



Queensland
Government

Queensland Health

SCHOOL BASED VACCINATION PROGRAMS
A Resource Kit For Vaccine Service Providers

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The Resource Kit draws on much useful information from other sources, in particular:

- *The Outreach Immunisation Programs in Education and Institutional Settings Manual* (Queensland Health 2003)
- *Guidelines for Immunisation Practice in Local Governments* (Victorian Department of Human Services, 2006)
- *Model Documents, South Australian School Based Immunisation Program* (South Australian Department of Health, 2005)
- *New South Wales Adolescent Vaccination Program Protocols* (NSW Health, 2006)

All contributions are gratefully acknowledged.

DISCLAIMER

The State of Queensland shall not be liable to any person under any circumstances whatsoever, arising by virtue of a claim for breach of warranty (express or implied), tort (including negligence), strict liability or otherwise for actual, incidental, contingent, special or consequential damages, lost profits or revenues arising directly or indirectly from or out of (but not restricted to) any claim arising from any information contained in this publication.

Any person investigating any issues addressed in this publication should also seek their own independent legal and technical advice and consult their relevant Population Health Unit.

Every effort has been made to ensure that the content contained within this manual is correct at the time of printing.

INTRODUCTION

This Resource Kit is for Vaccine Service Providers (VSPs) who provide school based vaccinations. School programs are generally regarded as a highly efficient and cost-effective way to deliver vaccination services to an age group that can otherwise be difficult to reach.

The Resource Kit provides an operational framework, checklists, materials for distribution and suggestions on clinic layout. It is recommended each VSP develop their own policies and procedures for conducting school based vaccination programs. This Resource Kit outlines standard vaccination procedures and should form the basis for developing these policies and procedures.

The contents are intended as a guide only, and it is recognised that various circumstances, including geography and school size, may mean alternative approaches are needed to suit local situations.

Whilst much of the resource kit is intentionally generic, some parts do apply specifically to varicella-zoster vaccine (VZV) and hepatitis B vaccine for Year 8 students, adult/adolescent formulation diphtheria-tetanus-pertussis (dTpa) vaccine for Year 10 students, and human papillomavirus (HPV) vaccine for female secondary school students. In the event of additional vaccines being recommended for school aged students by the National Health and Medical Research Council (NHMRC), this Resource Kit will be updated.

SECTION 1: VACCINES TO BE ADMINISTERED IN THE SCHOOL BASED VACCINATION PROGRAM

1.1 VACCINES TO BE ADMINISTERED

The School Based Vaccination Program in Queensland will commence in the beginning of the 2007 school year. Under this program, eligible Year 8 students with parental consent will be vaccinated for hepatitis B and varicella (chickenpox), and eligible Year 10 students will receive the adult/adolescent formulation diphtheria-tetanus-pertussis (whooping cough) (dTpa) vaccine. Eligible female Year 10, 11 and 12 students will also receive human papillomavirus (HPV) vaccine as a catch-up program in 2007.

From 2008, eligible female Year 8, 9 and 10 students will receive HPV vaccine, and from 2009, it will form part of the ongoing school based vaccination program, delivered to female Year 8 students.

Queensland Health will provide these vaccines free of charge for these students. Other adolescents and adults seeking vaccination are not eligible to be vaccinated under the School Based Vaccination Program.

Should additional vaccines be recommended for administration through the School Based Vaccination Program in the future, VSPs will be advised.

1.1.1 Hepatitis B Vaccine

Two doses of hepatitis B vaccine will be given to Year 8 students who have not previously had this vaccination. Dose 1 and Dose 2 will be given at two separate visits, with an interval of four to six months in between doses.

1.1.2 Varicella-Zoster (Chickenpox) Vaccine

One dose of varicella-zoster vaccine will be given to Year 8 students who have not previously had chickenpox infection or a varicella vaccination. This vaccination will be given at the same time as either the first or second dose of hepatitis B vaccine.

Please note: Students aged 14 years or older require *two* varicella vaccinations, given one to two months apart. *Only one vaccination will be provided in the school based vaccination program.* 14 year old students who receive their first vaccine as part of the school program are eligible to receive their second free vaccine from their doctor while they are still in Year 8 (a consultation fee may apply).

1.1.3 Diphtheria-Tetanus-Pertussis (Whooping Cough) Vaccine

One booster dose of adult/adolescent formulation diphtheria-tetanus-pertussis (dTpa) vaccine will be given to Year 10 students who have not previously had this vaccination and have previously had a primary course of diphtheria, tetanus and pertussis vaccine.

Adolescents who have completed a primary vaccination course with Combined Diphtheria and Tetanus vaccine (CDT) or Adult Diphtheria and Tetanus vaccine (ADT) are eligible, and it is recommended they receive a booster dose of dTpa to ensure protection against pertussis (whooping cough).

1.1.4 Human Papillomavirus (HPV) Vaccine

Three doses of human papillomavirus (HPV) vaccine will be given to female Year 10, 11 and 12 students in 2007 as a catch-up program. There will be an interval of up to two months between Dose 1 and Dose 2, and four months between Dose 2 and Dose 3.

In 2008, the catch-up program for HPV vaccine will be for female students in Years 8, 9 and 10. From 2009, HPV vaccine will be offered to female Year 8 students as an ongoing program.

1.2 DISEASES AND SIDE EFFECTS OF VACCINATION

The following is a summary of the effects of the diseases and side effects of vaccines that are used to protect against these diseases. All vaccines have the potential to cause an anaphylactic (severe allergic) reaction. This side effect is extremely rare and not listed beside each disease/vaccine.

| Disease | Effects of Disease | Side Effects of Vaccination |
|--|---|---|
| Diphtheria Contagious bacteria spread by droplets; causes severe throat and breathing difficulties. | About one in 15 patients die. The bacteria release a toxin, which can produce nerve paralysis and heart failure. | About one in 10 has local inflammation or fever. Serious adverse events are very rare. |
| Tetanus Caused by toxin of bacteria from soil; causes painful muscle spasms, convulsions, lockjaw. | About one in 10 patients die. The risk is greatest for the very young or old. | |
| Whooping Cough Contagious bacteria spread by droplets; causes uncontrolled coughing and vomiting, lasting up to three months. | About one in 200 whooping cough patients under the age of six months die from pneumonia or brain damage. | |
| Hepatitis B Virus spread mainly by blood, sexual contact or from mother to newborn baby; causes acute hepatitis or chronic carriage. | About one in four chronic carriers will develop cirrhosis or liver cancer. | About one in 15 to one in 100 has pain and fever. |
| Varicella (Chickenpox) Caused by highly contagious virus; causes low grade fever and vesicular rash. Reactivation of virus later in life causes herpes zoster (shingles). | One in 5,000 patients develop encephalitis (brain inflammation). About three in 100,000 patients die. Infection during pregnancy can result in congenital malformations in the baby. Onset of chickenpox infection in the mother five days before to two days after delivery results in severe infection in the baby in up to one-third of cases. | About one in 5 has a local reaction or fever. A mild varicella-like rash may develop in three to five of 100 recipients. |
| Human Papillomavirus Genital human papillomavirus (HPV) is highly contagious and many people will acquire an HPV infection within a few years of becoming sexually active. The symptoms for HPV range from no symptoms to genital lesions and warts, cervical and other genital abnormalities and cancers. | High risk HPV types can cause persistent cervical infection (in about 3-10% of infected women) which can result in cervical abnormalities, which can progress to cervical cancer. Up to 50-80% of people will become infected following unprotected sexual contact with a person with active HPV infection. | The most common side effects of HPV vaccine are discomfort, redness and swelling at the injection site. More serious side effects are extremely rare. |

(Department of Health and Ageing 2005 & 2006)

SECTION 2: PREPARING FOR A SCHOOL BASED VACCINATION PROGRAM

This section includes information on liaising with the school, setting a date for your clinic (taking timing and venue into consideration), staffing, equipment, vaccine management, emergency procedures, consent and contingency planning.

