



Western Australian Anaphylaxis School Survey 2008

Analyses Report

Table of Contents

List of Tables	3
Introduction	4
Overview and Rationale	4
Background	4
Purpose of Project.....	5
Objectives.....	5
Glossary of Abbreviations.....	6
Methodology	6
Ethical Considerations.....	6
Analysis	7
Study Population	7
Demographic Profile	7
Results	8
Students ‘at risk’ of anaphylaxis	8
Policy and Guidelines	8
Incidences and reporting of anaphylactic reactions.....	10
Staff Training	11
Storage of the EpiPen®.....	13
Risk Minimisation Strategies	13
Awareness Strategies	14
Discussion	15
Limitations	17
Conclusion	18
References	18
Appendix	20
Appendix A: WA Anaphylaxis School Survey.....	20
Appendix B: Consent Form.....	22

List of Tables

Table 1: Characteristics of responding schools.....	7
Table 2: 'At risk' of anaphylaxis.....	8
Table 3: Current school guides for anaphylaxis management	9
Table 4: 'At risk' student/s individual action plan and elements in plan.....	9
Table 5: 'At risk' student/s who have action plans displayed in agreed positions around the school	9
Table 6: 'At risk' students experiencing anaphylactic reactions	10
Table 7: Reactive students requiring the use of an EpiPen®.....	10
Table 8: Staff Training in anaphylaxis management	11
Table 9: Who conducted and elements of anaphylaxis training	11
Table 10: Training satisfaction	12
Table 11: Staff attendance at annual anaphylaxis training.....	12
Table 12: Access to a school/community health nurse	12
Table 13: New staff provided with information on 'at risk' students.....	13
Table 14: Staff awareness of anaphylaxis training options	13
Table 15: EpiPen® Storage	13
Table 16: Risk Minimisation Strategies	14
Table 17: Awareness Strategies	14

Introduction

The following report documents the results of the Western Australia Anaphylaxis School Survey 2008. The study provides baseline data on anaphylaxis prevalence and management in Western Australian schools to assist in the development of anaphylaxis resources and staff training.

Overview and Rationale

Background

Anaphylaxis is a sudden, severe and rapidly progressive allergic reaction requiring prompt recognition and immediate management. The aetiology of anaphylaxis is commonly known to be peanuts, but it can also be triggered from exposure to other allergens such as shellfish, egg, milk, insect stings, latex and medicines. While researchers and scientists continue to seek a cure for anaphylaxis, prevention is the only avenue to protect children from the condition.

Allergic reactions, including the potentially life threatening anaphylaxis, can and do occur in schools. The latest Australian figures show that hospital admissions for anaphylaxis have increased five-fold in children in the last decade¹. Parents of 'at risk' children are seeking reassurance that staff will know what to do if an emergency occurs.

The Western Australian Government has committed \$6.6 million over the next four years to implement the recommendations in the report *Anaphylaxis: Meeting the Challenge for Western Australian Children*. The state strategy will offer greater protection by providing anaphylaxis information, resources and training to those who work with children.

In May 2008, the *Anaphylaxis Management Implementation Group* (AMIG) was established to implement the state strategy. The group consists of representatives from the Department of Health, Department of Education and Training, Department for Communities and Department for Child Protection. Also represented on the committee are Anaphylaxis Australia, the Australasian Society of Clinical

Immunology and Allergy, Catholic Education, the Association of Independent Schools, Dieticians and General Practitioners.

In order to ensure resources and staff training meet the needs of WA schools, it was important for AMIG to gather a sound understanding of the scope of the issue. This includes baseline data on the prevalence and management of anaphylaxis among WA schools.

To date, there are limited studies in Australia that examine the prevalence of anaphylaxis among children. Previous studies focus on children with allergies and population based data is limited. Furthermore, little is known about the current management of anaphylaxis among schools in WA.

Purpose of Project

The aim of the WA Anaphylaxis School Survey 2008 was to provide baseline data on the prevalence and management of anaphylaxis among WA schools to assist in the development of the anaphylaxis resources and training. In addition, the survey was designed to foster ownership among schools by obtaining the views, opinions and ideas and was to be instrumental in raising the awareness of anaphylaxis.

