Policy for Intravenous Therapy Administration to Infants on the Neonatal Unit

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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>2</td>
<td>Purpose</td>
</tr>
<tr>
<td>3</td>
<td>Definitions</td>
</tr>
<tr>
<td>4</td>
<td>Responsibilities, Accountabilities and Duties</td>
</tr>
<tr>
<td>5</td>
<td>Policy</td>
</tr>
<tr>
<td>6</td>
<td>Training Implications</td>
</tr>
<tr>
<td>7</td>
<td>Monitoring Arrangements</td>
</tr>
<tr>
<td>8</td>
<td>Due Regard Assessment Screening</td>
</tr>
<tr>
<td>9</td>
<td>Links to other Trust policies</td>
</tr>
<tr>
<td>10</td>
<td>Associated Documentation</td>
</tr>
<tr>
<td>11</td>
<td>References</td>
</tr>
</tbody>
</table>

### Appendices

- **Appendix 1** Competency assessment document 14
- **Appendix 2** Due Regard Assessment Tool 17
1 Introduction

1.1 Intravenous (IV) therapy is a vital aspect of neonatal care. Administration of IV therapy by nurses on the Neonatal Unit must be undertaken within the NMC Code (2015) and take account of the NMC Standards for Medicines Management (2010).

2 Purpose

2.1 The purpose of this document is to standardise intravenous therapy by Neonatal Unit nursing staff to promote safe clinical practice.

2.2 This policy applies to the administration of intravenous therapy by registered nurses who work on the Neonatal Unit. This will include the administration of IV (antibiotics) to infants who are with their mothers on the Transitional Care facility of the Postnatal Ward and those who on the Neonatal Unit.

3 Definitions

3.1 A neonate is defined as a newborn infant who is less than four weeks old and an infant is defined as a baby/child between 0-1 years of age.

3.2 The Neonatal Units within Brighton & Sussex University Hospitals (BSUH) NHS Trust include the Special Care Baby Unit at Princess Royal Hospital (PRH) and the Trevor Mann Baby Unit (Neonatal Intensive Care Unit) at Royal Sussex County Hospital (RSCH). The term neonate/infant is used interchangeably, within this policy to encompass any baby that is nursed on the Neonatal Unit.

4 Responsibilities, Accountabilities and Duties

4.1 Responsibility of the Trust
The Trust is responsible for the provision of IV and infusion devices training for neonatal nurses. The Trust is responsible for the dissemination of any known internal and external safety alerts which relate to intravenous therapy or infusion devices e.g. Medicines & Healthcare Products Regulatory Agency (MHRA) alerts.

4.2 Responsibility of the Neonatal Unit Manager
Each unit manager is responsible for ensuring maintenance of a register of nursing staff that are competent at intravenous therapy administration and this should be available for audit purposes.
Each unit manager is responsible for ensuring that neonatal nurses are allocated time to attend the necessary training to administer intravenous therapy.

4.3 **Responsibility of the neonatal nurses**
All neonatal nursing staff are responsible for ensuring they are competent to undertake neonatal intravenous therapy by attending the relevant BSUH training and completing the competency document every three years (Appendix 1).

All neonatal nursing staff are responsible for ensuring they are competent to use infusion devices and should attend relevant medical infusion devices training every three years.

Nursing staff are responsible for removing any infusion devices found to be faulty or unfit for service from the clinical area and notifying the Unit technician/Electro-medical Department (EME) of the fault or problem.

4.4 **Responsibility of the Neonatal Unit Technician and Trust EME department**
The Neonatal Unit technician and Trust EME department are responsible for ensuring that all intravenous infusion devices are serviced annually and maintained appropriately. Default settings will be checked and agreed with senior neonatal staff e.g. Band 7, Matron or Medical Consultant to ensure safe parameters for neonatal therapy.

