Managing Multiple Vaccines at Powys Teaching Health Board Vaccination Centres

Standard Operating Procedure

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Version Control:

Version	Summary of Changes/Amendments	Issue Date
1	PTHB MMT SOP 0135 Managing Multiple Vaccines, including Covid Variants, in PTHB MVCs v3.2 (MMT template)	30/03/2021
2	SOP 0135 updated to MMP 442 Managing Multiple Vaccines at Powys Teaching Health Board Vaccination Centres and content (including updates), transferred onto PTHB SOP template. Updates include: • Clear reference to responsibilities • Training section • Essential reading section • All sections updated for greater clarity	08/04/2024

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Senior Pharmacy Technician, Immunisation/Vaccination, Therapies & Pharmacy Stores

Circulated to the following for Consultation

Date	Role / Designation
06/03/2024	Senior Clinical Lead Nurse, Immunisation & Vaccination
	Head of Service: Public Health Programmes & Projects
	Lead Nurse, Clinical Supervisor & Vaccination Centre Manager, Immunisation & Vaccination (South)
	Lead Nurse Vaccination Centre (North)

1 Introduction

Powys Teaching Health Board (PTHB) is committed to the safe and secure handling and administration of medicines and vaccines to protect patients and staff.

PTHB vaccination sites (VCs) keep stocks of multiple vaccine types at any one time, i.e., multiple Covid-19 vaccine products, flu vaccine, MMR vaccine.

Vaccine stocks are held in a single vaccine fridge at each VC, it is therefore vital that all vaccines are stored, selected, handled, and administered correctly, and that staff are trained in and practice safe preparation and administration of the vaccine, to ensure that every patient receives the right dose of the right product at the right time[1].

It is mandatory for all staff members involved in managing vaccines to always follow this standard operating procedure.

This SOP follows compliance with good practice guidance and legislative requirements.

2. Objective

This SOP clearly describes the processes required to:

- Ensure that trained and competent PTHB VC pharmacy support staff responsible for the management of refrigerated vaccines, understand the process for managing multiple vaccines at VCs and in other community settings (where appropriate).
- Ensure that all VC staff are fully engaged in making sure that the vaccination process is safe.
- Ensure that the correct vaccine is selected, handled, and managed correctly.

3. Definitions

- **PTHB** – Powys Teaching Health Board

[1] Good governance guidance when handling multiple COVID-19 vaccines – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

- **GPhC** – The General Pharmaceutical Council are the regulatory body for pharmacists, pharmacy technicians and pharmacies in Great Britain.

- **SPS** – Specialist Pharmacy Service. SPS is a specialist pharmacy service that provides specialist medicines advice to professionals across the NHS.

- **Cold Chain** - is the system of transporting and storing medicines within the recommended temperature range of +2°C to +8°C from the place of manufacturer to the point of administration to a patient.

- **Vaccine** - a suspension of attenuated or killed microorganisms (viruses, bacteria or rickettsia) or of antigenic proteins derived from them, administered for prevention, amelioration or treatment of infectious disease.

4. Role / Responsibilities

4.1 Senior Pharmacy Technician Immunisation / Vaccination, Covid Therapies & Pharmacy Stores

The Senior Pharmacy Technician has responsibility for:

- Ensuring that appropriate staff have access to and read and understand this SOP.
- Ensuring that VC pharmacy support staff are trained and competent to perform the duties required of them and that training meets the requirements of the General Pharmaceutical Council (GPhC).
- Ensuring that vaccination centre staff are trained in cold chain management.
- Arranging regular review to monitor compliance with this procedure at VCs.
- Providing advice on the management of multiple vaccines within VCs and other areas i.e. outreach clinics.
- Maintaining regular communication with VC staff to inform of vaccine deliveries and type.

4.2 Clinical Lead / Nurse in Charge

The clinical lead / nurse in charge (in collaboration with the senior pharmacy technician for immunisation/vaccination) are responsible for ensuring that all appropriate staff for whom they have responsibility:

- Have read and understand this SOP.
- Are trained and competent to perform the duties required of them in accordance with the requirements of the General Pharmaceutical Council (GPhC).
- Are trained in cold chain management and competent in all pharmacy support duties.

The clinical lead / nurse in charge must:

- Be aware of the different types of vaccines that are stored in the VC refrigerator at any one time and ensure that pharmacy support staff have been trained to manage the vaccine safely.
- Effectively communicate the vaccine(s) in use during vaccination sessions to the vaccination team for whom they are responsible.
- Oversee the management of the use of multiple vaccines during vaccination sessions where different vaccines may be in use at the same time.

4.3 Other Staff

- Unregistered staff supporting the pharmacy role must undertake education and training to meet GPhC standards.
- VC pharmacy support staff must be trained and competent in managing multiple vaccines stored in VC fridges and must understand the processes and checks required when multiple vaccines are used simultaneously during vaccination sessions.
- All staff employed in PTHB VCs must be aware of the vaccine(s) being used for each vaccination session.
- All staff involved in the vaccination process must have been assessed as being competent in the preparation and administration of the vaccine being used for that session.

