



## module 227

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**WELCOME** to the two hundred and twenty seventh module in the *Pharmacy Magazine* Continuing Professional Development Programme, which revisits immunisation services in community pharmacy.

Continuing professional development (CPD) is a statutory requirement for pharmacists. Journal-based educational programmes are an important means of keeping up to date with clinical and professional developments and can form a significant element of your CPD. Completion of this module will contribute to the nine pieces of CPD that must be recorded a year, as stipulated by the GPhC.

Before reading this module, test your existing understanding of the topic by completing the pre-test at [www.pharmacymag.co.uk](http://www.pharmacymag.co.uk). Then, after studying the module in the magazine, work through the six learning scenarios and post-test on the website.

Record your learning and how you applied it in your practice using the CPD report form available online and on pviii of this module.

### Self-assess your learning needs:

- How is the London pharmacy flu vaccination service being expanded in 2014-15?
- What are the premises criteria for the provision of pharmacy immunisation services?
- What groups are eligible for a seasonal flu jab?

## for this module

### GOAL:

To consider the role that community pharmacy can play in providing immunisation services.

### OBJECTIVES:

After completing this module you should be able to:

- Identify the range of immunisations that can be delivered from community pharmacy
- Discuss how influenza immunisation services can be provided from community pharmacy
- Identify actions you need to take in order to develop and run an immunisation service.



First in professional development  
**pharmacy** magazine

# the continuing professional development programme



This module is suitable for use by pharmacists as part of their continuing professional development. After reading this module, complete the learning scenarios and post-test at [www.pharmacymag.co.uk](http://www.pharmacymag.co.uk) and include in your CPD portfolio. It should be read in conjunction with the Practice Focus on the London pharmacy flu scheme in the August issue of *Pharmacy Magazine* (p18).

## Immunisation services in community pharmacy

**Contributing author:** Caroline Hind BPharm, PhD, MRPharmS, FFTM, RCPS (Glasgow), deputy director of pharmacy and medicines management at NHS Grampian

### Introduction

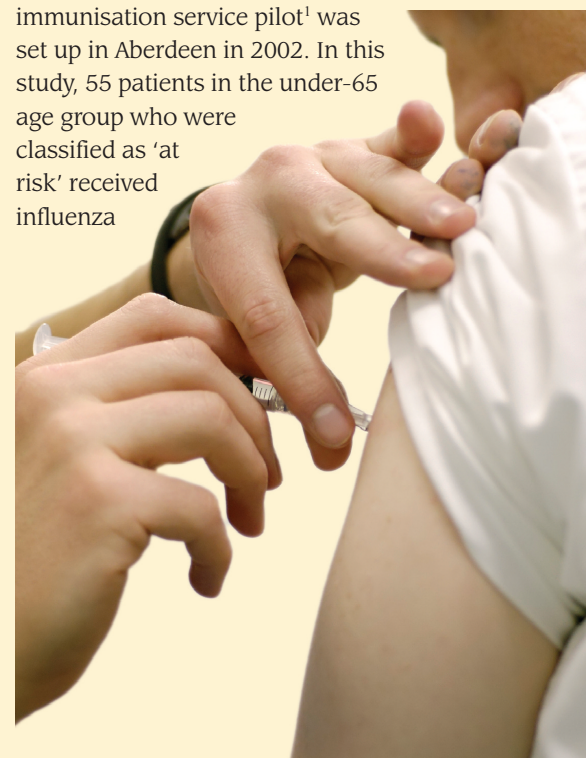
Historically, immunisation services have been provided by the nursing and medical professions but, increasingly, there is evidence that pharmacists can play an important role in disease prevention by advocating and administering certain immunisations.

While some may argue that the administration of immunisations is not part of the traditional role of pharmacists, it should instead be viewed as a logical extension to the activities of pharmacists in the preventative aspects of pharmaceutical care and in the broader public health arena.

Immunisation services initially started in the US, where pharmacists were given authority to administer vaccines under individual state laws and regulations. Initially, pharmacists were mainly authorised to administer influenza and pneumococcal vaccines but expansion of pharmacist-delivered immunisations followed the 2009 H<sub>1</sub>N<sub>1</sub> influenza pandemic, when the roles that pharmacists could play in improving this area of public health were clearly highlighted.

### Pharmacy immunisation in the UK

Within the UK, pharmacy immunisation services are less well developed, although they are growing rapidly. An early influenza immunisation service pilot<sup>1</sup> was set up in Aberdeen in 2002. In this study, 55 patients in the under-65 age group who were classified as 'at risk' received influenza



immunisation from a pharmacist and were asked to complete a patient acceptability questionnaire. The vast majority of patients thought that the vaccines had been administered as well as those they had received in the past from nurses and doctors and indicated they would be happy to receive immunisation from pharmacists in the future.

