Hypodermoclysis Policy

Policy: Client who is in danger of dehydration may receive fluids by hypodermoclysis

Indications:
1. Client does not need rapid emergency intravenous fluid replacement.
2. No history of bleeding or coagulation disorder.
3. Intact skin sites for access.
4. Client who is unable to take oral fluids related to nausea and vomiting, suspected aspiration, NPO waiting for physician assessment or test results, or gastrostomy feeding.

Preamble: Hypodermoclysis is a safe and effective intervention for rehydrating clients in non-emergency situations.

Purpose:
1. Provide treatment to clients in their familiar environment.
2. Improve functional status for clients who have mild to moderate reversible fluid deficit problem.
3. Improve the quality of life of clients
4. Reduce unnecessary transfer to hospitals

Interventions:
1. Medical order includes reason for therapy, type, volume, and rate of solution, and duration of infusion.
2. Monitor vital signs: blood pressure, heart rate and respirations
3. Auscultate chest for adventitious sounds
4. Give oral fluids if no contraindication
5. Assess mental status
6. Monitor and record the intake and output
7. Assess for site irritation for redness, swelling or obstruction.
8. Change infusion site PRN
9. Call and inform physician for reassessment, e.g. condition deteriorating, or no improvement.

Equipment:
1. IV tubing (prefers micro-drip chamber)
2. 21-25 gauge either metal butterfly needle (change at least q72h) with tubing, or silicone subcutaneous needle (change at least q5days) with tubing.

3. Alcohol and povidine swabs.

4. 2/3-1/3 solution, ½ strength NS, NS

5. Tape for tubing

6. Transparent occlusive dressing

7. 2x2” gauze

8. IV stand

9. 3cc syringe

10. vial of N/S

**Procedure**:

1. Obtain current medical order for hypodermoclysis

2. Explain the procedure to the client/family, and obtain consent

3. Verify 2/3-1/3 solution or ½ strength NS, and check expiry date

4. Wash hands

5. Assemble equipment, prime butterfly tubing with NS and 3cc syringe

6. Selection of appropriate site: if client is ambulatory- uses abdomen, intraclavicular, or scapula area; bed ridden client – uses anterior or lateral thighs and hips, or abdomen.

7. Use aseptic technique to clean the area with povidone and wipe povidone off using alcohol swabs.

8. Use index finger thumb to gather subcutaneous tissue together gently on the selected site.

9. Insert the needle with bevel up at 35-45 degree angle into the tissue

10. Slight withdraw the 3cc syringe, observe for blood

11. If blood is noted, withdraw the needle and repeat the procedure using a new needle and different site.

12. Attach the infusion set to the end of the butterfly tubing.

13. Secure the butterfly in place by applying a transparent occlusive dressing with a 2x2” gauze under the wings of butterfly.

14. Secure the tubing and date the dressing.
15. Date and time on fluid bag.

16. Initiate hypodermoclysis at 30ml for the first hour or as per MD order.

17. Increase the rate of infusion to 75ml per hour after the first hour or as per MD order to maximum 2000ml/24 hours.

18. Assess, monitor and record vital signs, intake and output.

19. Assess and monitor infusion site hourly for redness, swelling, pain, leaking or dislodged needle

20. Document the treatment in the chart with type and size of needle, location, rate, and type of solution, time of the infusion start, and client’s response.

21. Change the infusion site every 48-72 hours or PRN.

22. Assess and monitor for signs of fluid accumulation around the infusion site, change site PRN.

23. Monitor for signs of resolution of dehydration e.g. skin turgor, increase urine output, moist mucous membranes, less confusion.

24. Continue assess and monitor for signs of fluid overload e.g. edema, breathing difficulty, adventitious chest sound

25. Continue assess and monitor for signs of infection at the site, change site PRN, and report to MD.

26. Continue assess and monitor for dislodgement of needle and disconnection of tubing, change the equipment and site PRN.

27. Discontinue infusion by clamp tubing, remove the dressing, apply qauze and dry dressing after removal of needle.

Reference:


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Geriatric Emergency Management
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