Ambulance Service

A Public Hospital

A Report by the

Health and Disability Commissioner

Case 98HDC15374

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Miss B	Consumer
Mr C	Chief Ambulance Officer, New Zealand Ambulance Service
Mrs C	Ambulance Officer and Controller, New Zealand Ambulance Service
Dr D	Clinical Director, Emergency Department, the Public Hospital
Ms E	Daughter of Mrs A
Mr F	Former Ambulance Officer, New Zealand Ambulance Service
Mr G	Ambulance Office, New Zealand Ambulance Service
Ms H	Registered Nurse, the Public Hospital
Mrs I	Grandmother of Ms B
Mr J	Elementary Officer, New Zealand Ambulance Service
Ms K	Cadet Officer, New Zealand Ambulance Service
Dr L	Medical Director, New Zealand Ambulance Service

Complaint

On 29 June 1998 an investigation was commenced on the Commissioner's own initiative into:

- *The standard of ambulance services provided by the New Zealand Ambulance Service.*
- *The events surrounding the delivery of Mrs A and Miss B to the Public Hospital.*
- *Overall procedures at the Public Hospital in relation to the receipt of consumers at the Emergency Department who have been delivered by ambulance.*

The investigation covered all matters under the Code of Health and Disability Services Consumers' Rights, including overall consumer safety, documentation of procedures, compliance with relevant regulations and standards, communication issues, matters relating to staffing, training and hand-over procedures between Emergency Department and ambulance services.

Policies, procedures and patient records from the New Zealand Ambulance Service and the Public Hospital were obtained and reviewed, as were files from the New Zealand Ambulance Board. Visits were made to the Emergency Department at the Public Hospital, the New Zealand Ambulance Service and the New Zealand Ambulance Board.

Information gathered during investigation

History
In 1991 an independent ambulance service was established under the name "the New Zealand Ambulance Service" (NZAS). Over the following two years two further ambulance providers were established and these also traded under the NZAS name. In 1995 the "New Zealand Ambulance […] Trust Incorporated" was registered as a Charitable Trust. The Trust incorporates all three service providers using the NZAS name, and acts as a funding and advisory body.

Unlike the majority of other ambulance services in New Zealand, NZAS is a non-profit organisation that aims to provide urgent and non-urgent transport services which are completely free to consumers. NZAS advised the Commissioner it is a non-profit charitable organisation that relies totally on volunteers, donations, sponsorships and fundraising, and that the Trust receives no funding or financial assistance from the Public Hospital, the Health Funding Authority or ACC. NZAS has failed to provide the Commissioner with evidence of the nature of the charitable trust and how the services are funded. The Health Funding Authority confirmed it does not provide funding to NZAS or the Trust.

New Zealand Ambulance Board
The New Zealand Ambulance Board Incorporated (NZAB) is a registered society set up under the Incorporated Societies Act 1908. NZAB was established by ambulance operators to assist them to carry out, to acceptable international standards, the ambulance service role of co-ordination and delivery of any element of patient out-of-hospital emergency care and transport.

NZAS Systems
In 1996 NZAS filed an application to become an associate member of NZAB. NZAB informed the Commissioner that NZAB had ongoing discussions with NZAS for two and a half years regarding their application and attempted to obtain written material from NZAS which would satisfy its membership criteria, including information on systems, staff training and qualifications, vehicles, medical support and structure. According to NZAB, NZAS failed to supply any substantive information as requested, and much of what was supplied was inadequate and incomplete. Some documents, for example the Certificate of Incorporation and the transport service licence, were passed onto the Ministry of Commerce after NZAB became concerned about their authenticity.

