

# GOOD PRACTICE- INNOVATION AND COLLABORATION

## New Oral Anticoagulants –

### Hospital Pharmacists Improving the Safety of Patients



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## WHAT WAS DONE?

# 1

The following suite of activities were introduced in a drive to improve understanding, familiarity and awareness of NOAC therapy.

- Medication Safety Alert - A ready reference outlining the relevant background information, risks and safety tips for prescribing and administering NOACs (Figure 1).
- Quiz – A novel and fun method to ascertain the level of knowledge staff had on the NOACs by incentivizing participation.
- Prescribing Information Sheet – Developed to summarise all the pertinent prescribing information on NOACs to aid selection and detail the relevant clinical cautions and risks.
- A Point Prevalence Study (PPS) that captured data on all NOAC patients in the hospital to identify prescribing trends and appropriateness of prescribing.
- Staff Educational drive - The Drug Safety Facilitator has led in a major roll-out of education sessions to medical and nursing staff in the hospital including presentation at medical / surgical grand rounds, nursing forum and inclusion in e-learning programmes (Figure 2).
- Clinical Checklist Algorithm – Identifies the key prescribing decisions and risks when admitting a patient on a NOAC (Figure 3).
- Patient Education - Pharmacists now educate all patients newly started on NOAC therapy.



Figure 1: Medication Safety Alert



Figure 2: Educational Drive

## WHY WAS IT DONE?

# 2

Due to the high risk nature of the NOACs, the PD was, throughout 2014 and 2015, committed to a comprehensive NOAC risk minimisation strategy. The strategy targeted all points of care to address the various safety concerns with these medicines in response to their increasing use.

## HOW WAS IT DONE?

# 3

Introduction of this comprehensive pharmacist-led suite of activities required:

- Collaboration and communication with our nursing and medical colleagues in the hospital.
- Data collection and analysis
- Evidence based analysis of NOAC use and recommendations.

## WHAT HAS BEEN ACHIEVED

# 4

Knowledge and awareness of NOAC therapy has improved significantly among clinical staff and this has been reflected in reductions in NOAC medication variances.

The on-going safe use of this high risk group of medicines is of paramount importance in order to minimise patient risk with these agents and thus the work continues.

## WHAT NEXT?

# 5

The appropriateness of NOAC prescribing will continue to be assessed through the medication variance reporting process and a follow-up PPS will be completed. Rationalisation of NOAC therapies will be considered through the formulary process and the education of staff and patients will remain a priority.

The NOAC safety innovations developed by the MMUH PD will be shared with the members of the Irish Medication Safety Network to promote shared learning and experience nationally.



Figure 3: Clinical Checklist Algorithm



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## REFERENCES:

1. EHRA Practical Guide on the Use of New Oral Anticoagulants in patients with non-valvular AF: executive summary. European Heart Journal 2013; Vol 34, issue 7
2. HSE Medicines Management Programme. Oral Anticoagulants for Stroke Prevention in non-valvular atrial fibrillation. June 2015

## DISCLOSURE: None

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