On the basis of this positive feedback, the influenza immunisation service was expanded to other community pharmacies in Grampian. In the 2013/14 flu season, 47 (35.9 per cent) Grampian pharmacies delivered 1,962 influenza immunisations to NHS and local authority carers in support of the occupational health immunisation programme.

As in the US, the 2009 H<sub>1</sub>N<sub>1</sub> influenza pandemic provided a further impetus to the development of immunisation services from community pharmacies in the UK, both in terms of the numbers of pharmacies involved and the range of vaccines administered. Indeed seasonal influenza immunisation is now provided in a variety of NHS settings.

In 2005, pharmacists in City and Hackney PCT were trained to administer influenza vaccine to help improve uptake in east London<sup>2</sup>. Accredited community pharmacists identified 'at risk' patients bringing in prescriptions for dispensing and checked to see if they had received the influenza vaccine. If they hadn't, the pharmacist offered to administer the vaccine in a private consultation area in the pharmacy.

NHS Isle of Wight commissioned a patient evaluation of its community pharmacy influenza immunisation service, inviting feedback from over 2,000 patients<sup>3</sup>. The 2010/11 influenza campaign aimed to integrate community pharmacists as service providers working in collaboration with GP colleagues and occupational health. Seventeen community pharmacies vaccinated a total of 2,903 patients (approximately 10 per cent of the total vaccinated through all services). Of these, 36.6 per cent were under-65s with co-morbidities. The service was rated as excellent by 90.9 per cent of patients and 92.8 per cent said they found the service more accessible. Nearly all patients (98.4 per cent) said they would use the pharmacy service again.

NHS Wales has developed a national community pharmacy seasonal influenza



vaccination service to provide flu vaccines on the NHS to patients aged 65 years and over, and those under 65 years in other 'at risk' groups. In the 2012/13 influenza season, 81 pharmacies in Wales provided the service between October 2012 and January 2013, representing 11 per cent of the pharmacies in Wales. In total 1,537 people received vaccinations across the seven health boards<sup>4</sup>.

In December 2013, NHS England published 'Community pharmacy – helping with winter pressures'<sup>5</sup>, which suggested ways local commissioners could make better use of community pharmacy services to support

healthcare provision during the winter months. It detailed proposals for three services: influenza vaccination, emergency supplies of medicines and provision of self-care support for winter ailments. The document has been influential in supporting the commissioning of pharmacy influenza immunisation services.

In the 2013/14 influenza season, Pharmacy London (a forum of London local pharmaceutical committees) worked with commissioners at NHS England London region to develop a pan-London community pharmacy influenza vaccination service<sup>6</sup>.

Approximately 1,100 community pharmacies in the capital were commissioned to support its seasonal influenza vaccination programme. Authorised pharmacies were able to provide a NHS influenza vaccination service for patients aged 65 years and over and those under 65 years in other 'at risk' groups. This allowed patients who lived, worked or accessed services in any of the London boroughs to access the service from a participating pharmacy. Almost 70,000 people were vaccinated in these pharmacies<sup>7</sup>. (See also Practice Focus, *PM* August, p18.)



### Reflection exercise 1

Download the Health Protection Scotland 'Guidance on vaccine handling and storage 2013' from [www.documents.hps.scot.nhs.uk/immunisation/general/vaccine-storage-handling-2013-09.pdf](http://www.documents.hps.scot.nhs.uk/immunisation/general/vaccine-storage-handling-2013-09.pdf).

- Consider what vaccine handling and storage requirements are necessary to undertake immunisations within a community pharmacy
- How would your pharmacy do these?
- What changes/improvements would be required?



## new medicine service continues

The NMS has been extended until April 2015 pending the results of an evaluation study, published this month



As part of the flu plan for the 2014/15 winter season, NHS England London region has agreed to continue to commission community pharmacies to administer seasonal influenza vaccinations, expanding the range of eligible patients and including the use of Fluenz.

A significant number of people who were eligible for the seasonal influenza vaccination were also eligible for a number of other vaccines, such as pneumonia, shingles and pertussis vaccine. To make the most of the influenza vaccination opportunity, pharmacists are now also able to offer these vaccines to the appropriate eligible groups of patients.

While the largest numbers of community pharmacist services are for influenza immunisation, service commissioners are also starting to look at other areas where community pharmacy can support public health campaigns, such as pneumococcal and hepatitis B immunisation.

Both NHS Tayside and, at the time, Westminster PCT looked to community pharmacy to provide additional immunisation capacity to deliver the human papilloma virus (HPV) immunisation programme.

A feasibility study was undertaken in 2007 in two community pharmacies in Grampian to provide travel immunisations<sup>8</sup>. When patients were asked to rate the overall service on a scale of one to 10 – 10 being excellent – the median response was 10. Ninety-eight per cent said they would use the pharmacy service again and 81.4 per cent thought the pharmacy service provided value for money.

