

IV adverse events and emergency response

Document control

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Scope: reactions during or after adult clinic hydration, vitamin C and iron infusions and home IV sodium chloride 0.9% infusions (IV-002 section 16), including suspected reactions, administration errors, extravasation and delayed patient-reported concerns. Applies with IV-002 and IV-004. This is an approved supporting SOP under IV-001 v2.5. Keep staffing, equipment, training and clinical contact records current; verify safe arrangements for every session.

1. Readiness before each treatment

Confirm a competent clinician and trained responders are available for the planned treatment and observation period. Check immediate access to working monitoring/resuscitation equipment, oxygen with delivery equipment, an AED and appropriate emergency medicines; record expiry, access and function. Retain session checks and documented checks at least weekly. Staff receive resuscitation training at induction and at least annually. [R31-R32] Keep the current Resuscitation Council UK algorithm readily accessible. Confirm how to call 999, the full clinic address and access instructions, and who meets the ambulance. [R01, R16]

Review the patient's risks and explain symptoms to report. Record baseline observations and the planned monitoring. For IV iron, trained staff and resuscitation facilities must be immediately available, with monitoring during administration and for at least 30 minutes afterwards. Previous tolerance does not remove hypersensitivity risk. [R13] Home IV saline: The doctor carries an anaphylaxis kit (intramuscular adrenaline 1 mg/ml with Resuscitation Council UK dosing guidance), a pocket mask, and observation equipment (blood pressure monitor, pulse oximeter and thermometer). The kit is checked complete and in date before each visit, and treatment does not start unless it is.

Immediate response to a serious reaction

2. Immediate response to a suspected serious reaction

- Stop the implicated infusion, summon the responsible clinician and assess airway, breathing, circulation, disability and exposure. Record the onset time and observations while prioritising treatment.
- For suspected anaphylaxis or another life-threatening problem, call 999 without waiting for the clinic's internal escalation process. Use the current Resuscitation Council UK algorithm: trained staff give age-appropriate intramuscular adrenaline promptly when indicated, provide oxygen/resuscitation as required and reassess. IV adrenaline requires specialist expertise and is not a routine clinic substitute.
- At a home infusion: for suspected anaphylaxis or another serious reaction, stop the infusion, call 999 giving the home address, treat in line with Resuscitation Council UK guidance, stay with the patient and hand over to the ambulance crew.
- Position and support the patient according to the clinical situation and current guidance; do not allow a patient with suspected anaphylaxis to stand or walk. Monitor continuously and repeat emergency treatment according to the algorithm. If cardiac arrest occurs, commence CPR/AED management.
- Preserve or obtain appropriate IV access when clinically indicated, but do not continue the suspect product. If extravasation is suspected, follow section 3 rather than automatically flushing the line.
- Hand over the product, dose, dilution, timing, symptoms, observations and treatment to emergency clinicians. Do not discharge a patient with suspected anaphylaxis simply because symptoms initially improve. [R16]

Do not label a reaction as benign until assessed. Any restart requires an explicit prescriber decision supported by the product guidance and clinical assessment; never automatically restart a stopped infusion.

Extravasation, delayed concerns and reporting

3. Pain, leakage or swelling at the cannula

Stop the infusion immediately and assess the site and patient. Do not flush a cannula through which extravasation may have occurred. Keep access initially only as required for assessment/aspiration under the product-specific extravasation procedure, then remove/manage it as clinically directed. Identify the drug, concentration, estimated escaped volume and time. Obtain appropriate specialist advice for management, compresses or other treatment; do not improvise an antidote.

Document extent, symptoms, circulation and neurological findings where relevant; obtain consent for clinical photographs when useful. Explain the risk of persistent or permanent iron staining and arrange review. Escalate severe pain, progressive swelling, skin injury or neurovascular concern urgently. Record and report the event; preserve relevant packaging and evidence safely. [R15, R37]

4. Patient reports after discharge

Any staff member receiving a possible adverse-event report must identify emergency symptoms first and direct the patient to 999 when indicated. Record patient identifiers, callback number, current location, symptoms/onset, infusion date/product and immediate action. Do not require a complaint form or wait for proof of causation. Administrative staff must not offer clinical reassurance beyond their training.

