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

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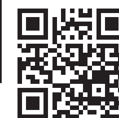


More information?

INTRODUCTION

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**.

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)*

   obtained from the hospital information systems → *processed via* Excel

2. we **surveyed** doctors and trainees working in our hospital
   - *multiple choice questions inquiring into their experiences*

   via Google Forms → Excel

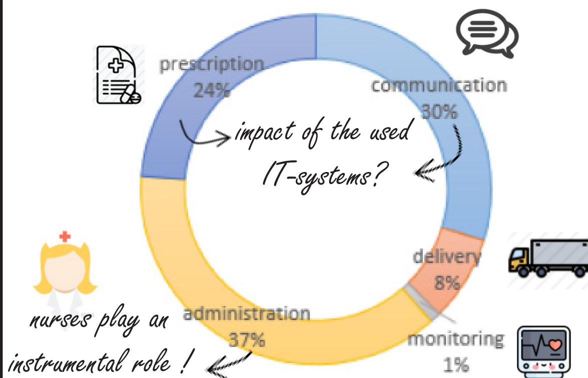
RESULTS

1 retrospective data analysis

incident reports (n=172)

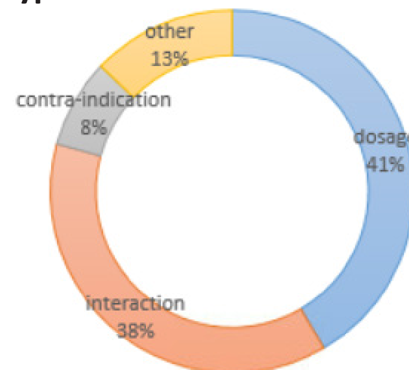
- most incidents
  - were related to LMWH* *(45%)*
  - took place in a surgery ward *(37%)*
  - could be linked to a transfer to another ward or operating theater *(35%)*

  ** low molecular-weight heparine*
- **type of problem?**



recommendations (n=132)

- most attention was paid to DOAC's (29%)
  → *although only 15% of registered usage (AC+AA)*
- patients on a temporary ward!
  → *relatively high number (11%)*
- **type of advice?**



2 survey

- n=74 < 21 disciplines
- 65% deals daily with AC
- **highlights?**
  - *non-prescribing of therapy was considered to be the main problem (49%), followed by incorrect dosing (42%)*
  - *only 23% agree that the patient receives sufficient information on paper*
  - *only 24% 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*
  - *additional monitoring by a clinical pharmacist would be considered an added value by 88% of the doctors*

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.