INTRAVENOUS POTASSIUM POLICY

This is a working document and any changes that become necessary to this policy must be notified in writing to the Medicine Management Group via the Chief Pharmacist, East Cheshire Trust

THIS POLICY MUST BE READILY ACCESSIBLE AT ALL TIMES AND AT THE POINT WHERE MEDICINES ARE USED.

Medicines Management Group
Version 4: November 2015
Review: November 2018
**Policy Title:** INTRAVENOUS POTASSIUM POLICY

**Executive Summary:**
Overview of the policy and its aims:
This policy provides guidance to staff on the safe prescribing, storage and administration of strong iv potassium solutions. It is adapted from the NPSA Patient Safety Alert 23/2/02 and NPSA Patient Safety Bulletin 2007.

<table>
<thead>
<tr>
<th>Supersedes:</th>
<th>Version 4</th>
</tr>
</thead>
</table>
| Description of Amendment(s): | Potassium ranges amended so it corresponds to the hyperkalaemia policy  
Cost amendments |

**This policy will impact on:**
All staff working within the Trust involved in the prescribing, ordering, storage and administration of iv potassium chloride in general ward areas, Critical Care, Coronary Care, Neonatal Unit and Pharmacy

**Financial Implications:**
Financial implication of releasing staff time for training relating to the policy, and for auditing compliance with the policy.
100ml 40mmol Potassium Chloride in 0.9% NaCl = £4.55 per bag
20mmol in 10ml Potassium Chloride Injection =£2.62 per box of 10 ampoules

**Policy Area:** Trust wide

**Version Number:** 4

**Issued By:** Chair of Medicines Management Group

**Author:** Impact Assessment Date:

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<table>
<thead>
<tr>
<th>APPROVAL RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committees / Group</td>
</tr>
<tr>
<td>Consultation:</td>
</tr>
<tr>
<td>Copies sent for comment to Dr Cubucku, Dr Wai, Dr Hunter, Dr Lufti Sulaiman .Lead clinician neonatal unit, neonatal pharmacists and lead pharmacists</td>
</tr>
<tr>
<td>Specialist Advice (if required)</td>
</tr>
<tr>
<td>Other (please specify) Medicines Management Group</td>
</tr>
</tbody>
</table>
| Approved by Director: | Medical Director  
Director of Nursing and Patient Care Standards |

*Intravenous Potassium Policy, version 4  
Lead Pharmacist Surgical Specialities  
10/11/2015*
INTRAVENOUS POTASSIUM POLICY

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1. INTRODUCTION

1.1 Policy Statement

The intravenous (IV) administration of solutions containing potassium chloride to prevent or correct hypokalaemia is associated with significant risk and potentially fatal cardiac effects resulting from the following:

- Improper preparation of infusions at ward level using ampoules of very concentrated potassium chloride (e.g. Strong Potassium Chloride injection 15%)
- High concentration solutions causing local thrombophlebitis, tissue necrosis and/or loss of IV access
- Inadequate mixing of locally prepared infusions resulting in “pockets” of highly concentrated potassium chloride
- Excessive rate of infusion
- Inappropriately prolonged use of the IV route.

Where there remains a clear clinical need for a patient to be treated with intravenous potassium infusions, all staff involved must ensure that this treatment is delivered in a way that minimises all of the known risks and hazards. To this end, the following Trust policy has been prepared in response to the National Patient Safety Agency (NPSA) Patient Safety Alert - dated 23.07.02 and NPSA Patient Safety Bulletin January 2007. Mis-selection of concentrated potassium chloride for intravenous administration for a flush or instead of the correct medication can have fatal effects and is also listed as a never event.

