High-Risk Medicine Standard: Anticoagulants
IMPLEMENTATION CHECKLIST

Last updated: 26 February 2024. **Printed copies are uncontrolled and should not be relied upon as up to date.**

Completion of this checklist is not mandatory. Health services may wish to use this tool to monitor compliance with the High-Risk Medicine Standard: Anticoagulants. For the most up to date standard, refer to the Anticoagulants webpage.

Facility name/LHD: _____ Assessed by: _____ Date: _____

Governance requirements

Adherence to the requirements specified in this standard is to be monitored by governance committees (for example, Drug and Therapeutics Committee) and service managers (including, but not limited to, Directors of Pharmacy and Nurse Unit Managers).

Governance requirements	**Requirement met**	**Requirement unmet**
1. Prescribing		
1.1. Before prescribing an anticoagulant, the prescriber is to determine if a female of childbearing age is pregnant or breastfeeding. If there is any doubt, a pregnancy test is to be ordered.		
1.2. Doses of anticoagulants are not to be omitted or delayed unless intended and documented clearly by the prescriber (for example, prior to surgery).		
1.3. Where a dose(s) of anticoagulant is to be omitted or the dosing schedule adjusted for a period of time (for example, for the duration of another course of medicine or therapy where there is known interaction or contraindication) the plan is to be clearly documented in the patient's health care record and the medication order withheld		
1.4. Treatment guidelines are to be referred to for recommended dosage and duration of therapy in relation to the indication for use. For example, the Clinical Excellence Commission Direct Oral Anticoagulant (DOAC) Guidelines.		

Governance requirements	Requirement met	Requirement unmet
1.5. The indication for anticoagulation and therapeutic targets, where appropriate, are to be documented in the health care record. The details are to include: • the anticoagulant name • dose and/or dose adjustments • intended duration of therapy, timeframe for review • whether anticoagulation is newly initiated or a continuation of previous therapy.		
1.6. When assessing VTE risk, the prescriber is to ascertain if the patient is already receiving any other anticoagulant medicines.		
1.7. A VTE risk assessment tool is to be used to reassess the patient's VTE risk regularly, particularly when there are any changes to clinical condition or mobility status, unplanned delays to surgery or increases in length of stay. VTE prophylaxis is to be monitored and doses adjusted accordingly.		
1.8. Where electronic Medication Management (eMM) systems are in use, anticoagulant prescribing is to be in accordance with local eMM guidelines.		
1.9. Where National Inpatient Medication Charts (NIMC) are in use, any dedicated sections for warfarin, VTE prophylaxis and regular medicines are to be used for anticoagulant medicine prescribing according to the Australian Commission on Safety and Quality in Health Care National Inpatient Medication Chart (NIMC) – User Guide.		
1.10. In adult patients, renal function is to be calculated to aid selection of the correct dose for renally excreted anticoagulants.		
1.11. Where patients are intentionally prescribed multiple anticoagulants for bridging therapy, the reason is to be clearly documented in the patient's health care record.		
2. Storage and supply		
2.1. Where unfractionated heparin solutions are required, commercially prepared pre-mixed solutions are to be used wherever possible.		
2.2. Where ampoules of concentrated unfractionated heparin injection are available as imprest stock, the strength should not exceed 5000 units per unit dose.		

Governance requirements	Requirement met	Requirement unmet
2.3. Where multiple concentrations are available, for example heparin 5000 units in 0.2 mL and 5000 units in 5 mL, they are to be physically separated and clearly distinguishable to prevent inadvertent selection errors.		
3. Administration		
3.1. An independent second person check is required for administration of oral (warfarin, apixaban, rivaroxaban and dabigatran) and parenteral (dalteparin, danaparoid, enoxaparin, heparin, nadroparin, bivalirudin and fondaparinux) anticoagulants. The second person check processes are outlined in the NSW Health Policy *Medication Handling* (PD2022_032) including circumstances where a second person check is not mandated (for example, when a medicine is administered by an authorised prescriber).		
3.2. Where patients have difficulty swallowing or are on enteral feeding tubes, ability to crush or disperse the tablet, or open the capsule, is to be determined prior to administration of oral anticoagulants.		
4. Patient monitoring		
4.1. Instructions for monitoring patients at higher risk of bleeding is to be recorded in the patient health care record. For example, laboratory tests, clinical observation requirements and actions to be taken. Clinicians are to refer to local guidance on the management of bleeding.		
4.2. Patients on anticoagulants who fall are at an increased risk of bleeding and serious trauma including brain injury and will require close observation and monitoring according to local guidelines.		
5. Medication review		
5.1. Where possible, all patients receiving an anticoagulant medicine are to have a medication review within 24 hours of admission (if continuation of existing therapy) or within 24 hours of initiation (if commenced as a new medication).		
6. Patient information/education		
6.1. Patients and/or their carer who are discharged home on anticoagulant therapy are to receive confirmation of their current anticoagulation regimen at the time of discharge. If patients have been initiated on new anticoagulation therapy, the patients and/or their carer are to be provided with verbal and written information on their medication.		

Governance requirements	Requirement met	Requirement unmet
6.2. Information and education are to address: • name, dose and frequency of prescribed anticoagulant • intended duration of therapy and timeframe for medical review • how to identify signs of bleeding, who to contact and actions to be taken • what to do in the case of a missed dose • instructions for any laboratory testing and review • any medication or food interactions and other lifestyle factors that may influence therapy • any specific storage and administration instructions.		
6.3. Patients and/or carers are to be given the opportunity to discuss anticoagulant therapy with a health practitioner.		
6.4. Patients on warfarin are to be provided with either a warfarin booklet for tracking warfarin therapy and results, or an update to an existing warfarin book to record INR results during their hospital stay.		
6.5. Provision of anticoagulant education is to be documented in the health care record.		
6.6. Professional Health Care Interpreters are to be utilised for patients and/or carers who are not fluent in English or who have hearing or visual impairments.		
7. Staff education		
7.1. Local protocols are to address any specific training, qualifications, skills or competencies required to prescribe or administer anticoagulants.		
7.2. Clinicians (where relevant to their scope of practice) are to receive education on the safe use of anticoagulants when working in clinical areas where anticoagulants are used. The Health Education and Training Institute eLearning module 'Safe Use of Anticoagulants' (Course code: 237965997) is available for this purpose.		

Action Plan				
Unmet requirement	*Reason/comment(s)*	*Proposed steps to meet requirement*	*Timeframe*	*Person responsible*