The Order of St John — Northern Region Trust Board

A Report by the

Health and Disability Commissioner

(Case 15HDC01841)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 14 June 2015, Mrs A (who previously had been diagnosed with atrial fibrillation) felt that her left foot had gone cold. On 15 June 2015, she was experiencing pain in her leg and was having difficulty walking. That morning, Mrs A presented to her GP's practice and was reviewed by a nurse and Dr D. Dr D advised Mrs A that if her leg did not improve by the afternoon, she was to return to see him. At 4pm on 15 June 2015, Mrs A's condition had not improved and she returned to see Dr D. Dr D sent an electronic referral letter to Hospital 1 and then telephoned St John Ambulance (St John) via 111 and asked for an ambulance to pick up Mrs A from her home address. He informed the dispatcher that Mrs A was to be transported to Hospital 1.

2. At 5.14pm, the call taker at St John who took Dr D's call recorded in the computer system that Dr D had telephoned and told her that Mrs A had an ischaemic leg and was to be transported to Hospital 1. The case was entered into the dispatch queue.

3. At 5.45pm, an Emergency Medical Dispatcher (EMD) recorded in the St John computer system that Mrs A was to be transported to Hospital 2 in the first instance, and noted that if Mrs A needed to go on to Hospital 1, another vehicle would need to take her. At 5.50pm, the EMD recorded that she had spoken to her Duty Manager and that he had suggested she dispatch Crew A. Crew A was dispatched with ambulance officers Ms G and Mr H.

4. A transcript of the two radio conversations between the EMD and her Duty Manager was provided to HDC. During the first conversation, Ms E informed Mr F that a Dr D had telephoned and told the call taker that Mrs A had an ischaemic limb. No mention is made in either conversation of Dr D's request for Mrs A to be transported to Hospital 1, and the destination of the call-out was not expressly discussed.

5. Although its formal destination policy stipulated that patients with ischaemic limbs should be transported directly to Hospital 1 or another main centre hospital, St John also told HDC that for resourcing reasons "there was an agreement in place at that time between St John and [Hospital 2], that non-urgent stable patients could be accepted as 'hold patients' with the agreement of the Charge Nurse. If accepted, those patients were held and placed onto the Patient Transfer Service next scheduled run." St John also referred to it being "customary" practice at the time of this incident to stop at Hospital 2 prior to transfer through to any other hospital by ambulance, and that this was a contributing factor in this case. In addition, St John said that it was customary practice for Communication Centre staff to factor in their local resources and attempt to manage these.

6. Crew A ambulance officer Ms G contacted Ambulance Control and spoke to Ms E on the way to pick up Mrs A. A transcript of this radio conversation was provided to HDC, which established that Ms G identified that the destination in the computer system was Hospital 1, and asked Ms E for confirmation that they would be going to Hospital 1. Ms E replied: "No, it will go to [Hospital 2] in the first instance." At approximately 7pm, the ambulance arrived at Mrs A's home. At 8.32pm, the ambulance arrived at Hospital 2.

7. On arrival, Mrs A was told that she would need to stay the night at Hospital 2 and travel to Hospital 1 the following day. At 10.30pm that night (15 June 2015) Hospital 2 became aware that the GP referral was for Mrs A to be admitted to Hospital 1. A fax was sent at 10.48pm by Hospital 2 to St John requesting pick-up and a double-crewed ambulance at 11.45pm for transfer to Hospital 1. This was logged by St John at 11.45pm, but no ambulance arrived.

8. Another fax was sent by Hospital 2 at 2am on 16 June 2015 requesting transfer to Hospital 1 with a pick-up time of 3am. Intravenous heparin infusion[1] was commenced at Hospital 2 at 2.45am as per District Health Board protocol. At 3.06am a St John ambulance was dispatched, and Mrs A was transferred.

Findings

9. It was found that the failure of several St John staff to instruct appropriately that Mrs A be taken to Hospital 1 demonstrated a pattern of poor care on a service level, for which ultimately St John is responsible. Not only did the dispatcher depart from the clear instructions of Dr D and the clear requirements of the destination policy, the Duty Manager did not rectify this departure or even discuss the destination policy. In addition, the ambulance crew accepted the dispatcher's change of destination without question and transported Mrs A to Hospital 2 either without, or despite, realising that she had a compromised limb. This series of failures meant that Mrs A was transported to Hospital 2 instead of the appropriate destination, Hospital 1.

