Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC01118)

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. On 22 May 2021, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her husband, Mr A, by The Priory in New Zealand of the Most Venerable Order of the Hospital of St John of Jerusalem (trading as Hato Hone St John Ambulance (St John)), on 18 May 2021.

3. Mrs A raised concerns about the length of time they were required to wait for an ambulance and that St John staff did not assess Mr A on arrival. Mrs A also raised concerns about poor communication by St John staff.

4. The report discusses the care provided to Mr A, aged in his forties at the time. In particular, the report concerns the ambulance officers' management of Mr A's situation on attendance.

Names have been removed (except Priory in New Zealand of the Most Venerable Order of the Hospital of St John of Jerusalem, trading as Hato Hone St John Ambulance) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. The following issue was identified for investigation:

- *Whether The Priory in New Zealand of the Most Venerable Order of the Hospital of St John of Jerusalem (trading as Hato Hone St John Ambulance) provided Mr A with an appropriate standard of care on 18 May 2021.*

6. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Complainant/wife
St John	Provider

7. Further information was received from:

Dr B	General practitioner (GP)
Te Whatu Ora	District provider
Ambulance Service 2	Provider

8. Also mentioned in this report:

Officer C	Intensive care paramedic
Officer D	Emergency medical technician
Officer E	Emergency medical technician
Ms F	Call handler

How the matter arose

Visit to GP (Dr B)

9. On the morning of 18 May 2021, Mr A visited his GP, Dr B. Mr A reported having experienced chest discomfort on 13 and 16 May 2021 when carrying out some physical activity. Mr A stated that although he had no chest pain at the time of this visit, his chest muscles, shoulders, and mid-back were sore. Dr B noted that Mr A had a family history of 'cardiac pathology (coronary syndrome[1])'.

10. Dr B performed an electrocardiogram[2] (ECG), which showed that there were 'Tall R waves noted in V4–V5 and V6'. Other tests carried out included thyroid function, renal function, lipid profile, liver function, and troponin[3] levels.

11. Mr A was prescribed omeprazole[4] for associated reflux symptoms, and Dr B advised him that if he had any recurrence of pain, he should call an ambulance. Dr B documented a plan to

[1] The term 'acute coronary syndrome' refers to a range of conditions related to a sudden, reduced blood flow to the heart.
[2] A test used to measure the electrical activity of the heart to assess heart conditions.
[3] Troponins are proteins released into the bloodstream when the heart muscle has been damaged. A high level may indicate a heart attack.
[4] A medication used to relieve symptoms of gastric reflux.

review Mr A as the need arose or to follow up with him the next day for long-term management.

12. Dr B's clinical notes show that at 5.05pm that day he received Mr A's results, which showed his troponin levels as 'critical' at 108.[5] At 5.07pm, Dr B rang Mr A and advised him to call an ambulance and go to the Emergency Department of the public hospital immediately, even if he was not experiencing any chest pain. Dr B also advised Mr A not to drive himself.

13. Dr B documented that he called the Emergency Department of the hospital to advise that he would be sending a referral for Mr A, and then he sent through the electronic referral. Dr B called Mr A again at 5.32pm and advised him that he was sending a referral to the hospital and reiterated that Mr A needed to call an ambulance and go to the Emergency Department straightaway.

St John and Ambulance Service 2 involvement

14. At 5.35pm, Mr A called for an ambulance via the 111 emergency phone number and spoke to an emergency call handler from another ambulance service (Ambulance Service 2).[6]

15. St John told HDC that both St John and the Ambulance Service 2 call handlers use a computer software tool called ProQA (the ProQA system) to process and dispatch their 111 emergency calls. For a patient presenting with chest pain, as Mr A was, the ProQA system guides the call handler through a series of questions and prompts to assess the patient's symptoms and provide appropriate advice and information while an ambulance is being dispatched.

16. The call transcript shows that Mr A explained to the call handler:

> 'I've had blood tests done this morning and [Dr B] told me my [troponin level] is 108 … [Dr B] told me to ring an ambulance and get to the Emergency Department at [the public hospital].'

17. The call handler asked Mr A, 'What are you experiencing yourself?' Mr A said: 'I am scared now but I was fine until he phoned.' When asked by the call handler, '… So what was it that required you to take a test?', Mr A responded, 'Um I've had pains in my chest.' Mr A stated that he was 'a long way out', and then said:

> 'My wife will be home soon, is it better that we just drive ourselves? [Dr B] seemed quite insistent that I got an ambulance and that's worried me more than anything.'

18. In response to this, the call handler stated:

> '… Oh I see, he was probably being a bit cautious and ah wanting to make sure you weren't driving yourself, but we can just triage you and we can go from there okay?'

[5] Troponin may be considered high if it is above 22ng/L for men.
[6] Emergency (111) calls go to one of three Communications Centres (Auckland, Christchurch, and Wellington). The centres take calls and dispatch ambulances for all New Zealand.

19. At the call handler's prompting, Mr A reported that his breathing was normal, he was not clammy or having cold sweats, and he had no history of heart attack or angina. The call handler asked whether Mr A had taken any drugs or medications in the past 12 hours, and Mr A said he had taken omeprazole and paracetamol. The call handler told Mr A that before the responders arrived, he should take one full, or three low doses of aspirin, if he had any, and that he was not to have anything to eat or drink.

