Medical Centre

Registered Nurse, RN B

Registered Nurse, RN C

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01125)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 14 July 2016 Mrs A took her son, Master A, to a medical centre for his 15-month immunisations. In accordance with the Schedule, Master A was to receive Act-HIB, M-M-R II and Prevenar 13.

2. RN B selected the vaccines from the medical centre's refrigerator prior to Master A's appointment. However, she mistakenly selected Infanrix-IPV instead of the intended Act-HIB vaccine.

3. RN B asked RN C to check the vaccines; however, RN C failed to identify RN B's error. RN B then administered the Infanrix-IPV vaccine to Master A instead of Act-HIB.

4. After giving Master A the vaccines, RN B looked at Master A's computer immunisation record and Well Child book, and realised her mistake. She conveyed this information to Master A's family and the appropriate health professionals.

Findings

5. By failing to identify and administer the correct vaccine to Master A, RN B did not provide Master A services with reasonable care and skill. Accordingly, she breached Right 4(1) of the Code.

6. By failing to check the vaccines against the appropriate immunisations for the age of the child and identify that the Infanrix-IPV vaccine had been selected mistakenly, RN C failed to provide Master A services with reasonable care and skill. Accordingly, she breached Right 4(1) of the Code.

7. The medical centre did not take all such steps as were reasonably practicable to prevent the acts and omissions of RN B and RN C that breached the Code. Accordingly, the medical centre is vicariously liable for RN B and RN C's breaches of Right 4(1) of the Code.

Recommendations

8. The Deputy Commissioner recommended that RN B provide a written apology to Master A, Mr A and Mrs A for her breach of the Code.

9. The Deputy Commissioner recommended that RN C provide a written apology to Master A, Mr A and Mrs A for her breach of the Code.

10. The Deputy Commissioner recommended that the medical centre provide training to medical staff on its revised Childhood Immunisation Policy, audit its compliance with the Childhood Immunisation Policy, and use this case as an anonymised case study for education of future medical staff employed by, or contracted to, the medical centre.

Complaint and investigation

11. The Commissioner received a complaint from Mr A about the services provided to his son, Master A, by the medical centre. The following issues were identified for investigation:

- *Whether the medical centre provided Master A with an appropriate standard of care in July 2016.*
- *Whether RN B provided Master A with an appropriate standard of care in July 2016.*
- *Whether RN C provided Master A with an appropriate standard of care in July 2016.*

12. This report is the opinion of Meenal Duggal, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

13. The parties directly involved in the investigation were:

Mr A	Complainant
Medical centre	Provider, medical centre
RN B	Provider, registered nurse
RN C	Provider, registered nurse

Also mentioned in this report:

Dr D	General practitioner
Ms G	Nurse Manager
Ms H	Immunisation Coordinator

14. Information from Ms E, the medical centre's Practice Manager, was also reviewed.

15. Independent expert advice was obtained from registered nurse (RN) Rosemary Minto.

Information gathered during investigation

Background

16. Master A, aged 15 months at the time of the events in question, is a registered patient of general practitioner (GP) Dr D. The medical centre is an organisation owned in partnership under a business agreement between a group of individuals. RN B[1] and RN C[2] are both employees of the medical centre. RN B and RN C are both authorised vaccinators,[3] and had completed vaccinator update courses at the time of these events.

[1] RN B has been a registered nurse for many years.
[2] RN C has been a registered nurse for a few years.
[3] The Director-General of Health or a medical officer of health may authorise any person to administer a vaccine (which is a prescription medicine) for the purposes of an approved immunisation programme.

Immunisations

17. The New Zealand National Immunisation Schedule (the Schedule) located in the Ministry of Health Immunisation Handbook (2014)[4] outlines the series of vaccines (including boosters) that are offered free of charge to babies, children, adolescents, and adults, at specific times.

18. The Schedule includes two vaccines to immunise children against *Haemophilus influenzae* type B disease.[5] First, Infanrix-hexa is given at the ages of six weeks, three months, and five months. In addition to *Haemophilus influenza* type B disease, Infanrix-hexa is used to immunise children against diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, and hepatitis B. Act-HIB, which protects only against disease caused by *Haemophilus influenzae* type B, is then given as a booster at the age of 15 months.