In 1997 NZAB produced an audit report regarding services provided by NZAS as part of the application process for membership. The audit report raised the following concerns:

- Use of the terms "New Zealand Ambulance" and "New Zealand Free Ambulance Service" which people could confuse with the New Zealand Ambulance Board;
- The ability of NZAS to provide acceptable emergency and non-urgent coverage of their area of operation given limited resources;

- The lack of formal arrangements with the two local public hospitals and the fact that NZAS had not responded to correspondence from the Public Hospital Emergency Department;
- The use of single crewed vehicles;
- The lack of formal arrangement for back-up and hand-over with other ambulance services;
- Delays in reaching the ambulance control room through use of the 0800 number due to the fact that the number was shared by another business and calls were answered as "Fencing and Trellis Warehouse";
- *The financial viability of NZAS;*
- The fact that the Trust and staff did not have Public Liability Insurance;
- The quality of ambulance officers and shift controllers and the training these staff receive;
- What form, if any, of transport licence was held;
- The carrying of Fortral for use in cases of severe pain;
- Lack of documentation to indicate which ambulance officers were certified to administer different medications;
- The use of a single doctor to supply 24 hour a day, 7 day a week advice and back-up support for ambulance staff;
- The lack of medical audit documentation.

NZAB criteria for membership used by the audit subcommittee covered only equipment and staff training. The audit found that the standard of NZAS vehicles and equipment was sound but raised serious concerns about the level of training NZAS staff had received.

The audit report states *"[Mr C] commented that there were representatives with previous experience with the [another ambulance service] and qualifications for NAOTS*. [National Ambulance officer Training Schedule]" (NZAB underlining). The subcommittee requested evidence to indicate the number of staff, their names and addresses and their qualification details. The audit report includes the comment "*The subcommittee has doubts that any of the Operational Staff have current NAOTS qualifications at any level. This is a critical issue. We have explained to the Trust that failure to produce this evidence will mean that the criteria for associate membership have not been fulfilled.*"

In summary the NZAB subcommittee concluded that there are "… *serious concerns regarding* [NZAS] *ability to provide a reputable Emergency service*". They further stated the "… *concern that this operator is unsafe*". The Committee informed Mr C, chief ambulance officer NZAS, that he would need to provide the information requested before they would submit his application to the Board.

In May 1998 NZAB advised NZAS that it was treating their application as lapsed on the basis that the information had not been provided.

Mr C advised the Commissioner that NZAS use the policies and procedures produced by NZAB as they existed up until November 1998. Mr C further stated that NZAS plans on becoming a member of NZAB because the membership would give NZAS access to

training, ACC and HFA funding, and would justify the use of emergency beacons on their vehicles. However he advised the Commissioner that he believes this is not possible due to the high proportion of St John's members on NZAB. Mr C believes these members have a conflict of interest and their influence has meant that in 1998 very high entry criteria were introduced, which his organisation is not capable of meeting. Correspondence between NZAB and NZAS indicates that while entry criteria for associate members was amended in 1997, NZAB agreed to assess NZAS on the old entry criteria.

Mr C informed the Commissioner that NZAS was a member of NZAB for a period of three years and during this period were only offered two places on NZAB training courses. Mr C believes they should have been offered six places and that NZAS was charged an excessive amount for the training. A review of correspondence between NZAS and NZAB indicates that NZAS has never been a member of NZAB but was granted the privileges of membership during the period that their application was being considered.

Mr C stated to the Commissioner that NZAS training is all in-house. A new volunteer to NZAS undergoes a 40-hour course covering first aid basics. Once this training is complete the volunteer is required to act as an attendant on an ambulance for six months. During this period the trainee has no specific duties but may assist the ambulance officer.

Mr C reported that after six months acting as an assistant a volunteer may become an elementary officer. After at least two years and 120 hours of further training an ambulance officer may be appointed as a proficiency officer. After an additional 120 hours of training with an extra 40 hours in hospital and 40 hours on the road a proficiency officer may be appointed as an intensive care officer.

Mr C stated that training is run over a three-hour period once a week and that all NZAS officers are required to attend at least 40 such sessions every year. NZAS policy on "Staff Training and Qualifications" states that in-house training is held once per week and "*All staff MUST attend 30 training sessions in any one calendar year*". According to Mr C, NZAS accept staff trained by another ambulance service but the reverse is not true – NZAS training is not accepted by the other ambulance service.

The training programme and operational protocols employed by NZAS were obtained from training courses run by NZAB and attended by NZAS staff. Mr C stated that updates on changes in training policy and operational guidelines are obtained from NZAB which supplies this information on request. Mr C reported that NZAS run in-house staff training courses directly from NZAB booklets. Mr C stated he had spent 15 years as a trainer for the Order of St John and that he runs most training sessions himself and NZAB is not involved in the provision of this training.

