Release Notes RTI 5213
Patient Safety and Quality Improvement Service

Right to Information application 5213

Documents relating to SAC1 unexpected deaths in Metro South HHS, including a detailed description of the event.

Date range: 01/05/2018 - 30/05/2019

Purpose of report

Provide applicant of RTI 5213 details of clinical incidents reported in RiskMan meeting criteria as per RTI 5213 Request for documents.

Important notes in considering the data

- The data presented is information directly reported by frontline clinicians
- The data presented includes deaths which were not reasonably expected as an outcome of healthcare **prior to an analysis being undertaken**
- The data includes deaths that may be a result of an underlying condition
- The data includes deaths that were not preventable i.e. there was no further or alternate action health professionals could have taken that would have prevented the death

Data source

- Data was retrieved from the RiskMan Clinical Incident database for Metro South Hospital and Health Service.
- RiskMan was progressively implemented across all Hospital and Health Services during 2017 and early 2018, replacing the PRIME information system. RiskMan was implemented by Metro South Hospital and Health service in August 2017.
- Riskman is designed to enable reporting, investigation and management of clinical incidents and consumer feedback reported/received by Hospital and Health Service (HHS) staff.
- All data presented for the current RTI 5213 was extracted from RiskMan and has been self-reported by Metro South Hospital and Health Service staff.
- The data for RTI 5213 is current in RiskMan as of 13 September 2019.

Search Criteria and Methodology

- RiskMan data was extracted based on search criteria and checked by Systems team, Patient Safety and Quality Improvement Service (PSQIS).

Date of incident	01/05/2018 to 31/05/2019
Harm	Confirmed level of harm = “Death”
Subject Affected	Subject Affected = “Patient / Client”
Patient affected type	Patient affected type = “Inpatient” or “Emergency presentation” or “Outpatient” or “Oral health”

Patient location	Patient location reported at time of incident in the Summary and/or Details fields as in the hospital and grounds or under the direct care of Queensland Health staff (e.g. inter hospital transfer)

Search Results

- 23 records were located as being relevant to the RTI application.

Interpretation notes

The vast majority of care delivered in hospitals and by other health services in Queensland is very safe and effective. However, despite excellent skills and best intentions of our staff, occasionally things do not go as expected. When this happens, it is distressing for patients, families and staff, particularly when the consequence is severe. Publicity around these events can also cause the community to lose trust in their healthcare system.

Queensland Health has worked hard to develop a patient safety culture that actively encourages staff to report clinical incidents and see these as opportunities to learn about and fix problems. The analysis of these incidents helps us better understand the factors that contribute to patient incidents, and implement changes aimed at improving safety. While some people may interpret reports of clinical incidents

as a sign of poor safety, we view incident reporting as an indicator of a good patient safety culture

that ultimately leads to better patient care i.e. staff are willing to report incidents to actively pursue implementation of actions in order to minimise the potential for the reoccurrence of a similar incident in the future.

Interpreting numbers of clinical incidents, comparing the number of clinical incidents between HHSs, or using the number of clinical incidents as indicators of performance is not advised due to:

- a degree of clinical subjectivity in deciding whether an adverse outcome is a clinical incident i.e. what is reasonably expected is different from one clinician to the next, as well as what is expected by the patient/family. For example, a death may not have been reasonably expected and therefore met the definition of a SAC1 incident, but is later determined to have been the result of an underlying condition. Consistent with best practice across the world, it is important to us to have a reporting system that captures a broad scope of adverse patient outcomes that *could* be potentially preventable so that we can continue to learn and improve.

- Classification of an adverse patient outcome as a clinical incident does not describe ‘negligence’ or ‘fault’ on behalf of our staff or systems.

- Not all clinical incidents are preventable.

- Higher incident reporting rates are generally accepted as an indicator of a positive and transparent safety culture, rather than a marker of less safety care.

1. For the patient who had the unwitnessed fall rushing to the toilet the recommendation was a planned multi-incident analysis of SAC 1 falls during 2018 will be undertaken.

2. For the patient who had an unwitnessed fall outside of bathroom while nursing staff were attending another patient next door. Patient was found sitting on the floor calling for help. Patient stated that they twisted their leg then had a fall while patient was trying to close bathroom door but did not hit their head.

   Post confirmation of SAC 1 decision. Transferred from this RiskMan incident attachment. Final Signed copy of QEII Clinical HEAPS review:

   Factual description of event

   On the 9 September an elderly patient was admitted to the QEII following a two (2) day history of chest pain. Patient was admitted for management of a late presentation STEMI. On the 11 September the patient had an unwitnessed fall and sustained a fractured neck of femur. The Patient was transferred to the orthopedic team for management. At approximately 23:00 patient was found unresponsive a code blue was called. Under the instruction of the ARP, CPR was not commenced. Patient deceased and the death was reported to the coroner.