19. Infanrix-IPV is listed on the Schedule as a booster given at the age of four years, after a child has received all three doses of Infanrix-hexa. Infanrix-IPV is used to immunise against diphtheria, tetanus, pertussis, and poliomyelitis.

20. The "Childhood Immunisation Policy" in place at the medical centre at the relevant time, dated 29 November 2012, stated:

> "• All nurses at [the medical centre] are expected to complete a full vaccinator's course, followed by attending regular vaccinator updates every 2 years.
>
> • All nurses at [the medical centre] are expected to be authorised vaccinators as per Section 88 [of the New Zealand Public Health and Disability Act 2000].
>
> • All immunisations should be given as directed by the [Ministry of Health] Immunisation Handbook or any updates that are released by [the Immunisation Advisory Centre] and/or the [Ministry of Health]."

21. Practice Manager Ms E told HDC that the process in place at the time of these events required:

1. The patient to present for the vaccination on an agreed date. The patient was then to be reviewed by a GP, who would advise on the vaccination and confirm that the vaccines could be given to the child.

2. The nurse to check the child's Well Child book[6] and computerised immunisation record. The nurse was to look at what vaccinations had already been provided to the child and what vaccines were due to be given on that day.

[4] The Immunisation Handbook 2014 provides clinical guidelines for health professionals on the safest and most effective use of vaccines in their practice.
[5] Disease caused by the bacterium *Haemophilus influenzae* type B.
[6] The Well Child Health Book is produced by the Ministry of Health, and is a parent information, health, and immunisation record for children.

3. The nurse to take the Well Child book to the vaccinations area and check the vaccines selected against the book and the National Immunisation Schedule cards.[7] The nurse was also required to check the expiration dates of the vaccines.

4. The nurse to show the vaccination to another nurse. The second nurse was required to ensure that the selected vaccine was correct and check the expiration date. While doing the second check, the second nurse was to check the vaccine against the computerised immunisation record for the child.

22. This process was not documented in the medical centre's "Childhood Immunisation Policy".

23. RN B told HDC:

> "The process that was in place at [the medical centre] that was additional to the Childhood Immunisation Policy was that registered nurse vaccinators would check off the vaccines for the child against the National Immunisation Schedule card appropriate for the child's age group … We place these cards into the kidney dish with the vaccines for the child, so the registered nurse checking has an extra check to accompany the computer check."

24. RN C told HDC: "[T]he immunisation cards were used as an additional tool to aid the nurses when doing a second check of childhood vaccinations …"

GP visit

25. On 6 July 2016, Mrs A took her son, Master A, aged 15 months at the time, to the medical centre for his 15-month immunisations. A GP assessed Master A and established that he was fit to receive his 15-month immunisations that day. However, as Master A was recovering from a cold, Mrs A made the decision to return with Master A in a week's time for him to receive his immunisations.

Medication administration error

26. On 14 July 2016, Mrs A took Master A back to the medical centre for his 15-month immunisations. In accordance with the Schedule, Master A was to receive Act-HIB, M-M-R II[8] and Prevenar 13.[9]

27. RN B told HDC that she selected the vaccines from the medical centre refrigerator for Master A prior to his appointment time, as she had a busy schedule for the day. RN B correctly selected the M-M-R II and Prevenar 13 vaccines, but she incorrectly selected Infanrix-IPV instead of the intended Act-HIB vaccine. RN B told HDC that she placed the vaccines in a kidney dish in the refrigerator. She stated:

[7] National Immunisation Schedule cards outline the series of vaccines (including boosters) that are offered free of charge to babies, children, adolescents, and adults, at specific ages.
[8] M-M-R II is given as a primary vaccine from 12 months of age to protect against measles, mumps, and rubella.
[9] Prevenar 13 is given at the ages of six weeks, three months, five months, and 15 months, to protect against disease caused by 13 types of *Streptococcus pneumoniae*.

> "It is not my normal practice to select the vaccines ahead of the appointment and without referring to the child's Well Child book. I would also usually have checked the vaccines against the National Immunisation Schedule card but we didn't have any available on that day."

