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# Safety Alert

# Response to Urgent Blood Transfusion

*"Sharing Lessons Learned"*

An incident was reported on delayed patient management of blood transfusion due to a series of unfortunate failures. Consequently the patient was transferred to ICU and passed away. The incident was discussed thoroughly by the *Sentinel Event Committee*, followed by Root Cause Analysis and action plan.

## Situation:

The patient did not receive timely blood product transfusion, after a drop in hemoglobin "around 11 hours delay".

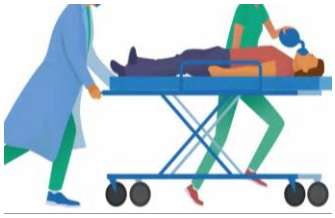
## Background:

Around 02:00 am, the Hemoglobin level was low with fluctuating vital signs, and the healthcare team was managing the patient's condition. Five (5) hours later, a repeat hemoglobin level was done, which showed further drop. Two (2) hours later, RRT was initiated; finally, the patient was transferred to ICU.


## Assessment:

Direct and indirect factors contributed to the delay of blood transfusion and patient management, including:

- failure of managing the drop in Hemoglobin level, despite the presence of two (2) critical results.
- Absence of baseline type and screen, during the patient's hospital stay.
- Delay in activating the Rapid Response Team (RRT), after detecting unstable vital signs.
- Failure in initiating a formal consultation with ICU.
- Failure to recognize early signs of the patient's deterioration.
- Delayed transfer to the Critical Care Unit.



## Recommendation:

- Strictly adhere to and enforce compliance with the Consultation Policy.
- Reinforce effective communication between on-calls, MDs and consultants, by escalating all challenges.
- Reinforce *Rapid Response Team Composition and Responsibilities (Adults) (CIPP-3663)* by activating the RRT, when criteria are met. Study the feasibility of having an ICU physician as a member on the Rapid Response Team.
- Standardize practice of ordering the Type and Screen for all admitted patients, as a baseline, regardless of their clinical condition.
- Train all MDs to perform femoral taping to obtain blood sampling for life-saving situations.
- Develop a strategy to improve residents' training in managing patients in critical situations.
- Reinforce awareness of early recognition of signs and symptoms for patients in shock.
- Reinforce the importance of having clear, direct communication about the transfer plan with Nursing, in addition to having an order for transfer in medical records. Reinforce the multi-departmental communication during transfer to facilitate and expedite safe and timely patient transfer.
- Develop a multidisciplinary mobile Critical Care Team.

*Prepared by: Quality Management Department*