Hull NHS
Teaching Primary Care Trust

IMMUNISATION OPERATIONAL POLICY

FOR

PRIMARY CARE

WITH

UNIVERSAL PROVIDER SERVICES

HARD TO REACH IMMUNISATION POLICY

CONTENTS

INTRODUCTION

This Policy document clarifies the processes, mechanisms and the roles and responsibilities of all Primary Care Staff involved in immunisation programmes. The Policy acknowledges the current context.

Improving access for hard to reach, vulnerable groups of the population is addressed by this policy through a series of communication pathways and interventions, to be carried out by General Practice, Health Visiting, School Nursing and Immunisation Team.

'A high level of knowledge and a positive attitude to immunisation in health care workers are important determinants in achieving and maintaining high vaccine uptake…' (Health Protection Agency 2005 page 3).

The Policy together with mandatory training will equip practitioners to deliver core immunisation programmes, specific campaigns for immunisation and mass vaccination campaigns in response to emergency needs.

It is the responsibility of Line Managers to bring this document to the attention of all clinical staff involved in immunisation.

It is the responsibility of all individual clinical staff to ensure that their practice follows the guidelines, protocols and minimum standards set out in this document. If for any reason the Policy cannot be complied with, staff must bring this to the attention of their line manager.

Section 1

1. The Current Context

The National Service Framework (NSF) for Children Young People and Maternity Services (2004) states the promotion of health and prevention of illness is key themes to addressing health inequalities. This is supported by (Vaccination Services - reducing inequalities in uptake DOH 2005) which states ‘’Unless the local design and delivery of immunisation services are able to reach disadvantaged groups effectively, those people most in need will continue to be left behind’’.

Choosing Health (DOH 2004) calls for a better organisation of local services and the need to identify and improve immunisation rates within areas of low uptake.

2. Purpose of the Policy

This policy sets out the principles and philosophy of the immunisation service together with the standards, guidelines and protocols necessary to provide a high quality, evidence based immunisation service with measurable outcomes. The policy has been developed in consultation with the School Nursing and Health Visiting Service. The policy is subject to regular review and reflects the fact that nursing practice is a dynamic process of evaluation and change as new evidence emerges.

The policy compliments and must be read in conjunction with the following documents:

1. The Operational Framework for Public Health Nursing

2. Patient Group Directions

3. Hull Teaching PCT – Hand Washing Policy

4. Hull Teaching PCT – The Clinical Supervision Framework

5. Hull Teaching PCT – Policy for consent to examination or treatment.

3. Principles and Philosophy of the Immunisation Service

The philosophy of the service reflects the following:

"No child should be denied any indicated immunisation without serious thought as to the consequences for the individual child or the larger community. (World Health Organisation 1980)

The service contributes to the delivery of the child health promotion programme, is grounded in the core standards of the National Service Framework for Children, Young people, and Maternity Service (2004).

4. Patient and Public Involvement (PPI)

This policy and service will be reviewed annually and modified using data from PPI activity.

5. Aim

Provide a flexible service for parents, children and young people which optimises opportunities for immunisation in the community and school setting, working alongside Primary Medical Services.

6. Objectives

- Develop a range of services, following consultation with clients, which address the needs of those individuals who are experiencing barriers to access of mainstream services. DOH Reducing Inequalities 2004

- To contribute to the improvement in the uptake of vaccinations to achieve and sustain a 95% target supporting Be Healthy Outcomes.

- To provide a quality service which will address any concerns the child or family has about the uptake of vaccinations, supporting Strategic Objective 9

- Provide specialist education, training and information to nursing teams across Hull PCT.

- Support the development of a screening service for children who require vaccinations within a controlled environment, which will support the 18 week waiting list target for hospital appointments.

- Develop skills within the wider workforce to enable them to deliver opportunistic advice and support.

- Support Public Health Initiatives which target local high risk groups.

Section 2

Standard Statement

The immunisation service is supported by the Immunisation Team who acts as a resource for other Primary Health care workers in the delivery of a comprehensive immunisation programme. These include Health Visitors, School Nurses, Practice Nurses and District Nurses. The team will promote an integrated approach that is complimented by The Operational Framework for Public Health Nursing.

2.1 Service Delivery Structure

- In order to effectively promote and administer immunisation all primary health care staff involved in immunisation will undertake mandatory basic immunisation training. This will include Basic Life Support and the Management of Anaphylaxis. The training will reflect the National Minimum Standards for Immunisation Training (Health Protection Agency 2005).

- All primary health care staff will work within Department of Health Guidelines, "Immunisation against Infectious Diseases" (1996) and updated chapters (2004).

- All primary health care staff will work within NMC Code of Professional Practice and the appropriate guidelines and policies of Hull Teaching Primary Care Trust. These are listed and included in the Appendix of this document.

- Patient Group Directions will be signed and followed.

- Health Needs Assessment and data generated by the health protection department will inform teams about specific areas in need of targeting.

- There is a need therefore for all Primary Care staff to ensure that immunisation status remains an intrinsic part of routine Health Needs Assessment at each client contact.

- All staff involved in immunisation will work flexibly alongside the Child Health Department in the delivery of the child immunisation programme.

- The immunisation team and all public health practitioners will work proactively to promote the immunisation programme via Health Education in a range of community settings.

- All staff will undertake and participate in audit in line with the clinical governance framework.

2.2 Primary Immunisation Programme – Practice Nurses within GP

Role and Function at General Practice

a. The immunisation and vaccination department are responsible for forwarding schedule lists of children who require immunisation to the GP Practices.

b. It is the responsibility of the individual practice to ensure sufficient appointments are available for those vaccines scheduled, and that sufficient time is allocated to deliver the required number of vaccination.

c. Following vaccination sessions, it is the responsibility of the practice nurse to ensure completed schedule sheets are returned to the vaccination department, within 7 working days.

d. It is the responsibility of the practice to contact children who do not attend by telephone or letter to arrange an alternative appointment, within 7 working days after the missed appointment.

e. Where children continue to have difficulties attending appointments the hard to reach protocols should be followed

2.3 School Based Programme – School Nurses

a. The Child Health Vaccination Team has responsibility for identifying the cohort of children eligible for participation in the programme.

b. Consent Forms are sent to schools from Child Health together with Information Leaflets. Non-returned consents will be followed up wherever possible prior to the session and every opportunity sought to obtain, e.g., by telephone, follow-up home visit or letter. School Nurse in collaboration with the immunisation team and schools where possible. Consent processes are fully explained in the Guidelines for Consent (page 11).

c. The Immunisation Team in consultation with the named School Nurse will actively promote immunisation through Health Education, both planned and opportunistic.

d. The designated person within the team will arrange the date/time of student appointments with the School/School Nurse and Vaccination department.

Role of the School Nurse

- To assist in the identification of Missing Families by co-ordinating Outstanding pre-school booster information with schools and Health Visiting Teams

- To deliver the school based immunisation programme,

2.4 Addressing Inequalities – Health Visitors / Immunisation Team

General Practice and Child Health Surveillance

Primary Vaccinations & MMR

- Every three months the vaccination department will supply lists of children's names who have previously been appointed on schedule lists to GP Practice's, but whose vaccine remains outstanding, to include Primary vaccinations, and MMR still outstanding at 16mths (see flow chart page).

