IMMUNISATION IN AGED CARE

A comprehensive, whole-of-facility program to protect residents, staff, and the broader community from vaccine-preventable disease.

CLINICAL GOVERNANCE

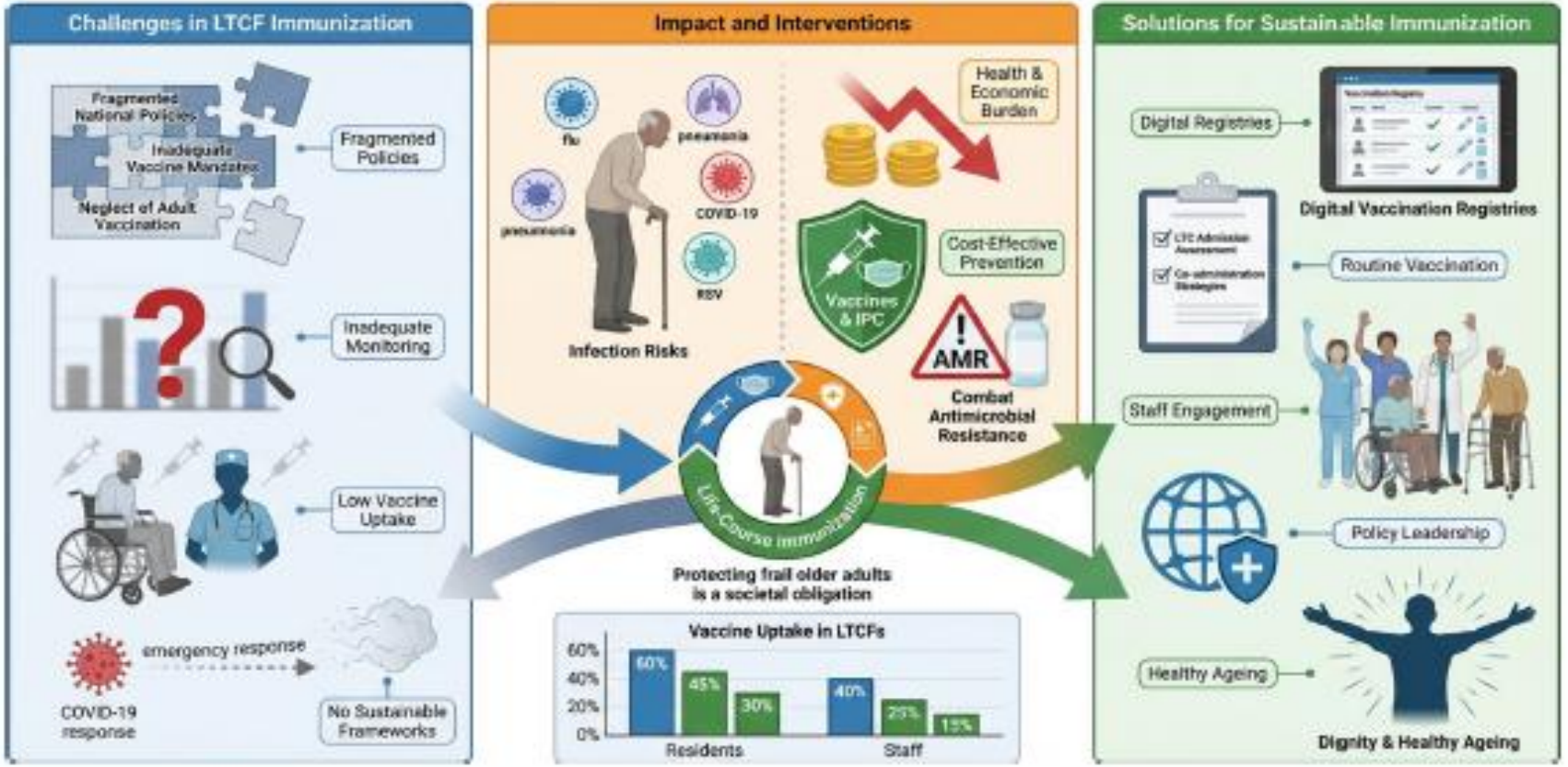
RESIDENTIAL AGED CARE

CONFLICTS OF INTEREST

- Neither Donna or myself have any conflicts of interest to declare

WHY IMMUNISATION MATTERS IN AGED CARE

- Older residents are at higher risk of severe disease
- Respiratory infections can cause outbreaks, hospitalisation and death
- Staff vaccination protects the workforce
- High coverage helps prevent outbreaks
- Immunisation is a key infection prevention strategy


Challenges in LTCF Immunization
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Protecting frail older adults is a societal obligation
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60%
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25%
15%
Residents
Staff
Solutions for Sustainable Immunization
Digital Registries
Digital Vaccination Registries
Routine Vaccination
Staff Engagement
Policy Leadership
Healthy Ageing
Dignity & Healthy Ageing

GOVERNANCE & COMMON CHALLENGES

Strong governance transforms a reactive approach into a proactive, sustainable program.

Anticipate these common challenges:

INCOMPLETE IMMUNISATION HISTORIES

Check AIR at admission (if in use). Reconcile records from previous providers and GPs early in the admission process. Have immunisation records as part of the admission paperwork.

CONSENT COMPLEXITIES

Establish clear protocols for capacity assessment, substitute decision-makers, and documentation standards.

