

**HYDRATION THERAPY**

**Section:** Nursing

**Compliance:** ACHC Infusion Pharmacy

**ACHC Standards:**

**Policy ID:** NUR213

**Effective:** 1/1/21

**Reviewed:** 5/1/21

**Revised:**

**Approved by, Title and Date Approved:** Kathleen Patrick, President 1/1/21, 5/1/21

**I. POLICY**

All patients referred for hydration therapy will meet the clinical admission criteria

**II. PROCEDURES**

- A. Hydration therapy is utilized for patients suffering from fluid/electrolyte imbalance. Common diagnoses include hyperemesis gravidarum, cancer and some GI disorders. Duration of therapy is generally short term since hydration provides only for patient's fluid needs.
- B. Hydration therapy may be administered via a peripheral or central catheter or vascular access port
- C. Patients receiving hydration should be monitored for fluid and electrolyte imbalances, i.e., weight, fluid balance, electrolyte serum levels, mental status changes, pulmonary status
- D. Physician orders will include:
  - 1. Volume and type of intravenous fluid
  - 2. frequency and duration of infusions
  - 3. Rate of infusion
  - 4. Order for lab work, as appropriate
- E. Supplies:
  - 1. Prescribed hydration fluid
  - 2. IV administration set
  - 3. IV pole
  - 4. Infusion control device
  - 5. Normal saline and heparin flushes
  - 6. Antiseptic swabs
  - 7. Supplies for peripheral or central venous access
  - 8. Blood pressure cuff and stethoscope

F. Procedure:

1. Wash hands.
2. Gather supplies.
3. Obtain baseline vital signs.
4. Establish venous access
5. Don gloves.
6. Prepare hydration fluid; close roller clamp on IV tubing; spike bag. If applicable, place cannula on end of tubing, prime tubing.
7. Cleanse injection cap with alcohol swab for 30 seconds. Allow to dry.
8. Flush catheter with normal saline.
9. Cleanse injection cap with alcohol swab for 30 seconds. Allow to dry.
10. Connect tubing of hydration fluid to needleless injection cap.
11. Begin infusion per prescribed rate
12. Change tubing every 24-72 hours based upon physician's orders.

G. Documentation and Assessment Should include:

1. Vital signs (TPR, BP)
2. Type of access device, location, and appearance
3. Volume and type of solution
4. Rate and duration of infusion, infusion control device
5. Labs drawn, as applicable
6. Patient response to therapy
7. Any noted adverse reactions
8. Physician notification, if applicable
9. Patient instructions