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allergy AWARE

Best Practice Guidelines for Anaphylaxis Prevention and Management in Children's Education and Care services (including Outside School Hours Care)

ascia australasian society of clinical immunology and allergy

national allergy council

Allergy & Anaphylaxis Australia

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The National Allergy Council is a partnership between the Australasian Society of Clinical Immunology and Allergy (ASCIA) and Allergy & Anaphylaxis Australia (A&AA).

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Contents

Abbreviations and definitions

Abbreviations

A&AA	Allergy & Anaphylaxis Australia
ASCIA	Australasian Society of Clinical Immunology and Allergy
CEC	Children's education and care

Definitions

Adrenaline (epinephrine)	A medication that reverses the effects of a severe allergic reaction (anaphylaxis). Adrenaline is a hormone produced naturally by the body however, the body is not able to produce enough adrenaline to treat anaphylaxis.
Adrenaline device	Adrenaline devices contain a single, fixed dose of adrenaline, designed for use by anyone, including people who are not medically trained. The adrenaline devices currently available in Australia are Anapen®, EpiPen®, Jext® and *neffy*®. Anapen®, EpiPen® and Jext® are injector devices, and *neffy*® is a nasal spray. Adrenaline devices are either prescribed to an individual or can be purchased by the CEC service and stored in first aid kits.
Allergen	A substance, usually a protein, that causes an allergic reaction.
Allergic reaction	An immune response to something (an allergen) that is harmless to most people. Allergic reactions can be mild, moderate or severe.
Allergy aware	Implementing a range of measures to minimise the chance of a child being exposed to a known allergen.
All staff	Refers to all staff including full-time, part-time, casual and relief educators, administration staff and staff who prepare and serve food and any other staff employed by the CEC provider.
Anaphylaxis	The most severe form of allergic reaction. Anaphylaxis is life-threatening and requires prompt administration of adrenaline.

ASCIA Action Plan	A standardised anaphylaxis response plan for people with allergies that can lead to anaphylaxis (also called medical management plans). ASCIA Action Plans must be completed by the child's doctor or nurse practitioner. There are different types of plans: • ASCIA Action Plan for Anaphylaxis (red) for people who have been prescribed an adrenaline device. • ASCIA Action Plan for Allergic Reactions (green) for people with confirmed allergy but who have not been prescribed an adrenaline device. These plans are not used for aeroallergens, such as allergies to pollen or animal dander. • ASCIA Action Plan for Drug (Medication) Allergy (dark green) for people with confirmed medication allergies. If a person also has other allergies, their drug allergy will be documented on their other ASCIA Action Plan so that they only have one plan. • ASCIA First Aid Plan for Anaphylaxis (orange) for storage with general use adrenaline devices or for use as a poster.
Children at risk of anaphylaxis	Children with an ASCIA Action Plan for Anaphylaxis (red), an ASCIA Action Plan for Allergic Reactions (green) or an ASCIA Action Plan for Drug (Medication) Allergy (dark green).
Children's education and care services	All education and care services including Early Children's Education and Care (ECEC), long daycare, family daycare, outside school hours care and vacation care.
Hands-on practice	Refers to physical demonstration of correct use of adrenaline devices using a trainer device.
Individualised anaphylaxis care plan	A plan that documents the child's allergies and the risk minimisation strategies that will be put into place by the school to prevent exposure to known allergens. These care plans may have different names (such as Individual Health Care Plan, Individual Anaphylaxis Management Plan) in different states and territories; however, the purpose of the plan is the same. This plan is in addition to the ASCIA Action plan.
Jurisdictions	The different states and territories in Australia.
Oral Immunotherapy (OIT)	Oral Immunotherapy (OIT) is an emerging treatment option for food allergy. OIT treatment is designed to help a child's body get used to a specific food that usually causes an allergic reaction. Under careful medical supervision, a small, controlled amount of the food that causes the allergy (e.g. peanut) is consumed. Doses slowly increase over time until the top maintenance dose is reached.
Parents	Refers to parents and carers.

Introduction

The National Allergy Council's Best Practice Guidelines *for Anaphylaxis Prevention and Management in Children's Education and Care* (the Best Practice Guidelines) are based on the current evidence-base and best-practice. The Best Practice Guidelines were developed by the National Allergy Council in consultation with key stakeholder organisations, staff working in the children's education and care (CEC) sector and parents of children who are enrolled in CEC services.

The Best Practice Guidelines aim to provide best practice guidance and support through the provision of sample documents and templates, to reduce the risk of anaphylaxis in CEC services while supporting children to participate in the full range of CEC activities.

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

- National laws[1] exist and CEC services must comply with the national regulations[2].
- CEC services must comply with national law[1] outlining CEC standards across Australia. National regulations[2] provide practical details on how to comply with the national laws.
- Where state and territory legislation exist, CEC services must comply with the legislation in their jurisdiction.
- Where state or territory guidelines exist, CEC services are encouraged to comply with the guidelines in their jurisdiction.
- The Best Practice Guidelines may recommend measures which are additional to the legislation and/or guidelines nationally and in your state or territory and implementing these additional measures where possible, is encouraged.

The Best Practice Guidelines can be used by overarching bodies (such as state and territory Departments) when reviewing and updating their legislation, central guidelines, policies and procedures, to standardise anaphylaxis management across Australia. The Best Practice Guidelines can also be used by individual CEC services to identify appropriate strategies to prevent and manage anaphylaxis.

The Best Practice Guidelines help prevent and manage anaphylaxis in children, however CEC services should also have strategies in place for staff, volunteers and visitors with allergies.

The 2026 update to the Best Practice Guidelines includes:

- guidance about the use of new adrenaline devices available in Australia.
- information on how to conduct an anaphylaxis drill.
- information and tools to assist services with risk assessment when planning events and excursions.
- a recommendation that children on oral immunotherapy treatment for food allergy have this documented on their individualised anaphylaxis care plan.

Recommendations related to requirements for staff members responsible for making and serving food to complete *All about Allergens Food Allergen Management training for CEC Food Service* have been strengthened. This is because knowing how to avoid exposure to known food allergen is important to manage risk for food-related anaphylaxis.

1 *Education and Care Services National Law Act 2010*
2 *Education and Care Services National Regulations 2011*

About this document

This document has been developed in two parts:

Part A
Includes the key principles for reducing the risk of anaphylaxis in CEC settings and Best Practice Guidelines recommendations.

Part B
Is an Implementation Guide which contains additional information to help CEC services to implement the Best Practice Guidelines recommendations. Resources, templates and sample documents are also provided to support the adoption of the recommendations. These resources are available as free downloads from the National Allergy Council's Allergy Aware website. The Allergy Aware website is a resource hub that includes links to evidence based resources for CEC services to help manage anaphylaxis. The website also contains links to state and territory specific information and resources.

How were these guidelines developed?

These guidelines were developed after reviewing current published literature about managing allergies and anaphylaxis in the CEC setting. Where published literature was lacking, the Best Practice Guidelines include recommendations based on what is considered best practice. During the development and review of the Best Practice Guidelines the National Allergy Council engaged with bodies overseeing children's education and care, CEC auditors, state and territory education departments, the Australian Children's Education & Care Quality Authority (ACECQA), CEC services and consumers.

Key principles for reducing the risk of anaphylaxis

Implement an allergy aware approach to preventing and managing anaphylaxis.

Have an anaphylaxis management policy. Review this policy and associated procedures if an allergic reaction occurs.

Obtain up-to-date medical information and develop individualised anaphylaxis care plans for each child at risk of anaphylaxis. These plans will include a copy of the child's ASCIA Action Plan.

Educate and train staff in the prevention, recognition and treatment of allergic reactions including anaphylaxis. Educate and train staff who prepare, serve or supervise meals, in food allergen management.

Ensure staff know which children are at risk of allergic reactions and understand that unexpected allergic reactions, including anaphylaxis, might occur for the first time in children not previously known to have allergy.

Provide age-appropriate education of children to help raise awareness and manage anaphylaxis risk in CEC services.

Implement reasonable and effective strategies to reduce the risk of accidental exposure to known allergic triggers and review anaphylaxis risk minimisation strategies if an allergic reaction occurs.

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

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

Offer support (including counselling) for CEC staff who manage an anaphylaxis.

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

Part A:

Recommendations

Allergy aware approach

1.1 CEC services should implement an allergy aware approach to the prevention and management of anaphylaxis.

An allergy aware approach is recommended rather than implementing food bans. Banning foods, and use of terms such as 'nut free' is not an effective strategy for preventing or managing anaphylaxis in CEC services.

Planning and implementing an allergy aware approach should be in line with requirements under the National Regulations and should be documented as part of the CEC service's policies and procedures.

See Implementation guide page 30

Anaphylaxis management policy and plans

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

- **Identifying children at risk.**
- **Allergy documentation.**
- **Prescribed and general use adrenaline devices.**
- **Staff and volunteer education and training.**
- **Risk management and risk minimisation.**
- **Communication plan.**
- **Education for children and the CEC community.**
- **Emergency response plan.**
- **Self-administration of medication (where the child is developmentally ready).**
- **Incident reporting.**

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

This recommendation is consistent with:

National Regulation 90: Medical conditions policy.

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

2.2 CEC providers should develop anaphylaxis risk management plans that are specific to the CEC site, activity or off-site activity (for example, excursions).

Risk management plans for children with food allergy should include detailed information about food and drink provision at the activity. This includes plans for food on the way to and from the activity. Food service providers for any offsite activity will require accurate information about children and staff with food allergies.

This recommendation is consistent with:

National Regulation 101: Conduct of risk assessment for excursion.

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

National Regulation 170: Policies and procedures to be followed.

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

Recommendation 2

2.3 CEC providers should implement reasonable risk minimisation strategies if the CEC provider has children with known allergies enrolled.

Risk minimisation strategies (such as hand washing and mealtime supervision) aim to reduce the chance of accidental exposure to an allergen.

CEC providers should access evidence based, best practice information when identifying and implementing appropriate risk minimisation strategies as detailed in Part B in the Implementation Guide.

This recommendation is consistent with:

National Regulation 101: Conduct of risk assessment for excursion.

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

CEC providers should clearly communicate an allergy aware approach.

