Anaphylaxis Management Guidelines for Western Australian Child Care and Outside School Hours Care Services
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Introduction

Anaphylaxis is a severe, rapidly progressive allergic reaction that is potentially life threatening. In the past four years admissions due to anaphylaxis to Princess Margaret Hospital for Children have doubled.¹

Surveys in other States in Australia report that:
- 1 in 170 school children had suffered at least one episode of anaphylaxis.¹
- 1 in 50 children under the age of five years had food allergies.¹

To date, there have been no reported deaths from anaphylaxis in children in Western Australia, however there have been recent deaths of children in Australia; one in a child care service in Victoria and one in a New South Wales school. The release of the coronial inquest in 2005 into the death of a child in New South Wales, led to the establishment in 2006 of the Western Australian Anaphylaxis Expert Working Group. The Group’s report, Anaphylaxis: Meeting the Challenge for Western Australian Children, which outlined recommendations for anaphylaxis management in school and child care settings, was endorsed by the Western Australian government in 2007.

These Guidelines have been developed by the Western Australian Anaphylaxis Management Implementation Group (AMIG) to assist child care services to respond effectively to the recommendations of the anaphylaxis report.

Legislative and regulatory context

These guidelines are consistent with the relevant sections of the following legislation:
- Child Care Services Act 2007
- Child Care Services Regulations 2007
- Child Care Services (Child Care) Regulations 2006
- Child Care Services (Family Day Care) Regulations 2006
- Child Care Services (Outside School Hours Care) Regulations 2006
- Civil Liability Act 2002
- Occupational Safety and Health Act 1984
- Poisons Act 1964
- Poisons Regulations 1965
- Privacy Act 1988

Policy context

The following guidelines should be applied in accordance with the legislative and regulatory requirements for Child Care, Family Day Care and Outside School Hours Care services. Current regulatory requirements can be found on the Department for Communities website: www.community.wa.gov.au

It is important for Supervising Officers or senior staff to develop an anaphylaxis management policy. By developing the policy, your service can assess potential risks and develop strategies to minimise the risk of exposure to known allergens. Your service will also be able to establish communication guidelines for staff and parents/guardians.

A sample Anaphylaxis Management Policy has been provided (see Appendix 1 or visit www.health.wa.gov.au/anaphylaxis) to assist with policy development for your service.
Definitions

Adrenaline
Adrenaline is a natural body hormone. Adrenaline is the only effective treatment for anaphylaxis. It works in minutes to relax breathing, maintain heart function and blood pressure.

Adrenaline autoinjector (such as an EpiPen® or Anapen®)
This is a device that automatically delivers a single fixed dose of adrenaline and is designed for use by people without specific medical training.¹

Allergens
Substances that can cause an allergic reaction.¹

Allergy (or Allergies)
Allergy is when the immune system reacts to substances (allergens) in the environment which are usually harmless such as food proteins, pollens, dust mites and insect venoms.

Anaphylaxis
A severe, rapidly progressive allergic reaction that is potentially life threatening. As deaths have occurred as a result of anaphylaxis, it must be regarded as a medical emergency.

Australasian Society for Clinical Immunology and Allergy (ASCIA) Action Plan
Provides details on how to manage mild to moderate allergic reactions and anaphylaxis including appropriate medications, as well as listing known allergens. It is important that the ASCIA Action Plan is completed by a medical practitioner.

Individual Anaphylaxis Health Care Plan
A plan completed in consultation with parents/guardians detailing the child’s known allergens and risk minimisation strategies to be employed.

Key principles
The Government of Western Australia and all child care services are committed to:

- Providing, as far as practicable, a safe and supportive environment in which children at risk of anaphylaxis can participate equally in all aspects of the child care activities;
- Raising awareness about allergies and anaphylaxis in the child care community;
Actively involving the parents/guardians of each child at risk of anaphylaxis in assessing risks, developing risk minimisation and management strategies;

Ensuring that an adequate number of staff members have an understanding of the causes, signs and symptoms of anaphylaxis and of their role in emergency response procedures.

The key to the prevention of anaphylaxis in child care services is awareness of known allergens and prevention of exposure to known allergens. Achieving this requires education and planning.

This resource has been developed to assist child care services in achieving ‘allergy awareness’ to support children with severe allergies.
7 Steps to ‘allergy awareness’ in child care services

1. Understand roles and responsibilities
   Parents/guardians and staff have important and differing roles and responsibilities in managing anaphylaxis in child care services. These responsibilities need to be identified and communicated.

2. Determine what allergies you need to manage
   It is important to obtain medical information from parents/guardians about allergies and the risk of anaphylaxis. This information can be recorded using an Individual Anaphylaxis Health Care Plan.

3. Assess the risk of allergen exposure
   It is important to assess the likelihood of exposure to known allergens.
Minimise the risk of allergen exposure

There are a range of practical strategies that child care services can implement to minimise the risk. Strategies implemented by the service should be determined by what allergies the service needs to manage. Child care services may like to develop policy specific to their local service and community.

Train staff and plan emergency response

Staff members need to know how to recognise, treat and prevent anaphylaxis, where medications are stored and the emergency response procedures to effectively manage anaphylaxis.

Communicate with the child care service community

Communicating with staff, parents/guardians and children is essential in successfully managing anaphylaxis in child care services.

Review and assess management strategies

Policies, procedures and strategies need to be reviewed each year as well as after a child has experienced a severe reaction while in the child care service’s care.
1 Understand roles and responsibilities
It is appreciated that some child care services do not have any children who have been diagnosed as being at risk of anaphylaxis. Despite this, licensees of child care services are advised that they should ensure that members of staff, who are responsible for first aid, have the knowledge and skills to respond to an anaphylaxis emergency.

Parents/guardians of children at risk of anaphylaxis

Parents/guardians who have a child at risk of anaphylaxis are encouraged to assist child care services in providing a safe environment for their child.

Parents/guardians should:

- Inform the licensee or supervising officer of the child care service of their child’s allergies and whether a diagnosis has been made as to the risk of anaphylaxis (e.g. provide an ASCIA Action Plan completed by their child’s medical practitioner). This advice should be provided either at enrolment or when a diagnosis has been made.
- Meet with the child care staff to develop their child’s Individual Anaphylaxis Health Care Plan (see Appendix 3). This plan should include an ASCIA Action Plan (see Appendix 7) completed by their child’s medical practitioner.
- Participate in annual reviews of their child’s Individual Anaphylaxis Health Care Plan.
- Inform child care staff of all other relevant information and concerns relating to the health of their child.
- Provide the adrenaline autoinjector and any other medications to the service.
- Replace the adrenaline autoinjector and any other medications before the expiry date. It may be advisable to check expiry dates quarterly.

- Alert staff to the additional risks associated with non-routine events and assist in planning and preparation for the child prior to field trips, child care service activities, excursions or special events.
- Discuss the supply of alternative food options for their child when needed.
- Inform staff of any changes to their child’s emergency contact details.
- Provide the licensee or supervising officer with an immediate update if there is a change to their child’s condition.
- Educate their child about only eating food provided from home. It is important to reinforce that their child should not share food.

