HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Health and Disability Commissioner

(Case 21HDC00752)

Executive summary

1. This report concerns the care provided to Mr A (aged 43 years at the time of the events) by St John. This case highlights the importance of having clear policies and procedures in place for staff, and a robust review process to ensure accurate reporting of adverse events to aid in determining what further support and training may be required for staff.

2. In Month1[1] 2021 Mr A lacerated his right arm resulting in significant bleeding. Two separate calls were made to St John by Mr A's son and another person at the scene. Both call handlers used the software-guided assessment to determine the nature and severity of the bleeding and provide advice while an ambulance was being arranged. The two calls were merged in the system and met the criteria for the immediate dispatch of an ambulance. Initially, no ambulances were available for dispatching, so the call was added to a 'pending queue' while waiting for an ambulance to become available. An ambulance was dispatched to Mr A at 4.19pm (34 minutes after the 111 calls), but when it arrived at the scene, Mr A had already been transported to a public hospital. Sadly, Mr A died at the hospital shortly after arrival.

Findings

3. The Commissioner found errors by multiple staff in both the call-handling and the dispatching, which contributed to the delay in an ambulance being dispatched to Mr A. Both call handlers failed to obtain and record appropriate information from the callers and to provide appropriate advice. The absence of welfare checks and multiple missed opportunities to escalate the calls to a Clinical Support Office for an urgent review and clinical advice also contributed to the poor incident management and the failure to dispatch an ambulance sooner.

4. The Commissioner found St John in breach of Right 4(1) of the Code for failing to provide services to Mr A with reasonable care and skill, due to its inadequate policies and a lack of staff understanding of the policies, which resulted in the individual errors by staff.

5. The Commissioner also made adverse comment about the Patient Safety Incident (PSI) review completed by St John, due to the confusion and inconsistency in the PSI, which created difficulty in assessing the care provided by the individuals involved in Mr A's care.

[1] The months are referred to as Month1–Month3 to protect privacy.

Names (except St John) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

6. The Commissioner recommended that St John provide a written apology to Mr A's family and that it review its 'Dispatch Guidelines' standard operating procedures (SOPs), its PSI policy, its dispatch personnel handovers, and the current training provided to dispatchers. St John is also to provide HDC with an update on the progress of the recommendations in its PSI review and use an anonymised version of this report to conduct a training session for call-handlers.

Introduction

7. This report is the opinion of Health and Disability Commissioner Morag McDowell.

8. The report discusses the care provided to Mr A by The Priory in New Zealand of the Most Venerable Order of the Hospital of St John of Jerusalem (St John).

9. On 3 Month3 2021 HDC received a complaint from Mrs A (wife) and Mr B (Mr A's son) about the care provided by St John to the late Mr A in Month1 2021 after a workplace accident, which, sadly, resulted in Mr A's death. I offer my condolences to his family for their loss.

10. The following issue was identified for investigation:

- *Whether [St John] provided [Mr A] with an appropriate standard of care in [Month1] 2021.*

Information gathered during investigation

11. In Month1 2021 Mr A, age 43 years at the time of the events, was working at a residential building site. Mr A was disposing of timber and glass waste into a bin when a window glass plate shattered as he picked it up, deeply lacerating his right arm at the elbow.

12. Mr A's son, Mr B, was with him and witnessed the accident. Mr B told HDC that he helped his father to their van, and his first instinct was to call for an ambulance, as the cut was deep and was bleeding significantly.

13. Both Mr B and another person at the scene (not identified) called 111 to request an ambulance at the same time.

Mr B's call to 111

14. Mr B's 111 call was received by St John at 3.39.21pm (incident number 1) and assigned to call-handler Ms C, who had been employed by St John in the Ambulance Communication Centre[2] for a few years.

15. HDC was provided with a transcript of the call. Mr B told Ms C that glass had fallen on his dad and cut his arm and that there was serious bleeding. Ms C asked whether Mr A was awake and breathing, and whether there was any serious bleeding. Mr B confirmed that his

[2] There are three National Clinical Communication Centres (in Auckland, Wellington, and Christchurch) that take 111 calls from anywhere in the country.

father was awake but in pain, he was still breathing, and there was serious bleeding from the wound. Ms C asked whether Mr A was 'completely alert', to which Mr B responded: 'Yes he's awake, he's awake but it's a dangerous injury. He's completely bleeding.' Ms C then asked whether Mr A's forearm was 'obviously bent out of shape', and Mr B confirmed that it was.

16. St John told HDC that it uses software to guide the call-taking process and prioritise the incidents received from 111 calls.[3] The software assesses the severity of the patient's symptoms, and, in the case of severe bleeding, this includes a guided assessment of the nature and severity of the bleeding. St John said that based on the response entered by the call-handler, further 'pop-up' boxes populate, and the call-handler provides the most appropriate advice while an ambulance is being dispatched.

17. Instructions on controlling the bleeding were provided to Mr B by Ms C. Mr B was advised to apply pressure to the wound with a clean, dry towel or cloth and, without lifting the cloth or towel, tell her if the bleeding was under control. Mr B replied that the bleeding was not under control as it was a 'way too deep cut'. Ms C asked whether a commercial tourniquet was available, and when Mr B responded that no commercial tourniquet was available, Ms C instructed: 'Keep pressing down [on the wound] as hard as you can until help arrives.'

18. After providing his and his father's names, Mr B advised Ms C that his father had fainted and was not conscious. Ms C responded by asking, 'Okay he's unconscious now?' to which Mr B responded: 'Yeah. He's going to bleed to death.' Ms C then asked whether Mr A was awake and Mr B responded yes, but that his father was running out of blood. Ms C further clarified asking: '[Y]ou just said he is unconscious and now you said he is awake. Is he awake right now? If you tap him on the shoulder and wake him up does he respond to you?' Mr B advised that his father was awake but was 'out of energy'.

