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| INTRAVENOUS THERAPY | | | | NO. | |
| Purpose: To provide guidelines for Intravenous Therapy.  Statement: It is the policy of this facility that Licensed Practical Nurses may render the care for IV’s if they have had an IV certification.  Procedure:   1. A physician’s order is required for intravenous therapy, and must state: 2. Route 3. Type of solutions and additives 4. Flow, rate, and time of administration 5. Type and frequency of flushes 6. Start date 7. Stop date 8. Nurses who have had IV training or certification are the only staff members authorized to: 9. Insert IVs 10. Identify and set up equipment and solutions for infusion 11. Monitor and adjust flow rates 12. Maintain IV sites 13. Change IV dressings 14. Change solutions 15. Flush IVs or heparin locks 16. Set or change any setting on transfusion pumps. 17. Remove IVs 18. Administering any medication into an IV or adding a piggy back must be done by a registered Nurse. 19. A registered nurse must render all care and maintenance of surgical ports. This would include infusions, medications, flushing of ports and dressing changes. 20. Nurses will not delegate any of the above tasks to any other staff members. 21. Insertion of the IV 22. Wear gloves when inserting an IV device. 23. Before insertion, cleanse the skin site with an appropriate antiseptic, such as alcohol or povidone-iodine. 24. Do not palpate the insertion site after the skin has been cleansed with antiseptic. | | | | | |
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| 1. Insertion site must be changed every 72 hours unless the physician’s order states otherwise. 2. Label tubing and dressing with date, time, and initials. 3. Use an arm board only when necessary to secure the site. 4. Document in the resident’s chart the site, date, and time of insertion. 5. Instruct the unit’s staff members to avoid touching the site. 6. Dressing 7. Apply sterile, transparent dressing and tape. 8. Use sterile or non-sterile clean gloves during dressing changes. 9. Replace dressings when they become damp, loose, or soiled. 10. Do not routinely apply topical anti-microbial ointment to insertion sites. 11. Change dressings at least every 72 hours unless the physician’s order states otherwise. 12. Date, time, and initial the dressing when it is applied or changed, and also document in the resident’s chart. 13. Solutions and Medications to be done by Registered Nurses ONLY. 14. Check all IV solutions and medications to make sure they are compatible, as certain combinations will cause clotting of fluids. 15. Check all solution and medications containers for turbidity, leaks, cracks, and particulate matter. 16. Check the manufacture’s expiration date before use. 17. Use single-dose vials for medications whenever possible. 18. Refrigerate multi-dose vials after they are opened as recommended by the manufacturer. 19. Cleanse the rubber diaphragm of multi-dose vials with alcohol before inserting a device into the vial. 20. Use a sterile device each time a multi-dose vial is accessed. 21. Discard multi-dose vials when suspected contamination occurs. 22. Transfusion Pumps 23. Refer to the pump’s manufacturer instructions in the policy and procedure manual. 24. Instruct the unit’s staff members that they must:  * Instruct the nurse whenever the pump alarms sound. * Inform the nurse whenever the resident must be moved or needs a procedure that would require the tubing or pump to be disconnected.  1. Instruct the unit’s staff members that they must NOT:  * Disconnect or reconnect any tubing from the pump * Change any settings on the pump * Turn the pump alarm off * Turn the pump on or off  1. Tubing and Bags 2. Change bags at least every 24 hours. 3. Replace IV tubing, including piggyback tubing and stopcocks, no more frequently than every 72 hours, unless clinically indicated. 4. Label all bags and tubing with date, time, and initials. | | | | | |
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| 1. Flushes 2. The physician’s order must specify the type and frequency of flushes. 3. The flush order must be entered in the resident’s record and Medication Administration Record (MAR) like any other medication order. 4. The most usual flush order is for saline. 5. For piggybacks, the typical flush order is: saline – antibiotic (or medication) – saline – heparin (SASH) 6. Whenever heparin flush is used, check the IV solutions to make sure they are compatible, as certain medication and heparin combinations will cause clotting of fluids. 7. All injection ports or heparin locks must be swabbed with alcohol before insertion of devices or needles. 8. Monitoring and Documentation 9. Check every four hours the:  * Resident * Site * Dressing * Tubing * Bag * Pump  1. Monitor for the following, and document in the resident’s chart:  * Redness * Swelling * Warmth * Pain * Fever – Temperature should be taken and documented at least once per shift. * Bag and tubing intact * Pump running correctly * Types of fluids and medications are as ordered * Flow and rate as ordered * Dressing intact, free of blood or drainage  1. Instruct the unit’s staff members to report to the RN any redness, swelling, or resident complaint of discomfort. 2. If the dressing is not transparent, remove enough of the dressing to see the area clearly. 3. If there are signs of infiltration or infection, stop and remove the IV immediately, and notify the physician. 4. Intake: 5. Keep strict intake on any resident receiving IV fluids. 6. A log of fluid administration must be included in the resident’s medication administration record (MAR). 7. At the end of the shift, record exactly how much of the IV fluids and medications the resident received. 8. These amounts should be added for totals at the end of night shift. | | | | | |
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| INTRAVENOUS THERAPY | | | | NO. | |
| 1. Discontinuing the IV 2. Remove the IV according to the physician’s orders or whenever there is any sign of infection or infiltration. 3. Wear gloves when removing the IV. 4. Apply pressure with sterile gauze until all bleeding stops. 5. Apply a dry, sterile dressing. 6. Check catheter to insure tip intact. | | | | | |
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