Acacium Group

Peripheral Intravenous (IV) Administration

Procedure Reference | SOP MEDS 07

Version | V4.0

Procedure Name	Peripheral Intravenous (IV) Administration
Purpose of Document	To ensure that the correct preparation, procedures & outcomes are achieved by implementing a safe, consistent and systematic approach to administration of IV medication
Target Audience	Clinical staff
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Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
V1	Dec 2016	Implementation of document history page	KNF/VM
V1	Apri2018	Updated front sheet to include new review frequency date	KMS/VM
V2	Sep 2019	3 Yearly Review and Implementation of new template	Clinical Advisory Group
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1. Introduction

Only Registered practitioners may administer Intravenous (IV) medication following recognised training.

The practitioner's responsibilities in relation to IV drug administration include:

1. Knowing the therapeutic use of the drug or solution, its normal dosage, side-effects, precautions, and contraindications.
2. Preparing the drug aseptically and safely, checking the container and drug for faults, using the correct diluent, and only preparing it immediately prior to administration.
3. Identifying the client and checking allergy status.
4. Checking the Medication Management Record.
5. Checking and maintaining patency of the venous access device (VAD).
6. Inspecting the site of the Venous Access Device (VAD) and managing/reporting complications if they arise.
7. Controlling the flow rate of the infusion and/or speed of administration.
8. Monitoring the condition of the client and reporting changes.
9. Make clear and immediate records of all drugs administered (RCN 2005, NMC 2008).

This standard operating procedure does not cover intra-arterial, intra-cardiac, intra- articular or intrathecal routes of administration.

The six rights: Prior to administering any medications it is important to consider the "The Six Rights".

NICE guideline [NG67]Published: 30 March 2017 , Six Rights for Medication Administration:

- Right drug
- Right time
- Right dose
- Right route
- Right client
- Right to refuse

It is also important to consider the right position of the client and the right documentation.

2. Aim

To ensure the safe and effective delivery of medications via the intravenous route.

3. General

Advantages of the IV route

Advantages of intravenous route of drug administration (Kwatra, S., Taneja, G. and Nasa, N. (2012).

1. Bioavailability, the proportion of the drug which enters the circulation, is 100%.
2. Drug reaches the stream of blood immediately having full access to the entire body and hence, rapid action is produced rendering this route to be the most efficient in life-threatening situations.
3. Irritating and non-isotonic solutions can be administered intravenously since the inner most layer of the vein is insensitive.
4. Drug dose titration is possible in a situation where the drug has a short duration of action and the response can be measured precisely.
5. Drugs can be delivered at a uniform rate.
6. Very large volume of infusion can be administered.
7. Highly irritant drugs, e.g. anticancer drugs can be given because they get diluted in blood.

- 'Nil by Mouth' (NBM) prior to procedures or surgery
- When there is the presence of nausea or vomiting in the patient
- Administration of precise quantities of medicines is possible
- Lowered consciousness or altered neurology affecting the safety of swallowing and increasing the risk of aspiration
    - If the client is Nil by Mouth

Disadvantages of the IV route

1. There is an inability to recall the drug and reverse its action. This may lead to increase toxicity or a sensitivity reaction.
2. Insufficient control of administration may lead to speed shock or circulatory overload.
3. Additional complications may occur such as infection or vascular irritation. Extravasation of some drugs can cause injury, necrosis, and sloughing of tissues and local irritation may cause phlebitis.
4. Needle phobia.
5. Pain at the site of injection.
6. Self-medication is not possible.
7. Altered body image especially when using central venous access devices (CVAD) l(refer to SOP MED 8).
8. Time taken to administer.

Principles for preparation and administration of IV's

Always use an aseptic non touch technique throughout the procedures, ensuring good hand washing and drying, if asepsis is not maintained it may lead to local infection, septic phlebitis or septicaemia (RCN 2005).

Accurate assessment of a Venous Access Device (VAD) will ensure prompt recognition of complications and other common occurrences.

The insertion site should be inspected at least once a day for complications such as redness or heat. This may indicate infection and phlebitis.(Standards for infusion therapy, RCN 2016.) Visual Infusion Phlebitis (**VIP**) **score** tool for assessment of the early signs of phlebitis, along with prompt removal of peripheral intravenous cannulas, reduces the incidence of phlebitis. See Appendix B.

It is desirable to have a closed system wherever possible, with as few connections as is necessary. This reduces the risk of contamination.

