

SULLIVAN COUNTY PUBLIC HEALTH SERVICES

<p><u>POLICY:</u> INFLUENZA VACCINE ADMINISTRATION POLICY THE INFLUENZA VACCINE WILL BE ADMINISTERED TO PATIENT(S) WITHOUT REQUIRING A PHYSICIAN ORDER IN ACCORDANCE TO AGENCY ESTABLISHED PROCEDURE</p>	<p>Original Approval: 11/02 Revised: 10/2018</p>
<p><u>PURPOSE:</u> To provide guidelines for vaccine administration per Federal Regulation Conditions of Participation § 484.18(c).</p>	
<p><u>RESPONSIBLE PARTY:</u> RN</p>	

EQUIPMENT:

N/A

PROCEDURE:

1. Explain purpose and procedure to patient.
2. RN will assess patient for contraindications according to NYS Department of Health Regulatory Guideline Form and provide educational information (see attached).
3. RN will obtain patient consent.
4. Documentation of assessment and immunization information will be done on the Plan of Treatment in patient's chart.
5. Emergency Treatment Guidelines are to be followed per agency policy (see attached).

immunization is the program that was conducted at the Minneapolis Veterans Affairs Medical Center since 1984. This hospital-wide program initially focused on influenza vaccination of outpatients and used a combination of a health-care, organizational, and patient-oriented interventions. No special interventions were made to involve physicians. Instead, the program was implemented by nurses according to a hospital policy that allowed them to vaccinate patients without a signed physician's order. By 1997, the program was vaccinating 84 percent of the hospital's elderly outpatients; by the late 1990s, a near 90 percent were regularly receiving influenza vaccinations of them through the hospital's program.

Among successful programs for hospital-based influenza and pneumococcal vaccinations, a standing order is probably the most innovative feature. The ACP has specifically recommended that standing orders be used to increase adult vaccination rates in all settings. Furthermore, none of the successful programs described thus far in the literature has depended on active physician participation. Instead, nurses or pharmacists have been responsible for their implementation. (Feldman, H22-699.)

2. Long-Term Care Facilities

We are changing our current regulations in the Conditions of Participation for LTCFs at § 483.49 (b)(3) to read "the physician must sign a standing order with the exception of orders for the administration of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

There were 1,598,724 individuals over 65 years of age in LTCFs in the United States in 1990, and the number is estimated to grow to 2.9 million by 2020. ("Membership Projections and Vaccination Rates Among Residents of Long-Term Care Facilities: Breakdown Based on Pneumonia, Influenza, and Pertussis Organizations in Their Western States," Kurt B. Stevenson, MD, John W. McArthur, Jr, MD, Ian Hacks, MSHA, CPE, J. Robert Trillman, MD, Steven D. Helgeson, MD, MPH, Infection Control and Hospital Epidemiology, Volume 21 (11) 1045-1046 (November 2000) Stevenson). A substantial increase in vaccination rates among such a large population will prevent a significant number of cases of influenza and pneumococcal pneumonia and related deaths. Standing orders appear to be an

intervention effective in improving successful vaccination efforts.

3. Home Health Agencies

We are changing the first sentence of the current requirements in the Code of Federal Regulations to read "Orders for influenza are administered by agency staff unless ordered by the physician, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per agency policy after consultation with a physician, and after an assessment for contraindications." HHA staff may include the immunization information on the patient's plan of care, although a physician or other qualified health-care professional must sign the order.

Providing vaccination is significantly available to adults who are aged in need of the services. In a rural, former mining town, the need to use transportation to reach a healthcare provider is a barrier in reaching percentile services. This barrier may be eliminated by offering preventive services (for example, administration of vaccines) in convenient locations such as the patient's home. Eliminating the need for making an appointment, in addition and avoiding the waiting time of an associate with a clinic or office visit are factors that also might increase the opportunities for some adults to receive medical examinations. ("Adult Immunization Programs in Nontraditional Settings: Quality Standards and Guidance for Program Evaluation, A Report of the National Vaccine Advisory Committee," MMWR 46 (RR017)-13, March 22, 2000.)

The 1999 RAND report states that the proportion of the U.S. population over age 65 has increased from 5 percent in 1950 to 13 percent in 1997. This increase in demographics, combined with an increase in average life expectancy, has highlighted the importance of preventive care services for older individuals. According to an October 1997 JAMA article, vaccination of elderly people against pneumococcal bacteremia is one of the few interventions that have been found to both improve health and save medical costs. ("Cost-effective use of Vaccination Against Pneumococcal Bacteremia Among Elderly People," JAMA; Chicago; Oct 25-Oct 29, 1997; 278:11; Jane E. Smith, Alan J. Mushinski, William W. Herzog, Jr, D. Tim, et al.)