2.1 STANDARD VACCINATION PROCEDURES

The current edition of the *Australian Immunisation Handbook* recommends the following vaccination procedures:

- 1 Check availability of the protocols, equipment and drugs necessary for the management of anaphylaxis, before each vaccination session.
- 2 Maintain and monitor vaccine refrigerator, and other 'cold-chain' components, according to current recommendations, and preferably check prior to each working day.
- 3 Provide, to the person to be vaccinated, or that person's parent/guardian, appropriate information about the risks and benefits of vaccination and the risks of vaccine preventable diseases.
- 4 Perform a pre-vaccination assessment to determine the student's medical fitness for vaccination. Any concern about the person's eligibility for vaccination must be discussed with a medical practitioner, paediatrician or public health physician with expertise in vaccination. If a person's health status or suitability for vaccination cannot be determined, defer vaccination.
- 5 Following the provision of appropriate information, and the pre-vaccination assessment, obtain valid consent from the person to be vaccinated, or from that person's parent/guardian. This should be documented.
- 6 Advise the person to be vaccinated, or that person's parent/guardian, that the student should remain under observation in a designated place for a minimum of 15 minutes after the vaccination.
- 7 The schedule, dose, route and technique of administration of the vaccines must be in accordance with National Health and Medical Research Council (NHMRC) guidelines. Note: Each individual dose must be checked to see that the expiry date has not lapsed, and that there is no particulate matter or colour change in the vaccine.
- 8 Administer the vaccine(s). Also check the vaccination status of other family members and offer catch-up vaccination where appropriate.
- 9 Dispose of needles, syringes and vaccine vials in accordance with standard infection control guidelines.
- 10 Advise the person, or the parent/guardian of a child who has just been vaccinated, on the management of the common adverse events that may occur following immunisation. It is important that they be given a contact phone number in case a significant adverse event occurs within 24 to 48 hours of the vaccination.
- 11 Before departure, inform the person or the child's parent/guardian, preferably in writing, of the date of the next scheduled vaccination.

- 12 Document the details of vaccination: (i) on a record to be retained by the person, or the parent/guardian of the person; (ii) on the relevant clinical record; and (iii) on an ACIR (or equivalent) encounter form, for children under the age of 7 years.
- 13 Promptly report any significant adverse event following immunisation to the Adverse Drug Reactions Advisory Committee (ADRAC), or in some instances to the relevant State/Territory Health authorities.

(NHMRC 2003)

2.2 LIAISING WITH THE SCHOOL

2.2.1 Setting a date and time

The first step is to contact the Principal for each school before the commencement of the school year to discuss the school based vaccination program for the coming year. You can provide the Principal's Kit (see Appendix 1) to each school at this time.

Arrange suitable dates and times for vaccination clinic sessions with the school, to ensure the program is accommodated within the school year.

You will need to take into consideration the following when setting a date for your vaccination clinic:

- **School and educational institution terms:** Allow adequate time for school staff to organise their calendars, distribute and collect returned consent forms, and collate them into class groups.
- **Session timing and duration:** Make sure you allow time for adequate post-vaccination observation (15 minutes after the last vaccination). Clinics should finish at least 15 minutes before school closes in the afternoon. Where extensive travel is required, consider transport time and subsequent clinic set-up. Determine the duration of the session by estimating the number of students, number of staff, administration and logistic support at the school. This will vary depending on the systems used to process each class or group of students.

Tips:

- Allow for the minimum time intervals between doses of hepatitis B vaccine for Year 8 students and human papillomavirus vaccine for Year 10-12 females
- Allow time for unavoidable delays at the beginning of the year eg. delays with consent forms
- Don't book the first visit too early – you may have to end up cancelling and rescheduling

Once the date and time are set, it is recommended that the VSP notifies each school in writing when sessions are confirmed and clearly identifies requirements from the school for the sessions. You may use the sample "fax back" form provided in Appendix 2 for this purpose.

Tips:

- Include a “fax back” form with proposed visit dates and requirements (see Appendix 2)
- Follow up with phone calls if the fax back form is not returned or if you need to further discuss dates
- Confirm immunisation dates in writing to the relevant school contact person
- Ensure that a contact person’s details are provided on all correspondence to enable the school/parent/guardian to access further information as required

2.2.2 First time visits

If this is the first visit by the VSP to the school, you will need to supply schools with relevant information concerning what you require to run the school based vaccination program. These may include:

- Details on how to set up an appropriate environment to conduct the session. You will require a well lit and ventilated room with a separate entry and exit is required (eg. school hall), preferably with screens or other means of ensuring privacy for the vaccination procedure, an emergency area, and an attached area for student observation post-vaccination (refer to Section 3.3 for further details). Water should be available for students to drink. Consider the logistics of the environment (eg. if an upper-storey room is suggested it may be cumbersome to bring equipment to the room)
- Nominating a school staff member to assist the VSP
- Making arrangements to deliver consent forms to the relevant year levels at an appropriate time in advance of the session, which are in turn sent home for parents/guardians (see Appendix 3)
- Making arrangements to collect returned consent forms from the school.

A sample letter is supplied in Appendix 2.

2.2.3 Approximately one month prior to vaccination day

Contact the school again to confirm the date. Ensure that the school contact person has confirmed the class numbers.

Arrange (well in advance) with the school to deliver consent forms to the relevant year levels or administrative person in the school. Familiarise the school contact person with the consent forms. There are different colour coded consent forms for Year 8, Year 10, Year 11 and Year 12 students, and for each vaccine. It is the VSP’s responsibility to ensure that there are adequate numbers of consent forms for each student being offered vaccination. Extra consent forms need to be given to the school to distribute to students who have lost their consent forms.

Signed consent forms should be returned to the school within one week of distribution or as per local arrangements. It is preferable that all consent forms are returned regardless of whether consent is given or not given. It is **essential** that written consent is obtained from the parent/guardian. This consent must be produced on the day of the vaccination.

The Queensland Health School Based Vaccination Program consent form must be used to ensure consistency across the State.

School staff are **not** eligible to receive vaccination as part of this program, however they are welcome to take a consent form to familiarise themselves with the contents.

Tips:

- If consent forms are delivered too long before the vaccination day, then it becomes more likely that the forms may not be returned
- Suggest that each class teacher attach a class list to the back of a large envelope, and as consent forms are returned, students can be marked off the list as consent forms are placed in the envelope. This also makes it easier to follow up students who have not returned forms

Confirm requirements for the vaccination day including room requirements, equipment, and assistance on the day (eg. teacher).

Ensure that an immunisation advice telephone number is available to discuss schedule or clinical issues (eg. a current local Population Health Unit contact number).

2.2.4 At least 10 working days prior to vaccination day

Collect all consent forms from the school and check them for irregularities. Allocate sufficient time for vaccinators to review all consent forms. Further contact may be required with the parent/guardian to clarify the information given on the pre-vaccination checklist. This is an ideal time to sort the consent forms into a logical order, such as class groups. If it is the VSP's practice for someone other than the vaccinator to split consent forms into "yes" and "no" piles, the vaccinator must still review all consent forms.

Where it is not practical to collect the consent forms prior to the vaccination day, the teacher should retain the consent forms and distribute them to the students immediately prior to the vaccination clinic. The vaccinator will then need to carefully check each consent form prior to vaccination.

Tips:

- It is important that the VSP reviews consent forms prior to the vaccination session. Irregularities can be followed up which streamlines the vaccination session, minimises disruptions to the VSP and the school and reduces mistakes
- It is quicker and easier on the day to have the consent forms separated into "yes" consents and "no" consents

Arrange times for each class to present to the vaccinators on vaccination day.

Advise staff to encourage students to have breakfast on the morning of vaccination. This has been shown to reduce the possibility of fainting.

Tips:

- The time for each class will vary depending on the vaccines to be administered and the number of vaccinators available on the day
- Be realistic with time allocation and adhere to booked times as this minimises disruption to the school
- Vaccinating on the allocated day meets parent expectations and ensures students have the opportunity to have breakfast on the appropriate day

2.2.5 Promoting the vaccination clinic

Parents/guardians and adolescent students need to be notified of all impending vaccination programs well in advance of the intended date(s). Primarily this will be via the consent forms. Other ways to promote upcoming vaccination clinics include school newsletter articles, flyers, letters, information distributed with school notices, parents and citizens association and like meetings, posters advertising the immunisation clinic days at the school, and the local media.

2.3 STAFFING REQUIREMENTS

Ensure staff resources allow you to fit **all** visits to **all** schools within the current year.

Staff numbers will depend on the anticipated size of the sessions. The staffing should be sufficient to allow for appropriate management of unforeseen events or emergencies.

Please note that all staff providing services at school premises on a regular basis must undergo a Working With Children Check and possess a current Blue Card.

2.3.1 Administrative Officer

Much of the work of a school based vaccination program involves administrative skills both in the planning stage and on the day of the clinic.

In less populated areas with smaller and fewer educational or institutional facilities to organise, a Registered Nurse or Environmental Health Officer may be able to complete the administrative duties.

In more densely populated locations or larger schools, an administrative officer will almost certainly be required as part of the team to efficiently plan the school based vaccination program and ensure smooth running of the clinic(s).

2.3.2 Medical Officer/Registered Nurse

The vaccinator may be a Registered Nurse with appropriate endorsement from the Queensland Nursing Council, a Registered Nurse acting under a Medical Officer's direct supervision, or a Medical Officer.

Appropriately endorsed Registered Nurses are required to practice in accordance with the current *Queensland Health Immunisation Program Drug Therapy Protocol (DTP)*, as approved under Section 175 (3) of the *Health (Drugs and Poisons) Regulation 1996*. The DTP requires the employer to have a current Health Management Protocol (HMP) that outlines the standard vaccination procedures the endorsed Registered Nurse will follow during the course of the vaccination program. Copies of the current *Drug Therapy*

Protocol are available from Environmental Health, GPO Box 48, Brisbane 4001, telephone (07) 3234 0938.

