

Anticoagulation Stewardship

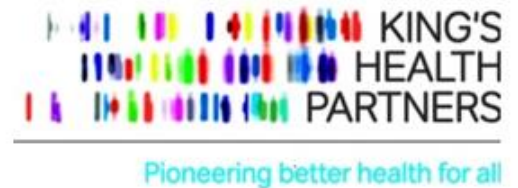
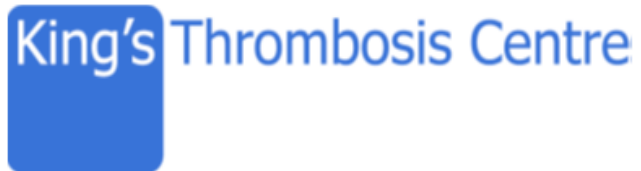
What it is, and what can we do in the UK?

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30/10/24



Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use

NICE guideline [NG151] Published 16 August 2023



Department
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Treatment summaries

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[NICE](#) > [BNF](#) > [Medicines guidance](#) > Antimicrobial stewardship

▼ BNF

Guidance Antimicrobial stewardship

Antimicrobial

Medicines guidance

Overview

On this page

Antimicrobial stewardship competency framework

Updated 16 August 2023

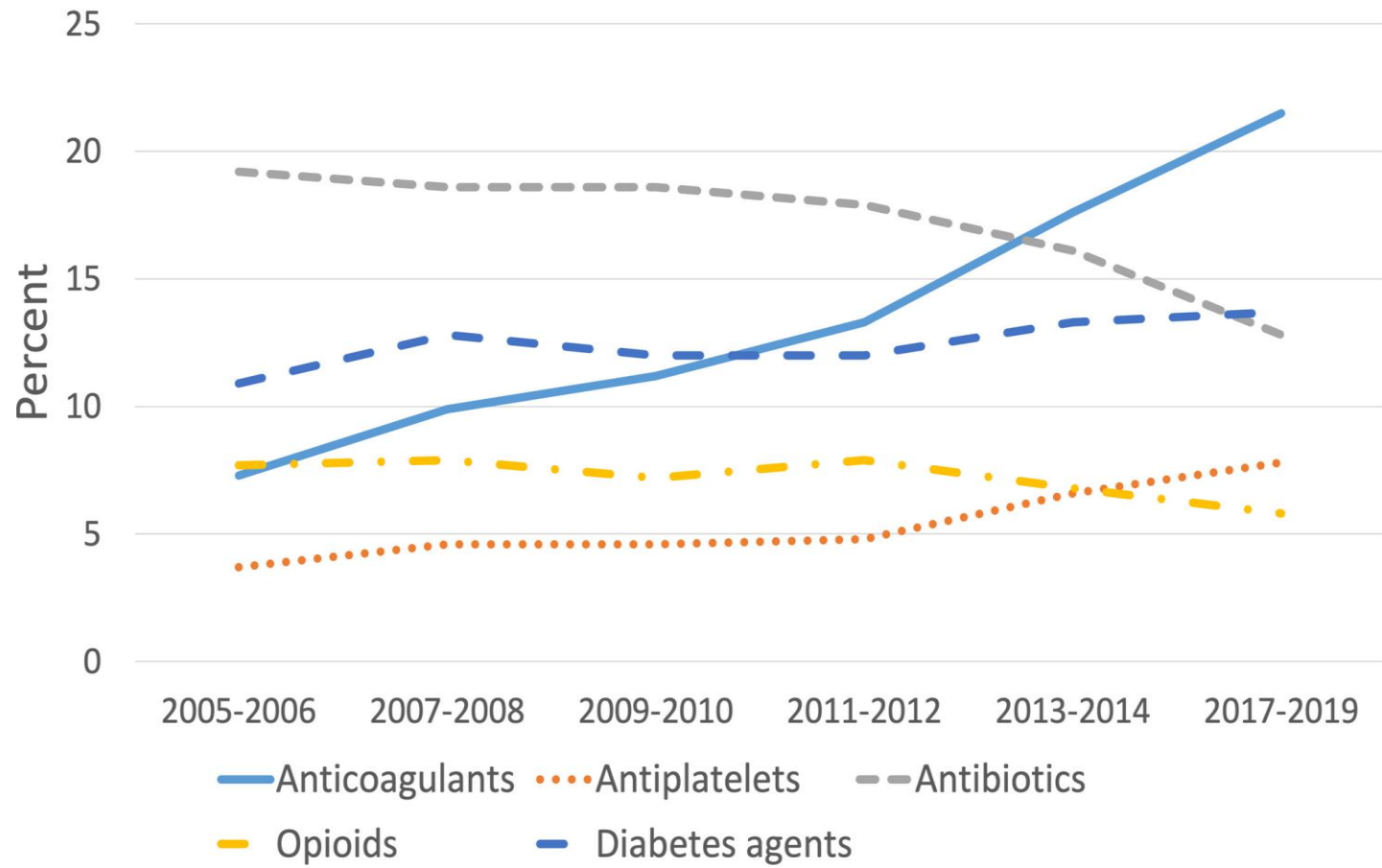
Update information

This guideline includes recommendations on:

- [antimicrobial stewardship programmes](#)
- [antimicrobial prescribing](#)
- [introducing new antimicrobials](#)

and front-line
implementation

National Estimates of US Emergency Department Visits for Adverse Drug Events



Research and Practice in Thrombosis and Haemostasis, Volume: 6, Issue: 5, First published: 17 July 2022, DOI: (10.1002/rth2.12757)

Anticoagulation Stewardship


Definition:

A co-ordinated, efficient and sustainable initiative designed to achieve optimal anticoagulant-related healthcare outcomes and minimise avoidable adverse drug reactions

National Quality Forum (NQF) Advancing Anticoagulation Stewardship: A Playbook. Washington DC: NQF; 2022

 King's Thrombosis Centre

 **VTE Exemplar Centres**
Providing leadership in thrombosis care

 KING'S
HEALTH
PARTNERS

Pioneering better health for all

Coordinated National Approach to Anticoagulation Safety in the United States

Led by Anticoagulation forum (Specialist Pharmacists) + National Quality forum (Not for profit organisation)

Produced an anticoagulation stewardship *playbook*

7 core principles to support implementation of anticoagulation stewardship practice across the healthcare system