1.2 General Principles

1.2.1 Prior to initiating intravenous therapy, the following require careful consideration:

- Urgency of potassium replacement, e.g. presence of cardiac arrhythmia, need for early surgery, very low serum potassium (<3mmol/L)
- Co-morbidity (e.g. fluid restriction, renal function) and co-prescription, notably digoxin or anti-arrhythmics
- The most appropriate infusion solution in terms of volume and potassium concentration.
- The rate of administration and mechanism of rate control (e.g. using IVAC type infusion pump)
- Intravenous treatment of hypokalaemia must only be instigated when the oral/enteral route is unavailable or will not achieve the required elevation of serum potassium within a clinically acceptable time.
- All prescribing of potassium must be expressed in terms of millimols of potassium and must include the rate of infusion.
- All ampoules of high concentration potassium containing solutions will be removed from use and will not be available to any ward or clinical area (except SCBU where they will be treated as a full controlled drug).
- Only pre-prepared, potassium-containing infusions must be used. These will be available in the following strengths and presentations:
  - 20mmol potassium chloride in 1000mL (0.15%) of 0.9% sodium chloride or 5% glucose (dextrose) or glucose 4% and sodium chloride 0.18% infusion.
  - 40mmol potassium chloride in 1000mL(0.3%) of 0.9% sodium chloride or 5% glucose (dextrose) or glucose 4% and sodium chloride 0.18% infusion.
  - 40mmol potassium chloride in 500mL (0.6%) of 0.9% sodium chloride infusion (This solution is not commercially available and is purchased as an unlicensed special)
All infusions containing 40mmol of potassium per litre (20mmol in 500ml) or above must be administered via a suitable infusion pump to control the infusion rate and volume.

All patients being treated with intravenous potassium are to have at least once daily measurement of serum potassium until levels are shown to be satisfactory.

Serum magnesium levels should be checked and corrected in patients with severe hypokalaemia.

2. INTRAVENOUS POTASSIUM IN GENERAL WARD AREAS

2.1 Prescribing of IV Potassium

- A written prescription must be provided before an infusion is commenced.
- The principles described in the Trust Policy for the Safe and Secure Handling of Medicines relating to writing of prescriptions must be adhered to.
- Potassium must only be prescribed by a qualified medical doctor (including foundation 1 doctors) or Trust approved Non-Medical Prescriber.
- Trust approved Non Medical Prescribers must not prescribe unlicensed preparations of potassium chloride.

2.2 Supply and Storage of IV Potassium

- Pre-prepared bags of potassium chloride infusions (except potassium chloride 40mmol in 100ml and 40mmol in 250ml) may be kept as stock on any ward.
- All pre-prepared bags of potassium chloride must be stored separately from other intravenous infusions.

2.3 Administration of IV Potassium

- A written prescription from a qualified doctor including foundation 1 doctors or a Trust approved Non Medical Prescriber must be provided prior to administering intravenous potassium.
- The prescription must clearly state the number of millimoles to be administered, the volume of diluent and the infusion rate.
- 40mmol is the maximum dose to be given in an infusion bag.
- Only pre-prepared potassium chloride infusions must be used.
- Intravenous potassium must only be administered by a doctor or registered nurse.
- Potassium must be administered via a suitable infusion pump to control the infusion rate and volume.
- Two qualified members of staff must check the prescription, infusion drug, concentration, and rate before starting the infusion.
- The rate of infusion should be checked periodically throughout administration in accordance with the policy on the administration of IV drugs.
See table below for the suggested infusion rates according to urgency and degree of hypokalaemia:

<table>
<thead>
<tr>
<th>Serum Potassium level (mmol/L)</th>
<th>Patients with NORMAL Renal Function and NO fluid restriction (where renal function and/or fluid intake is compromised, seek Senior advice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylaxis against Hypokalaemia (Normal = K 3.6 – 5.0)</td>
<td>20mmol in 1000mL of 0.9% sodium chloride or 5% glucose infusion administered peripherally (or centrally) over at least 8 hours as part of a normal fluids regimen</td>
</tr>
<tr>
<td>Mild Hypokalaemia (K 3.0 – 3.5 or non-urgent)</td>
<td>40mmol in 1000mL of 0.9% sodium chloride or 5% glucose infusion administered peripherally (or centrally) over at least 4 hours</td>
</tr>
</tbody>
</table>
| Severe Hypokalaemia <K 3 or very urgent | 40mmol in 500mL 0.9% sodium chloride infusion administered peripherally (or centrally) over at least 4 hours  
OR  
40mmol in 100mL 0.9% sodium chloride infusion administered in ICU/HDU/CCU over at least 2 hours via a central line with continuous ECG monitoring of rate and rhythm |

3. IV POTASSIUM FOR CRITICAL CARE AREAS (ICU, HDU AND CCU)

Potassium chloride 40mmol in 100mL (3%) of 0.9% sodium chloride infusion is not commercially available and is purchased as an unlicensed special.