19. Mr B told HDC that while he was on the phone to Ms C, his father's situation was getting worse. His father was slowly passing out, so he had to keep shaking him to ensure that he was 'still alive and okay'.

20. At 3.41pm, the software sent the call to the dispatch queue, where it awaited an available ambulance to be assigned to attend. Ms C told Mr B that help was coming as quickly as possible, before advising that she needed to hang up to take another emergency call but that he should call back immediately 'if [Mr A became] worse in any way'. The call was disconnected at 3.45pm and lasted 6 minutes and 42 seconds.

21. Mr B told HDC that while he was on the phone to Ms C, his father was in a lot of pain and was yelling out for an ambulance to be sent. Mr B said that the questions being asked were irrelevant and were going to delay the dispatch of an ambulance. Mr B said that after being

[3] The software is called ProQA. It reduces human error by offering structured protocols that capture the caller's primary concern and guide the caller to ask specific questions based on the protocol selected. The software records the answers input by the call-handler and analyses the information to determine the primary concern of the caller and how unwell the person is suspected to be in order to give the incident a colour-coded priority.

told by Ms C that the ambulance would be another 15 minutes away, he 'got mad' and hung up the call.

22. The call was triaged as protocol *'Haemorrhage — Trauma'* and the response priority was ORANGE 1, which the St John Dispatch Guidelines (Appendix A) define as appearing serious, but not immediately life-threatening.

23. A welfare check call was due to be completed at 4.12pm. St John told HDC that these are calls made by call-handlers to patients/callers when there is likely to be a delay in the dispatch of an ambulance. During these calls, further information is often gathered to determine whether the patient's condition has remained stable or has deteriorated (which would support the response priority being reviewed for upgrading). St John's Welfare Checks SOPs (Appendix A) states that '[c]ollectively all personnel have a responsibility to ensure that welfare checks are completed'. It also states that a senior staff member at the Ambulance Centre is responsible for ensuring that welfare checks are completed on time by monitoring the dashboard and queue and tasking an individual to carry out the welfare checks. However, no welfare check was completed.

24. Ms C no longer works for St John and has not provided a response to HDC.

Second call to 111

25. The second 111 call (incident number 2) was received by St John at 3.39.54pm (approximately 30 seconds after the first call) and was managed by call-handler Ms D, who had been employed by St John in the Ambulance Communication Centre for a few years.

26. HDC was provided with a transcript of the call, but the name of the caller was not taken by Ms D. The caller advised Ms D that Mr A had been loading glass into a rubbish bin when the glass slipped and cut his arms, saying there was 'a lot of blood'. Ms D asked the caller if Mr A was awake, with the caller responding, 'He's lying on the ground.' Ms D then asked if Mr A was conscious and if he was breathing, and the caller confirmed that Mr A was both conscious and breathing. After confirming with the caller that Mr A was bleeding from his lower arm, Ms D asked whether he was 'completely alert', with the caller responding that Mr A was alert but 'passing out slowly'.

27. Ms D asked again about Mr A's breathing, saying, 'Is he breathing normally,' with the caller responding, 'I'm not sure.' Ms D asked the caller to get closer to Mr A and check, also asking the caller if someone else was on the line with emergency services. The caller responded: 'He's not — he's just staring blankly.' Ms D asked again, 'Yeah is he breathing normally?' to which the caller responded, 'Yeah he's breathing.' The call transcript shows that Ms D then asked whether Mr A was still bleeding and whether the blood was 'spurting or pouring out?'. The caller advised that the blood was 'dripping out'.

28. Ms D advised the caller that she was organising help and requested that they stay on the line while she gave instructions on how to stop the bleeding. She told the caller to 'get a clean, dry cloth or towel and tell [her] when [the caller had] found it'. After advising that they could not find a towel or cloth, the caller told Ms D that another person on the scene was calling an ambulance. Ms D told the caller they could hang up, before saying: 'If there's

someone else on the line with the ambulance, I'll let you go okay?' The caller responding 'okay' and the call was disconnected at 3.42pm. The call duration was 3 minutes and 43 seconds.

29. At 3.41pm, the incident entered the dispatch queue triaged as protocol *'Traumatic injuries — Serious haemorrhage'* and was assigned the response priority of ORANGE 2. St John's Patient Transfer Service Prioritisation Framework classifies an ORANGE 2 priority as being a 'time sensitive transfer'.

30. Ms D told HDC that she followed the process that she had been taught since being signed off as a call-handler, and she thought this to be correct.

31. Ms D told HDC: 'This job will stay with me, and I am truly deeply sorry to [Mr A's] family.'

Ambulance dispatch and arrival

32. At 3.44pm, the two calls were merged in the system and were re-triaged as an ORANGE 1 response. As ORANGE 1, this incident met the criteria for immediate dispatch of an ambulance. St John told HDC that initially, there were no ambulances available for dispatch.

33. St John told HDC that it uses software that analyses the information provided during the 111 call and provides a predefined priority of ambulance dispatch.[4] St John said that when there are no ambulances available to dispatch for an incident, the incident is added to a 'pending queue' for an ambulance dispatch. The dispatcher is then responsible for reviewing the incident and should consider the following aspects before confirming dispatch of an ambulance to the most appropriate incident:

- Priority of the incident (ie, the colour code — such as ORANGE 1) — the higher the priority the more urgent.
- Time the incident has been waiting in the pending queue.
- The resource/skillset needed to provide the appropriate care to the patient.
- LTNZ Rules and regulations for meal breaks and fatigue management.
- The distance from where the available ambulance, if assigned, travels (estimated time of arrival to scene).

