PATIENT SAFETY RESOURCES

FAILURE TO RESUME ANTICOAGULATION AFTER PROCEDURE CAUSES STROKE

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DESCRIPTION

A failure to restart anticoagulation treatment after a stenting procedure led to a 70-year-old man having a stroke.

CLINICAL SEQUENCE

A 70-year-old male presented to the emergency department with a gangrenous toe and was found to have an obstructed superficial femoral artery. The patient's history included atrial fibrillation, stroke, hypertension, chronic kidney disease, coronary artery disease, diabetes mellitus type II, chronic obstructive pulmonary disease, and chronic heart failure. They were also being treated with Eliquis for atrial fibrillation.

The patient was admitted to the hospital, where a vascular surgeon was consulted and an angiogram was scheduled for the next day. The hospitalist caring for the patient (Hospitalist A) documented the plan for the angiogram and anticoagulation treatment was withheld in preparation for the angiogram. The patient was successfully stented on day two of admission. Hospitalist A's note stated the patient "was on Eliquis. As per vascular surgery, after procedure the patient may start Eliquis or low dose Lovenox, if needed and okay with surgery. Restart Eliquis whenever okay per surgery."

On day three of admission, the patient was seen by the vascular surgeon and there was no mention of anticoagulation in the note. The hospital medicine nurse practitioner (NP) documented that Eliquis was on hold since the patient's admission for possible right foot amputation. The NP also sent a page to Hospitalist B stating that the patient is not on DVT prophylaxis. Hopsitalist B saw the patient and documented he was having a vascular work-up to assess blood flow as he may require amputations. Hospitalist B saw the patient again the next day (four days since admission), and the assessment and plan seemed identical to the previous day.

At 8am the following day, Hopsitalist B noted the patient was walking, talking, and following commands. At 11:58 am, a Rapid Response was called for unresponsiveness. The patient suffered a massive cerebral vascular accident (CVA) resulting in aphagia and inability to walk.

ALLEGATION

A suit was brought forth against both hospitalists, alleging failure to properly manage anticoagulation.

DISPOSITION

An expert opinion stated it was the duty of the hospitalists to manage the patient's anticoagulation after the angiogram and stenting. Hospitalist B's notes did not reflect that he was monitoring the patient's need for anticoagulation. The case settled for more than $100,000.

ANALYSIS

Physician or service accountability for the patient was unassigned or unclear.

When more than one service is following a patient, it is important that roles and responsibilities are clear. The hospitalist team deferred to the surgical team for the anticoagulation plan, however, there was no evidence of a conversation and anticoagulation was not mentioned in the surgical documentation. Policies for consulting services need to be clear, and organizational culture needs to reflect an understanding and accountability of patient plans.

The clinical status of a known high-risk patient was not properly monitored.

The plan for a potential amputation was mentioned, but there was no order or discussion of short-acting anticoagulation in the meantime. Given the patient's history, an anticoagulation plan should have been addressed in the medical record.

Documentation issues.

The provider note seemed to have been copied and pasted from the previous day and did not address the page sent by the NP about anticoagulation. This contributed to the expert's opinion that the provider was not properly monitoring the patient's underlying condition and risk. According to the 2020 CRICO Benchmarking Report, The Power to Predict, the odds of a malpractice case closing with an indemnity payment increases by 76 percent when there are signs that documentation and care were insufficient in ensuring subsequent caregivers provide the appropriate care.