Checking process prior to administration of flu vaccine
18HDC00918, 5 June 2019

General practitioner ~ Medical centre ~ Vaccination ~
Needle stick injury ~ Documentation ~ Rights 4(1), 4(2)

A woman presented to a medical centre for an appointment with a general practitioner (GP) to receive the flu vaccine.

When the GP took the vaccine from the vaccine fridge, he did not check the contents of the syringe visually, or ensure that the plunger was not already decompressed. He proceeded to administer the vaccine.

After administering the vaccine, the GP realised that the syringe he had used was already empty and had no label, and that the plunger was fully decompressed prior to administration. He explained to the woman that either the injection may have been faulty, or it had already been used on an earlier patient.

The woman then asked the GP to continue with the appointment, and a second successful flu vaccine was administered. However, there is no record of either vaccine in the woman's PMS immunisation module or clinical records. The failed vaccine was treated as a needle-stick injury, and the woman underwent serological testing for transmissible diseases.

Findings

It was held that by failing to check the flu vaccine visually before it was administered to the woman, the GP did not provide the woman services with reasonable care and skill, and breached Right 4(1). In addition, by failing to document the required information for both flu vaccines, the GP did not provide services to the woman that complied with relevant standards, and breached Right 4(2).

The medical centre did not breach the Code.

Recommendations

The Commissioner recommended that the GP (a) provide a written letter of apology to the woman; (b) provide HDC with an audit of his clinical documentation, to check whether consent for vaccination is being recorded appropriately; and (c) undertake training on vaccine administration, and provide HDC with his reflections and learnings from the training.