Section 2: Conducting a school immunisation clinic

2.1 Setting up and conducting the clinic

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 cold chain requirements immediately prior to leaving the workplace for the clinic. Refer to Section 4 Vaccine management.

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

The clinic environment

Tips

- Arrive approximately half an hour before the first class is due to arrive for vaccination.
- For security reasons schools require you to sign in and collect a visitor badge.
- Collect any late consent cards or withdrawal of consent from from the school office or nominated school staff member.

Adequate time should be allowed to prepare the clinic area and set up relevant equipment. School staff involved in the clinic can be briefed during this time. 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 and should be sheltered from the sun.

Only students with signed consent cards should come to the vaccination clinic.

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.

The flow of students through the vaccination clinic should be controlled to ensure an efficient process and to minimise disruption to the school and its students. Each situation needs to be assessed based on factors such as school size, venue considerations, climatic conditions, staff skills and availability when planning how to conduct each clinic.

One class should be assembled at a time and sent into the administrative area. Students then move to the vaccination area one at a time, so that a steady stream of students is being presented to the vaccinator/s.

Administrative area

The VSP should hand the returned consent cards to the class teacher. The teacher then identifies the student and hands each student their consent card.

The VSP then checks the student's name against the vaccination list and the consent card is returned to the student who then proceeds to the vaccinator.

Late consent cards may have been returned on the day of the vaccination clinic. The VSP should read the consent card and draw the vaccinator's attention to any discrepancies or contraindications.

Please note: It is the vaccinator's responsibility to check the consent card prior to administering the vaccine.

Tips

- Ask students to remove jumpers and roll up sleeves to expose the deltoid muscle.
- 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 and date of birth (without prompting). This avoids mix up of students with same or similar names.

Vaccination area

The vaccinators are responsible for setting up the vaccination area and ensuring the emergency equipment has been checked and is ready for use. An adequate sized table is to be provided to allow the vaccinator to set up administration and waste disposal equipment.

The vaccinators should 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.

The vaccination area should have a separate entry and exit point so students arriving for vaccination do not cross paths with students leaving following vaccination.

If possible, the vaccination area should be free of stairs and concrete as these areas can contribute to injury following a fainting episode.

Recovery area

Students who have been vaccinated must be observed for 15 minutes to ensure they do not experience an immediate adverse event. **This timeline is not negotiable** as most life threatening adverse events begin within 10 minutes of vaccination. Students who state they are unwell or dizzy should be observed for a longer period or transferred under supervision to the school's first aid officer/sick bay.

The recovery area should be sheltered and readily accessible to the immunisation staff in the event of fainting or an adverse event. All vaccinated students should be requested to sit down during the recovery period.

Teaching staff and if possible a clinical staff member must supervise the students post vaccination. 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 there are any concerns. If possible, stairs, concrete and sharp surfaces in this area should be avoided as they can be hazardous if a student faints.

Once the observation period is over, the students may return to their normal activities; however, strenuous activity should be avoided for at least 30 minutes following vaccination.

Privacy area

It is suggested that an area is available for private discussions and/or vaccination with students if required. This area should be separated from the general area and screened for privacy.

Completion of the vaccination clinic

- Vaccinators must remain at the school for at least 15 minutes after the last student has been vaccinated.
- The status of any student taken to the school's first aid officer/sick bay following vaccination needs to be checked.
- All stock need to be repacked and sharps containers must be sealed.
- The clinic area should be left clean and tidy with all clinical waste removed.
- A contact phone number for the vaccination team should be left with the relevant school contact person.

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/legal guardians or authorised persons of absentees or students whose vaccination has been deferred should be advised in writing using the *Notice to parents of deferred vaccination* (Appendix 3).

For students who have not received vaccinations at this clinic, advice on alternative arrangements available for catch-up vaccination should be given. Finally, the VSP should check all vaccine doses, noting the correct number of doses has been administered and any discarded vaccines have been accounted for.