Each child will have three possible outcomes:

Vaccination Given

Enter the date given and contact the Vaccination Department by telephone direct. This represents work done but not recorded on the main Child Health Surveillance System, and may indicate a need to review information flow within the practice.

Vaccination Consent Withdrawn/Reason

Please indicate with a tick if the parents of the children have been contacted and do not wish to have the vaccination. Appointments will then cease, but can be reinstated at any time. Information will be collected by Child Health Surveillance Department for audit of those parents who do not want their child to have the primary vaccines, predominantly MMR.

Vaccination Remains Outstanding

It is recommended that the Practice Staff attempt to contact parents by letter or telephone twice and record this information in either practice notes or computer based records, for audit purpose

Most patients who are contacted in this way will present for a vaccination. If children have not responded to requests to present for vaccination within 2 weeks, a referral for community follow up should be made to the designated area lead for immunisations using the referral form (for audit purposes) and telephone (Appendix A). Community teams aim to follow up parents who have persistent difficulties in accessing universal services or who are difficult to engage within the concept of progressive universalism.

Health Visiting area lead, or named Health Visitor for the practice as locally agreed

Health Visitors, Community Staff Nurse and immunisation teams working together will return the completed information to the Vaccination Department within one month.

Where practice staff becomes aware that families are having difficulties accessing mainstream services, a referral for community follow up can be made at any time in line with the concept of progressive universalism

Home immunisations are undertaken in line with Hull PCT protocols for addressing inequalities and are delivered following assessment and at the Health Visitors discretion at any time.

Role & Responsibility of the Health Visitor

- Identification of additional Health Needs in Children who continue to have an incomplete primary vaccination programme.

- To undertake a home based assessment in collaboration with parent and community staff nurse.

- Vaccination can be given at assessment by prior agreement with the family.

- Home assessment can be undertaken prior to vaccination or in the case of a family with whom the Health Visitor is actively engaged as a part of routine contact visit.

- Children who are identified as having additional Health Needs should be allocated a named Health Visitor and become part of the Health Visitors active caseload.

Role of the Immunisation Team

- **Training & Development**. Working with the training department, undertake training which will enable all primary health care workers to undertake immunisations safely.

- **Strategic Overview.** Working with the wider primary health care team and the Health Protection agency to identify and deliver, a flexible and co-ordinated strategy of interventions to improve immunisation uptake.

- **Targeted Interventions.** Identified by the strategic overview develop alternative delivery systems to support families who have disengaged from the universal service delivery. Low uptake area's

- **Supporting the Hard to Reach Follow up programme** Working with Health Visiting Teams and Practice Nurses specifically in East & Park Areas who currently do not employ community staff nurses.

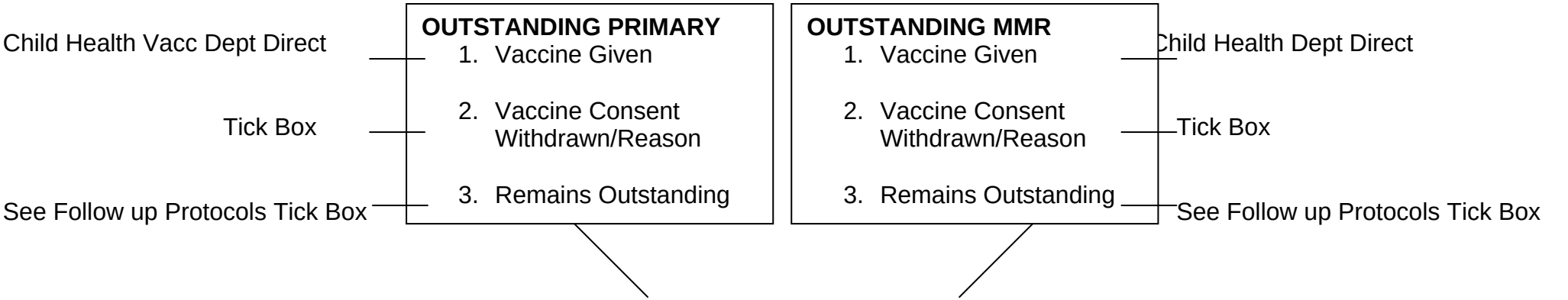
- **Public Health Initiatives** As identified both nationally and locally working with extended primary Health Care Teams and the Public Health Department and Health Protection Agency.

- **Support of Annual School Nursing Programme** Delivered annually, assisting in the collation of consents to vaccinate and co-ordinating mop-up sessions as required.

- **Tuberculosis Strategy** Working in Collaboration with the TB Nursing Team and the named immunisation lead for each area develop co-ordinated delivery plans for the screening of TB in each of the 7 areas.

