MORPHINE OVERDOSE FROM ERROR INFUSION RATE WITH INTRAVENOUS PUMP : FEEDBACK EXPERIENCE AND ACTION PLAN

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Background

Syringe Pumps (SP) are vital tool for administering medicine, especially in palliative care. However, an infusion rate error can be fatal for patient. It's part of the "never events" list (Programming error of administration device).

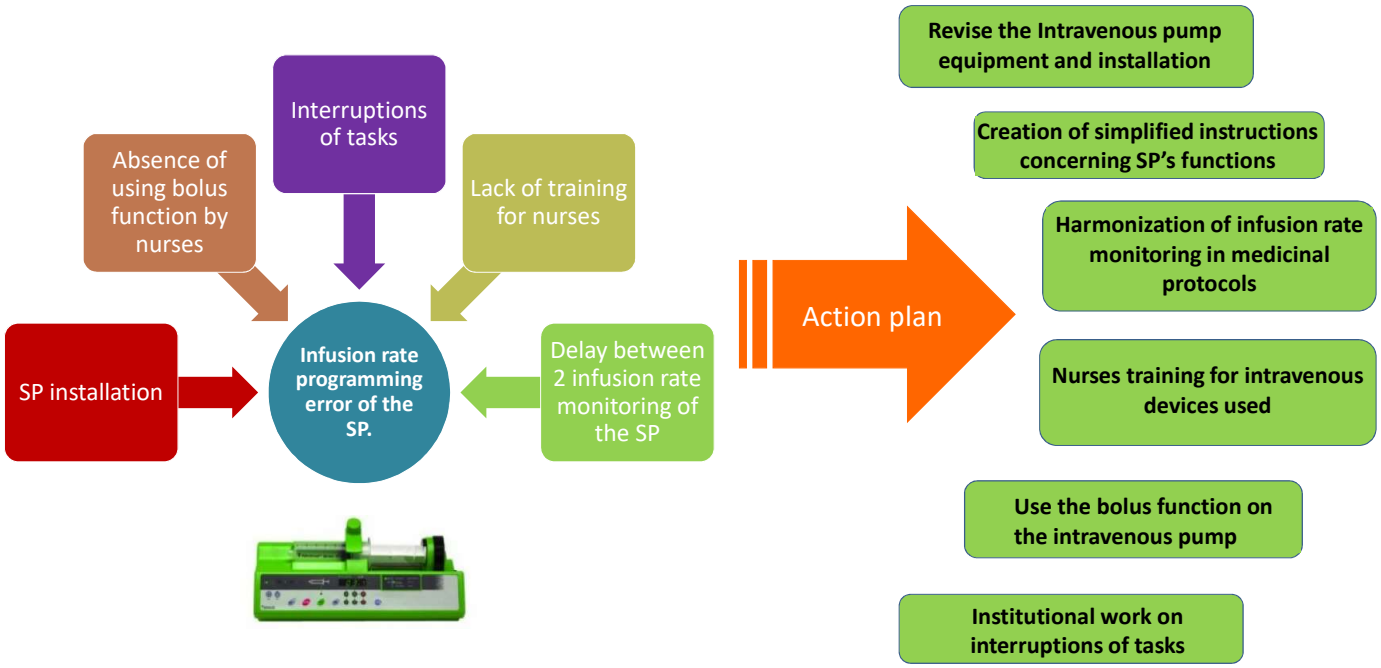
Purpose

An infusion rate error (7 mg/h administered versus 0.7 mg/h prescribed) on a SP of morphine in a palliative care patient was reported by the care team. The experience feedback committee (EFC) decided to clarify error's circumstances in order to establish an action plan to prevent this error from ever happening again.

Material and Methods

The adverse event was analyzed according to the ALARM (Association of Litigation and Risk Management) method.
The patient's medical file was investigated and 6 interviews with health professionals were conducted. We reported successive steps of systemic analysis according to ALARM process. Results of this analysis were presented at an EFC staff and, an action plan was established.

Results



Conclusion

The infusion rate programming error of the SP is a "never event" which requires to study causes and to set up preventives actions. The analysis of this adverse event and its presentation to the EFC allowed establishing an action plan within our hospital. Such analysis help identifying care management problems and their systemic causes. Thus it lead to corrective measures in order to prevent such events recurrence. This multidisciplinary work is part of the quality approach and the patient safety management of our establishment.