28. Ms E told HDC:

> "The responsibility for ensuring National Immunisation Schedule cards were/are available at both sites rested/rests with all nurses, coordinated by [an RN]. Nurse Manager [Ms G] has oversight of all nursing tasks and responsibilities."

29. Mrs A and Master A attended his appointment at 11am. RN B told HDC that she took Mrs A and Master A to consultation room one and left to get the vaccines checked by another registered nurse. RN B asked RN C, who was providing education on asthma inhalers to a patient in another treatment room, to check the vaccines she had selected. RN C did not identify RN B's error.

30. RN B told HDC that she informed RN C that the vaccines were for a 15-month-old child. In contrast, RN C told HDC that RN B did not inform her of Master A's age. RN C told HDC:

> "I checked the vaccines and the expiry dates, I recognised all of the vaccines as being childhood vaccinations so none of them stood out to me as not belonging, this is where the immunisation cards would have come in very helpful."

31. RN C stated that RN B did not provide her with the relevant National Immunisation Schedule card along with the vaccines because it was not available that day. RN C told HDC: "[The] cards were used when available but they often went missing and at that time weren't routinely checked and re-stocked by anyone in particular to my knowledge."

32. After RN C's check, RN B returned to the consultation room and administered the vaccines to Master A. RN B told HDC:

> "Straight after giving him the vaccines, I sat at the computer and looked at [Master A's] immunisation record on the computer and his Well Child book. I immediately realised I had given [Master A] one incorrect vaccine."

33. RN B told HDC that she excused herself from the consultation room and informed her nursing colleagues of the medication administration error.

34. RN B then telephoned the regional Immunisation Coordinator, Ms H. Ms H advised her that, in accordance with the evidence available from the Immunisation Advisory Centre,[10] the Infanrix-IPV vaccine would not be harmful to Master A. Ms H told RN B to inform Master A's GP, Dr D, and the Centre for Adverse Reactions, of the error. On 20 July 2016, following the incident, Ms H emailed the medical centre and

[10] A nationwide organisation based at The University of Auckland that provides New Zealanders with a source of independent, factual information based on international and New Zealand scientific research regarding vaccine-preventable diseases and the benefits and risks of immunisation.

informed Nurse Manager Ms G in writing that the Director of the Immunisation Advisory Centre had confirmed that the vaccine would not harm Master A.

35. RN B then contacted Dr D, who did not have any concerns that the Infanrix-IPV vaccine would be harmful to Master A. Dr D told HDC that RN B contacted him shortly after her error and informed him of the advice obtained from Ms H. Dr D told HDC: "I was satisfied at this stage that everything which needed to be done was in hand and I did not give [RN B] any further instruction."

36. RN B told HDC that these conversations took less than five minutes, and that she then returned to Mrs A and Master A in the consultation room. RN B told Mrs A of the medication administration error whereby Master A had received a vaccine intended for a child of four years of age instead of the vaccine intended for a 15-month-old child.

37. Mrs A telephoned her husband to inform him of the incident. Later that evening, Mrs A and Mr A took Master A to the Emergency Department at the public hospital. An Emergency Department Registrar reviewed Master A and documented: "[I]rritable post vaccination, no obvious cause … plan: home with paracetamol [follow-up] with GP."

Incident forms

38. Following the incident, RN B and RN C completed incident reporting forms in relation to the medication administration error.

39. RN B documented that the cause of the error was being very busy at the time and RN C being unable to check the vaccines on the computer.

40. RN C documented:

> "Because I was preoccupied I failed to provide my full attention to the vaccines and missed that one of the childhood vaccines was incorrect for the scheduled age. What happened was not usual procedure, it was because I was the only nurse [RN B] could find at the time. I should have been at the computer to check as we usually would. Unfortunately this caused me to miss [RN B's] mistake."

Complaint to medical centre

41. On 14 July 2016, Mr A telephoned the medical centre and spoke with Ms E. Mr A complained that Master A had received the incorrect vaccine for his age.