Licensee/Supervising Officer

Licensees have an overall responsibility for strategies and processes for ensuring a safe and supportive environment for a child at risk of anaphylaxis. The Supervising Officer is responsible for implementing those strategies and processes. In the case of a Family Day Care service, these roles are combined, however the Family Day Care service provider may seek the support of their Family Day Care scheme.
Licensee/Supervising Officer should:

- Actively seek information to identify a child with severe life threatening allergies at enrolment (e.g. ASCIA Action Plan completed by the child’s medical practitioner).

- If a child is identified with severe allergies, request that parents/guardians provide an ASCIA Action Plan that has been signed by the child’s medical practitioner. This Plan should have an up to date photograph of the child.

- Meet with parents/guardians to develop an Individual Anaphylaxis Health Care Plan for the child.

- In consultation with parents/guardians, review the child’s Individual Anaphylaxis Health Care Plan annually, particularly after a severe allergic reaction or if the child’s circumstances change.

- Ensure that parents/guardians provide a current adrenaline autoinjector.

- Encourage ongoing communication between parents/guardians and staff about the current status of the child’s allergies, the service’s procedures and risk minimisation strategies together with their implementation.

- Work with staff to conduct regular reviews of risk minimisation strategies.

- Provide information to all staff (including specialist staff, new staff, sessional staff, food coordinators and office staff) so that they are aware of:
  - a child at risk of anaphylaxis;
  - the child’s allergies;
  - the service’s risk minimisation strategies;
  - emergency response procedures.

- Ensure that an adequate number of staff are trained in how to recognise and respond to an anaphylactic reaction. This training should include how to administer an adrenaline autoinjector. Regular practice using adrenaline autoinjector training devices should also be carried out (e.g. at least twice yearly).

- The emergency response procedures can include providing copies or displaying the child’s ASCIA Action Plan in an area accessible to all staff, subject to parent/guardian agreement (see Step 6 regarding privacy considerations).

- Ensure that there are procedures in place for informing casual/relief staff of the child at risk of anaphylaxis and the steps required for prevention and emergency response. Visitors should also be provided with this information.

- Work with staff to develop strategies to increase awareness about severe allergies among child care staff, children and the child care service community.

- Liaise with any food service provider (where an external contractor is responsible for the food service), to ensure that the provider can demonstrate satisfactory training in the area of anaphylaxis and its implications on food handling practices.

- If needed or appropriate, provide or arrange post-incident support (e.g. counselling) for children and staff.

Staff responsible for the care of children at risk of anaphylaxis

Members of child care staff, who are responsible for the care of the child at risk of anaphylaxis, are encouraged to obtain training in how to recognise and respond to an anaphylactic reaction, including administering an adrenaline autoinjector. This should include casual staff and volunteers.

Staff should:

- Know the service’s first aid emergency procedures and their role in relation to responding to an anaphylactic reaction.

- Understand the causes, symptoms and treatment of anaphylaxis.

- Know the identity of the child in their care who is at risk of anaphylaxis.
Keep a copy of the child’s ASCIA Action Plan (or know where to find one quickly) and ensure it is followed in the event of an allergic reaction.

Know the risk minimisation strategies contained in a child’s Individual Anaphylaxis Health Care Plan and ensure they are followed.

Know where the child’s adrenaline autoinjector is kept. Remember that adrenaline autoinjector, is designed so that anyone can administer it in an emergency.

Consider undertaking training in how to recognise and respond to an anaphylactic reaction. This training should include how to administer an adrenaline autoinjector.

Be aware of the possibility of hidden allergens in foods and of traces of allergens when using items such as egg or milk cartons in art experiences.

Plan ahead for special activities or occasions such as excursions, in house activities and parties. Work with parents/guardians to ensure that food provided for the child is appropriate.

Avoid the use of food treats as rewards as these may contain hidden allergens.

Consider the risk of cross-contamination when preparing, handling and displaying food.

Ensure that tables and surfaces are wiped down regularly and that children wash their hands before and after handling food.

Raise child awareness about severe allergies and the importance of their role in fostering an environment that is safe and supportive for other children.

**Coordinators**

Coordinators take a lead role in supporting child care staff to implement risk minimisation strategies for their service.

**Coordinators should:**

- Keep an up to date register of children at risk of anaphylaxis.
- Obtain training in how to recognise and respond to an anaphylactic reaction, including administering an adrenaline autoinjector.
- Check regularly that the adrenaline autoinjector is not discoloured or out-of-date.
- Ensure that the adrenaline autoinjector is stored correctly (at room temperature and away from light) in an unlocked, easily accessible place, and that it is appropriately labelled. In hot climates, the adrenaline autoinjector should be stored in a small esky or similar container, but not refrigerated.
Determine what allergies you need to manage

It is important to obtain medical information from parents/guardians about allergies and the risk of anaphylaxis. This information can be recorded using an Individual Anaphylaxis Health Care Plan which incorporates the child’s ASCIA Action Plan. These forms can be accessed from the Department of Health Anaphylaxis website [www.health.wa.gov.au/anaphylaxis](http://www.health.wa.gov.au/anaphylaxis) and from the ASCIA website [www.allergy.org.au](http://www.allergy.org.au) respectively.

**Individual Anaphylaxis Health Care Plans**

Every child who has been diagnosed as being at risk of anaphylaxis should have an Individual Anaphylaxis Health Care Plan (see Appendix 3).

As a child’s allergies may change over time, it is important for child care services to ensure that all Individual Anaphylaxis Health Care Plans and ASCIA Action Plans (see Appendix 7) are kept current. They should be reviewed annually with the child’s parents/guardians. When reviewed, parents/guardians should also provide an updated photo of the child on the ASCIA Action Plan.

ASCIA Action Plans should be kept in a location that is visible and/or easily accessible by staff in the event of an incident (refer to Step 6 regarding privacy considerations). Remember a copy of the ASCIA Action Plan should be kept with the adrenaline autoinjector in the child’s medical kit.
Assess the risk of allergen exposure

When are children most at risk?

Children are most at risk when:

- Their routine is broken (e.g. special days);
- They are at food breaks and lunch;
- They are off the service site (e.g. excursions);
- Immediate access to medical services is not available;
- Staff changes occur (e.g. relief/casual staff);
- Participating in activities involving food.

Recorded deaths from anaphylaxis have most often occurred in situations where the emergency medication has not been readily available and/or has not been administered as soon as possible. Therefore it is important that suitable strategies are in place for the times when a child is most at risk. These strategies should be able to ensure a timely response to an anaphylactic reaction.
Minimise the risk of allergen exposure
The key to the prevention of anaphylaxis is the identification of allergens and prevention of exposure to these allergens.

For the child who has been diagnosed with a severe allergy, there is a range of practical prevention strategies that child care services can implement to minimise exposure to known allergens.

When considering appropriate prevention strategies, child care services should take into account factors such as the:
- allergen involved;
- age of the child;
- severity of the allergy (based on information provided by the child’s parent/guardian from the child’s medical practitioner).

Planning is essential:
- Consider how you can minimise the risk of exposure to allergens when planning excursions and special days;
- Encourage parents/guardians of the child with food allergies to be involved on special days that involve food.

Appendix 2 outlines potential exposure scenarios and strategies that a child care service may consider adopting to minimise risk of anaphylaxis for a child with severe allergies.

It is particularly important to have procedures in place to ensure that child care service casual or relief staff are kept informed of the child who may be subject to anaphylaxis. These procedures should include the steps required for prevention and the appropriate emergency response. A designated staff member should be given the responsibility for briefing new staff (including food coordinators, volunteers or casual relief staff) about these procedures.

