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Ms Fiona Murphy
Secretary
Select Committee on Transfer of Care Delays (Ambulance Ramping)
transferofcare@parliament.tas.gov.au

Dear Ms Murphy

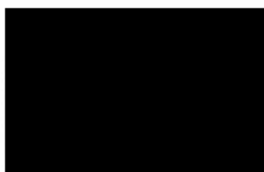
Subject: Provision of data requested by Select Committee – Final Response

I refer to your letter dated 6 October 2023, requesting a range of data to assist the House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping) to understand transfer of care delays in Tasmania, and my initial response to that request, dated 10 November 2023.

As noted in my initial response, additional time was required to prepare responses to questions 8, 9, 10 and 13 of the Committee's request due to the complexity of the areas covered by those questions.

Responses to those questions have now been prepared and are attached.

Yours sincerely



Dale Webster on behalf of

Kathrine Morgan-Wicks
Secretary

1 December 2023

Question 8

The number of Safety Reporting and Learning System (SRLS) reports made annually relating to medical risks and/or incidents affecting ramped patients from 2018-19 to 2022-23 (inclusive).

Table 1 provides a count of the number of SRLS events recorded from 2018-19 to 2022-23 that may relate to medical risk or incident affecting patients subject to Transfer of Care delay.

Table1: SRLS events potentially related to patients subject to Transfer of Care delay 2018-19 to 2022-23

Severity Assessment Code (SAC)	2018-19	2019-20	2020-21	2021-22	2022-23	Total
SAC 1	0	0	2	1	2	5
SAC 2	9	6	4	4	7	30
SAC 3	31	14	27	39	22	133
SAC 4	44	51	43	63	50	251
Rating not assigned	0	1	0	0	0	1
Total	**84**	**72**	**76**	**107**	**81**	**420**
Ambulance Arrivals at ED	47 654	47 102	52 593	53 612	53 002	253 963
All reported events as proportion of ambulance arrivals at ED (%)	0.176	0.153	0.145	0.200	0.153	0.165
SAC 1 and SAC 2 events as proportion of ambulance arrivals at ED (%)	0.019	0.013	0.011	0.009	0.017	0.014

This is a count of all patient/client safety events that were reported at an Emergency Department or Ambulance Tasmania, where the words 'transfer of care', 'offload delay', 'ramped', 'ramping' or 'ramp' appeared in the description or exact location field. Please note that as a result, this may include some incidents not directly related to ambulance transfer.

The table includes the Severity Assessment Code (SAC) for these events – with SAC 1 and SAC 2 incidents considered serious safety events.

Over the period covered by the data, there were 420 events recorded in total, which is equivalent to 0.165 per cent of the 253 963 ambulance arrivals to ED over that time. Of those, 91.7 per cent of reported incidents were in the lower severity categories. Serious safety events were equivalent to 0.014 per cent of all ambulance arrivals over that time.

Question 9

The number of investigations undertaken annually into SRLS reports related to medical risks and/or incidents affecting ramped patients – from 2018-19 to 2022-23 (inclusive).

All incidents reported on SRLS require review or investigation, with the severity of the incident determining the process for the investigation. Therefore, the number of SRLS incidents investigated annually is equivalent to the number of SRLS reports made, as provided in response to Question 8.

The SRLS generates a Severity Assessment Code (SAC) from one to four based on each incident's level of harm, level of care and treatment required, with SAC 1 being the most severe and SAC 4 the least severe.

The Department of Health's *Policy on Safety Event Management* specifies the following requirements for the investigation of incidents reported on SRLS:

- All SAC1 events are investigated using a Root Cause Analysis methodology. This is a standardised system-based approach used to investigate serious safety events for analysis and identification of system-based causes.
- All serious safety events (SAC 1 and/or SAC 2 ratings) are formally investigated, analysed and managed, with actions taken as appropriate, recommendations made and the event closed within 70 days from the date the event was reported into SRLS.
- All SAC3 and SAC4 events are investigated, analysed and managed with actions taken as appropriate and closed within 36 calendar days of the event being reported into SRLS. This often occurs at a local operational level.

Question 10

All SRLS reports related to medical risks and/or incidents affecting ramped patients – from 1 January 2021 to 30 June 2023 (personal identifying information omitted).

Table 2 provides the severity assessment classification, category, process and problem reported for all relevant safety events, as defined in the response to Question 8. These data are for the period 1 January 2021 to 30 June 2023. Over this time, there were 49,959 instances of transfer of care delay (transfer exceeding fifteen minutes) statewide.

This is information as recorded in the SRLS, extracted at summary level to ensure no personally identifying information is disclosed.

Table 2: Summary of SRLS reports, 1 January 2021 to 30 June 2023.

