis

Anaphylaxis must always be treated as a medical emergency.

Anaphylaxis is a potentially life threatening, severe allergic reaction. It's characterised by rapid onset airway, breathing and/or circulatory problems and is usually associated with skin symptoms and swelling.

Not all people with allergies are at risk of anaphylaxis.

Signs and symptoms of allergic reactions including anaphylaxis

Signs of mild to moderate allergic reaction

- Tingling mouth
- swelling of lips, face, eyes
- hives or welts
- abdominal pain, vomiting (these are signs of anaphylaxis when the trigger is insect venom).

Signs of anaphylaxis

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

Anaphylaxis and asthma

Always give the adrenaline autoinjector first, and then the asthma reliever puffer.

Treat for anaphylaxis if someone has asthma as well as an allergy and they have sudden breathing difficulties**,** even if there are no skin symptoms.

Anaphylaxis may present with symptoms affecting the airway including breathing difficulty, persistent cough or wheeze. If the child or young person has asthma it can be difficult to determine if they are experiencing anaphylaxis or asthma.

Go to asthma for more information.

Treatment for anaphylaxis

All education and care staff must provide first aid measures following any relevant Australasian Society of Clinical Immunology and Allergy (ASCIA) Action Plan.

First aid treatment for anaphylaxis

Go to ASCIA first aid plan for anaphylaxis.

- Lay the person flat. Don't allow them to stand or walk. If breathing is more difficult lying down, allow them to sit. If unconscious, place in recovery position.
- Make sure the person is no longer exposed to the allergen or trigger.
- Administer the adrenaline autoinjector into the muscle of the outer mid-thigh
- Call triple zero (000) for an ambulance.
- Phone the parent, guardian or emergency contact.
- Further adrenaline doses may be given if there's no response after 5 minutes, if another adrenaline autoinjector is available.
- Commence cardiopulmonary resuscitation (CPR) at any time if the person is unresponsive and not breathing normally.
- In **all** cases of anaphylaxis, the care for the child or young person must be transferred to the ambulance officer for admission to hospital for at least 4 hours of observation.
- The person experiencing anaphylaxis shouldn't stand or walk to the ambulance. They must be placed on a stretcher, even if they appear to have recovered from anaphylaxis.
    - Standing may cause the blood pressure to drop and lead to the condition worsening.
- The used adrenaline autoinjector should be handed to the ambulance officer, and they should be advised of the time of administration.

Using an adrenaline autoinjector (EpiPen®, EpiPen®Jr or Anapen®)

See the resources below for instructions on how to administer an EpiPen® (and EpiPen®Jr) or Anapen®:

- ASCIA how to give an EpiPen
- ASCIA how to give an Anapen.

Who can administer an adrenaline autoinjector?

Adrenaline autoinjectors have been designed for use by anyone in an emergency. This includes people who are not medically trained, such as a friend, teacher, childcare worker, parent, passer-by, or the individual with anaphylaxis (if they are capable and old enough).

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

Self-administration of an adrenaline autoinjector

If a child or young person self-administers their own adrenaline autoinjector, a staff member must:

- supervise and monitor the child or young person at all times
- follow the instructions on the child or young person's ASCIA Action Plan
- call an ambulance (000).

The decision for a child or young person to carry their own adrenaline autoinjector can be made by using the decision making tool for medication management in consultation with the child or young person and parent or guardian.

Staff can't expect children and young people experiencing anaphylaxis to self-administer their adrenaline autoinjector. Individuals experiencing anaphylaxis can become confused and the risk of error in administration is high. In these circumstances, education and care staff must administer the adrenaline autoinjector.

There is no clarification on what age a child or young person is reasonably able to administer their own adrenaline autoinjector. Allergy & Anaphylaxis Australia advise that children over 10 to 12 years of age may carry their own device. ASCIA advise that the decision should be based on a combination of factors, including age, maturity and ability to use the device.

Potential for a delayed response from emergency services

Anaphylaxis management can be difficult in rural and remote sites where ambulance bases are many kilometres away, or are operated by volunteer services.