Area SBVP Coordinators and Immunisation Nurses located in Population Health Units can assist you to develop Health Management Protocols. Appendix 4 provides a list of contact details for these staff.

2.3.3 Medical and/or Ambulance Back-Up

Medical and/or ambulance back-up should be arranged in case of emergency.

2.4 EQUIPMENT AND VACCINES

2.4.1 Equipment

The total number of students eligible for vaccination will determine the amount of equipment required.

Depending on organisational requirements, VSPs may wish to order equipment on either a clinic-by-clinic or total program basis. Make sure you allocate adequate time for ordering and supply.

A recommended list of equipment is included in Appendix 5.

Tips:

- Have dedicated containers/trolleys pre-packed with equipment (preferably on wheels)
- Leave a checklist in the equipment box for topping up on return from each school visit

2.4.2 Vaccine supply

The recommended National Immunisation Program vaccines are available to registered VSPs free of charge for the purposes of implementing the school based vaccination program.

Forecasting

VSPs will need to supply enrolment figures for Year 8, Year 10 and female Year 11 and 12 students to the Queensland Health Immunisation Program (QHIP) at the commencement of the school year (semester 1) and at the start of semester 2. This information will assist QHIP to ensure there is enough vaccine for all school based vaccination clinics across the state.

An electronic or hard copy form *Clinic Dates & Student Numbers* can be provided by your area SBVP Coordinator.

Ordering vaccine

- Prior to commencing SBVP clinics, complete the *Order Form* indicating your vaccine requirements for the first two weeks of clinics, quantity on hand (if applicable) and expiry date of vaccines.
- After receiving your *Order Form*, confirmation of your order will be emailed or faxed back to you. QHIP will provide the following:
 - *Order Date* – the date you provided the *Quantity on hand*

- *Dispatch Date* – the date your vaccines are packed by the vaccine distributor
- *EDA (estimated date of arrival)* – the date we expect you will receive your vaccines.
- *VSP No.*
- Order amounts of vaccines
- The *Order Form* must be completed each fortnight to ensure vaccine delivery is not delayed. This form can be faxed back to QHIP on 3234 1452 or emailed using the School Based Vaccination Program email address: SBVP@health.qld.gov.au
- Please keep a hard copy record of your order to refer to at a later date.

Follow up of School Based Vaccination Program Vaccine Orders

QHIP staff may need to contact the VSP to clarify information provided for SBVP orders. If there are any issues pertaining to the vaccine order or delivery of the order, QHIP may contact you by email or telephone. A copy of the *SBVP Clinic Dates & Student Numbers* and *Order Form* can be found in Appendix 6.

Orders outside of Brisbane metropolitan area are despatched on Mondays, Tuesdays or Wednesdays to minimise the risk of vaccine loss due to a breach in the cold chain.

By asking for consent forms to be returned in a timely manner, VSPs may be able to compile a reasonably accurate vaccine order.

Check expiry dates of vaccines on hand and rotate vaccine to use the shortest expiry date first. Keep an accurate vaccine audit of your stock, including recording the number of vials of each type of vaccine taken to each clinic. Any vaccines that may need to be discarded must continue to be refrigerated between +2°C and +8°C until the issues are discussed with QHIP. At the time of discard, vaccines must be recorded on *Vaccines to be Discarded or Transferred form* (refer to section 3.1.4 Unused Vaccines).

Orders should be based on the number of expected eligible students, plus an additional 10% to cover unexpected demand or wastage.

Tips:

- Provide enrolment figures to QHIP at the start of semester 1 and semester 2
- Supply to QHIP a list of planned clinic dates, grades (to be vaccinated on those dates), vaccine required, number of students to be vaccinated
- Provide SBVP vaccine requirements on the dates provided by QHIP and retain a hard copy of your orders for future reference
- Contact your SBVP to obtain an electronic copy of the *SBVP Clinic Dates & Student Numbers* and *Quantity on Hand Form*
- Ensure there is sufficient storage space in the purpose built vaccine refrigerator for school based program vaccines
- Check expiry dates of vaccines and rotate using the shortest expiry date first

2.5 VACCINE MANAGEMENT

2.5.1 Storage of bulk vaccine

The cold chain is the system of transporting and storing vaccines within the safe temperature range of +2°C to +8°C. The cold chain begins from the time the vaccine is manufactured, moves through state vaccine distribution centres and ends when the vaccine is administered.

The VSP should have access to the current *National Vaccine Storage Guidelines 'Strive for Five'*. These guidelines outline the basic principles of safe storage of vaccines. A copy can be obtained from your Area SBVP Coordinator. It is the responsibility of the VSP to ensure vaccine management within their immunisation service complies with the recommendations in these documents.

It is vital that vaccines are stored appropriately to:

- ensure that clients receive an effective vaccine which will provide immunity to the disease
- ensure efficient resource management – vaccines are an expensive resource that can be in limited supply
- avoid students requiring revaccination due to ineffective vaccines
- limit serious adverse events following immunisation.

VSPs must use a purpose built vaccine refrigerator unless otherwise negotiated with QHIP. VSPs must ensure they have sufficient space for the number of vaccines required. Please discuss this with your Area SBVP Coordinator.

2.5.2 Basic principles of vaccine management: people, equipment and process

People

- All people handling vaccines must receive education on how to manage and maintain the cold chain so that vaccines remain safe and effective. This involves all staff members whose roles may affect safe vaccine storage at any stage
- Have a trained designated person responsible for vaccine storage and implementation of protocols
- Have a trained nominated backup person/s available to relieve the designated person when required
- Have a trained designated person/s to receive and store vaccine deliveries.

Equipment

- VSPs participating in the school based vaccination program are required to use a purpose built vaccine refrigerator to store their school program vaccines, unless otherwise negotiated with QHIP. The purpose built vaccine refrigerator should have the ability to:
 - alarm when temperatures outside +2°C to +8°C are reached
 - either display a digital minimum and maximum temperature that can be reset **or** a data logger that continually monitors the temperature of the fridge and can be downloaded daily
 - store the quantity of vaccines required by the VSP to administer during school based vaccination programs sessions as well as other vaccination programs that the VSP may be involved with throughout the year

Please contact QHIP if you require further information on purpose built vaccine refrigerators.

Process

The VSP should:

- Establish simple, routine processes for vaccine management that can be easily maintained
- Establish written protocols to include:
 - ordering and receiving vaccines
 - storage and handling vaccines
 - temperature monitoring and recording
 - equipment monitoring and maintenance
 - vaccine management during transport and storage at outreach sessions
 - risk management for power failures and potential risks to vaccines
 - ongoing education of staff on vaccine management, including orientation of new staff
- Ensure the system and protocols are reviewed at least annually or as required (eg. through an audit, self-audit or peer review system)

2.5.3 Using your purpose built vaccine refrigerator

- Ensure the refrigerator is placed out of direct sunlight and follow the manufacturer's instructions for air circulation around the back and sides
- Ensure the refrigerator is in a secure area accessible to staff only
- Ensure the power source is marked clearly in a way to prevent the refrigerator from being accidentally unplugged or turned off
- Check and record the minimum and maximum temperature
 - every morning before vaccines are used and at the end of the working day
 - last thing Friday afternoon and first thing Monday if the centre closes over the weekend
- Ensure the purpose built vaccine refrigerator has a minimum/maximum temperature monitor to enable twice daily recording of minimum/maximum temperatures. Be aware that there are some purpose built vaccine refrigerators that require daily data logger downloads to monitor minimum/maximum temperatures
- Purpose built vaccine refrigerators should alarm if temperatures outside +2°C and +8°C are reached. This alarm should be tested once a week
- Some purpose built vaccine refrigerators have a back plate that may vary in temperature during their defrost cycle. Ensure vaccines are kept 4cm from the back plate and are not pushed up against it as these vaccines may be compromised
- In the event of a power failure, purpose built vaccine refrigerators with glass doors will lose their cool temperature quickly. Ensure your protocol for power failures is up to date and staff are aware of the procedure
- **Do not overstock** or crowd the vaccines by overfilling the shelves. Allow space between vaccine boxes for air circulation
- If you are storing very small amounts of vaccine in a purpose built vaccine refrigerator, you may need to add thermal mass to the spare space such as bottles of water to ensure even temperature is maintained throughout the refrigerator
- Keep door openings to a minimum and ensure the refrigerator door is not left open for long periods

- If you are using a chart recorder, the chart recorder paper must be changed and stored every seven days
- Depending on the quality and design of your purpose built vaccine refrigerator, it may warm quickly during a power failure. Always have an alternative means of vaccine storage available
- All vaccines must be kept in their original packaging until administered

2.5.4 Stability of vaccines

Vaccines are affected by temperatures below +2°C and above +8°C. If there is any doubt about breaches of the cold chain, contact QHIP during office hours (8am to 4.30pm) by telephoning 3234 1500 for further advice.