Anticoagulation Stewardship Success in the US

Fewer bleeding events

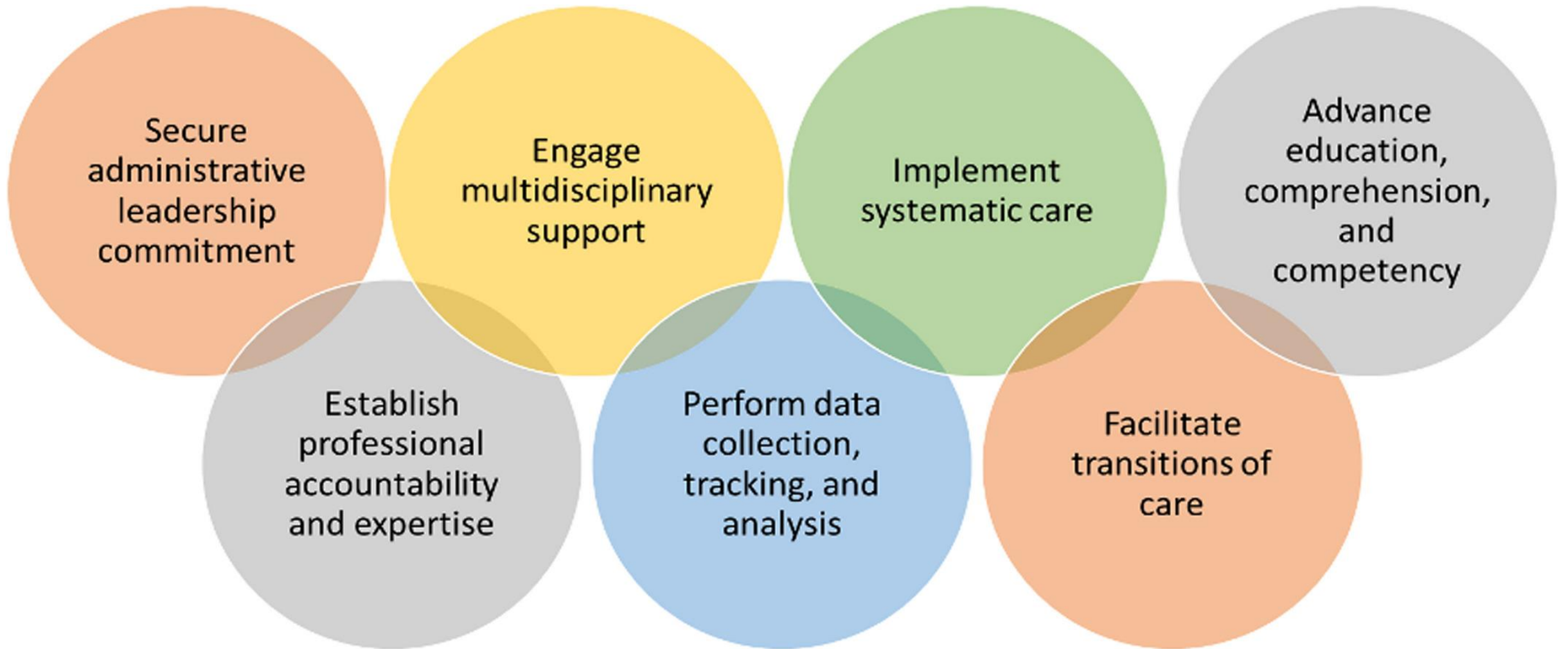
Fewer drug-drug interactions

Fewer hospital readmissions

Reduced length of stay

Reduced hospital related costs

Anticoagulation Stewardship (7 core elements)



Secure Administrative Leadership Commitment



What does this mean?

- Buy in from senior leadership
- Partnership with medication safety

What we do now

- Anticoagulation safety group – reports to med safety committee
- Representation on ICB cardiovascular medicine working group

Next steps

- ICB anticoagulation lead
- Anticoagulation pharmacist (or other HCP in secondary care)

Engage Multidisciplinary Support



What does this mean?

- Input from diverse specialists and disciplines across the system

What we do now

- Anticoagulation MDT ward round
- Provide a specialist resource for primary care (Advice + Guidance)

Next steps?

- Open communication channels to specialists for ALL member of the MDT.
- Hub and spoke models for anticoagulation specialist support

Implement systematic care



What does this mean?

- Creation of anticoagulation-related policies, procedures and order sets
- Establish clinical decision making support and risk assessment tools
- Promote protocols and guidelines for initiating and maintaining anticoagulation

What we do now

- Accessible guidelines for patient management (for primary and secondary care)

Next steps?

- Ensure guidelines are available and all stakeholders can access and input (including primary care)

Advance education, comprehension and competency



What does this mean?

- Healthcare professionals all have required knowledge and skills
- Patients – tailored information for all reading levels and languages

What we do now

- Various teaching (FY1, pharmacy team, practice pharmacists)
- Local PILs for DOACs – more digestible

Next steps?

- UKCPA/RPS advanced pharmacist anticoagulation curriculum and credentialing assessment – across the system (not just secondary care)
- Mandatory training – eg. An annual anticoagulation update
- Standard national patient information, in accessible formats

Facilitate transitions of care



What does this mean?

- Effective anticoagulation-related care transitions
- Clear and timely communication across the system
- Clearly defined roles

What we do now

- Discharge guideline
- Specialist initiation
- Dedicated anticoagulation follow up
- Patient Safety Incident Response Framework

What next?

- A point of contact (patients and HCPs)
- Review communication channels for stopping and restarting anticoagulation
- Simple way to report incidents between care settings

Perform data collection, tracking and analysis



What does this mean?

- Allocate time and resources to collecting and analysing data
- To identify areas for improvement
- Use to advocate for resources

What we do now

- Varies as no set standards
- Local audit – e.g. TTR

What next?