   Action taken at the time: Obs and ECG attended, ward call notified to review patient. Transferred information from attachment SAC 1 QEII Clinical HEAPS review: Information from the Coroner's Office basis for Decision. Having reviewed F1A + F9 + QEII Hospital records, it was determined that the death was reportable under the Coroners Act 2003 (complication of mechanical fall-related injury caused the death in the context of significant multiple medical comorbidities) but does not require further coronial investigation as on the information available. No concerns about the management of the patients falls risk, the circumstances of the fall or the health care provided. A coronial autopsy is not necessary as the probable cause of death is known.

3. For the patient with the potential failure to diagnose endocarditis on review no recommendations were made.

Severity Assessment Code (SAC) Definitions

SAC 1 - Death or permanent harm which is not reasonably expected as an outcome of healthcare

Incident ID	Incident date	HHS	Summary	Details	Action taken at time	Clinical review / progress notes	Type of Analysis	Recommendation-details
	2018	METRO SOUTH	IV contrast given to a patient , with a known and documented IV contrast allergy on the notes but not copied into the ED medication chart	This patient presented today. The patient had approximately medication and other allergies documented in her documentation. This was copied into EDIS by triage nurse, but not all of the listed allergies were copied onto the patients medication chart in the ED. IV contrast allergy was missing on the ED medication chart. It was decided that the patient needed to have a CT to further investigate , which was obvious on direct the scan was to investigate this further and also to check for . The patient went to the CT scanner The was asked by the r if the patient had any IV contrast allergy, and the checked the medication chart from ED and told the "not that I'm aware of or from this chart". The IV contrast was then given and within 30seconds the patient had a PEA cardiac arrest. Immediately the commenced CPR and the r pressed cardiac arrest alarm and ED staff attended ED - a consultant and registrarx2 and nursing staff. . By this stage, Dr (ICU) and Dr (ED consultant) were in consultation at bedside discussing goals of care. There was agreement between the 2 specialists that given this was a healthcare associated clinical incident/error that all efforts should be made to reverse any potentially reversible conditions.	The patient went to the CT scanner with an . The was asked by if the patient had any IV contrast allergy, and the checked the medication chart from ED and told "not that I'm aware of or from this chart". The IV contrast was then given and within 30seconds the patient had a PEA cardiac arrest. Immediately the commenced CPR and the pressed cardiac arrest alarm and ED staff attended ED - a consultant and registrarx2 and nursing staff. By this stage, Dr (ICU) and Dr (ED consultant) were in consultation at bedside discussing goals of care. There was agreement between the 2 specialists that given this was a healthcare associated clinical incident/error that all efforts should be made to reverse any potentially reversible conditions.	The allergies documented on the paperwork were not fully documented on the ED medication chart - specifically the IV contrast allergy was not documented on the ED medication chart. This directly lead to this clinical event. The patient has and was unable to give clinical details of medication allergies if asked. The patient did have a red arm band on, but it didn't list all of the medication allergies on it.	HEAPS	That ED reviews their clinical handover process for patients going for a procedure. That Queensland X-ray align their emergency trolley equipment and layout with that of Hospital. That Hospital provide BLS training for Queensland X-ray staff based at the That ED run BLS /ALS simulation in the X-ray department with X-ray staff twice a year.
	2018	METRO SOUTH	Pt. felt dizzy when stood up from toilet and fell	Pt. was set up in shower with shower chair and advised to buzz for assistance when finished. Pt. independently completed shower and went to the toilet. When standing up from the toilet the pt. felt dizzy, fell and hit head. Nurses heard the fall and assisted pt.	Assessed pt. neurological and physical observations. Post falls pathway commenced. Increased frequency of observations. Skin tear treatment. Environment cleared and tidied.	Pt sustained Subdural Haematoma from fall in bathroom plus multiple skin tears to arms and legs. Pt stood up and blacked out falling backwards.	Clinical review	1. To undertake a review of documentation in ward to identify compliance with completion. 2. To escalate the matter of privacy requirements during toileting and/or hygiene activities to the Falls Prevention and Advisory Committee when a patient has been identified as a falls risk. The committee is to consider if further actions required to ensure patient safety during toileting and/or hygiene activities.
