

# **NCHA Position Statement Home Parenteral Nutrition Patient Safety Incidents including Rapid Over-Infusion**

Version 1.0 11 Sept 2025

## **Introduction and Scope**

When the national specification for Home Parenteral Nutrition (HPN) was updated in 2024, it includes contractual provisions for investigation and reporting of rapid over-infusions within the HPN service. NCHA Members have engaged with the HPN specialist group of the Medicines Procurement and Supply Chain (MPSC)<sup>1</sup> to understand the expectation of Clinical Homecare Providers in response to this new wording, however, clarity was not achieved. NCHA formed a sub-group of the Clinical and Nursing Services Group to review this issue.

HPN Contact 2024 requires formalised response to rapid over-infusion incidents involving both adults and paediatric patients as follows:-

*“Suppliers MUST outline transparent procedures for handling of concerns or complaints with full details on how to contact their Medical Director.*

*Suppliers MUST ensure Nursing staff are responsible to the Purchasing Authorities lead nutrition nurse or pharmacist in respect of clinical matters. Suppliers are required to undertake a root cause analysis and submit a report to the Purchasing Authority if a nursed patient develops any of the following catheter related complications*

- *Catheter Related Blood Stream Infection*
- *Catheter occlusion*
- *PICC migration*
- *Rapid over infusion of prescribed parenteral support*

This position statement provides a working definition for Clinical Homecare Providers to support consistent understanding and robust reporting of incidents including rapid over-infusion and provide a basis for the assessment of contractual compliance.

## **Rapid over-infusion - Definition for HPN Services**

Over-infusion is defined as administration of prescribed parenteral support over and above the volume indicated on the prescription.

An rapid over-infusion is an over-infusion that:-

- has been infused over the recommended maximum rate per hour of any of the constituents contained within the bag; or
- where the prescribed volume has been administered faster than the prescribed rate and resulted in symptoms of fluid overload in the patient

## **Investigation and Reporting of incidents involving Rapid Over-Infusion**

Guidance for reporting complaints and incidents in Homecare Services is provided in Appendix 19 to the RPS Homecare Handbook<sup>2</sup>.

Any over-infusion of prescribed parenteral support over and above the volume indicated on the prescription should be investigated as a medicines administration error.

<sup>1</sup> formally the NHSE Commercial Medicines Unit (CMU)

<sup>2</sup> <https://www.rpharms.com/recognition/setting-professional-standards/homecare-services-professional-standards/homecare-handbook-appendices>

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All medication errors including over-infusions are reported as Patient Safety Incidents including “near misses” and irrespective of the level of harm. All medication errors that result in harm are subject to investigation including incidents of rapid over-infusion.

**History**

Version	Status	Date	Reason for change	Author(s)
v1.0	Approved	11 Sept 2025	New	C McCall, NCHA Clinical and Nursing Services Group

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