20. The call handler advised Mr A to ring back if he and Mrs A chose to drive to hospital themselves.

21. Subsequently, Mr A's call was triaged by a St John dispatcher utilising the 'Assessment for myocardial ischaemia[7]' protocol based on the ProQA system's assessment. Mr A's condition was triaged as being potentially serious but not immediately life-threatening and prioritised as a status 2 and/or 'Orange' response.[8]

22. St John explained the joint services approach it operates with Fire and Emergency New Zealand (FENZ) when managing medical callouts. St John First Response units are used for Purple[9] and Red[10] incidents owing to the life-threatening nature of these calls, whereas Orange incidents may have a Fire First Response prior to a more qualified ambulance resource arriving.

23. Given the 'Orange' prioritisation, and as the only available First Response ambulance was within its last hour of shift, an 'interCAD' message[11] was sent by the St John dispatcher to FENZ requesting assistance from their first responders, the Fire First Response (FFR).

24. St John advised that FFR was dispatched at 5.52pm and arrived at Mr A's home at 5.57pm.

25. St John told HDC: '[FFR units] are not designated as "transporting" ambulances and are not equipped to the same standards as front-line emergency ambulances.'

26. St John also said that because of the clinical practice levels of FFR units, they would 'be unable to clinically manage a deteriorating patient'.

St John ambulance staff attendance

27. The St John ambulance was dispatched at 6.19pm and arrived at Mr A's home at 7.10pm. The attending staff were an intensive care paramedic (ICP), Officer C, and two emergency medical technicians (EMTs), Officer D and Officer E. St John stated that Officer D was mentoring Officer E and took the lead in the care provided to Mr A.

[7] Reduced blood flow and oxygen to the heart muscle.
[8] An 'Orange' response is classed as urgent/potentially serious but not immediately life-threatening.
[9] Immediately life-threatening.
[10] Immediately life-threatening or time critical.
[11] A typed computer message between emergency services.

Assessment

28. On arrival, the ambulance staff were informed by the FFR personnel that they had carried out an initial assessment of Mr A, which included taking vital signs and monitoring his blood pressure (which was stated to be slightly elevated) and heart with an automated external defibrillator (AED).[12] St John told HDC that its staff were advised by FFR personnel that other than a slightly elevated blood pressure, Mr A was showing no abnormal signs and symptoms. St John said that its staff were also informed by the FFR personnel that Mr A had told them that he was 'pain-free', and they also clarified this with him during their visit.

29. St John staff reported that their intention was to complete their own assessment of Mr A during transit to the hospital. Initially, St John told HDC that attending staff did not complete any assessment of Mr A. However, later St John told HDC that Officer C recalled that 'heart rate, blood pressure, 3 lead ECG, 12 lead ECG, respiratory rate, GCS[13] and pain scale' monitoring were undertaken, but it was not clear whether this was done by the St John ambulance crew. On the other hand, Officer E stated that 'a 12 lead ECG was not acquired' during their attendance. In response to the provisional opinion, Mr and Mrs A confirmed that no assessment was carried out on Mr A by St John staff. They clarified that the assessment and monitoring was all undertaken by the FFR personnel.

30. Officer D said that during their attendance he was shown Dr B's referral letter. However, in his response to the provisional opinion, Mr A advised that at the time he did not have a physical referral letter from Dr B to show St John staff. He advised that 'the only communication with Dr B that evening was at 5.05pm by telephone'.

31. St John also advised that when questioned after the event, Officer C recalled that the troponin level from the Mobile Data Terminal (MDT)[14] notes was 30, not 108. However, St John confirmed that the information provided on the MDT in the ambulance that their staff would have seen confirmed that Mr A's troponin level was 108.

Transport decision

32. St John told HDC that its staff had discussions about transporting Mr A to hospital. St John staff reported that Mr and Mrs A raised concerns with them about delays in the ambulance arriving. Mr A asked St John staff whether he could transport himself to hospital, so that his wife would have a vehicle to return home if he was admitted to hospital.

33. Officer D said that he advised Mr and Mrs A that 'self-transport was an option if [Mr A] was pain free'. It appears that at that time, no treatment had been offered. It was decided that Mrs A would drive Mr A to hospital. Officer C stated that she felt that the Mode of Transport guidelines from St John's Clinical Procedures and Guidelines[15] had been complied with.

[12] A device that analyses the heart's rhythm and, if necessary, delivers an electric shock (defibrillation) to help to restore the heart's natural rhythm.
[13] Glasgow Coma Scale — a tool used to measure a person's level of consciousness.
[14] Information provided on the Mobile Data Terminal (MDT) in the ambulance is the information gathered during the 111 call when an ambulance is requested.
[15] Discussed at paragraph 43.

34. As a result of Mr A declining transport, St John staff reported that they advised Mr A that 'if there were any concerns such as chest pain, shortness of breath, altered level of consciousness, that they pull over and call 111 immediately'. St John staff also advised that on arrival at the Emergency Department, Mr A should show the nurse the GP referral.

35. In his response to the provisional opinion, Mr A told HDC that he inferred that it was a waste of ambulance time for St John to transport him because they told him he would 'just be sitting in the big seat to join the back of the queue' at the hospital. Mr A stated that he accepted this, as he felt there were probably more urgent cases than his. However, he advised:

> 'a) I was just following what my Doctor had told me to do.
>
> b) I was not aware of the seriousness of my own situation.
>
> c) We had already wasted two hours waiting around for St John's to do nothing. We could have been at [the hospital] in that time.'

