

Where is Your Limit?

A Review of Infusion Pump Library Hard Limit Practices

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Introduction





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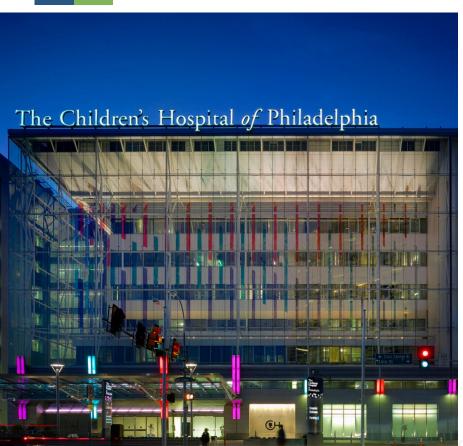
Navigating Zoom

Q&A Box and Chat Box: For any questions or comments throughout the presentation

Post-Meeting Survey: Following today's meeting, please let us know how we can improve going forward

Who We Are





Background

Founded by pharmacy and medication safety teams at a Philadelphia-based health system

Scope of Work

Make it easy and sustainable to consistently unlock value from infusion pump data

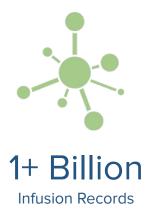
Value Areas

- → Safety/Compliance
- → Drug Utilization
- → Network Benchmarking & Knowledge Sharing

nfidentia

National Infusion Collaborative











>53,000 Pumps in Network

Background



Forcing functions High Leverage Barriers and fail-safes **Automation and** computerization Standardization Medium Leverage and protocols Redundancies Warnings, alerts, reminders, checklists **Rules and policies** Low Leverage **Educational programs Available information** Suggestions to "be more careful"

- Hard limits can completely stop the progression of an action that has potential to cause patient harm*
- It is recommended that soft and hard limits be implemented in smart infusion pump drug libraries⁺
- It may be difficult to determine hard
 limits for continuous dose medications
 - Wide therapeutic dose range
 - No well defined max doses

^{*} Institute for Safe Medication Practices (ISMP). A hard look at hard stops and workarounds in the acute care setting. ISMP Medication Safety Alert! Acute Care. 2023;28(13):1-4.

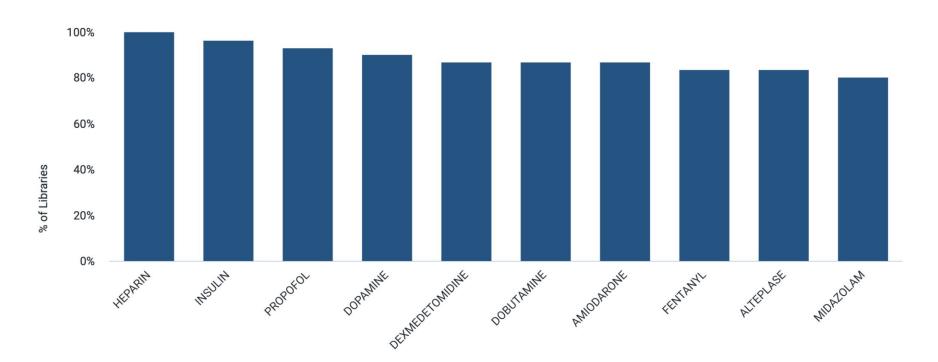
[†] Institute for Safe Medication Practices (ISMP). Guidelines for optimizing safe implementation and use of smart infusion pumps. ISMP; 2020.

Institute for Safe Medication Practices (ISMP), Implement strategies to prevent persistent medication errors and hazards. ISMP Medication Safety Alert! Acute Care. 2023;28(6):1-4

Library Data



Medications with highest adoption of continuous dose upper hard limits



Hard Limit Alerts By Volume

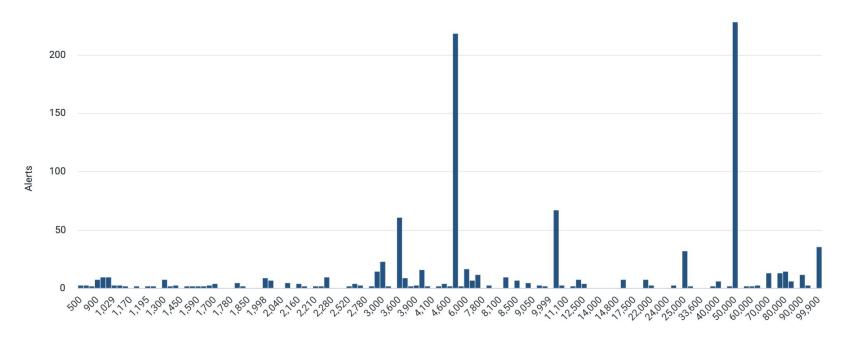


Medications with highest number of continuous dose upper hard limit alerts

	Medication Name	Alerts	~	% of Hospital Systems
1	OXYTOCIN	5,4	55	71%
2	PROPOFOL	3,843		88%
3	DEXMEDETOMIDINE	2,092		83%
4	HEPARIN	2,003		83%
5	FENTANYL	1,194		71%
6	INSULIN	888		92%
7	AMIODARONE	855		63%
8	FUROSEMIDE	826		58%
9	NOREPINEPHRINE	824		50%
10	VASOPRESSIN	810		50%