10. While St John's destination policy regarding ischaemic limbs was clear, it was found that the agreement with Hospital 2 created uncertainty for St John staff about the interaction between clinical need, resourcing considerations, and the destination policy, which was not addressed by St John appropriately. It was found that this is likely to have contributed to the decisions and actions of the St John staff involved in this case, and the associated failures. In addition, concern was expressed that the subsequent fax sent to St John by Hospital 2 at 10.48pm seeking transfer was not actioned by St John appropriately, further delaying Mrs A's transfer, and St John has not been able to ascertain why. For these reasons, St John failed to provide services with reasonable skill and care and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

Recommendations

11. It was recommended that St John provide a written apology to Mrs A. It was also recommended that it confirm the implementation of its formal destination policies for serious conditions and, once finalised, conduct a review of the compliance with these policies; provide evidence that all relevant staff have been trained in the updated formal destination policies for serious conditions; and report back to HDC. It was also recommended that St John use an anonymised version of this case for the wider education of its staff, and publish the anonymised version in its internal publication, and provide evidence of this publication to HDC.

[1] A blood-thinning medication administered directly into the bloodstream.

Complaint and investigation

12. The Commissioner received a complaint from Ms B about the services provided to her mother, Mrs A. The following issue was identified for investigation:

Whether the Order of St John — Northern Region Trust Board provided Mrs A with an appropriate standard of care in June 2015.

13. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant/consumer's daughter
The Order of St John — Northern Region Trust Board	Provider

14. Information was also reviewed from:

Dr C	Neurologist
Dr D	General practitioner
District Health Board	DHB
Ms E	Emergency medical dispatcher
Mr F	Ambulance officer/Duty Manager
Ms G	Ambulance officer
Mr H	Ambulance officer
Mr I	Manager

15. Independent expert advice was obtained from paramedic Geoff Procter (**Appendix A**).

Information gathered during investigation

Background

16. In 2009, Mrs A was diagnosed with atrial fibrillation[2] following a stroke in 2006. In May 2015, Mrs A self-referred to a neurologist, Dr C,[3] because of concerns about variability in her INR reading.[4] On 10 June 2015, Mrs A attended her appointment with Dr C. Dr C reviewed Mrs A and recommended that her medication be changed from warfarin[5] to dabigatran.[6]

[2] A type of irregular heart rhythm that causes poor blood flow to the body.
[3] Dr C had treated Mrs A previously following her stroke in 2006.
[4] INR (International Normalised Ratio) is an international system established to assist the reporting of blood coagulation (clotting) tests. For example, a patient taking the anticoagulant warfarin may optimally maintain an INR of 2 to 3.
[5] Blood-thinning medicine.
[6] An alternative blood-thinning medication that does not require monitoring by blood tests.

17. Following a discussion between Dr C and Mrs A's GP, Dr D, about a transition plan between the two medications, it was agreed that Mrs A would stop her warfarin after her evening dose on Thursday 11 June 2015 and would have a blood test carried out to check her INR on the morning of Monday 15 June 2015, with dabigatran to be commenced that afternoon if the INR was less than 2.0. Mrs A ceased taking warfarin accordingly.

18. On 14 June 2015, Mrs A's left foot went cold. On 15 June 2015, she was experiencing pain in her leg and was having difficulty walking. Mrs A presented to her GP's practice that morning and was reviewed by a nurse and Dr D. Dr D advised Mrs A that if her leg did not improve by the afternoon, she was to return to see him.

19. At 4pm on 15 June 2015, Mrs A's condition had not improved and she returned to see Dr D. Dr D contacted the DHB for further information, and then sent an electronic referral letter. Dr D then telephoned St John Ambulance (St John) via 111 and asked for an ambulance to pick up Mrs A from her home address. He informed the dispatcher that Mrs A was to be transported to Hospital 1. Mrs A returned home to collect some belongings and wait for the ambulance. Dr D was advised that the ambulance was coming from Hospital 2.

Ambulance care

111 call received

20. At 5.14pm, the call taker at St John who took Dr D's call recorded in the computer system that Dr D had telephoned and told her that Mrs A had an ischaemic leg and was to be transported to Hospital 1. The call taker coded the call as requiring acute admission and prioritised it as a "green response" (non-urgent and stable)". The case was entered into the dispatch queue.

