The administration of fluids by sub-cutaneous infusion in a community setting to Adult Patients.	
Standard Operating Procedure (SOP)	
Ref No: 1977 **Version: 9**	
Prepared by: Lead for Palliative and End of Life Care	
Presented to: Care and Clinical Policies Group	**Date: 21/12/2016**
Ratified by: Care and Clinical Policies Group	**Date: 21/12/2016**
	Review date: 13 January 2020
Relating to policies: **Mental Capacity Act 2005** **Torbay & South Devon NHS Foundation Trust Production and Control of Clinical Policies, Guidelines, Protocols and Standard Operating Procedures** **Torbay & South Devon NHS Foundation Trust Medicines policy for Registered Professionals – Standards for the Supply, Storage and Administration of Medicines** **NICE Guidelines Care of Dying Adults in the Last Days of Life (2015)** **One Chance to Get it Right (5 Priorities for Care at EOL 2014)**	**Torbay & South Devon NHS Foundation Trust Infection Control Policy** **Torbay & South Devon NHS Foundation Trust Standard Operating Procedure Preparing Injectable Medicines** **Torbay & South Devon NHS Foundation Trust Records Management Policy** **Choice and Control Risk Enablement Policy** **RCN Getting it Right Every Time Fundamentals of Nursing Care at End of Life (2015)**

1. Purpose of this document

To provide a framework for safety and guidance for Registered Nurses in the administration of sub-cutaneous fluids in the community setting, thereby preventing an unwanted hospital admission and enabling patient choice.

2. Scope of this SOP

Applicable to Registered Nurses employed by Torbay & South NHS Foundation Trust working within a community hospital or in the patient's home environment.

3. General Statement

3.1 The administration of fluids by the subcutaneous route is a safe, reliable, and minimally invasive method of assisting the control of delirium, nausea and thirst in end stage chronic disease and in the elderly. (Dogherty and Lister 2011).

3.2 Owing to the relative ease in setting up and administering subcutaneous fluids, the procedure can be carried out in the home setting by community/ district nurses, relatives or carers. The administration of s/c fluids enables people who require fluids to remain at home if this is their wish.

3.3 This will prevent unnecessary admissions to hospital, thereby promoting choice, comfort and dignity to patients who choose to remain at home or in a care home setting, if that is their preferred place of care.

3.4 It may be useful in patients who have difficulty taking fluids orally such as those who have dysphagia which results in decreased oral intake and symptom distress, (Dogherty and Lister 2011).

3.5 It should not be considered in cases of patients requiring emergency rehydration as this would require a hospital admission. Or in patients who have:

A: A clotting disorder
B: Have fluid overload e.g. congestive cardiac failure or marked oedema
C: Are on renal dialysis
D: Require precise control of fluid balance
E: At risk of cardiac and renal failure.

4: Maintaining Hydration at End of Life (last few days)

Patients who are in the last few days or weeks of life are often unable to tolerate oral hydration. The prime goal of any treatment towards the end of life must be the comfort of the patient.

Considerations around how to approach the issue of hydration at the end of life are complex and involve not only physical, psychological and social concerns, but also ethical dilemmas. It is therefore imperative that decisions to rehydrate a dying patient **MUST** be a multidisciplinary decision.

The National Institute Clinical Excellence (NICE 2015) for the Care of Adults in the Last Days of Life, advocates that staff should -

4:1: Support the dying person to drink if they wish to and are able to. Check for any difficulties, such as swallowing problems or risk of aspiration. Discuss the risks and benefits of continuing to drink, with the dying person, their carer and family and those involved in the dying person's care.

4.2: Offer frequent care of the mouth and lips to the dying person, and include the management of dry mouth in their care plan, if needed. Offer the person the following, as needed:

- Help with cleaning their teeth or dentures
- If they would like frequent sips of fluid.

4.3: Encourage people important to the dying person to help with mouth and lip care or giving drinks, if they wish to. Provide any necessary aids and give them advice on giving drinks safely.

4.4: Assess, preferably daily, the dying person's hydration status, and review the possible need for starting clinically assisted hydration, respecting the person's wishes and preferences.

4.5: Discuss the risks and benefits of clinically assisted hydration with the dying person and those important to them. Advise them that, for someone who is in the last days of life:

- Clinically assisted hydration may relieve distressing symptoms or signs related to dehydration, but may cause other problems (see recommendation 4.10)
- It is uncertain if giving clinically assisted hydration will prolong life or extend the dying process
- It is uncertain if not giving clinically assisted hydration will hasten death.