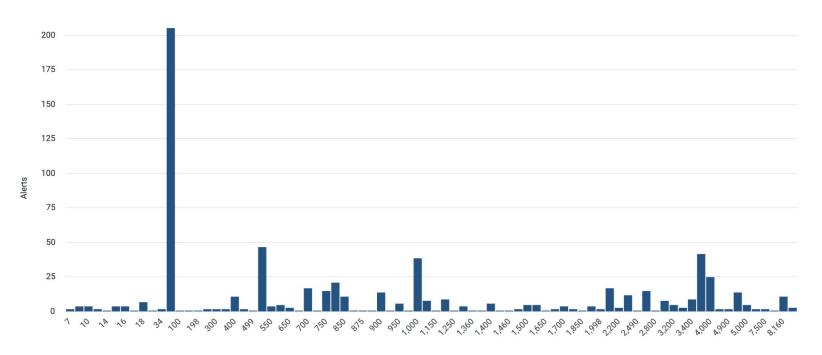


Programmed values that fired an alert for continuous dose upper hard limit



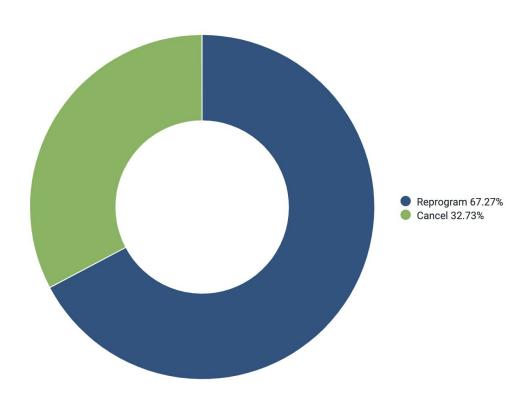


Re-programmed value after the continuous dose upper hard limit alert fired



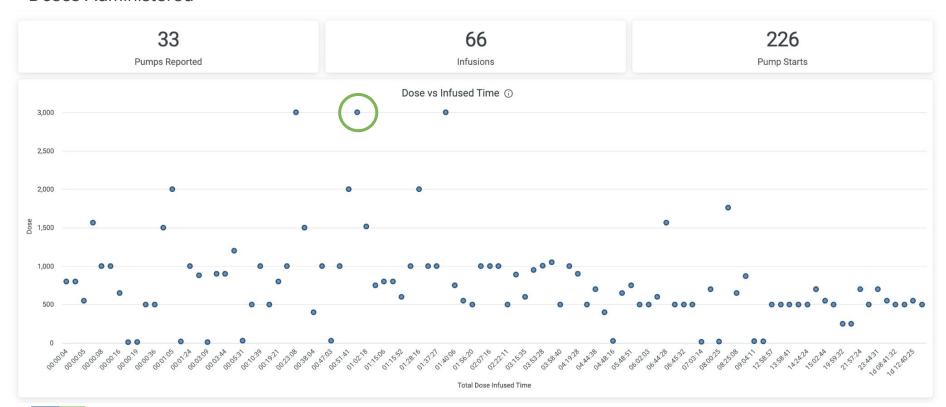


Alert Response



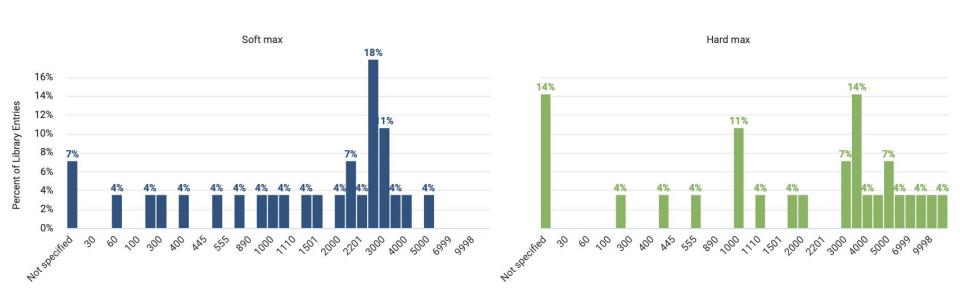


Doses Administered



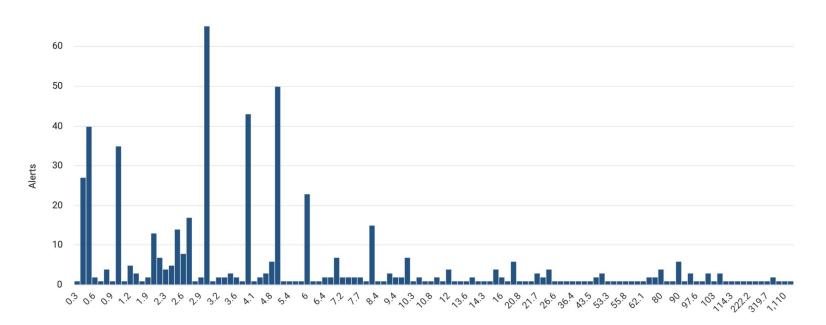


Bainbridge Health Network Adult Continuous Dose Library Limits



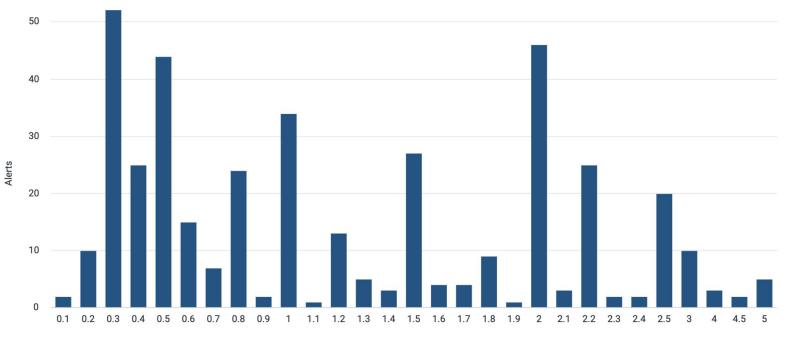


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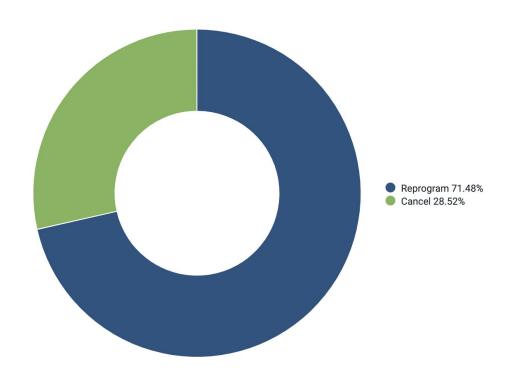


Re-programmed value after the continuous dose upper hard limit alert fired



