From The Chief Medical officer
Dr Michael McBride

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÀNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

For Action: Chief Executives, HSC Trusts
Chief Executive, RQIA (for cascade to Independent hospitals, hospices and relevant regulated establishments)

For Information:
Chief Executive, HSC Board
Chief Executive, Public Health Agency
Medical Directors, HSC Trusts
Directors of Pharmacy, HSC Trusts
NI Medicines Governance Team
Director of Performance and Provider Development, HSC Board
Medical Director, NIAS
Head of School of Medicine and Dentistry, QUB
Dean of Life and Health Sciences, UU
Head of School of Nursing and Midwifery, QUB
Head of School of Nursing, UU
Staff Tutor of Nursing, Open Nursing
Chief Executive NIMDTA, NICPLD, NIPEC

Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: [redacted]
Fax:
Email: Michael.mcbride[redacted]

Our Ref:

Date: 16 August 2010

Dear Colleagues

RQIA FOLLOW-UP REVIEW – REDUCING THE RISK OF HYPONATRAEMIA WHEN ADMINISTERING INTRAVENOUS INFUSIONS TO CHILDREN.

You will be aware that the Regulation and Quality Improvement Authority (RQIA) has recently completed its follow-up review into the application of NPSA Safety Alert 22: *Reducing the Risk of Hyponatraemia when Administering Intravenous Fluids to Children* and the RQIA Hyponatraemia Review 2008.

The final report of this review was published on 7 July 2010 and a copy can be accessed at www.rqia.org.uk/publications

It is encouraging to note that the review team found that "HSC Trusts and independent healthcare facilities in Northern Ireland have undertaken considerable work to reduce the risk of hyponatraemia when administering intravenous fluids to children and in all the areas visited by the review team there was evidence of improvement and commitment to achieving full compliance with the recommendations made in NPSA Safety Alert 22 and in the RQIA Hyponatraemia Review 2008". The Review Team

concluded that "Trusts and independent healthcare facilities in Northern Ireland have good operational control of the administration of intravenous fluids to children and that compliance with NPSA Safety Alert 22 has been substantially achieved."

The report contains 8 further recommendations designed to sustain and mainstream the initiative – 5 of which are directed at the HSC. These centre around:

- the potential for the complete removal of No. 18 solution;
- the development of a competency assessment tool on the administration of intravenous fluids;
- the development of a strategy to ensure there is collaborative clinical management between paediatric and adult clinicians for the administration of intravenous fluids to children in adult wards;
- training and assessment of staff in the administration of intravenous fluids to children; and
- dissemination of learning from adverse incidents.

I would stress the need for staff to be made aware of the current system and of the importance of ensuring that all adverse incidents are reported and managed appropriately in line with Departmental and HSC Board guidance.

The next challenge will be to build on the good work that has already been done and to put in place arrangements to deliver against the report recommendations. I would, therefore, ask that you review the recommendations made in the RQIA report and take whatever action is necessary to ensure that these are implemented within the following timescales:

- Recommendations 1 & 5 by **31 December 2010**
- Recommendations 2,3,4,6,7 & 8 **by 31 March 2011**

The Performance Management and Service Improvement Unit, HSC Board will monitor progress and will provide an update report to the Department by **29 April 2011.** The RQIA will assist independent healthcare providers to take forward the recommendations specific to their area and will monitor progress on implementation through its annual programme of inspections.

Yours sincerely

DR MICHAEL MCBRIDE
Chief Medical Officer