Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2015	Central Queensland	presented for elective which resulted in perforation to the and pt required to be ventilated	repair and ventilated, t/f to at hr and for T/F to	pt t/f from to hrs.
	/2015	Metro South	Patient with ? bowel obstruction vomited and aspirated. Nil NGT insitu. Code called. Patient deceased.	Code blue called when patient vomited.	Unable to revive patient.
	/2015	Metro North	Patient choked on . Compromised airway, eventually falling unconscious.	Attempt to provide first aid with no success. Team member notified MET team. Patient moved to room to facilitate treatment by MET team. CAC notified. Family members and consultant notified.	MET team managed to gain pulse, transport to ED via ambulance.
	/2015	Mackay	.2015 Patient presented with a history of feeling unwell, D&V for days, fever, general body aches,abdo examination - ? , . IV Fluids commenced. Reviewed @ Doctor ? Pneumonia, iv ab's commenced. hrs patient was observed to be deteriorating and was transferred to the where treatment continue with assistance via VC - Hospital. team & team. Patient had a cardiac arrest and all treatment was called at Patient deceased at	Medical Officer called to attend immediately. Transfer from ward to . Escalation to . Call made to)arrived at called to attend ( ) - arrived at	Patient was placed on CPAP via ventilator then Intubation Interossis access to infusion Patient stablized until arrival of team - during transfer of - patient had a Cardiac Arrest @ hrs - full CPR continued until event was called at hrs and patient deceased at hrs.
	/2015		/2015. Nursing was on Visual Observations this hrs. I had seen throughout the At approximately hrs I walked down the corridor to check on and found slumped up against the door with around neck and I called for the staff to come and assist. remove the to the floor. It was difficult to position to be able to commence resuscitation. Within a short period of time a second staff member had arrived and both Chest compressions and CPR commenced.Staff organised a MET call. Crash cart was taken to the room. CRP and compressions continued. The MET team arrived and immediately attempted to insert a hrs. Initially there was a problem with the equipment but within a short period of time was commenced. There was defibrillator pads where applied hrs there was a reading of sats at hrs of 67%. 1st dose of adrenaline was administered hrs. CPR was continued and was bagged initially with the in place. Adrenaline was administered was intubated at approx. hrs. CPR continued throughout the process. A total of Adrenaline was administered the last at hrs. The ICU register pronounced deceased at hrs according to notes. The shift co-ordinator was present throughout the incident	As above	As SAbove
	/2015		Death of baby @ weeks gestation attributed to maternal sepsis and Acute Respiratory Distress Syndrome.	Transferred to ED for stabilisation and specialised care.	Retrieved to for ongoing care.
	/2015	Metro North	Attended routine ANC appointment at No fetal Heart. IUFD confirmed. Attended routine ANC appointment at No fetal Heart. IUFD confirmed	Ultrasound Scan confirmed IUFD. Stillbirth Pathway initiated. Ultrasound Scan confirmed IUFD. Stillbirth Pathway initiated.	Care as per Stillbirth Pathway Care as per Stillbirth Pathway
	/2015	Metro North	Pt in Emergency Department for hours. Ongoing deterioration in patient's condition. Unclear what clinical program managing patient care. Pt not admitted to ward as directed. Pt deceased hours on admission to ward.	Family notified.	Consultant requested clinical review.
	/2015	Townsville	Patient redirected earlier in . Mobilising confidently. Patient GCS throughout - heard talking loudly to and other patients. Crash heard at hrs and immediate review found pt on floor at where slipped hitting immediately and easily staunched. Slight bruising noted on at time of incident. Patient not oriented to TPP. GCS O2 applied with effect resulting in SpO2 of 100%. Commenced on post falls pathway & neuro obs commenced, ECG, chem 8, venous gas, TnI. Notified MO. Relocated to for enhanced visual observation. Patient experienced seizure post fall, transfered to for CT scan. Noted subdural haemorrhage and subdural haematoma. Continued to deteriorate, palliated and life extinct /2015.	NULL	NULL
	/2015	Central Queensland	Mother presented in labour, unable to palpate uterine activity or auscultate fetal heart clearly, Staff assist called, mother managed for fetal distress: attempt to continuously monitor fetal heart rate, assessed by Obstetric Registrar, PV examination, determination of likely abruption, Emergency theatre team activated, continuous monitoring of contractions and fetal heart rate until on operating theatre table, and proceeded with The baby was born with no signs of life and resuscitation efforts were unsuccessful	staff assist called, mother managed for fetal distress: , attempt to continuously monitor fetal heart rate, assessed by Obstetric Registrar, PV examination, determination of likely abruption,	emergency theatre team activated, continuous monitoring of contractions and fetal heart rate until on operating theatre table, and proceeded with The baby was born with no signs of life and resuscitation efforts were unsuccessful
	/2015	Mackay	Urgent MRI required but as it was after unable to have at phoned around to the other sites with out success	admitted to ward fasted and MRI performed at following day.	delay in obtaining MRI lead to a delay in taking to operating theatre
	/2015	Gold Coast	yo on holiday at /2015 in severe shock - ??sec to sepsis with severe respiratory failure. Pt rapidly declined and required emergency peripheral VA ECMO. retrieval team were required to change the circuit at to enable t/f to /2015 - on arrival at ECMO circuit was found to have air within the lines - identified by TOE performed on arrival.	ECMO flows decreased until circut immediately changed. Pt continued to deteriorate with increasing inopressor requirement.	/2015 at pt deceased. Coroner notified. Family in attendance.
	/2015		An inpatient and hung The patient was found by nursing staff A Code Blue was implemented immediately. The Code Blue team and nursing staff attempted resuscitation of the patient, but regretfully were unsuccessful and the patient was declared deceased by the Code Blue team	The patient was found by nursing staff A Code Blue was implemented immediately	The Code Blue team and nursing staff attempted resuscitaiton of the patient, but regretfully were unsuccessful and the patient was declared deceased by the Code Blue team
	/2015	Cairns and Hinterland	Patient attended ED at complaining of sore throat, fever, vomiting. Triaged ATS 4 to waiting room. HR noted to be Possible discussion between patient triage staff regarding attending in context of overcrowded department and wait to be seen. Discussion with administration regarding cost of treatment as non-elegible. Patient elected not to wait to be seen and did not complete registration process. returned to ED hours later and died hours later from presumed severe sepsis Identified issues 1. Patient initially presented during time of significant ED overcrowding with patients in the department, inpatients waiting admission, patients ramped, patients waiting to be seen. The overcrowding of the department would have been clear to the patient and may have influenced decision to leave. This may have been influenced by discussions with triage staff. 2. The patient is It is unclear whether these issues were fully considered and whether they influenced the patient's decision to leave 3. It is unclear whether the discussion with administration staff regarding payment influenced the decision to leave	Reported to coroner	nil
	/2015	Metro South	During preparation patient vomited multiple times. Medical officer was notified x ordered. The following pt developed and rapid AF as a result. The pt was transferred to CCU for further management. The patient continued to deteriorate, an ARP was put in place and the patient died at /15.	During resident medical officers were notified times.	were ordered. Each resident reviewed the patient once.
	/2015	Wide Bay	Unwitnessed dall on way to unsupervised. Assessment demonstrated no loss of consciousness, new frontal headache. No head laceration. Neurological deterioration 1.5 hours post fall. Palliative care commenced and died	Observations, assisted to back to bed, Dr informed, CT ordered of head	Neuro observations found an hour later that , Met Called

