HHVNA PROCEDURE

ORIGINAL DATE:	02/13

SUBJECT: INFUSION PUSH LASIX

PURPOSE: To assure the safe administration of intermittent central line or peripheral intravenous (IV) Lasix supplied in a syringe or vial.

CONSIDERATIONS:

1. When IV Lasix is ordered and the patient is not on home telemonitoring, an order for Telehealth will be requested
2. A detailed physician order must be obtained prior to administering IV Lasix in the home.
    a. The follow information is required for the acceptance of an IV Lasix order:
        i. Pharmacy to which the prescription was sent and confirmation of availability
        ii. Duration of therapy
        iii. Baseline weight or "dry" weight of patient
        iv. Parameters for PRN administration (ex. weight gain, dyspnea, cough, edema, fatigue)
        v. Parameters for hold Lasix dosage
        vi. Venous access to be used
            1. Peripheral access
            2. Access existing line
        vii. Saline and heparin flush orders
        viii. Results of recent lab work, if available
3. Only Registered Nurses who have completed an approved IV therapy course and achieved competency as designated by the agency may administer IV push medications.
4. If the Lasix is supplied in single dose syringes, it must be refrigerated. Allow refrigerated Lasix syringe to stand at room temperature for 15 to 30 minutes prior to infusion.
5. The maximum recommended single dose of IV Lasix is 200mg/dose or a maximum daily dose not to exceed 600 mg.
6. Additional clinical orders to be entered into the patient's POC are as follows:
    a. Daily weights
    b. Breath sounds every visit
    c. Orthostatic blood pressure's at every visit
    d. Measurements of lower extremities every visit
    e. Measurement of abdominal girth every visit

EQUIPMENT:

IV Start Kit if available:	6 Alcohol Preps
Non-sterile gloves	Syringe with needle
Tourniquet	Saline syringe
Tape	Lasix as ordered
Access IV needle (butterfly)	If patient has existing line:
Sharps container	Heparin Syringe 10units/cc per physicians order

PROCEDURE:

1. Identify patient using 2 patient identifiers
2. Explain procedure to the patient/caregiver.
3. Obtain blood pressure prior to administration.
4. Adhere to Standard Precautions.
5. Prepare a clean working area.
6. Gather and organize all of the supplies.
7. If using multi-dose vial, draw up prescribed dose.
8. For either single dose or multi-dose vial, assess for:
    a. Correct medication.
    b. Correct dose.
    c. Expiration date.
    d. Inspect for discoloration or precipitate.
9. Wash hands using agency-approved hand hygiene.
10. Start peripheral line if needed
11. Open clamp, if one is present, on line or extension.
12. Clean the needle less connector with alcohol prep and allow to dry.
13. Attach saline flush to cap and flush.
14. Clean the cap with alcohol prep.
15. Attach medication syringe to cap. Slowly inject the medication at the prescribed rate of 5 – 10 minutes.
16. After the medication syringe is empty, remove it.
17. Wipe cap with alcohol, allow to dry and then flush IV with normal saline. If a compatible continuous IV solution is infusing, this step may be omitted.
18. If peripheral administration, remove line.
19. Wipe cap with alcohol, allow to dry and flush IV with heparin (if required). Remove syringe.
20. Close clamp or IV extension and secure.
21. Discard ALL used supplies per agency policy.

AFTERCARE:

1. Obtain blood pressure 10-15 minutes post administration.
2. Document in patient's record:
    a. Procedure and observations.
    b. Instructions given to patient/caregiver.
    c. Response to procedure.
    d. Communication with physician.
        i. Obtain type and frequency of follow-up lab tests

Approved Policy Committee: 02/12/13