The key messages from the patient safety alert that will affect social care providers are as follows:

1. When warfarin treatment starts, the person must be given verbal and written information, and this must be updated when necessary. In practice this probably means that the anticoagulant clinic will make sure that each person is given a ‘Yellow Book’ and that they and their care workers fully understand its contents. Note: This now comes with a credit card sized ‘Alert card’ which identifies that a patient is on anticoagulant therapy and gives essential details. The person should carry this with them and show it to any healthcare practitioner when they attend for treatment.

2. GPs and pharmacists should check that the patient’s INR (blood clotting) is being monitored regularly before they issue or dispense a repeat prescription for anticoagulant medication. The repeat prescription should only be dispensed if the INR is at a safe level. The GP or pharmacist may ask to see the patient-held INR record. This may be in the form of a single printed sheet, small booklet or other format used locally. There is a space in the back of the new yellow book to keep records issued from the anticoagulant clinic. Social care providers should be prepared to produce the yellow book and any other records about blood tests when they request a prescription for anticoagulants or collect the medicine from a pharmacy on behalf of the people they care for.

Further information and downloadable materials can be found at: [www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts/anticoagulant](http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts/anticoagulant)
In the UK, the colours of warfarin tablets are:

<table>
<thead>
<tr>
<th>Strength</th>
<th>Colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5mg (500 micrograms)</td>
<td>white</td>
</tr>
<tr>
<td>1mg</td>
<td>brown</td>
</tr>
<tr>
<td>3mg</td>
<td>blue</td>
</tr>
<tr>
<td>5mg</td>
<td>pink</td>
</tr>
</tbody>
</table>

Different brands of warfarin tablets may have different markings to those shown above. Other anticoagulants may come in different strengths and colours.

3. Additional blood tests may be necessary if the person has other medicines that interact with the anticoagulant. If this happens, the doctor or pharmacist will inform the person or their care worker. It is important for social care providers also to contact the anticoagulant service and make sure that the new arrangements are made.

4. Changes to the dose of anticoagulant should be written in social care records as mg. Warfarin tablets come in different strengths (as shown). If you confuse the number of tablets with mg, the person could get the wrong dose.

5. You should have written safe practice procedures for the administration of anticoagulants in your social care setting. The National Minimum Standards for care homes and domiciliary care agencies require providers to have written policies and procedures for medicines. The NPSA recommends that local policies should incorporate a specific section on anticoagulants.

6. All dose changes for anticoagulants should be confirmed in writing by the prescriber. It is safe practice to attach the written confirmation of the oral anticoagulant dosage, supplied by the anticoagulant clinic, to the medicine administration record (MAR) that you use. Only accept a verbal message to change the dose in an emergency, and always ask for written confirmation as soon as possible.

7. The NPSA recommends that oral anticoagulants are administered from the original packs dispensed for individual patients. Monitored Dosage Systems are not flexible enough to cope with frequent dose changes and are not recommended for anticoagulants. Care homes should make these arrangements with their local pharmacist or dispensing doctor.

8. Some people who are cared for in their own homes may rely on compliance aids to manage their medicines. For these people, a risk assessment is essential to decide whether the anticoagulant should be placed in it and, if it is thought necessary, the person who fills the aid must ensure that the tablets in the compliance aid match the latest prescribed dose. The general use of monitored dosage systems for anticoagulants should be minimised as dosage changes using these systems are more difficult.

9. Care workers who administer anticoagulants or support people to take their own must be trained to undertake their duties safely.

10. Social care providers should review and, where necessary, update their procedures and protocols for giving medicines so that anticoagulants will be given safely and they should provide training for their staff in these procedures.

11. People taking anticoagulants who need dental treatment may require a blood test up to 72 hours before treatment takes place. The social care provider should discuss this with the person’s dentist at least three days prior to treatment.

12. NHS anticoagulant services will be audited on an annual basis using a set of safety indicators covering the whole of the anticoagulant care pathway. Social care providers may be asked to participate in that audit.

Further information and downloadable materials can be found at: [www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts/anticoagulant](http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts/anticoagulant)