3.1 Prescribing of IV potassium 40mmol in 100ml in critical care areas.

3.1.1 The principles for prescribing intravenous potassium in critical care areas (except SCBU) are the same as for general ward areas. However, within critical care areas it may be necessary to prescribe and administer iv potassium as a more concentrated solution than is available on the general ward areas. This is administered as potassium chloride **40mmol in 100ml 0.9% sodium chloride for intravenous infusion**

3.1.2 When it is necessary to prescribe concentrated potassium:
- A written prescription must be provided before any infusion is commenced.
- Only a qualified doctor working in the critical care area can prescribe concentrated potassium.
- No more than **40mmol** of potassium must be prescribed at any one time
- Administration via a central line must be specified in the prescription for 40mmol of potassium chloride IN 100ml 0.9% sodium chloride, with continuous ECG monitoring of rate and rhythm
The rate of infusion must be stated, and **must not exceed 20mmol per hour** (i.e. no more than 50mls per hour of potassium chloride 40mmol in 100ml 0.9% sodium chloride).

The serum potassium must be checked following the administration of 40mmol of potassium.

### 3.2 Supply and storage of IV potassium 40mmol in 100ml in critical care areas:

- These bags are for use in critical care areas only, and must NOT be used on the general wards.
- The bags will be treated as a Controlled Drug (CD) and stored in the CD cupboard away from all other minibags. The principles outlined in the Trust Policy on Safe Management of Controlled Drugs must be adhered to.
- Supplies of these bags must be ordered in the CD order book by a registered nurse and the book sent to pharmacy in the locked CD box.
- Pharmacy will store the bags in the CD cupboard away from other minibags and record all receipts and issues in the Controlled Drugs book.
- The bags will be supplied from pharmacy in plastic bags labelled: “Potassium Chloride 40mmol in 0.9% Sodium Chloride 100ml. For administration via Central Line over at least 2 hours with continuous ECG monitoring.” The bags will also be labelled with the ward, date and CD requisition number.
- Porters and nursing staff collecting the bags will need to sign the CD consignment note and ensure a signature is obtained for receipt of the drug on the ward.
- On receipt of the bags the nurse must ensure they are locked away in the CD cupboard IMMEDIATELY away from any other minibags and enter details of receipt into the CD book. The bags should be checked carefully by a second nurse and the stock balance documented. Both nurses should sign the book.
- Stock levels of concentrated potassium should be checked as part of the daily controlled drugs check by 2 nurses.

### 3.3 Administration of IV Potassium 40mmol in 100ml in critical care areas:

- **This solution must only be administered in critical care areas, via a central line over at least 2 hours with continuous ECG monitoring of rate and rhythm.**
- When these KCL minibags are required, TWO nurses (one of whom must be a registered nurse), or appropriately qualified staff must be involved in the whole process. Both staff should check the following:
  - Check the intravenous administration sheet carefully, ensuring the rate of infusion is specified and is no greater than 40mmol in 2 hours. Check that the route of administration is via a central line.
  - Check the details of the bag carefully and complete the batch number and expiry date on the prescription/iv administration chart.
  - Before giving to the patient double-check the details again and check the patient name, date of birth and hospital number.
  - The bag must be administered via a suitable infusion pump. Check the pump has been set up correctly and programmed.
  - Complete the patient’s details in the CD book and check the balance of KCL minibags. Both staff should sign the book as confirmation of their involvement in the process.
  - The rate of infusion should be checked periodically throughout administration.
  - Serum magnesium levels should be checked and corrected in patients with severe hypokalaemia.
4. IV POTASSIUM FOR NEONATAL UNIT (NNU)

- Potassium chloride 15% (20mmol/10ml) is for paediatric/neonatal use only.
- Potassium chloride 15% will not be routinely stocked on the paediatric ward. If necessary it will be supplied for a named child and removed from the ward when not required.