2.2 Vaccine preparation and administration

Depending on organisational requirements, VSPs may wish to order consumable stock on either a clinic-by-clinic or total program basis ensuring adequate time is allocated for ordering and supply. For a list of recommended equipment refer to Appendix 7.

Tips

- Have dedicated containers (preferably on wheels) or trolleys pre-packed with equipment.
- Have an equipment checklist available so staff can indicate when supply is low.
- Restock at the completion of each vaccination clinic.

Preparing vaccines

- Each individual dose must be checked to see that the expiry date has not lapsed.
- Aseptic technique must be used to draw up all vaccines.
- Needles should be changed after drawing up from a vial.
- Vaccinators need to 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.
- Preparing reconstituted vaccines:
  - Only diluent supplied with the vaccine by the manufacturer should be used.
  - Vaccinators must ensure that the diluent and vaccine are completely mixed.
  - All reconstituted vaccines should be protected from light
  - The vaccinator should check product information regarding the maximum time for discarding reconstituted vaccines.
- When manufacturer prefilled syringes are not supplied with needles, the needles should be attached just before administration. If a needle is attached to a sealed manufacturer prefilled syringe, the syringe should be used or discarded at the end of the clinic day because the sterile seal has been broken.

Best practice

- Vaccines should be drawn up at the time of vaccination. **Pre-drawn doses not used are wasteful**.
- Store vaccines in original packaging until ready for use.
- Some vaccines are highly sensitive to light and should not be exposed until administered.

Problems associated with pre-prepared vaccines

Vaccines should only be prepared onsite at the school clinic. In the event of large or frequent quantities of vaccine being wasted due to having been drawn up and not used, Queensland Health may seek reimbursement of associated costs.

The problems associated with pre-prepared vaccines are:

- Once seal has been broken on prefilled syringes the vaccine is only eligible to be used for the clinic on the day because the sterile seal has been broken. Pre-prepared vaccines can lead to vaccine wastage if excess amounts are drawn up, or if there is unexpected change in the number of students to be vaccinated; for example, a large number of students are on sick leave or the school organises an excursion and forgets to notify the VSP.
- Extra care should be taken toward the end of the clinic to ensure that excess doses are not over-prepared.
- Pre-prepared vaccines increase the risk of vaccine storage under inappropriate conditions; manufacturer supplied vaccine packaging acts as an insulating barrier and includes air pockets to help protect the vaccine from exposure to freezing temperatures and direct sunlight, UV or fluorescent light. Vaccine packaging also provides physical protection to vials/syringes during transport.
- Most plastic syringes are designed for immediate administration and not for vaccine storage. Vaccines supplied in manufacturer filled glass vials/syringes are prepared under sterile conditions that meet standards for proper handling and storage, and they are individually labelled. They have been specially designed by the manufacturers and thoroughly tested to assure vaccine potency and sterility over prolonged storage times. No stability data are available for vaccines stored in plastic syringes where the seal has been broken and needles attached.

Sites and techniques

- Vaccine/s given in the SIP are intramuscular injections into the deltoid muscle.
- Intramuscular vaccines are:
  - dTpa
  - HPV (use student's dominant arm)
  - Meningococcal ACWY
- Blue 23G needle, 25 millimetres in length should be used for all intramuscular injections.
- Do not extrude small air bubbles through the needle for injection. However, in the rare instance of a large air bubble in a pre-filled syringe, first draw back on the needle to ensure no vaccine is expelled along with the air, and then expel the air through the needle, taking care not to prime the needle with any of the vaccine, as this can lead to increased local reaction.The needle should pierce the skin at a 90 degree angle.

Administering vaccine/s

- When the primary course consists of more than one dose, check when the previous dose was given prior to administering the next dose. This is to ensure that the minimum intervals have been met as per the NHMRC guidelines.
- Ask the student to clearly state their first and last name and date of birth.
- Tick or initial the consent card as the student answers each question.
- Tick or initial that the parent's/legal guardian's or authorised carer's signature is in the 'Yes to consent' section on the card.