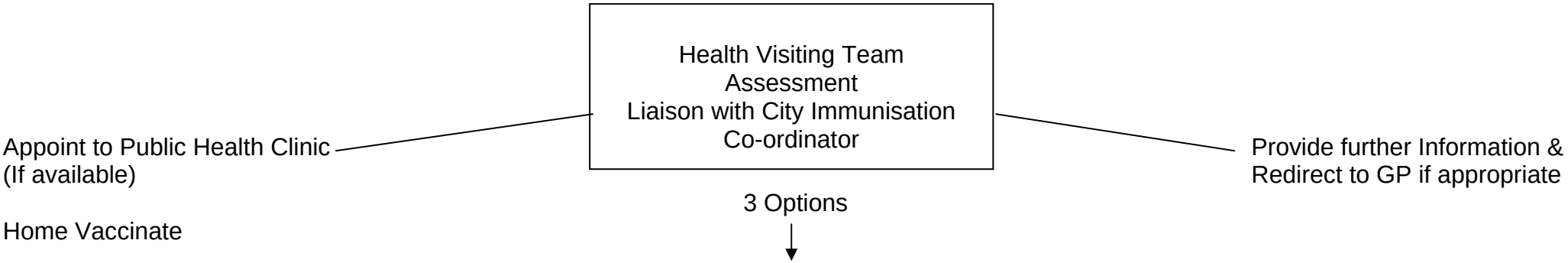
OUTSTANDING PRIMARY AND MMR FLOW CHART FOR FOLLOW-UP

To Practice Nurse
Every 3 months



Completed list with all Information

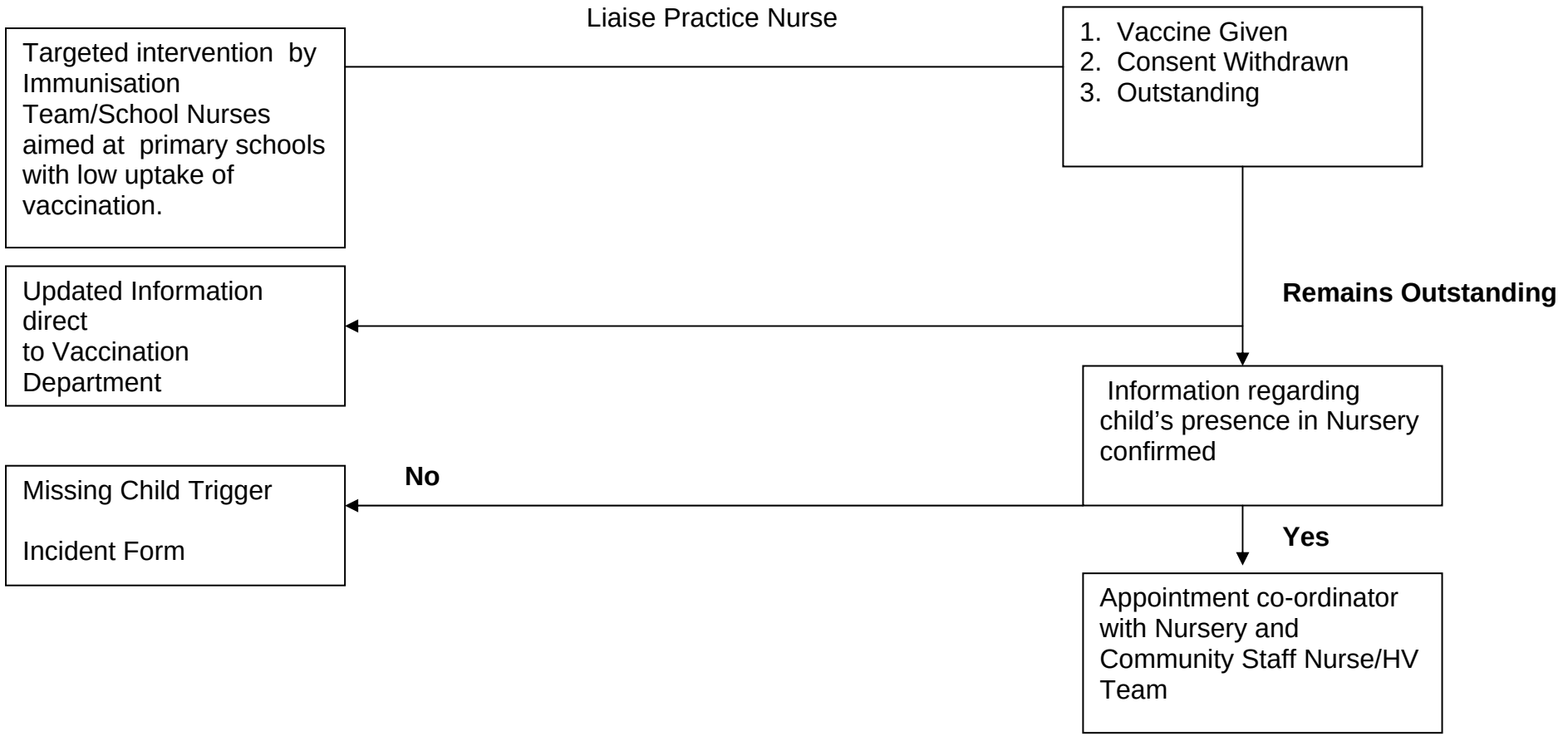
Named Area Lead for Immunisation



All Information to be returned to Child Health Department within one month

Follow up for Outstanding Pre-School Boosters

From Child Health Surveillance



Completed Information to be returned to Vaccination Department

Operation Delivery Framework for Community Follow up

- Contact will be made to the family by the named Health Visitor, Community Staff Nurse or Immunisation Team and either a suitable alternative appointment will be arranged or a home visit to undertake Health Needs Assessment and vaccination will be offered.

- Where a family cannot be contacted, a Health Needs Assessment should be undertaken by a named Health Visitor in line with progressive universalism

- Where vaccination is given in the home, two members of staff should be present, one of whom must be an RGN/RSCN and one of whom must have undertaken Anaphylaxis Resuscitation Training. Home Immunisation protocols should be followed (Appendix B).

- Appropriate documentation in keeping with Record Keeping Guidelines, the GP should be informed and Vaccination Department should be informed.

- Where opportunistic vaccination takes place in a setting other than the GP practice the following will apply –

    - Immunisation History will be confirmed from the parent, parent held record, the GP records and computer records at Child Health

    - Written consent should be obtained.

    - Vaccinations will always be given by a professionally qualified member of staff with support from someone who has up-to-date Paediatric Resuscitation and Anaphylaxis training (Appendix B Protocol for Home Clinic Vaccination)

    - The child's identity is confirmed by the child, parent/guardian.

- A copy of the Referral Form should be returned to the central Immunisation Team following all vaccinations undertaken by the Health Visiting/Staff Nursing teams for audit purposes (Appendix F).

2.5 Asylum Seekers / Refugees

Reports on the health needs of asylum seekers / refugees warn of low rates in vaccination and refers to this as an issue of public health concern (Dobson 2002).

