# Case Study

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PATIENT SAFETY RESOURCES

# LIFE-ALTERING MISUNDERSTANDING DURING SHIFT CHANGE

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## DESCRIPTION

A patient brought to the ED with a subdural hematoma suffered a life-altering injury in the aftermath of a misunderstanding about a blood bank order during a shift change.

## KEY LESSON

Structured handoff tools can prevent the loss of key clinical information across shifts.

## CLINICAL SEQUENCE

An 80-year-old male with a history of atrial fibrillation (on Coumadin) presented to the Emergency Department (ED) after falling and hitting his head. Upon exam, the patient had no neurologic deficits or obvious signs of trauma. A head CT revealed a small subdural hematoma. The patient's INR was 2.8 (anticoagulated patients are considered therapeutic between 2.0 and 3.0). The emergency medicine physician ordered fresh frozen plasma (FFP) and vitamin K to be given to reverse anticoagulation. The FFP order was put in the electronic system and went to the lab at 6:31 a.m. The blood bank prepared the FFP and it was ready to be dispensed at 7:41 a.m. While the day shift nurse had received the overnight nurse's report at the 7:00 shift change, the day nurse was not aware of the FFP order and did not know to look for the indication of its readiness in the patient's record.

The patient was admitted to the neurology unit and was transferred from the ED at 9:30 a.m. Over the next several hours, the patient's condition deteriorated and he began to have mental status changes. A repeat CT showed evolution of the subdural hematoma and the patient was taken urgently to the operating room for a right craniotomy. The patient received the FFP at 12:30 p.m.

After a nine-day admission, the patient was discharged to a rehabilitation facility. He had several readmissions to the ED and several subsequent stays in rehab. After making a partial recovery, the patient was discharged home. While there, he experienced an additional fall and required 24-hour care. Prior to this event the patient was living independently with his wife. He was retired but had continued to do some consulting work.

## ALLEGATION

The patient's son and health care proxy alleged that the delay in delivering fresh frozen plasma to his father after a subdural hematoma caused the evolution of the bleed and thus further neurologic damage resulting in the need for full time care and a loss of function for his father. The claim was brought against the hospital.

## DISPOSITION

The case was settled for more than $1M.

## ANALYSIS

- **A key piece of clinical information was missed in a change of shift handoff that resulted in a delay of care to the patient.**

## DISCUSSION QUESTIONS

- What standard handoff tools are used in your organization?
- How do you ensure quality care of patients boarding in the ED while they are awaiting an inpatient bed?

## REFERENCES AND LINKS


I-PASS Patient Safety Institute

Effects of the I-PASS Nursing Handoff Bundle on communication quality and workflow (BMJ Quality & Safety)

Patient Safety and Quality: An Evidence-Based Handbook for Nurses (National Library of Medicine)