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1	Incident ID	Incident Date	Hospital and Health Service	Facility	Summary	Details	Action taken at time	Clinical review / progress notes	Recommendation: Details
2	[redacted]	[redacted]/2019	CAIRNS AND HINTERLAND	[redacted] Hospital	pt presented via QAS from a crusie ship with a suspected STEMI, deteriorated while waiting for CT reporting, then arrested on transfer to cath lab, unable to be resuscitated.	[redacted]	NULL	PSQO update: Coroner determined" not reportable" and death certificate was issued. M&M reivews have been completed by Cardiology & ED Departments. Spoke to Clinical Director Cardiology [redacted]/19: main concerns relate to pre-hospital management however supports decision to proceed to verification meeting. Meeting booked [redacted]/19. Unable to be scheduled prior due to senior staff availability. Update [redacted]/19: Verification form signed by DMS and submitted for EDMS & CE signatures. PSQO update [redacted]/19: Verification signed by A/EDMS & CE. [redacted]/19 - Report presented to SRP by Director of Cardiology. Recs accepted. [redacted]/19 - Final Report signed by Director of Cardiology, PSQO to progress to CE for signing prior to sending to PSQIS	That patients with suspected ACS under the care of Emergency Medical Services or medical officer shall notify the Interventional Cardiologist early to discuss time critical cardiac patient management. Education to be provided to Emergency Department Medical staff on the [redacted] Hospital After Hours CCL (Cardiac Catheter Laboratory) Activation Flowchart
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2	[redacted]	[redacted]/2020	CENTRAL QUEENSLAND	[redacted] Hospital	Patient presented [redacted] with vomiting and lethargy [redacted] with fever diarrhoea clammy on presentation but afebrile [redacted]	Patient was monitored and treated from presentation in acute with a sudden decline post treatment at [redacted] hours CPR commenced and patient transferred to Resus [redacted] patient demised [redacted]	NULL	NULL	NULL

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2		/2019	DARLING DOWNS	Hospital	QADDS not documented appropriately	pt presented to Ed with productive cough , decreased O2 sats , QADDS not added correctly, follow up observations not recorded. Pt represented the following day and deceased in ED	NULL	for SAC1 HEAPS review	No recommendations

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1	Incident ID	Incident Date	Hospital and Health Service	Facility	Summary	Details	Action taken at time	Clinical review / progress notes	Recommendation: Details
2		/2019	MACKAY		was brought into Hospital ED by QAS unconscious, unresponsive with CPR in progress after being found	and commence CPR. QAS called. Brought to Hospital ED.	CPR continued in ED until life extinct declared	RCA completed - submitted to PSQIS on the /19.	Community Mental Health clinicians receive education on the complexity of the relationship between mental illness, psychotic illness and substance use to improve skills in differential diagnosis and intervention (including brief intervention). # Community Mental Health clinicians complete Alcohol and Other Drug screening assessments, available in CIMHA V 5.0, when substance use is identified. # All Rural Emergency Department Staff receive education on 'Recommendation for Assessment' under the Mental Health Act 2016. # Carers or significant other(s) of new mental health consumers are routinely offered a Carer Information package found on QHEPS: (https://qheps.health.qld.gov.au/__data/assets/pdf_file/0030/2145639/mhresource-carer-info.pdf). This brochure informs all carers of pathways to escalate concerns or deterioration in keeping with procedure C-PRO 472 V1.0 'Escalation pathway to request a second opinion in a community mental health service facility'. # Carers or significant other(s) of mental health consumers (e.g. family members, elders, next of kin) concerned about a consumer's substance use are offered relevant written information (e.g. fact sheets) about the substance(s) of concern. # Referrals to access the Alcohol and Other Drug Service are accepted in keeping with the Alcohol and Other Drug (AOD) Services – Model of Service. # All Rural Emergency Department Staff have knowledge and understanding of the Emergency Examination Authority under the Public Health Act 2005. # Rural facility Emergency Department Staff are educated in the management of drugs and psychosis presentations to the rural Emergency Department.
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4	[redacted]	[redacted]/2019	MACKAY	[redacted] Hospital	58 [redacted]- died in ED, unexpected death	58 y.o [redacted] Carried into ED [redacted] patient was unresponsive [redacted] airway, breathing absent and no heart sounds on auscultation. [redacted] and CPR initiated. [redacted] Lifepack showed asystole so nil shocks delivered. [redacted] See EDIS note for more detail.	Resuscitation	* M&M completed.	NULL