5 **Policy**

5.1 IV therapy may be used in the following circumstances:

5.1.1 For the administration of emergency/lifesaving medication;

5.1.2 For the administration of medication which cannot be tolerated orally;

5.1.3 When fluid and electrolyte balance cannot be maintained by enteral feeds and supplements;

5.1.4 For the administration of blood and blood products;

5.1.5 For the administration of parenteral nutrition;

5.1.6 For the administration of medication only available in an injectable form.

5.2 Many drugs used in neonates are off-label. As a result, the drug must be contained within the Unit formulary (agreed by Neonatal Consultants and the Unit Pharmacist) or other recognised Neonatal/Paediatric Formulary. If this is not the case, the details of the drug and rationale for use must be clearly documented in the medical notes by a Consultant/Registrar.

5.3 IV therapy should not be used in the following circumstances:

5.3.1 When alternative routes of administration (e.g. oral) would be as effective;

5.3.2 Where the patency of the IV access device in is doubt;
5.3.3 In any situation where the practitioner involved feels the administration of IV medication is inappropriate or unnecessary, non-administration must be reported to medical staff and documented in the medical notes and on the prescription chart.

5.4 IV therapy may only be administered by a registered nurse who has achieved the required BSUH NHS Trust level of competence.

5.5 All drugs for neonatal IV administration will be checked by two practitioners:

5.5.1 The first checker and the administrator of IV therapy must be a registered practitioner who is certified competent in IV therapy;

5.5.2 The second practitioner must be either a competent IV practitioner or a registered practitioner who is familiar with the process and policies relating to IV therapy and is aware of their personal accountability in checking the IV medication;

5.5.3 Student nurses/midwives may not act as a second checker or administer IV therapy, but may be involved in the process and act as a third checker.

5.6 Prior to the administration of IV therapy, practitioners must be familiar with the infant's plan of care (NMC 2010).

5.7 The practitioner must be sure that when administering drugs for clinical trials that consent to the trial is documented and a protocol of the trial is readily available.

5.8 The practitioner retains the right to pass the responsibility for the administration of an intravenous drug to another health professional, if they feel that this is beyond their level of competence (NMC Code 2015). In this instance, medical staff should be informed to ensure that the infant receives the prescribed medication. This should be documented.

5.9 Intravenous therapy should only be administered according to an accurate, clearly written, typed or computer generated, indelible prescription. Prior to administration, the practitioner is responsible for checking the following details on the prescription/patient record:

5.9.1 The infant's name, Trust/NHS number, current weight, date of birth, allergies;

5.9.2 The correct fluid/drug;

5.9.3 The correct dose/units and frequency;

5.9.4 The correct start and completion (if applicable) date and time;

5.9.5 Any additional instructions;

5.9.6 Signature and designation of prescriber;

5.9.7 Date and time of previous dose;

5.9.8 Appropriate drug blood levels and biochemistry results.

5.10 In the case of a neonatal resuscitation, it may be necessary to administer emergency drugs such as Adrenaline, Sodium Bicarbonate, Glucose and volume without a written prescription, if medical staff are actively involved
in the resuscitation. In this instance, a verbal instruction from the attending doctor must be heard by two registered practitioners and the medication prepared according to this instruction. Any such drugs must be prescribed and signed following the resuscitation.

5.11 Equipment
5.11.1 Blue tray - cleaned with Trust approved agent e.g. Clinell wipes;
5.11.2 Dressing pack (when accessing central lines and using aseptic technique);
5.11.3 Needles - a filter needle or blue needle (only if an in-line filter is used) should be used when drawing up solution from a glass ampoule. Since filter needles can only be used one way, the filter needle should be replaced with an ordinary needle when adding the drug to another solution. In this instance, extra care must be taken to minimise infection risk and to avoid sharps injury. A filter needle or blue needle should be used to draw up large volumes of intravenous fluids;
5.11.4 Diluents, if required
5.11.5 Syringes - 5-10ml syringes should be used for flushing, as syringes with a smaller diameter will generate a larger pressure (Evans & Dixon 2006). Smaller syringes are often required for drug doses;
5.11.6 Labels - all intravenous fluids should be labelled to include the name of the patient; the date and time; the name of the drug/diluent; the amount/strength of drug/diluent and the initials of two neonatal staff. The batch number of the drug/diluent may be recorded on the electronic patient record;
5.11.7 70% Alcohol with 2% Chlorhexidine swabs to clean end ports;
5.11.8 End port(s)/filter(s)/extension sets (if necessary);
5.11.9 0.9% sodium chloride or appropriate flush (pre-filled saline syringes may be used);
5.11.10 Non-sterile gloves (sterile gloves if using aseptic technique for central lines);
5.11.11 Apron;
5.11.12 Sharps container.

