

AL-11-01\*

The software referenced in AL11-01\* includes VA Computerized Patient Record System (CPRS) v1.0.27.90, Bar Code Medication Administration (BCMA) v3.0.32.47, and uses Veterans Health Information Systems and Technology Architecture (VistA) Inpatient Medication Package v5.0.

# Patient Safety Alert

Veterans Health Administration Warning System  
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- Item:** Standardized Process for Insulin Orders when used in Patient Controlled Insulin Pumps
- Specific Information:** A VA facility reported a close call when a provider transferred an outpatient prescription for insulin to be used in an insulin pump to an inpatient medication order. The patient was admitted to vascular surgery on insulin, aspart delivered via a patient controlled insulin pump. The provider copied the outpatient insulin aspart prescription which read "Insulin Aspart 40 units subcutaneous (SQ) daily" with extensive comments about basal rate 1 unit/hour, bolus rate 1.7 unit/hour after meal, etc. None of the comments carried over and the order was finished by inpatient pharmacy as a unit dose order. It appeared on the Bar Code Medication Administration (BCMA) system unit dose tab as "Insulin Aspart 40 units SQ daily". When the nurse attempted to administer the insulin, the patient stopped the nurse stating he receives insulin via his patient controlled insulin pump. If the patient had been obtunded or asleep, a potentially fatal dose of insulin could have been administered.
- General Information:** The VA National Center for Patient Safety and Pharmacy Benefits Management office have received a number of inquiries from facilities about safe practices regarding the placement of orders in the Computerized Patient Record System (CPRS) for insulin that is to be used in a patient's insulin pump. The types of insulin administered through an insulin pump are the short and ultra-short acting forms, which include regular insulin, insulin aspart and insulin lispro.
- Actions:**
1. By Close of Business (COB) November 5, 2010, the **Pharmacy Informaticist/ADPAC (or designee)** shall implement changes to the VistA pharmacy package to facilitate a standardized order for insulin to be used in an insulin pump order that makes it CLEAR when reviewing a medication list (CPRS Orders or Meds Tab, outpatient orders, inpatient orders, BCMA, etc.) that the insulin ordered is being used in an insulin pump. The drug name MUST contain the word "pump" since comments are not carried over in all views of the medication list. When ordering insulin from the alphabetic medication list, there MUST be an unambiguous selection choice for insulin to be used in insulin pumps.

2. By COB November 26, 2010, the facility **Chief of Pharmacy (or designee)** will educate all pharmacy staff of the insulin to be used in an insulin pump order entry process and **that comments must be carried over through all actions taken on insulin to be used in an insulin pump orders**. It must be clear when the insulin is dispensed from pharmacy that it is to be used in an insulin pump.
3. By COB November 26, 2010, the facility **Chief of Staff (or designee)** will educate all providers regarding electronic ordering of insulin to be used in an insulin pump.
4. By COB November 30, 2010, the **Patient Safety Manager** will document on the VHA Hazard Alerts and Recalls website that facility leadership has reviewed and implemented these actions.

**Additional Information:** All facilities are strongly encouraged to have Medication Quick Orders in place for insulin to be used in an insulin pump. Each facility shall determine if insulin for use in insulin pumps can be ordered via alphabetic medication order list, Medication Quick Orders, or both.

This alert provides national guidance to facilities regarding orders for insulin to be used in insulin pumps; however it is understood that local practices/policies might already be in place that provide an equivalent or increased level of safety as intended by the Alert. Decisions regarding ordering, dispensing, and administering insulin to be used in insulin pumps should be made with input from an interprofessional team with representation from nursing, pharmacy, providers, diabetes staff, and should include the bar code coordinator, patient safety manager, and local informatics staff.

Information letter 10-2009-010 Insulin Pumps (Continuous Subcutaneous Insulin Infusion Therapy) and Continuous Glucose Monitoring Systems:  
[http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2054](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2054)

Handbook 1108.03 Self-Medication Programs (SMP):  
[http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2166](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2166)

**Source:** Multiple VA Facilities

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