Objectives

1. To identify how many children in Western Australia are at risk of anaphylaxis
2. To identify current anaphylaxis policies and management plans in Western Australian schools
3. To identify how many children in Western Australia have had an anaphylactic reaction(s) in the last 12 months
4. To identify how many children in Western Australia who had an anaphylactic reaction required the use of an EpiPen(s)
5. To identify how many staff in schools are trained in anaphylaxis management and the type of training received
6. To identify strategies used in Western Australian schools to raise awareness and reduce exposure to possible risks of anaphylaxis

7. To provide recommendations to the AMIG Committee for planning and decision-making for future phases of the project.

Glossary of Abbreviations

AMIG Anaphylaxis Management Implementation Group

DoH Department of Health (WA)

DFC Department for Communities

DCP Department for Child Protection

DET Department of Education and Training

WA Western Australia

Methodology

The survey was developed and reviewed in consultation with the AMIG. The survey involved a doubled-sided A4 sheet leaflet that incorporated a variety of questions covering the following topics; children at risk of anaphylaxis, policy and guidelines, incidences and reporting, staff training, storage of EpiPens®, risk minimisation strategies, and awareness. A copy of the survey is provided in appendix A, along with the consent form (appendix B).

On 31 October 2008, approximately 1,117 surveys were distributed to each school in WA. Respondents were asked to complete and return the survey by mail before 14 November 2008. To maximise the response rate the survey was placed on the WA Health anaphylaxis website to be completed online. A gourmet teabag was supplied with each school survey to encourage the completion and return.

Ethical Considerations

The anaphylaxis school survey study was reviewed by the AMIG and was considered 'negligible risk' under the *National Statement on Ethical Conduct in Human Research 2007 (National Health and Medical Research Council)*. The study would not survey individual students and would collect unidentifiable data (i.e. no student's would be identified in the research). As such, there was no foreseeable risk of harm or discomfort; and any foreseeable risk would be no more than inconvenience.

All surveys were conducted with informed consent and with the assurance of confidentiality of responses. This is shown in the consent form in Appendix B.

Analysis

Frequency analysis was performed to determine anaphylaxis risk prevalence, minimisation and management strategies in WA schools. All analyses were performed in SPSS version 15, with assistance from the Department of Health Epidemiology team.

Study Population

Demographic Profile

A total of 658 schools across WA completed the Anaphylaxis School Survey (59% response rate). The majority of which were completed either by Principals or Deputy Principals. Identifying data was obtained of schools only and not of individual students. The characteristics of respondents are shown in Table 1. Respondents included primary schools (63.2%), secondary schools (23.3%) and pre-schools (13.5%). The school sectors included public (69.8%), catholic (16.4%) and independent (13.8%). Distribution by location included 58.7% from the metropolitan region and 40.4% from the rural region.

Table 1: Characteristics of responding schools

	n	%
School Type	<i>n=842*</i>	
Pre-school	114	13.5
Primary	532	63.2
Secondary	196	23.3
Position	<i>n=647**</i>	
Principal/Deputy Administration	479	74.0
Nurse	59	9.1
Teacher	73	11.3
	36	5.6
School Sector	<i>n=666*</i>	
Public	465	69.8
Catholic	109	16.4
Independent	92	13.8
Location	<i>n=652**</i>	
Rural	266	40.8
Metro	386	59.2

*Schools can be more than one type

**Excluding missing data

Results

Students ‘at risk’ of anaphylaxis

As shown in Table 2, a total of 3,174 students were identified by respondents to be ‘at risk’ of anaphylaxis (1.3%). Among the schools who responded to the survey, 82.7% ($n=541$) have at least one student ‘at risk’ of anaphylaxis and 56.6% reported there are 3 or more students ‘at risk’.

Table 2: ‘At risk’ of anaphylaxis

	n	%
How many students are ‘at risk’?	<i>n= 237,664</i>	
Students identified as ‘at risk’	3,174	1.3
Number of schools with ‘at risk’ students	<i>n=654</i>	
Schools with 1 or more student(s) ‘at risk’	541	82.7
Schools with 3 or more student(s) ‘at risk’	370	56.6

Policy and Guidelines

Majority of schools were guided on anaphylaxis management by general health and safety policies (64.4%) and department guidelines or recommendations (62.0%) (Table 3). A total of 440 of schools (78.6%) prepared individual management plans for all children ‘at risk’ of anaphylaxis, only 5% reported they did not prepare management plans (Table 4). The most common elements addressed in each student’s management/healthcare plan were information on the student’s allergen/s (85.7%), emergency contact details (83.6%), and emergency response plan/procedures (82.5%). Prevention strategies were the least reported element addressed in a student’s plan (48.3%) (Table 4). Furthermore, 82.0% of schools with students identified as ‘at risk’ of anaphylaxis had action plans displayed in agreed positions around the school, only 4.8% reported they did not display action plans (Table 5).