Community pharmacy immunisation programmes are no longer only the remit of NHS commissioned services. In 2008, one pharmaceutical wholesaler, in conjunction with an influenza vaccine manufacturer, launched a private influenza vaccination service under the guidance of a private patient group direction. Now, non-NHS vaccination services are widely available from community pharmacies in the UK.

Seasonal flu immunisation is the vaccine most frequently offered and customers are usually charged between £8 and £15 for the service. In 2011, the Co-operative Pharmacy group, in conjunction with the Muslim Council of Britain, offered meningococcal (ACWY135) vaccine to Muslims visiting Mecca as part of the Hajj<sup>9</sup>.

In developing pharmacy immunisation services, almost all pharmacists will have started by delivering seasonal influenza vaccinations. Once learnt, the key principles and techniques of providing influenza immunisation can be transferred to other similar services.

### Vaccine preventable disease

Vaccine preventable diseases are targeted by a range of immunisation programmes, including routine childhood immunisations, vaccines for 'at risk' groups of patients, immunisations for the purpose of travel and seasonal influenza jabs.

The overall aim of the routine childhood immunisation programme is to protect all children against the preventable childhood infections of diphtheria, tetanus, whooping cough, *Haemophilus influenzae* type B, polio, meningococcal serogroup C, measles, mumps, rubella and pneumococcus. The primary childhood immunisations are usually delivered by nurses working within general practice; booster immunisations may also be provided by school nurses. Human papillomavirus (HPV) is included in the routine immunisation programme for girls aged 12-13 years.

Within the UK there are groups of patients for whom additional immunisations are recommended – either due to the individual's occupational risk or their own health status. These include pneumococcal, rabies, tuberculosis and hepatitis B vaccines. For example, hepatitis B vaccine is recommended for a wide range of individuals from injecting drug misusers to healthcare staff. Immunisation for these groups of patients is available from a range of providers including GP practices, occupational health departments and community pharmacists.

Immunisations for the purpose of travel fall into two groups, those that are allowable on the NHS and those that are provided as a private service. Hepatitis A, typhoid, diphtheria/tetanus/polio, hepatitis B in combination with hepatitis A and cholera (but only for those at absolute risk) are allowable on NHS prescriptions. Meningitis ACW135Y, Japanese encephalitis, tick-borne encephalitis, yellow fever and rabies are usually provided as a private service. A full risk assessment, based on destination and type of travel, is required to determine the individual's need for immunisation.

Seasonal influenza immunisation will now be dealt with in more detail.

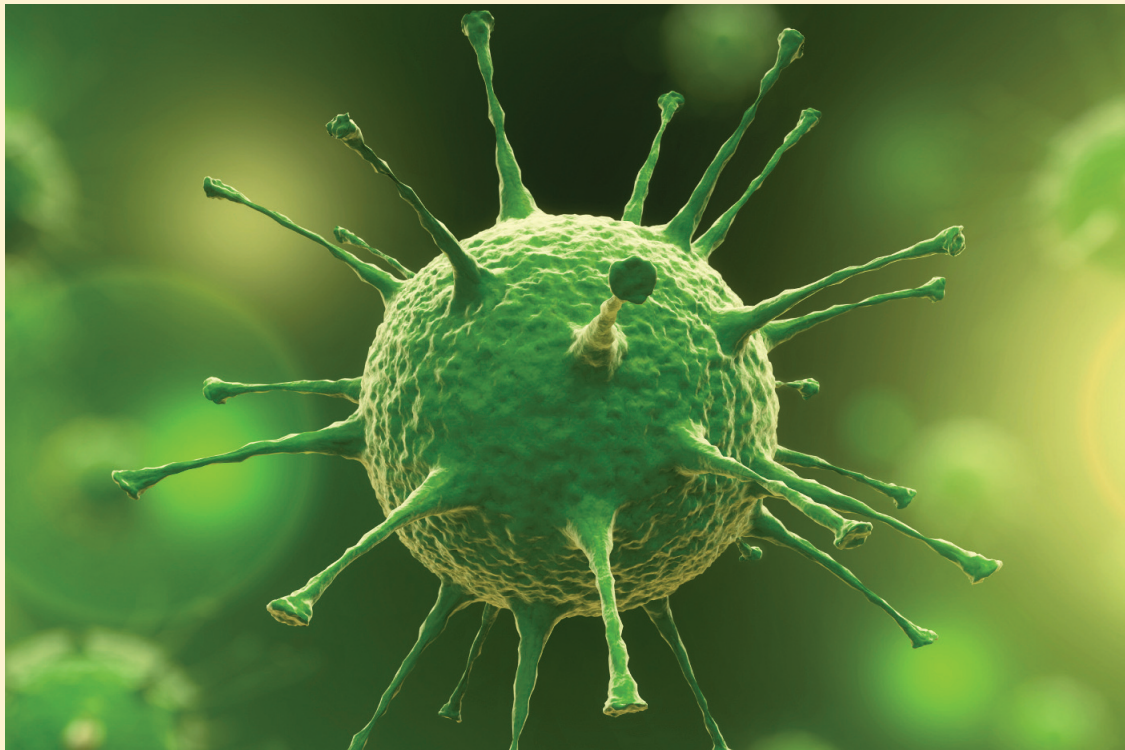
**Figure 1: GP consultations for influenza**

