Best Practice Guidelines

for anaphylaxis prevention and management in

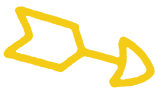
children's education and care services

(including outside school hours care)

Allergy & Anaphylaxis Australia

national allergy strategy

ascia australasian society of clinical immunology and allergy



CONTENTS

ABBREVIATIONS

A&AA	Allergy & Anaphylaxis Australia
ASCIA	Australasian Society of Clinical Immunology and Allergy
CEC	Children's education and care services (including outside school hours care)

DEFINITIONS

Adrenaline (epinephrine)	A medication that reverses the effects of a severe allergic reaction (anaphylaxis). Adrenaline is a hormone produced naturally by the body however, the body is not able to produce enough adrenaline to treat anaphylaxis.
Adrenaline injector	Adrenaline injectors contain a single, fixed dose of adrenaline, designed for use by anyone, including people who are not medically trained. Some adrenaline injectors (e.g. EpiPen® and Anapen®) are automatic injectors. Adrenaline injectors are either prescribed to an individual or can be purchased by the CEC service for general use and stored in first aid kits.
Allergic reaction	An immune response to something that is harmless to most people. Allergic reactions can be mild, moderate or severe.
All staff	Refers to all staff including full-time, part-time, casual and relief educators, administration staff and staff who prepare and serve food and any other staff employed by the CEC provider.
Anaphylaxis	The most severe form of allergic reaction. Anaphylaxis is life-threatening and requires prompt administration of adrenaline.

ASCIA Action Plan	A standardised response plan for people with allergies that can lead to anaphylaxis. ASCIA Action Plans must be completed by the child's doctor or nurse practitioner. There are different types of plans: – ASCIA Action Plan for Anaphylaxis (red) given to people who have been prescribed an adrenaline injector. – ASCIA Action Plan for Allergic Reactions (green) given to people with confirmed allergy but who have not been prescribed an adrenaline injector. – ASCIA Action Plan for Drug (Medication) Allergy given to people with confirmed medication allergies. If a person has other allergies, their drug allergy will be documented on their other ASCIA Action Plan so that they don't have two plans. – ASCIA First Aid Plan for Anaphylaxis (orange) for storage with general use adrenaline injectors or for use as a poster.
Children at risk of anaphylaxis	Children with an ASCIA Action Plan for Anaphylaxis (red) or an ASCIA Action Plan for Allergic Reactions (green) or an ASCIA Action Plan for Drug (Medication) Allergy.
Children's education and care service	All children's education and care services including long daycare, family daycare, outside school hours care and vacation care.
Hands-on practise	Refers to physical demonstration of correct administration of adrenaline injector devices using a trainer device.
Individualised anaphylaxis care plan	A plan that documents the child's allergies and risk minimisation strategies to prevent exposure to known allergens and treatment in the event of an allergic reaction. It also includes a copy of the child's ASCIA Action Plan. These care plans may have different names (e.g. Individual Health Care Plan, Individual Anaphylaxis Management Plan) in different jurisdictions however, the purpose of the plan is the same.
Jurisdictions	The different states and territories in Australia.
Parents	Refers to parents and/or guardians/carers.

INTRODUCTION

The *Best Practice Guidelines for the Prevention and Management of Anaphylaxis in Children's Education and Care* (the Guidelines) are based on the current evidence-base and best practice. The Guidelines have been developed in consultation with key stakeholder organisations, staff working in the children's education and care (CEC) sector and parents of children who are enrolled in CEC services. These Guidelines aim to provide best practice guidance and associated support documents to reduce the risk of anaphylaxis in CEC services while supporting children to participate in the full range of CEC activities.

The Guidelines have been developed to provide guidance and support to CEC services across all jurisdictions of Australia. However, it is important to note the following:

- National legislation exists and CEC services must comply with the national regulations.
- Jurisdictional legislation may exist, and CEC services must comply with the legislation in their jurisdiction.
- Where jurisdictional guidelines exist, CEC services are encouraged to comply with the guidelines in their jurisdiction.
- The Guidelines may recommend measures which are additional to the legislation and/or guidelines nationally and in your jurisdiction and implementing these additional measures where possible is encouraged.

The Guidelines can be used by overarching bodies (such as state and territory Departments) when reviewing and updating their legislation, central guidelines, policies and procedures to improve standardisation of anaphylaxis management across Australia. The Guidelines can also be used by individual CEC services (particularly where guidelines, policies or procedures are not available) to identify appropriate strategies to manage anaphylaxis at the individual CEC service level.

To support the adoption of the Guidelines, several supporting resources have been developed including an *Implementation guide* (Part B of this document), templates and sample documents. These resources are publicly available as free downloads from the National Allergy Strategy Allergy Aware website. The **Allergy Aware website** is a resource hub that includes links to useful resources for CEC services to help manage anaphylaxis. The website also contains links to state and territory specific information and resources.

While these guidelines refer to strategies for preventing and managing anaphylaxis in children, CEC services should also implement appropriate strategies for staff, volunteers and visitors with confirmed allergies (i.e. people with an ASCIA Action Plan for Anaphylaxis or an ASCIA Action Plan for Allergic Reactions).

Key principles for reducing the risk of anaphylaxis

1. Have an overarching anaphylaxis management policy and review anaphylaxis management policies and procedures if an allergic reaction occurs.

2. Obtain up-to-date medical information and develop individualised anaphylaxis care plans (risk minimisation plan) for each child at risk. Individualised anaphylaxis care plans must be developed in consultation with parents. ASCIA Action Plans (medical management plan) completed by the child's treating doctor or nurse practitioner should be included in the individualised anaphylaxis care plan.

3. Train staff in the prevention, recognition and treatment of allergic reactions including anaphylaxis.

4. Ensure staff awareness of children at risk of allergic reactions (i.e. children with an ASCIA Action Plan for Anaphylaxis (red), ASCIA Action Plan for Allergic Reactions (green) or an ASCIA Action Plan for Drug Allergy) and that unexpected allergic reactions, including anaphylaxis, might occur for the first time in children not previously identified as being at risk, while in the CEC service.

5. Provide age-appropriate education of children with allergies and their peers to manage risks in CEC services.

6. Implement practical strategies to reduce the risk of accidental exposure to known allergic triggers according to the CEC service's policy and individualised anaphylaxis care plans and review anaphylaxis risk minimisation strategies if an allergic reaction occurs.

7. Have at least one general use adrenaline injector in each CEC service.

8. Communicate about anaphylaxis management with CEC staff and the CEC community.

9. Provide support (including counselling) for CEC staff who manage an anaphylaxis and for the child who experienced the anaphylaxis and any witnesses.

10. Appropriate reporting if an allergic reaction occurs while the child is in the care of the CEC service.

PART A:
RECOMMENDATIONS

Recommendation 1

Anaphylaxis management policy and plans

1.1 CEC services should have a site-specific anaphylaxis management policy that details the following:

- Identifying children at risk
- Allergy documentation
- Prescribed and general use adrenaline injectors
- Staff training
- Risk management and risk minimisation
- Communication plan
- Peer education
- Emergency response plan
- Incident reporting

The policy should be reviewed and updated at least every two years.

Consistent with National Regulation 91: Medical conditions policy to be provided to parents.

1.2 CEC providers should develop anaphylaxis risk management plans that are specific to the CEC site, activity or off-site activity (e.g. excursions).

Consistent with National Regulation 101: Conduct of risk assessment for excursion.

Consistent with National Regulation 168: Education and care service must have policies and procedures.

Consistent with National Regulation 170: Policies and procedures to be followed.

Consistent with National Regulation 171: Policies and procedures to be kept available.

1.3 CEC providers should implement reasonable risk minimisation strategies if the CEC provider has children with known allergies enrolled (refer to Part B - Implementation guide).

1.4 CEC providers should have a communication plan detailing how the CEC service communicates with staff, volunteers, children (where appropriate), parents, visitors and their broader service community.

CEC providers should clearly communicate in their policy an 'allergy aware' approach.

Consistent with National Regulation 90: Medical conditions policy (iv) development of a communication plan to ensure that (a) staff and volunteers are informed about the medical conditions policy and the medical management plan and risk minimisation plan for the child.

1.5 CEC providers should have an anaphylaxis emergency response plan which follow the ASCIA Action Plan and identifies staff roles and responsibilities in an anaphylaxis emergency. Emergency response plans should be practised at least once a year.

Separate emergency response plans must be developed for any off-site activities.

Consistent with National Regulation 168: Education and care service must have policies and procedures.

Consistent with National Regulation 170: Policies and procedures to be followed.

See Implementation guide page 21

Recommendation 2

Allergy documentation

2.1 CEC providers should take all reasonable efforts to obtain a copy of the child's ASCIA Action Plan (medical management plan) as a means of obtaining the child's up-to-date written medical information regarding known allergies upon enrolment, diagnosis and as needs change.

In the CEC setting, the ASCIA Action Plan is designed to assist providers to meet the requirements of a medical management plan.

Consistent with National Regulation 162: Health information to be kept in enrolment record.

2.2 All parents of children with known allergies to attending the CEC service should provide an ASCIA Action Plan completed and signed by their child's doctor or nurse practitioner.

Individual ASCIA Action Plan for Anaphylaxis (red), ASCIA Action Plan for Allergic Reactions (green) or ASCIA Action Plan for Drug (medication) Allergy.

Consistent with the National Regulation 90 (c) (i): Requiring a parent of the child to provide a medical management plan for the child.

2.3 If there is a change in a child's allergy, parents should provide an updated ASCIA Action Plan.

If no updated plan is available, the most recent plan can still be used but parents need to be informed and instructed to see a doctor to update the ASCIA Action Plan as soon as possible.

If there is no change in the child's allergy, the plan should be updated before the date specified by the child's doctor or nurse practitioner on the current plan, usually every 12-18 months when they are reviewed by their doctor and receive a new adrenaline injector prescription. Specifically, there is no need to update the ASCIA Action Plan at the start of each calendar year.