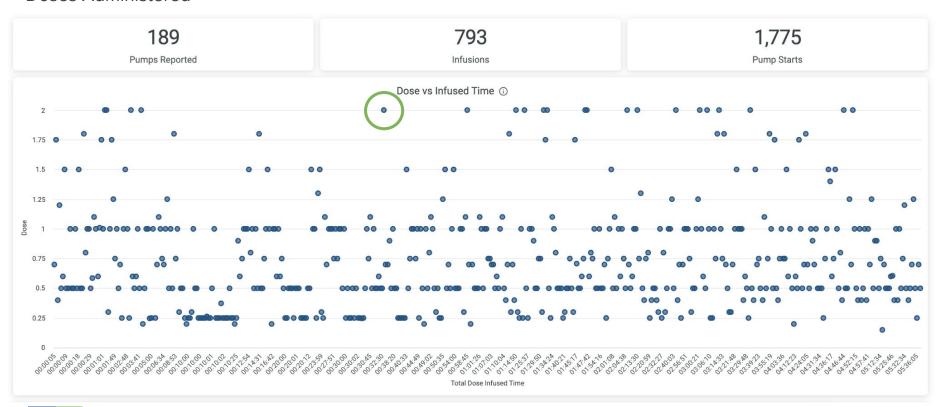


Alert Response



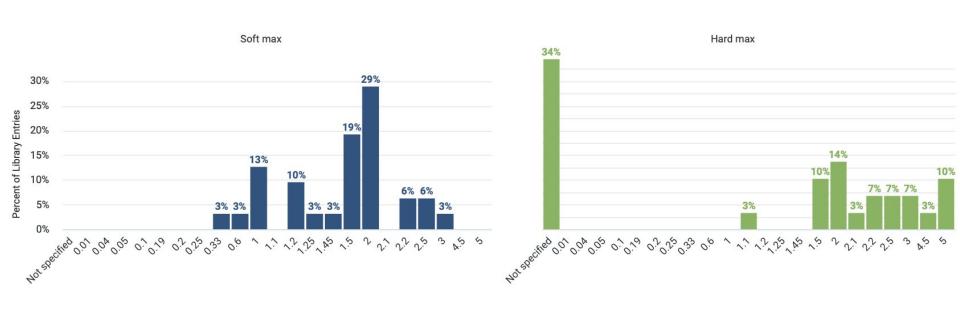


Doses Administered





Bainbridge Health Network Pediatric Continuous Dose Library Limits



Summary



- Hard Limits can prevent significant programming errors
 - Ex. magnitude errors
- Hard Limits are often cancelled and potentially re-programmed outside dose error reducing software (DERS) limits
- Reviewing infusion pump data can help determine clinically meaningful hard limits
 - Programmed values
 - Reprogrammed values
 - Doses administered
 - Network benchmarking



Questions

Email: soneill@bainbridgehealth.com

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