Trust Policy  

Patient Self Administration of Intravenous (IV) Antibiotics at Home

For use in: Clinical Areas  
For use by: Clinical Staff  
For use for: Patient self administration of IV antibiotics at home  
Document owner: Home IV Therapy team  
Status: Approved

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1 Introduction

The policy has been produced to address the increase in patients that are being discharged from the Acute Trust home on IV antibiotics. It has also been identified that at times the patients GP may wish to commence the patient on IV antibiotics in the community, and this policy will support the patient wishing to stay at home for their treatment through training to self-administer.

2 Main content of policy

The purpose of this policy is to detail the process of educating the patient or carer to administer the IV antibiotics via an IV device. This process must ensure that the learner is fully competent and has consented. The guidelines within the policy will support the teaching and education of the patient or carer to be competent to carry out specific IV antibiotic administration.
3 Policy Agreement Path
Intravenous Antibiotic Steering Group and Self administration Group WSH July 2014
Clinical Policy & Guidelines Group, SCH July 2014
Clinical Quality & Safety Assurance Group SCH August 2014
Clinical Policies Group WSH September 2014

4 Definitions
APS/EIT – Admission Prevention Service/Early Intervention Team
CIS – Community Intervention Service
HIT – Home IV Therapy
SCH – Suffolk Community Health
WSH – West Suffolk Hospital
IV – Intravenous
PICC – Peripherally Inserted Central Catheter

5 Cross Reference to Other Related Policies
- Standard Operating Procedure for Home IV Antibiotic Therapy
- Standard Operating Procedure SCH IV Medication and Sub Cutaneous Fluids Policy

6 The purpose of Self Administration is to:
- Enable patients to safely receive intravenous antibiotics therapy in their own home thereby facilitating early discharge from hospital or preventing hospital admissions.
- Ensure safe and consistent practice in administration of intravenous antibiotic therapies by patient and/or carer.
- Aim to promote a seamless discharge process and support for the patient from the acute Trust to the community.

6.1 Patient Self Administration Competency Tool
Please see Appendix 1 for the supporting IV therapy competency tool. This document sets out the requirements for the five specific skills for the patient to have a competency of in order to be deemed competent.

6.2 Process of Self Administration Training
Acute trust patient will have their first dose of antibiotics as an ambulatory or inpatient at WSH. Patients will be referred to the HIT team who will review the patient’s appropriateness for home IV antibiotics, if accepted, IV antibiotic self-administration teaching to the patients or carer, will be initiated and training will be conducted by the ward nurses and HIT nurses. The patient will be discharge from the acute trust only once deemed competent. Occasionally community nurse teams will be asked to
conduct a courtesy visit post discharge to check a patient/carer is confident in the home environment.

GP referred patients will have their first dose of IV antibiotic in the community setting; providing the administering/teaching registered nurse has anaphylaxis training and full equipment is present, the community nurse will remain for a suitable period post infusion to check for infusion related reactions. The process of teaching a patient or carer to be competent of administering IV antibiotics can be assessed by any registered nurse that has completed their IV drug administration competency. A patient or carer will only be deemed competent once they have completed the patient self-administration competency tool (appendix 1), this document should be filed in the patient notes. Once a patient or carer is competent then they can administer the antibiotic without the community team being present. Line care and blood monitoring will still be required by the community team.

6.3 Documentation to Support Patient Training

Please see Appendix 1 patient self-administration competency tool, this must be completed by the individual registered nurse carrying out the training. Community patient or carers self-administering IV antibiotics through a cannula must be able to complete a Visual Intravenous Phlebitis (VIP) Score (Appendix 2) and record this appropriately in their administration record (Appendix 3). WSH patient or carers self-administering IV antibiotics through a cannula will be provided with a WSH VIP score at discharge. If patient or carer is administering IV antibiotics through a PICC line, then a PICC line patient information leaflet should be provided and explained.

All patients with an intravenous access device should check the IV site prior to each administration for signs of infusion phlebitis.