21. St John told HDC:

> "The destination policy in force at the time had two sections specifically relevant for this case:
>
> > [Local area]
> >
> > All patients transported by road should be transported to Hospital 2 unless they have a 'Doctors Referral' and have been accepted by another hospital. If patients are to be transported past [Hospital 2], the [local] duty manager needs to be consulted about possible alternative crewing/transport options.
> >
> > And
> >
> > Vascular Surgical Conditions
> >
> > Clinical Diagnosis of Leaking AAA/Aortic Dissection; Ischemic Limbs[7]) (White and pulseless limbs) are to be transported direct to [Hospital 1 or another main centre hospital] by the most appropriate means."

[7] Occurs when there is an inadequate blood supply to part of the body.

Change of destination

22. At 5.45pm, an emergency medical dispatcher,[8] Ms E, recorded in the St John computer system that Mrs A was to be transported to Hospital 2 in the first instance, and noted that if Mrs A needed to go on to Hospital 1, another vehicle would need to take her.

23. At 5.50pm, Ms E recorded that she had spoken to the Duty Manager, Mr F, and that he had suggested that she use Crew A. Crew A was dispatched with ambulance officers Ms G and Mr H. Mr H told HDC that they were dispatched just before 5.30pm.

24. Ms E stated:

> "Due to lack of resources in the area, myself and the Duty Manager, discussed that we can take patient to [Hospital 2] ED in the first instance to get [Mrs A] reassessed [and] to see if it can wait until we got extra staff in to cover the transfer. I would have expected that if the patient was not suitable to be admitted to [Hospital 2] the Doctor would not have accepted the patient [and] advised us to divert to [Hospital 1]."

25. Duty Manager Mr F stated: "I do not remember the job and I do not remember why I was consulted. Sorry that I can not shed any light on this job."

26. A transcript of the two radio conversations between Ms E and Mr F was provided to HDC. During the first conversation, Ms E informed Mr F that Dr D had telephoned and told the call taker that Mrs A had an ischaemic limb. No mention is made in either conversation of Dr D's request for Mrs A to be transported to Hospital 1, and the destination of the call-out was not expressly discussed. However, during the second conversation, in discussing the option of dispatching Crew A, Mr F referred to bringing the crew "back down", and stated that one of the ambulance officers needed to finish their shift at 8.30pm.

27. Crew A ambulance officer Ms G contacted Ambulance Control and spoke to Ms E on the way to pick up Mrs A. A transcript of this radio conversation was provided to HDC. It shows that Ms G identified that the destination in the computer system was Hospital 1, and asked Ms E for confirmation that they would be going to Hospital 1. Ms E replied: "No, it will go to [Hospital 2] in the first instance." It is apparent from the transcript provided that Ms G accepted this explanation without question. The transcript does not record any discussion occurring between the dispatcher and the crew that the original destination of Hospital 1 had been requested by Dr D.

28. Ms G's and Mr H's recollection was that Mrs A had seen her GP, who had advised her to telephone an ambulance if her condition did not improve. This was documented on the patient report form completed by Mr H. Mr H also said that, from memory, the patient told them that she had been advised to go to Hospital 2 and had a referral letter.

29. At approximately 7pm, the ambulance arrived at Mrs A's home. At 8.32pm, the ambulance arrived at Hospital 2.

[8] St John dispatchers organise daily deployment of resources.

30. St John told HDC that Ms E's direction to transport Mrs A to Hospital 2 in the first instance, when the stated destination in the mobile data terminal was Hospital 1, involved a deviation from protocol, as it was done without input from the Clinical Control Centre or Operations Manager.

31. However, St John also told HDC that for resourcing reasons "there was an agreement in place at that time between St John and [Hospital 2], that non-urgent stable patients could be accepted as 'hold patients' with the agreement of the Charge Nurse. If accepted, those patients were held and placed onto the Patient Transfer Service next scheduled run." St John acknowledged that resourcing would likely have been a consideration in relation to this call-out.

Hospital 2

32. On arrival, Mrs A was told that she would need to stay the night at Hospital 2 and travel to Hospital 1 the following day. At 10.30pm that night (15 June 2015) Hospital 2 became aware that the GP referral was for Mrs A to be admitted to Hospital 1. A fax was sent at 10.48pm by Hospital 2 to St John requesting pick-up and a double-crewed ambulance at 11.45pm for transfer to Hospital 1. This was logged by St John at 11.45pm, but no ambulance arrived. St John stated that it has been unable to determine why this fax was not actioned, but "the assumption is that a double-crewed ambulance was not readily available".