		Consultation rate per 100,000 population		
Scheme:		RCGP (England)	NPHS (Wales)	HPS (Scotland)
Consultation for:		Influenza & influenza-like illness	Influenza	Influenza-like illness
<b>Baseline activity</b>	These levels reflect the situation for the majority of the year when the consultation rate is low	0 - 30	<25	<50
<b>Normal seasonal activity</b>	Observed each year and reflects the fact that some minimal influenza activity is expected each year	30 - 200	25 - 100	50 - 600
<b>Higher than average seasonal activity</b>	This is observed less frequently	-	>100 - 400	>600 - 1,000
<b>Epidemic</b>	This activity is reserved for periods of unusually high influenza rates. In the past 10 years this level of activity has only been observed once in the UK	>200	>400	>1,000



**'Once learnt, the key principles and techniques of providing influenza immunisation can be transferred to other immunisation services'**





The influenza A virus is particularly virulent and can cause severe illness



## Reflection exercise 2

Download the Health Protection Agency's 'National Minimum Standards for Immunisation Training' from [www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb\\_C/1204100464376](http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1204100464376).

- What should be included in an influenza immunisation training programme for pharmacists in order to develop the appropriate competencies?

## Influenza infection

The influenza virus was first identified in 1933. There are two main types of virus that cause infection: influenza A and influenza B. Influenza A usually causes a more severe illness than influenza B.

Influenza occurs most often in winter and usually peaks between December and March in the northern hemisphere. Illnesses resembling influenza that occur in the summer are usually due to other viruses (excluding the pandemic of 2009).

The influenza virus is unstable and new strains and variants are constantly emerging. For most people influenza infection is just a nasty experience, but for some it can lead to more serious illnesses. The commonest complications

of influenza are bronchitis and secondary bacterial pneumonia. These illnesses may require treatment in hospital and can be life-threatening, especially in the elderly, asthmatics and those in poor health.

Influenza activity is monitored by Public Health England (PHE), formerly the Health Protection Agency, through reports of new consultations for influenza-like illness from sentinel GP practices, combined with virological surveillance. The H<sub>1</sub>N<sub>1</sub> (2009) 'swine flu' pandemic virus emerged in Mexico in 2009 and spread around the world causing mild/asymptomatic disease in the majority of cases, but severe illness and death in a small proportion of cases, particularly in more vulnerable groups.

Severe epidemics were also recorded in 1975/76 and 1989/90, resulting in an estimated 29,646 and 23,046 deaths respectively in England and Wales. Even in winters when incidence has been comparatively low, 3,000-4,000 deaths have been attributed to influenza.

During the first influenza season after the 2009/10 H<sub>1</sub>N<sub>1</sub> flu pandemic, the UK experienced intense influenza activity. In 2013/14, low levels of influenza activity were seen in the community in

the UK, with virological activity occurring late in the 2013/14 season. Outbreaks were initially reported in care homes (mainly resulting from respiratory viruses other than influenza) followed by influenza A H<sub>1</sub>N<sub>1</sub> outbreaks primarily in hospital settings. With the 2009 pandemic A (H<sub>1</sub>N<sub>1</sub>) virus predominating, the impact was largely seen in young adults as observed in 2010/11, with little impact in the elderly.

In order to provide the public and the press with a simple and consistent statement regarding the levels of clinical reports of influenza and flu-like illness, a set of common definitions were agreed by PHE based on the rate of new GP consultations per 100,000 population per week (see Figure 1).

There are differences between the levels for England, Scotland and Wales due to the three schemes employing slightly different methodologies, case definitions and guidelines, which means the consultation rates are not directly comparable.

## Influenza vaccine

Changes in the principal surface antigens of influenza A – haemagglutinin (H) and neuraminidase (N) – make these viruses antigenically labile. Minor changes ('antigenic drift') occur progressively from season to season. Major changes ('antigenic shift') occur periodically, resulting in the emergence of a new sub-type with a different haemagglutinin protein. A new sub-type can cause widespread epidemics or even a pandemic if populations have little or no immunity. Three influenza pandemics occurred in the last century.

NHS service and business continuity plans are being updated and revised to cope with future influenza pandemics. The lessons learned from the 2009 H<sub>1</sub>N<sub>1</sub> pandemic are still high on the agenda as conditions continue to exist for the emergence of future strains with pandemic potential.

