Practice sting Wrong PCA pump

With a PCA pump, patients can self-administer a painkiller when they feel it is necessary. To avoid dosing errors, it is important to use as few different PCA pumps as possible in a department. In the notification, the department has opted for one type of PCA pump for this reason. However, as the notification, it went wrong.

Notification

A woman is given a PCA pump with remifentanil to combat the pain during labour. Special PCA pumps are available in the delivery rooms, which are set for the use of remifentanil. The dose and the interval between doses cannot be adjusted due to the risk of overdose. Only these PCA pumps are available in the delivery rooms. There is a sticker on these pumps: delivery room. However, for unknown reasons, another PCA pump ended up in the delivery room depot and the wrong pump was taken. There is a sticker on this pump: from a nursing depot. This sticker has not been noticed and because of this an incorrectly set pump has been connected. As a result, after applying the remifentanil, the patient is administered a too low dose of remifentanil with too long intervals. And she does not benefit from the pain medication. After administering two to three doses, it was noted that the pump was not set correctly and a new pump was installed.

Recommendations

For the committee dealing with medication safety

- Bring the above notification to the attention of hospital departments that use, maintain, and supply PCA pumps.
- Ask to discuss the following in the work meeting of the department:
  - Do we recognize this incident?
  - Can this incident also occur in our department?
  - Have we already taken measures to prevent such an incident? If so, what do we think of these measures?
  - Can we agree on measures to prevent such an incident from occurring in our department?
  - How are we going to evaluate these agreements?
  - How are we going to monitor that these incidents do not longer occur in our department?