Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC01253)

Introduction

1. This report is the opinion of Deputy Health and Disability Commissioner Deborah James and is made in accordance with the power delegated to her by the Commissioner.

2. 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).

3. This Office received a complaint from the Nationwide Health and Disability Advocacy Service on behalf of Mrs A regarding concerns about the care provided to her late husband, Mr A. The complaint concerns the delay in dispatch of an ambulance to Mr A, who was experiencing heart attack symptoms.

4. The following issues were identified for investigation:

- *Whether The Priory in New Zealand of the Most Venerable Order of the Hospital of St John of Jerusalem (St John Ambulance Service) provided Mr A with an appropriate standard of care in 2020.*
- *Whether Ms B provided Mr A with an appropriate standard of care in 2020.*

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

5. The parties directly involved in the investigation were:

Mrs A	Complainant
St John	Ambulance service/provider
Ms B	St John call-handler

6. Further information was received from:

Ambulance Service 2	Ambulance service/provider
Mr C	Ambulance Service 2 call-handler
Mr D	St John dispatcher

7. Call-handler Ms E is also mentioned in the report.

Summary of events

8. Mrs A raised concerns about the care provided to her husband by St John and Ambulance Service 2 in 2020. At 6.05pm Mrs A made a call to 111 as Mr A was experiencing 'classic heart attack symptoms'. However, there was a delay in an ambulance being dispatched, so Mrs A transported Mr A to hospital herself. Sadly, Mr A experienced a heart attack and died prior to reaching the hospital. Mrs A's main concerns were that she was not advised earlier that no ambulance was available (particularly as the hospital was close enough for her to drive Mr A there herself); why no 'welfare check' was conducted by staff when no ambulance was available to be dispatched; and why the Fire Service was not called to attend when a defibrillator was available about 7 kilometres from their home.

Initial 111 call

9. Three National Clinical Communications centres (in Auckland, Wellington, and Christchurch) take 111 calls from anywhere in the country. St John and Ambulance Service 2 communications centres use a software tool called ProQA.[1] The software supports call-handlers to use a structured set of protocols to ask a series of specific questions, with the answer to some of the questions determining what further questions will be asked. At the end of the call-taking process, the software tool automatically selects a determinant that best aligns with the person's chief complaint and how unwell the person is suspected to be — referencing the information provided during the call. The incident is then sent through to a virtual dispatch queue for ambulance dispatch.

10. Mrs A's initial 111 call was picked up from the national queue at 6.08.46pm by call-handler Mr C. At the time, Mr C was in the process of completing his call-handler training and was being 'actively mentored' by a senior call-handler, Ms E.[2] Both Mr C and Ms E were employed by Ambulance Service 2. Ambulance Service 2 told HDC that when a call-handler

[1] ProQA 'reduces human error by recording every answer input by the calltaker. ProQA intelligently analy[s]es this information using time-proven expert logic to quickly determine the appropriate response determinants and Pre-Arrival Instructions for the case.'

[2] Ms E had the role of Training and Quality Co-Ordinator — Call Taking.

is in the mentoring stage of their training, the mentor is 'physically sitting with them, listening, advising, and reviewing the calls they handle'.

11. Ambulance Service 2 told HDC that Mr C commenced the questioning sequence as set out by the Medical Priority Dispatch System. Ambulance Service 2 provided HDC with a transcript of the initial call. Mr C asked Mrs A, 'Okay, tell me exactly what happened?' and Mrs A responded, 'Ah we have someone with chest pain, quite badly. Pin[s] and needles down his arms and chest pain on the left side.' However, Mr C did not further explore the reason for Mr A's symptoms or clarify with Mrs A exactly what had happened.

12. In response to further questions asked by Mr C, Mrs A advised that Mr A was breathing but in pain, that he was very red in the face, but that he was not clammy or experiencing cold sweats. Mrs A also advised that Mr A had never had a heart attack or angina.[3]

13. Mr C advised Mrs A that he was organising help; that she needed to reassure Mr A that help was being arranged; and that if his condition declined, she should call back immediately for further instructions. Mrs A then states: 'Okay, yes, they'll come from [town], so it will take them at least 20 minutes or so, so. Yip, very good.' Mr C responded: 'It will be the closest ambulance available so, um yip … But that help has been arranged.'

14. The call was given a response priority of ORANGE1. Ambulance Service 2 provided HDC with a copy of the 'New Zealand Ambulance Guidelines for Determining the Priority of Emergency Calls'. The guidelines state:

> 'MPDS/ProQA groups patients with the same clinical symptoms into one of 1,828 "determinant codes". It does not recommend response priority. It rates them into groups of extreme to low risk (echo, delta, Charlie, bravo, alpha and omega) but it is up to the ambulance organisation to determine what priority (response colour) we attach to each individual full determinant.'

15. The guidelines state that an ORANGE1 and 2 priority response have an expected response time of 20 minutes, and that the priorities are 'Urgent/Serious but an extra 12 minute response time is unlikely to decrease the patient outcome'.

16. Ambulance Service 2 told HDC that the patient information and response priority code were sent to the St John dispatch queue at 6.11pm. Ambulance Service 2 said that the call was completed at 6.13pm, following which its call-handlers had 'no further input into the call'. Ambulance Service 2 stated: 'As the patient was in the St John catchment area, any subsequent contact or [decision-making] regarding dispatch was made by St John.'

Dispatch

17. St John told HDC that the first dispatcher read the incident notes at 6.22pm but did not launch the Initial Assign tool.

[3] A type of chest pain caused by reduced blood flow to the heart. Angina is a symptom of coronary artery disease.

18. The dispatcher assigned to Mrs A's initial 111 call was St John dispatcher Mr D. Mr D had been employed in the St John Communications Centre since 2018. Mr D said that he had been a dispatcher since 2019.

19. At approximately 6.25pm, Mr D took over the dispatch of the channel. He said that he received a handover from another dispatcher, which involved debriefing on any last-minute crew changes, hospital diversion, and other pertinent information. Mr D stated that he was advised that Mrs A's call had recently entered the pending queue as ORANGE1, which is considered 'serious but not immediately life threatening'. At this stage, the call had been in the St John dispatch queue for 14 minutes (since 6.11pm).

20. At 6.55pm, Mr D launched the 'Initial Assign' tool, which searches all units within a certain area that are available for dispatch for an incident.