Influenza B viruses are subject to antigenic drift but with less frequent changes. Due to the changing nature of the influenza virus, the World Health Organization (WHO) monitors influenza viruses throughout the world. Each year the WHO makes recommendations about the strains to be included in vaccines for the forthcoming winter season.



## Reflection exercise 3

How might you use your pharmacy's patient medication record system to identify patients who may be in the NHS target groups to receive influenza immunisation? What medications might these patients be receiving?

**Figure 2: Groups eligible for seasonal flu vaccination 2014/15**

<p><b>Pre-school children aged two to five years</b>  <b>All primary school children in P1-7</b></p>	
<p><b>All patients aged 65 years and over</b></p>	<p>“65 years and over” is defined as those aged 65 years and over on March 31, 2015 (i.e. born on or before March 31, 1950)</p>
<p><b>Chronic respiratory disease (aged six months or older)</b></p>	<ul style="list-style-type: none"> <li>• Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission</li> <li>• Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema, bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD)</li> <li>• Children who have previously been admitted to hospital for lower respiratory tract disease</li> </ul>
<p><b>Chronic heart disease (aged six months or older)</b></p>	<ul style="list-style-type: none"> <li>• Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease</li> </ul>
<p><b>Chronic kidney disease (aged six months or older)</b></p>	<ul style="list-style-type: none"> <li>• Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephrotic syndrome, kidney transplantation</li> </ul>
<p><b>Chronic liver disease (aged six months or older)</b></p>	<ul style="list-style-type: none"> <li>• Cirrhosis, biliary atresia, chronic hepatitis, chronic hepatitis from any cause such as hepatitis B and C infections and other non-infective causes</li> </ul>
<p><b>Chronic neurological disease (aged six months or older)</b></p>	<ul style="list-style-type: none"> <li>• Stroke, transient ischaemic attack (TIA)</li> <li>• Conditions in which respiratory function may be compromised due to neurological disease (e.g. polio syndrome sufferers)</li> </ul> <p>Clinicians should consider on an individual basis the clinical needs of patients including individuals with:</p> <ul style="list-style-type: none"> <li>• Cerebral palsy, multiple sclerosis and related or similar conditions</li> <li>• Hereditary and degenerative disease of the nervous system or muscles</li> <li>• Severe neurological or severe learning disability</li> </ul>
<p><b>Diabetes (aged six months or older)</b></p>	<ul style="list-style-type: none"> <li>• Type 1 diabetes, type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet-controlled diabetes</li> </ul>
<p><b>Immuno-suppression (aged six months or older)</b></p>	<p>Immuno-suppression due to disease or treatment</p> <ul style="list-style-type: none"> <li>• Patients undergoing chemotherapy leading to immuno-suppression, bone marrow transplant</li> <li>• HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4)</li> <li>• Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age) or a dose of 1mg or more per kg per day for children under 20kg.</li> </ul> <p>It is difficult to define at what level of immuno-suppression a patient could be considered to be at a greater risk of the serious consequences of flu and should be offered flu vaccination. This decision is best made on an individual basis and left to the patient’s clinician. Some immuno-compromised patients may have a sub-optimal immunological response to the vaccine. Consideration should also be given to the vaccination of household contacts of immuno-compromised individuals – i.e. individuals who expect to share living accommodation on most days over the winter and therefore for whom continuing close contact is unavoidable. This may include carers (see below)</p>
<p><b>Asplenia or dysfunction of the spleen</b></p>	<ul style="list-style-type: none"> <li>• This also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction</li> </ul>
<p><b>Pregnant women</b></p>	<ul style="list-style-type: none"> <li>• Pregnant women at any stage of pregnancy (first, second or third trimesters)</li> </ul>
<p><b>People in long-stay residential care or homes</b></p>	<ul style="list-style-type: none"> <li>• Vaccination is recommended for people in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow the introduction of infection and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, university halls of residence</li> </ul>
<p><b>Unpaid carers and young carers</b></p>	<ul style="list-style-type: none"> <li>• Someone who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability. A young carer is a child or young person under the age of 18 years carrying out significant caring tasks and assuming a level of responsibility for another person, which would normally be taken by an adult</li> </ul>
<p><b>Health and social care staff</b></p>	<ul style="list-style-type: none"> <li>• Health and social care workers who are in direct contact with patients/service users should be vaccinated by their employers as part of an occupational health programme</li> </ul>

To provide continuing protection, annual immunisation is necessary with a vaccine against the currently prevalent strains.

The currently available influenza vaccines give 70-80 per cent protection against infection with influenza virus strains well matched with those in the vaccine. Protection lasts for about one year. After immunisation, antibody levels may take up to 10 to 14 days to reach protective levels. While influenza activity is not usually significant before the middle of November, the influenza season can start early and therefore the ideal time for immunisation is between September and early November.