33. Another fax was sent by Hospital 2 at 2am on 16 June 2015 requesting transfer to Hospital 1 with a pick-up time of 3am. Intravenous heparin infusion[9] was commenced at Hospital 2 at 2.45am as per the DHB protocol. At 3.06am a St John ambulance was dispatched, and Mrs A was then transferred alongside another patient who needed to be transported to Hospital 1 from Hospital 2.

Hospital 1

34. Mrs A was admitted to Hospital 1 at 5.05am (11 hours and 54 minutes after the original call from Dr D). Heparin infusion was continued at Hospital 1, and Mrs A was observed in the vascular unit.

35. On the morning of 17 June 2015, Mrs A underwent further investigations. Later that day, when Mrs A's left foot deteriorated, consideration was given to amputation below or above the knee. However, the decision was deferred when the foot showed signs of improvement with ongoing heparin infusion. By 22 June 2015, there was further deterioration, and Mrs A underwent a left below-knee amputation on 23 June 2015. On 30 June 2015, Mrs A suffered a stroke and, on 6 July 2015, an infection was identified in her wound. On 8 July 2015, due to the infection, Mrs A underwent a left above-knee amputation.

Further information

36. St John told HDC:

[9] A blood-thinning medication administered directly into the bloodstream.

> "On behalf of St John, I would reiterate our unreserved apology to [Mrs A] and her family/whanau for our role in the delayed transfer to [Hospital 1]. We further acknowledge that at the time of this incident, while it was 'customary' practice to often stop at [Hospital 2] prior to transfer through to any other hospitals by ambulance; we accept that this has been a contributing factor in the adverse outcome for [Mrs A]. It was also customary practice for our communication centre staff at the time, to factor in their local resources and attempt to manage these according to their rostered hours of work. Increased resources in this area have in part, contributed to more timely transfer of patients by ambulance, out of [the area] and as transfers from [Hospital 2]."

37. St John also told HDC that it intends to introduce formal destination policies for serious conditions (including limb ischaemia) in 2018 to provide greater clarity to ambulance officers on the most appropriate hospital for individual conditions.

Responses to provisional opinion

38. St John was provided with a copy of the provisional opinion and stated that it accepts the recommendations made and has no further comment to make.

39. Mrs A and Ms B were provided with a copy of the "information gathered" section of the provisional opinion for comment, and had no further information to add.

Opinion: introduction

40. The scope of this investigation focuses on the care provided by St John to Mrs A. During the course of the investigation, expert advice was obtained in relation to the care provided by other providers, and no other areas of concern were identified.

Opinion: breach — The Order of St John — Northern Region Trust Board

Change of destination

41. At 5.14pm, Dr D telephoned via 111 and informed St John that Mrs A had an ischaemic leg and was to be transported to Hospital 1. The call was recorded into the St John computer system. Mrs A returned to her home to collect some belongings and wait for the ambulance.

42. St John dispatcher Ms E told HDC that because of the lack of resources in the area, she and the Duty Manager, Mr F, decided that Mrs A should go to Hospital 2 in the first instance, and that the medical staff at Hospital 2 could then determine the next appropriate course of action.

43. According to the transcript of their conversations, Ms E consulted with Mr F about which crew to send, and informed him that Mrs A had an ischaemic limb. It was agreed that Crew A would be sent. There is no record that Ms E informed Mr F that Dr D had requested Mrs A be transported to Hospital 1, and the destination was not otherwise expressly discussed. However, during their second conversation Mr F refers to bringing the crew "back down", and advised that Mr H needed to be "off the truck at 8.30pm".

44. Crew A was dispatched around 5.30pm and, when the ambulance was en route to pick up Mrs A, Ms E told Ms G that Mrs A was to be transported to Hospital 2. Ms G had identified that the destination stated in the computer system was Hospital 1, but did not question Ms E's instructions. Mrs A was then picked up around 7pm and transported to Hospital 2. She was not transferred to Hospital 1 until 4.08am the following day.

45. My independent expert paramedic advisor, Mr Geoff Procter, advised that if the communications centre staff were aware that Dr D had specified that the patient was to go to Hospital 1, it would be a significant departure from standards if they changed the destination without consultation with a fully informed manager, doctor, or ambulance crew.

46. While it is clear from the transcripts provided that Ms E spoke with Mr F regarding which ambulance to dispatch, it is also clear that she did not inform him that Mrs A's general practitioner had specified that Mrs A was to go to Hospital 1. It is therefore apparent that Ms E made the decision to change the destination without consultation with a fully informed manager, doctor, or ambulance crew. In addition, I note that the destination policy in place at the time, as it related to ischaemic limbs, required St John to transport Mrs A directly to Hospital 1 or another main centre hospital.

