Helicopter / Air Ambulance Incidents

As at 11 March 20

(Manual extraction from larger Datix search)

	Submitted date	Description	Action taken (Investigation)	Lessons learned
1	Apr-18	Patient arrived via helicopter to CCU direct with no prior consultation to CCU staff or CCU registrar. This caused a delay to getting treatment underway for the patient as the registrar was also not aware this patient was coming to CCU.	Communication to CCU staff continues to be an on going problem with work continuing to try and improve. Flow chart for SOP in process of development	
2	May-18	Paramedic had asked that the road team call CCU to ensure we knew about the handover, however this was not done. Potentially could have been a problem, if we had not had a bed for this patient.	See above	
3	Sep-18	Helicopter from Taranaki Helicopter Trust broken down on the helipad . Landing space therefore limited.	Helicopter tied-down and pilots made aware from local helicopter trusts.	
4	Nov-18	We were unaware of patient's arrival or reason for admission. The resigstrar from the oncall team was contatcted and stated that they were aware of the patient however forgot to inform the coordinator on CCU.	Ongoing issue - discussed with MDT. Discussing formally at Reg and HO orientations.	
5	Mar-18	The referrer failed to call the Cardiologist to let him know that the patient had left the regional hospital so the Cardiologist had no idea what time the patient was due to arrive at ACH and therefore what time to activate the on call team. This resulted in the patient arriving in the department before the on call team had arrived and therefore compromising that patient's safety.		This is a regular topic at regional working group meetings and the process is one that is under continual process improvement
6	Jan-19	Pt arrived in ACH ED in the afternoon. The on call cardiac cath team were not notified until the patient arrived. The patient was on the table with anaesthetics present before the on call team arrived.	On going discussions with the regional hospital re appropriate handovers via SCD. Have been made aware of issues.	
7	Jan-19	Correct base for the transport incubator was not available. The only base was already at the regional hospital being used by the PICU team.	The rig on its current base was loaded into the helicopter and secured with tiedowns.	
1	Apr-19	Upon arrival at the ward it became apparent that the baby had some concerning laboratory results from the regional hospital that had not been communicated to the accepting consultant.	Discussion on handover with the regional hospital .	
2	Apr-19	Despite their high acuity, patient was only transferred with one paramedic escorting. The patient went into cardiac arrest upon landing on the roof at ACH, and unfortunately did not survive this event.	This incident would not have changed the overall outcome of the patient, but it would have been problematic if patient had arrested while in transit, and not upon arrival.	
3	May-19	Pt transferred from another region by helicopter with STEMI in the early hours of the morning , no medical staff in ACH had been informed about the ETA.	No harm to patient. Learning for first responders	
4	May-19	Shortly after take off, the transport incubator (patient inside) was moving vigoursly (side-side motion) despite being secured as per protocol. Agreed to land helicopter in safe location (closest airport) to review incubator strappings. Incubator secure but noted to be loose enabling side to side motion.	NEST pilots will now add two extra strops to the rig SOP in the S76 helicopter to reduce the horizontal movement of both rigs while in flight	Correct and immediate communication with pilots followed Importance of removing rig from service until full investigation completed Immediate follow up by all departments
5	Jun-19	Regional ICU with a child that had spinal injuries. We also had another patient to collect from another ICU who was critically ill . Decision made to retrieve the other child the next day as the child was in an ICU in a stable condition. However, despite discussion with the ICU, helicopter arrived with the patient.	Follow up calls now being made prior to the transport team leaving.	The need for better communication between hospitals.
6	Sep-19	PICU retrieval team had an almost 3 hour delay being picked up from the helipad to go and retrieve a child . The delay was due to not having a dedicated helicopter and enough crew/s to the PICU/NICU/ECMO service.		
7	Nov-19	Call to retrieve a baby. NZAAS contacted, problem finding a transport provider. Later that morning (before the end of night duty) the flight arrived in NICU. NICU were unable to send the night flight team as they would be working over hours rostered so the morning team were called in, resulting in a delayed departure.	The delay in being unable to find an initial transport provider resulted in a cascade effect of delay for all services involved.	
8	Sep-19	A referral was made for the PICU retrieval team to retrieve a child in the early hours of the morning. Auckland helicopter crew were outside of hours; delay while Northland arrived from Whangarei.	The delay to PICU team leaving from Auckland Helipad was just over two hours.	On going review into the provisions of rotary wing service.
9	Nov-19	Whilst NICU team were stabilising a baby for retreval at the regional hospital, NEST team was called away to retrieve a sick infant from another regional hospital. Nest pilot tried to arrange ARHT to collect NICU. The baby was stable,following discussion with NICU consultant decision made to wait until NEST helicopter returned from the other regional hospital.	Confusion as to who was going to bring the team home.	
10	Dec-19	Patient brought to theatre on bed and was still covered in glass on their front as well as lying in glass shards. Had been helicoptered to Auckland after an accident.	Discussed situation with nurses involved. Appropriate actions prioritised and taken as able	
11	Nov-19	Going on a transport to a regional hospital. The pilots appeared unfamiliar with incubator. Transport from helipad to hospital via unmarked Van. The driver had to be yelled at to stop twice in fear of crashing.		On-going review by transport nurse specialist.
12	Dec-19	Decision to retrieve a baby in the early afternoon. NZAAS contacted, they advised not able to secure a helicopter operator for immediate retrieval.	The regional hospital was contacted to check on the condition of the baby	
13	Dec-19	Time critical retrieval. NZAAS confirmed that a helicopter provider had been located but staff needed clerance to use that helicopter. Arrived at the regional hospital - 3 hours after the initial phone call.	On consultation with NICU staff, the opinion is that there were no adverse effects.	
14	Dec-19	Retrieval of atient to PICU. No clearance to fly in the AW169. NEST would only activate if a AW169 was not available.		
15	Jan-20	Call to NZAAS by NICU in the early hours of the morning requesting urgent retrieval. Delays meant the team arrived at the regional hospital just after dayshift had commenced. The regional staff had been providing bag and mask ventilation to the baby for 3 1/2 hours.		
16	Jan-20	Back to back transfers to a regional hospital arranged for two babies - both requiring non invasive respiratory support. The team departed NICU with the first baby, in the early afternoon. Flightredeployed to another regional hospital abandoning flight nurse at the regional hopsital. Later that afternoon helicopter is deployed to a second mission delaying the return of the NICU team to Auckland. Shortly after arrival NICU flight nurse depart with second baby to the regional hospital.	The delay resulted in total hours away from NICU of 13 hours which also significantly impacted on clinical workloads in an acute Intensive Care Unit.	
17	Jan-20	ECMO base missing. Retrieval was delayed for over an hour. Due to urgency of needing to get to this patient, flight went ahead with incorrect/non-approved base.	No actual patient harm occurred.	
18	Feb-20	NICU retrieval team dispatched to retreive a baby; PICU ECMO team then dispatched as baby continued to deteriorate. While NICU team were handing over to PICU Team helicopter left as crew would be over their hours. Second helicopter sent to collect NICU team was tasked to another incident stranding NICU team and transport incubator in a regional hospital. No helicopter available NICU team returned to Auckland by Taxi .	NICU transport incubator left behind until the next evening. This left NICU without a transport Incubator base due to remaining base retrieving baby from another regional hopsital.	