This recommendation is consistent with:

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

2.5 CEC providers should develop site and activity specific (for example, excursions) anaphylaxis emergency response plans which includes the ASCIA Action Plan and identifies staff roles and responsibilities in an anaphylaxis emergency. Emergency response plans should be practised at least once a year.

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

This recommendation is consistent with:

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

National Regulation 170: Policies and procedures to be followed.

See Implementation guide page 33

Allergy documentation

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

There is no need to update the ASCIA Action plan at the beginning of each year. If there is no change in the child's allergy, the plan should be updated by the date specified by the child's doctor or nurse practitioner on the current plan. This usually occurs every 12-18 months when they are reviewed by their doctor and receive an updated adrenaline device prescription.

This recommendation is consistent with:

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

3.2 CEC providers should take all reasonable efforts to obtain a copy of the child's ASCIA Action Plan from the child's parents. The ASCIA Action Plan provides medical confirmation of the child's allergies.

CEC providers should request colour copies of the child's ASCIA Action Plan where possible. However, if the parent is unable to provide a colour copy, a black and white copy of the child's ASCIA Action Plan is acceptable.

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

This recommendation is consistent with:

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

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

Recommendation 3

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

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

If a child has medical confirmation that they no longer have allergies requiring an ASCIA Action Plan, the child's doctor or allergy clinic should provide a letter confirming that the child is no longer allergic.

This recommendation is consistent with:

National Regulation 90 (c) (iv): requiring the development of a communications plan to ensure that (B) a child's parent can communicate any changes to a medical management plan and risk minimisation plan for the child, setting out how that communication can occur.

3.4 An individualised anaphylaxis care plan should be completed by the CEC provider for all children with an ASCIA Action Plan for Anaphylaxis or an ASCIA Action Plan for Allergic Reactions in consultation with the child's parent.

Individualised anaphylaxis care plans should:

- **be completed as soon as the child starts at the CEC or when the CEC provider is informed about the child's allergies.**
- **be reviewed at the start of each calendar year and updated if the CEC is informed about changes to the child's allergies.**
- **include a copy of the child's current ASCIA Action Plan.**
- **indicate if the child is undergoing a medical treatment program for food allergy (oral immunotherapy (OIT) or desensitisation).**
- **include appropriate risk minimisation strategies that will be implemented to manage the child's allergies for both on-site and off-site activities including events and excursions.**
- **be agreed to and signed by a parent.**

Note: The child's doctor does not have to sign the individualised anaphylaxis care plan – this is a plan for the CEC service to complete in consultation with the parent and therefore should be signed by the CEC and the parent.

Children with an ASCIA Action Plan for Drug (medication) Allergy and no other severe allergy are not usually prescribed an adrenaline device.

In the CEC setting the individualised anaphylaxis care plan template is designed to help meet the requirements (as per National Regulations) of a risk minimisation plan.

The anaphylaxis care plan and ASCIA Action plan together complete the CEC requirements under the National Regulations when planning for the health and medical needs of individual children.

This recommendation is consistent with:

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

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

Recommendation 3

3.5 The child's individualised anaphylaxis care plan must be reviewed and updated:

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

If medical confirmation has been provided that a child no longer has a food allergy or an allergy where there is a risk of anaphylaxis (that is, they no longer have an ASCIA Action Plan), the CEC service is no longer required to have an individualised care plan specifically for anaphylaxis management for that child. However, the child may have other health care needs that require an individualised care plan.

This recommendation is consistent with:

National Regulation 85: Incident, injury, trauma and illness policies and procedures.

National Regulation 90 (c) (iv): requiring the development of a communications plan to ensure that (B) a child's parent can communicate any changes to a medical management plan and risk minimisation plan for the child, setting out how that communication can occur.

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

3.6 **Documentation for off-site activities:**

Hard copies of individual children's ASCIA Action plans must be kept with their adrenaline devices and/or other medication for treating an allergic reaction and be taken on all off-site activities.

Individualised anaphylaxis care plans should include risk minimisation strategies for off-site activities. This will help planning for events during the year.

For catered activities:

- **Accurate information about food allergies (child's names and their food allergies) must be provided within the required timeframe specified by the food service provider and no later than two weeks prior to the activity.**
- **A copy of the child's ASCIA Action Plans should also be provided with parental consent.**
- **Food service providers should acknowledge receipt of the information.**
- **The service, the parent and food service provider should liaise prior to the activity about food provision. Services should provide parents with the food service provider's contact details to enable this.**
- **All food allergies must be taken seriously regardless of the type of ASCIA Action Plan.**

Off-site activities include events (such as picnics, grandparent's day), excursions and sporting activities. These activities require additional checks as they differ to usual routines. Services should use the ACECQA Risk Assessment and Management Tool in addition to the allergy related documentation and follow any additional state or territory policies where they exist.

This recommendation is consistent with:

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

See Implementation guide page 40

Emergency response

4.1 The CEC service must be prepared to respond appropriately to an anaphylaxis emergency, even for children not previously identified as being at risk of anaphylaxis.

If any child is showing signs and symptoms of an allergic reaction, CEC staff should immediately follow the child's ASCIA Action Plan (if they are known to have allergies) or the ASCIA First Aid Plan for Anaphylaxis (for other children), positioning the child appropriately and administering an adrenaline device if required.

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

For children not previously identified as being at risk of anaphylaxis, staff should immediately administer the CEC service's general use adrenaline device and follow the ASCIA First Aid Plan for Anaphylaxis.

CEC staff do not require consent from a parent/carer before administering adrenaline for anaphylaxis.

This recommendation is consistent with:

National Regulation 85: Incident, injury, trauma and illness policies and procedures.

National Regulations Division 4 Regulations 92 – 96: Administration of Medication.

Regulation 94: Exception to authorisation requirement—anaphylaxis or asthma emergency (1) Despite regulation 93, medication may be administered to a child without an authorisation in case of an anaphylaxis or asthma emergency.

4.2 **The ASCIA Action Plan or ASCIA First Aid Plan should be followed in response to an anaphylaxis. After an adrenaline device has been administered, the child should stay in position as per the ASCIA Action Plan and an ambulance (where available) should be called to transport the child to hospital for medical monitoring (Consistent with National Regulation 94).**

Until the ambulance arrives the child must not be allowed to stand or walk (even if they appear well) and should lay flat or sit with legs outstretched (for example, on the floor) if breathing is difficult.

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

Where an ambulance is not available, staff should follow the directions of the ambulance service. If the child needs to be transported to a health care service, they must be taken to the vehicle without being allowed to stand, walk or being carried in an upright position, even if they appear to be well.

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

This recommendation is consistent with:

National Regulations Division 4 Regulations 92 – 96: Administration of medication.

National Regulation 99: Children leaving the education and care service premises

Recommendation 4

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

An adrenaline device and a copy of their ASCIA Action Plan should be made available to CEC staff for any excursion or off-site activity.

The CEC service's access to a prescribed adrenaline device may include a child over preschool age carrying their own adrenaline device to and from the CEC service (for example, outside school hours care, vacation care). This is dependent on the child and their ability to manage their own medication. Procedures need to be in place to ensure the adrenaline device is with the child when they arrive at the CEC service.

CEC services should allow parents to collect their child's prescribed device (if they leave it with the service) when the child is not in the care of the CEC service, such as weekends or during holidays.

This recommendation is consistent with:

National Regulation 90: Medical conditions policy

National Regulation 95: Procedure for administration of medication.

National Regulation 96: Self-administration of medication.

National Regulation 101: Conduct risk assessment for excursion.

4.4 CEC providers should have at least one general use adrenaline device. A copy of the ASCIA First Aid Plan for Anaphylaxis with the correct instructions for the general use adrenaline device must be stored with the general use device.

CEC providers should have at least one general use adrenaline device with a risk assessment undertaken to determine if additional devices are required. The device required (150 microgram or 300 microgram, or equivalent) will depend on the age of the children being cared for.

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

CEC providers should have a general use adrenaline device even when the service does not have a child at risk of anaphylaxis enrolled.

This recommendation is consistent with:

National Regulation 89: First aid kits.

National Regulation 95: Procedure for administration of medication.

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

This should be risk assessed to determine if additional devices may be required.

This recommendation is consistent with:

National Regulation 89: First aid kits.

National Regulation 90: Medical conditions policy.

National Regulation 100: Risk assessment must be conducted before excursion.

National Regulation 101: Conduct of risk assessment for excursion.

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

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

This recommendation is consistent with:

National Regulation 89: First aid kits.

National Regulation 90: Medical conditions policy.

4.7 A process should be in place to regularly check (at least every 3 months) the expiry date of all adrenaline devices (general use and prescribed) in the CEC service.

The devices should be replaced if they are out of date. Injectable devices (Anapen®, EpiPen® and Jext®) should be replaced if there is any sign of discolouration and sediment.

This recommendation is consistent with:

National Regulation 90: Medical conditions policy.

National Regulation 95: Procedure for administration of medication.

See Implementation guide page 44

Staff training

5.1 All staff should undertake anaphylaxis training at least every two years. This training must include preventing exposure to known allergens, and how to recognise and respond to an allergic reaction including anaphylaxis.

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

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

This recommendation is consistent with:

National Regulation 136: First aid qualifications.

5.2 Anaphylaxis training should:

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

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

This recommendation is consistent with:

National Regulation 136: First aid qualifications.

5.3 Anaphylaxis refresher training, including hands on practice with adrenaline device trainers should be undertaken at least twice a year.

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

In some states/territories, school or community nurses support schools and CEC services and may be able to assist with adrenaline device training.

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

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

This recommendation is consistent with:

National regulation 145: Staff record.

National Regulation 153: Register of family day care educators, co-ordinators and educator assistants.

Recommendation 5

5.5 **The National Allergy Council's *All about Allergens: Training for Food Service in CEC* online course:**

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

This recommendation is consistent with:

National Regulation 136: First aid qualifications.

Consistent with National Regulation 145: Staff record.

Consistent with National Regulation 153: Register of family day care educators, co-ordinators and educator assistants (k) evidence of any other training completed by the educator.

See Implementation guide page 50

Education for children and the CEC community

6.1 CEC providers should communicate with their CEC community about food allergy and anaphylaxis at least annually, ideally at the beginning of each calendar year or when enrolments, health plans, medical conditions or allergies being managed by the service change.

