1. PURPOSE:

1.1. To define which medication may be administered by IV push method.

1.2. To achieve a high blood levels of a medication into a short period.

1.3. To achieve immediate and maximal effects of a medication.

1.4. To administer the correct intravenous injection following the seven (10) rights

2. DEFINITION

2.1. **Single dose vials/ ampoules:** are medications that do not have preservatives, or are packaged for single dose administration only.

2.2. **IV Push:** is a specific amount of medication (diluted or undiluted) given directly into the vein over 30- 60 seconds, it should be given by trained registered nurse.

2.3. **Slow IV Push:** A specific amount of medication given into the vein over three to five (3-5) minutes.

2.4. **Rapid IV Push:** A specific amount of medication given directly into the vein over less than thirty (30) seconds.

3. APPLICABILITY

Registered Nurses

4. POLICY

4.1. A written doctor's order must be secured.

4.2. Medication must be kept in the medication trolley.

4.3. A nurse should not administer medication prepared by someone except those prepared by the Pharmacist and requires name and signature of the Pharmacist.

4.4. Two Staff Nurses are required to administer the medication.

4.5. Ensure that the medication room is clean and have a good lighting.

4.6. Patient identification is checked by patient name and medical record number through the ID band and using the seven rights.

4.7. Medication brought to hospital by patient should not be administered or left with patient without written order by the physician for continuation and medication sent to pharmacy for proper labeling.

4.8. Narcotics are to be checked on every shift change by the responsible nurse. All narcotics and controlled drugs will be kept under double lock system. The charge nurse or the appropriate nursing staff is responsible for the narcotic key throughout the shift.

4.9. Administration of medications to female patients that involves exposure or touching of the body must be carried out by a female nurse except in cases of extreme emergency

5. PROCEDURE

5.1. Equipments

A tray containing:

5.1.1. Injection tray with prepared medicine in a syringe with needle

5.1.2. Alcohol swab

5.1.3. Disposable gloves

5.1.4. IV cannula

5.2. Steps: Direct IV injection

5.2.1. Wash hands

5.2.2. Reassure the patient and explain the procedure.

5.2.3. Have the patient relax and support his arm below the vein to be used.

5.2.4. Apply tourniquet and look for a suitable vein.

5.2.5. Disinfect skin.

5.2.6. Stabilize the vein by pulling the skin taut in the longitudinal direction of the vein. Do this with the hand you are not going to use for inserting the needle.

5.2.7. Insert the needle, bevel up, through skin at an angle of 35- degree. Use a slow continuous motion.

5.2.8. If the vessel rolls, it is necessary to penetrate the skin first at a 20- degree angle and then apply a second thrust parallel to the skin.

5.2.9. Hold the syringe and needle steady.

5.2.10. Aspirate. If blood appears hold the syringe steady, you are in the vein.

5.2.11. Loosen tourniquet.

5.2.12. Inject (very) slowly. Check for pain, swelling, hematoma;

5.2.13. Withdraw needle swiftly. Press sterile cotton wool onto the puncture site. Secure with adhesive tape.

5.2.14. Check the patient's reactions and give additional reassurance, if necessary

5.2.15. Dispose the used syringes and needle safely.

5.2.16. Wash hands.

5.2.17. Document in the medication record including assessment findings, if it is indicated.

5.2.18. Assess client for therapeutic drug action and possible side effects.

5.2.19. Report to physician if any adverse reaction noticed and document in the client's file.

Steps: IV Push

5.2.20. Wash and dry hands

5.2.21. Don gloves

5.2.22. Administering Medication Into an Existing Intravenous Line

5.2.23. Clean injection port with antiseptic swab. Allow to dry

5.2.24. Connect syringe to IV line

5.2.25. Occlude IV line by pinching tubing just above injection port gently on syringe's plunger to aspirate for blood return.

5.2.26. Inject the medication slowly into the IV port at the prescribed rate.

5.2.27. After injecting medication, withdraw syringe and recheck fluid infusion rate.

5.2.28. Check the patient's reactions and give additional reassurance, if necessary

5.2.29. Dispose the used syringes and needle safely.

5.2.30. Wash hands.

5.2.31. Document in the medication record including assessment findings, if it is indicated.

5.2.32. Assess client for therapeutic drug action and possible side effects.

5.2.33. Report to physician if any adverse reaction noticed and document in the client's file.

APPROVALS:

PREPARED BY: Nursing Supervisor	Ms. Beny Remo Shiny	November 2022
REVIEWED & APPROVED BY: Medical Director	Dr. Kirti Mohan Marya	November 2022