NYSPFP ADVERSE DRUG EVENT REDUCTION INITIATIVE
TEAM ACTION PLANNING WORKSHEET FOR ANTICOAGULANTS

The following practice recommendations checklist, developed by NYSPFP in partnership with the Institute for Safe Medication Practices (ISMP), provides anticoagulant-related process improvement strategies for consideration as hospitals work to reduce adverse drug events.

PRACTICE RECOMMENDATIONS	CHECKLIST OF HOSPITAL'S IMPLEMENTATION STATUS			ACTION PLAN/NEXT STEPS
Practice Recommendations for Anticoagulants	FULLY	PARTIALLY	NONE	List specific activities your team will try to accomplish to fully implement each practice recommendation. Include a detailed plan (what, who, how, and starting when) in your notes.
Appropriate baseline laboratory values (H&H, serum creatinine, or platelet count) are obtained prior to the initiation of anticoagulant therapy.				
A baseline INR is obtained on all patients admitted on warfarin therapy.				
An actual metric weight is obtained for patients on continuous heparin therapy.				
Patients on warfarin have an order for daily INR monitoring.				
A baseline assessment of the patient's medical history and risk factors (e.g., history of trauma, HIT, prior anticoagulant use) is performed prior to prescribing anticoagulant therapy.				
Disease specific protocols (DVT, AF, PE) are readily available and used to provide appropriate and safe anticoagulant therapy.				

TEAM ACTION PLANNING WORKSHEET FOR ANTICOAGULANTS (continued)

PRACTICE RECOMMENDATIONS	CHECKLIST OF HOSPITAL'S IMPLEMENTATION STATUS			ACTION PLAN/NEXT STEPS
Practice Recommendations for Anticoagulants	FULLY	PARTIALLY	NONE	List specific activities your team will try to accomplish to fully implement each practice recommendation. Include a detailed plan (what, who, how, and starting when) in your notes.
Standardized heparin protocols are available and used.				
Establish protocols for standardized rapid (emergency) reversal of anticoagulation.				
Standard weight based protocols and order sets avoid the use of "u" to indicate "units" of heparin.				
Computerized prescriber order entry (CPOE) and pharmacy information systems alert providers to duplicate anticoagulant therapy and serious drug interactions/contraindications.				
Heparin flush, when necessary, is available in prefilled syringes.				
Concentrated heparin vials (e.g., 10,000 units/mL or 20,000 units/mL) are not available in automated dispensing cabinets (ADC) or unit stock.				
Continuous heparin infusions are administered using a smart infusion device which includes dose error reduction software.				
Independent double check for IV heparin therapy occurs prior to administration, at each rate change, and with each infusion bag change.				
Discharge counseling for patients on anticoagulants is provided by a pharmacist.				
Written materials on the risks of therapy and signs of toxicity are provided at the time of discharge.				
Laboratory results (aPTT) are available in 2 hours or less for patients on continuous heparin therapy.				