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

Communications with the CEC community should promote an allergy aware approach.

This recommendation is consistent with:

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

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

National Regulation 170: Policies and procedures to be followed.

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

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

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

This recommendation is consistent with

National Regulation 173: Prescribed information to be displayed (f) if applicable (i) or (ii) ...a notice stating that a child who has been diagnosed as at risk of anaphylaxis is enrolled at the service.

Recommendation 6

6.3 CEC providers should implement age-appropriate education programs for children.

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

A key component of this education includes children not sharing food, drink bottles and eating utensils, including food prepared in cooking activities.

See Implementation guide page 53

Post incident management and incident reporting

7.1 All allergic reactions (where there is a risk of anaphylaxis) should be notified to the Regulatory Authority by the approved provider. This can be done through the National Quality Agenda IT System (NQAITS) online reporting system and should be undertaken within 24 hours of the incident.

Documentation about the incident should include adequate details about the circumstances and the management of the reaction (see incident reporting checklist).

Allergic reactions to a packaged food that does not list the child's food allergen, or food provided by a food service provider after the allergy has been declared, should be reported to the local Health Department.

This recommendation is consistent with:

National Regulation 87: Incident, injury, trauma and illness record.

National Regulation 174: Time to notify certain circumstances to Regulatory Authority.

National Regulation 176: Time to notify certain information to Regulatory Authority.

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

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

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

This recommendation is consistent with:

National Regulation 87: Incident, injury, trauma and illness record.

Recommendation 7

7.3 When an incident occurs in an CEC service, support (for example, counselling) should be provided to staff where required.

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

This recommendation is consistent with:

National Regulation 87: Incident, injury, trauma and illness record.

7.4 Nationally standardised information about incidents should be collected at the state and territory level and collated into a national data pool. This will allow identification of common areas of risk, to inform risk minimisation strategies and policy.

This recommendation is consistent with:

National Regulation 87: Incident, injury, trauma and illness record.

See Implementation guide page 55

Part B:

Implementation Guide

The Implementation Guide provides more detailed information related to each recommendation in the Best Practice Guidelines to support their adoption and provides links to relevant resources including templates and sample documents. These resources are available as free downloads from the National Allergy Council's Allergy Aware website.

Allergy aware approach

Being allergy aware means implementing a range of measures to minimise the chance of a child being exposed to a known allergen. These measures include:

- Knowing which children are at risk of anaphylaxis.
- Knowing what allergies need to be managed in your CEC service.
- Working with parents of children at risk of anaphylaxis to identify appropriate risk minimisation strategies for their child.
- Completing a risk management plan for the CEC service including risk management plans for all off-site activities.
- Implementing appropriate strategies to minimise the risks identified. Some risk minimisation strategies include hand washing, procedures at meal and snack times to ensure that children with allergies get the right food, supervision of children at meal and snack times, use of allergen restricted areas, and not sharing food and drinks or drink bottles.
- Ensuring all staff have undergone anaphylaxis training including hands-on practice with adrenaline trainer devices.
- Ensuring all staff and volunteers responsible for preparing and serving food have undertaken *All about Allergens for CEC* online food allergen management training.
- Communicating with your CEC community about how your CEC service manages the risk of anaphylaxis and how they can help support the CEC service's approach.
- Communicating with parents of children with food allergies about any CEC activities that involve food.
- Informing children about allergies and how they can help to keep their friends and peers safe. This includes teaching children to not share food or drinks and washing their hands after they eat.

'Allergy aware' vs 'allergen free'

An allergy aware approach is recommended rather than implementing food bans.

- It is NOT recommended that CEC services 'ban' food and as such CEC services should not claim to be free of any allergen. Claiming to be 'nut free' or 'banning peanuts' for example gives staff, and families a false sense of security. Children can be allergic to a wide range of foods and cow's milk, egg, wheat or sesame allergies (for example) are just as serious as having a peanut or tree nut allergy.
- Some CEC services do not include peanuts and tree nuts in their menus as these are not essential foods and can easily be eaten at home. Foods such as wheat, cow's milk (dairy), egg and soy are staple foods providing important nutrition and therefore cannot be removed in CEC services. Instead, allergen-restricted areas may be implemented if required (see below for more information).

Supervision of meals and snacks

- Children with food allergy should be supported to engage with their peers and be included in mealtime routines and interactions. All young children and children with developmental delay or other issues that limit their ability to manage their own food allergies should be supervised at meal and snack times.

Allergen restricted areas

- Allergen restricted areas may be used to reduce the risk for children with allergies. Examples of allergen restricted areas include using a separate highchair for a young child with allergies (cleaned thoroughly after each use) or seating children eating messy egg meals, grated cheese or drinking milk or infant formula away from children with egg or milk (dairy) allergies. However, steps should be taken to avoid isolating children from their peers.

Hygiene practices

- The CEC services should have procedures in place for educators to support children to participate in personal hygiene practices such as handwashing to prevent contamination or spread of food residue on shared resources and equipment.

Water bottles

- Water bottles belonging to children with food allergy should be kept in a separate location (for example in an open shelf with the child's backpack) to reduce the chance of other children drinking from them.

Infant formula and other drinks

- The CEC service should have procedures in place to ensure that infants and children with allergies to cow's milk or soy are always given the correct formula or milk substitute.
- Children's education and care services should have a process for storing and labelling infant formula, including when supplied by parents.
- Formula for children with milk allergy should be made first, before making up formula that contains cow's milk or goat's milk.
- Formula tins and formula bottles should be labelled clearly with the child's name (and their allergy if they have one) to make sure the right milk is given to the right child.
- Care must be taken to make sure there is no cross contamination from one infant formula to another, when preparing infant formulas. All formula should be made up using the scoop belonging to that formula tin.

Food based activities

- Cooking and craft activities should be carefully planned to make sure they do not include the child's allergen.

Food service

- The food service provider (employed staff or external provider) may choose to remove peanuts and tree nuts from the menu to minimise the risk of accidental exposure through errors or cross contamination. As peanuts and tree nuts are not staple foods providing essential nutrients, this is a reasonable strategy to implement. Other common allergens such as milk (dairy), wheat containing products (such as bread) and eggs, are staple foods providing essential nutrients and it is not recommended that these foods are removed from the menu.
- Where the CEC service does not provide meals and parents provide food for their children, it is reasonable for the CEC service to request that food provided by parents does not contain peanuts or tree nuts as an ingredient.
- The CEC service should have procedures at meal and snack times to ensure that children with allergies get the right food. These may include coloured plates for children with allergies and checking of meals and snacks by two staff before giving the food to the child.

Resources

- → Examples of how to reduce the risk of allergic reactions for CEC services
- → All about Allergens for CEC online food allergen management training
- → Managing Food Allergies in Children's Education and Care Kitchen Handbook
- → What does it mean to be an Allergy aware CEC service?
- → How can families support Allergy aware CEC services?

Policy

- Policies help to guide practice and make sure that everyone understands how the CEC service plans to manage allergy. An anaphylaxis policy needs to address all issues outlined in Recommendation 2 'Anaphylaxis Management Policy and Plans'.
- In addition, the policy should:
  - Be reviewed and updated at least every two years to make sure that it still meets the needs of the children in the CEC service.
  - Be site specific to make sure it is appropriate for each individual CEC service.
- This policy must also comply with Regulations 90, 92, 162(c)(i) and 168(d) of the Education and Care Services National Regulations (the National Regulations).

Resources

→ Sample anaphylaxis management policy for CEC

Anaphylaxis risk management plan

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

Resources

→ ACECQA Risk Assessment and Management Tool

→ Anaphylaxis risk management plan template for CEC

Anaphylaxis risk management plans for off-site activities

A risk management plan including risk minimisation strategies specific to anaphylaxis must be developed for all off-site activities including events, excursions and sporting activities. The risk management plan for the activity will vary, depending on the location, duration of the activity, age of the children and their allergies.

The risk management plan should include:

- Names of children and staff at risk of anaphylaxis.
- Allergies that need to be managed.
- Communication strategy (internal and with parents).
- Mobile phone connectivity or coverage.
- Access to ambulance services/medical care.
- Staff education and training (first aid, anaphylaxis, food allergen management).
- Medication management (including expiry date checks).
- Management of prescribed adrenaline devices.
- Number of general use adrenaline devices.
- Food provision.
- Policy regarding taking food/sharing food.
- Type of activities to be undertaken.
- Emergency response.

The Anaphylaxis checklist: Preparing for off-site activities (events, excursions, sporting activities) has been designed to help develop risk management plans with risk minimisation strategies specific to anaphylaxis for off-site activities. Services should also use the ACECQA risk assessment and management tool for excursions to add to the anaphylaxis checklist, ensuring it remains relevant to the context of their service.

Resources

- → ACECQA Risk Assessment and Management Tool
- → Anaphylaxis risk management plan template for CEC
- → Anaphylaxis checklist for CEC services: Preparing for off-site activities (events, excursions, sporting activities)
- → Examples of how to reduce the risk of allergic reactions in CEC
- → All about Allergens for CEC online food allergen management training
- → All about Allergens for CEC Kitchen Handbook

Anaphylaxis risk minimisation strategies

- While it is not possible to completely remove the risk of a child having an allergic reaction while in the care of a CEC service, it is possible to reduce the risk using appropriate risk minimisation strategies. Therefore, it is important for CEC services to implement appropriate risk minimisation strategies for known allergens.
- Several site-specific factors (such as the age and number of children and the activities undertaken in the CEC service), will determine which risk minimisation strategies should be put into place.
- A whole of CEC service approach to anaphylaxis risk minimisation is recommended and many of these risk minimisation strategies adopted by the CEC service will also be included in the individualised anaphylaxis care plans for children with known allergies who attend the CEC service.
- Offsite activities and special events including excursions require special attention. Risk minimisation strategies should be discussed with parents of children at risk of anaphylaxis and the child if age appropriate when planning the activity.
- Risk minimisation strategies for children with food allergy should include clearly documented plans for the provision of meals, snacks and drinks for the entire time the children are off-site.
- ASCIA and A&AA, as the peak medical and patient support allergy bodies in Australia, have developed a list of appropriate risk minimisation strategies.
- The anaphylaxis checklist on page 68 is designed to assist services develop risk minimisation strategies when planning off-site activities.

