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29 October 2012

Dear Michael

RQIA REVIEW – REDUCING THE RISK OF HYPONATRAEMIA WHEN ADMINISTERING INTRAVENOUS INFUSIONS TO CHILDREN

In response to your letter of 3 October 2012 requesting a progress report on the implementation of the recommendations of the above review by HSC Trusts, I can confirm that the following recommendations have been implemented fully:

- Potential for the complete removal of NO. 18 solution – all Trusts have stated that this product is no longer stocked;

- Development of a strategy to ensure there is collaborative clinical management between paediatrics and adult clinicians for the administration of intravenous fluids to children in adult wards – all Trusts have reported that they are fully compliant with this;

- Standardisation of paediatric IV fluid prescription and fluid balance chart – all Trusts have confirmed that they are using a regional IV prescription and fluid balance chart;

- Dissemination of learning from adverse incidents – all Trusts have confirmed that they have robust systems in place for the dissemination of learning from adverse incidents.

There are two recommendations where our assessment is that further action is required:

- The development of a competency assessment tool on the administration of intravenous fluids; and
- Training and assessment of staff in the administration of intravenous fluids to children.

While Trusts have made significant progress on both of these recommendations, the tasks required to implement these are complex. Detailed discussions with Trusts have indicated a need for further work regionally to harmonise practice and ensure that the training provided is consistent across the region, that all relevant staff access the training, and that audits take place to ensure that the requirements are being met.

A task and finish group has therefore been established to develop, by end of January 2013, a competency framework and regional tools to test knowledge and competency of staff. This group is being led by PHA and has nominated representation across all five HSC Trusts. The Safety and Quality Alerts Team will monitor progress on this and I will provide a further update on progress to you in February 2013.

Yours sincerely

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DR CAROLYN HARPER
Executive Medical Director/Director of Public Health