5.12 Preparation and administration
Aseptic non-touch technique will be used for all peripheral venous lines and aseptic technique for all central venous lines. IV medication will be prepared on a dedicated cleaned trolley at the patient bedside on the Neonatal Unit;
5.12.1 Ensure parents (if present) are informed about the procedure and the infant is appropriately prepared;
5.12.2 Two practitioners are to be present;
5.12.3 Wash hands with soap, apply alcohol gel and clean blue tray (as described previously);
5.12.4 Gather together all equipment required (see list above) and check prescription (as described previously);
5.12.5 Perform necessary calculations and prepare labels (do not add labels to syringes/bags until after additions have been made);
5.12.6 If IV Gentamicin is prescribed, the National Patient Safety Agency (NPSA) Gentamicin double checking prompt must be used every time
Gentamicin is prepared and administered (NPSA February 2010) and use of this should be documented on the drug chart;

5.12.7 Put on disposable apron and wash hands;
5.12.8 Put on non-sterile gloves, if using aseptic non-touch technique, to access peripheral lines;
5.12.9 Open dressing pack and put on sterile gloves, if using aseptic technique, to access central lines;
5.12.10 Prepare equipment in tray, according to principles of aseptic non-touch technique, if accessing peripheral lines. Ensure all key parts are protected/covered;
5.12.11 Prepare equipment in tray, according to principles of aseptic technique, if accessing central lines. This will involve a second person to handle packaged equipment so that you can take the unpackaged sterile contents;
5.12.12 Reconstitute/prepare drugs as per the Unit formulary/manufacturer’s recommendations/prescription;
5.12.13 The only time that it is permissible to replace the cover of a needle that has been used to draw up medication is either when the needle is an integral part of the syringe and cannot physically be removed (as with vitamin K and certain immunisations) or if the needle is attached to a Luer lock syringe (as the risk of contaminating key parts is higher, since it is difficult to remove an unsheathed needle from a Luer lock syringe). In these instances, the needle may be carefully re-sheathed using a 45° angle to replace the cover. However, the re-sheathing of needles is not permitted at any other time. Instead, needles that have been used to draw medication up should be discarded and, if necessary, replaced with a bung to prevent contamination of key parts;
5.12.14 When a liquid drug requires further dilution, it is vital that the drug is always added to the diluent (rather than the other way round) to avoid dosing errors (Northern Neonatal Network Formulary 2014);
5.12.15 When preparing fluids to be administered via a central line (using aseptic technique), 70% Alcohol with 2% Chlorhexidine wipes should be used to clean the ports of total parenteral nutrition (TPN) and allowed to dry for thirty seconds, prior to attaching a giving set. This includes both the hub of the lipid syringe and the giving set port of the feeding solution bag, following removal of protective cap;
5.12.16 Confirm infant’s identity, by checking the name, NHS/Trust number and date of birth against either the identity band or cot card (as identity bands may compromise the integrity of the infant’s skin), prior to administration of any infusion/drug;
5.12.17 Change gloves prior to administration to a peripheral line;
5.12.18 Inspect cannula/insertion site for pain, redness, blanching, swelling, leakage, blockage, infiltration;
5.12.19 Clean administration port with 70% Alcohol with 2% Chlorhexidine swab and allow to dry for thirty seconds;
5.12.20 Flush with 0.9% sodium chloride, taking into account the lumen volume of the intravenous line and the potential need for fluid restriction, as dictated by the infant’s condition. If patency of device is questioned, do not continue;
5.12.21 Administer medication according to Unit formulary/manufacturer’s literature. This will ensure haemodilution and minimise the risk of "speed shock";

