COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Anticoagulation Policy		**DRM-051**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Drug Room	**10-1-2020**	**10-1-2020**
DEPARTMENT	REFERENCE	
Drug Room	**The Joint Commission**	

SCOPE

This policy applies to all patients receiving care and treatment at MANGUM REGIONAL MEDICAL CENTER.

PURPOSE

The purpose of this policy is to ensure the safe administration of anticoagulants (e.g. Heparin, Enoxaparin, and Warfarin). These medications are considered High-Alert/High-Risk medications.

DEFINITIONS

Anticoagulation therapy: medications intended for preventing, treating, and reducing the recurrence of venous thromboembolism and/or preventing stroke in patients with atrial fibrillation.

POLICY

The hospital will establish protocols for the safe administration of anticoagulants including IV Heparin. Anticoagulation protocols and monitoring parameters for anticoagulation will be utilized by the medical staff and the Pharmacist in Charge.

PROCEDURE

1. A licensed nurse on-duty will review all pertinent laboratory results available prior to the administration of any new anticoagulant therapy. Refer to Table 1 for anticoagulation therapy and administration guidelines.
2. Medical Staff approved Heparin Drip Protocols are strongly encouraged to be utilized. See Table 2 and 3 for reference.
    a. A second licensed personnel is required to verify all intravenous anticoagulant therapy doses and drug calculations prior to administration.
    b. Documentation of such should be recorded in the patient's medical record.

    c. The use of a programmable infusion pump is recommended for intravenous administration of heparin.
3. A sufficient supply of any potential anticoagulant reversal agent should be readily available:
    a. IV or PO Vitamin K for the reversal of Warfarin
    b. IV Protamine for the reversal of Heparin
4. Patient education and adverse reaction monitoring for anticoagulation therapy should include:
    a. Abnormal bleeding
    b. Bruising
    c. Local irritation and discomfort at the site of administration
    d. Heparin induced thrombocytopenia (HIT)

REFERENCES

https://www.jointcommission.org/media/tjc/newsletters/r3_19_anticoagulant_therapy_final2pdf.pdf?db=web&hash=710D79BDAEFFCA6C833BB823E1EEF0C6

ATTACHMENTS

Table 1: Guidelines for Anticoagulation Therapy and Administration
Table 2: Heparin Protocol Low Dose: ACS, Stroke
Table 3: Heparin Protocol Standard Dose: DVT, PE

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

Table 1: Guidelines for Anticoagulation Therapy and Administration

Anticoagulant	Monitoring Parameters:
Warfarin	• Draw INR and review INR prior to administration of the first dose. • Draw INR level's at least twice weekly for all active in-patients on Warfarin • Hold or discontinue use if INR is greater than 3.5
Direct Oral Anticoagulants (e.g., Pradaxa®, Xarelto®, Eliquis®)	• Draw CBC prior to administration of the first dose • Draw CBC at least weekly for all active in-patients on a direct oral anticoagulant • Draw BMP at least weekly for all active in-patients on a direct oral anticoagulant • Monitor Hgb and Platelet count trends closely (hold or discontinue use if Hgb is less than 8.5 or if Platelet count is less than 50,000)
All Heparin products intended for the treatment of Direct Vein Thrombosis (DVT)	• Draw CBC prior to administration of the first dose • Draw CBC at least three times a week for all active in-patients on any heparin product • Draw BMP at least three times a week for all active in-patients on any heparin product • Monitor Hgb and Platelet count trends closely (hold or discontinue use if Hgb is less than 8.5 or if Platelet count is less than 50,000) • Record daily weights for all active patients on any Heparin product for the treatment of a DVT

Table 2: Heparin Protocol Low Dose: ACS, Stroke

INITIATION:

1. Weigh patient STAT if baseline measured weight not in medical record. Dosed using adjusted body weight if Actual Body Weight/Ideal Body Weight is greater than 1.2

MEDICATIONS:

1. Heparin Sodium_____ units IV bolus STAT (_____ mL of 10,000 unit/mL vial).
   60 units/kg x Dosing Weight (**Maximum of 5,000 units)**

2. Heparin Sodium 25,000 units in D5W 500mL (50 units/mL) at_____ units/hour (_____ mL/hour) begin now.

   12 units/kg-hour x DW **(Maximum of 1,000 units/hr initially) _____** units/hour

LABS:

1. If not drawn already: STAT
   - ☐ CBC
   - ☐ PT/INR
   - ☐ PTT

2. Routine labs while on Heparin Drip:
   - ☐ PTT every 6 hours after initiation and after every dose change
   - ☐ Daily weight while on Heparin Drip
   - ☐ CBC every other day while on Heparin Drip
   - ☐ GUAIAC stool as needed

OTHER:

1. Draw blood for PTT from arm that doesn't have heparin infusion. Do not draw from heparin-flushed lines.

2. If there is no other access other than the heparin line, then **stop** the heparin, flush the line, aspirate 10 mL of blood to waste, and then re-flush the line prior to drawing a specimen.

3. Do not interrupt heparin infusion unless ordered.

4. Contact medical provider if platelet count is less than 150,000 microliter or a 50% drop from baseline; hematoma, bleeding or suspected bleeding occurs.

Table 3: Heparin Protocol Standard Dose: DVT, PE

INITIATION:

1. Weigh patient STAT if baseline measured weight not in medical record. Dosed using adjusted body weight if Actual Body Weight/Ideal Body Weight is greater than 1.2

MEDICATIONS:

1. Heparin Sodium_____ units IV bolus STAT (_____ mL of 10,000 unit/mL vial).
   80 units/kg x Dosing Weight (**Maximum of 10,000 units)**

2. Heparin Sodium 25,000 units in D5W 500mL (50 units/mL) at_____ units/hour (_____ mL/hour) begin now.

   18 units/kg-hour x DW **(Maximum of 2,000 units/hr initially) _____** units/hour

LABS:

3. If not drawn already: STAT
   - ☐ CBC
   - ☐ PT/INR
   - ☐ PTT

4. Routine labs while on Heparin Drip:
   - ☐ PTT every 6 hours after initiation and after every dose change
   - ☐ Daily weight while on Heparin Drip
   - ☐ CBC every other day while on Heparin Drip
   - ☐ GUAIAC stool as needed

OTHER:

1. Draw blood for PTT from arm that doesn't have heparin infusion. Do not draw from heparin-flushed lines.

2. If there is no other access other than the heparin line, then **stop** the heparin, flush the line, aspirate 10 mL of blood to waste, and then re-flush the line prior to drawing a specimen.

3. Do not interrupt heparin infusion unless ordered.

4. Contact medical provider if platelet count is less than 150,000 microliter or a 50% drop from baseline; hematoma, bleeding or suspected bleeding occurs.