Addressograph

Hinchingbrooke Health Care NHS
NHS Trust

Ward

Venofer Iron Infusion
Nursing Care Plan

Problem	Outcome	Intervention	
Patient is undergoing a Venofer intravenous infusion	To ensure a safe infusion episode with prompt detection of side effects	A	Check patent venous access, prescription is correct and confirm patient ID band is in place prior to preparing IV therapy
		B	Prepare IV therapy according to hospital policy with reference to manufacturers guidelines and online IV drug administration guide
		C	Confirm patient identity prior to commencement of infusion. Flush the IV access device as per hospital policy. Connect the infusion
		D	Where possible educate the patient to promptly report any new signs or symptoms during infusion and ensure call bell is close to hand
		E	Ensure baseline observations have been recorded in the 30 minutes prior to commencement of infusion
		F	Commence infusion by setting the IV pump rate and document start time on the prescription
		G	For 1st infusion administer 25mg test dose as per prescription over 15 minutes. Visually observe patient during test dose and remain in close proximity in case of reaction. If no adverse events occur the remainder of the infusion should be given at a rate of not more than 50mls in 15minutes (200mls / hr). For subsequent infusions continue to H.
		H	Subsequent doses may be given at a rate of up to 400mls/hr. e.g. *100mgs in 100mls – administer over at least 15 minutes * 200mgs in 100mls – administer over at least 30 minutes.
		I	Document IV pump number on the drug chart/ in the nursing notes
		J	Perform and record observations every 15 minutes during the test dose and observation period, and then every 30 – 60 minutes or as clinically indicated.
		K	Ensure IV access device is observed and VIP score recorded on an IV therapy care plan at the start of the infusion, whenever observations are taken, rate is changed or more frequently if indicated
		L	Administration should be carried out by an IV certified practitioner who has received anaphylaxis training. Observe the patient for potential reactions including; anaphylaxis, uticaria, rashes, itching, hypotension, nausea and shivering.

		M	Management of adverse events; • In the event of a serious anaphylactic or allergic reaction stop the infusion. IM adrenaline should be administered and appropriate resuscitation measures initiated. • Mild allergic reactions should be managed by stopping the infusion and administering anti-histamines • Hypotensive episodes may occur if administration is too fast, so decrease infusion time as clinically indicated.
		N	On completion of infusion. Flush IV access device as per hospital policy. Cannula to remain insitu until discharge. Document infusion time and volume infused
		O	Patient to wait on ward for 30 – 60 minutes for observation post-infusion.
		p	Prior to discharge record observations and remove cannula. Ensure patient is aware of what to look for / what to do / and who to contact should they have a post-infusion reaction after discharge.

Date Care plan commenced	Staff name	Staff signature

Date Care plan resolved	Staff name	Staff signature