

Synthesis of Evidence



Chamberlain University College of Nursing

NR-528: Leading and Managing Evidence-Based Change in

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Assignment Date

Synthesis of Evidence

It is a daily practice for emergency departments (ED) to deliver care to patients who are critically ill and in need of life-saving care. A medication error can be a deadly mistake in this type of chaotic environment and, unfortunately, occurs more frequently than one would assume. Errors in administering medication are a common source of illness and death in acute care environments, and they can lead to extended hospitalizations (Kerari & Innab, 2021). High-alert critical medications, commonly given to patients in the ED, must be monitored and delivered correctly to ensure patient safety. Heparin is a medication commonly administered to patients within the ED. When a patient is started on a heparin infusion, the nurse must pay close attention to the heparin infusion protocol, which gives specific titration guidelines in response to the results of the patient's bloodwork. This protocol, widely used in many hospitals, must be followed closely and is very time-specific. When nurses make titration errors, miss timed lab draws, and make protocol errors, the patient is ultimately the one whose health is affected. Errors like those listed above are easily made in a high-acuity and high-stress department such as the ED.

A clinical practice question has been formed to assist with maintaining and following the heparin nurse-driven protocol. In emergency department patients receiving heparin infusions, does implementing a standardized spreadsheet for heparin infusions, compared to the current practice without a standardized spreadsheet, reduce the number of heparin infusion errors over two months?

A search was executed using Chamberlain University's online library to find correlated scholarly articles to assist in answering the question posed. Keywords used for the search