RTI Release

DOH-DL 16/17-011

RTI Document No. 13

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2015	Metro North	Patient underwent . Over the course of the hours surgery there was an estimated blood loss of Litres. The patient was transferred to ICU and approximately hours post-operation was found to have an subsequently required an above later developed a and died of sepsis days post op.	Patient was returned to theatre for and returned again the following day for	Patient's condition stabilised.
	/2015	Mackay	Patient presented to with history of vomitting and nausea for 7. Very unsteady on feet, bloods taken. Temp of Patient encouraged to increase fluid intake and to represent if symptoms persist or worsen. Patient re-presented to Ed on /15 - passed away /15 - Septic - referred to Coroner.	Patient presented to /15, admitted to	Patient admitted, deteriorated and passed away. Cause of death unknown - case referred to Coroner and autopsy has been consented to by family.
	/2015	Gold Coast	Patient presented at approximately 2015. Discharged at approximately 2015 with a diagnosis of pneumonia. Patient re-presented to the ED at approximately 2015 in severe respiratory distress. Admitted to and then ICU. Transfered to where died of sepsis - pneumonia.	Assessment made chest xray taken showed patchy consolidation and consistent with pneumonic changes. Remained short of breath and required	Assessed and discharged with oral AB's, represented the same day referred by GP significant deterioration required transfer to hospital, patient died.
	/2015	Darling Downs	Presented with bleed and severe hypertension. Attempt to control blood pressure appears suboptimal. Rebleeding occurred possibley due to ongoing hypertension, and patient was palliated.	Patient died	Patient is dead.
	/2015	Metro North	Emergency presentation to hospital left ED and restraint initiated. QPS notified via 000. Pt suffered a cardiac arrest. Resuscitation unsuccessful.	MET call and resuscitation commenced.	Unsuccessful resuscitation. QPS in attendance.
	/2015		Pt deceased from suspected asphyxiation/hanging whilst on ward. Proceeding day met call received for patient and ED team arrived for cardiac arrest. Non-shockable algorithm identified and followed pathway - intubated and weak pulse returned but no good sign of life - decided to transfer to ED resuscitation room and ED resus team activated as backup. Pt moved to ED resuscitation room but team unsuccessful in resuscitation attmept. ED Consultant in collaboration with MET team and Resus team made decision to end resuscitation care as poor prognosis expected.	Non-shockable algorithm identified and followed pathway - intubated and weak pulse returned but no good sign of life - decided to transfer to ED resuscitation room and ED resus team activated as backup.	Pt moved to ED resuscitation room but team unsuccessful in resuscitation attempt. ED Consultant in collaboration with MET team and Resus team made decision to end resuscitation care as poor prognosis expected.
	/2015		TO HOSPITAL GIVING MOUTH TO MOUTH, AND WALKED INTO OPD AREA WITH HOURS. WITNESSED ENTERING HOSPITAL AND IMMEDIATELY ESCORTED THEM INTO A & E. PLACED ON PATIENT TROLLEY, CALLED FOR HELP AND INFORMED AND EMERGENCY ALARM INITIATED. INITIAL ASSESSMENT NOT BREATHING WITH CPR COMMENCED. APPROXIMATELY 60 MINUTES OF CPR FOLLOWING COMPLETED, LIFE EXTINCTED AT HOURS.		UNSUCCESSFUL RESUSCITATION, NO RETURN OF SPONTANEOUS CIRCULATION THROUGHOUT THE RESUSCITATION TREATMENT, DISCUSSED WITH FAMILY TREATMENT CEASED, AND CORONERS AND QPS NOTIFIED
	/2015	Wide Bay	Patient was admitted with exacerbation of on a background of previous ICU admissions with same. Pt was reportedly not happy with the treatment received, particularly in relation to frequency of . Patient ultimately decided to leave hospital against medical advice, despite having a high requirement, so that could treat symptoms at home. Patient stated made an appointment with hrs that day. Immediate action(s) taken Regularly reviewed by Doctor and strongly encouraged to stay in hospital to receive treatment. Result of immediate action(s) Pt still decided to discharge self against medical advice and reportedly against the advice of . Patient then returned to ED hours later in PEA arrest and was intubated, admitted to ICU and ultimately died as a result of presentation	Regularly reviewed by Doctor and strongly encouraged to stay in hospital to receive treatment.	Pt still decided to discharge self against medical advice and reportedly against the advice of . Patient then returned to ED hours later in PEA arrest and was intubated, admitted to ICU and ultimately died as a result of presentation.
	/2015	Mackay	years with extensive ongoing cardiac and medical history called the QAS after experiencing some shortness of breath; anxiety . Upon arrival to hospital the was triaged as a category 4. Comprehensive nursing assessment of patient was performed by the RN and the Medical Officer on-call was contacted. The patient was admitted to the ward for medical review Patient was present fell backwards and became unresponsive. A MET call was initiated and resuscitation commenced as per ARP in chart. Resuscitation efforts ceased shortly after as and recent discussion with patient revealed patient no longer wished for any interventions. Patient was declared deceased.	Discussion with Informed patient safety. Discussed with GP. Discussed with coroner.	Coroner stated it is a natural death and that a death certificate may be issued.
	/2015	Sunshine Coast	presented on /2015 to DEM with agitation, tachycardia and dehydration. Patient admitted to and treated at (ongoing noted in medical record) until the /2015 when transferred to Hospital. Advice recieved from the that this patient had died on the /2015 with probable meningitis.	Death has been reported to the coroner.	Care of patient to be fully reviewed and contact with family to be made.
	/2015	Wide Bay	. Patient had attended ED /15 with fever, pain & bleeding post procedure that day. Tranferred to ED and treated with IV antibiotics before discharge on 15. Patient represented to ED on /15 and again on /15 when was admitted to ED short stay unit. On evening of /15 patient deteriorated with sepsis and septic shock and transferred to ICU. Stabilised in ICU before transfer to ICU on 15. Returned from /15 pateint deteriorated and was for palliative care only. Deceased on /15. Immediate action(s) taken IV antibiotics administration in ED. In ICU patient was intubated and received antihypotensives and broad spectrum antibiotics before transfer to ICU. Result of immediate action(s) After return from , patient deteriorated and chest x-ray revealed progressive . Patient succumbed to cardiac failure on /15.	IV antibiotics administration in ED. In ICU patient was intubated and received antihypotensives and broad spectrum antibiotics before transfer to ICU.	After return from patient deteriorated and chest x-ray revealed progressive Patient succumbed to cardiac failure on /15.
	/2015	Townsville	A year old patient in , has died approximately hours following a routine change	Assessment and investigation in ED at as to cause of symptoms. Pain relief and care provided. Non contrast CT scan attended which identified throughout .	Patient consult and review by ICU, Surgical, and Palliative Care teams. contacted. with poor prognosis and decision not for surgical interventions. Despite medical treatment the patient continued to deteriorate and was died on the .
	/2015	Darling Downs	. I came into department at . I asked CN what patients were in the department. I was advised re and advised had received and the incorrect dose had been given.	Stabilisation of patient was continuing in readiness for . I asked if the incident was recorded. said it was in the notes.	I have searched the notes and cannot find reference to the incorrect dosage. I will need to speak with staff involved.
	/2015	Darling Downs	Pt was overbalanced fell to the floor, hit head on and hip on floor. An X-ray of pelvis and hip showed a # NOF and progressed to surgery on the /15.	Obs, soft collar to neck, hover jacked to lie pt flat on bed, analgesia given for pain to back	pt comfortable on bed
	/2015	Gold Coast	pt. admitted to MAU on the with diarrhoea and epigastric pain. with ongoing epigastric pain. Seen by cardio advanced trainee & consultant. ongoing epigastric pain. - given throughout admission for pain - Nil improvements in epigastric pain over period of adsmission, death on the 2015 hrs	given throughout admission for pain	Nil improvements in epigastric pain over period of adsmission, death on the /2015 hrs
	/2015		SAC 1 - reportable unexpected death. Reported to the Coroner. Request from	Given dieuretics and oxygen and attempts to provide non-invasive ventilation with bipap were fruitless at improving oxygen saturation. went into cardiac arrest and was successfully resuscitated once however condition continued to deteriorate and died on the	This patient death is considered reportable due to failure to provide adequate health care that is likely to have contributed to death. Further coronal investigation is necessary.

RTI Release

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2015		Well known patient who had relapsed due to non compliance to medication and treatment. A very psychotic agitated patient was admitted to A&E medically cleared. behaviour escalated immediately on arrival. The . Staff attempted to build rapport and de-escalate agitated and threatening posturing behaviours. was and staff due to being very psychotic. Staff offered oral medications and refused on each occassion. was offered food and water which accepted. After being assessed by Mental Health PHO On Call meet criteria and was placed on an was offered medciation which refused. was ordered and given hours and repeated at hours. On both occssions staff were requried to use ABM techniques and ward security to assist with the administration of the medciation due to continued agitated and threatening behaviour toward staff. To enable regular monitoring and visual observations and CCTV monitoring. Staff used ABM technique . During this escort the patient was due to an exacerbtion and staff idnetified being unable to hold their positions. Staff continued to communicate with Within seconds staff identified color had changed and had significant loss of consiciousness.Code Blue was called and CPR commenced by ward staff. ED Reponse team attended and continued with CPR. The patient was transferred to ED.	NUM was notified by ward staff CPR had commenced. NUM informed the Program Manager who contacted the Clincal Director, Executive Director, Operational Manager, CE, DMH and other senior mangment were notified, Staff were supported by NUM, Program Manager and Clinical Director post event. EAS was offered to staff phone number given to staff.	The ward was later informed the patient had died.
	/2015	Mackay	Nursing staff heard a banging noise went to investigate and found patient on Immediate action(s) taken Result of immediate action(s) What stopped the patient from being seriously harmed? Chance Patient refused Non compliant with nursing care and suggestions. Patient cognitively aware. Patient returned to with assistance of QAS. Post fall pathway commenced. Patient reviewed by MO in Patient refused analgesia following fall stating was painfree. XRay attended to in showing fracture of NOF. Family informed. Patient transferred to for further treatment.	NULL	NULL
	/2015	Wide Bay	2015 Inpatient on Surgical ward at Hospital was the subject of a RRT call. Outcome of RRT was a transfer to ICU. Patient hypotensive and tachycardic with an oxygen requirement. Patient reported as uncomfortable during procedure. Required top-ups and sedation. Noted to have an ongoing requirement for Successful insertion of CPR commenced due to non responsiveness and apnoea. Sequential documentation of ALS algorithm being followed. sutured in place by Family member arrives and has conversation with) Resuscitation ceased. conversation with patient's relative on outcome	CPR, volume resuscitation	Despite 40min CPR the spontaneous circulation did not return and patient died
	/2015	Central Queensland	Patient was mobilising to when as stated by had severe pain in said that 'blacked out' and that 'could remember falling". Nursing staff heard the fall and went to investigate and found patient lying on remained insitu. was across the	Went to find other staff. Assessed for injuries, good sensation, movement in all four limbs, could clench buttocks, could talk, was orientated. Patient lifted with where was further assessed, Doctor notified. notified. Patient complaining of nausea, given. Contacted Dr for analgesia anhd to report incident and vital signs and neurological signs. CPatient administered Patient reviewed by Doctor . Patient advised that must now 'buzz' for nurse assistance whenever is mobilizing to the or to the Falls assessment reviewed. Wound to dressed. Patient now insitu.	Patient is more comfortable.
	/2015	Mackay	Patient admitted 2015 to , transferred to medical from unit on 2015. Patient not seen by Consultant since admission. Met call attened. Patient passed away.	Coroner notified 2015	Passed away
	/2015	Mackay	Taken over the care of hrs, where pt responsive and talking. Pt rang bell for assistance to hrs. Once pt stood to walk to , pt became vague and c/o feeling unwell. Staff suggested pt return to insisted , On standing , with staff pt became grey and decrease in LOC. MET CALL at hrs.Sats noted to be but O2 on wall not on. O2 recommenced at (Pt previous rate) Rate increased slightly, applied at weaned slowly and returned to during MET call.	As above incident. ? Oxygen accidentally turned off at safety check, noticed approx 1 - 1.5 hrs that O2 was not running, patient still insitu.	As above met call intiated as decreased sats.
	/2015	Mackay	Patient vomiting and having abdo pain Dr notified and family discussion about situation. inserted, abdo xray ordered and attended. Attempted unsuccesful, IVC inserted and normal saline commenced. Pt NBM.Xray confirmed .Discussion with patient and family about options for treatment. Pt and family refused transfer to other facility, requested pain relief for comfort measures only. commenced at hrs, pt died hrs	Dr notified and family discussion about situation. inserted, abdo xray ordered and attended. Attempted unsuccesful, IVC inserted and normal saline commenced. Pt NBM.	Xray confirmed Discussion with patient and family about options for treatment. Pt and family refused transfer to other facility, requested pain relief for comfort measures only. commenced at hrs, pt died hrs
	/2015	Metro North	/15 - Year old had a fall at home and sustained a /15 - Hospital for management of /15 - /15 noted to be elevated at The patient had a medical review by Plan made for review by the treating team the following day (/15 - The patient complained of feeling unwell with a further review from increased to . ECG noted peaked T waves.	Medical Management plan initiated to reduce elevated which included Infusion, and follow up investigations ordered.	The patient became unresponsive and a for Cardiac arrest was called at Hrs. CPR commenced and continued for 40 minutes, when a decision was made to proceed to comfort cares. Patient deceased at Hrs.
	/2015		Pt presented to labour ward at hrs with abdominal tightening's. Hx weeks gestation. Pt transferred to imaging for obstetric ultrasound which confirmed open cervix Transferred to labour ward at hrs. stated they wanted active treatment . team prior to birth consultants and - briefly explained that is was unlikely would survive, and if so would have severe morbidity. Explained that they had discussed with and that do not resuscitate unless and born vigorous and breathing. Pt's labour progressed quickly. .	Decision not to resuscitate was made by present in birth suite at time of birth, based on gestation, weight and appearance. handed over to the parents. At hrs, were not breathing, occasional heart rate of < 40 bpm declared deceased at hrs. discussed with who stated it was not necessary to contact the coroner.	approx hours after birth. Supported by social worker. Death certificates completed by with the assistance of
	/2015	Central Queensland	Patient /15 for and under went surgery on the /2015. Patient was outlied to on the 2015 and deceased at There are potential missed opportunities for escalation of a deteriorating patient. Communique to be released to all staff to reinforce the importance of handover and ADDS.	Communique to be released to all staff to reinforce the importance of handover and ADDS.	Provided staff with education and increased knowledge.
	/2015	Central Queensland	At Patient presented to Emergency Department was diagnosed with Gastroenteritis, subsequently treated & then discharged. Approximately hours later patient represented with same like symptoms was admitted & treated with fluids but went into Cardiac arrest Patient was Hospital where patient again went into Cardiac arrest & was unable to be resuscitated	Incident escalated to ED oncall	Review & follow up facility site visit by EDMS to meet with staff & next of kin

