Transfer of patient to appropriate hospital
15HDC01841, 21 May 2018

Ambulance service ~ Transfer ~ Ischaemia ~ Destination policy ~ Right 4(1)

A woman with a previous diagnosis of atrial fibrillation felt that her left foot had gone cold during a transition period between the medications warfarin and dabigtran. The following day, she experienced pain in her leg and was having difficulty walking. That morning, she presented to her medical centre and was reviewed by a nurse and her general practitioner (GP). The GP advised the woman that if her leg did not improve by the afternoon, she was to return to see him. By 4pm the woman's condition had not improved and she returned to the medical centre. Her GP sent an electronic referral letter to a main centre hospital and then telephoned the ambulance service and asked for an ambulance to pick up the woman from her home address.

At 5.14pm, the call taker at the ambulance service recorded in the computer system that the GP had telephoned and told her that the woman had an ischaemic leg and was to be transported to the main centre hospital. The case was entered into the dispatch queue.

The ambulance service's formal destination policy at the time stipulated that patients with ischaemic limbs should be transported directly to one of two main centre hospitals. It also stated that all patients transported by road should be transported to the local hospital unless they have a "Doctor's Referral" and have been accepted by another hospital.

At 5.45pm, an Emergency Medical Dispatcher (EMD) recorded in the computer system that the woman was to be transported to a local hospital in the first instance, and noted that if the woman needed to go on to the main centre hospital, 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 a crew with two ambulance officers.

A transcript of the two radio conversations between the EMD and her Duty Manager was provided to HDC. During the first conversation, the EMD informed the Duty Manager that the GP had telephoned and told the call taker that the woman had an ischaemic limb. No mention is made in either conversation of the GP's request for the woman to be transported to the main centre hospital, and the actual destination of the call-out was not discussed. An ambulance officer on the crew dispatched contacted ambulance control on the way to pick up the woman. A transcript of this radio conversation was provided to HDC. The transcript established that the ambulance officer identified that the destination in the computer system was the main centre hospital, and asked for confirmation that they would be going there. Ambulance control replied: "No, it will go to [the local hospital] in the first instance." At approximately 7pm, the ambulance arrived at the woman's home, and at 8.32pm it arrived at the local hospital.

On arrival, the woman was told that she would need to stay the night at the local hospital and travel to the main centre hospital the following day. At 10.30pm that night the local hospital became aware that the GP referral was for the woman to be admitted to the main centre hospital. The local hospital sent a fax at 10.48pm requesting pick-up and a double-crewed ambulance at 11.45pm for transfer to the main centre hospital. This was logged by the ambulance service at 11.45pm, but no ambulance arrived.

Another fax was sent by the local hospital at 2am requesting transfer to the main centre hospital with a pick-up time of 3am. Intravenous heparin infusion was commenced at the

local hospital at 2.45am as per the district health board protocol. At 3.06am an ambulance was dispatched, and the woman was transferred.

Although its formal destination policy stipulated that patients with ischaemic limbs should be transported directly to one of two main centre hospitals, the ambulance service also told HDC that for resourcing reasons "there was an agreement in place at that time between the ambulance service and [the local hospital], 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." The ambulance service also referred to it being "customary" practice at the time of this incident to stop at the local hospital prior to transfer through to any other hospital by ambulance, and stated that this was a contributing factor in this case. In addition, the ambulance service said that it was customary practice for communication centre staff to factor in their local resources and attempt to manage these.

Findings

It was held that failures of several ambulance service staff demonstrated a pattern of poor care on a service level, for which ultimately the ambulance service is responsible. Not only did the dispatcher depart from the clear instructions of the GP 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 the woman to the local hospital either without, or despite, realising that she had a compromised limb. This series of failures meant that the woman was transported to the local hospital instead of the appropriate destination.

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

Recommendations

It was recommended that the ambulance service provide a written apology to the woman. 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 the ambulance service 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 the publication to HDC.