Table 3: Current school guides for anaphylaxis management

	n	%
What guides anaphylaxis management?	<i>n=658</i>	
General health & safety policies	424	64.4
School specific anaphylaxis policy	289	43.9
Department guidelines or recommendations	408	62.0
No policy	11	1.2
Unsure	8	1.7
Other	109	16.6

Table 4: 'At risk' student/s individual action plan and elements in plan

	n	%
How many students with individual plans?	<i>n=560</i>	
All	440	78.6
Most	35	6.3
Some	35	6.3
None	28	5.0
Unsure	22	3.9
What elements are in each management plan?	<i>n=658</i>	
Information on the child's allergen/s	564	85.7
Photo of the child	511	77.7
Emergency contact details	550	83.6
Emergency response plan/procedures	543	82.5
Prevention strategies	318	48.3
Staff to support the child	379	57.6
Information on EpiPen® storage	450	68.4
Parent Involvement	408	62.0
Unsure	9	1.4
No current management plan	83	12.6

Table 5: 'At risk' student/s who have action plans displayed in agreed positions around the school

	n	%
How many students have plans displayed in agreed positions around school?	<i>n=658</i>	
All	466	82.0
Most	29	5.1
Some	22	3.9
None	27	4.8
Unsure	24	4.2

Incidences and reporting of anaphylactic reactions

Of the 3,174 students 'at risk' of anaphylaxis, 122 had an anaphylactic reaction in the last 12 months (3.8%). Of these students, 22 experienced more than one reaction in the last 12 months (0.7%) (Table 6).

As shown in Table 6, a total of 90 schools (13.7%) reported caring for students that had an anaphylactic reaction in the last 12 months. A total of 20 schools (3.0%) cared for a child that had more than one reaction in the last 12 months.

Table 6: 'At risk' students experiencing anaphylactic reactions

	n	%
How many students/schools had anaphylactic reactions?	<i>n=3,174</i>	
'At risk' students who had a reaction in last 12 months	122	3.8
'At risk' students who had more than 1 reaction in the last 12 months	22	0.7
	<i>n=658</i>	
Schools that had a child with a reaction in last 12 months	90	13.7
Schools that had a child with more than 1 reaction in the last 12 months	20	3.0

EpiPen is a registered auto injector device that administers adrenaline in the event of an anaphylactic episode. Of the students that experienced an anaphylactic reaction 31.1% required the use of an EpiPen®, three children required more than one EpiPen®. A total of 29 schools (4.4%) reported the use of an EpiPen® after the occurrence of an anaphylactic reaction, three schools were required to use more than one EpiPen® (table 7).

Table 7: Reactive students requiring the use of an EpiPen®

	n	%
How many students/schools used an EpiPen®?	<i>n=122</i>	
Students who required the use of an EpiPen®	38	31.1
Students who required the use of more than one EpiPen®	3	2.5
	<i>n=658</i>	
Schools that required the use of an EpiPen®	29	4.4
Schools that required the use of more than one EpiPen®	3	0.5

Staff Training

As shown in Table 8, schools reported that 48% of WA teaching staff and 39.1% of non-teaching staff attended training on the use of an EpiPen® in the last 12 months .

Table 8: Staff Training in anaphylaxis management

	n	%
How many teaching staff were trained?	n=18,826	
Trained in anaphylaxis management	9,147	48.6
Not trained in anaphylaxis management	9,679	51.4
How many non teaching staff were trained?	n=10,830	
Trained in anaphylaxis management	4,238	39.1
Not trained in anaphylaxis management	6,592	60.9

The school nurse/community health nurse was the most likely person (61.6%) to conduct anaphylaxis training to school staff members (Table 9). The most frequently reported training elements included how to administer an EpiPen® (75.7%), recognise the signs and symptoms (70.7%) and practice with an EpiPen® (67.0%). Only 11.9% of schools reported training included information on how to write an anaphylaxis management plan (Table 9).