Manufacture of influenza vaccines is complex and conducted to a tight schedule, constrained by the length of time available between the WHO recommendations and the opportunity to vaccinate before the influenza season.

Manufacturers may not be able to respond to unexpected demands for vaccine at short notice. This has caused problems in recent years when manufacturers have had production problems or there has been an unexpected increase in uptake.

Within the UK, influenza immunisation is targeted at those individuals most at risk from the sequelae of influenza infection. They include:

- All those aged 65 years and over
- All those aged six months and over in the specified ‘at risk’ groups (see Figure 2)
- All pregnant women, irrespective of their stage of pregnancy
- Those living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality
- Those in receipt of a carer’s allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill
- Others involved directly in delivering healthcare such that they and vulnerable patients are at increased risk of exposure to influenza
- Health and social care staff directly involved in the care of their patients or clients.

In 2013/14, the universal childhood influenza vaccine programme with live attenuated influenza intra-nasal vaccine commenced across the UK, targeting two to three-year-olds and varying pilot groups by country. For the 2014/15 programme all



pre-school children aged two to five years and all primary school children are eligible for immunisation.

Influenza vaccine uptake in 2013/14 in England was similar to recent seasons in the elderly (73.2 per cent), in under 65-year-olds in a pre-defined clinical risk group (52.3 per cent) and in pregnant women (39.8 per cent), while an increase was seen in healthcare workers (54.8 per cent compared to 45.6 per cent in 2012/13).

In England, an uptake of 42.6 and 39.6 per cent was achieved in two and three-year-olds respectively and an overall uptake of 52.5 per cent in the primary school age pilots targeting four to 11-year-olds.

### Pharmacy immunisation clinics

In order to develop and set up community pharmacy NHS immunisation clinics, local clinical commissioning groups, public health commissioners and health boards are likely to take the lead in identifying need and determining the level of provision required. Dialogue with local GPs is essential to ensure cohesive service planning, recording arrangements and multi-disciplinary working. Decisions on which groups of NHS patients will be targeted in any community pharmacy scheme need to be agreed with clinical commissioning groups, public health commissioners or health boards. Remuneration arrangements also need to be decided and these are likely to differ between different areas.

### Legal authority to administer vaccines

At present, if a pharmacist is not an independent prescriber, patient group directions (PGDs) will be

required if he/she is to make the autonomous decision about who should receive vaccines. This is in order to comply with the Medicines Act 1968. PGDs are already used as the basis for most nurse-led immunisation services. In the future, once independent pharmacist prescribing becomes more established, a PGD may no longer be required.

It is also good practice to use a PGD for the administration of adrenaline in the event of anaphylaxis, although the POM restriction does not apply to adrenaline injection 1mg/ml where administration is for saving life in an emergency.

The legislation governing PGDs specifies that a senior doctor, senior pharmacist or clinical governance lead (or equivalent) should be involved in their development. Good practice recommends that local drugs and therapeutics committees, area prescribing committees and similar advisory bodies should also be involved in drawing up the directions. The legislation further specifies that each PGD must contain certain information (see Figure 3). A senior doctor and a senior pharmacist, both of whom should have been involved in developing the direction, must sign all PGDs.

For each profession required to operate within the direction, a senior person must sign as being responsible for the competencies, qualifications and training of the relevant authorised professionals. In addition, the clinical governance lead or their equivalent (who must not be the author of the PGD) must sign on behalf of the authorising NHS organisation.

### Pharmacy premises criteria for immunisation services

Fundamental to provision of a community pharmacy immunisation service is the necessity for a private clinical room. Minimum requirements are:

- Plumbed wash hand basin
- Washable floors (not carpet)
- Washable walls
- Clinical workbench sufficient to prepare vaccine and lay out ancillaries
- Vaccine refrigerator
- Chair(s)
- Couch (preferable)
- Wheelchair access

- Sufficient space to be able to access the patient from either side and to be able to lay the patient on the floor in the event of a faint.
  - Seated waiting area available pre- and post-immunisation
  - Filing cabinet for relevant documentation.
- More detailed specifications for community pharmacy clinical rooms are listed in the 2007 Scottish Health Planning Note 36 Part 3<sup>10</sup>.

### Training

Although authority to administer vaccines may be granted by the preparation and signing of a PGD, pharmacists must achieve competency in all aspects of vaccine administration prior to delivering a service. Ideally, immunisation training should take place at a local level and be led by local trainers. Involving experts like these in delivering training enables immunisers to raise local issues for further discussion.

