MENTAL HEALTH SERVICE BUSINESS RULE SESLHDBR/052

**Name**  
Administration of Ventrogluteal Intramuscular Injection

**What it is**  
This business rule identifies the correct site for ventrogluteal intramuscular injection and the correct steps involved with its safe administration.

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Medium</th>
<th>Review Date</th>
<th>March 2018</th>
</tr>
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</table>

**Who it applies to**  
This business rule applies to all staff of the South Eastern Sydney Local Health District (SESLHD) Mental Health Service (MHS) involved in the administration of ventrogluteal intramuscular injections.

**Identification of the Ventrogluteal Intramuscular Injection site**

**What to do**

2. Explain the procedure to the client and obtain verbal consent as per NSW Health Policy Directive ‘Consent to Medical Treatment – Patient Information’ PD2005_406.
3. Wash hands as per SESLHD Procedure ‘Hand Hygiene, hand care and bare below the elbows’ SESLHDPR/343.
4. Provide the client with appropriate information before the procedure, so that he/she understands what is happening and can comply with instructions. The client may stand, sit or lie in a lateral or supine position.
5. Prepare equipment (including a sharps disposal plan) and the injection site on the client while maintaining a high standard of hygiene and asepsis before, during and after the procedure.
6. Use a size 18 gauge, blunt drawing up needle.
7. Change the needle after preparation of the drug and before administration to ensure it is clean, sharp and dry. Ensure the needle is the right length for actual
8. Alternatively, for pre-packaged products, follow the manufacturer’s directions.

9. Position the patient so the muscle group is relaxed.

10. Locate the greater trochanter. It is the knobbly top portion of the long bone in the upper leg (femur). It is about the size of a golf ball.

11. Find the anterior iliac crest.

12. Place the palm of your hand over the trochanter. Point the first/index finger towards the anterior iliac crest. Spread the second or middle finger towards the back, making a ‘V’. The thumb should always be pointed towards the front of the leg. Always use the index finger and middle finger to make the ‘V’.

13. To avoid an accidental needle stick injury, move the non-dominant hand (the hand that made the ‘V’) before injecting.

14. Prepare the needle site with an approved facility antimicrobial preparation pad, using a circular outward motion.

15. Stretch the skin tight using the Z track technique.

16. Hold the syringe like a pencil or dart. Insert the needle at a right angle to the skin (90 degrees) to prevent shearing and tissue displacement. Enter the skin firmly with a controlled thrust.

17. Draw back on the syringe and check for blood return, to ensure the needle is not in a blood vessel. If blood is seen, the procedure needs to be recommenced.

18. Inject medication slowly and steadily: about 1mL per 10 seconds to allow the muscle to accommodate the fluid. You may give up to 3-5mL (cc) of fluid in this site.

19. Allow 10 seconds after completion of the injection to allow the medication to diffuse, then withdraw the needle at the same angle as it entered. Release the stretched skin.

20. Do not massage afterwards, but be prepared to apply gentle pressure with a gauze swab.

21. For regular depot injections, use the opposite side.

22. Document the procedure – including the time, date and site of insertion – in the medical record and in the appropriate medication form.


24. Use alcohol hand rub or wash hands as per SESLHD Procedure ‘Hand Hygiene, hand care and bare below the elbows’ SESLHDPR/343.

<table>
<thead>
<tr>
<th>Compliance evaluation</th>
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<tbody>
<tr>
<td>Staff using the ventrogluteal intramuscular technique will be able to:</td>
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<tr>
<td>1. Explain the rationale for using this technique. Answer criteria is as follows:</td>
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<td>- Older, malnourished or non-ambulatory patients may have dorsiogluteal muscle atrophy, leading to</td>
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decreased drug absorption.
- The relevant area has a greater thickness of gluteal muscle than the dorsogluteal site. Injections into this area are less likely to be inadvertently deposited into subcutaneous tissue rather than muscle tissue. Unintended subcutaneous injection is related to difficulty with assessing the thickness of the subcutaneous fat pad. Apart from altering drug absorption and response, this practice can cause injury to subcutaneous tissue.
- The area is relatively free of large penetrating nerves and blood vessels.
- The area is innervated and receives blood from multiple small nerve and blood vessel branches, thus reducing the potential for more significant injury.
- Landmarks are clearly defined.
- 3mL to 5mL can be injected.
- The drawback for this site is the small area suitable for injection. If the patient needs multiple injections, the clinical staff member may need to use other areas of the body.
- Locating landmarks may be difficult on obese patients.
- Very thin patients may not have adequate muscle tissue for an intramuscular injection at the ventrogluteal site.