‘Allergy aware’ versus ‘nut-free’

In communicating the strategies in place within a child care service to relevant stakeholders, it is important that the services do not promote that they either ‘ban nuts’ or are ‘nut-free’ as:
- It is impractical to implement and enforce;
- There is no evidence of effectiveness;
- It does not encourage the development of strategies for avoidance in the wider child care service community;
- It may encourage complacency about risk minimisation strategies (for staff, children and parents/guardians) if a food is banned.

There are a number of foods that children may be allergic to. It is therefore not always possible to remove all allergens. It is better for child care services to promote themselves as ‘allergy aware’ and implement practical, age-appropriate strategies to minimise exposure to known allergens.

Whilst services are advised not to claim to be ‘nut-free’, minimising exposure to particular foods such as peanuts and tree nuts can reduce the level of risk. Minimisation strategies can include removing nut spreads and products containing nuts from the child care service menu. It does not, however, include removing products that ‘may contain traces’ of peanuts/tree nuts.

Child care services that do not provide meals may also choose to request that parents/guardians of children who use the service to refrain from using any nut spreads in sandwiches or products containing nuts in the lunchbox.

Appendix 4 provides practical tips to minimise the risk and to become ‘allergy aware’ in your child care service.
5 Train staff and plan emergency response
Staff training

Child care services are required to plan first aid and emergency response procedures for both on-site and off-site settings, thereby allowing staff to react quickly if an anaphylactic reaction should occur.

Staff should receive regular training in the recognition, treatment and every day management of those at risk of anaphylaxis.

For more information about training providers, training packages and online training visit the Department of Health Anaphylaxis website www.health.wa.gov.au/anaphylaxis.

Responding to an incident

Where possible, only staff with training in the administration of an adrenaline autoinjector should administer the device. However, the adrenaline autoinjector is designed that in the event of an emergency it may be administered by any person following the instructions in the child’s ASCIA Action Plan.

If a child has a severe allergic reaction but has not been previously diagnosed with the allergy or as being at risk of anaphylaxis, the following action should be taken:

- If the child care service does not have an adrenaline autoinjector for general use, 000 should be called immediately. Instructions given by the emergency services should be followed, as well as the child care services’ first aid emergency procedures.
- If the child care service has an adrenaline autoinjector for general use, staff can administer the adrenaline following the instructions on the General ASCIA Action Plan (Orange) stored with the device. Staff must call an ambulance and the used adrenaline autoinjector should be given to the ambulance staff.

If an ambulance service is not immediately available (e.g. particularly in rural or remote settings) the supervising officer should seek medical advice as to the best transport option for the child. Parents/guardians should also be advised of the incident as soon as possible.

Post-incident support

Any incident reporting documentation (required by the Child Care Licensing and Standards unit) must be completed by staff in a timely manner. In addition, it needs to be recognised that an anaphylactic reaction can be a very traumatic experience for the child, staff, others witnessing the reaction, and parents/guardians.

In the event of an anaphylactic reaction, children and staff may benefit from post-incident counselling. Child care services should investigate counselling options as part of their policy development.

Adrenaline autoinjectors

The most effective treatment for anaphylaxis is to administer adrenaline through an autoinjector (such as an EpiPen® or Anapen®) to the outer mid-thigh muscle, as it can within minutes reverse potentially life threatening symptoms such as difficult/noisy breathing, swelling/tightness in the throat or loss of consciousness and/or collapse.

A medical practitioner may prescribe an adrenaline autoinjector to a child at risk of anaphylaxis for use in an emergency.

There are two different dosages that can be prescribed, namely:

- A smaller (junior) dosage of adrenaline for children between 10-20kg (1-5 years of age);
- A higher dosage of adrenaline for children over 20kg (or children over five years of age).

Two different adrenaline autoinjector devices are now available in Australia (EpiPen® or Anapen®). As they differ in their method of administration, it is important that the ASCIA Action Plan is kept with the device to ensure correct use (see Appendix 7). If a child has been prescribed an adrenaline autoinjector, one must be provided to the child care service by the child’s parents/guardians.
In some cases, exposure to an allergen can lead to an anaphylactic reaction in as little as five minutes. The following is therefore recommended:

- The adrenaline autoinjector should be stored in a central, unlocked location, out of reach for children yet easily accessible to staff.
- The adrenaline autoinjector should be placed away from direct heat or sunlight. It should not be stored in the refrigerator or freezer. In hot climates the adrenaline autoinjector should be stored in an esky or similar container.
- The adrenaline autoinjector should be checked quarterly to ensure it is not discoloured or out of date, and does not contain sediment.
- A copy of the child’s ASCIA Action Plan should be kept with the adrenaline autoinjector.
- The child’s adrenaline autoinjector should be distinguishable from other children’s adrenaline autoinjector and medications. For example, each child may have a plastic container clearly labelled with their name, into which their medications including the adrenaline autoinjector and ASCIA Action Plan can be kept.
- All staff should know where the adrenaline autoinjector is stored.
- The adrenaline autoinjector should be signed in and out when taken from its usual place, for example excursions.
Adrenaline autoinjector for general use

Child care services may consider purchasing an adrenaline autoinjector for ‘general use’ as a precaution when:

- A child is experiencing an anaphylactic reaction for the first time (i.e. they have not been diagnosed with anaphylaxis and do not have a prescribed adrenaline autoinjector).
- A child is experiencing an anaphylactic reaction, has been administered their prescribed adrenaline autoinjector, but requires a second dose of adrenaline because symptoms persist after five minutes.
- There is a problem with administering the child’s prescribed adrenaline autoinjector (e.g. out of date, not readily available, administered incorrectly).

For Outside School Hours Care Services a higher dose device is recommended which can be given to any child who weighs over 20kg, for all other services, a junior device is recommended which can be given to children 10-20kg (1-5 years of age). It should be clearly labelled as the adrenaline autoinjector for general use.

*Note:* Different adrenaline autoinjector devices are available and they differ in their administration, so if purchasing an adrenaline autoinjector for general use for your child care service, ensure you choose the type of device that staff are trained to use. Members of staff are advised to read the information included with the device.

Training devices

It is important that the adrenaline autoinjector trainer (a training device which does not contain a needle or adrenaline) is kept in a separate location from the child’s prescribed adrenaline autoinjector. Equally, the adrenaline autoinjector trainer should not be kept in a child care service’s first aid kit.

Food handling

Staff handling food, including snacks, should be trained about food handling and storage. In particular they should:

- Be aware of a child with food allergies and the foods the child is allergic to;
- Be able to identify foods that contain or are likely to contain the known food allergen and replace with other suitable foods (e.g. egg substitute) or remove food altogether;
- Be aware that if products or ingredients are ‘contaminated’ (e.g. may contain traces) with allergen, then the products and/or ingredients are not suitable for the child with food allergies;
- Be aware of cross contamination risks when storing, preparing and serving food; and
- Ensure all food provided from home is clearly and accurately labelled with the child’s name – this is particularly important for any child at risk of anaphylaxis.

