Administration of Inotropic Therapy

Level III

Purpose

The purpose of this procedure is to provide guidelines for the safe and aseptic administration of intravenous inotropic drug therapy in order to increase cardiac contractility, promote vasoconstriction and increase heart rate for residents with end-stage heart failure.

Preparation

1. A physician's order is necessary for this procedure.
2. Review the resident's care plan to assess for any special needs of the resident.
3. Assemble the equipment and supplies as needed.
4. The licensed nurse responsible for administering inotropic therapy shall be knowledgeable of:
   a. indications for use;
   b. appropriate doses and dilutents;
   c. side effects;
   d. monitoring parameters;
   e. toxicities;
   f. incompatibilities;
   g. stability;
   h. storage requirements; and
   i. potential complications.

General Guidelines

1. Administer dopamine, a vesicant, through a central venous access device only.
2. When administering inotropic medications, use an electronic infusion device to monitor rate of infusion.
3. Whenever practical, the **First Dose** of any intravenous medication should be administered in a controlled environment (e.g., hospital, ambulatory clinic, or physician's office).
4. If the medication to be infused is the **First Dose**, obtain an order for an anaphylactic protocol before administering the medication and observe the resident for a minimum of one hour after completion of the infusion.
5. Use a separate administration set for each medication.

Equipment and Supplies

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

Assessment

1. Inspect intravenous catheter site for signs of infection and/or complications at scheduled intervals and upon routine site care and administration set changes.
2. Prior to administration of inotropic medications assess resident's:
   a. cardiovascular status;
   b. baseline vital signs, height and weight;
   c. blood pressure and pulse parameters;
   d. code status;

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Assessment (continued)

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e. laboratory results, including electrolytes, BUN, and serum creatinine (assess for appropriateness of therapy); and
f. history of allergies.

3. Assess resident every 15 minutes during the first hour of infusion and every four hours during infusion.
4. Weigh resident daily.
5. Monitor mental status.
6. Review physician's order. Confirm type of medication, route, and rate of administration.
7. Verify the identity of the resident.
8. Check medication label and verify against the order.
9. Inspect medication for any leaks, cracks, precipitate, and expiration date.

Steps in the Procedure

1. Perform hand antisepsis and don gloves.
2. Prime tubing of administration set.
3. Disinfect catheter injection/access port.
4. Flush catheter, if appropriate.
5. Connect primed administration set to catheter injection/access port. (**Note**: Administer dopamine through a central venous access device only.)
6. Open roller clamp.
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.
8. Begin infusion.
9. Administer inotropic medications continuously as ordered.
10. Change administration set as indicated, per protocol.
11. Instruct resident on expected outcomes and potential side effects.
12. Document procedure in the resident's medical record.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time the medication was administered.
2. The type of medication administered.
3. The amount of medication administered.
4. The route of administration.
5. The rate of administration.
6. Notification of the physician, if any.
7. Resident's response.
8. The signature and title of the person recording the data.

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Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

References	
MDS (RAPs)	I1, K5a, K6, O2, P1c, P7, P8, P9 (RAP # 12; RAP # 14)
Survey Tag Numbers	F328
Related Documents	Administration Set Changes (*Intravenous Therapy*) Heart Failure – Clinical Protocol Intravenous Therapy: Preventing Catheter-Related Infections (*Infection Control*)
Risk of Exposure	Blood–Body Fluids–Infectious Diseases
Procedure Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____

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