Standardizing Protocol for Intravenous Heparin in Cardiac Critical Care Setting

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ABSTRACT

Background: A medication error is any preventable event and is the failure in the treatment process that may cause or lead to inappropriate medication use while the medication is in the control of the healthcare professional. Each year the FDA receives more than 100,000 U.S reports associated with suspected medication error. High alert medications are the most likely to cause significant harm to the patient that leads to potential patient suffering and additional healthcare cost. The ISMP has issued a warning about the potential for dangerous mix-ups when administering heparin and revealed that 8.9% involved heparin in it.

Objective: The goal of medication therapy is the attainment of defined therapeutic result that enhances a patient's quality of life while reducing patient risk.

Methods: Tabba Heart Institute pharmacy department leadership engaged all quality head department, nursing department, cardiologist doctors and raised awareness on heparin protocol to improve the patient safety. Based on the guidelines on safe use, we made protocol, guidelines and started training sessions with physicians and nurses and assure pre-mixed form of heparin, that will be prepared and dispensed from hospital pharmacy to ensure the safety of patients.

Results: The result showed us great improvement after implementation of process. Out of 25 patients, 20 target APTT ranges were achieved within 48 hours. None of the patient has been reported with bleeding episode.

Conclusion: We need to order, prepare, dispense, and administer Intravenous heparin with caution. Pre-mixing of heparin solutions in hospital pharmacy can help reduce errors. Use of protocol is most appropriate way to avoid errors.