36. When questioned by St John about why Mr A was not transported to hospital, Officer D stated:

> 'The patient was competent to make any transport decisions. I have always been instructed to respect [a] patient's wishes. If the patient had been transported by the ambulance, I feel that there would have been no interventions carried out apart from monitoring and baseline observations. Transport by ambulance was never refused.
>
> I feel that as a GP referral, like all GP referrals, they are easy tasking[s] for the ambulance. First job of the night, a "load and go" job. The weather was extremely poor so transport time for this patient would have been approximately 2 hours.'

Communication

37. In her complaint to HDC, Mrs A stated that she was concerned that Officer D did not assess Mr A, and Officer D's communication was 'rude'. Mrs A said that Officer D told them that 'people less sick than [Mr A] just wait in ED'. Mrs A told HDC that this left her and Mr A feeling 'stupid for ringing [and] wasting [St John staff] time'. St John did not address this concern about Officer D's communication in its response to HDC.

Clinical documentation

38. St John told HDC that during this investigation it became aware that 'no mandatory clinical documentation had been completed' by its attending staff at this incident.

39. St John also said that Mr and Mrs A were concerned about receiving a St John invoice for the ambulance. Officer D said he reassured Mr A that no invoice would be generated if they did not complete any vital signs and the patient declined transport. St John staff said that in light of the concerns about the invoice, they did not complete an electronic Patient Report

Form (ePRF[16]) and noted in their records that 'no ambulance was required'. In their response to the provisional opinion, Mr and Mrs A clarified that the St John invoice was 'not an issue for [them]'.

Admission to hospital

40. Mr A presented to the Emergency Department of the hospital at approximately 9pm on 18 May 2021 and was noted to be hypertensive.[17] He was admitted to hospital at 10.15pm under a Cardiology consultant. Mr A was transferred to the Critical Care Unit (CCU) in the early hours of the following morning (19 May 2021).

41. Te Whatu Ora's Electronic Admission Summary (EAS) states that Mr A was '[g]iven aspirin 300mg in ambulance today but has remained pain-free'. However, there is no written information by ambulance staff to confirm that aspirin was actually taken by Mr A.

Discharge from hospital and diagnosis

42. On 25 May 2021, Mr A was discharged from hospital. The discharge summary records his primary diagnosis as 'NSTEMI[18]', a type of heart attack. Mr A was to have a follow-up appointment with a Cardiology nurse specialist.

St John policies and procedures

43. St John provided HDC with sections of its Clinical Procedures and Guidelines dated 2019–2022, which were in place at the time of this incident and are attached as Appendix A.

Further information from St John Internal Audit Review

44. St John informed HDC that because the staff who attended Mr A on 18 May 2021 failed to undertake any clinical assessment and complete mandatory documentation (as outlined in its Clinical Procedures and Guidelines), a national clinical audit was carried out by its Clinical Audit and Research Team. Information for the audit was gained from interCAD data and statements taken from all St John staff in attendance.

45. St John told HDC that the audit, dated 19 August 2021, found that the patient care and documentation provided by its ambulance staff in attending Mr A was 'well below expected standard' and was not in accordance with its Clinical Procedures and Guidelines for the reasons outlined below:

- No thorough assessment was completed for Mr A.
- It is unclear whether a 12-lead ECG was done.
- Staff did not transport Mr A to hospital.

[16] An ePRF replaced handwritten clinical records and is used by St John as its ambulance electronic clinical record.
[17] His blood pressure was higher than normal.
[18] Non-ST-elevation myocardial infarction — a type of heart attack.

- Mandatory clinical documentation was not completed, including St John's ePRF, competency to decline, and non-transport checklist.
- There was no evidence of safe-guarding because of the above.

Ambulance Service 2 policies and procedures (as provided in response to the provisional decision)

46. Ambulance Service 2 referred to the guidelines in its Standard Operating Procedure, namely, 'Requests to Cancel an Emergency Incident prior to Patient Assessment' (Ambulance Service 2's policy), which states:

> '1. … If the chief complaint includes a priority symptom, (regardless of protocol) advise the caller that because of the nature of the call it may be a good idea to continue the ambulance response.'

47. In response to the provisional opinion, Ambulance Service 2 told HDC that as Mr A 'had been triaged using the Chest Pain Protocol, and Chest Pain is a priority symptom, it would have been more appropriate to encourage the patient to wait for an ambulance'.

Responses to provisional opinion

48. Mr and Mrs A were given an opportunity to respond to the 'How the matter arose' and 'Changes made' sections of the provisional opinion, and their comments have been incorporated into this report where relevant and appropriate.

49. Mr and Mrs A told HDC that they were not on a 'witch hunt' over this. They said: 'Things happen, people make mistakes and with the best will in the world will never get every decision right.' However, they advised that they felt that 'politics or protocol' had gotten in the way of Mr A being transported to hospital.

50. Mr and Mrs A also stated that their car was not equipped for dealing with a declining patient, but they felt that it was their only choice for transporting Mr A to hospital.

51. In response to the provisional opinion, St John stated:

> '[St John] accepts the breach and considers that the care provided by the officers did not meet the expected standard of care including completing documentation. HHSJ considers that the assessment and documentation of [Mr A] was a significant departure from the expected standard of care by both officers. Both officers were subsequently referred to the HHSJ Authority to Practice Committee for review.'