RTI Release

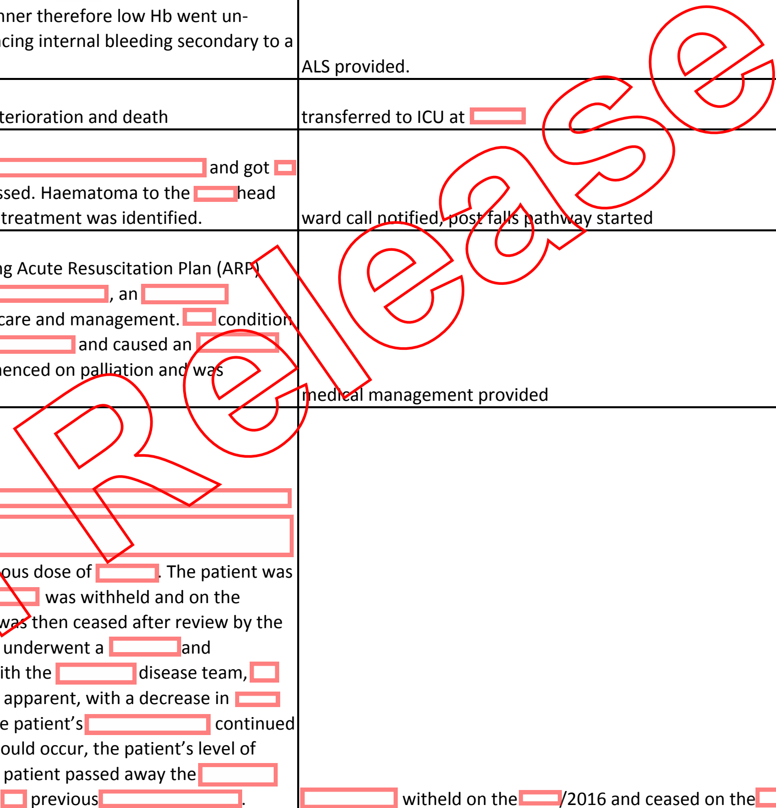
DOH-DL 16/17-011

RTI Document No. 15

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2015		Met call hours Responded to by Full met team in attendance. ?initially suspected pressure applied by ward staff to noted +++ patients breathing altered and marked tachycardia large bulging and increasing blood collection behind dressing. Note patient was on warfarin.	Oxygen applied, bloods collected, emergency blood ordered. Medical teams discussing appropriate movement for patient. ? Some discussion surrounding this. Theatre teams called in by pt transferred to after met call for massive haemorrhage. transfusion protocol initiated Some wait times experienced with transfusion protocol. echo performed. decision to take to OT once theatre team arrived. Patient had become unstable-hypotensive and bradycardic. Multiple adrenaline given and commenced on an adrenaline infusion. Awaiting arrival of anaesthetist.	Massive bleeding from visible. Unable to suture Unable to sustain BP Relentless bradycardia Ongoing product replacement and repeated doses of adrenaline. Patient RIP in OT
	/2015	Gold Coast	.15 Admitted to under the disease Recent admission with fevers, no organisms grown, On admission looking tired and unwell Bloods : , Plan to .15 Feeling better, RIB most of the shift, Plan: Continue IV , not for this week possibly next week, for .15 hrs patient called nurse buzzer, found patient laying on the , patient stating that slipped on the floor when getting up from using called code blue nursing staff noticed that a , observations attended to scoring in ADDs BP systolic patient would not stop applied pressure to to try to stop bleed, patient then coughed up a blood clot and vomited up frank blood RMO , stat order of platelets were administered to patient RMO inserted a foley catheter into patients and inflated the running CT attended CT head shows multiple sub-dural haematomas of Discussed with neurosurgery - in view of underlying diagnosis and lack pf platelet increments - not for surgical intervention ARP in place 15 Very drowsy, Nursing staff report has been getting agitated Increasing confusion, , palliative care review please 15 patient passed away RIP	CODE BLUE, large haematoma, unable to stop bleeding, multiple blood and platelet transfusions.	Bleed eventually eased, CT head performed. PLan discussed with family. ARP put in place.
	/2015	Metro North	Unexpected deterioration, appropriate and timely management of deteriorating patient. Docotr and MEt team notified	MET Call patient conscious and talking to MET Team staff on their arrival. Further deterioration that proceeded to Cardiac arrest call.	Patient unable to be resuscitated
	/2015		week old, premature baby, out of hospital arrest. QAS pre arrival care by arrived Intubated, CPR in progress . Baby deceased.	resuscitation measures	transfer to
	/2015	Cairns and Hinterland	year old presented with N&V diagnosed as severe myocarditis sent to CCU for urgent transfer to transfer did not occur until died just prior to arrived at CPR still in progress no viability resusc stopped. RIP	Cardiologists and ED Consultant contacted through to pt did not leave until after	transfer delayed to unaceptable levels
	/2015		Patient is en-route via and deteriorating. QAS Paramedic notified Heli Crew, who in turn notified ED of patient deterioration Arrived at with CPR in progress. Patient was in arrest en route at as per QAS paramedic with a total of shocks delivered. Chest complressions continued by staff Patient intubated and full Resuscitation proceded with no outcome of life. Patient declared deceased at after all avenues of treatment were depleted. Chest complressions continued by staff Patient intubated and full Resuscitation proceded with no outcome of life. Patient declared deceased at after all avenues of treatment were depleted Chest complressions continued by staff Patient intubated and full Resuscitation proceded with no outcome of life. Patient declared deceased at after all avenues of treatment were depleted. Despite senior medical team providing all the pathways of resuscitation, a decision to cease resuscitation efforts were made in conjunction with the) as they consulted via teleconference during CPR	Chest complressions continued by staff Patient intubated and full Resuscitation proceded with no outcome of life. Patient declared deceased at after all avenues of treatment were depleted	Despite senior medical team providing all the pathways of resuscitation, a decision to cease resuscitation efforts were made in conjunction with the) as they consulted via teleconference during CPR
	/2015	Gold Coast	Admitted on 15 for ongoing investigation for 15 at endoscopy was performed. Returned to ward at hrs. At hrs RMO requested to review patient complaing of abdo pain, CT head performed NAD patient given pain relief. On 15 at hrs patient reviewed by oncology team and CT abdo ordered referred to surgical team at hrs. hrs patient taken to OT for laparotomy for perforation, transferred to ICU and passed away on .15	At hrs RMO requested to review patient complaing of abdo pain, CT head performed NAD patient given pain relief. On 15 at hrs patient reviewed by oncology team and CT abdo ordered referred to surgical team at hrs.	hrs patient taken to OT for laparotomy for perforation, transferred to ICU and passed away on 15
	/2015	Metro South	Patient Presented in with possible suspicious follow up does not appear to have been completed. subsequent admission in December identified mass - possible delay in diagnosis	Medical Plan for care commenced	Referral to Respiratory Physician
	/2015	Gold Coast	.15 hrs yr BIB QAS chest pain since am central chest/ epigastric pain, SOB, no sweating Past Medical Hx O/E: Impression: Plan: IV access, bloods, IV morphine D/W interventional cardiologist aspirin PO, advised for) no contraindications, for T/F to CCU (no adverse events), +/- PCI rescue *Current GCHHS Intravenous Guidelines state Heparin 12 units/kg should be administered post tenecteplase ?? was not commenced hrs: QAS collected patient from hrs; admitted to CCU monitored in ST elevation worse than earlier ECG, patient c/o chest pain 8/10, escort nurse advised patient had been painfree. Advanced trainee was contacted was in MAU, administered Advanced trainee contacted for urgent review, consultant attended, patient become unresponsive. hrs MET call activated unable to resuscitate.	Advanced life support measures	Unsuccessful- R.I.P
	/2015	Mackay	patient weeks presented to LW with contractions. History of was admitted commenced on AB's and given steroids, discharged on the and follow up organised. Patient represented on the with contractions - CTG fetal bradycardia CAT 1 Caesar called. Infant born with apgar of and nil HR until approximately minutes post birth.	CAT 1 Caesar called and patient rushed to theatre. From time of arrival until birth < minutes	emergency caesarean performed. Infant required full resuscitation and despite ongoing treatment and retrieval to did not survive
	/2015	Metro North	CTG insitu on patient awaiting Attended patient buzzer to LOC, attempted to find fetal heart rate for approximately minutes, unable to locate staff assist bell called, attended by midwife who was unable to locate fetal heart rate, ultrasound monitor brought into room, Registrar performed bedside ultrasound - FHR below per minute. Emergency buzzer called, category 1 transfered to OT theater 2. IV access gained in theatre, Category performed under general anaesthetic. TOB Staff assist Buzzer called at approximately senior midwife unable to locate FHR with CTG, Registrar notified. Bedside ultrasound performed. FHR below Category 1 for fetal bradycardia. Immediate transfer to theatre. IV access gained in theatre. Category 1 performed under general anaesthetics. TOB . Unexpected Neonatal Death following LSCS.	Staff assist bell called at approximately senior midwife unable to locate FHR with CTG, Registrar notified, bedside ultrasound performed FHR below Category 1 called at for fetal bradycardia.	Immediate transfer to theatre 2. IV access gained in theatre. Category 1 performed under general anaesthetic. TOB
	/2016	Gold Coast	Unexpected death of a year old inpatient. Cause of death on preliminary autopsy report;	CPR commenced. Code called. Attendance of CTC.	Pt continued unresponsive. TOD

