



FOR AGED-CARE PROVIDERS

ACQSC compliance pack

A reference to the documentation we provide after every residential aged-care vaccination program. The pack is designed to satisfy the evidence requirements an Aged Care Quality and Safety Commission assessor typically asks for under the strengthened standards. Use this as a checklist for what you should expect from any pharmacy-led vaccination provider.

Mapped to the Aged Care Quality Standards

The documentation in this pack supports providers in evidencing requirements under Quality Standard 4 (Services and Supports for Daily Living) and Quality Standard 5 (Clinical Care), as well as the broader workforce planning expectations under Standard 7. This is a supporting document — it does not replace each provider's own quality system.

1 • Pre-clinic documentation

PRE-CLINIC PLANNING RECORD

- Date and time of clinic; rooms and rostering plan.
- Resident eligibility list, screened against medical risk factors and recent vaccinations.
- Vaccine selections with rationale (annual influenza, COVID-19 booster, RSV, pneumococcal, shingles, dTpa as required).
- Cold-chain plan for vaccine transport from the pharmacy to the facility (validated containers + continuous temperature monitoring).
- Anaphylaxis preparedness: location of adrenaline and trained responder identified.

RESIDENT-LEVEL CONSENT

- Individual consent form completed for each resident — by the resident if able, otherwise by the substitute decision-maker.
- Pre-vaccination screening checklist completed, signed by the immuniser.
- Vaccine information statement provided in advance.
- Conscientious objection or contraindications documented and respected.

2 • On-the-day documentation



COLD-CHAIN RECORD

- Vaccine batch numbers and expiry dates for every dose used.
- Temperature log for the duration of the clinic (continuous data-logger output).
- Confirmation that the +2 °C to +8 °C range was maintained throughout.
- Excursion records (if any) with documented assessment of vaccine viability.

PER-RESIDENT DOSE RECORD

- Resident identifier (Medicare or facility ID).
- Vaccine administered (by disease/category) and brand (recorded internally; not advertised externally per TGA Code).
- Dose, route (intramuscular or subcutaneous) and arm.
- Batch number, expiry, lot number.
- Time administered and observation period start/end times.
- Immuniser AHPRA registration number (verifiable via the AHPRA practitioner register).

ADVERSE EVENT LOG

- Any reaction occurring during the observation period documented in real time.
- Anaphylaxis preparedness procedures activated only if required, with full timeline recorded.
- Any subsequent SAFEVAC reports submitted listed by reference number.

3 • Post-clinic documentation (provided within 48 hours)

- Comprehensive post-clinic report including dose totals by vaccine type.
- AIR submission confirmation report (every dose lodged within 24 hours per the Australian Immunisation Register Act 2015).
- List of residents not vaccinated, with reason (declined, unwell on the day, contraindication, awaiting follow-up).
- Cold-chain temperature log printout with sign-off.
- Immuniser team list with AHPRA registration numbers, verifiable independently.
- Recommendations for follow-up doses, catch-up clinics, or staff vaccinations.

4 • Workforce vaccination evidence

Under the strengthened standards, providers are expected to maintain records of staff vaccination status against influenza and other recommended workforce vaccines. We can run separate staff clinics on the same day or schedule them independently — staff dose records are issued to each individual



and can be uploaded to the AIR if requested.

- Per-staff-member dose records issued at the time of vaccination.
- Aggregate, anonymised report to HR/management showing vaccination uptake percentages by team or shift.
- Annual rebooking reminder sent to the facility 8 weeks before the next flu season.

5 • Independent verification — what an assessor can check

- AHPRA register: every immuniser's registration number and current status (ahpra.gov.au).
- AIR via myGov: each resident or their substitute decision-maker can confirm dose entries on the Australian Immunisation Register.
- SAFEVAC: any adverse event report can be confirmed independently with SAFEVAC (safevac.org.au).
- Cold-chain data-logger output: validated against the +2 °C to +8 °C standard required by the Australian Immunisation Handbook.

Strengthened Standards: what is changing

The strengthened Aged Care Quality Standards introduced under the Aged Care Act 2024 increase the documentation rigour around clinical care (Standard 5), workforce planning and capability (Standard 7), and outcomes for older people (Standard 1). Vaccination programs sit primarily under Standards 4 and 5 — this pack is structured to support evidence collection for both.

Document retention

Vaccination records form part of the clinical record and should be retained in line with the Health Records Act 2001 (Vic) and the relevant aged-care record-keeping requirements — generally for the life of the resident plus 7 years for adults, and longer for residents who were vaccinated as children.

References

Aged Care Quality Standards (strengthened framework). Aged Care Quality and Safety Commission.
agedcarequality.gov.au

Australian Immunisation Handbook — Vaccination of people in residential care chapter.
immunisationhandbook.health.gov.au

Australian Immunisation Register Act 2015 (Cth).

AHPRA practitioner register. ahpra.gov.au

SAFEVAC adverse event surveillance. safevac.org.au

Health Records Act 2001 (Vic).