Resources

→ Examples of anaphylaxis risk minimisation strategies for CEC

→ Anaphylaxis checklist (CEC): Preparing for off-site activities (events, excursions, sporting activities)

Communication plan

- A communication plan outlines how the CEC service intends to communicate with staff, volunteers, children (where appropriate), parents and the broader CEC community about allergies.
- An allergy aware approach is recommended rather than focusing on banning specific food allergens. See Recommendation 1 Allergy aware approach for more information.

Staff, including casual staff and volunteers

- All staff need be aware of children at risk of anaphylaxis, what they are allergic to, and any changes to their allergies to manage risk.
- Inform staff who may not have been included in anaphylaxis training such as cleaners and grounds maintenance staff, about how the CEC service manages allergies and what role they have.

Parents of children with allergies

- Plan how you will inform parents of children with allergies about food provided and activities they will engage in, include any special activities such as incursions and off-site activities.
- Document in the child's individual anaphylaxis care plan how the parent would prefer this communication to occur (for example phone call, in person communication, email).

CEC community

- Plan when and how CEC will communicate with the wider community (for example in enrolment pack, newsletters, email reminders at set times during the year (see Education and the CEC community education information and resources).

Children

- Ensure any education about allergies is Australian, age appropriate and evidence based.

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

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

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

Resources

- → Allergy & Anaphylaxis Australia Jeremy book series for younger children
- → National Allergy Council – Template for sign complying with National Regulation 173(2)f
- → What does it mean to be an allergy aware children's education and care service?
- → How can families support allergy aware children's education and care (CEC) services?

Site specific anaphylaxis emergency response plan

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

Resources

→ National Allergy Council Anaphylaxis Drill Checklist

→ Anaphylaxis Drill Scenarios

Anaphylaxis drills

What is an anaphylaxis drill?

- An anaphylaxis drill is an opportunity to practice a real-life scenario of a person experiencing anaphylaxis. The scenario may relate to a child, student, staff member or visitor.
- When conducting an anaphylaxis drill, staff can practise the service's incident response including delineation of staff roles needed during an incident.
- An anaphylaxis drill gives an opportunity to practice first aid management of anaphylaxis including
  - following an ASCIA Action Plan.
  - correctly positioning the person having anaphylaxis.
  - procedures for raising the alarm.
  - locating and using an adrenaline device (trainer device).
  - calling emergency services (simulation).

Why hold an anaphylaxis drill?

- Conducting an anaphylaxis drill allows your service to practice your incident response plan for anaphylaxis to make sure that all the necessary steps have been thought about and included. This allows for improvements or changes to be made if necessary.
- Regular anaphylaxis drills help staff to know how to act in real life situations. People can forget what to do in an emergency.

How often should your service run an anaphylaxis drill?

- Anaphylaxis drills should be held every year.
- If services have different sites, it is recommended that drills are conducted at each site.

How do you run an anaphylaxis drill?

- Example scenarios to use during an anaphylaxis drill are included on page 67.
- Use the Anaphylaxis Drill checklist (page 64) to keep a record of the drill, and to identify areas for improvement.
- Schedule anaphylaxis drills to occur at different times during the day.
- Reflection after the drill is important to identify what went well, any gaps and points for improvement, and any additional training requirements.

Resources

- National Allergy Council Anaphylaxis Drill Checklist
- Anaphylaxis Drill Scenarios
- National Allergy Council animation on positioning
- A&AA How to use an anaphylaxis device animations series
- A&AA animation: Signs and Symptoms of Allergic Reactions
- ASCIA Anaphylaxis Resources

Allergy documentation

Allergy documentation is required to help CEC services prevent and manage the risk of anaphylaxis. ASCIA Action Plans are important as they provide medical confirmation of children's allergies and risk of anaphylaxis, and they support the development of individualised anaphylaxis care plans.

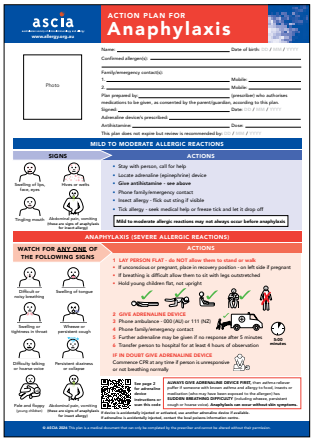
ASCIA Action Plans and individualised anaphylaxis care plans are different.

- ASCIA Action Plans are completed by the child's prescribing practitioner and provide guidance on when and how to respond to an allergic reaction including anaphylaxis.
- Individualised anaphylaxis care plans include information about what risk minimisation strategies the service will put in place for each individual child at risk of anaphylaxis. The individualised anaphylaxis care plans are developed by the education and care service in consultation with parents (and child if appropriate), not by the child's doctor.

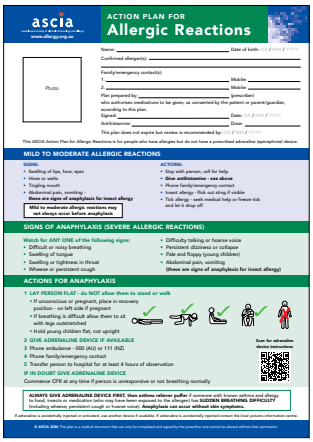
Additional information about ASCIA Action Plans and individualised anaphylaxis care plans is provided below.

ASCIA Action Plans

- Provide medical confirmation of allergies.
- Provide guidance on how to respond to an allergic reaction.
- Are completed by a doctor or nurse practitioner.
- Do not expire, but should be updated when allergies change.
- Do not need to be completed and signed each year.


ascia
ACTION PLAN FOR
Anaphylaxis
MILD TO MODERATE ALLERGIC REACTIONS
SIGNS
ACTIONS
ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS
ACTIONS

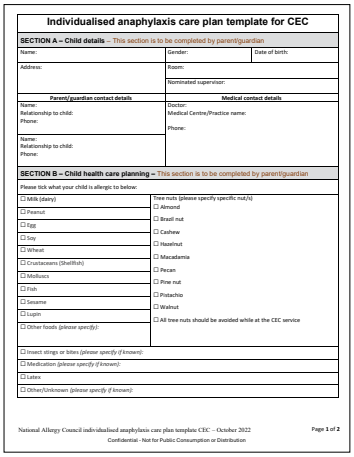
OR


ascia
ACTION PLAN FOR
Allergic Reactions
MILD TO MODERATE ALLERGIC REACTIONS
SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)
ACTIONS FOR ANAPHYLAXIS

Individualised Anaphylaxis Care Plan for Children's Education and Care Services

- Required for children with an ASCIA Action Plan for Anaphylaxis or ASCIA Action Plan for Allergic Reactions.
- A copy of the ASCIA Action Plan should be attached to the individualised anaphylaxis care plan.
- Outlines risk minimisation strategies that the CEC service will put in place to reduce the risk of an allergic reaction.
- Completed by CEC service with parents.
- Should be reviewed each year.

PLUS


Individualised anaphylaxis care plan template for CEC
SECTION A – Child details – This section is to be completed by parent/guardian
SECTION B – Child health care planning – This section is to be completed by parent/guardian
National Allergy Council individualised anaphylaxis care plan template CEC – October 2022
Confidential - Not for Public Consumption or Distribution

ASCIA Action Plans

There are different types of ASCIA Action Plans (see Figure 1, page 42)

- Parents of children with an ASCIA Action Plan must provide the education and care service with the most recent version of their child's ASCIA Action Plan.
- If no updated plan is available, the most recent ASCIA Action Plan can still be used but parents must see a doctor or nurse practitioner to update the ASCIA Action Plan as soon as possible.
- ASCIA Action Plans do not expire, and therefore the plan is still valid beyond the date of review, which is a guide for patients to see their doctor or nurse practitioner.
- Allergies to grasses, dust mite or mould do not require an ASCIA Action Plan or individualised anaphylaxis care plan as allergic reactions to these allergens do not result in anaphylaxis. However, medical information from parents is still required and a risk minimisation plan will need to be developed with the CEC service.
- Children can 'outgrow' allergies. If a child has had medical confirmation that they no longer have allergies, a letter of confirmation from the child's treating doctor or nurse practitioner should be provided to the CEC service. Once the CEC service has received a letter from the doctor or nurse practitioner stating that the child is no longer has allergies, the CEC service does not need to provide an individualised anaphylaxis care plan.

Resources

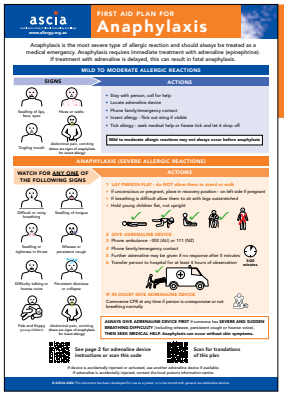
→ ASCIA Action Plans

→ ASCIA Action Plans FAQs

Allergy documentation

Figure 1 ASCIA Action Plans

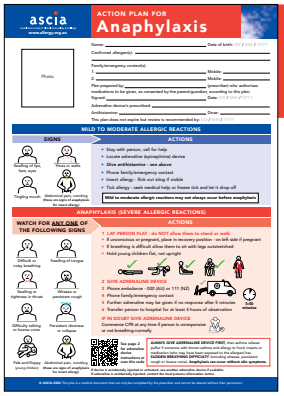
First Aid Plan for Anaphylaxis



ASCIA First Aid Plan for Anaphylaxis (orange)

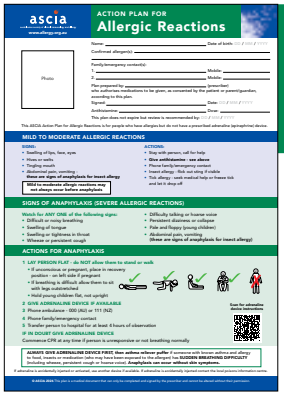
To be stored with general use adrenaline devices and used as a poster.

Action Plans for Individuals



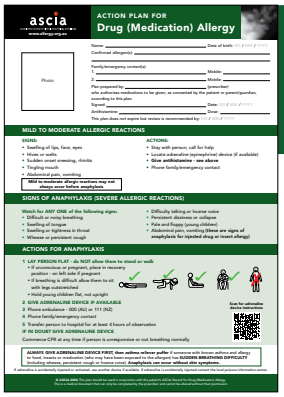
ASCIA Action Plan for Anaphylaxis (red)

For people with allergies prescribed an adrenaline device (Anapen®, EpiPen®, Jext® or neffy®).



