National Ambulance Sector Office

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Emergency ambulance service reportable events

For the quarter ending December 2015 (Oct to Dec 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.

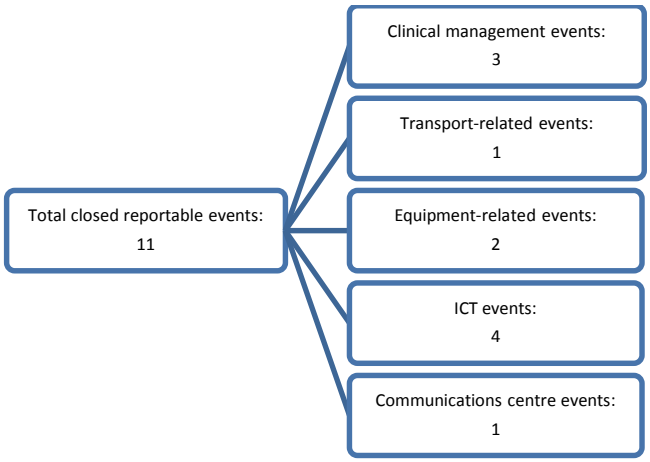
For more information

More information about adverse 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

- 11 reportable event investigations were closed this quarter.
- 49 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	Individual with respiratory problem managed incorrectly.	Paramedic did not recognise acute pulmonary oedema.	Provide clinical support to the paramedic who attended this patient.	Officer has undertaken voluntary study and requested mentoring.
2	St John	Ambulance crew didn't identify a myocardial infarction (heart attack), which delayed the time for the individual to be seen at hospital.	Crew not recognising the presenting condition.	Provide feedback to the crew on the inadequate clinical assessment in this instance.	Formal written feedback provided to staff on behalf of the Medical Director.
3	Wellington Free Ambulance	A patient in cardiac arrest received care that was inconsistent with best practice.	There was a combination of factors, including a breakdown of communication between team members and a failure to identify and manage the underlying condition.	Review the clinical guideline for the management of bradycardia. Investigate the need to have additional professional development for intensive care paramedics to practise critical skills that are infrequently used.	Findings from reviewing the bradycardia guideline will be considered at the national clinical guideline review in 2016. The learning and development team is developing an alternative approach to delivering professional development, which will increase the exposure of clinicians to critical skills that are not frequently practised.

Transport-related events

#	Provider	Summary of event	Root causes	Recommendations	Actions taken
4	St John	An ambulance broke down while responding urgently to an incident, which delayed the arrival of appropriate resources.	A manual transmission ambulance's clutch slipped, which was caused by operator error.	Vehicle to be removed from service. Discussion with relevant crew about correct operation of manual transmission vehicle.	Vehicle has been decommissioned. Discussion with station staff has occurred.

Equipment-related events

#	Provider	Summary of event	Root causes	Recommendations	Actions taken
5	St John	There was a 12 minute delay in responding to an incident due to pager issues.	The pager was faulty and the crew didn't check whether the pager was working at shift handover.	Pager checks to be added to the 'critical operations check' that is completed at the start of each shift.	Pager check added to critical operations check list.
6	St John	A defibrillator being used in advisory mode was unable to analyse the cardiac rhythm of a patient in cardiac arrest, requiring paramedics to replace it with another crew's defibrillator.	Although unable to be replicated in a simulation setting, it is believed that interference within the electro-magnetic fields of the external mains power and the proximity to high tension power lines and substation prevented the analysis function of the defibrillator.	Issue a safety alert to all staff identifying potential issues with monitoring and analysing cardiac rhythms within strong electro-magnetic fields with strategies to support staff should they be presented with a similar situation.	Safety alert issued to all clinical operations staff in January 2016.

Information and communications technology (ICT) events

#	Provider	Summary of event	Root causes	Recommendations	Actions taken
7	St John	There was a delay in an incident appearing in the dispatch queue. This required the incident to be re-entered and delayed the dispatch of resources for a cardiac arrest.	There was an unexplained failure of the dispatch software that could not be reproduced.	ICT team to develop a risk mitigation plan, which includes reporting and monitoring software issues resulting in delayed responses and near misses.	Six month review of risk mitigation to be conducted in May 2016. Work is progressing to update dispatch software, to be completed in mid-2016.
8	St John	Screen was unable to be seen by call taker, affecting their ability to deliver CPR instructions and delaying dispatch of resources.	There was an unexplained failure of the dispatch software that could not be reproduced.	ICT team to develop a risk mitigation plan, which includes reporting and monitoring software issues resulting in delayed responses and near misses.	Six month review of risk mitigation to be conducted in May 2016. Work is progressing to update dispatch software, to be completed in mid-2016.
9	St John	A software freeze delayed the dispatch of resources to three high priority incidents.	There was an unexplained failure of the dispatch software that could not be reproduced.	ICT team to develop a risk mitigation plan, which includes reporting and monitoring software issues resulting in delayed responses and near misses.	Six month review of risk mitigation to be conducted in May 2016. Work is progressing to update dispatch software, to be completed in mid-2016.
10	St John	A software freeze delayed the dispatch of resources to a high priority incident.	There was an unexplained failure of the dispatch software that could not be reproduced.	ICT team to continue monitoring for faults and work with the vendor to identify software fault.	It's expected that this will be addressed in an update in dispatch software in mid-2016.

Communications centre (ICT) events

#	Provider	Summary of event	Root causes	Recommendations	Actions taken
11	St John	Failure to verify incident address correctly resulting in a delay with an ambulance locating the patient.	Incorrect verification resulted in location of the address assigned to an incorrect block range. Cross street information offered by the caller was not utilised to correctly verify the address.	Call handler to receive training in relation to the correct process for verifying addresses.	Call handler has completed training.