2.4 All children with an ASCIA Action Plan for Anaphylaxis or an ASCIA Action Plan for Allergic Reactions should have an individualised anaphylaxis care plan completed by the CEC provider in consultation with the child's parent or guardian. Individualised anaphylaxis care plans should:

- be completed at the start of each calendar year or when the CEC provider is informed about the child's allergy.
- include a copy of the child's current ASCIA Action Plan.
- include appropriate risk minimisation strategies that will be implemented to manage the child's allergies for both on-site and off-site activities.
- be agreed to and signed by a parent.

In the CEC setting the individualised anaphylaxis care plan template is designed to help meet the requirements of a risk minimisation plan.

Note: Children who have only an ASCIA Action Plan for Drug (medication) Allergy do not require an individualised anaphylaxis care plan as the child can easily avoid the medication whilst in the care of the CEC service.

Consistent with National Regulation 90 (iii): Requiring the development of a risk minimisation plan in consultation with the parent of a child.

2.5 The child's individualised anaphylaxis care plan should be reviewed and updated:

- if the child's allergies change.
- after exposure to a known allergen while attending the CEC service.

Could be covered by National Regulation 85: Incident, injury, trauma and illness policies and procedures.

Individualised anaphylaxis care plan template for CEC

SECTION A – Child details – This section is to be completed by parent/guardian

Name:	Gender:	Date of birth:
Address:	Room:	
	Nominated supervisor:	

Parent/guardian contact details	Medical contact details
Name: Relationship to child: Phone:	Doctor: Medical Centre/Practice name: Phone:
Name: Relationship to child: Phone:	

SECTION B – Child health care planning – This section is to be completed by parent/guardian

Please tick what your child is allergic to below:

☐ Milk (dairy)	Tree nuts (please specify specific nut/s)
☐ Peanut	☐ Almond
☐ Egg	☐ Brazil nut
☐ Soy	☐ Cashew
☐ Wheat	☐ Hazelnut
☐ Crustaceans (Shellfish)	☐ Macadamia
☐ Molluscs	☐ Pecan
☐ Fish	☐ Pine nut
☐ Sesame	☐ Pistachio
☐ Lupin	☐ Walnut
☐ Other foods *(please specify)*:	☐ All tree nuts should be avoided while at the CEC service

☐ Insect stings or bites *(please specify if known)*:

☐ Medication *(please specify if known)*:

☐ Latex

☐ Other/Unknown *(please specify if known)*:

Name: CEC service: DOB:

SECTION C – Daily management – This section is to be completed in consultation with parent/guardian

List strategies that would minimise the risk of exposure to known allergens

(expand section as required if not completed electronically)

SECTION D – MEDICATION – This section is to be completed by parent/guardian

	Medication 1	Medication 2	Medication 3
Name of medication (include adrenaline injectors)			
Expiry date			
Where is the medication stored? Note: Adrenaline injectors must be stored in an unlocked location at room temperature (please tick all that are appropriate)	☐ Stored at CEC service Where: ☐ Kept and managed by self (if OSHC) Where: ☐ Other:	☐ Stored at CEC service Where: ☐ Kept and managed by self (if OSHC) Where: ☐ Other:	☐ Stored at CEC service Where: ☐ Kept and managed by self (if OSHC) Where: ☐ Other:

SECTION E – ASCIA ACTION PLAN – This section is to be completed by parent/guardian

Date ASCIA Action Plan completed by doctor or nurse practitioner:

Date of next review:

A copy of the child's ASCIA Action Plan completed by the child's doctor or nurse practitioner must be attached to this document.

SECTION F – AGREEMENT – This section is to be completed by the CEC nominated supervisor and parent/guardian

This agreement authorises CEC staff to follow the advice of the child's parent/guardian as set out in this child's individualised anaphylaxis care plan. It is valid for one year or until the parent/guardian advises the CEC service of a change in their child's health care requirements.

CEC nominated supervisor name: **Signature:** **Date:**	**Parent/guardian name:** **Signature** **Date:**
Review date:	

See Implementation guide page 23

Recommendation 3

Emergency response

3.1 If a child is showing the signs and symptoms of anaphylaxis, CEC staff should immediately administer an adrenaline injector according to the child's ASCIA Action Plan or the ASCIA First Aid Plan for Anaphylaxis.

Adrenaline is the first line treatment for anaphylaxis. If in doubt about whether a child is experiencing anaphylaxis or not, staff should immediately administer the child's adrenaline injector if they have one.

The CEC provider must be prepared to respond appropriately to an anaphylaxis emergency, even for children not previously identified as being at risk. Staff should immediately administer the CEC service's general use adrenaline injector and follow the ASCIA First Aid Plan for Anaphylaxis (orange).

Consistent with National Regulations 92–96: Administration of medication.

3.2 Ensure up to date medical advice and first aid practices are followed in response to an anaphylaxis.

- After an adrenaline injector has been administered, the child should stay in position as per the ASCIA Action Plan and an ambulance (where available) should be called to transport the child to hospital for medical monitoring (Consistent with National Regulation 94).
- Until the ambulance arrives the child must not be allowed to stand or walk (even if they appear well) and should lay flat or sit with legs outstretched (e.g. on the floor or on a bed) if breathing is difficult.

When paramedics arrive, they will take responsibility for emergency care. Paramedics should stretcher the child to the ambulance (they must not stand or walk even if they appear well).

- Where an ambulance is not available, staff should follow the directions of the ambulance service. If the child needs to be transported to a health care service, staff should stretcher the child to a vehicle. They must not be allowed to stand or walk, even if they appear to be well.

The CEC provider's emergency response plan should include a strategy as to how to manage situations where an ambulance is not available.

Consistent with the National Regulations 92–96: Administration of medication.

3.3 If the child has an ASCIA Action Plan for Anaphylaxis, one of the child's prescribed adrenaline injectors should be available to the CEC service and stored with their ASCIA Action Plan, while they are in the care of the CEC service.

- Where children have prescribed adrenaline injectors, one should be made available to the CEC staff for the excursion or off-site activity with a copy of their ASCIA Action Plan.

The CEC provider's access to a prescribed adrenaline injector may include the child carrying their own adrenaline injector, dependent on the child and their ability to manage their own medication (e.g. outside school hours care, vacation care).

CEC providers should allow parents to collect their child's prescribed device (if they leave it with the service) when the child is not in the care of the CEC service for a period of time (e.g. holidays).

Could be covered by National Regulation 90: Medical conditions policy.

3.4 Where legislation permits, CEC providers should have at least one general use adrenaline injector. A copy of the ASCIA First Aid Plan for Anaphylaxis must be stored with the general use device.

CEC providers should have at least one general use adrenaline injector with a risk assessment undertaken to determine if additional devices are required. The device required (0.15mg or 0.30mg) will depend on the age of the children being cared for.

General use adrenaline injectors are additional to a child's prescribed adrenaline injector and not a substitute for prescribed devices.

Could be covered by National Regulation 89: First aid kits.

3.5 CEC providers should equip appropriately trained staff on excursions or other off-site activities with at least one general use adrenaline injector and an ASCIA First Aid Plan for Anaphylaxis (orange).

Consistent with National Regulation 89: First aid kits must be taken on excursions.

3.6 Adrenaline injectors (general use and prescribed devices) should be kept out of the reach of young children. However, they should be easily accessible when needed and not in a locked cupboard, room, or office.

Adrenaline injectors should be stored at room temperature (not in the fridge) away from direct sunlight.

Consistent with National Regulations 89-90: First aid kits; Medical conditions policy.

3.7 A process should be in place to regularly check (quarterly) the expiry date of all adrenaline injectors (general use and prescribed) in the CEC service.

Adrenaline injectors should also be checked for discolouration and sediment.

See Implementation guide page 26

Recommendation 4

Staff training

4.1 All staff should undertake anaphylaxis training which includes preventing exposure to known allergens, and how to recognise and respond to an allergic reaction including anaphylaxis, at least every two years.

All staff have a role in anaphylaxis prevention and management and should know how to recognise and respond to anaphylaxis.

Even where CEC providers do not currently have children or staff with confirmed allergies, staff should be able to recognise and respond to an allergic reaction including anaphylaxis as someone not previously thought to be at risk could have their first anaphylaxis while at the CEC service.

Could be covered by National Regulation 136: First aid qualifications.

4.2 Anaphylaxis training should:

- Be evidence-based, follow best practice and be consistent with the recommendations outlined in this document. The *ASCIA anaphylaxis e-training for CEC* is recommended. Training can be face to face or online.
- Include how to follow the ASCIA Action Plan in an anaphylaxis emergency.
- Be undertaken by all CEC staff (including part-time, casual and relief staff).
- Be undertaken as a pre-requisite and completed before starting work with the CEC provider or on the first day of commencing work with the CEC provider.
- Include hands-on practise with adrenaline injector trainer devices.

CEC providers should have adrenaline injector trainer devices available for hands-on practise by staff. Adrenaline injector trainer devices should be kept separate to real adrenaline injectors to avoid confusion.

Could be covered by National Regulation 136: First aid qualifications.

4.3 Anaphylaxis refresher training, including hands-on practise with adrenaline injector trainer devices should be undertaken at least twice a year.

This should also include a revision of signs and symptoms and a reminder of which children are at risk of anaphylaxis. The *ASCIA anaphylaxis refresher e-training* is recommended.

In some jurisdictions, school/community nurses support CEC services and may be able to assist with adrenaline injector training.

4.4 A staff training register should be kept by the CEC provider.

The register should include all names of staff that have completed the training, the name of the course completed, training provider and the date of completion.

Consistent with National regulation 145: Staff record.

4.5 Staff responsible for preparing, serving and supervising food for children with food allergies (e.g. cooks, chefs and educators) should undertake the National Allergy Strategy All about Allergens for CEC online food allergen management training.

- This training should be undertaken at least every two years.
- A staff training register should be kept with names of staff who complete the training and the date of completion.
- Untrained staff should not be given the responsibility of preparing or serving food for children with food allergies.
- In CEC services where parents provide the food, staff should still undertake the *All about Allergens for CEC* online training to appropriately handle, serve and supervise meals.

Could be covered by National Regulation 136: First aid qualifications.