34. At the time the incident entered the dispatch queue at 3.41pm, Relief Dispatcher Mr F was overseeing the channel.[5] Mr F was employed by St John in the Ambulance Communication Centre and had been in this role for many years. St John told HDC that when the closest available ambulance, Ambulance 1, became available at 3.57pm, this ambulance should

[4] The priority of a call is determined by a clinical triage tool called the Medical Priority Dispatch System (MPDS) to determine the severity of the patient's condition. A code is assigned following structured questions that are asked by the call-handler. The code is made up of three elements. The first is the main complaint, the second is the priority and is associated with colour-response priorities, and the last is additional clinical information that may be useful.

[5] I note that Mr F initially stated that medical dispatcher Ms E was on duty at the time. However, St John has confirmed that it was Mr F on duty.

have been dispatched to the incident involving Mr A. Instead, Mr F put this ambulance on a rest break. St John also noted that another ambulance became available at 4.03pm, which was dispatched to another lower acuity incident.

35. St John said that during the incident, a handover of dispatch personnel occurred (to enable dispatch personnel to complete meal breaks), which further contributed to the reduced awareness of a high-priority incident waiting for an ambulance to be dispatched.

36. Mr F told HDC that there was not much detail in the incident information, which made it difficult to make accurate dispatch decisions. Mr F believes he would have sent an ambulance to an ORANGE 2 incident over this incident, due to the lack of notes added to the incident and the time that the incident had been waiting in the queue despite this contravening the Ambulance Dispatch Guidelines that say an ORANGE 1 incident should be dispatched before an ORANGE 2. Mr F said that he understands the requirement for ORANGE 1 incidents to be dispatched immediately where possible, and he acknowledged that he did not do so in this instance despite attempting to make the 'best decision possible'.

37. Mr F said that he was relieving the channel for a short time and did not know whether the incident had been notified to a Clinical Support Officer (CSO). CSOs are available for both call-handlers and dispatchers to escalate incidents for a review and for clinical advice. CSOs are clinicians who are able to review incidents at the call-handler or dispatcher's request or may request a call to be transferred to them to gain important information from the scene to aid in clinical care, decision-making, and making dispatch recommendations. Mr F said that these events have emphasised to him the need to follow guidelines and escalate calls when needed.

38. Medical dispatcher Ms E returned from her break at approximately 4.00pm and received handover from Mr F. Ms E told HDC that at 4.04pm she added a note to the call that there was a response delay as all relevant ambulances were committed to other incidents. She told HDC that she planned to assign Ambulance 1 to respond to the incident after they had completed their rest break.

39. Ms E reviewed the availability of all the ambulances at 4.19pm and decided to assign Ambulance 2 to respond, with an ETA of 6 minutes and 42 seconds.

40. Ambulance 2 arrived at the scene at 4.32pm. However, they were informed at the scene that Mr A had already been transported to the public hospital by his son in a private vehicle, almost 40 minutes earlier. Therefore, the incident was closed.

Subsequent events

41. Mr B said that after terminating the call with St John, he tied his father's hand in a t-shirt as tightly as he could, lifted his father up and loaded him in the work van before rushing him to the public hospital Emergency Department (ED). Mr B told HDC that his father was still alive and breathing when he arrived at the public hospital ED and handed over his father to staff.

42. Upon arrival at the public hospital at 3.56pm, Mr A was triaged immediately, and resuscitation commenced shortly afterwards at 4.01pm. The ED summary notes that Mr A had active arterial bleeding from a large laceration in his ante-cubital fossa (the front part of the right elbow) and had unrecordable blood pressure and oxygen saturation.

43. Sadly, despite a lengthy resuscitation, Mr A was pronounced deceased later that day.

Patient Safety Incident Review

44. St John conducted a Patient Safety Incident (PSI) review into the incident at the time and provided HDC with a copy of the review and its findings. The PSI is confusing regarding which call-handler took which 111 call, and regarding the protocol that was assigned to each of these calls.[6] There is also some ambiguity in respect of the order in which the calls occurred. The summation of the PSI review immediately below reflects what is said in the review, albeit that there is some considerable doubt about its accuracy with reference to the transcripts of the calls (that is, it appears to mix up the calls). This is discussed in more detail in the opinion section of this report.

Call handling

45. The PSI review found the initial 111 call to be only partially compliant with St John's procedures. The PSI review noted that when the call-handler asked the caller, 'Is he breathing normally?' and 'Is the blood spurting or pouring out?', the responses were ambiguous and further clarification was needed for the call-handler to record the answer as 'yes' or 'no' confidently.[7]

46. St John's review also noted that during the same call it was confirmed by the caller that another person on the scene was currently on the phone with another call-handler, who could be heard in the background giving bleeding control instructions, and therefore this call was disconnected.

47. The PSI review found the second 111 call to be non-compliant due to several errors with the call-handling process, which contributed to the failure to identify the seriousness of the incident and escalate it to a CSO for further review and clinical advice.

48. St John told HDC that call-handlers are not clinically trained, and the CSO desk was not notified that an urgent review was needed, which should have been done in accordance with the 'Emergency Call Handling' SOPs (2.10.15).

49. The PSI review identified that throughout the call, multiple comments were made to indicate the seriousness of the injury and that the bleeding was not controlled. Section

[6] In Ms D's statement she told HDC that she took the second call at 15:40, which was assigned incident number 2 and assigned priority Orange. In an email, St John told HDC that the first call was assigned incident number 1 and was taken by Ms D, and that the second call was assigned incident number 2 and was taken by Ms C. When HDC discovered this issue, we requested further clarification from St John. In a subsequent email, St John provided a correction to this previous information, advising that the call-handler for the first call (incident number 1) was Ms C, and the call-handler for the second call (incident number 2) was Ms D.

