Institute for Safe Medication Practices 200 Lakeside Drive, Suite 200, Horsham, PA 19044

www.ismp.org

FOR IMMEDIATE RELEASE November 20, 2015 CONTACT: Renee Brehio, Media Relations, ISMP

614-376-0212, rbrehio@ismp.org

More Attention Needs to Be Paid to Safe Use of Ambulatory Care Infusion Pumps

Horsham, Pa— Use of external ambulatory care infusion pumps has become common—more than half a million individuals with diabetes alone are using them--and according to the Institute for Safe Medication Practices (ISMP), significant safety risks associated with their use are not being addressed. An article published in the November 19 issue of the *ISMP Medication Safety Alert!*® newsletter outlines the results of an ISMP survey regarding ambulatory pumps, including insulin pumps, elastomeric pumps, and IV pumps (nonelastomeric).

The 372 survey respondents were mostly pharmacists (55%), nurses (31%), and diabetes educators (6%). Forty-one percent of all respondents held staff-level positions and 31% held supervisory, managerial, or administrative positions. Approximately half (52%) were from hospitals with 100 to 400 beds. Following are some highlights of survey findings.

Insulin Pumps

- More than three-quarters (75%) of survey respondents did not have a policy, procedure, or guideline in place regarding management of patients with an external insulin pump.
- Only half of respondents' hospitals provide guidance regarding how to manage a patient with subcutaneous or IV insulin if the pump must be halted, which causes risks ketoacidosis.
- Only one in four hospitals provide the patient with a flow sheet to document all self-initiated doses, glucose monitoring results, site changes, and rate changes.
- A quarter or less of respondents reported that insulin pump refills are carried out by clinicians who have demonstrated specific competencies (17%), or that an independent double check is required for refills before restarting the pump (25%).
- Just half of respondents ensure that patients discharged with insulin pumps understand how to use them, and even fewer provide the patient with written information about safe use.

Institute for Safe Medication Practices 200 Lakeside Drive, Suite 200, Horsham, PA 19044 www.ismp.org

Results from ISMP Survey on Ambulatory Pump Safety

Page 2

Elastomeric and IV Ambulatory Pumps

- About 1 in 4 respondents reported they halt the use of ambulatory elastomeric or electronic pump upon a patient's hospital admission, but of these, few receive specific guidance on how to disconnect and store the pump or manage patients whose pumps have been discontinued.
- Only about 1 in 10 respondents are confident that clinicians know how to disconnect an ambulatory elastomeric pump in case of an emergency.
- One in 5 hospitals provide guidelines for preparing and refilling ambulatory elastomeric or electronic pump; 1 in 3 require the pharmacy to dispense or verify the medication or solution used for refills. Very few require specific competencies for those who can refill the devices.
- Only 37% of respondents said that medications or solutions delivered via ambulatory elastomeric pump are listed on the patient's MAR or that nurses need to document administration at least once daily; 43% reported the same for non-elastomeric ambulatory pumps.
- Approximately one-third of respondents require anesthesia to assess the patient to determine if an ambulatory pump should be continued during a procedure requiring general anesthesia.

A copy of the ISMP newsletter cover article on the survey findings (part one of two) can be found at: http://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=125. For a PDF copy that includes a table with full results, contact Renee Brehio at rbrehio@ismp.org.

Part two of the article series will present ISMP strategies for safely managing hospitalized patients who present for treatment with external ambulatory pumps. The Institute also plans to develop practice guidelines that will help hospitals advance the skills and knowledge of staff in this area and establish a safer environment for patients.

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 40 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org.