

# Did you know?

## Heparin and anticoagulants



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Heparin and anticoagulants stand as the 'H' in 'A-PINCH', an acronym adopted by the World Health Organization (WHO) to recognise particularly high-risk medicines<sup>1</sup>.

From 1 April 2015 until 31 March 2020 NHS Resolution received 373 claims relating to heparin and anticoagulant medication errors.

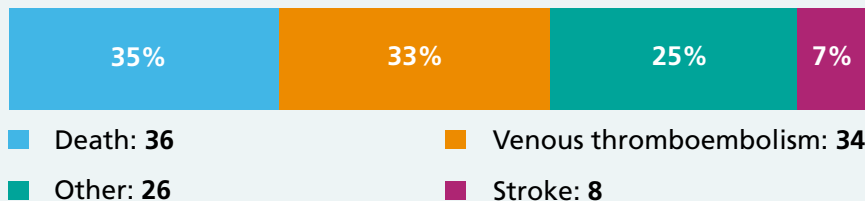
Out of these 373 claims, **104** were settled with damages paid, **114** without merit and **155** remain open. The total cost of closed claims is **£8,189,129**. This includes payments for claimant legal costs, NHS legal costs and damages although the cost will be higher when we factor in costs associated with periodical payments.

The analysis held within this leaflet only focuses on closed claims that have settled with damages paid and concern an element of the medication process: prescribing, transcribing, dispensing, administering and monitoring.

### Key facts

Heparin and anticoagulant claims result in significant patient harm.

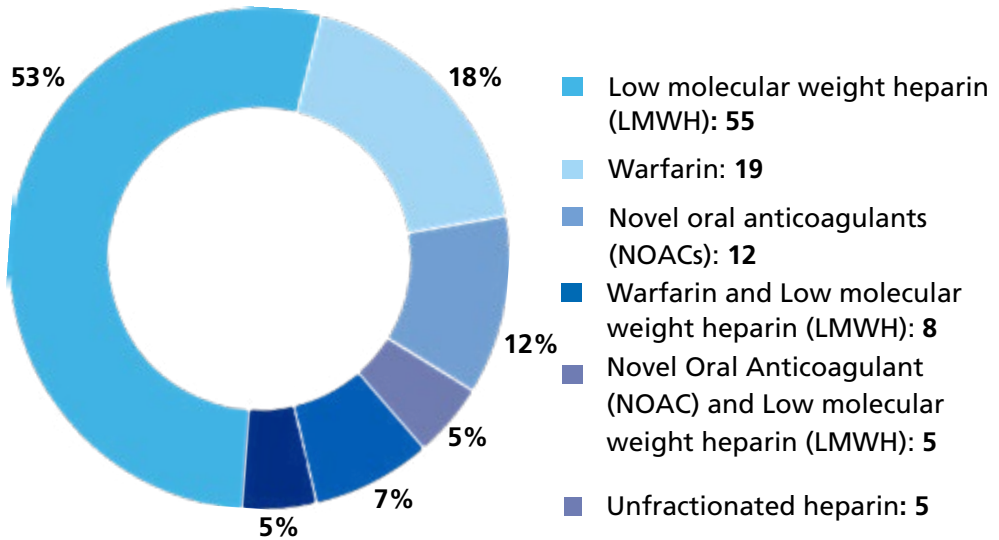
#### Types of patient harm identified within heparin and anticoagulant claims



Heparin and anticoagulant claims are most commonly seen in the specialities of orthopaedic surgery, general medicine, general surgery, cardiology and emergency medicine.

<sup>1</sup> <https://www.who.int/bulletin/volumes/95/8/17-198002.pdf>

## Which types of heparin and anticoagulant result in the most claims?



**Did you know?** Key causes for low molecular weight heparin (LMWH) medication error claims:

- Incorrect dose or course length was prescribed
- Delay or an omission with unknown reason
- Failure to ensure a sufficient course of LMWH was supplied at discharge from hospital

**Did you know?** Key causes for warfarin medication error claims:

- Failure to stop or reverse warfarin when indicated
- Failure to provide bridging therapy when warfarin was stopped pre-procedure
- Failure to restart warfarin post-procedure
- Stopping warfarin when not indicated
- The wrong drug had been given to the patient

**Did you know?** Key causes for novel oral anticoagulant (NOAC) medication error claims:

- Failure to stop the NOAC when indicated
- Delay or an omission with unknown reason
- Stopping a NOAC when not indicated

## What can you do?

- Ensure protocols concerning the prevention of venous thromboembolism (VTE) in patients include LMWH dose calculations and course lengths
- Communicate the importance of ensuring the timely prescription of LMWH where risk assessments have identified it is indicated
- Communicate the importance of avoiding delays in the administration of LMWH
- Ensure robust policies and procedures exist around pre and post-operative management of anticoagulated patients including bridging therapy
- Ensure protocols are in place which detail when anticoagulant reversal is indicated / should be considered
- Ensure that anticoagulant treatment plans are effectively and accurately communicated to providers of primary care