Managing multiple COVID-19 Vaccines

Dear Pharmacy,

The Taskforce and PPA notes the increased administrative complexity that is placed on Pharmacies by offering multiple COVID-19 vaccines at their premises, with each vaccine having different TGA approvals and unique cold chain and storage requirements.

Adhering to training requirements and implementing effective policies and procedures will help ensure proper vaccine handling and administration, and make sure that patients are administered the correct vaccine.

Administration Training

Pharmacies should make sure that all vaccine administration staff have completed the relevant training for the vaccines being administered at the premises. Refer to the Australian Government Department of Health COVID-19 Vaccination Training program at : https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/covid-19-vaccination-training-program

Vaccine Procedures

Pharmacies should check that there are clear procedures and checks in place for each vaccine, that is specific to the storage requirements, administration requirements and TGA approvals (including in relation to age suitability, and suitability for primary dose or booster shot) for each vaccine. For vaccine product information see:

- Pfizer
- Moderna
- AstraZeneca

The Taskforce has also developed a **one-page summary** that pharmacies can print and display on the wall to assist with managing multiple vaccines. This is available **here**.

Vaccine Separation

Where possible pharmacies should separate administration of different vaccines by time or space to minimise confusion between the administration of the vaccines. For example, pharmacies may:

- Provide vaccines in separate areas or spaces within the pharmacy;
- Allocate specific staff to manage each vaccination area or process;
- Allocate specific days or different time slots for each vaccine.

It is also recommended that different vaccines are not stored in the same area of the pharmacy at the same time. This may mean keeping vaccines in separate fridges, or on designated shelves.

Errors in Administration

Any administration of incorrect vaccine, or errors in vaccine storage should be reported immediately to the Vaccine Operation Centre (VOC), which will arrange for clinical advice to be provided to the report provider, specific to the error.

Over 2 million COVID-19 vaccines have now been administered by community pharmacy providers. The Taskforce and PPA appreciates the ongoing role of community pharmacies in supporting and implementing the national COVID-19 vaccine rollout to protect our community.

Kind regards,

Pharmacy Programs Administrator