Significant Incident Review

Date: 07/01/2024

Incident number: 18585908

Region: Metro North

Executive summary:

Description of incident:

Request for service, male pt post fall, disorientated and slurred speech.

Post incident review due to negative patient outcome identified incorrect dispatch of appropriate unit prior to finishing shift.

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1. **Operational readiness issues:** No

If yes, please provide brief details of findings with recommendations if applicable

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2. Call handling / Deployment issues: Yes

If yes, please provide brief details of findings with recommendations if applicable

The Triple Zero (000) calls for this incident were reviewed with an appropriate response and nil issues identified with either Triple Zero call. Dispatch of clinical response not consistent with SOP02 V5.5.0, CAD recommend response not followed by EMD, notes in the incident detail review indicate dispatch was held pending review by CDS, EMD initiated CDS review as recommended unit was a 0600 finish.

There was a delay of 11 minutes and 32 seconds from the incident being created at 05:47:11 to the initial dispatch of 502544 and 506415 at 05:58:43.
The initial recommendation for assignment at 05:47:21 was 501378. The expected response time was 6 minutes and 29 seconds.
The actual response time was 18 minutes and 36 seconds from the incident being created to the arrival of 501248 at scene at 06:05:47.
The reason for the delay was that the initial recommend was not followed and appropriate unit dispatched. Follow up occurred with Dispatcher with A/Director for reasoning of non dispatch and support provided through PDU regarding dispatch of resources to high acuity incidents. Further follow up occurred with Brisbane Operations Centre all staff with advice provided regarding to mandatory dispatch of high acuity incidents close to end of shift

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3. Clinical issues: No

If yes, please provide brief details of findings with recommendations if applicable

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4. External : Yes

If yes, please provide brief details of findings with recommendations if applicable

Experiencing demand pressures with emergency incidents outstanding in the community.

Prolonged delays noted in awaiting offload of patients within the HHS.

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Recommendation/s:

Recommendation 1:

Feedback provided to dispatcher 08 January 2024 – Working with dispatcher cohort one on one to enhance dispatch decision making.
09 January 2024 – Outcome - Officer temporarily suspended from Acute Dispatch duties as per AC, and education to Operations Centre 07 January 2024, As per direction by the Acting Commissioner. Code 1 incidents close to finishing times must not be held under any circumstances for shift logons. The closest recommended response needs to be dispatched and then appropriate backup units can be dispatched as required.

1) Actioned: Yes

Recommendation 2:

2) Actioned: Select

Recommendation 3:

3) Actioned: Select

Name	Position	Date
Matthew Salter	Operations Centre Manager	16/01/2024
Tony Armstrong	Regional Assistant Commissioner	24/02/2024
Dee Taylor-Dutton	Deputy Commissioner - South	07/02/2024

17020AS

Queensland Government

Significant Incident Review

Date: 25/01/2024

Incident number: 18668714

Region: Darling Downs and South West

Executive summary:

Description of incident

On the 25th January 2024 at 02: 40 the Brisbane Operations Centre received a Request for Service from an alarm activation at Irrelevant for a Irrelevantold female conscious breathing , lower back pain since last night. The initial dispatch was 2AH 050A01.

The call was placed into Clinical Hub waiting queue at 02:43 and then reassigned for acute dispatch at 03:12, due to workload in the Clinical Hub.

A unit was dispatched at 03:28, arriving on scene at 03:38 with the patient found to be in Cardiac Arrest, patient declared deceased onscene.

Significant Incident Review

Date: 25/01/2024

Incident number: 18668714

Region: Darling Downs and South West

1. Operational readiness issues: No

If yes, please provide brief details of findings with recommendations if applicable

2. Call handling / Deployment issues: Yes

If yes, please provide brief details of findings with recommendations if applicable

Quality Assurance has been undertaken of the Triple Zero call, with NIL issues identified.

The incident was received at Brisbane Operations Centre from 3rd party medical alert device, with limited information provided to EMD. EMD attempted call back to patient with NIL answer or ability to leave voice mail. Call referred to clinical hub, however unable to review case due to workload, referred for acute dispatch.
Toowoomba OpCen utilised recommend function in CAD, recommended single officer who was on a meal break and CCP was also available. EMD requested supervisor to review dispatch, however NIL evidence of decision in IDR. Single Officer and CCP not utilised, paramedic crew dispatched at 0328am.