5. Training

All staff using this SOP must be competent to undertake specific tasks within this procedure.

VC pharmacy support staff must be trained and competent to perform the duties required of them and that training meets the requirements of the General Pharmaceutical Council (GPhC) i.e. level 2 qualification in Stock Management.

Cold chain training can be accessed here:

070 Cold Chain Training –The safe and secure management of refrigerated medicine
000 Vaccine Storage

Staff involved in any aspect of management of the cold chain should undertake Good Distribution Practice (GDP) training.

GDP training can be accessed here:
https://nhswales365.sharepoint.com/:f:/r/sites/POW_MVCPharmacyTeam/Shared%20Documents/General/e-Learning?csf=1&web=1&e=UWT0a2

6. Essential Reading

All VC staff involved with management of multiple vaccines must read:

- SOP MMP 427 Safe and Secure Management of Refrigerated Medicines/Vaccines
- SOP MMP 429 Safe & Secure Stock Management, Handling and Preparation of Vaccines in Powys Teaching Health Board Vaccination Centres and Other Community Settings

SOPs can be accessed here:

Management of Refrigerated Medicines Vaccines

7. Managing Multiple Vaccines

7.1 Overview

It is important to mitigate the risks associated with the storage of multiple vaccines in PTHB VCs, therefore certain measures must be put in place to minimise the risk of the wrong vaccine being administered.

SPS recommend that when planning vaccination sessions there is as much separation of the different brands of vaccine as is practically possible throughout the process, from receipt through to administration.

The majority of vaccine used in VCs are Covid vaccines for seasonal campaigns i.e. for Spring/Summer and Autumn/Winter vaccination programmes. Multiple Covid vaccines are held within the VC fridges to accommodate these vaccination programmes i.e., adult Covid-19 vaccine (often more than one type/brand), Childrens Covid vaccine and Infant Covid vaccine. Other vaccines e.g., influenza vaccine

(during winter vaccination programmes) and childhood vaccine (for catch-up campaigns), may also be stocked at some point alongside Covid-19/Flu vaccines.

When planning vaccination sessions, and where possible, one vaccine type should be used for the entire vaccination session. However, there may be occasions where more than one vaccine type may be required during a vaccination session. Reasons may include, but are not limited to:

- Patient specific contraindication to current COVID-19 vaccine in use.
- Appointments for children's vaccination running alongside adult Covid vaccinations or running at the end of the day.
- Co-administration of flu vaccine
- Change in national Covid vaccination supply, where cross-over of available vaccine stock may occur.

7.2 Storage

Vaccine must be maintained at a temperature of between +2ºC - +8ºC for the entirety of the supply chain i.e. from product manufacture to administration to a patient.

- When putting stock away always ensure that stock is rotated i.e. place shorter dated stock to the front of the fridge to be used first.
- Ensure that different vaccines are separated in the fridge i.e. on different shelves or placed in separate labelled mesh baskets. If possible, try not to store more than one vaccine on a single shelf.
- Ensure packs are positioned so that the label and identity of the vaccine is clearly visible on every pack when the fridge door is opened.
- **Remember: Read the label on the pack not the label on the fridge shelf or storage container.**
- Refrigerators should not be over-filled. Sufficient space must be maintained within the fridge to permit adequate air circulation.

7.3 Vaccine Changeover - Multidisciplinary Team Safety Briefing

The clinical lead / lead nurse, in collaboration with pharmacy support staff, must highlight the vaccine in use at the morning briefing and

again immediately prior to a session changeover to different vaccine types. See Appendix A for an example of a safety briefing checklist.

The briefing must include but is not limited to:

- Name of vaccine
- Volume change when drawing up
- Visual differences of vials
- Size of vials
- Drawing up process
- Documentation procedures
- Reminder to check vaccine choice on WIS before entering details of administration.
- Change of Batch Number
- Reiterate any recent PGD changes
- Observation period (if indicated)

Remind vaccinators of the importance of the 6Rs:

- **Right Patient**
- **Right Vaccine**
- **Right Dose**
- **Right Route**
- **Right Time**
- **Right Records**

Prior to vaccine changeover, the VC pharmacy support member of staff must ensure that all PILs, vaccination cards and vaccine signage in each vaccination lane are replaced with new vaccine PILs, cards and signage. Pharmacy support staff and the VC clinical lead / lead nurse must ensure that all other VC staff i.e. admin, are aware of the sessional vaccine being administered and that, where applicable, they have possession of the correct vaccine PILs/leaflets to distribute to patients prior to entering and leaving the VC.

Only the vaccine, syringes, documentation, and consumables needed for the specific vaccine to be administered should be available in the designated vaccination lane during a vaccination session.

The pharmacy preparation table must only contain the consumables and coloured trays required for the vaccine in use.

7.4 Using Multiple Vaccines During the Same Vaccination Session

All staff must be fully engaged in making sure the vaccination process is safe.

