Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

No.13, December 2007

Failure to check of infusion pump flow

Two cases where hospital staff forgot to check the flow rate during use of infusion pumps (infusion pump and syringe pump), when replacing a medicine with another one, were reported (information collection period, from October 1, 2004 to June 30, 2007; the information is partly included in "Medical Adverse Event Information to Be Shared" in the 8th Quarterly Report).

Cases where hospital staff forgot to check the flow rate during use of infusion pumps, when replacing a medicine with another one have been reported.

- Regarding cases related to the infusion pump flow, mistakes in the operations, such as the wrong flow setting, or the infusion pump mix-up of multiple pumps in operation, etc., have been reported.

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Case 1

A blood product was administered by syringe pump at a rate of 50ml/hr. After the administration, another drug was planned to be administered at 5ml/hr, using the same syringe pump, but the hospital staff forgot to change and confirm the flow rate. The alarm of the syringe pump sounded, and it was noticed that flow rate was not confirmed.

Case 2

While using an infusion pump, solution X was switched to solution Y. After the administration of solution X at 125ml/hr, was finished, the administration of solution Y at 20ml/hr was planned, using the same infusion pump. However, the nurse A forgot to change and confirm the flow rate. Afterwards, the nurse B visited the patient's ward and noticed that the flow rate had not been changed.

Preventive measures taken at the medical institutions in which the events occurred.

When switching a drug to another while using an infusion pump, be sure to confirm the flow rate.

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of "Comprehensive Evaluation Panel" to prevent occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project. http://www.med-safe.jp/
* Accuracy of information was ensured at the time of preparation but can not be guaranteed in the future.
* This information is neither for limiting the discretion of healthcare providers nor for imposing certain obligations or responsibilities on them.

Division of Adverse Event Prevention
Japan Council for Quality Health Care
1-4-17 Misakicho, Chiyoda-ku, Tokyo 101-0061 JAPAN
Direct Tel:+81-3-5217-0252 Direct Fax:+81-3-5217-0253
http://www.jcqhc.or.jp/html/index.htm