[redacted]

Brace Street Health Centre

63 Brace Street

Walsall

WS1 3PS

Mr Zafar Siddique

Senior Coroner

Black Country Area

Dear Mr Zafar,

RE: Mrs Annie Lloyd

I can confirm that these are the improvements that we have implemented to prevent future deaths from occurring:

1. All of our patients (who take Warfarin) have been told that they must bring in their yellow Warfarin book every time they go to have their INR checked at the hospital. The Warfarin book will be scanned and then given to the practice manager who will code the latest INR. She will then enter on to their consultation the date the INR was taken, the result, what dose of medication they should be taking and when their next INR is due. She will then request the correct strength as per the yellow Warfarin book. The General Practitioner will also check the details before issuing the prescription.

2. We have recently undertaken safe prescribing audits on NSAIDs, Valproates and Lithium.

3. The Practice now has a written Procedure for the process of prescribing Warfarin, checking INR results and altering doses. Please find this document attached.

4. We have recently undertaken a death review audit so that we can look at the causes of a death and the factors that contributed to it. If there are any actions that could prevent future deaths we will put them into practice.

5. Our CCG pharmacist is undertaking Pincer audit regularly to ensure the safety of patients taking Warfarin. He runs a search on the practice computer and prints out a list of patients, if any, who have not had their INR checked recently and gives it to the practice manager. She will then telephone the patient and ask them to bring in their yellow Warfarin book.

6. We have already prevented future problems from happening on two occasions:

Date of incident: 30th August 2019

A letter from the Cardiologist was received at the practice stating that one of our patients needed to be put on Warfarin. [redacted] telephoned the patient and was told that he had been to the Warfarin clinic and had been started on Warfarin already. [redacted] was unaware of this as we had not received a letter from the Warfarin clinic informing us of this. [redacted] also noticed that the patient was prescribed Diclofenac last year when he was not taking Warfarin. The patient stated that the Warfarin clinic did not tell him not to take NSAID. [redacted] warned him that he must not take any Diclofenac, Ibuprofen, Naproxen while he is on Warfarin. [redacted] also contacted the anticoagulation nurse at the Warfarin clinic who told him that the patient had been seen by them and started on Warfarin and a letter had been sent to the practice but we did not receive it. [redacted] also told her that they must tell all patients to take their yellow Warfarin book to their General Practitioner.

Date of incident: 30th August 2019

The practice manager noticed that one of our patients had been to the Warfarin clinic twice and had his INR checked but had not brought in the yellow Warfarin book to show us. The practice manager also noticed that he had not reduced the dose of Warfarin as per the yellow book. I

telephoned the Warfarin clinic and told them he had been taking 6mgs daily continually instead of reducing this to 5.75mgs daily. They advised the patient to continue to take 6mgs and for him to have his INR done sooner than planned. The practice manager informed the patient that he must bring in his yellow Warfarin book every time he attends the Warfarin clinic so we can have up to date INR readings. The patient was also advised that he must follow the Warfarin clinic instructions when told to lower or higher the dose.

7. Further actions we have taken:

The receptionist will photocopy and scan the yellow book immediately and then give it to the practice manager who will code the latest INR and check the correct dose. The GP will then check it again. Our pharmacist is doing a quarterly audit to make sure we are not missing any patients.

a) The assistant practice manager will check Warfarin requests when the practice manager is on leave.

b) We have involved the CCG who will be sending someone from the Medicines Management Team to support the practice with high risk medication reviews.

c) Discussion with Medicines Management team took place on Wednesday 4th December 2019. CCG will undertake a shared care meeting to discuss what happened.

We now have a robust system in place to prevent any further recurrence of future deaths from Warfarin.

Yours sincerely,

[redacted]

20th December 2019

DR ANAND SINHA & DR MINAXI VERMA

BRAC E STREET HEALTH CENTRE

63 BRACE STREET

WALSALL

STANDARD OPERATING PROCEDURE

WARFARIN

29th November 2019

All patients must bring in their warfarin book every time they have their INR checked at the warfarin clinic.

The receptionist must take a photocopy of the warfarin book and scan it on to their computer record straight away.

The photocopy must then be given to the Practice Manager who will code their latest INR reading on to investigations.

She will then add a consultation with their latest INR reading, the date of the test, what dose of medication they should be taking and the date their next INR is due.

The correct dose of medication will be requested via EPS.

The GP will then check the entry and issue the prescription for warfarin.

Any strength of warfarin that is not currently being taken must be put in the past history.

When the Practice Manager is on leave Nazia (Assistant Practice Manager) will check the warfarin.

Staff must not ask the doctor to sign warfarin prescriptions during consultations. These must be done at the end of the surgery.

Signed:

Dr Anand Sinha