
ORGANIZATIONAL ASPECTS OF IV THERAPY

LEGAL ASPECTS OF INFUSION THERAPY FOR NURSES

Policy

Nurses administering infusion therapies will practice within the scope of practice for their licensure as established in the State Nurse Practice Act, and within their clinical level of competency as established by the facility training and competency evaluation programs.

Nursing Responsibilities in Infusion Therapy

1. Administering medications within specified times, starting treatments within a responsible time after order is written. Administering medications in a safe, responsible manner.
2. Maintaining clinical competencies through education and demonstration.
3. Performing ongoing assessments of resident during infusion therapy (at least every 2 hours during a continuous infusion or per facility policy).
4. Understanding the nature of the specific therapy being administered, including reason for the therapy, risks and potential complications and type and duration of therapy.
5. Knowing the *Five Rights of Medication Administration* (right medicine, right resident, right dose, right route, right time).
6. Intervening appropriately when complications arise.
7. Safely handling equipment. If a piece of equipment is not functioning properly, the equipment must be labeled as malfunctioning/broken and must be taken off of the unit.
8. Performing functions and procedures that are consistent with current standards of care, facility policy and procedure and that are within the scope of the State Nurse Practice Act.
9. Understanding how to conduct a detailed history and assessment of the resident. This includes an allergy history.
10. Understanding that at no time are they allowed to coerce or restrain a resident against a resident's will.
11. Clarifying an illegible, incomplete, or incorrect order.
12. Understanding of aseptic and sterile techniques and maintaining infusion equipment and medications in a way to avoid contamination.
13. Obtaining consent (verbal, written) from the resident before performing a procedure.
14. Establishing and maintaining supportive and appropriate relationships with resident, family, and other professionals that are involved in the care of the resident.
15. Maintaining adequate documentation (see documentation section).
16. Communicating complications to legally authorized prescribers, supervisors, and other professional staff.
17. Providing education to resident/family.
18. Supervising and providing a safe and secure environment for resident.
19. Completing incident reports for any unusual occurrence (according to facility policy and procedure).

Scope of Practice for Specific Infusion Therapy Nursing Functions

The following procedure/functions associated with infusion therapy must be verified with the State Nurse Practice Act regarding RN and LPN scope of practice, as the regulations differ from state to state.

1. Starting and discontinuing IV solutions.

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2. Administering and/or monitoring of IV solutions. (Note: Specialty treatments such as IV chemotherapy, blood products, total parenteral nutrition, pain medication, and immune therapies require specific education and knowledge of treatment, along with demonstrated clinical competency.)
3. Adding medications to existing IV solutions (admixture).
4. Administering IV push medications.
5. Caring for and maintaining infusion equipment and catheters (peripheral and central venous access catheters). This includes flushing, dressing changes, site assessment, site rotation (for short peripheral catheters only), changing IV tubing and needleless connection devices.
6. Inserting and removing short peripheral catheters. Insertion and removal of other catheters require special education, certification, and demonstration of clinical competency.
7. Monitoring function of IV pumps and IV tubing.
8. Calculating and adjusting flow rates of IV tubing and IV pumps.
9. Observing and reporting on catheter patency, insertion site, complications, resident reaction to treatment.
10. Converting continuous fluids to intermittent, and vice versa.
11. Documenting treatment, observations, complications, interventions, resident response to treatment.
12. Creating, documenting, and follow through on care plans for resident.
13. Providing education to resident and family.
14. Intervening in case complications related to IV therapy.

Facility/Administration Responsibilities for IV Therapy

1. Developing and approving policies and procedures for infusion therapy.
2. Providing education or verifying qualifications of the staff that will be providing infusion therapy. This may include IV fundamental classes, precepting and/or clinical competency evaluations.
3. Assuring that federal and state regulations are followed, along with facility policy and procedure.
4. Providing a safe, secure environment for the practice of infusion therapy.
5. Correcting and investigating infusion related problems.
6. Providing proper and safe equipment for use during infusion therapy.

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DOCUMENTATION GUIDELINES FOR INFUSION THERAPY

General Rules of Documentation

1. Only document factual, objective information in the chart.
2. Do not document opinion or speculate on the condition of the resident in the chart.
3. Write only in the past or present tenses, never in the future tense.
4. Quotes may be charted as long as they are within context and are relevant to the subject that is being documented.

General Rules of IV Documentation

1. Document per facility policy – usually every shift if resident has an infusion catheter in place, or whenever an infusion treatment is given.
2. Document continuous infusion every 2 hours. This includes observation of the insertion site, and how the resident is tolerating the infusion.
3. Complete an incident report for any unusual occurrences. Only include what was observed at the time of the incident or quotes from other observers. A nursing note should include exactly the same information.
4. Complete a nurse's note for the following:
 - a. If there are any complications.
 - b. When an infusion catheter is inserted, including the reason for insertion (hydration, medication, blood product, TPN, blood draws).
 - c. When an infusion catheter is discontinued, including the reason for the discontinuation (end of treatment, site rotation, complications, placement of different type of catheter).
5. The shift note should include the following information:
 - a. Date, time; signature and title of Nurse.
 - b. Location and objective description of insertion site.
 - c. Any complications, interventions.
 - d. Resident education, questions.
 - e. A quote from the resident stating how they are tolerating treatment; or if the resident is non-verbal, describe any objective signs/symptoms of problems.
6. Insertion of a catheter note should include the following information:
 - a. Date, time; signature and title of Nurse.
 - b. Physician order for type of treatment and catheter.
 - c. Verbal or written consent received.
 - d. Questions, education done.
 - e. Reason for insertion (hydration, medications, etc.).
 - f. Vein name and location of catheter insertion.
 - g. Number of attempts.
 - h. Any complications that arise after the insertion or attempt (bruise, hematoma, skin tear).
 - i. Gauge and length of catheter, along with brand name.
 - j. Type of dressing that was placed (transparent or gauze with transparent).
7. Complications note should include the following:
 - a. Nature of the problem – document just the facts or objective description. Do not use diagnostic terms such as “infiltration”, “infection”, or “phlebitis”.

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- b. Interventions that were done – such as “shut off infusion”, “removed catheter”, “received order for different type of catheter”, “informed Physician”, etc.
 - c. Plan for follow up – this must be written in past or present tense. Never write “next shift to continue to monitor”. Write that the information was reported to the next shift, or written in 24 hour report.
8. Unsuccessful catheter insertion note should include the following information:
- a. Location of attempt(s).
 - b. Number of attempts.
 - c. Gauge, length, manufacturer name of catheter.
 - d. Condition of insertion site post insertion.
 - e. Statement from resident on how he or she tolerated the procedure.

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LATEX ALLERGIES

Policy

The facility will provide non-latex equipment and supplies for individuals with latex sensitivities.

General Guidelines

1. Latex exposure will be minimized or eliminated among latex sensitive individuals.
2. The facility is responsible for providing latex-free supplies to residents or staff with latex sensitivity.
3. The nursing staff will have knowledge of guidelines from the Centers for Disease Control (CDC) and Occupational Safety and Health Administration (OSHA) regarding the prevention of allergic reactions to latex in the workplace.
4. Staff and resident education will be available concerning latex allergies.
5. The pharmacy will be available to help facility staff identify any products that may contain latex (such as rubber lids on tops of bottles).