NZAS is currently aiming for ISO accreditation. Mr C stated this would involve six monthly audits to ensure that service standards are met.

As at October 1999 NZAS did not have guidelines for dealing with Maori consumers.

NZAS has not supplied an outline of the role of the Medical Director, his job description or his responsibilities, and there is no reference to his role in the policies and procedures of NZAS. Mr C stated to the Commissioner that NZAS requires its Medical Director to review all Patient Record Forms (PRFs) once a month. However, he currently reviews only a portion of these forms once every three months. Mr C said that he reviews all forms himself on a monthly basis. He stated that the role of the Medical Director is to oversee medical procedures used by staff, which includes training and assistance in emergency situations. Mr C reported that the Medical Director must therefore be available and on call 24 hours per day, every day.

During the course of my investigation questions were raised regarding whether NZAS has been operating lawfully as an ambulance service. It is not appropriate for me to comment on such matters and I have referred this issue onto the Land Transport Safety Authority.

NZAS and The Public Hospital Emergency Department interface

All calls to NZAS are received by the Control Centre, which is located in the house of Mr C and his wife, Mrs C, ambulance officer and ambulance controller. Both radio telephones (RTs) and mobile phones are used in all ambulances and in the control room to achieve the best possible coverage. Mrs C advised the Commissioner she is on duty most of the time but that others are available to provide coverage when she is required elsewhere. At night Mrs C remains on duty and sleeps with the phone and RT by her bed.

When a call is received Mrs C completes an "ambulance call form". She assesses the urgency of the call and assigns the situation a status rating from 0 (patient deceased) to 4 (patient stable) and dispatches an ambulance (and paramedic where necessary).

Mrs C advised it is often difficult to assess a patient's condition as she is reliant on the information supplied by the caller alone. On arrival at the scene ambulance officers assess the patient's condition and transfer them to the ambulance. A "patient record form" (PRF) is completed.

Prior to the incident involving Mrs A in April 1998, ambulance officers were required to contact the Public Hospital Emergency Department through the main hospital switchboard. All parties agree that this was a time-consuming and frustrating process which often led to ambulances arriving at the Emergency Department without their arrival being announced. Mr C stated that the Public Hospital refused to allow his staff access to their direct line. The Public Hospital stated to the Commissioner that NZAS never requested this number from them.

From April 1998 Mrs C has acted as the sole contact prior to arrival at the Emergency Department and used a dedicated direct line. Ambulance officers take baseline readings and a history from the patient and pass this on to Mrs C by either RT or mobile phone. Mrs C then contacts the Emergency Department by the direct line and informs them of the patient's status, baseline readings and estimated time of arrival. Where Emergency Department staff require further information this is relayed to them via Mrs C, who remains in direct contact with the ambulance officers.

Emergency Department staff stated to the Commissioner that the quality of information received from NZAS is variable. It was stated that on some occasions a patient's GCS (Glasgow Coma Scale) is reported where this information is clearly not needed and on other occasions GCS is not reported where this is an important consideration. Some Emergency Department staff expressed dissatisfaction with having information relayed through Mrs C and stated they would prefer direct contact with ambulance officers.

NZAS staff reported that they had been instructed to take patients through reception if they were unable to contact the Emergency Department prior to arrival. Where the Emergency Department has been contacted ambulance officers take patients in via the dedicated ambulance entrance. An Emergency Department staff nurse interviewed by the Commissioner's staff was not aware of this instruction and indicated she found the inconsistency in NZAS arrival procedures confusing and frustrating.

The Public Hospital made written requests for copies of NZAS protocols, procedures, training and staff qualifications in August 1996, late 1996 and again in April 1997, to assist in the liaison between ambulance officers and Emergency Department staff. No response was received to these requests. Mr C states he cannot recall receiving the requests from the Public Hospital.

The Public Hospital has regular "ACHE" (Ambulance, Crown Health Enterprise) meetings which involve Emergency Department staff, Intensive Care staff, and staff from the Order of St John and the air ambulance service, primarily to deal with "A-zeros" (which are situations in which Emergency Department staff attend an ambulance situation). The Public Hospital stated to the Commissioner that it offered NZAS the opportunity to attend these meetings but received no response.

