

OKLAHOMA IMMUNIZATION UPDATE

MARCH 2016



The NEW Oklahoma State Immunization Information System is live

Visit the OSDH Immunization Service Website for OSIIS training, information, and updates.

Order Vaccine Educational Materials

Use this [form](#) to order educational materials for parents at no charge to you, including CDC's "Parents Guide to Childhood Immunizations".

Avoid Vaccine Administration, Storage & Handling Errors

On December 18, 2015 the Centers for Disease Control and Prevention (CDC) published "[Notes from the Field: Injection Safety and Vaccine Administration Errors at an Employee Influenza Vaccination Clinic—New Jersey, 2015](#)". The article describes vaccine administration, storage, and handling errors committed by a health services company contracted to hold an onsite employee influenza vaccination clinic.

The nurse administering the vaccine changed needles between each patient, but she reused syringes for multiple patients. The nurse also administered influenza vaccine to 67 adult patients using only two multi-dose vials of vaccine, a total of 20 doses (10 doses per vial).

Reuse of syringes for multiple patients, with or without reuse of needles, is recognized as a serious infection control breach that poses risks for transmitting bloodborne illness, such as hepatitis and HIV, as well as bacterial, fungal, and other viral infections. The errors at this clinic required testing and counseling for hepatitis B, hepatitis C, and HIV, HepB vaccination, and revaccination with flu vaccine of all who received vaccines at the clinic. These errors involved considerable cost for the company.

On February 19, 2016 CDC published "[Notes from the Field: Administration Error Involving a Meningococcal Conjugate Vaccine – United States, March 1, 2010-September 22, 2015](#)". This article describes the improper reconstitution of the two components of Menveo[®]. Menveo is supplied in two vials that must be combined before administration. This report prompted a search of the Vaccine Adverse Events Reporting System (VAERS). The search revealed 390 reports of administration of only one component of Menveo. Failure to prepare Menveo — a conjugate vaccine administered to prevent invasive meningococcal disease

caused by *Neisseria meningitidis* serogroups A, C, Y, and W-135 — as directed by the manufacturer's instructions can lead to lack of protection against intended pathogens.

The seriousness of the errors described above highlights the need for proper training of all staff administering vaccines. Immunization service providers should ensure their staff is adequately trained and adheres to CDC guidelines for infection control and vaccine administration. This can be accomplished by having staff view the following online training modules at <http://eziz.org/eziz-training/>:

- Preparing Vaccines (25 min.) which includes education on reconstituting and drawing up vaccines.
- Administering Vaccines (16 min.) which includes education on correct needle lengths, insertion angles, and injection sites for intramuscular (IM) and subcutaneous (SC) injections.

Or you can purchase this DVD [Immunization Techniques](#) for \$17.00 and use it repeatedly to train staff. The running time is 25 minutes. Additional sources of injection safety information and educational programs for healthcare personnel are listed on CDC's [Vaccine Administration and Storage and Handling Resources Guide](#).

Increase HPV Vaccination Levels

The chart below shows the estimated vaccination levels for Oklahoma teens 13 through 17 years of age as measured by the [2014 National Immunization Survey](#). HPV vaccination coverage lags behind the adolescent vaccination coverage estimates for Tdap and MCV and remains far below the Healthy People 2020 target of 80% coverage.

Vaccination levels for the first dose of HPV could conceivably be as high as the Tdap levels [if missed opportunities to provide HPV were eliminated](#). A [strong, confident recommendation](#) from physicians and nurses has been shown to result in higher levels.