47. In light of my expert's advice and St John's destination policy, I am concerned that Ms E did not discuss with Mr F, a doctor, or an ambulance crew the fact that Mrs A's GP had requested she be transported to Hospital 1, before making the decision that Mrs A would instead be transported to Hospital 2.

48. Despite information about the requested destination not being passed on to Mr F, it is nevertheless clear that he was told that Mrs A had an ischaemic limb. As above, under the destination policy, an ischaemic limb meant that she should have been transferred directly to Hospital 1 or another main centre hospital. While the destination was not expressly discussed between Ms E and Mr F, in my view it is apparent from Mr F's reference to one of the ambulance officers needing to finish at 8.30pm, and to the ambulance (which was dispatched at around 5.30pm) bringing them "back down" by this time, that it was the mutual intention of Ms E and Mr F to have Mrs A transferred to Hospital 2. It would not have been possible to collect Mrs A, transport her to Hospital 1 or the other main centre hospital stated in the destination policy, and return by 8.30pm.

49. I am concerned that not only was the destination policy not followed by Ms E, but that Mr F did not rectify this error or even discuss the policy during his conversation with Ms E.

Care provided by ambulance crew

50. As above, following the directions from Ms E, Ms G and Mr H transported Mrs A to Hospital 2 instead of Hospital 1, which was the destination specified in the computer system. They did so without questioning the reason for the change.

51. Mr Procter advised that if the crew were aware that the doctor intended the destination to be Hospital 1 it would be a moderate departure from expected standards of care not to ascertain why the intended destination was Hospital 1 before changing the destination. However, he advised that it would not be a departure if the crew were not aware that the doctor intended the destination to be Hospital 1.

52. While it is clear that the ambulance crew were aware that the initial destination was to be Hospital 1, it is not clear whether they were aware that the destination had been specified by Dr D. Ms G and Mr H stated that their recollection was that Mrs A had seen her GP, who had advised her to telephone an ambulance if her condition did not improve. This information is recorded in the patient report form completed by St John. Mr H also said that, from memory, Mrs A said that she had been told to go to Hospital 2. I also note that in the transcript of the conversation between Ms E and Ms G, there is no mention of Dr D's request for Mrs A to be transported to Hospital 1. Accordingly, based on the information available, I accept that Ms G and Mr H were not aware of the GP's direction that Mrs A be taken to Hospital 1.

53. However, Mr Procter also advised:

> "If the crew were told to redirect to another hospital by the communications centre, the crew would be expected to ensure that it was clinically safe for the patient to do so. In this situation it would be expected standards that the crew investigate the conflicting information regarding the intended destination, in case the intended destination was specified by the doctor. Failing to do this would be seen as a mild departure from expected standards."

54. Mr Procter further stated that the ultimate responsibility for ensuring the patient is transported to the most clinically appropriate destination rests with the attending clinicians, as they will have the most accurate clinical impression of the patient.

55. I am guided by this advice. I am concerned that, although Ms G was aware that the destination had been changed from Hospital 1 to Hospital 2, she did not investigate the conflicting information she had received from the call centre. She and Mr H had ultimate responsibility for ensuring that Mrs A was transported to the most clinically appropriate destination, and I therefore consider that further questions should have been asked.

56. In addition, it is recorded in the patient report form that at least one of the crew recognised that Mrs A's leg was abnormally cool to the touch. Mr Proctor advised: "It would be a moderate departure from expected standards of care if the crew did not recognise the limb as potentially compromised, particularly in the presence of long term Atrial Fibrillation." Mr Proctor also advised that, if they had identified that Mrs A's limb was potentially compromised, it would be a moderate departure not to take Mrs A to the appropriate hospital (Hospital 1) for her condition.

57. I accept Mr Proctor's advice. It appears that the ambulance crew did not realise that the limb was potentially compromised, but I am unable to make a definitive finding on this from the information they have provided. Nevertheless, I am highly concerned that the ambulance crew either failed to realise that Mrs A's leg was compromised or, having realised that it was compromised, did not transport Mrs A to Hospital 1, the appropriate destination for that condition.

