Intravenous Pain Management

Purpose

The purpose of this procedure is to provide guidelines for the safe and aseptic administration of intravenous (IV) pain medication.

Preparation

1. Verify with state Nurse Practice Act LPN/RN scope of practice for this procedure.
2. A physician's order is necessary for this procedure.
3. Review the resident’s care plan to assess for any special needs of the resident.
4. Assemble the equipment and supplies as needed.
5. The licensed nurse responsible for administering IV pain therapy shall be knowledgeable of:
   a. indications for use;
   b. appropriate doses and dilutents;
   c. side effects;
   d. toxicities;
   e. incompatibilities;
   f. stability;
   g. storage requirements;
   h. potential complications; and
   i. conventional and alternative methods of pain control.
6. Follow state Nurse Practice laws regarding scope of practice for administering prescribed intravenous pain medicine.
7. Anaphylaxis and naloxone medication protocols/orders/medications must be in place in the facility prior to the administration of IV pain medication.
8. Do not leave narcotic bags or cassettes in an unsecured locked area when not in use for resident infusion.

General Guidelines

1. First Dose of medication should be given in a situation in which close observation of resident and the ability to intervene in the case of complications is possible.
2. Frequent observation of the resident is necessary when IV pain medication is given. Monitor for pain control, change in vital signs, mental status, breathing status, nausea/vomiting, rash, or intolerance of medication.
3. Use a separate administration set for each medication.
4. When administering continuous IV or subcutaneous pain medication, use electronic infusion device to monitor rate of infusion.
5. Choose proper type of intravenous catheter to accommodate type of medication and duration of treatment.

Equipment and Supplies

1. Prescribed medication;
2. Administration set;
3. Saline or heparin for flush, as appropriate;
4. Needleless access device/adaptor;
5. Electronic infusion pump;
6. Gloves;
7. Alcohol swabs; and
8. Tape.

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Assessment

1. Inspect intravenous catheter site for signs of complications at scheduled intervals and upon routine site care and administration set changes.
2. Prior to administration of pain medications assess resident’s:
   a. level of pain using appropriate pain scale;
   b. level of consciousness;
   c. history of allergies; and
   d. baseline vital signs, height and weight.
3. Monitor resident during administration of pain medication for signs of:
   a. respiratory depression;
   b. level of consciousness/confusion;
   c. unsteady gait, risk of falling;
   d. nausea and vomiting;
   e. pruritis;
   f. constipation;
   g. urinary retention; and/or
   h. hypotension or hypertension.
4. Review physician’s order. Confirm type and amount of medication, route, and rate of administration.
5. Verify the identity of the resident.
6. Check medication label and verify against the order.
7. Inspect medication for any leaks, cracks, precipitate and expiration date.

Steps in the Procedure

1. Perform hand antisepsis and don non-sterile gloves.
2. Prime tubing of administration set.
3. Disinfect catheter injection/access port.
4. Flush catheter.
5. Connect primed administration set to catheter injection/access device.
6. Open clamp on tubing.
7. Establish prescribed rate of flow using an electronic infusion pump.
   a. Follow orders for amount to be infused and duration.
   b. Follow manufacturer’s directions to program pump.
   c. Program to achieve desired flow rate.
9. Instruct resident on expected outcomes and potential side effects.
10. Monitor resident closely.
11. When infusion is complete, clamp tubing and disconnect from catheter.
12. If tubing will be reused, replace sterile end cap on tubing.
13. Flush catheter per protocol.
14. Document procedure in the resident’s medical record.

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**Documentation**

1. The following should be documented in the resident’s medical record, and/or narcotic control record.
   a. Results of the initial and/or follow-up pain assessments.
   b. Any complications, side effects, problems with infusion, change in dose, refusal of medication.
   c. Any communication with physician, supervisor, or oncoming shift.
   d. Any waste of narcotic when treatment is finished.
   e. Effectiveness of pain treatment, per resident statement or use of scale.
   f. Any changes in orders.
   g. Condition of catheter and any complications/interventions.
2. Document narcotic administration in appropriate controlled medication record.

**Reporting**

The following should be reported to physician, supervisor, and oncoming shift as per facility policy.

1. Resident refusal of treatment.
2. New onset or worsening of assessed or resident-reported pain level.
4. Any side effects or complications from treatment/interventions.

**References**

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