	2018	METRO SOUTH	Patient discharged to community	Patient discharged to community represented weeks later with multiple PI's and died from sepsis related to PI's	(None Entered)	RCA to be undertaken	Root cause analysis (RCA)	1. The development of a guide to the care of vulnerable older adults which incorporates education on elder abuse/neglect risk factors and alert process. 2. Funding for the development of a Geriatric Evaluation and Management model of care to be implemented into the organisation. 3. Development of a standardised Multidisciplinary Team Discharge planning document, with clean roles and responsibilities, of which can be incorporated into the ieMR system. 4. Future redevelopment within the Hospital Department of Medicine bed platform, plan for sub-acute beds.
	2018	METRO SOUTH	Pt called for help. Pt found on floor- L) side, tangled in 4 ww.	Nursing team attended to pt's calls for help. Pt found on floor on L) side, tangled in 4 ww. Pt refused to lay on ground and forced way into an up right sitting position. Ward call and Wardies called. Pt began to insist needed to stand up , attempted self. Nurse x2 and Wardie assisted pt as pt refused to wait for Ward call. Pt stood , c/o mild back pain and demanded to lay in bed. Pt refused again to wait for ward call and continued to lay down in bed with help of nurse and Wardie. Ward call attending pt ATOR.	Support and educate pt in demands and refusals. Ob's + Neuro's. Ward call r/v. Falls pathway commenced.	At 2155 hrs on the /18 the patient was found on the floor beside bed. Approximately 2 hours post fall the patient deteriorated markedly and a MET was called for hypotension 83/56. A chest xray identified multiple rib fractures but no pneumothorax. Patient observations and laboratory tests demonstrate ongoing pain at 5-8/10, hypotension, anaemia, decreasing renal function and hypoxaemia ongoing for approximately 2 days post injury CT showed intra-abdominal bleeding source thought to be from splenic laceration. Patient deceased.	Clinical review Morbidity and Mortality review	1. Escalation of afterhours workloads and staffing/acuity mismatch in the Department of Medicine over weekends at Hospital. It is noted that there is one Consultant rostered who is required to cover all medical and cardiology patients including ED admissions and phone calls. There is currently no capacity for Consultant ward rounds on weekends. 2. Review of ward composition and patient cohort across the campus to ensure optimal placement of admissions with consideration given to workloads associated with a high turnover in the digital workspace and the diverse patient cohort in the mixed acute surgical/medical ward. 3. Education for nursing staff in the effective escalation to medical staff regarding the deteriorating patient. 4. Education for medical staff regarding best practice pain management and the importance of referral to the Pain Service or on-call Anaesthetist (after hours) to optimise use of multi-modalities such as nerve blocks and non-pharmacological management in patients with fractured ribs. 5. Implementation of strategies such as a Team Leader vest to optimise interdisciplinary communication through the clear identification of the nursing team leader on each shift in the Ward. 6. A review of processes/ tools which support the recognition and escalation of deteriorating patients by the Ward Call doctor to the Consultant, in the absence of the Doctor's Ward-Call SBAR Tool (which utilised prior to the implementation of the ieMR).
	2018	METRO SOUTH	Patient had an unwitnessed fall, stated felt like and was in a rush to toilet.	Laceration on finger, head strike, nil LoC, complaining of hip pain after the fall, haematoma present.	Review by RWC. Stat morphine for pain, CT of the head, x-ray of spine and hip. dressing to laceration.	Patient had unwitnessed fall on ward going to the toilet. Admission previous day, with falls assessment. Assessed by physio prior to the fall who deemed patient safe with single point stick. Patient was feeling like and rushed to toilet and fell onto hip and head. superficial injuries as noted. Immediate radiology showed no injury in head or hip. Further imaging to hip was attended due to pain which picked up small fracture to the GT with changes to the femoral neck trabecular. Post fall, the patient's CT hip indicated a left greater trochanter femur fracture which was managed conservatively. Pain from the fracture had a significant impact on the patient's recovery and led to immobility. The fall was recorded as a Severity Assessment Code (SAC) of 2 and the clinical division undertook a local Falls review in line with Falls Prevention Advisory Committee (FPAC) guidelines. The patient developed complications from prolonged bed rest and subsequently died from aspiration pneumonia. The Clinical Incident report was amended to reflect a SAC 1.	Clinical review	-

