Health and Social Care Board

Directorate of Integrated Care
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Sent via email:
To: GP practices
Community Pharmacists

22 December 2021

Dear Colleague

Adverse Incident: Double COVID Booster Vaccination

An adverse incident has occurred where an elderly patient in residential care received their COVID booster vaccine by the Trust vaccination team and subsequently received a further booster vaccine in primary care in error. A record had been made on the Vaccine Management System (VMS) by the Trust vaccination team.

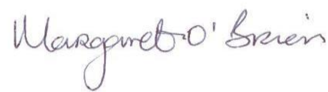
All patients vaccinated at any stage of the COVID vaccine programme e.g. primary or booster should have their details recorded on VMS. This provides a record that the vaccine has been supplied and administered and can be accessed by GPs, community pharmacists and Trust staff who are involved in the vaccination programme.

Action required:

- Vaccination records must be entered onto the VMS as soon as possible after vaccine administration, ideally on the same day.
- Vaccinators should check a patient's vaccination status, ideally by both asking the patient/carer and checking VMS.

Any such incidents must be reported to your local HSCB office and followed up as an adverse incident. If appropriate the PHA duty room pha.dutyroom@hscni.net should also be contacted for medical advice to ensure the appropriate management of the patient.

Yours sincerely,



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cc Bernie Owens, Owen Harkin, Vivienne Toal, Tanya Dal, Karen Hargan