5.12.22 When several drugs are to be given at the same time, each drug should be separated with a 0.9% sodium chloride flush to reduce the risk of incompatibility reactions, unless there are specific instructions to use another flush solution e.g. Amphotericin should be followed with a flush of 5% glucose;

5.12.23 Instil a final flush of 0.9% sodium chloride, taking into account the lumen volume of the IV line and the potential need for fluid restriction, as dictated by the infant’s condition. The clamp on the IV line/T piece should be closed whilst instilling the final fraction of the flushing solution, to prevent the backflow of blood into the cannula, by creating pulsatile positive pressure. Some neonatal drug volumes are so small that the entire drug dose will remain within the cannula T-piece, prior to flushing. In this instance, it may be appropriate to administer a 0.9% sodium chloride flush as a slow push/infusion to avoid a rapid bolus of medication;

5.12.24 Infusions that are currently running through the required IV line must be paused during IV drug administration and 0.9% sodium chloride flushes (or appropriate flush) used before and after administration, to prevent incompatibility reactions. The exception to this rule is the administration of Furosemide during a blood transfusion;

5.12.25 Discard of all sharps safely;

5.12.26 Remove gloves and apron. Wash hands and clean blue tray (as described previously);

5.12.27 Document administration of IV therapy.

5.13 Ongoing care of intravenous infusions and devices

5.13.1 Careful consideration of the risks should be made prior to the administration of any flush through a line containing another drug e.g. inotropes, morphine;

5.13.2 It is important to note that any infusion given at a low flow rate e.g. inotropes, insulin, morphine may take considerable time to reach a patient with an extension set. When initiating such infusions, the administration set and/or any extension sets should be fully primed with the drug/infusion, while still disconnected from the patient. This will ensure that the drug has to infuse through the minimum distance before it reaches the patient;

5.13.3 Bags of heparin-saline may be kept in the refrigerator for up to 24 hours, if it is used for a single named infant. It is not permitted to use the same bag for more than one infant, due to the risk of cross-infection. Other bags of diluents must not be kept and should be discarded after single use;

5.13.4 Insulin syringes must be used to prepare insulin infusions as these are marked with units rather than millilitres;

5.13.5 Ideally, TPN will be administered via a dedicated lumen of a central venous catheter. TPN may not be administered peripherally (Evans & Dixon 2006), except in extreme circumstances where central venous access is not possible and the total TPN concentration is less
than 600mOsm/l (this is calculated on the TPN prescription). This
decision should be made by a Neonatal Consultant and documented
in the patient notes;

5.13.6 In cases of limited venous access, the central venous catheter may
be used for more than one compatible infusion, following discussion
with Consultant or senior medical personnel and in line with Unit
formulary or Northern Neonatal Network Formulary for compatibilities.
In such instances, terminal co-infusion is safest, where connectors
are placed as close to the infant as possible so that multiple infusions
are only in contact with one another, for as short a time as possible
(Northern Neonatal Network Formulary 2014);

5.13.7 When administering infusions that are hyperosmolar/highly irritant to
peripheral veins e.g. sodium bicarbonate, calcium, there may be an
increased risk of extravasation injury (Restieaux et al 2013). In this
case, the infant should be nursed so that the peripheral cannula site
is highly visible (e.g. not lying on the cannula), as far as is possible.
The site should be assessed as often as is possible, but this should
involve a visual check of the entry site at least every ten minutes.
This is to aid early identification of any signs of phlebitis, swelling,
leaking, blanching, and redness. An infusion device which monitors
the pressure in numbers should be used to administer all intravenous
drugs/fluids;

5.13.8 All infusions including administration sets, must be changed every 24
hours, unless the drug formulary/manufacturer’s instructions dictate
otherwise;