	2018	METRO SOUTH	STEMI pt with ECG changes & elevated troponin was transferred from ED via QAS, Arrested enroute and RIP in ED	Diagnosed STEMI pt with positive troponin & ECG changes transferred by QAS from and was RIP in ED following approx 40 minutes of CPR & 6mg adrenaline.	CPR commenced PEA arrest. Transport delayed awaiting ICP support. ACLS Algorithym followed- 6mg Adrenaline total approx 47 minutes CPR. LMA insitu on arrival at ED. Pt RIP .	Distributed to ED NUM & QAS Medical Supervisor for review of existing processes for IHT patients	Root cause analysis (RCA)	1. The RCA team recommend a review of the process for patients presenting to the emergency department with suspected cardiac chest pain identifying reasons delaying ECGs being completed within ten minutes of arrival, and exploring areas for improvement. 2. All ECGs completed in the Hospital Emergency Department are immediately transferred to IEMR. 3. All acutely unwell cardiology patients with a suspected STEMI are to be referred to the STEMI Hotline (PAH) and transferred to a public facility to reduce delays. The patient is to be triaged by the STEMI Hotline and accepted for either direct transfer to the Cath lab or transfer to the Princess Alexandra Emergency Department for further assessment. If the patient is not accepted for transfer to either the Cath lab or emergency department, the referral is to be re-escalated to the STEMI Hotline if there is ongoing clinical concern, delay to treatment or new clinical concerns. 4. Information and contact details for the STEMI Hotline are to be re-circulated to all emergency departments referring to the Princess Alexandra Hospital. 5. All referrals to external facilities should be made by a clinician familiar with both the case involved and the expected outcome of that referral. Should the outcome of the referral not be what is expected then the consultant responsible for the care of that patient should escalate that referral appropriately with the receiving consultant. When possible, referrals should be made consultant to consultant. The names and roles of those involved in a referral will be recorded in the medical record.
	2018	METRO SOUTH	Staff found patient .	Staff found the patient with Staff immediately called for assistance, duress activated. removed using a cut down knife, and patient removed Patient unresponsive, BLS commenced. Met call and code blue initiated, emergency response team attended the incident. Patient was resuscitated and transferred to ICU for further cares. Relevant stakeholders notified.	(None Entered)	Clinical governance to coordinate review.	Root cause analysis (RCA)	1. Documentation audit of the Multidisciplinary Team Review (MDTR) process to ensure risk assessment completed and documented to ensure the translation of identified risks moves to mitigation strategies implemented. 2. Multidisciplinary Team Review (MDTR) meeting procedure be updated to reflect changes of the implementation of the ieMR and changes in the CIMHA patient information system. An assessment of the various pro-forma and workflows associated with all sites inclusive of community and inpatient areas to identify if a consistent template or work flow can be established. 3. All Nursing staff have completed the mandatory basic life support training - site specific as documented in Leap on Line 4. Addiction and Mental Health Services Nurse Education add recognising & responding to patient deterioration to in-services schedule
	2018	METRO SOUTH	The patient was mobilising without supervision when stumbled and fell to the floor.The patient hit head on the floor and has a deep laceration.The patient is complaining of not being able to move r R) arm.	The patient was mobilising without supervision when stumbled and fell to the floor. The patient hit head on the floor and has a deep laceration.The patient is complaining of not being able to move r R) arm.The patient has a 4WW for mobilising with supervision which was not in use at the time.	The patient was lifted back onto the bed by staff. MWC informed. Family informed. Analgesia given. Obs taken. BGL taken. Forehead laceration attended.	Patient had fall next to bedside. Fall was witnessed by other in patients in bed room. Fall not witnessed by staff. Physiotherapy weekly summary assessed patients mobility as requiring supervision with 4ww. Patient is a high falls risk and would often mobilise without the use of 4ww and without the supervision of staff. At the time of the fall patient was witnessed by other patients mobilising around bed to put away some personal belongings. Patient can recall that tripped at end of bed after R) foot was caught on bed and fell on R)side hitting shoulder and R) side of face and head. Sustained laceration to head. Dressing applied to same. Medical officer contacted for review. Post falls pathway commenced and observations attended to as per pathway. . For CT head. Pain relief administered. Will need to be transferred to as per medical registrar. Post fall, the patient's head CT indicated a right small volume subarachnoid haemorrhage (SAH). The patient was on venous thromboembolism (VTE) chemical prophylaxis and aspirin for ischaemic heart disease at the time of the fall. An urgent head CT the following day identified an expansion of the SAH and a midline shift, the patient's condition deteriorated, and was declared deceased on 2018 . (approx. 2 weeks post fall) The Clinical Incident report was amended to reflect a Severity Assessment Code (SAC) of 1. A clinical review was undertaken.	Clinical review	1. For discussion at the Falls Prevention and Advisory Committee: patient education and the importance of reinforcing to Falls Risk patients, the need to seek assistance/supervision prior to mobilising.
