# Appendix A: Frequently Asked Questions

## General facts

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| **What is the difference between an allergy and anaphylaxis?** |
| An allergy is an overreaction by the body’s immune system to a normally harmless substance. Substances that can trigger an allergic reaction are called allergens. Allergens may be in medication, in the environment (e.g. pollens, grasses, moulds, dogs and cats), or proteins in the foods we eat. Individuals can have mild to moderate or severe allergies. The most common allergic conditions are food allergies, eczema, asthma and hay fever (allergic rhinitis).  Anaphylaxis is the most severe form of allergic reaction and can be life-threatening.  Having an allergy means that when you are exposed to the allergen (e.g. eating a food you are allergic to), the immune system releases massive amounts of chemicals, triggering symptoms that can affect a person’s breathing, stomach, skin and/ or cause persistent dizziness and collapse.  Anaphylaxis can occur within minutes or up to 2 hours after exposure to the allergen. The most serious symptoms are breathing difficulties and/or a sudden drop in blood pressure which can be life-threatening. Mild to moderate symptoms such as hives and swelling of the face, lips and eyes may also be present. Vomiting and/or abdominal pain is a mild to moderate symptom for food and medication allergy, but a severe symptom for insect allergy. |
| **How do I know if the student at risk of anaphylaxis is experiencing anaphylaxis and not asthma?** |
| Unlike asthma, anaphylaxis can affect more than one system in the body. This means that, during a reaction, you may see one or more of the following symptoms: swelling or welts on the skin, stomach pain, vomiting or diarrhoea, in addition to breathing difficulties and increased heart rate or altered consciousness.  If someone with known food or insect allergy suddenly develops severe asthma-like symptoms, give adrenaline autoinjector FIRST, then asthma reliever medication as stated on the ASCIA Action Plan for Anaphylaxis.  If you mistakenly treat asthma as anaphylaxis and give the adrenaline autoinjector according to the student's ASCIA Action Plan for Anaphylaxis, you will do no harm. If in doubt, it is better to give the adrenaline autoinjector. Call an ambulance immediately and advise that you have administered the adrenaline autoinjector and also give them the time of the dose. Administer the student’s asthma reliever medication according to their Asthma Action Plan while waiting for the ambulance. |

## School response

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| **What can I do to keep a student with anaphylaxis safe in my class?** |
| * be familiar with the student's Individual Anaphylaxis Management Plan and the school’s anaphylaxis management policy * be familiar with signs and symptoms of a reaction * know where the student’s adrenaline autoinjector is kept and how to administer it properly * consult with the student's parents about potential hidden allergens in foods or other substances (e.g. soaps or lotions) * ensure you have completed all risk minimisation strategies for the different areas the child may be in while in your care * participate in anaphylaxis training to identify the causes, symptoms and treatment of anaphylaxis and the administration of an adrenaline autoinjector and practise regularly using an adrenaline autoinjector trainer device * familiarise yourself with the school’s emergency response procedures for anaphylaxis * plan ahead for special class activities * avoid the use of food treats * discuss anaphylaxis with your class * if you have any questions or concerns, ask your School Anaphylaxis Supervisor or first-aid officers. |
| **If we follow all the policies and recommendations, will we prevent anaphylactic reactions in our school?** |
| The school can take many steps to minimise the risk of a reaction and be well equipped to manage a reaction if it occurs. However, there is no guarantee that you will prevent anaphylaxis from occurring. Remember that advance planning and good preparation and risk minimisation for all school settings is the best way to minimise the risk and effectively manage anaphylaxis. |

