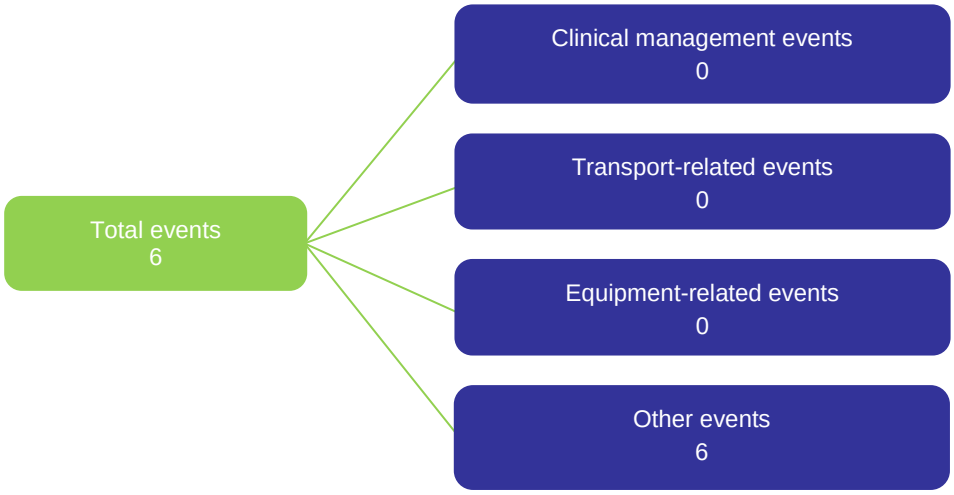
Emergency Ambulance Service Reportable Events: April - June 2018.

Total number of reportable events and near misses

- Six closed reportable events and near misses were reported to NASO for the period.
- Nil SAC one and two SAC two reportable events remain open as at the end of the quarter.



Other events

#	Summary of Reportable Event	Root Cause Analysis	Recommendations	Action Taken
REP3954	Incorrect coding of the initial 111 call resulted in the delayed dispatch of an EAS ambulance to a high acuity patient.	Inappropriate progression of the incident for clinical telephone assessment (CTA). Failure to select ProQA code '30D05: High Velocity Impact/Mass Injury' given the mechanism of injury.	Targeted training for High Velocity Impact/Mass Injury Coding be provided to all call handlers.	Targeted training enacted.

REP4543	There was a delay in emergency services reaching the scene of a high acuity patient due to an incorrect address being entered into the system.	The call handler had difficulty hearing the caller and misheard the street number of 448 as 44A. The call handler did not correctly verify the suburb. They entered a suburb that the caller initially indicated was incorrect and then did not await verification from the caller before sending the call to the queue and proceeding with further questioning.	The call handler is to receive additional training/coaching. The dispatcher is to receive additional training/coaching. The findings and learnings from this review are to be disseminated throughout Clinical Communications.	Additional training and coaching enacted. The findings and learnings of this review were disseminated throughout Clinical Communications.
REP4674	Multifactorial delayed dispatch and subsequent arrival at scene and provision of care to a high acuity patient due to concerns regarding scene safety.	Factor 1: There was a delay in the launch of Initial Assign and the assignment of an emergency ambulance. Factor 2: A three minute delay between the crew indicating they were responding and the ambulance responding. Factor 3: A delay in the crew arriving at the scene due to the dispatcher advising crew 'to remain at current location' (informal safe forward point).	Review of criteria for forwarding crews to safe forward points (SFPs).	Review scheduled for August – September 2018.
REP4757	Delayed dispatch of an emergency ambulance to a high acuity patient due to the initial 111 call being under triaged.	The initial 111 call was incorrectly triaged as a fall (17A02), resulting in a GREEN response priority, instead of chief complaint 28 which would have assigned a higher response priority. The caller was English as a second language (ESL) speaker and described the patient as having "fall down" and resulted in the call handler processing the call as a fall instead of a medical collapse.	The provision of Clinical Communications centre-wide training and induction training to include this reportable event as a case study to support training regarding ESL callers.	Inclusion of this reportable event as a case study to support training regarding ESL callers is yet to be enacted.

REP4793	Selection of an incorrect ProQA determinant resulted in the incident being under triaged and delayed the dispatch of an ambulance which resulted in a high acuity patient being transported to ED in a private vehicle.	The call handler overlooked the comments by the caller that the patient was “very sleepy.” The call handler did not recognise that the patient had a lowered level of alertness and that this should have resulted in the incident being assigned a RED response priority.	Further education and training to be provided to call handler regarding active listening and indicators of lowered levels of consciousness. The issuing of a reminder to all call handlers regarding the utilisation of Protocol 30 to triage ‘high velocity impact.’	Further education and training provided to call handler regarding active listening and indicators of lowered levels of consciousness. Reminder issued to one watch, yet to be issued to remaining watches.
REP5162	Delayed dispatch of ambulance and provision of care to a high acuity patient due to incorrect processing of the 111 call and all vehicles being committed to incidents.	Factor 1: The patient had not been assessed by a Nurse or Doctor and therefore the call should have been processed through ProQA not protocol 35. Factor 2: The incident was triaged as an ORANGE response due to the call handler not recognising the severity of the arterial bleed as a result of the registered nurse stating that the bleed was ‘potentially immediately life threatening’. This incident was received during a high volume workload period and the responding resource was diverted to a higher priority RED incident.	Further training and education to be provided to the call handler regarding the use of Protocol 35. Further training and education to be provided to the dispatcher in regards to the deployment plan. That a discussion/debrief of this incident be held with the residential aged care facility and that the process for triaging and prioritising calls be discussed.	Further training and education yet to be provided to call handler regarding the use of Protocol 35. Further training and education provided to the dispatcher. A discussion/debrief held with the residential aged care facility.