The department recommends children and young people who have been prescribed a personal adrenaline autoinjector carry this with them when travelling to and from the education and care service.

If a second adrenaline autoinjector is required to be administered (under the instruction of emergency services), the general use adrenaline autoinjector, or another child or young person's device, can be used.

ASCIA action plans and health support agreements

ASCIA have developed action plans as part of a comprehensive anaphylaxis management plan. They provide instructions for the management and first aid treatment of anaphylaxis.

ASCIA action plans are completed by a medical or nurse practitioner.

A health support agreement and safety and risk management plan should be developed in consultation with the parent or guardian. This should identify risk minimisation strategies, management and treatment for the child or young person in the event of an allergic reaction or anaphylaxis in the context of the education or care setting.

General ASCIA Action Plan for Anaphylaxis (orange plan)

The general ASCIA Action Plan for Anaphylaxis (orange plan) doesn't contain any personal information and must be stored in the education and care service with the general use adrenaline autoinjector. It is used as an instruction guide.

Personal ASCIA Action Plan for Anaphylaxis (red plan)

The personal ASCIA Action Plan for Anaphylaxis (red plan) is for a person who has been prescribed an adrenaline autoinjector.

This is used as a medication agreement for the adrenaline autoinjector and antihistamine medication included in the plan.

Personal ASCIA Action Plan for Allergic Reactions (green plan)

The personal ASCIA Action Plan for Allergic Reactions ('green plan') is for a person with medically confirmed allergies considered to be at a low risk of anaphylaxis. An adrenaline autoinjector has not been prescribed.

This is used as a medication agreement for antihistamine medication included in the plan.

Health support agreement

A child or young person may be identified to be at risk of an allergic reaction or anaphylaxis, even without a medical diagnosis or ASCIA action plan. In this case, the education or care service must complete a health support agreement with the parent or guardian. They should also complete the safety and risk management plan. This will make sure site-specific strategies have been identified. It will also identify individual management and treatment for the child or young person in the event of an allergic reaction or anaphylaxis. The guide to planning health support can help the health support agreement.

The health support agreement should be reviewed in consultation with the parent or guardian in each of the following circumstances:

- when the ASCIA Action Plan has been reviewed and updated
- as soon as practicable after anaphylaxis at the education or care service, to make sure all risk minimisation strategies have been identified
- prior to the child or young person participating in an offsite activity (for example, camps or excursions) or at onsite special events (for example, class parties, cultural days, sports or swimming events).

Go to health support planning for more information.

Where allergies or anaphylaxis are identified but there is no ASCIA Action Plan

In some circumstances, parents or guardians may indicate a child or young person has allergies or anaphylaxis, however there is no ASCIA Action Plan in place. In this instance, the education or care service should:

- encourage the parent or guardian to seek advice from a health professional to obtain an ASCIA Action Plan and an adrenaline autoinjector (if required)
- develop a health support agreement and safety and risk management plan in consultation with the parent or guardian
- advise the parent or guardian of the standard first aid response for managing anaphylaxis in an education or care service.

Copies and locations of ASCIA action plans

Original copies of the ASCIA action plans can be photocopied or scanned, preferably in colour as they are colour coded.

Copies of the child or young person's **personal** (red) ASCIA Action Plan must be located with their adrenaline autoinjector and easily accessible.

Additional copies of the **personal** (red) and **allergic reaction** (green) ASCIA Action Plan should be kept in various locations around the education or care service so they are easily accessible in an emergency situation. Locations may include the child or young person's classroom, canteen, sick bay, school office and yard duty bag.

A **general** (orange) ASCIA Action Plan must be stored with the general use adrenaline autoinjector.

The number and location of care plans will be decided by the principal or director of the education or care service based on a risk assessment, with consideration of timeliness of access in an emergency situation.

A document control for care plans and support agreements form may be used to identify the number and location of all copies of the care plans. When a care plan is reviewed and updated, all forms in all locations must be replaced.

