Part C: Service Specification for emergency road ambulance services

1 Term

This Agreement will start on 1 April 2012 or when duly executed by the parties and will, subject to Part 1, Schedule 2 clause 11 (Termination) or clause 16 (Conflict), continue for a period of 48 months to 31 March 2016 with a further right of renewal for a 24 month term. The right of renewal is at the sole discretion of the Purchasers subject to the satisfactory performance of the Services

2 Purpose

Emergency Ambulance Providers (EAPs) provide Emergency Ambulance Services (EAS) to the public. EAS includes timely, appropriate emergency care and where necessary, emergency transport of patients to a place of definitive care.

3 Service Objectives

The objectives for this Service are:

a That it is essential that people get the right care, at the right time, in the right place from the right person[1].

b Emergency ambulance services ensure the care given facilitates the best possible outcomes, for patients who access emergency ambulance services and complies with quality requirements.

c Integration of EAS into the wider health sector.

4 Principles

4.1 The following are guiding principles for primary retrievals / treatment / transport:

a Treatment delivered is necessary, appropriate and of the required quality.

b Treatment is delivered by the staff with the appropriate skill level and support.

c Transport to treatment is undertaken only when necessary and appropriate and is related to patient need.

5 Overview of Emergency Ambulance Services

5.1 Emergency Ambulance Services includes Emergency Ambulance Communication Centres (EACCs) and Emergency Ambulance Providers.

5.2 EACCs:

a provide the telecommunication interface between the caller and the EAP;

b determine the patient need through an agreed telephone triage system;

[1] *Roadside to Bedside – A 24-hour Clinically Integrated Acute Management System for New Zealand*; ACC/Health Funding Authority/Ministry of Health and Council of Medical Colleges; 1999. Available from www.moh.govt.nz

c effectively manage ambulance resources to ensure emergency calls are appropriately responded to.

5.3 The types of resources available to the EACC for dispatch are:

a Emergency Road Ambulances including water ambulances[2];

b Emergency Air Ambulances; and

c Primary Response in Medical Emergency (PRIME) doctors and nurses.

5.4 EAPs:

a provide road ambulance services across New Zealand, with a range of services and capability levels to meet the needs of their communities within available resources;

b are dispatched by the EACCs;

c respond in a timely manner to calls for assistance made through the EACCs in order to provide appropriate care and, where necessary, emergency transport of people requiring urgent treatment as a result of one of the following medical emergencies: illness, injury or obstetric emergency.

5.5 The Crown expects that the resource most appropriate to the patient's triaged needs will be utilised. This means an ambulance resource will be dispatched and/or referral to an alternative care pathway.

5.6 It is expected, that if an ambulance has been dispatched and it is deemed clinically appropriate, then the EAP shall refer the patient to an alternative care pathway rather than transport the patient to a place of definitive care.

6 Background

6.1 Roadside to Bedside

a Roadside to Bedside outlines the framework necessary to provide the best possible outcomes for people who need to access emergency services by ensuring that people get 'the right care, at the right time, in the right place, from the right person'.

b EAPs must follow the Roadside to Bedside framework.

6.2 The New Zealand Ambulance Service Strategy

The New Zealand Ambulance Service Strategy[3] (the Strategy) was announced in June 2009. The Strategy was developed by the Accident Compensation Corporation (ACC) and the Ministry in consultation with the ambulance sector and other stakeholders. The Strategy provides a framework for future development and growth of emergency ambulance services, and ongoing collaboration between Crown, sector and stakeholders. The 10 initiatives from the Strategy were developed taking into consideration advice and recommendations following several reviews of the Ambulance Sector. These initiatives have been prioritised and are being implemented over time.

[2] Services usually organised through EAPs and provided by Coast Guard services
[3] The New Zealand Ambulance Service Strategy – *The first line of mobile emergency intervention in the continuum of health care. 4 June* 2009. Available from www.naso.govt.nz.

6.3 **Integration into the wider health sector**

The integration of Emergency Ambulance Services into the wider Health Sector may contribute to more services being delivered in local communities. Thereby potentially reducing the demand on secondary and tertiary services. This may lead to providing better care for patients, closer to home.

6.4 **Obligations for response to major emergencies**

EAPs must comply with the following:

a The National Civil Defence Emergency Management Plan Order 2005.

b The Ambulance New Zealand Ambulance National Major Incident Plan (AMPLANZ) framework.

c The New Zealand Standard, Ambulance and paramedical services standard (NZS 8156).

