Nudge Day Stagione 3 Europa

GIOVEDÌ 30 SETTEMBRE 2021
ORE 14:30 - 18:30

CREDITI ECM: 2,8

Regione Toscana

Il fattore umano (e la gentilezza) nella gestione del rischio durante la campagna vaccinale anti COVID-19

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All’avvio della campagna vaccinale

Fare presto

Fare tanto

Consumare tutte le dosi disponibili

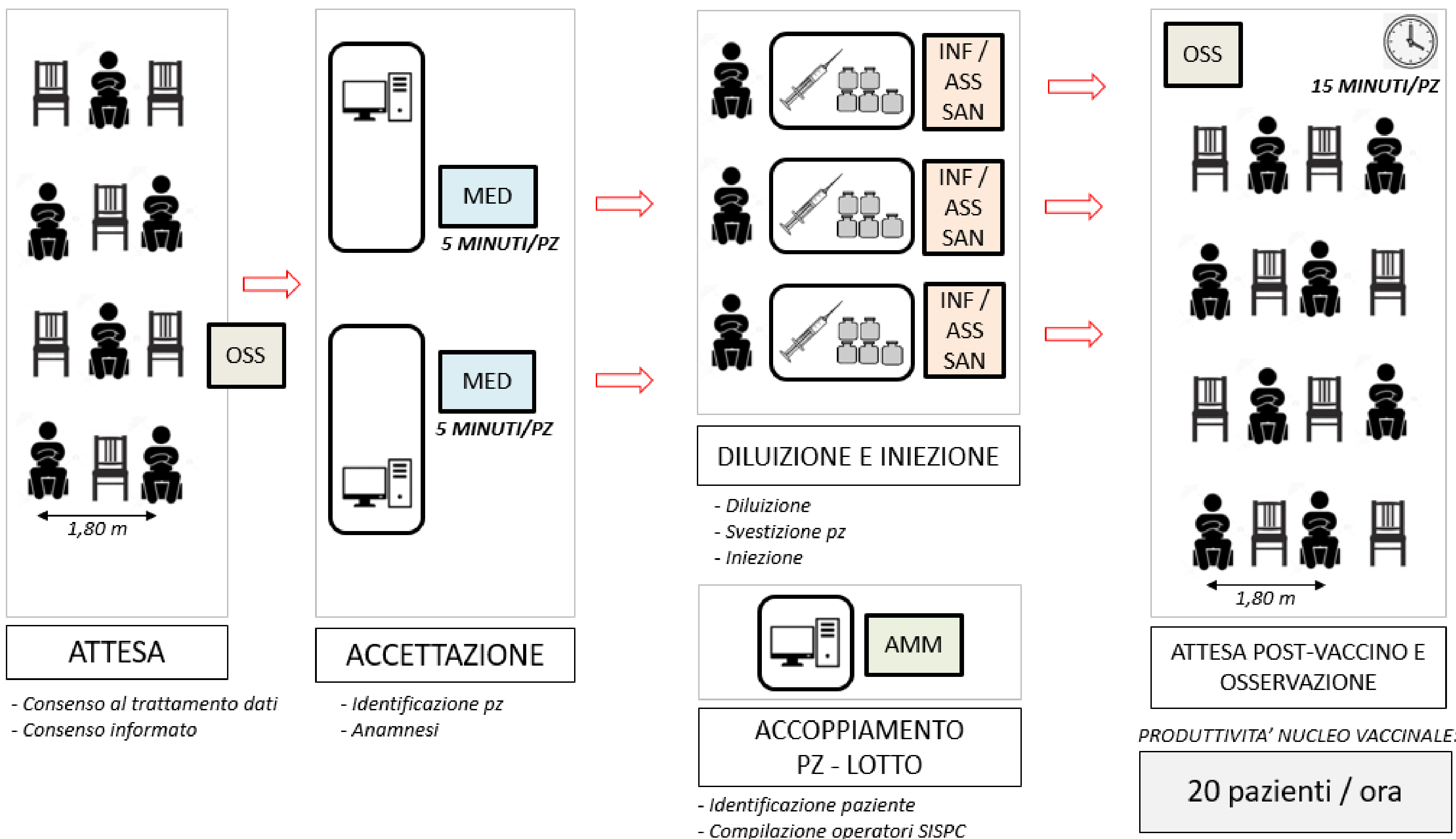
Fare presto * organizzazione?