RTI Release

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2016	Wide Bay	team leader handover received pt medical admission awaiting bed no urgency or clinical deterioration highlighted apart from patient drowsy. Primary nurse handover stated patient had been and was seen by med team at approx No nurse written documentation since no GCS recorded stated drowsy but rousable. Pt was scoring on QADDS no escalation apparent Iv access lost at some point not documented. ED MO aware needed access but was busy with a no apparent escalation to on call . was not handed over the patient was acutely unwell. As nurse team leader reviewed pt at obs attended pt hypotensive, very drowsy GCS no urine output. Informed ED MO to review pt as urgent. IDC inserted and assessed IV access nil apparent. Flow nurse informed, and to review patient as matter of priority. attended to try to insert IVC difficult unable to access. review for IVF bolus once line in situ. Ongoing issues with IV access. S/b MED consultant at approx confirmed with for full treatment patient for ICU. Patient moved to resus for access ongoing difficulties with same. During attempts pt continued to deteriorate agitated then respiratory arrest with PEA. Unsuccessful resusitation attempt. There was a clear breakdown in the management of this patient since transfer from and a lack of escalation of deterioating clinical condition	See above.	Resusitation discontinued after 15mins all in aggreeance. Pt deceased.
	/2016	Metro North	was found laying over , not breathing at approximately rs.	Duty manager notified by phone and QAS notified to attend. CPR commenced immediately hrs, QAS attended hrs Nil Pulse or BP Pupils fixed and dilated, . QAS ceased CPR at hrs , NUM informed , Contaced QAS informed at hrs. Family contacted hrs unable (no answer) will contact Police to follow up contact with NOK. Acute Care Team notifed hrs. hrs a On call Psychiatrist notified at Adult Mental Health.	Police notified and investigation has commenced and now been referred to the Coroner for further investigation. Staff remained at to speak with police and give statements.
	/2016	Metro South	Failure to recognise and act accordingly for a Deteriorating Patient. During a rapid response call bloods were collected @ hrs. FBC = clotted result. New bloods collected @ hrs. Results indicated a decrease in Hb. Hb results not reviewed in timely manner therefore low Hb went un-observed until second rapid response called. It was unknown at the time that the patient may have been experiencing internal bleeding secondary to a rupture. Patient deceased.	ALS provided.	Transferred to ICU. Transfused with units
	/2016	Gold Coast	yo BIBA to ED . - delayed diagnosis of - transferred to ICU at Deterioration and death	transferred to ICU at	deterioration and death
	/2016	Sunshine Coast	year old experienced an unwitnessed fall Patient stated that was in a hurry and got resulting in falling to the floor. The patient did not call for assistance. Patient assessed. Haematoma to the head (region) identified. Medical imaging conducted post fall. An acute SDH requiring conservative treatment was identified.	ward call notified, post falls pathway started	ward call r/v, ct brain done
	/2016	Gold Coast	On the 2016 A year old with end stage disease and a pre-existing Acute Resuscitation Plan (ARP) presented to the Emergency Department in severe respiratory distress. was assessed as having a , an) was inserted into the was admitted to the respiratory in-patient unit for ongoing care and management. condition deteriorated on the 2016, and a second was inserted; this second crossed the and caused an The condition deteriorated, and in consultation with the family, was commenced on palliation and was declared deceased on the 2016.	medical management provided	Patients condition improved after the first insertion of however a MET call was initiated after the 2nd was inserted.
	/2016	Metro North	year old presented to DEM with 7 history of fevers and vomiting. Past Medical History included an The patient was commenced on a stat dose of 2016 ( ) with a further regular intravenous dose of . The patient was administered a /2016 and /2016. The was withheld and on the /2016 @ hrs, only) of the prescribed dose of was administered. The order was then ceased after review by the Medical Team ( ). The appeared infected and the patient underwent a and A provisional diagnosis of Sepsis with a component of was made and in consultation with the disease team, antibiotic therapy was changed to . Following theatre, became apparent, with a decrease in It was noted that the patient had increasing abdominal pain with . The patient's continued to deteriorate and level of consciousness was fluctuating. The plan was to commence , but before this could occur, the patient's level of consciousness significantly deteriorated and a decision was made to provide palliative rather than active care. The patient passed away the . It is thought that the dose may have contributed to on the background of previous .	witheld on the /2016 and ceased on the /2016	Patients condition continued to deteriorate with fluctuating levels of consciousness and patient was place on palliative care and subsequently passed away
	/2016	West Moreton	Patient was being taken to , nurse took patient and asked if patient has . Staff left patient to and patient attempted to return to bed by and fell to the floor. Falls pathway commenced and skin check attended - patient has skin tears on both . X-ray of order. ADD IT - xray attended and r/v by ward call in - nil #'s noted by ward call. Next xray re-reviewed and #'s found in Patient deteriorated with decreased sats - patient not for surg intervention and "NFR" form completed with patient and family. Patient died that afternoon 16 @ hrs.	FALLS PATHWAY COMMENCED ASSISTMENT AND SKIN CHECK ATTENDED	PT HAS SKIN TEARS TO BOTH X RAY OF ORDED
	/2016	Central Queensland	Management of the deteriorating patient over a period of days without clear communication and management plan with the referral facility.	Patient transferred to referral facility	Intubated