FRAGMENTED DOCUMENTATION

Integrate immunisation records into a single system. Audit regularly for completeness and reporting alignment.

A WHOLE-OF-FACILITY APPROACH

Effective immunisation in aged care is **not a one-off task**. It is a structured program with two interconnected components

🏠 RESIDENT IMMUNISATION

- **GP/NP-led vaccination** tailored to each resident's health and clinical history.
- Where available, an **authorised immuniser** may administer vaccines in collaboration with the GP.
- Obtain **appropriate consent**, involving the resident and/or support person as required.
- Residents must remain **involved in decision-making** wherever possible.
- **Consent can be withdrawn at any time**, including on the day of vaccination.

👩‍⚕️ WORKFORCE IMMUNISATION

- **Designated vaccination providers** support staff immunisation and occupational health requirements.
- Requirements vary between states and jurisdictions.
    - E.g. Victoria: Public RACF clinical staff are required to have influenza vaccination by **15 August**.

Program advice for health professionals – 2026 Influenza vaccination

QUIZ 1

Do you know your current resident immunisation rate?

menti.com

8471 2061

SHARED RESPONSIBILITY & GOVERNANCE

Clear accountability prevents gaps and duplication. Defined roles ensure every step — from consent to administration to recording — is owned and executed.

GP / NP

Leads resident vaccination: clinical assessment, prescription, and administration. Cold chain as applicable. Responsible for clinical oversight.

PROGRAM COORDINATOR/IPC LEAD

Oversees scheduling, consent collection, cold chain compliance (as applicable), AIR/facility reporting (as appropriate), and in conjunction with facility manager liaison with external providers.

DESIGNATED VACCINATION PROVIDER /PHARMACY STAFF

Administers staff vaccines under standing orders or collaborative arrangements. Manages cold chain compliance, AIR reporting and workforce immunisation records.

FACILITY MANAGER

Ensures governance frameworks, policies, and resources are in place to support a sustainable program, liaison with external providers.

Australian Government
Aged Care Quality and Safety Commission

Infection Prevention and Control

2. Clean your hands often

You should clean your hands before and after you prepare food and visit people, and after you use the toilet. Use soap and water and wash your hands after you use the toilet and if your hands are visibly dirty, otherwise use hand sanitiser to clean your hands.

3. Use protective equipment

Protective equipment can include masks, gowns, aprons, gloves and eye protection. Always check instructions on their use. If these items are required, talk to a staff member about how to use them properly so you and your loved ones are protected.

1. Stay at home if you feel unwell

Even if you only have mild symptoms of an infection staying at home is the best thing to do to protect everyone.

4. Follow cough etiquette

If you have to sneeze or cough, make sure that you sneeze or cough into your elbow. Dispose of dirty tissues in a bin. Always perform hand hygiene after coughing, sneezing and after using a tissue.

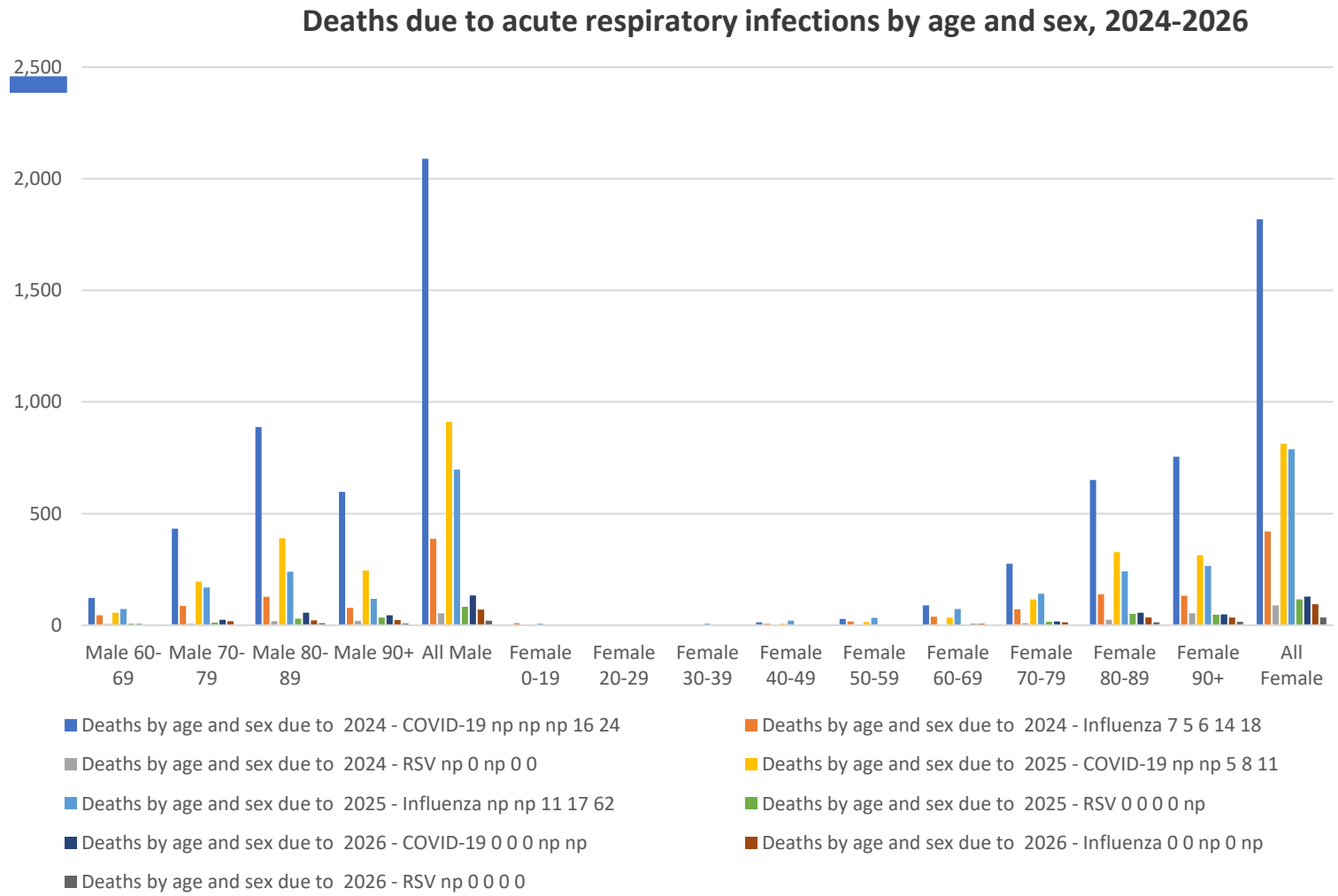
Scan the code for a virtual introduction to infection prevention and control in aged care services.