## Use of adrenaline autoinjectors

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| **What happens to the student once I give them the adrenaline autoinjector?** |
| Within a few minutes the symptoms should stop progressing and the student’s condition should slowly start to improve. However, they may feel very anxious and shaky. This is a side-effect of adrenaline. Reassure the student and closely watch them in case of a repeated deterioration requiring further doses of adrenaline.  Arrange for another staff member to call the ambulance (000) as soon as possible. |
| **Can I give a second dose of the adrenaline autoinjector?** |
| Watch the student closely in case of worsening symptoms or no improvement. In situations where there is no improvement and/or deterioration in severe symptoms (as described in the student’s ASCIA Action Plan for Anaphylaxis) further adrenaline doses may be administered after 5 minutes, if another adrenaline autoinjector for general use is available while you wait for an ambulance. |
| **What happens if I accidentally inject myself while trying to assist a student having a reaction?** |
| If a student is having a reaction and you have inadvertently injected yourself with that student’s individual adrenaline autoinjector, immediately ask another staff member to assist the student by:   * retrieving the school’s adrenaline autoinjector for general use if available or another student’s adrenaline autoinjector if that is all that is available * asking someone else to administer the adrenaline autoinjector for general use, or another student’s autoinjector to the student experiencing anaphylaxis if no adrenaline autoinjector is available, someone should call 000 immediately and closely monitor the student until an ambulance arrives * ask someone to monitor your reaction to the adrenaline and, if required, seek advice by calling 000 * you must seek medical attention for yourself as soon as possible if you feel unwell. |
| **What if I administer an adrenaline autoinjector to a student with anaphylaxis and it turns out to be something else?** |
| If in doubt, it is better to use an adrenaline autoinjector than not use it, even if in hindsight the reaction is not anaphylaxis. Under-treatment of anaphylaxis is more harmful (and potentially life threatening) than over-treatment of a mild to moderate allergic reaction.  The adrenaline autoinjector contains adrenaline, which is a natural hormone. If it is given to a student whose adverse reaction does not ultimately progress to anaphylaxis, the student will have a raised heart rate and become pale and sweaty. They will feel anxious and shaky. These are common side-effects of adrenaline. The student may also require reassurance from you.  Call an ambulance immediately to treat the other medical symptoms. Make sure you advise the ambulance service that you have administered the adrenaline autoinjector and also give them the time of the dose. |
| **Can I give an adrenaline autoinjector to a student at risk of anaphylaxis who is experiencing severe allergic reaction if the device has expired and it is cloudy or discoloured?** |
| An expired device is less effective than an in-date device. If a student’s adrenaline autoinjector has expired or it is cloudy or discoloured, call an ambulance immediately after administering the school’s adrenaline autoinjector for general use. However, if an expired, cloudy or discoloured device is the only device available in an emergency, it should be used.  Remember, the key to effective anaphylaxis management is preparation. Do not allow yourself to be in a situation where you have a student who is at risk of anaphylaxis in your care and the adrenaline autoinjector has expired, or is cloudy or discoloured. No school in Victoria should be holding an expired adrenaline autoinjector. |
| **If a student is having a first time severe allergic reaction or anaphylaxis (without any prior diagnosis), can the school administer an adrenaline autoinjector?** |
| **If the school has an adrenaline autoinjector for general use, this should be used in the first instance. If one is not available,** then it is recommended that you call 000 and seek medical advice. |
| **Can school staff use a student’s personal adrenaline autoinjector (provided by parents of the child) on another student in an emergency?** |
| If the school has an adrenaline autoinjector for general use, this should be used in the first instance. If one is not available, YES schools can use another student’s adrenaline autoinjector. The priority and overarching duty of care is to assist the student having the reaction as it may be life-threatening. However, school staff should only use another student’s adrenaline autoinjector if the school’s adrenaline autoinjector(s) for general use is NOT available and it is an emergency.  School staff should also immediately call 000, and ensure the student whose adrenaline autoinjector has been used is not exposed to any risks. For example, the student should be supervised indoors if possible (particularly if environmental or other external factors (such as bees) pose a risk). For food related risks, the student should not be allowed to eat until another adrenaline autoinjector is made available and a medical officer/parent has advised the student may eat low risk food e.g. fruit if the child is not allergic to fruit.  This advice applies regardless of whether the student is having a first time reaction, or has previously been diagnosed as being at risk of anaphylaxis. All schools are required to undertake risk minimisation strategies, including the purchase of adrenaline autoinjectors for general use that will minimise the risk of this occurring. It is acknowledged however that this may be difficult to manage for students experiencing a first time anaphylactic reaction without a prior diagnosis of anaphylaxis.  If another student’s adrenaline autoinjector has been used, the school should immediately purchase a replacement adrenaline autoinjector for that student from a pharmacy at the schools expense. |
| **A student has provided one type of adrenaline autoinjector, but the adrenaline autoinjector for general use is not the same brand. Does this matter?** |
| No, as long as the dosage of both adrenaline autoinjectors is the same, the brand of the adrenaline autoinjector does not matter. However, because the delivery mechanism varies between adrenaline autoinjectors, the instructions on administration of the device should be followed. It may be necessary to instruct staff in the appropriate use of the different types of adrenaline autoinjector. |
| **Can a higher dose adrenaline autoinjector be given to a young child if no lower dose "Junior" device is available?** |
| A general guide to adrenaline autoinjector dose is as follows:   * EpiPen® (300 microgram) is prescribed for adults and children over 20kg (aged around five years or over) * EpiPen® Jr (150 microgram) is prescribed for children 7.5-20kg (aged around one to five years) * Anapen® 500 (500 microgram) is prescribed for adults and children over 50kg (aged around twelve years or over) * Anapen® 300 (300 microgram) is prescribed for adults and children over 20kg (aged around five years or over) * Anapen® Jr.)  (150 microgram) is prescribed for children 7.5-20kg (aged around one to five years) * Children under 1 year of age are not usually prescribed an adrenaline autoinjector. If anaphylaxis is suspected only a lower dose containing 150 microgram of adrenaline should be given. Higher dose adrenaline autoinjectors should NOT be administered to children under 1 year of age. * In children aged 1 to 5 years of age, devices containing 150 microgram of adrenaline) should be used. However, if a device containing 300 microgram of adrenaline is available, this should be used in preference to not using one at all. * In children over 5 years of age or adults, an adrenaline autoinjector with 300 microgram should be used. However if only a device containing 15 microgram of adrenaline is available, this should be used in preference to not using one at all. * In children over 12 years of age or adults, an adrenaline autoinjector with 300 microgram or 500 microgram should be used. However, if only a device containing 15 microgram of adrenaline is available, this should be used in preference to not using one at all. |
| **Is there financial assistance available for schools to purchase adrenaline autoinjectors for general use?** |
| Adrenaline autoinjectors for general use are available from pharmacies without a prescription at a retail price. The Department does not have a budget to support schools to buy these devices.  In Australia, the Pharmaceutical Benefits Scheme (PBS) listing for adrenaline autoinjectors allows for authority prescriptions of a maximum quantity of 2 adrenaline autoinjectors (EpiPen) for children or adults. They are available at a subsidised cost when prescribed by doctors for individuals considered to be at high risk of anaphylaxis.  Unfortunately this PBS is currently only available for parents and families. |

