



SHEA Member Feedback: IV Fluid Conservation Strategies in the wake of Hurricane Helene (as of October 11, 2024)

The below summary of strategies was collected from members of SHEA who have experience and expertise in developing mitigations strategies under crisis conditions. The strategies compiled in this document are being shared to temporarily support the healthcare epidemiology and antibiotic stewardship clinical communities throughout the duration of the IV fluid supply chain disruption following the temporary closure of Baxter International's North Cove site in Marion, NC. This document is provided for information sharing purposes only and does not represent official guidance of SHEA.

- 7 days hang time for commercially prepared IVF
- Change the hang time from 24 h to 72 h of IV fluids (non-additive).
- Will be converting as many people as possible to saline locks.
- Going to switch from 1L bags to 500ml bags for pressure bags.
- Will be stopping use of carrier bags with IV piggy back medications when possible – exceptions insulin drips, PCAs
- Limit changing bags when patients are transferred in from other facilities or EMS to when they are visibly contaminated or there is a question of conditions line/fluids started.
- Going to use 100ml NS bags to prime and flush tubing with blood transfusions (except in mass transfusions)
- No need to do IV push at this time.
- Will be updating some standing orders to accommodate these changes.
- Will decrease the unit PAR levels to 50% - exceptions L&D, Burn units, ICUs, OR, and ED.
- Prioritizing oral hydration whenever possible.
- Avoid waste: Do not pre-spike bags, and only hang fluids after an order has been placed.
- Use the lowest clinically necessary IV fluid rate.
- Reassess NPO status and IV fluid needs daily.
- Transition from IV to oral medications as soon as clinically appropriate.
- Restricting IV tmp/smx & IV azithromycin to patients who are NPO and increasing efforts to discontinue empiric vancomycin use guided by nasal PCR testing for MRSA



- In limited areas, using tubing with one-way valves that allows for use of a single bag of fluid for multiple patients. That is a conventional strategy that we simply have not allowed before.
- Establishing a framework to define conventional, contingency and crisis stages (perhaps based on days on hand), and the strategies that would be employed in each category.
- A lot of IV to oral switching for antibiotics, potassium, etc...; considering moving some IV antibiotics to push, rather than hanging in small bags
- Working with peritoneal dialysis patients to have them bring supplies in from home when possible
- Messaging OR teams to not place IV bags in warmers
- Not considering use of tap water for scopes