Incident Review of Care Provided to Mrs MJ on 18/6/22

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This incident review was undertaken to investigate the care provided to Mrs MJ on Saturday 18th June 2022. The request for the review was made on 27th June 2022 by the A/CE of SA Health. I have predominantly focused on the delay in arrival of an ambulance to initiate treatment for Mrs MJ and her transport to hospital. The care provided to Mrs MJ by the ambulance service and subsequently on arrival to hospital has also been considered.

In the course of this review, I have spoken with Mrs MJ's family and representatives of the SA Ambulance Service (SAAS), Northern Adelaide Local Health Network (NALHN) and the Department for Health and Wellbeing executive on-call team.

Incident Description

Summary. Mrs MJ is a 77 year-old female who fell whilst trimming trees at home in Andrews Farm sustaining head and hip injuries. Subsequent investigation at Lyell McEwin Hospital (LMH) found Mrs MJ to have sustained a fracture of her right neck of femur and fractures of the medial wall of the orbit and non-displaced fractures of her nasal bones.

In her previous medical history Mrs MJ was known to suffer from stage 4 lung cancer with brain metastases which had been diagnosed in October 2020. Mrs MJ had received treatment with both radiotherapy and chemotherapy previously.

Following the first 000 call there was a delay of 2 hrs 36 minutes before Mrs MJ was attended to by a SAAS ambulance crew.

Timeline. There were 6 calls made to SAAS from the scene:

1. The first call was received at 16:41 when Mrs MJ was triaged as Priority 3 (target of 92% of calls responded to in within 30 minutes). Mrs MJ's daughter was present throughout and had made the call for an ambulance advising of her brain tumour and an increased propensity for bleeding.
2. The second call was received 38 minutes later at 17:19 requesting an estimated time of arrival (ETA). The Emergency Medical Dispatch Support Officer upgraded the urgency from a Priority 3 to a Priority 2 (target of 90% of calls responded to within 16 minutes). Mrs MJ was recorded to be unable to be moved from the road due to extreme hip pain and was noted to be bleeding from her head. She was also recorded to be going blue around her hands and face potentially due to cold weather but with the additional possibility of hypoperfusion due to internal bleeding resulting from her fall. At this point the extent of Mrs MJ's injuries were unclear and internal haemorrhage could not be excluded.
3. At 17:45 a call back request was initiated. The ETA was estimated to be 60 minutes for a Priority 2 patient. This information was not provided to Mrs MJ's daughter at the scene.
4. A third call was received at 18:16 by SAAS from a bystander indicating that Mrs MJ was outside on the footpath and possibly had a fractured hip.
5. A fourth call was received a short while later at 18:20 stating that the patient was very cold and in considerable pain.

6. At 19:06 an Elizabeth crew were dispatched, arriving on scene at 19:17 (2 hours and 36 minutes post triple zero call and 1 hour and 57 minutes post upgrade to Priority 2).
7. Two further calls to SAAS were received at 19:14 and 19:15 prior to the arrival of the SAAS crew.
8. The patient departed the scene at 20:08 and arrived at Lyell McEwin Hospital (LMH) at 20:24.

Ambulance Service

The management of the initial 000 call has been reviewed and SAAS have confirmed that it had been assigned with the appropriate response priority – being given a Priority 3 at 16:41. A Priority 3 call has a target response time of within 30 minutes. At 17:19, 37 minutes after the initial 000 call, a second call was received by SAAS seeking an ETA and providing additional information about the condition of Mrs MJ. The urgency was appropriately upgraded to Priority 2. A Priority 2 call has a 16-minute response target and is accompanied by lights and sirens.

A SAAS incident review determined that the response to this patient far exceeded the required response times - 2 hours and 36 minutes post triple zero call and 1 hour and 57 minutes following upgrade to Priority 2.

A clinical review of the care provided once SAAS had attended the scene considered this to be appropriate and no concerns were identified. This was confirmed by Mrs MJ's family who were on the scene throughout the period after she fell.

