

Anticoagulant patient safety alert

Advice for social care providers

In response to reports of patient safety incidents involving anticoagulants received from all sectors of NHS healthcare in England and Wales, the National Patient Safety Agency (NPSA) has issued a patient safety alert, and a series of support materials designed to help reduce the potential harm to patients taking this type of medication. This guidance applies to all healthcare sectors, including social care settings.

This document is being sent to social care providers to remind healthcare staff that the key recommendations should be implemented by 31 March 2008.

The key messages from the patient safety alert that will affect social care providers are as follows:

1. When warfarin treatment starts, the person must be given verbal and written information, and this must be updated when necessary. In practice this probably means that the anticoagulant clinic will make sure that each person is given a 'Yellow Book' and that they and their care workers fully understand its contents. Note: This now comes with a credit card sized 'Alert card' which identifies that a patient is on anticoagulant therapy and gives essential details. The person should carry this with them and show it to any healthcare practitioner when they attend for treatment.
2. GPs and pharmacists should check that the patient's INR (blood clotting) is being monitored regularly before they issue or dispense a repeat prescription for anticoagulant medication. The repeat prescription should only be dispensed if the INR is at a safe level. The GP or pharmacist may ask to see the patient-held INR record. This may be in the form of a single printed sheet, small booklet or other format used locally. There is a space in the back of the new yellow book to keep records issued from the anticoagulant clinic. Social care providers should be prepared to produce the yellow book and any other records about blood tests when they request a prescription for anticoagulants or collect the medicine from a pharmacy on behalf of the people they care for.

Continued overleaf:

NHS
National Patient Safety Agency

Patient safety alert

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Alert

 28 March 2007

Immediate action	<input type="checkbox"/>
Action	<input checked="" type="checkbox"/>
Update	<input type="checkbox"/>
Information request	<input type="checkbox"/>

Ref: NPSA/2007/18

Actions that can make anticoagulant therapy safer

Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm and admission to hospital.¹⁻³ Managing the risks associated with anticoagulants can reduce the chance of patients being harmed in the future.

This patient safety alert has been developed in collaboration with the British Society for Haematology (BSH) and a broad range of other clinical organisations and individual clinicians, patients and patient groups.

Action for the NHS and the independent sector

The National Patient Safety Agency (NPSA) is recommending that NHS and independent sector organisations in England and Wales take the following steps:

- 1 Ensure all staff caring for patients on anticoagulant therapy have the necessary work competences. Any gaps in competence must be addressed through training to ensure that all staff may undertake their duties safely.
- 2 Review and, where necessary, update written procedures and clinical protocols for anticoagulant services to ensure they reflect safe practice, and that staff are trained in these procedures.
- 3 Audit anticoagulant services using BSH/NPSA safety indicators as part of the annual medicines management audit programme. The audit results should inform local actions to improve the safe use of anticoagulants, and should be communicated to clinical governance, and drugs and therapeutics committees (or equivalent). This information should be used by commissioners and external organisations as part of the commissioning and performance management process.
- 4 Ensure that patients prescribed anticoagulants receive appropriate verbal and written information at the start of therapy, at hospital discharge, on the first anticoagulant clinic appointment, and when necessary throughout the course of their treatment. The BSH and the NPSA have updated the patient-held information (yellow) booklet.
- 5 Promote safe practice with prescribers and pharmacists to check that patients' blood clotting (International Normalised Ratio, INR) is being monitored regularly and that the INR level is safe before issuing or dispensing repeat prescriptions for oral anticoagulants.

For response by:

- All NHS and independent sector organisations in England and Wales

For action by:

- The chief pharmacist/pharmaceutical advisor should lead the response to this alert, supported by the chief executive, medical director, nursing director and clinical governance lead/strategic manager.

We recommend you also inform:

- Medical staff
- Nursing staff
- Pharmacy staff
- General practitioners
- Community pharmacists
- Dental surgeons
- Patient advice and liaison service staff in England
- Community health coaches in Wales
- Medical laboratory scientists

The NPSA has informed:

- Chief executives of acute trusts, primary care organisations, ambulance trusts, mental health trusts and local health boards in England and Wales
- Chief executive/regional directors and clinical governance leads of strategic health authorities (England) and regional offices (Wales)
- Healthcare Commission
- Healthcare Inspectorate Wales
- Commission for Social Care Inspection

Medicines and Healthcare products Regulatory Agency

- Welsh Health Supplies
- Royal colleges and societies
- NHS Direct
- Relevant patient organisations and community health councils in Wales
- Independent Healthcare Forum
- Business Services Centre (Wales)
- Independent Healthcare Advisory Services

NHS
National Patient Safety Agency

THE BRITISH SOCIETY FOR HAEMATOLOGY

Oral Anticoagulant Therapy

Important information for patients

Anticoagulant Alert Card

This patient is taking anticoagulant therapy. This card should be carried at all times and shown to healthcare professionals.

Name of patient: _____

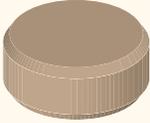
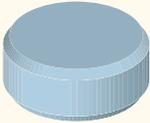
Address: _____

Postcode: _____ Telephone: _____

Name of next of kin: _____

Hospital number: _____ NHS Number: _____

In the UK, the colours of warfarin tablets are:

0.5mg (500 micrograms) – white	
1mg – brown	
3mg – blue	
5mg – pink	

Different brands of warfarin tablets may have different markings to those shown above. Other anticoagulants may come in different strengths and colours

- Additional blood tests may be necessary if the person has other medicines that interact with the anticoagulant. If this happens, the doctor or pharmacist will inform the person or their care worker. It is important for social care providers also to contact the anticoagulant service and make sure that the new arrangements are made.
- Changes to the dose of anticoagulant should be written in social care records as mg. Warfarin tablets come in different strengths (as shown). If you confuse the number of tablets with mg, the person could get the wrong dose.
- You should have written safe practice procedures for the administration of anticoagulants in your social care setting. The National Minimum Standards for care homes and domiciliary care agencies require providers to have written policies and procedures for medicines. The NPSA recommends that local policies should incorporate a specific section on anticoagulants.
- All dose changes for anticoagulants should be confirmed in writing by the prescriber. It is safe practice to attach the written confirmation of the oral anticoagulant dosage, supplied by the anticoagulant clinic, to the medicine administration record (MAR) that you use. Only accept a verbal message to change the dose in an emergency, and always ask for written confirmation as soon as possible.
- The NPSA recommends that oral anticoagulants are administered from the original packs dispensed for individual patients. Monitored Dosage Systems are not flexible enough to cope with frequent dose changes and are not recommended for anticoagulants. Care homes should make these arrangements with their local pharmacist or dispensing doctor.
- Some people who are cared for in their own homes may rely on compliance aids to manage their medicines. For these people, a risk assessment is essential to decide whether the anticoagulant should be placed in it and, if it is thought necessary, the person who fills the aid must ensure that the tablets in the compliance aid match the latest prescribed dose. The general use of monitored dosage systems for anticoagulants should be minimised as dosage changes using these systems are more difficult.
- Care workers who administer anticoagulants or support people to take their own must be trained to undertake their duties safely.
- Social care providers should review and, where necessary, update their procedures and protocols for giving medicines so that anticoagulants will be given safely and they should provide training for their staff in these procedures.
- People taking anticoagulants who need dental treatment may require a blood test up to 72 hours before treatment takes place. The social care provider should discuss this with the person's dentist at least three days prior to treatment.
- NHS anticoagulant services will be audited on an annual basis using a set of safety indicators covering the whole of the anticoagulant care pathway. Social care providers may be asked to participate in that audit.