

Medical Centre
Registered Nurse, RN C
Registered Nurse, RN D

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC00512)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 20 February 2017, Miss A (12 years old at the time) attended a medical centre with her mother, for her first dose of the Gardasil vaccine, but was given the Boostrix vaccine in error.
2. Prior to the vaccination, practice nurse RN C asked Miss A: “Have you had this vaccine before?” but did not state the name of the vaccine, and Miss A responded that she had not. Although Miss A’s immunisation history showed that she had received the Boostrix vaccine already, RN C did not scroll down far enough on the practice management system to see the entry.
3. RN C became aware of the administration error when she updated Miss A’s immunisation history. She discussed the issue with Miss A, who agreed to have Gardasil administered in her other arm. Neither of the vaccines were administered under a standing order or prescription, and RN C was not an authorised vaccinator at the time.
4. RN C submitted an incident report to RN D, the Nurse Lead, on the day of the incident. RN D did not complete her section of the report until 27 March 2017.

Findings

5. By failing to identify and administer the correct vaccine to Miss A, RN C did not provide Miss A services with reasonable care and skill, and, accordingly, breached Right 4(1) of the Code.
6. By failing to comply with the Medicines Act 1981, RN C also breached Right 4(2) of the Code.
7. By allowing RN C to administer vaccines without appropriate authorisation, the medical centre breached Right 4(2) of the Code.
8. Adverse comment is made about RN D regarding her failure to complete the incident reporting form in a timely manner.

Recommendations

9. In response to the recommendations set out in the provisional opinion, RN C and the medical centre provided letters of apology to Miss A and her mother.
10. It was recommended that RN D provide HDC with evidence that she has completed training on the electronic recording of accidents and events.
11. It was recommended that the medical centre update its vaccination policy and report back to HDC on the steps taken to ensure that it complies with legislation and professional standards relating to the administration of prescription medicine.

Complaint and investigation

12. The Commissioner received a complaint from Ms B about the services provided to her daughter, Miss A, by the medical centre. The following issues were identified for investigation:
- *Whether the medical centre provided Miss A with an appropriate standard of care in 2017.*
 - *Whether Registered Nurse RN C provided Miss A with an appropriate standard of care in 2017.*
 - *Whether Nurse Lead RN D provided Miss A with an appropriate standard of care in 2017.*
13. This report is the opinion of Meenal Duggal, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.
14. The parties directly involved in the investigation were:
- | | |
|----------------|---------------------------------|
| Ms B | Complainant, consumer's mother |
| Medical centre | Provider |
| RN C | Provider, registered nurse (RN) |
| RN D | Provider, registered nurse |
15. Also mentioned in this report:
- | | |
|------|----------------------------|
| RN E | Provider, registered nurse |
| RN F | Provider, registered nurse |
16. Independent expert advice was obtained from RN Wendy Findlay (**Appendix A**).
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Information gathered during investigation

Introduction

17. This report discusses RN C's incorrect administration of a Boostrix vaccine to a 12-year-old girl who had presented for a Gardasil vaccine.
- Immunisations*
18. Boostrix and Gardasil are two vaccinations available to children around the age of 11 and 12 under the National Immunisation Schedule.¹
19. Boostrix boosts the protection that children receive as babies, against tetanus, diphtheria, and pertussis. It is given as one injection.

¹ The schedule outlines the series of vaccinations (including boosters) that are offered free of charge to babies, children, adolescents, and adults at specific times.

20. Gardasil protects against various strains of human papillomavirus (HPV). It is given as two injections, spaced out over at least six months to those aged 14 years or under.²

Statutory requirements

21. Section 19 of the Medicines Act 1981 requires prescription medicines (such as vaccines) to be administered only under prescription or a standing order, unless otherwise permitted by regulations made under that Act.
22. Pursuant to regulation 44A of the Medicines Regulations 1984, the Director-General of Health or a medical officer of health may authorise any person to administer a vaccine for the purposes of an approved immunisation programme. Where a person has obtained such authorisation, he or she is often referred to as an “authorised vaccinator”.
23. In order to achieve authorised vaccinator status, the applicant must provide evidence that he or she has:
- a) Within the preceding 12 months, attended, completed and passed a vaccinator training course consisting of a minimum of 16 hours’ educational input and a written open-book assessment;
 - b) Undergone an independent clinical assessment by an immunisation coordinator or an approved assessor;
 - c) A current practising certificate from his or her registration authority; and
 - d) A current cardiopulmonary resuscitation certificate.