5. Let the service know if you develop symptoms of an infection within 5 days

If you develop symptoms of a viral, respiratory or gastrointestinal infection within 5 days of visiting, let the service know so that they have information to keep everyone safe.

RECOMMENDED IMMUNISATIONS

- The importance of maintaining the recommended vaccination schedule for older people cannot be underestimated
- Vaccines aid in reducing the risk of contracting a specific infection as well as the possible severity and complications including death if caught in later life
- The vaccination of staff creates a heard immunity – keeping everyone safe.


Deaths due to acute respiratory infections by age and sex, 2024-2026
2,500
2,000
1,500
1,000
500
0
Male 60-69
Male 70-79
Male 80-89
Male 90+
All Male
Female 0-19
Female 20-29
Female 30-39
Female 40-49
Female 50-59
Female 60-69
Female 70-79
Female 80-89
Female 90+
All Female
Deaths by age and sex due to 2024 - COVID-19 np np np 16 24
Deaths by age and sex due to 2024 - Influenza 7 5 6 14 18
Deaths by age and sex due to 2024 - RSV np 0 np 0 0
Deaths by age and sex due to 2025 - COVID-19 np np 5 8 11
Deaths by age and sex due to 2025 - Influenza np np 11 17 62
Deaths by age and sex due to 2025 - RSV 0 0 0 0 np
Deaths by age and sex due to 2026 - COVID-19 0 0 0 np np
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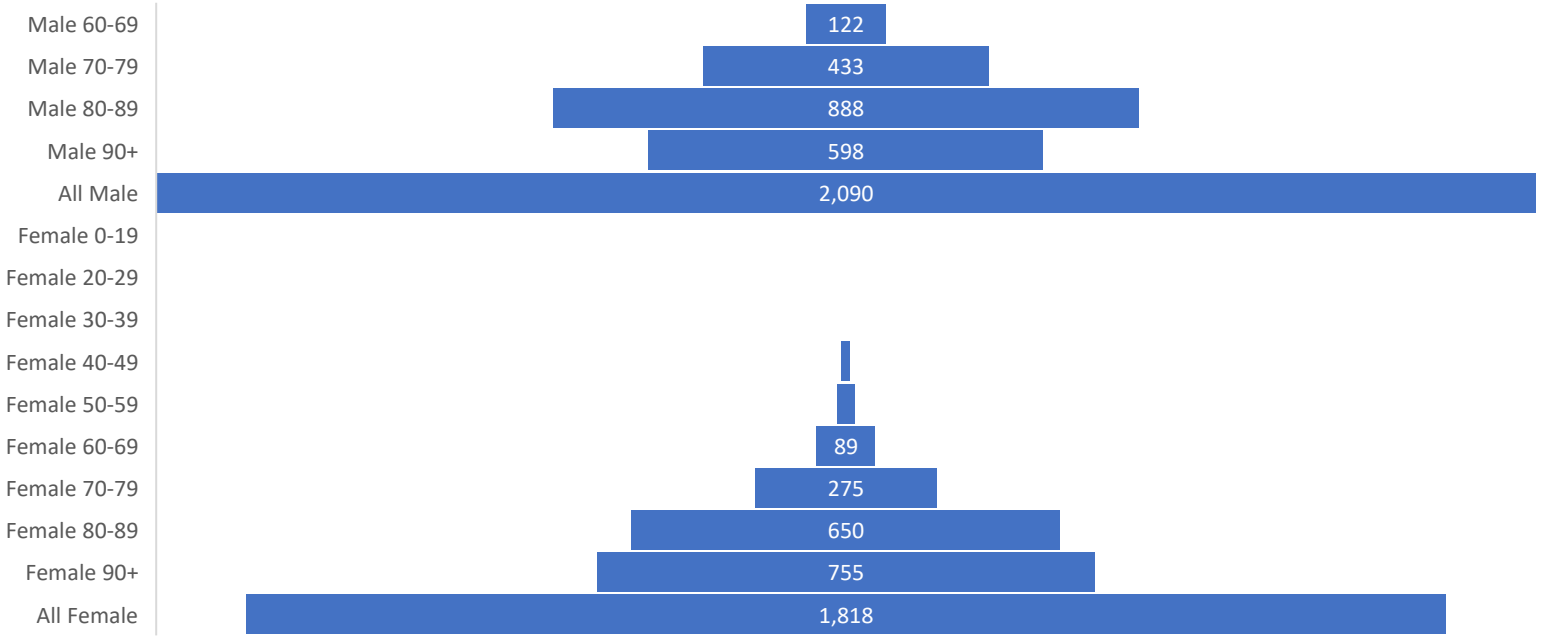
Deaths due to acute respiratory infections by age and sex, 2024-2026



