# Patient Group Direction for the administration of Varicella (chickenpox) vaccine without a prescription to a named individual

## Date direction comes into force

<table>
<thead>
<tr>
<th>Date direction comes into force</th>
<th>Date direction expires (review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} September 2014</td>
<td>31\textsuperscript{st} August 2016</td>
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## Staff group

Duly registered Health Care Professionals who:

- Have received training to undertake administration and supply of medicines under Patient Group Directions
- Competent to undertake immunisation and discuss issues related to immunisation, (NES Immunisation Programme Promoting Effective Immunisation Practice)
- Competent to assess the person’s capacity to understand the nature and purpose of the immunisation in order to give or refuse consent,
- Have knowledge of the NHS D&G policy on anaphylaxis and competence to recognize and treat anaphylaxis
- Have received training and are competent in the administration of adrenaline (epinephrine) 1:1000 I/M and training in the treatment of acute anaphylaxis and resuscitation within the last 1 year

may supply and administer, without medical prescription, the preparation specified in, and in accordance with, this Patient Group Direction.

## Clinical condition to be treated

Active immunisation against varicella.

## Client group: criteria for inclusion

The aim of varicella immunisation is to protect from exposure those who are at most risk of serious illness. This is done by immunising specific individuals who are in regular close contact with those at risk:

- Non-immune health care workers who work in general practice and in hospitals and who have direct patient contact
- Laboratory staff who may be exposed to varicella virus in the course of their work, in virology laboratories and clinical infectious disease units
- Healthy susceptible contacts of immunocompromised patients where continuing close contact is unavoidable

## Criteria for exclusion

- Individuals who have had a confirmed anaphylactic reaction to a previous dose of the vaccine
- Individuals who have had a confirmed anaphylactic reaction to any component of the vaccine including neomycin or gelatin
- Children under the age of 1 year
- Pregnancy and breastfeeding
- Individuals with immunodeficiency e.g. leukemias, lymphomas, clinically manifest HIV
- Patients receiving immunosuppressive therapy (including high dose corticosteroids)
- Individuals suffering acute febrile illness - postpone immunisation until patient has fully recovered
## NHS Dumfries and Galloway

**Patient Group Direction for the administration of Varicella (chickenpox) vaccine without a prescription to a named individual**

<table>
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<th>Action if excluded</th>
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| Advise as to rationale for vaccination and risks of infection or when vaccine can be given  
Refer to doctor if in high risk group  
Immunosupressed patients who require protection against chickenpox seek advice from a specialist  
Temporary exclusion: In case of postponement due to acute severe febrile illness, arrange a future date for immunisation. |

<table>
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<tr>
<th>Action for patients declining treatment</th>
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<tbody>
<tr>
<td>Advise of the risks of not receiving the varicella vaccine</td>
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<table>
<thead>
<tr>
<th>Name of medicines which may be administered under this protocol</th>
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</table>
| Varilrix® (Live attenuated varicella-zoster virus (Okra strain) propagated in human diploid cells)  
Varivax® (Live attenuated varicella-zoster virus (Okra/Merck strain) propagated in human diploid cells) |

<table>
<thead>
<tr>
<th>Legal status of medicines</th>
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<tbody>
<tr>
<td>POM</td>
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<table>
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<tr>
<th>Storage Requirements</th>
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</table>
| Varilrix®: Store between 2°C and 8°C in a refrigerator. The vaccine should be used immediately after reconstitution, can be kept for up to 60 minutes in a refrigerator  
Varivax®: Store at 2°C - 8°C in a refrigerator. Keep vial in the outer carton to protect from light. Discard if not used within 30 minutes after reconstitution.  
NHS board guidance on Storage and Handling of vaccines should be observed. |

<table>
<thead>
<tr>
<th>Dose to be given</th>
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<tr>
<td>0.5ml</td>
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<tr>
<th>Frequency of administration</th>
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<tr>
<td>Children from one year of age or older and adults should receive two doses of varicella vaccine, four to eight weeks apart.</td>
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<table>
<thead>
<tr>
<th>Number of doses to be given</th>
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<tbody>
<tr>
<td>2 (see frequency of administration above).</td>
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</table>

<table>
<thead>
<tr>
<th>Route/method of administration</th>
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</table>
| Varilrix®: Subcutaneous injection only  
Varivax®: Intramuscularly or subcutaneously |

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<th>Advice to be given to patient</th>
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| Pregnancy should be avoided for 3 months after vaccination  
Advice on the management of local reaction (may develop within 4 – 6 weeks of first or second vaccination).  
If vaccine related cutaneous rash develops contact with varicella-susceptible pregnant women and individuals at high risk of severe varicella should be avoided. |

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<th>Adverse reactions</th>
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| Injection site reaction pain, redness and swelling. Fatigue, fever, headache, rash, irritability  
For full details/information on possible side effects, refer to the marketing authorisation holder’s SPC.  
As with all vaccines there is a very small possibility of anaphylaxis and facilities for its management must be available.  
In the event of severe adverse reaction individual should be advised to seek medical advice.  
Any adverse events that may be attributable to Varicella vaccine should be reported using the yellow card system on http://yellowcard.mhra.gov.uk/  
Any serious adverse reaction to the vaccine should be documented in an individual’s record. GP should also be informed. All suspected reactions, including minor ones, should be reported to the CSM using the yellow card system. |
### Additional Information

Varicella vaccine can be administered at the same time as other vaccines including live vaccines such as MMR. The vaccines should be given at a separate site, preferably in different limbs. If given in the same limb they should be given at least 2.5cms apart.