ASCIA Action Plan for Allergic Reactions (green)

For people with known food, insect, or latex allergies who have not been prescribed an adrenaline device.



ASCIA Action Plan for Drug (medication) Allergy (dark green)

For people with medication allergy. People with this ASCIA Action Plan are not usually prescribed an adrenaline device.

Individualised anaphylaxis care plans

- Individualised anaphylaxis care plans are different documents to the ASCIA Action Plans.
- Children with an ASCIA Action Plan (red or green) should have an individualised anaphylaxis care plan. These plans may have a different name in different states and territories. Regardless of the name of the plan, the purpose is the same.
- The purpose of the individualised anaphylaxis care plan is to document the child's allergies, and the risk minimisation strategies that will be put into place to prevent exposure to known allergens, who is responsible for implementing these strategies, and information about where the child's adrenaline device (and any other medication) will be stored.
- A copy of the child's ASCIA Action Plan should be attached to the individualised anaphylaxis care plan.
- The child's ASCIA Action Plan must be followed if the child has an allergic reaction.
- Individualised anaphylaxis care plans must be updated at the start of each calendar year, when allergies change and when exposure to a known allergen occurs while attending the CEC service.
- Individualised anaphylaxis care plans must be developed in consultation with, and signed by, parents.
- Appropriate risk minimisation strategies to be implemented should be documented and should be considered within a whole of CEC service approach to anaphylaxis management.
- Children undergoing medical treatment programs for food allergy (oral immunotherapy (OIT) or desensitisation) are at greater risk of anaphylaxis. Parents should notify education and care services if their child is having OIT and provide written risk minimisation strategies from their allergy specialist.
- Children who do not have an ASCIA Action Plan and children with an ASCIA Action Plan for Drug (Medication) Allergy do not need an individualised anaphylaxis care plan.
- To help collect information about the child's food allergy that can help the cook or chef to provide appropriate meals, a food allergy record template has been developed.
- If medical confirmation has been provided that a child no longer has any allergies where there is a risk of anaphylaxis (that is, they no longer have an ASCIA Action Plan), the service is no longer required to have an individualised care plan specifically for anaphylaxis management for that child. The child may have other health care needs and may however, require an individualised care plan relating to those health needs.

Resources

→ Individualised anaphylaxis care plan template

→ Food allergy record template

→ ASCIA FAQs: Oral Immunotherapy for Food Allergy

Adrenaline

- Adrenaline is the first line treatment for anaphylaxis.
- Staff should follow emergency response procedures to make sure the child receives adrenaline as quickly as possible.
- When responding to an allergic reaction, the following principles should be followed:
  - The ASCIA Action Plan should be followed to guide staff as to when and how to give the adrenaline device.
  - All staff should be trained to follow the ASCIA Action Plan and give the adrenaline device.
  - Staff should ALWAYS be prepared to administer an adrenaline device in an anaphylaxis emergency.
  - Staff do not need permission from a parent before giving adrenaline.
  - No child experiencing anaphylaxis should be expected to be fully responsible for self-administration of an adrenaline device as they may be too unwell and/or have poor judgement during such an emergency.
  - Children who are having anaphylaxis may have asthma-like symptoms without other signs such as rash or swelling. **If a child with asthma and a known allergy has sudden severe breathing difficulty, staff should follow the ASCIA Action Plan and treat for anaphylaxis first, rather than asthma.**
  - If in doubt, administer the adrenaline device FIRST and then other medication as indicated on the ASCIA Action Plan. Antihistamines, corticosteroids and asthma medicines are not suitable alternatives to adrenaline for treating anaphylaxis.
- After an adrenaline device has been given, an ambulance must be called to transport the child to hospital for medical monitoring.
- Once a child's adrenaline device has been used, it must be replaced by the parents as soon as possible.
- If a general use adrenaline device has been used, this must be replaced by the CEC provider immediately.

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

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

Regulation 94 - Exception to authorisation requirement—anaphylaxis or asthma emergency.

Resources

→ A&AA How to use an anaphylaxis device animation series

→ ASCIA adrenaline device FAQs

Positioning and further monitoring

- Staff should make sure the child experiencing anaphylaxis is lying down or sitting with legs out flat and is not upright (not sitting in a chair, not held in an upright position if a baby or young child, and not standing or walking). This can potentially save their life.
- If the child has low blood pressure due to anaphylaxis, they could collapse if allowed to sit up in a chair, stand or walk, and may not be able to be resuscitated.
- Therefore, paramedics must stretcher the child to the ambulance (they must not stand or walk) even if they appear to have recovered. If the child will not lay on a stretcher they could sit with an accompanying adult or be carried laying flat.
- The child needs medical monitoring for at least 4 hours in case they have a biphasic reaction, and their anaphylaxis symptoms return. Therefore, they must be transported by ambulance (where possible) to a hospital (or medical facility).

Resources

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

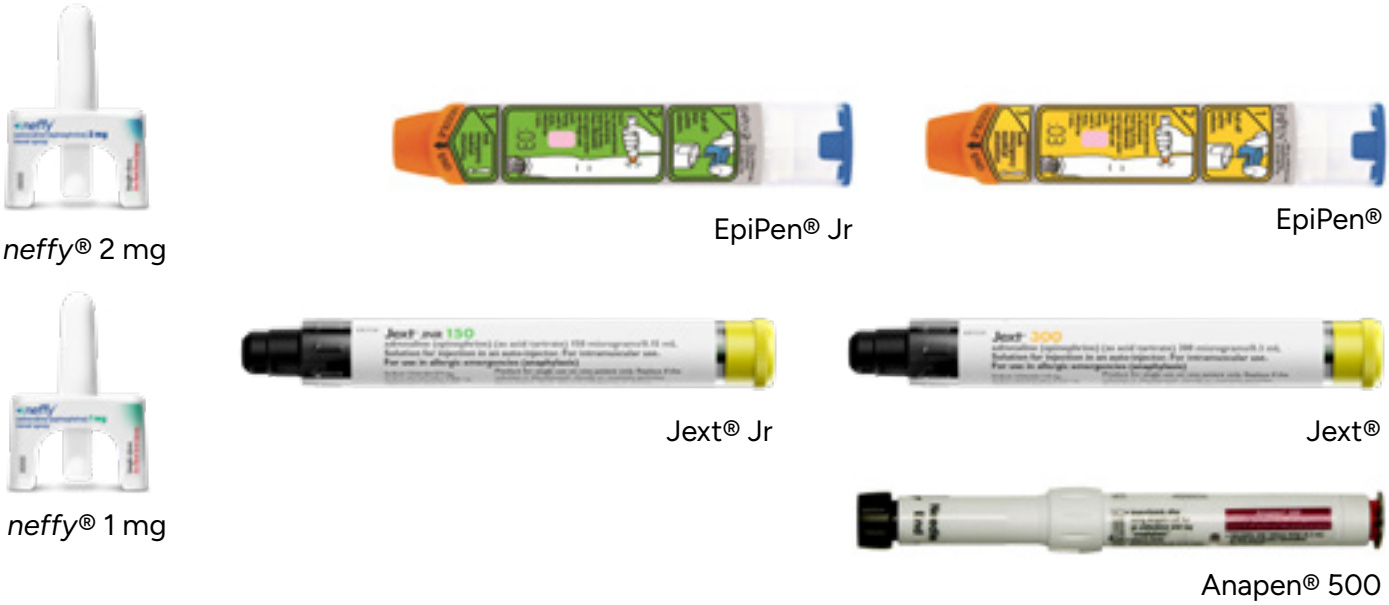
Prescribed adrenaline devices

- In Australia, EpiPen® and Anapen®, Jext® and *neffy*® adrenaline devices are available, and CEC services must accept children with any device as prescribed by their doctor or nurse practitioner. Staff should be trained in how to administer all devices. The ASCIA adrenaline devices FAQ webpage (below) has up to date information about adrenaline devices available in Australia.
- If the child has an ASCIA Action Plan for Anaphylaxis, one of the child's prescribed adrenaline devices must be available to the CEC service accompanied by their ASCIA Action Plan, while they are present at the CEC service.
- For older children attending outside school hours care or vacation care, the parents may prefer the child to carry their adrenaline device rather than hand it over to the CEC service. A decision about whether this is appropriate is site-specific and the following issues should be considered:
  - Will the adrenaline device always be remembered and be with the child while they are at the CEC service?
  - How easy is it for the CEC staff to access the adrenaline device if it is kept in the child's bag?
  - Does the CEC service have a general use adrenaline device in case the CEC service cannot access the child's prescribed device?

Resources

→ ASCIA adrenaline devices FAQs

Figure 2: Adrenaline devices available in Australia.



General use adrenaline devices

- CEC providers should have at least one general use adrenaline device.
- The device required (150 micrograms or 300 micrograms) will depend on the weight of the children being cared for.

  Different doses of adrenaline devices are available

  - 150 microgram adrenaline devices - for children 7.5 – 20 kg (approximately up to 5 years of age).
  - 300 microgram adrenaline devices - for children over 20kg or more (usually aged 5 and up) and adults.
  - 500 microgram adrenaline devices are also available and may be used if the person weighs 50kg or more.

  Note that at the time of publication of these guidelines, the 1 mg *neffy*® adrenaline device is approved for children 4 years and over, 15 to 30kg. There is a 2mg device for people 30kg and over.
- A risk assessment should be undertaken to determine if additional devices are required.
- General use adrenaline devices are important for the following situations:
  - A child who is known to be at risk of anaphylaxis does not have their own device immediately accessible or the device is out of date.
  - Further doses of adrenaline are required before an ambulance has arrived.
  - A child's device has accidentally been misfired, activated or injected.
  - A child previously diagnosed with a mild or moderate allergy and not prescribed an adrenaline device has their first anaphylaxis.
  - A person has anaphylaxis for the first time, who was not previously known to be at risk (for example, a child having their first reaction at the CEC service).

It is safe to use the CEC service's general use adrenaline device for anyone having anaphylaxis, even if it is a different brand to the child's own prescribed adrenaline device or a different strength.

