Anticoagulant management within a hospital setting: identifying risk factors affecting patient safety

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Anticoagulants (AC) are
• hospital-wide used drugs
• involving many healthcare providers
• classified as high-risk
The use of these drugs is therefore subject to a stricter policy.

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INTRODUCTION

Anticoagulants (AC) are hospital-wide used drugs involving many healthcare providers and classified as high-risk. The use of these drugs is therefore subject to a stricter policy. Despite the many precautions and vast experience with these drugs, errors often occur in daily practice.

PURPOSE

Which factors are associated with an increased risk of error and therefore negatively affect patient safety in our hospital?

METHODS

1. Retrospective data analysis related to AC and anti-aggregants (AA):
   • Incident reports and registered usage (2018-2019)
   • Pharmaceutical recommendations (09-10-11/2019)

2. We surveyed doctors and trainees working in our hospital:
   • Multiple choice questions inquiring into their experiences

RESULTS

1. Retrospective data analysis
   Incident reports (n=172)
   • Most incidents were related to LMWH* (45%)
   • Took place in a surgery ward (37%)
   • Could be linked to a transfer to another ward or operating theater (35%)

2. Survey
   Recommendations (n=132)
   • Most attention was paid to DOAC’s (29%)
   • Although only 15% of registered usage (AC+AA)
   • Patients on a temporary ward (35%)
   • Relatively high number (11%)

3. Type of advice?
   • Prescription
   • Communication
   • Impact of the used IT-systems
   24% administration
   30% monitoring
   8% delivery
   12% prescription
   1% contra-indication

4. Type of problem?
   • Nurses play an instrumental role!
   • Impact of the used IT-systems?
   • Other

5. Survey
   • N=74 < 21 disciplines
   • 65% deal daily with AC
   • Highlights:
     • Non-prescribing of therapy was considered to be the main problem (49%), followed by incorrect dosing (42%)
     • Only 28% agree that the patient receives sufficient information on paper
     • Only 28% agree that it is sufficiently clear to nurses where the prescribed policy can be found
     • Only 28% think that new employees are sufficiently informed about the hospital-wide agreements

CONCLUSIONS

A number of risk factors were identified such as the IT systems used, communication, the opening of temporary wards and the transfer of patients to/from another nursing unit or operating theater. More attention should be paid to education, raising awareness and therapy omissions. A multidisciplinary, centralized approach with a focus on monitoring is imperative.