III. Response to Comments

Because of the large number of items of correspondence we normally receive on Federal Register documents published by government, we are not able to acknowledge or respond to them

individually. We will examine all comments we receive by the date and time specified in the DATES section of this preamble and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the Federal Register and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rule itself.

The delay in publishing the rule would be extremely detrimental to the health of her citizens, as evidenced by influenza typically seen during the winter months and are responsible for an average of approximately 20,000 to 40,000 deaths per year in the United States. Influenza viruses also can cause an illness, during which rates of illness and death from influenza and complications can increase dramatically. Rates of infection are highest among children, but rates of serious illness and death are highest among persons older than 65 years of age and persons of any age who have medical conditions that place them at increased risk for complications from influenza and pneumonia. Vaccines are the most effective means to protect against many complications related to influenza and pneumonia. The ACIP recommendations for 2002 to 2005 to reduce the risk of influenza state that the optimal time for influenza vaccinations is October through November. Therefore, it is imperative that this rule is published and final rule is published as soon as possible so the process be implemented without delay this year and influenza-related complications can be prevented. The goal of CDC and HUD, to immunize at least 60 percent of the adult population against the Healthy People 2010 objectives, can be attained earlier if the barrier requiring a physician's order is removed as soon as possible, even though pneumococcal vaccines can be administered throughout the year through the participation of patients and providers immunized routinely. Thus, therefore, this final rule will be a vehicle to improve

1. See also, "Influenza Vaccination Rates Among Residents of Long-Term Care Facilities: Breakdown Based on Pneumonia, Influenza, and Pertussis Organizations in Their Western States," Kurt B. Stevenson, MD, John W. McArthur, Jr, MD, Ian Hacks, MSHA, CPE, J. Robert Trillman, MD, Steven D. Helgeson, MD, MPH, Infection Control and Hospital Epidemiology, Volume 21 (11) 1045-1046 (November 2000) Stevenson).

INACTIVATED INFLUENZA VACCINE

WHAT YOU NEED TO KNOW

2004-2005

3 Who should get inactivated influenza vaccine?

1 Why get vaccinated?

Influenza ("flu") is a serious disease.

It is caused by a virus that spreads from infected persons to the nose or throat of others.

Influenza can cause:

- fever
- sore throat
- chills
- headache
- muscle aches

Anyone can get influenza. Most people are ill with influenza for only a few days, but some get much sicker and may need to be hospitalized. Influenza causes an average of 36,000 deaths each year in the U.S., mostly among the elderly.

Influenza vaccine can prevent influenza.

2 Influenza vaccine

Two types of influenza vaccine are now available. Inactivated (killed) influenza vaccine, given as a shot, has been used in the United States for nearly 50 years. A live, weakened vaccine was licensed in 2003. It is sprayed into the nostrils.

Influenza viruses change often. Therefore, influenza vaccine is updated every year.

Protection develops about 2 weeks after getting the shot and may last up to a year.

Some people who get the vaccine may still get flu, but they will usually get a milder case than those who did not get the shot.

The vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

Some manufacturers of vaccine contain thimerosal, a form of mercury, as a preservative. Some contain only a trace of thimerosal. There is no scientific evidence that thimerosal in vaccine is harmful, and the known benefits of the vaccine outweigh any potential risk from thimerosal. If you have questions about thimerosal or red-head thimerosal U.S. vaccine, ask your doctor.

People 6 months of age and older are at risk for getting a serious case of influenza or influenza complications, and people in close contact with them (including all household members) should get the vaccine.

An annual flu shot is recommended for:

- All children 6-23 months of age.
- Household contacts and out-of-home caretakers of infants from 6-23 months of age.
- People 50 years of age or older.
- Residents of long-term care facilities housing persons with chronic medical conditions.
- People who have long-term health problems with:
 - heart disease
 - kidney disease
 - lung disease
 - metabolic disease, such as diabetes
 - asthma
 - anemia, and other blood disorders
- People with a weakened immune system due to:
 - HIV/AIDS or another disease that affects the immune system.
 - long-term treatment with drugs such as steroids.
 - cancer treatment with surgery or drugs.
- People 6 months to 16 years of age on long-term aspirin treatment (these people could develop Reye Syndrome if they get the flu).
- Women who will be pregnant during an active season.
- Physicians, nurses, family members, or anyone else coming in close contact with people at risk of serious influenza.
- Anyone else who wants to reduce their chance of catching influenza.

An annual flu shot should be considered for:

- People who provide essential community services.
- People at high risk for flu complications who travel to the Southern Hemisphere between April and September, or who travel to the tropics or to organized tourist groups at any time.
- People living in dormitories or under other crowded conditions, to prevent outbreaks.

Inactivated Influenza Vaccine

5/24/04

4 | When should I get influenza vaccine?

The best time to get a flu shot is in October or November.