Fare tanto * persone?

Consumare tutte le dosi disponibili * prodotti?

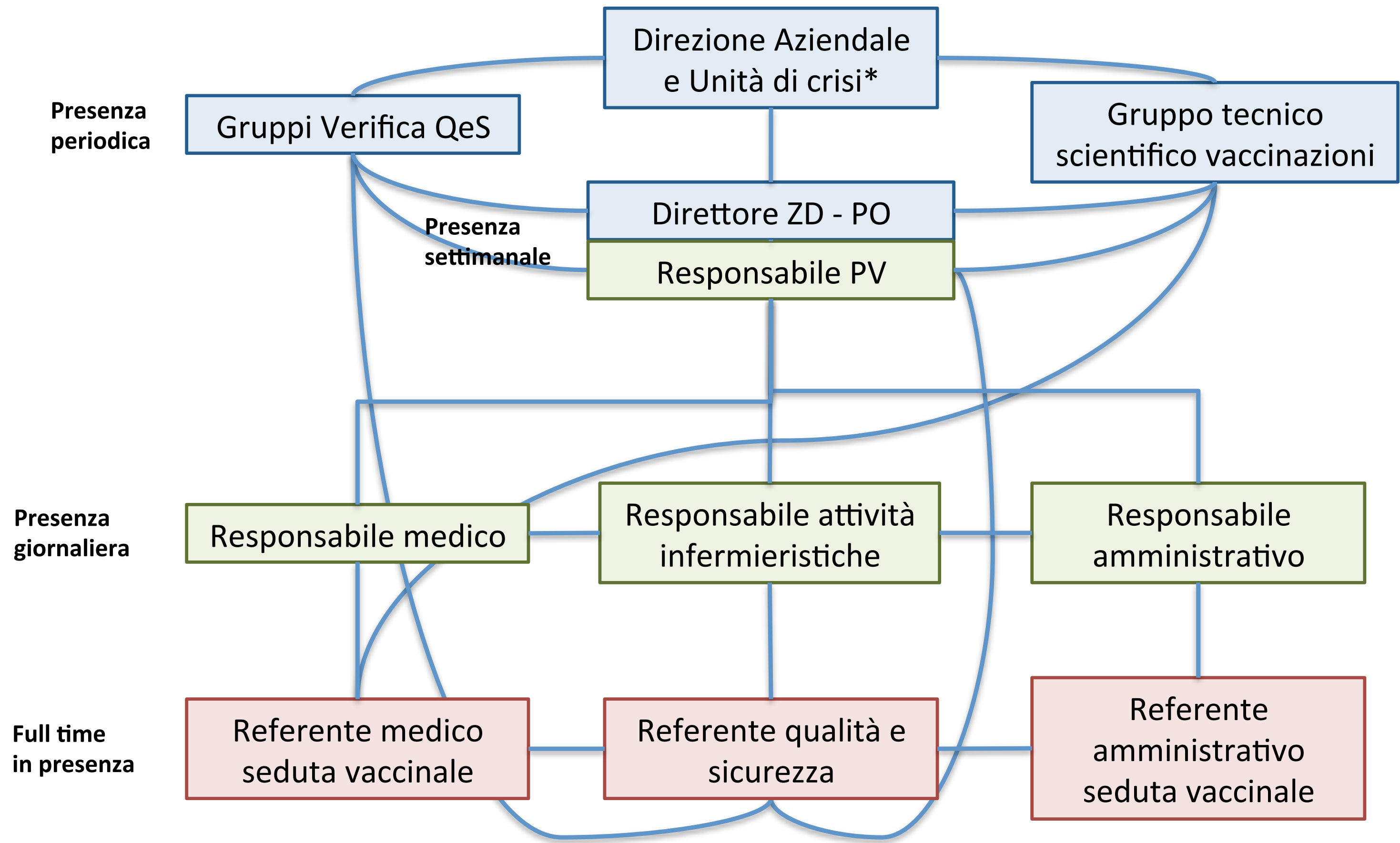
*****sicurezza?**

Organizzazione campagna vaccinale >> flusso



Organizzazione campagna vaccinale >> struttura

ORGANIZZAZIONE PUNTI VACCINALI



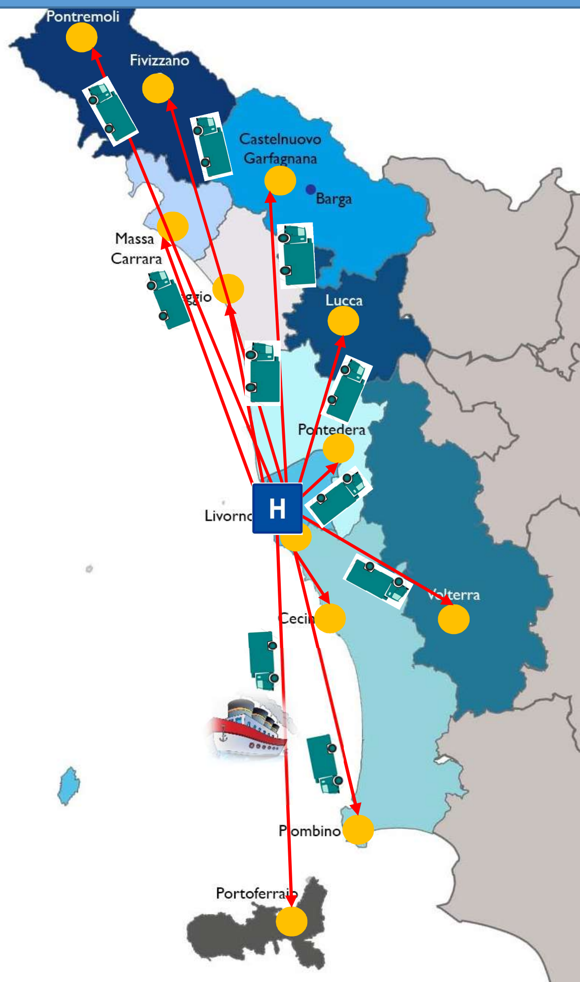
Varietà

Occasionalità

Motivazione

Prodotti campagna vaccinale >> distribuzione

4 Scongelamento del Vaccino da parte della farmacia Ospedale HUB Livorno ed invio alle farmacia Ospedali SPOKE



- Scongelamento giornaliero flaconi dose vaccino (da -80° a +2°+8°) in base alle richieste
- Invio refrigerato a +2°+8° tardo pomeriggio* di tutti i giorni dosi richieste nelle Farmacie degli ospedali Spoke

Legenda:

- Lunigiana
- Apuane
- Valle del Serchio
- Piana di Lucca
- Versilia
- Pisana
- Livornese
- Valli Etrusche
- Val d'Era al Val di Cecina
- Elbana

H HUB Farmacia OSPEDALE HUB (LIVORNO) (Congelatore -80°)

Farmacie OSPEDALI SPOKE (frigo 2°-8°)

* Per l'Elba si prevede al mattino sempre del giorno precedente alla somministrazione (valutare eventuale invio per più giorni in considerazione dell'imprevedibilità condizioni meteo-marine)

Sicurezza campagna vaccinale >> prevenzione dei rischi

ALL14 PTO AZ 921
Elementi sicurezza processo vaccinale
rev 2

BRIEFING EQUIPE INIZIO SEDUTA VACCINALE

- CONTROLLO CONSEGNA VACCINI E KIT MATERIALE
- CONTROLLO CONNESSIONI RETE
- CONTROLLO CARRELLO/ ZAINO EMERGENZA
- CONTROLLO TEMPERATURA FRIGO
- CONTROLLO MATERIALI AMBULATORIO VACCINALE