Source: Australian Bureau of Statistics, Deaths due to acute respiratory infections in Australia June 2026

PROMOTION & EDUCATION

Informed participation begins with clear, accessible communication. Education strategies must address both residents and staff, acknowledging different health literacy levels and cultural backgrounds.

RESIDENT-FACING MATERIALS

Use plain-language handouts, visual aids, an immunisation dashboard and resident-led videos, supported by family engagement sessions to promote informed decision-making

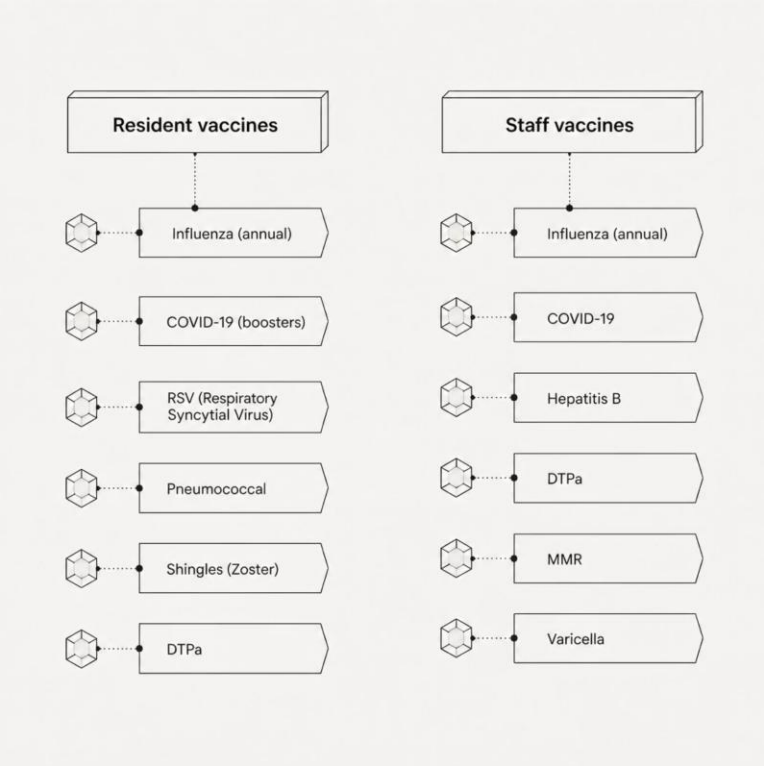
ADDRESSING HESITANCY

Trained champions/IPC lead who can respond to concerns with evidence-based, empathetic communication.

STAFF EDUCATION

In-services on vaccine benefits, safety, and the facility's immunisation program expectations. Promotion material: plain-language handouts, posters, an immunisation dashboard

RECOMMENDED VACCINES



KEY CONSIDERATIONS

Vaccine schedules should align with the **Australian Immunisation Handbook** and be individualised based on clinical assessment, heritage(ATSI), age, and risk factors.

Influenza and COVID-19 vaccines are the highest-priority annual programs for both residents and staff.

In residents:

RSV is closely followed for precipitating further comorbidities

Pneumococcal and shingles is a new vaccine

DTPa is important to cover their grandchildren that are visiting.

National Immunisation Program Schedule *(continued)*

Australian Government
Department of Health, Disability and Ageing

National Immunisation Program
A joint Australian, State and Territory Government initiative

Adult vaccination

(also see vaccination for people with medical risk conditions)

Age	Diseases	Vaccine Brand	Notes
18 years and over	Influenza (adults with specified medical risk conditions) Influenza (Aboriginal and Torres Strait Islander adults) Pneumococcal (adults with specified medical risk conditions) Shingles (herpes zoster) (adults with specified medical risk conditions)*	Age appropriate Age appropriate Capvaxive® Shingrix®	Influenza vaccine: Administer annually. For information on age-appropriate vaccines or specified medical risk conditions refer to the Immunisation Handbook or the annual ATAGI advice on seasonal influenza vaccines. Pneumococcal vaccine: For people with specified medical risk conditions administer a dose at diagnosis. Shingles vaccine: For immunocompromised people aged 18 and older with specified medical risk conditions administer 2 doses. Refer to the Immunisation Handbook for dose intervals.
25 years and over	Pneumococcal (Aboriginal and Torres Strait Islander adults)	Capvaxive®	
50 years and over	Shingles (herpes zoster) (Aboriginal and Torres Strait Islander adults)*	Shingrix®	Shingles vaccine: For Aboriginal and Torres Strait Islander people 50 years and older administer 2 doses. Refer to the Immunisation Handbook for dose intervals.
60 years and over	Respiratory Syncytial Virus (RSV) (Aboriginal and Torres Strait Islander adults)	Arexvy®	
65 years and over	Influenza (annually) Shingles (herpes zoster) Pneumococcal	Age appropriate Shingrix® Capvaxive®	Influenza vaccine: Administer annually. For information on age appropriate vaccines refer to the Immunisation Handbook or the annual ATAGI advice on seasonal influenza vaccines. Shingles vaccine: For people 65 years and older administer 2 doses. Refer to the Immunisation Handbook for dose intervals.
75 years and over	Respiratory Syncytial Virus (RSV)	Arexvy®	
Pregnant women	Pertussis (whooping cough) Influenza Respiratory Syncytial Virus (RSV)	Boostrix® or Adacel® Age appropriate Abrysvo®	Pertussis vaccine: Single dose recommended each pregnancy, ideally between 20–32 weeks, but may be given up until delivery. Influenza vaccine: In each pregnancy, at any stage of pregnancy. Respiratory Syncytial Virus (RSV) vaccine: Single dose recommended between 28-36 weeks of pregnancy, but may be given after 36 weeks based on clinical advice.