Other issues relating to food that should be considered by child care services include:

- **Good hand hygiene:** Children should wash their hands before and after meals as this is a simple and effective way to minimise allergen exposure.
- **Food preparation areas** should be clearly marked off to ensure that the allergic child’s food is not prepared with other foods.
- **Dining areas:** Food should be eaten in a specified area which is supervised. This will prevent sharing of food, cutlery, bowls and cups.
- **Allowed food:** Ensure the child at risk of anaphylaxis is only offered ‘allergy free’ foods.
- **Cleanliness:** All tables and high chairs should be cleaned after meals.
Communicate with the child care service community
It is important to work with the child care service community to better understand how to provide a safe and supportive environment for all children, including those with severe allergies.

**Work with parents/guardians of children at risk of anaphylaxis**

Parents/guardians of a child at risk of anaphylaxis may experience high levels of anxiety about sending him/her to child care. It is important to encourage an open and cooperative relationship with parents/guardians so that they can feel confident that appropriate risk minimisation strategies are in place. Communicating with staff, parents/guardians and children, is essential in providing a safe environment for the child at risk of anaphylaxis. This should include:

- Staff being advised that the service is caring for a child at risk of anaphylaxis.
- Frequent communication is to be maintained with staff and parents/guardians about changes in known allergens and/or anaphylaxis policies and procedures.
- Parents/guardians of the child with food allergies being kept informed of planned parties/celebrations ahead of time so that the provision of suitable food can be discussed.3
- Parents/guardians of non-allergic children should be informed of known food allergies.3

It is important to have regular discussions with children about the importance of eating their own food and not sharing with others.3 These discussions should be held with both children who are at risk of anaphylaxis, and those who are not at risk.

**Engage the broader child care service community**

Raising awareness about anaphylaxis in the child care service community should be undertaken so that parents/guardians of all children have an increased understanding of the condition.

To facilitate this awareness raising, posters, fact sheets and brochures can be downloaded from the Western Australian Department of Health Anaphylaxis website [www.health.wa.gov.au/anaphylaxis](http://www.health.wa.gov.au/anaphylaxis).

**Privacy considerations**

Some parents/guardians may not wish the identity of their child who is at risk of anaphylaxis to be disclosed within the service. It is recommended that this be discussed with the child’s parents/guardians and written consent obtained to display the child’s name, photograph and relevant treatment details in staff areas, the child’s room and food preparation areas.
Review and assess management strategies

Review management processes

If there has been an anaphylactic reaction:

- Any used adrenaline autoinjector must be replaced by the parent/guardian before the child returns to the child care service.
- The child care service should review the child’s Individual Anaphylaxis Health Care Plan and ASCIA Action Plan with the child’s parents/guardians. This review should also consider any advice from the child’s medical practitioner.
- The Child Care Licensing and Standards Unit is notified according to the requirements of the appropriate regulations.
- Appropriate steps should be taken to reassure the child and parents/guardians which may include:
  - taking steps to avoid the child’s exposure to relevant allergen(s);
  - closer monitoring of the child by staff;
  - a training update for staff.
Resources/useful links

- Department of Health Anaphylaxis website www.health.wa.gov.au/anaphylaxis
- Anaphylaxis Australia Inc website www.allergyfacts.org.au
- Australasian Society of Clinical Immunology and Allergy website www.allergy.org.au
  ASCIA Action Plans can be accessed from www.allergy.org.au/content/view/10/3/#r1
- Department for Communities website www.community.wa.gov.au
- Child Australia PSCWA website www.childaustralia.org.au

References


Sample Anaphylaxis Management Policy for Child Care Services

Note: this is a sample policy and has been developed to be used in conjunction with the Anaphylaxis Management Guidelines for Child Care and Outside School Hours Care Services in Western Australia document. Your service may choose to develop or update your own anaphylaxis management policy.

Considerations:

Philosophy: Protection of children in the service; inclusiveness/non-discrimination; educating parents; raising community awareness.

Legislation: Duty of Care requirements; Equal Opportunity — Anti-discrimination; Privacy Act 1988; Child Care Services Act 2007 and relevant regulations (WA); Poisons Act 1964; Poisons Regulations 1965;

Children’s needs: To be accepted as normal – not singled out as different; to feel safe: to be protected from their allergens.

Parent’s needs: To reduce their anxiety and feel confident that their child is safe; to feel that their concerns are taken seriously.

Staff needs: Training; clear action plans to follow; opportunities to practise and refresh knowledge; to reduce their anxiety in dealing with an anaphylactic response; to debrief after an incident; sufficient notice of the introduction of new policy.

Management needs: That parents/guardians understand the serious nature of some allergies and how they can assist the service to avoid allergens; to be informed and educated in regard to anaphylaxis; appropriate policies are written, adhered to and regularly updated; staff are prepared to act in emergency situations; Action Plans are prepared with input from a child’s medical practitioner and parent/guardian, and endorsed by both.

Background

Anaphylaxis is a severe, rapidly progressive allergic reaction that is potentially life threatening. The prevalence of allergies is increasing with approximately 1 in 20 Australian children having food allergy and approximately 1 in 50 having peanut allergy.

The most common allergens in children are:

- peanuts
- eggs
- tree nuts (e.g. cashews)
- cow’s milk
- fish and shellfish
- wheat
- soy
- sesame
- certain insect venoms (particularly bee stings)

The key to the prevention of anaphylaxis in child care services is knowledge of those children who have been diagnosed as at risk, awareness of allergens, and prevention of exposure to those allergens. Communication between child care services and parents/guardians is important in helping children avoid exposure.

Adrenaline given through an adrenaline autoinjector (such as an EpiPen® or Anapen®) into the muscle of the outer mid thigh is the most effective first aid treatment for anaphylaxis.
Scope
This policy applies to:
- All children diagnosed by a medical practitioner as being at risk of anaphylaxis;
- All children enrolled at the service including their parents/guardians;
- Relevant members of the service community (e.g. volunteers working at the child care service);
- All staff and the licensee.

Policy statement
This child care service is committed to:
- Providing, as far as practicable, a safe and supportive environment in which children at risk of anaphylaxis can participate equally in all activities;
- Raising awareness about anaphylaxis and the child care service’s anaphylaxis management policy in the child care community;
- Engaging with parents/guardians of children at risk of anaphylaxis in assessing risks and developing risk minimisation strategies for the child.

The purpose
The aim of this policy is to:
- Minimise the risk of an anaphylactic reaction occurring at the child care service.
- Ensure members of staff are adequately trained to respond appropriately and competently to an anaphylactic reaction.
- Raise awareness about diagnosis throughout the child care community through education and policy implementation.

When introducing the Anaphylaxis Management Policy to staff it is important to first meet with them to explain the new policy, what it entails and when it will commence. Give them sufficient notice to ask questions and have any concerns addressed prior to it being introduced.

Procedure
Identifying allergic children
- Prior to enrolment or as soon as an allergy is diagnosed, the child care service will develop an Individual Anaphylaxis Health Care Plan for the child in consultation with the child’s parents/guardians and appropriate health professionals.
- At the time of enrolment parents/guardians will be asked to identify if their child has any special dietary needs. Where special needs are stated, the parent/guardian will be asked to complete a ‘Special Diet Record Form’ (see Appendix 6). This form will be reviewed with the parent/guardian every six months, and a copy will be provided to those staff members who have responsibility for preparing food.

