Anticoagulation management review in primary care

Implementing NICE quality standards for AF

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Introduction

- Patient are often on long-term anticoagulant management if they are at risk of stoke due to Atrial fibrillation (AF) or have had prior deep vein thrombosis (DVT) or Pulmonary embolism (PE).[1]
- Warfarin and other vitamin K antagonist are effective treatment options but their narrow therapeutic range, [1] food and drug interactions and frequent monitoring and risk bleeding reduces their efficiency leaving patients open to stroke, [1] DVT and PE risks. [1]
- The NOAC (new oral anticoagulants) are now present and licensed on the market as alternative to Vitamin K antagonist (VKA). [1]
- NICE recommends NOAC as alternative treatment option for patients whom cannot be stabilised on VKA. [1]
- This is signified by therapeutic time range (TTR) less than 65% despite adequate adherence thus indicating suboptimal control. [1]
- Patients must be actively involved with their clinician in decision making about their anticoagulant treatment options and agree the therapy that is best for them. [1]

Aims & objectives

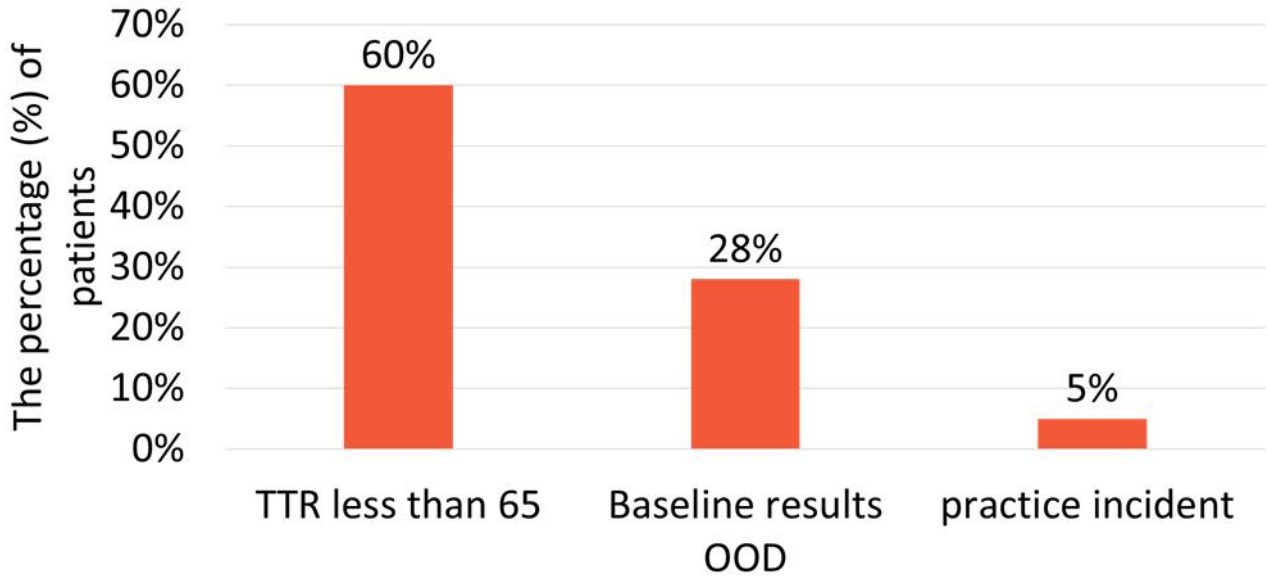
- ***Aim:***
  - To identify and review patients with poor anticoagulation management on VKA (warfarin) and to establish patients on suitable alternative treatment options (NOACS)
- ***Objectives:***
  - To identify the number of patients with time TTR less than 65%
  - To Identify the number of patients whom, baseline bloods are out of date on the system (more than a year old)

Methodology

- A Emis report was generated to identify the patients currently on warfarin
- The search criteria used was: 'current drug course issues', 'warfarin', 'Aspirin', 'AF', 'DVT' and 'PE'
- Each patients HASBLED and annual TTR score per visit was calculated and $CHAD_2SVASc$ score where appropriate
- Patients with poor control classed as having a TTR<65%, the clinical profile was assessed and suitable NOAC assigned based on discussion with the GP
- Patients had face-to-face consultation with the pharmacist where the risk-benefit of sub-optimal anticoagulation control was highlighted to the patient and the option to switch to NOAC was provided
- If the patient had consented to switching the warfarin to NOAC, the practice pharmacist counselled the patient and gave appropriate instructions to switching to a NOAC
- Anti-coagulant clinic instructed the patient to omit warfarin for x days, then the INR was re-tested once it was below 2 the warfarin was stopped and the NOAC was started [1]
- The practice pharmacist followed-up patients at 2weeks, 3,6 and 9 [1] months as a safety net

Results

- ***Figure 1. A graph showing the % of patients whose TTR < 65%, the % of patient whom baseline result were out of date (OOD) on the system and the percentage of practice incidence that occurred.***



Results

- ***Table 1. Summarises the outcome of patients with TTR less than 65%.***

Objective criteria	Percentage of patients (n=)
Total number of patients identified with TTR less than 65%	60% (17/28)
Patients changed to NOAC	47%(8/17)
Patients wished to remain on warfarin	17% (3/17)
Patients not suitable for NOAC conversion due to social or learning difficulties	17% (3/17)
Patients re-tested for AF found to be no longer in AF	5% (1/17)
Patients that did not respond to invitation to anticoagulant review	11% (2/17)

Conclusions

- The audit reveals 60% (17/28) of patients had a TTR less than 65% potentially putting patients at risk of AF, DVT & PE
- Despite annual routine check-ups 28% (8/28) of patient's baseline results of haemoglobin, platelets, U&Es and LFTs were out of date (OOD) on the system.
- The audit also revealed one significant event where a patient was issued warfarin for 2 years with no monthly INR on the system
- The Audit revealed significant lapse of housekeeping system by the practice in this high-risk group patients.
- **ACTIONS:**
- **Fully endorse NHS PE, DVT, AF & stroke prevention agenda by achieving NICE quality standards on appropriate anticoagulation**

Recommendations

- Anti-coagulant clinic to provide monthly TTR for warfarin patients to identify poorly controlled patients along with the monthly INR reviews
- Practice to introduce ‘birth-month’ annual biochemical reviews to keep patients baseline data up to date.
- Warfarin repeat prescriptions not to be generated until admin staff have checked that recent INR is present.

References

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Any questions