SECTION 8B: PUMPS & DRUG ADMINISTRATION	POLICY: 8B.14
POLICY: HYDRATION THERAPY EDUCATION PRACTICES	PAGE: 1 OF: 5

PURPOSE:

- To provide instruction and guidance on patient education, safe self-administration, and nursing management of IV hydration therapy for patients in the home setting.

POLICY:

- Hydration will be administered by a trained RN in accordance with a physician's order, any available / provided pharmacy or manufacturer instructions, and Agency policy.

GENERAL INFORMATION:

- Hydration fluids are received intravenously through the bloodstream. Fluid is given from a bag connected to an intravenous line. The intravenous flow is regulated by gravity or an ambulatory / peristaltic pump.

- The rate, quantity, and frequency of intravenous fluid given depends on the patient's medical condition, body size, and age and is determined, supervised, and managed by an ordering physician or practitioner.

- The Agency RN is responsible for educating the Patient / Caregiver on proper administration of the correct amount of fluid by physically and verbally demonstrating administration steps, verifying the frequency and rate per order, and receiving teach-back from the Patient / Caregiver.

Helms Home Care RNs providing hydration therapy services will be knowledgeable on:

- PICC / CVC / Port Care and flushing protocols (as applicable)
- Ambulatory / Peristaltic Pumps (as applicable)
- Gravity / Dial-a-Flow tubing (as applicable)

Therapy Types:

- Dextrose 5% Water
- Sodium Chloride 0.9%
- Lactated Ringers
- Sodium Chloride 0.45%

Reference: PDN Policy 13107

Indications:

- Rehydration after becoming dehydrated from illness / surgery
- Treatment of an infection using antibiotics
- Pre, post, or concurrent administration with specialty medication infusions

SPECIAL CONSIDERATIONS:

The primary concerns when administering fluid are: (1) ensuring the IV remains patent; (2) monitoring for signs and symptoms of fluid overload; and (3) ensuring the patient is educated on these signs and symptoms if they will be self-administering. **Note:** Most hydration patients will be taught to self-administer. If the RN is unsure, please verify with the Care Coordination team.

Signs & symptoms of IV infiltration:

- Redness around the site
- Swelling, puffy or hard skin around the site
- Blanching (lighter skin around the IV site)
- Pain or tenderness around the site
- Inability to flush IV
- Cool skin temperature around the IV site

Signs of fluid overload may include:

- Rapid weight gain
- Noticeable swelling (edema) in the arms, legs, and face
- Swelling in the abdomen
- Cramping, headache, and stomach bloating
- Shortness of breath
- High blood pressure

If any of these symptoms are noted while the RN is present, the RN should stop the infusion and apply applicable nursing interventions. In the case of IV infiltration, the RN should discontinue use of the IV and remove it. A warm compress may be applied.

If any of these symptoms are noted during patient self-administration, the patient should be educated to stop the infusion and contact the Agency immediately. The Agency will send out a nurse as necessary to apply appropriate nursing interventions and report any issues or concerns to the ordering physician and authorizing Pharmacy.

PROCEDURE:

1. Gather supplies:
    - IV pump and pole or ambulatory pump, gravity tubing or elastomeric device.
    - 0.9% sodium chloride and Heparin flushes
    - Alcohol pads
    - Extension set
    - IV start kit (if IV needs to be started}
    - IV catheter for IV insertion
    - Port access kit, Huber needle, sterile access kit (if patient has a port)
        - *Port access is a sterile procedure
    - Sharps container

2. Obtain and verify physician's orders for hydration and rate of infusion.
3. Explain procedure and purpose to patient and caregiver.
4. Follow appropriate standard precautions.
5. Assemble supplies on a clean, dry surface.
6. Assure ordered IV access is in working condition (if no access is currently available, start peripheral IV. **DO NOT** tamper with medication until IV access is established. **After 2 unsuccessful IV attempts, notify Agency immediately for further instruction on how to proceed.**
7. Assess and record patient's vital signs to establish baseline.

8. Assemble equipment (e.g., IV Pole, Pump (if needed), tubing primed with prescribed IV solution).
9. Flush IV access device per provider orders.
10. Attach primed tubing directly into IV line.
11. Set IV rate on pump or dial a flow/gravity tubing or connect elastomeric device.
12. Begin infusion.
13. Assess vital signs at baseline, every 15 minutes for the first hour, hourly, and post infusion.
14. When infusion complete, assess vital signs and patient's response to the infusion.
15. Flush catheter per order.
16. Flush catheter with Heparin per physician order if needed.

    ******If the infusion is running via peripheral IV, a heparin flush/lock is not necessary, however if the patient will remain accessed for subsequent days for infusion and the pharmacy provides heparin, it may be used to increase the longevity of the IV.

17. If infusion is only one day, discontinue peripheral IV.
18. Discard needle(s) in Sharps container.
19. Cleanup work area and ensure that all trash is disposed of.
20. Document procedure and patient's response.

<u>When teaching Patient/ Caregiver to self-administer</u>:

- Assess patient's ability to self-administer medications correctly. If the RN has any concerns regarding the patient's ability to self-administer, reach out to the Agency immediately to discuss next steps.
- Teach patient how to administer medications, i.e., process, time, frequency, route of administration, dose (based on procedure above).
- Assist the patient with setting up the infusion for the first time.

- Educate patient/ caregiver(s) how to assess peripheral IV patency, troubleshooting steps, and how to discontinue peripheral IV when therapy is completed.
- Answer questions/concerns expressed by the patient/family regarding patient's self-administration of medications.
- Once teaching is complete, document in the clinical note that patient has verbalized a demonstrated understanding and is independent with administration.