DOH-DL 16/17-011

RTI Document No. 17

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2016	Gold Coast	16 presents to ED, day history of sudden onset confusion o Lives with o Medical history includes , .16 .16 admission. .16 hours unwitnessed fall o Transferred to ED – S/B ED Reg, Anaesthetic Reg, Ortho Reg, Med Reg identified as o .16 hours reviewed for sedation RMO hours the is now unrousable, observations now met MET call criteria - Med Reg reviews the patient and requests Medical Consultant review: Medical Consultant review: "Phoned by Dr) regarding palliative management of was transferred from following a fall and fractured Orthopaedics asked the consult question: Should this patient be palliative rather than undergoing surgery? Apparently has already been reviewed by the anaesthetic team and deemed not fit for surgery ("). Apparently ED, anaesthetics and Dr have also discussed with) and they do not want to undergo surgery because of high perioperative risk. Dr informs me that pt is currently: - unconscious/unrousable - .... ie. close to death. But appears comfortable (no vocalisation/grimacing etc) I suggested that even though a patient is deemed high risk for surgery, this should not be an absolute contraindication to go ahead with this surgery. Surgical management of the fracture is usually the only effective management for pain relief. However, given the information that anaesthetics suggest not to proceed with surgery & do not want to undergo surgery and death may be imminent for , a purely palliative approach seems reasonable at this time. I suggest that Pt be placed on the Care of the Dying Pathway and commence a CADD pump. I also suggest the use of the Abbey Pain Scale. I suggested that Pt be for a .....apparently had one done ." 16 hours confirmed deceased. The Cause of Death certificate 'disease or condition leading directly to death' identifies 'fall with ', and a Form 1A reporting this death to the Coroner has been completed. meets the criteria of a SAC 1 CI as a reasonably unexpected outcome of healthcare (fall in a healthcare facility resulting in death).	Made comfortable, Vitals and Neuro observations attended. Doctor Contacted	QAS contacted for transfer to main hospital
	/2016	Darling Downs	pt was mobilising with i had returned patient to i left patient to check on another patient who was in . as i returned toward i saw patient fall to floor and basically roll onto floor and strike noisily onto floor. Immediate action(s) taken patient found immedaitely, not ko'd; full recall. mo examined patient, large egg to . Result of immediate action(s) neuro obs commenced, falls pathway, prime and medical reviews. What stopped the patient from being seriously harmed?	patient found immedaitely, not ko'd; full recall. mo examined patient, large egg to	neuro obs commenced, falls pathway, prime and medical reviews.
	/2016		Then at hours the presented to the desk again and requested more pain relief. The doctor was again contacted and stated that the patient needed more analgesia. The RMO stated would speak with PHO then came over and ordered stat because it was only an hour from previous dose. requested by EN to check with RN for patient. RN accidently took from the cupboard and RN caring for patient drew up half the ampoule and discarded the other half. The drug book was written up and reconciled and the count was Error was picked up when the drug count at end of shift was undertaken only mins later. It was then discovered that the patient was given were notified and then the PHO was notified as was on the ward reviewing another patient. Patient then passed away soon after at hrs.	Notified Team Leaders and Medical PHO. Nurse Manager notified.	Patient had passed away. Family were with patient at that time.
	/2016		Pt arrived to maternity ward with head on view at weeks gestation. Delivered baby with next contraction at side of bed. Baby flat at birth. On moving baby to resus equipment, slipped and fell to knees, Baby ended up on the floor. Resus resumed immediately following. Apgars Intubated, ventilated. Arrest called hrs. Rapid deterioration. Withdrawal of care @ Life extinct hrs. Temporary stabilisation followed by arrest and death whilst awaiting retrieval services.	Resuscitation.	temporary stabilisation followed by arrest and death whilst awaiting retrieval services.
	/2016	Mackay	Had post-op discussion with family h	Initial work-up by ED - 1.5hrs post arrival Arrange theatre and call-in surgical consultant	Delay in adequate fluid resuscitation and management of and developing sepsis / multi-organ dysfunction Delay in transfer of patient from Hospital significant impact on outcome - arrival after hours places significant strain on resource and delay in care Likely significantly deterioration prior to arrival at and onset of MODS inevitable on arrival Poor communication Hospital regarding transfer Delay in transfer needs investigation
	/2016	Metro North	yo pt involved in 2015 - did not seek medical attention. 2016 presented to . CT Chest - disruption - contained haemorrhage. Dx - Traumatic with contained rupture. /2016 - Replacement & De-branch performed. /2016 - isolated IV Antibiotics commenced. /2016 - A/B commenced. At home ongoing productive cough & "blackouts" following coughing. at - pt r/v RN - febrile & tachycardic. - pt collapsed, unable to be resuscitated by QAS. Body to Coroner	Coroners autopsy found rupture of site of t as a result of secondary infection	Discussions with CTS & ID Triage Decision Support Tool completed Recommendation - clinical review of pt's post-operative care & pt's post-op expectations
	/2016	Cairns and Hinterland	PT ADMITTED TO 2016 WITH PERFOMED /2016 SEVERE MAIN FOR URGENT TRANSFER TO FOR SENT TO /16 DELAY IN TRANSFER PT ARRESTED ON	PERFOMED /2016 SEVERE MAIN FOR URGENT TRANSFER TO	SENT TO /16 DELAY IN TRANSFER PT ARRESTED ON

RTI Release

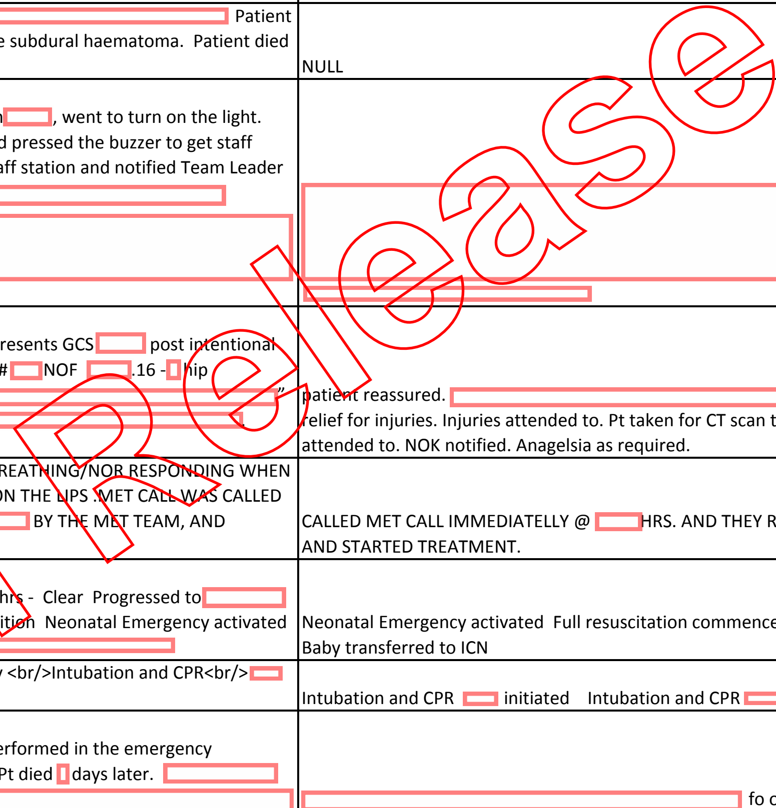
Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2016	Mackay	The patient had as a diagnosis possibly secondary to was commenced to correct on 16. levels were not checked for days (16) and patient was found to have . The IV fluids given caused fluid overload with subsequent acute . Patient was transferred to , admitted to the Medical ward for a short period, transferred to ICU through palliated and died days later.	Discussion with all medical staff about the use of drugs that change without appropriate safeguards to check or limit the use of the drug. Also discussion regarding checking patients weights.	Drugs which alter only to be given for a definite period with a cut off in the medication chart or in the one of prescribing section of the chart. Patients weights which are done weekly to have the admission weight carried forward onto each subsequent ADDs chart where the weight is recorded.
	/2016	Metro North	On 2016 a year old was brought in by hospital emergency department having experienced days of coughing and fever and being referred by General Practitioner (GP) for investigation possible heart failure and possible chest infection. The patient's medical history included: The patient was admitted under the care of the medical team to the medical assessment unit where the medical officer reviewing the patient noted that history indicated that was experiencing Allied health management included speech pathology, physiotherapy, dietician and pharmacy interventions. The patient was noted to have decreased ability to swallow and fluctuating level of consciousness. A was inserted so that the patient could be fed and given medications safely. The patient's levels fluctuated. The patient was given that did not respond to. An infusion was not commenced. The patient's respiratory symptoms deteriorated. A chest x-ray was performed on the 2016 that noted there was progressive and of the patient's lungs and minor changes indicating worsening	There was no evidence that these investigation findings were considered.	The patient's condition continued to deteriorate and died on 2016. This case was referred to the Office of the State Coroner. On). The Coroner authorised issue of the cause of death certificate as completed: Disease or condition directly leading to death - 1a) Other Significant Conditions – 2) The reviewing Unit officer recommended that "the hospital should look to review this case through a Analysis, particularly the days of the patient's admission. This advice was supported by the Coroner who referred the case to the Hospital Director of Medical Services for a formal clinical incident review.
	/2016	West Moreton	Patient presented to Ed and admitted to ward with epigastric pain and Surgical team consulted and advised CT scan, nil CT abdo scan ordered by medical team. The patient continued to deteriorate over following days and was admitted to ICU following MET call.	CT abdo scan undertaken when patient in ICU which identified a perforated free fluid	Patient identified as not a surgical candidate as would not survive theatre. Coroner and police notified of death.
	/2016		The mother, admitted on 2016 was at weeks gestation for induction of labour (IOL) due to . The was failing to progress. A lower section caesarean section was attended and the baby's Baby was delivered at 2016 and was transferred to Special Care Nursery because of increased work of breathing (WOB), pallor and tachycardia. Baby had multiple activity was noted. Transferred to a hospital Neonatal Intensive Care Unit (NICU) with an bleed. At the NICU extensive bleeds with associated injury of the were found. Baby discharged for palliative care at home and passed away on 2016 at .	A decision was made to send the baby to for further care. The baby was transferred to hours via retrieval.	The baby has been diagnosed with comminuted and a hemorrhages. Preliminary advice from the treating team in , 2016 is that the baby will most likely die or suffer permanent .
	/2016	Central Queensland	Patient found cynosis, cold & GCS . MET called by . CPR started & pad insitu (1 on). ALS nurse arrived. Mental Health nurse on airways. Mental Health in room & took over airways. MH asked if wanted a IVC or IO inserted - unable to give answer. IVC inserted by ALS nurse. MH asked OSO to take over baging patient - OSO refused. MET team arrived. Assessed rythm & appropiate meds given, bloods done & clinical decision made to Called End of Life	CPR started & pad insitu (1 on). ALS nurse arrived. Mental Health nurse on airways. Mental Health in room & took over airways. MH asked if wanted a IVC or IO inserted - unable to give answer. IVC inserted by ALS nurse. MH asked OSO to take over baging patient - OSO refused. MET team arrived.	Assessed rythm & appropiate meds given, bloods done & clinical decision made to Called End of Life.
	/2016	Townsville	An year old patient was admitted for ongoing care and management of an fractured . The patient was consistently tachycardic and hypotensive with no identified care management plan and implementation. The patient on assessment was considered for surgical repair of the , but review by the anaesthetic team identified the need to resuscitate status No action is documented or evidenced of managing the patients There is also a limited plan of care. There was an ARP from the previous admission ( ) but this has not been acknowledged in this admission The patient died less than hours from admission	No action is documented or evidenced of managing the patients . There is also a limited plan of care. There was an ARP from the previous admission (but this has not been acknowledged in this admission	The patient died less than hours from admission
	/2016	Darling Downs	I received a phonecall from ward clerk to advise me that I was required to attend to the below as a client had been found in the area. On arrival other staff ( ) were already in attendance. Client had an altered level of consciousness, was spontaneously breathing, obvious deformity of . Immediate action(s) taken Client transferred on lifting sheet onto stretcher, wheeled to Emergency department for further assessment. Result of immediate action(s) Cleint in emergency department.	Client transferred on lifting sheet onto stretcher, wheeled to Emergency department for further assessment.	Cleint in emergency department.
	/2016	Metro South	Day POST Repair. Noted to be bradycardic on telemetry. Rate - . Epicardial leads were attached and was paced a Rhythm deteriorated into VF. CPR and ALS was commenced and continued for approximately 40 minutes at which time it was decided that further treatment was futile. It was noted that for the previous days was managed with	CPR and ALS was commenced	Patient passed away from a VF arrest. Family notified.
	/2016	Metro North	Admitted /16 for poor oral intake and days post dose (for recently resected stage , which was being treated with curative intent. on admission Started on as a precaution Poor oral intake continued due to oesophagitis – demonstrated on endoscopy added to prophylactic treatment /16 Poor nutrition and fluid intake. Concerned re medical care that would be provided over the weekend. TPN commenced (?viral gastroenteritis – in stool) Ward team unable to manage fluid and electrolyte abnormalities ( ) satisfactorily on the ward Met call /16 Hypotension Second Met call /16 Hypotension Admitted to ICU sepsis Metabolic acidosis & AKI Whilst in ICU Changed Abx as not improving Required support. One episode of deterioration managed with the above measures. However, deteriorated for a second time and it was decided that further attempts would not have restored to previous function and CPR was withheld. Family were present at this time. Died at /16	NA	NA
	/2016	Metro North	Staff noted patient having without assistance. Patient subsequently fell from standing as staff moved to provide assistance. Fracture neck of femur and sub arachnoid haemorrhage sustained as a result of the fall.	Assessed patient on floor. Ward call review. CT head, xray of pelvis and chest.	post fall pathway, increase frequency of obs. patient kept rest in SAH and # NOF
	/2016	Wide Bay	yo patient with history of . Admitted for bleed. Fasted from at least on . Prolonged fasting time prior to gastroscopy on , further fasting as patient ' . bloods show blood results not complete until Code blue at about . for hypotension, bradycardia, reduced GCS, then vomiting and aspiration. Therapy withdrawn, time of death 2016.	administered when low noted during the MET call.	improved. Aspiration had already happened by that time and led to the death.
	/2016	Wide Bay	Alerted by patient in Pt found lying in supine position on the floor Was checked only minutes prior to this and was observed to be Two skin tears observed to Pt transferred back to assist. C/o severe pain in . Patient unable to report if had hit head. Pt explained attempting to prior to fall. Neuro obs intact - GCS due to confusion/disorientation. Vital signs stable. MO was notified at hrs to assess pt. Post-fall clinical pathway commenced.	Placed pillow under head. MO notified. Pt transferred to assist. Vital signs and neuro obs attended. Physical assessment.	Pt sent for Xray and CT scan. Pain relief given.