Table 9: Who conducted and elements of anaphylaxis training

	n	%
Who conducted the training?	n=658	
Teacher	45	6.8
Parent	33	5.0
School Nurse/Community Health Nurse	405	61.6
First Aid training organisation	108	16.4
Unsure	9	1.4
No answer	131	19.9
Other	32	4.9
What elements are in the training?	n=658	
Recognise the signs and symptoms	465	70.7
Manage and treat an allergic reaction	423	64.3
How to write an anaphylaxis management	78	11.9
Risk minimisation strategies	203	30.9
How to administer an EpiPen®	498	75.7
Practice with an EpiPen®	441	67.0
Unsure	24	3.6
No answer	134	20.4

As shown in Table 10, anaphylaxis training was considered helpful by 76.1% of schools. Approximately 35.4% of schools reported that no staff attend annual anaphylaxis training, whereas 24.5% of schools reported all staff attend annual training (Table 11).

Table 10: Training satisfaction

	n	%
Was the training helpful?	n=658	
Yes	501	76.1
No	1	0.2
Unsure	17	2.6
No Answer	139	21.1

Table 11: Staff attendance at annual anaphylaxis training

	n	%
How many staff attend training?	n=658	
All	161	24.5
Most	168	25.5
Some	96	14.6
None	233	35.4

Among respondents, 84.0% reported they had access to a school/community health nurse for training purposes. Only 5.8% reported no access to nurses. These results are shown in Table 12 below.

Table 12: Access to a school/community health nurse

	n	%
Does your school have access to a nurse?	n=658	
Yes	553	84.0
No	38	5.8
Unsure	57	8.7
No Answer	10	1.5

Majority of schools (63.1%) reported they provide all new and temporary staff with information on students 'at risk' of anaphylaxis (Table 13). Whilst 33.3% of schools are aware of anaphylaxis training options available to them, 42.1% are unaware of available training options (Table 14).

Table 13: New staff provided with information on 'at risk' students

	n	%
Is new staff provided information?	<i>n=658</i>	
Yes	415	63.1
No	129	19.6
Unsure	66	10.0
No Answer	48	7.3

Table 14: Staff awareness of anaphylaxis training options

	n	%
Are you aware of training options?	<i>n=658</i>	
Yes	219	33.3
No	277	42.1
Unsure	137	20.8
No Answer	25	3.8

Storage of the EpiPen®

Of the students 'at risk' of anaphylaxis, 69.0% have a prescribed EpiPen® stored on site and 19.0% carry an EpiPen® with them. Majority of schools (74.0%) reported a student who has a prescribed EpiPen® stored on site while 187 schools (28.4%) have a student who carries an EpiPen® with them. These results are shown in Table 15.

Table 15: EpiPen® Storage

	n	%
How many students store on site/carry an EpiPen®?	<i>n=3,174</i>	
'At risk' students who have an EpiPen® stored on site	2192	69.0
'At risk' students who carry an EpiPen®	613	19.0
	n	%
School storage of EpiPens®	<i>n=658</i>	
Schools with a student who has an EpiPen® stored on site	487	74.0
Schools with a student who carries an EpiPen®	187	28.4

Risk Minimisation Strategies

As shown in Table 16, anaphylaxis risk minimisation strategies were used by schools predominantly for school excursions and camps (77.2%), class-room activities (69.6%) and in the playground yard (61.4%). Only a small proportion of schools were unsure (3.8%) or had no risk minimisation strategies in place (3.0%).

Table 16: Risk Minimisation Strategies

	n	%
Where are strategies in place to reduce triggers?	n=658	
School excursions and camps	508	77.2
School canteen	375	57.0
Class-room activities	458	69.6
Playground/Yard	404	61.4
Sporting or special event	385	58.5
No strategies in place	20	3.0
Unsure	25	3.8
No children at risk	79	12.0

Awareness Strategies

The most common strategy used by schools to increase anaphylaxis awareness was through newsletter articles for parents (63.2%). Other strategies used include; information at staff/parent meetings (45.9%), posters or brochures (40.7%) and letters sent to parents (35.6%). A total of 86 schools (13.1%) reported no strategies in place to raise anaphylaxis awareness (Table 17).