5.13.9 Babiven® can be changed every 48 hours, in line with the
manufacturer’s recommendations;

5.13.10 In-line filters must be changed every four days and in line Y
connectors without filter must be changed every seven days (as per
manufacturer’s recommendations) and a sticker placed on the filter to
show this;

5.13.11 All end ports must be changed each time they are removed;

5.13.12 All lines should be labelled with the date of insertion;

5.13.13 All IV administration sets must have an integral clamp and clamps on
intravenous administration sets must be closed before removing the
administration set from an infusion pump or switching the pump off.
This is required regardless of whether the administration set has an
anti-free flow device (NPSA August 2010);

5.13.14 IV infusions should be disconnected from the patient once they are no
longer required. Disconnected fluids should be discarded;

5.13.15 IV drugs and infusions should always be administered via a
volumetric pump or syringe pump and the number of the device
documented on the IV fluid chart each shift;

5.13.16 When using a syringe pump to administer IV fluids or medicines to
neonates, a bag of fluid should not be left connected to the syringe,
except for the administration of blood products (NPSA August 2010);

5.13.17 When using an Asena CC syringe pump to administer infusions, a
second person should use the purge facility prior to connecting the
infusion to the patient. This ensures that the mechanical slack is
taken up and avoids any unnecessary delay in the drug reaching the patient;

5.13.18 During infusion administration, both the volume to be infused and the pressure limit should be set (30mmHg above resting pressure). It is important to remember that the pressure reading illustrates the pressure being exerted by the pump, in order to push the fluid through the equipment rather than the pressure inside the vein. This pressure will change depending on the viscosity of the infusion, the infusion rate, the lumen size of the giving set, the lumen size of the venous access device, the position of the pump in relation to the infant and the alarm limits should be altered accordingly e.g. when the incubator height is adjusted;

5.13.19 The IV site, fluid rate, volume infused and pressure reading should be checked and recorded hourly on the IV fluid chart. All these details should be checked at the start of each shift against the prescription. The neonatal visual infusion phlebitis score (ViPS) should be assessed for each peripheral and central venous access device at least once a shift, using the peripheral or central line care bundle. This tool is designed to evaluate the catheter site and allow early detection of problems;

5.13.20 After each patient use the pump should be wiped clean with a Trust approved agent e.g. Clinell® wipe and a decontamination label applied until the pump is in use;

5.13.21 All pumps should be kept plugged in when not in use, to maintain battery.

6 Training Implications

6.1 Prior to unsupervised practice, all registered neonatal nursing staff must have attended a recognised neonatal IV study day, which precedes a subsequent period of supervised practice and successful completion of the BSUH NHS Trust competency based assessment (see appendix 1). Evidence of an update will be required by all neonatal nursing and midwifery staff every three years.

6.2 The practical competency for IV therapy must be assessed by a registered nurse/midwife who holds a mentorship or teaching qualification e.g. ENB 997/998, PGCE. In addition, the assessor must also hold a current IV therapy certificate and administer IV drugs on a regular basis. Assessors should utilise the competency document in Appendix 1 of this document. This has been compiled to take into account the expanding role of the nurse and the NMC Code (2015). It has been designed to ensure uniformity and consistency of practice throughout BSUH NHS Trust and to encourage nurses to rationalise their actions. The competency involves two components: a theoretical component which is completed on the neonatal IV study day and a practical assessment which should be completed within six months of attending the study day.
7 Monitoring Arrangements

7.1 The effectiveness of this policy will be monitored by the following means:

7.1.1 A list of all those who are competent at neonatal IV therapy will be held by the Unit manager and be available for audit purposes. Staff will attend a neonatal IV therapy course every three years;

7.1.2 A peripheral line care bundle is completed for every peripheral cannula on the neonatal unit and a central line care bundle is used for each central line. Nursing staff must complete these once a shift to document that the cannula is managed and cared for as this policy dictates. This is audited daily by one of the Neonatal Team Leaders or Infection Prevention Link Nurse and entered onto the neonatal shared drive. This data is also entered onto the Trust Infection Prevention dashboard by the Infection Prevention Link Nurse or Neonatal Team Leader;

