

HQIC Change Pathway: Thromboprophylaxis of Hospitalized COVID-19 Patients

Part 2 of an Adverse Drug Event (ADE) Prevention 3-Part Webinar Series

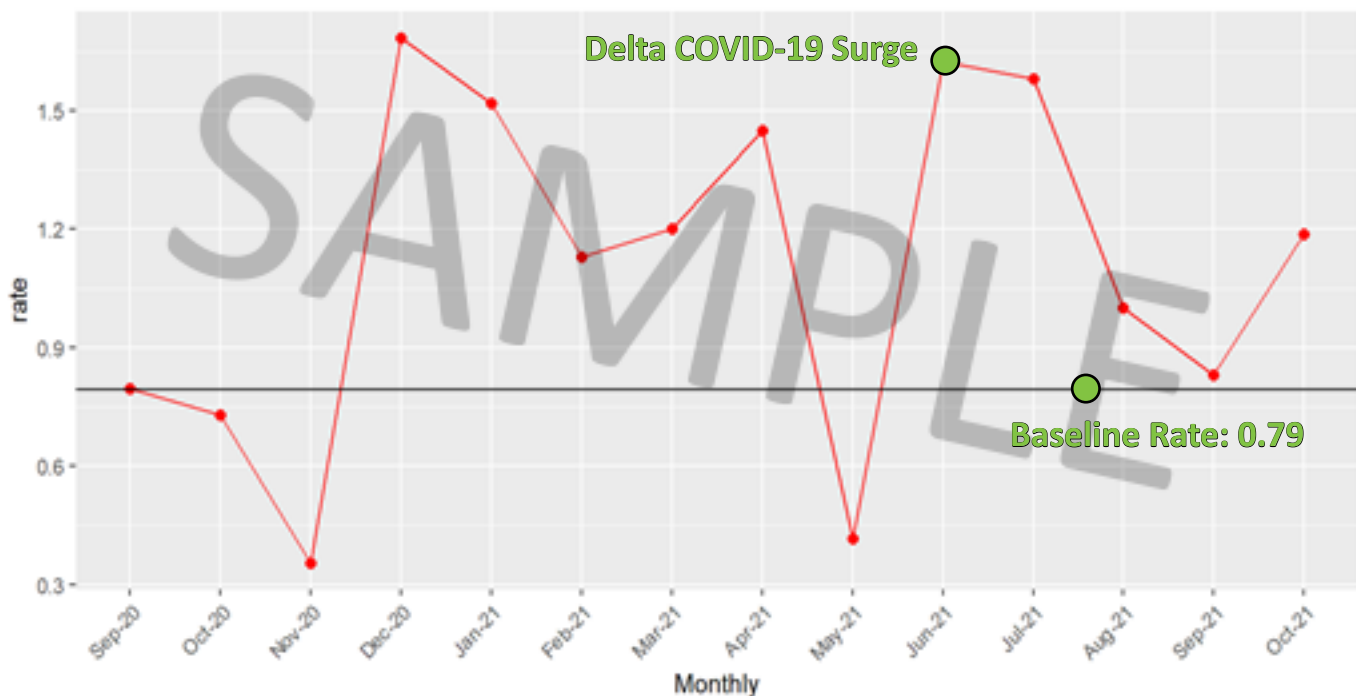
Thank you for registering for and/or attending the [Hospital Quality Improvement Contractor \(HQIC\) Thromboprophylaxis of Hospitalized COVID-19 Patients](#) webinar! Hospital leaders from across the country attended the event. This webinar discussed practical methods for incorporating the latest research on preventing thromboembolism in high-risk COVID-19 patients. Furthermore, our subject matter expert shared up-and-coming research and sources for updated clinical guidelines. Now, it is time to act!

Why Now

Anticoagulation medications are high-risk medications due to complex dosing, insufficient monitoring and inconsistent patient compliance [1]. Anticoagulation therapy has been identified as a leading cause of harm among hospitalized Medicare beneficiaries [2]. Errors involving anticoagulant prescribing and administration in hospitals occur far too frequently and are considered largely preventable. Anticoagulation management is complicated by patient transitions between care settings [3]. During the pandemic, a new challenge has presented itself. Recent research suggests that patients with COVID-19 have a higher incidence of thromboembolic events. One study cited during the webinar states that up to 60% of COVID-19 related deaths are associated with thrombotic complications, particularly in patients with a history of cardiovascular disease. COVID-19 has underscored the importance of safe anticoagulant therapy in the hospital setting [4].

Review the Data

Anticoagulant Adverse Drug Event Rate per 1,000 Discharges



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Consider Common Barriers

Review common barriers identified during the webinar and brainstorm ways to mitigate challenges to implementation in your organization.

