TuftsMedicine
Care at Home

First-Dose TPN In-Home Checklist (RN Use)

1. Arrival & Pre-Infusion

☐ Verify patient identity with two identifiers (name, DOB).

☐ Confirm provider order and pharmacy label match (components, volume, rate, additives, expiration).

☐ Review most recent labs (electrolytes, glucose, renal/hepatic, triglycerides).

☐ Assess home environment: clean workspace, refrigeration, safe disposal area.

☐ Perform hand hygiene and don PPE.

☐ Inspect TPN bag: clarity, no precipitate, intact, within expiration.

☐ Confirm TPN bag was stored refrigerated and has warmed to room temp (1–2 hr out).

☐ Ensure emergency readiness: 911 access, provider on call, infusion company contact, spare batteries.

2. Central Line & Patient Assessment

☐ Inspect central line site: dressing intact, no redness, swelling, drainage.

☐ Verify line patency: blood return present, flush without resistance.

☐ Confirm TPN will be administered via dedicated lumen only.

☐ Obtain and document baseline vitals (BP, HR, RR, Temp, O2 sat).

☐ Check baseline blood glucose if ordered.

3. Equipment Setup

☐ Gather supplies: IV tubing with filter, flushes, pump, batteries, PPE.

☐ Spike TPN bag and attach correct filter (0.2 micron without lipids; 1.2 micron with lipids).

☐ Prime tubing fully (no air).

☐ Load tubing into Solis CADD Pump.

☐ Program pump per order: VTBI, infusion rate, duration.

☐ Double-check programmed settings against order/label.

4. **Initiation & Monitoring**

- ☐ Connect tubing aseptically to dedicated lumen.
- ☐ Start infusion and verify flow.
- ☐ Remain with patient for first monitoring window (30–60 min minimum).
- ☐ Recheck vitals at 15–30 min, then per policy.
- ☐ Observe for: rash, SOB, chest pain, wheeze, fever, chills, edema, confusion, or pump alarms.
- ☐ Check glucose at ordered interval (often 1–2 hour post-start).

5. **Patient & Caregiver Teaching**

- ☐ Explain TPN purpose and infusion schedule.
- ☐ Demonstrate pump basics: start, stop, silence alarms.
- ☐ Teach infection prevention: hand hygiene, hub scrub, site monitoring.
- ☐ Review daily monitoring: weight, temp, glucose (if ordered).
- ☐ Provide written materials and emergency contacts.
- ☐ Perform teach-back and return demonstration with caregiver.

6. **Emergency Response (If Needed)**

- ☐ Stop infusion immediately if reaction suspected.
- ☐ Maintain IV access with saline if ordered.
- ☐ Assess Airway, Breathing, Circulation (ABCs).
- ☐ Call 911 for severe/life-threatening symptoms.
- ☐ Notify provider and infusion company.
- ☐ Document event and interventions.

7. **Post-Infusion / Departure**

- ☐ Verify pump is running correctly at ordered rate.
- ☐ Reassess vitals and patient tolerance before leaving.
- ☐ Confirm central line secure and dressing intact.
- ☐ Ensure supplies are safely stored/disposed of.
- ☐ Reinforce education and provide opportunities for questions.
- ☐ Document in EMR: pre-checks, infusion details, vitals, patient response, teaching provided, caregiver demonstration, and any provider notifications.