7 Accountability, Responsibility and Governance

All practitioners are responsible for their own practice.

- **Patient/carer**: "For the purpose of this document the term carer will mean an individual that the patient has consented to give them their IV’s, that has been taught by the responsible nurse practitioner.

- **Clinician**: The clinician will accept overall clinical responsibility for the patients they place on HIT for the specific area of care they are treating the patient for. The Clinician will liaise with a Consultant Microbiologist and HIT Pharmacist to establish a treatment plan that is suitable for patient management.

- **Consultant Microbiologist**: Recommending appropriate antibiotics in relation to the infection.

- **HIT Pharmacist**: Advice on dosage and supply, available on bleep 654 at West Suffolk Hospital.

- **GP**: The patients GP is expected to treat the patient for any unrelated conditions. If the GP is seeing the patient and the patient refers to the condition they are being treated with IV antibiotics for, then it is expected the GP will signpost the patient to HIT or the discharging clinician at West Suffolk Hospital.

If the patient has been started on IV antibiotics by the GP directly with the community nurse then the GP will retain governance of the patient. The GP can liaise directly Consultant Microbiologist as required. If the patient is complex then the patient should be referred to the Acute Medical Unit where the WSH procedure will be followed for HIT referral.
8. **Review period for this policy**

24 months

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| Other contributors: | Gemma Kerridge, Antibiotic Pharmacist  
| Approvals and endorsements: | Suffolk Community Healthcare  
|                     | WSH Nursing & Midwifery Policies & Procedures Group  
|                     | Drugs & Therapeutics Committee (April 16)  
| Consultation:       |  
| Issue no:           | 2  
| File name:          | PP(16)319 Patient Self Administration of IV Antibiotics – April 16  
| Supercedes:         | None  

**Implementation**

**Monitoring:** (give brief details how this will be done)

**Other relevant policies/documents & references:**

**Additional Information:**
APPENDIX 1

Patient Self Administration
IV Therapy Competency Tool

For patients to be able to self administer intravenous antibiotics they are required to demonstrate competency in five specific skills:
1. Hygiene and infection control, including hand washing
2. Drug reconstitution and administration
3. IV access management and maintenance
4. Safe storage of drugs and equipment
5. Disposal of sharps

The patient’s competency can be assessed by any registered nurse who has completed their own IV Drug administration competency (Band 5 or above). The patient will be discharged under the care of the Home IV Antibiotic Therapy Team and will require first dose of IV within the acute Trust. The patient will be provided with a demonstration by the nurse and then must be observed undertaking 3 procedures in a competent manner. If the patient requires any more than 3 observed procedures the decision as to how many further observations will be a clinical professional judgement by the nurse at that time.

<table>
<thead>
<tr>
<th></th>
<th>Hygiene and infection control including hand washing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The patient is able to relate to the assessor the importance of preparing a suitable clean area for the preparation of the IV drugs and equipment.</td>
</tr>
<tr>
<td>1.2</td>
<td>They demonstrate transferability of this skill from hospital to home setting i.e. they are able to talk about where this will take place, preparatory clearing and cleaning, removal of animals and children as required.</td>
</tr>
<tr>
<td>1.3</td>
<td>They demonstrate checking of packaging integrity and expiry dates.</td>
</tr>
<tr>
<td>1.4</td>
<td>Within the process they are observed cleansing /washing their hands in the correct manner and at appropriate times.</td>
</tr>
<tr>
<td>1.5</td>
<td>Drying is achieved by using clean paper/kitchen towels. Gel/foam is used appropriately.</td>
</tr>
<tr>
<td>1.6</td>
<td>The patient understands that they need to use sterile gloves when accessing the line.</td>
</tr>
<tr>
<td>1.7</td>
<td>Assess patient’s knowledge of how to recognise if the line is becoming infected, i.e. pain, redness and exudate from line/insertion site. Recognition of systemic infection, “flu-like” symptoms, shivering, and steps to take in this situation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Drug reconstitution and administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>The patient is able to demonstrate a ‘non-touch’ technique when opening capped vials, utilising spikes etc.</td>
</tr>
<tr>
<td>2.2</td>
<td>The patient is aware of the different uses of 0.9% saline and water for injection.</td>
</tr>
<tr>
<td>2.3</td>
<td>The patient is able to demonstrate the ability to accurately read the information provided on vials/ampoules and the information and guidance sheets.</td>
</tr>
<tr>
<td>2.4</td>
<td>Patient demonstrates knowledge of the names of all the component parts.</td>
</tr>
<tr>
<td>2.5</td>
<td>Patient is able to perform push pause technique for the administration of drugs.</td>
</tr>
<tr>
<td>2.6</td>
<td>Competency is demonstrated for the purging of administration sets/lines ensuring the line is free of any air.</td>
</tr>
</tbody>
</table>
### 3. IV access management/maintenance