Table 17: Awareness Strategies

	n	%
What strategies are in place to increase awareness?	n=658	
School Newsletter articles for parents	416	63.2
Letters sent to parents	234	35.6
Community awareness meeting	41	6.2
Student education of anaphylaxis	192	29.2
Student awareness programs	135	20.5
Information on the staff portal	108	16.4
Information at staff/parent meetings	302	45.9
Posters or brochures	268	40.7
No strategies in place	86	13.1
Other	51	7.8

Discussion

This study is the first in Western Australia to report on anaphylaxis prevalence and management within schools throughout the state. The results will provide baseline data for monitoring the prevalence of anaphylaxis for WA children and evaluating management within WA schools.

The prevalence of children at-risk of anaphylaxis in WA schools was identified as 1.3%, with over 80% of schools reporting at least one student 'at risk' of anaphylaxis. This result was significantly higher than the results of South Australian study conducted in 1999, which revealed an anaphylaxis prevalence of 0.59% in school age children². The suggested rise in the prevalence of anaphylaxis in Australia is consistent with the well-documented rise in the incidence of peanut allergies. For instance, Mullins et al. (2008) found a rise in peanut allergies from 0.73% in 2001 to 1.15% in 2004 for children born in the Australian Capital Territory (ACT)³. Furthermore, a recent study suggests the prevalence of nut allergy to be as high as 3.8% among children in the ACT⁴.

Research on anaphylaxis management within schools is severely limited. Boros *et al* (2000) reported that less than half of children 'at risk' of anaphylaxis had a management plan at school. In contrast, it is pleasing to note that 78.6% of schools surveyed in WA had individual management plans for all children identified as 'at risk' of anaphylaxis. Furthermore, a large proportion of schools were guided by some form of policy or department guideline to manage children 'at risk' of anaphylaxis. Whilst these results are positive, there are still inconsistencies in management highlighting the need to develop anaphylaxis policy and guidelines which outline consistent roles and responsibilities for all WA schools.

One hundred and twenty two students were identified by WA schools as having had an anaphylactic reaction in the last 12 months. Approximately 1 in 7 schools reported at least one student who had a reaction in the last 12 months. The high rate of anaphylactic episodes was consistent with a study in California on schools nurses which revealed 38% had personally witnessed anaphylaxis at school⁵. Similar results have also been found for studies examining allergic reactions. For instance, a study by Sicherer in 2001 revealed of the 4536 registrants on a US

peanut allergy register, 16% reported suffering an allergic reaction at school or in day care⁶. The results of the WA survey highlight the fact that anaphylactic reactions are occurring in WA schools and emphasises the need for improved prevention strategies and emergency management plans.

Survey respondents reported that 38 students required the use of an EpiPen® (adrenaline auto-injector) at the time of an anaphylactic reaction in the last 12 months. While this number may seem small, the availability and timely use of an EpiPen® potentially saved these students lives. It is therefore concerning that of the children 'at risk' of anaphylaxis, only 69.0% had an EpiPen® stored on site of the school they attend. Similarly, a Californian study by Posner found 72.5% of school nurses were aware of children with anaphylaxis with no auto-injector at school⁵. Anaphylactic events are largely unpredictable and administration of adrenaline should be immediate upon evidence of occurrence⁷. The results of the WA survey therefore support the recommendation to ensure all WA schools are equipped with adrenaline auto-injectors for immediate first aid management.

Less than half of all teaching staff attended training on how to administer an EpiPen® in the last 12 months. This result is particularly concerning as it may place a number of students at risk of a fatal reaction. Furthermore, it was revealed that a large proportion (42.1%) of respondents were unaware of staff anaphylaxis training options. These results emphasise the need to establish a state-wide training program that is accessible to all schools in WA and extensively promoted. Interestingly, school nurses were currently conducting 61.1% of anaphylaxis training in schools highlighting the potential to build on the already existing service.

Risk minimisation is a fundamental step in reducing the risk of anaphylaxis, it is vital that schools implement such strategies to reduce the likelihood of a reaction on site. It is therefore pleasing to note that most schools have risk minimisation strategies in place, particularly on excursions and camps (77.2%), in class (69.6%) and in the yard (61.4%). Although positive, the results of the survey do indicate areas for improvement to promote and apply risk minimisation strategies.