52. St John accepted the recommendations made in my provisional decision. St John stated:

> 'In the period since this incident occurred, [St John] is not aware of similar incidents where an urgent referral has not been facilitated or appropriate documentation and a treatment plan completed. Notwithstanding this, [St John] has guidance and education in place to ensure any urgent referrals are completed and documented and will provide

evidence of this education to HDC. St John proposes further education and monitoring of reportable events to identify and respond to any reoccurrence.'

53. St John also told HDC that it accepts the adverse comment for Officer D, who is no longer employed by St John.

54. Ambulance Service 2 was given an opportunity to respond to the comments in the provisional decision in relation to how its call handler dealt with the 111 emergency call made by Mr A.

55. Ambulance Service 2 confirmed that the call handler is no longer in its employment and has not been contacted to make comment. However, Ambulance Service 2 stated:

> 'The 111 call has been reviewed against the audit standards set by the International Academy of Emergency Medical Dispatch and also against the national Standard Operating Procedures.
>
> The comments in this call review make it clear that the call taker could have done more to encourage Mr A to wait at home for an ambulance rather than driving to hospital. There were two aspects to this:
>
> - *The call taker could have been more specific in encouraging Mr A to take his doctor's advice with respect to travelling by ambulance*
> - *Given that chest pain is a priority symptom, Mr A should have been encouraged to wait for an ambulance.'*

56. Ambulance Service 2 stated:

> 'Please pass on [our] apologies to [Mr A] that he was not advised to follow the safest course of action, which in this instance, would have been to wait for the ambulance to transport him to hospital.'

57. Officer D was also given an opportunity to respond to the relevant sections of the provisional report relating to him, and he did not comment.

Opinion — breach

Introduction

58. On 18 May 2021, Mr A followed the urgent recommendation and advice of his GP and called St John for an ambulance to transport him to hospital. Given Dr B's concern over Mr A's troponin levels, I recognise that this would have been a worrying time for Mr and Mrs A whilst waiting for Mr A to be transported to hospital. I commend them for bringing this complaint to HDC's attention and highlighting their concerns, and I note that this helped St John to recognise failures in its systems around the assessment and management of the care provided to Mr A by attending staff.

59. To determine whether Mr A was provided with services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code), I have taken into consideration the outcome of the audit findings provided by St John.

60. Following an assessment of the information gathered as part of this complaint, I find that St John breached Right 4(2) of the Code.[19] The reasons for my decision are set out below.

111 call

61. St John told HDC that it considers that the 111 call was triaged appropriately as an 'Orange' response. I accept that the call was triaged appropriately. I have made further comment below (paragraphs 85–89) regarding the handling of the call.

Assessment, monitoring, and 12-lead ECG requirements

62. On arrival at Mr and Mrs A's home, St John ambulance staff, Officers C, D and E, were informed that an 'initial assessment' had been carried out by the FFR personnel who had attended first. St John staff were advised that other than Mr A's slightly elevated blood pressure, he showed no abnormal signs and symptoms and had stated that he was pain free.

63. Officer D confirmed that he saw the referral form from Dr B, and, as such, attending staff were aware of the urgency and concern for Mr A. In contrast, Mr A disputes this and stated that he did not have a physical referral letter to show St John staff at that point, having only spoken with Dr B by telephone. Given that it appears that Mr A did not return to the surgery after the referral was made by Dr B, I accept that Mr A did not have a copy of the referral letter.

64. Given Mr A's chest pain the previous week and InterCAD notes of Mr A's high troponin level of 108 earlier in the day, I consider that an assessment in accordance with Section 3.1 of St John's Clinical Procedures and Guidelines for concerns around myocardial ischaemia should have been undertaken and appropriate investigations carried out.

65. Officer C reported that various monitoring had been undertaken (see paragraph 29 above). However, Mr A stated that no monitoring was undertaking by St John staff, only by the FFR personnel. Officer E also confirmed that no 12-lead ECG was acquired to comply with requirements under Section 3.1 of St John's Clinical Procedures and Guidelines, which state that a '12 lead ECG should be obtained in all patients with either typical or atypical symptoms [of myocardial ischaemia]' and that 'in the absence of a clear diagnosis, a 12 lead ECG should be repeated every 10–15 minutes looking for evolving ECG changes'. Given that no documentation was completed to provide clarification around this, Mr A's evidence that no monitoring was undertaken by St John staff, and Officer E's evidence that no 12-lead ECG was acquired, I consider it more likely than not that the required monitoring was not undertaken.

[19] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

66. I have considered St John's Clinical Procedures and Guidelines regarding 'Treatment and referral decisions' and 'Obligations of personnel' (see Appendix A, section 1.18). I note that when making decisions and conveying recommendations, a full assessment of a patient must be carried out. This includes taking the patient's history, performing primary and secondary surveys, and measuring appropriate vital signs. It also requires obtaining informed consent from the patient on any recommendations made by personnel and outlining the benefits and risks of any alternative courses of action.

67. I am concerned that attending St John staff failed to recognise the seriousness of Mr A's condition and ensure that he was assessed fully prior to leaving the scene when he was not to be transported by ambulance, which is also required by the 'Non-transport pause and checklist' section of St John's Clinical Procedures and Guidelines.

68. Further, the team's decision to support Mr A to self-drive to hospital was in direct contradiction of Mr A's GP, who had directed him to go by ambulance even if he was not in pain. Without undertaking their own assessments, and knowing the urgency of the referral from the GP, I am critical that this decision was supported contrary to another health professional's directions.

