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Safety Matters Newsletter HSHS WWD

HSHS Sacred Heart St.Joseph's

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Delay in Transfusion of Fresh Frozen Plasma

What happened?

Situation:

A patient was admitted to the hospital for observation through the ED after a fall at home that resulted in a small bleed in his brain. There was a delay in the administration of Fresh Frozen Plasma (FFP) and KCentra (used for warfarin reversal). Unfortunately, the FFP and KCentra were given after the bleed had already progressed to a critical level.

Background:

The patient was on Coumadin and the INR was 2.5. FFP was ordered to be administered ASAP. His neuro status was within normal limits during his time in ED. The patient was transferred to the inpatient unit without having received FFP. There was a delay in getting the FFP administered on the unit as well. A change of shift occurred about an hour after arrival to the floor. When the two nurses were completing beside shift report, the patient was found to be lethargic. FFP had still not been given and patient was transferred to ICU for FFP and KCentra. Bleeding complications are a common concern with the use of anticoagulant agents, especially with known or suspected injury or trauma. FFP replaces coagulation factors lowered by warfarin.

What went wrong?

Assessment:

1. The ED provider placed the nursing order to transfuse in Epic but did not order the blood product, which alerts the blood bank. Once the missing order was noticed, the order was placed.
2. While blood bank was processing the FFP order, the patient was anxious to be out of the ED, the team was very focused on door to admit time, and there was a misperception by the ED nurse that FFP preparation would be about 45 minutes. Therefore, getting the patient to the inpatient unit was prioritized over the administration of the FFP.
3. On the inpatient side, it was late in the evening shift and the nurse had competing priorities including a transfer of a patient to another floor. Across the continuum of care, there was a lack of urgency in administering the FFP.

What are we doing?

Recommendation:

1. Ensuring all medical staff are aware of the two separate orders required for blood product administration (one nursing and one non-nursing).
2. Reminding all caregivers of the potential for rapid deterioration in patients with known or suspected bleeds, especially in the presence of anti-coagulation – timely assessment, frequent re-assessment, and **prompt treatment** are critical.
3. To help support effective teamwork, TeamSTEPPS implementation at the unit level continues throughout WWD to enhance team members' capacity for effective communication, ability to adjust to each other's actions and the changing environment, and techniques for shared understanding of how a procedure or plan of care should happen.

Contact SafetyMatters@hshs.org with questions or feedback