Limitations

The WA Anaphylaxis School Survey was mailed to all public and private schools in Western Australia (n=1,117) however, participation in the survey was voluntary. Self selection bias may therefore be evident as respondents were not randomly selected. For instance, schools that have had experience with a student 'at risk' of anaphylaxis may be more willing to respond to the survey whereas, schools that have had little or no experience with students 'at risk' of anaphylaxis may feel less compelled to respond to the survey.

Self-report bias may have also impacted on the results due to the fact that respondents had to report the number of students 'at risk' of anaphylaxis at their school. Although a factsheet on anaphylaxis was attached to the survey, it is highly likely that an understanding of anaphylaxis varied from respondent to respondent. For instance, food sensitivity and minor allergies may be mistaken for an anaphylactic reaction. Furthermore, parental or carer disclosure to the school of their child's allergies may not be based on a clinical diagnosis by an immunologist.

A number of questions in the survey asked participants to recall information in the last 12 months. The ability for participants to accurately recall this information may have impacted the results.

Another limitation of the survey is attention bias whereby services may attempt to respond to the questions in the way which is socially desirable to prevent the school being viewed negatively. This may result in schools over-reporting questions such as the number of risk minimisation strategies and management plans in place at their school.

The final limitation to the study is the extent to which the findings can be generalised beyond the participants studied. A response rate of 59% may be too limited for broad generalisations as it may not be an accurate and holistic representation of schools in WA.

Conclusion

The WA Anaphylaxis school survey has been fundamental in providing baseline data on anaphylaxis prevalence and management in WA schools. The results show that the majority of WA schools have at least one enrolled child at risk of anaphylaxis, which highlights the severity of the issue and supports the State Government's commitment in 2007 to a WA Anaphylaxis Plan. There were encouraging results on the management of anaphylaxis among schools however, inconsistencies in approach and uncertainty among participants highlight the need for standardised guidelines and training. It is important that WA Health continue to conduct a survey approximately every two years in order to analyse trends and assess the impact of the anaphylaxis project and its objectives.

References

- ¹ Poulos LM, Waters AM, Correll PK, et al. Trends in hospitalizations for anaphylaxis, angioedema, and urticaria in Australia, 1993-1994 to 2004-2005. *J Allergy Clin Immunol*; 2007; 120(4): 878-84
- ² Boros C, Kay D, Gold MS. Parent reported allergy and anaphylaxis in 4173 South Australian children *Journal of Paediatrics & Child Health* 2000;36:36-40
- ³ Mullins R, Dear K, Tang M. Characteristics of childhood peanut allergy in the Australian Capital Territory, 1995 to 2007 *Journal of Allergy and Clinical Immunology*, 2009;123:689-93
- ⁴ Kljakovic M et al. The parent-reported prevalence and management of peanut and nut allergy in school children in the Australian Capital Territory *Journal of Paediatrics and Child Health* 2009;45:98-103
- ⁵ Posner L, Spradling N. Anaphylaxis & Acute Asthma in California Schools *APAAI California*
- ⁶ Sicherer SH, Furlong TJ, DeSimone J, Sampson HA. The US Peanut and Tree Allergy Registry: Characteristics of reactions in schools and day care *Journal of Pediatrics*. 2001;138:560-565
- ⁷ Ellis A, Day J. The role of epinephrine in the treatment of anaphylaxis *Current Allergy and Asthma Reports* 2003;3:11-14

WA Anaphylaxis School Survey

Available to complete online at www.health.wa.gov.au/anaphylaxis/survey



Identifying data

1. Please enter your school details:

- Pre-school Primary Secondary
- Public Catholic Independent
- School name
- Contact name
- Position
- Address
- Suburb
- Postcode
- Phone
- Fax
- E-mail

Students at risk of anaphylaxis

2. How many students are currently enrolled in 2008?

.....

3. How many of these students have been identified as 'at risk' of anaphylaxis?

.....

Policy and Guidelines

4. What currently guides your school on anaphylaxis management? Please tick

- General policies (e.g. health and safety)
- School specific anaphylaxis policy
- Department guidelines or recommendations
- Unsure
- None
- Other, please detail:

.....