69. Whilst attending staff told St John that they were intending to complete further assessment in transit to hospital, I consider that once they were aware that this was not going to happen, an assessment should have occurred at Mr A's home before he transported himself. Based on the information I have reviewed, and the lack of documentation provided (referred to below), I find that attending St John staff completed no clinical assessments of Mr A, and I am highly critical of this.

70. I note that there was also confusion around Mr A's troponin level. St John told HDC that Officer C thought that the MDT notes recorded this as 30, not 108, despite the result clearly being stated as 108 on the InterCAD message, which was seen by Officer D. It is unclear which MDT notes Officer C saw, as St John confirmed that the information on the MDT showed that Mr A's troponin level was 108. I am concerned that this confusion also added to the poor decisions made by staff when attending Mr A.

Transport to hospital

71. St John's Clinical Procedures and Guidelines state under 'The mode of transport' that private transport should be recommended only if the patient is 'unlikely to require treatment or intervention during transport'. Clearly, St John staff did not consider Dr B's specific recommendation that it was crucial for Mr A to be transported to hospital by ambulance because of his high troponin level, and I am critical of this.

72. I am concerned that there were no discussions with Mr A about the risks of potential myocardial ischaemia and the implications of him transporting himself to hospital (as required by Section 3.2 of the Clinical Procedures and Guidelines). This was especially important given that St John staff would have had specialist equipment onboard the ambulance should Mr A's condition have deteriorated during transportation to hospital.

73. I am critical that St John staff did not follow the requirement in the Clinical Procedures and Guidelines, which states that while a competent adult patient has the right to decline recommendations, the implications must be explained to them.

Documentation

74. In addition to the above failings, I note that attending St John staff were required to complete mandatory clinical documentation on St John's ePRF system, or on paper, in accordance with Section 1.20 of the Clinical Procedures and Guidelines. This section outlines the particular importance of this when a patient is not transported, and it notes that an ePRF should be completed even if staff are unclear about whether one is required. As there was a handover from FFR staff to St John staff when they arrived, the Clinical Procedures and Guidelines also required the 'entire incident' to be recorded on the ePRF.

75. When Mr A offered to be driven to the hospital by his wife, and St John staff agreed to this, St John staff should have asked him to sign the 'patient declined transport' section of the ePRF. I note that this section states that any 'assessment, interventions, recommendations and interactions' should be documented. St John confirmed that this did not happen, and, because of this, it is unclear who carried out the monitoring of Mr A that Officer C reported had been undertaken (see paragraph 29 above). Had these documents been completed, it may have prompted St John staff to recognise that a full assessment was required before Mr A was transported to hospital by his wife.

76. The lack of documentation by St John staff led to confusion about some of the assessments carried out and which attending team performed them. This has made the assessment of Mr and Mrs A's complaint challenging for HDC. The Clinical Procedures and Guidelines state that all staff are responsible for ensuring that documentation is accurate and complete, and I am critical that no one completed any documentation of this callout.

Safe-guarding

77. St John acknowledged the failure of its staff to undertake any clinical assessment and complete clinical records, against the requirements outlined in its Clinical Procedures and Guidelines. St John informed HDC that these failures came to light only when information was requested as part of this complaint. I am concerned that this failure was missed, and that no safe-guarding measures are in place to ensure that St John's Clinical Procedures and Guidelines are met by staff when a health provider has recommended that a patient be transported by ambulance.

78. I acknowledge that once these failings came to light, a thorough internal review was carried out by St John to identify and address the failings and minimise the risk of a similar event happening in the future. St John confirmed that the attending staff involved 'have openly engaged and reflected on their future practice as a result of this complaint'.

Conclusion

79. In reaching my decision, I have considered the information provided by St John as part of its internal audit review. I consider that ultimately St John is responsible for the failings in the

lack of care provided to Mr A, as there were errors of judgement by all the staff in attendance. St John staff collectively failed to carry out an assessment of Mr A, no 12-lead ECG was done, they failed to transport Mr A to hospital against medical advice, and they did not complete mandatory documentation. Accordingly, I find that St John breached Right 4(2) of the Code by failing to follow relevant standards, being St John's Clinical Procedures and Guidelines.

Officer D — adverse comment

80. I note from the information provided by St John that Officer D was 'taking the lead', as well as mentoring Officer E, and therefore had overall responsibility when attending Mr A on 18 May 2021. In this capacity, Officer D should have complied with St John's Clinical Procedures and Guidelines and been mindful of demonstrating appropriate standards of care for the benefit of Officer E. I am concerned that Officer D did not provide appropriate leadership to the team in his engagement with Mr A in accordance with St John's Clinical Procedures and Guidelines or guide the team to complete mandatory documentation.

81. I also note Officer D's comments when questioned by St John as to why Mr A was not transported by ambulance. Officer D said that he was respecting Mr A's decision to transport himself, having been instructed to always respect a patient's wishes. Officer D also said that he considered that Mr A was competent to make that decision, and the team never refused transport by ambulance.

82. Further, Officer D said that he advised Mr and Mrs A that 'self-transport was an option if [Mr A] was pain free', in direct contradiction to the advice and direction from the GP.