6.5 **EAP and EACC Interface**

a The EACCs dispatch EAP resources to the scene of the medical emergency, as appropriate, based upon information received from the caller. Allocation and dispatch of resources is based on patient need, within available resources. EAPs are responsible for the supply of the EAS resources.

b EAPs are required to have a formal, signed Service Level Agreement (SLA) with EACCs that describes the operational relationship, including location finding responsibilities. Communication between the EAP and EACCs is paramount at all times and this will be reflected in the SLA. A copy of the signed SLA will be provided to the National Ambulance Sector Office (NASO). Any subsequent changes will be formally agreed and signed by the EAP and EACCs, and then advised to NASO.

c The EAP will be a participating member of the Emergency Ambulance Communication Centre User Group. The Terms of Reference[4] should be revised at least every two years with EACCs leading the process with involvement of all EAPs and NASO.

6.6 **Emergency Care Coordination Teams**

EAPs must be participating members of the appropriate regional Emergency Care Coordination Team (ECCT), where they exist.

6.7 **Interface Between the Ministry and ACC**

a The NASO is a joint ACC and Ministry team which manages all EAS contracts, including EACC and EAP contracts, on behalf of the two Crown Agencies.

b ACC and the Ministry have different funding models for EAS; these will continue until such time as a joint funding model has been agreed and approved for implementation. Any changes to the funding model will be recorded in a contract variation.

[4] EACC User Group Terms of Reference are approved by NASO, Ambulance New Zealand and the EACC Oversight Committee. Current ToR are available from Ambulance New Zealand

6.8 ACC Responsibilities

ACC is responsible for the funding of EAS for certain eligible people[5] who have suffered personal injury in terms of the 'Act' for which a claim for cover has been accepted, or is likely (in the EAP's experience) to be accepted. Eligible people are those for whom the EAS starts within 24 hours of suffering a personal injury or within 24 hours of being found after suffering a personal injury (whichever is the later), and for whom the emergency transport is necessary for the purpose of obtaining treatment urgently for the claimant's personal injury. Those eligible are all those resident in New Zealand and visitors to New Zealand.

6.9 Ministry Responsibilities

a The Ministry funds EAS for all Eligible People[6] who have a need for emergency medical attention. For the purposes of this service specification emergency medical attention means services provided to a patient who requires medical attention (not caused by trauma) from the time of the EAS being notified (via the EACC) of the need for services; to the time the patient arrives at a place of definitive care.

b Transport between public hospital emergency departments within three hours of arriving by ambulance is included in the service provided under this Agreement.

c In this specification, "emergency" means those cases triaged as life threatened or potentially life threatened as determined by the Triage system used in the EACC.

d The EAS is capacity funded to meet this urgent demand and may be used to respond to non emergency situations but non emergency volumes are not considered a basis for change in funding levels.

e The use of funded capacity to respond to non-emergency situations must not impact on the ability to respond to emergency situations.

7 Service Description

7.1 General

The Emergency Ambulance Provider must:

a Comply with NZS 8156 (including but not limited to clinical governance) and relevant legislation outlined in NZS 8156.

b Be a member of Ambulance New Zealand.

c Comply with International Organisation for Standardization 9001: 2001 (ISO 9001:2001).

d Use best endeavours to meet the required response time targets (refer Appendix 2).

e Respond and supply an emergency road ambulance service for people requiring assistance as a result of a medical emergency when required and dispatched by the EACC.

[5] Refer to Part Two, Service Schedule – Emergency Road Ambulance Services for the definition of Eligible Persons for ACC EAS Services.
[6] Refer to Part Two, Service Schedule – Emergency Road Ambulance Services for the definition of Eligible Persons for Ministry EAS Services.

f Be available 24 hours a day, 7 days a week inclusive of statutory and public holidays, and have contingency services in place for back-up in the event of their inability to provide the Services for any reason.

g Respond to requests by the EACC to transport a treatment provider(s) to the scene of an incident where it is clinically appropriate (eg where the patient is not able to be moved), and where it is reasonable, to return that treatment provider to town or residence, (e.g. emergency physician, anaesthetist, lead maternity carer).

h Crew road ambulances with appropriately skilled staff (refer Appendix 1).

i Meet service delivery requirements described in this service specification.

j Send the most appropriate, closest/fastest resource regardless of geographical boundary.