4.6: Ensure that any concerns raised by the dying person or those important to them are addressed before starting clinically assisted hydration.

4.7: When considering clinically assisted hydration for a dying person, use an individualised approach and take into account:

- Whether they have expressed a preference for or against clinically assisted hydration
- Or have any cultural, spiritual or religious beliefs that might affect this.
- Is it documented in an advance statement or an advance decision to refuse treatment
- Their level of consciousness
- Any swallowing difficulties
- Their level of thirst

- The risk of pulmonary oedema
- Whether even temporary recovery is possible.

4.8: Consider a therapeutic trial of clinically assisted hydration if the person has distressing symptoms or signs that could be associated with dehydration, such as thirst or delirium, and oral hydration is inadequate.

4.9: For people being started on clinically assisted hydration:

- Monitor at least every 12 hours for changes in the symptoms or signs of dehydration
- For any evidence of benefit or harm.
- Continue with clinically assisted hydration if there are signs of clinical benefit.
- Reduce or stop clinically assisted hydration if there are signs of possible harm
- Such as fluid overload, or if they no longer want it.

4.10: For people already dependent on clinically assisted hydration before the last days of life:

- Review the risks and benefits of continuing clinically assisted hydration with the person and those important to them.
- Consider whether to continue, reduce or stop clinically assisted hydration as the person nears death.

Important: A decision to rehydrate a dying patient MUST be a multi-disciplinary decision. Quality of life at this time is paramount. (NICE 2015, GMC Guidance "Treatment and Care towards end of life: good practice in decision making, 2010).

5: Roles and Responsibilities

5.1 Torbay and South Devon NHS Foundation Trust heads of Professional Services are responsible for the implementation of this policy across the Adult Community Service Directorate.

5.2 Communications and Information Governance teams will assist in the distribution of the policy and ensure that ratified document is accessed via the relevant site on icare.

5.3 Torbay and South Devon NHS Foundation Trust is responsible for providing and ensuring that all staff required to use medical devices and administering subcutaneous fluids are appropriately trained. The management of a s/c infusion/injection is covered in the Trusts mandatory syringe pump training.

5.4 All Registered Nursing Staff administering sub cutaneous fluids must have current effective level 1 Nursing and Midwifery Council (NMC) registration.

5.5 Registered Nurses must use this policy in conjunction with The Code (NMC 2016), Standards for the administration of medicines (NMC 2007), Record Keeping Guidelines (NMC2007) and Records Management Policy.

5.6 All Registered Nursing Staff are personally responsible and accountable to ensure they receive training and maintain competency in the safe use and observation of medical devices and the administration of subcutaneous fluids they are required to use in the course of their duties.

6: Competencies required

6.1 Registered Nurse

Registered nurses must have undergone the relevant training session provided by Torbay and South Devon NHS Foundation Trust. The management of a s/c infusion/injection is covered in the Trusts mandatory syringe pump training.

7: Patients Covered.

7.1 Adult patients aged 16 years or above, registered with a Care Trust GP, requiring the administration of sub cutaneous fluids in the home setting.

8: Prescribing.

8.1 The GP or Non-medical prescriber (NMP) must prescribe on the patient's Medical Administration Record (MAR) Fluid Prescription sheet, 0.9% Sodium Chloride for intravenous infusion, 500mls.To be delivered sub-cutaneously over the required time period, (eg. 500 mls Sodium Chloride for injection over 24 hours)

No more than one litre of fluid should be infused within a 24 hour period

8.2 The MAR form must be signed by GP or NMP for authorisation of procedure by Registered Nurse.

8.3 Side effects: Prolonged use with large volumes of fluid has been shown to lead to localised pain and oedema.

8.4 Cautions: Caution is required in patients with pre-existing oedema as swelling at the site may not be easily observed.

8.5 Clotting disorders which may predispose the patients to bleeding at the cannula sites.

9: The administration of sub-cutaneous fluids **should not** be considered in patients who:-
A: are on renal dialysis

B: require precise control of fluid balance
C: are at risk of cardiac or renal failure

10: No medication should be added to the infusion fluid.

11: Equipment.