5. Of the children identified as 'at risk' of anaphylaxis, how many have an individual Management/ Healthcare Plan regarding their condition? Please note we are NOT referring to the ASCIA anaphylaxis action plan

- All Most Some None
- Unsure No students at risk

6. What elements are addressed in each child's Management/Healthcare Plan? Please tick more than one option if appropriate

- Information on the child's allergen/s
- Photo of the child
- Emergency contact details
- Emergency response plan/procedures
- Prevention strategies
- Arrangements for staff to support the child
- Information on where the EpiPen® is stored
- Parent Involvement
- Unsure
- No current management plan

7. Of the children identified as 'at risk' of anaphylaxis, how many have an ASCIA anaphylaxis action plan OR their photograph, emergency contact details and emergency response procedures placed in agreed positions around the school?

- All Most Some None
- Unsure No students at risk

Incidences and Reporting

8. How many students had an anaphylactic reaction at school in the last 12 months? (i.e. at least one of the following reactions: swelling of the throat or tongue, hoarse voice, noisy or difficulty breathing, pale/floppy, collapse, loss of consciousness)

.....

9. How many students had more than one anaphylactic reaction at school in the last 12 months?

.....

10. In the last 12 months, how many students had an anaphylactic reaction that required the use of an EpiPen® (adrenaline)?

.....

11. In the last 12 months, how many students had an anaphylactic reaction that required the use of more than one EpiPen®? (i.e. two or more doses for the single reaction)

.....

12. How many staff are employed by your school in 2008:

- Teaching?
- Non teaching?

13. How many staff have attended training on the use of an EpiPen® in the last 12 months:

- Teaching?
- Non teaching?

14. Who conducted the training?

- Teacher
- Parent
- School Nurse/Community Health Nurse
- First Aid training organisation
- Unsure
- No answer
- Other, please detail:

.....

15. What elements did the training include? Please tick more than one option if appropriate

- Recognise the signs and symptoms
- Manage and treat an allergic reaction
- How to write an anaphylaxis management plan
- Risk minimisation strategies
- How to administer an EpiPen®
- Practice with an EpiPen®
- Unsure
- No answer

16. Do you feel the training was helpful?

- Yes No Unsure No answer

17. How many teaching staff attend annual training in the use of an EpiPen®?

- All Most Some None

18. Does your school have access to a school nurse/community health nurse for EpiPen® training purposes?

- Yes No Unsure No answer

19. Are ALL new and temporary staff provided with immediate information on children at risk of anaphylaxis, relevant action plans and emergency procedures?

- Yes No Unsure No answer

20. Are you aware of staff anaphylaxis training options available?

- Yes No Unsure No answer

Storage of the EpiPen®

21. How many students currently have an EpiPen® that is stored on site?

.....

22. How many students currently carry an EpiPen® on them at all times?

.....

Risk Minimisation Strategies

23. When or where are strategies in place to reduce the exposure of students to potential anaphylactic triggers? Please tick more than one option if appropriate

- School excursions and camps
- School canteen
- Class-room activities
- Playground/Yard
- Sporting or special event
- No strategies in place
- Unsure
- No children at risk

Awareness

24. What strategies are in place to increase awareness about severe allergies among students, parents or staff? Please tick more than one option if appropriate

- School Newsletter articles for parents
- Letters sent to parents
- Community awareness meeting
- Student education of anaphylaxis
- Student awareness programs
- Information on the staff portal
- Information at staff/parent meetings
- Posters or brochures
- No strategies in place
- Other, please detail:

.....

Final Comments

25. What strategies, resources or training would assist your school to be better equipped to deal with anaphylaxis issues?

.....

26. Additional comments or suggestions are welcome:

.....

Appendix B



Delivering a Healthy WA



Consent Form

- I have read this document and understand the aims, procedures, and risks of this project, as described within it.
- For any questions I may have had, I have taken up the invitation to ask those questions, and I am satisfied with the answers I received.
- I am willing for my school or child care service to become involved in the research project, as described.
- I understand that participation in the project is entirely voluntarily.
- I understand that my school or child care service is free to withdraw its participation at any time, without affecting the relationship with the research team.
- I understand that this research may be released online provided that the participants are not identified in any way.
- I understand that my school or child care service will be provided with a copy of the findings from this research upon its completion.

Name:

Signature:

Date: / /



Delivering a **Healthy WA**