21. Mr D said that the Initial Assign tool acts as a 'safety net', to ensure that all possible resources are considered. The resources in the area included an ambulance that was responding to another ORANGE1 incident that had been pending since 5.10pm; a second ambulance that was with another patient at the time of the call but would become available at 9.09pm; and a third ambulance that was with another patient at the time of the call but would become available at 7.27pm. Mr D advised that even if two of the ambulances had been available, 'they wouldn't have been assigned to this incident before their rostered finish time of [7.00pm]' due to St John Policy.[4]

22. The IA tool also recommended the Fire First Response Unit (FFRU).

23. Section 3.21.2 of the St John Standard Operating Procedure (SOP) states under 'Orange Incidents' that dispatchers must also consider FFRUs but that they should '[o]nly send Fire First Response where it is apparent, they will make a difference to the clinical outcome of the patient'. The guideline states that if it is unclear whether the FFRU would make a difference to the clinical outcome of the patient, dispatchers should discuss this with the Clinical Support Officer.

24. A Fire First Response is a response by Fire and Emergency New Zealand (FENZ) with personnel and equipment equivalent to the ambulance sector clinical practice level of First Responder, with the aim of providing patient assessment and treatment until an ambulance resource arrives to assume management of the patient. St John told HDC that Fire First Responders are trained by St John to the First Responder Clinical Practice level and that all the equipment required is provided to FENZ by St John. St John advised that for a FENZ vehicle to respond to an incident, a minimum of one (preferably two) First Responders must form part of the crew. St John said that outside of legislative requirements and PURPLE incidents, it is never compelled to request a medical support response from FENZ. However, it said that the following factors would be taken into

[4] OMP 3.4.1 Clinical Operations Fatigue Management and Driving Policy states: '5.3.4 a. If it appears likely that at an end of shift incident will take personnel over their rostered finish time, then: ii. If the incident is ORANGE or GREEN, the incident should not be dispatched unless it is reviewed by a Clinical Support Officer and upgraded (to RED or PURPLE).'

account when considering an FFRU unit for an incident: the likely benefits for the patient; the skills required to deal with the incident; the availability of any ambulance resource in the specific location; where the patient has requested FENZ do not respond; and where a health practitioner is present on scene.

25. St John said that while the FFRU does not have the equipment to determine a diagnostic ECG, 'they do have an Automated External Defibrillator (AED), are competent at CPR, have pain relief available and also oxygen if required'. St John said that if the decision to dispatch the FFRU had been actioned, a notification to FENZ would have occurred and FENZ would have paged the FFRU to determine whether volunteers were available to attend the incident.

26. Mr D told HDC that he did not consider FFRU to be appropriate for this incident because Mr A was completely alert, had no difficulty breathing, and had no cardiac history, and, as such, 'would gain little to no benefit from Fire First Response'. Mr D said that he discussed the possibility of FFRU with another dispatcher (who had handed over the channel to him), and there was no uncertainty between them about whether FFRU was appropriate. Mr D did not document the discussion in the clinical notes, or his rationale for not dispatching FFRU.

27. Mr D said that he considered asking a Clinical Support Officer to review the incident, but he did not deem this necessary as it is 'common practice for ORANGE1 and ORANGE2 incidents to wait over an hour before dispatch'.

28. In response to the provisional opinion, Mr D said that the determination of acuity and clinical benefit of the FFRU unit should be made by clinical personnel, 'which is why it's so concerning that the SOP requires dispatchers to make these decisions'.

29. St John told HDC that based on the information provided, Mr A 'did not present with symptoms that were immediately life threatening (RED response)'. However, St John said that as dispatchers are not clinically trained, the incident did require review by a Clinical Support Officer (CSO) to determine whether it would have been beneficial for the FFRU to attend. St John said: 'This may have included a CSO calling Mr[s] A to gather further information regarding [Mr A's] symptoms.' In response to the provisional opinion, Mr D said that the above statement made by St John 'implies that [he has] not done the right thing'. Mr D stated: 'I followed the standard operating procedure that the Ambulance Communications Senior Leadership team authorised.'

30. In relation to his delay in launching the Initial Assign tool, Mr D said:

> 'I acknowledge there was a delay in the use of Initial Assign, wholly due to channel workload. In my opinion, the delay in utilising initial assign did not [a]ffect the response time to [Mr A] due to the availability of vehicles as per St John [SOPs].'

31. In response to the provisional opinion, Mr D advised HDC of the workload during the afternoon handover and what tasks a dispatcher must complete at the start of the shift. This list was extensive. Mr D said that during the night shift (beginning 6–6.30pm), two

channels, usually operated independently during the day shift, are merged and managed by one dispatcher. He stated:

> 'Afternoon handover is one of the busiest periods for a dispatcher because of the volume of pending incidents that are being held for oncoming ambulance crews. The dispatcher can be responsible for up to 100 active emergency incidents, as well as the responsibilities outlined above. There are times where it is impossible to avoid delays in launching Initial Assign due to the competing demands of other dispatch tasks.'

32. St John told HDC that no timelines are specified within the dispatch guidelines indicating when the IA tool should be utilised, only that it must be utilised. However, St John noted that the dispatch guidelines outline the responsibilities of the dispatcher to 'assess all incidents as they arrive to the pending queue' and 'review incident notes and launch [the IA tool] and accept and respond the most appropriate resource(s)'.

33. In a letter to Mrs A following the events, St John said that when the request for an ambulance was made, it was noted that all vehicles were committed, as all ambulances in the region were with other patients or responding to patients with more serious symptoms. The letter also noted that when there is likely to be a delay before an ambulance can be dispatched, staff will call back and perform a welfare check at regular intervals to check on the patient's condition, re-triage if a change is reported, and provide further advice or assistance. St John said that a welfare check of Mr A was due at 6.55pm, but as Mr D was about to assign a response at 7.00pm, 'this was not made'.

Second 111 call

34. Mrs A told HDC that following the initial 111 call, she waited for 30 minutes and then called 111 again. This call was answered by St John call-handler Ms B. Ms B had been working in this role since 2019.

35. Ms B told HDC that at 6.58pm she was presented with Mrs A's second 111 call. Ms B noted that it was a subsequent call for an existing job, and so she appended the incident to the original incident to ensure that the calls were linked.