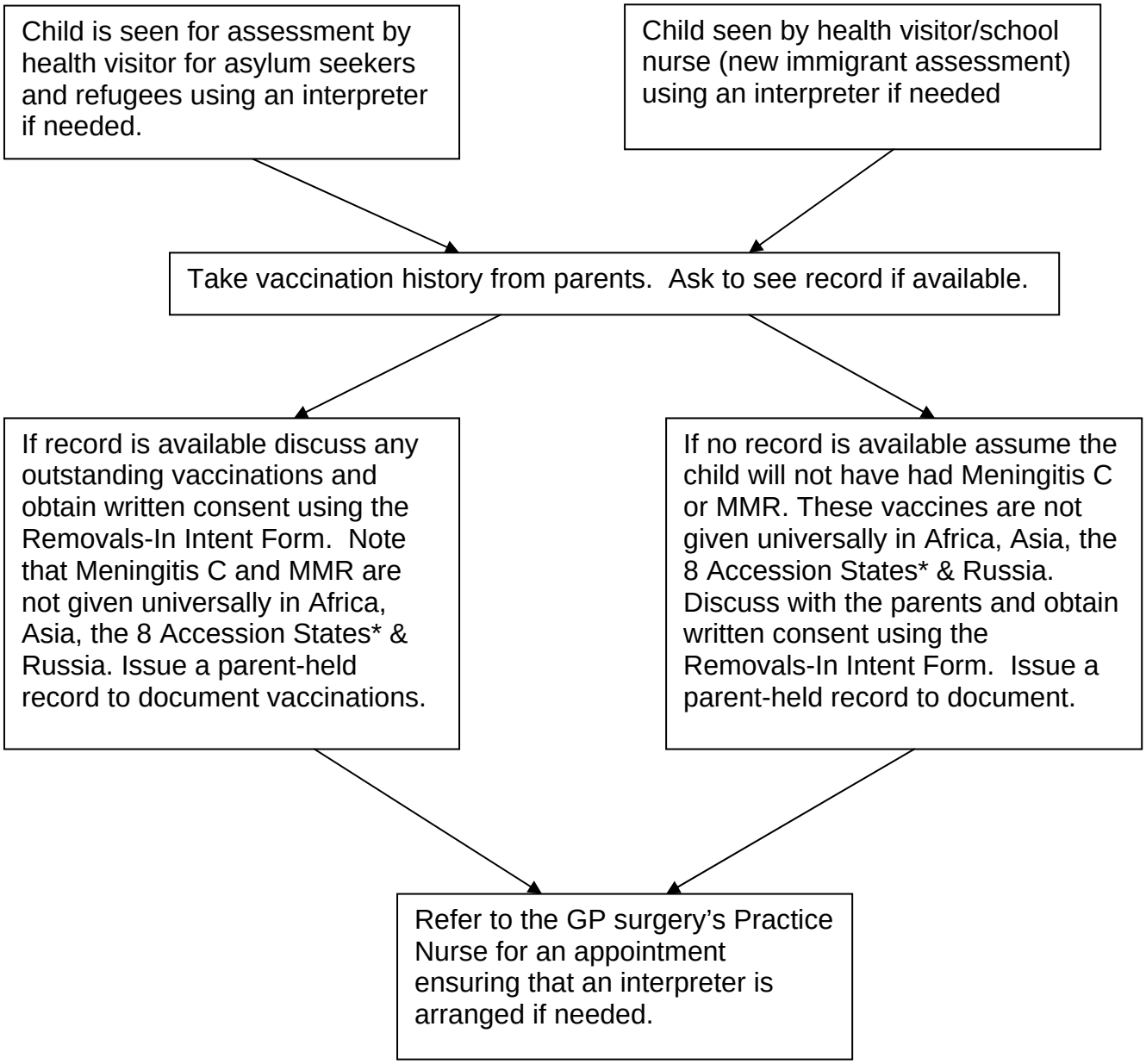
Immunisation Status

Asylum seekers / refugees may have no documentation or knowledge of past immunisation. In the absence of information / documentation to the contrary, children should be assumed to be un-immunised (HPA 2006) and started on a catch-up programme; following current U.K. immunisation schedule.

Practitioners involved in the care of Asylum Seekers / Refugees need to follow the referral pathway to ensure children receive outstanding vaccines.

Asylum Seekers / Refugees Referral Pathway

Immunisation pathway for asylum seeker/refugee and new immigrant children - 0-18 years.



Hull PCT have a contract with ITS – (Interpretation and Translation Service)
Telephone 01482 331544/5

Also see attached Removals-In Intent Form

** Poland, Hungary, Slovenia, Slovakia, Czech Republic, Estonia, Latvia & Lithuania*

2.6 Guidelines for obtaining consent to immunisation

Obtaining consent is essential and has three functions:

1. A legal function to ensure that the individuals right to autonomy has been addressed.

2. A clinical function to foster trust and co-operation with children and parents as clients of the service.

3. An educative function that informs about the benefits and potential risks of treatment.

There is no legal requirement to obtain written consent as legally verbal consent is acceptable possible.

Consent

- Written consent is obtained when home vaccination or clinic vaccination where no doctor is present, as this is outside the usual pathways of the primary immunisation programme. (Appendix C)

- The immuniser signs to say that they have given information and are confident that this has been understood.

- The person with Parental responsibility signs that they have received adequate information and agree to immunisation.

- People looking after a child do not have parental responsibility but can be authorised by parents to take medical decisions. The professional immunising should be satisfied that there is no recorded disagreement with immunisation and that the person with parental responsibility is aware and has made arrangements (The Children's Act Section 2 (9)) 1989.

- Consent form should be stored in the Child Health Record.

The primary immunisation programme

- It is the responsibility of the Health Visitor to obtain the 'Immunisation Intent' form and the Pre School Health Examination Centre Details form. This is consent for Child Health to generate appointments for immunisation.

- As part of the process for obtaining consent for any immunisation this should be discussed with the person with parental responsibility / young person prior to administration. Relevant supporting literature should be given and opportunity for discussion and any questions answered. The advantages/disadvantages, possible side effects and how to treat should be discussed.

The School Based Immunisation Programme

<u>Consent and the under 16's</u>

A young person may consent to immunisation once the immuniser has assessed the young person's competency and all the relevant documentation has been completed. (Appendix D) The process of assessing the competency of the young person must be evidenced in the child health record by the nurse immuniser.

2.7 Administration of Vaccines

Responsibilities of the nurse immuniser

It is the responsibility of the nurse immuniser to ensure that:-

- They have completed all training and are competent to administer vaccines and the management of anaphylaxis
- They have read, understood and signed all Patient Group Directions for the vaccines to be administered
- They are familiar with and work to all the standards, protocols and guidelines in this operational framework.
- Liaise with the Lead Nurse should any query arise
- Report any untoward incident to the Lead Nurse
- They are responsible for drawing up the required vaccine prior to administration.
- Checking the name of the child against the vaccine given with a second person, prior to administration.

Protocol for administration of vaccines by injection at school based immunisation sessions

Aim:

To carry out safe methods of vaccination

Roles and responsibilities of the Lead Nurse

It is the responsibility of the Lead Nurse to ensure each session is

a) Risk Assessed
b) Planned
c) Implemented
d) Evaluated

The Lead Nurse must ensure that they have completed all the relevant training and are competent to undertake the role in line with this operational framework.

Assessment of risk

The Lead Nurse will ensure that the working environment is assessed for risk to ensure safety for clients and staff using the following criteria

- The area will support the privacy and dignity of clients
- Appropriate work space is available for immunisers and there is an area designated for unwell pupils
- The appropriate equipment is available and checked

Planning

The Lead Nurse will ensure that sessions are planned in advance by liaising with the school and named School Nurse to ensure that:

- The length of the session is appropriate for the number of children to be immunised

- Staffing levels will allow a minimum of 4 minutes per client

Implementation

The Lead Nurse is responsible for:

- The delegation of roles and responsibilities ensuring that staff are adequately briefed at the start of each session

- Liaising with parents and the school as necessary

- Act as the main point of contact for the nurse immuniser

- Where the Lead Nurse observes any protocols, policies or guidelines are not being followed they will take action to remedy this immediately

- Any untoward incident is reported in line with the Clinical Governance Framework

Evaluation

The Lead Nurse will support staff in evaluating each session:

- By ensuring that staff are debriefed
- Following the Clinical Supervision Framework

2.8 Guidance for the Management of Anaphylaxis

Anaphylactic reactions to vaccines are extremely rare but have the potential to be fatal. All Primary care staff involved in immunisation should be able to distinguish an anaphylactic reaction from fainting and panic attack.

Fainting is relatively common when vaccinating adults and adolescents, but infants and children rarely faint. Sudden loss of consciousness in young children should be presumed to be an anaphylactic reaction, particularly if a strong central pulse is absent (Green Book 2006 Chapter 9 page 5).

In the event of an anaphylactic reaction all staff will follow the British Resuscitation Council (UK) algorithms which relate to the treatment of anaphylaxis, see appendix K and L.

