Stroke: Nursing Standard Of Care Articulated By Court.

The patient suffered a stroke and was taken to the hospital.

The emergency department triage nurse examined the patient and made note of his chief complaint as, "altered mental status." Another nurse in the emergency department documented that he, "could not verbalize comprehensible words ... [and] had right-hand weakness – flaccid."

According to the US District Court for the Southern District of Texas, neither nurse made the physician aware of his signs and symptoms or contacted the Stroke Team, a specialized team of physicians that were available.

The patient's stroke was not diagnosed until the next morning, and the patient has permanent neurological damage from the stroke.

Expert Opinions

Nursing Standard of Care

In its recent ruling the court covered only a preliminary question. The court ruled the patient's attorneys did in fact file reports from their medical experts which correctly stated the legal standard of care for the nurses involved in this case:

A nurse should be able to recognize presenting signs and symptoms of an acute stroke. The nurse's systematic ongoing neurological assessment should monitor changes, i.e., level of consciousness, pupil size and reactivity, ability to speak, extremity mobility and sensation.

Vital signs should be taken on admission and q 15 minutes.

Emergency room personnel, physicians or nurses, should recognize that an aphasic patient with right-handed weakness shows signs of stroke, recognize that a history of hypertension leaves a patient more vulnerable to stroke, perform an NIH Stroke Scale exam and notify the Stroke Team so that more qualified medical personnel can evaluate treatment options. **Young v. Memorial Hermann Hosp., 2006 WL 39102 (S.D. Tex., January 4, 2006).**