CHECK IN

- CHECK POINT
- IDENTIFICAZIONE CON DOCUMENTO D'IDENTITA' E TS
- CONTROLLO APPUNTAMENTO
- VERIFICA DOCUMENTAZIONE
- IGIENE MANI E RESPIRATORIA
- GARANTIRE DISTANZIAMENTO
- AREAZIONE LOCALI

OSS

AMBULATORIO VACCINALE

- PREPARAZIONE MATERIALE E DOSI PRESTABILITE
- CORRETTA IDENTIFICAZIONE DEL VACCINDANDO
- RACCOLTA ANAMNESTICA
- CONSENSO INFORMATO
- INFO REAZIONI AVVERSE
- CONTROLLO CORRISPONDENZA LOTTO IN USO E LOTTO SU SISPC
- CORRETTO UTILIZZO DEI DPI E IGIENE MANI

INFERMIERE
MEDICO
ASSISTENTE SANITARIO

CHECK OUT

- CORRETTA IDENTIFICAZIONE DEL VACCINATO CON TS E DOCUMENTO D'IDENTITA'
- CORRISPONDENZA CARTACEO - SIPSC
- CONSEGNA CERTIFICATO VACCINALE ED EVENTUALE SECONDO APPUNTAMENTO
- CORRETTA IGIENE MANI E RESPIRATORIA
- GESTIONE NON PRESENTATI E/O RINVIATI

AMMINISTRATIVO

SALA OSSERVAZIONE

- INDIVIDUAZIONE PRECOCE DELLE REAZIONI AVVERSE
- GESTIONE REAZIONI AVVERSE
- IGIENE DELLE MANI E RESPIRATORIA
- OSSERVAZIONE PROLUNGATA A 30MIN IN SITUAZIONI A RISCHIO
- DISTANZIAMENTO
- AREAZIONE LOCALI

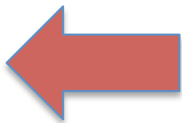
INFERMIERE
ASSISTENTE SANITARIO

DEBRIEFING EQUIPE FINE SEDUTA VACCINALE

- CONTROLLO CARRELLO/ZAINO EMERGENZA
- CONTROLLO TEMPERATURA FRIGO
- CONTROLLO MATERIALI AMBULATORIO VACCINALE
- CONTROLLO DOSI IN GIACENZA
- RIORDINO AMBULATORI CON SANIFICAZIONE DEI PIANI LAVORO
- CHIUSURA SEDUTA VACCINALE CON CONTROLLO DOCUMENTALE

Sicurezza campagna vaccinale >> tipi di evento avverso

Error Type	Description/Examples	Percent (%) of Reports
General Error Types with All Current FDA-Authorized COVID-19 Vaccines		**62**
Wrong Dose (Lower or Higher than Authorized) (excludes dilution errors)	■ Syringe/needle malfunction, spillage/leakage ■ Dose measurement error ■ Administration of an empty syringe of vaccine (air)	20
Wrong Age	■ Less than 16 years for the Pfizer-BioNTech vaccine ■ Less than 18 years for the Moderna/Janssen vaccines	17
Wrong Administration Technique	■ Shoulder injury related to vaccine administration (SIRVA) ■ Reuse of an empty syringe and needle	8
Wasted Vaccine (excludes dilution errors)	■ Leakage, contamination prior to administration ■ Insufficient dose left in vial	5
Incorrect Storage and Handling	■ Temperature excursions outside of recommendations ■ Administration of expired vaccine	4
Contraindicated Coadministration	■ Administration within 14 days of a non-COVID-19 vaccine ■ Administration within 90 days of monoclonal antibodies	2
Other	■ Wrong needle size ■ Other reasons for vaccine waste ■ Wrong drug	6
Error Types Specific to the Two-Dose mRNA Vaccines (Moderna/Pfizer-BioNTech)		**20**
Mixed Vaccine Series	■ Incorrect mRNA vaccine administered for second dose	11
Wrong Time Interval	■ Second dose administered at the wrong interval ■ Third dose administered	9
Dilution Errors Specific to the Pfizer-BioNTech Vaccine		**17**
Wrong Volume of Diluent	■ Too little diluent, leading to overdoses or waste ■ Too much diluent, leading to underdoses or waste ■ Diluted the vial twice	11
No Diluent	■ Administered undiluted vaccine ■ "Diluted" vaccine with air in syringe thought to be diluent	3
Wrong Diluent	■ Sterile water used as diluent	3
Error Type Specific to the Single-Dose Viral Vector Vaccine (Janssen)		**1**
Confusing Vaccine Card	■ Two-dose vaccine cards shipped with single-dose vaccine	1



