Service Priorities and Programmes

Electronic Presentations

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Infusion Pump Safety

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Introduction

We have reviewed the medication incidents reported to AIRS related to the use of infusion pump. Incorrect rate of infusion was the most frequent error. It could be due to staff not familiar with the use of that particular pump, inadequate checking and counter-checking while setting the pump. In view of these, our Medication Safety Committee has formed a Task Force of Infusion Pump Safety in January 2016 , in order to deal with the problem at a hospital-wide level.

Objectives

1.To develop local guidelines on safe use of infusion pumps. 2. To standardize the practice in using infusion pumps. 3. To reinforce training on use of infusion pumps. 4. To develop measures to minimize errors related to the use of infusion pumps.

Methodology

1.We have set up a Task Force for Infusion Pump Safety, under Medication Safety Committee, in January 2016, in order to deal with the issue in a hospital-wide level. Members consists of 3 parties: doctor, pharmacists and nurses from different clinical areas. 2. The Task Force has drawn hospital Guidelines on Safe Use of Infusion Pumps. Under the guidelines, we limit the number of each type of infusion pumps in-use in a clinical area to two. Moreover, we standardize the countersigning after the double-check for high risk medication to be on I/O chart. 3. We have made demonstration videos for each type of infusion pumps and uploaded to our Medication Safety Committee website. 4. We have made quick reference cards for each type of infusion pump, and attached to every pump in-use since Oct 2016. 5. We have designed competency test for each type of pump . 6. For promulgation, we have set up screensavers, have made glass cloth for distribution, held workshop and forum.

Result

To decrease medication incidents related to the use of infusion pumps. 1.Able to decrease medication incidents related to the use of infusion pumps. 2. The Task Force will continue to help keeping the number of models of infusion pumps in-use in each clinical area to two, by swapping the different models intra-or inter-departmentally. Moreover, the Task Force has an advisory role in the procurement of infusion pumps. 3. Staff's competency in the use of each pump as reflected by the results of the competency tests. 4. Audit on the compliance of the Guidelines on Safe Use of Infusion Pumps will be carried out in 2Q17.