7.2 **Clinical Governance**

a The EAP must have an established Clinical Governance Framework within their organisation, and must be able to demonstrate both the framework, and application of the framework to daily business, if requested by NASO.

b The EAP will be a participating member of the ambulance sector's National Clinical Leadership Group (NCLG)[7].

c The EAP shall implement policies and procedures directly relating to clinical issues which have been promoted by the NCLG.

7.3 **Training and Education**

The EAP will have a continuing clinical education programme to ensure that ambulance personnel maintain clinical competence and currency.

7.4 **Staff and Service Capability Levels**

a The Service Capability Levels (refer Appendix 1) describes the crewing required of the EAP.

b If Ambulance Personnel become regulated and registered health professionals under the Health Practitioners Competence Assurance Act (HPCA Act) 2003, then each Ambulance crew member/staff member/officer will hold an annual practicing certificate and will work within their scope of practice (if any).

c The EAP will be responsible to ensure staff meet the registration requirements under the HPCA Act, in a timeframe agreed by the EAP and NASO (on behalf of ACC and the Ministry).

7.5 **At the Scene of a medical emergency**

The EAP must:

a ensure Services provided comply with NZS 8156;

b ensure all Ambulance Personnel are appropriately trained and work within the current authorised patient care protocols issued by the responsible Medical Advisor/Medical Director; and

[7] The purpose of the NCLG is to provide a consistent approach to all clinical issues across the New Zealand Ambulance Sector.

c co-ordinate with other emergency services present at the scene (e.g. Police and Fire).

7.6 **Patient Handover**

The EAP must ensure continuity of care for the patient is maintained by :

a The seamless transfer of care to the accepting treatment facility.

b Handover by both a verbal report, and a properly documented copy of the Patient Report Form (PRF), and, where appropriate, the ACC45, to the receiving treatment facility

Where it is appropriate, the ACC45 must be signed by the patient wherever possible; if the patient is unable to sign, the reason for this must be documented on the PRF.

The responsibility remains with the EAP until an alternative clinical pathway has been agreed and accepted by the other party, and a warm handover has been completed, as per the developed protocols and/or guidelines.

8 Maori Health and Cultural Requirements

8.1 EAPs will provide services in a culturally appropriate way and will comply with relevant cultural requirements as prescribed by the Ministry and ACC from time to time.

9 Exclusions

9.1 EAS services for the following incidents are excluded from this Agreement:

a for the Ministry:

i the inter-hospital transfer of patients with the exception of those medical patients transferred between facilities within three hours of arrival at that facility; and

ii non emergency attendances including attendance at public events, standby in support of other emergency services and any transports privately funded.

b for ACC:

i patients transferred more than 24 hours after suffering their personal injury;

ii non-emergency transport unless the transport meets the Planned Non Emergency Transport by Ambulance (NETBA) service descriptions. Prior approval must be obtained for Planned NETBA

iii any time spent in the search for a Claimant; and costs incurred if the Claimant dies before the EAS arrives; and

iv patients, where the location of the patient is outside New Zealand's territorial waters.[8]

[8] Territorial Sea, Contiguous Zone and Exclusive Economic Zone Act 1977 and Injury Prevention, Rehabilitation, and Compensation Act 2001.

10 Service Linkages

10.1 The purpose of key linkages is to maintain a working relationship of communication, consultation and inclusion. Those organisations identified in clause 10.2 are not exclusive and the EAP is encouraged to explore opportunities to develop and maintain key linkages with other organisations nationally, or within the region that enable and/or promote effective service delivery and achievement of the objectives of this service specification.

10.2 The EAP must maintain key linkages with the following organisations or entities in order to provide an efficient and effective emergency ambulance service:

a other EAPs (road and air) in the region and neighbouring regions;

b PRIME providers;

c EACCs;

d receiving District Health Boards which have an involvement in emergency care as well as DHBs which provide specialist services on a national or sub national basis (e.g burns, spinal injury);

e the ECCT for the region;

f the Ministry;

g ACC;

h NASO;

i other emergency services including New Zealand Police, Fire, Search and Rescue;

j relevant national Sector and Stakeholder groups eg Ambulance New Zealand;

k other local organisations with a direct interest in the provision of emergency care including Primary Health Organisations and private emergency medical clinics.