Category	Process	Problem/Issue	SAC1	SAC2	SAC3	SAC4	Total
Behaviour					**4**	**19**	**23**
	N/A	Aggressive/Inappropriate Behaviour			2	10	12
		Missing Patient/Client				**3**	3
		Other				6	6
		Self Harming Behaviour			2		2
Care Management Process			**4**	**5**	**40**	**63**	**112**
	Admission	Incomplete/Inadequate			3		3
	Consent	Incomplete/Inadequate				1	1
	Discharge	Wrong Process/Service				1	1
	Emergency Response	Incomplete/Inadequate		1	4	5	10
		Not Performed				1	1
		Other				1	1
		Wrong Process/Service		1			1
	Handover	Incomplete/Inadequate		1	6	4	11
		Not Performed			2	7	9
		Other				1	1
		Unavailable			1	6	7

Category	Process	Problem/Issue	SAC1	SAC2	SAC3	SAC4	Total
	Other (Clinical Administration Process)	Incomplete/Inadequate			3	2	5
		Not Performed		1		2	3
		Other			1	6	7
	Referral/Consultation	Incomplete/Inadequate				1	1
		Not Performed				1	1
		Other				2	2
	Task Allocation	Incomplete/Inadequate				3	3
		Not Performed				1	1
		Other	1			1	2
	Transfer of Care	Incomplete/Inadequate	2	1	12	5	20
		Not Performed			1	1	2
		Other	1		1	6	8
		Unavailable			3	4	7
		Wrong Process/Service			2	1	3
	Waiting List	Incomplete/Inadequate			1		1
Clinical Process/ Procedure			**1**	**6**	**23**	**36**	**66**
	Diagnosis/Assessment	Incomplete/Inadequate			2	3	5
		Not Performed			1		1
		Unavailable			1	1	2
	General Care/Management	Incomplete/Inadequate	1	2	5	8	16
		Not Performed			1	3	4
		Other			1	2	3
		Wrong Process/Treatment/Procedure				2	2
	Other (Clinical Process process)	Incomplete/Inadequate		1	1	2	4
		Not Performed			2	1	3
		Other				3	3
		Unavailable			1		1

Category	Process	Problem/Issue	SAC1	SAC2	SAC3	SAC4	Total
	Procedure/Treatment/Intervention	Incomplete/Inadequate			1	2	3
		Not Performed			1	2	3
		Other				2	2
		Unavailable			1		1
		Wrong Process/Treatment/Procedure		1	1	1	3
	Recognition and Response to Deterioration	Incomplete/Inadequate		1	4	2	7
		Other		1			1
	Screening/Prevention/Routine Checkup	Incomplete/Inadequate				2	2
Documentation					**1**	**4**	**5**
	N/A	Document for Wrong Patient or Wrong Document				2	2
		Document Missing or Unavailable			1	2	3
Equipment/Medical Device					**2**	**5**	**7**
	N/A	Dislodgement/Misconnection/Removal				1	1
		Lack of Availability			2	2	4
		Other				2	2
Falls					**3**	**3**	**6**
	N/A	Collapse			1	1	2
		Loss of Balance			1		1
		Other (falls problem 2)			1	1	2
		Slip				1	1
Healthcare associated infection						**1**	**1**
	N/A	Infection Control Processes/Procedures				1	1

Category	Process	Problem/Issue	SAC1	SAC2	SAC3	SAC4	Total
Medication IV Fluids					**3**	**7**	**10**
	Administration to patient/client	Extra/duplicate dose				2	2
		Failure of administration technique				1	1
		Incomplete/ missing or error in documentation				1	1
		Omitted dose			2	1	3
		Wrong time (too early/too late)			1	1	2
	Ordering, storage and disposal	Misplaced medication				1	1
Skin Tissue					**2**		**2**
	N/A	Blister			1		1
		Pressure Injury			1		1
Total			**5**	**11**	**78**	**138**	**232**

Question 13

Broken down by year and by hospital, the number of patients who have died within 24 hours of Emergency Department/hospital admission after having been subjected to extended (greater than 30 minutes) ramping from 2018-19 to 2022-23.

The Department of Health records data, including date and time of death, for patients that die in hospital, including the Emergency Department (ED).

A review of these two datasets over the period 2018-19 to 2022-23 identified 136 deaths that occurred within 24 hours of care being transferred to the ED, following delayed transfer of care (exceeding 30 minutes). These cases are outlined in table 3 below.

As ambulance arrivals usually reflect the most acutely unwell presentations, it is not unexpected that some patients will die while in hospital, with around half the deaths in Tasmania each year occurring in a major hospital. A causal link cannot be drawn between transfer of care delay and cause of death based on these administrative data.

The deaths in Table 3 are equivalent to 0.014 per cent of ambulance arrivals over the period.

Table 3: Deaths within 24 hours of delayed transfer of care

Hospital	2018-19	2019-20	2020-21	2021-22	2022-23
LGH	4	8	11	10	9
MCH	0	0	3	0	3
NWRH	2	0	4	6	6
RHH	10	10	12	12	26
	16	**18**	**30**	**28**	**44**

Note: An additional 24 deaths occurred on the day after transfer of care; however, these cases have a date recorded but not an accurate timestamp, so it cannot be ascertained if they occurred with 24 hours or later. This would primarily represent deaths that occur following discharge from hospital, where time of death is generally not available in hospital information systems.