# Triage assessment of patient with reported exposure to meningitis; delays in treatment (12HDC01172, 30 June 2014)

*District health board ~ Registered nurse ~ Senior registrar ~ Emergency department ~ Triage ~ Meningococcal meningitis ~ Delays ~ Staffing ~ Overcrowding ~ Discharge from ED ~ Right 4(4)*

A young woman presented to the Emergency Department (ED) of a public hospital with her partner. She was complaining of a sore throat, stiff neck, headache and vomiting. Her classmate had been diagnosed with meningococcal meningitis ten days earlier.

There was one nurse assigned to the ED waiting room that night. The young woman was triaged by that nurse as requiring assessment within 30 minutes (ATS category 3). The young woman waited approximately three hours and 20 minutes to be seen by a doctor. Due to the acuity of the ED that night, a full set of vital signs was not taken and her condition was not reassessed while she waited to be seen by a doctor. The young woman was diagnosed by a senior registrar as having pharyngitis and was discharged the following morning after receiving intravenous antibiotics overnight.

The young woman then developed a rash on her hands and legs. She returned to the ED and was triaged as requiring assessment within 10 minutes (ATS category 2). She waited approximately 55 minutes to be seen by a doctor, following which she was admitted to the hospital with a primary diagnosis of meningococcal meningitis and septicaemia, and a secondary diagnosis of Group A Streptococcal throat infection. She received five days of intravenous antibiotics before being discharged home.

The Commissioner concluded that a series of systemic and individual failures led to delays in the young woman's medical assessment on both presentations to the ED which were suboptimal in the circumstances. The young woman exceeded the recommended waiting time for a factor of four on each occasion, which was unacceptable in the context of suspicion of significant sepsis both initially and on representation.

It was held that by failing to provide adequate staffing and resources to enable its triage procedures to be implemented effectively and safely, the district health board failed to provide services in a manner that minimised the potential harm to the young woman and, accordingly, breached Right 4(4). Adverse comment was also made about the triage nurse and the registrar.

The Commissioner recommended that the district health board review its triage policy and undertake an audit of the various changes made since this incident.