[7] The PSI review attributes the discussion about whether blood was 'spurting or pouring out' to the first call. On review of the call transcripts, these discussions occurred during the second call (incident number 2).

2.10.2 of St John's Call Handler Responsibilities SOPs states that call-handlers must '[e]nsure any additional information obtained relating to the patient and/or incident is recorded in the incident comments'. The PSI review found that no notes were added to the incident regarding the seriousness of the bleeding, the call-handler did not provide the appropriate instructions for bleeding control, and the CSO was not notified that an urgent review was needed.

50. In subsequent information provided by St John, it advised that the call review of the second 111 call also found that no 'override' was selected when the caller advised that there was obvious deformity to the limb.[8] Doing so would have sent the incident to the dispatch queue immediately for ambulance dispatch while further information was gathered.

51. The St John SOPs 'Reconfiguring Response Priority' policy (Section 2.15.5) necessitates that when a caller has advised of a limb injury when asked what part of the body has been injured, the call-handler is required to follow up by asking: 'Does the limb look grossly deformed or is the bone visible?' The policy states that if the caller responds 'yes' to this question, the caller is required to select the DELTA Override code in the ProQA 'send to queue' screen, which sends the incident, including its status (eg, ORANGE 1) to the dispatch queue while further information is recorded.

52. Ms D acknowledged to HDC that she did not provide the appropriate instructions for bleeding control, and she did not add notes to the incident report regarding the seriousness of the bleeding, nor did she notify the CSO that an urgent review was needed.[9] She said that she was not aware of the protocol requiring her to notify the clinical desk, or that she was missing vital information. She stated that she has since received further training and coaching and now knows the protocols.

53. The call-handling errors were identified as an adverse event.

Dispatching

54. The PSI review concluded that the failure to assign the first available ambulance to attend to Mr A was an adverse event.

55. St John told HDC that in accordance with the 'Dispatch Guidelines' SOPs (3.21.1a EAS Prioritisation Framework), an ORANGE 1 incident met the criteria for immediate dispatch of an ambulance. The PSI review found that while initially there were no ambulances available to dispatch, ambulances became available at 3.57pm and 4.03pm that were not allocated to respond to the incident. Had they been dispatched, they would have arrived at the scene at 4.05pm and 4.07pm respectively, and instead they were dispatched to lower acuity incidents. However, the PSI review noted that although the incident had been coded as ORANGE 1, there were no obvious notes in the incident report that alerted the dispatchers

[8] Discrepancies regarding the discussion of limb deformity have been identified. St John told HDC that during the second call, no override was selected when the caller advised that there was obvious deformity to the limb. When comparing this to the call transcripts provided by St John, the discussion of limb deformity occurred during the first call.

[9] If Ms D's statement is correct, then the call transcript provided to HDC reveals that this is the second call, which was terminated by Ms D when she discovered that someone else was on the line with St John.

to the seriousness and uncontrolled nature of the bleeding, and therefore the need for an ambulance to be dispatched immediately.

56. St John's PSI review of the dispatching also noted that the change of dispatchers at the time of the incident, to enable dispatch personnel to complete meal breaks, 'further contributed to the reduced awareness of a high-priority incident awaiting dispatch'. Regarding the meal break and handover of information process, the PSI review determined that the SOP was followed between the dispatcher (Ms E) and the relief dispatcher (Mr F) as there were no obvious notes documented within the incident report to indicate immediate ambulance response was required.

57. The PSI review noted that ORANGE 1 incidents allow for the completion of meal breaks, if already being taken, before an ambulance is dispatched. I note that the St John SOPs also state that 'rest breaks must not be broken for ORANGE 1 incidents'. St John's finding was that when the nearest ambulance (Ambulance 1) became available at 3.57pm, putting it on a meal break was an error in judgement, and the failure to assign this ambulance constituted an adverse event, as it should have been dispatched immediately after becoming available.

Relevant policies

58. Relevant policies are set out in Appendix A.

Response to provisional opinion

Mrs A and Mr B

59. Mrs A and her son, Mr B, were given an opportunity to comment on the 'information gathered during investigation' section of the provisional opinion, and to date have not commented.

St John Ambulance Service

60. St John was given an opportunity to comment on the provisional opinion. St John said that it accepts the breach finding and the recommendations. St John also acknowledged that these events occurred at a time that was difficult for all St John personnel due to the COVID-19 pandemic.

61. St John told HDC that approximately 70 dispatch handovers occur per shift and, while it had not seen high adversity incidents during this complex and high-risk period of the dispatch process, it accepts that there is room for improvement.

Opinion: St John Ambulance Services — breach

Introduction

62. As a healthcare provider, St John had a responsibility to provide Mr A with an appropriate standard of care in accordance with Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

63. The PSI review of these events has highlighted that multiple staff at St John failed to follow the relevant policies in place at the time. Comments from staff also indicate a lack of knowledge and understanding of St John policies and procedures. This lack of understanding

and lack of clarity in some policies resulted in several individual errors, both in call-handling and dispatching. Collectively, these indicate systemic issues for which St John is responsible.

Incident management — breach

Call-handling errors

64. As described above, two call-handlers made errors in their handling of the two 111 calls. St John identified the errors in the call-handling as an adverse event. The PSI review concluded that the first call was only partially compliant with St John's procedures, and the second call was non-compliant with St John's procedures. Notwithstanding my concerns about the accuracy of the PSI review (in that it appears to mix up the two calls), collectively it identifies errors in the call-handling, which I accept and have relied upon.