At the time this incident occurred, SAAS were under significant operation pressure and had escalated to Opstat White at 14:40 that day. Opstat White is triggered in the SAAS Capacity Management Plan when 'levels of demand mean SAAS cannot achieve patient response times and patient safety is directly affected'.

SAAS had experienced a number of absences from the shift on 18th June 2002 due to sickness which resulted in significant reduction in available ambulances across the metropolitan region peaking at a crewing deficit of 7/52 crews (13.4%).

This was compounded by high sustained 000 call demand. There were 977 triple zero calls answered on 18th June 2022 which was 28% above the daily average for 2021 – equivalent to an additional 216 calls.

There were 1,168 ED presentations on 18th June 2022. Overall, ED activity was 1% below the daily average for 2021. Presentations to the LMH ED were 9% less that day compared with the 2021 average which would equate to 18 fewer presentations. Ambulance transports to metropolitan EDs were reduced by 12% compared with the 2021 average.

A total of 106.6 of ambulance hours were lost due to delays in Transfer of Care (TOC) at the LHNs on 18/6/22, including 43.1 hours at the Royal Adelaide Hospital (RAH), 30.2 hours at Flinders Medical Centre (FMC) and 9.7 hours at LMH.

The combination of sustained high 000 call volumes and reduced crewing are likely to have rendered SAAS more vulnerable to the service impacts caused by delays in TOC that result in ambulances being held on hospital ramps.

While the total TOC delay at LMH was limited relative to the RAH and FMC on 18/6/22, across the time period examined, the number of ambulances delayed at LMH peaked at 11 (range 0-11) reflecting the dynamic nature of TOC delays.

It was noted by SAAS that LMH had undertaken significant work over an extended period and were highly committed to minimising handover delays and the problems experienced there have been more recent than in other parts of the health system. SAAS has been in discussions with NALHN regarding TOC delays to identify processes to minimise these.

SAAS described being unable to shift crews to support the northern suburbs due to TOC delays occurring across all LHNs which prevent the redeployment of resources. This flexibility had been further impacted by both the high 000 demand and loss of crewing noted earlier. SAAS expressed anxiety regarding the risk of harm to patients when they are unable to respond within the necessary timeframe.

In addition, there has been on-going significant work to increase available resources that will potentially avoid further delays in the community. SAAS have announced an additional 99 FTE of staff for 2022/23 alongside short-term measures to supplement crewing whilst these staff are recruited too. The recruitment processes are well advanced.

Northern Adelaide Local Health Network

NALHN has less bed capacity relative to the other major metropolitan LHNs and yet would typically see a similar number of emergency presentations across a 24-hour period. Recent data reviews of the Relative Stay Index indicates that NALHN makes efficient use of their capacity. With less available in-patient capacity, the NALHN team have felt their emergency departments to be more vulnerable to increases or surges in demand than those in other networks.

A challenge that was described for the ED in receiving Transfers of Care is where the urgency of patients in ambulances that have been held on the ramp is lower than the acuity of those in other areas of the ED. It was noted on the 18th of June 2022 that a number of ambulance patients at LMH where there was a delayed TOC had been prioritised as P4.

LMH had been under sustained pressure (>100% capacity in the LMH ED) and on Code White escalation for an extended period with the LHN reporting that Code White felt like it was ‘the new normal’. Like SAAS, the NALHN team spoke of escalation fatigue.

The immediate strategies employed by NALHN when urgent SAAS offload is required are:

- Maximise cubicles
- Fill non-traditional spaces
- Sit those who are well enough to sit in the waiting room
- Offload SAAS patients into the waiting room when appropriate • Advocate for any admitted patients to leave the ED to the inpatient unit
- Maximise use of all potential flexed areas.

In discussing the response to SAAS escalation and associated state-wide flow teleconferences, the view expressed was that there was on occasion limited additional action possible as most if not all strategies were already in use. The NALHN team also felt on occasion there was a lack of system support between the LHNs. This it was felt reflected the pressure that all parts of the health system were operating under.