Mr C stated to the Commissioner that he tried to instigate regular meetings with the Public Hospital but was informed by Emergency Department staff that this was not necessary. He stated that meetings are now held on a "crisis" basis, where an incident occurs correspondence is exchanged or a meeting held. This was confirmed by Dr D, Clinical Director, Emergency Department, the Public Hospital, who advised that contact between the Public Hospital and NZAS is informal and happens when an incident occurs. If the incident is serious enough, an incident report is completed and NZAS is notified by mail. Dr D could not recall ever receiving a written response to such correspondence. She reported that Emergency Department staff now follow up incidents with a phone call "… *as we at least get a verbal response* [from NZAS] *that way*".

Mrs A

Mrs A was an elderly Maori woman in the terminal stages of renal failure. While Mrs A had been an inpatient of the Public Hospital on 16 April 1998 a discussion was held with her family during which staff from the Renal Department explained that she was dying.

On 11 May 1998 Mrs A's condition began to deteriorate. Her daughter, Ms E, phoned the Public Hospital Renal Department and was instructed to phone for an ambulance. She consulted the phone book and rang NZAS at approximately 3.50pm.

Mrs C received the call and attempted to ascertain Mrs A's status. Ms E informed Mrs C that her mother's feet had swollen and her doctor had instructed her to call an ambulance immediately. Ms E was upset and unable to provide further information.

At 3.52pm Mrs C contacted the ambulance driven by Mr F. She apologised for the lack of information and did not assign the call a status level, but informed Mr F that Mrs A needed to go to hospital "quickly". Mr G, who was acting as an attendant to Mr F, interpreted this to mean that the job was urgent and turned on the siren. The ambulance arrived at the residence of Mrs A at 4.00pm.

Mr F entered the house and found Mrs A sitting on a couch. He noted blood and mucus oozing from Mrs A and that she appeared incoherent and unaware of events happening around her. Mr F reported the family was anxious and impatient so he did not assess Mrs A or take any baseline readings apart from a history of her condition. Mr F and Mr G placed Mrs A on a stretcher in a sitting position and transferred her to the ambulance. The ambulance departed at 4.14pm.

Mr F used a cell-phone and attempted to contact the Public Hospital Emergency Department. At this time NZAS protocol was to contact the hospital switchboard and ask to be transferred to the Emergency Department receptionist. Mr F reported that by the time he had contacted the hospital switchboard the ambulance had arrived at the hospital so he hung up. The ambulance arrived at 4.19pm and was backed into the ambulance bay. Mrs A was transferred to a stretcher, as her preferred position appeared to be sitting.

NZAS protocol dictated that unannounced calls had to be delivered through Emergency Department reception so Mr F took Mrs A through the front entrance accompanied by Ms E. Mr G remained with the ambulance and cleaned the stretcher.

Mr F does not recall where he placed Mrs A or what he said to Emergency Department staff. However, his routine and usual practice was to hand the patient record form to one of the Emergency Department receptionists and wait for them to read and check this before leaving. Mr F informed Ms E that *"someone will see you shortly"* and departed.

Hospital records indicate that at 4.30pm Mrs A was registered at reception and a chart completed with a brief summary of her details. Emergency Department staff do not recall seeing a PRF and there is none on record. Emergency Department staff believe that Ms E supplied details for her mother's chart. Ms E states she did not approach reception and did not speak to any Emergency Department staff before 5.00pm.

At around 5.00pm one of the Emergency Department receptionists noticed that Mrs A appeared unwell and informed the triage nurse, Ms H. Ms H had a brief discussion with Mrs A and Ms E. She felt that Mrs A was not responding well and took her through to the treatment rooms. Ms H attempted to obtain a history from Ms E and Mrs A but was unable to develop a clear picture of her background.

Mrs A was triaged and was taken to the resuscitation room at 5.05pm. She died at 6.00pm.

It is acknowledged that Mrs A's condition was terminal and earlier treatment would not have saved her.

Miss B
On 31 May 1998 Mrs C received a call from Mrs I, the grandmother of Miss B, at 12.13pm. Miss B was two years old at the time of this incident. Mrs C reported that Mrs I sounded "*terrified*" and said her granddaughter was not breathing and her lips were turning blue. Mr C said that Mrs I was well known to NZAS as an asthmatic who had used the service many times.