Some people should get their flu shot in October or earlier. This includes:

- people 50 years of age and older,
- young people at high risk from flu and its complications (including children 6 through 23 months of age),
- household contacts of persons at high risk, health care workers, and children under 9 years of age getting the flu shot for the first time.

The flu season can peak anywhere from December through March, but most often it peaks in February. So getting the vaccine in December or even later can be beneficial in most years.

Most people need only one flu shot each year to prevent influenza. Children under 9 years old getting the vaccine for the first time should get 2 doses. With the inactivated vaccine, these doses are given one month apart. Children in this age group who got one dose the previous year, even if it was the first time they got the vaccine, need only one dose this year.

5 | Some people should talk with a doctor before getting influenza vaccine

Talk with a doctor before getting a flu shot if you:

- 1) ever had a serious allergic reaction to eggs or to a previous dose of influenza vaccine, or
- 2) have a history of Guillain-Barré Syndrome (GBS).

If you have a fever or are severely ill at the time the shot is scheduled, you should probably wait until you recover before getting influenza vaccine. Talk to your doctor or nurse about whether to reschedule the vaccination.

6 | What are the risks from inactivated influenza vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious illness or death is extremely small.

Serious problems from inactivated flu vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so you cannot get influenza from the vaccine.

Most problems—swelling, redness, or soreness where the shot was given—(very rarely) resolve.

If there are problems soon, they usually happen soon after the shot and last 1-2 days.

Severe problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is within a few minutes to a few hours after the shot.

- In 1976, a live flu vaccine was associated with a severe paralytic illness called Guillain-Barré Syndrome (GBS). Inactivated vaccines since then have not been heavily linked to GBS. However, if there is a risk of GBS from inactivated influenza vaccines, it is estimated as 1 or 2 cases per million persons vaccinated . . . much less than the risk of severe influenza, which can be prevented by vaccination.

7 | What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hives, swelling of the throat, hives, rashes, weakness, a fast heart beat, or dizziness.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your doctor, nurse, or health department to report the reaction by filling a Vaccine Adverse Event Reporting System (VAERS) form.

Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-833-3287. VAERS does not provide medical advice.

8 | How can I learn more?

- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call 1-800-232-2512 (English)
 - Call 1-800-232-0233 (Spanish)
- Visit CDC websites at:
 - www.cdc.gov/ncidod/diseases/flu/influenza.htm
 - www.cdc.gov/nip



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL IMMIZATION PROGRAM

Inactivated Influenza Vaccine (2020-2021) Vaccine Information Statement



**SULLIVAN COUNTY
DIVISION OF HEALTH AND FAMILY SERVICES**

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SULLIVAN COUNTY PUBLIC HEALTH IMMUNIZATION CLINIC

EMERGENCY TREATMENT GUIDELINES

Registered Nurses administering biologic products or serum should be prepared to treat adverse reactions including anaphylaxis. An emergency box should be placed in each room where immunizations are administered. (Emergency boxes are kept in the locked syringe room.) For off-site clinics, a bag with emergency supplies is brought to each clinic.

1. SIMPLE FAINING:

Occurs before, during, or shortly after injection. Be observant, fainting and the injuries that go with it can usually be prevented.

- ❖ **Pale color and feeling faint:** Have the patient lie flat or sit in head-down position for several minutes.
- ❖ **Fainting:** Place patient flat on the floor with feet slightly elevated. Allow patient to rest in a quiet area for 10 minutes after regaining consciousness. (Ammonia ampoules for inhalation may be helpful).

2. ACUTE REACTIONS:

Includes urticaria, generalized pruritis, shortness of breath, and anaphylaxis.

- ❖ Have someone call EMS at 911 and be prepared to start CPR.
- ❖ Assess vital signs including airway, pulse and blood pressure.
- ❖ Epinephrine (1:1000) should be administered immediately subcutaneously according to the following schedule:

BODY WEIGHT (pounds)	EPINEPHRINE HCL (1:100)
15 or less	.05 ml
16 - 30	.1 ml
31 - 40	.15 ml
41 - 50	.2 ml
51 - 60	.25 ml

61 - 74	.3 ml
75 - 90	.35 ml
91 - 100	.4 ml
101 - 110	.45 ml
Over 110	.5 ml

❖ **Bicardyl®** should be given IM (2mg/kg) immediately after epinephrine.

POUNDS	KILOGRAMS
5	2.27 kg
10	4.54 kg
15	6.81 kg
20	9.09 kg
30	13.63 kg
40	18.18 kg
50	22.72 kg
60	27.27 kg
70	31.81 kg
80	36.36 kg
90	40.90 kg
100	45.45 kg
110	50 kg

• 1 kg = 2.2 lbs.

❖ Record incident in the patients' record, and begin a VAERS (Vaccine Adverse Event Reporting Form). Send a copy of the VAERS report to the child's pediatrician/physician.


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Date