See Implementation guide page 31

Recommendation 5

Community and peer education

5.1 CEC providers should communicate with their CEC community about food allergy and anaphylaxis at least annually, ideally at the commencement of each calendar year or when the allergies being managed by the CEC provider change.

This is to help raise awareness and provide information about current CEC provider policies.

Consistent with National Regulation 90: Medical conditions policy (iv) development of a communication plan to ensure that (a) staff and volunteers are informed about the medical conditions policy and the medical management plan and risk minimisation plan for the child.

Consistent with National Regulation 168: Education and care service must have policies and procedures.

Consistent with National Regulation 170: Policies and procedures to be followed.

Consistent with National Regulation 171: Policies and procedures to be kept available.

5.2 Communication should be undertaken with volunteers, the parent body and the broader CEC community about the CEC provider's anaphylaxis management policy.

CEC providers should clearly communicate in their policy an 'allergy aware' approach.

5.3 CEC providers should implement age-appropriate peer education programs.

Australian evidence-based, best-practice resources should be used. Peer education about the seriousness of food allergies may help to educate children and prevent food allergy specific bullying.

A key component of peer education includes children not sharing food and eating utensils, including food prepared in cooking lessons.

See Implementation guide page 33

Recommendation 6

Post incident management and incident reporting

6.1 The following data should be collected by CEC providers for all allergic reactions (where there is a risk of anaphylaxis):

- Child's name and date of birth.
- Date and time of the allergic reaction.
- Does the child have an ASCIA Action Plan for Anaphylaxis or ASCIA Action Plan for Allergic Reactions?
- What caused the allergic reaction? Was the child exposed to a known allergen and how did the exposure occur?
- If no known allergies, what was the suspected cause of the allergic reaction?
- Name and position (e.g. educator, supervisor, administrator) of the staff member who provided first aid.
- Signs and symptoms observed.
- Was the child's ASCIA Action Plan followed?
- Location of the child when the allergic reaction occurred?
- Where was the child treated?
- Was the child positioned appropriately during the anaphylaxis (sitting with legs outstretched or lying down)?
- Was a prescribed adrenaline injector device used? If not, why (e.g. expired, misfired, not as close to hand as a general use device)?
- Was a general use adrenaline injector device used? If so, why (e.g. first anaphylaxis, second dose)?
- How long after observing anaphylaxis symptoms was the adrenaline injector administered?
- What medications were given, including additional doses of adrenaline?
- Was an ambulance called?
- Was the child stretchered to the ambulance?
- Was the child transported to hospital?
- Was the parent/emergency contact called?
- Any additional information that may be relevant to the incident.

Allergic reactions to packaged foods or food provided by a food service provider after the allergy has been declared, should be reported to the Health Department in that jurisdiction that the CEC service operates.

Could be covered by National Regulation 87: Incident, injury, trauma and illness record.

6.2 When an incident occurs in an CEC service, a debriefing meeting should be held:

- to discuss the incident for emotional processing.
- to discuss any areas of improvements or learnings (e.g. whether there needs to be any changes to the risk management strategies in place).

The child's individualised anaphylaxis care plan should be reviewed and updated if required.

Could be covered by National Regulation 87: Incident, injury, trauma and illness record.

6.3 When an incident occurs in an CEC service, support (e.g. counselling) should be provided to staff and children where required.

Staff involved in managing the anaphylaxis, the child who experienced the anaphylaxis and children who witness the anaphylaxis may require support.

Could be covered by National Regulation 87: Incident, injury, trauma and illness record.

6.4 A consistent data set should be collated at a jurisdictional level to allow national pooling of de-identified data that will facilitate improved risk-minimisation strategies and inform policy at all levels.

Collection of standardised, centralised data across all jurisdictions will facilitate improved risk-minimisation strategies and inform policy at all levels.

Could be covered by National Regulation 87: Incident, injury, trauma and illness record.

See Implementation guide page 35

PART B:
IMPLEMENTATION GUIDE

Anaphylaxis management policy and plans

Information and resources

Policy

- Policies help to guide practice and make sure that everyone understands how the CEC service plans to manage allergy. An anaphylaxis policy needs to address all the issues outlined in Recommendation 1 'Anaphylaxis Management Policy and Plans'.
- In addition, the policy should:
  - Be reviewed and updated at least every two years to make sure that it still meets the needs of the children in the CEC service.
  - Be site specific to make sure it is appropriate for each individual CEC service.
- This policy must also comply with Regulations 90, 92, 162(c)(i) and 168(d) of the Education and Care Services National Regulations (the National Regulations).

Resources

Sample anaphylaxis management policy for CEC

Anaphylaxis risk management plan

- A risk management plan:
  - Helps to identify areas of potential risk and possible solutions to reduce the risk.
  - Should be developed for day-to-day allergy management at the CEC service.
  - Should also be developed for off-site activities, as the risks will be different.
- An anaphylaxis risk management plan template has been developed to help staff consider possible risks.

Resources

Anaphylaxis risk management plan template for CEC

Anaphylaxis risk minimisation strategies

- While it is not possible to completely remove the risk of a child having an allergic reaction while in the care of a CEC service, it is possible to reduce the risk using appropriate risk minimisation strategies.
- Therefore, it is important for CEC services to implement appropriate risk minimisation strategies for known allergens.
- Several site-specific factors (such as the age and number of children and the activities undertaken in the CEC service), will determine which risk minimisation strategies should be put into place.
- A whole of CEC service approach to risk minimisation is recommended and many of these risk minimisation strategies will also be included in the individualised anaphylaxis care plans for children with known allergies that attend the CEC service.
- ASCIA and A&AA, as the peak medical and patient support allergy bodies in Australia, have developed a list of appropriate risk minimisation strategies.

Resources

Examples of anaphylaxis risk minimisation strategies for CEC

Communication plan

- A communication plan outlines how the CEC service intends to communicate with staff, volunteers, children (where appropriate), parents and the broader CEC community about allergies.
- An 'allergy aware' approach is recommended rather than focusing on banning specific food allergens. See Community and peer education information and resources.
- It is important that CEC services have a plan for informing staff about children with allergies, including any changes to their allergies. This includes informing new and relief staff and volunteers.
- All staff need to know that there are children at risk of anaphylaxis and what they are allergic to, so that they can help to manage risk.
  - It is important for the CEC service to inform staff who may not have been included in anaphylaxis training such as cleaners and grounds maintenance staff, about how the CEC service manages allergies.
  - It is also important to have a plan for how you will inform parents of children with allergies about food provided and activities they will engage in, include any special activities such as incursions and off-site activities.

Regulation 90(1)(b) of the National Regulations requires staff members and volunteers to be informed about the practices of the service in relation to managing medical conditions that are contained within the service's medical conditions policy.

Regulation 90(1)(c)(iv)(A) of the National Regulations requires communication plans to be developed to ensure that relevant staff members and volunteers are informed about the medical conditions policy and the medical management plans and risk minimisations plans of children.

Regulation 173(2)(f) of the National Regulations also requires services to have a notice, stating that there is a child enrolled at the service who has been diagnosed as at risk of anaphylaxis.

Site specific anaphylaxis emergency response plan

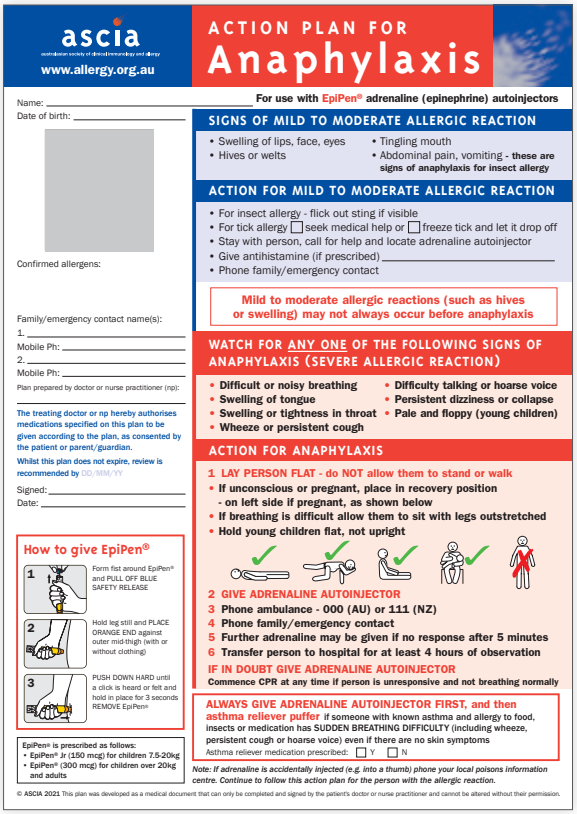
- It is important for CEC services to develop site specific information about how the service will respond to suspected allergic reactions, including in children with no known risk of anaphylaxis.
- The emergency response plan should follow the ASCIA Action Plan in terms of actions for anaphylaxis, but it should also identify staff roles and responsibilities in an anaphylaxis emergency.
- The plan should have enough detail to guide staff, so that they have a clear understanding of who does what and when, in an anaphylaxis emergency.
- The plan should include the location and accessibility of adrenaline injectors (prescribed and general use).
- It is recommended that the emergency response plan is practised at least once a year (like you would practise a fire drill).
- Emergency response plans and risk assessments should be developed for all off-site activities and excursions to support anaphylaxis management.