3. Clinical issues: No

If yes, please provide brief details of findings with recommendations if applicable

Significant Incident Review

Date: 25/01/2024

Incident number: 18668714

Region: Darling Downs and South West

4. External pressures: Yes

If yes, please provide brief details of findings with recommendations if applicable

Toowoomba Base Hospital at Escalation Level 1 at time of Incident

Clinical Hub had increased workload.

Recommendation/s actioned:

1) Description: OpCen and EMD to review SOP01.18 incident call back and SOP03.3 Notification of Senior Officers and feedback to be given.

Yes

2) Description:

Select

3) Description:

Select

Name	Position	Date
Nicole Thies	District Director	15/02/2024
Alex Thompson	Regional Assistant Commissioner	20/02/2024
Dee Taylor-Dutton	Deputy Commissioner - South	20/02/2024

Significant Incident Review

Date: 02/02/2024

Incident number: 18707570

Region: Metro South

Executive summary:

Description of incident

Request for service, Irrelevant old male patient, complaining of chest pain and shortness of breath.

Delay in identifying an appropriate ambulance to respond due to high workload at the time of call.

Post arrival of QAS, the patient went into a cardiac arrest, resulting in resuscitation being commenced.

Despite resuscitation efforts patient was declared deceased at scene.

Operational Readiness review identified some night shift vacancies across the Region, however these were appropriately offset with the addition of Twilight shifts ensuring coverage was maintained.

Call Handling / Deployment review identified that the question around difficulty speaking between breaths was subjective and that the initial response code would have been altered if this question was answered differently.

External Pressures review identified that they was significant hospital pressures at the time of the incident and the week leading up.

Significant Incident Review

Date: 02/02/2024

Incident number: 18707570

Region: Metro South

1. Operational readiness issues: No

If yes, please provide brief details of findings with recommendations if applicable

Staffing across Metro North and Metro South Regions was appropriate with the additions of Twilight shifts covering any night shift shortfalls.

Moreton and North Brisbane Districts were +7
South Brisbane and Logan Districts +1
West Moreton District - 2

2. Call handling / Deployment issues: Yes

If yes, please provide brief details of findings with recommendations if applicable

A review of the initial Triple Zero (000) call identified the 1st party caller indicates his breathing is rapid. There is some audible shortness of breath at times. However, also able to speak in full sentences at times, which would not necessarily meet the MPDS definition. This question requires the EMD to make a subjective call, based on what they can hear. The initial response code would have been altered if this question was answered differently.

PDO to discuss this with the EMD and provide education around shifting subjective threshold to a more conservative position.

3. Clinical issues: No

If yes, please provide brief details of findings with recommendations if applicable

Clinical Incident Review completed by Metro South Region Clinical Education Unit with nil issues identified.

Significant Incident Review

Date: 02/02/2024

Incident number: 18707570

Region: Metro South

4. External pressures: Yes

If yes, please provide brief details of findings with recommendations if applicable

Metro South HHS had sustained pressures with 4 Hospitals on a QAS Level 3 escalation. Delays of over 6 hours to offload ambulance patients was noted.

West Moreton HHS also had sustained pressures with Ipswich Hospital on a QAS Level 3 escalation and delays in offloading over 4 hours.

Extensive and sustained pressure across the HHS throughout the week leading up to and the day of the incident. QAS Managers and Executives had continual engagement with HHS Executives regarding the impacts.

Recommendation/s actioned:

1) Description: At the time of the incident, Metro South Region was undertaking a realignment of rosters to the resource allocation model to ensure staffing is appropriate.

Yes

2) Description: Feedback and training provided to Emergency Medical Dispatcher (EMD) in line with findings of call handling review.

Select

3) Description:

Select

Name	Position	Date
Anthony Hose	District Director	
Peter Warrener	Regional Assistant Commissioner	
Dee Taylor-Dutton	Deputy Commissioner - South	19/03/2024