Injection sites on administration sets or caps should be cleaned using an alcohol-based antiseptic, allowing time to dry before use.

Administration sets should be changed according to use (intermittent/continuous therapy), type of device and type of solution.

Administration sets should be labelled with the date and time of change.

Replace all tubing when the Vascular access device (VAD) is replaced.

Replace solution administration sets and stopcocks used for continuous infusion every 24 hours unless clinically indicated e.g. for drug stability.

All administration sets for intermittent infusions e.g. antibiotics should be discarded immediately after use and not left for reuse (RCN 2005).

Inspection of fluids, drugs, equipment and packaging must be undertaken to detect areas where contamination may have occurred e.g. cloudiness, discolouration, or the presence of particles.

Three methods for IV administration

There are three methods of administering intravenous drugs: continuous infusion, intermittent infusion, and direct intermittent injection.

Prior to using a vascular device the patency must be assessed. The method and technique will vary according to the device and its location.

Continuous infusion

Continuous infusion may be defined as the intravenous delivery of a medication or fluid at a constant rate over a prescribed length of time. The greater the dilution the less irritant the medication, however the diluent ratio and type must be prescribed.

Pre-prepared infusion fluids with additives should be used whenever possible. This reduces the risk of extrinsic contamination, which can occur during the mixing of drugs (Weinstein and Hagle 2014).

Prepared infusion fluids should be used wherever possible as mixing drugs can introduce the risk of contamination and subsequent infection.

If additives are added, then the fluids must be mixed well to avoid the layering of the substances, this is achieved by inverting the container of the fluids once mixed several times.

If additives have been used, the container must be clearly labelled after the addition has been made.

Intermittent Infusion

This is the administration of a small-volume infusion i.e. 50-100ml over a period of time usually between 20min and 2 hours. This may be a one specific dose or at repeated intervals during a 24-hour period.

An intermittent infusion may be used when:

- The pharmacology of the drugs dictates this specific dilution
- The drug would not remain stable for the time required to administer a more dilute volume
- The client is on restricted intake of fluids

All the points above for the continuous infusions should also be considered for the intermittent infusion, but the instructions for delivery should be followed from the client's care plan and the Medication Administration Chart.

Delivery of a drug by intermittent infusion may utilize a system such as a 'Y' set/Beret, if the primary solution is compatible, or a burette set with a chamber, this is when the drug can be added to the chamber with the primary fluid switched off. The method of delivering will be detailed in the care plan and the method to be used.

After completion of an intermittent infusion, an appropriate diluent solution should be administered via the administration set. This is to ensure the full dose of medication has been administered to the patient.

The National Infusion and Vascular Access Society has published guidance on appropriate line flushing after infusion. This was prompted by concerns about the theoretical risk of under-dosing in intravenous infusions, when some of the drug is left in the tubing of the giving set at the end of the administration (NIVAS 2019). As this guidance is new and under regular review, it is advised that it be accessed online for the most up-to-date advice (https://nivas.org.uk).

Direct Intermittent Injection

Also known as intravenous push or bolus, involves the injection of a drug from a syringe into the injection port of the administration set or directly into a vascular access device (VAD). Most are administered anywhere from 3 to 10 minutes depending on the drug.

This method may be used when:

- A maximum concentration of drug is required to vital organs. This is a bolus e.g. adrenaline
- The drug cannot be further diluted for pharmaceutical or therapeutic reasons or does not require dilution. This is given as a controlled 'push' injection over a few minutes.
- A peak blood level is required which cannot be achieved by small-volume infusion.

Rapid administration could result in toxic levels and an anaphylactic-type reaction. Manufacturers recommendations of rates of administration should be adhered to - refer to summary of product characteristic sheet. In the absence of such recommendations, administration should proceed slowly with caution, over 5 –10 minutes. If in doubt, check with a colleague.

Delivery of the drug by direct injection may be via a cannula, through a re-sealable needleless injection cap, extension set or via the injection site of an infusion set.

The site must always be inspected either through a transparent dressing or by removing a non-transparent dressing e.g. bandage.

The access should be flushed with 0.9% sodium Chloride prior to and following administration to ensure patency, and that all the medication has been administered.

All sharps must be disposed of in a sharps bin (provided by the CCG or Pharmacy) needles and syringes must not be separated after use, the needle and syringe must be disposed of as a single unit. Needles and syringes are for single use only.

