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## A look at The Joint Commission

# Alert warns of blood thinner deaths and overdoses

Surgeons need to be cognizant of the potential dangers facing their patients when an anticoagulant is administered during a procedure and when they are receiving anticoagulation therapy before an operation. The need for greater attention to dangers associated with the use of anticoagulants is emphasized in The Joint Commission's new *Sentinel Event Alert*.

A number of recent, high-profile errors related to commonly used blood thinners highlight a safety issue that too frequently results in harm or even death to patients, according to the *Alert*.

"Anticoagulants are vital to maximizing the effectiveness of many medical treatments and surgical procedures that benefit patients, but the systems necessary to ensure that these drugs are used safely are not adequate," says Mark R. Chassin, MD, MPP, MPH, president, The Joint Commission. "The strategies contained in this *Alert* give health care organizations and caregivers the tools to make a difference in preventing anticoagulant medication errors."

Anticoagulant medication errors are such a serious patient safety issue that The Joint Commission addresses these types of errors in the 2009 National Patient Safety

Goals. 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.

The Joint Commission's *Alert* highlights factors that contribute to anticoagulant medication errors, including lack of standardized labeling and packaging, failure to document and communicate patient instructions during handoffs, and inappropriate dosing for pediatric patients.

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

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

Other strategies for reducing

the errors related to anticoagulants include staff communication and collaboration; patient education and participation; designating pharmacists to manage anticoagulant services; and use of computerized physician order entry and bar coding technology, if available.

The warning about preventing errors related to commonly used anticoagulants is part of a series of *Alerts* issued by The Joint Commission. Much of the information and guidance provided in these *Alerts* is drawn from The Joint Commission's Sentinel Event Database, one of the most comprehensive voluntary reporting systems for serious adverse events in health care in the U.S. The database includes detailed information about both adverse events and their underlying causes. The complete list and text of past issues of *Sentinel Event Alert* can be found on The Joint Commission's Web site at [www.jointcommission.org](http://www.jointcommission.org).