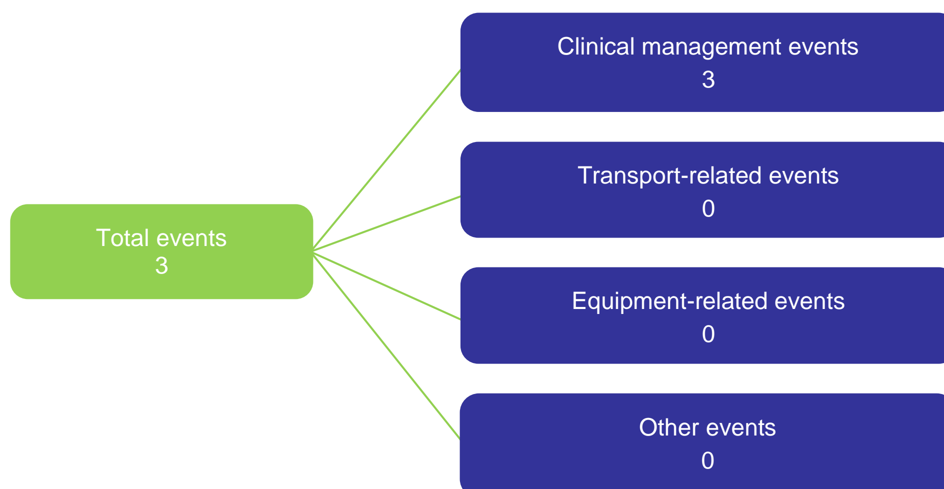
Emergency Ambulance Service Reportable Events: October – December 2018.

Total number of reportable events and near misses

- One closed reportable event was reported to NASO for the period. Two reports have been completed from the previous period and included in this quarter's report.
- Nil SAC one or 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
REP6201	Patient subjected to a preventable delay in being transported to hospital, deteriorating in transit into cardiac arrest and could not be successfully resuscitated.	First-attending ambulance crew affected a crew change-over (at end of shift) prior to patient being transported through to hospital. First attending ambulance crew failed to recognise the potential for patient to deteriorate.	Personnel referred for competency review and clinical support (as required) specific to: (a) Recognising potential for elderly patients to deteriorate. (b) Ensuring the continuation of care is optimal, specifically when change-over is with personnel holding lower clinical practice levels. Audit of incidents (i.e. specifically incidents where crew change-overs occur) attended by personnel involved in the incident to be reviewed to ensure compliance with CPGs (3 months, January 2019).	Referral enacted. Audit scheduled for January 2019.

REP6677	Patient attended twice within 24 hour period (not assessed/transported at first attendance), at second attendance, was assessed to be significantly unwell and deteriorated into cardiac arrest and could not be successfully resuscitated.	Failure to consider patient irritability and aggression as symptomatic of serious illness at first ambulance attendance. Non-compliance with clinical procedures and guidelines (CPGs) specific to clinical assessment at first ambulance attendance.	Personnel referred for competency review and clinical support (as required) specific to compliance with 'non-transportation' checklists. Audit of incidents (i.e. specifically 'non-transportation') attended by personnel involved in this incident to be reviewed to ensure compliance with CPGs (6 months, April 2019).	Referral enacted. Audit scheduled for April 2019.
REP6911	Delayed response to incident, patient cardiac arrested while self-mobilising to ambulance and could not be successfully resuscitated.	The response was received at shift changeover and there were miscommunications between the two crews as to whether the day crew or night crew were expected to respond.	Reinforcement of the requirements for all operational staff when finishing and starting shift to ensure a formal handover has occurred, to ensure delays in responding are restricted only to the mandatory critical vehicle checks. Audit of responses by personnel involved in this incident to be reviewed to ensure compliance with standard operating procedures (6 months, May 2019).	Memo yet to be issued. Audit scheduled for May 2019.