Agreement with Hospital 2

58. Although its formal destination policy stipulated that patients with ischaemic limbs should be transported directly to Hospital 1 or another main centre hospital, as stated above, St John also told HDC that for resourcing reasons "there was an agreement in place at that time between St John and [Hospital 2], that non-urgent stable patients could be accepted as 'hold patients' with the agreement of the Charge Nurse. If accepted, those patients were held and placed onto the Patient Transfer Service next scheduled run." St John also referred to it being "customary" practice at the time of this incident to stop at Hospital 2 prior to transfer through to any other hospital by ambulance, and that this was a contributing factor in this case. In addition, St John said that it was customary practice for Communication Centre staff to factor in their local resources and attempt to manage these.

59. In this case, while Mrs A was known by Ms E and Mr F to have an ischaemic leg, she was also labelled as a non-urgent and stable patient. She therefore fell into the category of patient that could be accepted as a hold patient at Hospital 2 under the agreement with that hospital. In addition to this, I note that Ms E cited a lack of resourcing as the reason Mrs A was transported to Hospital 2 in the first instance, without reference to the destination policy, and that the ambulance crew accepted the direction given by Ms E to change the destination without question. This does indicate that a customary practice had developed, under which Hospital 2 was considered by staff as a default destination, at least in the first instance.

60. For the above reasons, I am of the opinion that the agreement with Hospital 2 created confusion and uncertainty for St John staff about how resourcing and clinical issues were to be resolved and prioritised. I am critical that St John did not ensure that there was clarity about the interaction between clinical need, the destination policy, and the agreement with Hospital 2 to ensure that patients were transported to the appropriate destination. I consider that the agreement with Hospital 2, and the "customary" practice that appears to have developed of often stopping at Hospital 2, is likely to have contributed to the change of destination, the departure from clear policy, and the unquestioning acceptance of the change of destination by the ambulance crew in this case.

Failure to respond to request for pick-up

61. At 10.30pm, Hospital 2 became aware that the GP referral was for Mrs A to be admitted to Hospital 1. A fax was sent to St John at 10.48pm requesting pick-up at 11.45pm. This was logged by St John at 11.45pm, but no ambulance was dispatched. A further fax was sent to St John at 2am requesting pick-up at 3am. An ambulance was dispatched in response at 3.06am, and Mrs A was transferred to Hospital 1 at 4.08am.

62. I am critical that although St John received the fax at 10.48pm and logged it, no ambulance was dispatched in response to that request to transfer Mrs A. This further delayed Mrs A's

transfer to the appropriate hospital. I am also concerned that St John has been unable to establish why this request was not acted upon.

Conclusion

63. St John is responsible for the operation of the clinical services it provides, and can be held responsible for any service failures. It is the responsibility of St John to have adequate systems in place and adequate oversight of its staff to ensure that an acceptable standard of care is provided to consumers. This includes ensuring that staff understand and are compliant with policies.

64. While individual staff hold some degree of responsibility for their failings, the failings referred to above represent a pattern of poor care on a service level, for which St John is ultimately responsible. Not only did the dispatcher depart from the clear instructions of Dr D and the clear requirements of the destination policy, the Duty Manager did not rectify this departure or even discuss the destination policy. In addition, the ambulance crew accepted the dispatcher's change of destination without question and transported Mrs A to Hospital 2 either without, or despite, realising she had a compromised limb. This series of failures as outlined above meant that Mrs A was transported to Hospital 2 instead of the appropriate destination, Hospital 1.

65. While St John's destination policy regarding ischaemic limbs was clear, as stated above, I consider that the agreement with Hospital 2 created uncertainty for St John staff about the interaction between clinical need, resourcing considerations, and the destination policy, which was not addressed by St John appropriately. I also consider that this is likely to have contributed to the decisions and actions of the St John staff involved in this case, and the associated failures. In addition, I am concerned that the subsequent fax sent to St John by Hospital 2 at 10.48pm seeking transfer was not actioned by St John appropriately, further delaying Mrs A's transfer, and St John has not been able to ascertain why. For these reasons, St John failed to provide services with reasonable skill and care and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[10]

Recommendations

66. I recommend that St John:

a) Provide a written apology to Mrs A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Confirm the implementation of its formal destination policies for serious conditions and, once finalised, conduct a review of the compliance with these policies and report back to this Office within six months of the date of this report.

c) Provide to HDC, within six months of the date of this report, evidence that all relevant staff have been trained in the updated formal destination policies for serious conditions.

[10] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

d) Use an anonymised version of this case for the wider education of its staff, publish the anonymised version in its internal publication, and provide evidence of this publication to HDC when it is available.

