

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 lead 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.

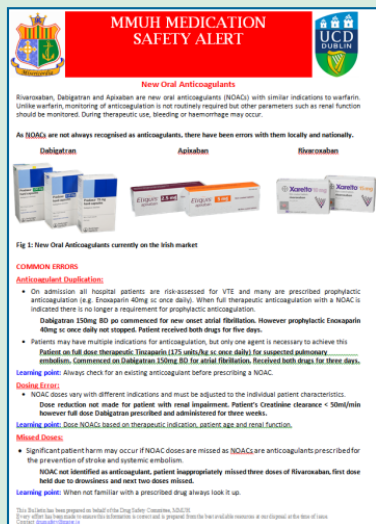


Figure 1: Medication Safety Alert

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.

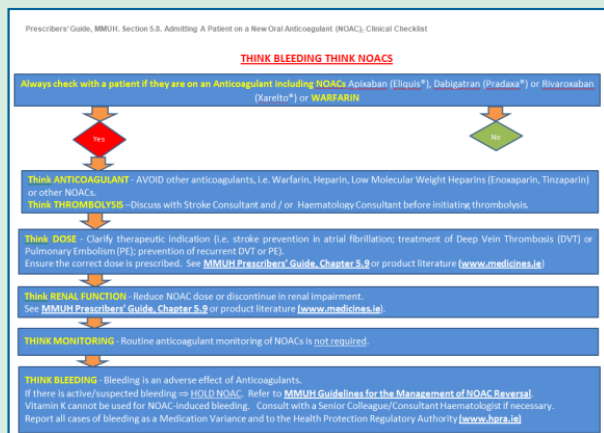


Figure 3: Clinical Checklist Algorithm



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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

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