Allergy documentation

Information and resources

ASCIA Action Plans

- There are different types of ASCIA Action Plans:
  - ASCIA Action Plan for Anaphylaxis (red) – provided to people with allergies who have been prescribed an adrenaline injector (e.g. EpiPen® or Anapen®).
  - ASCIA Action Plan for Allergic Reactions (green) – provided to people with known food, insect, or latex allergies who have not been prescribed an adrenaline injector.
  - ASCIA First Aid Plan for Anaphylaxis (orange) – a general plan to be stored with general use adrenaline injectors and used as a poster.
  - ASCIA Action Plan for Drug (medication) Allergy. Adrenaline injectors are not usually prescribed for people with medication allergy (because it is relatively easy to avoid having a medication compared with avoiding eating a food), and therefore children or staff with this ASCIA Plan, may not have an adrenaline injector.


ascia
www.allergy.org.au

ACTION PLAN FOR
Anaphylaxis

Name: _____ For use with EpiPen® adrenaline (epinephrine) autoinjectors
Date of birth: _____

SIGNS OF MILD TO MODERATE ALLERGIC REACTION
- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - these are signs of anaphylaxis for insect allergy

ACTION FOR MILD TO MODERATE ALLERGIC REACTION
- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person, call for help and locate adrenaline autoinjector
- Give antihistamine (if prescribed) _____
- Phone family/emergency contact

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

Confirmed allergens:

Family/emergency contact name(s):
1. _____
Mobile Ph: _____
2. _____
Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np): _____

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

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

Signed: _____
Date: _____

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)
- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough
- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)

ACTION FOR ANAPHYLAXIS
1 LAY PERSON FLAT - do NOT allow them to stand or walk
- If unconscious or pregnant, place in recovery position - on left side if pregnant, as shown below
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright

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

IF IN DOUBT GIVE ADRENALINE AUTOINJECTOR
Commence CPR at any time if person is unresponsive and not breathing normally

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

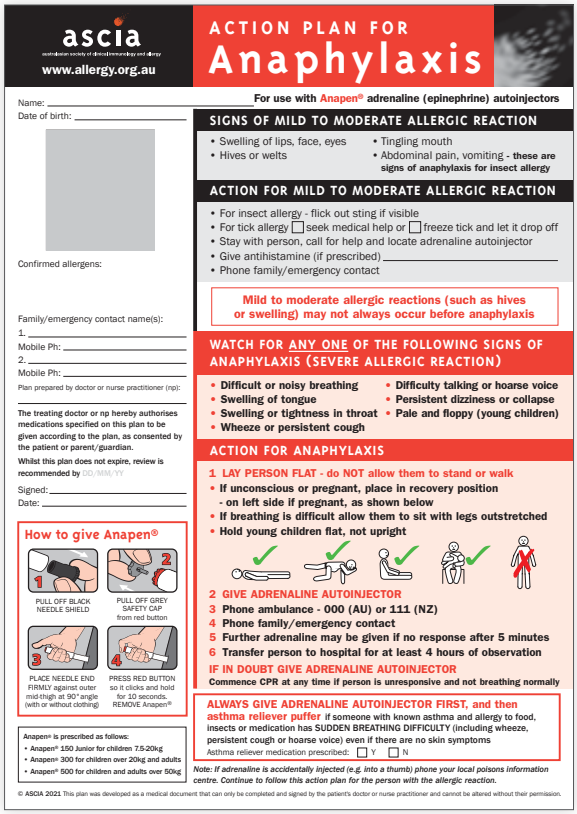
ALWAYS GIVE ADRENALINE AUTOINJECTOR FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms
Asthma reliever medication prescribed: ☐ Y ☐ N

EpiPen® is prescribed as follows:
- EpiPen® Jr (150 mcg) for children 7.5-20kg
- EpiPen® (300 mcg) for children over 20kg and adults

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

© ASCIA 2021 This plan was developed as a medical document that can only be completed and signed by the patient's doctor or nurse practitioner and cannot be altered without their permission.

ASCIA Action Plan for Anaphylaxis for EpiPen®


ascia
www.allergy.org.au

ACTION PLAN FOR
Anaphylaxis

Name: _____ For use with Anapen® adrenaline (epinephrine) autoinjectors
Date of birth: _____

SIGNS OF MILD TO MODERATE ALLERGIC REACTION
- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting - these are signs of anaphylaxis for insect allergy

ACTION FOR MILD TO MODERATE ALLERGIC REACTION
- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person, call for help and locate adrenaline autoinjector
- Give antihistamine (if prescribed) _____
- Phone family/emergency contact

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

Confirmed allergens:

Family/emergency contact name(s):
1. _____
Mobile Ph: _____
2. _____
Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np): _____

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

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

Signed: _____
Date: _____

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)
- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough
- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)

ACTION FOR ANAPHYLAXIS
1 LAY PERSON FLAT - do NOT allow them to stand or walk
- If unconscious or pregnant, place in recovery position - on left side if pregnant, as shown below
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright

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

IF IN DOUBT GIVE ADRENALINE AUTOINJECTOR
Commence CPR at any time if person is unresponsive and not breathing normally

How to give Anapen®
1 PULL OFF BLACK NEEDLE SHIELD
2 PULL OFF GREY SAFETY CAP from red button
3 PLACE NEEDLE END FIRMLY against outer mid-thigh at 90° angle (with or without clothing)
4 PRESS RED BUTTON so it clicks and hold for 10 seconds. REMOVE Anapen®

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

Anapen® is prescribed as follows:
- Anapen® 150 Junior for children 7.5-20kg
- Anapen® 300 for children over 20kg and adults
- Anapen® 500 for children and adults over 50kg

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

© ASCIA 2021 This plan was developed as a medical document that can only be completed and signed by the patient's doctor or nurse practitioner and cannot be altered without their permission.

ASCIA Action Plan for Anaphylaxis for Anapen®

- Parents of children with an ASCIA Action Plan must provide a current copy of the ASCIA Action Plan to the CEC service.
- If no updated plan is available, the most recent ASCIA Action Plan can still be used but parents need to be informed and instructed to see a doctor or nurse practitioner to update the ASCIA Action Plan as soon as possible.
- Allergies to grasses, dust mite or mould do not require an ASCIA Action Plan or individualised anaphylaxis care plan as allergic reactions to these allergens do not result in anaphylaxis.
- ASCIA Action Plans do not expire, and therefore the plan is still valid beyond the date of review, which is a guide for patients to see their doctor or nurse practitioner.

Resources

ASCIA Action Plan

ASCIA Action Plan FAQ

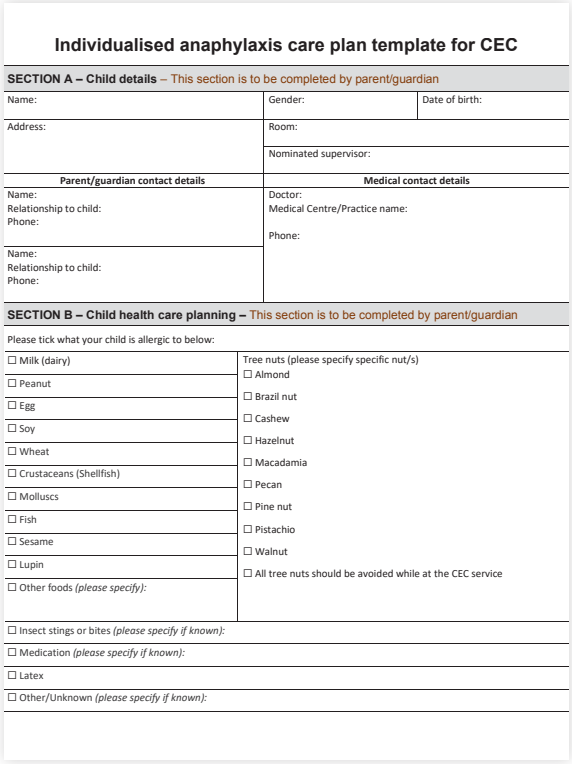
Individualised anaphylaxis care plans

- Children with an ASCIA Action Plan (red or green) should have an individualised anaphylaxis care plan. These plans may have a different name in different jurisdictions. Regardless of the name of the plan, the purpose is the same.
- The purpose of the individualised anaphylaxis care plan is to document the child's allergies, treatment to be administered in the event of an allergic reaction including anaphylaxis, and the risk minimisation strategies that will be put into place to prevent exposure to known allergens.
- A copy of the child's ASCIA Action Plan should be attached to the individualised anaphylaxis care plan.
- Individualised anaphylaxis care plans must be updated at the start of each calendar year, when allergies change and when exposure to a known allergen occurs while attending the CEC service.
- Individualised anaphylaxis care plans must be developed in consultation with, agreed and signed by, parents.
- Appropriate risk minimisation strategies to be implemented should be documented and should be considered within a whole of CEC service approach to anaphylaxis management.
- Children who do not have an ASCIA Action Plan (red or green) and children with an ASCIA Action Plan for Drug (Medication) Allergy DO NOT need an individualised anaphylaxis care plan.
- To help collect information about the child's food allergy that can help the cook or chef to provide appropriate meals, a food allergy record template has been developed.

Resources

Individualised anaphylaxis care plan template for CEC

Food allergy record template



Individualised anaphylaxis care plan template for CEC

SECTION A – Child details – This section is to be completed by parent/guardian

Name:	Gender:	Date of birth:
Address:	Room: Nominated supervisor:	

Parent/guardian contact details	Medical contact details
Name: Relationship to child: Phone:	Doctor: Medical Centre/Practice name: Phone:
Name: Relationship to child: Phone:	

SECTION B – Child health care planning – This section is to be completed by parent/guardian

Please tick what your child is allergic to below:

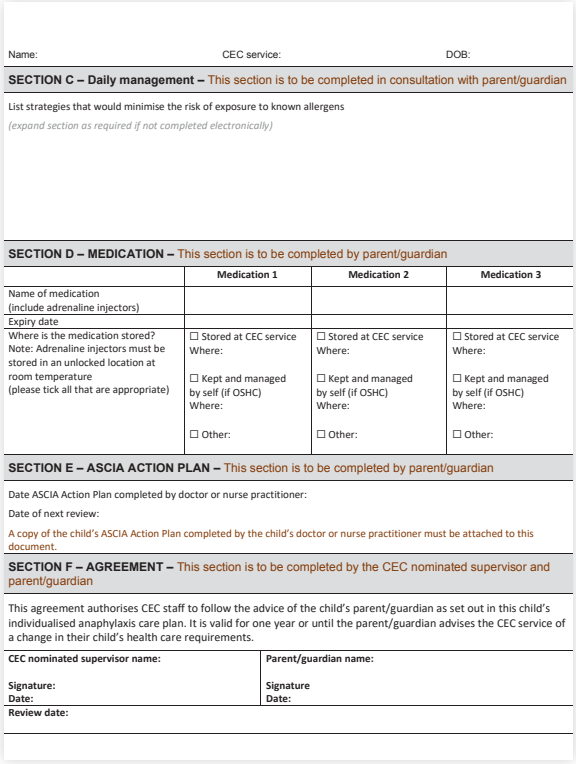
☐ Milk (dairy)	Tree nuts (please specify specific nut/s)
☐ Peanut	☐ Almond
☐ Egg	☐ Brazil nut
☐ Soy	☐ Cashew
☐ Wheat	☐ Hazelnut
☐ Crustaceans (Shellfish)	☐ Macadamia
☐ Molluscs	☐ Pecan
☐ Fish	☐ Pine nut
☐ Sesame	☐ Pistachio
☐ Lupin	☐ Walnut
☐ Other foods *(please specify)*:	☐ All tree nuts should be avoided while at the CEC service