Additional vaccination for people with medical risk conditions

Age	Diseases	Vaccine Brand	Notes
All ages	Meningococcal ACWY Meningococcal B	Nimenrix® Bexsero®	For people with specified medical risk conditions that increase their risk of meningococcal disease. Refer to the Immunisation Handbook for dosing schedule. The number of doses required varies with age.
≥6 months (annually)	Influenza	Age appropriate	For children aged 6 months to less than 9 years with a specified medical risk conditions, administer 2 doses in the first year, with a minimum interval of 4 weeks between doses.
≤12 months	Pneumococcal	Prevenar 20®	For people with specified medical risk conditions that increase their risk of pneumococcal disease, administer an additional dose of 20vPCV in infancy. Refer to the Immunisation Handbook for dose intervals.
>12 months to <18 years	Pneumococcal	Prevenar 20®	For people with specified medical risk conditions that increase their risk of pneumococcal disease, administer a dose of 20vPCV at diagnosis. Refer to the Immunisation Handbook for dose intervals.
≥5 years	*Haemophilus influenzae* type b (Hib)	Act-Hib®	For people with asplenia or hyposplenia, a single dose is required if the person was not vaccinated in infancy or incompletely vaccinated. (Note that all children aged <5 years are recommended to complete Hib vaccination regardless of asplenia or hyposplenia).
≥ 12 years to ≤ 26 years	Human papillomavirus (HPV)	Gardasil®9	For people with specified medical risk conditions that increase the risk of human papillomavirus disease, administer 3 doses. Refer to Immunisation Handbook for eligibility and dose intervals.
≥18 years	Shingles	Shingrix®	For people with specified medical risk conditions that increase their risk of shingles disease. Refer to the Immunisation Handbook for information on eligibility requirements.
	Pneumococcal	Capvaxive®	For people with specified medical risk conditions that increase their risk of pneumococcal disease. Refer to the Immunisation Handbook for dose intervals.

State and territory health departments may also fund additional vaccines. Check the immunisation schedule for your area.

State/Territory	Contact Information
Australian Capital Territory	(02) 5124 9800
New South Wales	1300 066 055
Northern Territory	(08) 8922 8044
Queensland	13 HEALTH (13 4325 84)
South Australia	1300 232 272
Tasmania	1800 671 738
Victoria	immunisation@health.vic.gov.au
Western Australia	(08) 9321 1312

- The National Immunisation Program (NIP) provides the above routine vaccinations free to infants, children, adolescents and adults who have, or are eligible for a Medicare card.
- All Aboriginal and Torres Strait Islander children aged 6 months to less than 2 years of age are eligible for meningococcal B vaccines if missed at the recommended schedule points. Refer to the Immunisation Handbook for timing of doses.
- For information on pneumococcal vaccine catch-up doses for Aboriginal and Torres Strait Islander children in WA, NT, SA, Qld and children with specified medical risk conditions who have not received Prevenar 20® previously, refer to the catch-up tables in the pneumococcal chapter of the Immunisation Handbook.
- All people (including refugees and humanitarian entrants) less than 20 years of age are eligible for the NIP vaccines missed in childhood, except for HPV which is available free up to and including age 25. The number and range of vaccines and doses that are eligible for the NIP funded catch-up is different for people aged less than 10 years and those aged 10-19 years. Refer to the Immunisation Handbook for timing of doses.
- Refugees and humanitarian entrants aged 20 years and over are eligible for the following vaccines if they were missed: diphtheria-tetanus-pertussis, chickenpox, poliomyelitis, measles-mumps-rubella and hepatitis B, as well as HPV (up to and including age 25). Refer to the Immunisation Handbook for timing of doses.
- *If individuals have received Zostavax® through the NIP, they will need to wait 5 years before accessing Shingrix® for free. If individuals have received Zostavax® privately, they are eligible for Shingrix®.
- National Immunisation Program Schedule current from June 2026.