Vaccines that must be protected from light include:

- reconstituted Measles, Mumps, Rubella (MMR) vaccine
- reconstituted Varicella vaccine.

2.5.5 Receiving vaccines

Queensland Health uses a distribution contractor to deliver vaccine to VSPs. It is the responsibility of the VSP to ensure vaccines are accepted and received by a responsible nominated staff member trained in vaccine management issues. Vaccines must be checked immediately on arrival to ensure:

- vaccines arrive in good condition
- that vaccine containers arrive intact with lids well sealed
- the cold mark monitor and heat monitor must be checked at the time of delivery; any variations from the manufacturer's recommendations should be reported to QHIP on 3234 1500
- there is ice still present in the ice packs
- vaccines are within their expiry date
- the number of vaccines received is the same as the number on the Vaccine Order Form contained in the order

If there are any discrepancies in the consignment against the packing slip, notify QHIP on 3234 1500.

If the cold mark monitor or the heat monitor have any colour changes that are detrimental to the vaccines (ie. the cold mark monitor bulb is clear unless exposed to temperatures of 0°C and below, and the heat indicator bull's-eye at the centre of the indicator is darker than the outer ring):

- isolate the vaccines in your vaccine refrigerator
- label '**Do Not Use**'
- do not discard vaccine until advice has been sought from QHIP
- contact QHIP by telephone on 3234 1500 as soon as possible.

2.5.6 Outreach clinics

When conducting outreach school vaccination sessions, it is vital that correct cold chain management is continued until the vaccine is administered. Vaccines are particularly vulnerable during both transport to outreach immunisation clinics and at the time of preparation and use. Please refer to the current *National Vaccine Storage Guidelines* for further information.

The type of coolers used by VSPs will depend on the type of clinics to be conducted, the length of time the vaccines will be stored in the box and the ambient temperatures the cooler is likely to be exposed to. When selecting a cooler, please refer to the

National Vaccine Storage Guidelines and the manufacturer for technical specifications and performance of the cooler.

VSPs should be aware that freezing episodes happen very easily in all coolers (often soon after packing) and they are generally not appropriate for prolonged storage of vaccines (more than eight hours).

Equipment required for outreach clinics includes:

- solid-walled insulated container/s with a tight fitting lid (adequate size for transport and storage of vaccines)
- ice packs or gel packs according to number required to transport and maintain required temperature
- insulation material to ensure vaccines
 - do not come into direct contact with ice packs or gel packs
 - are secure and do not move around during transport
- digital minimum/maximum thermometer to monitor the vaccines during transport and at the outreach clinics
- freeze indicator
- temperature log book to record temperatures.

Packing vaccines

Please refer to the current *National Vaccine Storage Guidelines* for information on 'How to pack a cooler' and 'Freezing and conditioning of ice packs and gel packs'.

Monitoring for outreach clinics

Monitor the minimum and maximum temperature of your vaccines:

- before you leave
- during transport if your travelling time exceeds one hour
- when you arrive
- prior to administering
- regularly throughout the vaccination session (at least hourly).

Tips:

Danger: *Incorrect conditioning of ice packs/gel packs may cause vaccines to freeze easily because they may be too cold for safe vaccine storage.*

- Ensure vaccines are not in direct contact with ice packs/gel packs
- Coolers should **not** contain any other pharmaceuticals and **must not** contain food
- Consider the ambient temperatures the cooler is exposed to, particularly in the summer months
- Remember to place left-over vaccines transported for outreach clinics back into the vaccine refrigerator on return to the clinic
- Vaccines returned after an outreach clinic should be used first in the next clinic

2.6 DEVELOPING EMERGENCY PROCEDURES

Emergency procedures must be considered and planned prior to each individual vaccination clinic. The procedure and the roles of those involved may differ according to the venue, the number of people being immunised and the number of staff available to assist. All participating staff must be aware of the emergency plan and their own role in that plan.

The emergency plan should consider the following:

- at least one team member as well as the vaccinator should be trained in resuscitation and Cardio Pulmonary Resuscitation (CPR) techniques - ideally all members should be trained
- particularly in smaller centres, it is advisable to contact the ambulance and local hospital to advise that an vaccination clinic will be conducted on the specified date and time
- ensure a private area is set aside at the venue to treat any adverse reactions to vaccination and that the emergency equipment is accessible to this area
- telephones must be available at each venue, with emergency phone numbers prominently displayed
- appropriate emergency equipment should be available (see Appendix 5)
- anaphylaxis management and treatment records are easily accessible (see Appendix 7)

It is also necessary to ensure that any student experiencing a significant adverse reaction is reported to Queensland Health by filling out the *Adverse Event Following Immunisation – Part A: Initial Report form* (see Appendix 8).

2.7 VALID CONSENT

Valid consent must be obtained from a parent or the person receiving the vaccine before carrying out a vaccination.

2.7.1 Elements of valid consent

The following elements are necessary for valid consent:

- Consent is given freely and voluntarily
- Consent covers the specific procedure to be performed (ie. vaccination)
- The person giving consent has the legal capacity to give such consent
- The person giving consent has been informed of the risks and benefits of the procedure.

For consent to be valid, there needs to be sufficient information provided about the vaccination, including adequate information about the risks and benefits, to enable the person to make a decision. This may include information about common reactions to vaccinations and also the more serious, but rare, side effects or inherent risks of certain vaccines.

The information may be provided verbally by a doctor or nurse or by providing immunisation fact sheets. The understanding and/or knowledge of the person giving consent may be verified through the use of a pre-vaccination checklist.

The person giving consent should be provided with sufficient time to ask questions or request further information. It is also important to consider whether the person may require translation or other assistance.

Valid consent is required before any medical procedure, including vaccination. Valid consent should be attained for a particular vaccination prior to the administration of that particular vaccine and **after** the parent/guardian has received adequate information to make an informed decision. It must also be established that there are no medical conditions that contraindicate the vaccination.

2.7.2 Obtaining valid consent in school based vaccination programs

In most cases, valid consent for school students to receive a vaccination is provided by the parent/guardian of the student. However, as students get older, they gain the capacity to give or withhold consent themselves. Therefore, even in cases where parents withhold consent, students can still consent to receiving a vaccination (or vice versa) provided that the student has a sufficient understanding of the implications of the procedure.

In order for the parent/guardian/student to give valid consent, they must be provided with the following prior to vaccination day:

- information about the vaccine to be administered
- information regarding the comparison of vaccines and vaccine preventable diseases from the current *Australian Immunisation Handbook*, or other appropriate information.

Written and/or verbal information should be available in a language easily understood by the parent/guardian/student and should accompany the consent form that is sent home with students. The school Principal or nominated staff member will be a good resource person to identify parents/guardians/students with special needs. Extra information should be available if parents or the student request it.

A child who is of sufficient capacity and understanding to give consent to his or her own treatment must be given the opportunity to do so. A child of 15 years of age or older (ie. most Year 10 students and older students) is likely to have sufficient capacity to provide consent to their own treatment. Accordingly, the VSP must consider the capacity of a student and where appropriate, discuss the vaccination and obtain their consent prior to administering the vaccine. The student must have been provided with relevant information to give informed consent. In order to address this issue, the Year 10, Year 11 and Year 12 consent forms contain an additional check box on the back page for VSPs to record whether or not the student has given their consent to the vaccination. VSPs should also be aware that both students and parents are to read the information about the vaccination in the front pages of the consent form.

Vaccination should only proceed after written consent from the parent/guardian has been obtained **or** in relation to Year 10, Year 11 and Year 12 students who are capable of providing consent, such consent has been recorded by the VSP on the back of the consent form. The student must produce consent forms on the day of vaccination. Consent forms completed in pencil must not be accepted. If further clarification is required of incomplete details then the vaccinator should contact the parent/guardian (preferably prior to the clinic date) to clarify any issues. Please note any actions taken on the consent form. If there are any problems with the consent form, the vaccine should not be administered.

To obtain valid consent, a consent form must be provided to parents/guardians/students well in advance of the event. Only those students who have returned completed signed consent forms are to be vaccinated on the day of the clinic.

As part of the pre-vaccination procedure, the vaccinator must make his/her own efforts to check the identity of the student. Special effort needs to be made to ensure that the correct student has the correct signed consent form and is given the correct vaccine. A teacher who knows the student should be available to help identify the student by name to the vaccinator checking the consent form.

2.7.3 Withdrawal of consent

If the student is old enough to adequately understand the implications of the procedure, and withdraws their consent, the vaccination should not proceed even if prior written/verbal consent has been obtained from the parent/guardian.

On the day of the clinic, notify the parent/guardian in writing that the student has withdrawn consent and the vaccine was not given (see Appendix 10 for sample letter).

In addition, a parent/guardian may withdraw their consent by:

- attending the school in person to withdraw their consent and to retrieve the signed consent form; or
- providing the school with written notification of the withdrawal of their consent.