RTI Release

DOH-DL 16/17-011

RTI Document No. 19

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2016	Metro South	On the 2016 at approximately hrs an year old patient slipped and fell to the ground while being assisted by two staff members to get out of bed and . The patient landed on . Post fall the patient assisted back to bed, both physical and vital observations undertake, the post fall pathway commenced, and analgesia was provided to patient, and a PRIME incident report was completed. On the patient underwent a pelvic x-ray on /2016 @ hrs due to hip pain and it was found that the patient had sustained fractured neck of femur as a direct result of fall. On 2016 @ hrs the patient underwent a hip without any intraoperative complications. The patient's recovery from this surgical intervention was not without complications, and medical condition continued to deteriorate and sadly the patient passed away in the Palliative care unit on the /2016. Cause of Death was determined as 1(a) , 1(b) 2. .	ASSESED FOR ANY DANGERS TO PATIENT,PATIENT MADE COMFORTABLE,OBS WERE DONE ,DOCTOR NOTIFIED,PHYSICAL ASSESMENT DONE.PATIENT ASSISTED BACK TO BED.FALLS PATHWAY COMMENCED.ANALGESIA GIVEN TO PATIENT.	PATIENT WAS COMFORTABLE BACK IN BED.
	/2016	Mackay	year old initially admitted 2016 for managed conservatively with antibiotics. Review of the Category 1 Death Review documentation identified that the patient sustained a fall whilst in hospital on the 2016 whilst in the Patient sustained significant head injury – and passed away on the 2016. CT was attended at the time		Immediate review by on call and CT undertaken, neuro observations as recorded.
	/2016	Townsville	Staff found patient between the Patient states was trying to put and overbalanced. Patient deteriorated and CT revealed a large subdural haematoma. Patient died on 2016.	NULL	NULL
	/2016	Darling Downs	Unwitnessed ? fall - asked to attend , assisted by - no patient in , went to turn on the light. Found lying on the floor unresponsive and cold to touch. Stepped over and turned light on and pressed the buzzer to get staff assistance - Pt found in a . No response to buzzer so I went to staff station and notified Team Leader of my findings. Other staff attended and took over care.		Met call initiated. Team arrived,
	/2016	Gold Coast	year old with a significant medical history - end stage 16 – presents GCS post intentional overdose of , given 16 - Admitted to Respiratory ward on BIPAP 16 - mechanical fall - # NOF .16 - hip Pre-anaesthetic notes discussion " " " " with patient & NOK. ARP created. 16 – family meeting, deceased. D/W Coroner Form 1A (in view of apparent OD & mechanic fall) QPS informed	patient reassured. . Pt given pain relief for injuries. Injuries attended to. Pt taken for CT scan to assess. Hip xray attended to. NOK notified. Anagelsia as required.	Pt anagelsia effective. Resting in bed. Medical officer reviewed scans and ordered further anagelsia.
	/2016	Metro South	WAS LYING ON SIDE IN BED. NURSING STAFF AND DOCTOR FOUND THAT PATIENT WAS NOT BREATHING/NOR RESPONDING WHEN CALLED NAME TO ATTEND ECG. PATIENT WAS OBSERVED TO BE UNCONCIOUS, WARM TO TOUCH AND BLUE ON THE LIPS .MET CALL WAS CALLED IMMEDIATELY. STARTED ON EMERGENCY TREATMENT BY THE MET TEAM. PATIENT WAS TRANSFERED TO ED @ BY THE MET TEAM, AND PRONOUNCED DEAD @ HRS.	CALLED MET CALL IMMEDIATELY @ HRS. AND THEY RESPONDED QUICKLY AND STARTED TREATMENT.	PATIENT HAS BEEN TRANSFERED TO THE ED BY MET CALL. THE PATIENT HAS BEEN PRONOUNCED DEAD @ HRS.
	/2016	Metro North	Induction of labour re /16. Spontaneous rupture of membranes at hrs - Clear Progressed to @ hrs Abnormal CTG delivery at hrs Baby born in poor condition Neonatal Emergency activated Baby transferred to ICN following resuscitation Baby remains in poor condition	Neonatal Emergency activated Full resuscitation commenced by neonatal team Baby transferred to ICN	Birth Suite MUM aware AHNUM updated and aware Conultant Dr and Registrar Dr aware of adverse outcome
	/2016	Central Queensland	Patient in theatre having operation for Maternal collapse at birth of baby Intubation and CPR initiated resuscitation attempts unsuccessful patient deceased 	Intubation and CPR initiated Intubation and CPR initiated	resuscitation attempts unsuccessful resuscitation attempts unsuccessful patient deceased
	/2016	Metro North	pt had out of hospital arrest. Bought in by hospital in cardiac arrest. Pt was weeks pregnant. Emergency LSCS performed in the emergency department, unable to resusitate infant. fo ongoing care. Pt died days later.	fo ongoing care. Pt died days later. as below	Cares resumed by as below
	/2016		year old with known was admitted for a routine procedure for . Following the administration of anaesthetic drugs the anaesthetist identified that the patient had a possible severe anaphylactic reaction to the anaesthetic drugs. The patient was resuscitated and stabilised with intravenous fluids and medication and transferred to a secondary facility for intensive care and died later.	Patient intubated. Ephedrine and metaraminol boluses given with minimal effect. Adrenaline boluses given with some effect and transitioned to adrenaline infusion. Transfer arranged to Collected by retrieval ~ , Arrived ICU ~	On arrival investigations show signs of multi-organ ischaemic insult: Neurological status unknown on arrival due to sedation - subsequently has remained GCS) for > hrs and repeat CT demonstrates marked and loss of
	/2016			NULL	NULL