70% Isopropyl Alcohol swab
Butterfly Cannula Infusion Set
Sodium Chloride for intravenous infusion 500 mls (to be stored at room temperature and out of direct sunlight)
Giving Set Baxter Solution Administration Set.
Please note: A Baxter administration/ infusion set will not be used in the home/community environment
Infusion Stand – available from CES, Cat. No. PRE 0142
Please note: It is unlikely that an infusion stand will be available in the home/community environment.
Clear Adhesive dressing
Sterile Swabs
Adhesive Tape
Sterile Gloves
Sharps Container

12: Procedure

12.1 Obtain Consent - Explain and discuss the procedure with the patient in order to ensure he/she understands and is able to give informed consent (NMC 2008). Where informed consent has not been obtained from the client in either setting, the nurse must be able to demonstrate that a multi-disciplinary assessment has been made including an assessment of capacity. Consent form 4 „Form for adults who are unable to consent to investigation or treatment" (Syringe driver policy appendix 1) must be completed to demonstrate that any decision to proceed has been made in the best interests of the client. (Mental Capacity Act 2005 section 1(5)

Informed consent must be recorded in accordance with Torbay and South Devon NHS Foundation Trust Policy.

12.2: Infusion sites:-
Lateral aspects of the upper arms and thighs
Abdomen
Anterior chest below the clavicle,
Occasionally the back. (if confused)
These areas usually have adequate amounts of subcutaneous tissue and will not interfere with movement.
Sites must be rotated to minimise tissue damage

12.3: Areas to avoid for site of cannula are:-
Lymph oedematous limbs
Sites over bony prominences
Previously irradiated skin
Sites near a joint

12.4: The infusion site should be checked by the nurse at each visit and the site changed if there are signs of inflammation (erythema) or poor absorption (a hard subcutaneous swelling)

§ Check that the infusion is due and not already been given.
§ Check the information on the PMAR is complete, correct and legible
§ Check the infusion for clarity and contamination, record batch number and expiry date
§ Check dose, date and time of administration, route and method of administration, signature of doctor/prescriber.
§ Wash hands
§ Open Butterfly infusion set and giving set.
§ Apply sterile gloves using aseptic technique
§ Attach infusion set line to giving set as extension
§ Connect giving set to fluid for infusion and hang on the infusion stand(other in community)prime line and infusion set . Sub-cutaneous fluids must only be infused by gravity.
§ Cleanse entry site with 70% isopropyl Alcohol swab (Pratt 2007) and allow to dry
§ Site infusion set cannula at angle of 45 degrees beneath skin of chosen area
§ Secure with clear adhesive dressing to prevent movement of cannula and to allow observation of the site
§ Calculate drip rate **(See equation for calculation)**
§ Adjust roller clamp to set drip rate
§ Monitor flow rate and device site 4 hourly (12 hrly in the community) or more frequently according to patient need
§ Monitor site for signs of swelling, redness or pain. Re site as necessary.
§ Monitor patient for any signs of respiratory distress, report to GP. Discontinue infusion if appropriate
§ When infusion is complete wash hands, apply sterile gloves and remove cannula
§ Cover exit site with sterile swab if necessary
§ Discard waste into designated receptacle as per Torbay & South Devon NHS Foundation Trust Waste Management Policy
§ Ensure patient is comfortable
§ Ensure that patients and carers know how to regularly observe the infusion site and to contact Registered Nurse during the 24 hour period in the event of any concerns.
§ Record the administration on PMAR charts and in patient care plan
§ Record daily fluid balance, report negative/positive balance to GP

Calculation for infusion drip rate
Volume to be infused x Drop rate = Drops per minute
Time in hours 60 minutes

13: Infection Control – the procedure will be carried out in accordance with local infection control protocols and should include hand washing at intervals throughout the setting up process i.e. at the beginning, before connecting the infusion, before insertion of the infusion device and at the end of the process, to minimise the risk of infection. Pratt (2007).

14: Record Keeping – All aspects of care and management of the procedure must be recorded accurately in the patient's care plan and MAR sheet, to include date, time, batch number, and expiry date, in line with TSDFT Medicines Policy and Records Management Policy.

15: Training and Implementation

15.1 TSDFT is responsible for providing and ensuring that all staff required to use medical devices are appropriately trained, assessed and updated.

15.2 For all Registered Nurses required to set up and manage clients who receive sub-cutaneous fluids the following training is also required:-

15.3 Attendance at the Administration of Sub-cutaneous syringe pump/infusion training as provided as provided by TSDFT and is mandatory yearly.