11 Quality Requirements

11.1 **General Quality Requirements**

The EAP will:

a comply with the quality requirements in the overarching Agreement(s); and

b be certified as compliant with the current version of NZS 8156.

Response time targets are defined in Appendix 2 (Response Time Targets).

11.2 **Data Quality**

a The EAP must work with EACCs to ensure that the data stored by EACC is accurate and reliable.

b The EAPs will work with EACCs to ensure that the classifications (ie Urban, Rural and Remote) that are applied to each Service Area are aligned with the latest Census data available.

c Agreement is required by the EAP, the EACC and NASO to apply a classification to a Service Area(s) that is not in line with the latest census data available. The reason for the change must be documented by the EACC and reported in the next Quarterly Report.

12 Reporting

12.1 The EAP will provide reports electronically to NASO, in an agreed format.

12.2 The EAP will provide reports to NASO as per the following table. Data should be provided in Microsoft Excel spreadsheet format where appropriate. Appendix 3 contains indicative templates for data required.

Reporting Requirement	Frequency/Period	Due
1. **Response Time Performance (Latest month and 24 months history)** Performance against response time targets as defined in appendix 2	**Monthly**	20th calendar day of the following month
2. **Volume Data (Latest month and 24 months history)** a. Volume of incidents attended where there was no patient transported b. Volume of incidents attended where there was at least one patient transported (by life threatening, potentially life threatening and non emergency)	**Monthly**	20th calendar day of the following month
3. **Frontline Staffing** Staff establishment Full Time Equivalent (FTE) numbers by Skill level for a. FTE paid establishment b. FTE vacancies for paid positions c. Headcount of Volunteers	**Six-monthly:** July-December January to June	20th January 20th July
4. **Clinical outcomes:** The EAP will to report on clinical outcome measures for at least one medical condition and one trauma related condition. This report must also be sent to the NCLG. The conditions and reporting requirements are determined by the NCLG with NASO and may be reviewed annually.	**Six-monthly:** July-December January to June	20th January 20th July
5. **Quality** a. Copy of Annual Patient Experience Survey b. Copy of the NZS8156 audit summary with any corrective actions	**Annual**	As available

12.3 The EACC service providers may provide data to NASO. Where the data represents an individual EAP the data will first be sent to the EAP for the opportunity to verify the data and provide commentary.

13 Incident reporting

All incidents will be assigned a Severity Assessment Code (SAC) rating for the actual and potential outcome of the incident. Ratings shall be in accordance with the New Zealand Incident Management System (NZIMS). See Appendix 4 for details.

13.1 Incident Reporting - Serious and Sentinel Events

a Specific Event Reporting

Serious and Sentinel events with a SAC 1 or SAC 2 rating of the outcome of the incident must be reported as per NZIMS.

i NASO must be notified of SAC 1 and SAC 2 events no later than five working days from identification of the event. The EAP will provide NASO with a copy of the NZIMS report.

b The EAP will provide NASO with updates of any developments regarding the investigation including:

i Progress of investigation

ii Findings of the investigation

iii Media releases/responses

iv Mitigation strategies.

c Media

The EAP will immediately advise NASO if it becomes aware of a serious or sentinel event which in the EAP's opinion has or may have media or public interest. This may be provided orally in the first instance, and followed up in writing.

d Quarterly Reporting

i The EAP must provide NASO with quarterly reports summarising Serious and Sentinel events.

ii These reports should be from the same data source as the NZIMS reports.

iii The minimum data required is shown in the template in Appendix 5 (Serious and sentinel events quarterly report). This data may either be entered into the template or in an alternative format.

13.2 Incident Reporting - Adverse Events and Complaints

a Media

The EAP will immediately advise NASO if it becomes aware of an adverse event or complaint which in the EAP's opinion has or may have media or public interest. This may be provided orally in the first instance, and followed up in writing.

NASO will be informed of the following information, following internal investigation:

i Cause of incident

ii Impact/Potential Impact

iii Mitigation Strategies

iv Outcome.

b Quarterly Reporting

The EAP must report to NASO, volumes of adverse event, using the template in Appendix 6 (Volume Template – Adverse Events). This will be used to monitor trends.

13.3 **Other Reporting**

NASO may make reasonable requests for ad-hoc information relating to the provision of EAS and the EAPs must provide any such requested information within an agreed timeframe that is reasonable for the information requested.