RN C

24. The medical centre told HDC that, at the time of the administration error, RN C “was not working under any standing orders for childhood vaccinations as she is an authorised vaccinator”.³
25. The medical centre stated:
- “A vaccinator training is a 2 day theory training and then the train[ee] has a year to complete the practical. During the practical training the trainee will get already trained authorised vaccinators to check their progress. [RN C] did her theory in [2016]. The incident in question occurred in February 2017 six months after [RN C] started the training.”
26. RN C said that she was under the indirect supervision of another registered nurse and independent vaccinator, and although she was still gaining experience in the practical element of vaccinating, she “felt competent in administering vaccines”.
27. RN C completed the Immunisation Advisory Centre’s 18-hour vaccinator training course in September 2016 and had received a certificate of completion, which stated: “This does not allow the participant to be an authorised or approved vaccinator. Authorisation is to be obtained from a Medical Officer of Health.”

² It is given as three injections over six months for those aged 15 years and older.

³ RN C became an authorised vaccinator in May 2017.

28. While RN C had completed some aspects of the required training, she was not at the time of the incident an authorised vaccinator in accordance with the Medicines Regulations 1984. RN C was therefore not able to vaccinate without a prescription or standing order.

Medication administration error

29. On 20 February 2017, Ms B took her 12-year-old daughter, Miss A, to the medical centre for her first dose of the Gardasil vaccination.

30. Ms B said:

“The nurse ([RN C]) ushered us into one of the cubicles and explained that she was in the process of getting signed off for giving vaccinations and did we mind that she had another nurse supervising her ... At no time did she or her supervisor ask any questions with regards to the vaccination that [Miss A] was about to receive.”

31. The medical centre’s vaccination policy documents the steps to be taken before and after vaccination. It requires the vaccinator to review the patient’s immunisation history to check whether the patient has been administered the vaccine previously and whether there has been a reaction previously, and to ensure that there is appropriate spacing between doses of the same vaccine. The vaccination policy does not detail who is permitted to administer vaccines.

32. RN C stated that she assumed that Miss A was attending for the Boostrix vaccine. RN C said that she asked Miss A, “Have you had this vaccine before?”, but did not state the name of the vaccine, and Miss A responded that she had not.

33. RN C told HDC that she checked the immunisation tab for Miss A on Medtech,⁴ and asked RN E to check the “11-year vaccine” that she was about to administer. RN E confirmed that it was a Boostrix vial within its expiry date, and RN C proceeded to administer the vaccine to Miss A.

34. The vaccine was not given under a prescription or a standing order.

35. RN C told HDC that she realised she had administered the incorrect vaccine when she went to record the details in Medtech, and the immunisation history showed that Miss A was given Boostrix on 7 April 2015. RN C said that she had missed this entry in the initial check as she had not scrolled down far enough.

36. RN C consulted with RN F, the senior nurse with a responsibility for vaccinations, regarding the error. RN C said:

“Myself and [RN F] explained [to Ms B and Miss A] what had happened, both [RN F] and I apologised. [We] then proceeded to discuss what had happened, the possible side effects, and [RN F] explained that it was okay for [Miss A] to have the HPV vaccination today, if she wished. Alternatively, [Miss A] could wait [four] weeks, and then have the HPV vaccine.”

⁴ A patient management system.

37. Miss A agreed to have RN C administer Gardasil in her other arm, and this proceeded without incident.
38. Ms B told HDC that, although both RN F and RN C appeared apologetic about the mistake at the time, she expected to receive a written acknowledgement of the error and an apology, as well as an assurance that the medical centre had implemented procedures to prevent a similar occurrence. Ms B said that she did not receive any such correspondence.