36. The St John SOP 'Emergency Call Handling CHSOP 2.10 Version 9.5' is the procedure used to guide call-handlers in handling emergency calls. Section 2.10.7 outlines the procedure to be followed in managing subsequent calls, which are defined as follow-up or secondary calls for the same incident. The procedure states that once the call has been identified as a secondary or follow-up call, the call-handler should ask the caller if the patient's condition has changed. If the answer is 'yes', and the caller gives 'priority symptoms' (defined as a decreased level of consciousness, shortness of breath, non-traumatic chest pain, and/or severe bleeding), the new call should be re-triaged.

37. The call transcript of Mrs A's second call shows that Ms B gathered Mrs A's details and apologised for the delay in an ambulance attending the incident. She advised that her colleague was arranging help. Ms B then asked Mrs A whether there had been any change in Mr A's condition since the first call, to which Mrs A answered that Mr A was 'getting

worse'. Mrs A raised concerns that an ambulance had not yet arrived and asked whether one was on its way, to which Ms B responded: '[Due to the demand in the area] we have not been able to assign an ambulance.' Mrs A then advised Ms B that she would transport Mr A to hospital herself. Ms B responded: 'Okay so you're wanting to stand that down is that correct?' Mrs A responded that she thought that would be best, and Ms B told her that if anything changed, she could phone back. The call was completed at 7.00pm and the incident was closed as no longer needing an ambulance response.

38. Mrs A told HDC that it is a 15-minute (18km) drive to the hospital, but, sadly, three minutes from the hospital Mr A suffered a cardiac arrest and could not be revived by Emergency Department (ED) staff.

Further information

39. Mrs A told HDC:

> 'Their processes seem to be flawed — why could they not have rung back as soon as they knew there was no ambulance immediately available for dispatch. Why would they wait for such a long time to do what they called a "welfare check" when they knew there was no ambulance available … I know that there is a defibrillator available just down the road … which is operated by a voluntary fire service — could they not have been called until an ambulance was available. I would love to see a change made in the process of alerting anyone that calls for an ambulance for such a serious condition as [Mr A's] to be [kept] informed as soon as possible about any delays. I guess believing that by getting help as soon as possible after the onset of cardiac symptoms doesn't always save someone unless the service is reasonably easily accessible which I believed [it] would have been.'

40. Subsequently, Mrs A made a complaint directly to St John.

St John

Incident report and response to initial complaint

41. St John provided a letter of response to Mrs A and outlined the findings of its internal review, which included the following:

- The audit of the initial 111 (handled by Mr C and Ms E from Ambulance Service 2) found that based on the symptoms, the correct priority (ORANGE1) was generated. However, it was noted that Mr C did not explore the cause of Mr A's chest pain and further clarification should have been sought.
- An audit of the second 111 call (handled by Ms B from St John) identified that Ms B did not re-triage the call despite being advised that Mr A's symptoms had become worse, and this was not in line with St John's usual procedure. St John stated: 'It is not known for certain if the re-triage of [Mr A] would have changed the response but that does not negate the fact it should have been done.'

- The review also identified that when Mrs A advised Ms B that she would take Mr A to hospital herself, there was a need for Ms B to recommend that she wait at home for the ambulance.
- A review of the dispatch decisions identified: '[W]e were unable to get to [Mr A] due to an acute demand for our ambulances throughout [the region] and it was not possible to get help [to Mr A] any earlier.'

42. The internal review by St John also noted:

> 'Following an audit of the dispatch decisions, it was determined there was a delay in the "initial assign" tool being utilized which recommended [the] Fire First Response unit (FFRU) as being available to respond. As per the dispatch procedures, a FFRU can be assigned to an ORANGE1 where it is apparent, they will make a difference in the clinical outcome of the patient. If it is unclear whether it would be of benefit, the dispatcher is to discuss this with a Clinical Support Officer. It was not documented within the incident notes whether [the] FR was considered for this incident.'

43. The letter from St John stated that as a result of the above findings, Ms B and Mr C both received reviews and feedback on the highlighted issues, and they received side-by-side coaching from their managers on how to handle similar calls in the future.

44. In summary, the letter stated:

> 'This is well below the level of service we would wish to provide but is unavoidable with our current funding. We are currently working with the Government on a long-term sustainable funding model that will provide the ambulance service that New Zealand needs and enables us to reduce such delays in responding to the increasing demand for emergency ambulance services.'

Ms B

45. Ms B acknowledged that she neglected to advise Mrs A that it 'may be a good idea to continue with the ambulance response'. She said that as a result of these events, she received further coaching and training, and now she always re-triages call-backs if there has been a change in the patient's condition and the patient has priority symptoms such as shortness of breath, chest pain, serious haemorrhage, or altered level of consciousness. Ms B said that she encourages the caller to continue with an ambulance response, and, if the caller refuses, she escalates the call to the Clinical Support team for review and further clinical assistance. Ms B told HDC:

> 'Since this incident I have thought about the family, and if I could change anything. I would have encouraged the caller to continue with the ambulance, and I wished I had followed the procedure correctly. This job will stay with me, and I am truly deeply sorry to the family.'

Mr D

46. Mr D told HDC that he did not consider FFRU to be appropriate for this incident because Mr A was completely alert, had no difficulty breathing, and had no cardiac history, and, as such, 'would gain little to no benefit from Fire First Response'. Mr D said that he discussed the possibility of FFRU with another dispatcher (who had handed over the channel to him), and there was no uncertainty between them about whether FFRU was appropriate. However, he acknowledged that this conversation and his rationale for not dispatching an FFRU was not documented in the clinical notes.

St John

47. St John told HDC that it 'acknowledge[s] that the Ambulance Communications personnel have openly engaged and reflected on their future practice as a result of this complaint'.

Ambulance Service 2

48. Ambulance Service 2 undertook a review of the initial 111 call. The review showed that Mr C should have explored the cause of Mr A's chest pain. The review noted:

> '… [T]he caller advised that the patient had chest pain and pins & needles in arms. We need to remember that the intent of this question is to determine exactly what has happened. In this case the caller had provided symptoms of chest pains but had not explained exactly what happened. There was a need to further clarify. It's important we do this to ensure we have a good understanding of the situation and that the appropriate Protocol is selected.'