14 Monitoring and Evaluation

14.1 Representatives from NASO will meet quarterly with the representative from the EAP to review and discuss the reports received by NASO and any performance issues.

14.2 All reports that are provided to NASO from both the EAP and EACCs will form the basis for quantitative measurement of performance of that EAP.

14.3 Prior to the regular performance monitoring meetings as detailed in clause **Error! Reference source not found.**4.1, the EAP will provide NASO with written commentary/explanations regarding

a changing trends and exceptions identified in the reports

b regional/district performance issues

c activities planned and being undertaken to improve performance

14.4 The EAP will participate in the EACC User Groups as per clause 6.5c.

14.5 Upon reasonable notice (not less than 10 working days), the EAP will collate and provide information for audit to the Ministry and ACC.

14.6 NASO retains the right to evaluate any aspect of the EAP's performance. At least 10 days notice will be given of any evaluation audit.

Appendix 1: Service Capability Levels as per NZS 8156

Service Capability Levels	Road
Basic Life Support (BLS)	All emergency Basic Life Support capable ambulances must be crewed with at least one crew member who holds at a minimum: the Ambulance New Zealand recognised National Diploma in Ambulance Practice (NZQA Level 5) or equivalent.
Intermediate Life Support (ILS)	All emergency Intermediate Life Support capable ambulances must be crewed with at least two crew members who hold an Ambulance New Zealand recognised ambulance qualification. One must hold a minimum: the Ambulance New Zealand recognised Bachelor of Health Science, ILS Pathway (WFA/OSJ) or equivalent.
Advanced Life Support (ALS)	All emergency Advanced Life Support capable ambulances must be crewed with at least two crew members who hold an Ambulance New Zealand recognised ambulance qualification. One must hold a minimum of Post Graduate Certificate in Speciality Care – Advance Paramedic Practice or equivalent as recognised by Ambulance New Zealand.

OTHER SERVICE CAPABILITY LEVELS

Service Capability Levels	Road
First Responder	A response which may have a qualification of less than BLS and is the first resource available to respond to an incident. This may or may not be a response in a vehicle with patient carrying capability. This may include the fire service.
Rapid Response Unit	A response is a non transport capable vehicle. This response is designed for early arrival at cases where immediate intervention is required and can also be used for back up for lower skilled crew levels.
Urgent Community Care (UCC)/Extended Care Paramedics (ECP)	A response with a skill level of ECP/UCC who are trained to assess patients conditions to determine the best patient care pathway, which may be typically involve treatment at home or referral to other care pathways, rather than direct transport to ED.
PRIME	PRIME is a co-response with ambulance services, for medical emergencies in identified PRIME locations. PRIME Practitioners are Doctors and Nurses who are PRIME trained.

Appendix 2: Response Time Targets

Response times will be reported for the following types of incident:

1 Immediately Life Threatening Incidents

2 Potentially Life Threatening Incidents, and

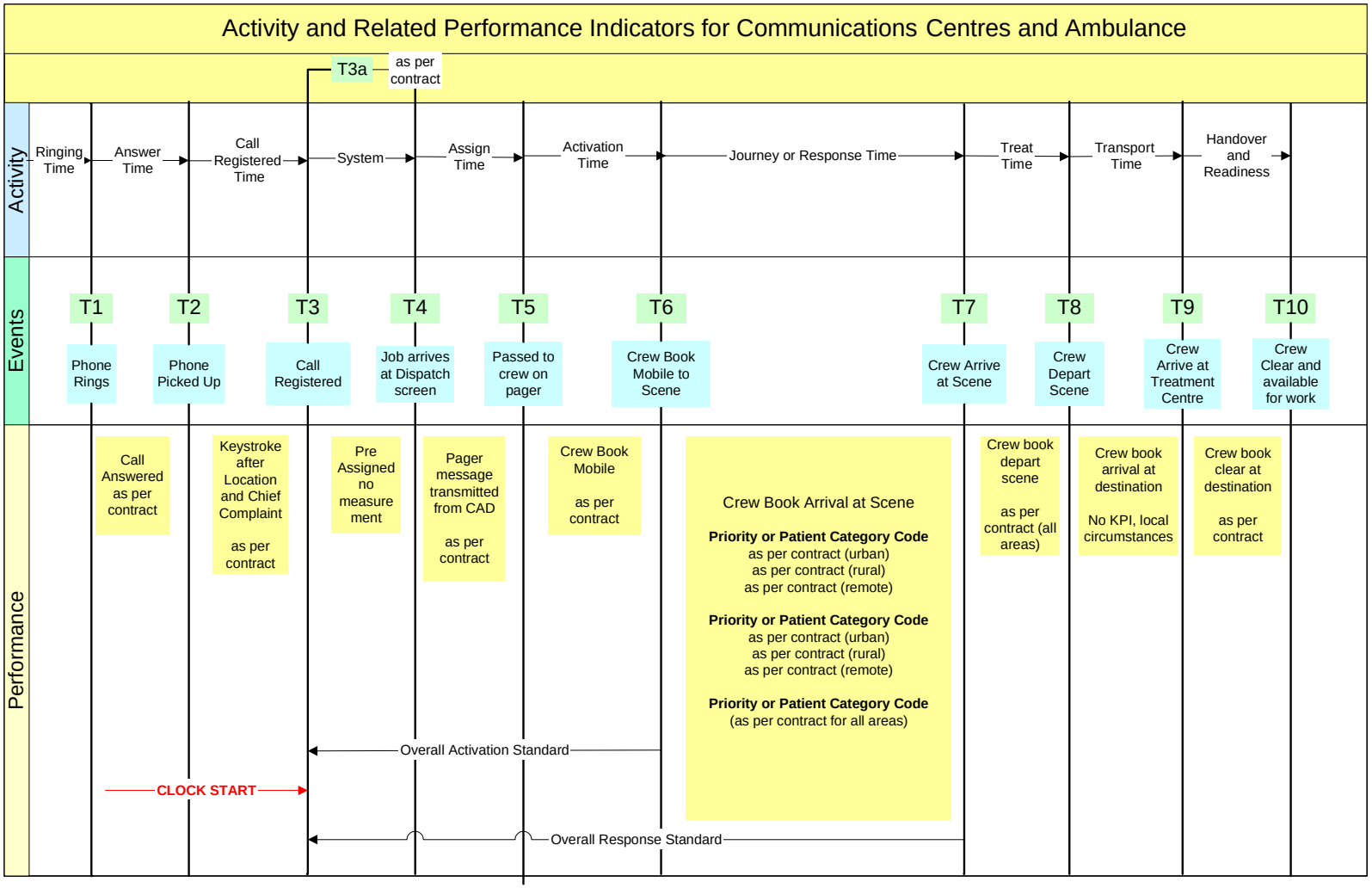
3 Non Emergency Incidents

ProQA is an internationally recognised medical dispatch system and triage tool. The definitions for the various ProQA determinant levels are in the Service Schedule glossary. The determinant level assigned to each incident will form the basis of classifying the type of incident.

Type of Incident	Urban service area (Main urban centres > 15,000 population – responses within city boundary as specified on service area map)		Rural service area (Rural areas surrounding urban cities, or non-remote rural areas, or minor urban/provincial town centres < 15,000 population as specified on service area map)		Remote rural service area (Very rural and remote locations as specified on service area map)	
Immediately Life Threatening Emergency Incidents	Arrive at request point within 8 minutes from time of sufficient information collected for the call to be entered into the queue for 50% of calls	Arrive at request point within 20 minutes from time of sufficient information collected for the call to be entered into the queue for 95% of calls	Arrive at request point within 12 minutes from time of sufficient information collected for the call to be entered into the queue for 50% of calls	Arrive at request point within 30 minutes from time of sufficient information collected for the call to be entered into the queue for 95% of calls	Arrive at request point within 25 minutes from time of sufficient information collected for the call to be entered into the queue for 50% of calls	Arrive at request point within 60 minutes from time of sufficient information collected for the call to be entered into the queue for 95% of calls
Potentially Life Threatening Emergency Incidents	Arrive at request point within 20 minutes from the time of sufficient information collected for the call to be entered into the queue for 80% of calls		Arrive at request point within 30 minutes from the time of sufficient information collected for the call to be entered into the queue for 80% of calls		Arrive at request point within 60 minutes from the time of sufficient information collected for the call to be entered into the queue for 80% of calls	
Non Emergency Incidents	Time out as requested or specified by control and within normal road restrictions		Time out as requested or specified by control and within normal road restrictions		Time out as requested or specified by control and within normal road restrictions	