4.1 Prescribing of IV potassium on NNU

4.1.1 When it is necessary to administer concentrated potassium:
- A written prescription must be provided before any infusion is commenced.
- Only a qualified doctor working in the special care baby unit can prescribe concentrated potassium.
- Potassium 15% injection must only be used to make up maintenance intravenous sodium and potassium infusions. This must be made up as per procedure in section 5.
- Serum potassium must be checked at least once daily whilst receiving a potassium containing infusion.

4.2 Supply and storage of potassium chloride 15% injection on NNU:

- This solution will not be available on the general wards.
- The injection will be treated as a Controlled Drug (CD) and stored in the CD cupboard away. The principles outlined in the Trust Policy on Safe Management of Controlled Drugs must be adhered to.
- Supplies of this injection must be ordered in the CD order book by a registered nurse/midwife and the book sent to pharmacy.
- Pharmacy will store the injection in the CD cupboard, and record all receipts and issues in the Controlled Drugs book.
- The injection will be supplied from pharmacy labelled with the ward, date and CD requisition number.
- Porters and nursing/midwifery staff collecting the injection will need to sign the CD consignment note and ensure a signature is obtained for receipt of the drug on the ward.
- On receipt of the injection the nurse/midwife must ensure it is locked away in the CD cupboard and enter details of receipt into the CD book. The injection should be checked carefully by a second nurse/midwife and the stock balance documented. Both nurses should sign the book.

4.3 Administration of potassium chloride 15% injection on NNU:

- When potassium infusion is required, TWO nurses/midwives should be involved in the whole process. Both staff should check the following:
  - Check the intravenous administration sheet carefully, ensuring the rate of infusion is specified. Double check all calculations.
  - Check the details of the injection carefully and complete the batch number and expiry date on the prescription/iv administration chart.
  - Before giving to the patient double-check the details again and check the patient name, date of birth and hospital number.
  - The infusion must be administered via a suitable infusion pump to control the rate of infusion. Check the pump has been correctly set up and programmed.
  - Complete the patient’s details in the CD book and check the balance of potassium injection. Both staff should sign the book as confirmation of their involvement in the process.
5. **PROCEDURE FOR MAKING UP MAINTENANCE IV POTASSIUM INFUSIONS FOR NEONATES.**

- **Suggested dose:**
  - Sodium: 3mmol/kg
  - Potassium: 2mmol/kg

- This can be infused in Glucose 5% or glucose 10%

5.1 **Sodium requirement:**

- Calculate total dose required per day:
  \[
  3\text{mmol/kg} \times \text{weight of baby in Kg} = A \text{ mmol}
  \]

- Calculate total fluid requirement of the baby per day in mls/kg:
  \[
  \text{mls/kg multiplied by weight} = B \text{ mls}
  \]

- Therefore you require \( \frac{A \text{ mmol of sodium}}{B \text{ mls}} \) over 24 hours.

- To calculate how much sodium you require to add to the 500ml bag:
  \[
  500 \times \frac{A}{B} = \text{mmol to be added to the 500ml bag}
  \]

- Sodium is available as 50mmol in 10ml

  To calculate the number of mls to be added:
  \[
  \frac{\text{number of mmol needed} \times 10\text{ml}}{50}
  \]

5.2 **Potassium requirement:**

- Calculate total dose required per day:
  \[
  2\text{mmol/kg} \times \text{weight of baby in Kg} = C \text{ mmol}
  \]

- Therefore you require \( \frac{C \text{ mmol of potassium}}{B \text{ mls}} \) over 24 hours (using volume \( B \) calculated from the sodium requirement above).