7.1.3 The Trust Infection Prevention team and the IV therapy team conduct ad hoc audits on the neonatal unit to check peripheral/central lines, involving inspection of dressing type, labelling of device and the length of time the device is in situ;

7.1.4 An annual safe and secure handling of medicines audit is conducted which involves the observation of two drug administration processes to check that these are performed according to policies. This is performed by a Neonatal Team Leader;

7.1.5 The neonatal staff conduct weekly hand hygiene audits, to ensure staff are decontaminating their hands prior to procedures, such as intravenous therapy. These results are shared throughout the Directorate and Trust.

7.1.6

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<th>Measurable Policy Objective</th>
<th>Monitoring / Audit Method</th>
<th>Frequency</th>
<th>Responsibility for performing monitoring</th>
<th>Where is monitoring reported and which groups / committees will be responsible for progressing and reviewing action plans</th>
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<td>Care bundles will be completed for all venous lines</td>
<td>Audit of completed care bundles</td>
<td>Daily</td>
<td>Neonatal Team Leader</td>
<td>Neonatal shared drive Trust Infection Prevention Dashboard Team days Infection Prevention Link Nurse</td>
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<td>Drug checking procedure</td>
<td>Audit of drug checking</td>
<td>Annual</td>
<td>Neonatal Team Leader</td>
<td>Mandatory audit for safe and secure handling of medicines</td>
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<td>Hand hygiene compliance</td>
<td>Audit</td>
<td>Weekly or monthly</td>
<td>Neonatal nurse or Team Leader</td>
<td>Local clinical governance meetings Infection Prevention updates Directorate and Trust meetings</td>
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8 Due Regard Assessment Screening

The Due Regard Assessment tool for this policy is included in Appendix 2. The due regard statements have been discussed with and agreed by the Head of Equality, Diversity and Human Rights. A full impact assessment is not deemed to be necessary.

9 Links to Other Trust Policies

This policy should be read in conjunction with the following policies:

- Policy for the Safe and Secure Handling of Medicines
- Administration of Blood and Blood Components (Appendix 5 contains information relating to neonates and to Jehovah’s Witnesses.)
- Standard Principles of Infection Prevention and Control

10 Associated Documentation

- Local neonatal unit guideline on aseptic technique
- Local neonatal unit guideline on Hickman/Broviac catheter

Both of these guidelines are available via the Trust website at


11 References


Appendix 1:
COMPETENCY BASED ASSESSMENT FOR INTRAVENOUS THERAPY ADMINISTRATION TO INFANTS ON THE NEONATAL UNIT

NAME:
GRADE:
WARD/HOSPITAL:
LEARNING PROGRAMME DATE:
LEARNING PROGRAMME VENUE:

COMPETENT TO PRACTISE: YES/NO
DATE ASSESSED:
NAME OF ASSESSOR:
SIGNATURE OF ASSESSOR:
PRACTICE REVIEW DUE: 3 YEARS

PLEASE SEND A COPY TO THE IV THERAPY TEAM, SUSSEX HOUSE, RSCH AND THE NEONATAL PRACTICE EDUCATOR
COMPETENCY BASED ASSESSMENT: INTRAVENOUS THERAPY ADMINISTRATION TO INFANTS ON THE NEONATAL UNIT

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<th>Not competent</th>
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<td>The candidate should be able to:</td>
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<td>▪ Discuss relevant Trust and Unit policies relating to the administration of intravenous medications;</td>
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<td>▪ Calculate various drug doses and infusion rates;</td>
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<td>▪ Describe the various sites for intravenous access and the individual management of these;</td>
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<td>▪ Explain: a) what is meant by a 1% solution;</td>
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<td>b) How many milligrams in 1 gram;</td>
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<td>c) How many micrograms in 1 milligram;</td>
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<td>▪ State what is meant by the following:</td>
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<td>a) 1:1000;</td>
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<td>b) 1:10 000;</td>
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<td>▪ Describe what complications may arise from the administration of intravenous medication;</td>
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<td>▪ Describe the actions you would take in the event of these complications occurring;</td>
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<td>▪ Describe the action to be taken in the event of an error in the administration of an intravenous drug;</td>
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<td>▪ Demonstrate an understanding of the legal and professional responsibilities and accountability issues, relating to the administration of intravenous therapy.</td>
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### Practical performance