- Ask all students the pre-vaccination assessment questions and tick or initial this has been completed on the consent card. All students must be given privacy especially female students when asked 'Could you be pregnant?'
- It is recommended that students be seated when being vaccinated.
- The ideal situation is to have the student sitting on a chair (swivel chair is preferable) so both arms can be easily accessed when administering two vaccines.
- Provided the skin is visibly clean there is no need to clean it with an antiseptic wipe.
- Indicate on the consent card which arm received which vaccine by ticking the correct box.
- Batch numbers can be peeled from the vaccine vial or pre-filled syringe and placed onto the consent card (two stickers with batch numbers are supplied per vaccine). One for the consent card and one for the record of vaccination card given to the student.
- As per the recommendation in the Australian Immunisation Handbook, it is not considered necessary to withdraw the syringe plunger before injecting the vaccine. However, if this is done and a flash of blood appears in the needle hub, it should be withdrawn and a new vaccine and injection site chosen.
- Do not rush the process; however, be mindful of the school environment.

If you are uncertain about any of the above issues, do not vaccinate until further clarification has been sought and resolution achieved.

Post vaccination

- Cover injection site quickly with dry cotton ball (tape can be used to secure the cotton ball).
- Students should be advised to place used cotton balls in the appropriate waste receptacle.
- If the student is not allergic to band-aids, small dot band-aids can be used.
- Do not rub the site as this will encourage the vaccine to leak back up the needle track which can cause pain and may lead to local irritation.

Unused vaccines

Discard any unused reconstituted vaccines and any pre-prepared vaccines in accordance with clinical waste protocols (refer to Waste management in Section 2.7). Record all discards on the *Vaccines to be discarded or transferred form* available online at www.health.qld.gov.au/__data/assets/pdf_file/0021/443730/vaccine-discard-transfer-form.pdf

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 the fridge and use them first at the next session.

2.3 Managing anxious students

It is important to remember when carrying out a SIP that students may become anxious or distressed. The vaccinator may alleviate this anxiety by:

- vaccinating anxious students prior to commencement of the main clinic
- maintaining a calm and reassuring manner with students
- conversing with student at eye level
- explaining to students what will happen at the vaccination clinic.

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

If the student continues to demonstrate anxiety and be obviously distressed, the vaccinator should not proceed with vaccination. Instead, a letter should be sent to the parent explaining the reason why the student was not immunised and recommending the student be offered a catch-up vaccination at a catch-up clinic or other clinic offered by the VSP, or by their family doctor as soon as possible (refer to example letter at Appendix 3).

2.4 Adverse event following immunisation (AEFI)

An adverse event following immunisation (AEFI) 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.

An AEFI falls 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, seek information from the student about any serious adverse events that may have occurred following previous vaccinations.

> The most serious immediate AEFI is anaphylaxis. **Anaphylaxis following routine vaccination is very rare, but can be fatal**. However, in adults and older children, the most common immediate adverse event is a vasovagal episode (fainting), either immediately or soon after vaccination.

Anaphylaxis

Anaphylaxis following routine vaccination is very rare but can be fatal and is a true emergency. It occurs in approximately three cases per one million vaccinations. The onset is sudden and rapidly progresses. Severe cases of anaphylaxis are 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.

Anaphylaxis and anaphylactoid reactions can occur after exposure to the vaccine but the most severe cases occur up to 10–15 minutes after the vaccination.

Please note: It is important to ensure all vaccinated students 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 the online version of the *Australian Immunisation Handbook* for details.

Emergency procedures

Emergency procedures must be considered and planned for prior to each school 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 cardiopulmonary resuscitation (CPR) techniques and all members should receive annual training.
- Mobile telephones must be available at each venue, with emergency phone numbers prominently displayed.
- An anaphylaxis response kit must be at hand.
- Emergency equipment must be available (see Appendix 7 for an equipment list)
- VSP may wish to contact their local ambulance and/or hospital to advise that a school vaccination clinic will be conducted on a specified date and time.

