

From the Chief Medical Officer
Dr Michael McBride

Mr Colm Donaghy
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Your Ref:
Our Ref:
Date: April 2008

Dear Colm

**RE: AUDIT OF NPSA PATIENT SAFETY ALERT 22: REDUCING THE RISK OF
HYPONATRAEMIA WHEN ADMINISTERING INTRAVENOUS FLUIDS TO CHILDREN**

Dr Briscoe wrote to you on 27 April 2007 (HSC(SQS) 20/2007) to advise you of the above NPSA Alert, and to ask you to ensure an action plan was completed and an audit proforma was returned to the DHSSPS.

Thank you for returning the audit template. It is clear that all HSC Trusts have undertaken significant work to reduce the risks of hyponatraemia when administering intravenous fluids to children. The audit proformas indicate that there is some variation across Trusts in:

- reporting of adverse incidents and near misses;
- audit programmes;
- ensuring that actions are implemented in all areas where children under 16 are treated, including "Adult" services where older children are treated; and
- signature of the proforma by appropriate person.

Your Medical Director has agreed to provide details of Trust audit undertaken/to be undertaken on the prescribing fluids in children. This will be discussed at my next meeting with medical directors on 19 May 2008.

Could you please give details of the "triggers" for incident reporting in prescribing fluids for children, and confirm that the following actions are now complete, or give a date for completion:

- Fluid calculation sheet has been implemented in all areas treating children under 16;
- Regional Guideline has been approved by Drugs and Therapeutics Committee and implemented in all areas treating children under 16; and
- Training and awareness for staff undertaken.

I would be grateful for a reply by 2 May 2008. The reply should be sent to

Yours sincerely

DR MICHAEL McBRIDE
Chief Medical Officer

cc: Medical Director of Trust
Chief Executive, RQIA
Roisin Perkins
Dr Heather Neagle