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SUBMISSION

Monday, 29 June 2026

Consultation on draft guidance to support the safe, appropriate and sustainable use of intravenous fluids

The Australian Medical Association (AMA) welcomes the opportunity to comment on the Australian Commission on Safety and Quality in Health Care's (the commission) draft guidance for the safe and appropriate use of intravenous fluids. We support the commission's attention to the sustainable use of intravenous (IV) fluids in hospital settings, particularly given the significant disruption caused by the national IV fluid shortage during 2024 and 2025. It is appropriate the lessons of that period now inform more consistent and deliberate practice, and the AMA recognises good stewardship of IV fluids must sit alongside broader policy action to strengthen Australia's medicine supply resilience.

IV fluids are a critical clinical resource and should be treated with the same care, planning and oversight as other medicines. We support the draft guidance's central emphasis on deliberate initiation, clear documentation of clinical intent, ongoing review, timely cessation, transition to oral hydration or medicines where clinically appropriate, and strong organisational systems to support safe practice. We also support the accompanying fact sheet on avoiding venous air embolism, particularly its focus on priming, equipment, competency, and the risks associated with pressurised infusions and some substitute products used during supply disruptions.

At the same time, the AMA considers the guidance should do more to acknowledge the realities exposed by the previous IV fluid shortages: communication to clinicians was often uneven and impacts varied considerably across health settings. Conservation measures sometimes required changes to usual practice, and supply substitution introduced practical and safety concerns requiring active management. These lessons reinforce the need for guidance that is not merely clinically sound, but also workable in real hospital settings and aligned with a broader, proactive approach to sustainable medicines supply in Australia.

The final guidance should retain a strong implementation focus and be understood as one part of the broader policy effort to support a safer, more sustainable and more resilient medicines supply system.

IV fluid therapy as a deliberate clinical intervention, not a routine default

The AMA agrees IV fluid therapy is not a low-risk or routine intervention. The draft correctly identifies that inappropriate initiation, administration, monitoring or prolonged use of IV fluids can lead to patient harm, including fluid overload, infection, electrolyte disturbance, acute kidney injury, thrombophlebitis and extravasation. It is therefore appropriate the final guidance places clear emphasis on deliberate decision-making throughout the patient journey.

This emphasis is also consistent with broader lessons from the IV fluid shortage. When in shortage, governments, health services and clinicians were required to use IV fluids more sparingly, conserve supply where appropriate, and reconsider practices which had sometimes become habitual rather than clinically necessary. The AMA's public commentary during the shortage recognised both the critical importance of IV fluids to patient care and the need for their judicious use when supply was constrained.

The AMA supports retaining the "Start, Stop, Switch" framework in the final guidance. It is simple, clinically intelligible and useful as a practice anchor. Beyond the context of shortage management, this framing promotes good clinical care while supporting more resilient, sustainable use of IV fluids during future periods of increased demand or supply disruption.

The AMA recommends the guidance be more precise in its references to involving family members or carers in decisions about IV fluid therapy. Where an adult patient has decision-making capacity, family members or carers should be involved in treatment discussions only with the patient's consent. Where a patient lacks decision-making capacity, involvement of a substitute decision-maker, family member or carer should occur in accordance with applicable legal and clinical requirements, and where time and clinical circumstances allow. This clarification would avoid any implication that family members have an automatic role in treatment decisions for competent adult patients.

Documentation, review and active cessation of IV fluid therapy

The AMA supports the draft's focus on documenting the indication, goals of therapy, monitoring requirements and stopping criteria for IV fluid therapy. The draft is right to identify "continuation by default" as a recurring problem, especially in emergency departments, acute medical and surgical wards, and out-of-hours settings where junior or rotating clinicians may be recharting or continuing therapy without a clearly communicated plan.

Clearer documentation of clinical intent will improve continuity of care, reduce unnecessary or prolonged IV use, and support safer multidisciplinary review. The final guidance should maintain a strong expectation that IV fluids be prescribed with the same care and clarity as other medicines, including the indication, volume, rate, intended duration, review points and criteria for cessation or modification.

This focus on communication is critical. Timely, accurate and consistent communication supports safe clinical care and more effective responses to medicine supply challenges. Clinical care is safer when treating teams can see clearly why therapy was started, what it is intended to achieve, and when it should stop.

Early transition to oral hydration and oral medicines

The AMA agrees with the draft guidance that oral hydration and oral medicines should be used where clinically appropriate, and that timely transition away from IV therapy should be planned proactively rather than deferred by default. The draft appropriately links this to pre-procedural fluid management, medicine administration decisions, and patient-centred care.

The AMA also considers this aspect of the guidance to be one of the clearest examples of where safe practice and sustainable resource use appropriately intersect. During the IV fluid shortage, conservation strategies necessarily focused on avoiding unnecessary IV use, using the smallest appropriate volume, and transitioning to alternative routes where clinically safe. The commission's

own shortage guidance and the wider national response recognised these strategies could reduce waste and help maintain supply without compromising care when applied judiciously.