	2018	METRO SOUTH	Unwitnessed fall	Patient had an unwitnessed fall outside of bathroom while nursing staff was attending another patient next door. Patient was found sitting on the floor calling for help. Pt stated that twisted her leg then had a fall while was trying to close bathroom door, but did not hit head.	Obs and ECG attended, ward call notified to review patient.	ongoing by NUM	HEAPS analysis	1. Feedback clinical review to clinical staff involved in the patients care 2. nursing team to read the updated falls procedure for documentation of falls within the ieMR. 3. Review the current paper based ordering of the contrast echocardiograms and explore ieMR ordering of the test.
	2018	METRO SOUTH	Patient was found on the floor across from foot of bed with blood on floor. Unwitnessed fall.	Nursing staff had gone to check if the IV antibiotic infusion that had been put up approx 25 minutes earlier had finished. Pt was in bed at time of IVAB being commenced and was able to state name and DOB prior to commencing IVAB. Pt was found on the floor in a sitting position with blood over arms and gown. Called other nurse for assistance. Pt asked if had his head, speech difficult to understand at this time and displaying generalised jerky movements. No obvious injury to head noticed at this time. Assisted to sit on nearby chair then mobilised with 2 x nurses back to bed. Vitals and neuro obs done, commenced on post falls assessment careplan and Renal ward call paged to come and assess pt. However, as GCS 11 and unintelligible speech and had previously been reported to be alert and orientated on morning shift, it was decided to call an RRT for drop in GCS.	commenced on post falls assessment careplan. Neuro obs commenced. RWC notified. RRT called for drop in GCS	iEMR reviewed. Cognition and falls assessment completed on admission to ward 0945. Patient accommodated in single room nearest to nurses station due to isolation requirement. Documented that patient mobile under supervision; alert and orientated. Nil documentation of review by physiotherapist, falls risk plan of care not initiated. Post fall - RRT called due to , observations and Glasgow Coma Assessment performed, Post falls assessment documented, CT Head performed showing left acute extradural hematoma.	Clinical review	1. Identify the impact of the Falls Management Plans on patient harm - Conduct a retrospective audit to determine the relationship between SAC 1 falls and the falls management plan over the last 12 months by ☐ Identifying how many suggested Falls Risk Plans of Care were initiated ☐ Identifying the contribution from each discipline into the Falls Risk Plans of Care ☐ Identifying the access to the Falls Risk Plans of Care and the documentation against the Falls Risk Plans of Care ☐ Identifying the number of patient specific falls prevention interventions initiated ☐ Identifying the frequency of the revision of the Falls Risk Plans of Care ☐ Identify the number of patients with documented falls prevention education prior to the fall ☐ Identify the discipline undertaking falls prevention education - Revision of the Falls prevention plan of care section of the Falls Prevention and Management Procedure (2017) in respect to ☐ Clear outline of roles and responsibilities of each discipline ☐ Revision requirements for the falls prevention plan ☐ Protective equipment ☐ Significant co-morbidities and risk 2. Increase the safety of patients by improving the signage in the room where the patient fell - Conduct an environmental safety scan of the room with Workforce Services and implement any recommendations 3. Increase the awareness of patients at risk of falling by - Including a risk section on the ward handover sheet
	2018	METRO SOUTH	Missed opportunity in recognising interaction between Diltizem and Ibrutininb.	Pt commenced on Diltiazem during admission for atrial flutter. Ibrutinib was withheld during admission. On discharge patient received both Diltiazem and Ibrutinib. Pt suffered out of hospital cardiac arrest approximately later and ICU SMO documents possible contributing factor was the interaction between the two drugs.	Notified of incident by , Triage meeting held on the /18- incident confirmed as SAC-2 and HEAPs review to be performed. (Riskman completed in retrospect from Iemr record)	On clinical review of patient's medical notes: 2018 Patient presented and admitted to with chest pain, tachycardia and pre-syncope Patient transferred to Patient ordered Ibrutinib 560mg, capsule, morning - given at 0843hr .2018 Diltiazem ordered for 30mg, 0.5 tablet, oral, 3 times a day .2018 - 1508hr (given), 2000hr (given) 2018 - 0800hr, 1218hr (withheld), 2000hr (withheld) due to bradycardia .2018 - 0930hr (given), 2206hr (withheld), 1416hr (given) .2018 - 0905hr (given), 1426hr (given) .2018 Patient discharged from RLH Discharge medications as attached Diltiazem 60mg, oral, immediate release, 3x a day Ibrutinib 140mg, oral, 4 capsules, morning 2018 Patient presented back to with central chest pain Discharged home with referral to the following day 2018 Patient presented back to from with severe chest pain Transferred to 2018 RIP from hypoxic brain injury due to cardiac arrest	Clinical review HEAPS analysis	1. Escalation of findings from this review to the Statewide Alerts Review Working Group to ensure that appropriate alerts will be seen by the end user. 2. Development of a system trigger/criteria tool to identify patients who are prescribed high risk medications or have significant medication changes during admission or at discharge for a clinical pharmacist review prior to discharge. 3. Ongoing push to improve the rate of discharge summaries completed within 48hrs across all medical teams and that there is agreed criteria for high risk patients to have a mandatory discharge summary prepared prior to leaving the hospital. 4. There is consideration of an increase in clinical pharmacy coverage for the HDU. 5. There is a review of the Service Capability for Cardiology at given the concerns identified by this review. 6. Relevant staff involved in this incident are reminded of the VQ scan ordering process at Hospital

