

**FROM THE DIRECTOR SAFETY, QUALITY AND STANDARDS  
Dr Jim Livingstone**

**For action**

Chief Executives of HSC Trusts  
Chief Executives HSS Boards  
Chief Pharmacists in HSC Trusts/Boards  
Medical Directors HSC Trusts for cascade to all relevant staff

Room C3.8  
Castle Buildings  
Stormont  
BT4 3SQ

Tel: 028 90522788  
Fax: 028 90520725

**For information**

Medical Director NIAS  
Directors of Nursing HSS Boards/HSC Trusts  
Directors of Public Health in HSS Boards  
NI Medicines Governance Team  
Regulation and Quality Improvement Authority (for cascade to relevant regulated establishments and independent hospitals, clinics and hospices)  
Professor Sean Gorman, Head of School of Pharmacy, QUB  
Professor Patrick Johnston, School of Medicines and Dentistry, QUB  
Regional Medicines Information Service  
Chief Executives NIMDTA, NICPPET, NIPEC  
General Manager, HSC Safety Forum

Email: [jm.livingstone@dhsspsni.gov.uk](mailto:jm.livingstone@dhsspsni.gov.uk)

Our Ref: HSC (SQSD) 43/08  
Date: 6<sup>th</sup> November 2008

Dear Colleague

**Re: National Patient Safety Agency: Rapid Response Report 3: Risks with Intravenous Heparin Flush Solutions**

**Status: Best Practice Guidance**

The NPSA has advised on the risk concerning mis-selection of sodium heparin products 25,000 units in 5ml (Monoparin) instead of sodium heparin 50 units in 5ml (Hepsal). This has resulted in a number of patient safety incident reports between January 2005 and December 2007.

Following NPSA advice, the following actions should be co-ordinated by Chief Pharmacists of HSC Organisations:

- Organisations should review local policies to minimise the use of heparin flush solutions in all devices, including complex central venous or arterial catheters. This should take into account the evidence reviewed by UK Medicines Information (UKMi) which confirms that heparin flushes should not normally be used to flush peripheral intravenous catheters;
- All flush solutions should only be administered following a prescription or patient group direction;

**Chief Medical Officer Group**

- Local policy and procedures should be reviewed to ensure risk with heparin flush solutions is minimised;
- Healthcare organisations should ensure that all relevant staff are made aware of this guidance and revised policy.

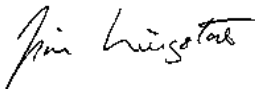
The NPSA has previously recommended that the use of concentrated sodium heparin products should be minimised, and wards and departments should normally only stock sodium heparin products of 1,000 units / ml or less. (NPSA Alert 18 – March 2007 issued under Circular [HSC \(SQSD\) 28/07](#)).

Rapid Response Report 3 issued on 24 April 2008 is available on:  
<http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/rapidrr/risks-with-intravenous-heparin-flush-solutions/>

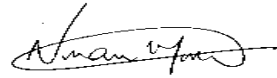
You will wish to bring the contents of this document to the attention of staff, particularly those involved in governance and risk management within your organisation. Organisations need to be aware of this safer practice notice in order to assist in complying with the *Quality Standards for Health & Social Care* –

- Criteria 4.3(i) and 5.3.1(a) (the appropriate management of risk);
- Criterion 5.3.1(f)(viii) and (ix) (ensuring safe practice in medicines management); and
- Criterion 5.3.3(f) (implementation of evidence-based practice through guidance, for example, NPSA guidance).

Yours sincerely



**DR JIM LIVINGSTONE**  
Director Safety, Quality and Standards



**DR NORMAN MORROW**  
Chief Pharmaceutical Officer

**Chief Medical Officer Group**