Prevention of over infusion of intravenous fluid and medicines in Neonatal Patients

See also:
- Administration of injectable Medicines via the Intravenous Route policy and procedures.
- Competency for administration of intravenous drugs
- Medicines policy
- Peripheral venous catheter care policy
- Central venous catheter policy
- Medical devices policy

INTRODUCTION

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 the overriding of safety mechanisms on infusion pumps. This risk has the potential to result in death.

BACKGROUND

The NPSA received a report of a neonatal death following an accidental intravenous dextrose overdose. It is likely that the overdose occurred as a result of the clamp being left open from the 500 ml bag of dextrose and the 3 way tap positioned so that the patient was receiving dextrose from both the bag and the syringe. An alternative explanation is the tap was closed to the syringe pump and the solution infused directly from the 500 ml bag. In addition to these incidents, a further five ‘near miss’ incidents were identified where the safety mechanisms associated with volumetric pumps had been overridden. These include instances where the intravenous fluids were removed from the infusion device and remained attached to the baby with the clamps open,
Ensure that all discontinued infusions have been double clamped and the infusion device turned off.

* This action does not apply to the administration of blood components to neonates.