83. I acknowledge the importance of respecting a patient's wishes, and I accept that it appears that Mr A was competent to decide how to be transported to hospital. However, in the absence of an appropriate assessment of Mr A, I consider that ambulance staff had insufficient information on which to make a recommendation that contradicted the GP's advice regarding the method of transport. Without an appropriate assessment and recommendation, or a fulsome discussion of the risks of the alternative, Officer D did not provide Mr A with the information he required to make an informed choice about his options for transport to hospital. As such, I consider that it was not reasonable for Officer D to have relied on Mr A's assessment of his needs without providing him with further information about his condition (via an assessment) and a recommendation about transport. I am critical of Officer D's care in this regard.

Other comment

84. I note Mrs A's comment that she felt that Officer D's manner when attending Mr A was 'rude'. Whilst it is not possible to determine exactly what was said, I note that Officer D was dismissive of the GP's advice, and he did not explain to Mr A the risks of not taking the ambulance to hospital. I can appreciate why Mr and Mrs A were left with this impression of Officer D's manner. This serves as a reminder of the importance of sensitive communication

in situations where consumers are likely to be experiencing a high degree of anxiety and uncertainty, as would have been the case for Mr and Mrs A.

Ambulance Service 2 — educational comment

111 call

85. I note that the call handler, Ms F, was employed by Ambulance Service 2, which had a responsibility to ensure that the emergency 111 call from Mr A was handled appropriately.

86. Whilst I acknowledge the challenges faced by call handlers managing 111 calls of this nature, and Ms F's pleasant manner with Mr A, I highlight that Mr A stated to Ms F that his GP was 'quite insistent' that he be transported by ambulance, and Mr A explained how worried he was about this. However, I note that in the 111 transcript Ms F says that Dr B was 'probably being a bit cautious' and states twice that Mr A should call back if he chose to transport himself to hospital.

87. I also note that Ambulance Service 2 has acknowledged that its policy required the call handler, Ms F, 'to encourage [Mr A] to wait for an ambulance', as he had been triaged using the Chest Pain Protocol, with chest pain being a priority symptom.

88. I consider that it would have been more appropriate for Ms F to have stressed to Mr A that he follow Dr B's advice and wait for the ambulance, rather than infer on two occasions that it would be okay to transport himself, especially given that the ambulance would have specialist equipment available. This would have been consistent with Ambulance Service 2's policy.

89. I also consider that if Ms F had supported the advice of Dr B, rather than minimising it, Mr and Mrs A may not have questioned St John staff about transporting themselves. This serves as a reminder that if clinical advice has been recommended, that advice should be followed unless there is a clinical indication for an alternative, to maintain consistency from all providers in emergency situations such as this.

Changes made since events

90. St John told HDC that education and guidance continues to be provided to ambulance staff utilising its Clinical Procedures and Guidelines, Clinical Bulletins, and educational material around the need for 'complete and accurate documentation'.

Recommendations

91. I acknowledge that St John recognises that there is an ongoing need for education and guidance for its staff to ensure that its Clinical Procedures and Guidelines are complied with around the need for complete and accurate documentation. I outline further recommendations below.

92. I recommend that St John provide a written apology to Mr and Mrs A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr and Mrs A.

93. I also recommend that St John undertake the following, and report back to HDC within six months of the date of this report:

a) Provide the materials and schedule of training for staff around the need for 'complete and accurate documentation' in line with its Clinical Procedures and Guidelines.

b) Confirm that regular training is provided to staff on appropriate and effective communication with patients and provide the training materials and schedule of the training provided.

c) Implement a quality review system of its emergency ambulance attendances where health provider referrals are made that specify that urgent ambulance transport is required. The system should provide for assessing compliance with those referrals and its own Clinical Procedures and Guidelines and identify whether mandatory documentation has been completed. St John is to report back to HDC with details of the system put in place and how it will be audited/monitored going forward.

d) Use an anonymised version of this report as a case study for its staff, to encourage reflection and discussion during education sessions on the importance of good communication, recognising the seriousness of GP referrals if stated to be urgent, ensuring that assessments are carried out where required, and keeping detailed documentation.

Follow-up actions

94. A copy of this report with details identifying the parties removed, except the Priory in New Zealand of the Most Venerable Order of the Hospital of St John of Jerusalem (trading as Hato Hone St John Ambulance), will be sent to Ambulance New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: St John's Clinical Procedures and Guidelines

The following sections of the Clinical Procedures and Guidelines have been outlined as relevant to this report:

'**1.18 Treatment and referral decisions**
Whenever personnel are assessing a patient, the following initial decisions must be made:

— Is treatment required?
— Is referral to a medical facility required?
— If referral to a medical facility is required, what type of medical facility is most appropriate?
— If referral to a medical facility is required, what mode of transport is most appropriate?

Obligations of personnel
Personnel must convey these decisions to the patient as clear recommendations. When making decisions and conveying recommendations personnel must:

- Fully assess the patient including taking a history, performing a primary and second survey and measuring appropriate vital signs.
- Fully assess the patient's competency to make informed decisions.
- Take into account all available information, including non-clinical information such as social factors.
- Obtain informed consent by fully informing the patient regarding their condition, the recommendations being made to them, the reasons for the recommendations and the benefits and risks of any alternative courses of action.
- Act in the patient's best interest, while allowing a competent and informed patient to decline recommendations.
- Insist on treatment and/or transport if it is in the best interest of a patient who is not competent to make decisions.
- Fully document the assessment, interventions and recommendations.
- Seek clinical advice if the situation is difficult to resolve.