Regulation 94: Exception to authorisation requirement—anaphylaxis or asthma emergency (1) Despite regulation 93, medication may be administered to a child without an authorisation in case of an anaphylaxis or asthma emergency.

Resources

→ ASCIA adrenaline devices for general use

→ ASCIA adrenaline devices FAQs

Using another child's adrenaline device

- If there is no other adrenaline device available, CEC staff may use another child's adrenaline device. This may save a life.
- If another child's adrenaline device is used in an anaphylaxis emergency, it is essential that the child's parents are notified, and the device is replaced immediately by the CEC service.

Regulation 94: Exception to authorisation requirement—anaphylaxis or asthma emergency (1) Despite regulation 93, medication may be administered to a child without an authorisation in case of an anaphylaxis or asthma emergency.

Resources

→ ASCIA adrenaline devices FAQs

Expired adrenaline devices

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

Resources

→ ASCIA adrenaline devices FAQs

Storing adrenaline devices

- In CEC services, adrenaline devices are exempt from being stored in locked first aid cabinets. They should be easily accessible to staff, but out of reach of young children.
- Adrenaline devices should be stored at room temperature away from direct sunlight.
- When participating in off-site activities, store the adrenaline devices in an insulated wallet or container out of direct sunlight (for example, in the shade). The *neffy*® device may be exposed to temperatures up to 50°C for short periods.
- Adrenaline devices must not be left in cars or buses (as they will get too hot) and they must not be stored in a fridge or directly touching a freezer brick (this can affect the device mechanism).

Resources

→ ASCIA adrenaline device storage, expiry and disposal

Anaphylaxis training

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

- For family day care services, under current legislation, each family day care educator and family day care educator assistant needs to:
  - hold a current approved first aid qualification; and
  - have undertaken current approved anaphylaxis management training; and
  - have undertaken current approved emergency asthma management training.

Resources

→ National Allergy Council's minimum standards for anaphylaxis management training

→ ASCIA anaphylaxis e-training for CEC

Anaphylaxis refresher training

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

Resources

→ ASCIA anaphylaxis refresher training

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

→ A&AA How to use an adrenaline device animation series

Staff training

Food allergen management training for food service

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

Resources

- → All about Allergens for CEC online food allergen management training
- → All about Allergens for CEC Kitchen Handbook
- → Food allergen menu matrix template and sample
- → Standardised recipe template and sample
- → Food allergen ingredient substitution tool
- → Meal sign off form for children with food allergies and special dietary needs
- → Food allergy record template
- → Food allergen management audit tool for CEC

Awareness raising in the CEC community

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

Resources

→ Template letter to parents

→ What does it mean to be an allergy aware children's education and care service?

→ How can families support allergy aware children's education and care (CEC) services?

Education about allergies for children

- It is important that children learn about allergy as they can provide support to their friends with food allergy, and also potentially help alert staff if their friend is having an allergic reaction.
- Educating children about the seriousness of food allergies may help prevent bullying.
- Incorporating peer education into story time in the early years, can help support children with food allergy.
- Key strategies to be communicated to children include:
  - children not sharing food and utensils.
  - always drink from their own water bottle.
  - food prepared in cooking activities should not be shared.
  - wash hands before and after eating, especially if eating something their friend is allergic to.

Resources

→ A&AA curriculum resources

- Staff from the CEC service must report all allergic reactions and anaphylaxis through the National Quality Agenda IT System (NQAITS) system within 24 hours of the incident.
- CEC services are encouraged to use an anaphylaxis incident reporting template following any anaphylaxis or near miss. An anaphylaxis incident reporting template has been developed so the same information can be collected across all states and territories.
- If an allergic reaction has occurred to a packaged food that does not list the child's food allergen, or to food provided by the CEC service, the incident should be reported to the local Health Department or State Food Authority. The suspected food that triggered the allergic reaction should be covered, clearly labelled, and stored in the freezer as it may be required for analysis in an investigation.
- Counselling or psychological services may be required by staff or children involved in or witnessing an anaphylaxis and the CEC service should encourage access where required.

Resources

- → Anaphylaxis incident reporting template
- → National Quality Agenda IT System (NQAITS) online reporting system
- → A&AA How to report a food thought to have triggered an allergic reaction / anaphylaxis

Appendices

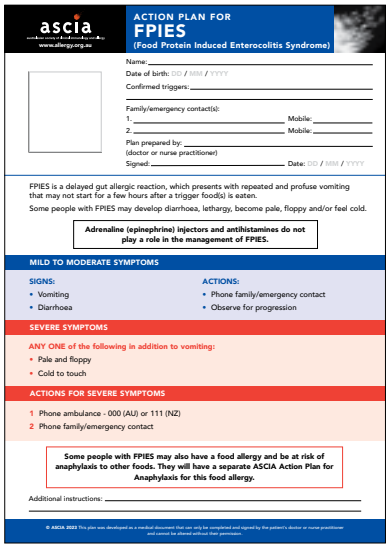
Other serious forms of food allergy that do not trigger anaphylaxis

Food Protein Induced Enterocolitis Syndrome (FPIES) and Eosinophilic oesophagitis (EoE) are serious forms of food allergy, even though they do not trigger anaphylaxis. Food Protein Induced Allergic Proctocolitis (FPIAP) and Food Protein Enterocolitis (FPE) are more common forms of non IgE mediated food allergy. It is important that children and staff with these forms of food allergy strictly avoid their trigger foods for these conditions. Appropriate risk minimisation strategies to prevent exposure to known triggers should be put in place.

Food Protein Induced Enterocolitis Syndrome (FPIES)

What is food protein induced enterocolitis syndrome?

- Food protein-induced enterocolitis syndrome (FPIES) is a reaction to food that involves the immune system, but in a different way to more common food allergies that can potentially result in anaphylaxis.
- FPIES mainly affects babies and young children, but can affect older children and adults.
- It is caused by an allergic reaction to trigger foods when eaten, which results in inflammation of the small and large intestine (the gut).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ACTION PLAN FOR
FPIES
(Food Protein Induced Enterocolitis Syndrome)

Name:
Date of birth: DD / MM / YYYY
Confirmed triggers:
Family/emergency contact(s):
1. Mobile:
2. Mobile:
Plan prepared by:
(doctor or nurse practitioner)
Signed: Date: DD / MM / YYYY

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

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

MILD TO MODERATE SYMPTOMS

SIGNS:
- Vomiting
- Diarrhoea

ACTIONS:
- Phone family/emergency contact
- Observe for progression

SEVERE SYMPTOMS

ANY ONE of the following in addition to vomiting:
- Pale and floppy
- Cold to touch

ACTIONS FOR SEVERE SYMPTOMS

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

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

Additional instructions:

- FPIES is different to common food allergies (where there is a risk of anaphylaxis) as FPIES reactions:
  - are usually delayed (2-4 hours after eating the food).
  - only involve the gastrointestinal system (no hives or swelling).
  - do not progress to anaphylaxis and are not treated with adrenaline.
- Some people with FPIES will also have a food allergy and be at risk of anaphylaxis.

What are the symptoms and treatment?

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

Management of FPIES in CEC services and schools.

- Children diagnosed with FPIES should have an ASCIA Action Plan for FPIES completed and signed by their doctor.
- Parents should provide a copy of the ASCIA Action Plan for FPIES to the CEC service or school.
- Staff should be aware of which children have FPIES.
- STRICT AVOIDANCE OF THE TRIGGER FOOD is the only way to manage FPIES.
- Appropriate risk minimisation strategies to prevent exposure to known triggers should be implemented identical to strategies implemented to prevent anaphylaxis.

Further information is available at https://www.allergy.org.au/patients/food-other-adverse-reactions/food-protein-induced-enterocolitis-syndrome-fpies

Other serious forms of food allergy that do not trigger anaphylaxis

Eosinophilic oesophagitis (EoE)

What is eosinophilic oesophagitis?

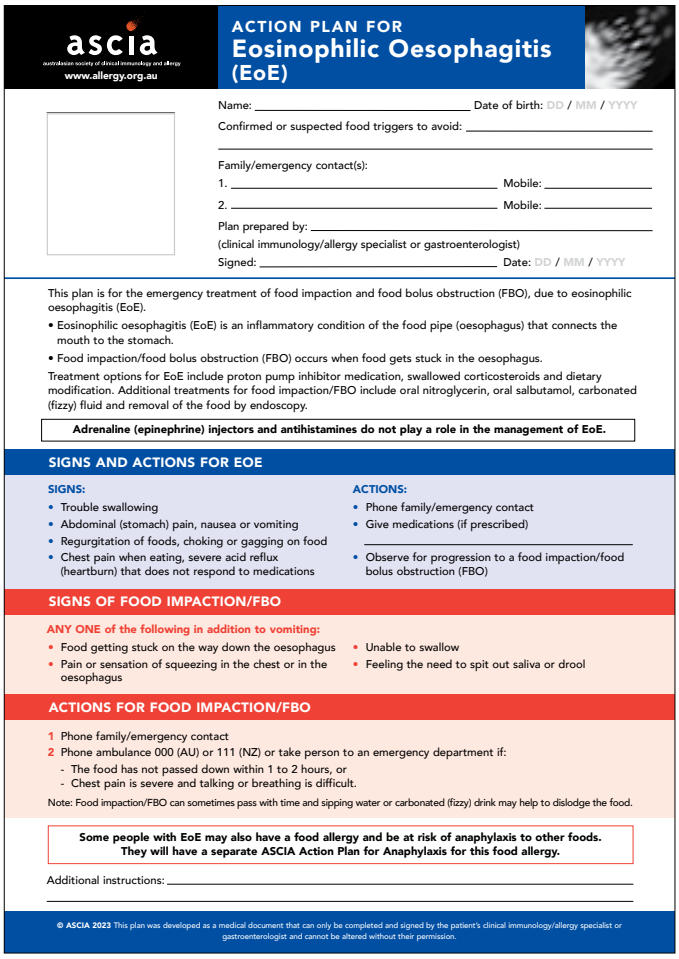
- Eosinophilic oesophagitis (EoE) is a condition where white blood cells (eosinophils) are found in the lining of the oesophagus (the food tube that connects the mouth to the stomach).
- EoE can be caused by an allergic reaction to a food.
- EoE is different to common food allergies (where there is a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

What are the symptoms and treatment?