PROTOCOL

1. Call medical help / Ambulance – request 'Blue Light'. **Do not leave the patient alone.**

2. Lie patient down, ideally with the legs raised (unless the patient has breathing difficulties) (Green Book 2006 Chapter 9 page 5).

3. Administer Adrenaline (Epinephrine) 1:1000 (1mg/ml) as per Patient Group Direction Intramuscularly into the thigh slowly over one minute.

4. Give oxygen 100% via face mask (if available).

5. The dose of Adrenaline as per dosage chart in Patient group Direction can be repeated after 5 minutes if no clinical improvement in BP, pulse and respiratory function.

(British Resuscitation Council, 2005)

See Appendix E – Resuscitation Equipment

Anaphylactic Shock: Treatment Algorithm for Children in the Community

Insert page

http://www.resus.org.uk/pages/anapost2.pdf

(Current Resus Council Anaphylactic Reactions – Initial treatment)

2.9 Vaccine Management And Storage – Guidelines For Maintaining The Cold Chain

Vaccines should be stored in conditions that maximize their potency and assist vaccine efficiency rates (the cold chain).

The Cold Chain

The cold chain is a system designated to ensure that each vial of vaccine is maintained under appropriate conditions until its use. The cold chain begins when the vaccine is manufactured, moves through to the distribution centre, continues with the transportation and storage of the vaccine and ends with the local immunisation provider at the time of administration. Failure to maintain the temperature anywhere along the chain from delivery to storage will decrease the vaccine potency.

Vaccines are delicate biological substances that become less effective or destroyed if the are:

- Frozen
- Allowed to get too warm or hot
- Exposed to direct sunlight or fluorescent light

Vaccines should be stored and maintained within the recommended temperature range of 35º F (2º C) to 45º F (8º C)

Transport and storage management

- Vaccines should be transported to surgeries and health centres in refrigerated containers or dedicated cool boxes

- Vaccines should be checked on arrival at surgery or health centres to ensure the cold chain has been maintained and that there is no damage to vaccines

- A designated person should take responsibility for storage and handling

- Care should be taken not to overstock on vaccines and ensure stock rotation

- Vaccines should be placed immediately on receipt into a refrigerator that is specifically designated to store vaccines

- Storage of vaccines in fridge should be adequate, not more that 50% full to allow air to circulate

- Vaccines should not be stored in storage compartments in the fridge door

- Vaccine fridges should be lockable and kept locked

- Domestic refrigerators **ARE NOT** suitable for vaccines storage

- Food, milk or specimens **SHOULD NOT** be placed in the vaccine fridge

Maintaining and Monitoring Refrigerator Temperatures

Measures need to be in place to prevent an accident or unannounced disruption of the electrical supply to the fridge, which can cause a break in the cold chain. Switchless sockets and notices on switches not to switch them off may be an option.

A fridge thermometer needs to measure the temperature close to the vaccine vials. The thermometer is required to keep an accurate measure of the temperature of the fridge, particularly overnight and at weekends.

- **A digital type maximum/minimum thermometer is recommended for use, irrespective of what type of built-in mechanism is present within the fridge.**

- **The maximum/minimum temperature should be taken and recorded daily by suitably trained person who is responsible for the management of the fridge.**

Maintenance of the vaccine refrigerator

- Ensure regular maintenance by the manufacturer or qualified technician

- Report breakdowns immediately so repairs can be made

- Check door seals regularly to ensure cold air is not leaking out. Replace damaged or worn seals

- Defrost fridge regularly if fridge requires defrosting

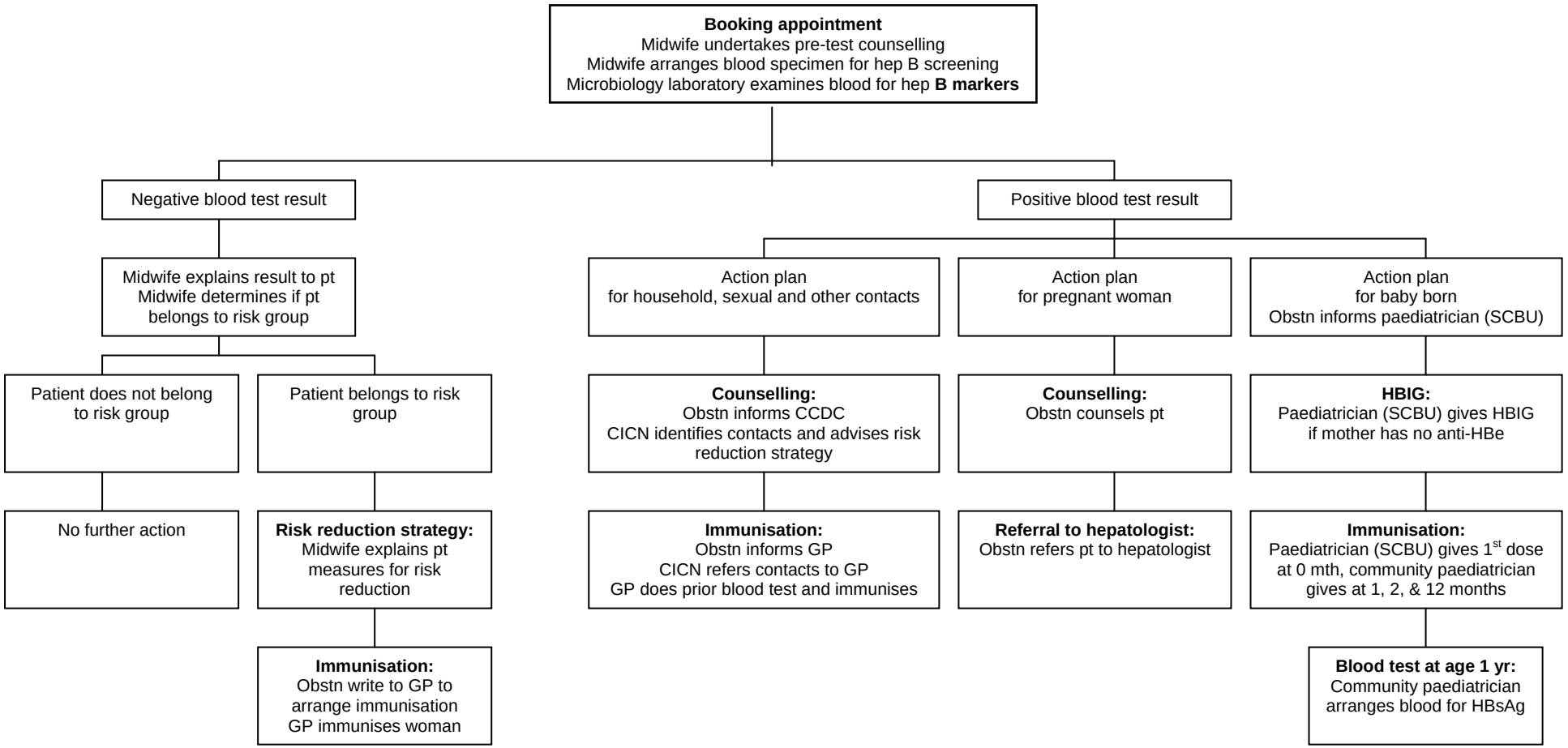
- Ensure area around fridge (behind and under) is clean and dust free

- During defrosting or cleaning of fridge, move vaccines to another fridge

- Ensure the other fridge is monitored at the recommended temperature range: 35º F (2º C) to 45º F (8º C)

Section 3

Universal screening of pregnant women for hepatitis B



NB. For cases who opted for home confinement the named midwife arranges referral, notifications, and immunisation in discussion with the GP.
CICN: Community Infection Control Nurse
Obstn: Obstetrician
HBIG: Hepatitis B immunoglobulin

Section 4

Measurable Indices

Audit of categories of those at risk of low uptake of immunisations will be carried out as identified in Choosing Health (2004) using referral criteria to community health teams.

