Management of stroke in Emergency Department

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Public hospital ~ Emergency Department ~ Medical registrar ~ Nurse ~ Management of stroke ~ Triage times ~ Investigations and pain relief ~ Rights 4(1), 4(2)

A woman complained about the services provided to her 73-year-old mother at a public hospital. The patient was taken to the hospital by ambulance with a suspected stroke. During the wait in the Emergency Department, her daughter repeatedly told the staff of her mother's worsening symptoms. The complaint was that there was a delay in the patient receiving appropriate examination and pain relief and obtaining a CT scan and treatment, and inadequate monitoring of her deteriorating condition.

The Commissioner held that:

1 the hospital did not breach Right 4(2) because although the patient was not assessed by a doctor within one hour of her arrival, thereby failing to meet the emergency medicine triage standards, the staff still responded reasonably in the circumstances;
2 the triage nurse did not breach Right 4(1), as the assessment of the patient as triage 4 was reasonable on the basis of the patient's presentation on arrival at the Emergency Department;
3 the Emergency Department nurse did not breach Right 4(1), as there was no evidence that she failed to perform her duties appropriately;
4 another nurse did not breach Right 4(1) in that:
   (a) although the delay in providing the patient with paracetamol was regrettable, it is inevitable that minor delays will occur in busy Emergency Departments; and
   (b) she monitored the patient's condition regularly and, when the patient showed signs of further deterioration, appropriately informed the medical registrar; and
5 the medical registrar did not breach Right 4(1) in relation to:
   (a) the CT scan, as there was no inappropriate delay in ordering and completing the scan;
   (b) obtaining a neurosurgical opinion, as she attempted to gain the results quickly and, in response to the patient's further deterioration, sought advice about whether anything else could be done;
   (c) the consultation with the on-call physician, as her intervention was timely and appropriate; and
   (d) not prescribing dexamethasone and Vitamin K sooner, as the CT scan needed to be reported first, and earlier medical input would not have influenced the final outcome.