Actions that the healthcare community can do now to improve infusion system safety

1. Hold weekly morbidity/mortality conferences; not punitive; problem-solving session around a real-life issue that has occurred.
   - Identify process changes needed;
   - Integrate into training;
   - Identify workarounds and understand the “why.”

2. Use CQI data:
   - Identify top 10 low-hanging fruit items to address.
   - Use CQI data to help standardize practices, processes and systems in place

3. Standardize:
   - Standardize the system (policies, processes, practices, checklists, and devices)
   - Standardize and limit the number of drug concentrations and dosing units used in the hospital. Use ISMP’s Checklist of what should be in the drug library as a model

4. Include wireless as essential requirement in purchasing decisions
5. Maximize use of smart pump features and capabilities;
6. Assess competency on IV principles and use of devices (note: suggestion that the AAMI Foundation ask TJC to make on-going competency assessment a requirement)
7. Engage the C-Suite to create an imperative for change: Provide hospital wide strategy for change
8. Collaborate:
   - Encourage more collaborative meetings among front-line clinicians, nursing, clinical engineering and pharmacy on use of IV pumps, training, etc.
   - Collaborative clinical assessment at the nursing level for comprehensive competency assessments so pharmacy understands what is needed at the clinical level.
   - Encourage collaborative training.
9. Reinforce one practice
   - "Mind the gap" of research, training, etc.
   - "Do one thing at a time"
   - "Mind the drip"
   - “One pump at a time” for multiple infusions
   - Learn the 3Ms (Method, Mechanism, Mindfulness): What are you doing, How does it work; How could it go wrong?
   - Photograph the screen of the pump; 15-second video to get data on what is happening versus what should happen
   - Identify infusion device training and retraining
10. Evaluate pump alarms based on the Alarms Summit