Review of ASCIA action plans

A review date is not an expiry date. Where a review date has expired, the care plan is still valid until an updated plan is received. Parents or guardians should be contacted to provide an updated plan.

ASCIA action plans should be reviewed when the child or young person is reassessed by their treating health professional and each time they obtain a new adrenaline autoinjector prescription (approximately every 12 to 18 months).

The expiry date of the adrenaline autoinjector must be checked to ensure it is still current, and if not, it must be replaced as soon as possible.

Adrenaline autoinjector (eg EpiPen®, EpiPen Jr® or Anapen®)

If in doubt give adrenaline autoinjector.

It's better to use the adrenaline autoinjector even if in hindsight the reaction is not anaphylaxis.

The potential risks of not giving adrenaline far outweigh the potential risks of giving adrenaline.

ASCIA advises that no serious harm is likely to occur from mistakenly administering adrenaline to a child or young person who is not experiencing anaphylaxis.

Adrenaline autoinjectors are automatic injectors that contain a single pre-measured dose of adrenaline. They can't be reused. They can be used by anyone in an emergency, including people who aren't medically trained. Instructions are shown on the label of each autoinjector and on the ASCIA Action Plan.

Adrenaline works within minutes to reduce throat swelling, open up the airways and maintain blood pressure in people experiencing anaphylaxis. Withholding or delaying adrenaline may result in deterioration and potentially death of someone experiencing anaphylaxis.

In all cases when an adrenaline autoinjector is administered, an ambulance must be called. Care for the person must be transferred to the ambulance officer for admission to hospital for observation and monitoring. It's important that the child or young person be placed on a stretcher and not walked to the ambulance.

General use adrenaline autoinjector

One clearly labelled, '**general use'** adrenaline autoinjector that has **not** been prescribed to a particular child or young person must be available at each preschool and school:

- Preschools must have 1 general use 0.15mg adrenaline autoinjector (EpiPen®Jr)
- Schools must have 1 general use 0.3mg adrenaline autoinjector (EpiPen®).

Where a school has campuses across multiple physical locations and staff are unable to access the general use adrenaline autoinjector across campuses, the principal or director may purchase additional devices.

Adrenaline autoinjectors for general use are available for purchase at any pharmacy without a prescription. When purchasing an adrenaline autoinjector, it's important to make sure the date on the device has at least 12 months before expiry.

Adrenaline autoinjectors are funded by the education or care service.

Adrenaline autoinjectors must be replaced as soon as practicable after use, when the integrity of the medication is compromised, or before expiry.

The anaphylaxis risk assessment form can be completed by education and care services to assist in planning and measuring the implementation and use of general use adrenaline autoinjectors.

Prescribed adrenaline autoinjector

The child or young person's treating health professional will prescribe the adrenaline autoinjector within the

context of a comprehensive anaphylaxis management plan.

Two adrenaline autoinjectors are prescribed to a child or young person where they have a high risk of anaphylaxis. These are subsidised under the Pharmaceutical Benefits Scheme (PBS). One of these devices must be provided to the education and care service. At least 1 adrenaline autoinjector should be kept within close proximity of the child or young person.

Additional adrenaline autoinjectors can be purchased without prescription from a pharmacy at full cost.

Not all children or young people with a diagnosed allergy will be prescribed an adrenaline autoinjector.

Storing adrenaline autoinjectors

Adrenaline autoinjectors must be kept out of reach of small children but quickly accessible and not locked in a cupboard or classroom (during recess or lunch). In some cases, exposure to an allergen can lead to anaphylaxis within 5 minutes. The ASCIA Action Plan for Anaphylaxis must be kept with the adrenaline autoinjector. A **general** (orange) ASCIA Action Plan must be kept with the general use adrenaline autoinjector, and the **personal** (red) ASCIA Action Plan must be kept with an individual's prescribed adrenaline autoinjector.

Adrenaline autoinjectors are light and heat sensitive and must be stored in a cool dark place at room temperature (between 15 and 25 degrees Celsius). Where there is a fluctuation outside of these temperatures, the adrenaline autoinjector may be stored in an insulated wallet or travel pouch with an ice brick. However, it should not be in contact with the ice brick as this may damage the autoinjector mechanism.

