CLINICAL DOCUMENTATION EXPECTATIONS FOR INFUSION THERAPY

The ACHC survey process relies heavily on documented evidence to support compliance with ACHC Accreditation Standards. Below are key documentation requirements that should be met.

PHYSICIAN ORDERS

- **Orders for vascular access device (VAD) care/dressing changes should include:**
  - Technique (sterile) and cleansing agent used (chlorhexidine gluconate [CHG] vs. povidone-iodine/alcohol).
  - Frequency of dressing changes.
  - Dressing type (transparent semipermeable membrane [TSM], gauze, medication-impregnated).
  - Application of any patches, ointments, or stabilization devices (StatLock, splints, etc.).
- **Orders for medication administration should include:**
  - Drug/solution and dosage, including unit of measure (mg or units).
  - Diluent type and volume.
  - Route of administration.
  - Rate and method (continuous/intermittent/bolus).
  - Start and stop dates.
  - Use of pump/infusion device, if applicable.
- **Orders for catheter flushes for pre-/post-medication administration, pre-/post-blood draw, and maintenance flushes should include:**
  - Frequency, solutions (normal saline [NS], heparin), volumes, and concentrations, including when the saline, administer infusion, saline, heparin (SASH) method is to be used. (Cannot just write "SASH.")

MEDICAL RECORDS

- **For all VADs, skilled nursing visit documentation should include:**
  - Type of device used. (Include the number of lumens, if applicable.)
  - Gauge at start of care (SOC), recertification, or resumption of care (ROC) visit, or on insertion of new device.
  - Location of device.
  - Functionality of device: patency; resistance when flushing; presence of blood return, if flushed; and signs and symptoms of complications, if any.
  - Site assessment: redness, swelling, drainage, pain, or odor.
  - Care provided (flushes, dressing change, lab draw, medication administration, cap/connector, tubing change) and response.
  - VAD problems, issues, and/or complications; missed/delayed doses.
  - Patient/caregiver education and response to education.

- **VAD removal documentation should include:**
  - » Date and time of removal.
  - » Condition of site.
  - » Integrity and length of catheter.
  - » Dressing applied.
  - » Patient response.
  - » Patient education.
  - » Reason for device removal.
  - » Problems encountered/interventions during VAD removal.
  - » Physician contact, if applicable.
- **Infusion administration documentation should include:**
  - » Solution/medication/drug.
  - » Dose (appropriate units of measure and/or concentration).
  - » Rate and duration (start and stop times).
  - » Route to include lumens used for multi-lumen VADs.
  - » Method of administration (intermittent, bolus, continuous).
  - » Pump used with settings.
  - » Assessment of IV site before and after infusion.
  - » Medication side effects, if any.
  - » Patient response.
- **Dressing change documentation should include:**
  - » Issues with removing previous dressing, if applicable.
  - » Cleansing agent used (CHG, alcohol, and/or povidone-iodine).
  - » Securement/anchoring devise used (StatLock, Hubguard, WingGuard).
  - » Antimicrobial patches or gels used (Biopatch, CHG).
  - » Skin-prepping agents used.
  - » Type of dressing applied (TSM, gauze, CHG-impregnated).
  - » Any complications.
  - » Any communications with physician or actions taken to resolve complications.
  - » Patient response.
- **Blood draw documentation should include:**
  - » Method used (syringe vs. vacuum-assisted).
  - » Lumens used.
  - » Flushes used pre-/post-blood draw, including solutions, volumes, and concentrations (heparin), if applicable.
  - » Amount of discarded blood.
  - » Labs drawn.
  - » Cap/connector changed.
  - » Assessment of VAD site after blood draw.
  - » Patient response.

- **Patient and caregiver education documentation should include:**
  - Medication purpose, actions, side effects, dosing times.
  - IV tubing/medication setup/pump setup.
  - Use of pumps/infusion devices.
  - Flushing and care of VAD.
  - Possible VAD complications and what/how to report.
  - Return demonstration of tasks and competency by patient/caregiver.
- **First-dose administration documentation should include:**
  - Medication purpose, actions, side effects, dosing times.
  - IV tubing/medication setup/pump setup.
  - Use of pumps/infusion devices.
  - Flushing and care of VAD.
  - Any VAD complications.
  - Patient history of any allergies to this class of medication.
  - Orders on steps to take and medication(s) to be given should an anaphylactic reaction occur.
  - Patient's consideration of and rejection to receiving the first dose in a hospital, physician's office, or other medical facility.
  - Return demonstration of tasks and competency by patient/caregiver.
  - Identification of locations and phone numbers for emergency support; development of an emergency support contact procedure.
  - Appropriate monitoring of the client/patient after first-dose administration. (Nurse administering the medication stays with the client/patient at least a half hour after the administration of the medication to ensure the client/patient has tolerated the medication well.)
- **Catheter flush documentation should include:**
  - Frequency, solutions used (NS, heparin), volumes, and concentrations, including when the SASH method is to be used. (Cannot just write "SASH.")
- **Medication profile should document:**
  - Drug/solution and dosage, including flushes (normal saline [NS], heparin) and unit of measure (mg or units).
  - Diluent type and volume.
  - Route of administration.
  - Rate and method (continuous/intermittent/bolus).
  - Start and stop dates.
  - Use of pump/infusion device, if applicable.
- **On date of insertion, peripheral IV catheter documentation should include:**
  - Date and time of insertion, number of attempts, and location.
  - Length and gauge (or size) of device. (Both required.)
  - Cleansing agent used for site preparation (CHG, alcohol, or povidone-iodine).
  - Type of dressing used after insertion.

- **Midline/peripherally inserted central catheter (PICC) documentation should include:**
  - External catheter length. (Provide only at SOC or if problems arise.)
  - Baseline arm circumference 10 cm above antecubital fossa to assess the presence of edema and possible deep vein thrombosis (DVT). (Provide only at SOC or if problems arise.)

DEVICE TYPES

- **Peripheral IVs**
  - Short peripheral
    - Less than 3 inches in length; inserted into superficial vein in hand or forearm.
  - Midline peripheral
    - Catheter 3-8 inches in length; inserted in larger veins of upper arm.
- **Central IVs**
  - PICC
    - Catheter inserted into the larger veins of the upper arm, then threaded into the central circulation system above the heart.
  - Tunneled catheter
    - Catheter inserted into the superior vena cava, then tunneled under the skin; exits through the neck, chest, or abdomen.
  - Non-tunneled catheter
    - Catheter inserted through subcutaneous tissue directly into the subclavian, jugular, or femoral veins.
  - Implantable port (port-a-cath)
    - Self-sealing injection port body implanted beneath the skin, generally in the chest region; attached to an IV catheter threaded above the heart.

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