4. Patient Observations

It is important to have an understanding of the baseline observations of your patient prior to administering any IV medication or infusion.

Depending on the condition of the patient and the drug that that was to be administered would inform you on what vital signs would need to be measured following and during administration.

5. Injections Administration

Equipment

- Clean tray or receiver containing the prepared drug to be administered
- Alcohol swab
- Container of appropriate IV infusion fluid
- Infusion administration set
- Infusion device/pump if required
- Medicines administration recording chart and care plan
- PPE

	Action	Rationale
1.	Explain and discuss the procedure with the client.	To ensure the client understands the procedure and has given his/her consent.
2.	Inspect the infusion in progress.	To check it is the correct infusion being administered at the correct rate and that the contents are due to be delivered on time in order for the next prepared infusion bag to be connected. To check whether the client is experiencing any discomfort at the site of insertion, which might indicate the peripheral device might need replacing (NPSA 2007).
3.	Before administering any prescribed drug check that it is due and has not already been given.	To protect the client from harm.
4.	Before administering any prescribed drug, consult the MAR and ascertain the following: a) Dose b) Drug c) Date and time of administration d) Route and method e) Diluents as appropriate f) Allergies	To ensure the client is given the correct drug in the prescribed dose using the appropriate diluent and by the correct route (DH 2003) To protect the client from harm (DH 2003)
5.	Wash hands with bactericidal soap and water.	To prevent contamination of medication and equipment.
6.	Prepare the drug for injection described in section 6 of this SOP.	To ensure the drug is prepared.
7.	Check the name, strength and volume of the IV fluid against the MAR.	To ensure the correct type and quantity of fluid are administered.

8.	Check the expiry date of the fluid.	To prevent an ineffective or toxic compound being administered to the client.
9.	Check that the packaging is intact and inspect the container and contents in a good light for cracks, punctures, air bubbles.	To check there is no contamination of the container.
10.	Inspect the fluid for discolouration, haziness and crystalline or particulate matter.	To prevent any toxic or foreign matter being infused into the client.
11.	Check the identity and the amount of the drug to be added consider: a) Compatibility of fluid and additive b) Stability of mixture over the prescription time c) Any special directions for dilution d) Sensitivity to external factors such as light e) Any anticipated allergic reaction If any doubts exist about the reference points, seek advice.	To minimise the risk of error. To ensure safe and effective administration of the drug.
12.	Any additions must be made immediately before use.	To prevent possible microbial growth or degeneration.
13.	Wash hands thoroughly with bactericidal soap and water.	To minimise the risk of cross contamination.
14.	Place infusion bag on a flat surface.	To prevent puncturing the side of the infusion bag when making additions (NPSA 2007).
15.	Remove any seal present.	To expose the injection site.
16.	Clean the site with a swab and let it dry.	To minimise the risk of cross contamination.
17.	Inject the drug using a new sterile needle into the bag, bottle or burette. A 23 or 25G needle should be used.	To minimise the risk of cross contamination. To enable the resealing of the latex or rubber injection site (NPSA 2007).
18.	If the addition is made into a burette at the client's side: a) Avoid contamination of the needle and inlet port b) Check the correct quantity of fluid is in the chamber c) Switch the infusion off briefly d) Add the drug	To minimise the risk of cross contamination. To ensure a bolus is not given.

19.	Invert the container a number of times to, mix especially if adding to a flexible infusion bag.	To ensure adequate mixing of the drug.
20.	Check again for haziness, discolouration and particles. This can occur even if the mixture is theoretically compatible, thus making vigilance essential.	To detect incompatibility or degradation.
21.	Complete the drug additive label and fix it on the bag, bottle or burette.	To identify which drug has been added, when by whom.
22.	Place the container in a clean receptacle, wash hands.	To minimise the risk of cross contamination.
23.	Check the identity of the client with the prescription chart and infusion bag.	To minimise the risk of error and to ensure the correct infusion is administered to the correct client.
24.	Check that the contents of the previous container have been delivered.	To ensure the preceding prescription has been administered.
25.	Switch off the infusion. Place the new infusion bag on a flat surface and then disconnect empty infusion bag.	To ensure the administration set spike will not puncture the side wall of the bag.
26.	Push the spike in fully without touching the spike and hang the new infusion onto the hook/stand provided.	To minimise the risk of cross contamination.
27.	Restart the infusion and adjust the rate of flow as prescribed.	To ensure the infusion will be delivered at the correct rate over the correct period of time.
28.	If the addition is made into a burette, the infusion can be restarted immediately following mixing and recording and the infusion rate adjusted accordingly.	To ensure the infusion will be delivered correctly.
29.	Ask the client whether any abnormal sensations etc are experienced.	To ascertain whether there are any problems that may require further care and referral to the GP or other medical staff where appropriate.
30.	Discard waste, making sure that it is placed in the correct containers e.g. sharps bins.	To ensure safe disposal and to avoid injury to staff and others. (MHRA 2004).