42. Ms E contacted Ms G to discuss the complaint. Following their discussion, Ms G telephoned Mr A to explain what had occurred and to apologise for the error. Mr A requested a meeting, which Ms G agreed to.

43. On 20 July 2016, Mr A attended the medical centre and met with Dr D, Ms E, and Ms G. Ms E told HDC that Mr A was concerned about any potential harm the vaccine may cause Master A, and asked how such an error could occur. Ms E told HDC that she provided Mr A with a copy of the email from Ms H outlining that the vaccine

would not harm Master A, and that Dr D also told Mr A that the vaccine would not be harmful.

Further information from RN B, RN C, and the medical centre

44. RN B told HDC: "The morning of 14th July 2016 was compounded by a busy schedule for me, but no excuse for my error." She added: "The error, due to not checking the vaccination correctly (not as per the medical centre protocol) has been addressed and we all now follow the correct procedures vehemently."

45. RN C told HDC:

> "I fully understand and accept the role I played in the vaccination error that occurred that day. I was in no position to be a second checker and should never have accepted that responsibility in that instance."

46. The medical centre provided HDC with a print-out of its appointment books for 14 July 2016. The print-out shows that Master A was allocated a 30-minute appointment for his immunisation. However, it is not possible to determine from the print-out how busy the medical centre was at the time. Ms E told HDC: "Outside of running the booked appointments there are often other nursing tasks to be completed during the day which would not be shown on these appointment books."

Actions taken by the medical centre

47. On 22 July 2016, Ms E wrote a formal letter of apology to Mr A and informed him of the subsequent changes implemented at the medical centre to minimise the risk of such an error occurring in the future.

48. The medical centre has revised its "Childhood Immunisation Policy", which now states:

> "Prior to vaccination, when selecting the vaccine the vaccinator must check the vaccine is the correct one to administer by referring to the child's computerised medical record, the child's Well Child book and the National Immunisation Schedule immunisation card appropriate to the age of the child.
>
> The vaccine must be second checked by another nurse who also checks it is the correct vaccine to give by referring to the child's computerised medical record, the child's Well Child book and the National Immunisation Schedule immunisation card."

49. RN B told HDC that it is now part of the medical centre's policy to have the National Immunisation Schedule cards available at all times.

50. Ms E also told HDC: "[W]hile not a direct result of this incident, we are taking even more care to check future nurse appointment books ahead of time to make sure the correct amount of time is booked for each patient (depending on the reason for their visit)."

Response to provisional opinion

51. Mr A was provided with an opportunity to respond to the "information gathered" section of the provisional opinion. Mr A had no further information to add.

52. The medical centre, RN B, and RN C were provided with an opportunity to respond to the provisional opinion. They had no further information to add.

Opinion: RN B — breach

53. On 14 July 2016, RN B mistakenly administered the Infanrix-IPV vaccine to Master A instead of Act-HIB. She told HDC that she had a busy schedule that morning and, as a result, selected Master A's vaccines prior to his appointment. However, she accepts that her busy schedule is not an excuse for her error.

54. In administering the wrong vaccine, RN B did not comply with the medical centre's "Childhood Immunisation Policy" or with the Schedule in the Ministry of Health Immunisation Handbook. RN B also did not check the vaccine against Master A's Well Child book or computerised immunisation record, or against the appropriate National Immunisation Schedule card (which was not available that day).

55. My expert advisor, RN Rosemary Minto, advised:

> "[RN B] made a drug error by not adhering to the current medical centre policy of checking that she had the correct immunisation for the age of the child. In my opinion this was a moderate departure from accepted standards of nursing care."

56. I accept RN Minto's advice and find that, by failing to identify and administer the correct vaccine to Master A, RN B did not provide Master A services with reasonable care and skill. Accordingly, she breached Right 4(1) of the Code.

57. I note that RN B took appropriate action following her identification of the error by discussing the error with Master A's GP, Dr D, and Immunisation Coordinator Ms H. RN B also appropriately informed Master A's family of the error and conveyed the information she had obtained regarding any implications the error may have for Master A.

