

Practice sting Adequate Management of Bleeding

This Practice Sting is particularly relevant for committees involved in medication safety.

VMI advises medication safety committees to establish clear protocols and agreements regarding the reversal of anticoagulants.

Incident

A patient was found during the night with a head injury following a fall from bed. The patient was using a DOAC (Direct Oral Anticoagulant). Due to changes in neurological status, a CT scan was performed, revealing multiple intracranial hemorrhages. In accordance with protocol and based on the patient's body weight, the physician prescribed a high dose of prothrombin complex concentrate to reverse the effects of the DOAC.

The nursing staff refused to administer the high dose (5,000 IU = 10 vials of 500 IU) because they only had experience administering doses up to 1,000 IU. Additionally, the ward's stock was insufficient. The patient ultimately received the prothrombin complex 2.5 hours later after being transferred to a stroke unit. Due to limited availability, only half of the prescribed dose was administered. Upon reassessment in the morning, neurological symptoms had worsened, and the CT scan showed a more extensive hemorrhage.

Recommendations

For committees involved in medication safety:

- Ensure clear protocols are in place for the reversal of anticoagulants, including defined roles and responsibilities.
- Disseminate these protocols to all relevant healthcare professionals within the hospital.
- Guarantee that outside regular working hours, a qualified and authorized individual is always available to administer coagulation factors and antidotes. Ensure everyone knows how and where to reach this person.
- Communicate the availability of coagulation factors and antidotes for anticoagulants in the emergency cabinet and clarify who has access to it outside regular hours.

Analysis

It cannot be stated with certainty whether the outcome for this patient would have been different had the prothrombin complex been administered immediately. However, this incident raises several points for discussion.

- The nurses on the ward where the patient was admitted did not feel competent to administer a high dose of prothrombin complex. In such situations, it is crucial that nurses and prescribers know how to act swiftly. Whether such agreements exist in this hospital is unknown to VMI; in any case, they were not known to all staff involved.

- There was an insufficient supply of prothrombin complex on the ward. The healthcare professionals involved were unaware that prothrombin complex was available in the hospital's emergency cabinet.

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