It is important to include the following when devising training for pharmacists to administer vaccines:

- Principles of immunisations
- Understanding of the disease(s) and national target groups for immunisation
- Current legal requirements for consent
- Data protection
- Documentation required
- Professional accountability
- Use of the PGDs
- Knowledge of cold chain requirements
- Assessment of fitness for vaccination
- Identification of true contraindications to vaccination
- Practical vaccination skills including route, needle size and injection site for administration
- Dosage and presentation of vaccine
- Preparation and disposal of vaccination equipment
- Physiology of anaphylaxis and allergic reactions
- Potential causes of anaphylaxis and ways of decreasing the risks
- Signs and symptoms of, and differences between, anaphylaxis and fainting
- Treatment of anaphylaxis, equipment required, adrenaline dosages and sites for its administration
- Recording of adverse events to vaccinations and using the Yellow Card reporting system.

### Figure 3: Information required to be included in a PGD

- The name of the business to which the direction applies
- The date the direction comes into force and the date it expires
- A description of the medicine(s) to which the direction applies
- Class of healthcare professional who may supply or administer the medicine
- Signature of a doctor and pharmacist
- Signature by an appropriate health organisation
- The clinical condition or situation to which the direction applies
- A description of those patients excluded from treatment under the direction
- A description of the circumstances in which further advice should be sought from a doctor and arrangements for referral
- Details of the appropriate dose and maximum total dosage, quantity, pharmaceutical form and strength, route and frequency of administration, and minimum or maximum period over which the medicine should be administered
- Relevant warnings, including potential adverse reactions
- Details of any necessary follow-up action and the circumstances; a statement of the records to be kept for audit purposes

### Useful websites

- Department of Health. The Green Book – Immunisation Against Infectious Disease: [www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book](http://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book)
  - Health Protection Agency\*. National Minimum Standards for Immunisation Training: [www.hpa.org.uk](http://www.hpa.org.uk)
- \* now part of Public Health England

Usually this will require a full day's training. Following on from a formal training session it is necessary to undertake a number of supervised administrations, the number required depending on the individual. Pharmacists need to be confident in their own ability and the supervisor needs to be satisfied of their competency.

The Health Protection Agency (now part of PHE) has developed national minimum standards for immunisation training and an accompanying core curriculum has also been developed by an advisory group led by the Centre for Infections' immunisation department.

### Setting up a community pharmacy immunisation service

The development of standard operating procedures and appropriate documentation will assist in the smooth running of any immunisation service. Utilising support staff to help patients complete elements of the documentation prior to seeing the pharmacist can streamline the process.

While the occasional walk-in immunisation can be accommodated during quiet periods, it is good practice to schedule specific appointment times. This will allow pharmacies to ensure that there is a second pharmacist on duty to cover routine dispensary duties and other aspects of pharmaceutical care provision. Providing clinic appointments at times that are convenient for the patient (e.g. evenings and weekends) has been one of the strengths of community pharmacy immunisation services.

Combined record forms that include the key information required and space for written patient consent can simplify the paperwork. Patients will be required to stay for at least 10 to 15 minutes after their immunisation in order to be observed for immediate adverse effects post-vaccination. Patients should therefore be seated in an area where they can be observed by a member of staff at all times. Good organisation involving all members of pharmacy staff will be required in order to run successful immunisation services.



### Reflection exercise 4

**How can community pharmacy support parents and carers with advice on childhood immunisations? What advice can you provide to encourage uptake and how can you provide support post-immunisation?**

The publicity developed to promote a pharmacist-led immunisation service needs to ensure that the public get the right messages concerning the target group of patients and the service they can expect from pharmacy. NHS communications teams can play a vital role in supporting a new pharmacy service.

Appropriate patient information leaflets will also need to be developed, not only to inform patients about the scheme, but also to provide the specific information about the immunisation in order for the patient to give informed consent.

Support from other healthcare professionals, such as nurses, experienced in the running of immunisation clinics is essential in the early stages of service development.

Evaluation of new and innovative services is important for the improvement and development of future services. It is therefore valuable to build an element of audit/evaluation into the service design from the outset.

### Conclusion

Immunisation services from community pharmacies are growing steadily in the UK and there is clear potential for pharmacists to be involved both in identifying patients requiring immunisation and administering the relevant vaccine itself.

Pharmacist-led influenza immunisation services across various parts of the country have been both successful and feasible. The accessibility of community pharmacies has proved popular with patients wishing to use these services.

A collaborative approach to service delivery across the NHS, such as utilising the pharmacy network, gives greater options and increased choice for patients, both of which are likely to improve uptake of immunisation services.



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Pharmacy Magazine's CPD modules are available on Cegedim Rx's PMR systems, Pharmacy Manager and Nexphase. Just click on the 'Professional Information & Articles' button within Pharmacy KnowledgeBase and search by therapy area. Please call the Cegedim Rx helpdesk on 0844 630 2002 for further information.