2. Demonstrate safe and accurate use of this technique. Answer criteria is via correct ‘Identification of the Ventrogluteal Intramuscular Injection site’ (see diagram above).

3. Explain how the client is treated with dignity and respect throughout the procedure. Answer criteria is as follows:
   - The client is given knowledge regarding the efficacy and therapeutic outcomes of ventrogluteal intramuscular injections.
   - The client’s ability to provide informed consent about the desired intramuscular injection site is assessed.
   - The client is prepared with appropriate information before the procedure, so that he/she understands what is happening and can comply with instructions.
   - The client is informed that the intramuscular injection will be given in alternate sites during his/her treatment regime.

<table>
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<tr>
<th>When to use it</th>
<th>This business rule is to be referred to and complied with whenever there is a clinical decision to administer an intramuscular injection to a client/patient via the ventrogluteal route.</th>
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</table>
| Why the rule is necessary | This business rule is necessary to ensure that:  
  - Mental Health clinical practice is evidence-based.  
  - Ventrogluteal intramuscular injections are administered in a safe and accurate manner. |
Clients/patients are treated with dignity and respect through safe and accurate nursing practice.

Expectations of the role and function of nurses are consistent with standards of practice for mental health nurses in Australia.

Expectations of the role and function of nurses are consistent with the standards of practice of the Nursing and Midwifery Board of Australia.

**Definitions**

**Vento**gluteal: Ventro – A prefix denoting ventral. Pertaining to the belly or to any venter. Gluteal – Relating to the buttocks.

**Trochanter:** One of the bony prominences developed from independent osseous centres near the upper extremity of the femur; there are two in humans.

**Anterior iliac crest:** Front surface of the long, curved upper border of the wing of the ilium (the broad, flaring portion of the hipbone).

(Source: Stedman’s Medical Dictionary for the Health Professions and Nursing)

**Who is responsible**

Site and service managers are responsible for ensuring this business rule is circulated and implemented locally. Clinical line managers are responsible for ensuring this business rule is available to all staff in their work area. Clinical staff involved in the administration of ventrogluteal intramuscular injections are responsible for referring to and complying with this business rule.

**Ministry of Health/SESLHD reference**

- NSW Ministry of Health Policy Directive ‘Sharps Injuries – Prevention in the NSW Public Health System’ 2007_052
- NSW Ministry of Health Policy Directive ‘Medication Handling in NSW Public Health Facilities’ PD2013_043

**SESLHD References**

- SESLHD Procedure ‘Hand Hygiene, hand care and bare below the elbows’ SESLHDPR/343

**Other References**

- National Standards for Mental Health Services 2010: Standard 2. Safety (2.4)

**Executive Sponsor**  
Dr Murray Wright, SESLHD MHS Director.

**Author**  
Angela Karooz, SESLHD MHS Clinical Nurse Manager.

## Revision and Approval History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision Number</th>
<th>Author and Approval</th>
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<tbody>
<tr>
<td>July 2011</td>
<td>0</td>
<td>Original draft by Keri de Carlo, St George MHS Nurse Educator.</td>
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<tr>
<td>November 2011</td>
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<td>Approved by SESLHD MHS Clinical Council.</td>
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<td>November-December</td>
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<td>Edited and reformatted by Victoria Civils-Wood, SESLHD MHS Policy and Document Development Officer. Circulated to Nurse Educators for comment and relevant feedback incorporated.</td>
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<td>1</td>
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<tr>
<td>February 2015</td>
<td>1</td>
<td>Endorsed by MHS Clinical Council.</td>
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