PRHI Regional Advisory

ATTN: Hospital CEOs
Please disseminate for shared learning

November 21, 2002

IV Pump Errors Target of 24-Hour Problem-Solving at UPMC Northwest

UPMC Northwest and a PRHI field manager are working together to prevent IV-pump errors. During "piggyback" connections of IVs (a secondary drug, usually an antibiotic), connections can remain clamped due to human error, which can result in missed doses. Through an investigation and discussion with the manufacturer of the IV pump, staff developed a "call-back" solution using existing sensors and alarms on the pumps to notify staff when the an IV remains clamped.

How Common is the IV-Pump Problem?

UPMC Northwest's PRHI field manager conducted a search on the MedMARx national database and discovered 2,425 IV errors in the past four years. The causes of error were attributed either to incorrect medication activation, improper pump use, or issues with the dispensing device. Of these, 130 referred to the IV clamp. The problem is so common that a "Nursing Lite" item in the September 2002 *RN* describes a patient giving a puzzled student nurse a reason why a piggyback IV wasn't dripping, saying, "*It's the clamp!*"

What Can Your Hospital Do?

Find out whether you are relying on nurses to *"remember"* to release the clamp. Talk with your staff, and see whether your IV pumps are equipped with necessary sensors and alarms to prevent clamp errors. Or, ask your PRHI Field Manager about how a "nurse call-back feature," available on some pumps for the main IV, can be used to alert a nurse that a piggyback IV remains clamped.

Do you want to continue to receive this bulletin? Tell Naida Grunden, Communications Director. Call 412-594-2572 or email grunden@jhf.org.

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