Acute Training Solutions

Subcutaneous Fluids - Administration

Name of patient		Status	
Plan prepared by		Signature	
Qualifications			

Patients need	Overall goal
..... appears to be dehydrated.	To correct dehydration by ensuring a fluid balance of at least 2 – 2.5 litres of fluid intake daily and an equal amount of fluid output.

Date commenced sign & qualifications / status	Plan	Date discontinued sign & qualifications / status
	Encourage patient to take oral fluids or high fluid content foods e.g. jelly's, melon. strawberries etc if possible. This must be done at least hourly and documented in appropriate food and fluid charts. Consult with doctors and MDT and consider administering fluids via the subcutaneous route if oral intake continues to be inadequate. **When dehydration is suspected, where possible, a blood sample will be taken and sent for urea and electrolyte levels prior to commencing Sub cutaneous fluid administration.**	
	Subcutaneous fluid administration procedure	
	1. Prepare the patient and explain the procedure. Give re-assurance and gain consent.	
	2. Medical/authorised nursing staff to document procedure in patients notes.	
	3. Limit amount of people in the area during procedure.	

Date commenced sign & qualifications / status	Subcutaneous fluid administration procedure contd	Date discontinued sign & qualifications / status
	4. Clean dressing trolley or tray with alcohol wipe and set all equipment ready. (Equipment list in subcutaneous fluid administration PGN.	
	5. Put on disposable apron.	
	6. Check fluid type against prescription, in accordance with medicine policy.	
	7. Check expiry date, batch number and for discolouration.	
	8. Document and sign on the appropriate, fluid recording charts, and medicine kardex.	
	9. Cross check the identity of the patient with the prescription sheet.	
	10. Wash hands with soap and water, then perform alcohol rub.	
	11. Connect fluid to giving set and prime the line. (Priming the system ensures patency and expels air prior to application).	
	12. Ensure the patient is in a comfortable position.	
	13. Wash hands using soap and water. Dry hands thoroughly.	

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Date commenced sign & qualifications / status	Subcutaneous fluid administration procedure contd	Date discontinued sign & qualifications / status
	14. Apply alcohol gel to hands.	
	15. Put on non-sterile gloves.	
	16. Clean the chosen site with an alcohol swab and allow to air dry. The site must be clean unbroken and free from oedema.	
	17. A fatty area allows for volume of infusion (1000mls – 2000mls in 24 hours. For example; 500mls every 4 – 6 hours). Patient comfort must be considered when choosing a site. **Best sites are abdomen lateral aspects of upper arms and thighs, anterior chest wall and occasionally the back.Avoid boney prominences, joints, lymphoedema and old radiotherapy sites.**	
	18. Grasp the skin firmly, Insert Cannula at 45 degrees. If blood appears in the infusion line, (this indicates that the cannula is in the wrong position and is in a blood vessel). Remove cannula and cover with a sterile dressing. Repeat the process at an alternative site.	
	19. Coil line once and secure with transparent dressing to allow observation of site.	
	20. Remove gloves and wash hands.	
	21. Set to the prescribed rate and commence infusion.	
	22. Ensure patient is comfortable.	

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Date commenced sign & qualifications / status	Subcutaneous fluid administration procedure contd	Date discontinued sign & qualifications / status
	23. Document the site, rate and time the infusion commenced, in relevant care plan, chart and case notes – two nurses to sign and witness all documentation involved.	
	24. On completion of the procedure, waste must be disposed of in the sharps container and clinical waste bag.	
	Observations	
	Inspect site 1 hour after infusion start for local irritation or fluid leakage. **Action** - stop infusion and ask doctor to review.	
	Observe for signs of fluid overload i.e. peripheral oedema, dyspnoea. **Action** – discontinue infusion and inform the doctor immediately to review.	
	Observe for oedema at infusion site. **Action** – Consider a different site for infusion.	
	Observe 2 hourly for local irritation, infection, bruising and pain. Record observations in care plan and subcutaneous infusion chart. **Action** - Dependant upon severity, observe the site and record. Consider re-siting infusion. Dress the site as required, review with doctor.	
	Management	
	• Record all fluid input, including subcutaneous fluids and oral intake and fluid output including urine and vomit, on fluid balance chart • Monitor Urea and electrolytes every 24 hours whilst infusion in situ • Change the site and the infusion set, every 2-3 days and rotate the site, document • If any of the above complications arise, stop infusion, remove the cannulae and contact the doctor • Evaluate care daily to ensure infusion is discontinued when appropriate	