Practice sting Check of the setting of the infusion pump

VMI regularly receives notifications from hospitals regarding errors of the setting of infusion pumps. These errors have not been detected in the nursing ward, because no check by a second nurse has been carried out.

Notifications

1. During the first round of the night shift, the nurse finds a very drowsy woman. She lies in a crooked position in bed. An alarm is sounding indicating that the morphine pump is empty. It turns out that the morphine pump is at position 21, while the pump should have been at position 1.5. The woman is still approachable, but her respiratory rate and oxygen saturation are much too low. After treatment with naloxone, the woman recovers. The setting of the pump has not been checked by a second nurse.

2. A patient who has to receive 1.5 mg midazolam subcutaneously per hour via the infusion pump receives only 0.3 mg per hour. A nurse discovers this when the patient becomes more and more restless during the night. A second nurse was unable to perform a double check as the evening shift was very busy.

Recommendations

For the hospital committee dealing with medication safety

Bring the above notifications to the attention of all nursing departments that work with infusion pumps.

- Ask to discuss the following:
  - Do we recognize that the position of the infusion pump is not always checked by a second healthcare professional?
  - Does this also happen in our department?
  - Have we already taken measures in order that a check by a second healthcare professional always is carried out? If so, are these measures effective enough? If not, what measures can we take?
  - How are we going to monitor and evaluate the agreements made?