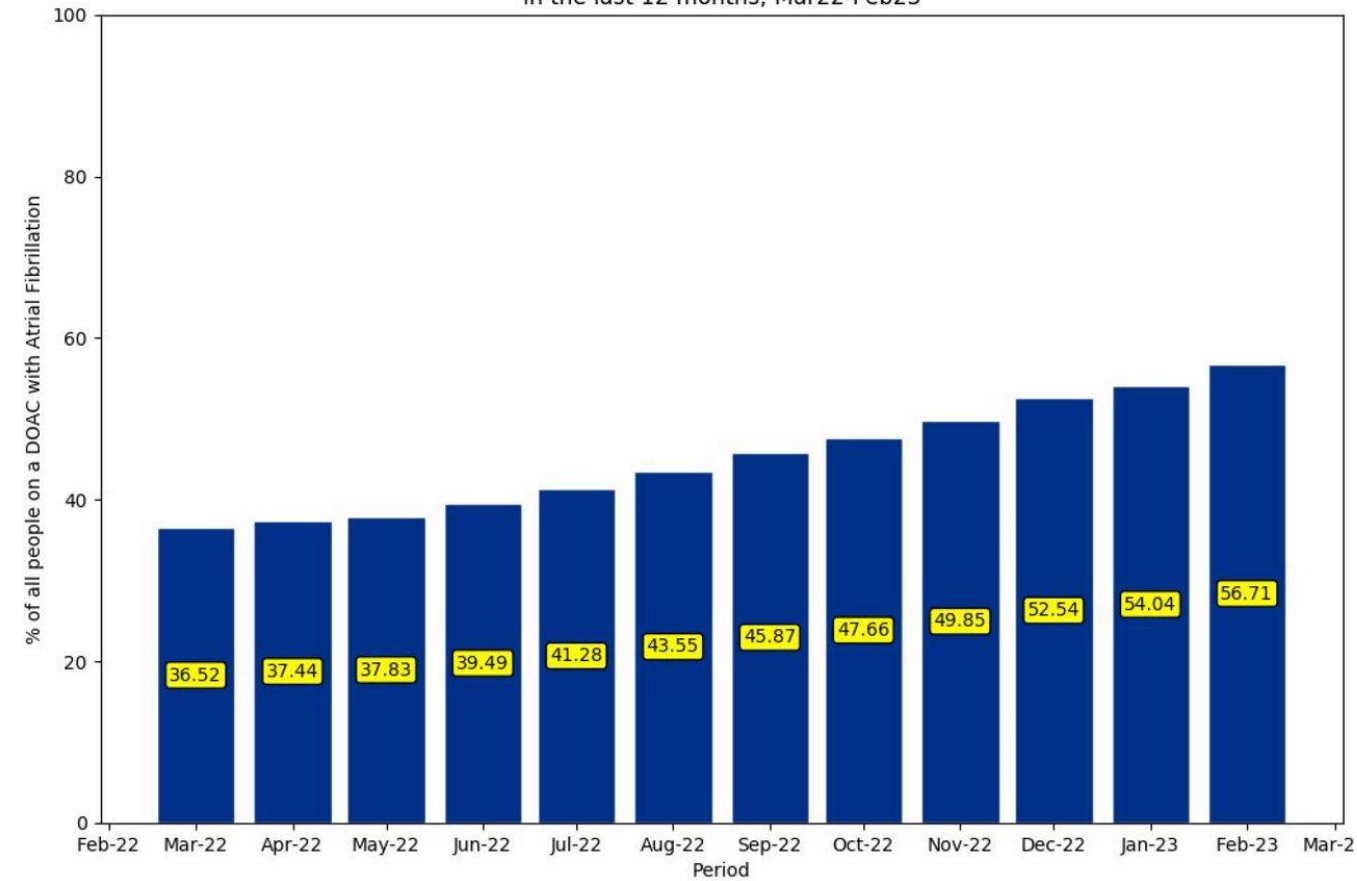
- Standard metrics for warfarin clinics and anywhere prescribing DOACs.
- Renal function/weight – DOACs

**Monitoring of DOACs now sits,
mostly in primary care.**

**It is a lot of work, could we use
routinely collected data to target
interventions?**

DOAC prescribing in England

% of people prescribed a DOAC with Atrial Fibrillation and Cr/Cl recorded in the last 12 months; Mar22-Feb23



Clinical coding for AF, CrCL and weight is improving for patients prescribed is improving.

But it isn't 100%

Is it that the monitoring isn't being done?

or that the activity isn't recorded

or maybe its recorded elsewhere?