- Lack of effective hospital and patient/family partnering strategies to prevent anticoagulant-related harm and readmissions
- Challenges of COVID-19 affecting care coordination and hand-offs to the next level of care
- Difficulty understanding COVID-19 guidelines for anticoagulant therapy for special populations such as those with a BMI >31 and pregnant patients
- Difficulty collecting and utilizing anticoagulant-related data

Perform a Root-Cause Analysis

Fill in the [Five Whys](#) template to identify potential causes for your hospital's adverse drug events.

Fill in the [PDSA Worksheet](#) to identify your goal and complete the Plan-Do-Study-Act cycle for test of change and improvement.

Identify Promising Practices

Beginner	Intermediate	Expert
Complete an anticoagulation adverse drug event gap analysis	Establish a medication reconciliation process at admission and discharge	Implement pharmacist/nurse-managed anticoagulation services
Screen for Social Determinants of Health (SDOH) : Access to transportation to lab draws; ability to afford medications; readability of discharge education materials; family support	Implement core elements of inpatient Anticoagulation Stewardship programs	Implement perioperative anticoagulant management tools
Use structured communication process (SBAR) for communication to the next provider of care	Implement Interdisciplinary Anticoagulation Safety Rounds	Use clinical decision-support tools specific to anticoagulation management
Educate patients and families using the teach-back method	Implement a COVID-19 anticoagulation protocol	Implement strategies to minimize/prevent adverse drug events involving anticoagulants-use of programmable pumps, alarm device
Use the trigger tool to measure adverse events	Implement evidence-based clinical policies, guidelines and protocols related to anticoagulation	Implement strategies to improve surveillance of anticoagulant adverse drug events
Provide tools for providers on anticoagulation		
Provide patient education tools		

Patient and Family Engagement & Health Equity Promising Practices

- Share patient stories with staff to create awareness and prompt buy-in to implement anticoagulation stewardship
- Provide education to staff on using the [teach-back method](#)
- Use a [standardized process](#) to assess individual needs in the event of an urgent/emergent incident (e.g., risk for falls)
- Provide [education](#) to patient and families using the teach-back method on [managing anticoagulation medications](#) after discharge

Craft Your AIM Statement

Identify your organization's goals related to adverse drug event prevention. Fill in the blanks with your AIM.

By _____, the _____ at _____ will
implement _____ to improve
by _____ to benefit _____.

Example AIM:

By April 30, 2022, the team at my hospital will implement an anticoagulation protocol for high-risk COVID-19 patients to reduce adverse drug events related to anticoagulants by 5%.

Next Steps

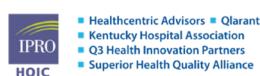
Not sure how to identify your organization's root cause? Need help getting started on implementing your selected intervention? Seeking feedback on your AIM statement? Reach out to your HQIC quality improvement partner for assistance.

References

1. [R3 Report Issue 19: National Patient Safety Goal for Anticoagulant Therapy](#)
2. [Anticoagulation-associated adverse drug events. Am J Med.](#)
3. [Anticoagulant medication errors in hospitals and primary care: a cross-sectional study, International Journal for Quality in Health Care](#)
4. [Anticoagulation in COVID-19: reaction to the ACTION trial - The Lancet](#)

Resources

- HQIC ADE Prevention LAN Series: Part-1 - [The Impact of Meaningful Medication Reconciliation on ADEs](#) recording and [slides](#) and [Medication Reconciliation Change Pathway](#)
- [The Joint Commission Anticoagulant Therapy National Patient Safety Goal](#)
- [Anticoagulation Agent Adverse Drug Event Gap Analysis](#)



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- [CMS-Health-Related Social Needs \(HRSN\) Screening Tool](#)
- [Patient Safety Movement Foundation-Handoff Communications](#)
- [Teach Back Training](#)
- [IHI Trigger Tool for Measuring Adverse Drug Events](#)
- [Michigan Anticoagulation Quality Improvement Initiative-Provider Toolkit](#)
- [Medications at Transitions and Clinical Handoffs \(MATCH\) Toolkit for Medication Reconciliation](#)
- [Anticoagulation FORUM, Core Elements of Anticoagulation Stewardship Program](#)
- [Develop a Warfarin Dosing Service or Clinic](#)
- [Harm Due to Anticoagulants](#)
- [The Impact of Interdisciplinary Anticoagulation Safety Rounds at a Large Urban Teaching Hospital](#)
- [Anticoagulation Protocol \(guidelines\)](#)
- [Management of Anticoagulation in the Peri-Procedural Period \(MAPPP\) app](#)
- [National Action Plan for Adverse Drug Event Prevention](#)
- [Educate Patients to Manage Warfarin Therapy at Home](#)
- [AHRQ Patient Education-Blood Thinner Pills: Your Guide to Using Them Safely](#)
- [Blood Thinner Safety Plan](#)
- [NIH COVID-19 Coagulopathy: Current Knowledge and Guidelines on Anticoagulation](#)
- [The HEP-COVID Randomized Clinical Trial](#)