49. The Executive Director of Quality Improvement and Innovation at Ambulance Service 2 told HDC:

> 'I would like to express my sincere condolences to [Mrs A] on the loss of her husband, and I hope that the information supplied by [Ambulance Service 2] in this response answers her questions about the handling of the first 111 call.'

Relevant standards

50. Relevant policies are set out at Appendix A.

Responses to provisional opinion

51. Mrs A was given the opportunity to respond to the 'Summary of Events' section of the provisional opinion but had no further comments to make.

52. St John, Ms B, and Mr D were given an opportunity to comment on relevant sections of the provisional opinion. Where relevant, their comments have been incorporated into this report. In addition, they made the following comments.

St John

53. St John accepted the proposed findings and recommendations in the provisional report.

54. In relation to the proposed finding for Ms B, St John disagreed with the proposed breach finding, and said it believes 'the finding is not appropriate for the procedural error that

occurred'. St John stated that it 'would like to recommend an opinion of adverse commentary for [Ms B]'.

Ms B

55. Ms B accepted the proposed findings and recommendations and had no further comment to make.

Mr D

56. In relation to the delay in launching the IA tool, Mr D said:

> 'I share your concern about the delay in using the Initial Assign tool. I am actively involved in reviewing our dispatcher training and competency assessments. Recently, I inquired about the timeframes for dispatchers to launch Initial assign, and how this is graded in dispatch audits. I was informed that these timeframes are deliberately unspecified to allow discretion in individual circumstances. This vagueness, as you've suggested, contributed to significant risks in patient care.'

57. Mr D also stated:

> 'Numerous incidents over the past years have resulted in adverse patient outcomes due to dispatcher workload and staffing issues. I have observed dispatchers managing multiple channels simultaneously, increasing the risk of patient adversity.'

58. He said that he is 'a strong advocate for self-reflection and continuous improvement'.

Ambulance Service 2

59. In response to the proposed recommendation that Ambulance Service 2 provide further training to its call-handling staff on the importance of further clarifying causes for symptoms, Ambulance Service 2 said that the review noted that the cause for the chest pain had not been determined 'in the sense that the call taker had not asked whether there was a reason for the chest pain such as an external force'. It said that the comment was included in the call review as a teaching note for a new call handler 'and was not intended as an indication that further clarification would have altered the determinant or response priority in this case'. It said that further clarification of Mr A's symptoms was sought appropriately during the call.

60. Ambulance Service 2 also told HDC: 'It is worth noting that in 2022 a review of response priorities undertaken by both Hato Hone St John and [Ambulance Service 2] changed the national response priority for patients who are triaged with the determinant 10-C-3 [the determinant given to Mr A] from an Orange response to a Red response.'

61. In response to the proposed recommendation that Ambulance Service 2 educate staff on the need to communicate expected wait times clearly, Ambulance Service 2 said that this issue is covered in the International Academy of Emergency Dispatchers performance standards regarding 'positive ambiguity' when talking to callers. Ambulance Service 2 stated:

> 'At any time during an ambulance response, unless the ambulance is responding to a patient who is in an "immediately life threatening situation", such as a cardiac arrest, (Purple response) the ambulance can be diverted to a higher acuity case. Because of this, calltakers are discouraged by the Academy from giving expected arrival times, in order to avoid [what] is termed "unrealistic expectations".'

62. Ambulance Service 2 provided HDC with an excerpt from the Academy about communication around wait times.

Opinion: Ms B — breach

63. At the time of the events, Ms B was employed as a call-handler. She had been working in this role since 2019.

64. At 6.58pm, Ms B received Mrs A's second 111 call and noted that it was a subsequent call for an existing job. She appended the call to the original call to ensure that the incidents were linked.

65. St John's Standard Operating Procedure (SOP) 'Emergency Call Handling CHSOP 2.10 Version 9.5' is the procedure used to guide call-handlers in handling emergency calls. Section 2.10.7 outlines the procedure to be followed in managing subsequent calls, which are defined as follow-up or secondary calls for the same incident. The procedure states that once the call has been identified as a 'secondary' or 'follow up call', the call handler should ask the caller if the patient's condition has changed. The procedure states:

> 'If [the answer is] "YES" and the caller gives "Priority Symptoms" for example, a decreased level of consciousness, shortness of breath, non-traumatic chest pain, and or severe bleeding — link the new call using the LINK button and re-triage.'

66. Ms B asked Mrs A whether Mr A's condition had changed since the first call, and Mrs A advised that his condition was worsening. Although Ms B did ask Mrs A if Mr A's condition had changed since the first call, the St John incident review identified that she did not enquire as to what symptoms had worsened and did not re-triage the call, in accordance with the St John SOP (outlined above).

67. Following Ms B advising that an ambulance had not yet been dispatched, Mrs A responded that she would transport Mr A to hospital herself. Ms B responded: 'Okay so you're wanting to stand that down is that correct?' Mrs A responded that that would be best, and Ms B advised her to call back if anything changed. The call was completed at 7.00pm and the incident was closed as no longer requiring an ambulance response.

68. St John's SOP 'Requests to cancel an emergency incident prior to patient assessment' CHSOP 2.51 Version 1.3 outlines how to manage requests to cancel an emergency incident before a unit is dispatched or located at an incident.

69. The policy states:

> 'Call Handlers will often receive a request to cancel an emergency incident prior to ambulance attendance and an evaluation of the patient is undertaken. It is our policy to ensure that checks are taken prior to cancelling an incident to ensure there is no risk to the patient if an ambulance does not attend.'

70. The policy outlines when incidents can be cancelled without consultation (2.51.1). It states:

> '1. The original caller or patient advises an ambulance is no longer required. If the chief complaint includes a priority symptom, (regardless of protocol) advise the caller that because of the nature of the call (i.e. breathing problem) it may be a good idea to continue the ambulance response. If they still refuse the ambulance, cancel the incident. If there is any concern regarding the patient's need to be assessed discuss with a Clinical Support Officer (CSO).
> 2. A medical alarm activation is confirmed as being accidental
> 3. Alternative transport has been used
> 4. The caller advises the patient has left the scene and their whereabouts is unknown
> 5. An off-duty Ambulance Officer arrives at the incident prior to the responding resource and has an authority to practice (ATP) of Emergency Medical Technician (EMT) or higher.'

