

Emergency ambulance service reportable events

For the quarter ending June 2015 (April to June 2015)

About this document

This document summarises all emergency ambulance service reportable events where the investigation was completed this quarter.

Patient and other identifiable information have been removed to preserve patient confidentiality.

Encouraging a culture of safety

Emergency ambulance providers encourage their staff to report and log these events. Lessons are learnt and actions are implemented to prevent the event occurring again. The reports contribute to a culture of safety, transparency and continuous improvement.

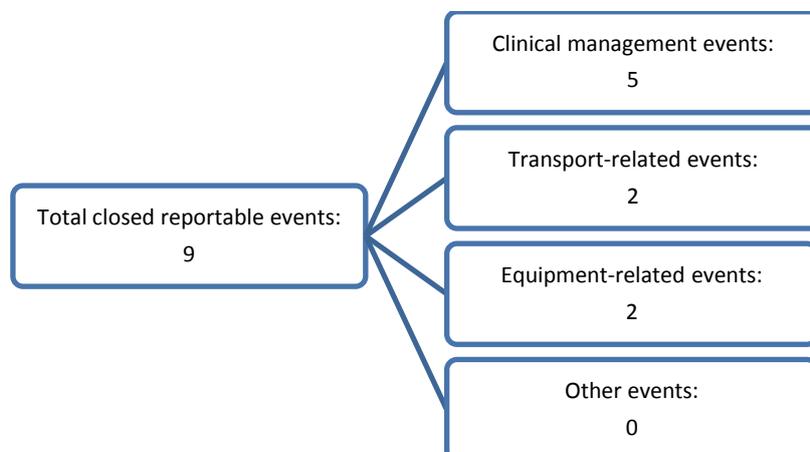
For more information

More information about reportable events can be found by visiting the [Health Quality and Safety Commission website](#).

For more information about specific events contact the service provider directly – their contacts details can be found on the [Wellington Free Ambulance](#) and [St John](#) websites.

Reportable events for this period

- 9 reportable event investigations were closed this quarter.
- 23 reportable event investigations remain open as at the end of the quarter.



Clinical management events

#	Provider	Summary of event	Root causes	Recommendations	Actions taken
1	St John	An ambulance crew called for backup for an unwell woman, but failed to recognise she had a life-threatening cardiac rhythm. The paramedic backup identified it and successfully treated it.	A failure by the ambulance crew to recognise a life-threatening cardiac rhythm. It was also not recognised by the advisory mode (internal software) of the defibrillator.	<ul style="list-style-type: none"> Formal debrief with staff. Staff to attend relevant simulation-suite training. Staff to be supported by a clinical coach. Provide feedback to defibrillator's supplier regarding recognition capabilities. 	<ul style="list-style-type: none"> Formal debrief with staff. Provided feedback to defibrillator supplier.
2	St John	A registered nurse from the Clinical Hub performed a clinical telephone assessment and provided incorrect advice. See St John website (www.stjohn.org.nz) for more information about the Clinical Hub.	Failure to comply with requirements defined by the Clinical Hub triage tool.	<p>A bulletin to be issued to all Clinical Control Centres stating that in all cases of severe pain, an 'orange' determinant (urgent / potentially serious, but not immediately life-threatening incident) ambulance response was required.</p> <p>No recommendations for staff member as no longer working in Clinical Hub.</p>	<ul style="list-style-type: none"> Bulletin issued. Nurse no longer works within Clinical Hub. Formal notification sent to New Zealand Nursing Council for ongoing investigation. Apologised to the patient.
3	St John	Ambulance crews temporarily discontinued cardiopulmonary resuscitation (CPR) to extricate the patient from the house.	Ambulance staff failed to follow Clinical Procedures and Guidelines (CPGs).	<ul style="list-style-type: none"> District Management Team to facilitate debrief with crews involved. Specific feedback to be given regarding scene management and clinical reasoning. 	A debrief with all attending ambulance personnel has been held to ensure understanding of and the need to comply with the CPGs with reference to resuscitation and extrication.
4	St John	A single-crewed paramedic attending to a pedestrian struck by a truck failed to request assistance and had significant delays.	Failed to recognise need for assistance.	Provide feedback outlining concerns for aspects of the decision-making (noting single-crewing has contributed considerably).	Written feedback has been provided from the Medical Director and their District Operations Manager.
5	St John	A crew attending to a very unwell woman having an asthma attack were concerned about some family members behaving in an agitated and confrontational manner. The crew called for police and loaded the patient into the ambulance where she respiratory- and then cardiac-arrested. The patient eventually died.	Inability to assess and prioritise care of a patient with life-threatening asthma due to concerns about safety at the scene.	A formal debrief with all staff involved with specific discussions around scene management, patient assessment and respiratory compromise.	A debrief has occurred. The crew were receptive to this and open to the lessons learnt.