Time intervals

The following diagram shows the intervals that are used for time based reports



Appendix 3: Reporting Templates

Response Time Performance

Provider _____

Period _____

Date _____

	Urban			Rural			Remote		
	Immediately Life threatening emergency incidents		Potentially life threatening emergency incidents	Immediately Life threatening emergency incidents		Potentially life threatening emergency incidents	Immediately Life threatening emergency incidents		Potentially life threatening emergency incidents
	50%	95%	80%	50%	95%	80%	50%	95%	80%
	8 minutes	20 minutes	20 mintues	12 minutes	30 minutes	30 minutes	25 minutes	60 minutes	60 minutes
Jul-09									
Aug-09									
Sep-09									
Oct-09									
Nov-09									
Dec-09									
Jan-10									
Feb-10									
Mar-10									
Apr-10									
May-10									
Jun-10									
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Aug-10									
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Oct-10									
Nov-10									
Dec-10									
Jan-11									
Feb-11									
Mar-11									
Apr-11									
May-11									
Jun-11									
Jul-11									

Volume Reporting

Provider
Period
Date

	Volume of incidents attended where there was no patient transported	Volume of incidents attended where there was at least one patient transported		
		Immediately life threatening	Potentially life threatening	Non-emergency
Jul-09				
Aug-09				
Sep-09				
Oct-09				
Nov-09				
Dec-09				
Jan-10				
Feb-10				
Mar-10				
Apr-10				
May-10				
Jun-10				
Jul-10				
Aug-10				
Sep-10				
Oct-10				
Nov-10				
Dec-10				
Jan-11				
Feb-11				
Mar-11				
Apr-11				
May-11				
Jun-11				
Jul-11				

Front Line Staffing

Provider
Period
Date

	ALS	ILS	BLS	Total
Full Time Equivalent Paid Establishment				
Full time Equivalent vacancies for paid positions				
Headcount of volunteers				

Appendix 4: Allocating the Severity Assessment Code (SAC Score)

STEP 1 - Consequences Table

Severity Assessment Code (SAC)

(Revised) Version 1.0

	Analyse all incidents against ACTUAL and POTENTIAL outcomes				
	Serious	**Major**	**Moderate**	**Minor**	**Minimal**
CLINICAL CONSEQUENCE	Unexpected patient(s) death resulting from the process of health care, which is unrelated to the expected outcome of a patient's management Or any of the following events: • Inpatient suicide • Wrong patient, wrong site or wrong invasive procedure, wrong implant events • Retained equipment / swabs etc requiring surgical removal • Misadministration of radioactive materials • Patient / infant abduction / discharge to the wrong family • Any investigation commenced by police related to patient abuse (eg rape) • Blood transfusion resulting in haemolysis	Major permanent disability or loss of function (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management Or any of the following: • Suicide of an outpatient known to the mental health service within 7 days of contact with the service • Unauthorised leave of a mental health patient with an assessed high risk of serious harm to self or others • Unauthorised leave of Special Patient • Threatened or actual physical or verbal assault of patient or staff requiring police intervention		An Increased level of care including: • Review and evaluation • Additional investigations • Referral to another clinician	No injury or increased level of care or length of stay
CORPORATE CONSEQUENCE	**Staff, contactor, visitor:** Death(s) of staff member contactor or visitor	**Staff, contactor, visitor:** Permanent disability or loss of function to staff member, contactor or visitor; requires major additional medical or surgical intervention	**Staff, contactor, visitor:** Staff member, contactor or visitor requires extended treatment	**Staff, contactor, visitor:** Staff member or contractor requires short term treatment only with no lost time or restricted duties. Visitor requires short term treatment	**Staff, contactor, visitor:** Minimal injury to staff member, contactor or visitor; first aid required
	Services: Non delivery of a key service; loss of Certification / accreditation status	**Services:** significant ongoing disruption to a key service; Certification for 1 year or less / recommendations requiring action within 6 weeks	**Services:** Disruption to a key service; Certification awarded for 2 years or less / recommendations requiring action within 3 months	**Services;** Disruption to service; Certification recommendations requiring action within 6 months	**Services:** Minimal disruption to; low impact on Certification / accreditation status service
	Finances: Cost overrun or reduction in revenue: the lower of >$3M or > 10%	**Finances:** Cost overrun or reduction in revenue: the lower of >$2M or > 7-10%	**Finances:** Cost overrun or reduction in revenue: the lower of >1.2M or > 4-7%	**Finances:** Cost overrun or reduction in revenue: the lower of >$0.5M or > 2-4%	**Finances:** Cost overrun or reduction in revenue: the lower of >$0.1M or > 0-2%
	Environment: Toxic release off-site with detrimental effect. Fire requiring evacuation	**Environment:** Off-site release with no detrimental effects or fire that grows larger than an incipient stage	**Environment:** Off-site release contained with outside assistance or fire at incipient stage or less	**Environment:** Off-site release contained without outside assistance	**Environment:** Nuisance releases