Adrenaline autoinjectors must not be stored in a refrigerator or freezer as this may affect the autoinjector mechanism.

In some circumstances, the adrenaline autoinjector may be carried by the child or young person (refer to self-administration of an adrenaline autoinjector). For young children (childcare or early primary) it's not appropriate for them to carry an adrenaline autoinjector.

Labelling

Where a child or young person has a personal adrenaline autoinjector, these must have a pharmacy label and be stored in the original container that's clearly labelled with the child or young person's name.

The education or care service's general use adrenaline autoinjector must be stored within the original labelled container and clearly labelled as '**general use'**.

Training devices

Adrenaline autoinjector training devices must **never** be stored in the same location as personal use or general use adrenaline autoinjectors to avoid the risk of confusion.

All adrenaline autoinjector training devices must be clearly labelled '**training device only'.**

Disposal of adrenaline autoinjectors

An EpiPen® is designed for the needle to automatically retract back into the device when administered,

preventing the risk of needle stick injury.

After an Anapen® is used, put it to one side and do not touch the exposed needle. After calling for an ambulance, place the needle into the wide end of the black needle. Any used adrenaline autoinjector should be handed to the ambulance officer.

Expired or damaged adrenaline autoinjectors should be returned to the pharmacy when replacing the device.

Expired or damaged adrenaline autoinjectors

The shelf life of an adrenaline autoinjector is around 1 to 2 years from the date of manufacture. Devices must be replaced before the expiry date. It's important to check the expiry date on the device, rather than the box.

Education and care services are encouraged to register with the EpiClub® reminder program when an EpiPen® is purchased. This free service sends a reminder via SMS, email or post, when the EpiPen® is nearing expiry.

Where the adrenaline autoinjector is for a child or young person's personal use, and it's noted by the education and care staff that the expiry date is nearing, the parent or guardian should be notified as soon as practicable. It is the responsibility of the parent or guardian to make sure medications are in date at all times, and in the original container with a pharmacy label that includes name, dose and administration instructions.

The ASCIA website notes that a recently expired adrenaline autoinjector should be used in preference to not using one at all. However, the education or care service must make sure a regular review is undertaken and general use adrenaline autoinjectors close to expiry date are replaced.

Review of adrenaline autoinjectors

Education and care services should have a nominated staff member to undertake a regular review of all adrenaline autoinjectors. This includes all general use devices, and personal use devices that are held by the education or care service.

The review requires a visual inspection of each adrenaline autoinjector to check the expiry date and the integrity of the adrenaline. This should be completed on the review of adrenaline autoinjectors checklist.

Using a personal use adrenaline autoinjector for another person

If the education or care service has a general use adrenaline autoinjector, this should always be used in the first instance.

If the general use adrenaline autoinjector is not available and it's an anaphylaxis emergency, the priority and overarching duty of care is to assist the person having the allergic reaction as it may be life-threatening. In this instance, another child or young person's personal use adrenaline autoinjector may be used.

In the event of this, education and care staff must make sure the child or young person whose adrenaline autoinjector has been used is not exposed to any risks until a replacement device is available. This may include supervision inside if the allergen is environmental or insect related. Or if food related, it may include

restricting food options to make sure exposure is minimised.

If a child or young person's personal use adrenaline autoinjector has been used on another person, the education or care service must, as soon as practicable, purchase a replacement adrenaline autoinjector from a pharmacy at the education or care service's expense. The parent or guardian must be notified.

Medication legislation for adrenaline autoinjectors

In all cases, education and care services must make sure medication is not administered to a child or young person unless the administration is authorised and complies with the department's medication management in education and care procedure.

The requirement for an authorisation to administer doesn't apply where the emergency relates to anaphylaxis or asthma (see Regulation 94(1)). Where an adrenaline autoinjector is administered in an emergency without an authorisation, the education or care staff must notify the parent or guardian, call the ambulance and transfer duty of care of the child or young person to the ambulance officer.