Preparing an anaphylaxis response kit

The availability of protocols, equipment and drugs necessary for the management of anaphylaxis should be checked before each vaccination clinic. An anaphylaxis response kit should be on hand at all times and should contain:

- Adrenaline 1:1000 (minimum of 3 ampoules – check expiry dates)
- Minimum of 3 x 1 millilitres syringes (not insulin syringes)
- Minimum of 3 x 23G needles (for deep intramuscular injection administered into the thigh, not the deltoid region)
- Pen and paper to record time of administration of adrenaline on the *Clinical sequence of events flow chart and form* (Appendix 8)
- Laminated copy of *Recognition and treatment of anaphylaxis* (refer to the current *Australian Immunisation Handbook*).

Any student experiencing a significant adverse reaction is to be reported to Queensland Health by completing the *Adverse Event Following Immunisation Reporting Form* (Appendix 9).The form is available online at www.health.qld.gov.au/__data/assets/pdf_file/0033/442968/aefi-reporting-form.pdf

Management of anaphylaxis

Rapid intramuscular administration of adrenaline is the cornerstone of treatment of anaphylaxis. Adrenaline is lifesaving and must be used promptly. This is a S3 drug and as such it can be used by registered nurses immediately without requiring a doctor's authorisation or prescription.

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 into the thigh** (not the deltoid region).
- Adrenaline 1:1000 *must not* be administered intravenously.
- Adrenaline1:1000 contains 1mg of adrenalin per mL of solution in a 1ml glass vial.
- The use of 1:1000 adrenaline is recommended because it is universally available.
- Use a 1mL syringe to improve the accuracy of measurement when drawing up small doses.

The following table lists the doses of 1:1000 adrenaline to be used if the exact weight of the individual is not known.

10-12 years (approx 40kg)	**0.4 mL**
>12 years and over (over 40kg)	**0.5 mL**

The dose of 1:1000 (one in one thousand) adrenaline may be repeated every five minutes as necessary until there is clinical improvement.

Anaphylaxis occurs without warning, usually within 15 minutes of giving a vaccine. A protocol for the management of anaphylaxis, adrenaline, and one millilitre syringes must always be immediately at hand whenever vaccines are given.

The following steps should be undertaken:

- If the student is unconscious place him/her on their left side and position the student to keep the airway clear.
- If the student is conscious, lie supine in 'head down and feet up' position (unless this results in breathing difficulties).
- If there are any respiratory and/or cardiovascular symptoms or signs of anaphylaxis, give adrenaline by intramuscular injection into the anterolateral thigh (see next page for dosage). Adrenaline is not required for generalised non-anaphylactic reactions (such as skin rash or angioedema). If in doubt, intramuscular adrenaline should be given. No serious or permanent harm is likely to occur from mistakenly administering adrenaline to an individual who is not experiencing anaphylaxis.
- Call for the assistance and the ambulance (dial triple zero – '000'). Never leave the student alone.
- If oxygen is available, administer by facemask at a high flow rate.

- If there is no improvement in the student's condition within five minutes, repeat the dose of adrenaline every five minutes until improvement occurs.
- Check breathing: if absent, commence basic life support or appropriate cardiopulmonary resuscitation (CPR) as per the *Australian Resuscitation Council guideline* available at www.resus.org.au/policy/guidelines
- All cases should be admitted to hospital via ambulance for further observation and treatment.
- Complete full documentation of the event, including the time and dose(s) of adrenaline given.
- Experienced practitioners may choose to use an oral airway if the appropriate size is available, but its use is not routinely recommended unless the student is unconscious.
- Antihistamines and/or hydrocortisone are not recommended for the emergency management of anaphylaxis.
- Upon connection to triple zero ('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) or nearest road
  - junction or cross street
  - location within the school
  - nature of problem
  - your contact phone number.

