Intravenous news: The NPSA report “There is a risk of the accidental over infusion of intravenous fluids and medicines to neonates associated with the setting up of specific intravenous infusions or theÂ overriding of safety mechanisms on infusion pumps. This risk has the potential to result in death.

The Alert is for all NHS organisations that provide neonatal services. Departments providing neonatal services should:

1. Ensure that a local neonatal intravenous administration policy is available that specifies:

a) When using a syringe pump to administer intravenous fluids or medicines to neonates, a bag of fluid should not be left connected to the syringe.*

b) All clamps on intravenous administration sets must be closed before removing the administration set from the infusion pump, or switching the pump off. This is required regardless of whether the administration set has an anti-free flow device.

c) The frequency and responsibility for monitoring :
i. the intravenous infusion device
ii. the infusion administration equipment
iii. the patient receiving intravenous infusion

2. The above points should all be included in local standards for education, training,

assessment and subject to audit to ensure clinical practice is in accordance with the local policy.

*This action does not apply to the administration of blood components to neonates. These should continue to be administered as per The British Committee for Standards in Haematology â€˜Guidelines on the Administration of Blood Components (2009) www.bcshguidelines.org/pdf/Admin_blood_components050110.pdf (pg.51)

Click here for further advice from the NPSA on this alert.