Joint Commission issues alert on anticoagulants

The Joint Commission's Sentinel Event Alert on anticoagulants, issued September 24, 2008, urges greater attention to the dangers associated with anticoagulants.

Patients being treated with these medications must be closely monitored and screened for drug and food interactions, given that commonly used anticoagulants such as heparin and warfarin have narrow therapeutic ranges and a high potential for complications. Adding to the problem is a lack of standardized naming, labeling and packaging of anticoagulants that creates confusion and leads to devastating errors.

Anticoagulant medication errors are such a serious patient safety issue that The Joint Commission addresses these types of errors in the 2008 National Patient Safety Goals, with full implementation of the requirements expected by January 1, 2009 for hospitals, outpatient clinics, home care and long-term care organizations across the United States. In addition, The Joint Commission's medication management standards require organizations to pay particular attention to high-risk drugs such as anticoagulants in order to improve safety.

To reduce the risk of errors related to commonly used anticoagulants, The Joint Commission's Alert recommends that healthcare organizations take a series of 15 specific steps, including the following:

a. Assess the risks of using anticoagulants.
b. Use best practices or evidence-based guidelines regarding anticoagulants.
c. Establish standard dose limits on anticoagulants and require that a doctor confirm any exceptions.
d. Clearly label syringes and other containers used for anticoagulants.
e. Clarify all anticoagulant dosing for pediatric patients, who are at higher risk because these drugs are formulated and packaged for adults.


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