Mrs C called for an ambulance crewed by Mr J, elementary officer, and Ms K, officer cadet, by radio telephone at 12.15pm. It is noted that Ms K was 14 years old at the time of this incident. Mrs C advised this was a Code 1 situation. She then contacted another ambulance crewed by Mr C to request Paramedic assistance.

Both ambulances arrived at the residence at 12.21pm. The family was living in a garage at the time and after checking the house Mr J and Ms K found them in the garage. Mr C said that Miss B was crying and screaming which indicated to him that she was not in respiratory distress. Mr J said that Miss I was breathing quite well when he first saw her. Mr J assessed Miss I while Mr C and Ms K observed. Mr J stated he took around 10-15 minutes to assess Miss B and that he monitored her breathing and assessed her skin colour. A history was taken from the family, which indicated Miss B was asthmatic and had received 15 pumps of Ventolin the previous night and an additional 15 pumps by 11 a.m. that morning. At 12.00am Miss B had vomited, prompting Mrs I to call for the ambulance.

Mr C explained that there are often difficulties in making a full patient assessment of children. NZAS policy is to take those readings that can be taken. Where a reading cannot be taken easily, it is not recorded.

As paramedic assistance was not required Mr C departed.

Mr J decided not to nebulize Miss B. Instead he decided to give her a low supply of oxygen and take her to the Emergency Department at the Public Hospital. Ms K contacted Mrs C by cell-phone and informed her of Miss B's condition. Mrs C contacted the Emergency Department and supplied them with details of Miss B's condition and an estimated time of arrival. Mr J completed the patient report form.

The ambulance departed the residence at 12.33pm with Mr J, Ms K, Miss B and both her parents on board

Mr J parked in the Emergency Department ambulance bay at 12.40pm and placed Miss B on a portable oxygen cylinder. Mr J stated that he took Miss B into the Hospital through the ambulance doors. He reported that the Emergency Department Co-ordinator asked him to take Miss B to the waiting room. Mr J took Miss B through to this area and presented the patient report form to the receptionist, who began processing it. The senior receptionist noted Miss B was on oxygen and arranged immediate triage. Mr J took the patient report form back from the receptionist and accompanied Miss B through to the triage area. Miss

B was swapped from the ambulance oxygen supply to the hospital supply. Mr J reported that the triage nurse ignored him and the form, and began taking a history directly from the family. He therefore placed the patient report form on her desk and said that he had to leave.

Mr J departed and had no further involvement in the care of Miss B during this incident.

Miss B was triaged by the Triage Nurse as a rating 3. She was examined and found to have a moist cough, shortness of breath, tachypnoea (rapid breathing) and tachycardia (increased heart beat). Miss B was admitted to the Paediatric Ward at 10.50pm on 31 May 1998.

An incident form was completed on 4 June 1998. This form stated Miss B was "… *referred to me, before I had a chance to speak to officer – notes handed to me and he was gone – no handover, no explanation*".

Response to Provisional Opinion

In response to my provisional opinion legal counsel for the NZAS, stated:

"*1. I am instructed that [Dr L] has been the Medical Director for the Service for some considerable time. [Dr L] has given the Service permission to call him twenty-four hours a day, seven days a week. [Dr L] donates his services free of charge as a contribution to the Ambulance Service and in the spirit of community service generally.*

2. In the […] region seven GP's are rostered on a seven day a week, twenty four hour a day basis to give medical back up.

3. In the […] region there are up to four GP's who are rostered on a similar basis.

4. In both regions the rostered General Practitioners donate their time as a charitable contribution to the Ambulance Service.

5. [Dr L] alone carries out the patient reviews once a month.

6. Some considerable time ago, the Service requested [the Public Hospital] Emergency Department to audit patient report forms. <u>The Department refused to do this, yet they audit the patient report forms for [another ambulance service].</u>

7. I have not had the opportunity of examining all of the patient report forms that you have uplifted or which have been sent to you. I am instructed

however, that the emergency patient report forms should all be properly completed. However, there may be patient report forms for non-urgent work that are not completed in the usual way. For example, a client will be taken to a doctor and the client does not and will not accept a full examination and report by the service. Therefore their patient report form could well be incomplete. You may find this is particularly true in the non-urgent jobs that the Service undertakes.