31.	Complete the client's MAR.	To maintain accurate records.

6. Intermittent Infusion of IVs

Equipment

- Clean tray or receiver containing the prepared drug to be administered
- Alcohol Swab
- Administration set
- Sterile needles and syringes
- Dressing pack
- 20ml for injection of a compatible flush solution e.g. 0.9% sodium Chloride
- Flushing solution to maintain patency plus sterile injection cap
- Medicines administration recording chart
- Tape
- Container of appropriate IV infusion fluid
- PPE

	Action	Rationale
1.	Explain and discuss the procedure with the client.	To ensure the client understands the procedure and has given his/her consent.
2.	Before administering any prescribed drug check that it is due and has not already been given.	To protect the client from harm.
3.	Before administering any prescribed drug, consult the MAR and ascertain the following: a) Dose b) Drug c) Date and time of administration d) Route and method e) Diluents as appropriate	To ensure the client is given the correct drug in the prescribed dose using the appropriate diluent and by the correct route (DH 2003). To protect the client from harm (DH 2003.
4.	Prepare the intravenous additive as stated in the continuous infusion procedure above sections 2 -13.	To ensure the drug is prepared correctly.
5.	Prime the intravenous administration set with infusion fluid mixture and hang it on the hook or designated stand.	To ensure the removal of air and check that the tubing is patent.
6.	Draw up 10 ml of compatible flush solution for injection in two separate syringes, using an aseptic technique.	To ensure sufficient flushing solution is available.

7.	Draw up the solution to be used for maintaining the patency.	To prepare for administration.
8.	Place the syringes in a clinically clean receiver or tray.	To prepare for administration.
9.	Collect the other equipment.	To ensure all the equipment is ready to commence the procedure.
10.	Place the dressing pack onto a clean surface.	To minimise the risk of cross infection.
11.	Check all necessary equipment is available and ready to use.	To prevent delays to the procedure.
12.	Wash hands thoroughly with bactericidal soap and water.	To minimise the risk of cross contamination.
13.	Check the identity of the client with the prescription chart and infusion bag.	To minimise the risk of error and to ensure the correct infusion is administered to the correct client.
14.	Open the dressing pack.	To minimise the risk of cross infection.
15.	Add lotion for cleaning the injection cap into the galipot in order to wet the swab.	To minimise the risk of cross infection.
16.	Wash hands thoroughly with bactericidal soap and water.	To minimise the risk of cross infection.
17.	If peripheral device is in situ remove the bandage and dressing.	To detect signs of inflammation, infiltration etc, if present take appropriate action.
18.	Wash hands as above.	To minimise the risk of cross infection.
19.	Put PPE on.	To protect against contamination.
20.	Place a sterile towel under the client's arm.	To create a sterile work area.
21.	a) If using a needleless injection system, clean the cap with alcohol swab. b) If using a non-injectable cap, clean the connection between the cap and the device/extension set then remove the cap while	To minimise the risk of cross infection, maintain a closed system and prevent blood spillage.

	applying digital pressure at the point in the vein where the cannula tip rests.	
22.	Inject gently 10ml of 0.9% sodium chloride for injection.	To confirm patency.
23.	Check that no resistance is met, no pain or discomfort is felt by the client, no swelling is evident, no leakage occurs around the device.	To confirm patency.
24.	Connect the infusion to the device.	To commence treatment.
25.	Open the roller clamp.	To check the infusion is flowing freely.
26.	Check the insertion site and ask the client if he/she is comfortable.	To confirm that the vein can accommodate the extra fluid flow and that the client experiences no pain etc.
27.	Adjust the flow rate as prescribed.	To ensure that the correct speed of administration is established.
28.	Tape the administration set in a way that places no strain on the device, which could in turn damage the vein.	To reduce the risk of mechanical phlebitis or infiltration.
29.	If peripheral device is in situ cover it with a sterile dressing.	To maintain asepsis.
30.	Remove PPE and wash hands.	To minimise cross infection.
31.	If the infusion is to be completed within 30 mins bandaging is unnecessary, otherwise apply bandage.	To reduce the risk of disturbing the device.
32.	Clear the equipment.	
33.	Monitor the flow rate and the device frequently.	To monitor the flow rate and that the client is comfortable.
34.	When the infusion is complete, wash hands thoroughly with bactericidal soap and water and check all the equipment required is present.	To maintain asepsis.
35.	Stop the infusion when all the fluid has been delivered.	To ensure that all the of the prescribed mixture has been delivered and prevent infusing air into the client (NPSA 2007).

