PostScript Safety

NHS Greater Glasgow and Clyde

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Warfarin Safety: Do you know?

That all adult patients on warfarin MUST be referred to the Glasgow and Clyde Anticoagulant Service (GCAS) on discharge from hospital? This applies even if the patient was admitted on warfarin or even if they are stable on discharge. Failure to ensure warfarin patients are appropriately followed up and monitored post discharge compromises patient safety with potentially serious consequences.

In 2010, 216/328 anticoagulation incidents (66%) reported on Datix involved failure to ensure that the appropriate follow up and monitoring arrangements were in place.

Prior to discharge, ward staff must ensure that:

- Contact is made with GCAS to ensure an appropriate follow up appointment is in place
- The patient knows exactly what dose they should be taking until their next GCAS appointment
- Each patient is given a yellow anticoagulant booklet
- The booklet is completed with at least the last 3 warfarin doses and INR results
- Fax/send a copy of the GCAS anticoagulant monitoring and clinic referral form to the GCAS service
- For further information, please refer to the Therapeutics Handbook

This is an important patient safety issue.

Contacts

For guidance and advice on reporting medicines incidents contact your Clinical Risk Manager or Pharmacist.

Comments and suggestions for future editions are welcome and we would also love to hear from you if you have any examples of good practice that you would like to share.

Please email:catherine.mclaughlin@ggc.scot.nhs.uk

DATIX…

Thank you to all staff who report incidents on DATIX. Here are a few reminders to get the best out of reporting.

Reporters

- Anyone involved in the incident can report it
- Keep the description of the incident brief and stick to the facts
- Avoid patient and staff names in the descriptor field

Reviewers

- Do not reject the incident if you think it has come to you in error. Either add an appropriate investigator or send feedback to Elaine.mcnish@ggc.scot.nhs.uk
- Please ensure coding is appropriate and that the descriptor field is concise and accurate
- Consider who else to notify within your own or other department
- Consider if there is a specific learning point that should be shared across the organisation
- Provide feedback to the reporter
- Record completion of the review on DATIX

The number of incidents in the holding bay (where incidents awaiting review sit) is increasing, therefore, please review incidents in a timely fashion.

Caution: Concentrated Liquids

Always check the strength on the medicine label! This is important for all medicines but particularly for medicines such as opiates. Recent incidents have resulted in significant overdoses and harm to patients when standard and concentrated strengths of opiates have been confused.

The following opiates are available in more than one strength (please note this list is not exhaustive):

Drug	Standard strength	Concentrated strength
Morphine	2mg/ml	20mg/ml
Oxycodone	1mg/ml	10mg/ml
Methadone[1]	1mg/ml	10mg/ml

[1]also available as 5mg/ml and 20mg/ml strengths

In the unusual situation where a concentrated solution of any of the 3 drugs above is required please:

- Discuss the prescription with a member of pharmacy, Addiction Liaison, Palliative Care or other relevant specialty
- Clearly state on the Kardex the form, strength and dose in milligrams. See example below

Oral and Other Drugs: Regular Prescription

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

H	DRUG: METHADONE ORAL SOLUTION 1MG/ML		
DOSE: 20MG	ROUTE: ORAL	DATE: 07/10/10	STOPPED — DATE: / INITIALS:
PRESCRIBER (PRINT & SIGN): *A N Other* (A N OTHER)			
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE			
MONTH			
Other time			
0700-0900	√		
1200-1400			
1600-1800			
2200-2400			
Other time			

- Always carefully read the label and get a second check
- Enter it in a separate page of the CD register and highlight its use to all members of staff
- Store it separately from standard strength liquids in the CD cupboard and ask your pharmacist to return or destroy any unused stock as soon as possible
- On discharge, effectively communicate the strength of the liquid prescribed for the patient to the appropriate primary care practitioner
- Report any medication incidents, including near-misses, as soon as possible

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