Royal Flying Doctor Service Queensland Section (RFDS) Clinical Case Review Quality Assurance Committee (CCRQAC). Quality Assurance Committee's (QAC) functions:

The RFDS CCRQAC allows for a confidential and systems-based approach to the analysis of high interest and sentinel events, along with any other cases which are deemed to be of interest to clinicians from a learnings or improvement perspective.

A panel of experts representing the key clinical areas of the organisation review and provide feedback on cases to not only identify weaknesses in our systems and processes, however, also examine the successful events and outcomes, with the aim of continuous improvement and patient safety.

The purpose of CCRQAC is to improve the safety and quality of health services provided by RFDS:

- Maintain oversight of the RFDS Clinical Case Review Framework.
- Assess Clinical Case Reviews and evaluate the quality of these RFDS health services.
- Report and make recommendations concerning relevant RFDS health services
- Monitor the implementation of CCRQAC recommendations.
- Maintain oversight of a register of case reviews and associated recommendations.
- Ensure dissemination of lessons learned through case review across the RFDS.
- Highlight any emerging clinical risks to the Clinical Governance Committee, RFDS.
- RFDS review all Clinical Quality Indicators and High Interest events

Current committee members

The Chairperson - Dr Katie Clift, RFDS Head Medical Consultant
Qualifications:
Fellowship Australian and New Zealand College of Anaesthetists, Fellowship Royal College of Anaesthetists UK, Membership Royal College of Surgeons of England, Bachelor of Medicine and Bachelor of Surgery.

Experience:
24 years' experience as a medical officer with experience across emergency, aeromedical retrieval and healthcare administration. 17 years' experience as an anaesthetist including as a consultant anaesthetist and consultant trauma clinician. Two year as the Clinical Lead to the aero-medical team at Lifeflight. Elected member of council for the Neuroanaesthesia Society for Great Britain and Ireland from May 2013 until May 2015.

Lee Poole, Head of Clinical Governance and Nursing
Qualifications:
Master of Nurse Practitioner Studies (Aviation), Master of Nursing (Professional Studies), Graduate Diploma in Midwifery with Distinction, Graduate Certificate in Emergency Nursing, Graduate Certificate in Management, Bachelor of Health (Nursing).

Experience:
20 years' experience as a registered with experience in emergency care, aeromedical retrieval, maternity care and healthcare administration. Five years' experience with Royal Flying Doctor Service in Brisbane as a Flight Nurse conducting aeromedical retrievals.

Dr Jennifer Hardman, Medical Officer – Aeromedical

Qualifications:

Bachelor of Medicine, Bachelor of Surgery (MBBS); Bachelor of Science – Strands Biochemistry and Pharmacology; Fellow of the Australasian College for Emergency Medicine (FACEM).

Experience:

10 years' experience in medical practice. She has worked in retrieval medicine and general practice with the Royal Flying Doctor Service since October 2018. She has also worked as an emergency medicine staff specialist from January 2018. Prior to this she had 3 years 3 months experience in a tertiary emergency department, 12 months intensive care, 6 months general paediatrics, 9 months anaesthetics, and 3 months in a regional emergency department.

Dr Michelle Hannan, Medical Officer – Primary Health Care

Qualifications:

Fellowship with Australian College of Rural and Remote Medicine (FACRRM); Diploma of Child Health; Bachelor of Medicine/Bachelor of Surgery/Bachelor of Science (Medicine) MBBS/BSc; Bachelor of Medical Science (Honours First Class). Education in progress: Fellowship with Australasian College for Emergency Medicine (FACEM – expected completion 2019); Master of Public Health; Master of Health Management/Master of Infectious Diseases Intelligence.

Experience:

10.5 years' experience as a medical officer with experience in both general practice and emergency care. Three years' experience with Royal Flying Doctor Service in Broken Hill and Mt Isa working in general practice in remote clinics as well as aeromedical retrieval. Board member for the Rural Doctors Association of Australia (RDAA). In addition, holds a university school of medicine clinical lecturer position since 2014.

Ms Priscilla Lange, Registered Nurse – Aeromedical

Qualifications:

Associates degree in Nursing, Intensive Care Nurse Certificate, Post Graduate Diploma Midwifery.