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Patient is observed being able to successfully connect administration sets and perform effective cleaning of lines.</td>
</tr>
<tr>
<td>3.2</td>
<td>Patient understands the need for the PICC/cannula line dressing to remain intact.</td>
</tr>
<tr>
<td>3.3</td>
<td>The patient can explain what to do if the dressing should become loose or soiled.</td>
</tr>
<tr>
<td>3.4</td>
<td>The patient understands the need to safeguard the security of the PICC/cannula line site and the external line(s) and can demonstrate how they will achieve this.</td>
</tr>
<tr>
<td>3.5</td>
<td>The patient knows what to do should the line break (fracture) / leak.</td>
</tr>
<tr>
<td>3.6</td>
<td>The patient can refer to guidance and possible adverse signs and symptoms indicating that assistance should be sought.</td>
</tr>
</tbody>
</table>

### 4. Safe storage of drugs and equipment

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>The patient is able to state where, at home (in their community setting) they plan to store the drugs and equipment provided.</td>
</tr>
<tr>
<td>4.2</td>
<td>Appropriate use of refrigeration is demonstrated (including a separate space for drugs away from family foods)</td>
</tr>
<tr>
<td>4.3</td>
<td>The patient includes within their statement consideration of children and access by others.</td>
</tr>
</tbody>
</table>

### 5. Safe disposal of sharps

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>The patient understands the importance of sharps disposal and how to use the sharps container safely – no over filling, safe closure, and appropriate disposal of used container.</td>
</tr>
</tbody>
</table>

Once the patient has consented to assessment for self administration the assessment process should follow a stepped approach.

Initially the patient should observe, information should be provided verbally and in the written form. The assessor must guide, correct and facilitate.
# Addressograph

## Competency Checklist

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Date Demo</th>
<th>Date supervised practice</th>
<th>Date competent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hygiene &amp; Infection control, hand washing</strong></td>
<td>Patient has been observed washing hands correctly, understands the need to dry and use hand rub and allow to dry. Patient can complete VIP score if using cannula.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drug reconstitution &amp; administration</strong></td>
<td>Patient has been observed undertaking 3 procedures in a competent manner: checks expiry date, checks packaging, prepares area surface appropriately, opens vial without contamination or injury, uses sterile non-touch technique.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IV access management/ maintenance</strong></td>
<td>Demonstrates required dexterity in handling vials, ampoules, needles &amp; syringes etc. Cleans ports, maintain security of line/dressing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Storage of drugs &amp; equipment</strong></td>
<td>Demonstrates understanding of how to store: antibiotics, water for injections &amp; saline flushes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disposal of sharps</strong></td>
<td>Patient has been observed disposing of sharps safely.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient has IV drug administration protocols &amp; guidelines</strong></td>
<td>Patient has written possible drug reactions &amp; can demonstrate a basic understanding of them &amp; what action to take.</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Patient has information booklet given</strong></td>
<td>Patient has all equipment required &amp; can identify each component by name.</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Patient has all prescribed drugs including saline flushes and water for injection</strong></td>
<td>There will be someone at home with you whilst administering IV’s.</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Name:**