71. Incidents that require consultation with a Clinical Support Officer/Clinical Advisor, Duty Centre/Team Manager or Call Handling Team Leader prior to cancelling include (among other non-relevant points), '[a]ny requests to cancel an ambulance that are not covered above'.

72. I note that although section 2.51.1 states that an ambulance may be cancelled without consultation when alternative transport has been used, I interpret that to mean that the patient is en route to hospital in a vehicle or has already been successfully transported to hospital. In my view, as supported by the findings in the St John incident review, it would have been appropriate for Ms B to have managed Mrs A's request to cancel the ambulance either under point 1 of section 2.51.1 or to have escalated Mrs A's request to a CSO or other relevant senior. This was particularly important given that Mrs A had indicated that Mr A's condition had worsened since her initial call.

73. As stated above, the St John incident review identified that when Mrs A advised Ms B that she would take Mr A to hospital herself, there was a need for Ms B to advise Mrs A that it might be a good idea to continue waiting for the ambulance response. I note that Ms B's failure to re-triage Mrs A's second 111 call may have affected her decision not to advise Mrs A to wait for the ambulance to arrive. Unfortunately, despite Mrs A telling Ms B that Mr A's condition had worsened, Ms B did not ask for any further information about his symptoms. This meant that she was unaware of the seriousness of Mr A's condition when

she failed to advise Mrs A that it might be a good idea to wait for an ambulance response. Ms B also did not discuss the incident and decision to cancel the ambulance with any other staff, including a CSO. Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) provides that every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards. In my view, by failing both to re-triage Mrs A's second 111 call and failing to advise Mrs A that it might be a good idea to continue to wait for the ambulance response, Ms B did not follow the St John SOP Dispatching Guidelines. I acknowledge St John's response to the provisional opinion, that it does not consider that Ms B should be found in breach of the Code for the 'procedural error'. However, St John has provided no new information to warrant a review of this finding. Accordingly, I find that Ms B breached Right 4(2) of the Code.

Opinion: Mr D — adverse comment

74. The dispatcher assigned to Mrs A's initial 111 call was St John dispatcher Mr D.

75. Mr D told HDC that at approximately 6.25pm he took over the dispatch of the channel. He said that he was advised by the previous dispatcher that the call had recently entered the queue as ORANGE1 priority, which is considered 'serious but not immediately life threatening'.

76. At 6.55pm, Mr D launched the Initial Assign tool, which showed that most of the resources in the area were attending other incidents. Mr D said that even if two of the units had been available, 'they wouldn't have been assigned to their incident before their rostered finish time of [7.00pm] due to St John policy'. However, the FFRU was showing as available for response.

77. Section 3.21.2 of the St John SOP states under 'Orange Incidents' that dispatchers must also consider Fire First Response Units, but that they should '[o]nly send Fire First Response where it is apparent, they will make a difference to the clinical outcome of the patient'. The guideline states that if it is unclear whether the FFRU would make a difference to the clinical outcome of the patient, dispatchers should discuss this with the Clinical Support Officer.

78. St John told HDC that FFRUs have personnel and equipment equivalent to the ambulance sector clinical practice level of First Responder, and that the aim of the FFRUs is to provide patient assessment and treatment until an ambulance resource arrives to assume management of the patient. St John said that when considering an FFRU response, the following factors would be taken into account: the likely benefits for the patient; the skills required to deal with the incident; and the availability of any ambulance resource in the specific location.

79. St John said that based on the initial information provided by Mrs A, Mr A did not present with symptoms that were immediately life-threatening. However, it said that the incident did require a review by a CSO to determine whether it would have been beneficial for the

FFRU to attend. St John stated: 'This may have included a CSO calling [Mrs A] to gather further information regarding [Mr A's] symptoms.'

80. Mr D told HDC that he did not consider FFRU to be appropriate for this incident because Mr A was completely alert, had no difficulty breathing, and had no cardiac history, and, as such, 'would gain little to no benefit from Fire First Response'. Mr D said that he discussed the possibility of FFRU with another dispatcher (who had handed over the channel to him), and there was no uncertainty between them about whether FFRU was appropriate. However, he acknowledged that this conversation and his rationale for not dispatching an FFRU was not documented in the clinical notes.

81. Mr D said that he considered asking for support from a CSO, but he did not deem this necessary as it was 'common practice for ORANGE1 and ORANGE2 incidents to wait over an hour before dispatch'. In response to the provisional opinion, Mr D agreed that the determination of acuity and clinical benefit of the FFRU should be made by clinical personnel, but that the St John SOP requires dispatchers to make the decision, and he followed the SOP in this case.

82. The St John incident review noted:

> 'Following an audit of the dispatch decisions, it was determined there was a delay in the "initial assign" tool being utilized which recommended [a] Fire First Response unit (FFRU) as being available to respond. As per the dispatch procedures, a FFRU can be assigned to an ORANGE1 where it is apparent, they will make a difference in the clinical outcome of the patient. If it is unclear whether it would be of benefit, the dispatcher is to discuss this with a Clinical Support Officer. It was not documented within the incident notes whether [the] FR was considered for this incident.'

83. I am concerned that there was a delay of 30 minutes in Mr D launching the Initial Assign tool, which has been noted in the St John incident review. I acknowledge Mr D's comments that the delay in launching the IA tool was due to channel workload, and that afternoon handover is one of the busiest periods for a dispatcher because of the volume of pending incidents that are being held for oncoming ambulance crews. Mr D said: 'There are times where it is impossible to avoid delays in launching the Initial Assign due to the competing demands of other dispatch tasks.' However, I am still concerned by the delay, and I note Mr D's comments that the IA tool is used as 'safety-netting'. In my view, this is a very important reason why the tool should be used as soon as possible following receipt of an incident.

84. Further, despite the IA tool recommending the FFRU as being available to respond, Mr D did not discuss the recommendation with a CSO, which St John has advised should have occurred. I acknowledge Mr D's comments that the SOP did not require review by a CSO. I note that the SOP states that an FFRU should be dispatched only if it is apparent that it would make a difference to the clinical outcome of a patient, and that '[i]f unclear discuss this with the CSO'. However, I also note that St John advised that consultation with a CSO should have occurred in this case. I agree, despite it not being clearly stipulated in the SOP.