Incident reporting

39. The medical centre's "Incident Management Information" policy in place at the time sets out the expectation that incidents are reported in a timely manner and that managers are responsible for undertaking initial investigations as indicated. On the day of the incident, RN C submitted an incident report to Nurse Lead RN D.⁵ It stated:

"Patients presented to have 11yr HPV vaccine. Given boostrix. Patient had already had. Parent aware — right vaccine given. Documented on Medtech."

40. As Nurse Lead, RN D was responsible for ensuring that all events and incidents were recorded in the incident register and investigated, and that recommended improvements were implemented. RN D discussed the incident with RN F and RN C, but no further action was taken at the time. RN D said: "I didn't see that it was urgent to report [it] to others, as the mother appeared happy and understanding at the time."
41. On 27 March 2017, RN D completed her section of the incident form and backdated it to 20 February 2017. She wrote that she had discussed the matter with RN C, and that it would be reported at the next Quality Risk and Safety (QRS) meeting. RN D explained that she did not mean to misrepresent the date, and that it was intended to reflect the date on which her conversation with RN C took place. RN D stated: "[T]he event was truthful, the recording of same was accurate, but I did not complete [the incident report] in a timely manner."
42. The matter was not raised at the first QRS meeting following the incident (15 March 2017). RN D told HDC that she had forgotten to do so. At the QRS meeting on 19 April 2017, nurses were reminded of the need to provide patients with vaccine information and to state the name of the vaccine before administering it.

Further information

RN C

43. RN C stated that there was a "communication error" when discussing the vaccine with Miss A, and that she ought to have referred to the Gardasil vaccine by name.
44. RN C said that she is now more careful in rechecking the immunisation record and ensures that she names the vaccine she is about to administer. She stated that she received closer supervision following the incident. RN C told HDC: "I was frightened by this experience and have done everything in my power to make sure it never happens again."

RN D

45. RN D acknowledged that her actions did not allow the medical centre to investigate the event in a timely manner. She stated that she was not functioning at her usual high level of

⁵ The incident was also recorded in Miss A's clinical notes.

care because of work and home life stressors, and that she has since taken an eight-week break away from nursing. In addition, she has undergone several counselling and mentoring sessions, and has planned to undertake training on the electronic recording of accidents and events.

The medical centre

46. As a result of the incident, the medical centre made the following amendments to its vaccination policy:
 - a) There is now a clause stating that nurses are to check for outstanding vaccines appropriate for age and gender.
 - b) There is now a clause stating that nurses are to refer to the vaccine to be administered by name.
 - c) The steps have been reorganised to better reflect the order in which each action should take place.
 - d) There is now a specific section on what action to take in the event of a vaccination error or incident. This includes the requirement to notify the patient's preferred provider as soon as practicable.
47. The medical centre told HDC that the nurses involved with vaccination have been informed of the changes made.

Responses to provisional opinion

48. Ms B was provided with the opportunity to respond to the "information gathered" section of my provisional opinion. Ms B stated that she had no comments to make.
49. RN C, RN D, and the medical centre were provided with the opportunity to respond to my provisional opinion.
50. In response to the recommendations set out in my provisional opinion, RN C and the medical centre each provided letters of apology for forwarding to Miss A and Ms B.
51. RN D stated that she had made a "grave mistake" and wished to apologise to everyone concerned.

Opinion: RN C — breach

52. Registered nurses are required to administer medications in compliance with legislation, codes, and scopes of practice. Pursuant to section 19 of the Medicines Act 1981 and regulation 44A of the Medicines Regulations 1984, a vaccine may be administered only under a standing order or prescription unless it is undertaken by an authorised vaccinator for the purposes of an approved immunisation programme.
53. On 20 February 2017, Miss A attended the medical centre for her first dose of the Gardasil vaccine. RN C assumed that Miss A had presented for the Boostrix vaccine and asked Miss A whether she had had "this vaccine" previously. Miss A confirmed that she had not.