Where an ASCIA Action Plan includes a description of other medication under the 'action for mild to moderate allergic reaction' section, completed by the treating health professional, this is used as the authorisation to administer.

If a parent or guardian hasn't provided an adrenaline autoinjector

Enrolment or attendance can't be refused because an adrenaline autoinjector is not provided where a child or young person has a known risk of anaphylaxis.

Parents or guardians are ultimately responsible for their child or young person's wellbeing. They have a duty of care to provide information to the education or care service about their child or young person's healthcare needs together with the appropriate documentation, equipment and medication. The parent or guardian should be strongly encouraged to provide a personal adrenaline autoinjector for their child or young person.

If a parent or guardian doesn't provide the education or care service with an adrenaline autoinjector when this has been prescribed for their child or young person, the education or care service should:

- Use their general use adrenaline autoinjector if the child or young person experiences anaphylaxis.
- Reduce the child or young person's involvement in high-risk activities, for example:
    - food allergy: only eating food provided from home (need to be very careful at class parties and during cooking classes, and restrict canteen purchases).
    - insect allergy: kept inside if a bee swarm is present or away from grassed areas on high-risk occasions such as sports days on ovals and during recess and lunch breaks.
    - go to the communication and risk management section (in this procedure) for further risk minimisation activities.
- Advise the parent or guardian of the standard first aid response for managing anaphylaxis in an education or care service.

Transport

Where a child or young person has a known health condition, consideration must be given to providing safe transport to and from the education and care service and for excursions and offsite activities. This includes where a child or young person has been prescribed emergency response medication.

It's the responsibility of the education and care service to develop strategies to ensure the safe management of first aid during transport in the event of an anaphylaxis incident.

The department recommends children and young people that have been prescribed a personal EpiPen® carry this with them when travelling to and from the education and care service.

Training and education

All education and care settings must have at least 1 designated first aider who is trained in HLTAID004 Emergency First Aid Response in an Education and Care Setting in attendance at all times. They must be immediately available to administer first aid and emergency response medication (where required).

All education and care staff are encouraged to complete the free ASCIA anaphylaxis e-training. This training is approved by the Australian Care and Education Council Quality Association (ACECQA) for preschools and children's centres in meeting first aid training requirements. This course should be completed every 2 years. It can be used as refresher training when a child or young person at risk of anaphylaxis is enrolled in the education or care service.

All canteen staff and food technology educators should undertake the free National Allergy Strategy All about Allergens online training. Regular volunteers should also be encouraged to undertake this training. However, they should not have the responsibility of preparing food for children and young people or staff with food allergies.

All education and care staff should regularly undertake a practical training session in the use of an adrenaline autoinjector. The department recommends this is completed at least twice a year.

- Adrenaline autoinjector training devices are available from pharmacies, patient support organisations and adrenaline autoinjector distributors in Australia.
- Training devices must be clearly labelled with **'training device only'** and must never be stored with general or personal use adrenaline autoinjectors.

Education about allergies should go beyond affected children and young people, parents or guardians, and education and care staff. It should include non-affected children and young people, their parents or guardians and the broader school community to enable a safe environment in education and care services.

ASCIA have a range of anaphylaxis e-training modules and resources available for education and care services as well as modules for community first aid that can be undertaken by the broader school community.

The Allergy and Anaphylaxis Australia Be a M.A.T.E program is an educational awareness program designed to help parents and education staff teach students about food allergies, and how to help their friends who are at risk of anaphylaxis. The Be a M.A.T.E. resources help increase allergy awareness and understanding within the whole school community.

Communication and risk management

Communication

Go to health support planning for general communication strategies.

Communication strategies where a child or young person with a known risk of allergy and anaphylaxis must be developed with an assurance that parents or guardians understand the content.

