SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

PATIENT INFORMATION

Height: _____ Weight: _____

Allergies: _____

Vancomycin Continuous IV Infusion Order Set

DATE/ TIME INITIAL

Indication

Indication for vancomycin therapy: _____

Consults

☒ Pharmacist to dose, monitor & adjust doses as necessary, unless otherwise specified by physician.
☐ HCACC ☐ Follow up Care Clinic Infectious Disease Consultation on discharge

Lines

Central line is recommended for continuous IV infusion

☐ PICC insertion ☐ _____
☒ Please indicate for pharmacy: ☐ Patient has central line ☐ Patient does not have central line currently

Vancomycin Continuous Infusion Dose

Doses will be rounded to the nearest 250 mg increment

A. Patients being transitioned from intermittent vancomycin

- No vancomycin loading dose required
- Current total daily vancomycin dose should be reduced by 10 – 20 %; Patients with Serum Creatinine greater than 100 µmol/L or CrCl less than 90 mL/min will require even further dose reduction

☐ vancomycin _____ mg IV q24h as continuous infusion (each dose infused over 24 hours) via pump
☒ Stop vancomycin intermittent dosing and start continuous infusion immediately when available (no need to wait for next dosing time); communicate start time to pharmacy

B. Patients not currently on vancomycin and starting continuous vancomycin infusion

Vancomycin Loading and Maintenance Dose Guideline (for patients with CrCl greater than 90 mL/min)

Actual Body Weight (kg)	Loading Dose (mg)**	Maintenance Dose (mg) IV q24 h each dose infused over 24 hours via pump**
Less than/equal to 59 kg	750 mg x 1 over 1 hour	1,250 mg
60 – 75 kg	1,000 mg x 1 over 1 hour	1,500 mg
76 - 99 kg	1,000 mg x 1 over 1 hour	2,000 mg
100 – 119 kg	1,500 mg x 1 over 2 hours	2,500 mg
Greater than/ equal to 120 kg	2,000 mg x 1 over 2 hours	3,000 mg

**approx. 10 – 15 mg/kg loading dose and 20-25 mg/kg maintenance dose; assumes CrCl greater than 90 mL/min

☐ Vancomycin loading dose: _____ mg IV x 1 dose
☐ Vancomycin _____ mg IV q24h as continuous infusion (each dose to be infused over 24 hours) via pump, to start immediately after Loading dose is finished, or if no loading dose ordered, as soon as available; communicate start time to pharmacy

BARCODE

Physician Name: _____ Signature: _____ Date: _____ Time: _____

Processed by: _____ Nurse Verified: _____

Date: _____ Time: _____ Date: _____ Time: _____

PatientOrderSets.com

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Lab Investigations

☒ CBC, Creatinine, BUN (if not taken in last 24 hours), and q3days while on vancomycin unless otherwise specified

☒ Random vancomycin serum level, at least 24 hours after initiating continuous infusion; draw time should be between 0600 and 1800 to allow for pharmacist adjustment

☒ Collect vancomycin serum level from arm opposite to vancomycin infusion as follows:

- The preferred site for random vancomycin level sampling is peripheral
- If PICC is used for sampling, stop and clamp vancomycin infusion for 1 minute prior to obtaining sample
- Draw sample from a lumen not being used to infuse vancomycin if possible; if not possible or single lumen then, flush the line with 10 mL of 0.9% NS; after flushing, withdraw fluid until blood is visualized in the syringe; slowly withdraw another 2-3 mL and discard
- Aspirate amount of blood required for random vancomycin level sample
- Flush the lumen with 10-20 mL of 0.9% NS, then resume vancomycin continuous infusion

☐ _____

Dose Adjustment based on Random Vancomycin Levels

☒ Nurse to continue as follows until new orders are received from pharmacist:

Random level result (mg/L)	Action
Less than 15 mcg/mL	Continue current infusion and restart new higher dose infusion when available as ordered by pharmacist
15 - 20 mcg/mL	Continue current infusion as ordered
21- 25 mcg/mL	Continue current infusion and restart new lower dose infusion when available as ordered by pharmacist
26 - 30 mcg/mL	Hold infusion x 1 hour then restart new lower dose infusion as ordered by pharmacist
Greater than 30 mcg/mL	Hold infusion x 6 hours then restart new lower dose infusion as order by pharmacist

BARCODE

Physician Name: _____ Signature: _____ Date: _____ Time: _____

Processed by: _____ Nurse Verified: _____

Date: _____ Time: _____ Date: _____ Time: _____