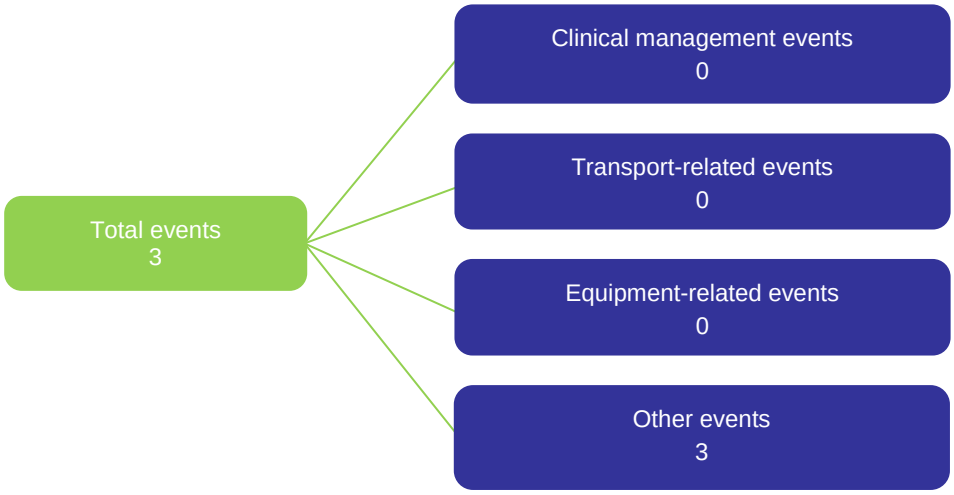
Emergency Ambulance Service Reportable Events: January– March 2018.

Total number of reportable events and near misses

- Two closed reportable events and near misses were reported to NASO for the period.
- Nil SAC one and four SAC two reportable events remain open as at the end of the quarter.



Other events

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP3459	Delayed dispatch of an ambulance resulted in delayed provision of care to a high acuity patient because the dispatcher inadvertently overlooked the incident notes specifying 'CPR in progress.' As a result the ambulance was re-assigned to another incident.	The dispatcher did not see the additional notes made regarding 'CPR in progress.' The dispatcher experienced a skill based error (slip-up) and reassigned the responding resource to another job in response to a request for 'back up.'	Dispatch Standard Operating Procedure 3.21 to be updated in recognition of incidents where 'back up' is requested' specifically incidents where an ambulance crew is already on scene versus incidents awaiting arrival of an ambulance. Dispatcher to receive additional training/coaching.	The standard operating procedure (DSOP 3.2.1) is under review. ProQA determinant 12D01 (Fit/not breathing) has been altered in ProQA to a 'PURPLE' response priority. The dispatcher has received additional training/coaching.

REP3524	Delayed dispatch (with delayed arrival) of an ambulance to a high acuity patient because of the non-availability of EAS, Manager and Delta resources.	Nil resources available – all committed to prior incidents. The dispatcher's decision to comply with St John policy and the MOU resulted in Fire and Emergency New Zealand (FENZ) being stood down. St John policy and the MOU with FENZ indicated that FENZ were not required to respond given the incident was a RED prioritisation.	Discussion with dispatcher regarding consideration of early involvement of the Clinical Desk when resources are delayed. Review of Memorandum of Understanding (MOU) with Fire and Emergency New Zealand (FENZ) to enable co-response in specific circumstances for RED priority incidents.	Discussion enacted. St John has negotiated with Fire and Emergency New Zealand (FENZ) that in areas where Fire 'First Response Units' (FRUs) are not in place; where medical co-response support is requested, front-line FENZ resources will attend (upon request). The Memorandum of Understanding (MOU) is to be reviewed this year. The revised standard operating procedure (DSOP 3.29) is also currently under review.
REP4194	Delayed entry and provision of clinical care to a high acuity patient primarily because of issues relating to accessibility of the 'lock box' containing a house key.	The 'lock box' was placed in a position that was difficult to access from outside the house and gate by emergency first responders. The emergency first responders had difficulty locating the correct address because the number on the unit was presented as 3/1 (i.e. indicating Unit 3/No.1) and the crews had been dispatched to 'Unit 1, number 3.' The call handler entered 'lock-box' details (i.e. 4-digit combination) and location of same; in an irregular format that was not easily interpreted.	Utilisation of standardised format/abbreviations for 'lock box' details that are communicated to emergency first responders (in progress). Revision of requirements within the Alarm Provider Contract to ensure installation stipulates maintenance of easy access to 'lock box' and compliance within standards for address identification when multiple housing units are noted.	All call handlers have been advised of what format/abbreviations are acceptable to be used when providing lock box details. Review completed and all staff have been advised to review physical address signage.