They should include:

- promotion of the education and care service as an allergy-aware environment
- regular communication with children and young people, parents or guardians and the wider school community to promote allergy awareness
- promotion of the ASCIA and Allergy & Anaphylaxis Australia websites to access resources and e-training modules
- staff awareness of all children and young people currently enrolled with a known risk of anaphylaxis and to be informed of the general triggers, management strategies and emergency response for that child or young person
- raising awareness with all children and young people about the ways to minimise the risk for children and young people with a known risk of anaphylaxis
- regular communication with parents or guardians of children and young people with a known risk of anaphylaxis to provide assurance that appropriate management, risk minimisation and emergency response strategies are in place
- communication from parents or guardians of any changes to the child or young person's allergy and risk factors to ensure education and care staff have up-to-date information
- alternative communication mechanisms to prevent accidental exposure to allergens ie medical identification jewellery such as a MedicAlert bracelet
- where age appropriate, communication with the peers of the child or young person identified to be at risk of anaphylaxis, to identify risk minimisation strategies that apply to them, such as hand washing before and after eating, and not sharing food.

Risk minimisation strategies

Blanket bans on food (ie 'nut-free environment') or other allergy triggers aren't recommended.

It's impossible to guarantee complete removal of all allergens, or a specific allergen from the education or care service or community. Children and young people can be at risk of anaphylaxis from many foods or insect bites. It's not possible, nor practical, to ban or remove all food or insect allergens from an education or care service.

It may give parents or guardians, and children and young people suffering from allergies, a false sense of security and assume the education or care service is free from a specific allergen, for example, nut-free.

It's more important to develop appropriate risk minimisation strategies and consider children and young people with anaphylaxis when planning activities.

Creating **allergy-aware** education and care services can minimise the risk of exposure for children and young people. This may include asking that some food products (for example, nuts) aren't sent in lunch boxes or not using some foods in cooking classes or science experiments. It's not banning the food.

Education and care staff can't confiscate foods that contain identified allergens, but they can carefully monitor the child or young person at risk. They can also monitor peers in close proximity who are eating, to ensure no sharing of food. Children and young people should be reminded of allergy-aware strategies and the child at risk should be kept safe, ensuring that hand washing and wiping of tables occurs.

Children and young people with food allergies should not be isolated from their peers and friends.

Certain foods and insect stings are the most common causes of allergic reaction and anaphylaxis in children and young people, with other common allergens including some medications and latex.

- **Food** is the main trigger for allergic reactions in infants, children and adolescents. In Australia, there are 10 foods that cause 95% of food-induced allergic reactions including cow's milk, tree nuts, peanuts, shellfish, fish, sesame seeds, eggs, soy, wheat, and lupin.
- **Insects**: bee venom is the most common cause of insect allergy. Other Australian insects that inject venom known to cause an allergic reaction include the Hopper ant (also known as Jack Jumper ant, located mainly in the Adelaide Hills), wasps and, rarely, other ants.
- **Medication**: antibiotics (usually penicillin) are the most common cause of allergic reactions. Less frequently, allergic reactions have been noted in non-steroidal anti-inflammatory medication (eg ibuprofen/Nurofen).
- **Latex**: exposure to latex can lead to generalised and serious allergic reactions, including anaphylaxis. Latex is most often associated with disposable gloves, but other common items that may contain latex include balloons, bandages, rubber bands, paint, swimming caps, condoms and syringes.

Individual risk minimisation strategies should be documented in the safety and risk management plan where a child or young person has allergies or anaphylaxis.

Allergy & Anaphylaxis Australia have developed examples of risk minimisation strategies for schools, preschools and childcare services. This is endorsed by ASCIA. The department recommends this is reviewed when developing risk minimisation strategies.

More resources are available from the Allergy & Anaphylaxis Australia website.

Other considerations for anaphylaxis

Mental health and anaphylaxis

Children and young people who have severe allergies and are at risk of anaphylaxis, and their parents or guardians, may be anxious about their allergies.

In a small number of cases, anxiety may become debilitating, preventing the child or young person from engaging in daily activities at home, school, or socially. For example, a child or young person with an insect

sting allergy might completely avoid the outdoors, or a child with a food allergy might follow an overly restrictive diet or avoid friends' homes for fear of encountering an allergen. A young child with anaphylaxis might refuse to stay at school for fear of having a reaction there.