A1 Children in Care
A2 Young people who missed previous immunisations
A3 Children with physical or learning difficulties
A4 Children of lone parents
A5 Children not registered with a General Practitioner
A6 Children in larger families
A7 Children who are hospitalised
A8 Minority ethnic groups
A9 Vulnerable adults e.g. Asylum Seekers and the Homeless
A10 Travellers
A11 Other

A copy of the Referral Form should be returned to the central Immunisation Team following all vaccinations undertaken by the Community Health Team.

Outcomes

- Parents and young people can make informed choices about immunisation.

- Maximum uptake will be achieved and the incidence of Infectious Diseases will be reduced.

- Practitioners will be trained and competent in all aspects of immunisation including consent, contra-indications to specific vaccines and the management and treatment of anaphylaxis.

- Primary Health Care Staff will have access to clinical staff who is clinical experts.

- The delivery of local immunisation services will be developed with client input through PPI and audit activity.

Hull NHS
Teaching Primary Care Trust
Immunisation Team
Clarendon Health Centre
Victoria House,Park Street
Hull, HU2 8TD

Tel: (01482) 335703
Fax: (01482) 336917

Appendix A

REFERRAL FOR COMMUNITY TEAM FOLLOW-UP

Name …… **DOB** …… **M/F** ……

Address……

……**Post Code**……...

Contact No …… **Parent/Guardian Name** ……...

G.P. ……...

HV / PN / SN (please specify) ……**Base:** ……

Referral Details ……

……

Referral Code ***(Please tick appropriate box)***

A1	**Children in LAC system**		**A7**	**Children who are hospitalised**	
A2	**Young people who missed previous immunisations**		**A8**	**Minority ethnic groups**	
A3	**Children with physical or learning difficulties**		**A9**	**Vulnerable adults, e.g. Asylum Seekers and the homeless**	
A4	**Children of lone parents**		**A10**	**Travellers**	
A5	**Children not registered with a General Practitioner**		**A11**	**Other** (please give details)……. …… …… ……	
A6	**Children in larger families**				

Signed ……**Date** ……

Audit Information

Referral received ……

Vaccine(s) required …… ……

Home visit appointment date ……

Signed ……

APPENDIX B

Protocol for Home / Clinic Vaccination

1. **Prior to vaccination**.

   (a) Check with Child Health and GP surgery which immunisation is outstanding (see referral pathway)

   (b) Contact parent by either letter / telephone

   (c) Check the name of the child against the vaccination to be given with a second person.

   (d) Draw up only the vaccination for one child at a time.

   (e) Confirm the child's identity with the child, parent/guardian

2. **Home vaccination is only undertaken if:**

   (a) A working telephone either Mobile or Land line is available.

   (b) Access to resuscitation equipment is available and working.

   (c) Two staff present, one of whom is a registered nurse and one trained in resuscitation/anaphylaxis.

3. **Home Vaccinations**

   (a) Guidelines for consent must be followed.

   (b) Complete checklist for contraindications to vaccine.

   (c) Ensure all Child Health Records are completed if available including parent held record if available.

   (d) Ensure **batch number** and **date of expiry** are checked and recorded.

   (e) Unscheduled form to be sent to Vaccination and Immunisation Department.

   (f) Arrange further appointments if required.

   (g) Information should go to GP / Practice Nurse, Health Visitors and School Nurse.

Hull NHS
Teaching Primary Care Trust

Appendix C

Parent/Guardian – Consent for Immunisation

Name …… **DOB** ……..

Address ……

GP …… **School Attended** ……

Immunisation Offered:		Batch No. / Exp Date:	Parent/Guardian	Nurse	Date
- 1st Primary	DTaP/IPV/Hib:	……	……	……	……
	1st PCV:	……	……	……	……
- 2nd Primary	DTaP/IPV/Hib:	……	……	……	……
	1st Men C	……	……	……	……
- 3rd Primary	DTaP/IPV/Hib:	……	……	……	……
	2nd Men C:	……	……	……	……
	2nd PCV:	……	……	……	……
- Hib / Men C:		……	……	……	……
- 1st MMR:		……	……	……	……
& 3rd PCV:		……	……	……	……
- PSB	DTaP/IPV:	……	……	……	……
	2nd MMR:	……	……	……	……
- Other		……	……	……	……

The advantages and disadvantages of these immunisations have been fully explained to me. I have had the opportunity to ask questions and consent to immunisations been given.
I understand that I can withdraw my consent at anytime. All child health records are stored on a central computer and the statistics may be used in the future for research purposes.

Parent/Guardian Signature…….…… Date ……

Nurse Signature ……..…Date ……

Pre-Vaccine Checklist

Date:						Comments
Are you well today?	Y/N	Y/N	Y/N	Y/N	Y/N	
Are you on any medication or receiving any medical treatment?	Y/N	Y/N	Y/N	Y/N	Y/N	
Do you have any allergies?	Y/N	Y/N	Y/N	Y/N	Y/N	
Have you had any reactions to previous vaccines?	Y/N	Y/N	Y/N	Y/N	Y/N	
Have you had any vaccines in the last 3-4 weeks?	Y/N	Y/N	Y/N	Y/N	Y/N	
Could you be pregnant?	Y/N	Y/N	Y/N	Y/N	Y/N	

I have explained the immunisations to the child/ young person and his or her parents. In particular I have explained the advantages and disadvantages of the proposed immunisations.

Nurse Signature……**Date**……

Name (PRINT)……**Job Title**……..

Statement of interpreter
I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand

Signed…….…… **Date**……..

Name (PRINT)……

Appendix D

Young Persons – Consent for Immunisation

Name ……**DOB** ……..

Address …….. **GP** ……

School Attended……

Immunisation Required:	**Batch No.**	**Young Person**	**Nurse**	**Date**
Td\IPV	……..	……	……	……..
2nd MMR	……..	……	……..	……
Other	……..	……	……	……..

The advantages and disadvantages of these immunisations have been fully explained to me. I have had the opportunity to ask questions and consent to immunisations been given.

I understand that I can withdraw my consent at anytime.

All child health records are stored on a central computer and the statistics may be used in the future for research purposes.