Analisi di 160 report di eventi avversi raccolti dal sistema di vigilanza del CDC https://www.ismp.org/resources/any-new-process-poses-risk-errors-learning-4-months-coronavirus-disease-2019-covid-19

Periodo di riferimento: 14 dicembre 2020 e 17 aprile 2021

Vaccini somministrati nel periodo: 206 milioni (107 Pfizer, 91 Moderna, 8 Janssen)

Non sono disponibili dati italiani ed europei

Sicurezza campagna vaccinale >> eventi avversi & media

Dr. Tommaso Bellandi, director of patient safety for the northwest Tuscany health authority, said the accident occurred because **the nurse had an attention lapse.** "This is something that should never happen," he said. "Unfortunately, due to **our limits as human beings, as well as organizational limits**, these things can happen."

Bellandi said the incident occurred on an **extremely busy day**, during a period in which health workers were trying to administer as many vaccine doses as possible. He said the hospital had launched an investigation **to review safety procedures**.

"I'm not trying to justify something that we hoped would never happen," he said. "**We are extremely regretful, especially towards the young woman**."

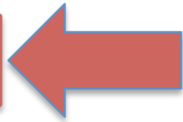
Bellandi said the **nurse and the attending doctor were "heartbroken"** at what had occurred, and a psychologist described them as "traumatized" by the event.

Sicurezza campagna vaccinale >> eventi avversi & conseguenze

COVID-19 Vaccine
Administration Errors and Deviations

Interim recommendations for COVID-19 vaccine administration errors and deviations

Vaccines	Type	Administration error/deviation	Interim recommendation
Pfizer-BioNTech only	Diluent	• ONLY diluent administered (i.e., sterile 0.9% sodium chloride)	• Inform the recipient that no vaccine was administered. Administer the authorized dose immediately (no minimum interval) in the opposite arm.#
		• No diluent, resulting in higher than authorized dose (i.e., 0.3 ml of undiluted vaccine administered)	• Do **not** repeat dose*† Inform the recipient of the potential for local and systemic adverse events.
		• Incorrect diluent type (e.g., sterile water, bacteriostatic 0.9% NS)	• Contact the manufacturer for guidance. If the manufacturer provides information supporting that the dose should be repeated, the repeated dose may be given immediately (no minimum interval) in the opposite arm.
		• Incorrect diluent type (e.g., sterile water, bacteriostatic 0.9% NS)	• For doses administered with diluent volume less than 1.8 ml, inform the recipient of the potential for local and systemic adverse events.*† • For doses administered with diluent volume greater than 1.8 ml, do not repeat dose. * (Note: Dilution with a volume up to 4.0 ml [which exceeds vial capacity] results in more-than-half of the authorized dose administered.)



*If the dose given in error is the first dose, a second dose should be administered at the recommended interval (21 days [Pfizer-BioNTech] or 28 days [Moderna]).

†If the administration error resulted in a higher-than-authorized vaccine dose, in general the second dose may still be administered at the recommended interval. However, if local or systemic side effects following vaccination are clinically concerning (outside of the expected side effect profile), lead to serious adverse reactions, or are ongoing at the time of the second dose, the decision to administer the second dose may be assessed on a case-by-case basis.

Il futuro è dei vecchi