Anticoagulant therapy: information for GPs

In response to a series of reports of patient safety incidents involving anticoagulants received from all sectors of the NHS in England and Wales, the National Patient Safety Agency (NPSA) is issuing guidance designed to help reduce potential harm to patients taking this type of medication.

NHS
National Patient Safety Agency

Patient safety alert 17

Alert

XX March 2007

Immediate action ☐
Action ☑
Update ☐
Information request ☐

Ref: NPSA/2007/17

Actions that can make anticoagulant therapy safer

Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harms and admissions to hospitals.[1,2] 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 of Haematology and a broad range of other clinical organisations and individual clinicians, patients and patient groups.

Action for the NHS and the independent sector

The 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 British Society of Haematology 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.

6 Promote safe practice for prescribers co-prescribing one or more clinically significant interacting medicines for patients already on oral anticoagulants

For response by:
- All NHS and independent sector organisations in England and Wales

For action by:
- The chief executive/pharmaceutical adviser shall lead the response to this alert, supported by the chief executive, medical director, nursing director and clinical governance lead/risk manager

We recommend you also inform:
- Medical staff
- Nursing staff
- Practice manager
- General practitioners
- Community pharmacists
- Dental surgeons
- Patient advice and liaison services (PALS) leads
- Community health councils in Wales
- Medical laboratory scientists

The NPSA has informed:
- Chief executives of acute trusts, primary care organisations, ambulance trusts, mental health trusts and health boards in England and Wales
- Chief executives/regional directors and clinical governance leads of strategic health authorities (England)
- Chief executive, Wales Centre for Healthcare Commission
- Healthcare Inspectorate Wales
- Commission for social care inspection
- Medicines and Healthcare products Regulatory Agency
- Royal Pharmaceutical Society
- Royal colleges and societies
- NHS Direct
- Relevant patient organisations and community health councils in Wales
- Department of Health, England
- Business Services Centre (Wales)
- Independent Healthcare Advisor Services

This guidance, which involves a patient safety alert and supporting materials, applies to all healthcare sectors, including primary care. It is particularly important that general medical practitioners understand the key messages from this alert and how they apply to their practice.

For further information on the NPSA's safer medication practice work programme for 2007, including electronic versions of all the alerts and supporting materials, go to **www.npsa.nhs.uk/health/alerts**

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The alert should be read in detail, but the key messages for GPs are that they should:

Ensure that before issuing a repeat prescription for anticoagulant medication, they check that the patient's INR is being monitored regularly and that it is at a safe level for the repeat prescription to be issued. The easiest way to do this is to ask to see the patient-held INR record, which may be in the form of a single printed sheet, a small booklet or another format used locally.

Ensure that if a patient who is already on oral anticoagulants is co-prescribed one or more clinically significant interacting medicines, that arrangements are made for additional INR blood tests, and that the anticoagulant clinic is made aware that an interacting medicine has been prescribed. The patient may be empowered to ensure this happens in appropriate cases.

Ensure that all surgery staff caring for patients on anticoagulant therapy have the necessary work competences commensurate with their role in that process. This includes GPs, practice nurses, practice pharmacists and receptionists. To help with this, the NPSA has developed a series of workforce competence statements and two e-learning modules, as listed below:

Workforce competence statements:
- initiating anticoagulant therapy;
- maintaining oral anticoagulant therapy;
- dispensing oral anticoagulants;
- reviewing the safety and effectiveness of an anticoagulant service.

e-learning modules:
- starting patients on anticoagulants;
- maintaining patients on anticoagulant therapy

Ensure that doses are expressed in mg and not in number of tablets.

Review and, where necessary, update any sections of clinical procedures and protocols that relate to parts of the anticoagulant care pathway for which they or their staff take responsibility.

Ensure that patients on anticoagulant therapy have received appropriate verbal and written information at the start of their therapy, and when necessary throughout their treatment. In practice, this means making sure that patients have received a 'yellow book' and ensuring that they (or their carers) fully understand its contents.*

Ensure that all dose changes, originated by the surgery, for patients in care homes are confirmed in writing.

Participate in an annual audit of anticoagulant services

***Note:** This booklet now comes with a credit card sized alert card designed to be carried by the patient at all times; it informs health professionals that the patient is taking anticoagulants and provides a contact phone number.*