Young Person Signature…… Date ……

Nurse Signature ……Date ……

Pre-Vaccine Checklist

DATE						**COMMENTS**
Are you well today?	Y/N	Y/N	Y/N	Y/N	Y/N	
Are you on any medication or receiving any medical treatment?	Y/N	Y/N	Y/N	Y/N	Y/N	
Do you have any allergies?	Y/N	Y/N	Y/N	Y/N	Y/N	
Have you had any reactions to previous vaccines?	Y/N	Y/N	Y/N	Y/N	Y/N	
Have you had any vaccines in the last 3-4 weeks?	Y/N	Y/N	Y/N	Y/N	Y/N	
Could you be pregnant?	Y/N	Y/N				

Statement of health professional
I have explained the immunisations fully and completed the pre-immunisation checklist with the young person. In particular I have explained the advantages and disadvantages of the proposed immunisations

Signed…….. **Date……**……..…

Name (PRINT)…… **Job Title**……

Appendix E

Resuscitation Equipment.

In the Community Clinic:

- ☐ Airways for 0 years – Adult [Infant: 00- blue; Child: 1– white; Medium Adult: 3 - orange]
- ☐ Ambubag x1
- ☐ Selection of face masks
- ☐ 1 x pocket mask
- ☐ Mucus extractor with 30ml trap and mouthpiece
- ☐ Mouthshields suitable for use with children
- ☐ 4 x 23g needles
- ☐ 4 x 1ml syringes
- ☐ 2 x ampoules – adrenaline 1:1000 solution

In the School Environment:

(Supplied by Vaccination and Immunisation Department, Victoria House for each session).

- ☐ Airways for 4 years – Adult. [Child: 1– white; Medium Adult: 3 - orange]
- ☐ 1 x Ambubag
- ☐ Selection of face masks
- ☐ 1 x pocket mask
- ☐ Mucus extractor with 30ml trap and mouthpiece
- ☐ 4 x 23g needles
- ☐ 4 x 1ml syringes
- ☐ Sphygmomanometer
- ☐ Stethoscope
- ☐ Mouth shields suitable for use with children
- ☐ Clinical thermometer
- ☐ 2 x ampoules – adrenaline 1:1000 solution

Appendix F **IMMUNISATION AUDIT TOOL**

A1	**Children in LAC System**	
A2	**Young people who missed previous immunisations**	
A3	**Children with physical or learning disabilities**	
A4	**Children of lone parents**	
A5	**Children not registered with a General Practitioner**	
A6	**Children in larger families**	
A7	**Children who are hospitalised**	

A8	**Minority ethnic groups**	
A9	**Vulnerable adults, eg. Asylum Seekers and the Homeless**	
A10	**Travellers**	
A11	**No access gained**	
A12	**Other** please specify below …… …… …… ……	

Visited By:	Name:
Health Visitor:	
Community Staff Nurse:	
School Nurse:	
Immunisation Nurse:	

To be completed by Immunisation Team:

GP:	
Signature:	
Print Name:	
Date:	

Appendix G

Adrenaline dosage in volume (To be given normally by intramuscular injection) (May be repeated once, in 5 minutes if no clinical improvement)	
Age	Volume of adrenaline 1 in 1000
Under 6 months	0.05 ml
6 months - 6 years	0.12 ml
6 - 12 years	0.25 ml
Over 12 years	0.5 ml (0.25 ml if child is small or prepubertal)

DRUG DOSAGES AND GENERAL GUIDANCE NOTES

Emergency Treatment Pack for Anaphylaxis

List of contents

1. Adrenaline Injection BP 1 in 1000 (1 mg/ml):
   1 ml ampoule 3 ampoules
2. Syringes:
   - 1 ml syringe 5
   - 2 ml syringe 2
3. Needles:
   - 25G25mm (orange) 5
4. Airways: 3 assorted sizes of airways: blue (size 00) for infants, white (size 1) for child, and orange (size 3) for medium adults
5. Mucus extractor with 30 ml trap and mouthpiece
6. Mediswabs 10
7. Copy sheet of "Drug dosages and general guidance notes"

