PHARMACY QI

Practical Tips for Quality Improvement

July 2018

Improving Medication Safety – Anticoagulants[1,2,3]

STAGE OF MEDICATION INCIDENT	ANTICOAGULANT-RELATED EXAMPLES	QI PREVENTION MEASURES
Prescribing	Prescribing anticoagulants without adequate information:	
	• No recent INR data resulting in inadequate dosing of warfarin	• Consult laboratory results before initiating/ changing therapy.
	• No recent renal function results resulting in overdosing of a DOAC	• Standardize the baseline information, such as weight in kg and serum creatinine, needed during the ordering of oral anticoagulants.
'	• Lack of best possible medication history (BPMH) during transition of care resulting in duplicate therapy or inadvertent discontinuation of an anticoagulant	• Complete BPMH using at least two sources of information during the medication reconciliation process.
Order entry/ transcription	• Misinterpretation of verbal orders	• Eliminate verbal orders unless in emergency situations and use "read back" method for verification.
	• Lack of identification of potential drug interactions on order entry	• Thoroughly assess computer warnings about unsafe doses or drug interactions.
Pharmacy dispensing	Dispensing wrong drug/dose due to:	
	• look-a-like, sound-a-like drugs (1,000 unit/mL vs. 10,000 unit/mL heparin vials)	• Use distinctive labels to differentiate between look-a-like, sound-a-like drugs.
	• orders requiring calculations of dosing/body weight, scheduling of alternating warfarin doses	• Consider using independent double check when dispensing complex orders.
Nurse administration	• Administering an anticoagulant that has been discontinued	• Use "directions changed, refer to MAR" label when processing a discontinue order.
	• Administration of wrong dose of injectable heparin or LMWH	• Avoid use of multi-dose vials and replace with prefilled syringes. • Use independent double check for nurse verification of dose.
Monitoring	• For residents taking warfarin: Lack of INR monitoring and communication of results to prescriber	• Monitor INR results and communicate with prescriber to adjust warfarin dose accordingly.
	• For other anticoagulants (e.g., DOACs): Lack of regular monitoring of renal function that might result in overdose	• Regular monitoring of renal function and communicating changes to prescriber.

References:

1. ISMP Medication Safety Self Assessment® for High-Alert Medications. 2017. https://www.ismp.org/sites/default/files/attachments/2018-01/EntireAssessmentWorkbook.pdf. Accessed April 24, 2018.
2. Accreditation Canada Medication Management Standards - Date Generated: January 18, 2017 - Ver. 12.
3. Medical Pharmacies Policy and Procedure Manual – Jan. 2018.

CANADA'S BEST MANAGED COMPANIES Platinum member

Courtesy of Medical Pharmacies Group Limited

1-866-689-3169 • medicalpharmacies.com

MEDICAL PHARMACIES