Experience:

15 years nursing experience in critical care environments and healthcare leadership. This has included a 10-year working history with Royal Flying Doctor Service QLD a flight nurse within aeromedical retrieval and 7 years as the Manager - Clinical and Base Operations (previously known as Nurse Manager).

Ms Leanne Hill, Registered Nurse – Primary Health Care

Qualifications:

Diploma of Applied Science – Nursing; Bachelor of Nursing; Post Graduate Certificate of Intensive Care Nursing; Diploma of Midwifery; Post Graduate Certificate – Child and Family Health; Masters of Nurse Practitioner.

Experience:

25 years nursing experience. This has included a 10-year working history with Royal Flying Doctor Service QLD a flight nurse within both aeromedical and primary health care teams. 5 years 9 months experience in intensive care units and 23 months experience working in remote areas.

Ms Jo Mahony, Registered Nurse – Primary Health Care

Qualifications:

Bachelor of Nursing, Graduate Diploma of Midwifery, Graduate Certificate of Child, Youth and Paediatric Health, Master of Nurse Practitioner Studies (Rural & Remote Health), Certificate IV in Training and Assessment, Master of Health Management.

Experience:

21 years nursing experience. This has included a 17-year working history with Royal Flying Doctor Service QLD as a flight nurse within both aeromedical and primary health care teams and 10 years as the Manager - Clinical and Base Operations (previously known as Nurse Manager). 4 years' experience working in rural and remote hospitals in the emergency departments and maternity services.

Ms Aimee Dilger, Clinical Safety and Quality Manager

Qualifications:

Bachelor of Nursing; Master of Health Practice (Infection Prevention and Control); Master of Health Services Management.

Experience:

Adult nursing and Infection Control Practitioner experience. Currently responsible for leading the operationalisation of clinical governance processes and systems; overseeing clinical audits and case review processes.

Recommendations from 2017 – 2019

2017

Learnings and reminders from case reviews distributed through the internal newsletter:

- Potential of airway obstruction in the premature infant transferred in a baby capsule.
- Hyperoxygenate ventilated patients prior to changing source of oxygen, e.g. From aircraft oxygen to QAS oxygen.
- Bag/Valve/Mask needs to be immediately available with ventilated patients.
- Consider other causes of desaturation, e.g. The result of a re-accumulation of a pneumothorax.
- A full set of observations are required prior to departure for inter-hospital transfers, particularly if a tarmac handover is planned. Commend and encourage flight nurses to call for MO backup if warranted.
- Request back up suction and close loop of communication to ensure it is available.
- Ensure video laryngoscope blade is attached with clip and it is not unclipped during use.
- RFDS to use their own airway equipment to avoid any confusion.
- Aim to set up RSI airway kit on MO's dominant side, if layout of room allows.
- Consider moving patient onto RFDS stretcher prior to RSI. It is noted that for much larger patients it is more stable to leave the patient on the hospital stretcher.
- Reiteration around legislation and education about patient rights, guardianship, lack of capacity and end of life cares.
- RFDS FN must complete airway registry form for LRM MO RSIs.
- Emergency equipment including portable suction to be checked at beginning of shift prior to tasking.

Develop the RFDS telehealth chest pain pathway protocol
MOs supervising staff to ensure that two means of communication exist, e.g. Two phone numbers
"Patient Severity" document referred for discussion at RSQ/RFDS Clinical Governance

2018
Learnings and reminders from case reviews distributed through the internal newsletter: • Ask for baseline electrolytes for patients with suspected cardiac related concerns. • RFDS nursing staff to site ECG. • If non-medical escorts are not appropriate, refer to RSQ for transfer. • Be mindful of own wellbeing after challenging cases. • Follow up with Cairns MCBO to encourage FNs to attend CNS meetings. • When multiple teams at site – confirm clinical leadership early. • Confirm with RSQ and RFDS Clinical Handover SOP follow up relating to "formally stating that patient has been handed over to RSQ". • In setting of complete heart block, non-invasive measurements can be unreliable. • Crews may suggest assessment of patient using telehealth to help in decision making. • Document management decisions made in sitrep calls to RSQ medical coordinator.
Follow up with QAS regarding them staying at the airstrip to assist with next tasking.
Add use of restraints to new electronic record as drop-down box as yes/no. Document reasons and use of restraints during flight.
CT6 splint reviewed and rejected due to splint being too long past persons legs.
Simple script to be developed for MOs for chest pain – share with ROCC.
Request to other healthcare provider for early notification of patients that are likely to require aeromedical evacuation.
Appointment of Practice Coordinators to support Primary Health clinics.
Home access to be set up to MD3 so that all telehealth calls can be documented.
Medico legal education update provided to MO's
HIM to develop procedure outline parameters around identifiable patient data and use of smart phones.
Follow up with Senior Primary Health Clinicians re recall systems with HHS.
Development of procedure for recognition of the deteriorating patient.