DOAC prescribing in England

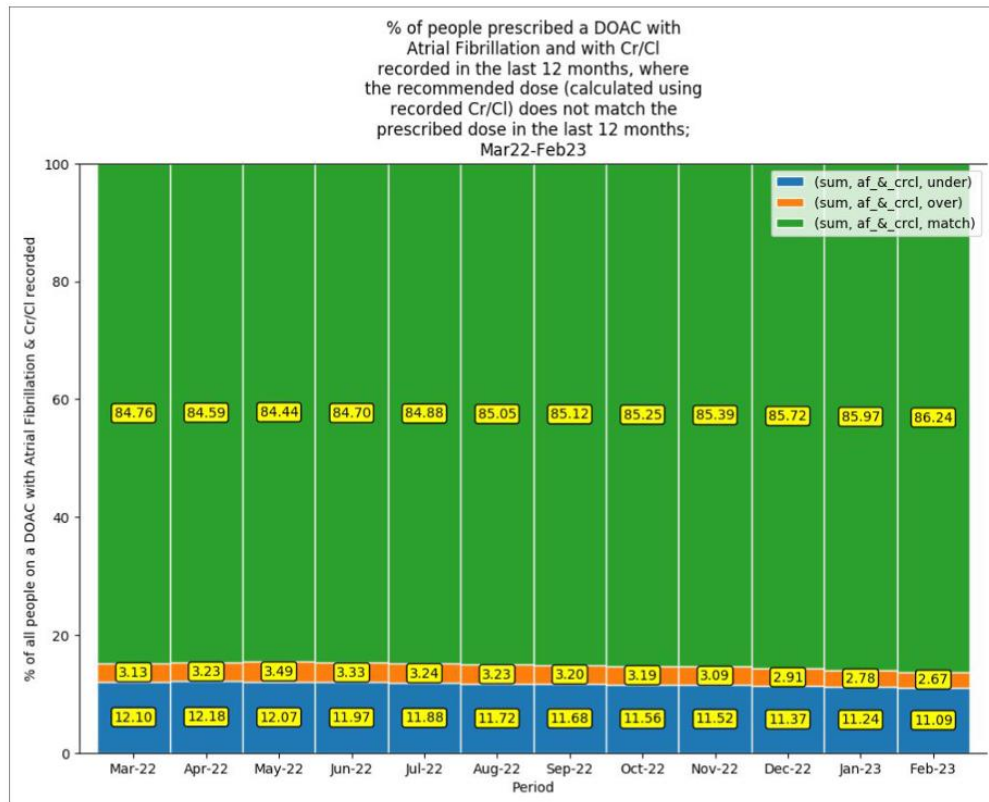


Figure 3 Percentage of people prescribed a DOAC with AF and with CrCl recorded in the past 12 months where the recommended dose (calculated using recorded CrCl) does not match the prescribed dose in the past 12 months; March 2022–February 2023. AF = atrial fibrillation. CrCl = creatinine clearance. DOAC = direct-acting oral anticoagulant. sum = total number of patients in which the AF and CrCl were recorded and the DOAC dose prescribed either matched, was an underdose or was an overdose compared to the DOAC dose calculated for their CrCl.

The good news is that 86.4% had the correct dose of DOAC based on renal function.

However...

