"NPSA actions can make anticoagulant therapy safer"

The National Patient Safety Agency published safety alert 18 on anticoagulation in March this year. Roz Perrott, Anticoagulation and Thrombosis Pharmacist at King's College Hospital, discusses progress towards implementing the actions, and outlines her team's challenges and successes

"At Kings, Lynda Bonner (anticoagulation nurse) and myself are responsible for implementing the NPSA alert actions. We are progressing well towards the deadline for implementation. We have all our written procedures and clinical guidelines in place and have a dedicated anticoagulation chart for in-patients.

Audit is an ongoing process and we are using the DAWN anticoagulation database software for our patients. We are recording bleeding rates (major and minor), completion of referrals and follow-ups. At Kings we were already using the INR/time in range measurements to monitor safe levels and dosing. Using DAWN makes it relatively easy to pull off the relevant data in a monthly report, to then present to the Thrombosis Committee.

"COLLECTING DATA ON PATIENTS ADMITTED WITH A MAJOR BLEED ON ANTICOAGULATION IS DIFFICULT AS THESE ARE NOT NECESSARILY CODED AS RELATING TO ANTICOAGULATION"

Kings is also one of the NPSA's baseline audit sites, presenting us with some challenges in obtaining the required data. For example, collecting data on patients being admitted with a major bleed on anticoagulation is difficult as these incidents are not necessarily coded as relating to anticoagulation. This is something that we are trying to address in conjunction with clinical coding. We are also planning an audit of all major bleeding admissions to find out how many are related to anticoagulation and identify any common causes.

Communication

We have in place a robust system for communication with other organisations. We have a policy for discharging patients on anticoagulation and are involved in the discharge arrangements for the majority of patients on warfarin. This helps to reduce the numbers who are discharged from hospital without referral for continued monitoring.

Pic: Alamy

King's has a particularly successful "Did not attend" (DNA) policy. Our nurses are particularly thorough in managing patients who miss tests. If a patient does not attend for an INR test we initially send them a letter and rebook their test. If they fail to attend twice we attempt to contact them and send a letter to their GP advising them not to supply any more warfarin until INR testing has resumed. We will also immediately follow up particularly high risk patients who do not attend.

We have done a mail-shot to GPs on interacting medicines. This highlights their responsibility to inform patients of any medication changes and potential interactions. The patient then needs to inform us to arrange testing within 4 –7 days of starting the new drug.
We also plan to do a mail-shot to community pharmacists, to ask them to check the yellow anticoagulation record book before supplying warfarin to ensure regular INR monitoring.
Unfortunately not all patients chose to visit the same pharmacist each time they get a prescription filled, so this may be more difficult to enforce.
I think there could be more clarity from the NPSA on what information these other organisations have already received. This would certainly help us in planning communications.

"IF THEY FAIL TO ATTEND TWICE WE ATTEMPT TO CONTACT THEM AND SEND A LETTER TO THEIR GP ADVISING THEM NOT TO SUPPLY ANY MORE WARFARIN UNTIL INR TESTING HAS RESUMED"

Competencies and training

The most challenging action to implement has been the work competencies for anticoagulant care. Currently we hold annual workshop training on Safe Prescribing for F1 and F2 doctors, which includes anticoagulation. We will be looking at developing this, possibly using the template of consent training so that every member of staff involved in anticoagulation is required to complete appropriate training. I think this is an area that would benefit from being more formalised nationally, whilst still remaining flexible to local needs. We are also looking to develop a new role for our thrombosis team in advising on in-patient anticoagulation management. Competence training for pharmacists to advise on dosing at ward level is something that we will also be looking to pursue.

Patient information

All patients are given the Yellow Book when they are started on anticoagulation. Patients are also counselled on the ward (usually by the pharmacist), at discharge and by me on their first visit to the anticoagulation clinic. The ward counselling needs to be more formalised so that we know that every patient who is discharged on warfarin has been counselled appropriately. We have also ordered the new anti-coagulation packs from the NPSA, which provides patients with a separate information booklet.

■ www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts