The Regulation and Quality Improvement Authority

Evaluation of the Management of Warfarin in Nursing and Residential Care Homes

November 2015

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

Introduction

Anticoagulants are high-risk, high-alert medicines, and are one of the classes of medicines most frequently identified as causing preventable harm and admission to hospital. Anticoagulants have a heightened risk of causing significant patient harm when they are used in error, and require special safeguards to reduce the risk of error. Incidents that have resulted in harm, or near harm, to patients have been reported with both oral and parenteral anticoagulants.

In response to reports of patient safety incidents involving anticoagulants received from all sectors of NHS healthcare in England and Wales, the National Patient Safety Agency (NPSA) issued a patient safety alert, and a series of support materials, designed to help reduce the potential harm to patients prescribed this type of medication. The guidance applies to all healthcare sectors, including social care settings.

The Regulation and Quality Improvement Authority (RQIA) has, through the medicines management inspections programme, assessed the management of warfarin. It is the most commonly used anticoagulant in nursing and residential care homes, over the last cycle of inspections to nursing and residential care homes.

Inspection Outcomes

The statistics quoted relate to RQIA's inspection year 1 April 2014 – 31 March 2015.

	Number of Nursing Homes	Number of Residential Care Homes
Number of inspections	107	66
Number of occasions warfarin is prescribed	80	28
Satisfactory arrangements in place for warfarin	70 (87.5%)	22 (78.5%)
Improvements required as identified at most recent inspection	10 (12.5%)	6 (21.5%)
Previous requirement or recommendation addressed	15 out of 16	6 out of 6

The evidence from inspection indicates that in relation to the management of warfarin, safe practice has been embedded as routine practice in the majority of nursing homes and residential care homes. This has resulted in fewer requirements/recommendations during this inspection year. The evidence collated focused on:

- the availability of policies and procedures for warfarin
- written confirmation of warfarin regimes or alternative arrangements where a second member of staff is made available to witness/repeat back telephoned regimes

- the maintenance of a separate warfarin administration record
- a record of the daily stock balance of each strength of warfarin prescribed
- the involvement of a second member of trained staff to witness any transcribing

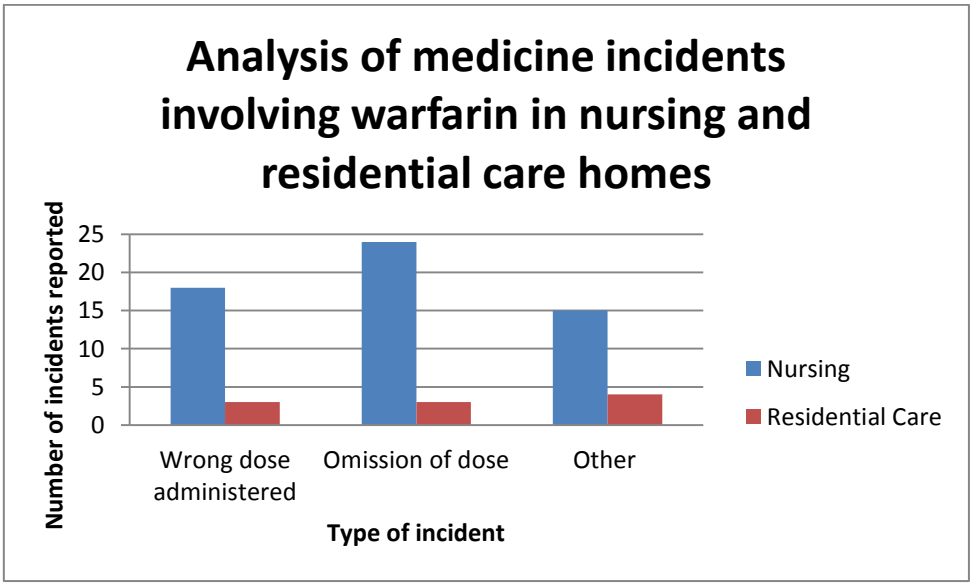
The good practice of ensuring that two trained staff were involved in the dispensing and administration of warfarin was acknowledged in those homes where this occurs.