Whenever a child with severe allergies is enrolled at the child care service, or newly diagnosed as having a severe allergy, all staff will be informed of:
- The child’s name and room;
- Where the child’s ASCIA Action Plan will be located;
- Where the child’s adrenaline autoinjector is located;
- Which staff member(s) will be responsible for administering the adrenaline autoinjector.
New and relief/casual staff will be given information about children’s special needs (including children with severe allergies) during the orientation process.

The child care service will discuss the provision of a Medic Alert bracelet for the child at risk of anaphylaxis with parents/guardians.

Staff training

An appropriate number of staff will be trained in the prevention, recognition and treatment of anaphylaxis in child care settings, including the use of adrenaline autoinjectors.

Each child care service will need to determine which of their staff should be trained to ensure that someone in close proximity to the child is always on hand to act in an emergency. In a small service this may mean that all staff should be trained, whilst in a larger service it may be sufficient for only those staff who work with the child to be trained. Best practice, however, would be for all staff to undergo training so there is always support in any situation.

The child care service will ensure the Food Coordinator is trained in managing the provision of meals for a child with allergies, including high levels of care in preventing cross contamination during storage, handling, preparation and serving of food. Training will also be given in planning appropriate menus including identifying written and hidden sources of food allergens on food labels.

The child care service will have available adrenaline autoinjector trainers to allow staff to practise using the devices.

Anaphylaxis emergency procedures will be conducted and evaluated every six months to ensure staff are confident in the procedure and able to act in an emergency.

Emergency procedures

The child’s Individual Anaphylaxis Health Care Plan should be completed in consultation with the child’s parents/guardians. Such consultation includes:

- approval of the Plan;
- consent to display the child’s ASCIA Action Plan;
- consent for the information contained within the Plan to be made available to both child care staff and emergency medical personnel (if necessary).

The child’s Individual Anaphylaxis Health Care Plan must include information relating to the immediate transport to hospital in an ambulance after an anaphylactic reaction. Repeat episodes of anaphylaxis may necessitate the child requiring additional medical treatment.

The child’s ASCIA Action Plan will be placed in a prominent position. This will ensure it can be regularly read by child care staff where the child may be present during the day. The need to display the child’s ASCIA Action Plan will be fully discussed with the child’s parents/guardians and their authorisation obtained for this.

The Supervising Officer will inform the child care service management of the agreed Individual Anaphylaxis Health Care Plan for the child and obtain their endorsement for the Plan to proceed.

All information on the child’s Individual Anaphylaxis Health Care Plan should be reviewed annually with the child’s parents/guardians to ensure information is current to the child’s developmental level.

The child’s Individual Anaphylaxis Health Care Plan should be reviewed prior to any special activities (e.g. excursions) to ensure information is current and correct, and any specific contingencies are pre-planned.
It is understood that early recognition and prompt treatment for an anaphylactic reaction can be life saving. Staff will therefore routinely review a child’s ASCIA Action Plan to ensure they feel confident in how to respond quickly in an emergency.

Parents/guardians are responsible for supplying the adrenaline autoinjector and ensuring that the medication has not expired.

After each emergency incident, the Individual Anaphylaxis Health Care Plan will be evaluated to determine if the child care service’s emergency response could be improved.

The child’s adrenaline autoinjector (and any other medication), must be labelled with the name of the child and recommended dosage. Medication must be located in a position that is out of reach of the children, but readily available to child care staff. Consideration must also be given to the need to keep the adrenaline autoinjector away from excessive light, heat or cold when deciding on a suitable location.

The expiry date of the child’s adrenaline autoinjector will be included on the Individual Anaphylaxis Health Care Plan. Child care staff will check the adrenaline autoinjector regularly to ensure it is not discoloured or expired and therefore in need of replacement. Staff will advise the parents/guardians at the earliest opportunity if the adrenaline autoinjector needs to be replaced.

Adrenaline autoinjectors are available in different dosages, namely:
- a smaller (junior) dosage of adrenaline for children between 10–20kg (1–5 years of age);
- a higher dosage of adrenaline for children over 20kg (or children over five years of age).

Where it is known a child has been exposed to their specific allergen, but has not developed symptoms, the child’s parents/guardians should be contacted. A request should be made to collect the child and seek medical advice. The child care service should closely monitor the child until the parents/guardians arrive. Immediate action should be taken if the child develops symptoms.

It is quite possible that a child with no history of a previous anaphylaxis, may have their first anaphylactic reaction whilst at the child care service, as these reactions only occur after the second exposure to the allergen. If child care staff believe a child may be having an anaphylactic reaction and the child care service has an adrenaline autoinjector for general use, this should be administered immediately and an ambulance called. If the child care service does not have an adrenaline autoinjector for general use, staff must follow emergency First Aid procedures and ring for an ambulance immediately.

Risk minimisation strategies

In the child care environment, strategies used to reduce the risk of anaphylaxis for individual children will depend on the nature of the allergen, the severity of the child’s allergy and the maturity of the child.

Wherever possible the child care service will minimise exposure to known allergens by:
- A child at risk of food anaphylaxis should only eat lunches and snacks that have been prepared at home or at the child care service under strictly supervised conditions. Children should not swap or share food, food utensils and food containers.
- Special care will be taken to avoid cross contamination occurring at the child care service by providing separate utensils for a child with allergies, taking extra care when cleaning surfaces, toys and equipment, and ensuring strict compliance with the child care service’s hygiene policies and procedures.
Only appropriately trained staff are to prepare, handle and serve the allergic child’s food, thus minimising the risk of cross contamination occurring.

For some children with food allergy, contact with small amounts of certain foods (e.g. nuts) can cause allergic reactions. For this reason, all parents/guardians will be advised of specific food allergies and how they can assist the child care service minimise the risk of exposure to known allergens.

Some children have severe allergic reactions to insect venoms. Prevention of insect stings from bees and wasps include measures such as:
- wearing shoes when outdoors;
- closing windows in cars and buses;
- taking great care when drinking out of cans, walking around pools, at the beach, or when walking in grasses which are in flower.

Child care staff will regularly inspect for bee and wasp nests on or near the property and store garbage in well-covered containers so that insects are not attracted.

Particular care will be taken when planning cooking or craft activities involving the use of empty food packaging to avoid inadvertently exposing the child to allergens. The same level of care will be employed to outside activities.

Child care staff will help the child at risk of anaphylaxis to develop trust and confidence that they will be safe while they are at the child care service by:
- talking to the child about their symptoms to allergic reactions so they know how to describe these symptoms to a carer when they are having an anaphylactic reaction;
- taking the child’s and their parent’s/guardian’s concerns seriously;
- making every effort to address any concerns they may raise.

Education of children

Child care staff will talk to children about foods that are safe and unsafe for the anaphylactic child. They will use terms such as ‘this food will make ..... sick’, ‘this food is not good for .....’, and ‘..... is allergic to that food’.

Staff will talk about symptoms of allergic reactions to children (e.g. itchy, furry, scratchy, hot, funny).

With older children, staff will talk about strategies to avoid exposure to unsafe foods, such as taking their own plate and utensils, having the first serve from commercially safe foods, and not eating food that is shared.

Child care staff will include information and discussions about food allergies in the programs they develop for the children, to help children understand about food allergy and encourage empathy, acceptance and inclusion of the allergic child.