54. RN C checked Miss A's immunisation history on the practice management system but did not scroll down far enough to see that Miss A had already received Boostrix on 7 April 2015.
55. RN C proceeded to administer the Boostrix vaccine to Miss A. After RN C became aware of the error, she discussed the issue with RN C and Ms B, and obtained consent to administer Gardasil in Miss A's other arm.
56. RN C was not an authorised vaccinator at the time. Neither of the vaccines were given under prescription, and there was no standing order in place permitting RN C to administer vaccines as a non-authorised vaccinator.

Failure to administer correct vaccine

57. My expert advisor, RN Wendy Findlay, was critical that RN C failed to ascertain which vaccine was being agreed to, and that RN C did not check the available clinical documentation accurately. RN Findlay advised that RN C's process in this regard was a moderate departure from accepted practice.
58. I agree that RN C's practice was deficient. RN C did not complete a thorough check of Miss A's immunisation record, which documented that Miss A had received Boostrix previously. In addition, as RN C has acknowledged, she ought to have referred to the vaccine by name when conversing with Miss A. By not doing so, she left it ambiguous as to which vaccine she was intending to administer. I find that by failing to identify and administer the correct vaccine to Miss A, RN C did not provide Miss A services with reasonable care and skill, and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).⁶

Compliance with legal standards

59. While I acknowledge that RN C had completed a vaccinator training course and "felt competent" administering vaccines, she did not administer the Boostrix and Gardasil vaccines under a standing order or prescription, and she was not an authorised vaccinator at the time. By failing to comply with the Medicines Act 1981, RN C also breached Right 4(2) of the Code.⁷

Opinion: RN D — adverse comment

60. The administration of the incorrect vaccine was reported to Nurse Lead RN D on 20 February 2017, the same day on which the incident occurred. The medical centre's "Incident Management Information" policy stipulates that incidents are to be reported in a timely manner, and that managers are responsible for undertaking initial investigations as indicated.

⁶ Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

⁷ Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

61. RN D did not complete her section of the incident form until 27 March 2017 but backdated it to 20 February 2017. She wrote that she had discussed the matter with RN C and would report it at the next QRS meeting. RN D told HDC that she did not mean to misrepresent the date she filled in on the incident form, and that it was intended to reflect the date on which her conversation with RN C took place. RN D did not report the matter at the first QRS meeting following the incident, as she forgot to do so.
 62. RN Findlay advised that RN D's lack of follow-up was a moderate departure from the usual standard of practice.
 63. It is important to ensure that learning occurs from mistakes. Incident reports assist in understanding what has happened, why it happened, and what can be done to prevent a recurrence. I am critical that RN D did not complete the incident form in a timely manner or discuss the incident at the following quality meeting to enable wider staff learning.
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Opinion: Medical centre — breach

64. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. It has a responsibility to ensure that the services it provides, and the services its staff provide on its behalf, are done so within relevant scopes of practice, professional standards, and legal requirements.
 65. As noted above, section 19 of the Medicines Act 1981 and regulation 44A of the Medicines Regulations 1984 provide that a vaccine may be administered only under a standing order or prescription unless it is undertaken by an authorised vaccinator for the purposes of an approved immunisation programme.
 66. On 20 February 2017, RN C, while employed at the medical centre, administered two vaccines to RN C. Neither vaccine had been prescribed, and there was no standing order in place authorising RN C to vaccinate. RN C had completed a vaccinator training course but was not an authorised vaccinator at the time. The administration of the vaccines was therefore in breach of the requirements of the Medicines Act 1981.
 67. The medical centre told HDC that RN C, at the time of the administration error, “was not working under any standing orders for childhood vaccinations as she is an authorised vaccinator”. This was incorrect as, at the time, RN C had not been authorised in accordance with the Medicines Regulations 1984 to administer vaccines as part of an approved immunisation programme.
 68. The medical centre's vaccination policy did not provide any information on the legal restrictions around who could administer vaccines. In addition, the medical centre appeared unaware that the completion of a vaccination training course was not sufficient to authorise RN C to vaccinate as required by the Medicines Regulations 1984.
 69. I find that by allowing RN C to administer vaccines without appropriate authorisation, the medical centre breached Right 4(2) of the Code.
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Recommendations

