Infusion Pump Safety
An Accreditation Canada Required Organizational Practice (ROP).

Accreditation Canada surveyors will be at Covenant Health facilities. October 3 – 7, 2016

A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pumps is implemented.

• **Instructions** and user guides for each type of infusion pump are easily accessible at all times.
  ➢ **Do staff know where to access user guides**

• **Initial and retraining** on the safe use of infusion pumps is provided to team members:
  o New staff & staff returning from extended leave
  o New or upgraded infusion pumps
  o Competence evaluation indicates re-training
  ➢ **Staff training is required to:**
    ▪ Minimize adverse events
    ▪ Ensure the appropriate device is used for each type of therapy
    ▪ Improve staff competence
    ▪ Promote reporting of adverse events
    ▪ Keep current with pump information

• When infusion pumps are infrequently used, **just in time training** is provided.

• The **competence** of team members to use infusion pumps safely is **evaluated and documented** at least every 2 years.
  ➢ **Programs** must maintain records of training and competence assessments
  ➢ **Staff** must feel confident to use infusion devices or request additional training

• The **effectiveness** of the approach is **evaluated**.
  o Monitor RLS incidents related to pump use
  o Review available data from smart pumps
  o Monitor evaluations of competence
  o Seek feedback from patients, families and team members.

• When evaluation information indicates improvements are needed, training is improved or adjustments are made to infusion pump libraries.

• When patients are provided with patient operated infusion pumps, training is provided, and documented, to patients and families on how to use them safely.
  ➢ **Standardize training provided to patients and families on how to operate pumps and provide them with information to take home**
  ➢ **Use teach back to ensure patients understand what they have been taught**

• Ensure infusion lines are labeled and trace the line to the origin prior to beginning any infusion of fluids or medications.

**Examples from RLS of Pump Incidents:**
• Programming errors
• Pump malfunction
• Secondary line clamped
• Secondary line not connected
• Outdated or uncapped tubing
• Unlabeled medication solutions
• Infusion by gravity of medications requiring infusion by pumps

**If a Pump Malfunctions:**
• Remove pump from service
• Leave administration set in the pump if that does not compromise patient care
• Label the pump “DO NOT USE”
• Contact Clinical Engineering
  o Complete Product Feedback form
• Inform your manager
• **If a pump malfunction is a critical incident, secure the pump until it can be transported to Clinical Engineering**