36.	Put sterile gloves on.	To minimise the risk of cross infection.
37.	Disconnect the infusion set and flush the device with 10ml of 0.9% sodium chloride for injection.	To flush any remaining irritating solution away from the cannula.
38.	Attach a new sterile injection cap if necessary.	To maintain a closed system.
39.	Flushing must follow.	To maintain the patency of the device.
40.	Clean the injection site with a swab.	Wash hands thoroughly with bactericidal soap and water.
41.	Administer the flushing solution (using a 23 or 25G needle) using the push pause technique and ending with positive pressure.	To maintain the patency of the device.
42.	If a peripheral device is in situ cover the insertion site and cannula with a new dressing and bandage.	To minimise the risk of cross infection and reduce the risk of dislodging the cannula.
43.	Remove gloves.	To minimise the risk of cross infection.
44.	Assist the client into a comfortable position.	
45	Record the administration on the MAR.	To maintain accurate records, provide a point of reference and prevent duplication of treatment (NMC 2005, NPSA 2007).
46.	Discard waste.	To ensure safe disposal and prevent injury.

7. Injection (bolus or push) of IV Drugs

Equipment

- Clean tray or receiver containing the prepared drug to be administered
- Alcohol Swab
- Administration set
- Sterile needles and syringes
- Dressing pack
- 20ml for injection of a compatible flush solution e.g. 0.9% sodium Chloride
- Flushing solution to maintain patency plus sterile injection cap

- Medicines administration recording chart
- Tape
- PPE

	Action	Rationale
1.	This procedure may be carried out via any of the following: 1. The injection or Y site of an IV administration set 2. An injection cap attached to any VAD 3. An extension set, multiple adaptor or stopcock (one, two or three way)	
2.	Explain and discuss the procedure with the client.	To ensure the client understands the procedure and has given his/her consent.
3.	Before administering any prescribed drug check that it is due and has not already been given.	To protect the client from harm.
4.	Before administering any prescribed drug, consult the MAR and ascertain the following: a) Dose b) Drug c) Date and time of administration d) Route and method e) Diluents as appropriate	To ensure the client is given the correct drug in the prescribed dose using the appropriate diluent and by the correct route (DH 2003). To protect the client from harm (DH 2003.
5.	Select the appropriate medication and check expiry date.	Treatment with medication that is outside the expiry date is dangerous, drugs deteriorate with storage (NPSA 2007).
6.	Wash hands thoroughly with bactericidal soap and water.	To minimise the risk of cross infection.
7.	Prepare the drug for injection.	To prepare the drug correctly.
8.	Prepare the 20ml syringe of 0.9% sodium chloride for injection, using an aseptic technique.	To use for flushing between each drug.
9.	Draw up the flushing solution.	To prepare for administration.
10.	Place syringes in the clean tray along with the drugs to be administered.	To prepare for administration.

11.	Collect the other equipment needed.	To ensure all the equipment is available and ready to use.
12.	Place the dressing pack onto a clean surface.	To minimise the risk of cross infection.
13.	Wash hands thoroughly with bactericidal soap and water.	To minimise the risk of cross infection.
14.	Check the identity of the client with the prescription chart and prepared drug.	To minimise the risk of error and to ensure the correct drug is administered to the correct client.
15.	Open the dressing pack and add lotion for cleaning the injection cap into the galipot in order to wet the swab.	To minimise the risk of cross infection.
16.	Check the VAD site for and signs of infection or swelling.	To detect signs of inflammation, infiltration etc, if present take appropriate action.
17.	Observe the infusion if in progress.	To confirm the infusion is being administered at the right rate, to prevent interaction.
18.	Check whether the infusion fluid and drugs are compatible.	
19.	Wash hands thoroughly with bactericidal soap and water.	To minimise the risk of cross infection.
20.	Place a sterile towel under the client's arm.	To create a sterile work area.
21.	Clean the injection site with swab and allow to dry.	To reduce the number of pathogens introduced by the needle at the time of the injection.
22.	Switch of the infusion or close the fluid path of a tap or stopcock.	To prevent excessive pressure within the vein. To prevent contact with an incompatible infusion fluid.
23.	If a peripheral device is in situ use a sterile 23 or 25G needle if the injection is made via a re-sealable site and gently inject 0.9% sodium chloride.	To enable resealing of the site and to confirm patency of the vein.