If the student or a parent/guardian withdraws consent, the vaccination should not proceed.

2.8 DOCUMENTATION

2.8.1 Clinic/organisational records

It is essential that records can be easily recalled, and that VSPs meet legislative requirements for the length of time records are kept. It is especially important with a computerised database that a backup system is in place.

2.8.2 Parent records

Information must be given to the student detailing the vaccination(s) administered along with the expected side effects and how to manage them. The record of vaccination (attached to the consent form) contains advice on expected side effects and how to manage these.

Parents requesting evidence that their student was vaccinated as part of a school based vaccination program will be notified to the VSP in the first instance. Such requests should be made in writing in order to adhere to privacy legislation. The request letter should include the following details:

- Student's full name
- Date of birth
- Address
- Date of vaccination (or estimate)
- Vaccination requested
- Student's school and year

2.8.3 Vaccine Information and Vaccine Administration System (VIVAS)

VIVAS is an electronic population based vaccination register operated by Queensland Health that has been recording vaccination details in Queensland since January 1996.

A record of all adolescent vaccinations made using vaccine supplied by QHIP should be forwarded to VIVAS at:

VIVAS
Communicable Diseases Unit
Queensland Health
Reply Paid 48
BRISBANE QLD 4001

VSPs should send data to VIVAS via spreadsheet or vaccine software package, rather than as individual records. If the spreadsheet has not previously been provided to VIVAS, it will require approval before it is submitted. Queensland Health has developed a spreadsheet for use in the SBVP if VSPs choose. Contact your local SBVP Coordinator to obtain a copy. Details of the vaccination event must include: VSP number, date of vaccination, student's full name, student's date of birth, student's Medicare number*, student's address, student's gender, student's Indigenous status, vaccine administered and dose number, expiry date of vaccine, and batch number of vaccine.

*The Australian Government has announced its requirement for Medicare numbers to be reported for each student that receives HPV vaccinations.

The Service Agreement between Queensland Health and each VSP requires that data be submitted to VIVAS on a weekly basis. It is important that data is submitted promptly to VIVAS as it provides:

- An important means of accountability and evaluation of the school based vaccination program; and
- A central immunisation history for each student vaccinated.

2.8.4 Australian Childhood Immunisation Register (ACIR)

The Australian Childhood Immunisation Register (ACIR) does not currently record data on vaccinations given to people over the age of seven years. For school based vaccination programs, VSPs will need to send data to VIVAS.

2.9 PRIVACY

Each VSP should have its own privacy policy, which should be available to the public upon request with copies readily available (including at vaccination clinics).

Queensland Health is committed to safeguarding the privacy of client information in accordance with the National Privacy Principles set out in *Information Standard 42A: Information Privacy for the Queensland Department of Health*. Further information regarding the legislation can be obtained from: <http://www.health.qld.gov.au/privacy/>.

VSPs should be mindful of client privacy when conducting administrative procedures, collecting personal information and administering vaccines.

2.9.1 Privacy notification

Parents/guardians and students should be given appropriate notice regarding the use of health information collected as part of the vaccination service.

In Queensland, some VSPs use a computerised database for the generation of their vaccination records. It is necessary that staff using these systems undergo adequate training in their use and are familiar with legislative requirements relevant to the records.

2.9.2 Accessing VIVAS data

Access to VIVAS records for VSPs and use of the data must comply with the *Privacy Act 1998 (Cth)*.

Information about students and their immunisation status may be released to a recognised VSP where the information is sought for a purpose relating to the immunisation or health of the child.

As routine practice, parents/guardians should be advised that vaccination information will be passed to VIVAS and under what circumstances this information is released.

2.9.3 Retaining and disposing of immunisation records

Immunisation records (including consent forms) used in a school based vaccination program must be retained for a period of 25 years from the child's date of birth or for a period of 10 years after the child's 18th birthday (whichever is sooner). Immunisation records should only be disposed of in accordance with the *Public Records Act 2002*.

Administrative records for the school based vaccination program may be destroyed after three years.

2.10 RESOURCES

VSPs should ensure that adequate copies of the latest edition of the *Australian Immunisation Handbook* are available and that the vaccination team is fully conversant with accessing information from this valuable resource.

In addition, a range of resource materials is available from QHIP. Appendix 9 provides a list of appropriate resource material for use by both VSPs and parents/guardians.

2.11 CONTINGENCY PLANNING

Provision must be made to have back-up staff available at short notice in the event of illness or other unforeseen circumstances. This may mean having a designated list of casual staff or co-operative arrangements with other VSPs to assist at short notice.

The administrative officer must identify and organise back-up supplies of vaccines, equipment and alternative transport arrangements to be readily available prior to the commencement of the program.

2.12 OTHER PREPARATION

Area SBVP Coordinators and/or Immunisation Nurses will be able to advise on the latest recommendations in relation to immunisation and can assist in the planning and development of new school based vaccination programs (refer to Appendix 4 for contact details).

In planning, implementing and managing school based vaccination programs, VSPs should ensure that they comply with current legislation, professional standards and codes of practice. Staff should be aware of their occupational health and safety (OH&S) obligations and the program should be conducted in a way that conforms to OH&S requirements.

Ongoing education of staff is a central aspect of quality assurance and it is recommended that all VSPs provide access to a continuous quality education program, to ensure appropriate skills and knowledge of the vaccination team. Copies of *Quality Improvement Guidelines for Public Immunisation Providers* are available from QHIP on 3234 1500.

Providers should conduct a regular review of vaccination services as part of their yearly planning exercise and make appropriate alterations as necessary in order to ensure optimal quality of vaccination services. See Section 4.2 Evaluation of the School Based Vaccination Program for further detail.

SECTION 3: CONDUCTING A SCHOOL BASED VACCINATION CLINIC

3.1 SETTING UP AND CONDUCTING THE CLINIC

3.1.1 Transport to clinic

All equipment except the vaccines should be packed in easy to carry containers prior to the day of the clinic. The vaccines should be packed, meeting the cold chain requirements, immediately prior to leaving the workplace for the clinic. Refer to Section 2.5 Vaccine Management.

Ensure all school based vaccination program staff are familiar with the estimated travel time associated with the location of the venue and the vaccination site within the school.

3.1.2 The clinic environment

Allow adequate time to prepare the clinic area and set up relevant equipment. School staff involved in the clinic can be briefed during this time.

Tips:

- Arrive approximately half an hour before the first class is due to arrive for vaccination
- For security reasons, many schools require you to sign in and collect a visitor badge
- Ensure that you have your Blue Card with you

When setting up, care should be taken to organise for a direct flow of students through the clinic, thereby preventing congestion and confusion:

- students should not be amassed in large groups and kept waiting for long periods of time
- time should be kept to a minimum between the completion of one group and the arrival of the next
- adequate supervision must be provided prior to vaccination and during the 15 minutes following vaccination

Aim to control the flow of students through the vaccination clinic to facilitate an efficient process, and minimise disruption to the school and its students. Assess each situation based on factors such as school size, venue considerations, climatic conditions and staff skills and availability when planning how to conduct each clinic within the program.

For example, assemble everyone one group at a time and send them into the clerical area (and then vaccination area) one at a time, so that a steady stream of individuals is being presented to the vaccinators and groups are brought to the assembly area at timely intervals.

3.1.3 Maintaining the cold chain at the school based vaccination clinic

All vaccines should be stored in the original packaging until prepared for administration. On arrival at the school, place the vaccine container in the coolest place possible making sure it is out of the sun.

Keep vaccines in the container with the lid tightly closed until all other preparation for the clinic has been completed.

In a best practice clinic, vaccines should only be drawn up immediately prior to use.

Should you choose to pre-draw vaccines, then strict cold chain conditions **must** be maintained:

- Only pre-draw enough vaccines to ensure that all vaccines will be used within one hour of drawing up. Take extra care toward the end of the clinic to ensure that excess doses are not drawn up
- Place pre-drawn vaccines on top of an ice brick/freezer block wrapped in bubble plastic or newspaper in a hard sided plastic “six pack” cooler. Ensure the lid is kept closed as much as possible as a number of vaccines are highly sensitive to light
- Regularly monitor the condition of the ice packs to ensure they have not fully melted.

For all day clinics, carry a cooler that contains only ice bricks/freezer blocks and use these to replace those ice bricks/freezer blocks to keep vaccines cool during the clinic and for transport following the clinic. Take care not to expose vaccines to temperatures of 0°C and below. Cold packs and cold washers (for students who faint) may also be kept in this cooler.

3.1.4 Unused vaccines

Loss of vaccine must be minimised at all times. Refer to Section 3.1.3 Maintaining the Cold Chain at the Clinic. Vaccines exposed to temperatures outside +2°C to +8°C must be reported to QHIP on phone 3234 1500 before discarding.

Discard any unused reconstituted vaccines and any pre-drawn vaccines in accordance with clinical waste protocols (refer Section 3.8.2 Waste Management). Record all discards on the *VIVAS Discard Form*.