65. The PSI review identified that during the first 111 call, further clarification was needed from the caller to confidently record a 'yes' or 'no' answer to the system-generated questions regarding the nature of Mr A's bleeding. Across the two calls, the call-handlers did not adequately determine the severity of Mr A's bleeding and record this in the incident notes, as required by the 'Call Handler Responsibilities' SOPs, and they did not provide appropriate instructions to the callers to control the bleeding. These errors resulted in both call-handlers failing to recognise the seriousness of the incident.

66. Ms D commented that she was following the process that she had been taught during her call-handler induction, which she thought to be correct.

67. I am concerned that similar errors were made by both call-handlers during the calls they were managing. In my view, this indicates a broader systems concern about the adequacy of the training provided to call-handling staff in obtaining appropriate information from callers and recording it on the incident, and in providing appropriate information to the caller.

68. The PSI review also highlighted that the Override code was not selected when the caller advised of obvious limb deformity. The 'Reconfiguring Response Priority' SOPs policy (2.15.5) necessitates that when a caller has advised of a limb injury when asked what part of the body has been injured, the call-handler is required to follow up by asking: 'Does the limb look grossly deformed or is the bone visible?' The policy states that if the caller responds 'yes' to this question, the caller is required to select the DELTA Override code in the ProQA 'send to queue' screen. Had the 'Reconfiguring Response Priority' policy been followed, and the Override code been selected, the incident, including its status (eg, ORANGE 1), would have been sent to the dispatch queue while further information was gathered from the caller.

69. In my view, the errors that have been identified with the call-handling represent an organisational failing for which St John is responsible rather than isolated individual errors. I consider that this highlights a need for St John to review the training and support provided to its staff in this area.

Missed opportunities to escalate to CSO

70. St John's Emergency Call Handling SOPs (section 2.10.15) set out the process for call-handlers to follow when 'request[ing] additional support from a CSO', including the process for making the request for a review and that for an urgent review. The 'Dispatching Guidelines' SOPs also state that it is the responsibility of dispatchers to 'where appropriate seek advice from [CSOs]'.

71. The PSI review identified that a CSO was not notified of the need for an urgent review and clinical advice on this incident. I consider that multiple opportunities were missed to escalate to a CSO.

72. Ms D stated that she was unaware of escalating calls to a CSO. I am concerned that Ms D was unaware of the policy around escalation of calls to the CSO in order to have a clinician review the incident.

73. I note that in accordance with the 'Emergency Call Handling' and 'Dispatching Guidelines' SOPs, Ms C, Ms D, Mr F, and Ms E all had the discretion to escalate this incident to the CSO and did not do so.

74. In light of Ms D's statement and the fact that none of the St John personnel involved in this incident escalated the call to a CSO, I am concerned that there is a gap in knowledge about when an incident should be escalated to a CSO, indicating a further systemic issue that affected the care provided to Mr A by St John. This is another area in which the adequacy of the training provided to staff on this process needs to be reviewed.

Dispatching

75. The PSI review into the dispatching of this incident identified that there was a failure to assign the first available ambulance to attend to Mr A, noting that a lack of incident notes and a change of dispatchers may have contributed to the decisions made by the dispatchers. St John found that the nearest ambulance (Ambulance 1) being put on a meal break when it became available at 3.57pm was an error in judgement by Mr F. Mr F told HDC that he is aware of the guidance in the St John SOPs for ORANGE 1 incidents to be dispatched immediately where possible, after all PURPLE and RED incidents, and he acknowledged that he did not do so in this instance.

76. The 'Dispatch Guidelines' SOPs state that rest breaks should not be broken for ORANGE 1 incidents. In my view, this wording is unclear because it could read as applying to both a rest break that has already commenced, or a rest break that is due (as was the case here). The findings of the PSI review clarified this and stated that rest breaks should not be broken when they have already been commenced. However, when reading the policy, it remains unclear where an ORANGE 1 incident is pending dispatch whether there is a discretion as to whether to put an ambulance on a rest break when it is due one.

77. In my view, the lack of detail in the SOPs around when rest breaks are legally mandated, and what to do when an ambulance is due a rest break (but has not started it) creates a risk of confusion when making dispatching decisions, and provides insufficient guidance as to the extent, if any, of the discretion as to when to dispatch an ambulance. I am concerned about

the lack of guidance around the existence and exercise of discretion when dispatching ambulances, and I have made recommendations in this respect.

78. Mr F and Ms E, who were involved with the dispatching decisions for this incident, also made conflicting statements to this office about who was on duty at the time the incident entered the dispatching queue. I also note that neither dispatcher's response mentioned the availability of the 16.03 ambulance, and it is unclear who was responsible for the dispatching decisions when this ambulance became available. I am concerned that this was not clarified by St John.

79. It is the responsibility of St John to have clear and appropriate policies in place in order to guide staff and to ensure that the responsibilities and expectations of staff are consistent. I am concerned that the current policies in place to guide the dispatching decisions are unclear and inconsistent with St John's expectations.

80. I am also concerned by St John's comments in respect of the change of dispatchers and the impact this may have had on the awareness of a 'high-priority incident awaiting dispatch'. St John is responsible for having robust systems and processes in place to ensure that staff handovers do not disrupt or impact the delivery of its services. I encourage St John to review its current handover process and the associated policies to ensure that there is clear guidance on who is the responsible dispatcher and at what point in the handover process this responsibility shifts to the relief dispatcher. This will help to ensure that no important information is missed, and all duties are performed during this handover period.

81. I consider that the confusion over the responsibility for the dispatching decisions, the lack of clarity in policies, and the suggestion that a handover in staff affected the care provided, indicates further systemic issues that may have contributed to the delay in dispatching an ambulance to Mr A.

Provision of welfare checks

82. St John's SOP 'Welfare Checks CCSOP 1.20 Version 2.9' states that welfare checks are to be completed at regular intervals and serve as an opportunity to review a patient's condition and/or provide further instructions or information.

