Inquest into the death of Leon Streader

Leon Streader died on 22 February 2004 at Pinjarra Lodge, a privately owned level three care facility. The coroner found that Mr Streader died due to the effects of coronary atherosclerosis worsened by heat stroke.

Deputy State Coroner Christine Clements delivered her findings of inquest on 1 October 2009.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Recommendation 3

Level three facilities which distribute medication are required to properly document this process and that consideration be given to some form of audit to ensure medication is being received regularly by the residents.

Response and action: the recommendation is implemented.

Responsible agency: Department of Housing and Public Works.

On 5 August 2015 the Minister for Housing and Public Works and Minister for Science and Innovation responded:

An accreditation system for service providers has been in place since 2004. Existing accreditation processes require that medication is stored appropriately. The distribution of medication, and instances where medication is refused, are currently required to be recorded in the resident's medication record. A *Medication management guideline* has been developed for consultation within the sector to further enhance the requirements for service providers around medication management. The intention of the guideline is for the process of medication management to be more comprehensive. For example, under the guideline a service provider will be required to inform the resident's doctor if the resident has refused to take their medication and ensure this medication is returned to the pharmacy which dispensed the medication on behalf of the doctor. Under the guideline, staff conducting accreditation audits will seek specific information from service providers about their medication management practices to determine if the guideline is being followed.

It is envisaged that this accountability will augment practices already in place and foster improved practices where necessary. Accreditation of a residential service is required at least once every three years under the *Residential Services (Accreditation) Act 2002* and the Residential Services (Accreditation) Regulation 2002 and compliance with required processes is assessed at that time. Additional compliance checks do occur in response to any concerns raised by residents or their advocates. The guideline is currently in the consultation phase.