70. In response to the recommendations made in my provisional report, RN C and the medical centre each provided a written apology for Miss A and her mother.
 71. I recommend that RN D provide HDC with evidence that she has completed training on the electronic recording of accidents and events. This should be done within three weeks of the date of this report.
 72. I recommend that the medical centre:
 - a) Update its vaccination policy to include information on who may legally administer vaccines. A copy of the updated vaccination policy is to be sent to HDC within two months of the date of this report.
 - b) Report back to HDC on the steps taken to ensure that nurses undergoing training on vaccinations are compliant with legislation and professional standards relating to the administration of prescription medicine. This is to be completed within two months of the date of this report.
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Follow-up actions

73. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name and RN D's name.
74. A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Nurses Organisation, the district health board, Medsafe, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Wendy Findlay:

“Please consider the following information as my expert advice to the Commissioner on case number C17HDC00512, care provided to [Miss A] by [the medical centre] on 20th February 2017. I have read and agree to follow the Commissioner’s Guidelines for Independent Advisors.

Background

On 20th February 2017 [Miss A] and [her mother] presented at [the medical centre] for [Miss A’s] HPV vaccination. [Miss A] was given the 11 year old vaccine in error by [RN C]. The vaccination error was acknowledged by the Practice Nurse and a Senior Nursing colleague involved, both [Miss A] and her mother were informed of the error and verbal apologies were given. [Miss A] consented to receive the HPV vaccination (correct vaccination) following the disclosure of error and informed consent obtained.

Sources of Information Supplied

1. Letter of complaint dated 22nd March 2017
2. [The medical centre’s] response dated 10th April 2017
3. Documentation received from [the medical centre], including
 - a. [Miss A’s] clinical notes from 20th February 2017
 - b. Minutes of Investigation meeting with [RN C] (24th March 2017)
 - c. [RN C’s] individual response, RN — Vaccine Incident (27 March 2017)
 - d. [RN C’s] statement, RN — Events of 27th March 2017 (8th April 2017)
 - e. Minutes of Investigation Meeting with [RN F] (24th March 2017)
 - f. [RN F’s] individual response, RN — incident details (31st March 2017)
 - g. Minutes of Investigation Meeting with [RN D], Nurse Lead (28th March 2017)
 - h. Lead [RN D], Nurse Lead Assessment (7 April 2017)
 - i. Copy of incident report (20th February 2017)
 - j. Copies of Vaccination Policies
 - k. A personal statement from [RN E]
 - l. Minutes of Investigation Meeting — [RN E] (26th April 2017)
 - m. Incident Management Information
 - n. Clinical and Practice Risk Management V2.2.
 - o. Significant Events — E.12.3
 - p. [RN C’s] Clinical Assessment — [Central PHO Immunisation Co-ordinator]
 - q. [RN C’s] Certificate of Completion — Immunisation Advisory Centre

Expert Advice Requested

I have been asked to review the documentation and advise whether I consider the care provided to [Miss A] by [the medical centre] was reasonable in the circumstances, and why:

In particular, I have been requested to comment on:

1. [RN C’s] verification process

a. What is the standard of care/accepted practice?

From the statements provided [RN C] has not obtained informed consent to vaccinate [Miss A]. [RN C] has assumed what vaccine [Miss A] presented at the practice to receive and not clearly ascertained from either [Miss A] or [her mother] what vaccination they were consenting to. [RN C] also did not accurately check her assumptions with the clinical documentation that was available.

According to the MOH Immunisation Handbook 2017, page 42

‘Providing meaningful information to enable an informed choice, and seeking informed consent, is a duty that all health and disability providers must meet to uphold the rights of health and disability consumers.’

The informed consent process

Informed consent is a process whereby the individual and/or their representative (if the individual does not have the capacity to consent) are appropriately informed in an environment and manner that are meaningful. Then, having been well informed, they are willing and able to agree to what is being suggested without coercion.

Regardless of age, an individual and/or their parent/guardian must be able to understand:

- that they have a choice
- why they are being offered the treatment/procedure
- what is involved in what they are being offered
- the probable benefits, risks, side-effects, failure rates and alternatives, and the risks and benefits of not receiving the treatment or procedure.