Opinion: RN C — breach

58. During Master A's appointment for his 15-month immunisations, RN B collected the relevant vaccines and asked RN C, who was located in a separate consultation room, to check them. RN B had incorrectly selected Infanrix-IPV instead of the intended

Act-HIB. RN C did not identify RN B's error. RN B then returned to the consultation room and administered the vaccines to Master A.

59. RN C told HDC that she was providing education on asthma inhalers to another patient at the time. She said that RN B came in with the vaccines but did not inform her of Master A's age. RN B, on the other hand, stated that she told RN C that the vaccines were for a 15-month-old child. RN C told HDC:

> "I checked the vaccines and the expiry dates, I recognised all of the vaccines as being childhood vaccinations so none of them stood out to me as not belonging, this is where the immunisation cards would have come in very helpful."

60. RN C stated that RN B did not provide her with the relevant National Immunisation Schedule card along with the vaccines because it was not available that day.

61. My expert advisor, RN Rosemary Minto, advised:

> "By failing to check the vaccines against the appropriate immunisations for the age of the child … [RN C] … failed to provide an adequate standard of care and the resulting care was a moderate departure from accepted standards of nursing care."

62. I am unable to make a finding as to whether RN B informed RN C that the vaccines were for a 15-month-old child. Regardless, however, I consider that RN C had a responsibility to ascertain the age of the relevant child and check that RN B had selected the appropriate vaccines as specified in the Ministry of Health Immunisation Handbook.

63. Guided by my expert's advice, I find that, by failing to check the vaccines against the appropriate immunisations for the age of the child and identify that the Infanrix-IPV vaccine had been selected mistakenly, RN C failed to provide Master A services with reasonable care and skill. Accordingly, she breached Right 4(1) of the Code.

Opinion: Medical centre — breach

64. RN B and RN C are employees of the medical centre. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any act or omission by an employee. However, a defence is available to the employing authority under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the act or omission.

65. Policies provide set procedures that assist staff in complying with their legal and professional obligations. The medical centre's "Childhood Immunisation Policy" in place at the time of this incident required all immunisations to be given as directed by the Ministry of Health Immunisation Handbook. In addition, the practice manager Ms E told HDC that the process in place at the medical centre in July 2016 required

nurses administering vaccines to check each vaccine against the child's computerised immunisation record and Well Child book, and against the appropriate National Immunisation Schedule card for the child's age. The nurse was then required to show the vaccine to another nurse, who would also check it against the computerised immunisation record. These requirements were not outlined in the "Childhood Immunisation Policy".

66. It is not clear to what extent the requirements listed by Ms E were viewed as mandatory by the medical centre's nurses. While both RN B and RN C appear to have been largely aware of the steps outlined by Ms E, it appears that those steps may have been viewed as optimal rather than compulsory. That perception may have resulted in part from the failure to include the requirements in the medical centre's written policy.

67. Further, despite the process outlined by Ms E, on 14 July 2016 the card outlining vaccines to be administered to a 15-month-child was not available. RN C told HDC that the cards "often went missing and at that time weren't routinely checked and re-stocked by anyone in particular". Ms E told HDC:

> "The responsibility for ensuring National Immunisation Schedule cards were/are available at both sites rested/rests with all nurses, coordinated by [an RN]. Nurse Manager [Ms G] has oversight of all nursing tasks and responsibilities."

68. I am of the view that the medical centre had a responsibility to ensure that these cards were available so that the process outlined by Ms E could be followed. It is clear from the events of 14 July and the responses of the various parties that there was not an adequate process in place at the time to ensure that the cards were always available.

69. While she accepted that it was no excuse for her error, RN B told HDC that she had a busy schedule on 14 July 2016, which was the reason she prepared Master A's vaccines in advance. RN C told HDC that she was in no position to perform the role of a second checker, and should not have accepted that responsibility. The medical centre provided HDC with its appointment books for 14 July 2016 and stated: "Outside of running the booked appointments there are often other nursing tasks to be completed during the day which would not be shown on these appointment books."

70. I am unable to make a finding in relation to how busy the medical centre was on 14 July 2016. However, I note generally that it is important for medical centres to ensure that staff are not so busy as to be unable realistically to follow established policies and processes.