Return any other unused vaccine to the main vaccine fridge (after transporting them back under cold chain conditions). Place these vaccines in a separate ‘returns’ bin in fridge and use them first at the next session.

3.2 VACCINE PREPARATION AND ADMINISTRATION

3.2.1 Preparing vaccines

The following information is provided as a best practice model in preparing vaccines:

- Each individual dose must be checked to see that the expiry date has not lapsed
- Reconstitution:
 - Use only diluent supplied with the vaccine by the manufacturer
 - Providers should check product information regarding the necessity to protect from light and maximum time for discarding post reconstitution
 - As most reconstituted vaccines deteriorate rapidly at room temperature, cold chain should be maintained until administration
 - Providers should ensure that they are familiar with the recommended time period for use of each vaccine post reconstitution
 - Reconstituted vaccines should be used within the recommend time period
- Aseptic technique must be used to draw up all vaccines
- Needles should be changed after drawing up from a vial

- Ensure there is no particulate matter or colour change in the vaccine
- The recommended dose should always be drawn up and given regardless of the amount contained within the vial

Refer to Section 3.1.4 Unused Vaccines regarding the disposal of vaccines.

3.2.2 Administering vaccines

All vaccines in the National Immunisation Program Schedule can be given during the same visit at different sites (except for multiple doses of the same vaccine, for example, only one dose of hepatitis B vaccine or human papillomavirus vaccine should be given at once). All vaccines appropriate for age should be given at the same visit. Simultaneous vaccination is safe, does not increase the likelihood of side effects and does not compromise the effectiveness of vaccine components. It ensures that all vaccinations are given and provides the best protection against disease.

If a vaccinator elects not to administer a needed vaccine due to a genuine short-term contraindication, the student's record should be flagged and the student should be advised of catch-up options to ensure they receive the vaccine(s) at a later date.

3.2.3 Sites and techniques

The latest edition of the *Australian Immunisation Handbook* gives detailed descriptions for standard vaccine administration techniques including recommended needle sizes, injection site and angle for injection of vaccines in infants, children and adults.

3.3 RUNNING THE CLINIC

3.3.1 Entry/waiting area

Arrivals should be staggered to keep numbers manageable. This will help to keep the excitement level down, minimising fainting and associated hysteria.

Only students with "yes" consent forms should come to the clinic.

3.3.2 Administrative area

The person attending to the administrative duties should have an appropriate level of knowledge of vaccination.

On arrival at the venue:

- where consent forms have previously been returned to the VSP, check the previously sorted class groups of consents against the vaccination list and enquire about absentees and new consent forms
- advise the vaccinator of any change to predicted student numbers
- advise the vaccinator of any irregularities on the new consent forms or conditions noted on the pre-vaccination assessments for appropriate action.

The administrative officer should hand the previously sorted consent forms to the class teacher. The teacher then identifies the student and hands each individual their consent form.

The administrative officer then checks the student's name against the vaccination list and the consent form is given back to the student who then proceeds to the vaccinator.

Alternatively, where the consent forms have not been returned to the vaccination program, the administrative officer should scan the consent form as presented for vaccination and draw the vaccinator's attention to any discrepancies or contraindications to vaccination on the consent form.

NB It is the vaccinator's responsibility to check the consent form prior to a pre-vaccination assessment. Administrative staff are able to provide an additional check.

Tips:

- As each class arrives, the vaccinator may wish to give a brief talk to the students about the vaccination and answer any questions
- Ask students to remove jumpers, roll up sleeves (or take arm out of sleeve as appropriate) and line up alphabetically
- Encourage students who have not had breakfast to have something to eat and drink prior to vaccination (this reduces the possibility of fainting episodes)
- Ask each student their full name (without prompting "are you ..."). This avoids mix up of students with same or similar names
- Mark the students off the class list of those consented and due for vaccination. This is a first check and should pick up errors of students presenting when the list says not consented which can then be clarified by the nurse
- Give student their consent form to take to the vaccinator so they can check each individual's name, contraindications and consent
- When vaccinators are working in pairs, each vaccinator should give one specific vaccine (eg. one vaccinator gives varicella-zoster vaccine (VZV) and the other gives hepatitis B). This avoids confusion and reduces the risk of students receiving the wrong vaccines

3.3.3 Vaccination area

The vaccinator(s) are responsible for setting up the vaccination area and ensuring that the emergency equipment has been checked and is ready for use. Ensure an adequate sized table is provided to allow the vaccinator to set up administration and waste disposal equipment.

Ensure sharps disposal and other clinical waste bins are positioned close to the vaccinator but out of reach of the students.

Adequate hand washing facilities should be nearby. However, if these facilities are not available, antimicrobial hand rub will be required.

Tips:

- Vaccinators may find that there is less strain on their backs if they sit on swivel chairs when vaccinating

Prior to any vaccination, the vaccinator needs to review the student's vaccination history and determine the suitability for vaccination. It is recommended that a clinical assessment is conducted to ensure that the student is medically well enough for the vaccination, has no contraindications to any specific vaccine, and there are no medical precautions to a specific vaccine. Comprehensive guidelines for pre-vaccination

assessments are documented in the latest edition of the *Australian Immunisation Handbook* to assist both medical officers and nurse immunisers. If uncertain whether the person should be vaccinated, consult the current *Australian Immunisation Handbook* in relation to the true and false contraindications to the vaccine(s).

Check the identity of the student against the consent form and ensure the form has been signed. This should include a very brief clinical assessment to ascertain if the student has an acute febrile illness.

Should a student withdraw consent, even though the parent/guardian has provided written consent, it is important to counsel the student and to notify the parent/guardian if they continue to withhold consent.

Check identity and condition of the vaccine to be administered.

The current *Australian Immunisation Handbook* notes that the injection site should be clean and that when the skin is clean, skin antiseptics are unnecessary. If alcohol swabs are used for skin preparation, adequate drying time must be allowed prior to injection to avoid inadvertent introduction of the alcohol during injection, resulting in impairment of the vaccine potency.

Administer vaccine(s) using the correct technique (see the current *Australian Immunisation Handbook* for details on needle selection, needle angle, injection location, and position of the recipient). Some experts, including the World Health Organization, no longer recommend withdrawing the syringe plunger before injecting a vaccine. However it is still acceptable to do so gently if preferred. If a flash of blood appears in the needle hub, the needle should be withdrawn and a new site selected for injection.

Complete and sign all required documentation including the batch number of the vaccine(s) given. Signing of documentation, particularly the record of vaccination, cannot be delegated. Provide the record of vaccination stating which vaccination has been given and outlining possible reactions (attached to the consent form). It is important that the vaccine is not indicated on the post-vaccination information sheet until it has actually been administered.

The student then proceeds to the recovery area.

3.3.4 Recovery area

Students who have been vaccinated should remain under observation for a short time to ensure they do not experience an immediate adverse event. It is recommended that recipients remain in the vicinity of the clinic for 15 minutes. In general, the more severe the reaction, the more rapid the onset. Most life-threatening adverse events begin within 10 minutes of vaccination. It is advisable to provide shade in the recovery area. If possible, avoid concrete and sharp surfaces in this area as they can be hazardous if a student faints.

Teaching staff are ideal to supervise the recovery area as they have recognised authority and may be better able to keep order among students. Vaccinated students should remain seated for at least 15 minutes during the recovery period. It can be useful to distract the students' attention by engaging them in passive activities during this time.

Ensure the recovery area supervisor has been made aware of the signs and symptoms of an adverse reaction. This person should be in verbal contact with the vaccination team so that they can be called upon if assistance is required. The assistance of a qualified health professional should be sought immediately if any of the signs or symptoms described in the following sections are observed.

Vaccinators must remain at the school for at least 30 minutes after the last student has been vaccinated. Check the school sick bay for students who may have attended the clinic, repack stock and seal sharps containers. Leave the clinic area clean and tidy, remove all clinical waste. Leave a contact phone number for the vaccination team at the school.

3.3.5 Emergency area

The emergency area should be separate from the waiting and recovery areas, affording a degree of privacy from other students. However, it must be easily accessible and preferably in the line of sight of the vaccinator.

The vaccinator must ensure the area is set up and checked prior to the start of the clinic. Telephone access, either on-site or mobile, is essential in this area. See Appendix 5 for a list of emergency equipment that should be brought to the venue.

If an adverse reaction occurs, the vaccinator is responsible for instigating the appropriate management (see Section 3.6 Adverse Events Following Immunisation for details on managing adverse events following immunisation).

3.3.6 Exit

Once the observation period is over, the students may return to their normal activities. Ideally, students should be accompanied by the teacher. The exit route should be located away from the waiting area where others may still be queuing for their vaccinations. It is inadvisable to allow those students who have recently been vaccinated to mix with those who are still waiting.