	2018	METRO SOUTH	Pt was found on the floor with small skin tear to head and small lump. Bleeding from skin tear. Pt was able to stand up and get back into bed. RWC informed. Pt unable to recollect how ended up on the floor - NESB	Nursing staff heard loud bang . Pt found on the floor bleeding from small skin tear on front of head (left side). Pt was able to sit up with assistance of nursing staff and get back to bed. RWC paged straight away. Bump on head became progressively bigger - ice pack applied. 1 - pt was trying to use bathroom but doesn't recall how got on the floor. Attended CT-H - RWC was called with the findings. When returned to the ward - bloods taken from PICC line - pt was not responding to voice anymore, only responding to pain. RRT called. Attempted to call and multiple times before and during code - no answer.	RWC informed ASAP. CT-H Urgent bloods done. RRT called for drop on GCS - pt currently in theatre	Nursing staff heard loud bang . Pt found on the floor bleeding from small skin tear on front of head (left side). Pt was able to sit up with assistance of nursing staff and get back to bed. RWC paged straight away. Bump on head became progressively bigger - ice pack applied. 1 - pt was trying to use bathroom but doesn't recall how got on the floor. Attended CT-H - RWC was called with the findings. When returned to the ward - bloods taken from PICC line - pt was not responding to voice anymore, only responding to pain	Clinical review	1. Planned multi-incident analysis of SAC 1 falls over the last 12 months to include - Cognitive and neurological assessment of patients at risk of falling 2. A case review with identified learnings to be provided to the interdisciplinary team through the Unit Morbidity and Mortality meeting and educational sessions.
	2018	METRO SOUTH	Potential failure to diagnose endocarditis	Patient hospitalised with /18 to the /18 and treated with IV antibiotics. Readmitted on the /18 in septic shock. Palliated and passed away on the /18. Case triaged /18 for M&M discussion.	(None Entered)	deceased on the /18 from sepsis related to enterococcus faecalis bacteraemia secondary to possible osteomyelitis of the spine and or subacute bacterial endocarditis. This case was reported to the Coroner in view of the hospital acquired bacteraemia (HABSI) which was identified during the routine mortality review of the patient's care at) via RiskMan audit. The HABSI (Enterococcus Faecalis) had been identified during the patient's presentation with sepsis on the /18 and potentially traced by Infectious Diseases (ID) to the inadequate treatment of a infection treated at /18. Case reviewed at M&M - report attached. Nil recommendations made by review team.	Morbidity and Mortality review	-
	2018	METRO SOUTH	Patient was found on the floor by the wardsman when we finished the pad round.	Patient was found sitting on the floor. The ward call was notified and he came to review the patient before we got the patient up. Post falls pathway commenced. the fall was witnessed by	Ward call notified.	who usually resides at home (independently mobilising on 4WW) and cared for by was referred to on the /18 by GP with Community Acquired Pneumonia (CAP) with a Smart cop of 3. The patient was commenced on IV antibiotics in the Emergency Department (ED) and remained in the ED for 24 hours due to lack of inpatient bed availability and was transferred to the Medical Ward around 1430 hrs on the day following presentation to the ED (Day2). Approximately 10 hours post admission to the ward, around midnight, the patient sustained an unwitnessed fall on way to the bathroom and was found on the floor by the Wards Man. A CT of the head showed nil acute pathology however an X-ray of the hip and pelvis showed bony irregularity; concerning for acute rami fractures. Later a CT of the pelvis confirmed acute right superior and inferior pubic rami fractures with an associated pelvic haematoma. Difficulties with providing adequate analgesia in the context of the acute respiratory failure led to reduced conscious state, hypoxaemia requiring MET calls and Naloxone leading to further patient distress. A decision for conservative management was made in consultation with the family and the patient was palliated and passed away at on the /18.	HEAPS analysis	1. Adopt a system wide approach for falls prevention with consideration of relevant components of the "Redcliffe Model" and other best practice models of intervention. 2. Complete appropriate environmental audit with appropriate response interventions to issues identified such as low lighting levels 3. Streamline the work flows around bedside assessments for the nurses on shift to improve compliance. 4. Investigate and implement a proactive communication strategy with families/carers/NOK regarding preferences for contact/ consultation
	2018	METRO SOUTH	Concern about fail to transfer to a tertiary facility for consideration of intervention	On review in mortality meeting, concerns were raised about why was not transferred to for consideration of intervention earlier. presented with a NSTEMI with significantly elevated TnI and BNP with evidence of acute heart failure. Was discussed with Cardiology at multiple times with initial plan to transfer only if ongoing pain and/or ECG changes. When discussed again the next day, when had ongoing pain and ECG changes, the plan was still for patient to remain at . Over the following 24-48 hrs progressively declined with worsening chest pain and heart failure before being palliated. As per National Heart Foundation recommendations, someone with very high-risk NSTEACS who is considered appropriate for revascularisation should ideally have this performed within 2 hours.	(None Entered)	This case was discussed at a cardiology multi-incident analysis and the decision has been made to triage as a potential SAC1 clinical incident. Clinical Reviews undertaken by 2 external cardiologists identified the absence of Consultant to Consultant conversation resulted in not accepting a NSTEMI patient experiencing ongoing chest pain. Full report attached.	Clinical review	1. Early Consultant to Consultant escalation with any concerns regarding pushback from Cardiology around transfer of patients from Hospital.
	2018	METRO SOUTH	Patient suffered cerebral post thrombolysis for CVA	Severe haemorrhagic stroke; patient palliated	(None Entered)	Clinical review undertaken and no contributing factors identified	Clinical review	1. Escalation to Metro South Executive regarding the patient safety risks associated with the potential delays in time to administration of Alteplase for Stroke Lysis at Hospital related to the infrequency of practice, inconsistency of service (only certain hours per day) and lack of 24 support services such as CT. 2. Escalation regarding the risks associated with current governance processes around the potential duplication and upload of clinical forms and procedures across MSHHS. 3. Escalation the MMC committee regarding concerns identified around the Alaris pump guard rails and the administration of Alteplase. 4. Escalation to the Metro South digital medicines committee regarding the lack of a Power Plan for the ordering and administration of Alteplase and the need for this to be accessible in both FirstNet and PowerChart. 5. Escalation to the Stoke Sub-committee in relation to the consideration of the use of Tenecteplase for Stoke Lysis at Hospital as an alternative to Alteplase and the potential issues around the multiple procedures and forms available on the Metro South web page and the confusion caused by the ml/min statement on current Procedure.