71. Overall, I do not consider that the medical centre took all such steps as were reasonably practicable to prevent the acts and omissions of RN B and RN C that breached the Code. Accordingly, the medical centre is vicariously liable for RN B and RN C's breaches of Right 4(1) of the Code.

Recommendations

72. I recommend that RN B provide to Master A and his parents a written apology for breaching the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

73. I recommend that RN C provide to Master A and his parents a written apology for breaching the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

74. I recommend that the medical centre:

a) Provide training to medical staff on the revised "Childhood Immunisation Policy" and report back to HDC on the completion of this training. The report is to be provided to HDC within two months of the date of this report.

b) Audit its compliance with its current "Childhood Immunisation Policy" for a period of two months following the date of HDC's final report, and provide HDC with the outcome of that audit within three months of the date of this report.

c) Use this case as an anonymised case study for education of future medical staff employed by, or contracted to, the medical centre.

Follow-up actions

75. 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 B's name and RN C's name.

76. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Nursing Organisation, and the Health Quality and 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 registered nurse Ms Rosemary Minto:

> "I have been asked to provide advice on the complaint case number 16HDC01125 and I have read and agreed to follow the Guidelines for Independent Advisors as described in the documentation I have received from the Office of the Health and Disability Commissioner dated the 30th November 2016.
>
> I am a Registered Nurse and adult family Nurse Practitioner, having graduated from Tauranga Hospital School of Nursing in 1983. I received a Masters in Health Practice in 2006 and gained NP registration in 2008. I have worked in general practice since 1999 and during the time I worked as a practice nurse I was an independent vaccinator.
>
> My instructions from the Investigator for this report are to provide advice on the following:
>
> 1. The reasonableness of care provided by [RN B]
> 2. The reasonableness of care provided by [RN C]
> 3. The adequacy of the policies and procedures in place in July 2016 at [the medical centre].
> 4. The adequacy of the draft Childhood Immunisation policy in place currently at [the medical centre].
> 5. Any other matters in this case that I consider warrant comment.

For each question I have considered:

a. The standard of care/accepted practice

b. If there has been a departure from the standard of care or accepted practice, how significant that departure may be.

c. How it would be considered by my peers.

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

e. I have been provided with the following information:

   i Letter of complaint dated […]

   ii. [The medical centre's] response dated 23rd August 2016

   iii. Incident Report Form dated 14th July 2016

   iv. Incident report Form dated 20th July 2016

   v. Statement from [RN B] dated 23rd August 2016

vi. Letter to RN from the Centre for Adverse Reactions Monitoring dated 19th July 2016

vii. Verbal Transcript of complaint from [Mr A] by Practice Manager [Ms E] dated 20th July 2016

viii. Letter from [Ms E] to [Mr A] dated 22nd July 2016

ix. Email from [Immunisation Coordinator Ms H], Immunisation Coordinator to Nurse Manager [Ms G] at [the medical centre] dated 20th July 2016

x. Clinical records from [the medical centre] in relation to Master A.

xi. [Medical centre] minutes from nurses meeting dated 28th July 2016

xii. [Medical centre] draft immunization policy

xiii. Vaccination information relating to [RN B]

xiv. Vaccination information relating to [RN C]

Brief Summary of events as reported to me:

On the 14th July [Master A], the 15 month baby of the complainant, was brought by his mother and grandmother to have his 15 month immunizations.

As per the schedule [Master A] was to have Hib, MMR and Pneumoccocal immunization.

[RN B] preselected the immunizations for [Master A] prior to his appointment due to the large volume of bookings that day, and placed them in the fridge with his name on them.

[RN B] checked the immunizations with [RN C] prior to giving them to [Master A].

[RN C] was with another patient at the time and only checked the expiry dates.

[RN B] gave the vaccinations and then discovered she had given the incorrect immunizations.

[RN B] contacted the Immunisations Coordinator and GP [Dr D]. [RN B] then informed [Master A's] mother of the error.