15.4 Attendance at Medicines Policy Training for Registered Staff. Successful completion of competency assessment.

15.5 Records of training and competency assessment will be held within individual's portfolio and reviewed as part of annual appraisal process and will also be recorded within T&SDFT staff records.

16. Standards

This SOP relates specifically to the NICE Guidance (2015) National End of life Care Strategy and Quality Markers, Strategic Health Authority, and Torbay & South Devon NHS Foundation Trust ambitions, through the avoidance of unnecessary hospital admissions, and enabling patient choice.

Troubleshooting

Adverse Effects

Observation	Possible cause	Action
Site is red and inflamed	**Needle may have been placed intradermaly**	**Re-site immediately, away from affected area. Check for nickel allergy, use Silhouette soft set if necessary**
Localised oedema	**Most common adverse effect**	**Massage area as oedema will re-absorb. Re-site if uncomfortable for the patient**
Pain	**Can be related to the insertion of the needle**	**Adjust needle position slightly to exclude nerve ending placement. Re-site needle if pain persists**
Infusion running too slowly	**Check gravity feed**	**Raise height of infusion bag. Check lines for occlusion**
Large white flat area around site	**Needle may need re-siting if red and inflamed**	

17. Monitoring

Torbay and South Devon NHS Foundation Trust, through the clinical governance framework will ensure a process for monitoring compliance and effectiveness of this document.

The process will include reviewing incidents reported through the incident reporting process. Individual practitioner monitoring through competency assessments are reviewed as part of the annual appraisal process.

18. References:

Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice

Nursing and Midwifery Council (2008) Standards for Medicines Management. NMC. London.

Pratt, RJ. Et al (2007) Epic 2: National evidence-based guidelines for preventing healthcare associated infections in NHS hospitals in England. Journal of Hospital Infection, 65(suppl), s2-12

The Royal Marsden Hospital Manual of Clinical Nursing Procedures (2008) Seventh Edition.

The Royal Marsden Hospital Manual of Clinical Nursing Procedures, Eighth Edition. Dougherty and Lister (2011)

Torbay & South Devon NHS Foundation Trust infection control policy.

Watson M, Lucas C, Hoy A, Back I, (2005) Dehydration, Oxford Handbook of Palliative Care Part 1, Oxford University Press

“Sub Cutaneous Fluids in Palliative Care” Palliative Care Guidelines, www.palliativecare guidelines.scot.nhs.uk

GMC Guidance towards end of life: good practice in decision making, GMC 2010.

NICE Guidance for the Care of Dying Adults in the Last Days of Life (2015)

1. Monitoring tool:

Standards:

Item	%	Exceptions

Equality Statement.
The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.

The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy

Appendix:

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Ratified	20 April 2010	Rewritten in New SOP format Response to comments from Paul Humphries re prescribing and drug storage concerns.	J.Bailey
2	Ratified	07 July 2010	Additions re patient information leaflet in response from comments from Lorraine Webber	J.Bailey
3	Ratified	22 July 2010	Reference made to GMC Guidance for end of life care decision making and maximum dise recommendations by Dr Jo Sykes	J.Bailey
4	Ratified	22 July 2010	Alterations to layout and prescribing issues recommended by Paul Humphries Inclusion of “troubleshooting” section	J.Bailey
5	Ratified	29 July 2010	Competency Assessment Bev Glanville Geake	J.Bailey
6	Ratified	16 September 2010	Competency Assessment personalised. Accountability in maintaining competency added.	J Bailey
7	Ratified	16 October 2015	Due for renewal	Lead for Palliative and End of Life Care
8	Ratified	10 November 2016	Response to NICE Guidance 2015	Lead for Palliative and End of Life Care
9	Ratified	13 January 2017	Revised	Care and Clinical Policies Group
9		12 February 2018	Review date extended from 2 years to 3 years	

Appendix 1

Flow chart patient being considered for s/c fluids

Linked to Guidance G2110

Appendix 2

Nutrition & Hydration in the last few days: key points

Linked to Guidance G2110

Appendix 3

Consent Form

Form for adults who are unable to Consent to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name.....

Patient's first names.....

Date of birth .....

Responsible health professional.....

Job title .....

NHS number (or other identifier).....