2019
Learnings and reminders from case reviews distributed through the internal newsletter • If clinicians order tests it is their responsibility to follow up. • Respiratory alkalosis is a very common feature of both pregnancy and PE. • D-dimer levels increase during a normal pregnancy and slowly decline post-partum. Lack of normal reference ranges in pregnancy, therefore unreliable. High false positives as well as high false negative rates

• In a very unwell paediatric patient, consider using an I/O for vascular access early for first line treatment • Give steroids prior to antibiotics in meningitis – prevents hearing loss. • Use of the RSQ Medical Coordinator or TEMSU in complex patients can be helpful to ensure optimal safe care • Resources available to clinicians for paediatric cases, i.e. Monash Book, the Shann Book, Broselow Tape, Cooksley Cards and RCH App. • Advocate for use of early meropenem in suspected melioidosis. • Repeat iSTAT results if results are inconsistent with the clinical picture. • Document discussions with the DTO/pilot in the clinical record. • Use MD3 for all radiological requests. • When opening a patient record in MD3, always check the recalls. Remember to clinically handover clinic patients to the next medical officer going to that clinic to follow up with required actions. • A reminder that all obstetric guidelines are open access on the QHealth website. • Anti-D is given at 32 and 34-36/40 gestation in the rhesus negative pregnant patient. • iSTAT INR isn't valid in snake envenomation • Document verbal discussions regarding end of life care in MD3. • Beware inverse ratio ventilation and breath stacking/gas trapping in addition to hypotension post induction. • Consider accessing paediatric advice via formal TEMSU request. • Remote access to MD3 is available to everyone and telehealth calls should be documented in MD3 wherever possible. • Don't piggy back inotropes onto lines going into CVC lumens. Attach them straight onto one lumen of the CVC or they may get disconnected in the handover. • Consider adding droperidol or ketamine to facilitate preoxygenation in agitated patients to increase safe apnoea time. • Discuss implications of ARP which includes interventions with medical coordinator at the time of tasking so there is a clear action plan between parties if patient deteriorates. • If not comfortable with tasking, follow the escalation of care procedure. • Keep 12 lead ECG as well as rhythm strips as part of the clinical record.
Review and update of handover process between on call RFDS MO and local doctors/nurses.
Completion of the review of the recall process**.**
Letter to EDMS at HHS regarding improving communication with specialists and referring GPs.
Escalation to Clinical Resources committee regarding the number of nasal prongs carried on the aircraft

Summary of the QAC's privacy policy

CCRQAC members are bound by the disclosure of information provision in Part 6, Division 1, of the Hospital and Health Boards Act 2011.

The CCRQAC will adopt, by resolution, a privacy policy which states the ways the CCRQAC, or a member of the CCRQAC, may do any of the following:
acquire and compile relevant information

- securely store relevant information
- disclose relevant information
- ask an individual for consent to disclose the individual's identity under s.
- 83(2) of the Hospital and Health Boards Act 2011
- how a record containing relevant information may be copied or destroyed.

CCRQAC members are prohibited from disclosing information acquired in the course of their involvement in CCRQAC activities. The exceptions include:

- for the purpose of exercising their functions as committee members
- mandatory reporting to the Office of the Health Ombudsman
- providing information to a prescribed patient safety entity
- providing information to another Quality Assurance Committee (QAC) if the information is relevant to that committee's functions.

Prescribed patient safety entities are those entities described at s.28 of the Hospital and Health Boards Regulation 2012