



Department of

**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

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Safety, Quality and Standards Directorate
Office of the Chief Medical Officer

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**Circular HSC (SQS) 20/2007 -
Addendum**

16 October 2007

Dear Colleague

**NPSA PATIENT SAFETY ALERT 22: REDUCING THE RISK OF HYPONATRAEMIA
WHEN ADMINISTERING INTRAVENOUS INFUSIONS TO CHILDREN – REGIONAL
CLINICAL GUIDELINES**

Introduction

Circular HSC(SQS) 20/2007 informed you about the National Patient Safety Agency alert on
administering infusions to children aged from 1 month to 16 years.

The NPSA alert is to be implemented by 30 September 2007, and an audit template
completed and returned to **DHSSPS by 31 October 2007.**

The Northern Ireland Regional Paediatric Fluid Therapy Working Group and the Northern Ireland Medicines Governance Team were asked to develop a clinical fluid guideline in accordance with NPSA guidance, to be disseminated to HSC Trusts for local implementation and monitoring. A regional paediatric fluid guideline, which has been endorsed by the Department, is attached.

The Regional Paediatric Fluid Guideline

The fundamental layout selected for this guideline complements a structured approach to patient clinical assessment. A sequence of questions is offered that prompts the clinician to assess for the presence of shock and guides treatment, if required; further assessment of whether there is also a deficit to be considered and then the calculation and prescribing for maintenance requirements, is also included.

The guideline emphasises that assessment of each patient should include a decision on whether oral fluid therapy could be appropriately initiated instead of intravenous therapy and further prompts reconsideration of this question when IV therapy is reviewed. ***The guidance is not a replacement for individual patient assessment, treatment and reassessment or for consultation with a senior clinician.***

Promoting Safe Use of Injectable Medicines

Organisations should also note that the NPSA Patient Safety Alert 20 on Promoting Safe Use of Injectable Medicines was issued on 4 June 2007 for local implementation. Circular HSC(SQSD)28/2007 refers. Action included a risk assessment of injectable medicine procedures and products and the development of an action plan to minimise risk. As indicated in this circular, Chief Executives should have nominated Chief Pharmacists, Pharmaceutical Directors/Advisers and Heads of Pharmacy and Medicines Management in HSC organisations to lead the action required.

Organisations should use ready to administer preparations and, if possible, avoid the need for potassium chloride to be added in clinical settings. Staff should consult the local Trust policy on IV strong potassium. Information about the availability of infusion fluids in individual hospitals should be attached to the Regional Paediatric Fluid Guideline wall chart so that all prescribers are made aware of the infusion fluids available for use in the local hospital.

ACTION

1. ***HSC Trusts (and other establishments) should ensure that the guideline is available and followed for fluid prescribing for children aged 1 month to 16 years. Children may be treated in adult wards and Accident and Emergency units, therefore, the guideline should be implemented in all settings where children aged 1 month to 16 years are treated.***

Certain groups of children such as those with renal, cardiac or hepatic conditions, or suffering from burns or diabetic keto-acidosis (DKA) or those treated in intensive care will require management under special protocols; however, this guideline will be helpful in their initial assessment and management.

2. ***Where a senior clinician(s) considers that a "special" maintenance infusion fluid is required, then this alternative choice for fluid maintenance must be endorsed by the Chief Executive of the Trust with clear documentation of the reasons for that endorsement.***

3. **Information about the availability of infusion fluids in individual Trusts should be developed by Trust Directors of Pharmacy and attached to the regional paediatric fluid guideline wall chart locally.**
4. **Medical directors, in collaboration with other Directors and educational providers, should ensure that all prescribers are made aware of this circular and wall chart, and that the contents are brought to the attention of new junior prescribers on an ongoing basis.** Educational material to support this guideline is available on
<http://www.bmjlearning.com/planrecord/servlet/ResourceSearchServlet?keyWord=All&resourceId=5003358&viewResource>.

In order to ensure the effective implementation of this guidance and to promote a user friendly version for the use by individual clinicians, the Department has asked the NI Medical and Dental Training Agency to work with Regional Paediatric Fluid therapy Group to produce wall and pocket charts appropriate to the needs of individuals and teams. These will be circulated in the near future. In addition, the NIMDTA should work with Trusts and other training agencies to ensure that the principles of paediatric fluid therapy and its potential risks, as highlighted in the National Patient Safety Agency Alert, are highlighted in postgraduate training programmes.

5. **Trust Directors of Pharmacy should develop a progress report on important supply issues in respect of all infusion fluids relevant to this regional paediatric fluid guideline and submit a report to the Pharmacy Contracting Evaluation Group and copied to the Regional Paediatric Fluid Therapy Working Group.**

Conclusion

This circular is an addendum to Circular HSC(SQS)20/2007 which informed you about implementation of the NPSA alert on reducing the risk of hyponatraemia when administering intravenous infusions to children. This Alert is applicable to HSC Trusts and other independent hospitals, hospices and regulated establishments.

A regional clinical guideline is attached to assist in implementation of Circular HSC(SQS)20/2007.

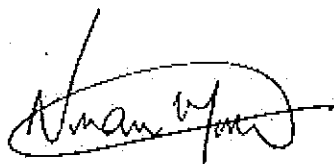
A commercially produced version of the wallchart and pocket version will be circulated by NIMDTA to HSC organisations when it becomes available. This should be complemented by information about the availability of infusion fluids in individual Trusts.

The Department expects HSC organisations to complete the NPSA audit template and return it to the Department by 31 October 2007, as outlined in Circular HSC(SQS)20/2007.

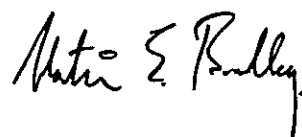
Yours sincerely



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