Provide comprehensive clinical information, including a completed *Clinical sequence of events form* (see Appendix 8), regarding the incident to the ambulance officers. 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.

Reporting an adverse event following immunisation (AEFI)

Under the *Public Health Act 2005*, VSPs are required to report any adverse events following immunisation directly to Queensland Health. Prompt reporting of an AEFI is an essential part of surveillance to monitor vaccine and immunisation program safety and to allow for timely corrective action when needed.

Any serious or unexpected reaction following vaccination should be reported to Queensland Health by completing the *Adverse Event Following Immunisation Reporting Form* (Appendix 9), which is also available at www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/aefi-reporting-form.pdf

Forward the *Adverse Event Following Immunisation Reporting Form* within 24 hours of the incident to Queensland Health by:

Email: CDIS-NOCS-Support@health.qld.gov.au OR
Fax: 3328 9434

Enhanced surveillance will be required for implementation of the expanded National HPV Program. Regardless of the vaccine provided, immediate same-day reporting is required for the following AEFIs of acute significance:

- anaphylaxis
- generalised allergic reaction
- any condition requiring referral to hospital or Emergency Department on the same day of vaccination.

This information will be collected by completing the Clinical sequence of events flow chart and form (Appendix 8) as well as the AEFI reporting form (Appendix 9). The Clinical sequence of events form should be completed at the time of the incident. A copy of the form should accompany any student who is referred to hospital, an Emergency Department, or a General Practitioner, and a copy should be faxed immediately after the incident to the nearest PHU. PHUs will then assess each AEFI and will contact you to follow up on the reported AEFI.

2.5 Fainting (vasovagal episode)

Fainting is relatively common after vaccination of adults and adolescents. A strong central pulse (e.g. carotid) persists during a faint or convulsion.

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

Staff education must include:

- awareness about its possibility and ways of avoiding it, especially as fainting has a contagious element to it among students
- recognition of premonitory signs and symptoms
- the swift intervention 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.

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 student down immediately on a gym mat (if possible) or on the floor. Make sure you elevate the student's legs. Stay with the student and observe them until you are satisfied that their condition has improved. If physical signs are satisfactory, administer the vaccine if not yet given.

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.

Faints should be reported to the local SIP coordinator as per local protocol.

2.6 Clinical incident management

A clinical incident is any event or circumstance which has actually, or could potentially, lead to unintended and/or unnecessary mental or physical harm to a student.

Clinical incidents may include, but are not limited to, the following:

- student sustains an injury while being vaccinated, e.g. student moves and needle grazes his/her arm
- student sustains an injury but not as the direct result of vaccination, e.g. student falls in recovery area
- administering an incorrect vaccine
- administering a vaccine outside the recommended schedule
- administering a vaccine without the parent's/legal guardian's or authorised carer's consent
- administering a vaccine twice to the same person
- needle stick injury.

All clinical incidents should be documented (refer to Appendix 10) and reported to the PHU. Hospital and Health Services (HHSs) will document and report clinical incidents as per their HHS protocol.

2.7 Infection control

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 healthcare provision. The *National Health and Medical Research Council (NHMRC) – Infection Control in the Health Care Setting Guidelines for the Prevention of Transmission of Infectious Diseases* can be accessed at www.nhmrc.gov.au/guidelines/publications/cd33. By applying generic infection control principles, the risk of infection is minimised.

Needle stick injury

Needle stick injuries are usually preventable by following standard precautions (e.g. 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 blood borne 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.

Waste management

Waste generated through School Immunisation Programs can be categorised into two groups:

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

The *NHMRC – Infection Control in the Health Care Setting Guidelines for the Prevention of Transmission of Infectious Diseases* 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.

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)
- 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 container must meet 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.

Note, each vaccinator should have their own sharps disposal container.

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

When transporting waste from clinics:

- use 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 www.ehp.qld.gov.au/waste/guidelines-information.html

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