ÿ Male ÿ Female

Special requirements .....
(eg other language/other communication method)

To be retained in patient's notes

Patient identifier/label

All sections to be completed by health professional proposing the procedure

A: Details of procedure or course of treatment proposed
(NB see guidance to health professionals overleaf for details of situations where court approval must first be sought)

B: Assessment of patient's capacity

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because:

The patient is unable to comprehend and retain information material to the decision; and/or
……..

The patient is unable to use and weigh this information in the decision-making process; or…….

The patient is unconscious……..

Further details (excluding where patient unconscious): for example how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful.
……
……
……
……
……

C: Assessment of patient's best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient's best interests because:
……
……
……
……

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)
The treatment cannot wait until the patient recovers capacity because:
……
……
……
……

D: Involvement of the patient's family and others close to the patient

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests", and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare. (to be signed by a person or persons close to the patient, if they wish).

I/We have been involved in a discussion with the relevant health professionals over the treatment of……..(patient's name).

I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision)

Name ……Relationship to patient……..

Address (if not the same as
patient……
……

Signature ……..
Date……..

If a person close to the patient was not available in person, has this matter been discussed in any other way (eg over the telephone?)

ÿ Yes ÿ No

Details……
……

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for him or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature…… Date ……

Name (PRINT) …… ……. Job title …….. ……

Where second opinion sought, s/he should sign below to confirm agreement:

Signature:…… Date……

Name (PRINT) …… ……. Job title …….. ……..

Guidance to health professionals (to be read in conjunction with consent policy)

This form should only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards.

If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or "living will"), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health's Reference guide to consent for examination or treatment (www.doh.gov.uk/consent).

When treatment can be given to a patient who is unable to consent

For treatment to be given to a patient who is unable to consent, the following must apply:

• The patient must lack the capacity („competence") to give or withhold consent to this procedure AND
• The procedure must be in the patient's best interests.

Capacity

A patient will lack capacity to consent to a particular intervention if he or she is:
• Unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question; and/or
• Unable to use and weigh this information in the decision-making process.

Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in taking their own decisions (this will clearly not apply if the patient is unconscious). This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates or supporters.

Capacity is "decision-specific": a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions.

Best interests

A Patient's best interests are not limited to their best medical interests. Other factors which form part of the best interest's decision include:
• The wishes and beliefs of the patient when competent
• Their current wishes
• Their general well-being
• Their spiritual and religious welfare

Two incapacitated patients, whose *physical* condition is identical, may therefore, have different best interests.

Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, you should attempt to involve people close to the patient (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the patient cannot require you to provide particular treatment which you do not believe to be clinically appropriate. However they will know the patient much better than you do, and therefore are likely to be able to provide valuable information about the patient's wishes and values.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. Donation of regenerative tissue such as bone marrow, sterilisation for contraceptive purposes and withdrawal of artificial nutrition or hydration from a patient in PVS must never be undertaken without prior High Court approval. High Court approval can also be sought where there are doubts about the patient's capacity or best interests.

Appendix 4

THE ADMINISTRATION OF SUB CUTANEOUS FLUIDS

PATIENT INFORMATION

The procedure you are undergoing allows fluids to be absorbed though the tissues below your skin.

Any risk to you is minimal, however, please contact your Community Nurse at any time over the 24 hour period if any of the following arise:-

- There is any swelling at the infusion site

- There is redness or inflammation at the infusion site

- There is any pain or discomfort at the infusion site

- If any blood appears in the tubing

- If you become breathless (switch off infusion – this will be demonstrated to you by your Community Nurse.)

Please see your patient held care plan for contact details for your Community Nursing Team

Appendix 5

Linked to Patient Information Leaflet 25350

Appendix 6

Competence Assessment Template

PERFORMANCE CRITERIA	Date Achieved	Practitioner Signature	Assessor Signature
You need to be able to:			
1. Greet and accurately identify the patient			
2. Introduce yourself and any colleagues involved in the procedure to the patient and/or carer.			
3. Assess the patient's psychological and emotional state and respond appropriately including referrals to appropriate agencies and personnel			
4. Gain consent, prepare patient and explain procedure			
5. Check that the patient and/or carer understands the treatment to be given and any potential side effects together with their management.			
6. Check fluid with prescription chart to ensure correct fluid and quantity is administered, frequency and length of treatment.			
7. Inspect the infusion fluid to ensure clear, colourless and in date			

8. Ensure all equipment is assembled to avoid unnecessary stress to the patient			
9. Wash hands in accordance with Trust Hand Washing Guidelines to comply with Prevention and control of infection guidelines			
10. Prime the giving set and butterfly with the fluid to be infused to prevent air bubble formation in the cannula and promote a safe procedure			
11. Assess the patient for suitable site for insertion of butterfly. This should include condition of skin and patient's mobility to provide a comfortable and safe area for fluid absorption.			
12. Clean the site with a 2% Chlorhexidine /70% alcohol wipe using an up and down motion allowing solution to dry completely (approximately 30 seconds) to allow microbes coagulate during the drying process and reduce the subsequent risk of infection. (Povidine Iodine 10% must be used as an alternative if the patient is sensitive to Chlorhexidine.)			