**Assessor:**

**Signature:**

**Designation:**

**Date:**

**Time:**

---

Source: Home IV Therapy team

Issue date: April 2016

Status: Approved

Review date: April 2018

PP(16)319
## APPENDIX 2

### Patient Visual Scoring of Intravenous Skin Site

<table>
<thead>
<tr>
<th>Appearance of access site skin</th>
<th>SCORE</th>
<th>PATIENTS INITIAL ACTION</th>
<th>ONGOING ACTION FOR CLINICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>site appears healthy</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| One of the following signs is evident:  
  - Slight redness of skin near insertion site  
  - Slight pain in skin near insertion site | 1     | Observe insertion site skin |                             |
| TWO of the following are evident on the access site skin:  
  - Pain  
  - Swelling  
  - Redness | 2     | Please contact your community nurse | TAKE OUT CANNULA, RESITE NEW and continue care |
| ALL of the following signs are evident on the access site skin:  
  - Pain  
  - Pus  
  - Redness  
  - Swelling  
  - Site may feel warm | 3     | Please contact your community nurse if they are not aware already | TAKE OUT CANNULA, RESITE NEW AND continue care |
| ALL of the following signs are evident on the access site skin:  
  - Pain  
  - Pus  
  - Redness  
  - Swelling  
  - For a patient with a cannula you may be able to feel vein swollen and painful running under skin from site | 4     | Please contact your community nurse if they are not aware already | TAKE OUT CANNULA, RESITE NEW and continue care  
Liaise with patients GP or Acute clinician as appropriate  
Refer to Rapid Access Review Flow Chart for Home Patients |
| ALL of the following signs are evident on the access site skin:  
  - Pain  
  - Pus  
  - Redness  
  - Swelling  
  - For a patient with a cannula you may be able to feel vein swollen and painful running under skin from access site  
You may feel like you have a temperature | 5     | Please contact your community nurse if they are not aware already | TAKE OUT CANNULA, RESITE NEW and  
Liaise with patients GP or Acute clinician as appropriate  
Refer to Rapid Access Review Flow Chart for Home Patients |
### APPENDIX 3

**Patient Self Administration Record**

Before you administer your intravenous antibiotics please complete your visual score and write in the table below.

#### Patient Visual Scoring of Intravenous Site

<table>
<thead>
<tr>
<th>Day</th>
<th>VIP Score – you will need to score each time you have to administer your antibiotic</th>
<th>Record of Action (administration or reason not given)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 2</td>
<td></td>
<td></td>
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<tr>
<td>Day 3</td>
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<td>Day 4</td>
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<td>Day 5</td>
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<td>Day 6</td>
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<td>Day 7</td>
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<td>Day 8</td>
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<td>Day 9</td>
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<td>Day 10</td>
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<td>Day 11</td>
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<td>Day 12</td>
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<td>Day 13</td>
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<tr>
<td>Day 14</td>
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<tr>
<td>Day 15</td>
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</tbody>
</table>
APPENDIX 4

Rapid Access Review for Self Administering Home IV Antibiotic Therapy Patients

Patient has been discharged from West Suffolk Hospital on Home IV Therapy (HIT)

If symptoms are not related to the condition being treated by the acute Trust patient must call their GP

Weekdays:
8am - 5pm: HIT Clinical Nurse Specialist (Switchboard) 01284 713000, Bleep 170 or Telephone 01284 712783
HIT nurse will liaise with the patient’s clinician and AMU co-ordinator if admission required
5pm – 8pm: AMU co-ordinator.

Overnight: Contact On call GP or Attend Emergency Department (if symptoms require immediate attention)

Weekend:
8am - 8pm: AMU Coordinator

Overnight: Contact On call GP or Attend Emergency Department (if symptoms require immediate attention)

HIT nurses/APS may be advised to ask the patient to attend AMU for review