24.	Open the roller clamp of the administration set fully. Inject the drug at a speed sufficient to slow but not stop the infusion and inject the drug smoothly in the direction of flow at the specified rate.	To prevent back flow of drug up the tubing. To prevent excessive pressure within the vein. To prevent speed shock (NPSA 2007).
25.	Ensure the used needles and syringes are disposed of immediately into an appropriate sharp's container.	To reduce the risk of needle stick injury.
26.	Observe the injection site throughout.	To detect complications at an early stage. Extravasation or allergic reaction.
27.	Check the client does not have any discomfort.	To detect complications at an early stage.
28.	If more than one drug is administered, flush with 0.9% sodium chloride between administrations by restarting the infusion or changing syringes.	To prevent drug interactions.
29.	At the end of the injection, flush with 0.9% sodium chloride by restarting the infusion or changing syringes.	To flush any remaining irritant solution away from the device.
30.	Observe the site and cannula carefully.	To detect complications at an early stage.
31.	After the final flush of 0.9% sodium chloride adjust the infusion rate as prescribed or open the fluid path of the tap/stopcock or use the flushing solution.	To continue the delivery of the therapy. To maintain the patency of the cannula.
32.	If peripheral device is in situ cover the insertion site with a sterile dressing.	To minimise the risk of cross infection.
33.	Assist the client into a comfortable position.	To ensure the client is comfortable.
34.	Record the administration on the MAR.	To maintain accurate records, provide a point of reference and prevent duplication of treatment (NMC 2005, NPSA 2007).
35.	Dispose of used syringes with needles, unsheathed directly into a sharp's container. Do not disconnect needle from syringe prior to disposal.	To avoid needle stick injury (MHRA 2004).

8. Associated Policies / SOPs

Policies
CLIN 03 Medicines Management Policy
CLIN 06 Consent Policy

SOPs
SOP Meds 01 Controlled Drugs
SOP Meds 02 Oral Administration
SOP Meds 03 Rectal Administration
SOP Meds 04 Subcutaneous Administration of Medicines
SOP Meds 05 Administration via Gastrostomy and Jejunostomy Tubes (PEG, PEJ and JEJ)
SOP Meds 06 Intramuscular Injection Administration
SOP Meds 08 Administration via Central Line (Hickman, PIC and Porta Cath)
SOP Meds 09 Removal of Medicines from Client's Home
SOP Meds 10 Vaginal Administration
SOP Meds 11 Topical & Transdermal Application of Medicines
SOP Meds 12 Administering Ear Drops
SOP Meds 13 Administration of Eye Drops or Ointments
SOP Meds 16 Buccal or Sublingual Administration of Medicines
SOP Meds 17 Administration of Medication via a metered Dose Inhalers
SOP Meds 18 Administration of Epi-pen, Anapen and Emerade
SOP Meds 19 Self Administration of Medicines
SOP Meds 20 Oxygen Therapy: Adult and Child

9. References

- NMC 2018 Guidelines for records and record keeping (this is updated version) Procedure no 4
- The Royal Marsden 2015 Manual of Clinical Nursing procedures 9th Edition (this is updated version)
- CQC Medicines training and competency in adult social care settings – this relates to appropriate training, support and competencies making care safe, high quality and consistent (Training is referred to in all SOP's)
- NICE Guidance NG67 Managing medicines for adults receiving social care in the community March 2017 – this relates to general medicines management and details all processes
- NPSA 2007 promoting safer use of injectable medicines, Alert No 2007/20
- MHRA 2004 Reducing needlestick and sharps injuries
- RCN 2005 Standards for infusion therapy
- NMC 2008 Standards for medicine management
- DH 2003 Supplementary prescribing National Health Service
- The National Infusion and Vascular Access Society (https://nivas.org.uk)

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

pulse Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group

Appendix B: RCN VIP Chart Standards of Infusion Therapy