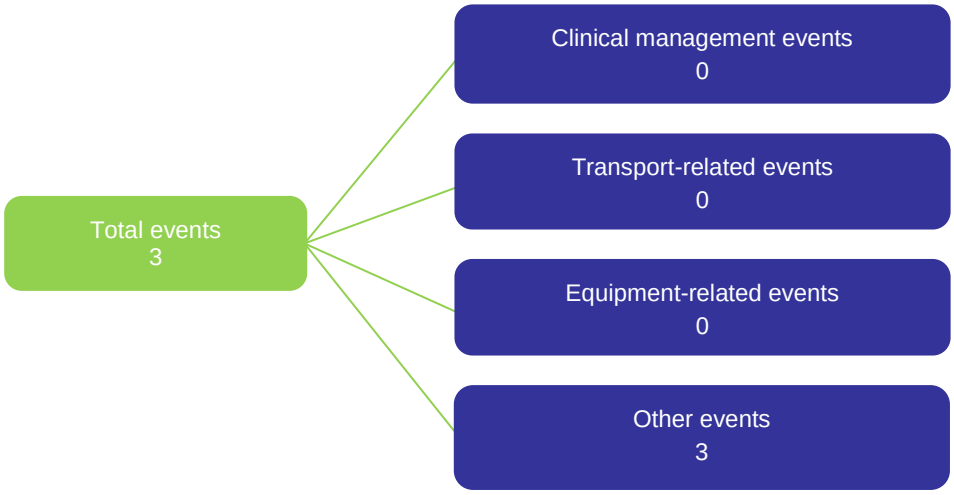
Emergency Ambulance Service Reportable Events: October– December 2017.

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.



Other events

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP1832	Delayed dispatch of rescue-helicopter and delivery of Intensive Care Paramedic (ICP) to incident scene and consequential delay in transportation of patient to hospital.	The absence of an established standard operating procedure (SOP) for clinical advisors and how they should liaise with call-handlers during a 111 call presented a possibility that vital scene information might not be recorded in the incident notes. This led to a direct interruption of the call and resulted in the delayed escalation of this incident. The absence of established SOPs supporting the collective activities of call-handlers, clinical advisors (Clinical Desk and Air Desk), dispatchers and managers presented a possibility that opportunities associated with the identification of ANTS criteria might not be escalated to the 'Air Desk'.	(1) SOPs to be developed detailing how clinical advisors shall interact with call-handlers. (2) SOPs to be developed defining how Clinical Control and Clinical Advisory functions shall interact and specifically with incidents meeting criteria for 'Air Desk' review.	These recommendations will be submitted for committee approval in February 2018.

REP2794	Delayed transportation of multi-system trauma patient, with deterioration during transport.	Human Error – Mistake (Knowledge-based mistake): The crew failed to recognise the potential for serious internal injuries based on the mechanism of injury and the patient's age, and the need to prioritise transport to hospital. Human Error – Mistake (Knowledge-based mistake): The crew initially spent a prolonged time on scene attending to skin tears; these could have been attended to in transit. Violation – Exceptional Violation: The day crew violated standard procedure by deciding to hand over care of the patient to the night crew at the local station, instead of directly transporting towards hospital.	The seven attending crew members were referred to the Authority to Practice (ATP) Credentialing Committee.	The seven attending crew members were referred to the Authority to Practice (ATP) Credentialing Committee and two underwent gap analysis (Note: Gap analysis: A process designed to measure a staff member's performance against St John Clinical Procedures and Guidelines).
REP3045	A high acuity, multi-system trauma patient was transported by private vehicle to hospital.	Human Error – Mistake (Knowledge-based mistake): The call handler did not recognise that the patient should not have been moved due to the mechanism of injury and potential injuries and subsequently advised the caller that it was acceptable to self transport the patient to hospital if they did not wish to wait for the ambulance.	(1) Further educational support provided to call-handler. (2) Reinforcement to all call-handlers and dispatchers about the appropriateness of cancelling calls in response to suggestions from patients/bystander about private transport when high-priority symptoms and conditions are identified and particularly when ambulances are responding and/or near to locating at the scene/incident.	(1) Educational support enacted (October 2017). (2) National communication to all call-handlers and dispatchers disseminated (January 2018).