

Unfractionated Heparin Audit Tool

From the Victorian Medicines Advisory Committee

Name of organisation	Audit completed by	Designation	Date

Recommendations	Circle Appropriate (yes/no/not applicable)	If yes, include evidence. If no, indicate planned actions to mitigate risk.	Examples of evidence
<p>1. Is there promotion of heparin as a high risk medicine in your organisation?</p> <p>For high alert drugs- see link www.health.vic.gov.au/vmac/projects/hrm.htm</p>	Y / N / NA		<ul style="list-style-type: none"> Audit of promotional material. Audit of orientation information for clinical staff. Staff Survey
<p>2. Does your organisation promote use of the word 'units' in full instead of the dangerous abbreviation 'u' in prescriptions?</p>	Y / N / NA		<ul style="list-style-type: none"> Prescribing or abbreviations policy Audit of prescriptions
<p>3. Do policies and culture exist to support staff who question potentially unsafe or ambiguous prescriptions?</p>	Y / N / NA		<ul style="list-style-type: none"> Relevant prescribing, bullying and harassment policies Reported incidents
<p>4. Do standardised Antithrombotic guidelines for unfractionated heparin, low molecular weight heparin (LMH) and fondaparinux exist in your organisation? Do these include information on:</p> <ul style="list-style-type: none"> That a patient must specifically be asked if they have a history of Heparin Induced Thrombocytopenia (HIT) or previous allergy to heparin prior to prescribing UFH or a LMW heparin and the response documented in the patient's medical history and where appropriate on the medication chart. 	<p>Y / N / NA</p> <p>Y / N / NA</p>		<ul style="list-style-type: none"> Approved Antithrombotic guidelines.

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<ul style="list-style-type: none"> ▪ An accurate and current medication history must be recorded and the patient asked about over the counter (OTC) medicines and complementary medicines (eg St John's Wort and Gingko). 	Y / N / NA		
<ul style="list-style-type: none"> ▪ Recent trauma, surgery and co-existing medical conditions should be noted. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ Prescribers should document the indication and therapeutic goal for antithrombotic therapy in the patient's medical record and medication chart. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ Clearly defined weight-based dosing regimens for prophylaxis and treatment. These identify whether the patient's ideal body weight, actual weight or a medical staff-approved dosing corrected weight is to be used. A dosing maximum is included where appropriate. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ Definition of dosage modification required for impaired renal function. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ A dosing table for adjustment of infusion rate in response to APTT results and the frequency for ongoing APTT monitoring is included. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ The use of a standard concentration for infusions, eg a maximum concentration 50 Units/mL for premixed infusions is included. Advice is given to adjust the rate of infusion, not the concentration, to achieve dose changes. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ An independent double check of heparin calculations, preparations, labelling and prescriptions is encouraged. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ A process for withholding or resuming UFH pre- and post-invasive procedures. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ Advice on the management of UFH or LMW heparin overdose with reversal agents. 	Y / N / NA		
<ul style="list-style-type: none"> ▪ Advice that doses of UFH, low molecular weight heparin products and fondaparinux require dose confirmation if prescribed within 6-12 hours of each other. 	Y / N / NA		

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5. Develop strict monitoring guidelines for frequent and timely review. <ul style="list-style-type: none"> ▪ Include all blood results and monitoring required (noting frequency of blood tests required) when UFH is prescribed. ▪ Monitoring blood results should be documented in a standardised way. ▪ Consider a separate heparin order form that includes APTT monitoring. The form should allow review of a range of results over a period of time. ▪ Develop systems so that urgently required laboratory results are made available in a timely manner, for example within two hours of a blood test. ▪ Ensure that staff alter infusion rates in a timely manner in accordance with the prescriber's order, APTT results and guidelines 	Y / N / NA Y / N / NA Y / N / NA Y / N / NA Y / N / NA		<ul style="list-style-type: none"> ▪ Standardised guidelines are available for monitoring, documentation and dosage adjustment.
6. Ensure dosing tables are readily accessible to all staff at the point of heparin prescribing and administration.	Y / N / NA		<ul style="list-style-type: none"> ▪ A standard dosing table than has been approved for use by the organisation is available on the intranet.
7. Include a process for non-standard or unusual UFH orders: <ul style="list-style-type: none"> ▪ Unusual heparin orders should be questioned with the prescriber. ▪ Consider dose validation system for non-standard orders. For example, a second authorised person to countersign the medical notes. ▪ Consider preparation of non-standard heparin infusions by pharmacy. 	Y / N / NA Y / N / NA Y / N / NA		<ul style="list-style-type: none"> ▪ Provision in the Antithrombotic guidelines for non-standard UFH orders to be utilised provided verification with the prescriber.
8. Rationalise and minimise the concentrations of UFH stocked. <ul style="list-style-type: none"> ▪ Consideration is given to removal of 25,000 Unit/5 mL ampoules and replacing them with premixed heparin 	Y / N / NA Y / N / NA		<ul style="list-style-type: none"> ▪ Audit of clinical areas

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<p>infusion bags. Storage of heparin infusions, preferably packaged in a contrasting colour, is separate from other infusions.</p> <ul style="list-style-type: none"> ▪ 5,000 units/1 mL and 1,000 Units/1 mL ampoules are only stored in ward areas if there is a specific requirement for the presentation(s). ▪ Heparinised saline is only stocked where there is a specific requirement (other than for maintenance of peripheral venous cannulae). Where heparinised saline must be stocked, it is stored separately from other heparin products and sodium chloride 0.9% ampoules. 	<p>Y / N / NA</p> <p>Y / N / NA</p>		

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Action Plan			
Insert recommendation for implementation (Identified from audit tool)	Actions required to implement recommendation	Person responsible	Date for completion

Insert further lines if necessary

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Governance			
Recommendation	Circle Appropriate (yes/no/not applicable)	If no, indicate what actions (if any) are planned	Person Responsible
1. Does a formal process exist for approving guidelines, prescription order forms and flow sheets before use in your organisation?	Y / N / NA		
2. Are heparin guidelines and procedures part of your organisation's training programmes? <ul style="list-style-type: none"> ▪ Are they included in orientation and continuing education sessions for relevant clinical staff? 	Y / N / NA Y / N / NA		
3. Has the competency of medical, nursing and pharmacy staff been assessed in their roles and responsibilities for heparin therapy?	Y / N / NA		
4. Is effective communication provided to all relevant staff regarding heparin dosing and monitoring (including documentation of results) and any changes to heparin formulations stocked?	Y / N / NA		
5. Is there a reporting process designed to capture heparin errors and near misses in your organisation? <ul style="list-style-type: none"> ▪ Are reported events used to develop error prevention strategies? 	Y / N / NA Y / N / NA		

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Overall comments and actions recommended by clinical governance

Person responsible:

Signature:

Date:

Next audit review date:

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