☐ Insect stings or bites *(please specify if known)*:

☐ Medication *(please specify if known)*:

☐ Latex

☐ Other/Unknown *(please specify if known)*:



Name: CEC service: DOB:

SECTION C – Daily management – This section is to be completed in consultation with parent/guardian

List strategies that would minimise the risk of exposure to known allergens

(expand section as required if not completed electronically)

SECTION D – MEDICATION – This section is to be completed by parent/guardian

	Medication 1	Medication 2	Medication 3
Name of medication (include adrenaline injectors)			
Expiry date			
Where is the medication stored? Note: Adrenaline injectors must be stored in an unlocked location at room temperature (please tick all that are appropriate)	☐ Stored at CEC service Where: ☐ Kept and managed by self (if OSHC) Where: ☐ Other:	☐ Stored at CEC service Where: ☐ Kept and managed by self (if OSHC) Where: ☐ Other:	☐ Stored at CEC service Where: ☐ Kept and managed by self (if OSHC) Where: ☐ Other:

SECTION E – ASCIA ACTION PLAN – This section is to be completed by parent/guardian

Date ASCIA Action Plan completed by doctor or nurse practitioner:

Date of next review:

A copy of the child's ASCIA Action Plan completed by the child's doctor or nurse practitioner must be attached to this document.

SECTION F – AGREEMENT – This section is to be completed by the CEC nominated supervisor and parent/guardian

This agreement authorises CEC staff to follow the advice of the child's parent/guardian as set out in this child's individualised anaphylaxis care plan. It is valid for one year or until the parent/guardian advises the CEC service of a change in their child's health care requirements.

CEC nominated supervisor name: **Signature:** **Date:**	**Parent/guardian name:** **Signature** **Date:**
Review date:	

Emergency response

Information and resources

Adrenaline

- Adrenaline is the first line treatment for anaphylaxis.
- Staff should follow emergency response procedures to make sure the child receives adrenaline as quickly as possible.
- When responding to an allergic reaction, the following principles should be followed:
  - The ASCIA Action Plan should be followed to guide staff as to when and how to give the adrenaline injector.
  - Staff should ALWAYS be prepared to administer an adrenaline injector in an anaphylaxis emergency. No child experiencing anaphylaxis should be expected to be fully responsible for self-administration of an adrenaline injector as they may be too unwell and/or have poor judgement during such an emergency.
  - All staff should be trained to follow the ASCIA Action Plan and give the adrenaline injector. If a staff member has not had training, they should still be able to follow the ASCIA Action Plan and administer the adrenaline injector if needed.
  - Anaphylaxis can sometimes present with asthma-like symptoms without other signs such as rash or swelling. If a child with asthma and a known allergy has sudden severe breathing difficulty, staff should follow the ASCIA Action Plan and treat for anaphylaxis first.
  - Antihistamines, corticosteroids and asthma medicines are not suitable alternatives to adrenaline for treating anaphylaxis. If in doubt, administer the adrenaline injector FIRST and then other medication as indicated on the ASCIA Action Plan.

EpiPen® Jr

Anapen® Junior 150

- After an adrenaline injector has been administered, an ambulance must be called to transport the child to hospital for medical monitoring.
- Once a child's adrenaline injector has been used, it must be replaced by the parents as soon as possible.
- If a general use adrenaline injector has been used, this must be replaced by the CEC provider immediately.

Procedures when staff are administering medication, including adrenaline, under regulation 94 and 95 of the National Regulations must also be followed.

Regulation 94(2) of the National Regulations requires both emergency services and the parent of the child to be notified as soon as practicable.

Resources

A&AA How to give an EpiPen® animation

A&AA How to give an Anapen® animation

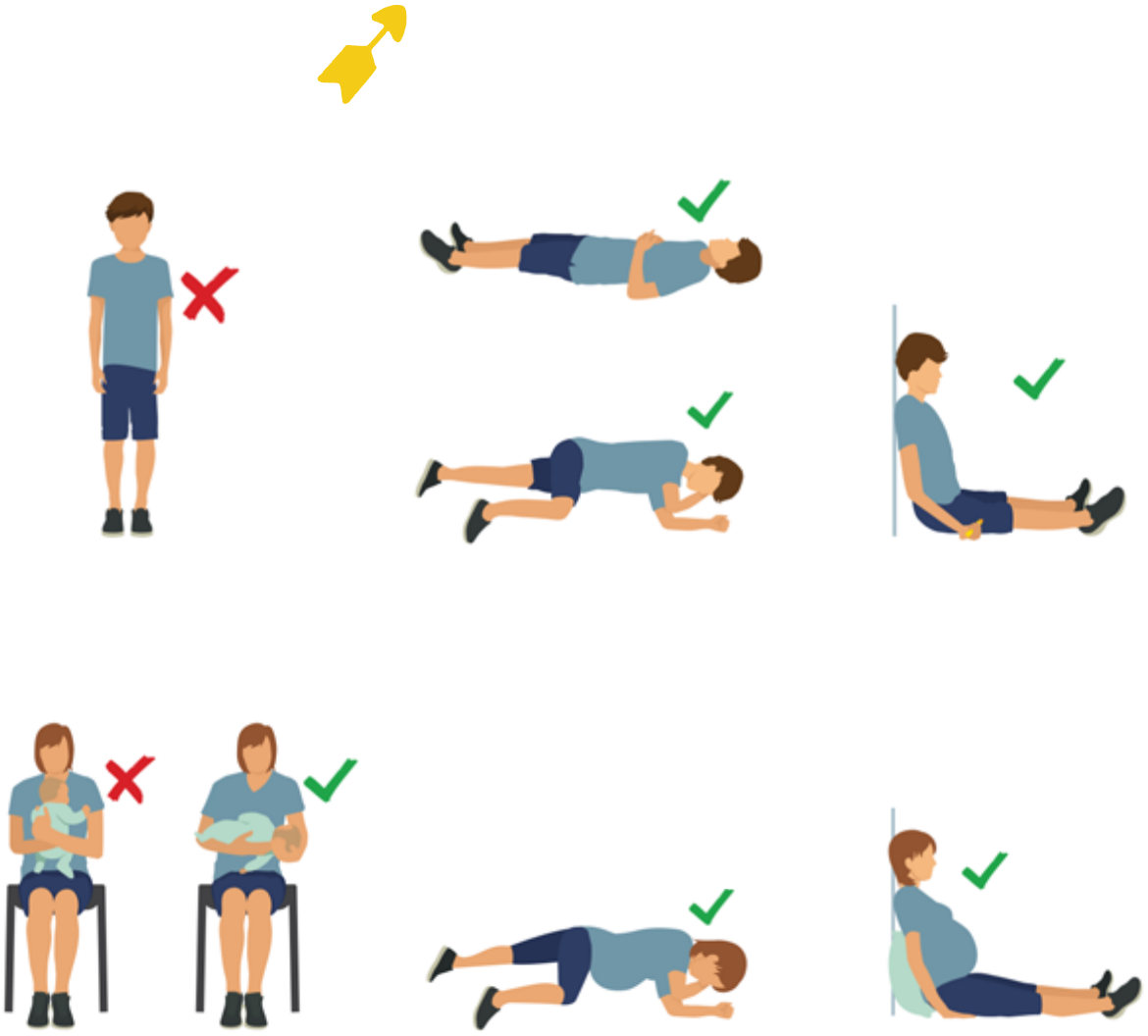
ASCIA adrenaline injectors FAQ

Positioning and further monitoring

- Staff should make sure the child experiencing anaphylaxis is lying down or sitting with legs out flat and is not upright (i.e. not sitting up, not being held in an upright position if a baby or young child, or not standing or walking). This can potentially save their life.
- If the child has low blood pressure due to anaphylaxis, they could collapse if allowed to be upright and may not be able to be resuscitated.
- Therefore, paramedics must stretcher the child to the ambulance (they must not stand or walk) even if they appear to have recovered as per the ASCIA Action Plan.
- The child needs medical monitoring for at least 4 hours in case their reaction gets worse, therefore they must be transported by ambulance (where possible) to a hospital (or medical facility).

Resources

How to position a child or adult having a severe allergic reaction (anaphylaxis) animation



Prescribed adrenaline injector devices

- If the child has an ASCIA Action Plan for Anaphylaxis, one of the child's prescribed adrenaline injectors must be available to the CEC service accompanied by their ASCIA Action Plan, while they are in attendance at CEC service.
- For older children attending outside school hours care or vacation care, the parents may prefer the child to carry their adrenaline injector rather than hand it over to the CEC service. A decision about whether this is appropriate is site-specific however, the following issues should be considered:
  - How likely is it that the adrenaline injector will not be forgotten and be with the child while they are in attendance at the CEC service?
  - How easy is it for the CEC service to access the adrenaline injector if it is kept in the bag of the child?
  - Does the CEC service have a general use adrenaline injector in case the CEC service cannot access the child's prescribed device?

General use adrenaline injector devices

- CEC providers should have at least one general use adrenaline injector.
- Different doses of adrenaline injectors are available:
  - 0.15mg adrenaline injectors - for children 7.5-20 kg (usually aged around 1 to 5 years).
  - 0.30mg adrenaline injectors - for children/adults over 20kg or more (usually aged 5 and up).

Most CEC services would have a 0.15mg adrenaline injector available as the general use device, as most of their children would be less than 20 kg (usually under 5 years).

Most outside school hours care services would have a 0.30mg device, however the service would need to consider the age of the children they primarily care for.