At the end of the session, any names not checked off the vaccination list should be queried with the school contact person to confirm non-attendees. Parents/guardians of absentees or students whose vaccination has been deferred should be advised in writing by handing a note to the teacher to ensure delivery (see Appendix 10).

For students who have not received vaccinations at this clinic, advice on alternative arrangements available for catch-up vaccination should be given.

Finally, the administrative officer should check all vaccine doses, noting the correct number has been administered and any discarded vaccines have been accounted for.

Tips:

- If time allows, the administrative person may be able to collate statistics (this is easier to do one class at a time when you have all the returned forms for the class): number of students in each class, number of consent forms returned, number of consents given, number of consents not given, number vaccinated on the day and number absent on the day. This saves time on return to the office

3.4 MANAGING ANXIOUS STUDENTS

It is important to remember when carrying out school based vaccination programs that students may become anxious or distressed. The vaccinator may alleviate this anxiety by:

- maintaining a calm and reassuring manner with students
- conversing with student at eye level.

An awareness of occupational health and safety is of the utmost importance when immunising in a school setting and dealing with adolescents. Gently supporting the student's arm to vaccinate maintains some control over the environment and prepares the vaccinator for any unexpected movement from the student that could possibly lead to inadvertently harming either the vaccinator or the student.

If safety and/or legal liability is in question, vaccination should not proceed.

A pre-vaccination discussion should allow students to raise concerns before the vaccination, with assurance of confidentiality and privacy.

When a student is obviously distressed or anxious:

- explain that someone will come over to be with him/her
- call for assistance and ask the student to sit on the chair
- assistant to kneel beside the student on the opposite side to the vaccination arm and reassure the student
- instruct assistant to clasp the forearm of the arm to be injected, bend arm at the elbow and rest arm across the student's abdomen holding it firmly in place, together with the other arm.

If the student continues to be uncooperative and obviously distressed, do not proceed with vaccination. Send a letter to the parent explaining the reason why the student was not immunised and recommending the student be offered a catch-up vaccination at either a catch-up clinic or other clinic offered by the VSP as soon as possible (see Appendix 10).

3.5 IMMUNISATION EMERGENCY MANAGEMENT PROCEDURES

Each VSP should establish emergency procedures and protocols and ensure staff training and familiarity so that emergency or unforeseen events are dealt with promptly and correctly.

At least one member of the team must be trained in resuscitation and CPR techniques. Nurse immunisers must complete CPR training as part of their initial endorsement and repeat this training with each mandatory annual update.

It is recommended that VSPs develop emergency procedures which include:

- clear documentation and easy availability at each session of:
 - address of venue
 - map of venue
 - landline and/or mobile telephone (with all staff aware of number)

- key numbers including ambulance service, hospital (rural areas only) and police
- pre-identified roles for vaccination team members in case of emergency
- regular practice sessions of established emergency procedures for vaccination teams
- necessary emergency equipment that is checked regularly according to the manufacturers guidelines to ensure it is in working order
- notification procedures for adverse events following immunisation (AEFI).

3.6 ADVERSE EVENTS FOLLOWING IMMUNISATION

An adverse event is a serious, uncommon or unexpected event following immunisation. Such an event may be caused by the vaccine or may occur by chance after vaccination (that is, it would have occurred regardless of vaccination). Any vaccination may be followed by an adverse event.

Adverse events following immunisation (AEFI) fall into three categories that are not mutually exclusive:

- local – least severe and most common
- systemic – less common than local
- allergic – least common but the most severe.

As part of the pre-vaccination assessment at each visit, seek information from the student about any serious adverse events that may have occurred following previous vaccinations.

3.6.1 Fainting

Fainting is the most common adverse event. Staff education must include:

- awareness about its possibility and ways of avoiding it, especially as fainting has a contagious element to it in students and young adults
- recognition of premonitory signs and symptoms
- the swift intervention required to prevent additional problems such as trauma
- proper management of faints to minimise their consequences.

Fainting is often preceded by paleness and unsteadiness with sweat visible on top of lip. The student may be clammy to touch and appear to be ‘a bit out of it’. The collapse (or faint) that follows is the body’s mechanism of restoring the blood supply to the brain.

The difference between fainting and anaphylaxis is that central pulses (eg. carotid) remain strong during a faint.

If a student looks pale or faints, lay the student down on the floor (on a gym mat), raise their legs on a chair and monitor them until they recover. Send student back to class when they feel well enough or arrange for student to be sent to the school sick room. Complete a “fainting” form and attach to the student’s record of vaccination to be taken home to parent (see Appendix 11).

3.6.2 Managing the warning signs of fainting

All staff involved in the vaccination program should observe students carefully for the following warning signs:

- pallor (especially lip pallor)

- sweating (observe upper lip for early signs)
- clamminess (during vaccination the arm may feel cold and clammy).

If a student indicates he/she is feeling sick or faint, lie the person down immediately, in the emergency area if possible. If they refuse, insist they sit on a chair (or on a gym mat on floor) and stay with the person and observe them until you are satisfied with their condition. If physical signs are satisfactory, administer the vaccine if not yet given.

Make sure you elevate the student's legs. In the event of a near faint, the quicker the legs are elevated, the quicker the faint is overcome.

Feel for the student's pulse. In most cases, this will feel normal or will rapidly return to normal once the person is lying down with their legs elevated. If the pulse is weak and thready, suspect anaphylaxis and continue to observe.

3.6.3 Anaphylaxis

Anaphylaxis due to vaccination is rare but is a true emergency. It occurs in approximately three cases per million vaccinations.

The onset is sudden and rapidly progresses. Anaphylaxis is characterised by circulatory collapse. Initially, there may be a feeling of impending doom and apprehension, followed by tingling of the mouth, a feeling of warmth, difficulty swallowing and chest tightness.

True anaphylaxis and anaphylactoid reactions can occur up to 60 minutes after exposure to the vaccine but the most severe cases occur up to 10-15 minutes after the vaccination.

It is important to ensure that all students vaccinated remain in close proximity to medical attention within the first 15 minutes following vaccination.

In its less severe (and more common) form, early signs are generalised erythema and urticaria with upper and/or lower respiratory tract obstruction. In more severe cases, limpness, pallor, loss of consciousness and hypotension follow.

Health professionals administering vaccines must be able to recognise all the signs and symptoms of anaphylaxis. See current *Australian Immunisation Handbook* for details.

3.6.4 Managing collapse and anaphylaxis

Manage warning signs as you would for fainting (refer Section 3.6.4) by having the student lie down, elevating their legs and feeling for the pulse. With a simple faint, consciousness will usually return rapidly once these measures are taken.

Sometimes signs of fitting may occur - dilated pupils, myoclonic spasms, or even incontinence of urine. If this occurs, initiate the usual first aid by placing the person into the recovery position, maintaining the airway. If possible, the student's legs should remain elevated whilst in the recovery position, for at least five minutes.

If the student's signs do not resolve immediately or if other signs emerge, suspect anaphylaxis and start the emergency procedure as outlined below.

Give adrenaline by deep intramuscular injection for any signs of anaphylaxis, except for erythema (flushing) or itching alone, which are observed for progression. If there is no

improvement in the patient's condition by five minutes, repeat doses of adrenaline every five minutes until improvement occurs.

Adrenaline administration

Adrenaline 1:1000 = 0.01mL/kg of body weight (equivalent to 0.01mg/kg) up to a maximum of 0.5mL or 0.5mg, given by deep intramuscular injection.

| |
|-------------------|
| 13 years and over |
|-------------------|

| |
|-----------|
| 0.4-0.5mL |
|-----------|

The dose of 1:1000 adrenaline for adults is 0.5 mL (0.5mg). Repeat every 5 minutes as necessary until there is clinical improvement.

Two adrenaline packs should be provided for each team. If nurses are called away from the clinic to review a student in another part of the school, they should take one pack and a mobile phone with them to the student.

If oxygen is available, administer by face mask at a high flow rate.

Never leave the patient alone.

Call for an ambulance by dialing "000". You will be requested to provide the following information (you should prepare this information in advance on arrival at each school in case of emergencies):

- Name of school
- Exact street address (current UBD map reference is ideal)
- Nearest road junction or cross street
- Section of school/room name
- Nature of problem
- Your contact phone number

Provide comprehensive clinical information, including medication chart, regarding the incident to the ambulance officer. If an ambulance is called, ensure ambulance officers are met on arrival and directed to the patient. The student's parents must be contacted and informed of the student's condition.

Begin expired air resuscitation for apnoea, and check for a central pulse. If a central pulse is not palpable, commence external cardiac massage (ECM).

All cases must be transferred, with appropriate documentation, to hospital for further observation and possible treatment.

Note that intramuscular adrenaline is the mainstay of treatment for anaphylaxis. This is a S3 drug and as such it can be used by registered nurses immediately without requiring a doctor's authorisation or prescription.