## Legal issues

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| **What are my legal rights if I make a mistake?** |
| All civil claims that allege that school staff from a Victorian government school have been negligent in managing (or failing to appropriately manage) an anaphylactic reaction must be immediately referred to the Department’s Legal Division.  In the unlikely event that a legal claim is brought against a government school in relation to the handling of an anaphylactic reaction (whether actual or reasonably suspected), the Department will conduct the defence of that claim for and on behalf of the school. Individual staff members will be ordinarily indemnified by the Department unless the staff member has acted maliciously, with criminal intent or with extreme recklessness. The cost of defending any such claim will be borne by the Department, as will the payment of any damages to the claimant (whether court-ordered or by way of agreed settlement).  School staff from Victorian non-government schools should follow their school’s procedures relating to negligence claims. |

## Family communication

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| **What should I do if the parents haven't replaced their child's adrenaline autoinjector after it has expired?** |
| Contact the parents immediately by both phone and in writing and request them to replace the adrenaline autoinjector. A reminder system should be in place to ensure the parents are followed up if a replacement adrenaline autoinjector is not received within a reasonable time. The school should develop an interim Individual Anaphylaxis Management Plan for the student until the parents provide the replacement adrenaline autoinjector.  The school should document these communications as this may become a child protection issue. In addition, it is important to retain evidence that the school has taken reasonable steps to discharge its duty of care to the student. |
| **What if the parents haven’t told us about their child’s condition, but the child mentions it in class?** |
| Contact the student's parents **immediately** to verify if their child is diagnosed as being at risk of anaphylaxis and seek written medical advice from the child’s medical practitioner. If the diagnosis is confirmed, ask the parents to obtain an adrenaline autoinjector and ASCIA Action Plan for Anaphylaxis (device specific) for the school as soon as possible. In the meantime, the school should develop an interim Individual Anaphylaxis Management Plan for the student. |
| **Can we ask the parents to not send nut products to school? What if they refuse?** |
| It is **not** recommended that schools ban food or other products known to cause anaphylaxis because:   * it can create complacency amongst school staff and students * it does not eliminate the presence of hidden allergens * it is difficult to 'ban' all triggers: remember that foods other than nuts can trigger anaphylaxis.   It is preferable that the school take appropriate and regular action to raise awareness about anaphylaxis in the school community so that there is an increased understanding of the condition and the risk it presents. The school may also wish to help parents to identify more suitable food options for their children.  While food bans or allergen-free environments are not supported, schools must consider the needs of children with food allergies in school activities. Schools should encourage students not to consume particular high risk foods at school, particularly if they have a child with a nut allergy in their class e.g. discourage satay days, cooking with peanut or tree nuts during class. Teachers are discouraged from eating nuts as a quick snack in the class room where there is a child with a nut allergy or when on playground duty. A common sense approach to management is encouraged.  The ASCIA Guidelines provide further advice about anaphylaxis prevention at: [www.allergy.org.au/health-professionals/papers/prevent-anaphylaxis-in-schools-childcare](http://www.allergy.org.au/health-professionals/papers/prevent-anaphylaxis-in-schools-childcare) |

For additional FAQs on adrenaline autoinjectors, visit the ASCIA website at:

[www.allergy.org.au/health-professionals/anaphylaxis-resources/adrenaline-autoinjectors-faqs](http://www.allergy.org.au/health-professionals/anaphylaxis-resources/adrenaline-autoinjectors-faqs)