- General use adrenaline injectors are important for the following situations:
  - A child who is known to be at risk of anaphylaxis does not have their own device immediately accessible or the device is out of date.
  - Further doses of adrenaline are required before an ambulance has arrived.
  - A child's device has misfired or accidentally been discharged.
  - A child previously diagnosed with a mild or moderate allergy who was not prescribed an adrenaline injector has their first anaphylaxis.
  - A child having their first anaphylaxis who was not previously diagnosed or known to be at risk (e.g. a child having their first reaction at the CEC service).

Resources

ASCIA adrenaline injectors for general use

Using another child's adrenaline injector device

- If another child's adrenaline injector is used in an anaphylaxis emergency, when there is no general use adrenaline injector, it is essential that the child's parents are notified, and the device is replaced immediately by the CEC service.

Resources

ASCIA adrenaline injectors FAQ

Expired adrenaline injectors

- Risk management plans should make sure that there is always an in-date adrenaline injector available for use in an anaphylaxis emergency.
- However, should the situation arise where only an expired adrenaline injector is available, this device should be used rather than using no device at all.

Resources

ASCIA adrenaline injectors FAQ

Storing adrenaline injectors

- In CEC services, adrenaline injectors are exempt from being stored in locked first aid cabinets. They should be easily accessible to staff, but out of reach of young children.
- Adrenaline injectors should be stored at room temperature away from direct sunlight.
- When participating in off-site activities, consideration needs to be given to keeping the adrenaline injectors out of direct sunlight (e.g. keeping the devices in the shade when participating in off-site activities).
- Adrenaline injectors must not be left in cars or buses (as they will get too hot) and they must not be stored in a fridge or directly touching a freezer brick (this can affect the injector mechanism).

Resources

ASCIA adrenaline injector storage, expiry and disposal

Staff training

Information and resources

Anaphylaxis management training

- All staff have a role in anaphylaxis prevention and management and should know how to prevent, recognise and respond to anaphylaxis.
- Training (online or face-to-face) should be undertaken every two years. *ASCIA anaphylaxis e-training for CEC* is recommended and takes about one hour to complete with a certificate issued upon successful completion.
- First aid training courses, even those that include some reference to anaphylaxis, do not meet the requirement of anaphylaxis training.
- If not undertaking the *ASCIA anaphylaxis e-training for CEC*, theoretical training should meet the *National Allergy Strategy minimum standards for anaphylaxis management training*, which includes:
  - What is allergy and anaphylaxis?
  - Common causes of allergic reactions including anaphylaxis.
  - Signs and symptoms of mild to moderate and severe allergic reactions.
  - Using ASCIA Action Plans as the emergency guide to manage allergic reactions including anaphylaxis.
  - Instruction on how to use adrenaline injectors including hands-on practise with adrenaline injector trainer devices.
  - Identifying appropriate risk minimisation strategies to prevent exposure to allergic triggers.
- Other training considerations include:
  - CEC staff being made aware about the site's emergency response plan for anaphylaxis.
  - If an allergic reaction occurs, staff training requirements need to be reviewed.
  - Staff should know where individual and general use adrenaline injectors are stored.
- For family day care services, under current legislation, each family day care educator and family day care educator assistant needs to:
  - hold a current approved first aid qualification; and
  - have undertaken current approved anaphylaxis management training; and
  - have undertaken current approved emergency asthma management training.

Resources

National Allergy Strategy minimum standards for anaphylaxis management training

ASCIA anaphylaxis e-training for CEC

Anaphylaxis refresher training

- *ASCIA anaphylaxis refresher training* is recommended and provides staff with the opportunity to revise anaphylaxis signs, symptoms and actions including how to use adrenaline injectors. This is a free course and takes about 10-15 minutes to complete and should be undertaken twice yearly. A certificate is available upon successful completion.
- Hands-on practise with adrenaline injector trainer devices is important to help staff confidence to give an adrenaline injector device in an emergency and should be supported through local processes as part of staff development and training.
- In some jurisdictions, school/community nurses support CEC services and may be able to assist with adrenaline injector training.

Resources

ASCIA anaphylaxis refresher training

Trainer devices are available from the distributor of the device or from A&AA

A&AA How to give an EpiPen® animation

A&AA How to give an Anapen® animation

How to safely remove ticks animation

Food service training

- It is important that staff responsible for preparing, serving and supervising food (e.g. cooks, chefs, educators) understand food allergen management.
- *All about Allergens for CEC* is recommended and should be completed at least every two years. This is a free course developed by the National Allergy Strategy and takes about one hour to complete and a certificate is issued upon successful completion.
- Several supporting resources have been developed to assist CEC staff responsible for preparing and serving food to children with food allergies, including staff who supervise mealtimes.

Resources

All about Allergens for CEC

Food allergen menu matrix template and sample

Standardised recipe template and sample

Food allergen ingredient substitution tool

Food service form for children with special dietaries template and sample

Food allergy record template

Food allergen management audit tool for CEC

The Usual Suspects poster

Community and peer education

Information and resources

Awareness raising in the CEC community

- CEC services should communicate about anaphylaxis management with their broader CEC community to help raise awareness and provide information about current policies.
- Raising awareness can help support children with food allergy.
- CEC services should communicate with the community at the start of each year to remind parents that children with severe allergies attend the service.
- Communicating at other times throughout the year is also encouraged, such as a short notice in the CEC newsletter.

Resources

Template letter to parents

Promoting 'allergy aware' rather than food bans

- It is NOT recommended that CEC services 'ban' food and as such CEC services should not claim to be free of any allergen (e.g. 'nut free').
- An 'allergy aware' approach which focuses on implementing a range of appropriate risk minimisation strategies is recommended.
- In cases where the children are of a young age (e.g. infants, toddlers) or have cognitive impairments limiting their ability to manage their own food allergies, it may be appropriate to implement allergen-restricted zones to reduce the risk that they will accidentally eat a food allergen. For example, this may be appropriate if there are children eating messy egg meals, grated cheese or drinking milk, so that they are not sitting next to children with egg or milk (dairy) allergy.
- Children with food allergy must not be isolated from others.
- Some CEC services do not include peanuts and tree nuts in their menus as these are not essential foods and can easily be eaten at home. Foods such as wheat, milk (dairy), egg and soy are staple foods providing important nutrition and therefore cannot be removed in CEC services, hence the use of allergen-restricted areas if required.

Food service

- The food service provider (employed staff or external provider) may choose to remove peanuts and tree nuts from the menu to minimise the risk of accidental exposure through errors or cross contamination. As peanuts and tree nuts are not staple foods providing essential nutrients (such as milk (dairy), wheat and eggs), this is a reasonable strategy to implement.
- Where the CEC service does not provide meals and parents provide food for their children, it is reasonable for the CEC service to request that food provided by parents does not contain peanuts or tree nuts as an ingredient.

Resources

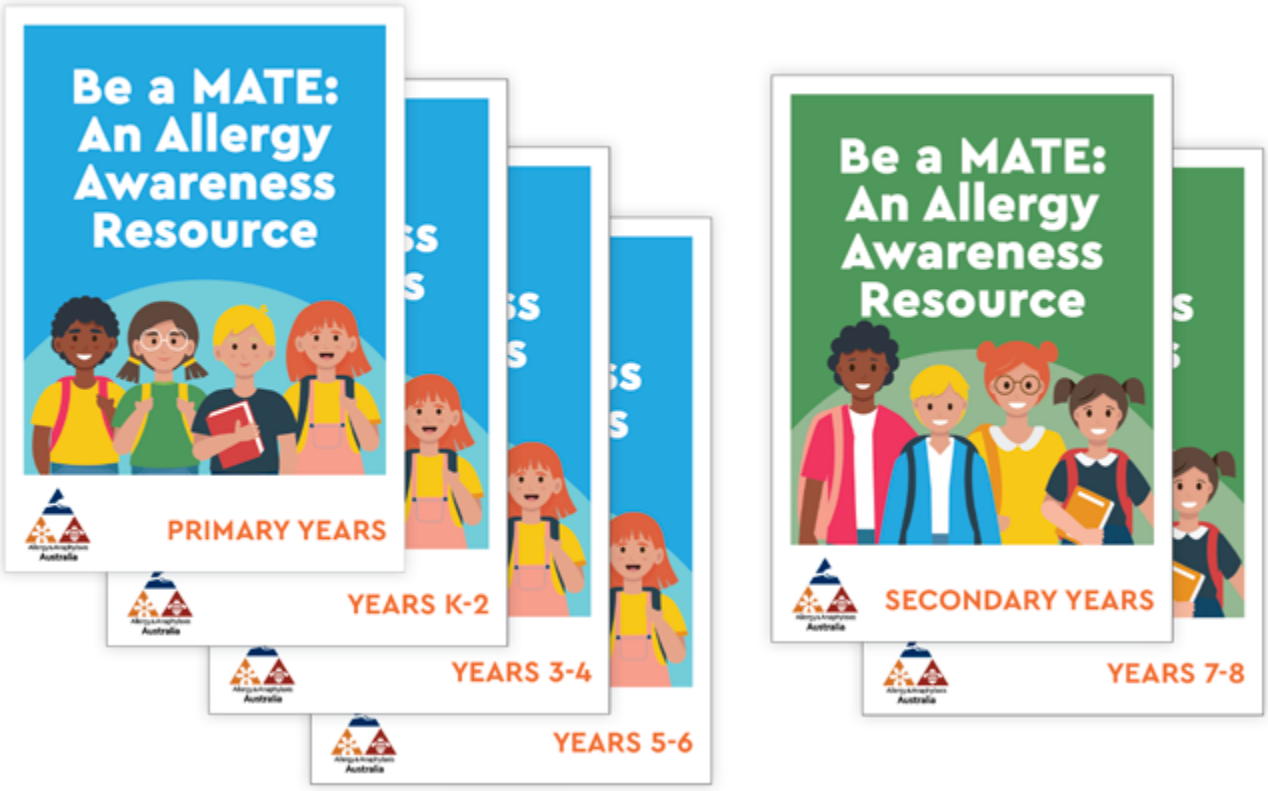
Examples of anaphylaxis risk minimisation strategies for CEC

Peer education

- It is important that children are educated about allergy as they can provide support to their friends with food allergy, and also potentially help alert staff if their friend is having an allergic reaction.
- Peer education about the seriousness of food allergies may help prevent bullying.
- Incorporating peer education into story time in the early years, can help support children with food allergy.
- A key component of peer education includes children not sharing food and eating utensils, including food prepared in cooking activities as well as washing hands after eating something their friend is allergic to.

