Virtual IMSN Conference 2021

Innovation to deliver Medication Safety

Antithrombotic Stewardship Programme
Time to formalize the role.

Presented by Dr Virginia Silvari

Antithrombotic Stewardship Programme

Haematology consultant

Clinical Pharmacist specialist in anticoagulation

Clinical nurse specialist in anticoagulation

Medication Safety Pharmacist

Irish Medication Safety Network

HSE Audit Cycle 1-3

› **Planning for audit:**

- To improve the quality and safety of care of patients on anticoagulation.

› **Standard/criteria selection**

- Adult patients who have been prescribed anticoagulants. Patient on LMWH for hospital thromboprophylaxis were not included in the audit.

› **Measuring performance**

- One day data collection
- Data analysis was performed using Microsoft Excel.

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Appropriate prescribing of anticoagulants.

Table1

	Anticoag. Wrongly Prescribed	Anticoag. Appropr. prescribed	Appropriate, after intervention	Tot
Anticoagulation on hold				11
Pt not on Anticoagulation				337
No chart available				12
Pt already audited				9
Pt not on ward any longer				24
Yes Pt on Anticoagulation	**16**	**79**	**5**	**100**

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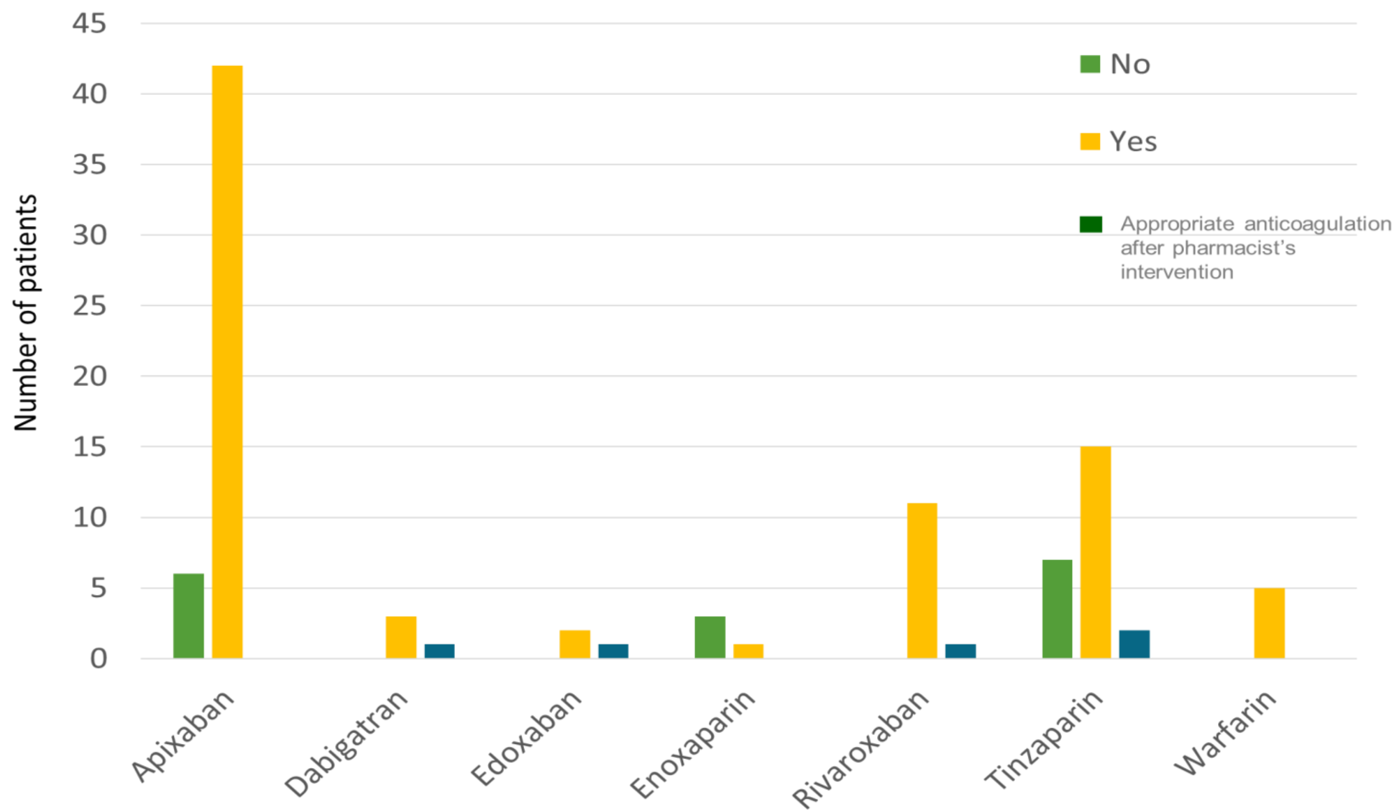
Appropriate prescribing of anticoagulants.



