Failure to consider broader differential diagnosis of meningitis
15HDC01144, 21 June 2017

Doctor ~ Registered nurse ~ Student health service ~ Telephone triage ~ Meningitis ~ Right 4(1)

A 20-year-old university student presented to the University's health service. She had had a sore throat and tiredness for two days. She was seen by a registered nurse (RN) who took a throat swab, which returned a negative culture result, and advised the student about sore throat management. At 1pm the following day, the student telephoned the health service as she was feeling worse. She spoke to a second RN, who arranged an appointment with a doctor that afternoon.

The student later cancelled the appointment as she felt too unwell to go to the health service. However, at 4pm her boyfriend telephoned the health service and spoke to a third RN. The third RN recorded that the student was getting worse, and was unable to swallow or get out of bed. The RN made a new appointment for the student with a doctor for review.

The student and her boyfriend presented to the health service at around 4.30pm for the appointment with the doctor. The doctor recorded his impression that the student had a flu-like illness, and prescribed pain relief and anti-nausea medications.

The student's condition deteriorated further and at 3.10pm the following day, her flatmate telephoned the health service and spoke to a fourth RN, who made the first available appointment for the student at the health service. The fourth RN also suggested that the student's flatmates call an ambulance if they were unable to get the student up to come to the health service.

Before leaving to go to the appointment, the student collapsed. She was unable to walk or answer questions and became drowsy. Her flatmates called an ambulance and the student was taken to the emergency department at the local public hospital. The student was diagnosed with bacterial meningitis and treated in hospital.

Findings

It was held that the doctor failed to take an adequate history from the student, did not undertake an adequate physical assessment, and did not consider a broader differential diagnosis (including meningitis). In these circumstances, the doctor did not provide services with reasonable care and skill, and breached Right 4(1).

The fourth RN failed to ask further focussed questions of the student's flatmate relating to the student's symptoms, did not consider meningitis as a differential diagnosis, and did not advise the student's flatmate to call an ambulance immediately to take the student to hospital. In these circumstances, the RN did not provide services with reasonable care and skill, and breached Right 4(1). Adverse comment was made about the second and third RNs' documentation.

The Commissioner found that the University was not vicariously liable for the RN's or the doctor's breach of the Code.

Recommendations

The Commissioner recommended that the doctor and the fourth RN each provide a written apology to the student for their breach of the Code, and that the University provide an update to HDC on the use of its generic protocols to provide consistency of telephone triage and clinical record-taking.