The dot point lists provided above relate mostly to secondary and tertiary care. Primary care and other health and disability services must assess the consequence of the incident using the **descriptors** provided.

STEP 2 – Likelihood Table

PROBABILITY CATEGORIES	DEFINITION
Certain	Is expected to occur again either immediately or within a short period of time (likely to occur at least once in the next 3 months)
Almost certain	Will probably occur at least once in the next 4-12 months
Likely	Is expected to occur within the next 1 to 2 years
Unlikely	Event may occur at some time in the next 2 to 5 years
Highly unlikely	Unlikely to recur – may occur only in exceptional circumstances ie 6+ years)

STEP 4 – Action Required Table

ACTION REQUIRED FOR ACTUAL INCIDENT RATING	
1	Extreme risk – immediate action required – A Root Cause Analysis (RCA) investigation must be completed within 70 calendar days. Reportable Event Brief (REB) must be forwarded to the national central agency
2	High risk – senior management attention needed – Notification to the national central agency and a detailed investigation must be completed within 70 calendar days
3	Medium risk – All incident forms to be reviewed, review in common incident types may be most appropriate to develop a common action plan. Responsibility for management of these incidents must be assigned.
4	Low risk – manage through team level review and improvement procedures.
Incidents rating a SAC of 3 or 4 may also be reported to the national central agency if the incident is considered by the organisation's senior manager to represents potential risk of serious harm, that should be widely known.	

STEP 3 – SAC Matrix

		CONSEQUENCE				
		Serious	Major	Moderate	Minor	Minimal
LIKELIHOOD	Certain	1	1	2	3	3
	Almost certain	1	1	2	3	4
	Likely	1	2	2	3	4
	Unlikely	1	2	3	4	4
	Highly unlikely	2	3	3	4	4

Source: http://www.moh.govt.nz/moh.nsf/indexmh/improvingquality-reportableevents-resources

Appendix 5: Serious and Sentinel Events Quarterly Reporting Template

Incidents - Quarterly Report

Reported by:		(name)
Operator:		(select)
Date Reported:		(date)
Year:		2010/11
Quarter:		(select)

Required fields												Required for SAC1 and SAC2 events (not required for SAC3 & SAC4)			If known:			
Organisation	Event Ref	Date Reported to NASO	Type of Incident	Date of incident	Region	Serious, Sentinel or Adverse	Actual / Potential (Near Miss)	**Actual Severity Assessment Code (SAC) Score**	Incident Category	Description of what happened and immediate actions taken	Final SAC Score (following investigation / mitigation)	Findings/Outcome of Investigation	Recommendations	Mitigation (Investigation / Response / Actions)	Media coverage (if any)	Media Story (if any)	Complaint?	Incident Number
			(select)		(select)	(select)	(select)	(select)			(select)						(select)	

Appendix 6: Volume Template – Adverse Events

This template relates to clause 13.2.b

Reported by:	(name)
Operator:	(select)
Date Reported:	(date)
Year:	2010/11
Quarter:	(select)

Categories		**Adverse Events**
Attitude	The attitude of the attending member(s)	
Late	Late arrival	
Driving	Any issues around the driving of the ambulance	
Payment	Specific issues involving payment	
Refusal	Refusal of patient to transport or the member believes there is no need to transport	
Equipment	Specific equipment issues - maybe safety related	
Injury	Where the patient is injured as a direct result of transporting to destination	
Treatment	Medical treatment - suitability thereof etc.	
Communication	Whether there may have been a breakdown in Communication with crew and RCC or even hospital / patient	
Cultural	Any issues around cultural matters	
Privacy	Issues involving privacy concerns	
Other	Where complaint does not neatly fit into any of the other categories	
Total		**0**