Re-use of needle for injection, and communication of error (13HDC00917, 4 June 2014)

Registered nurse ~ Medical centre ~ Inadequate care ~ Administering medication ~ Reused needle ~ Open disclosure ~ Rights 4(1), 4(2), 6(1)

A woman attended a medical centre to receive a Depo-Provera injection. Another patient was also awaiting a Depo-Provera injection. The registered nurse attending to the patients obtained two Depo-Provera injections from the drug cupboard and placed both in the same kidney dish. After administering the injection to the first patient, she placed the used needle and syringe back in its box instead of immediately disposing of it in the sharps bin. The box was returned to the kidney dish.

The nurse then attended to the second woman and injected her with the used needle. In addition, the nurse did not check the woman's weight and blood pressure but documented that she had done so. The nurse realised her mistake immediately and mentioned to the woman that the first syringe was empty, but did not explain that she had injected the woman with a used needle. The nurse then allowed the woman to go home without informing her of the needle-stick error.

The following day the nurse advised the practice manager of the error and was told to inform the woman and the woman's general practitioner (GP) of the error. The nurse did not do so and went on leave for the next four days.

When the nurse returned to work she informed the GP. The woman was immediately contacted and blood tests for Hepatitis B, Hepatitis C and HIV were arranged. The blood tests all returned negative.

It was held that the reuse of a needle from another patient indicated a lack of reasonable care and skill and accordingly the nurse breached Right 4(1). By failing to assess the woman's blood pressure and weight, but documenting she had done so, the nurse failed to comply with professional standards and breached Right 4(2).

The nurse's failure to notify the woman of the adverse event promptly meant that the woman did not have the information that a reasonable consumer, in her circumstances, would expect to receive. Accordingly, the nurse breached Right 6(1). The nurse's failure to disclose her error to the GP openly and promptly was a departure from professional standards and a breach of Right 4(2).

Whilst the medical centre had appropriate policies in place in relation to the administration of injections and managing stress in the workplace, adverse comment was made that the medical centre needed to be more cognisant of individual staff stress and of its ongoing responsibility to ensure that all nurses comply with its policies.

Adverse comment was also made about the practice manager for failing to follow up with the nurse to confirm that she had discussed the needle-stick error with the GP and make arrangements for the woman to return to the medical centre to undergo blood tests.