Deciding if the patient requires referral to a medical facility
Not all patients assessed by ambulance personnel require referral to a medical facility. It is appropriate for a patient with minor illness or minor injury to be managed in the community provided:

- The obligations previously outlined have all been followed, and
- The patient receives appropriate advice on what to do if they do not improve, including when to seek further clinical advice, and
- The non-transport pause and checklist is used, and

- Appropriate documentation is completed.

Criteria for immediate referral to a medical facility

* Personnel must recommend immediate referral to a medical facility if any of the following criteria are met:

— Personnel are unable to reasonably exclude serious illness or injury or
— There is a significant abnormality in any vital sign recording.

* Further details on specific referral criteria are contained within each section.

Non-transport pause and checklist

* If a patient is being given a recommendation by ambulance personnel that transport to a medical facility by ambulance is not required, the crew must pause briefly to go through the non-transport checklist (below) and agree that non-transport is the right decision. If consensus is unable to be easily achieved, personnel should have a low threshold for seeking clinical advice or recommending the patient is transported.

* The following non-transport checklist must be completed prior to leaving the scene:

- The patient has been fully assessed including a set of vital signs and appropriate investigations; and
- No vital signs (excluding temperature) are significantly abnormal, and
- Serious illness or injury has been reasonably excluded; and
- No red flags requiring transport to ED are present, and
- The patient is seen to mobilise (when able to normally do so), noting that if the patient is unable to mobilise there must be a minor or long-standing condition preventing this, and
- The patient and/or caregivers have been given a verbal and written explanation of when to seek further clinical advice.

Deciding where the patient should be referred

* If a patient is being referred to a medical facility, referral should be to the most appropriate medical facility taking into account:

- The patient's expected healthcare requirements, including investigation and treatment, and
- The most effective and efficient way of meeting those requirements.

* The patient may not require referral to an ED. It is preferable to refer the patient to a primary care facility, provided that:

- The patient's healthcare requirements can be reasonably met at that facility, and
- It is reasonable and practical to refer the patient to that facility.

When a competent adult patient declines recommendations

* A competent adult patient has the right to decline recommendations. In this setting personnel must:

- Explain the implications of the patient's decisions to them, and
- Involve the patient's family, friends or GP, provided the patient consents to this and it is appropriate to do so, and
- Provide the patient with appropriate advice on what to do if they do not improve, and
- Ask the patient to sign the "patient declined transport" section of the ePRF, and
- Fully document the assessment, interventions, recommendations, and interactions (consider utilising the recording function on an ePRF (if available), and
- Provide the patient with instructions on how to access a copy of the ePRF.'

'**The mode of transport**

* Not all patients requiring transport to a medical facility require transport in an ambulance. It is appropriate to recommend private transport provided all of the following criteria are met:

- The patient is very unlikely to require treatment or intervention during transport, and
- The referral guidelines within each section are followed, and
- A reasonable and appropriate alternative form of transport is available, and
- Personnel are reasonably assured the patient and/or family will comply with transport arrangements.

When the patient or family members insist on transport by ambulance

* A competent patient has the right to decline recommendations but neither a patient nor family members have the right to insist on transport that personnel do not think is clinically indicated.

* However, if the insistence appears to be based upon genuine concern and no other reasonable transport option is available, then the patient should be transported by ambulance. If the insistence appears to be based on maliciousness, convenience or petty concerns, then personnel may decline to transport the patient provided they:

- Explain the reasons for not providing transport, and
- Fully document their involvement with the patient and family, and
- Seek a second opinion via the Clinical Desk, and
- Forward the ePRF for audit.

When a registered health professional insists on transport by ambulance

* A registered health professional might insist on transport by ambulance that personnel do not think is clinically indicated.

* Personnel should try to resolve this by achieving consensus via collegial discussion, taking into account that the registered health professional may know the patient well. However, if consensus cannot be achieved, personnel should follow the principles contained within the previous paragraph.'

'**1.20 Documentation**

General principles

* Documentation must be accurate and complete

* Comprehensive documentation is particularly important when a patient is not transported to a medical facility.

* Documentation must be objective and subjective statements should be avoided. Take particular care to avoid subjective statements about the behaviour or demeanour of the patient, their family or other healthcare professionals, as they may subsequently read the documentation.

* As a general rule, a third party (for example, the Health and Disability Commissioner) will assume that if something is not recorded it did not occur.

* A third party should be able to read the documentation and understand what happened and why.

* One person will usually lead the patient assessment and treatment and this person should usually complete the electronic patient report form (ePRF). However, all clinical personnel in the crew are responsible for ensuring the documentation is accurate and complete.

* Documentation must occur on a paper PRF if an ePRF device is not available, and subsequently entered into the ePRF system when possible.

* A separate ePRF is required for each patient transported. This includes for example, a separate ePRF for a mother and her newborn.

* An ePRF should be completed whenever personnel are uncertain if one is required.

Information documented in the ePRF

* The ePRF must include all the following:

— The patient and incident details.
— The history and assessment of the patient.
— A description of all significant treatment administered and/or interventions provided prior to ambulance arrival.
— All treatment administered and interventions provided by ambulance personnel or by people assisting ambulance personnel, for example PRIME responders.
— A description of any clinical advice received, for example via the Clinical Desk.
— At least one set of vital signs. See the "vital signs" section for more information.
— Known allergies to medicines.

