Inquest into the death of Marcia Joy Loveday

Mrs Loveday died on 23 July 2010 at the Bundaberg Base Hospital. Mrs Loveday died due to multi-organ failure, overlaid by an episode of an anaphylaxis reaction of which the effects had passed, leading to her death four days later.

Coroner David O'Connell delivered his findings of inquest on 28 October 2013.

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 department named in the response.

Recommendation 2

Queensland Health and the Queensland Ambulance Service consult with the very experienced specialist doctors in this area, and prepare brief, and appropriate, educational material, to disseminate and educate their medical personnel, especially those who practise in the accident and emergency department setting and as first response ambulance officers.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

The Queensland Ambulance Service reviewed its *Clinical procedures manual* in relation to anaphylaxis and allergies in conjunction with a specialist doctor, making minor changes to information about the drug adrenaline. The manual outlines treatment pathways and active management expected when treating a patient presenting with allergic responses.

The changes to the manual will be implemented and notified to staff by a statewide directive through local ambulance service networks. Follow up education will occur within the roll-out of a fully revised and updated *Clinical procedures manual*.

The Department of Health's Patient Safety Unit, in collaboration with the statewide emergency department, published a patient safety communique regarding the lessons learned from this inquest. The communique includes specific information about the recognition of anaphylaxis without cutaneous features for hospital and health services to incorporate in their ongoing clinical education.

Recommendation 3

Queensland Health conduct an audit, within six months, of their hospitals to identify if any similar 'Bundaberg Base Hospital 2010 style triage situation' exists elsewhere. If it does they will need to take appropriate action to implement the necessary changes of the type of changes seen in the Bundaberg Base Hospital situation.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Minister for Heath and Minister for Ambulance Services responded:

The Department of Health developed a draft audit tool to review emergency department triage arrangements in hospitals across the state.

The Department of Health conducted the audit. Once the results are compiled, feedback and recommendations will be provided to hospital and health services in line with the coroner's recommendations. The implementation of any changes will be considered and actioned by each independent hospital and health service.

Recommendation 4

Queensland Health and the Queensland Ambulance Service consult, investigate, and, if appropriate, devise a policy to implement a wristband alert system for patients who have significant medical conditions.

Response and action: the recommendation was not implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

The Department of Health and the Queensland Ambulance Service decided not to implement this recommendation based upon current evidence and recommendations of the Australian Commission on Safety and Quality in Health Care (the commission).

The commission does not recommend the use of coloured bands to alert clinicians to specific clinical information and suggests that the use of such coloured bands is based on tradition rather than evidence of any patient safety benefit. Inconsistencies in the meaning attached to the various colours of band in different hospitals can lead to confusion and error, particularly when the workforce works across different health service organisations. In one Australian state it was found that over 60 different types of identification and alert bands were in use, and there was significant variation in the type of risk indicated by a particular colour of band.

Incorrect or out-of-date bands can also have tragic consequences for patients, particularly when they are used to indicate resuscitation status.

The commission recommends if a risk alert band is deemed absolutely necessary, then only a red band be used with information regarding the specific nature of the risk documented in the patient record.

All hospital and health services are required to be accredited against the commission's ten national safety and quality health service standards, including standard five (patient identification and procedure matching). Standard five includes a criterion for ensuring that when a patient identification band is used, it meets the national specifications for a standard patient identification band that have been developed by the commission and endorsed by health ministers for use in public and private health services.

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Queensland Health should also have a system of continual education, at regular intervals, by issuing their patient safety notices regarding the types and styles of medical information products. Whilst I do not make this a formal recommendation of this inquest I do encourage Queensland Health to set an appropriate timeframe for education, or reminding, of all clinicians to be aware of, and look for, the various medical information products which may be worn by patients.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

The Department of Health advised all hospital and health services to continue using signage on the recognition of medical alert products in all their accident and emergency departments and resuscitation bays. An example of the sign was provided for hospital and health services to display as a reminder for clinical staff. The department recommended that hospital health services identify specific opportunities to incorporate the information from the patient safety notices titled *Medical alert jewellery and accessories* and *Re-exposure of a patient to a medication to which they have a documented allergy or adverse drug reaction*, in ongoing clinical education about identifying allergies prior to medication prescribing/administration and recognising anaphylaxis, especially for emergency department staff.