In addition, Mr D did not document his rationale for not dispatching the FFRU despite having discussed this with another staff member, which was also identified in the internal review by St John. Documenting such discussions ensures continuity of care and enables clear communication between staff, while allowing for retrospective reviews of dispatching decisions. I encourage Mr D to reflect on my comments.

Opinion: St John — breach

Guidelines regarding use of Initial Assign tool

85. As a healthcare provider, St John had a responsibility to provide Mr A with an appropriate standard of care. The St John incident report identified some concerns with the call-handling and dispatching decisions by staff at St John. Overall, the incident report identified: '[W]e were unable to get to [Mr A] due to an acute demand for our ambulances throughout [the region] and it was not possible to get help [to Mr A] any earlier.'

86. Mrs A's first call to 111 was picked up from the national 111 queue at 6.08.46pm by Ambulance Service 2 call-handlers, and the response priority code was sent to the St John dispatch queue at 6.11pm. The call was completed at 6.13pm. St John told HDC that the first dispatcher read the incident notes at 6.22pm but did not launch the Initial Assign tool, and at 6.25pm, dispatcher Mr D took over the channel. It is unclear what happened between 6.13pm and 6.22pm but the call did not progress during that time. Mr D launched the Initial Assign tool 30 minutes later at 6.55pm. In total, it took St John 32 minutes to launch the Initial Assign tool following the handover of Mrs A's first call to St John at 6.11pm.

87. I have considered the fact that two St John staff members (the first dispatcher and Mr D) failed to launch the IA tool. St John advised that there are no timelines specified within the dispatch guidelines to indicate when the IA tool should be utilised, only that IA should be utilised. St John also noted that the dispatch guidelines outline the responsibilities of the dispatcher to 'assess all incidents as they arrive to the pending queue' and 'review incident notes and launch Initial Assign (IA) and accept and respond the most appropriate resource(s)'. I have addressed above the delay in launching the IA tool as it relates to Mr D. However, I am concerned that two staff members in the space of an hour failed to launch the IA tool. I consider that this indicates that St John has not provided enough clarity in its dispatch guidelines to highlight the importance of launching the IA tool promptly. I find this concerning.

Provision of welfare checks

88. A letter to Mrs A following the events stated that when there is a likely delay before an ambulance can be dispatched:

> '[W]e will call back (welfare check) at regular intervals to check on the patient's condition, re-triage if a change is reported, and provide further advice or assistance. There was a welfare check due at 6.55pm approximately, however as the dispatcher was going to assign a response at 7.00pm[,] this was not made.'

89. St John's SOP 'Welfare Checks CCSOP 1.20 Version 2.9' states that welfare checks are 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.

90. 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.'

91. 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.

92. I acknowledge St John's comments that a welfare check was not conducted at 6.55pm because it had planned to assign an ambulance at 7.00pm. However, Mrs A's call was initially picked up at 6.08pm, queued at 6.11pm, and ended at 6.13pm, meaning that it was approximately one hour between her initial call and her second call at 6.58pm. In my view, the failure to make a welfare check (irrespective of the fact that an ambulance was expected to be assigned at 7.00pm) does not align with the St John SOP. This is concerning, particularly in light of St John's comment: '[W]e were unable to get to [Mr A] due to an acute demand for our ambulances throughout [the region] and it was not possible to get help [to Mr A] any earlier.'

93. It is clear that St John did not meet the 'expected' wait time (for arrival of an ambulance) of 30 minutes. I acknowledge that in this case, demand for ambulance services outweighed available resources. There will undoubtably be times where ambulances are unavailable to respond to incidents immediately. However, it is St John's responsibility to find ways to mitigate the risks associated with unavailable ambulances. In my view, conducting welfare checks every 30 minutes (as outlined in St John's SOP) is an appropriate tool in mitigating such risk. I do not accept St John's explanation for its failure to conduct a welfare check in these circumstances, and am critical 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.

94. Right 4(2) of the Code stipulates that all consumers have the right to have services provided that comply with professional and other relevant standards. St John's SOP stated that welfare checks were to be completed every 30 minutes if an ambulance was unable to be dispatched. Mr A was due to receive a welfare check between 6.45 and 6.55pm, but this did not occur. I am also concerned that St John's SOP did not include specific guidance on when the IA tool should be launched on receipt of an incident. In my view, this ambiguity in the policy meant that staff were unaware of the importance of launching the

tool promptly to ensure that appropriate resources were identified for dispatch. Accordingly, I find that St John breached Right 4(2) of the Code for failing to comply with its SOP and for failing to provide clarity in its SOP regarding launching of the IA tool.

Provision of information

95. I have also considered Mr A's rights under Right 6(1) of the Code — the right to the information that a reasonable consumer in the circumstances would expect to receive. I note that in this case, Mrs A was communicating on behalf of Mr A.

96. Mrs A's call entered the dispatch queue at 6.11pm but it appears that no action was taken on the incident until 6.55pm when Mr D launched the IA tool. In my view, St John was aware that there was a delay in dispatching an ambulance, especially by 6.55pm, but did not call back Mrs A to provide her with an update or conduct a welfare check for Mr A. I have also considered the fact that when Mrs A called 111 for a second time at 6.58pm, she was not advised that it would be a good idea for her to wait for an ambulance response. In my view, the above was information that Mr A could reasonably have expected to receive (through Mrs A), and I am critical that this information was not shared, particularly as Mrs A has indicated in her complaint that had she known the ambulance would be delayed, she would have transported Mr A to hospital earlier. Accordingly, I find that St John breached Right 6(1) of the Code.

Ambulance availability

97. I note the comments made by St John regarding the resourcing issues currently facing ambulance providers in New Zealand. I am also aware of other similar complaints relating to the availability of ambulances for dispatch to emergency situations, and this Office has written to Health New Zealand|Te Whatu Ora (Health NZ) National Ambulance Services to advise it of concerns relating to ambulance response times. While I do not consider that the resourcing issues mitigate the omissions outlined in this report, I am concerned that this trend has been identified and consider that it is in the public interest for these issues to be addressed. Accordingly, I will be providing a copy of this report to Health NZ National Ambulance Services and asking for a response to my concerns.