* The ePRF must contain all relevant information for the entire incident if the care and/or transport of the patient is transferred from one crew to another.
* The use of abbreviations should be minimised.
* Do not use terminology specific to ambulance personnel, for example R codes.

When an ePRF must be completed

An ePRF must be completed whenever:

* A single patient is assessed (even if vital signs are not recorded) following dispatch of an ambulance and is not transported to a medical facility. If more than one patient is assessed at an incident an ePRF is not always required for each patient, see below for more information …'

'**When a patient is not transported to a medical facility**

* When a single patient is assessed following dispatch of an ambulance and not transported to a medical facility, the documentation must include all the following:

— The patient and incident details, the assessment, all treatment administered, all interventions performed and at least one set of vital signs. See the "vital signs" section for more information.
— A clear description of the recommendation made to the patient and/or family/guardians/caregivers, including why the recommendation was made.
— A clear description of the communication between ambulance personnel and the patient and/or family/guardians/caregivers if a recommendation to be transported to a medical facility by ambulance is declined.
— A competent patient or guardian must be asked to sign the "patient declined transport" section of the ePRF if they decline a recommendation for transport to a medical facility by ambulance. They must not be asked to sign the "patient declined transport" section of the ePRF if they are deemed not competent to make decisions, or if a recommendation was made that transport to a medical facility by ambulance was not required.
— An electronic copy (or photograph) of the 12 lead ECG if one was acquired.
— Completion of the non-transport pause and checklist.

Providing advice to a patient not transported to a medical facility

* When a patient is not transported to a medical facility, advice on when to seek further clinical assessment and/or treatment should be provided.

* Advice should be provided in writing whenever this is feasible, for example using an ambulance care summary advice sheet.

Where applicable, information sheets (such as the concussion information sheet) must be provided.

* Written advice should be photographed using the ePRF device.

* Advice should be provided to:

— The patient if they appear to be competent.
— An appropriate person, for example a guardian or caregiver, if the patient appears to be not competent.
— A parent or guardian if the patient is a child.

Checking the ePRF before it is finalised and submitted

* The ePRF must be checked to ensure it is complete and accurate prior to it being finalised and submitted, unless the crew are required to immediately respond to an urgent incident.

* All clinical personnel in the crew that assessed the patient are responsible for ensuring the ePRF is checked if the patient is not transported to a medical facility.

* The ePRF check must include confirmation that:

— All appropriate sections have been completed.
— The information is accurate and free of errors.
— The information adequately reflects all that occurred, in a manner that ensures a third party could read the ePRF and understand what happened.
— The discarding of controlled medicines that were drawn up but not administered is documented. The discarding of controlled medicines must be witnessed by a second crew member whenever possible.'

'**3.1 Assessment for myocardial ischaemia**

Introduction

* Chest pain/discomfort or shortness of breath without an obvious non-cardiac cause in patients over 35 years of age must be considered to be possible myocardial ischaemia until proven otherwise. The distribution of the autonomic nerve supply to the intrathoracic and upper abdominal organ is such that the pain/discomfort from myocardial ischaemia may mimic the pain from many other causes in terms of location, sensation and radiation.

* Even if myocardial ischaemia is considered unlikely, a patient with chest pain/discomfort will usually require assessment in an ED because of the possibility of a potentially life-threatening cause, for example, pulmonary embolism, myocarditis, oesophageal tear/rupture, aortic dissection and pneumothorax.

* Personnel must have a very low threshold for clearly recommending that a patient with chest pain/discomfort or shortness of breath without an obvious cause is transported to an ED by ambulance.

History

* Taking a good history is usually the key to making a correct provisional diagnosis.

* Always begin by asking open questions.

Symptoms

* Patients with myocardial ischaemia will usually describe central chest pain or discomfort which is dull, heavy or compressing in nature and radiates to their neck, jaw or arms. However, myocardial ischaemia may present with atypical symptoms including:

— Sharp or non-specific pain.
— Epigastric (upper abdominal) pain.
— Burning or indigestion-like pain.
— Pain in the tongue or mouth.
— Breathlessness without pain.
— A feeling of impending doom.

* Some patients have silent myocardial ischaemia without typical pain or discomfort.

* Patients with autonomic neuropathy are at particular risk of this because the pain of myocardial ischaemia is carried by autonomic nerves. Patients who are elderly or have diabetes are at increased risk of having autonomic neuropathy. They may present with shortness of breath, fatigue, weakness, non-specific malaise or feeling light-headed. However, it is unusual for a patient to develop silent ST elevation myocardial infarction (STEMI) and if this is suspected personnel should seek clinical advice prior to treating the patient as having STEMI.

* Women are more likely to have myocardial ischaemia under-recognised and more likely to present with atypical features. Women are also less likely to have a 12 lead ECG acquired and this appears to be partly due to a higher threshold to acquire a 12 lead ECG. It is important that the investigations are determined by the nature of the clinical presentation and not by the sex of the patient.

Investigations and examination

* A 12 lead ECG should be obtained in all patients with either typical or atypical symptoms, noting that a normal 12 lead ECG does not rule out myocardial ischaemia. Up to 50% of patients having an acute myocardial infarction have a 12 lead ECG that is initially normal. In the absence of a clear diagnosis, a 12 lead ECG should be repeated every 10–15 minutes looking for evolving ECG changes.

* Although a patient with myocardial ischaemia may be pale and sweaty, physical examination usually reveals no significant abnormality.'