MORE INFORMATION: health.gov.au/immunisation · Immunisationhandbook.health.gov.au

IMMUNISATION SCHEDULES

The Australian Immunisation Handbook

ACT Immunisation Schedule

NSW immunisation schedule (children and adults)

Immunisation schedules | NT Health

Immunisation schedules and programs | Queensland Health

National+Immunisation+Schedule+Adolescent+and+Adult+July+2026.pdf (SA)

Adult and child immunisation schedule | Tasmanian Department of Health

immunisation-schedule-victoria-june-2026.docx

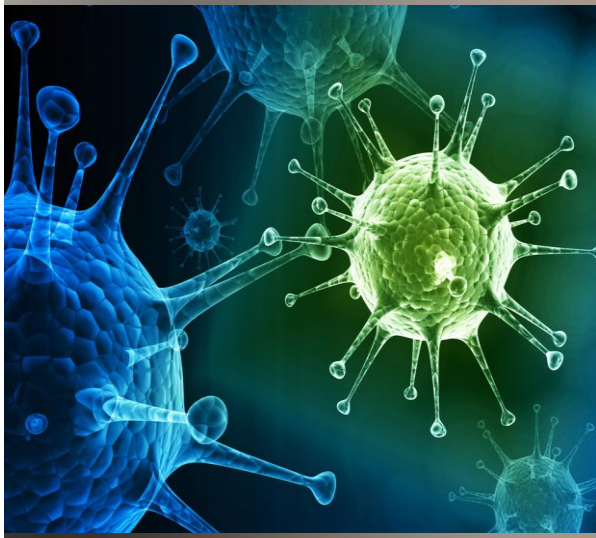
Adult immunisation (NT)

National Immunisation Schedule (NZ)

Immunization, Vaccines and Biologicals (WHO)

INFLUENZA

- Annual
- Aged specific vaccination
- Residents >65 receive vaccine with a specific booster
- Healthcare Workers
- Vaccine is effective for over 9 months
- Get vaccinated as early as possible



COVID-19

- After primary vaccine course (1 -3 doses)
- Aged 65 to 74
- Annual (can consider dose every 6 month)
- Aged >75
- Offered every six months
- Healthcare workers

PNEUMOCOCCAL

- **Aboriginal and Torres Straight Islander ATSI >25**
- 18 if they have specified medical conditions
- Single dose of Capvaxive *(12 months after any other pneumovax vaccine)

- **Non ATSI**
- >65
- Single dose of Capvaxive *(12 months after any other pneumovax vaccine)

SHINGLES

- **Aboriginal and Torres Straight Islander ATSI >50**
- 2 doses of Shingrix 2-6 months apart
- People who have had a previous episode of Shingles can still receive the vaccine

- **Non ATSI**
- > 65
- 2 doses of Shingrix 2-6 months apart
- People who have had a previous episode of Shingles can still receive the vaccine

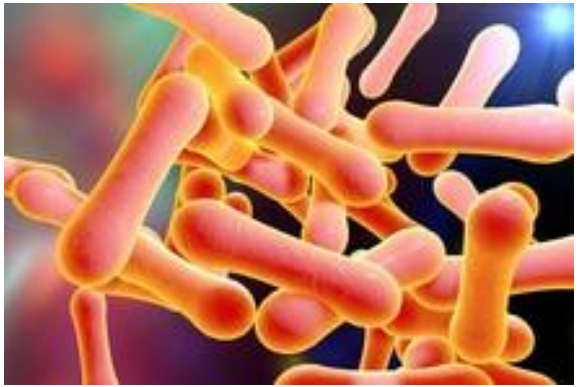
RESPIRATORY SYNCYTIAL VIRUS (RSV)

- Unfunded in the general community
- Single dose for the
- Recommended for >75
- ATSI or people with High Risk Medical factors Recommended for > 60 y/o

- All resident > 60 in Aged Care Facilities in Victoria provided a free single funded dose
- Found to decrease the presentation of secondary comorbidities such as stroke, heart problems the following year post RSV in the age group >60
- Benefits found to last 2 years

WHY INCLUDE dTpa in AGED CARE

- Protects
- Current recommendations
- Protects visiting newborns
- Current epidemiology and risk factors



Quiz 2

Do you know your staff's immunisation rate?

PLANNING A VACCINATION CLINIC

VACCINE SUPPLY & COLD CHAIN

SUPPLY COORDINATION

Vaccines may be sourced through state health departments, the National Immunisation Program, or private suppliers.
Facilities may store or GPs/vaccine providers may bring to the clinic.
Adequate vaccine must be assigned to scheduled clinics.

COLD CHAIN COMPLIANCE

Strict temperature-controlled storage is non-negotiable. Key requirements include:

- Dedicated vaccine refrigerator with continuous temperature monitoring
- Twice daily (if not continuous) temperature log reviews and documented breaches
- Staff trained in cold chain management protocols
- Backup plans for power outages or equipment failure

CONSENT & DOCUMENTATION

Robust consent processes protect staff and residents' rights and meet legal and regulatory obligations. Documentation must be accurate, accessible, and audit-ready.

CAPACITY ASSESSMENT

Residents: Determine decision-making capacity. Where needed, engage substitute decision-makers or guardians.
Staff: provide consent

INFORMED CONSENT

Document consent using approved forms. Resident verbal consent must be witnessed and recorded. Decision on the day of the immunisation by the person receiving it.

CLINICAL RECORDS

Record vaccine type, batch number, date, site, and provider in the resident's health record and staff vaccine report.

AIR NOTIFICATION

Submit to the Australian Immunisation Register promptly to maintain accurate national records. Submit records within 24 hours, and no more than 10 working days after giving the vaccine.