Reporting procedures

After each emergency situation the following will need to be carried out:
- Staff involved in the situation are to complete an Incident Report, which will be countersigned by the person in charge of the child care service at the time of the incident.
- If necessary, send a copy of the completed form to the insurance company and file a copy of the Incident Report on the child’s file.
- The Supervising Officer will inform the child care service management about the incident.
- The Supervising Officer or the Licensee is required to inform the Child Care Licensing and Standards Unit about the incident.
Staff will be debriefed after each anaphylaxis incident and the child’s Individual Anaphylaxis Health Care Plan evaluated. Staff will need to discuss their own personal reactions to the emergency that occurred, as well as the effectiveness of the procedures that were in place. It is important to learn from each incident.

Time is also needed to discuss the exposure to the allergen and the strategies that need to be implemented and maintained to prevent further exposure.

**Legislation**

The child care service will ensure personal details provided by parents/guardians are collected, used, disclosed, stored and destroyed (when no longer needed) according to the Privacy Act 1988 and other regulatory requirements. The need to display personal details included on the child’s ASCIA Action Plan will be discussed with parents/guardians, and their written consent obtained prior to display.

The licensee must ensure that, except in an emergency, medication is not administered to an enrolled child without the written authority of the parent/guardian. In all other circumstances, the child care service will require the parent/guardian’s written authority (including the Child’s ASCIA Action Plan) to administer any medication to their child.

The child care service may confirm with their insurance company that child care staff who administer adrenaline using an adrenaline autoinjector, are covered under the child care service’s professional indemnity insurance cover.

All staff must comply with the:

- Child Care Services Regulations 2007.
- Child Care Services (Child Care) Regulations 2006
- Child Care Services (Family Day Care) Regulations 2006
- Child Care Services (Outside School Hours Care) Regulations 2006

Child care services have a duty of care to take reasonable care for the health and well being of children placed in their care.

This duty of care requires staff members to:

- Take reasonable care to eliminate or minimise foreseeable risks of personal injury to children under their supervision, due to the susceptibility of some children to allergies, special care must be taken to protect these children if the condition is known, or ought to be known, and exposes them to special risk of injury.
- Seek appropriate medical assistance for children in the event of an allergic reaction such as calling an ambulance or seeing a medical practitioner.
- Render whatever first aid is reasonable in circumstances where there is insufficient time to arrange for a child to be seen by a medical practitioner or be admitted to hospital via ambulance.
- The Poisons Regulations 1965 have been amended and child care staff are able to supply (and administer) a general use adrenaline autoinjector to a child in their service experiencing an anaphylactic reaction.

In order for a child care service to discharge its duty of care, the service will need to ensure that members of staff are appropriately trained in the prevention, identification and treatment of children who may experience an allergic reaction.

Adapted from the Professional Support Coordinator Western Australia – Child Australia, Managing Anaphylaxis Policy (2006).
### Possible Exposure Scenarios and Strategies

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>STRATEGY</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>The child care service provides food to children and a food allergen is unable to be removed from the service’s menu (for example milk)</td>
<td><strong>Menus are planned in conjunction with parents/carers of the child at risk and food is prepared according to parents/guardians instructions.</strong> Alternatively the parents/guardians provide all of the food for the child at risk.</td>
<td>Food coordinator, Supervising officer, Parent</td>
</tr>
<tr>
<td></td>
<td>Ensure separate storage of foods containing allergen.</td>
<td>Supervising officer and Food coordinator</td>
</tr>
<tr>
<td></td>
<td>Cook and staff observe food handling, preparation and serving practices to minimise the risk of cross contamination. This includes hygiene of surfaces in kitchen and children’s eating area, food utensils and containers.</td>
<td>Food coordinator, staff and volunteers</td>
</tr>
<tr>
<td></td>
<td>There is a system in place to ensure that the child at risk is served only the food prepared for him/her.</td>
<td>Food coordinator, staff and volunteers</td>
</tr>
<tr>
<td></td>
<td>An ‘at risk’ child is served and consumes their food at a place considered to pose a low-risk of contamination from allergens from another child’s food. This place is not separate from all children and allows social inclusion at mealtimes.</td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td>Children are regularly reminded of the importance of no food sharing with the child at risk.</td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td>Children are supervised during eating.</td>
<td>Staff and volunteers</td>
</tr>
<tr>
<td>Party or celebration</td>
<td>Give plenty of notice to parents/guardians about the event.</td>
<td>Supervising officer and Team leader</td>
</tr>
<tr>
<td></td>
<td>Ensure a safe treat box is provided for the child at risk.</td>
<td>Parent/ Staff</td>
</tr>
<tr>
<td></td>
<td>Ensure the child at risk only has the food approved by his/her parent/guardian.</td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td>Specify a range of foods that parents/guardians may send for the party and note particular foods and ingredients that should not be sent.</td>
<td>Supervising Officer</td>
</tr>
<tr>
<td>Minimising insect sting allergies</td>
<td>Ensure the child at risk wears shoes at all times while outdoors.</td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td>Quickly manage any instance of insect infestation. It may be appropriate to request exclusion of the child at risk during the period required to eradicate the insects.</td>
<td>Supervising Officer</td>
</tr>
<tr>
<td>SCENARIO</td>
<td>STRATEGY</td>
<td>WHO</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Latex allergies</td>
<td>Avoid the use of party balloons or contact with latex gloves.</td>
<td>Staff</td>
</tr>
<tr>
<td>Cooking with children</td>
<td>Ensure parents/guardians of the child at risk are advised well in advance if ingredients need to be provided by the parents/carers.</td>
<td>Staff</td>
</tr>
<tr>
<td>Craft</td>
<td>Be aware of allergen residue in empty food containers and wrappers.</td>
<td>Staff</td>
</tr>
<tr>
<td>Bathroom products</td>
<td>Staff using hand cream or perfumes need to be aware that these may contain allergens (e.g. nut oils).</td>
<td>Staff</td>
</tr>
</tbody>
</table>

## CHLDR DETAILS – To be completed by parent/guardian

<table>
<thead>
<tr>
<th>Child Care Service:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Male □ Female □</td>
</tr>
</tbody>
</table>

### PARENT/GUARDIAN CONTACT DETAILS

<table>
<thead>
<tr>
<th>Address:</th>
<th>Doctor 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Child:</td>
<td>Doctor 2:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone: (W) (H) (M):</th>
<th>Medical Centre:</th>
<th>Telephone:</th>
</tr>
</thead>
</table>

### SECTION A: CHILD HEALTH CARE PLANNING – To be completed by parent/guardian

Please list specific allergens and most recent reactions in the table below:

<table>
<thead>
<tr>
<th>MY CHILD IS ALLERGIC TO:</th>
<th>Please indicate which allergen(s) your child is allergic to.</th>
<th>Where applicable, please indicate your child's most recent reaction to the allergen (e.g. anaphylaxis, hay fever, hives, eczema).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peanuts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tree nuts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow's milk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eggs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soy products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shellfish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sesame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insect Stings or Bites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other/Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**SECTION B: DAILY MANAGEMENT** – To be completed in consultation with parent/guardian

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

**SECTION C: STAFF TRAINING** – To be completed by Supervising Officer

Is specific training for staff required? YES □ NO □ Date attended:

Type of training:

Name of person(s) trained:

**SECTION D: EMERGENCY RESPONSE** – As per the child’s ASCIA Action Plan attached (this must be completed by the child’s medical practitioner)

**SECTION E: MEDICATION** – To be completed by parent/guardian

<table>
<thead>
<tr>
<th>INSTRUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication 1</td>
</tr>
<tr>
<td>Name of medication</td>
</tr>
<tr>
<td>Expiry date</td>
</tr>
<tr>
<td>Dose/frequency – may be as per the pharmacist’s label</td>
</tr>
<tr>
<td>Duration (Dates)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Storage instructions (please tick appropriate box)</td>
</tr>
</tbody>
</table>

**SECTION F: AGREEMENT BETWEEN THE SUPERVISING OFFICER AND PARENT/GUARDIAN** – To be completed by Supervising Officer and Parent/Guardian

This agreement authorises the child care service staff to follow the advice of the child’s parent/guardian and medical practitioner as set out in child’s Individual Anaphylaxis Health Care Plan and the child’s ASCIA Action Plan. It is valid for one year or until I advise the child care service of a change in my child’s health care requirements.