8. *In the last twelve months a decision was taken to focus on taking in fewer jobs overall. In days gone by it was not uncommon for the Service to accept up to fifty (50) or sixty (60) jobs per day with a heavy weighting toward emergency work. Now the workload is much lighter and about ten (10) jobs a day with some emergency jobs included is the usual workload.*

9. *Non-emergency jobs include taking patients to doctor's appointments, clinical appointments and the like.*

10. *If the Service does not have the capacity to take on an emergency job, it is handed over to [another ambulance service] straight away.*

11. *I am instructed that a letter was sent to you some time ago enclosing a copy of the Transport Licence and Deed of Trust.*

12. *In relation to the allegation that the Service has failed to supply adequate information to support its application to the Board, I couriered some 4,500 pages down to the Board. This information was very detailed and included information on protocols, rosters, staff training and so on. This information would have been couriered down over two years ago and I can give you the exact date if required from my old file. We provided more information than any other organisation of a like nature has been asked to do.*

13. *I am instructed that the letters referred to in August 1996, late 1996 and April 1997, from the Public Hospital have never been received – if they had been, they would have been answered.*

14. *Page 18 Right 4(2) of your Interim Report refers. I am instructed that there has been no contact with the Service by [the Public Hospital] Emergency Department regarding the Department's policies since the Commissioner has been involved in investigating these complaints.*

15. *I am instructed that the Service has spent some $12,000.00 to get ISO9000 accreditation. The Service will have to spend another $5,000.00 to $6,000.00 to complete accreditation. The accrediting agency had enlisted the services of [paramedic previously employed by another ambulance service] to review all systems including staffing, training, patient safety, documentation of procedures and compliance with relevant regulations and standards.*

16. It is hard to escape the conclusion that the 'powers that be' have no wish to see this Service succeed. There seems to be a history of ill feeling between [another ambulance service] and [Mr C] of NZAS. [Mr C] had been a member of [another ambulance service] and a high ranking one at that for many years before he departed.

17. The point I wish to make here is that [Mr C] is one of the many volunteers who run this Service. I have seen their work in the field for myself and am impressed with their dedication and desire to help their fellow citizen. They are endeavouring to assist those who require a free ambulance service, but there is not intention to compete with the scale of operations currently undertaken by the [another ambulance service], who have been a feature of our landscape since the turn of the century.

On receipt of this information the Commissioner wrote to NZAS and requested further information relating to the medical back-up provided to NZAS by general practitioners and asked that information originally requested on 10 August 1999, 17 August 1999, 7 September 1999, 11 October 1999 and 15 November 1999 be forwarded. No response to this request was received.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Other relevant standards

Policies and Procedures for NZAS

Ambulance Crew Responsibilities

"*… All documentation raised by the ambulance crew is to be completed in full and the appropriate copies passed to an authorised person for analysis and record keeping on a monthly basis.*"

Triage in the Emergency Department – The Public Hospital

Assessment

"*All patients will be triaged on their arrival at the Emergency Department by a suitably qualified nurse …*"

Opinion: Breach – New Zealand Ambulance Service/The Public Hospital

Right 4(5)
In my opinion, both the Public Hospital and NZAS have breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights.

There is a conflict in the evidence concerning the handover details for Mrs A and Miss B. The Public Hospital staff found the arrival procedures of NZAS officers inconsistent and confusing and NZAS staff found the Public Hospital staff unco-operative in their dealings with them. Communication is a two way process. It appears from my investigation that there have been serious communication breakdowns between the Public Hospital Emergency Department staff and NZAS Officers. The admissions of Mrs A and Miss B reflect a failure on the part of both providers to communicate adequately. In order for there to be quality and continuity of services both parties must co-operate and communicate. This did not occur in the two admissions investigated.

I note that the Public Hospital is in the process of implementing a new protocol for ambulance admissions to the Emergency Department and as part of this process has asked for review and comment from NZAS and the other ambulance services that use the Public Hospital facilities.

