Australian
Private Hospitals
Association

Draft guidance to support the safe, appropriate and sustainable use of intravenous fluids

APHA FEEDBACK

JUNE 2026

Contents

Executive Summary

The Australian Private Hospitals Association (APHA) welcomes the opportunity to provide feedback on the two draft guidance documents: *Intravenous fluid therapy: Principles for safe and appropriate use* and *Safe administration of intravenous fluids: Avoiding venous air embolism*.

Overall, APHA supports the guidance and its intent. The documents are clinically sound, well structured, and consistent with contemporary patient safety principles. They bring together best practice for IV fluid management into a single, practical resource, and the principles they set out are relevant and broadly achievable in private hospital settings. We also acknowledge that the expert group included clinical representatives with experience across both public and private settings. We particularly support the emphasis on deliberate use, clear clinical intent, regular review, multidisciplinary care coordination and responsible stewardship. This is especially important given the supply disruptions that have affected hospitals, including private hospitals, in recent years.

We would be pleased to consider endorsing the final guidance. To support that endorsement, and to help the guidance translate into consistent practice across the private sector, we ask the Commission to consider the points below. A single principle runs through them: system design should support safe care, while clinical decision making and accountability remain with the treating clinician.

Feedback

CLINICAL ACCOUNTABILITY AND THE PRIVATE HOSPITAL WORKFORCE MODEL

Many of the core elements of safe IV fluid practice (confirming the need for therapy, assessing requirements, selecting and prescribing fluids, and reviewing and ceasing therapy) are inherently clinical decisions that rest on professional judgement. They cannot be meaningfully influenced by organisational systems alone, and the guidance should avoid any misalignment between responsibility for decision making and the mechanisms intended to influence practice.

The draft guidance, and Attachment 1 in particular, weights accountability toward documentation and organisational enablers, despite identifying known drivers of inappropriate IV fluid use, including junior prescribing and limited oversight. This framing matters in the private sector, where most prescribing is undertaken by independent credentialed medical practitioners (visiting medical officers) rather than employed staff. Private hospitals credential these practitioners, govern their practice, and put supporting systems in place, but they do not direct, and cannot substitute for, a practitioner's clinical judgement within their scope of practice.

We recommend the guidance more clearly attribute clinical accountability to prescribers, set a clear expectation of senior clinical oversight, and recognise the role of professional standards and training in shaping prescribing practice. Organisational systems should be positioned as enablers of safe practice, not as substitutes for clinical decision making.

ENGAGEMENT AND ENDORSEMENT BY MEDICAL COLLEGES AND SPECIALTY BODIES

Because the changes the guidance seeks are largely changes to prescribing practice, their uptake depends on ownership by the professions. It is not evident from the consultation materials that the relevant medical colleges and specialty bodies have been engaged in the development or review of the guidance, or that they will formally endorse and support the prescribing practice changes it describes.

We encourage the Commission to seek the involvement and endorsement of the relevant colleges and professional bodies. In the private sector in particular, where care is delivered largely by visiting practitioners, professional standards, training and endorsement are likely to be more effective levers for changing prescribing practice than organisational systems alone.

IMPLEMENTATION IN PRIVATE HOSPITAL SETTINGS

APHA supports the practices set out in the guidance. We note three areas where implementation may be more challenging in private settings, and where refinements of the guidance would reflect these considerations.

- The guidance suggests improving visibility of IV fluid orders for treating teams, for example through real time dashboards or reports. This assumes an electronic medical record, which is not yet in place across all private hospitals. We recommend qualifying this enabler with the words "where possible".
- Supporting education and training is achievable for employed clinicians and registered nurse prescribers. It is more challenging for non-employed credentialed visiting medical officers, particularly where IV fluid management would generally be considered part of their core

scope of practice. We recommend the guidance acknowledge this and frame the organisational role as promoting and supporting access to education rather than assuring training for every prescriber.

- APHA supports documenting both the indication and the goals of IV fluid therapy. Documenting the indication is already common practice. Documenting fluid specific goals is less established, particularly in settings without a junior medical workforce charting fluid orders. We support this direction but note that it will take time for clinicians to adapt, and we suggest any implementation guidance recognise a reasonable transition period.

SAFE ADMINISTRATION OF INTRAVENOUS FLUIDS

APHA considers Attachment 2 to be clear, practical and operationally strong, and we support it. We note that several of the higher risk scenarios it describes, including pressurised infusions and the use of alternative IV fluid products are shaped by clinical decisions rather than administrative processes alone.

We recommend the guidance recognise explicitly that the decisions which influence venous air embolism risk in these scenarios are clinically determined and require appropriate clinical accountability. Without this, there is a risk that responsibility may be read as primarily associated with organisational systems and processes.

Conclusion

APHA is broadly supportive of the draft guidance and its objectives. The documents are clinically sound, well structured, and provide a useful national reference point for safe, appropriate and sustainable IV fluid management. APHA's feedback is directed to ensuring the final guidance is practical for private hospital settings and clearly reflects the distinction between organisational systems that support safe care and the clinical judgement and accountability of treating clinicians. Addressing the matters raised in this submission would strengthen the guidance and assist its consistent implementation across the private hospital sector.

END OF DOCUMENT