Overall, 85% of nursing and residential care homes were managing warfarin in the required manner. Where a requirement or recommendation had been made in the previous inspection years, this had been addressed in 94% of nursing homes and 100% of residential care homes.

During this inspection year, 15% of nursing and residential care homes were identified as needing to improve the management of warfarin within the home, which resulted in a requirement or recommendation being made.

Notifications reported to RQIA involving warfarin

In excess of 2,300 medicine related incidents were reported to RQIA over the inspection year. Sixty seven notifications were received from nursing and residential care homes in relation to the management of warfarin. Ten nursing homes reported more than one incident during the year. This was followed up by the relevant inspector to ensure that any learning was identified and addressed.



Conclusion

While RQIA inspection activity has identified improvement in practice, in the management of warfarin, incidents continue to be reported. The challenge for management and staff is to ensure that the learning identified from inspection activity, incidents, and the availability of guidance is embedded into practice. This is of particular importance, given the potential consequences of any errors in prescribing or administration.

RQIA has produced guidance, based on the available national guidance to aid the development of robust policies and procedures. This should be embedded into practice. Registered providers should ensure that any incident involving these medicines is investigated thoroughly to establish the root cause. The learning should be identified and shared with all relevant staff to ensure that incidents are kept to a minimum.

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GOOD PRACTICE GUIDANCE REGARDING WARFARIN (AND OTHER ANTICOAGULANTS) IN NURSING AND RESIDENTIAL CARE HOMES

1. Written policies and procedures for the safe management of anticoagulants are in place and readily available for staff reference.

2. All designated members of staff are trained and deemed competent in the management of warfarin and other anticoagulants.

3. Ensure all members of staff are familiar with NPSA Alert - NPSA/2007/18, March 2007 as per link, for anticoagulants and associated information.

   www.npsa.nhs.uk/patientsafety/alerts/anticoagulant

4. A specific care plan in relation to warfarin is maintained for each patient/resident.

5. Written confirmation of warfarin regimes is obtained and located in an appropriate place for reference at administration.

6. Obsolete records of warfarin regimes are discontinued and securely archived.

7. A separate warfarin administration record is maintained.

8. Any transcribing of warfarin regimes on the separate administration record should involve two trained members of staff and the entry should be signed by both staff. The second member of staff checking and signing the record should be trained and deemed competent to do so, and should be aware of the responsibility he/she is undertaking.

9. Where possible, two trained members of staff should administer and witness each dose.

10. The least number of tablets required to provide the specific dose of warfarin should be administered to the patient/resident.

11. A record of the daily stock balance of supplies of warfarin and other anticoagulants should be maintained. This should include injections and the new anticoagulant medicines that do not require frequent blood monitoring.

12. The date of opening should be recorded on warfarin containers and other anticoagulant medicines to facilitate audit.

13. Warfarin should be administered from original packs and should not be included in monitored dosage medicine systems.

14. The date of the next INR (International Normalised Ratio) blood test and collection of results must be clearly recorded and communicated.

15. The management of anticoagulant medicines should be included in the audit process on a regular basis.

Further guidance is available from the Health and Social Care Board at:

http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/Anticoagulants/002%20HSCB%20Safe%20use%20of%20warfarin%20in%20primary%20care%20guideline%20v%202%200%20January%202014.pdf

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WARFARIN ADMINISTRATION RECORD

PATIENT'S NAME:		
D.O.B:	Room No:	GP:

Regime	Mon	Tues	Wed	Thur	Fri	Sat	Sun

Staff signatures			Date:

Date of next INR:

DAY	DATE	TIME	DOSE GIVEN	GIVEN BY (Signature)	GIVEN BY (Signature)	STOCK BALANCE 1mg	STOCK BALANCE 3mg

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