For vaccination sessions where plans have been put in place for different types of vaccine to be administered alongside each other i.e. Covid/flu vaccine, the clinical lead / lead nurse, in collaboration with pharmacy support staff, must highlight this at the morning briefing.

When more than one vaccine type is in use, safe practice is essential to ensure that the correct vaccine and the correct dose is administered via the right route. It is vital that the vaccine and dose given on each occasion are unambiguously detailed in all documents and records.

Covid vaccines - Only a single type of COVID vaccine should be administered in any vaccination administration lane during a single vaccine administration session. (See section 7.3 for vaccine changeover).

Wherever possible, specific vaccination clinics must be set up for vaccinating those people requiring an alternative Covid vaccine.

Where an alternative Covid vaccine is required i.e. where a patient has a specific contraindication to the current COVID-19 vaccine in use, then a separate vaccination lane must be set up to accommodate this.

However, there may be rare occasions where alternative Covid vaccinations run alongside regular Covid vaccinations. Where this occurs, the different Covid vaccines must be administered in separate vaccination lanes.

Multiple vaccines - When more than one vaccine is in use during a vaccination session i.e. Covid vaccine plus Flu vaccine, the following must be adhered to:

- Where practically possible, use specific vaccination lanes for individual vaccines. The exception to this will be for co-administration of Covid and Flu vaccines during Winter vaccination programmes, where both vaccines are likely to be offered alongside each other.
- Pharmacy support must ensure that the vaccination lane is properly prepared before vaccination begins i.e. the correct

pharmacy vaccine folders are present, the correct vaccine signage is displayed for the vaccines in use.
- Always ensure that the correct colour vaccine tray is being utilised for the vaccine in use, i.e. Covid vaccine (blue tray)/Flu vaccine (red tray).
- Ensure that the correct quantity and type of consumables are chosen and present in the tray before handing out to vaccinators i.e. for Covid vaccine.
- Double check that the correct vaccine is handed out to vaccinators, particularly where different strengths of the same vaccine type are in stock i.e. Comirnaty vaccines; ask the vaccinator for a second check to confirm.
- Vaccine should only be handed out if there are citizens in line to receive it.

Always remind vaccinators of the importance of the 6Rs:

- **Right Patient**
- **Right Vaccine**
- **Right Dose**
- **Right Route**
- **Right Time**
- **Right Records**

7.5 Stock Checks/Waste

- Ensure that the correct vaccine is identified when completing stock and waste records as these records are used to plan for future vaccine supplies.
- Where large volumes of stock are present, it is good practice to ask a suitably qualified and competent VC colleague to double check the stock count before submitting.
- When completing stock checks, always remember that stock may contain part boxes i.e. some of the vials may have been used. Part boxes will be marked with crosses to easily identify them.

7.6. Errors/Near Misses

If an error/near miss occurs, immediately notify the clinical lead / nurse in charge / senior pharmacy technician for immunisation/vaccination for advice, and complete and submit a Datix report. This will ensure that safety concerns can be addressed immediately, learning can be shared more widely, and the content of SOPs adjusted if appropriate.

8. Monitoring Compliance / Audit / Review

Compliance with this SOP will be reviewed during annual pharmacy audits in vaccination centres.

This SOP will be reviewed every three years or earlier should changes to legislation or to practice indicate otherwise.

9. References

PTHB MMP 427 Safe and Secure Management of Refrigerated Medicines and Vaccines Medicines Management - SOPs - All Documents (sharepoint.com)

SPS: Safe practice for handling multiple COVID-19 vaccines https://www.sps.nhs.uk/articles/safe-practice-for-handling-multiple-covid-19-vaccines/ accessed 27/02/2024

Appendix A

Checklist for safety briefing when using multiple COVID-19 vaccines

	Action	Initials
Q1	Has the work station been cleared and cleaned from previous sessions?	
Q2	Is there absolute clarity on which product is being used for next session?	
Q3	Have all staff present been assessed as competent in the use of the vaccine being administered in this session?	
Q4	Is there clarity on which form of authorization / legal mechanism is being used? (Protocol / PGD / PSD)?	
Q5	Is there clarity on the dose of which vaccine is to be used for the next session?	
Q6	Is the right strength of the right vaccine being used?	
Q7	Are correct syringes, needles and other consumables available?	
Q8	Is a process needed for dilution and if so are staff clear on process?	
Q9	Is process for drawing up vaccine clear for all staff?	
Q10	Is the right documentation available for use?	
Q11	Are staff familiar with the IT system being used and competent in using it?	
Q12	Are eligible staff able to access the SCR if necessary and understand the need for patient consent to view their records?	
Q13	Is there adequate vaccine available to meet anticipated requirements for the vaccination session?	
Q14	If No to Q13 are there plans in place to access supplies needed in a timely way?	
Q15	Are staff aware of any post vaccination observation period (if required), and any advice the patient requires post administration?	
Q16	Do staff know where to access anaphylaxis kits if needed and the appropriate management?	
Q17	Is there any learning from previous incidents to be shared?	
Q18	Does anyone have any questions to ask or issues to raise?	
Signature	Date	