Follow-up actions

67. A copy of this report with details identifying the parties removed, except The Order of St John — Northern Region Trust Board, and the expert who advised on this case, will be sent to the New Zealand Ambulance Association, for educational purposes.

68. A copy of this report with details identifying the parties removed, except The Order of St John — Northern Region Trust Board, and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from paramedic Mr Geoff Procter:

"**Independent Advice to the Health and Disability Commissioner**

Case C15HDC01841

Geoff Procter

8th September 2016

Statement
This statement is to confirm that I have read, understood, agreed to and followed the guidelines for independent advisors to the Health and Disability Commissioner. Additionally I have no known conflict of interest with any of the individuals involved in the investigation.

Personal Qualifications
I currently hold a Bachelor of Health Sciences in Paramedicine, and have been a practicing paramedic since 2007 with Wellington Free Ambulance. I currently hold an authority to practice at Paramedic level. Additionally my current role, which I have held for four years, is as Field Operations Manager for Blue Shift.

Instructions from the Commissioner
Below are the instructions received from the Commissioner verbatim:

1) *Please comment on the decision to send [Crew A], so not to breach driving times;*
2) *Please advise what standard practice is regarding calls being attended to when driving hours may be breached?*
3) *Please comment on the management of [Mrs A's] transport to [Hospital 1] by St John Ambulance staff, including the decision to stop at [Hospital 2];*
4) *Please comment on the information entered by the dispatcher in relation to [Dr D's] request;*
5) *Please make any further comment regarding the overall management and care [Mrs A] received from St John Ambulance Service.*

Subsequently, the questions have been amended with the following information:

a) *With regards to question 3 of our advice request, we are seeking comments relating to any staff involvement in the management of transporting [Mrs A] to [Hospital 1].*
b) *Question 4 of our previous advice request should be amended to read: 'Please comment on the information entered by the* ***call taker*** *in relation to [Dr D's] request'.*

Upon looking at the information in the Incident Detail Report for the initial ambulance response, there is information entered in the incident notes by both the call taker and the dispatcher. I have commented on both.

Facts and Assumptions
All advice I have formed has been based solely on the material provided by the Health and Disability Commissioner. I have not seen fit to source any further external input to this advice. As such, I have formed my advice on the assumption that all information provided is a full and accurate representation of the course of events, and the accounts of the individuals involved.

Advice and Reasoning
As requested by the Health and Disability Commissioner I have formed my advice below:

1) Please comment on the decision to send [Crew A], so as not to breach driving times;

The Land Transport Rule: Work Time and Logbooks 2007 under the Land Transport Act 1998 states that in any cumulative work day a driver can work a maximum of 13 hours before they must take a continuous break of at least 10 hours.

Emergency services have an exemption to the driving regulations for emergency work. Whilst emergency work is not specifically defined, it is widely accepted by St John, Wellington Free Ambulance and the New Zealand Transport Authority that incidents coded as 'green' priority do not qualify as emergency work. The cumulative work day driving restrictions would apply to the current incident.

If responding to the current incident was to take any ambulance past the 13 hour cumulative work day, it would be illegal to respond that vehicle, and it would be necessary to consider an alternative resource or delay responding to the incident until an alternative resource was available.

Subsequent information is provided by St John that [Crew B] was due to finish at 1830. Whist the start time of the vehicle is not mentioned in the information if responding to the incident would have taken [Crew B] over the 13 hours cumulative work day, it would be standard practice to respond a more appropriate resource, such as [Crew A].

2) Please advise what standard practice is regarding calls being attended to when driving hours may be breached?

Standard practice would be to not respond any resource to any non-urgent calls if the resource would breach its driving hours. A green incident is always considered a non-urgent incident, and so it is not appropriate to breach driving hours for a green incident.

3) Please comment on the management of [Mrs A's] transport to [Hospital 1] by St John Ambulance staff, including the decision to stop at [Hospital 2];

Management by Ambulance Staff
Standard practice would be for ambulance staff to obtain a full history from the patient including, in this situation, details of the patient's visit to their doctor today. The information from St John provided indicates that there was no referral letter with the patient for the ambulance staff to read. The response from the staff state that there was a referral letter. There was information in the mobile data terminal (MDT) that indicated

that the ambulance crew were initially advised of the intended destination being [Hospital 1], however this was changed by the dispatcher to [Hospital 2] 15 minutes after the ambulance began responding to the incident.

If the crew were aware that the doctor intended the destination to be [Hospital 1] it would be a moderate departure from expected standards of care to not ascertain why the intended destination was [Hospital 1] before changing the destination.

