Delay in neurology review
16HDC00761, 29 May 2018

District health board ~ Involuntary movements ~ Abnormal CT ~ Neurology referral process ~ Escalation ~ Right 4(1)

A 62-year-old man presented to an emergency department with sudden onset of left-sided weakness and twitching, and reported a week-long history of dizziness upon standing. A CT scan identified the possibility of a dural arteriovenous fistula, and the report recommended a neurological opinion.

The man was admitted to the general medicine ward with a working diagnosis of an ischaemic stroke the same day. The admitting medical registrar completed a handwritten neurology referral but it was erroneously sent using the process for outpatient referrals and there was nothing on the form to indicate that it was intended to be an inpatient referral. As a result, the referral was not triaged until 3 days later.

The man was noted to have left arm tremors, which progressed to intermittent twitching of the left leg. The consultant general physician maintained the working diagnosis of ischaemic stroke when he reviewed the man in the morning of the following day. Nursing notes throughout that day refer to twitching and "on and off restlessness" in the man's left leg. On the third day of admission, another medical registrar queried in the notes whether the man's ongoing left-sided weakness was caused by seizures. This possibility was raised again during the physiotherapy and occupational therapy review in the afternoon, but the matter was not escalated to the consultant general physician.

On the fourth day of admission, the medical registrar from the previous day noted that the man had yet to be been seen by a neurologist, and made active enquiries about the referral. As a result of these enquiries, the man was reviewed by the visiting neurologist, who diagnosed focal status epilepticus. The man was commenced on intravenous anti-seizure medication, and his involuntary movements improved. He was later transferred to another hospital, where he received further treatment.

Findings
There were deficiencies in the care provided, which constituted a pattern of poor care on a service level, for which the district health board was ultimately responsible:

- The admitting medical registrar did not make an acute referral to the neurology service following the abnormal CT scan result.
- The admitting medical registrar's non-urgent referral was erroneously sent to the outpatient clinic.
- The consultant general physician did not discuss the CT report with the neurology service on his ward round the day after admission, when the man had been experiencing ongoing involuntary twitching.

- Junior staff did not escalate concerns about the man's ongoing involuntary movements, and the consultant general physician did not enquire.

In addition, the Commissioner was concerned that there were not adequate safeguards in place to enable the identification of errors in the neurology referral process. For all these reasons, the district health board did not provide services to the man with reasonable care and skill, and breached Right 4(1).

Recommendations

It was recommended that the district health board conduct an audit of neurology referrals, use this case as an anonymised case study for education on the importance of team communication, and update HDC on the implementation of its "TransforMED" project. It was also recommended that the district health board provide a formal written apology to the man for the deficiencies in his care.