The NALHN team described a significant body of on-going work to improve flow – particularly across their in-patient areas. NALHN are also undertaking work to improve ambulance offload and processing within their emergency departments.

The NALHN team are exploring bringing other specialties or craft groups into the ED to create a diverse group of clinicians with differing skill sets including GPs, acute physicians, geriatricians and nurse practitioners. This would potentially form the basis of a contemporary model of care aligned to the needs of patients presenting to the ED.

Department of Health & Wellbeing

The DHW supports and contributes to on-call arrangements of managers and executives providing 24/7 coverage across the health system. In addition to a cadence of daily meetings, there are additional teleconferences called to deal with specific issues as they arise. Any of the system participants (LHNs, SAAS, DHW) may call a meeting which the DHW would typically chair.

The DHW executive receive texts alerting to local issues within the system – often focused on areas of delay. These are responded to on an 'as needs' basis and will on occasion involve contacting the executive on-call at an LHN to discuss local pressures and maintenance of service provision in the community.

There is a degree of 'escalation fatigue' across the system and the actions that could be taken in response to acute increases in demand have become more limited as they are routinely operationalised. It was noted that SAAS moving to Opstat White on 18th June 2022 had not been specifically communicated to the wider system that day.

Conclusions

- The care provided to Mrs MJ was far below what would be expected due to the significant delay in an ambulance attending her. Not only did this result in unnecessary pain but risked further harm as the extent of her injuries were at that stage unknown. The prolonged period on the ground in a cool environment also created a risk for other

negative sequalae including pressure injury and is likely to have delayed her subsequent recovery.

- The care provided once the SAAS crew attended and later at the LMH was satisfactory.
- Emergency and urgent care have been under sustained pressure for a significant period both within the ambulance service and in NALHN.
- Transfer of Care Delays are experienced across the metropolitan hospitals. These delays reduce the overall capacity of the ambulance service impacting upon the ability of SAAS to respond to increases in demand.
- The combination of staff sickness and high 000 call volumes further impact upon SAAS capacity and together with delays in transfer of care can result in a marked reduction in available ambulance crews. The interaction of these factors varies but has the potential to create a significant safety risk for the South Australian community.
- When SAAS is under pressure there is a risk that the prioritisation response times won't be achieved with the attendant risk of harm to members of the public.
- Escalation within services and organisations is commonplace and prolonged. As a consequence, the organisations involved here describe experiencing 'escalation fatigue'.
- As a result of continued escalation there are fewer measures that can be deployed in response to a surge or crisis as they are already in use. Nonetheless specific targeted requests to an LHN by SAAS or the DHW executive on-call will sometimes expedite ambulance transfers of care. That this is required in order to balance community and ED risk and is not uncommon is a cause for concern.
- SAAS are undertaking significant improvement work to increase capacity and have created alternative pathways to manage the calls they receive.
- NALHN have limited bed stock relative to the other metro LHNs despite seeing similar numbers of emergency presentations and are continuing work to improve ED and inpatient flow. Election commitments are noted to also have a focus on this.

Recommendations

- Further develop a focus on all patients within a locality by giving emergency departments visibility on SAAS responses in the community – so that decision making supports the provision of timely care to all patients irrespective of their location.
- Reinvigorate the system escalation process to identify meaningful actions that release immediate SAAS capacity when it is required.
- Consideration be given to a review by SAAS of their response prioritisation when the service is under pressure to ensure remaining crews are focused on those most in need.
- Though not directly assessed in this review, there is a requirement for similar meaningful responses in receiving hospitals to acute SAAS escalation that clear patients from the ED enable patient offload and the release of held crews.
- Continue to focus on strategies to improve whole of hospital and system flow to prevent hospital ramping and the follow-on impacts to patients in the community.

- Support the adoption of emergency models of care that include and promote utilisation of general practitioners, general/acute physicians, geriatricians and increased nurse practitioners in the ED.