If the crew were not aware that the doctor intended the destination to be [Hospital 1], there would be no departure from expected standards by them changing the destination from what the MDT specified.

If the responding crew were told to redirect to another hospital by the communications centre, the crew would be expected to ensure that it was clinically safe for the patient to do so. In this situation it would be expected standards that the crew investigate the conflicting information regarding the intended destination, in case the intended destination was specified by the doctor. Failing to do this would be seen as a mild departure from expected standards.

The ultimate responsibility for ensuring the patient is transported to the most clinically appropriate destination rests with the attending clinicians, as they will have the most accurate clinical impression of the patient.

Management by Communications Centre Staff
If the communications centre staff were aware that the doctor had specified that the patient was to go to [Hospital 1], it would be a significant departure from standards if they changed the destination without consultation with a fully informed manager, doctor or ambulance crew.

Management by Management Staff
The information provided by St John states that the management staff that were consulted were not provided with the destination specified by the doctor, and therefore were not fully informed.

If the management staff being consulted were aware that the doctor intended the destination to be [Hospital 1] it would be a moderate departure from expected standards of care to not ascertain why the intended destination was [Hospital 1] before accepting the change of destination.

If the management staff were not aware that the doctor intended the destination to be [Hospital 1], there would be no departure from expected standards of care in accepting the change of destination.

4) Please comment on the information entered by the call taker in relation to [Dr D's] request;

The information entered by the call taker when receiving the call from [Dr D] appears to be an accurate reflection of [Dr D's] wishes. The call taker appears to be represented by the user ID number […], and early on in the call, at 17:14:01, has added a transport

information specifying [Hospital 1] Emergency Department as the intended destination for the incident.

The dispatcher appears to be represented by the user ID number […]. At 17:45:17, 15 minutes after the ambulance was dispatched, user ID number […] has entered the notes '[Crew A] TO TRANSPORT TO [Hospital 2] IN THE FIRST INSTANCE — IF NEEDS TO GO ONTO [Hospital 1] — ANOTHER VEH HAS TO TAKE IT' and at 17:50:47 '[PRIVATE] SPOKE WITH [Mr F] — WHO SUGGESTED [Crew A]'. The first message would have been visible to the ambulance crew on their MDT. The second message is marked [PRIVATE], so it would not have been visible to the ambulance crew on their MDT.

5) Please make any further comment regarding the overall management and care [Mrs A] received from St John Ambulance Service.

[Crew A] arrived at their destination of [Hospital 2] at 2032. The subsequent transport by [Crew B] to [Hospital 1] took 57 minutes, along with 44 minutes at the destination hospital before they were available to return to station. This means that if [Crew A] had directly transported to [Hospital 1] during the initial transport, they would have likely been clear to return to station at around 2213. This would have left them 17 minutes to return to station before the end of their shift, and 47 minutes to return to station before they reached their driving hours limit (13 hours from 1000).

If [Crew A] had completed the entire transport to [Hospital 1], it is likely they would have run past both their shift finish time and their driving hours restrictions.

If an ambulance crew reasonably believes that there is a threat to the life or limb of a patient they are currently attending, they would be justified in breaching the driving hours regulations to provide the best possible care to the patient. From the Patient Report Form, it appears that the crew have identified that the patient's left leg is abnormally cool to the touch. It is not clear from the Patient Report Form if the crew identified the limb as potentially compromised.

It would be a moderate departure from expected standards of care if the crew did not recognise the limb as potentially compromised, particularly in the presence of long term Atrial Fibrillation.

If the crew identified the limb as potentially compromised, they would be justified in breaching the driving hours regulations to complete transport to the most appropriate destination. [Mr Proctor further advised: If the crew realised that the limb was compromised I would have expected them to contact the duty manager to arrange for a more immediate transport to [Hospital 1] (i.e. via a crew change rather than an inter-hospital transfer). Not doing so would be a moderate departure from the expected standards of care.]

If the crew identified the limb as not potentially compromised, they would not be justified in breaching the driving hours regulation to complete transport to the most appropriate destination.

Literature and Materials Used

The majority of literature and materials relied on are restricted to the documentation provided by the Health and Disability Commissioner. These materials were sufficient in this case to form advice on the reasonableness of the ambulance responses for [Mrs A].

Examinations, Tests and Investigations Relied On

There were no further examinations, tests or investigations relied on or necessary for my advice on this investigation."