With regard to vaccination, the individual or parent/guardian needs to understand the benefits and risks of vaccination, including those to the child and community, in order to make an informed choice and give informed consent. The essential elements of the informed consent process are effective communication, full information and freely given competent consent.

Upon recognition that the error had been made [RN C] has taken ownership of the mistake and sought assistance from a senior colleague and openly disclosed the error to the patient and her mother. An informed consent process was then undertaken by [RN C] and [RN F] that resulted in [Miss A] receiving the correct vaccination.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

[RN C's] failure to gain informed consent is a moderate departure from accepted practice. In an environment where there are human beings involved there is always the possibility of mistakes being made. After the identification of the error [RN C] followed an accepted standard of practice in relation to disclosure of an error.

b. How would it be viewed by your peers?

As described above

c. Recommendations for improvement that may help to prevent a similar occurrence in future?

A recommendation for improvement to ensure this error doesn't occur in the future would be for the practice to create a team approach to vaccination. From the documentation supplied by [Ms B] the reception staff were advised that [Miss A] was attending the practice for an HPV vaccination, this information could have been communicated to the nursing staff, the supervising and checking nurse could have verified the vaccination event with the patient. A robust policy and a systematic approach to clinical practice when vaccinating would assist to ensure this event doesn't occur again.

2. [RN E's] verification process

a. What is the standard of care/accepted practice?

[RN E] was presented with information from [RN C] that she was checking an 11 year old vaccination. It is usual practice for the checking nurse to confirm that they are being presented with the correct vial/s, the batch number and the expiry date on each vial/s. The statement provided from [RN E] describes that this is what occurred. It would not be usual practice for the checking nurse to confirm with the patient what vaccination they were about to receive.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

[RN E] has provided care to an acceptable level of practice in relation to checking of the vaccination that she was advised was going to be given.

c. How would it be viewed by your peers?

The peer group that I would utilise to inform my discussion on this type of scenario would support the view in the scenario described in this case, the role of the checking nurse was to provide confirmation that the vaccination that was what was being presented and that the batch number and expiry date were valid.

d. Recommendations for improvement that may help to prevent a similar occurrence in future?

To help prevent a similar instance of this occurring the checking of the vaccine could occur in the same room as the patient and utilise the patient (or caregiver) to confirm the vaccine by name, batch number and expiry date. This provides an opportunity for the patient to be involved in their care and also provides a double check that the correct vaccine is to be administered.

3. [RN C's] administration of the vaccine

a. What is the standard of care/accepted practice?

From the documentation supplied [RN C's] administration of the vaccine has been undertaken in a safe manner. A checking process has occurred, 20 minute wait post

vaccination, checking of the vaccination sites post 20 min wait and post vaccination information given. The error as discussed previously was in the verification process. The documentation of the event could have been more explicit to fully document the course of events in relation to the error but the clinical information documented was of expected standard.

[RN C] has completed a Vaccinator Training Course and has successfully completed a clinical assessment. This is a standard and expected level of professional development to support safe vaccination.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

No departure from standard of care or accepted practice in relation to the administration of the vaccine.

c. How would it be viewed by your peers?

As described above.

d. Recommendations for improvement that may help to prevent a similar occurrence in future?

Clearer documentation of the error in the notes would have assisted the General Practitioner to discuss the issue with [Miss A] and her mother at their next visit.

4. Incident Reporting in this instance

a. What is the standard of care/accepted practice?

An incident form was completed by [RN C] to advise the Nurse Lead that the incident had occurred. The incident report was signed off by the Nurse Lead — [RN D], dated the 20th February 2017. From the documentation provided the Nurse Lead was made aware of the incident on the day that it occurred but did not follow due process and discuss the incident with Senior Management of the practice. It was identified that the Nurse Lead — [RN D] had not accurately represented the date she signed the form. This inaccurate representation of the date and lack of notification to management would not be considered acceptable practice from a Senior Nurse.

On notification of a complaint, the usual practice would be to acknowledge the complaint in writing, undertake an investigation and identify quality improvements that need to be made. If any practice changes are required, identify and nominate who is responsible to implement the changes and clearly provide a timeline for implementation. The complainant should then be notified of the investigation and any improvements that have occurred.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

As discussed above Nurse Lead — [RN D's] lack of follow through in relation to this incident is a moderate departure from usual standard of practice.

