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IMMEDIATE MESSAGE TO:

Medical Directors NHS Boards
Directors of Pharmacy

14 January 2026

Dear Healthcare Professional,

NATIONAL PATIENT SAFETY ALERT/2026/001/DHSC - Steriflex® No. 109 (1L) and No. 171 (2L): Potassium Chloride 0.15%, Sodium Chloride 0.45%, Glucose 2.5% Bags

This National Patient Safety Alert provides information about the Fresenius Kabi Steriflex® range of licensed and unlicensed IV fluid bags to DEHP-free IV fluid bags. In line with changes to reach regulations, they have experienced a shortage during this change due to increased demands and lack of availability of raw materials.

For onward transmission as detailed below :

Please could all Directors of Pharmacy please forward this alert to:-

- Chief Pharmacists
- Hospital Pharmacists

Please could Medical Directors arrange to forward this alert on to:-

- Clinical Specialists in adult & paediatric oncology and haematology teams
- Critical Care
- Accident & Emergency Departments

Thank you for your co-operation.

Yours sincerely

IRENE FAZAKERLEY
Medicines Policy Team

National Patient Safety Alert

Department of Health & Social Care

NHS England

Steriflex® No. 109 (1L) and No. 171 (2L): Potassium Chloride 0.15%, Sodium Chloride 0.45%, Glucose 2.5% Bags

Date of issue:	14-Jan-26	Reference no:	NatPSA/2026/001/DHSC

This alert is for action by all organisations involved in prescribing Steriflex® No.109 and No.171 IV fluid bags.

This is a safety critical and complex National Patient Safety Alert. Implementation should be co-ordinated by an executive lead (or equivalent role in organisations without executive boards) and supported by pharmacy teams and relevant clinical specialists including adult and paediatric oncology/haematology teams and Medication Safety Officers (MSO).

Explanation of identified safety issue:

Fresenius Kabi are transitioning their Steriflex® range of licensed and unlicensed IV fluid bags to DEHP-free IV fluid bags in line with changes to reach regulations, and have experienced a shortage during this change due to increased demands and lack of availability of raw materials.

The following products will be continued within their portfolio however there will be a shortage during this transitional period:

- Steriflex® No. 109 (1L): potassium chloride 0.15%, sodium chloride 0.45%, glucose 2.5% containing potassium 20mmol in 1L is out of stock until September 2026.
- Steriflex® No. 171 (2L): potassium chloride 0.15%, sodium chloride 0.45%, glucose 2.5% containing potassium 40mmol in 2L will be out of stock from May until August 2026.

Fresenius Kabi have applied monthly allocations for Steriflex® No.171 (2L) bag. Contact your FK account manager if you require further information.

A range of alternative IV fluid bags from other suppliers are available, but the use of these products will require review of protocols and prescriptions on electronic prescribing systems and some may require additions to pre-made bags.

Where possible prepare infusions in an aseptic unit as preparing them in clinical areas using individual components poses a significant patient safety risk from calculation, measurement and preparation errors, resulting in incorrect dosing and microbial contamination.

A Medicine Supply Notification relating to supply issues with other Steriflex® bags will be issued.

Actions required

Actions to be completed by 06/02/2026

Pharmacy teams should:

1. assess where the Steriflex® No. 109 (1L) and No.171 (2L) bags are used within their Trust including paediatric and adult oncology/ haematology.
2. maintain their usual ordering patterns.
3. work with clinical leads in the identified Specialist areas to assess if the suggested alternative products [Note A] would be suitable for their patients.
4. review and update local guidelines, protocols, charts and/or ePrescribing systems to set up the new product(s).
5. where additions will need to be made to IV fluid bags, undertake risk assessments as appropriate to ensure correct calculations and safe practice.
6. ensure concentrated potassium is not added to bags in clinical areas.

For further detail, resources and supporting materials see: Enter specific webpage provided by alert issuer

For any enquiries about this alert contact: DHSCmedicinesupplyteam@dhsc.gov.uk

Failure to take the actions required under this National Patient Safety Alert may lead to CQC taking regulatory action

Additional information:

NOTE A: available alternatives for Steriflex® (potassium chloride 0.15%, sodium chloride 0.45%, glucose 2.5%) No.109 (1L) and No. 171 (2L) bags.

1. Potassium chloride 0.15%, sodium chloride 0.45%, **glucose 5%**, 500ml bag supplied by Fresenius Kabi

2. Potassium chloride 0.15%, **glucose 5%** 1L FKE1134 bag supplied by Baxter

    - To make up a 1L bag containing approximately potassium chloride 0.15%, sodium chloride 0.45% and **glucose 5%**:
        - Add 15mL of sodium chloride 30% solution for injection (equivalent to 4.5g of sodium chloride) to a 1L bag of potassium chloride 0.15% and **glucose 5%** (FKE1134 supplied by Baxter). Mix thoroughly by gentle rocking to ensure a uniform concentration of the solution. This is essential to prevent the patient receiving a concentrated and potentially harmful amount of sodium chloride.

A local risk assessment is recommended to assess the risk of the addition of sodium chloride 30% to a fluid bag supplied by Baxter versus more frequent change of the 500mL fluid bag supplied by Fresenius Kabi.

Please note, FKE1134 contains 5% glucose compared to 2.5% glucose in Steriflex® No.109 (1L) and No.171 (2L) bags. This is not considered to be clinically significant; however, blood glucose levels should be monitored if deemed necessary.

References:

Patient Safety Alert: Potassium chloride concentrate solution

Stakeholder engagement

The following stakeholders have been engaged in the management and consulted in the drafting of this alert: NHS Specialist Pharmacy Service Medicine Advice; Medicine Shortage Response Group; NHS England; national clinical experts in paediatrics and paediatric oncology; national patient safety team; Medicine and Healthcare products Regulatory Agency and the Devolved Governments.

Advice for Central Alerting System (CAS) officers and risk managers

This is a safety critical and complex National Patient Safety Alert. In response to CHT/2019/001 your organisation should have developed new processes to ensure appropriate oversight and co-ordination of all National Patient Safety Alerts. CAS officers should send this Alert to the executive lead nominated in their new process to coordinate implementation of safety critical and complex National Patient Safety Alerts, copying in the leads identified on page 1.