

**Information and instructions given by paramedic
17HDC01734, 27 June 2019**

*Ambulance service ~ Call handler ~ Clinical support officer ~
Bleeding ~ Self transport ~ Rights 4(1), 6(1)*

Ten days after a woman had delivered her baby by Caesarean section, she woke up in a pool of blood. Her husband rang 111 and asked for an ambulance. The call handler established the address and telephone number and asked the man to describe the emergency. The call handler advised that she would organise help immediately, and told the man not to touch his wife's wound.

The call handler arranged for a clinical support officer (CSO) to call the man. The CSO confirmed with the man that his wife had had a Caesarean section, and that the bleeding was occurring from the wound. The man told the CSO that they had woken to feed the baby and had found a pool of blood in the bed, and that when his wife got up to go to the toilet she saw blood dripping across the floor. He also told the CSO that he had not sighted the wound and had not applied pressure to it.

The CSO confirmed the location for service and advised the man that "the next available ambulance [would] come to [him]". Following a discussion about whether or not the man should drive his wife to the hospital himself, the man told the CSO that he would take his wife to the hospital immediately.

The woman was admitted to hospital and taken to theatre for an evacuation of retained products of conception. She had suffered a secondary post-partum haemorrhage and required a blood transfusion.

Findings

It was held that the CSO breached Right 4(1) by not applying the correct response code, not giving instructions to control the bleeding, not recommending against self-transport, and not providing detailed instructions on what to do if the woman's condition worsened. It was also held that by failing to inform the man and his wife of the risks associated with self-transport, the CSO breached Right 6(1).

The call handler was criticised for failing to provide advice to control the bleeding.

The ambulance service was not found in breach of the Code.

Recommendations

It was recommended that the CSO and the call handler each provide a written apology to the family, and that the CSO undergo refresher training in the use of the triage system and the application of the various tools available during a call.

It was also recommended that the ambulance service provide refresher training sessions on surgical wound scenarios in relation to bleeding control instructions and what to say if a patient wants to self-transport to hospital, and provide a copy of the CSO's call review audits.