Use this form to record your learning and action points from this module on **Immunisation services in community pharmacies** and include it in your CPD portfolio and record online at [www.uptodate.org.uk](http://www.uptodate.org.uk)

IMMUNISATION SERVICES IN COMMUNITY PHARMACIES

# assessment questions

- Which of the following is included as part of the routine childhood immunisation programme?
  - Diphtheria
  - Tuberculosis
  - Hepatitis B
  - Rabies
- Pregnant women are offered a dose of pertussis vaccine:
  - Before they reach 28 weeks of pregnancy
  - From 28 weeks of pregnancy
  - Directly after they have delivered the baby
  - In the first trimester of pregnancy
- Which group is the UK influenza 2014/15 immunisation programme NOT targeting?
  - All those aged 65 years and over
  - All pregnant women
  - All children over two years and up to less than 18 years
  - Health and social care staff directly involved in the care of their patients or clients
- Which statement is TRUE? Shingles vaccine is routinely offered to:
  - All people over 80 years of age
  - People aged 79 years of age
  - People aged 65 years of age
  - People aged 60 years of age
- Which does NOT have to be included in immunisation training?
  - Assessment of fitness for vaccination
  - Knowledge of UK pandemic influenza plan
  - Practical vaccination skills
  - Preparation and disposal of vaccination equipment
- A patient has just received an immunisation in a community pharmacy. Which statement is TRUE?
  - Patients should be provided with written information on their immunisation
  - The site of the immunisation should be rubbed to ensure the vaccine is absorbed into the muscle
  - Patient should be asked to remain on the premises for at least five minutes post-immunisation but are free to walk around
  - Patient can leave the premises immediately
- Which respiratory condition is NOT on the JCVI list of 'at risk' conditions?
  - Cystic fibrosis
  - COPD
  - Stable asthma and receiving only a salbutamol inhaler
  - All pregnant women
- Which MUST be included in a PGD?
  - A description of the circumstances in which further advice does not have to be sought from a doctor
  - Details of the proprietary/brand of the medicine that can be administered
  - A description of those patients who cannot be treated under the PGD
  - The name(s) of the patient(s) receiving the medicine via the PGD from your pharmacy

Activity completed. (Describe what you did to increase your learning. Be specific) (ACT)

Date: \_\_\_\_\_ Time taken to complete activity: \_\_\_\_\_

What did I learn that was new in terms of developing my skills, knowledge and behaviours? Have my learning objectives been met? (EVALUATE)

How have I put this into practice? (Give an example of how you applied your learning) Why did it benefit my practice? (How did your learning affect outcomes?) (EVALUATE)

Do I need to learn anything else in this area? (List your learning action points. How do you intend to meet these action points?) (REFLECT & PLAN)

\* If as a result of completing your evaluation you have identified another new learning objective, start a new cycle. This will enable you to start at Reflect and then go on to Plan, Act and Evaluate. This form can be photocopied to avoid having to cut this page out of the module. Complete the learning scenarios at [www.pharmacymag.co.uk](http://www.pharmacymag.co.uk)

**ENTER YOUR ANSWERS HERE** Please mark your answers on the sheet below by placing a cross in the box next to the correct answer. Only mark one box for each question. Once you have completed the answer sheet in ink, return it to the address below together with your payment of £3.75. Clear photocopies are acceptable. You may need to consult other information sources including the August edition of *Pharmacy Magazine* to answer the questions.

- |    |    |                          |    |    |                          |    |    |                          |    |    |                          |    |    |                          |    |    |                          |    |    |                          |    |    |                          |
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| 1. | a. | <input type="checkbox"/> | 2. | a. | <input type="checkbox"/> | 3. | a. | <input type="checkbox"/> | 4. | a. | <input type="checkbox"/> | 5. | a. | <input type="checkbox"/> | 6. | a. | <input type="checkbox"/> | 7. | a. | <input type="checkbox"/> | 8. | a. | <input type="checkbox"/> |
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Name (Mr, Mrs, Ms) \_\_\_\_\_

Business/home address \_\_\_\_\_

Town \_\_\_\_\_ Postcode \_\_\_\_\_ Tel \_\_\_\_\_ GPhC/PSNI Reg no.

I confirm the form submitted is my own work (signature) \_\_\_\_\_

Please charge my card the sum of £3.75 Name on card \_\_\_\_\_  Visa  Mastercard  Switch/Maestro

Card No. \_\_\_\_\_ Start date \_\_\_\_\_ Expiry date \_\_\_\_\_

Date \_\_\_\_\_ Switch/Maestro Issue Number \_\_\_\_\_

**Processing of answers**  
Completed answer sheets should be sent to Precision Marketing Group, Precision House, Bury Road, Beyton, Bury St Edmunds IP30 9PP (tel: 01284 718912; fax: 01284 718920; email: [cpd@precisionmarketinggroup.co.uk](mailto:cpd@precisionmarketinggroup.co.uk)), together with credit/debit card/cheque details to cover administration costs. This assessment will be marked and you will be notified of your result and sent a copy of the correct answers. The assessors' decision is final and no correspondence will be entered into.