Transport-related events

#	Provider	Summary of event	Root causes	Recommendations	Actions taken
6	St John	During a routine stop to take a set of observations for a mental health patient being transported to hospital, the patient exited the back of the ambulance and walked in front of an oncoming truck. The patient died at the scene.	<p>The transport was treated as a medical transfer, as opposed to transporting someone subject to a compulsory treatment order. This resulted in a lower level of oversight than was necessary.</p> <p>The practice of stopping in transit to monitor vital signs in a medically-stable patient provided an opportunity for the patient to exit.</p>	<ul style="list-style-type: none"> Develop minimum supervisory levels for mental health patients being evaluated for compulsory treatment orders. Ambulance staff to liaise with their line managers to discuss transfers for acutely-unwell mental health patients where there are concerns about the level of resourcing. Prior to ambulance transport, clarify accountability for patient care for mental health patients in acute crisis. 	<ul style="list-style-type: none"> Established criteria for transfer of patients who have been subject to a compulsory treatment order with specific focus on supervisory oversight and patient support. Provided feedback to ambulance staff in this area that establishing vital signs needs to be managed on an 'as required' basis. Report shared with DHB.

7	St John	There were delays in dispatch of closest available resources to a road traffic crash involving nine patients, including one who died at the scene.	<ul style="list-style-type: none"> Failure to identify and declare a multi-casualty incident (MCI). No situation report (scene update). Absence of operational manager oversight. Sub-optimal scene management. Clinical control centre (CCC) unable to declare an MCI (as per policy). 	<ul style="list-style-type: none"> For clinical control centre staff involved, reinforce relevant standard operating procedures. Clinical control centre to follow up if information is lacking. Reinforce standard operating procedures for MCI scene management. Reinforce to senior managers the need to be actively involved in the management of rural and remote incidents. Changes to support dispatchers (CCC) to make firm recommendations to declare MCIs. 	<ul style="list-style-type: none"> District communications manager (DCM) remediated with relevant dispatcher. Notification to the DCM regarding delay in resource allocation with follow on duty manager involvement.
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Equipment-related events

#	Provider	Summary of event	Root causes	Recommendations	Actions taken
8	St John	<p>A technology failure of network switches resulted in the loss of the majority of critical operations applications and related functionality within the Clinical Control Centre in Christchurch. The Clinical Control Centre in Auckland took over all calls.</p> <p>One caller was subjected to a delayed response following activation of a medical alarm. A full internal review found no adverse outcome to that individual.</p>	<p>The fault occurred in a cluster of outdated network switches.</p>	<ul style="list-style-type: none"> Complete Infrastructure as a Service (IaaS) project which will remove all vulnerable equipment and provide a highly fault-tolerant computing environment. Progress business continuity and emergency preparedness work. 	<ul style="list-style-type: none"> Regularly maintaining and supporting the current technology. Escalation procedures are in place to manage patient and business impact. System backups are regularly taking place. Fault tolerant hardware has been installed. Business continuity plans in place for mission-critical functions and are regularly reviewed. External review by PwC completed – recommendations being implemented.
9	St John	<p>A Fire Service paging system utilised by St John failed and resources nearest to a cardiac arrest were not activated.</p> <p>Fire attended and reported the patient as deceased at the scene; this was confirmed by ambulance.</p>	<p>The cause and duration of the failure were unable to be identified.</p> <p>A technological repair discovered another unresolved issue that has since been resolved.</p>	<ul style="list-style-type: none"> Review all areas and situations where co-dependent paging systems used by St John are provided by the NZFS paging system. Regularly review co-dependent paging systems by clinical control services. 	<ul style="list-style-type: none"> Dual frequency settings of first response unit pagers tested. Deletion of personal radio identification code from computer aided dispatch (CAD) system to exclude dual use of first response unit individual pagers.

Other events

#	Provider	Summary of event	Root causes	Recommendations	Actions taken
None					