13. Insert the butterfly needle as for subcutaneous injection Pinch the cleaned chosen skin site between thumb and forefinger, insert butterfly needle at an angle of 45 degrees, with the beveled end facing down. Alternatively, use a plastic infusion set (Sofset) to avoid nickel irritation.			
14. Coil butterfly line to prevent kinking at insertion site and ensure security of line.			
15. Cover with semi-permeable film dressing e.g. Tegaderm to secure the line and protect site from infection.			
16. Set infusion at prescribed rate and record time and date commenced on fluid chart.			
17. Make sure the patient is comfortable			
18. Document the name and signature of the nurse inserting the needle and instigating procedure in nursing notes			
19. Check site and infusion after 30 minutes (or ask relative or carer to check and report) to ensure no sign of leakage, oedema and signs of fluid overload			

20. Report any skin change immediately and seek advice before re-siting.			
21. Observe for inflammation around the needle site.			
22. Give relevant contact numbers in case of any emergency for patients peace of mind and to provide support as necessary			
23. Provide information on how to obtain help at any time.			
24. Record the details of the treatment in patient's notes, prescription chart and patient held records, as appropriate, according to local guidelines.			
25. Communicate with appropriate professional colleagues as required by local guidelines			

Adapted from Skills for Health Competence for Delivering Intravenous Therapy – Bev Glanville Geake July 2010

REFLECTION

Appendix 7

Fluid Balance Chart

FLUID PRESCRIPTION RECORD

PATIENT'S NAME:
Hospital Number:
NHS Number:

NURSES: STAT DOSES OF DRUGS, E.G. FUROSEMIDE (FRUSEMIDE) SHOULD BE PRESCRIBED IN THE ONCE ONLY DRUG SECTION

Date	Site of vascular access device	Type of Fluid (BLOCK CAPITALS)	Volume (mls)	Route of Admin.	Duration	Prescriber's signature	Batch Number	Date/Time Infusion Begun	Given By (Signature)

Rate of Flow = VOLUME OF FLUID (ml) x 20 (DROPS/MIN)
DURATION (Mins) (1ml 20 drops)

APPROXIMATE RATE FOR 500ML
4 hr. = 42 drops/min
6 hr. = 28 drops/min
8 hr. = 21 drops/min

APPROXIMATE RATE FOR LITRE
4 hr. = 83 drops/min
6 hr. = 56 drops/min
8 hr. = 42 drops/min

RATE OF FLOW = Volume of blood (ml x 15) (Drops/Min
DURATION (Mins) (1ml = 15drops)

e.g. 323 ml blood (mean) over 4 hrs and using a blood set (nearest round figure)
Flow rate = 323 x 15 = 20 drops/min 4 x 60 (mins)

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☒
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process?	☐
If you answer yes to this question, please complete a full Quality Impact Assessment. No	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐	No	
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?	n/a			

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Details *(please state):*	Community staff		

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	***The administration of fluids by sub-cutaneous infusion in a community setting to adult patients & associated documents***	**Version & Date**	***V9 December 2016***
Policy Author	Lead for Palliative and End of Life Care		

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

Age	Yes ☐ No☒	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒
Please provide details for each protected group where you have indicated 'Yes'.	
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion	
Is inclusive language[5] used throughout?	Yes ☒ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☒ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☒ No☐
Could there be an adverse impact on an individual's independence or autonomy?	Yes ☐ No☒
If 'Yes', how will you mitigate this risk to ensure fair and equal access?	
EXTERNAL FACTORS	
Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☐ No☒
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)	
NICE Guidance	
Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?	
Community Staff	

ACTION PLAN: Please list all actions identified to address any impacts

Action	**Person responsible**	**Completion date**

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Lead for Palliative and End of Life Care	**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.