We suggest retaining and, if possible, sharpening the message that switching to oral routes is a marker of good care when clinically appropriate, rather than merely a rationing response. Framing this as good routine practice will help avoid the impression that stewardship is only relevant in times of scarcity. Appropriate clinical practice and sustainable supply policy are mutually reinforcing rather than competing objectives.

Venous air embolism

The AMA supports the separate draft fact sheet on safe administration of intravenous fluids: avoiding venous air embolism. The document addresses a serious safety issue in a practical way by emphasising proper line priming, in-line air detection where possible, vigilance during administration, not allowing infusions to run dry, not re-spiking bags, adherence to manufacturer instructions, and appropriate clinician training and competency assessment.

Importantly, this resource explicitly addresses the elevated risks associated with pressurised infusions and some alternative products, including certain section 19A substitutes with larger residual air volumes. This is an important lesson from the shortage period. Where substitute products are introduced into the system, attention must be paid not only to availability, but also to usability, compatibility and safety in real clinical settings.

In the AMA's view, the final fact sheet should remain closely tied to practical implementation. Acknowledging practitioner vigilance is important, the guidance should also continue to communicate air embolism prevention depends on product choice, device capability, local protocols, training, and organisational support not solely a matter of individual vigilance.

Implementation, governance and clinician communication

The draft's consideration of prescribing-system prompts, documentation requirements, multidisciplinary review, visibility of IV fluid orders, incident monitoring and staff education is sensible and should remain central to the final version.

The AMA supports the overall direction of the guidance, but suggests the Commission further clarify the intended audience for each document. Some content restates basic principles of clinical care and may dilute the core messages. The final guidance would be strengthened by clearer signposting of the key practice changes it seeks to promote, particularly around documentation of clinical intent, review, cessation, oral transition where appropriate, and safe administration practices.

AMA member feedback gathered during the 2024 IV fluid shortage reinforces the value of this guidance. The AMA's survey in the second quarter of 2024, and the broader experience during that shortage, highlighted how the effects of supply disruption were uneven across health settings and often poorly communicated. Members reported altered clinical practice, delays to treatment, procedure disruption, with increased administrative burden and reduced caseload. Practitioners also expressed concern with the inadequate communication across governments and stakeholders regarding the scale of shortages, how they were being managed, and whether essential supply chains were being protected. Local responses varied considerably, creating uncertainty across the system in the absence of clearer messaging and better visibility of how shortages were being addressed. These experiences support the need for national guidance that promotes deliberate, well-documented and

regularly reviewed IV fluid use. They also demonstrate stewardship guidance must sit alongside stronger implementation support and clearer clinician communication in the context of broader action to improve the resilience of Australia's medicines supply.

The AMA encourages the commission to ensure the final guidance is accompanied by practical implementation support rather than relying on principle statements alone; materials that help hospitals embed review prompts, support clear prescribing documentation, reinforce oral transition where appropriate, and communicate changes consistently to doctors, nurses, pharmacists and patients would be most useful. System-wide communication and coordination are indispensable to safe clinical responses in the medicines space.

IV fluid use within broader sustainable and secure medicines supply policy

The AMA welcomes the draft guidance's recognition that appropriate IV fluid use is both a patient safety issue and a matter of responsible stewardship. However, this guidance must be understood as one part of a broader policy response. Safe and appropriate clinical practice must be matched by stronger national action to secure Australia's medicines supply, improve coordination, strengthen communication to clinicians and patients, and prepare for future disruptions.

The AMA supports appropriate stewardship of IV fluids, but this must not be confused with normalising scarcity. Decisions to commence, continue, modify or cease IV fluid therapy should be based on clinical need, patient factors and response to treatment — not on acceptance that essential supplies may be unavailable. The IV fluid shortage demonstrated the importance of avoiding unnecessary use and waste, but it also exposed a more fundamental policy failure: Australia should not face shortages of such a basic and essential healthcare product. Guidance on safe and appropriate use is welcome, but it must sit within a broader policy architecture for sustainable supply, including stronger national coordination, clearer communication, improved preparedness, diversified supply arrangements and greater resilience in domestic supply settings.

This guidance is therefore welcome and useful, but it will have greatest value if framed within a wider approach to sustainable supply — one that links clinical stewardship with preparedness, communication, and more resilient supply settings.

Strengthening the final guidance

The AMA broadly supports the draft guidance and reiterates the final materials should continue to recognise implementation will depend on workable systems for documentation, review and multidisciplinary communication. This is essential if the guidance is to influence practice meaningfully.

We recognise the current draft maintains an important distinction between high-level principles and condition-specific regimens, while ensuring clinicians are clearly directed to authoritative specialty resources where more detailed advice is needed. The AMA emphasises the final guidance should also continue to acknowledge the safety and practical implications of substitute products used during shortages, including differences in residual air volume, compatibility and handling requirements. The fact sheet on venous air embolism addresses this directly and should remain clearly linked to the broader principles document.

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