83. The SOP stipulates:

> 'It is our policy to ensure that all incidents are monitored, and welfare checks are completed every 30 minutes (including assigned incidents) prior to arrival or emergency services. The welfare check dashboard is a live tool providing clear visuals of the pending queue to enable Call Handlers to complete welfare checks in a timely manner regardless of centre of origin.'

84. The policy states that collectively, all personnel have a responsibility to ensure that welfare checks are completed in a timely manner. However, it also states that the Call Handling Team Leader/nominated delegate is responsible for ensuring that welfare checks are completed on time by monitoring the dashboard and queue and tasking an individual to carry out the welfare checks.

85. In my view, conducting welfare checks every 30 minutes (as outlined in St John's SOPs) is an appropriate tool in mitigating risks when there is a delay in ambulance dispatch, regardless of the reason for the delay. Mr A was due to receive a welfare check at 4.12pm, but this did not occur. I am concerned that in this case, St John did not have a robust system in place to schedule and ensure that a timely welfare check occurred for Mr A.

Conclusion

86. When reviewing the evidence that was available at the time of the events, it is apparent that an ambulance should have been dispatched sooner to attend to Mr A. Errors by multiple staff in both the call-handling and the dispatching, and the absence of a welfare check, contributed to this delay. As outlined above, I have identified several issues with St John's policies and procedures in place at the time of these events, and I am concerned about the number of instances in which staff failed to follow the policies or were unaware of their contents.

87. I consider that the errors identified in the management of this incident resulted in a systemic failure to provide Mr A with an appropriate standard of care and, as such, I find that St John breached Right 4(1) of the Code.

PSI review — adverse comment

88. Following these events, St John conducted an internal review into the management of this incident (the PSI review) and provided a copy to HDC. I am concerned about the accuracy of the PSI review, especially in respect of the information included about the call-handling. I have reviewed the call transcripts, the PSI review, and the statements of the St John staff, and I am unable to reconcile them. In the responses received from St John, there was confusion regarding which call-handler was responsible for each of the 111 calls, the triage protocol that was assigned to each of the calls, and the order the calls were received, with some of my specific concerns noted above. In the PSI review itself, statements from the second call are ascribed to the first and vice versa. This has made it difficult to determine where the criticisms outlined in the PSI review fall.

89. I am concerned about the difficulty this confusion and inconsistency poses in assessing the care provided by the individuals responsible for the management of this incident and therefore determining the further support and training that may be required for the individuals. I conclude that the PSI review is not reliable evidence for the purpose of assessing the care provided by individuals, and I have taken that into consideration in reaching my conclusions.

90. Accurate adverse event investigation and reporting is important for identifying and minimising risks relating to patient harm in order to reduce the likelihood of recurrence and improve patient safety. Therefore, I consider that when St John became aware of the error in reporting regarding which call-handler was responsible for each of the calls, this should have prompted a subsequent review into the incident to ensure that this error had not affected any of the findings. I have made recommendations in this respect.

Changes made since events

91. St John identified the following recommendations in its Patient Safety Incident Review:

- To arrange a formal face-to-face meeting with Mr A's family/whānau and advocacy support to 'enable the findings from the investigation to be conveyed in person and to offer an apology'.
- To advise the Coroner of the St John investigation findings.
- To debrief the call-handler for the second 111 call (Ms D) with reference to this incident. This was completed the following month.
- To debrief the dispatcher with reference to this incident to review dispatch decisions and rationale for dispatch of an ambulance to the highest priority incident when there is an available ambulance. This was completed ten days after the incident.

Recommendations

92. I recommend that St John:

a) Provide a written apology to Mr A's family. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Review the process for dispatch personnel handovers to enable staff handover to ensure continuity in dispatch queue management and awareness of high-priority incidents. St John is to report back to HDC with evidence of having completed this, including providing a copy of any policy or procedural documents developed, within six months of the date of this report.

c) Review the 'Dispatch Guidelines' SOPs to ensure clarity and consistency in the guidance for the provision of rest breaks when making dispatching decisions. St John is to report back to HDC with evidence of having completed this review, including providing a copy of any amendments to the current policy or any procedural documents developed, within six months of the date of this report.

d) Review the current training provided to dispatchers to ensure that there is sufficient guidance for staff on the expectations around dispatching. St John is to report back to HDC with evidence of having completed this review, including providing a copy of any policy or induction documents developed, within six months of the date of this report.

e) Provide HDC with an update on the progress of the recommendations identified in the internal review (PSI) into these events, within six months of the date of this report.

f) Review the Patient Safety Incident policy to ensure that there are sufficient quality assurance processes in place to avoid factual and interpretation errors by the drafters of PSI reviews. St John is to report back to HDC with evidence of this policy review and any amendments, within six months of the date of this report.

g) Use an anonymised version of this report to conduct a training session for call-handlers, with particular focus on clarifying the nature of bleeding in acute situations and

providing appropriate bleeding control advice. St John is to report back to HDC within six months of the date of this report.

Follow-up actions

93. A copy of this report with details identifying the parties removed, except the name of St John, will be sent to Ambulance New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Relevant St John policies

Standard Operating Procedure

St John
Here for Life

DISPATCH GUIDELINES
DPSOP 3.21
Version 6.6

Purpose
This procedure is to inform Ambulance Communications personnel in effective and efficient incident resource deployment to ensure optimum ambulance service delivery to improve patient outcomes.

Policy
It is our policy to optimise the use of ambulance resources to ensure effective and efficient incident coordination, ensuring the most appropriate resource is responded, relative to the patient's clinical need.

