

## 10 CARE OF THE NEONATE

### 10.4 MEDICATION ADMINISTRATION TO A NEONATE

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10.4.5 Administration of Neonatal Intravenous Medication on the Obstetric  
Wards  
Section B  
Clinical Guidelines  
King Edward Memorial Hospital  
Perth Western Australia

### 10.4.5 ADMINISTRATION OF NEONATAL INTRAVENOUS MEDICATION ON THE OBSTETRIC WARDS

#### AIM

To ensure the administration of intravenous medication to neonates is safe, efficient and appropriate.

#### KEY POINTS.

1. Only registered nurses / midwives who have completed a KEMH practical assessment can perform neonatal IV medication administration.
2. All Registered Nurses /Midwives are accountable for their own practice and therefore their competency. Any registered nurse / midwife who has not undertaken neonatal IV medication administration in the last 12 months shall update their knowledge and skills by attending an 'update' session before continuing to practice this skill.
3. Clinical guidelines [P 2.1 Administration of Medications](#) , [P2.5 Checking and Administration of Intravenous Drugs by Medical and Nursing / Midwifery Staff](#) and [P 2.6 Standard Procedure for the reconstitution and Administration of Intravenous drugs](#) shall be adhered to at all times.
4. Two Registered Midwives/ Nurses are required to check all neonatal intravenous medications (See Key Point 1) .Both are equally responsible for ensuring that the correct procedure is followed.
5. All midwifery students must have completed a relevant neonatal drug calculations assessment prior to checking any neonatal medications with a Registered Midwife / Registered Nurse.
6. All midwifery students may administer a range of medications including neonatal medications, depending on their stage of education and level of competency, under the direct supervision of a Registered Midwife / Registered Nurse.
7. All pre registration nursing and midwifery students must achieve a score of 100% for medications calculations assessment and demonstrate clinical competence in the management of medications, to be eligible fore registration with the Nurses and Midwives Board of WA.

8. Four hourly flushes of 0.5mL 0.9% Sodium Chloride shall be prescribed on the MR 811 by the Medical Officer.
9. The person who administers the dose must sign the medication chart after administration.
10. Only intravenous antibiotics (bolus dose) and sodium chloride 0.9 % flushes may be administered by the intravenous route on the obstetric wards.
11. All lines and syringes must be labelled appropriately. See clinical guideline [A 4.14 Labelling of Injectable Medicines and Fluids](#)
12. Prior to reconstitution and administration refer to [NCCU Drug Protocols](#) or the manufacturer's instructions as required. The ward pharmacist must be consulted if there are any concerns about reconstitution or administration.
13. All neonatal peripheral intravenous cannulas will have a single lumen, short extension set, two ports and anti reflux valves in situ.
14. All connections / syringes used for intravenous medication to a neonate must have a luer lock tip.
15. Use an aseptic technique and follow standard infection control procedures for all cannula site care.
16. The number of component parts for the intravenous access shall be kept to a minimum. Each connection provides a potential break in the line with subsequent contamination risk.
17. The cannula and extension set must be secured and stabilised in a manner that does not interfere with accessing and monitoring of the site.
18. If the cannula requires removal, **scissors shall not be used** on neonates to remove the strapping.
19. The cannula insertion site must not be enclosed in covering e.g. mittens, cloth wraps, swaddled.
20. IV site assessment
  - Shall be performed 4 hourly with baby observation and documented on the MR 425.10, noting any redness, swelling or pain at the site which must be reported to the shift coordinator and a medical officer.
  - Before and after the administration of intravenous medications / flushes.
21. Routine replacement of an intravenous cannula in neonates is not required unless there are signs or symptoms of complications.
22. All equipment shall be taken to the neonate using an injection tray.

## EQUIPMENT

10mL syringe  
Luer lock tip 3mL syringes  
Antibiotic and diluent as prescribed.  
Sterile 0.9% sodium chloride for injection  
Disposable gloves  
Alcohol swab.

## PROCEDURE

1. Perform hand hygiene.
2. Don gloves.
3. Assess the site noting any redness, swelling or pain which must be reported to the shift coordinator and a medical officer.
4. Cleanse the port to be accessed with the antiseptic swab and allow to dry for 30 seconds.
5. Insert the normal saline filled syringe into the access port and flush with 0.5mL.
6. While administering the medication and / or flush observe for
  - Resistance
  - Pain
  - Swelling around the insertion site
  - Leaking around the insertion site.If any of the above signs or symptoms occur, cease administration and notify the medical officer.
7. Remove the flush syringe and connect the medication syringe to the access port. Ensure that no air enters the system.
8. Administer the medication at the specified rate following the recommended administration guidelines.
9. After completion of the medication administration, attach the flush syringe and flush the line with 0.5mL 0.9% normal saline. The flush is to be given as the same rate as the medication to avoid rapid infusion of any medication that remains in the intravenous line/ cannula.
10. Ensure that both clamps are in the closed position after all line access.