Where there are recurrent episodes of anxiety related to anaphylaxis or allergies, a health support agreement should be developed (or updated) to reflect strategies to reduce and manage the anxiety. It's important to return the child or young person quickly to class activities to distract the focus from remaining symptoms and prevent reinforcement of avoidant behaviours that may increase anxiety. Calling parents or guardians to remove the child or young person from the education or care service may promote school avoidance.

High levels of anxiety may often be seen in parents or guardians of children and young people with anaphylaxis, particularly those with nut allergies. Prescribing adrenaline autoinjectors has been associated with a reduction in anxiety for parents or guardians.

Stress and anxiety for children and young people with severe allergies, and their parents or guardians, can significantly increase when there is a change in lifestyle such as starting (or changing) education or care service.

There are 4 main causes of stress and anxiety relating to anaphylaxis for parents or guardians:

- the potential seriousness of anaphylaxis (life-threatening)
- the inconvenience and changes in lifestyle (difficulty with shopping, reading labels, constantly having to explain the allergy)
- feeling isolated and that others don't understand
- letting go (trusting the child or young person and others to deal with the allergy).

Regular and ongoing communication with parents or guardians is important to reassure them of the strategies in place to manage the child or young person's allergies. There should be emphasis on the ability of the education or care service to ensure a safe environment.

Bullying and allergies

Studies have demonstrated that children and young people with food allergies experience a decreased quality of life across a number of areas. More recent evidence suggests that these children and young people experience an increased occurrence of bullying compared to similar school-aged children, with 42% having experienced some form of bullying because of their allergy. See bullying in Australian children and adolescents with food allergies.

Some individuals have reported being bullied because of their allergies, while others have reported specific allergy-related-bullying, such as being touched with foods that they are allergic to or having their food being intentionally contaminated with an allergen. Where there may be a risk of severe anaphylaxis, this is of great concern.

Education and care services have a duty of care to ensure the safety of children and young people with a known risk of allergic reaction.

Education and care staff must identify and manage incidents of bullying of children and young people at risk of allergic reactions (ie teasing, tricking the person at risk into eating a food, or threatening with a substance

they are allergic to). All incidents of bullying must be dealt with in line with the education and care service anti-bullying policy.

Any attempt to harm a child or young person at risk of anaphylaxis must be treated as a serious and dangerous incident.

Definitions

Access Assistant program

Supports children and young people with a disability and/or complex health support needs so they can participate in education and care services.

adrenaline autoinjector

Adrenaline rapidly reverses the effects of anaphylaxis and is considered the emergency medication for anaphylaxis. Adrenaline autoinjectors:

- are spring loaded automatic injector devices for emergency and first aid treatment of anaphylaxis
- contain a single, fixed dose of adrenaline to be administered intramuscularly for safe, rapid absorption
- are designed for use by anyone, including people who are not medical or nursing trained.

ASCIA

Australasian Society of Clinical Immunology and Allergy. The peak professional body of clinical immunology and allergy in Australia and New Zealand.

Supporting information

ASCIA action plans

ASCIA first aid for anaphylaxis

ASCIA how to give an EpiPen®

HSP120 Health support agreement

HSP121 Safety and risk management plan

HSP130 Document control for care plans and support agreements

HSP151 Medication agreement

HSP154 Decision making tool for medication management

HSP321 Anaphylaxis risk assessment

HSP322 Review of adrenaline autoinjectors

Information sheet for parents – EpiPen® and anaphylaxis

Management of anaphylaxis (flowchart)

Planning and documentation for anaphylaxis and allergies (flowchart)

Related legislation

Code of practice first aid in the workplace 2012

Disability Discrimination Act 1992

Disability Standards for Education 2005

Education and Early Childhood Services (Registration and Standards) Act 2011

Education and Care Services National Regulations

National Disability Insurance Scheme Act 2013

State Records Act 1997

Work Health and Safety Act 2012

Related policy documents

Duty of care policy

First aid and infection control standard

Medication management in education and care

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