- To calculate how much potassium you require to add to the 500ml bag:
  \[
  500 \times \frac{C}{B} = \text{mmol to be added to the 500ml bag}
  \]

- Potassium is available as 20mmol / 10ml

  To calculate the number of mls to be added:
  \[
  \frac{\text{number of mmol needed} \times 10\text{ml}}{20}
  \]

5.3 **Withdraw the equivalent amount of fluid from the 500ml bag and then add the sodium and potassium. Mix well to avoid layering and infuse at the prescribed rate.**

6. **PHARMACY – SAFE AND SECURE HANDLING OF POTASSIUM SOLUTIONS**

- The pharmacy holds stock of all forms of concentrated potassium.

- All preparations of concentrated potassium will be considered as a controlled drug in East Cheshire NHS Trust. These solutions must be stored in the controlled drugs cupboard or designated cupboard specifically for potassium.

- A receipt, supply and usage of concentrated potassium must be recorded in the controlled drugs register.

- Wards must requisition supplies of concentrated potassium in the ward controlled drugs requisition book.

**All staff involved in the storage, prescribing, preparation and administration of potassium solutions MUST read the Trust IV potassium administration policy.**
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.
Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

East Cheshire NHS Trust Potassium Policy

Details of person responsible for completing the assessment:
Jabeen Razzaq-Sheikh
Lead Pharmacist for Surgical Specialities, Clinical Support & Diagnostics Services.
Pharmacy
Pharmacy services.

State main purpose or aim of the policy, procedure, proposal, strategy or service:
(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)
This policy aims to govern the use of potassium product to ensure appropriate prescribing and administration. This Policy follows relevant clinical guidelines (Trust Clinical guidelines available on Trust website)

2. Consideration of Data and Research
To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service
2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document
Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
• 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
• 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.
• Gypsies & travellers – estimated 18,600 in England in 2011.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
• In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
• In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
• Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
• C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
• In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
• Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
• CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
• CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
• Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
• Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
• Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
• Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
• Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
• Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
• Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
• None: 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
• Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

Carers: In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)
No evidence of complaints
2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?
Not aware of any issues

3. Assessment of Impact
Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

**RACE:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes ☐ No X
**Explain your response:**
Administration should be given in line with clinical guidelines – if any explanation needs to be given to patients/carers and their first language is not English, staff will follow the trust interpretation policy.

**GENDER (INCLUDING TRANSGENDER):**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes ☐ No X
**Explain your response:**
Prescribing and Administration should be in line with clinical guidelines.

**DISABILITY**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes ☐ No X
**Explain your response:**
Prescribing and Administration should be in line with clinical guidelines. If a patient has particular needs, staff can follow the trust interpretation policy to ensure understanding.

**AGE:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, age groups differently? Yes ☐ No X
**Explain your response:**
Prescribing and Administration should be in line with clinical guidelines. Age appropriate explanations can be given as required.

**LESBIAN, GAY, BISEXUAL:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes ☐ No X
**Explain your response:**
Prescribing and Administration should be in line with clinical guidelines.

**RELIGION/BELIEF:**
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From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, religious belief groups differently?  
**Yes ☐ No ☑**

**Explain your response:**  
Prescribing and Administration should be in line with clinical guidelines.

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**CARERS:**

From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, carers differently?  
**Yes ☐ No ☑**

**Explain your response:**  
Prescribing and Administration should be in line with clinical guidelines.

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**OTHER:** EG Pregnant women, people in civil partnerships, human rights issues.

From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect any other groups differently?  
**Yes ☐ No ☑**

**Explain your response:**  
Staff make sure medication appropriate for stage of pregnancy.

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### 4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
<th>Yes ☑ No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:</td>
<td></td>
</tr>
<tr>
<td>Prescribing and Administration should be in line with clinical guidelines</td>
<td></td>
</tr>
<tr>
<td>c. If no please describe why there is considered to be no impact / significant impact on children</td>
<td></td>
</tr>
</tbody>
</table>

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### 5. Relevant consultation

_Having identified key groups, how have you consulted with them to find out their views and that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?_

Clinicians, specialist pharmacists, Medicines Management group.

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### 6. Date completed:  Nov 2015               Review Date: Nov 2018

### 7. Any actions identified:  Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### 8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead  
**Lead lynbailey@nhs.net**

Approved by Trust Equality and Diversity Lead:  
 Date:8.12.15

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Lead Pharmacist Surgical Specialities  
10/11/2015