Opinion: Ambulance Service 2 — other comment

98. As a healthcare provider, Ambulance Service 2 had a responsibility to provide Mr A with an appropriate standard of care. The St John incident report identified some concerns with the call-handling decisions made by Mr C and Ms E at Ambulance Service 2.

99. At the time of Mrs A's 111 call, Mr C was in the process of completing his call-handler training and was being 'actively mentored' by a senior call handler, Ms E. Ambulance Service 2 told HDC that when a call-handler is in the mentoring stage of their training, the mentor is 'physically sitting with them, listening, advising and reviewing the calls they handle'.

100. During the initial call, Mr C asked Mrs A, 'Tell me exactly what happened,' and Mrs A answered, 'Ah we have someone with chest pain, quite badly. Pin and needles down his arms and chest pain on the left side.'

101. A review of the call showed that while the call was 'compliant' and the correct priority (ORANGE1) was generated, Mr C did not explore the cause of Mr A's chest pain, when further clarification about its cause should have been sought.

102. The review noted:

> '… [T]he caller advised that the patient had chest pain and pins & needles in arms. We need to remember that the intent of this question is to determine exactly what has happened. In this case the caller had provided symptoms of chest pains but had not explained exactly what happened. There was a need to further clarify. It's important we do this to ensure we have a good understanding of the situation and that the appropriate Protocol is selected.'

103. In response to the provisional opinion, Ambulance Service 2 told HDC that the above comments were included in the call review as a teaching note for a new call handler 'and was not an indication that further clarification would have altered the determinant or response priority in this case'. Ambulance Service 2 considered that further clarification of Mr A's symptoms was sought appropriately during the call. I acknowledge Ambulance Service 2's comments in this regard. However, while Mr C may have clarified Mr A's symptoms appropriately, it still stands that in this case, Mr C did not seek further clarification on the cause of those symptoms. In addition, I note that while further clarification may not have changed the determinant or response priority, it is nonetheless important that the cause of symptoms is clarified during a call.

104. As Mr C was in training at the time of these events, I do not consider this error to be attributable solely to Mr C. An experienced staff member (Ms E) was overseeing the call and, as such, had a role in managing the call. I consider that the lack of further questioning to clarify exactly what was occurring during the call highlights a need for Ambulance Service 2 to review the training and support provided to new staff members. I encourage Ambulance Service 2 to reflect on my comments in this regard.

105. I have also considered the fact that during the initial call, Mr C advised Mrs A that he was organising help; that she needed to reassure Mr A that help was being arranged; and that if his condition were to decline, then she should call back immediately for further instructions. Mrs A responded: 'Okay, yes, they'll come from [town], so it will take them at least 20 minutes or so …' Mr C then responded: 'It will be the closest ambulance available, so, um yip … But that help has been arranged.' Given that there was a substantial delay in ambulance dispatch, resulting in Mrs A transporting Mr A to hospital herself, I note that Mrs A was led to believe that an ambulance would be dispatched imminently. Again, as Mr C was in training at the time of these events, I do not consider this error to be attributable solely to Mr C. I acknowledge Ambulance Service 2's comments in response to the provisional opinion, that the International Academy of Emergency Dispatchers'

performance standards discourage call handlers from giving expected arrival times. However, I find that the lack of clarity in expected wait times indicates a need for Ambulance Service 2 to review the training and support provided to new staff members to ensure that they answer questions about wait times appropriately.

Changes made since events

Ms B

106. St John told HDC that Ms B was debriefed on the incident, and feedback was provided, with further coaching referencing the correct procedure for cancelling an ambulance and re-triaging a 111 call.

Mr D

107. St John told HDC that Mr D was debriefed on the incident, and feedback and coaching was provided regarding his dispatch decisions relating to the dispatch of FFRUs.

St John

108. St John told HDC that it introduced the 'Delayed exit statement' policy at the beginning of 2021 due to an 'increased demand for ambulance resources'. The policy is to be utilised during periods of moderate pressure or above, using the Resource Escalation Action Plan (REAP) real-time reporting. The Resource Escalation Action Plan is utilised to enable a consistent approach to operational escalation in situations where ambulance service demand exceeds both business and usual capacity and surge capacity.

Recommendations

Ms B

109. I recommend that Ms B provide a written apology to Mrs A for the failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

Mr D

110. I recommend that Mr D undergo further training on the use of the IA tool and escalation to CSOs and provide a written reflection of his learnings to HDC, within three months of the date of this report.

St John

111. I recommend that St John:

a) Provide further training to its call-handling and dispatching staff on the importance of welfare checks, and the process for conducting them (including the shared responsibility of managing welfare checks). St John is to use an anonymised version of this report as part of this training and provide evidence of the training to HDC within six months of the date of this report.

b) Update its dispatching guidelines to include clarity about the use of the Initial Assign tool in a timely manner, as well as information about how to determine whether FFRU units are likely to improve a patient's clinical outcome. This updated guideline is to be provided to HDC within three months of the date of this report.

Ambulance Service 2

112. I recommend that Ambulance Service 2 provide further training to its call-handling staff on the importance of further clarifying causes for symptoms and on how to communicate appropriately when questions about expected wait times arise. Ambulance Service 2 is to use an anonymised version of this report as part of this training and provide evidence of the training to HDC within six months of the date of this report.

St John and Ambulance Service 2

113. I recommend that both St John and Ambulance Service 2 work together to provide a response to HDC about any actions they have taken to address the ambulance resourcing concerns. In addition, St John and Ambulance Service 2 are to advise HDC of what plans are in place to mitigate the risks associated with this under-resourcing. St John and Ambulance Service 2 are to provide this response to HDC within three months of the date of this report.

Follow-up actions

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

115. A copy of this report with details identifying the parties removed, except St John Ambulance Service, will be sent to Health NZ National Ambulance Services for comment.

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.

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

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 LIGHTS
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
Issued by: Tenaia Lawrence, Operations Process Manager	Issue Date: Nov 2020	Page 2 of 9
Authorised by: Ambulance Communications SLT	Date for Review: Nov 2021	

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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'

Names have been removed (except St John Ambulance Service) 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

REQUESTS TO CANCEL AN EMERGENCY INCIDENT PRIOR TO PATIENT ASSESSMENT
CHSOP 2.51
Version 1.3

Purpose
This procedure is to direct personnel on how to manage requests to cancel an emergency incident before a unit is dispatched or locates at an incident and a patient evaluation is completed.