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

Management of EoE in schools and CEC services.

- Children diagnosed with EoE should have an ASCIA Action Plan for EoE completed and signed by their doctor.



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ACTION PLAN FOR
Eosinophilic Oesophagitis (EoE)

Name: _____ Date of birth: DD / MM / YYYY
Confirmed or suspected food triggers to avoid: _____
Family/emergency contact(s):
1. _____ Mobile: _____
2. _____ Mobile: _____
Plan prepared by: _____
(clinical immunology/allergy specialist or gastroenterologist)
Signed: _____ Date: DD / MM / YYYY

This plan is for the emergency treatment of food impaction and food bolus obstruction (FBO), due to eosinophilic oesophagitis (EoE).
- Eosinophilic oesophagitis (EoE) is an inflammatory condition of the food pipe (oesophagus) that connects the mouth to the stomach.
- Food impaction/food bolus obstruction (FBO) occurs when food gets stuck in the oesophagus.

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

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

SIGNS AND ACTIONS FOR EOE

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

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

SIGNS OF FOOD IMPACTION/FBO

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

ACTIONS FOR FOOD IMPACTION/FBO

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

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

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

Additional instructions: _____

- Parents should provide a copy of the ASCIA Action Plan for EoE to the school or CEC service.
- Staff should be aware of which children have EoE.
- Avoidance of the trigger foods helps to manage EoE. Appropriate risk minimisation strategies to prevent exposure to known triggers should be implemented identical to strategies implemented to prevent anaphylaxis.
- CEC services should discuss management options with parents which will be guided by the child's treating doctor.

Further information is available at https://www.allergy.org.au/patients/food-other-adverse-reactions/eosinophilic-oesophagitis

Other serious forms of food allergy that do not trigger anaphylaxis

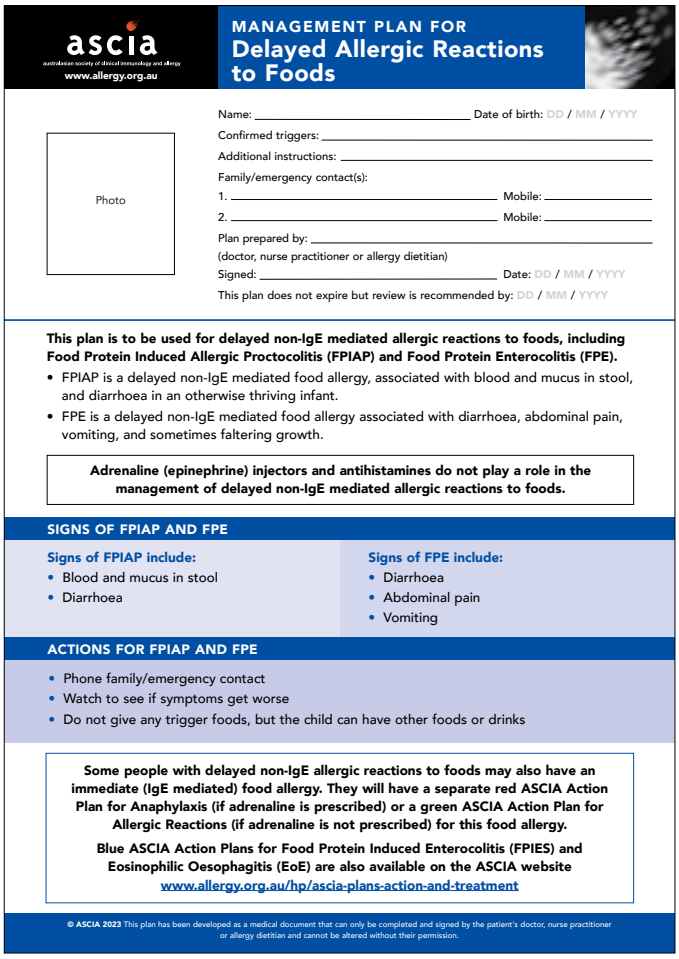
Food Protein Induced Allergic Proctocolitis (FPIAP) and Food Protein Enterocolitis (FPE)

- FPIAP is a delayed non-IgE mediated food allergy, associated with blood and mucus in stool, and diarrhoea in an otherwise thriving infant.
- FPE is a delayed non-IgE mediated food allergy associated with diarrhoea, abdominal pain, vomiting, and sometimes faltering growth.

Management of FPIAP or FPE in CEC services.

- Children diagnosed with FPIAP or FPE should have an ASCIA Action Plan for Delayed Allergic Reactions to Foods completed and signed by their doctor, nurse practitioner or allergy dietitian.
- Parents should provide a copy of the ASCIA Action Plan for Delayed Allergic Reactions to Food to the CEC service.
- Staff should be aware of which children have FPIAP or FPE.
- Appropriate risk minimisation strategies to prevent exposure to known triggers should be implemented identical to the strategies implemented to prevent anaphylaxis.

Further information is available at https://www.allergy.org.au/patients/food-other-adverse-reactions/proctocolitis-fpiap



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MANAGEMENT PLAN FOR
Delayed Allergic Reactions to Foods

Photo

Name: _____ Date of birth: DD / MM / YYYY
Confirmed triggers: _____
Additional instructions: _____
Family/emergency contact(s):
1. _____ Mobile: _____
2. _____ Mobile: _____
Plan prepared by: _____
(doctor, nurse practitioner or allergy dietitian)
Signed: _____ Date: DD / MM / YYYY
This plan does not expire but review is recommended by: DD / MM / YYYY

This plan is to be used for delayed non-IgE mediated allergic reactions to foods, including Food Protein Induced Allergic Proctocolitis (FPIAP) and Food Protein Enterocolitis (FPE).

- FPIAP is a delayed non-IgE mediated food allergy, associated with blood and mucus in stool, and diarrhoea in an otherwise thriving infant.
- FPE is a delayed non-IgE mediated food allergy associated with diarrhoea, abdominal pain, vomiting, and sometimes faltering growth.

Adrenaline (epinephrine) injectors and antihistamines do not play a role in the management of delayed non-IgE mediated allergic reactions to foods.

SIGNS OF FPIAP AND FPE

Signs of FPIAP include:
- Blood and mucus in stool
- Diarrhoea

Signs of FPE include:
- Diarrhoea
- Abdominal pain
- Vomiting

ACTIONS FOR FPIAP AND FPE

- Phone family/emergency contact
- Watch to see if symptoms get worse
- Do not give any trigger foods, but the child can have other foods or drinks

Some people with delayed non-IgE allergic reactions to foods may also have an immediate (IgE mediated) food allergy. They will have a separate red ASCIA Action Plan for Anaphylaxis (if adrenaline is prescribed) or a green ASCIA Action Plan for Allergic Reactions (if adrenaline is not prescribed) for this food allergy.

Blue ASCIA Action Plans for Food Protein Induced Enterocolitis (FPIES) and Eosinophilic Oesophagitis (EoE) are also available on the ASCIA website www.allergy.org.au/hp/ascia-plans-action-and-treatment

List of supporting resources

Anaphylaxis management policy and plans	 → Sample anaphylaxis management policy for CEC	 → Anaphylaxis risk management plan template for CEC	 → Examples of anaphylaxis risk minimisation strategies for CEC
	 → National Allergy Council Anaphylaxis management checklist for children's education and care services		 → Anaphylaxis checklist (CEC): Preparing for off-site activities (events,excursions, sporting activities)
Allergy documentation	 → ASCIA Action Plan	 → ASCIA Action Plan FAQ	 → Food allergy record template
	 → Individualised anaphylaxis care plan template for CEC	 → National Allergy Council – Template for sign complying with National Regulation 173(2)f	
Adrenaline devices	 → A&AA How to give an adrenaline device animation series	 → ASCIA adrenaline devices for general use	 → ASCIA adrenaline device FAQ
	 → ASCIA adrenaline device storage, expiry and disposal	 → How to position a child or adult having a severe allergic reaction (anaphylaxis) animation	

List of supporting resources, page 2

Staff training – anaphylaxis management	→ ASCIA anaphylaxis e-training for CEC	→ ASCIA anaphylaxis refresher training	→ How to safely remove ticks animation
	→ National Allergy Council minimum standards for anaphylaxis management training	→ Trainer devices are available from the distributor of the device or from A&AA	→ Anaphylaxis drill checklist and example Anaphylaxis drill scenarios
Staff training – food service	→ All about Allergens for CEC online food allergen management training	→ All about Allergens for CEC Kitchen Handbook	→ Food allergen menu matrix template and sample
	→ Standardised recipe template and sample	→ Food allergen ingredient substitution tool	→ Food service form for children with special dietary needs template
	→ Food allergy record template	→ Food allergen management audit tool for CEC	→ All about Allergens resource hub

List of supporting resources, page 3

Education for children and the CEC community	→ Template letter to parents	→ A&AA resources, including the Be a Mate program	→ NSW Department of Education 'Allergy & Management within the Curriculum P-12'
Incident reporting	→ Anaphylaxis incident reporting template	→ A&AA Reporting an allergic reaction guide	

Anaphylaxis Management Checklist for CEC Services

Allergy Aware approach

The Children's Education and Care (CEC) service implements an allergy aware approach to preventing and managing anaphylaxis.

Allergy documentation

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

Allergy medications

- ☐ Where prescribed, the child's adrenaline injector and other medication should be available at all times.
- ☐ Where adrenaline devices are stored by the CEC service, they should be stored unlocked, easily accessible to staff but not accessible to children. They are stored at room temperature, away from direct heat and sunlight.
- ☐ Adrenaline devices are stored with a copy of the child's ASCIA Action Plan.
- ☐ Adrenaline devices (general use and prescribed) are checked for expiry at least every 3 months.
- ☐ A process is in place to make sure adrenaline devices and ASCIA Action Plans are taken whenever the child goes to off-site activities.
- ☐ At least one general use (non-prescribed) adrenaline device is in a first aid kit and stored with a copy of the ASCIA First Aid Plan for Anaphylaxis.

Staff training

- ☐ All staff undertake anaphylaxis training including hands on practice with adrenaline trainer devices, at least every two years and prior to starting work at the CEC service.
- ☐ All staff undertake anaphylaxis refresher training including hands on practice with adrenaline trainer devices, twice yearly.
- ☐ All staff responsible for preparing and serving food undertake *All about Allergens for Children's Education and Care training*, at least every two years.
- ☐ A staff training register is kept.