Opinion

In my deliberations of this issue I have utilized the following resources:

a Ministry of Health *Immunisation Handbook (2nd Ed) 2016* — this is a resource well known and utilized by all vaccinators. It includes clinical guidelines detailing the processes for safe immunisation practice including standards for vaccinators and guidelines for organisations offering vaccination services.

b Nursing Council of New Zealand's *Competencies for Registered Nurses* (December 2007).

c The Nursing Council of New Zealand's *Code of Conduct* (June 2012).

d New Zealand Nurses Organisation (2014). Guidelines for nurses on the administration of medicines. Wellington: New Zealand Nurses Organisation.

I provide the following opinions with the understanding that the registered nurses are aware that they are responsible for ensuring their adherence to professional standards and legislative regulations. The competencies and regulations applicable to this complaint include:

The Nursing Council of New Zealand's Competencies for registered nurses (December 2007):

Competency 1.1

Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements. Indicator: Practises nursing in accord with relevant legislation/codes/policies and upholds health consumers' rights derived from that legislation:

Indicator: Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice.

Competency 2.1

Provides planned nursing care to achieve identified outcomes:

Indicator: Administers interventions, treatments and medications, (for example: intravenous therapy, calming and restraint), within legislation, codes and scope ofpractice; and according to authorised prescription, established policy and guidelines.

The Nursing Council of New Zealand's Code of Conduct (June 2012)

Principle 4.

Maintain health consumer trust by providing safe and competent care:

4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines.

Regulation 44A of the Medicines Regulations 1984 (as at 01 August 2011) states that 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 if that person, following written application, provides documentary evidence satisfying the director-general or the medical officer of health, that they:

- can carry out basic emergency techniques including resuscitation and the treatment of anaphylaxis;

- have knowledge of the safe and effective handling of immunisation products and equipment;
- can demonstrate clinical interpersonal skills; and
- have knowledge of the relevant diseases and vaccines in order to explain the vaccination to the patient, or to the parent/guardian of the patient who is to consent to the vaccination on behalf of the patient, to ensure the patient or the parent/guardian can give informed consent to the vaccination.

The Regulations also state that authorisation is valid for a period of two years, is subject to conditions, and may be withdrawn at any time.

1. The reasonableness of care provided by [RN B]:

1a. The RN made a drug error by not adhering to the current medical centre policy of checking that she had the correct immunization for the age of the child. In my opinion this was a moderate departure from accepted standards of nursing care.

1b. The error was due to not checking accurately against the child's Well Child book or the Immunisation Schedule card as noted in the [RN B's] statement (v).

1c. This error was compounded by not having the vaccines checked adequately by the second nurse.

1d. [RN B] acted appropriately and in a timely manner to inform the parents and [medical centre] management of the error.

2. The reasonableness of care provided by [RN C].

2a. By failing to check the vaccines against the appropriate immunizations for the age of the child as stated in [RN C's] statement (iv), [RN C] also failed to provide an adequate standard of care and the resulting care was a moderate departure from accepted standards of nursing care.

3. The adequacy of the policies and procedures in place in July 2016 at [the medical centre].

3a Whilst [the medical centre] had an immunisation policy in place (vii) I note that the policy at the time was not specific in its requirement for checking immunizations other than to state that the vaccines are to be given 'as directed by the MoH immunization Handbook' (vii). However the letter from the practice manager (ii) states that the nurse checks the child's Well Child book and the computerized immunization record. So there were some inconsistencies between accepted practice and the policies.

3b The updated draft immunization policy corrects this inconsistency.

3c The appropriate actions were taken to respond to the complainant, inform CARM of the error and to seek advice from IMAC Director regarding possible repercussions to the health of the child from having the incorrect vaccine. [The medical centre] also took adequate steps to reduce the risk of future errors by discussing this in a nurses meeting and ensuring adequate immunization schedule cards are available at the practice sites.

3d The education and training of the vaccinators is adequate and meets recommended practice guidelines and regulations.

4. The adequacy of the draft Childhood Immunisation policy in place currently at [the medical centre].

4a. The draft immunization policy(xii) provided by [the medical centre] is an improved version as it specifically requires the two nurses checking the vaccine to use 3 resources including the National Immunisation Schedule immunization card. In my opinion this will improve the service and reduce errors if adhered to by vaccinators.

Regards

Rosemary Minto

RN/Nurse Practitioner”