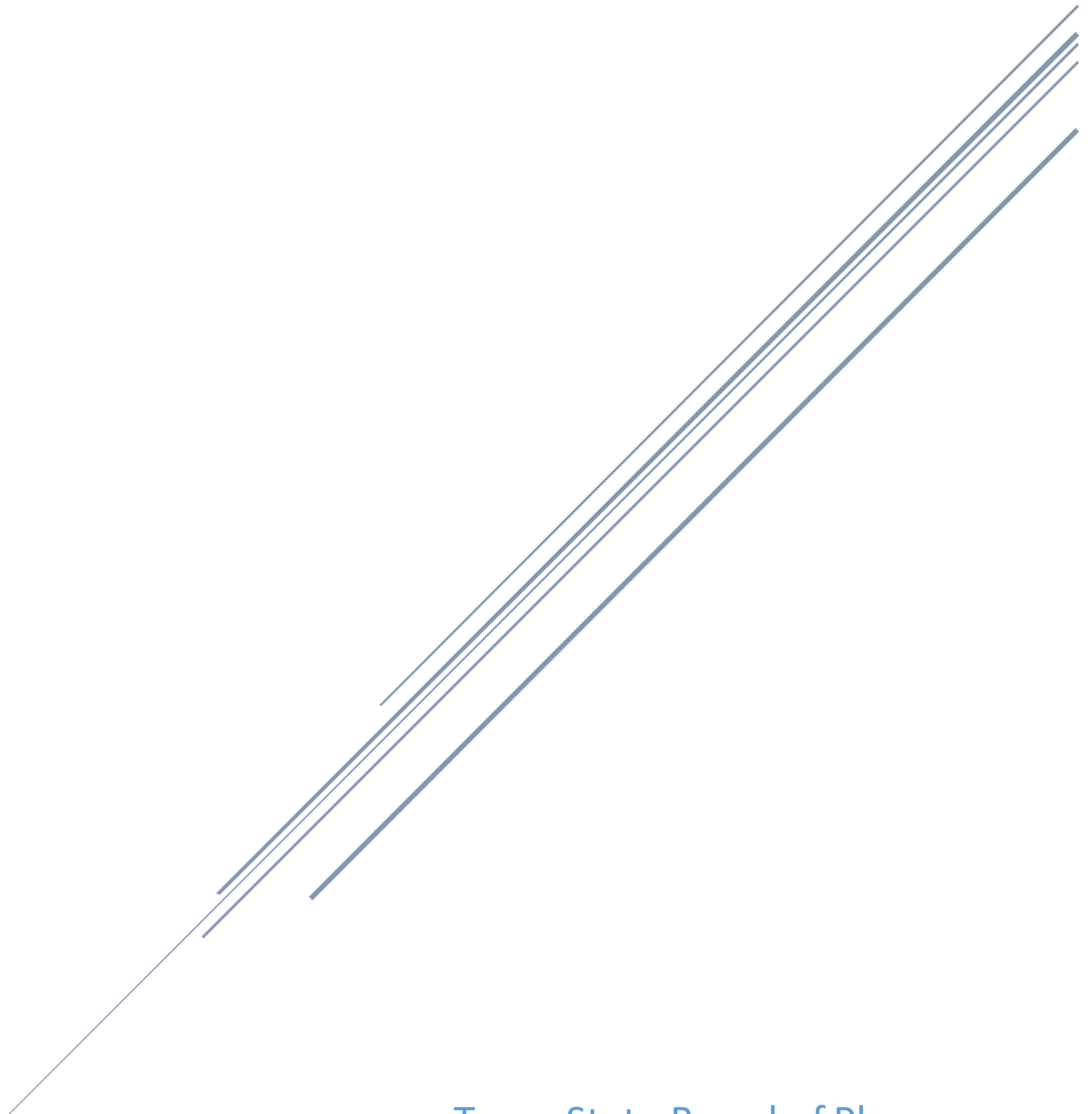
POLICY AND PROCEDURE RECOMMENDATIONS

to Help Prevent Immunization or Vaccination Administration Errors in the Pharmacy



Texas State Board of Pharmacy

July 2023

Errors

Immunization or vaccination administration errors can be caused by insufficient staff training, staff distraction, miscommunication, and lack of sufficient policies and procedures and best practices for personnel to follow.

The actions listed below include preventative measures from the U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC) Website, the Institute for Safe Medication Practices (ISMP) Website, and additional TSBP recommendations. These considerations may prevent common errors when included in your pharmacy's Policies and Procedures.

General Prevention of Administration Errors

1. Educate personnel when new products are added to inventory and provide timely in-service training regarding product and recommendation updates.

2. Establish cross-checks for data entry of immunization or vaccine information into pharmacy's data processing system prior to immunization or vaccine preparation and administration.

3. Set up distraction-free work areas and utilize Do NOT Disturb times for immunization or vaccine preparation and during the administration session with the patient.

4. Engage with the patient by asking the patient to state their full name and what services they are expecting. Provide the patient with written documentation regarding the immunization or vaccine prior to administering the product, and encourage conversation with the patient to verify the product prior to administering.

5. Never sacrifice proper vaccination technique and do not compromise safe practices for time-saving efficiencies. Risky practices include pre-preparing syringes, foregoing proper hand hygiene, labeling, or failing to engage with the patient.

Common Categories of Immunization or Vaccine Administration Errors:

1. Wrong vaccine or dosage (amount), or expired product:
    a. Verify the patient's age by asking the birth date with the patient or patient's agent. Check the patient's history and vaccination consent form to ensure the patient is an appropriate candidate for the immunization or vaccine.
    b. Use the patient's immunization or vaccination record prior to administering the product to the patient to cross-check the vaccine name, dose, lot number, and check product expiration date.
    c. Check the manufacturer's label and vial characteristics (e.g., color codes) for the product prior to beginning the preparation process, after preparing the medication, and again before administering it to the patient.
    d. Store look-alike vaccines in different storage areas, such as different shelves for pediatric and adult formulations. Consider purchasing products from different manufacturer's if the packaging is similar for pediatric and adult formulations.

2. Wrong diluent:
    a. Ensure the diluent is supplied and packaged by the manufacturer for the immunization or vaccine product. Educate personnel that diluents are not interchangeable between products and to only use diluents that are clearly marked.

   b. Train personnel on proper storage of diluents for the immunization or vaccine.
   c. Add highlighting or other marks on the manufacturer's label to help personnel distinguish different diluent products.
   d. Check that the correct amount of diluent has been extracted prior to reconstitution of the immunization or vaccine.

3. Wrong patient:
   a. If multiple children, adults, or an adult and child are being seen at the same time for the vaccination, only bring one patient's vaccine into the area where the administration will take place.
   b. Prepare immunization or vaccine syringe immediately prior to administration.

Per the CDC, healthcare providers are strongly encouraged to report vaccine administration errors to Vaccine Adverse Event Reporting System (VAERS) https://vaers.hhs.gov/reportevent.html