Avoid concomitant use of live vaccines with abatacept, adalimumab, anakinra, belimumab, certolizumab pegol, corticosteroids, pixantrone, etanercept, golimumab, infliximab, leflunomide, tocilizumab, ustekinumab.

Avoidance of vaccines advised by manufacturer of interferon gamma

Surveillance cases of inadvertent vaccination in pregnancy in the US has not identified any specific risk to the foetus. Nevertheless, it is important to record such cases and to document the outcome of pregnancy.

Health workers who develop a generalised papular or vesicular rash in the month following vaccination should report to their occupational health department for assessment before commencing work.

If the rash is generalised (popular or vesicular) the health care worker should avoid patient contact until the lesions have crusted.

Healthcare workers with localised vaccine rashes that can be covered with a bandage and/or clothing should be allowed to continue working unless in contact with immunocompromised or pregnant patients. In the latter situation, an individual risk assessment should be made.

### Documentation to be completed

The approved practitioner must ensure maintenance of records for each vaccine administered and may be required to share information with appropriate parties in line with confidentiality protocols. The information relating to immunisation of each individual must include as a minimum:

- Patient’s name, date of birth and CHI number
- Dose
- Site and route of injection
- Brand, batch number and expiry date of vaccine
- Date given and by whom

All records must be clear and legible and, ideally, in an easily retrievable format.

Depending on the clinical setting where immunisation is undertaken, the information should be recorded manually or electronically, in one (or more) of the following systems, as appropriate:

- GP practice computer
- Individuals GP records,
- Child Health Information Services
- Personal Held Child Record (red book)
- Consent forms
NHS Dumfries and Galloway

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Medical Practitioner

Name: [Illegible]

Signature: [Illegible] Date: 27/8/14

Pharmacist

Name: P. Beardo

Signature: [Illegible] Date: 1/9/14

Other Health Care Professional – Please state designation

Professional Group: Nurse Consultant

Name: [Illegible]

Signature: [Illegible] Date: 27/9/14

This PGD was devised by

Name: Angus Cameron

Signature: [Illegible] Date: 3/9/14

Name: Hazel Borland

Signature: [Illegible] Date: 05/09/14

Name: M. Pratt

Signature: [Illegible] Date: 30/14

For NHS Dumfries and Galloway
NHS Dumfries and Galloway
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Authorisation for named professional to work within this patient group direction

Professional’s name .............................................................................................................................................

Designation/Grade .............................................................................................................................................

I the undersigned have read and understood this patient group direction.

- I am duly registered as a ..................................................................................................................................
  with the .............................................................................................................................. Registration Number ...

- I am competent to administer the medicine specified in this Patient Group Direction

- I am competent to manage anaphylaxis
  Date of last training for managing anaphylaxis ............................................................................................

- I agree to work within the confines of this Patient Group direction

Professional’s signature ................................................................................................................................. Date

The above named professional is authorised to work within the confines of this Patient Group Direction

Authorised by (name) .................................................................................................................................

Signature .................................................................................................................................................. Date

Approved Practice Base

One copy to be retained by the lead clinician
One copy to be retained by the professional
Send a copy of this page only to Primary Care Development, Logan East, Crichton Hall, Bankend Road, Dumfries, DG1 4TG.
NHS Dumfries and Galloway
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CHECKLIST for the administration of the medicine specified in this Patient Group Direction without a prescription for a named individual
Please file in patient's notes

Patient’s name .................................................................................................................................................. Date of Birth (CHI) ........................................
Address...........................................................................................................................................................

GENERAL QUESTIONS
Are you well today? ................................................................................................................................... YES/NO
Have you had a reaction to any other medicines before? ............................................................................... YES/NO
Details............................................................................................................................................................
Are you allergic to anything? .................................................................................................................... YES/NO
Details............................................................................................................................................................
Is it possible that you may be pregnant (if appropriate)? ........................................................................... YES/NO
Details............................................................................................................................................................

VACCINE QUESTIONS
As above plus the following:-
Have you had any recent chemotherapy or radiotherapy (if appropriate)? ........................................... YES/NO
Are you taking steroids? .............................................................................................................................. YES/NO
Have you had another vaccination within the last three weeks? .............................................................. YES/NO

PATIENT (or CARER) CONSENT
Do you (or the carer) give consent to the administration of the above preparation? ................ YES/NO
Patient’s (or carer’s) name ............................................................................................................................
I have received and understand the advice given to me and consent to the administration of the medicine described in this Patient Group Direction.
Patient’s (or carer’s) signature .................................................................................................................... Date ........................................

Date ........................................ Name of medicine (and brand) ........................................................................
Batch No .......................... Expiry Date ................. Site of administration(if appropriate) ..........................
Signature of Health Care professional ................................................................................................................

N.B. If the patient has answered yes to any of the above questions refer to inclusion/exclusion criteria