Nurse and General Practitioner

Report on Opinion - Case 97HDC10686

Complaint

The Commissioner received a complaint from parents on behalf of their son, the consumer. The complaint is that in early November 1997 the provider, a practice nurse at a doctors' surgery, inoculated the consumer (aged almost six months) with the inoculation specified for a 15-month old child.

Investigation

The complaint was received on 16 December 1997 from the complainants. An investigation was commenced and information was obtained from:

The Provider / Practice nurse
One of the Clinic's GPs
The Consumer's Mother / Complainant

The Commissioner sought advice from a Public Health Physician at the Ministry of Health.

Outcome of Investigation

The complainant visited the Medical Centre for the first time in early November 1997 in order that her son, the consumer, could receive his third lot of vaccinations. The consumer, who was almost five months old at the time, was due for the DTPH (diphtheria, tetanus, pertussis and haemophyllus influenza type B) and the hepatitis B vaccination plus the oral polio vaccine.

One of the General Practitioners at the surgery stated that he would not normally have seen the consumer because he was there for a routine immunisation visit. However as the consumer was a new patient with no previous health information available, the GP saw him first and instructed the practice nurse to give him the five-month vaccine. The practice nurse reported that she read the GP's instruction as 15 months rather than five months and proceeded to give the 15-month vaccination. Therefore instead of administering DTPH, hepatitis B and polio vaccines, the nurse administered the DTPH and MMR (measles, mumps and rubella) vaccines.

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Outcome of Investigation, *continued*

The GP in his response to the Commissioner stated that there were a number of reasons for the error, such as a measles epidemic at the time resulting in a large number of MMR vaccinations being given, and also that in the consumer's case the usual routine was not followed. The usual procedure is to check the dose with the patient's records. However as the consumer was a new patient without records this was not done. In addition, the dose was usually checked with the parents, and the practice nurse thought that the GP had done so.

The practice nurse, in her reply to the Commissioner, stated that she misread the GP's instruction and gave the 15-month vaccination. She did not notice the error as they had been giving the MMR vaccinations to all age groups recently because of the measles epidemic.

Following the vaccination, the practice nurse documented what she gave in the medical records and the Plunket book including the site of injection, number of batch and expiry of vaccine and date given. The practice nurse reported she then gave an explanation to the mother about the possibility of a local or general reaction within 48 hours, and indicated how to recognise this and what to do if it occurred. The mother stated that she was not given any explanation by the practice nurse.

The practice nurse then advised the mother to keep the consumer in the surgery to be monitored for a further 20 minutes in case he had an anaphylactic reaction, a rare possibility following a vaccination. The mother confirms that she was given this instruction and that they waited for about 15 minutes. After the mother had left the surgery with the consumer, the nurse entered his treatment on the computer. The practice nurse then realised her mistake and immediately told the GP. The consumer's father was contacted soon after by the nurse and informed of the error. The practice nurse apologised and advised the father of the oral polio vaccine and hepatitis B vaccine still to be given. The mother returned later in the day to discuss this further with the GP.

The GP reported that he also apologised to the mother and explained the consequences of the error. The DTPH vaccine was identical to the one required at five months so there was no error as to dose. The Public Health Physician at the Ministry of Health confirmed this.

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Outcome of Investigation, *continued*

The GP also reported the hepatitis B vaccine that should have been given could be delayed until the next scheduled vaccination at 15 months without effect on the consumer's immunity.

The main problem according to the GP would be the need for the consumer to receive a booster for the MMR vaccine at 15 months as there is doubt as to how long the immunity would be conferred from the MMR for someone of the consumer's age. The GP advised the mother of the need for this further vaccination at 15 months. The Public Health Physician confirmed this by saying the MMR would be ineffective at five months because the maternal antibodies are still active rendering the vaccine impotent. The child would require another MMR injection at 15 months. The Public Health Physician also confirmed that there would be no ill effects apart from the usual risk factors associated with the administration of any vaccine.

The GP stated that the practice nurse had not made similar mistakes either before or since this incident and has an impeccable 15 year record at his practice.

The practice nurse, in her response to the Commissioner, has described the protocol at surgery for the administration of vaccinations.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

...
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards

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Opinion: Breach, Practice Nurse

In my opinion there has been a breach of Right 4(2) of the Code of Health and Disability Services Consumers' Rights by the practice nurse. The Code of Conduct of the Nursing Council of New Zealand, Criteria 2.8 requires that:

> *The nurse or midwife observes rights and responsibilities in the prescription, possession, use, supply, storage and administration of controlled drugs, medicines and equipment.*

The Nursing Council views the administration of the correct medicine as a basic professional standard and this includes vaccinations. MMR vaccine was administered instead of the hepatitis B vaccine and no oral polio vaccine was given. In giving the wrong injection and omitting the polio vaccine, the practice nurse did not comply with relevant professional standards.

I do not accept that the MMR vaccine was a reasonable mistake in the circumstances due to the epidemic. The GP and the Public Health Physician confirm that MMR at five months is ineffective and that any child receiving MMR at this age would need to be re-vaccinated later.

Opinion: No Breach, General Practitioner

In my opinion the GP has not breached the Code of Health and Disability Services Consumers' Rights. The GP wrote the correct vaccination schedule in the clinical notes but this was read incorrectly by his practice nurse.

The GP took appropriate action once the error was discovered. He correctly advised the mother on the implications of the vaccination error and which vaccines were needed to compensate for this error.

Other Comments

The process of providing vaccinations at this doctors' surgery should be reviewed. Full advice about vaccinations must be given prior to inoculation to ensure informed consent is given. After the inoculation, it is appropriate to restate the advice to ensure effective communication occurs. I suggest the GPs and Practice Nurses at the surgery become more familiar with the Ministry of Health's *Immunisation Handbook*, which sets out standards for immunising.

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Actions

The practice nurse is to provide a written apology to the complainants for her breach of the Code of Health and Disability Services Consumers' Rights. The apology is to be sent to the Commissioner who will forward it to the family.

A copy of this opinion will be forwarded to the Nursing Council of New Zealand.

On receipt of the written apology this file will be closed.