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2	[redacted]	[redacted]/2020	METRO NORTH	[redacted]	Triaged ED patient Cardiac arrest in Hospital Car Park	Triaged patient had left ED to go to vehicle in car park [redacted], ED Notified of collapsed patient found in car park. CPR commenced By ED Nurse and bystander, Code Blue called by nurse attending to patient. Assistance sought by Student Nurse to get Help from ED. ED Team response to arrest. CPR continued, defib applied [redacted] scoop used to transfer patient to stretcher and transferred to ED. Resus Bay and appropriate airway equipment prepared and ready for patient arrival in ED. Resuscitation attempts unsuccessful. Patient RIP [redacted]	Code Blue Cardiac Arrest Called from Nurse attending Patient, ED Team response called for until Met Team arrived.	Situation On [redacted] 2020, [redacted] Hospital Emergency Department (ED) nurse responded to a request to assist an unresponsive patient in the car park. The unresponsive [redacted] was located and was assessed to be in Cardiac Arrest. Background A 74-year-old [redacted] The patient was triaged at [redacted] as a Category 3 and was noted to be well. [redacted] The patient had not been reviewed by a Medical Officer. At approximately [redacted] an ED nurse was notified [redacted] of an unresponsive [redacted] in the car park. The ED nurse attended the patient to find [redacted] with laboured breathing [redacted] Following assessment, Cardiopulmonary Resuscitation (CPR) was commenced and the Medical Emergency Team were called. The patient was transported to the Resuscitation Bay in the ED. [redacted] The patient had a persistent non-shockable rhythm without any clear reversible causes [redacted] The patient was declared deceased [redacted] Assessment The Medical Officer (MO) was unable to determine the cause of death, as there were no medical records at [redacted] Hospital. The case a has been referred to the Coroner to determine the cause of death.	A review of resuscitation requirements for MET team [redacted] carpark (including the multistorey car park) is undertaken to include: • Physical space including lighting, safety • Communications with MET team and ED • Automated External Defibrillator (AED) requirements and proximity # A review of the Death Box occurs to ensure compliance with all documentations that are required following a death in the Emergency Department.
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2	[redacted]	[redacted]/2019	METRO SOUTH	[redacted] Hospital - [redacted]	Potential for earlier consideration of ventilation options for a patient in respiratory distress.	Patient experienced apnoea. Increased CO2 and pH 6.95 Commenced on BiPAP	Medical and nursing reviews and intervention.	Patient hx [redacted] presented post aspiration on tablet at home, deteriorated, was for emergency broncosopy in AM. Patient continued to deteriorated post trial of NIV. MO did not intubate due to poor quality of life and difficult wean. The NOK was unable to be contacted for end of life discussion. Patient died. Reviewed by coroner questions regarding not performing bronch overnight. Pt was stable nil indication at time of consultation by Resp SMO. [redacted]/19: For further review to be coordinated by PSO.	That the [redacted] Hospital Emergency Department consider the implementation of spirometry to periodically assess the respiratory status of patients with [redacted] conditions such as [redacted] in order to identify respiratory deterioration.

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2	[redacted]	[redacted]/2019	WEST MORETON	[redacted] Hospital	Author advised by ED staff that patient known to Acute Care Mental Health Services had presented (CPR in progress). Out of hospital cardic arrest. Patient deceased. [redacted]	Advised that patient known to mental health services had been transported to [redacted] ED with CPR in progress, [redacted] Patient deceased in ED QPS present	Death reported to Mental Health Executive on call [redacted]	HEAPS analysis undertaken	[redacted] assessment to be completed when the Mental Health Services Triage and Rapid Assessment Tool is undertaken during an ACT assessment.
3	[redacted]	[redacted]/2020	WEST MORETON	[redacted] Hospital	Patient had over a 1.5 hour delay in transfer to PAH due to RSQ wishing to retrieve the patient	Patient having a STEMI - received Tenectaplase at [redacted] - QAS ICP from Toowoomba on scene at [redacted] though they were told that they were unable to transport due to the patient having received Tenectaplase. Delay in care by nearly 2 hours while awaiting aero retrieval.	NULL	Increased monitoring of patient was attended though there was a significant delay in getting the patient to the cath lab.	HEAPS Rec 1: Rural Mortality and Morbidity meeting to present this case including the outcome of this HEAPs review for learnings across all WMHS Rural Facilities # [redacted]

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2		/2019	WIDE BAY	Hospital	Acute coronary syndrome and severe chest trauma	75yr old Presented with chest pain and fall. Diagnosed with NSTEMI and standard treatment provided. Subsequent diagnosis of severe chest trauma with hypotension and increasing hypoxia. Decision to provide palliative treatment. Patient died.		Reviewing team agreed that treatment and outcome is unlikely to have been different for this patient, however lessons learnt from this event could possibly prevent an unexpected outcome for other patients Lessons Learnt: 1. Education should be provided to clinicians to remind them that there is a higher chance of multiple injuries following falls events in elderly patients. Extra caution should be taken in events where recollection of the event is not clear and multiple injuries should be considered. 2. All diagnoses should be identified early in the presentation and management of the patient should include the management of all presenting concerns and additional concerns identified during assessment and investigations 3. Case should be used as a learning opportunity, highlighting the risks of cognitive bias.	Nil recommendations
3		/2020	WIDE BAY	Hospital	Patient presented to ED on /2020 with interscapular pain. Died following cardiorespiratory arrest. on call 30 minutes away resulting in poor response time to cardiac arrest of this patient.	Patient presented to ED on 2020 at Patient transferred via QAS to ED on with back pain between shoulder blades. Plan to transfer to HBH. Patient arrested and CPR commenced. Patient passed away at s on 2020. Coroner notified. on call not within 30 minutes response time of facility. As a result, delayed involvement of the on call for this patient. Took >30 minutes to respond. on had failed attempt at intubation of this patient during code.	NULL	Business case for staffing already submitted	NULL