VACCINE SAFETY & AEFI

Most vaccine reactions are mild and short-lived.

Post resident's vaccination, clinical staff should be aware of:

- Expected reactions
- When further assessment is required
- How to manage anaphylaxis
- How to report an adverse event
- Where to obtain further advice

Post staff vaccination, staff should be aware of :

- 15 minute observation time
- Expected reactions
- When further assessment is required
- How to report an adverse event
- Where to obtain further advice

SCHEDULING & AIR REPORTING

PLAN

Schedule clinics and confirm supply

CONSENT

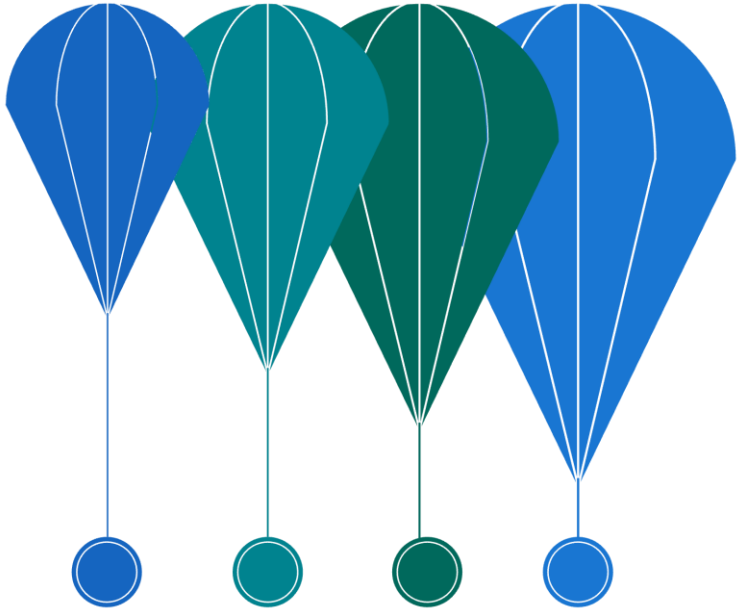
Collect and verify documentation

ADMINISTER

Vaccinate residents and staff

RECORD

Update records and notify AIR



A structured workflow ensures nothing is missed. Scheduling should align with seasonal programs (e.g., annual influenza) and accommodate resident availability, GP calendars, and staff rosters. AIR notification should occur within seven days of administration.

WHY IT MATTERS: THE CASE FOR ACTION

A well-governed immunisation program delivers measurable benefits for residents, staff, and the facility.

🦠 FEWER OUTBREAKS

Reduces the frequency and severity of vaccine-preventable disease outbreaks.

🏥 FEWER TRANSFERS

Minimises avoidable hospitalisations, reducing risk and cost for residents and the facility.

👥 PROTECTED WORKFORCE

Staff immunisation maintains workforce capacity during outbreak periods.

✅ REGULATORY CONFIDENCE

Demonstrates compliance with Aged Care Quality Standards and infection control obligations.

REPORTING & MONITORING

DOB	Age	Aged Criteria Met	Pneumococcol / Prevanar 23	Had 23 and now requires a Prevanar 13	Consent given
28/04/1950	76		13-Mar-19	21-Aug-24	Completed Course
28/11/1946	79		13-Mar-19	21-Aug-24	Completed Course
22/10/1947	78		28-Jul-18	21-Aug-24	Completed Course
11/07/1936	90			Eligible	Eligible
17/03/1950	76				16/06/26: Awaiting AIH
6/12/1956	69			14-May-25	Completed Course
12/03/1947	79			Refused	Refused
14/08/1933	92		9 May 2014 - 26 March 2018	10-May-21	Completed Course
10/02/1951	74			Refused	Refused
26/04/1924	102			Refused	Refused
17/05/1936	90			06-Dec-21	Completed Course
2/05/1945	81			05-May-21	Completed Course
25/03/1941	85			13-Oct-22	Completed Course
1/10/1938	87				16/06/26: Awaiting AIH
20/06/1939	87		22-Oct-20	Had prevenar 13	Completed Course
10/06/1952	74		13-Mar-19	21-Aug-24	Completed Course

DOB	Age	1st dose	2nd dose	3rd dose	4th dose	5th dose	6th dose	7th dose	
28/04/1950	76	15-Mar-21	13-Apr-21	25-Nov-21	11-May-22	7-Jun-23	3-Jul-24	22-Jan-25	1
28/11/1946	79	15-Mar-21	13-Apr-21	25-Nov-21	9-May-22	8-Aug-24	22-Jan-25	16-Jul-25	2
22/10/1947	78	5-Mar-21	13-Apr-21	25-Nov-21	3-Jul-24	22-Jan-25	Refused July 2025	28-Jan-26	
11/07/1936	90	13-May-21	05-Aug-21	01-Mar-22	19-Jul-22	Refused April 2026			
17/05/1950	76								
6/12/1956	69	02-Jun-21	26-Aug-21	10-Nov-21	12-Apr-22	10-May-23	3-Nov-23	28-Mar-24	2
12/03/1947	79	26-Apr-21	19-Jul-21	17-Jan-22	21-Feb-23	3-Jul-24	Refused Jan 2026		
14/08/1933	92	21-Jul-21	11-Oct-21	18-Feb-22	14 June 20222	12-Apr-23	14-Dec-23	17-Jun-24	1
10/02/1951	75	29-Nov-21	10-Jan-22	13-Apr-22	2-Aug-25	Refused Jan 2026			
26/04/1924	102	15-Mar-21	13-Apr-21	25-Nov-21	3-Jul-24	22-Jan-25	2-Aug-25	Refused Jan 2026	
17/05/1936	90	27-May-21	19-Aug-21	10-Feb-22	27-Jun-22	8-Nov-23	26-Jun-24	24-Dec-24	5
2/05/1945	81	18-Apr-21	11-Jul-21	13-Jan-22	29-Jun-22	22-Mar-23	15-Jan-24	4-Apr-25	
25/03/1941	85	28-Sep-21	03-Dec-21	04-Mar-22	9-Jul-22				

