10 CARE OF THE NEONATE

10.4 MEDICATION ADMINISTRATION TO A NEONATE

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 intravenous (IV) medication administration.
2. 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. Two Registered Nurses/ Midwives are required to check all neonatal IV medications (See Key Point 1). Both are equally responsible for ensuring that the correct procedure is followed.
4. All midwifery students must have completed a relevant neonatal drug calculations assessment prior to checking any neonatal medications with a Registered Midwife / Registered Nurse.
5. 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 Nurse/ Midwife.
6. See also P 2.6 Standard Procedures for Reconstitution and Administration of Intravenous drugs, both shall be adhered to at all times.
7. Four hourly flushes of 0.5mL 0.9% sodium chloride shall be prescribed on the MR 811 by the Medical Officer.
8. The person who administers the dose must sign the medication chart after administration.
9. Only IV antibiotics (bolus dose) and sodium chloride 0.9 % flushes may be administered by the IV route on the obstetric wards.
10. All lines and syringes must be labelled appropriately. See clinical guideline A 4.14 Labelling of Injectable Medicines and Fluids.
11. 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.
12. All neonatal peripheral IV cannulas will have a single lumen, short extension set, two ports and anti-reflux valves in situ. All connections / syringes used for IV medication to a neonate must have a luer lock tip.
13. Use aseptic technique and follow standard infection control procedures for all cannula site care.
14. The number of component parts for the IV access shall be kept to a minimum. Each connection provides a potential break in the line with subsequent contamination risk.
15. The cannula and extension set must be secured and stabilised in a manner that does not interfere with accessing and monitoring of the site.
16. If the cannula requires removal, scissors shall not be used on neonates to remove the strapping.
17. The cannula insertion site must not be enclosed in covering e.g. mittens, cloth wraps, swaddled.
18. 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.

19. Routine replacement of an IV cannula in neonates is not required unless there are signs or symptoms of complications.

20. All equipment shall be taken to the neonate using an injection tray.

**EQUIPMENT**

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

**PROCEDURE**

1. Prepare equipment, check the 6 patient medication rights, and have the medication/ flush checked by a second Registered Nurse or Midwife.
2. Confirm patient ID.
3. Perform hand hygiene.
4. Don gloves.
5. Assess the site noting any redness, swelling or pain which must be reported to the shift coordinator and a medical officer.
6. Cleanse the port to be accessed with the 2% chlorhexidine and 70% alcohol swab and allow to air dry for 30 seconds.
7. Insert the normal saline filled syringe into the access port and flush with 0.5mL.
8. 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 occurs, cease administration and notify the medical officer.
2. Remove the flush syringe and connect the medication syringe to the access port. Ensure that no air enters the system.
3. Administer the medication at the specified rate following the recommended administration guidelines.
4. 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 at the same rate as the medication to avoid rapid infusion of any medication that remains in the IV line/ cannula.
5. Ensure that both clamps are in the closed position after all line access.
6. Perform Hand Hygiene.
**REFERENCES (STANDARDS)**

- National Standards – 4- Medication Safety
  3- Preventing and Controlling Healthcare Associated Infections
- Legislation - Nil
- Related Policies – [W027- Administration of Parenteral Drugs](#)
  [W104 Infection Control Policy](#)
- Other related documents – [Infection Control Manual](#)
  [P 2.6 Standard Procedure for the Reconstitution and Administration of IV Drugs](#)

**RESPONSIBILITY**

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<tr>
<th>Policy Sponsor</th>
<th>Nursing &amp; Midwifery Director OGCCU</th>
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