|  |  |
| --- | --- |
| FOR IMMEDIATE RELEASE | CONTACT |
| September 22, 2022 | Renee Brehio, ISMP Public and Media Relations |
|  | rbrehio@ismp.org • 614-376-0212 |

## ISMP Draws Attention to Age-Related Vaccination Errors

### *Recent Analysis Focuses on Mistakes with Non COVID-Related Vaccines*

###

**Plymouth Meeting, Pa.**– While there has been intense focus on COVID vaccine safety during the global pandemic, errors with other vaccines continue to increase the risk of disease outbreaks, costly overvaccination, and loss of public confidence in vaccines and the healthcare delivery system. The 2022 analysis by the Institute for Safe Medication Practices National Vaccine Errors Reporting Program (ISMP VERP) addresses this issue by focusing on vaccines outside of those intended to prevent COVID, and offers safe practice recommendations.

ISMP found that during the 19-month timeframe examined, some of the most frequent types of vaccine-related events (excluding COVID vaccines) included age-related errors, which often are associated with administering the wrong vaccine or the wrong dose. Wrong age plus wrong vaccine or dose errors contributed to nearly half (46%) of all non-COVID vaccine errors reported to the ISMP VERP during that time.

Wrong age formulation and wrong dose errors occurred frequently between age-related formulations of influenza virus vaccines (31%), diphtheria, tetanus, and acellular pertussis vaccine (DTaP) (23%), hepatitis A vaccines (16%), and hepatitis B vaccines (16%). Unfortunately, the frequency of mix-ups between age-related formulations of these four vaccines has not improved much during the past decade.

ISMP’s safe practice recommendations to prevent age-related vaccine errors include:

* **Maximize technology.** Utilize clinical decision support and barcode scanning, and develop order sets based on the Centers for Disease Control and Prevention (CDC) immunization schedules to guide prescribers to the appropriate age-based formulations.
* **Streamline purchasing**. Investigate purchasing differing age-specific formulations of the same vaccine from different manufacturers to help distinguish them.
* **Store separately**. Separate vaccine storage on different shelves in bins, ensure that they are properly labeled, and do not store vaccines with similar names, abbreviations, or overlapping components near each other.
* **Verify identity, age, and vaccine(s) requested**. When checking in a patient scheduled to receive vaccine(s), ask the parent, caregiver, or patient to provide at least two patient identifiers—their full name and date of birth. Verify age and which vaccine(s) they requested.
* **Label syringes**. Clearly label all syringes that do not come prefilled; print labels for each patient or provide practitioners who prepare vaccines with strips of preprinted labels that differentiate formulation and dose for each patient.
* **Engage the patient**. Involve the patient and their caregiver or parent in verifying vaccine, formulation, and dose by reviewing the label.
* **Document the vaccine(s)**. Document the lot number and expiration date prior to administration. This is often the step where errors can be detected and mitigated.
* **Educate practitioners**. Educate staff about new vaccine products and when adding new vaccines to formulary, provide resources listing indication and vaccine schedules, share impactful stories, and print ISMP’s table ([www.ismp.org/ext/55](http://www.ismp.org/ext/55)) as a teaching tool.

ISMP also has encouraged manufacturers and the U.S. Food and Drug Administration (FDA) to review labeling strategies to reduce the risk of age-related vaccine mix-ups. One recommended strategy is to prominently display **PEDIATRIC** or **ADULT** formulations in a different color on the top of the cartons, vials, and on syringe labels.

For a copy of the September 12, 2022, *ISMP Medication Safety Alert!® Acute Care* newsletter cover article with more details and the full list of recommendations, visit: <https://www.ismp.org/node/39582>

**About the Institute for Safe Medication Practices**

The Institute for Safe Medication Practices (ISMP) is the nation’s first 501c (3) nonprofit organization devoted entirely to preventing medication errors. ISMP is known and respected for its medication safety information. For more than 25 years, it also has served as a vital force for progress. ISMP’s advocacy work alone has resulted in numerous necessary changes in clinical practice, public policy, and drug labeling and packaging. Among its many initiatives, ISMP runs the only national voluntary practitioner medication error reporting program, publishes newsletters with real-time error information read and trusted throughout the global healthcare community, and offers a wide range of unique educational programs, tools, and guidelines. In 2020, ISMP formally affiliated with ECRI to create one of the largest healthcare quality and safety entities in the world, and ECRI and the ISMP PSO is a federally certified patient safety organization by the U.S. Department of Health and Human Services. As an independent watchdog organization, ISMP receives no advertising revenue and depends entirely on charitable donations, educational grants, newsletter subscriptions, and volunteer efforts to pursue its life-saving work. Visit [www.ismp.org](http://www.ismp.org) and follow @ismp\_org to learn more.