Case Study #3 – Root Cause Analysis
Intra-Hospital Transfer Medication Error

EVENT SUMMARY & BACKGROUND

A 71-year old was transferred from an acute care teaching hospital to a second acute care hospital for rehabilitation services post embolic stroke. Both hospitals were members of the same health care system. Six hours after admission to the second facility the patient suffered an unexpected brain hemorrhage.

The event involved an intra-hospital transfer, which caused some serious concerns regarding patient management among both physicians and staff since the type of hand-offs experienced in this case were similar to those occurring on a daily basis in the health system. It was believed there were systematic flaws involved in the transfer of this patient and uncovering them would result in possible system-wide recommendations to prevent recurrence in the future, thus protecting patients from exposure to harm. Although there was no proven relationship to the occurring brain hemorrhage, there were many system failures identified in the transfer process that could have potentially contributed to the event.

Executive Summary Recommendations

Root Cause	Type	Recommendation	Responsible	Estimated Completion Date	Completed
Failure to review most recent lab results	Human	Develop inter/intra transfer process.	Director RM/QA	11/20/2003	No
Monitoring	Latent	Patients receiving IV anticoagulation will no longer be candidate for admission to rehab unit.	Director RM/QA	10/1/2003	Yes
Information Systems	Latent	Nursing Staff Development will provide staff education on SMS. Chief of Staff will communication to physicians.	Director RM/QA	11/4/2003	Yes

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CONCLUSIONS

In conclusion, both facilities assumed that their Coumadin dosing schedules were the same. This was found not to be the case and the patient who had received a 5 mg dosage of Coumadin prior to the transfer, received another 7.5 mg dosage within two and a half hours. A series of miscommunications and misinterpretations as to test results also contributed to this adverse outcome as evidenced in the Logic Tree and associated Verification Logs.