Strategies to reduce risk

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

Anaphylaxis drill checklist

	Yes/No	Comments
Identify that the child or adult is having anaphylaxis		
• The person was recognised as having anaphylaxis.		
• The person was positioned correctly (laid flat). If breathing is difficult, allow them to sit with legs outstretched.		
• The person was not moved, unless there was danger. Do not allow them to stand or walk.		
Getting help		
• Staff knew how to alert others to the emergency and obtain help (for example, by phone).		
• It was clear which staff was responsible for removal of bystanders from the area (such as other children) and provide support.		
Adrenaline device and ASCIA Action Plan		
• It was clear who should bring the adrenaline device and ASCIA Action Plan to the person having anaphylaxis.		
• There were no delays in bringing the device to the person having anaphylaxis.		
• Appropriate medication (as listed on ASCIA Action Plan) was brought to the person having anaphylaxis.		
• An ASCIA Action Plan was stored with the adrenaline device.		
• The adrenaline device was easy to locate.		
• The adrenaline device was not locked in a room or cupboard.		
• The adrenaline device was in date.		
• Which device was brought to the person – a general use or personal device? • Was this appropriate?		

Anaphylaxis drill checklist, page 2

	Yes/No	Comments
ASCIA Action Plan		
• Staff correctly followed instructions on the ASCIA Action Plan according to signs.		
Administering the adrenaline device*		
• Staff followed the steps on the ASCIA Action Plan to correctly administer the device. *Note: The person having anaphylaxis may prefer to administer the device themselves with staff supervision.*		
• The time of administration was recorded.		
Calling Emergency Services		
• The service has a policy about calling emergency services, communicated to all staff.		
• It was clear which staff member was responsible for simulating a call to emergency services. *Note: A team member could act as the emergency call line and take a simulated call.*		
• The staff member had enough information about the incident to make the call.		
• Staff member knew school address and had information about where the ambulance should enter.		
• A staff member was assigned to meet the ambulance staff, and to ensure clear access to the premises.		
• It was clear which staff member was responsible for communicating details about the incident to ambulance staff.		
• Staff are aware of the service's policy regarding accompanying a child in an ambulance.		

Anaphylaxis drill checklist, page 3

	Yes/No	Comments
Monitor the person having anaphylaxis		
• The ASCIA Action Plan continued to be followed to check for signs of anaphylaxis.		
• The person was kept in an appropriate position even when they appeared to be recovering.		
• Staff knew when to administer an additional adrenaline device.		
• There was a plan in place for getting the additional device. Was it a general use device?		
Notify emergency contact		
• It was clear which staff member was responsible for contacting the child or adult's emergency contact.		
• The emergency contact was notified in a timely manner.		
Note taking		
• It was clear which staff member was responsible for recording details of the incident. This includes possible trigger, symptoms, the time adrenaline device given and all actions taken.		
Reporting the incident		
• It was clear which staff member was responsible for completing the report to the appropriate leadership and/or authority.		
Debrief and follow up		
• What went well?		
• What could have been improved?		
• Did anything unexpected happen?		

Note:
*Staff should be familiar with administration of the service's general use device, and the prescribed adrenaline devices carried by child. The ASCIA website has instructions on how to correctly give an adrenaline device. This information is also on the ASCIA Action Plan, and the ASCIA First Aid Plan for Anaphylaxis.

Anaphylaxis drill scenarios

The following anaphylaxis drill scenarios can be tailored to your service.

Consider varying the timing of your drill – running drills early in the morning, or late in the day, or during snack times or lunch breaks may help identify different issues.

Scenario A

A child with a known egg, tree nut and sesame allergy comes to you 10 minutes after lunchtime. They have hives on their body and complains of a tight throat. You can hear they have noisy breathing and a hoarse voice. You know that they have an ASCIA Action Plan for Anaphylaxis and an adrenaline device in the office.

Scenario B

A child has been stung by a bee on the playground and has come inside to receive First Aid. They have a rash spreading over their body and they complain of a sore stomach and then begin to vomit. This child has no history of allergies or other medical conditions.

Scenario C

A staff member with known food allergies at your service complains of persistent dizziness and "feeling faint" after a shared lunch in the staff room where they ate a food they had never tried before. You notice they have been coughing since lunch, and their eyes and lips are puffy. They start looking for their asthma puffer when they suddenly slump to the floor.

Scenario D

Part 1: A child has known allergies to peanuts, egg and cow's milk. The child's parents have provided the service with a prescribed adrenaline device and prescribed antihistamine, which are both listed on their ASCIA Action Plan for Anaphylaxis. You are on an excursion, and the children have eaten their morning snack. The child complains they have an itchy throat and are not feeling well. You notice they look pale and have puffy lips.

Part 2: After 10 minutes, the child starts to breathe noisily and develops a persistent cough.

Scenario E (for CEC services or schools with Early Learning Centres)

A young child with a known cow's milk allergy is accidentally served the wrong lunch with a savoury muffin containing cheese. The child suddenly begins to scratch their neck, and you notice hives developing. When you take them from their highchair you notice they become pale and floppy.

Anaphylaxis Checklist for off-site activities

Preparing for off-site activities (events, excursions, sporting activities)

This checklist aims to guide services when planning off-site activities such as events, local excursions and sporting activities. This should be completed as the risk management plan for the activity is developed. The checklist may be adapted as template for service protocols.

Prior to the off-site activity:

Assessing risk, planning and communication

- ☐ When planning excursions and activities, identify which children are at risk of anaphylaxis and which allergies need to be managed. Assess planned activities for inclusivity.
- ☐ Discuss with the child's parent or caregiver about the off-site activity and seek their authorisation and advice on risk minimisation strategies. This should be documented in the child's Individualised Anaphylaxis Care plan.
- ☐ At least one general use adrenaline device must be included in the first aid kit with an ASCIA First Aid Plan for Anaphylaxis. An assessment of risk should be undertaken to determine if more than one adrenaline device should be taken. Determine location and storage of additional devices for the duration of the event.
- ☐ Arrange for a copy of the children's ASCIA Action Plans, their prescribed adrenaline device and medication listed on the ASCIA Action Plan to be taken on the event.
- ☐ Communicate an allergy aware approach with staff, parents and children. This may be via briefings and written information. Briefings should be repeated at the start of the excursion and when required throughout.

In case of emergencies

- ☐ Follow instructions on the ASCIA Action Plan.
- ☐ Ensure staff always have access to a suitable service-authorised or service-supplied communication device for the location.
- ☐ Ensure staff have an up-to-date list of emergency contacts (emergency services, the child's medical team or practitioners, parents and caregivers).
- ☐ Have a plan for who will accompany the child to hospital, and which staff member is responsible for communication with emergency services, parents and service leadership.

Staff training

- ☐ Staff attending the event should have current first aid and anaphylaxis training consistent with state / territory requirements.
- ☐ Staff providing food and supervising mealtimes should complete the All about *Allergens for CEC online training* prior to the event (within the last two years).

For children with food allergy

- ☐ Develop a plan to ensure children with food allergy have appropriate food and drinks brought from home for consumption during the excursion, event or sporting activity.
- ☐ If food is provided on the excursion, food allergens need to be declared to the food service providers by the service prior to the event, and then again by staff when the food is made available.
- ☐ If food or drink is to be purchased during the activity, a plan to ensure that this is appropriate for the child's allergies should be developed prior to the event.

Anaphylaxis Checklist for off-site activities, page 2

During the off-site activity:

Remind all children:

- ☐ To not share other children's food or drinks.
- ☐ To report any insect or wasp nests or bee hives.
- ☐ To notify a staff member if they have any concerns about other children with allergy.

Remind children with allergies:

- ☐ To tell a staff member if they feel unwell or have any signs of an allergic reaction.
- ☐ To ask a staff member if they are not sure about a food or drink.
- ☐ To wear shoes and appropriate clothing when outside if they are allergic to insect stings or bites.

After the off-site activity:

- ☐ Ensure all ASCIA First Aid Plans, medications and first aid kits are returned to their correct location.
- ☐ Ensure any forms, contact details or personal ASCIA Action Plans taken offsite are returned and filed or disposed of appropriately.
- ☐ Ensure children's medication is returned to the service or parents.

Notes: .....

Template for reporting an allergic reaction

The following information should be collected by children's education and care services for all allergic reactions (where there is a risk of anaphylaxis):

Child's name and date of birth.

_____

Date and time of the allergic reaction.

_____

Does the child have an ASCIA Action Plan for Anaphylaxis or ASCIA Action Plan for Allergic Reactions? ☐ Yes ☐ No

Where was the child when the allergic reaction occurred?

_____

_____

What caused the allergic reaction? Was the child exposed to a known allergen and how did the exposure occur?

_____

_____

_____

If no known allergies, what was the suspected cause of the allergic reaction?

_____

_____

_____

Name and position (for example; nurse, educator, administrator) of the staff member who provided first aid. Note if this is not known.

_____

Signs and symptoms observed.

_____

_____

Template for reporting an allergic reaction, page 2

Was the child's ASCIA Action Plan followed? ☐ Yes ☐ No

Where was the child treated?

_____

How was the child positioned during the allergic reaction (sitting with legs outstretched or lying down)?

_____

Was a prescribed adrenaline device used?
If not, why (for example expired, misfired, not as close to hand as a general use device)?

_____

Was a general use adrenaline device used? ☐ Yes ☐ No

If so, why (for example first anaphylaxis, second dose)?

_____

How long after observing anaphylaxis symptoms was the adrenaline device administered?

_____

What medications were given, including additional doses of adrenaline? When were they given?

_____

Was an ambulance called? ☐ Yes ☐ No

Was the child stretchered to the ambulance? ☐ Yes ☐ No

Was the child transported to hospital? ☐ Yes ☐ No

Was the parent/emergency contact called? ☐ Yes ☐ No

Any additional information that may be relevant to the incident. ☐ Yes ☐ No

_____

_____

_____

Allergic reactions to packaged foods that do not list the child's food allergen, or to food provided by a food service provider after the allergy has been declared, should be reported to the local Health Department.

allergy AWARE