Clinic hours: Monday-Friday 09:00-20:00; Sunday 09:30-17:30. Clinical concerns on 020 8882 8088 are routed to a doctor. Saturday: clinic closed; NHS 111 for urgent advice or 999 for emergencies. Outside other staffed hours, calls divert to Dr Parmar and Dr Alpa. Diversion is not guaranteed availability; if urgent help is needed and no clinician responds, use NHS 111 or 999 as appropriate. Keep cover and routing records privately.

The clinician must assess, arrange examination/tests or emergency transfer as needed, give clear safety-netting and document a follow-up plan. Record attempts to contact the patient and the action if contact fails. A normal immediate post-infusion period does not exclude a delayed reaction. Consider product-specific risks, including hypophosphataemia after ferric carboxymaltose where relevant. [R14]

5. Reporting and preservation of evidence

Record all suspected events locally, including near misses and preparation/administration errors. Report serious suspected reactions to established medicines and all suspected reactions to additional-monitoring products through MHRA Yellow Card; suspicion is sufficient. MHRA's IV iron advice asks for any suspected iron ADR, identifying the exact product. Record the report reference and any follow-up. [R12-R13, R29]

If a quality defect or contaminated product is suspected, segregate affected stock, preserve identifying evidence safely and notify the supplier/manufacturer and MHRA as appropriate. Use the confirmed patient-linked bag/additive batch and expiry records in IV-004 to identify other potentially exposed patients. Do not return or destroy evidence until the reporting/investigation requirements are agreed. [R28]

Candour, review and continuity of care

6. Duty of candour and statutory notifications

Be open and honest with the patient about what is known, what is uncertain and the next steps. The Clinical Director must assess whether the statutory duty of candour applies. For this independent provider, use Regulation 20(9), not the NHS-body 'moderate harm' shorthand. Qualifying outcomes include specified lasting impairment or harm, structural bodily change, reduced life expectancy, incident-related death, or treatment needed to prevent death or qualifying injury. Apply the complete legal definition to the case. [R03]

Where the duty applies, notify the relevant person as soon as reasonably practicable, offer support, give a truthful account of the known facts, explain further enquiries and apologise. Keep a secure record and follow up in writing with the required information and investigation outcome. Record unsuccessful contact attempts or refusal to engage. An apology does not require waiting for a completed investigation.

Separately assess CQC notification duties, including serious injuries and deaths under the Registration Regulations. Submit required notifications without delay and keep the reference. A Yellow Card, complaint or candour conversation does not replace a statutory notification. Not every ADR meets every reporting threshold. [R19-R20]

7. Follow-up and investigation

- Assign a clinician to follow the patient's recovery, outstanding investigations and treatment consequences. Agree responsibility for any referral or transfer of care and confirm receipt of time-critical information.
- Share relevant information with the patient's usual clinician with consent or another appropriate lawful basis; document the basis and any urgent justification. Update adverse-reaction/allergy records appropriately, preserving uncertainty where the cause is not established.
- Review the assessment, product selection, batch, preparation, storage, administration, observations, staffing and aftercare. Review serious events before resuming the implicated pathway. Distinguish patient report, observed findings, recorded facts and clinical opinion.
- Determine whether other patients, the same batch or a wider process may be affected. Pause only the unsafe affected activity while arranging alternative care. Record corrective actions, owners and evidence before resumption.
- Explain findings and next steps to the patient, close outstanding follow-up and share learning with relevant staff. The complaints route remains available and must not delay clinical care.

