

Notice Information: - Warning 24 April 2014

Part 1. Product Information

a)	Title:	Paradigm Insulin Infusion Pump. Priority 2 – Warning
b)	Product Name/Type:	Paradigm Insulin Infusion Pump. Priority 2 – Warning
c)	Reference:	SN2014(20)
d)	Manufacturer/Supplier:	Medtronic MINIMED

Part 2. Target Audience

a) Target Audience:

All Hospital Staff

All Nursing Home Staff

A&E Departments

Ambulance Service

Cardiology Departments

Cardiothoracic Departments

Carers

Chief Executive Officers

Clinical Directors

Day Surgery Units

Emergency Medical Technicians

Diabetic Clinics/ outpatients

Diabetic nurse specialists

Diabetic departments

Endocrinology units

Endocrinology Consultants

Gastroenterology Departments

General Practitioners

General Public

Haemodialysis Units

Healthcare professionals who use these devices

Healthcare professionals managing patients who use these devices

High Dependency Units

Hospital Managers

Hospital Pharmacists

Intensive Care Units IV Nurse Specialists Maternity Units Midw fery Department

Intensive Care Units

IV Nurse Specialists

Maternity Units

Midwifery Departments

Neonatology Departments

Nursing Managers

Nursing staff

Obstetrics and Gynaecology Departments

Oncology Nurse Specialists

Paediatric Departments

Paramedics

Peritoneal Dialysis Units

Purchasing / Procurement / Material Managers

Renal Medicines Departments

Resuscitation Officers

Risk Managers

Supplies Managers

Theatre Managers and nurses

Urology Departments

Part 3. Problem/Issue

a) Problem/Issue:

Medtronic has received a number of reports regarding users who have accidentally programmed the pump to deliver the maximum bolus amount, including one incident that resulted in severe hypoglycaemia.

All insulin delivery programmed through the Main Menu will allow the down arrow button to scroll from 0.0 units to the programmed maximum bolus insulin dose.

Part 4. Background Information

a) Background Information:

This action applies to Paradigm Pump models MMT-511, MMT-512, MMT-712, MMT-712E, MMT-515, MMT-715, MMT-522, MMT-522K, MMT-722, MMT-722K, MMT-523, MMT-523K, MMT-723K, MMT-554, and MMT-754.

When using the Express Bolus button to deliver a bolus, the down arrow will scroll to 0.0 units and stop.

Because accidental button pressing errors may occur, it is important that patients always confirm the insulin dose flashing on the display is correct before pressing ACT to start delivery.

The IMB is working with Medtronic and the HSE to ensure awareness of this issue.

Part 5. Action to be taken

a) Action to be taken:

The IMB advise that users:

- (1) Follow the instructions outlined by the manufacturer in the field safety notice (FSN) attached.
- (2) When programming insulin doses through the Main Menu, pay close attention because scrolling down allows the dose displayed on the screen to go from 0.0 units to the maximum programmed insulin dose.
- (3) Always confirm the insulin dose flashing on the display is correct before pressing ACT to start delivery.
- (4) The Max Bolus and Max Basal safety limits should be programmed in your patients' pumps according to their individual insulin needs.
- (5) Forward this IMB Safety Notice to all those within your organisation that need to be aware of this information. Please also pass this Safety Notice and the attached FSN on to any end users or organisations where these devices may have been distributed.

Part 6. Enquiries

 All enquiries should be made to: Enquiries to the manufacturer should be addressed to:

Medtronic MINIMED

18000 Devonshire Street

CA 91325 -1219

Northridge

USA

Telephone: +1 818 576 5555

Fax: +1 818 365 2246

E-mail: N/A

Website: N/A

Enquiries to the distributor should be addressed to:

Medtronic Limited

Building 9 Croxley Green Business Park

WD18 8WW

Watford

United Kingdom

Telephone: +44 1923 212213

Fax: N/A

E-mail: vigilance.eu@medtronic.com

Website: N/A

IMB CONTACT INFORMATION

All adverse incidents relating to a medical device should be reported t

All adverse incidents relating to a medical device should be reported to:

Irish Medicines Board

Human Products Monitoring

Kevin O'Malley House

Earlsfort Centre

Earlsfort Terrace

Dublin 2

Telephone: +353-1-6764971

Fax: +353-1-6344033

E-mail: vigilance@imb.ie

Website: www.imb.ie

Please click here to view a PDF version of this safety notice

Please click here to view a copy of FSN 1

Please click here to view a copy of FSN 2