REPORTING

Resident vaccination rates

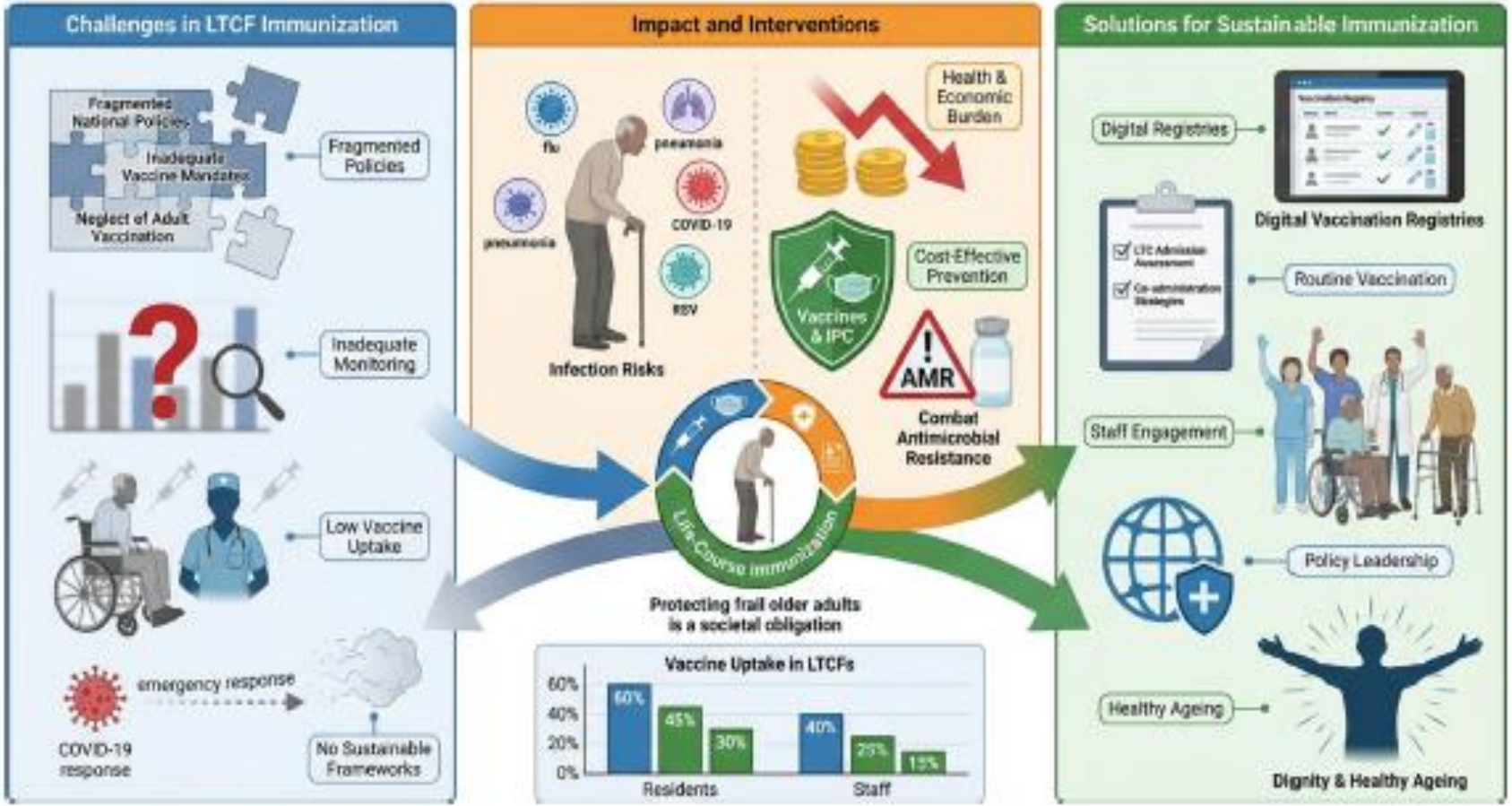
Internal reporting, ongoing:

- COVID-19
- Influenza
- Herpes zoster
- Pneumococcal

Healthcare Worker vaccine rates

Internal reporting, ongoing:

- COVID-19 (voluntarily provider informed)
- Influenza (voluntarily provider informed)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Digital Registries
Digital Vaccination Registries
Routine Vaccination
Staff Engagement
Policy Leadership
Healthy Ageing
Dignity & Healthy Ageing

QUIZ 3

What are some of the barriers to that you face with maintaining your resident and staff immunisation databases?

KEY MESSAGES

- Governance matters
- Vaccination is a term effort
- Engagement matters
- Documentation matters
- Immunisation is ongoing


WHEN?
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