Policy
Call Handlers will often receive a request to cancel an emergency incident prior to ambulance attendance and an evaluation of the patient is undertaken. It is our policy to ensure that checks are taken prior to cancelling an incident to ensure there is no risk to the patient if an ambulance does not attend.

Situations for application of this procedure include, but are not limited to:
- A non-clinical person phones to advise an ambulance is not required
- An accidental medical alarm activation
- The responding resource is unable to locate the patient
- Allied emergency services; or an off-duty Ambulance Officer is on scene and confirm an ambulance is not required.

Procedure
2.51.1 Cancelling Incidents Without Consultation
Incidents can be cancelled without consultation in accordance with *CHSOP 2.10 Emergency Call Handling and Address Verification* when:
1. The original caller or patient advises an ambulance is no longer required. If the chief complaint includes a priority symptom, (regardless of protocol) advise the caller that because of the nature of the call (i.e. breathing problem) it may be a good idea to continue the ambulance response. If they still refuse the ambulance, cancel the incident. If there is any concern regarding the patient's need to be assessed, discuss with a Clinical Support Officer(CSO)
2. A Medical alarm activation is confirmed as being accidental
3. Alternative transport has been used
4. The caller advises the patient has left the scene and their whereabouts is unknown
5. An off-duty Ambulance Officer arrives at the incident prior to the responding resource and has an authority to practice (ATP) of Emergency Medical Technician (EMT) or higher.

2.51.2 Incidents that Require Consultation Prior to Cancellation
A Clinical Support Officer/Clinical Advisor, Duty Centre / Team Manager or Call Handling Team Leader must be consulted prior to cancelling an incident CHSOP 2.10 Emergency Call Handling and Address Verification point when:
- An off-duty Ambulance Officer arrives at the incident prior to a response resource and s/he does not hold a BLS qualification or higher, i.e. First-aid or PHEC qualified. If appropriate, advise the Ambulance Officer that you will transfer them to the CSO who will complete a further assessment, warm transfer the call to the CSO
- Ambulance has located and unable to locate the patient and reasonable attempts have been made to try and locate the patient. Ensure that all information is recorded in the incident allowing the Dispatcher to cancel the incident
- Any requests to cancel an ambulance that are not covered above

Standard Operating Procedure

St John WELLINGTON FREE AMBULANCE

EMERGENCY CALL HANDLING
CHSOP 2.10
Version 9.5

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.

2.10.7 Subsequent Call
Subsequent calls are defined as follow up or secondary calls for the same incident. Calls requiring re-triage must be linked to the previous incident and ProQA/MPDS followed. All other subsequent calls must be appended.

1. Enter the address into the ECT Screen
   - If advised by the caller that this is a duplicate call and no duplicate call window is presented, then confirm you have the correct address of the patient.
   - If the duplicate call window is presented and you have not already been told this is a duplicate call, ask the caller if a call has already been made for this patient/incident *(confirm patient name as required)*.
     - If **no** or **unsure**, continue entering a new incident at this location.
     - Confirm patient name and details of the original call.
2. Ask the caller "Tell me again, exactly what happened." *(This would identify if the Chief Complaint used on the initial call accurately reflects the information given by the caller. If not, re-triage using the correct Chief Complaint.)*
   - Ask if the patient's condition has changed.
   - If **"Yes"** and the caller gives "Priority Symptoms" for example, a decreased level of consciousness, shortness of breath, non-traumatic chest pain, and/or severe bleeding – link the new call using the LINK button and re-triage.
   - If **"No"** or **"Other changes"**, such as increased pain or non-priority symptoms, for example, "vomiting" – append the call using the APPEND button and add notes. There is no need to re-triage.

   Note: There should be a low threshold for seeking CSO assessment by utilising /CSOR, if the patient is in severe pain or there is reason to believe the patient would benefit from further assessment.
   - The Dispatcher will then append the lower priority incident to the higher. Excluding subsequent calls for a 32B01 Unknown, or when the subsequent caller is a 1st or 2nd party when the initial caller was 3rd or 4th
   - If there has been no change in the patient's condition and the call is for any other request (cancel, eta, information update, etc) the EMD can enter these comments directly into the appended incident. Requests to cancel the incident must be private

     and made using notify to alert the Dispatcher who will cancel the incident on the appropriate cancelation code.

If caller advises they have already made a call and give a reference number (WFA)

1. Find the incident in Incident editor
2. Enter the address from the initial incident into the newly presented F8 screen
3. Continue from 2.10.4.2 Step 2

Note: If the patient indicates their condition has improved/pain has decreased, it is not necessary to re-triage their condition.

3.21.13 Resource Classification

Transport Capable Ambulance	Classified as having a minimum of two crew, one of which must hold an ATP of EMT, PARA or ICP. When this criterion is not met, FRU rules apply. Emergency Medical Assistants must always be crewed with an EMT or above. *During the DCP roll-out there are a number of stations where single crewed resources are still permitted to respond without backup. This list is available within each communication centre. The double crewing project will be complete by 30 June 2021.*
First Response Unit (FRU)	Designed to first-respond to incidents and must be backed up by a transporting ambulance as soon as practical. A double crewed ambulance where both crew are First Responders is considered an FRU. First Responders may stand back-up down if they hold ATP of EMT or above or by consultation with the Clinical Desk. In some locations FRU will be deployed that have stretcher capability (FRU-SC). This capability is designed to transport patients a short distance from the scene to a nearby helicopter or a nearby medical centre to avoid the need to wait for a backup transporting ambulance which may be coming from a long distance away. An FRU-SC may also be used to transport a patient towards a backup transporting ambulance if appropriate. FRU-SC's are not designed to be used as a frontline transporting ambulance, or to transport patients to hospital. They have limited space and are not suitable for long distance transport or where clinical care of the patient requires additional space, such as advanced airway care. The following rules apply when using an FRU-SC: a. Patients may only be transported from a scene to a nearby helicopter, medical centre or towards a backup ambulance b. Patients will only be transported if it is clinically appropriate to do so c. In all other circumstances the first response crew will not transport and will wait for a backup ambulance to arrive If transport beyond these rules is required, then the crew will consult with the clinical desk who may grant permission for longer distance transport or referral to the air desk to ensure other transport options have been considered.