Procedure
It is the responsibility of the Dispatcher to;

- Assess all incidents as they arrive to the pending queue
- Prioritise incidents based on incident type, priority and the information contained within the incident notes
- Dispatch incidents, considering notes and time in queue and resource availability
- Where appropriate seek advice from Clinical Support Officers (CSO's)
- Upgrade incidents where there is clear information noted that identifies a higher response is required as per DPSOP 3.20 Reconfiguring Response Priorities
- Notify Centre of allocated resource (after assignment) if a recommended resource is assigned outside of a Dispatcher's jurisdiction
- Escalate as per CCSOP 1.41 Manager Notifications.

ORANGE INCIDENTS

General Guidelines

1. Rest breaks must not be broken for ORANGE incidents
2. Crew should elect to respond under lights if doing so will save clinically significant time
3. Unit must not be allocated if it is likely the job cycle will take the crew over their working hours or past their finishing time
4. Dispatch ORANGE1 before ORANGE2 incidents.

Dispatch Process
Dispatchers MUST

1. Review incident notes and launch Initial Assign (IA) and accept and respond the most appropriate resource(s)
2. Consider First Response Units/Community First Response Groups.
3. PRIME should not routinely be dispatched to ORANGE incidents but may be dispatched if it is clear PRIME will bring additional skills which are not being met by local ambulance resourcing (for example IV pain relief). If there is any doubt consult with a CSO
4. Consider Fire First Response Units for ORANGE1 incidents. Only send Fire First Response where it is apparent, they will make a difference to the clinical outcome of the patient. If unclear discuss this with the CSO
5. If the crew is unable to advise they are travelling under lights via their MDT. Enter /UL into the incident comments.

Resource Guidelines

- **DELTA** > Based on availability level, Dispatch to complex or unusual incidents. Delta units may request to be assigned to incidents where the incident is serious, unusual or a person in education/internship programme is attending.
- **OSCAR** > Generally are not co-responded for ORANGE incidents however is based on availability level. Oscar's must be backed up to be relieved of their clinical duties.
- **TANGO** > Dispatch when the unit is the most appropriate based on skill level to the incident. TANGO units are the preferred option for clinical backup.

3.21.1a EAS Prioritisation Framework

Priority	% status 0, 1 or 2	Resources dispatched or requested	
PURPLE *Suspected cardiac or respiratory arrest*	60%	Immediately send: • Closest Ambulance • Closest ICP if practical • Closest Unit (including OSCAR, DELTA, FRU/FRG) • Notify PRIME • Request Fire Co-Response • GoodSAM (automatic for selected incidents) • Break rest-break	UNDER LGHTS
RED 1 *Appears immediately life threatening*	30%	Send: • Most appropriate resource • Closest FRU/FRG • Notify PRIME if no ICP or PARA within 30 mins or any incident with multiple patients. • Request Fire First-Response • Break rest-break	
RED 2	25%	• Same rules as RED1. Dispatch RED1 before RED2	
ORANGE 1 *Appears serious but not immediately life threatening*	15%	Send: • Most appropriate resource • Closest FRU/FRG • Consider consultation with CSO for PRIME • Consider Fire First Response • Do not break rest break	ROAD SPEED (Under lights if clinically significant time saving)
ORANGE 2 *Appears serious but not immediately life threatening*	10%	Send: • Most appropriate resource • Consider FRU/FRG • Consider consultation with CSO for PRIME • Do not break rest break	
GREEN 1 *Does not appear to be serious*	5%	Send: • Most appropriate resource • Consider FRU/FRG • Consider consultation with CSO for PRIME • Do not break rest break	ROAD SPEED
GREEN 2 *Does not appear to be serious*	<5%	Send: • Most appropriate resource • Consider FRU/FRG • Do not break rest break	
GREY *Clinical Telephone Advice*	Very low incidence	• 111 Clinical Hub for triage	

Clinical Communications – Standard Operating Procedure		
Title: DPSOP 3.21 Dispatch Guidelines	Issue No: v6.6	Doc No. DPSOP 3.21
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Authorised by: Ambulance Communications SLT	Date for Review: Nov 2021	

Names (except St John) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Standard Operating Procedure

St John WELLINGTON FREE AMBULANCE

RECONFIGURING RESPONSE PRIORITIES
CHSOP 2.15
Version 3.2

Purpose
This procedure is to direct Call Handlers in the management of an incident that may require reconfiguring of the assigned response priority to better meet a patient's clinical needs or circumstances.

Policy
It is our policy to triage all emergency incidents using ProQA/MPDS. Each of the ProQA determinants has been aligned to an appropriate response through clinical analysis and Clinical Director sign-off.

It is recognised that from time to time additional information cannot be factored into the logics of ProQA and under these circumstances the response priority may require reconfiguring in order to better meet the patient(s) individual needs or circumstances surrounding the incident. Under these circumstances it is the responsibility of personnel to consider the requirement to reconfigure a response.

2.15.5 Overriding a Response Priority
For all incidents where the below criteria is met, Call Handlers are required to select the DELTA Override code in the ProQA 'send to queue' screen and enter the reason for selecting the override in the incident comments using the appropriate shorthand comment

Protocol 04: Assault/Sexual Assault/Stun Gun, Protocol 17: Falls, and Protocol 30: Traumatic Injuries

1. If the caller has confirmed there is a limb injury at the question "What part of the body was injured?" and the caller hasn't volunteered any information regarding the injury, the EMD is required to ask, "does the limb look grossly deformed, or is the bone visible?"
    - If yes, the EMD is required to select the DELTA Override code in the ProQA 'send to queue' screen.
    - If no, the EMD is required to continue with ProQA as per usual.
    - If previously volunteered, then there is no requirement for the EMD to ask the question.