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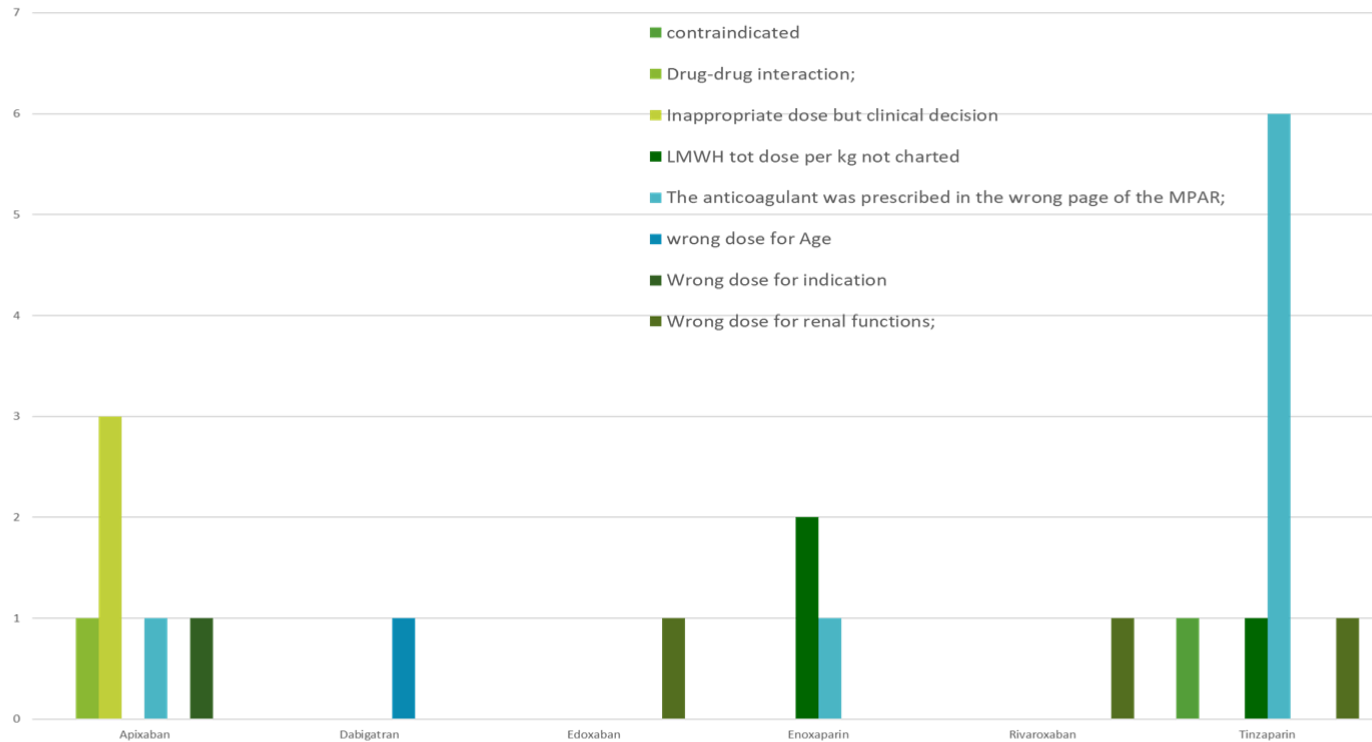
Reasons for inappropriate prescribing



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Duplication/Switching between anticoagulants

	Switching between anticoagulants
N/A	76
Wrong Switching	3
Appropriate Switching	21
Total	**100**

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HSE Audit Cycle 4-5.

Making the improvements:

- An alert in the new hospital MPAR will prevent errors when switching between anticoagulants.
- An improved layout of the new MPAR should prevent errors of prescribing the anticoagulants in the correct section of the MPAR.

Sustaining improvements:

- Education will be provided to clinicians on safe prescribing in anticoagulation.
- Medication Safety Bulletin on safe prescribing of anticoagulants will be circulated.
- A follow-up audit will be conducted in a year.

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Anticoagulants prescribing incidents 2020

Anticoagulant prescribing Incidents (n=78)	Type of anticoagulant	% of anticoagulants prescribing incidents
Wrong dose/ frequency/duration prescribed	LMWH	20.5
	DOAC	28.2
Dual prescription	DOAC + LMWH	30.8
	LMWH + LMWH	1.3
Prescription omitted	warfarin	5.1
	DOAC	2.6
	LMWH	1.3
Prescribing contraindicated	LMWH	2.6
	warfarin	1.3
Prescribed for incorrect patient	UFH	1.3
Other anticoagulant prescribing errors		4.0

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Conclusion

- Developing an antithrombotic stewardship programme to properly use antithrombotics is essential for inpatient facilities.
- Within an antithrombotic stewardship programme, the clinical pharmacists play an important role to improve management of patients on antithrombotics.
- Future work for the group includes improvements to transfer of care of patients on antithrombotics including patient counselling at discharge.
- Raising awareness of our work will help in formalizing the role of the antithrombotic stewardship across Primary and Secondary care.

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Ms Deirdre Lynch-Chief Pharmacist, CUH

Dr Maeve Crowley- Consultant Haematologist, CUH