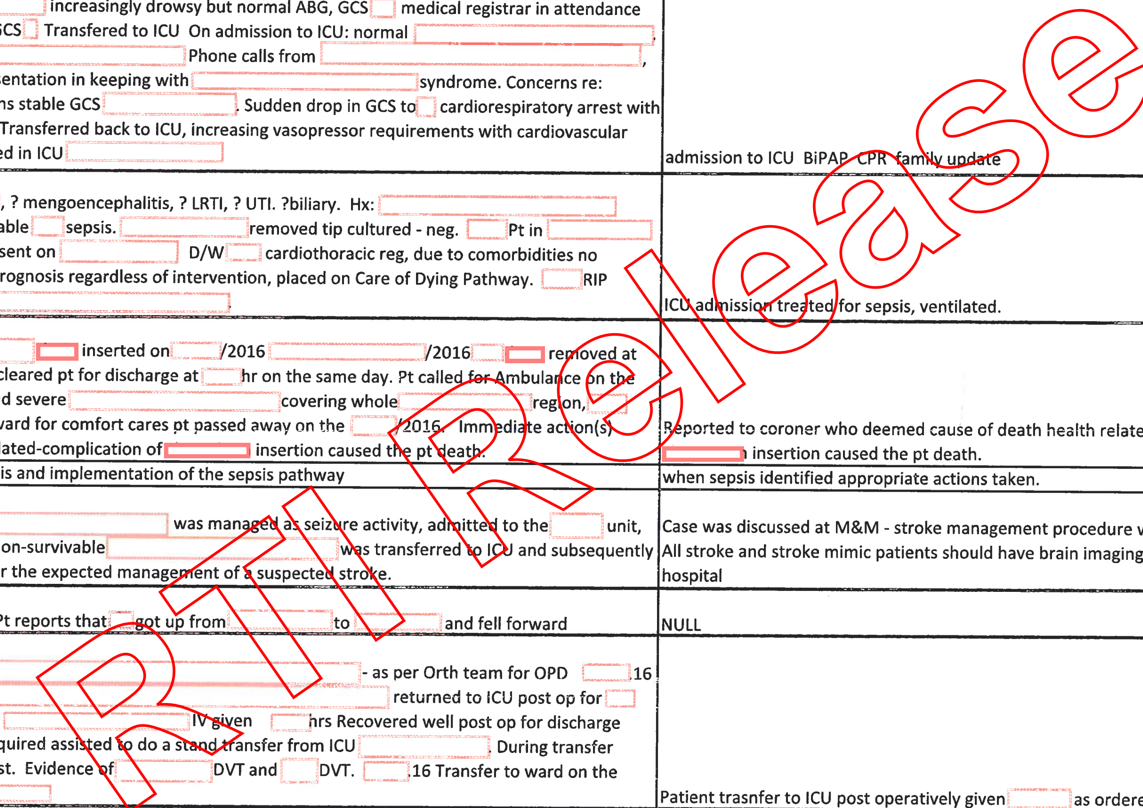
DOH-DL 16/17-011

RTI Document No. 20

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2016				
	/2016	Metro North	Patient was admitted with secondary to required continuous IV fluids and strict fluid balance. was not able to comply with treatment due to impaired cognitive state, most likely delirium (on a background of). A was called on 16, patient had tachycardia, low oxygen and fever – type 1 respiratory failure. was admitted to ICU for intubation and management of respiratory failure. The patient vomited and aspirated during intubation. Intubation occurred but with difficult ventilation due to . went to theatre for and but died soon after. The cause of death was recorded as . Initial review of the case found that the patient's condition could have been recoverable with earlier admission to ICU for fluid administration under sedation	No initial actions taken.	Current
	/2016	Mackay	Patient admitted to Hospital /2016 with abdominal pain. Delayed transfer to Hospital with arrival approximately, on the 16 with CT abdomen on , abdominal surgery Patient deceased on .16. Death review by Dr and Dr .16 deemed that further review by Surgical team was warranted. Category 2 death review by Dr 16 recommended SAC1 for assessment of reason for delay in transfer.	Abdominal surgery	Pt deceased
	/2016	Metro North	First heard about case @ hrs from surg reg. Booking form received roughly 20-30mins later - contacted nurse manager immediately. called anaes reg to ask if was aware of case - anaes reg was stabilising pt as pt had prev met call. anaes reg said it was unsafe for pt to come to OT at this stage. @ surg reg said to get pt ready for @ start - this was organised. pt got to OT suite @ roughly. no surgical checklist prior to OT was complete - ward nurse and anaes nurse completed it together. ward nurse left not long after handover. surg consultant arrived just after @ and informally stated "we are not operating". surg consultant than arrived at pt and stated that pt needed to be transferred and then walked away. Another RN from OT (also an anaes nurse) with anaes reg came at bedside and suggested to monitor pt in recovery due to pt risk of another met call - while waiting for surg consultant decision and plan. Pt was monitored asap in recovery and vital signs were recorded. At this stage nurse manager talked to surg consultant liasing plan. nurse manager told nursing staff to wait until they have decided to bring to ICU or be transferred to . Care was continued and were provided by deals with transferring pt and plan - at no plans at this stage was communicated over who were all trying to provide the best care possible to care for pt and help stabilise pt. cares provided included - all within scope of practice. @ pt finally then transfered to for further care via ambulance. handover was provided to transferring RN Immediate action(s) taken Result of immediate action(s) What stopped the patient from being seriously harmed? Staff intervention	NULL	NULL
	/2016	Gold Coast	Found unresponsive and . Code Blue activated Pt found to be deceased.	Attempts to rouse patient were unsuccessful. Code blue immediately activated.	Met team and PSO's arrived. Patient was found to be deceased.
	/2016	Metro North	Nursing was assisting patient in . RN was assisting other pt. came to tell RN pt in was no . Told pt we would try again soon. proceeded with medications from . pt asked for pain relief, RN went out to find other RN for when saw pt in on the floor. was down and was up high. RN hit the emergency button and went and got the back board and asked another nurse to bring an obs machine. Completed a full set of obs on pt while on floor. Dr's were present and reviewing pt. Pt was verbal at the time on floor. pt had sustained a wound on the head, bleeding a lot. Vitamin K given via IV and mcg given	NULL	NULL
	/2016	Darling Downs	Patient was seen in and admission was advised. Pt refused and returned to SB. Advised would present to but waited until profoundly unwell at home. Sats on arrival to . Immediate action(s) taken Bipap commenced.. Ab&# . GCS lowered to . QCC called.Decions for immediate retreval. Recommended to intubate while waiting as team at least an hour away. Result of immediate action(s) Failed intubation followed. Seveal attempts made. Med super called in as well as anaesthetic on call. Patient developed VF and failed cardioversion. Patient deceased.	Bipap commenced.. Ab's, . GCS lowered to Called for immediate retreval. Recommended to intubate while waiting.	Failed intubation followed. Seveal attempts made. Med super called in as well as anaesthetic on call. Patient developed VF and failed cardioversion. Patient deceased.
	/2016	Metro North	Pt was being assessed by doctor. When I returned from break, the curtain was still pulled and I assumed the doctor was still in attendance. A short time later, I was notified by the emergency physician that the patient was on the floor and had fallen out of bed. The patient stated needed the and was unable to alert a staff member, so climbed over the , falling onto hip, which complained of severe pain to also had a small skin tear to was assisted back into bed by and myself.	Assisted into X-ray ordered by emergency physician and attended to by the patient. Medical registrar notified. Nil pain relief was given due to patient's poor Ensured patient then had a nurse call bell on at all times.	Fracture to found on x-ray.
	/2016	Gold Coast	Unwitnessed fall in patient with acute delirium resulting in # NOF	Obs attended, neuro obs attended, CTC notified, RMO notified. called to assist with patient tfr. Sheet placed under patient and patient transfered to bed.	After RMO review patient was taken for x-ray of
	/2016	Metro North	At hours loud noise audible, three Registered Nurse attended to noise and found patient lying on unwitnessed fall. Patient unable to recollect event. Prior to fall, patient had been escorted to . Patient had previously notified via nurse call bell for assistance. Call bell within reach. Room not cluttered.	Doctor notified, observations and neurological observations taken immediately and post falls protocol followed. contacted and assisted patient into bed. Doctor reviewed patient, commenced as instructed. Ice pack applied to head. Patient RN escorted to medical imaging due to and observations requirements. Medical Oncology Registrar and Day Ward Call notified. Medical Oncology Registrar and Day Ward Call notified Medical Oncology Registrar and Day Ward Call notified Medical Oncology Registrar and Day Ward Call notified	Continue post falls protocol. Patient investigation performed promptly. Doctors able to promptly diagnose patients condition. Patient comfortable and safe. Observations and neurological continue.
	/2016	West Moreton	Patient was given dose in ED while waiting transfer to with further transfer to under team when bed available.Patient became agitated and then unresponsive and went into PEA arrest.	Patient was transferred to resus and CPR commenced	ARP found from previous admission identifying patient did not wish for CPR, CPR ceases and patient declared deceased at and coroner and family were notified
	/2016	Metro North	yo with /2016 - AVR + MVR. Difficult procedure with prolonged time. on adm to ICU with ongoing shock. Developed sepsis, CT abdomen - , likely . GCS 15. 2016 - performed. Immediate action(s) taken Intraoperative laceration of blood loss - transfused. /2016 - Pt deceased hrs on return from OT. Form1A to Coroner	Intraoperative laceration of blood loss - transfused.	/2016 - Pt deceased hrs on return from OT. Form1A to Coroner
	/2016	Wide Bay	Unexpected Death in ED. Patient deteriorated in the Unit. Patient had a significant period of time without recording observations and also spent a period of time in the corridor of the Emergency Department	Patient moved from into the Resus department for active treatment.	Active treatment commenced but not successful