	2019	METRO SOUTH	intracranial and psoas muscle haemorrhage 2nd anticoagulation therapy	as above, multiple day 'bridging therapy' for INR <2.5. Need to review appropriateness of prescribing.	(None Entered)	The patient received bridging anticoagulation prior to surgery with enoxaparin however during the reinstatement of warfarin therapy and concurrent administration of enoxaparin the patient suffered bilateral subdural and psoas muscle haemorrhages on the /19. Upon review of the case the analysis team have noted that the INR target range for warfarin dosing was higher and narrower then usual and that during after recommencement of warfarin therapy that enoxaparin was recommenced when the INR fell transiently to an INR of 2.1, without evidence of reconsideration of the risk of haemorrhage versus thrombosis. Post realisation of cerebral haemorrhage the patient was managed with clotting factors and was transferred to the Hospital where had a craniotomy and evacuation of haematoma from intracranial extradural space. Sadly, there was a poor response to surgery and the patient remained unstable throughout admission with decreased GCS. Active treatment measures were stopped and a palliative care referral made with the patient passing away on the /2019.	HEAPS analysis	1. A review of current available guidelines on the management of perioperative anticoagulation including MSH Prescribe is undertaken. If during this review, significant gaps in content or clarity are noted, these are to be escalated and if required, there is the implementation of a temporary local guideline until gaps are addressed. 2. Increased pharmacy involvement in warfarin titration where possible at Hospital
	2019	METRO SOUTH	Patient suffered cardiac arrest following induction of anaesthesia during surgical preparation	Patient was booked for an elective laparoscopy +/- cholecystectomy. During surgical preparation of draping and set up new ST elevation was noted in leads II and III which was not present on commencing induction. Assistance called for and CPR commenced. During CPR, electrical activity present with a non shock-able rhythm. No cardiac output. PEA on monitors. Discussed with other clinicians present. No reversible causes able to be identified. Decision to withdraw CPR @ 1408. Patient Deceased RIP.	, further follow up by DMS and DON Coroner informed - .	Review - clinical review in conjunction with Anaesthetic team. to be confirmed with Ex Dir Clinical Governance /2019 - Coroner Authorised COD	Clinical review	1. Review the case at the Hospital Morbidity and Mortality
	2019	METRO SOUTH	Patient's in room alerted staff to patient fall next to bed. Patient found sitting on floor next to bed. Patient opposite stated patient did not hit head but landed on with right shoulder into the bed.	Patient in room notified staff of patient fall in bed and patient sitting on the floor bedside bed. Patient had been getting up from bed with walker and tripped/fell onto floor not hitting head but leaning on right arm/shoulder into bed rail. Staff using manual handling techniques assisted patient back into bed. Home team doctors present with patient and reviewed in ward. Observations taken and patient made comfortable.	Manual handling techniques used to assist back into bed, observations taken as per protocol and RMO in attendance.	Fall unwitnessed by staff but witnessed as per ward RMO by a cognitively intact patient. Collateral from neighbouring patient who called for help. Patient slipped sideways; fell onto R) Shoulder; did not see head hit the floor. Patient returned to bed using manual handling techniques. Patient was unsure why was trying to mobilize.(Patient usually mobile with 4ww with staff assistance. Post falls pathway and observations commenced. RMO notified.RMO Ordered Neurological observations as per Falls pathway. Not for CT head scan at that stage. Review if change in neurological function. Alarm bed activated. RRT at 0620hrs on /2019 patient unconscious-Review CT head confirms acute on Chronic SDH in cerebral convexity worse than previous. Discussion with NOK-palliation and comfort cares.RIP ON /2019	HEAPS analysis Clinical review	1. Patient education to staff allocated patient care on AM/PM/ shift to ensure alarm beds in use are turned on.Staff meeting on /2019 1.Provided further education to staff of safely monitoring alarm beds. 2. Further education on post falls documentation.3. Staff education to ensure neurological observations completed at allocated times and in full. 2. Report on the current handover process in to identify the safety management processes including but not limited to the safety management checklist outlined in the Nursing Assessment and Documentation Procedure (2017) and develop an action plan for identified areas for improvement 3. Compare current nursing assessments conducted in with the expectations of the Nursing Assessment and Documentation Procedure (2017) 4. To determine the definition of a witnessed and unwitnessed fall
	2019	METRO SOUTH	Delayed recogntion and management of deterioration in a patient with pancreatitis	Severe necrotising pancreatitis however specialists have determined that delays did not impact outcome in this case.	Patient transferred to when deterioration noted	Patient ( ) brought in by ambulance to Emergency Department on the /19 with pancreatitis and admitted to Ward under the surgical team for fluid replacement, pain management and monitoring. The patient experienced severe ongoing pain and deteriorated on day 2 of admission with the development of oliguria despite fluid resuscitation and a sudden marked decline in liver function. Some delays in care were identified with a missed IV fluid bolus on the morning of the /19 and deterioration in liver function not picked up for 14 hours and then not escalated to Consultant. Delayed escalation by ward call to surgical PHO on-call regarding anuria/ lack of response to fluid loading in the early hours of the /19 with lack of escalation to Consultant on call.	HEAPS	1. Development of internal escalation pathways to assist staff with appropriate clinical escalation with the aim of empowering junior staff to call Consultants directly if indicated. 2. Training for doctors around identified knowledge gaps in fluid sequencing and ordering fluid boluses in the MAR. 3. Feedback to Standard 8 Committee regarding the issues identified with MET call with a request for risk mitigation strategies to presented to CIRC by Chair.