The candidate will:

- Demonstrate an adequate knowledge of the relevant history and present condition of the infant;
- Explain the intravenous procedure to the parent (when present) and prepare the infant appropriately;
- Demonstrate a sound understanding of the IV administration of:
  - a) inotropes;
  - b) total parental nutrition;
  - c) sedation;
  - d) heparin;
  - e) antibiotics (including Gentamicin NPSA alert February 2010);
  - f) analgesics;
  - g) insulin;
  - h) blood products;
- Demonstrate use of:
  - a) volume controlled pumps and their administrations sets;
  - b) syringe pumps and their administration sets, adhering to NPSA report (August 2010);
- Administer IV medications and additives according to a prescription sheet/Unit formulary, with attention to the following:
  - a) infant identification;
  - b) drug storage;
  - c) drug preparation;
  - d) drug compatibilities;
  - e) aseptic technique to access central lines e.g. Broviac, long line, femoral lines
  - f) aseptic non-touch technique to access peripheral lines;
  - g) calculation of dose;
  - h) calculation of rate;
  - i) awareness of side effects;
  - j) safety of infant;
  - k) safety of self;
  - l) safety of environment;
- Complete accurate records

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## Appendix 2: Due Regard Assessment Tool

The following due regard statements have been discussed with and agreed by the Head of Equality, Diversity and Human Rights.

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Does the document/guidance affect one group less or more favourably than another on the basis of:</strong></td>
<td></td>
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<tr>
<td>• Age</td>
<td>No</td>
<td></td>
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<tr>
<td>• Disability</td>
<td>No</td>
<td>Any baby who is born with an absent limb or a limb deformity may still be cannulated and receive intravenous therapy. An alternative limb may need to be used or an alternative site e.g. a scalp vein</td>
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<tr>
<td>• Gender</td>
<td>No</td>
<td></td>
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<tr>
<td>• Gender identity</td>
<td>No</td>
<td></td>
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<tr>
<td>• Marriage and civil partnership</td>
<td>N/A</td>
<td></td>
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<tr>
<td>• Pregnancy and maternity</td>
<td>N/A</td>
<td></td>
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<tr>
<td>• Race</td>
<td>No</td>
<td></td>
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<tr>
<td>• Religion or belief</td>
<td>No</td>
<td>Guidance for the treatment of Jehovah’s Witnesses, in relation to blood product administration, can be found in Appendix B of the Trust Policy Administration of Blood and Blood Components.</td>
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<tr>
<td>• Sexual orientation, including lesbian, gay and bisexual people</td>
<td>N/A</td>
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<tr>
<td>2. <strong>Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?</strong></td>
<td>No</td>
<td></td>
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<tr>
<td>3. <strong>If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?</strong></td>
<td>N/A</td>
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<td>4. <strong>Is the impact of the document/guidance likely to be negative?</strong></td>
<td>No</td>
<td></td>
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<tr>
<td>5. <strong>If so, can the impact be avoided?</strong></td>
<td>N/A</td>
<td></td>
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<tr>
<td>6. <strong>What alternative is there to achieving the document/guidance without the impact?</strong></td>
<td>N/A</td>
<td></td>
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<td>7. <strong>Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?</strong></td>
<td>N/A</td>
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<td></td>
<td>Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)</td>
<td>Yes</td>
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</tbody>
</table>

If you have identified a potential discriminatory impact of this policy, please refer it to the Neonatal Practice Educator, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Clare Morfoot, Neonatal Practice Educator on the Neonatal Unit, RSCH (ext 63450).