3.6.5 Reporting adverse events

Prompt reporting of AEFI is essential to ensure monitoring of vaccine safety, allow for timely corrective action when needed, and to continually update information regarding vaccine risk-benefit and contraindications. Reporting of AEFI assists in the detection of changes in the rates of known adverse events, any adverse events previously undocumented or adverse events that result from incorrect vaccine delivery.

Any serious or unexpected reaction following vaccination should be reported to the Communicable Diseases Unit, Queensland Health by completing an Anaphylaxis Treatment Record (see Appendix 7) and the *Adverse Events Following Immunisation – Part A: Initial Report Form* (see Appendix 8).

Population Health Units must assess each AEFI and will contact you to follow up on the reported AEFIs.

Occasionally, minor reactions may be noted. These may highlight a problem with technique and are not necessarily true adverse reactions. VSPs may wish to develop and complete incident forms to record minor events (such as faints, injuries, minor local reactions etc). See Appendix 12 for an example.

For details of reportable adverse reactions following immunisation, see the current *Australian Immunisation Handbook*.

3.7 VACCINE ADMINISTRATION ERRORS

Vaccine administration errors may include:

- administering an incorrect vaccine
- administering a vaccine without the parent's/guardian's consent
- administering a vaccine twice to the same person
- administering an accidental 'part dose' eg. needle dislodges (in this circumstance the full dosage needs to be administered).

Should any of these errors occur, document the circumstances, sign and date the notation. Contact the parents/guardians or student and explain that an error has occurred, along with any expected consequences of the error. Generally speaking, there are no untoward effects attributable to these types of errors however, if in doubt, or for more serious errors, contact your local Population Health Unit.

3.8 INFECTION CONTROL

All VSPs must have infection control policies and protocols in place. Infection control programs allow health services to meet legislative and accreditation requirements for safety and quality in health care provision. The *Queensland Health Infection Control Guidelines* have been developed to assist a range of health care services in the design and delivery of an infection control program. By applying generic infection control principles, the risk of infections is minimised. Should VSPs wish to implement these guidelines to meet this requirement, the guidelines are available at: <http://www.health.qld.gov.au/infectioncontrol/guidelines.html>

All occupational exposures need to be fully documented to meet relevant legal requirements.

3.8.1 Needle stick injury

Needle stick injuries are usually preventable by following standard precautions (eg. not re-sheathing needles and having needle disposal units immediately to hand). A needle stick injury involving a needle, which has not yet penetrated anybody else's skin, carries little risk of serious infection.

The risk of bloodborne virus infection following a needle stick injury involving a needle that has already accidentally penetrated another person's skin depends upon a variety of factors. Seek medical advice promptly should such a needle stick injury occur.

Should a needle stick injury occur:

- seek medical advice promptly
- follow standard first aid measures
- report the incident and document as per usual workplace arrangements.

3.8.2 Waste management

Waste generated through school based vaccination programs can be categorised into two groups:

- clinical or related waste, including sharps
- general waste.

The *Queensland Health Infection Control Guidelines* outline waste management in clinical settings, however waste management in community settings and during transport is controlled through the *Environmental Protection (Waste Management) Policy 2000* and the *Environmental Protection (Waste Management) Regulation 2000* administered by the Environmental Protection Agency.

Infectious waste is defined as waste that may or will cause the transfer of infection, including:

- sharps (regardless of whether they have been contaminated with blood eg. needles)
- vaccine waste which may arise from used and partly used vials, or from vaccines that have passed their recommended shelf life
- waste consisting of items contaminated by free flowing blood.

Cotton wool balls, tissues, bandages and band-aids with no free flowing blood are not classified as clinical waste and can go into the general waste stream.

Disposal of clinical waste

Sharps and vaccine vials must be disposed of appropriately in a rigid wall, puncture - resistant and leak proof container. The standard vivid yellow Y 13 container meets the *AS4031 - Non-reusable container* and the *AS4261 - Reusable container requirements*. Sharps bins should be stored in a locked facility until they go to an approved disposal facility. They must also be secured for transport to and from the school vaccination clinics.

Other infectious (contaminated) waste is to be disposed of in opaque containers or thick walled bags (vivid yellow Y13). Household garbage bags are not acceptable.

When transporting waste from clinics:

- transport waste in rigid-walled, leak-proof, puncture resistant containers
- do not use plastic bags
- fit secure lids to containers
- ensure reusable containers are in good condition
- keep the passenger area segregated
- use a vehicle that is easy to load and clean, and is fitted with a method of securing containers, to prevent containers falling in transit.

Disposal of vaccine

According to the *Environmental Protection (Waste Management) Regulation 2000*, vaccines are classed as a restricted S4 drug under the *Health (Drugs and Poisons) Regulation 1996* and are therefore considered to be pharmaceutical waste.

High temperature incineration (ERA76(e)) is currently the only option for the treatment of pharmaceutical waste. The incineration process renders the waste inactive and unrecognisable.

Disposal of general waste

General waste is waste material that will not cause the transfer of infection. There are no specified requirements for the disposal of general waste. Clear bags are recommended for easy identification of inappropriately segregated materials. Opaque bags may be a secondary option.

For further information on waste management in community settings, please refer to: http://www.epa.qld.gov.au/environmental_management/waste/waste_management/

It is an expectation that all waste generated in vaccination clinics is removed from the school or institution and disposed of by the VSP.

SECTION 4: FOLLOWING UP AFTER A SCHOOL BASED VACCINATION PROGRAM

4.1 FOLLOWING UP UNVACCINATED STUDENTS

The school based vaccination program is committed to maximising the number of eligible students immunised with hepatitis B vaccine, varicella-zoster vaccine (VZV), adult/adolescent formulation diphtheria-tetanus-pertussis vaccine (dTpa) and human papillomavirus (HPV) vaccine.

If a student was unable to be appropriately vaccinated during the school based vaccination clinic, the parents/guardians should be notified as soon as possible. This should be in writing and include the reason(s) why the vaccine was not administered. These reasons may include absenteeism, withdrawal of consent or illness on the day. The VSP should notify the school staff member of vaccination sessions to which parents may bring their students to catch up.

A follow-up letter should be forwarded to parents/guardians with details of available vaccination sessions for catch-up. See Appendix 10 for an example letter.

In addition, notices may be placed in the school newsletters at the completion of the vaccination program, advising parents of alternative 'catch-up' vaccination opportunities.

4.2 EVALUATION OF THE SCHOOL BASED VACCINATION PROGRAM

To assist Queensland Health and VSPs to ensure optimal quality of vaccination services and to improve the efficient and effective use of available staff and resources, data gained through monitoring and review should be analysed and interpreted. It is recommended that VSPs establish evaluation methods for collecting vaccination information which must be forwarded to VIVAS. In addition, VSPs should develop procedures for debriefing with the clinic staff, school staff and parents/guardians to assess their satisfaction with the vaccination program. If you require assistance to develop suitable evaluation methods, please contact your SBVP Coordinator.

4.2.1 Vaccine coverage

In addition to forwarding all vaccination information to VIVAS, school based vaccine program VSPs are required to collect data as prescribed in the Service Agreement with Queensland Health. Required data includes:

- Year level of students
- Number of students enrolled
- Number of consent forms returned
- Number of consents given
- Number of consents declined
- Number of students already vaccinated
- Number of students vaccinated
- Number requiring catch-up vaccination.

This information must be provided to Queensland Health monthly.

4.2.2 Clinic staff debriefing

Clinic staff can benefit from a staff debriefing session following the clinic, concerning the planning, conduct and outcomes of the vaccination program. All aspects of the school based vaccination program including liaison, ordering of vaccines, preparation of equipment, emergency procedures, cold chain requirements, valid consent, documentation, venue layout, timing of clinic, setting up and conducting the clinic, any adverse events and waste management should be discussed. It is by doing this that future clinics will become more efficient.

4.2.3 School debriefing

It is important that debriefing discussions are held with the school administration and/or teachers involved in the school based vaccination program. This may be an informal debrief at the conclusion of the clinic. Any issues can be raised and suggestions made as to how improvements can be implemented into future programs.

VSPs are requested to provide each school with a feedback form to facilitate addressing any issues encountered when conducting the program. The feedback form is attached at Appendix 13.

Schools may send their feedback forms back to the VSP, or directly to QHIP.

4.2.4 Parent/guardian satisfaction

In the interests of public health, VSPs have a responsibility to provide sessions that deliver quality vaccination services and encourage students to return for follow-up vaccinations.

In order to assess if the vaccination service provided meets the needs of the parents/guardians, it is recommended that the VSP conducts regular consumer reviews of their service. Possible methods for conducting these reviews include:

- written questionnaires at sessions
- telephone interviews
- mail-out questionnaires
- comments box at sessions.

Possible areas for the VSP to ascertain feedback include:

- the parents/guardians overall satisfaction with the service
- information given prior to vaccination
- quality and quantity of written information
- session layout – privacy for injections, waiting area
- opportunities to discuss concerns with staff
- parent/guardian awareness of who to contact in case of concerns or a reaction.

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