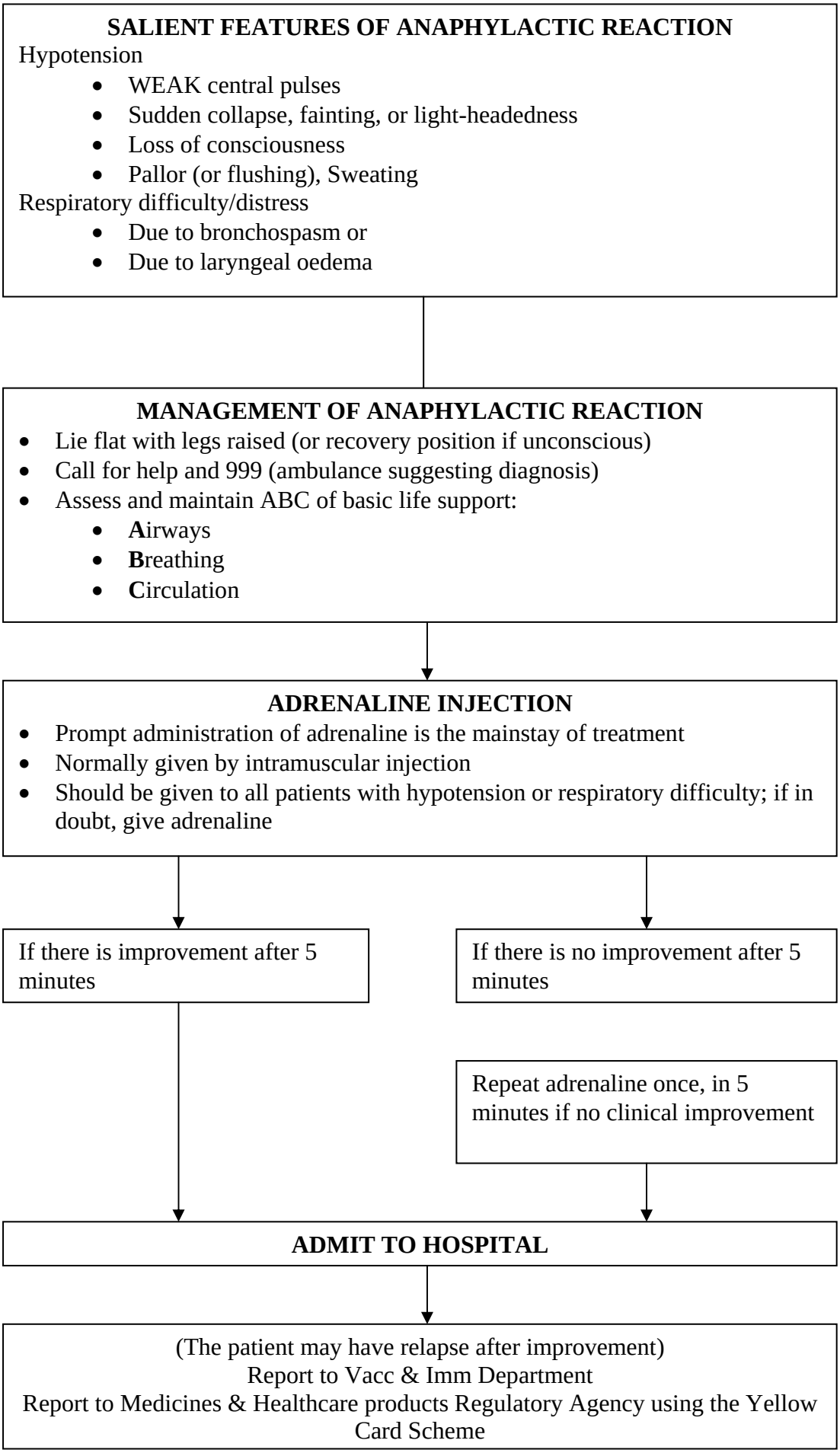
IMPORTANT NOTES

! It is recommended all the contents listed above are provided in a plastic box of an appropriate size with a tight-fitting lid and the box labelled clearly **EMERGENCY TREATMENT PACK FOR ANAPHYLAXIS**. The box should preferably be sealed and once the seal is broken or tampered with it should be returned to the designated person stated below.

! A designated person (preferably the same person who is designated to supervise the vaccine cold chain storage) should be made responsible to ensure the pack is complete and the drugs are not beyond their expiry dates, at all times.

! The drugs that are past their expiry dates should not be discarded; they should be returned to the Vacc & Imm Dept. for replacement.

! Contact Vacc & Imm Dept. for any further information


SALIENT FEATURES OF ANAPHYLACTIC REACTION
Hypotension
WEAK central pulses
Sudden collapse, fainting, or light-headedness
Loss of consciousness
Pallor (or flushing), Sweating
Respiratory difficulty/distress
Due to bronchospasm or
Due to laryngeal oedema
MANAGEMENT OF ANAPHYLACTIC REACTION
Lie flat with legs raised (or recovery position if unconscious)
Call for help and 999 (ambulance suggesting diagnosis)
Assess and maintain ABC of basic life support:
Airways
Breathing
Circulation
ADRENALINE INJECTION
Prompt administration of adrenaline is the mainstay of treatment
Normally given by intramuscular injection
Should be given to all patients with hypotension or respiratory difficulty; if in doubt, give adrenaline
If there is improvement after 5 minutes
If there is no improvement after 5 minutes
Repeat adrenaline once, in 5 minutes if no clinical improvement
ADMIT TO HOSPITAL
(The patient may have relapse after improvement)
Report to Vacc & Imm Department
Report to Medicines & Healthcare products Regulatory Agency using the Yellow Card Scheme

Routine childhood immunisation programme

Each vaccination is given as a single injection into the muscle of the thigh or upper arm

When to immunise	Diseases protected against	Vaccine given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib) Pneumococcal infection	DTaP/IPV/Hib + Pneumococcal conjugate vaccine (PCV)
Three months old	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib) Meningitis C	DTaP/IPV/Hib + MenC
Four months old	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib) Meningitis C Pneumococcal infection	DTaP/IPV/Hib + MenC + PCV
Around 12 months	*Haemophilus influenza* type b (Hib) Meningitis C	Hib/MenC
Around 13 months	Measles, mumps and rubella Pneumococcal infection	MMR + PCV
Three years four months to five years old	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella	DTaP/IPV or dTaP/IPV + MMR
Thirteen to eighteen years old	Tetanus, diphtheria and polio	Td/IPV

APPENDIX I

For World Health Organisation country-by-country vaccination schedules and coverage information, see:
www-nt.who.int/vaccines/globalsummary/Immunization/CountryProfileSelect.cfm

Centre for Infections, Immunisation Department
March 2007

Health Protection Agency

Vaccination of Individuals with Uncertain or Incomplete Immunisation Status

2 months – 12 months of age

DTaP/IPV/Hib* + PCV*
4 week gap
DTaP/IPV/Hib + Men C*
4 week gap
DTaP/IPV/Hib + Men C + PCV

*When **Hib** and/or **Men C** have not been given as part of a **primary** course *give:*
-3 doses of Hib containing vaccine at monthly intervals
-2 doses (minimum) of Men C containing vaccine at monthly intervals
Or
- 3 doses of MenC/Hib combined vaccine

*When **PCV** has not been given as part of a **primary** course *give 2 doses at least 2 months apart*

Please note: ***It is not contraindicated to give doses of PCV one month apart, however response is better at an interval of two months. Where children are unlikely or unable to complete this course, then two doses at a one month interval would be better than a single dose.***

Boosters
As per UK schedule

>12 months – 2 years of age

DTaP/IPV/Hib# + PCV# + MMR + Men C#
4 week gap
DTaP/IPV/Hib
4 week gap
DTaP/IPV/Hib

#*All children require 1 dose of **Hib, Men C and PCV** over the age of 1 year*

Boosters
As per UK schedule
Additional doses of DTaP/IPV/Hib given under 3 years of age do not count as a booster to the primary course and should be discounted

>2 years – 10 years of age

DTaP/IPV/Hib~ + Men C~ + MMR
4 week gap
DTaP/IPV/Hib + MMR
4 week gap
DTaP/IPV/Hib

~*All children require 1 dose of **Hib and Men C** over the age of 1 year*

Boosters
1st dTaP/IPV or DTaP/IPV
1st booster can be given as early as 1 year following completion of primary course to re-establish on routine schedule

10 years of age and over

Td/IPV + Men C^ + MMR
4 week gap
Td/IPV + MMR
4 week gap
Td/IPV

^*1 Men C for 24yrs and under*

Boosters
1st Td/IPV
Preferably 5 years following completion of primary course

2nd Td/IPV 5-10yrs later

MMR - From 12 months

- Doses of **MMR/measles** given prior to 12 months of age should not be counted.
- For individuals < **18** months of age a minimum interval of 3 months should be left between 1st and 2nd dose.
- For individuals >**18** months of age a minimum of 1 month should be left between 1st and 2nd doses.
- 2 doses of **MMR** should be given irrespective of history of measles, rubella or mumps infection and/or age.

General Principles

- Unless reliable vaccine history, individuals should be assumed to be **unimmunised**, and a full course of immunisations planned.
- Individuals coming to UK part way through their immunisation schedule should be transferred onto the UK schedule and immunised as appropriate for age.
- If primary course has been started but not completed, continue where left off - **NO NEED TO REPEAT DOSES OR RESTART COURSE.**
- **IPV** should be used to complete a vaccination course which may have been started with OPV.
- **aP** should be used to complete a primary course which may have been started with whole cell.
- **MenC/Hib** combined vaccine can be used when Hib alone or Hib/Men C are required.
- A minimum of 1 year should be left between DTP/IPV primary course and 1st booster. A minimum of 5 years should be left between the 1st and 2nd Boosters.

Note: BCG and Hepatitis B should be given according to local policy and has not been included in this algorithm.