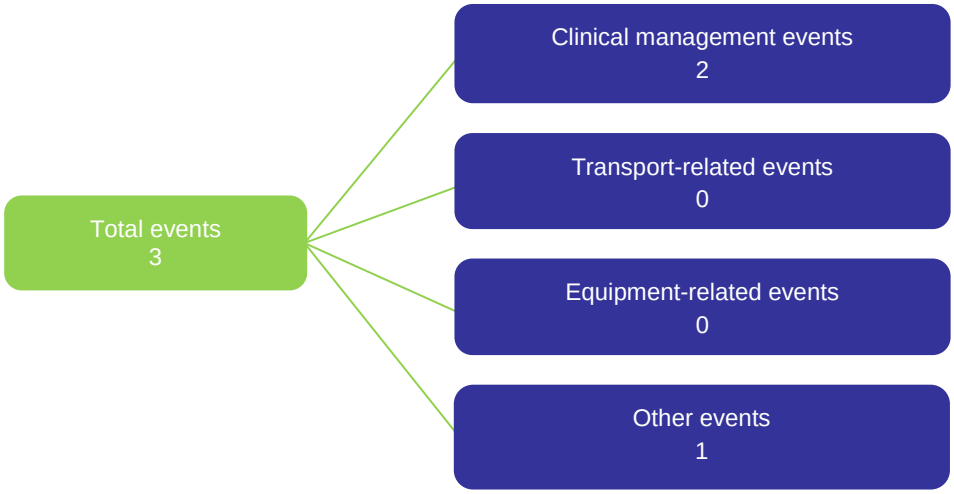
Emergency Ambulance Service Reportable Events: July– September 2017.

Total number of reportable events and near misses

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



Clinical management events

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
2790SJA2016	A patient was left at home after being attended to by an ambulance crew. The patient was transported to hospital in a serious condition by a different ambulance crew 3.5 hours later.	The crew involved did not consider that the patient's refusal to be assessed and confused state was the result of an underlying medical condition and believed that the patient's resistance/refusal to be assessed meant that an ePRF did not have to be completed. The crew did not adequately consider the information provided by the caregiver.	Debrief of the incident be conducted with the first attending crew.	Debrief enacted. One of the crew members is no longer employed by St John.

REP1837	The misidentification of the primary clinical impression resulted in a crew recommending a high acuity patient be transported by family to an after-hours medical centre.	Human Error – Mistake (Knowledge Based Mistake): The primary clinical impression (respiratory tract infection) identified by the crew was not consistent with the history provided regarding the patient's unresponsive episode that occurred prior to the crew's arrival. Human Error – Mistake (Knowledge Based Mistake): The crew were not aware that all babies that suffer a suspected ALTE should be transported to ED.	A debrief session be held for the attending crew with a Clinical Support Officer (CSO). The first attending crew revise their knowledge of ALTE and hyperkalaemia.	The debrief session has been scheduled (16 October 2017). The revision is in progress.

Other events

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP2368	The failure to recognise the severity of the patient's condition and correctly triage the response priority of a 111 call resulted in the delayed dispatch of required resources to a high acuity patient.	Human Error – Mistake (Knowledge-based mistake): The call handler failed to recognise the severity of the patient's condition and failed to enter notes regarding the patient's history of anaphylaxis, ICU admissions and the reference to the patient being 'shut down', had this occurred it is highly likely that the call would have been escalated to the Clinical Desk and subsequently there may not have been a delay in the dispatch of resources. Human Error – Mistake (Knowledge-based mistake): The call handler did not ask to speak with the registered nurse on scene and did not clarify with the caller 'what she's shut down' meant, which could have subsequently resulted in the call being classified as a 'PURPLE' response.	Call handling issues to be managed via the performance management pathway.	Referral enacted July 2017.