Supervising Officer: Date: Parent/Guardian: Date:

Annual review date:

A copy of the child’s ASCIA Action Plan completed by the child’s medical practitioner must be attached to this document.

Adapted from the Department of Education and Training Western Australia, Form 4 – Severe Allergy/Anaphylaxis Management & Emergency Response Plan (2005).
Anaphylaxis: Practical Tips to Minimise the Risk and be ‘Allergy Aware’

Food allergy:
- Encourage those caring for a child with food allergy to be educated on the daily management and emergency treatment of anaphylaxis.
- Keep information about the food allergic child in a prominent place where all staff and helpers will remain aware of it.
- Rethink what food you stock and serve. Avoid peanut and tree nut (e.g. hazelnuts, cashews, almonds) products, including nut spreads.
- If food items cannot be removed, work on strategies to minimise the risk of a reaction (e.g. hold babies whilst they drink their milk, babies with food allergy should have a dedicated high chair).
- Avoid cross contamination during food preparation.
- Include the needs of a child who is allergic when planning any activities and making purchases.
- Discourage sharing of food, drinks and utensils (e.g. straws, bottles).
- Wash hands after eating – no playing with toys whilst eating.
- Do not allow children to wander whilst they are eating food.
- Clean up spills immediately.
- Wash toys and equipment regularly.
- Remember craft items can contain food allergens (e.g. egg cartons).
- Parents/guardians of a child at risk of anaphylaxis should be informed if sunscreen is offered to children – they may want to provide their own.
- Avoid putting up a sign saying ‘nut-free’ service. It is better to educate parents/guardians that the service is working toward being ‘allergy aware’.

Insect venom allergies:
- Ensure grass is kept short.
- Ensure the child with insect sting allergy wears shoes at all times.
- Keep lids on garbage bins.
- Do not leave drinks or drink bottles exposed in the outdoor area.
- Remove insect nests.

Latex allergy:
- A child with latex allergy should not come into contact with party balloons and latex gloves.

Adapted from the Anaphylaxis Australia Inc, Childcare Checklist for Managing Food Allergy Poster (2009).
Appendix 5

Anaphylaxis Management Checklist for Child Care Services

☐ Actively seek information to identify a child with severe life threatening allergies at enrolment.
☐ If a child has been diagnosed as being at risk of anaphylaxis, meet with the parents/guardians to complete an Individual Anaphylaxis Health Care Plan.
☐ Parents/guardians are to provide copies of the child’s ASCIA Action Plan completed by their medical practitioner with an up to date photo.
☐ Display the child’s ASCIA Action Plan in appropriate staff areas around the service (e.g. staff room).
☐ Parents/guardians are to provide the child’s adrenaline autoinjector and other medication (e.g. asthma reliever medication) within expiry date.
☐ Adrenaline autoinjectors are stored in an unlocked location, easily accessible to staff, but not accessible to children. It is stored with the child’s ASCIA Action Plan and away from direct sources of heat and sunlight.
☐ Establish a process for checking the adrenaline autoinjector to make sure it has not expired and has no discolouration or sediment.
☐ Establish processes for checking the adrenaline autoinjector and ensuring ASCIA Action Plans are taken whenever the child participates in off-site activities.
☐ Develop a service-based anaphylaxis management policy and implement strategies to minimise exposure to known allergens.
☐ Arrange staff training which should include the recognition of allergic reactions, emergency treatment, practice with adrenaline autoinjector trainer devices and risk minimisation strategies.
☐ All food preparation staff are trained in providing food to allergic children and measures are in place to prevent contamination of the food given to a child at risk of anaphylaxis (a safer option is for parents/guardians of a child with allergies to provide their child’s food).
☐ Hand out anaphylaxis fact sheets to staff to raise awareness about anaphylaxis.
☐ Mail/distribute letters to parents/guardians in the child care community and include information snippets in newsletters to raise awareness about anaphylaxis and the service’s policies/guidelines.
☐ Ensure all babies have tried new foods at home before they are given in the child care service.
☐ Regularly review anaphylaxis management strategies and practise scenarios for responding to an anaphylaxis emergency.
☐ Review child’s Individual Anaphylaxis Health Care Plan annually, if the child’s situation changes or after an anaphylactic incident.

## Appendix 6

### Template: Special Diet Record

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Parent/Guardian Names:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
<td></td>
</tr>
<tr>
<td>Phone (H):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 1. Reason for special diet:           | Religious | Health/Medical |
|                                       | Other | Please specify: |
|                                       |      |                  |

<table>
<thead>
<tr>
<th>2. What are the foods and substances that your child must avoid?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

| 3. What are the alternative foods that your child can consume? |
|                                                               |
| (e.g. Eggs, dairy, nuts, tofu, beans instead of meat for vegetarian diets) |
|                                                               |

<table>
<thead>
<tr>
<th>4. How long will/has your child be on this special diet?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Who will provide the following foods for your child while in care?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Snacks:</strong></td>
</tr>
<tr>
<td>□ Parent                □ Centre</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Lunch:</strong></td>
</tr>
<tr>
<td>□ Parent                □ Centre</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Drinks:</strong></td>
</tr>
<tr>
<td>□ Parent                □ Centre</td>
</tr>
</tbody>
</table>

| 6. Do you want to discuss with staff the programs involving food |
| (e.g. parties, menu plans, food experience activities)?          |
| □ Yes                  □ No                                        |

To enable the centre to continue to provide your child with adequate nutrition, this record will be reviewed every six (6) months or whenever there is more up to date information available.

Parent/Guardian Signature: Date:

Acknowledgment to Community Nutrition Unit, Department of Health and Human Services, Tasmania, for information contained in this form.
ASCIA Action Plans

The Australasian Society of Clinical Immunology and Allergy (ASCIA) has developed four Action Plans.

ASCIA Action Plan for Allergic Reactions
This Action Plan is green and is provided to children (or adults) with known mild to moderate allergies (including insect allergy), who are not thought to be at risk of anaphylaxis and therefore have not been prescribed an adrenaline autoinjector.

ASCIA Action Plan for Anaphylaxis
This Action Plan is red (pictured) and is provided to children (or adults) at risk of anaphylaxis to all allergens except insect venoms. These children (or adults) have been prescribed an adrenaline autoinjector.