Resources

A&AA resources, including the Be A Mate program



Post incident management and incident reporting

Information and resources

- Collection of standardised, centralised information across all jurisdictions will facilitate improved risk-minimisation strategies and inform policy at all levels.
- Effective reporting systems allow collection and pooling of de-identified data on prevalence of anaphylaxis and suspected anaphylaxis that can be used to monitor trends, inform policy and staff training changes as required.
- Psychological services may be required by staff or children involved in or witnessing an anaphylaxis and the CEC service should encourage access where required.
- If an allergic reaction has occurred to a packaged food or food provided by the CEC service, it should be reported to the Health Department in the jurisdiction that the CEC service operates. In addition, the suspected food that triggered the allergic reaction should be covered, clearly labelled and stored in the freezer as it may be required for analysis in an investigation.

Resources

Anaphylaxis incident reporting template

APPENDIX A:

Other serious forms of food allergy that do not trigger anaphylaxis

Other serious forms of food allergy that do not trigger anaphylaxis include Food Protein Induced Enterocolitis Syndrome (FPIES), Eosinophilic oesophagitis (EoE) and Food Protein Induced Allergic Proctocolitis (FPIAP). These are serious forms of food allergy, even though they do not trigger severe allergic reactions (anaphylaxis) and are not treated with adrenaline (epinephrine). Children with FPIES and EoE should have an ASCIA Action Plan while babies with FPIAP may have a modified diet care plan from their healthcare professional.

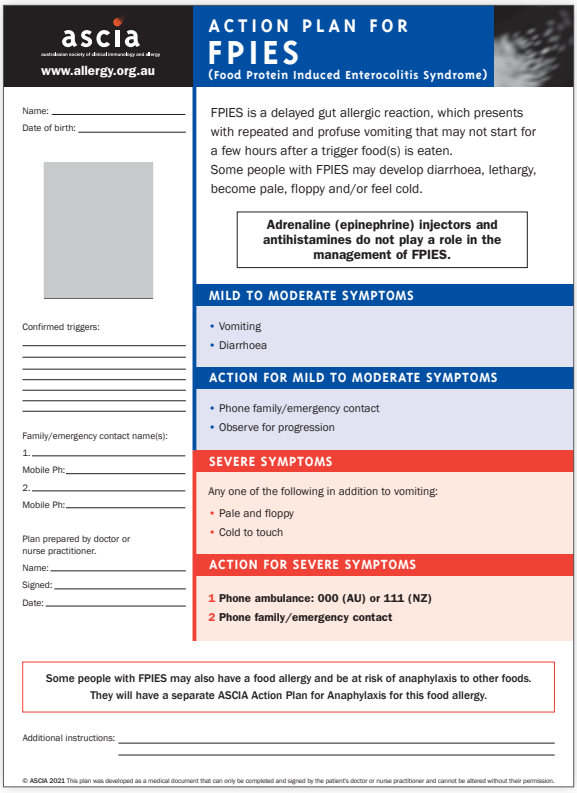
FPIES and EoE can result in symptoms that require medical treatment, so it is important that children students and staff with these conditions strictly avoid their trigger foods. Appropriate risk minimisation strategies to prevent exposure to known triggers should be put in place.

What is FPIES?

- FPIES is a reaction to food that involves the immune system, but in a different way to more common food allergies that can potentially result in anaphylaxis.
- FPIES mainly affects babies and young children.
- It is caused by an allergic reaction to trigger foods when eaten, which results in inflammation of the small and large intestine (the gut).
- FPIES is different to common food allergies (where there is a risk of anaphylaxis) as FPIES reactions:
  - are usually delayed (2-4 hours after eating the food).
  - only involve the gastrointestinal system (no hives or swelling).
  - do not progress to anaphylaxis and are not treated with adrenaline.
- Some people with FPIES will also have a food allergy and be at risk of anaphylaxis.

What are the symptoms and treatment?

- Profuse vomiting (and sometimes diarrhoea) most commonly occurs two to four hours after eating a trigger food.
- Some children may become pale, floppy, have a reduced body temperature and/or reduced blood pressure during a reaction.
- If a child becomes pale and floppy or cold to touch, an ambulance should be called as the child needs **urgent** medical treatment.
- Adrenaline is NOT a treatment for FPIES, unlike anaphylaxis where adrenaline is a lifesaving treatment.



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

ACTION PLAN FOR
FPIES
(Food Protein Induced Enterocolitis Syndrome)

Name: _____
Date of birth: _____

Confirmed triggers:
_____
_____
_____
_____
_____
_____

Family/emergency contact name(s):
1. _____
Mobile Ph: _____
2. _____
Mobile Ph: _____

Plan prepared by doctor or nurse practitioner.
Name: _____
Signed: _____
Date: _____

FPIES is a delayed gut allergic reaction, which presents with repeated and profuse vomiting that may not start for a few hours after a trigger food(s) is eaten.
Some people with FPIES may develop diarrhoea, lethargy, become pale, floppy and/or feel cold.

Adrenaline (epinephrine) injectors and antihistamines do not play a role in the management of FPIES.

MILD TO MODERATE SYMPTOMS

- Vomiting
- Diarrhoea

ACTION FOR MILD TO MODERATE SYMPTOMS

- Phone family/emergency contact
- Observe for progression

SEVERE SYMPTOMS

Any one of the following in addition to vomiting:

- Pale and floppy
- Cold to touch

ACTION FOR SEVERE SYMPTOMS

1 **Phone ambulance: 000 (AU) or 111 (NZ)**
2 **Phone family/emergency contact**

Some people with FPIES may also have a food allergy and be at risk of anaphylaxis to other foods. They will have a separate ASCIA Action Plan for Anaphylaxis for this food allergy.

Additional instructions: _____
_____

Management of FPIES in CEC services

- Children diagnosed with FPIES should have an ASCIA Action Plan for FPIES completed and signed by their doctor.
- Parents should provide a copy of the ASCIA Action Plan for FPIES to the CEC service.
- Staff should be aware of which children have FPIES.
- **Strict avoidance of the trigger foods** is the only way to manage FPIES.
- Appropriate risk minimisation strategies to prevent exposure to known triggers should be implemented such as those strategies implemented to prevent anaphylaxis.

Further information is available from

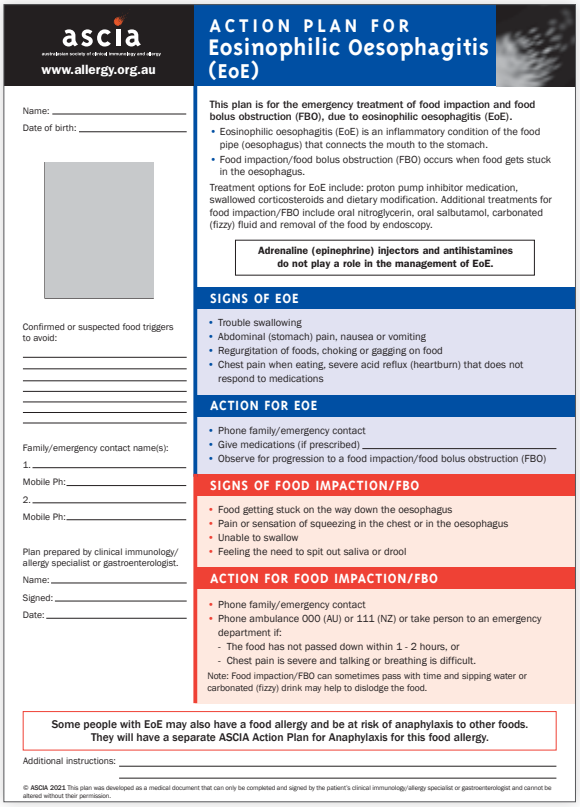
ASCIA

What is EoE?

- EoE is a condition where white blood cells (eosinophils) are found in the lining of the oesophagus (the food tube that connects the mouth to the stomach).
- EoE can be caused by an allergic reaction to a food.
- EoE is different to common food allergies (where there is a risk of anaphylaxis) as EoE reactions:
  - can result in food getting stuck in the oesophagus (food tube between mouth and stomach).
  - only involve the gastrointestinal system/gut (no hives or swelling).
  - do not progress to anaphylaxis and are not treated with adrenaline.
- Some people with EoE will also have a food allergy and be at risk of anaphylaxis.

What are the symptoms and treatment?

- Trouble swallowing, abdominal pain, nausea or vomiting.
- Reflux of foods, choking or gagging on food.
- Chest pain when eating, severe acid reflux (heartburn) that does not respond to medications.
- Food impaction – food getting stuck, pain or squeezing sensation in the chest or oesophagus, unable to swallow, feeling the need to spit out saliva or drool.
- An ambulance should be called if food is stuck, or the child has severe chest pain and talking or breathing is difficult.



ascia
www.allergy.org.au

ACTION PLAN FOR
Eosinophilic Oesophagitis (EoE)

Name: _____
Date of birth: _____

This plan is for the emergency treatment of food impaction and food bolus obstruction (FBO), due to eosinophilic oesophagitis (EoE).

- Eosinophilic oesophagitis (EoE) is an inflammatory condition of the food pipe (oesophagus) that connects the mouth to the stomach.
- Food impaction/food bolus obstruction (FBO) occurs when food gets stuck in the oesophagus.

Treatment options for EoE include: proton pump inhibitor medication, swallowed corticosteroids and dietary modification. Additional treatments for food impaction/FBO include oral nitroglycerin, oral salbutamol, carbonated (fizzy) fluid and removal of the food by endoscopy.

Adrenaline (epinephrine) injectors and antihistamines do not play a role in the management of EoE.