RTI Release

Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2016		Patient was found by a nursing staff hanging with a around neck from door during 15 minute visual observations. Patient was found unconcious and assisted by nursing staff to the ground. Duress alarm activited. CPR initiated and Code Blue activated. Patient maintained a pulse throughout incident. CPR was adminestered for approximately 40 minutes before was taken to ICU.	Duress alarm. Blue code and immediate CPR.	Patient maintained pulse during CPR in the ward.
	/2016		2016 Patient was admitted via ED at following a fall at home. Triaged as a cat 4. "Mechanical fall using . Injuries to . On floor for about . Nil loc, neck tenderness. Alerts noted as Patient was kept in the area with IV antibiotics for At RN noted that when moving the patient in the bed in bed RN notes that nil have been given since then and when pt. asked where they came from stated escalated to SMO and patient was moved to ED for further treatment at hrs. At the patient was reviewed in ED by the Med Team At an ICU review requested by the ED team. At ICU reviewed the patient in ED and feedback from intensivist is that there are no ICU issues Patient stayed in ED with clinical notes indicating that ADDS consistently /2016 Patient remains on ED until the . Further review by Intensivist at in ED. , no issues requiring HDU or ICU intervention 9retrospective note in after ICU admission). Patient transferred to medical ward) at ADDS at this time due to heart rate. Reviewed by Medical team and at impression + acute exacerbation of Patient ordered stat and patient has a history of acute medication. ICU review requested at for increasing agitation. ICU review: only abnormal finding; mild confusion, no symptoms, nursing team struggling with patient. Very limited ICU space. MET call at increasingly drowsy but normal ABG, GCS medical registrar in attendance with ICU registrar. Further deterioration and MET call at , GCS Transfered to ICU On admission to ICU: normal . WCC Patient is Phone calls from , bed Patient's clinical presentation in keeping with syndrome. Concerns re: given, no significant response. Patient remains stable GCS . Sudden drop in GCS to cardiorespiratory arrest with CPR commenced. Patient taken to CT for CT head, further arrest Transferred back to ICU, increasing vasopressor requirements with cardiovascular deterioration, family update, patient continued to deteriorate, died in ICU	admission to ICU BiPAP CPR family update	patient initially stabilized but deterioration whilst writing this report the patient has sustained a further cardiorespiratory arrest and is undergoing CPR
	/2016	Darling Downs	/16 Admitted with reduced LOC. Sepsis ? source: ? , ? mengoencephalitis, ? LRTI, ? UTI. ?biliary. Hx: replaced due to sepsis. probable sepsis. removed tip cultured - neg. Pt in via . ECHO - post , not present on D/W cardiothoracic reg, due to comorbidities no surgical option would be offered. Family conference grave prognosis regardless of intervention, placed on Care of Dying Pathway. RIP Death Certificate: Cause of death: .	ICU admission treated for sepsis, ventilated.	Patient failed to recover, no surgical options.
	/2016	Metro North	Pt admitted on the 2016 with recurrent inserted on /2016 /2016 removed at approx observation if stable can be discharged. Dr cleared pt for discharge at hr on the same day. Pt called for Ambulance on the /2016 at hrs with SOB arrived to ED with severe SOB and severe covering whole region, and reinserted to admitted to medical ward for comfort cares pt passed away on the /2016. Immediate action(s) taken Reported to coroner who deemed cause of death health related-complication of insertion caused the pt death.	Reported to coroner who deemed cause of death health related-complication of insertion caused the pt death.	Coroner has requested a clinical review.
	/2016	Mackay	Patinet presented to ED and there was a delay in diagnosis of sepsis and implementation of the sepsis pathway	when sepsis identified appropriate actions taken.	delay in treatment
	/2016	Gold Coast	A year old presented to the ED with altered neurology of was managed as seizure activity, admitted to the unit, experienced a clinical deterioration, and CT scanning identified a non-survivable was transferred to ICU and subsequently died. did not receive a CT head on presentation to the ED as per the expected management of a suspected stroke.	Case was discussed at M&M - stroke management procedure was not followed. All stroke and stroke mimic patients should have brain imaging on arrival to hospital	reiteration of stroke management procedure review please at least
	/2016	Townsville	Pt placed in by family - family did not notify nursing staff. Pt reports that got up from to and fell forward	NULL	NULL
	/2016	Gold Coast	.16 - A yr old fell from - as per Orth team for OPD .16 - Elective admission T/R to OT for radical returned to ICU post op for .16 IV given hrs Recovered well post op for discharge from ICU to ward IV given hrs Required assisted to do a stand transfer from ICU . During transfer became SOB and with O2 saturation drop cardiac arrest. Evidence of DVT and DVT. .16 Transfer to ward on the care of dying pathway. .16 Passed away due to	Patient trasnfer to ICU post operatively given as ordered.	The following prior to transfer to ward developed chest pain and had a cardiac arrest. Imaging showed multiple in fractured .16. The patient did not full recovery and died on 16 due to a severe
	/2016		week, low risk pregnancy (presented to labour ward at hrs in active labour. During of labour FH noted to be low, CTG monitoring commenced, FH? Infant born with no signs of life, Apgar resuscitation commenced. Infant ventilated, severely unresponsive, pupils fixed and dilated, decision made in consultation with to withdraw treatment.	Resuscitation commenced, MET called	Infant ventilated, infant severely and prognosis poor, decision made to withdraw treatment
	/2016	Central Queensland	Palliative patient found on the floor under , post unwitnessed fall. Patient unable to move or talk and had sustained cut to the area. contacted immediately & reviewed patient who was found to have a GCS Wound was cleaned and steri strips applied. Care of the Dying Pathway implemented. Patient was later found deceased minutes post fall	ED NOTIFIED IMMEDIATELY. PATIENT HOISTED BACK TO BED X STAFF MO ATTENDED AND ASSESSED, GCS . OBS TAKEN BP . WOUND CLEANED AND APPLIED STERI STRIPS AS PER MO ORDER. NOK NOTIFIED. AT HRS PATIENT DECEASED. MO NOTIFIED AND CAME TO CERTIFY PATIENT. NUM ON CALL NOTIFIED.	REVIEWED BY ED DOCTORS WITHIN 5 MINUTES. ARP REVIEWED AND MO DECISION FOR NO ACTIVE TREATMENT, MADE PATIENT COMFORTABLE. WOUND CLOSED WITH STERI STRIPS.
	/2016	Central Queensland	Patient found by nurse when doing observation rounds to be deceased Patient. Informed CN on duty and doctor	informed CN on duty and doctor informed CN on duty and doctor	Patient found to be deceased. Patient found to be deceased.
	/2016	West Moreton	Patient was mobilising with nurse as a stand by assist to the when observed no nurse turned to retrieve and patient fell hitting head Patient states cannot remember what caused fall, believes to have overbalanced. Another witnessed the fall and confirms hitting of the head and appeared to have over balanced . Staff assist buzzer was pressed, pillow placed under patient's head and hoisted back to bed x assist. team Doctor was on the ward at the time and assessed patient. Patient sustained a haematoma to head and small abrasions to applied to both. Neuro obs commenced as per post falls pathway, GCS and Adds . Patient was sent for a CT head scan awaiting results. Bed rails up and bed lowered to ground. Nurse call buzzer within patient reach.	NULL	NULL



Incident ID	Date of Incident	District Name	Incident Description Of Event	ActionTaken	Result Of Actions
	/2016	Metro North	was day post elective open and had acute on A medical consult was requested at with regard to patient's , acute on chronic . Med reg gave advice over the phone to give and perform ECG. said will come and see the patient if gets some time, otherwise will hand over to the reg. No one from medical team came to see the patient. The the patient had MET call at had a cardiac arrest and died.	Patient had resuscitation for 30 mins. Bedside ultrasound showed dilated at the time of MET call was . The cause of death was thought to be either secondary to	patient died.
	/2016	Metro North	Nursing staff found the patient unresponsive in bed whilst undertaking their regular visual observations. A code blue was called and the Medical Emergency Team attended the scene	Resucitation attempts were conducted by the treating team but theses were unfortunately unsuccessful	The patient was pronounced deceased at hrs
	/2016	Metro North	patient died as a result of complications in removal of	Full resuscitation and urgent	Transferred from main operating theatre to intensive care unit and further deterioration occurred.
	/2016		year old with . Not suitable for Palliative radiation treatment under palliative scheme. History of Admitted 16 for increasing shortness of breath. pleural effusion. Pleural .16. inserted .16. .16 Patient found on floor at approx. small, bleeding laceration to forehead, conscious and distressed. Nurse initiated met call. ARP in place. Not for defib, CPR or ICU. Patient deteriorated, continued to decline and passed away at .	Nurse assist call bell was activated, pt was reassured and metcall activated	Metcall team attended to the patient and metcall called off as pt was handed over to the home team for palliation
	/2016	Metro North	BIBA 2016 at Admitted to ED. Triage category 4. Presenting complaint (PC): cough for and after a cough this Triage assessment: became SOB after a cough at hrs.N/H nurse measured SaO2 was in the applied O2 with good effect, well at present, well perfused, normal alertness. Observations recorded: Temp: Risked assessed as a high falls risk and has a At the patient was reviewed by the ED JHO. It was noted: with cough and SOB over past and declining level of function. PMH: PC: cough over last productive cough, function declining now requires assistance with transfers in and out of bed, reports weight loss, lethargic decreased appetite. O/E , , afebrile, patient looks well, very frail, poorly orientated, chest: reduced air entry lower zone, nil crackles or wheeze, Heart sounds and loud , nil peripheral oedema, abdomen soft and non-tender. Plan: chest X-ray, Bloods and Urine. At the patient had a Chest X-ray At the ED nurse noted: PRIME CI was not reported as issues with system. At the patient had a chest X-ray At the JHO noted: mildly elevated, WCC Chest X-ray: large . A was performed under sterile conditions with Consultant, was drained and sample sent for . pH analysis and cytology Repeat Chest X-ray was undertaken and JHO review and noted: nil pneumothorax. Plan:refer for medical admission and further treatment and analgesia. The xray showed a pneumothorax but this was not observed by the JHO and handed over to the Medical Reg - nil pneumonthorax was handed over At the MAU nurse noted: the patient was admitted to the unit at Q-ADDS score of . Awaiting medical review for further management. At the patient underwent a CT scan of chest with contrast: greater than There is also a pneumothorax the Medical Reg had not seen the pt and not reviewed the CT scan - nil call from Radiologist. Pt observed last at pt found unresponsive on floor at approx MET called Pt pronounced dead at attempt made to contact family and coroner.	MET call for unresponsiveness ? fall off or collapse	none
	/2016	Mackay	Pt. was found to be deceased during ward round at No sound had been heard and pt. had been observed at different times during the M.O. was called and confirmed deceased Immediate ac) taken Check for signs of life. M.O. called Result of immediate action(s) Pt. declared deceased. Police notified of unexpected death. notified and 	Check for signs of life. M.O. called	Pt. declared deceased. Police notified of unexpected death. notified and
	/2016	Sunshine Coast	The event relates to the possible delay in recognition of a . On the 2016, a year old was admitted to complaining of the sudden onset of headaches, nausea, tightness of the chest, and pain in jaw. The patient was admitted to the Cardiac Ward . The patient was in hospital for approximately hrs when suffered a cardiac arrest. Resuscitation efforts were unsuccessful.	Resuscitation efforts were unsuccessful.	Death reported to the Coroner at the time of the event
	/2016	Metro North	EEN heard noise in room and went to investigate, found patient laying on but toward the . EEN called for help from RN to move patient but no response. EEN left room to ask RN for assistance. On arrival back in room, patient was found on the floor with a bleeding laceration on scalp (area).	MET call for immediate medical review. Neuro observations CT Head Scalp wound reviewed Family notified MET call for immediate medical review. Neuro observations CT Head Scalp wound reviewed Family notified	CT results show new cerebral bleeds (as per medical chart). Scalp laceration glued CT results show new cerebral bleeds (as per medical chart). Scalp laceration glued

RTI Release