Care provided by paramedic during patient transfer (13HDC01190, 25 June 2015)

Paramedic ~ Ambulance officer ~ Medical officer ~ Rural hospital ~ Chronic shortness of breath ~ Rights 4(1), 4(2)

A 69-year-old woman lived in her own home in a rural area. She had multiple co-morbidities including diabetes, ischaemic heart disease, and chronic obstructive airway disease (COAD). She was using oxygen at home because of her COAD.

The woman had had a cough for approximately three days. Her daughter was with her overnight. At around midnight, the woman was finding it difficult to breathe, and had chest pains. The daughter activated her mother's medical alarm and 111 was called.

The responding ambulance was manned by a paramedic and a volunteer. They found the woman sitting in a chair using oxygen. Her observations were abnormal, in particular, her oxygen saturations were low and her temperature was low. The paramedic telephoned the duty medical officer at the local rural hospital. The medical officer recalls being told that the woman's vital signs were stable, and there were no other associated symptoms besides her baseline chronic shortness of breath. The woman was not transported to the hospital. The paramedic and volunteer told the daughter that if things got worse, she was to call the ambulance again.

About two hours later, the daughter called the ambulance again. The paramedic went to the volunteer's home to pick him up, but he was unable to wake him, so he responded to the call alone. On arriving at the woman's home a second time, the paramedic recognised that the woman was seriously unwell. He rang the medical officer again, reporting her vital signs, and was advised to transport the woman to the hospital.

The woman had to walk eight metres to a wheeled chair outside the front door. Her daughter and the paramedic then wheeled the woman to the ambulance, but during that time she had no oxygen as the paramedic had not brought any portable oxygen up to the house. When they got to the ambulance, the chair tipped over. The woman was still strapped in, and the paramedic then tilted the woman upright. The woman collapsed and fell to the ground as they attempted to get her to move into the ambulance. The daughter and the paramedic lifted her onto a stretcher to transfer her into the ambulance.

The paramedic put the woman on oxygen via an acute mask, and put her on a monitor so that he could record her heart rate and rhythm. Despite alarms sounding because the woman's oxygen levels were low, the paramedic did not stop the ambulance until they reached the hospital. The woman died during the journey.

It was found that during the second attendance, the paramedic did not take sufficient steps to obtain the volunteer's assistance or other support. The paramedic should have obtained assistance prior to moving the woman when he arrived at her house and became aware of her condition. The paramedic decided to move the woman without portable oxygen when she was seriously unwell and dependant on oxygen. When the woman collapsed, he failed to assess her sufficiently, and took no action when the alarms sounded during the journey to the hospital.

The cumulative effect of these failings was that the paramedic's assessment and treatment of the woman was seriously inadequate. The paramedic failed to provide

services with reasonable care and skill and, accordingly, breached Right 4(1). The substandard documentation in this case represented a departure from accepted standards of care. Accordingly, the paramedic failed to provide services in accordance with relevant standards and breached Right 4(2).