Confirmed or suspected food triggers to avoid:
_____
_____
_____
_____
_____
_____
_____

Family/emergency contact name(s):
1. _____
Mobile Ph: _____
2. _____
Mobile Ph: _____

Plan prepared by clinical immunology/ allergy specialist or gastroenterologist.
Name: _____
Signed: _____
Date: _____

SIGNS OF EOE

- Trouble swallowing
- Abdominal (stomach) pain, nausea or vomiting
- Regurgitation of foods, choking or gagging on food
- Chest pain when eating, severe acid reflux (heartburn) that does not respond to medications

ACTION FOR EOE

- Phone family/emergency contact
- Give medications (if prescribed) _____
- Observe for progression to a food impaction/food bolus obstruction (FBO)

SIGNS OF FOOD IMPACTION/FBO

- Food getting stuck on the way down the oesophagus
- Pain or sensation of squeezing in the chest or in the oesophagus
- Unable to swallow
- Feeling the need to spit out saliva or drool

ACTION FOR FOOD IMPACTION/FBO

- Phone family/emergency contact
- Phone ambulance 000 (AU) or 111 (NZ) or take person to an emergency department if:
  - The food has not passed down within 1 - 2 hours, or
  - Chest pain is severe and talking or breathing is difficult.

Note: Food impaction/FBO can sometimes pass with time and sipping water or carbonated (fizzy) drink may help to dislodge the food.

Some people with EoE may also have a food allergy and be at risk of anaphylaxis to other foods. They will have a separate ASCIA Action Plan for Anaphylaxis for this food allergy.

Additional instructions: _____

Management of EoE in CEC services

- Children diagnosed with EoE should have an ASCIA Action Plan for EoE completed and signed by their doctor.
- Parents should provide a copy of the ASCIA Action Plan for EoE to CEC service.
- Staff should be aware of which children have EoE.
- Avoidance of the trigger foods helps to manage EoE. Appropriate risk minimisation strategies to prevent exposure to known triggers should be implemented such as those strategies implemented to prevent anaphylaxis.
- The CEC service should discuss management options with parents which will be guided by the child's treating doctor.

Further information is available from

ASCIA

ausEE

APPENDIX B:

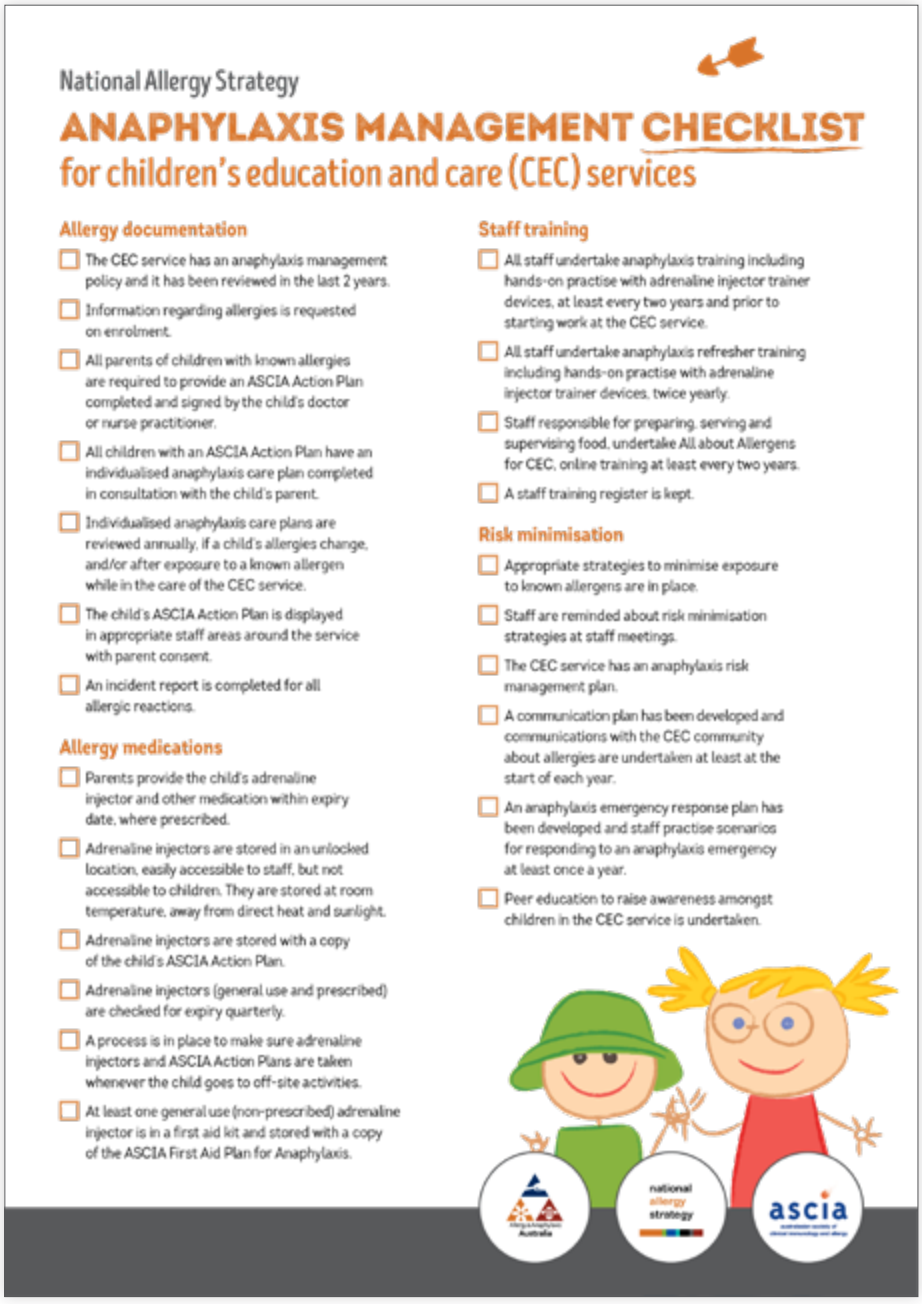
List of supporting resources

Anaphylaxis management policy and plans	• Sample anaphylaxis management policy for CEC • Anaphylaxis risk management plan template for CEC • Examples of anaphylaxis risk minimisation strategies for CEC
Allergy documentation	• ASCIA Action Plan • ASCIA Action Plan FAQ • Individualised anaphylaxis care plan template for CEC • Food allergy record template
Emergency response	• A&AA How to give an EpiPen® animation • A&AA How to give an Anapen® animation • ASCIA adrenaline injectors FAQ • How to position a child or adult having a severe allergic reaction (anaphylaxis) animation • ASCIA adrenaline injectors for general use • ASCIA adrenaline injector storage, expiry and disposal
Staff training – anaphylaxis management	• National Allergy Strategy minimum standards for anaphylaxis management training • ASCIA anaphylaxis e-training for CEC • ASCIA anaphylaxis refresher training • How to safely remove ticks animation • Trainer devices are available from the distributor of the device or from A&AA

Staff training – food service	• All about Allergens for CEC • Food allergen menu matrix template and sample • Standardised recipe template and sample • Food allergen ingredient substitution tool • Food allergen management audit tool for CEC • Food service form for children with special dietaries template and sample • Food allergy record template • The Usual Suspects poster
Community and peer education	• Sample letter to CEC service community • A&AA resources, including the Be A Mate program • A&AA curriculum resources
Post incident management and incident reporting	• Anaphylaxis incident reporting template

APPENDIX C:

Anaphylaxis Management Checklist



National Allergy Strategy

ANAPHYLAXIS MANAGEMENT CHECKLIST
for children's education and care (CEC) services

Allergy documentation

- ☐ The CEC service has an anaphylaxis management policy and it has been reviewed in the last 2 years.
- ☐ Information regarding allergies is requested on enrolment.
- ☐ All parents of children with known allergies are required to provide an ASCIA Action Plan completed and signed by the child's doctor or nurse practitioner.
- ☐ All children with an ASCIA Action Plan have an individualised anaphylaxis care plan completed in consultation with the child's parent.
- ☐ Individualised anaphylaxis care plans are reviewed annually, if a child's allergies change, and/or after exposure to a known allergen while in the care of the CEC service.
- ☐ The child's ASCIA Action Plan is displayed in appropriate staff areas around the service with parent consent.
- ☐ An incident report is completed for all allergic reactions.

Allergy medications

- ☐ Parents provide the child's adrenaline injector and other medication within expiry date, where prescribed.
- ☐ Adrenaline injectors are stored in an unlocked location, easily accessible to staff, but not accessible to children. They are stored at room temperature, away from direct heat and sunlight.
- ☐ Adrenaline injectors are stored with a copy of the child's ASCIA Action Plan.
- ☐ Adrenaline injectors (general use and prescribed) are checked for expiry quarterly.
- ☐ A process is in place to make sure adrenaline injectors and ASCIA Action Plans are taken whenever the child goes to off-site activities.
- ☐ At least one general use (non-prescribed) adrenaline injector is in a first aid kit and stored with a copy of the ASCIA First Aid Plan for Anaphylaxis.

Staff training

- ☐ All staff undertake anaphylaxis training including hands-on practise with adrenaline injector trainer devices, at least every two years and prior to starting work at the CEC service.
- ☐ All staff undertake anaphylaxis refresher training including hands-on practise with adrenaline injector trainer devices, twice yearly.
- ☐ Staff responsible for preparing, serving and supervising food, undertake All about Allergens for CEC, online training at least every two years.
- ☐ A staff training register is kept.

Risk minimisation

- ☐ Appropriate strategies to minimise exposure to known allergens are in place.
- ☐ Staff are reminded about risk minimisation strategies at staff meetings.
- ☐ The CEC service has an anaphylaxis risk management plan.
- ☐ A communication plan has been developed and communications with the CEC community about allergies are undertaken at least at the start of each year.
- ☐ An anaphylaxis emergency response plan has been developed and staff practise scenarios for responding to an anaphylaxis emergency at least once a year.
- ☐ Peer education to raise awareness amongst children in the CEC service is undertaken.

Allergy & Anaphylaxis Australia

national allergy strategy

ascia
australasian society of clinical immunology and allergy