13.8% received a non-recommended DOAC dose according to CrCl (

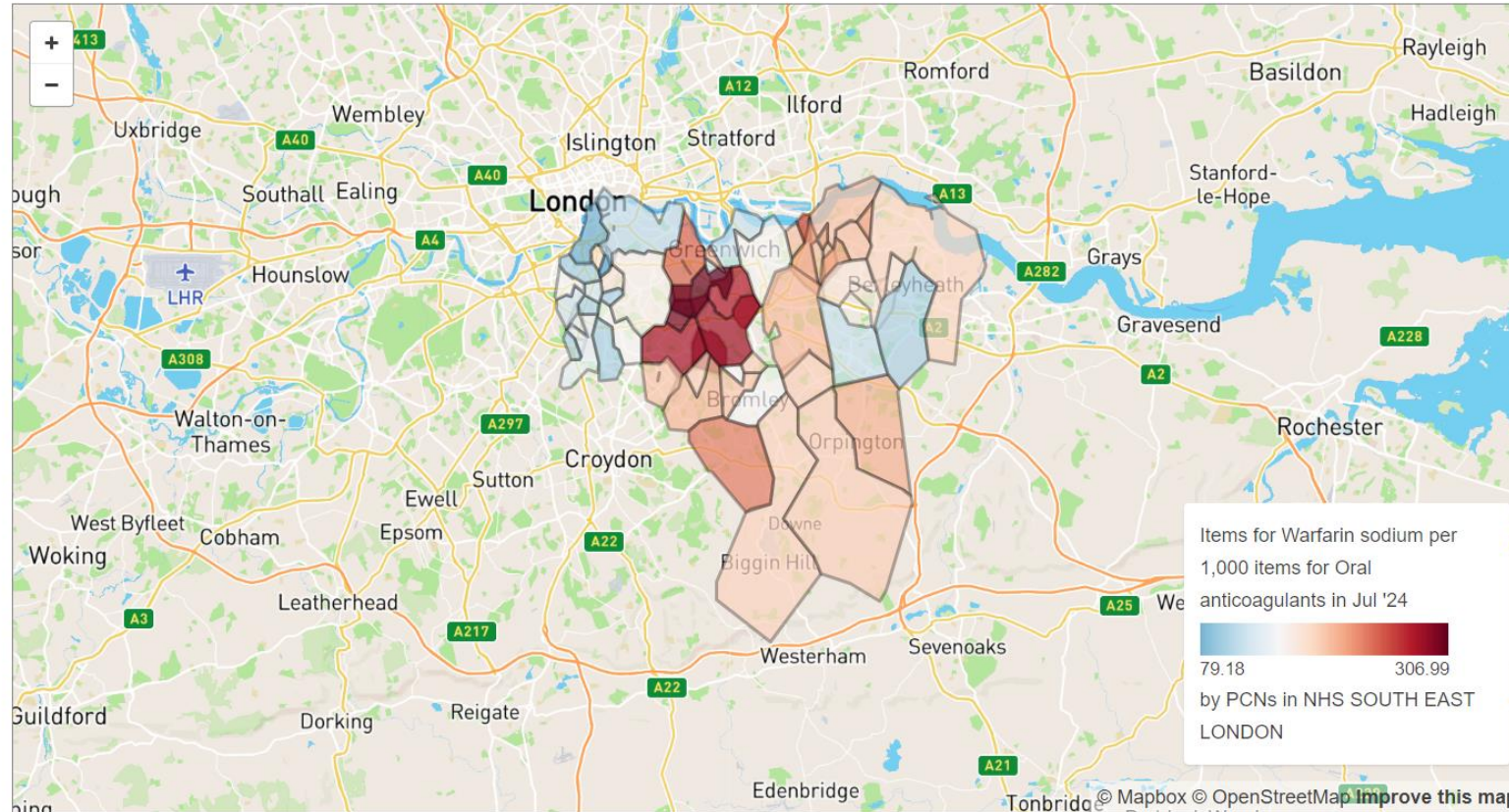
- 2.7% higher than recommended dose
- 11.1% a lower than recommended dose

Homan, Karen, et al. "Safety of direct-acting oral anticoagulant (DOAC) prescribing: OpenSAFELY-TPP analysis of 20.5 million adults' electronic health records." *BJGP open* (2024).

What can we do to reduce variation in anticoagulation prescribing?

Items for Warfarin sodium vs Oral anticoagulants by PCNs in NHS SOUTH EAST LONDON

in Jul '24



For clarity, practice graphs and maps only show standard GP practices, and exclude non-standard settings like prisons, out-of-hours services, etc. CCG boundaries from NHS England. Practice locations are approximate, based on postcode. Only practices with a known location are shown here. PCN boundaries are illustrative only.

Develop professional accountability and expertise

What does this mean?

- Program leader to oversee AS
- Responsible for outcomes
- Communicating results
- Identifying areas for improvement

What we do now

- Thrombosis committee
- Non medical prescribers

What next?

- Primary care – AC lead/specialist in each ICB?

In an ideal world we need...

Named responsible person

- Across primary and secondary care area
- Provide training
- Link to specialists
- Use routine data to measure activity (eg. best value prescribing)
- Responding to incidents (working with secondary care)
- Reporting activity to senior leadership



Three takeaways

- Anticoagulants are high risk drugs commonly prescribed across the system
- A nationally coordinated approach is needed for safe, evidence based and best value treatment with anticoagulants.
- Anticoagulation stewardship is the approach in the United States, and could be used in the UK.

Thank you for listening

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