Opinion: Breach – New Zealand Ambulance Service

In my opinion NZAS breached Right 4(1), Right 4(2) and Right 4(5) of the Code of Health and Disability Services Consumers' Rights.

Right 4(1)
In response to my provisional opinion NZAS stated that medical back-up to ambulance services was provided by eleven general practitioners throughout the region. I requested further information on this matter from NZAS but no response was received. I must therefore accept the information gathered during the course of my investigation which indicates that medical back-up to NZAS is supplied by a single Medical Director.

In my opinion NZAS does not have adequate medical back-up for services. The role of the Medical Director in overseeing medical procedures includes reviewing all patient record forms once a month and assisting in emergency situations. A single medical advisor cannot be expected to provide support 24 hours a day, 7 days a week.

Every consumer is entitled to have services provided with reasonable care and skill. In my opinion the failure of NZAS to have adequate medical support indicates a lack of reasonable care and skill and is a breach of Right 4(1) of the Code.

Right 4(2)
In my opinion NZAS also breached Right 4(2) of the Code by failing to document adequately actions taken by NZAS during ambulance procedures. Patient report forms reviewed during the course of this investigation are incomplete, not of a consistent standard, and do not include the steps taken to investigate incidents. Failure to ensure that documentation is completed and accurate is in breach of the "Policies and Procedures for "[NZAS…]" and is therefore a breach of a relevant standard for purposes of Right 4(2).

Right 4(5)
NZAS has consistently failed to provide information when requested by NZAB, the Public Hospital and the Commissioner.

On three occasions the Commissioner, by notice in writing, required NZAS to produce copies of the their transport service licence and the deed of trust for the "[New Zealand Ambulance Service … Trust]", in the exercise of the Commissioner's powers under section 62 of the Health and Disability Commissioner Act 1994. No response to any of these requests was received. I note that under section 73(b) of the Act, the failure, without reasonable excuse, to comply with a lawful requirement of the Commissioner is an offence.

NZAS failed to supply adequate information to support its application for membership of NZAB and in 1998 NZAB informed NZAS that as this information had not been produced it was treating the application as lapsed.

In August 1996, late 1996 and April 1997 the Public Hospital wrote to NZAS requesting copies of protocols, policies and staff training to assist in the liaison between Emergency Department staff and ambulance officers. This information was not supplied.

Liaison between agencies involved in complementary services is vital to ensure the quality and continuity of services. NZAS has consistently failed to provide information to assist other health providers, professional bodies and the Commissioner's office. In my opinion this failure is a breach of Right 4(5).

Opinion: Breach – The Public Hospital

Right 4(2)
The Public Hospital records indicated that someone approached the Emergency Department reception at 4.30pm and that Mrs A was registered by the receptionist. The Public Hospital stated that it did not receive any information from an ambulance officer, however Mr F informed the Commissioner he provided handover at this time and Ms E stated neither she nor her mother approached the reception desk. On the balance of probabilities, it is my opinion that Mr F provided information about Mrs A's arrival to reception staff.

It was not until 5.00pm, half an hour after Mrs A was registered, that she was seen by Emergency Department staff and this delay is unacceptable and does not comply with the procedure outlined in "Triage in the Emergency Department – [The Public Hospital]". Failure to provide immediate triage to Mrs A on her arrival is therefore a breach of a relevant standard for purposes of Right 4(2).

Actions

I recommend that NZAS:

- Ensure that NZAS has adequate 24 hour per day, 7 day per week medical advice coverage.
- Ensure that all patient report forms are audited by a medical officer on a monthly basis and take active steps to improve the standard of these forms, with input from the Public Hospital.
- Initiate an independent review of their systems. This review should focus on staffing, training, patient safety, documentation of procedures, compliance with relevant regulations and standards and communication issues.

I recommend that the Public Hospital:

- Continues with its review of Emergency Department ambulance admission procedures with input from all ambulance services, and in future ensures that all ambulance service providers are supplied with current copies of admission procedures.

Further actions

- I refer the matter whether NZAS has been operating lawfully as an ambulance service under current transport legislation to the Land Transport Safety Authority.
- A copy of this file will be sent to the New Zealand Ambulance Board, the Ministry of Health and the Minister of Transport.