2. At the question "What part of the body was injured?" If the caller has earlier volunteered that there is a dislocation, the bone is visible/breaking through the skin, or a gross deformity, the EMD is required to select the DELTA Override code in the ProQA 'send to queue' screen.
   Note: Dislocations to the hip, shoulder and jaw can lead to neurovascular damage and therefore are included as a gross deformity. Swelling to the upper leg is also to be regarded as a gross deformity. This does not apply for finger, thumb, or toe injuries.

Standard Operating Procedure

St John
Here for Life

WELFARE CHECKS
CCSOP 1.20
Version 2.9

Purpose
Welfare checks are required to be completed at regular intervals where there is a delayed response and serve as an opportunity to review a patient's condition and or provide further instructions or information. This procedure outlines the process for managing welfare checks before ambulance arrival.

Policy
It is our policy to ensure that all incidents are monitored, and welfare checks are completed **every 30 minutes** (including assigned incidents) prior to arrival of emergency services. The welfare check dashboard is a live tool providing clear visuals of the pending queue to enable Call Handlers to complete welfare checks in a timely manner, regardless of centre of origin.

Procedure
1.20.1 Responsibility of welfare checks
Collectively all personnel have a responsibility to ensure that welfare checks are completed in a timely manner.

The Call Handling Team Leader (CHTL) / nominated delegate is responsible for ensuring that welfare checks are completed on time by monitoring the dashboard and queue appropriately tasking an individual/s (based on staffing numbers) to welfare checks when any of the following situations occur

- 1 or more incidents are queued as "overdue'.
- 3 or more incidents are queued as "due soon"
- 5 or more incidents are queued as "due in time"

Where required the CHTL/Delegate should consider discussing with their counterparts to arrange sharing the workload or dedicating an individual Call Handler to complete welfare checks across the centres.

Where a Dispatcher identifies that a welfare check is required and has not been completed the Dispatcher can enter **/wele** to escalate to the CHTL (or delegate)/DCM to arrange completion.

1.20.2 Identifying an incident due for a welfare check
To identify an incident for a welfare check Call Handlers must utilise the 'Welfare Check Report' which outlines the incident requiring the welfare check by ID number (which correlates to the ID number in InformCAD) and by time as outlined in the welfare check status.

Welfare Check Status

RED	Overdue by 'time'
ORANGE	Due soon 'time'
GREEN	Due in 'time'

Standard Operating Procedure

St John WELLINGTON FREE AMBULANCE

EMERGENCY CALL HANDLING
CHSOP 2.10
Version 9.6

Purpose
This procedure is to guide Emergency Medical Dispatchers (EMDs) in handling emergency calls.

Policy
It is our policy that all calls from the public must be triaged using the Medical Priority Dispatch System (MPDS) inclusive of calls where the caller is asking for medical advice or is unsure about the help they may need. EMDs must gain information about the incident location and the condition of the patient(s). This information is used to prioritise a response and determine what resources are required for the incident.

2.10.12 Requests to transfer to CSO/CPA/CSOAD
Clinicians may request a call be transferred to them to gain important information directly from scene to aid in clinical care, decision making and making dispatch recommendations. When required, they will enter **/CSOTELE** – [PRIVATE] Please teleconference in the CSO on extn **** into the incident comments. When this occurs, the call handler will:

1. Complete ProQA/MPDS and give all relevant PDIs/PAIs as required
2. Once Card X1 is complete, or the EMD is staying on the line, or the EMD is at the end of the call, the EMD will advise the caller they are going to conference in a clinician to assist them, the line will go quiet but to stay on the line
3. The EMD will use the conference function to bring the CSO into the call, and introduce the CSO to the caller
4. If ProQA requires the EMD to stay on the line, they will remain on the line and once the CSO has finished their interaction, they will verbally hand the caller back to the call taker. If not required to stay on the line, the call handler will hang up once contact is confirmed between the CSO and caller.

2.10.15 Notifying for a Clinical Review
To request additional support from a CSO, Call Handlers should use the following notifications:

- **'/caar'** to request a CSO view the incident.
- **'/csor'** to request a CSO urgently view the incident

Supporting information should also be added to any request to identify the Call Handlers concerns.

If an incident is GREY, a Registered Nurse or Paramedic has already been identified as needing to call the patient back. If the Call Handler believes it is unsafe for the patient to wait 10-30 minutes for a call-back, then they should notify **'/csor'.**

Standard Operating Procedure

St John WELLINGTON FREE AMBULANCE

CALL HANDLER RESPONSIBILITIES
CHSOP 2.01
Version 2.2

Purpose
This procedure is to inform EMDs of their role and responsibilities while undertaking Call Handling duties.

Policy
It is the responsibility of all personnel to comply with all standard operating procedures while undertaking call handling duties to ensure that all requests for ambulance services are processed in an accurate, timely and professional manner.

Call Handlers must ensure there is no interruption to service delivery during shift handover. It is critical there are sufficient staff members available to receive phone calls at all times during the shift and during shift handover in all three centres.

2.01.5 Handover
The Call Handling Team Leader or Duty Centre / Team Manager will advise Call Handlers of any handover instructions that are required to be completed during the shift. Where there is limited access to the DCM / TMC and no CHTL then the off-going staff member will inform the on-coming staff member of any handover instructions. This may include but is not limited to;

- Pending incidents that are due for call backs.
- Process changes/updates that the on-coming staff member may/may not be aware of depending on when the communications was distributed.
- Notifications regarding road/traffic or health facility limitations.
- Any actions they are required to perform during their shift.
- **WFA Only**: Freedom alarm information (Sleeping alarms, faults, pending tests etc)

Note: The CHTL, DCM or TMC may allocate consoles to on-coming staff. This may be on a console that is already occupied.