8. Review standards

The Clinical Director reviews serious events promptly and all other events through a risk-based governance process. Audit time to triage/escalation, complete records, reporting decisions, patient communication and closure. Reassess staff competencies or procedures where the event identifies a gap. Review this SOP annually and sooner after material change.

Patient information: after your IV infusion

Give this information after treatment, including after a home infusion, and complete the patient-specific fields. Contact arrangements below reflect the clinic's confirmed hours and Saturday closure. Personal mobile numbers are not published; use the clinic number.

Get emergency help immediately

Call 999 if you develop difficulty breathing, swelling of your tongue or throat, collapse, severe chest pain or another severe or rapidly worsening reaction. Tell the call handler that you recently had an IV infusion. Do not wait for the clinic to reply to an email or message, and do not drive yourself if seriously unwell. [R17]

Get prompt clinical advice

Contact the clinical service below for a new rash, fever, persistent dizziness, worsening symptoms, or pain, redness, swelling or discolouration around the infusion site. If urgent advice is needed and you cannot reach a clinician, use NHS 111. If symptoms become severe, call 999.

After iron, leakage around the vein can cause long-lasting or permanent staining. Report new site pain, swelling or skin changes promptly. Delayed aches or fatigue can have several causes; worsening or persistent symptoms need assessment. If your product requires phosphate checks or other follow-up, the clinician will record the plan below.

Your treatment and follow-up

Patient / date

Product(s) and dose - Infusion fluid and medicine; attach batch details or treatment summary:

Individual instructions - Expected effects, specific warning signs and activity/travel advice:

Follow-up - Tests/review date; responsible clinician; how results will be communicated:

Clinical contact - 020 8882 8088. Mon-Fri 09:00-20:00; Sun 09:30-17:30. Clinical concerns are passed to a doctor.

Outside clinic hours - Saturday closed: NHS 111/999. Other out-of-hours calls divert to a doctor; response is not guaranteed. If urgent and unanswered, use NHS 111; emergencies 999.

For urgent problems when the clinical service is unavailable: NHS 111. For an emergency: 999. General booking email and WhatsApp are not emergency channels; do not send confidential medical details through general enquiry routes. You can also report suspected medicine side effects to the MHRA Yellow Card scheme; reporting does not replace medical assessment.

Appendix: adverse-event record and references

Patient / reporter - Identifiers; reporter and contact; date/time received; current location:

Exposure - Infusion date; product/dose; fluid and additive batches; preparation/administration times:

Event and assessment - Patient account; onset; observations/examination; severity; suspected causes:

Immediate action / outcome - Infusion stopped; treatment; escalation/transfer; times and responsible clinicians:

Reporting / notifications - Incident ID; Yellow Card; supplier; CQC/candour assessment; references/dates:

Follow-up / closure - Advice; review/tests; patient/GP communication; investigation; actions/owner; closure:

Practical control

Use a secure clinical record and incident log. Restrict access to authorised staff, retain dated, attributable corrections without overwriting original entries, and record decisions not to report as well as reports made. Retention follows the clinic's approved records schedule. Blank templates may be published; completed records and staff-sensitive operational details must remain private.

Sources checked 22 October 2026

R01. CQC: Regulation 12 - safe care and treatment
R03. CQC: Regulation 20 in full - duty of candour
R12. MHRA: Yellow Card guidance
R13. MHRA: intravenous iron and serious hypersensitivity
R14. MHRA: ferric carboxymaltose and hypophosphataemia
R15. NHS SPS: minimising risks with injectable iron
R16. Resuscitation Council UK: emergency treatment of anaphylaxis
R17. NHS: anaphylaxis - patient emergency advice
R19. CQC Registration Regulations: regulation 18 notifications
R20. CQC Registration Regulations: regulation 16 death notifications
R28. NHS SPS: managing defective medicines
R29. GMC: reporting adverse reactions and patient safety incidents
R32. CQC: emergency care in general practice
R37. Venofer: UK SmPC - confirmed clinic iron product