From the documentation provided [the medical centre] has acknowledged the complaint, undertaken a comprehensive investigation and identified areas for improvement.

c. How would it be viewed by your peers?

The peers that I would consult with in relation to the role of a Senior Nurse in relation to incident management would support my discussion. As a Senior Nurse there is a responsibility to support and nurture the nurses you lead as well as ensure that the care provided by the nursing team is safe and of a high quality. There is also the responsibility to the organisation that you follow due process, practice policies and procedures.

d. Recommendations for improvement that may help to prevent a similar occurrence in future?

Regular auditing of the incident management process would assist in developing a culture that ensures incidents within the practice are acted upon and quality improvement activities occur following any incident.

5. The adequacy of relevant policies and procedures at [the medical centre] relating to vaccination administration and incident reporting.

a. What is the standard of care/accepted practice?

On review of [the medical centre's] Vaccination Policy, [RN C] appears to have followed the policy document for administering vaccines to patients. In my view the policy document could be further enhanced to guide the nurse (particularly nurses new to vaccinating) through the process. Further discussion will be included in recommendations for improvement section.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

The [the medical centre] [has] provided a vaccination policy that reflects the minimum of necessary information required, it was not clear from the documentation provided what [the medical centre's] process is for supporting new practice nurses in relation to vaccination i.e are they able to vaccinate prior to attending a vaccinators training course, and what supervision is in place for new vaccinators.

c. How would it be viewed by your peers?

The peer group that I would utilise to inform my discussion on vaccination policies would support the view that the policy provided meets minimum requirements.

d. Recommendations for improvement that may help to prevent a similar occurrence in future?

Additional information and reorganisation of the policy would enhance its readability and provide clearer clinical application. As discussed previously information regarding new vaccinators and supervision of vaccination would add value to the policy. Ordering the policy to reflect the order of the steps involved in the vaccination event would support clearer understanding of the nurse's role and responsibilities, i.e. 2.8. The

vaccinator must get another clinician to confirm that vaccine is correct follows 2.7. Check the injection site prior to the patient leaving. In practice the nurse would check the vaccine is correct prior to giving the vaccine not after they check the injection site prior to the patient leaving.

Additional information in the Pre-Vaccination information may assist in preventing a similar occurrence in the future. Section 2.2.1 could state: ascertain from the patient what vaccination event they have attended the practice for. Clearly outlining the role of the checking nurse would also add clarity to the policy.

Additional wording in 2.4. The vaccinator must check verbally (clearly naming the vaccines) with the patient whether they have had the vaccine prior.

Expert Independent Advisor Qualifications, training and experience

I trained as a Comprehensive Nurse at Southland Polytechnic between 1990 and 1992. First Registered with Nursing Council NZ on 10th February 1993, I hold a current annual practising certificate. I completed a Bachelor of Nursing degree at Southland Polytechnic in 1998 and a Master of Nursing at Otago Polytechnic in 2006.

I have worked as a Practice Nurse for a solo General Practitioner for a period of 7 years, been a Practice Nurse Education Facilitator and Mentor, Practice Nurse Education Manager, Nursing Lecturer at Otago Polytechnic School of Nursing, PHO Professional Nursing Advisor, Chief Nursing Officer — Primary Care, DHB Nurse Director — Women and Children's Directorate, and am currently Director of Nursing Primary Care for a large Primary Health Organisation.

I currently have operational management of a Long Term Conditions Team of clinicians that includes Clinical Nurse Specialists (Diabetes, Respiratory and Cardiac), Community dieticians, and Clinical Pharmacists, Brief Intervention Mental Health and HPV Immunisation team. I teach code of conduct and professional boundaries education to Practice Nurses in our PHO. I also hold the role of Privacy Officer with our PHO.

Thank you for the opportunity to provide expert advice on this complaint. If you have any questions regarding this report please feel free to contact me further.

Yours sincerely

Wendy Findlay”