ASCIA Action Plan for Anaphylaxis (Insect Allergy)
This Action Plan is yellow and is provided to children (or adults) at risk of anaphylaxis to insect venoms. It highlights danger signs for insect venom anaphylaxis — watch for abdominal pain and/or vomiting.
It also includes the advice — If sting can be seen, flick it out immediately, but do not remove ticks.

ASCIA General Action Plan for Anaphylaxis
This Action Plan is orange and is a general Action Plan for Anaphylaxis. A copy should be stored with the adrenaline autoinjector for general use. It can also be used as a poster.

Action Plans for EpiPen® and Anapen®
Instructions on how to give an adrenaline autoinjector are shown on the ASCIA Action Plans for Anaphylaxis. As there are two adrenaline autoinjector devices in Australia, there are two versions of each Action Plan.

The Action Plans shown are the:
- ASCIA Action Plan for Anaphylaxis for EpiPen®;
- and
- ASCIA Action Plan for Anaphylaxis for Anapen®.

For more information about the ASCIA Action Plans, please refer to the ASCIA Action Plan Information Sheet or visit the ASCIA website www.allergy.org.au
What is the difference between an allergy and anaphylaxis?

Allergy occurs when a person’s immune system reacts to substances (allergens) in the environment which are usually harmless (e.g. food proteins, dust mites, pollen).

Anaphylaxis is the most severe form of allergic reaction and is potentially life-threatening. Not everyone with allergies will have anaphylaxis.

An anaphylactic reaction involves the respiratory and/or cardiovascular system. Signs and symptoms include breathing difficulties, swelling of the tongue, tightness in the throat, difficulty talking, wheezing or persistent cough and even loss of consciousness or collapse.

Hives, welts, vomiting, diarrhoea by themselves are mild to moderate symptoms of food allergy, but can be early warning signs of an anaphylactic reaction. For insect allergy, vomiting and abdominal pain are signs of anaphylaxis.

How do I know if it is anaphylaxis and not asthma?

Unlike asthma, anaphylaxis can affect more than one system in the body. This means that during a reaction, you may see one or more of the following symptoms: swelling or welts on the skin, stomach pain, vomiting or diarrhoea, in addition to breathing difficulties and increased heart rate or altered consciousness. If you treat asthma as anaphylaxis and give the adrenaline autoinjector according to the child’s ASCIA Action Plan, no harm will be done. If in doubt, give the adrenaline autoinjector.

What if I think it is anaphylaxis, administer the adrenaline autoinjector and it turns out to be something else?

The adrenaline autoinjector contains adrenaline, which is a natural hormone produced by the body. If it is given to a child who does not have anaphylaxis, the child will have a raised heart rate and become pale and sweaty. They may feel anxious and shaky. These are common side-effects of adrenaline but medical advice indicates there will be no lasting ill effects. You must dial 000 and ask for an ambulance immediately to treat the other medical symptoms. Make sure you advise the ambulance officers that you have administered an adrenaline autoinjector and the time it was given.

What is the difference between a junior and higher dose adrenaline autoinjector?

Children aged approximately 1–5 years (10–20kg) are generally prescribed a Junior adrenaline autoinjector (green), which has a smaller dosage of adrenaline.

For children over five years (over 20kg), a higher dose adrenaline autoinjector (yellow) is prescribed.

What should I do if I do not have an adrenaline autoinjector with the age/weight appropriate dose available in an emergency?

In children over one year of age, if an adrenaline autoinjector is available it should be administered regardless of the dose.

Children under one year of age are not usually prescribed an adrenaline autoinjector as reactions are not severe and deaths are extremely rare. If anaphylaxis is suspected only the Junior adrenaline autoinjector can be given.

Can I give an adrenaline autoinjector if it has expired, is discoloured or contains sediment?

It is recommended that the adrenaline autoinjector should only be given if the device is not out of date and the fluid inside is clear. In an emergency, when there is no general use autoinjector available, Princess Margaret Hospital for Children advises to give the adrenaline autoinjector regardless of expiry date, discolouration or sedimentation and dial 000 for an ambulance immediately. Remember the key to effective management is preparation – strategies should be in place to prevent being in a situation where you have a child with anaphylaxis that does not have a current adrenaline autoinjector.

What happens to the child once I give them the adrenaline autoinjector?

You will soon see a reversal of the more serious symptoms of the child’s reaction. They will breathe more easily as the swelling and tightness...
in their throat will recede. However, they may feel very anxious and shaky. This is a side effect of adrenaline. Reassure the child and closely watch them in case of a repeat reaction.

Can I give a second adrenaline autoinjector? Watch the child closely in case of a repeat reaction. In the rare situation where there is no marked improvement and severe symptoms (as described in the ASCIA Action Plan) are present and/or persist, a second adrenaline autoinjector (of the same dosage) may be administered after five minutes.

What happens if I accidentally inject myself? Call for assistance as you will require support, if the child is having a reaction, ask another staff member to take over. If you have an adrenaline autoinjector for general use on site, ask someone to retrieve it and administer to the child. Adrenaline has no long term ill effects though it is advisable for you to seek medical assistance for yourself.

If a child does not have an adrenaline autoinjector and appears to be having a reaction, can I administer another child’s adrenaline autoinjector to them? No. If the child care service has an adrenaline autoinjector for general use, this can be administered and an ambulance called.

What should I do if the parents/guardians have not replaced their child’s adrenaline autoinjector and it has expired? Contact the parents/guardians immediately and request them to replace the adrenaline autoinjector. If the child care service has an adrenaline autoinjector for general use, be prepared to use it in the interim and make sure that staff members know where it is stored.

What if the parents/guardians have not told us about their child’s condition, but the child mentions it in the child care service? Contact the child’s parents/guardians as a priority to verify if their child is at risk of anaphylaxis. If necessary, ask the parents/guardians to obtain an adrenaline autoinjector and ASCIA Action Plan for the child care service as soon as possible. It is advisable to complete an Individual Anaphylaxis Health Care Plan with the parents/guardians.

Can we ask parents/guardians not to send nut products to the child care service? What happens if they refuse? Before you make this request of parents/guardians, ask yourself why you are doing this and if there are other risk minimisation strategies that you could put into place instead. You can request parents/guardians not to send nut products to your child care service but it is important to realise that this does not mean that your child care service is ‘nut-free’. While most parents/guardians will be happy to comply, there may be a small group who disagree. In those situations it is best to work with them. Educate them about how severe anaphylaxis can be. Help them to develop alternative, nutritious food options for their children.

What can I do to keep a child at risk of anaphylaxis safe in my child care service? Be well prepared. Minimise their exposure to known allergens by planning ahead and thinking about alternatives for certain activities when necessary. Consult with the child and their parents/guardians when any food is to be consumed and keep a separate treats box for the child at risk of anaphylaxis. Be familiar with the child’s ASCIA Action Plan and know where the adrenaline autoinjector is and how to administer it. Consult with the parents/guardians about potential hidden allergens in foods or other substances (e.g. soaps or lotions).

If we follow all the policies and recommendations, will we prevent anaphylactic reactions in our child care service? You will certainly minimise the risk of a reaction and be well equipped to manage one should it occur. However, there is no guarantee that you will prevent one. Remember that advance planning and good preparation for all child care service settings is the key to minimising the risk and effectively managing anaphylaxis.

This document can be made available in alternative formats such as computer disc, audio tape or Braille, on request.