	2019	METRO SOUTH	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 DMD 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. 19: For further review to be coordinated by PSO.	Clinical review	1. That the Emergency Department consider the implementation of spirometry to periodically assess the respiratory status of patients with neuromuscular conditions such as DMD in order to identify respiratory deterioration.
	2018	METRO SOUTH	Potential missed opportunity to diagnose macrosomia in the antenatal period	Patient was seen on occasions from prior to labour. While most features were reassuring, strict following QLD Health protocols with regard to macrosomia and reduced fetal movements may have led to earlier delivery.	(None Entered)	female, (pre-birth), low risk pregnancy suffered fetal demise during labour resulting in the baby being delivered unresponsive, pale, floppy, unable to be resuscitated. (. The patient had attended the Unit times in the week preceding the birth for concerns including increased BP and reduced fetal movements. It is noted that during one of these presentations on the there were concerns voiced by the assessing Midwife who suggested to the Registrar that the patient required an USS due to the large size of the baby.	External review	1. The implementation of back to basics methodology for antenatal care at Hospital which will ensure compliance with State-wide Clinical Guidelines in care delivery.
	2019	METRO SOUTH	As documented in the clinical record - Patient found	As documented in the clinical record: - Approx 10mins prior to this (~2050hrs), pt was seen well, at nurses station - CN performed visual observation check at 2100hrs and found patient . Duress activated. - pt was unresponsive and pulseless -> CPR commenced and CODE BLUE called at approx 2108hrs - CODE Team arrived ~4mins later (approx 2112hrs), - rhythm check at 2115hrs showed PEA so 1mh adrenaline given once IV access was secured - intubated and bagged, minor soiling of airway with blood was noted - ROSC on rhythm check at approx 2118 with palpable femoral pulse and sinus rhythm HR 140bpm on monitor - BP post-ROSC 67/32 -> given intermittent boluses of metaraminol while in MH -	(None Entered)	As documented in the clinical record - Patient found As documented in the clinical record: - Approx 10mins prior to this (~2050hrs), pt was seen well, at nurses station - CN performed visual observation check at 2100hrs and found patient . Duress activated. - On discovery of pt, NS immediately and transferred into bed - pt was unresponsive and pulseless -> CPR commenced and CODE BLUE called at approx 2108hrs - CODE Team arrived ~4mins later (approx 2112hrs), AHNM also arrived with team - rhythm check at 2115hrs showed PEA so 1mh adrenaline given once IV access was secured - intubated and bagged, minor soiling of airway with blood was noted - ROSC on rhythm check at approx 2118 with palpable femoral pulse and sinus rhythm HR 140bpm on monitor - BP post-ROSC 67/32 -> given intermittent boluses of metaraminol while in MH - Patient has a diagnosis of . - Nursing staff contacted the psych reg on-call who attended the ward (code blue team already present) -clinical documentation from psych reg states there were nil clear precipitants or triggers prior to the attempt and nil clear recent indications for elevated risk of suicide noted. -on call psych reg notified the on call consultant and executive on-call -on call psych reg completed de-briefing with staff	Rbot cause analysis (RCA)	1. Clinical review, to mitigate potential risk. has