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**CMH REGIONAL HEALTH SYSTEM Wilmington, OH**

**Policy and Procedure**

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| **TITLE: Venipuncture Procedure**  | **POLICY NO: LAB-SC.014** |
| **DEPARTMENT: Laboratory** | **PAGE: 1 of 4** |
| **APPROVED BY: Walter W. Timperman, Jr., M.D.**Laboratory Medical Director | **ORIGINATION DATE:3/83** **REVIEWED DATE:** **REVISED DATE: 9/6/16 MM** |
| **REVISED BY: Michael Meade, MLS (ASCP)** |
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**PURPOSE:**

To establish a standardized method for blood collection at CMH. All hospital staff performing phlebotomy must follow Standard Precautions for Blood and Body Fluids during collection procedures.

**POLICY:**

**I. IDENTIFICATION:**

Every patient must be positively identified by two methods.

1. Outpatients – Ask the patient their name and Date of Birth (DOB) and compare to the requisition or order.
2. Outpatients that cannot speak English or speak – Ask them for a picture ID and compare that to the requisition, which would have their name, birth date and address. If need be, call an interpreter to help with this process.
3. Outpatients when the name does not match order with registration – Those patients will have their records changed before we can obtain the specimens. They may have to return to their physician and get the orders changed to reflect the correct name or have registration change their records. The physician’s office may fax an updated and corrected order.
4. Inpatients – Ask patient to state their name and date of birth. Compare to printed labels. Perform “Final Check” by repeating the last four digits of the patient’s account number on their arm band and the last four digits of the patient’s account number on the specimen label to ensure that they are the same. .
5. Comatose inpatients or patients that cannot speak – Check armband with labels to compare name and Date of Birth. (Use the mobile care unit, if available.) Have the nurse identify the patient.
6. Nursing Home Patients – We must have a picture of the patient in the chart or picture ID and also have the nurse identify the patient.
7. ER patients – Check the labels with the ER arm band and ask the patient their name and DOB.
8. ER patients that are unconscious – Check labels with ER armband and have nurse identify. If a John Doe, check armband for the name and have nurse identify that this is John Doe.

Any specimens collected from a patient must be labeled properly with patient name, DOB, date, time collected and initials of person drawing the specimen. **All specimens MUST be** **labeled at the bedside per accreditation requirements.**

**II VENIPUNCTURE:**

Venipuncture means the collection of blood from a vein. Arm veins are generally the best source from which to obtain blood. Sometimes it will be necessary to use hand or foot veins, when arms are bandaged or have been punctured repeatedly and is sore.

Thrombosed means that clots have formed and blood no longer flows. Thrombosed veins are usually firm, discolored and tender. If the arm veins are thrombosed, you must use another site.

Position the patient. This makes the vein more accessible and if you are in a comfortable position will also increase your chances of performing a successful venipuncture. Put something under the arm, if necessary, to straighten and brace it.

**In compliance with the OSHA guidelines for blood borne pathogens, gloves will be worn for each venipuncture**.

1. Inspect the area you plan to use. The most common site for performing a venipuncture is the antecubital area of the arm. Attempt to locate a medial vein on either arm before considering alternative veins.

2. Apply tourniquet about midway between the elbow and shoulder and have the patient make a fist. Pumping the fist is **not** recommended as this can elevate levels of potassium and ionized calcium in the bloodstream.

 The tourniquet must be applied with enough tension to compress the vein but not the artery.

3. Always feel for the vein, even when it is seen. This helps you find deeper, unseen veins. Veins "give" under the pressure of your finger, somewhat like a rubber band. Arteries pulsate, so make certain the area you feel is NOT pulsating.

 4. If the vein is difficult to find, rub the area from wrist to elbow, to force the blood into the vein. DO NOT slap the area. You can also use an alcohol swab to palpate the vein.

 5. Do not be afraid to look at the other arm if you are not sure. The veins may be larger in the other arm. **If vein selection alone takes longer than one minute, release the tourniquet and allow two minutes to pass before retightening it and performing the puncture.** Step 6 can be performed while you are waiting.

 6. Scrub area to be punctured with an alcohol pad. If area where you plan to use is accidentally touched, re-clean area again with alcohol. If the condition of the patient’s arm necessitates excessive cleansing, several alcohol preps may be necessary. Allow alcohol to dry. If blood cultures are being collected, follow the cleaning procedure in L-SC.206.

 7. Have equipment all ready to use (i.e. syringe with needle or vacutainer). Place the first tube, stopper end first, into the tube holder without advancing it fully onto the interior needle. Remove the sheath from the needle and discard.

 8. Insert needle into the vein with the bevel up and at a 15-30o angle to the arm.

 9. The vein should be "fixed", “anchored” or held taut during the puncture. If you are right handed, use the left thumb to hold the vein about an inch below where the needle is to enter and press down on the area and at the same time, pull the skin toward the hand. This stretches the skin and also holds the vein taut. ( Vice-versa if left-handed.) You should not have a finger above the vein as this could result in a needle stick to the collector.

10. The needle should be in line with the vein and at about a 15o to 30 degree angle with the skin. As the needle enters the vein, a little "give" will be felt. "The most common errors a beginner makes are to fail to fix the vein, or failure to insert the needle tip all the way into the vein." Advance the collection tube fully forward in the holder so that the interior needle punctures the stopper of the tube. Change tubes if required.

11. Leave tourniquet in place until you are sure that you have a good flow of blood or until you get a backflow of blood into the hub of needle.

12. Release tourniquet with one movement; use dry clean gauze to place on puncture after removing needle in case of venipuncture.

13. Apply pressure after venipuncture or removal of any needle that is not to remain in vein. Observe that bleeding has stopped prior to using tape or Band-Aid. **Patients on** **anticoagulants must have pressure applied for five minutes or longer.**

14. Dispose of contaminated materials in proper biohazard containers. NO NEEDLES OR SYRINGES ARE TO BE THROWN IN TRASH CONTAINERS OR REUSED.

15. Use blood collection transfer device to put blood in the appropriate tubes if a

 Syringe or butterfly assembly with a syringe is used.

16. Needles are not to be recapped or clipped.

17. ***No Phlebotomist or Technologist is to attempt more than two venipunctures on the*** ***same patient at any one time***. If unsuccessful, another Phlebotomist or Technologist is to be called to draw the blood. If a second person is unsuccessful, and a capillary specimen cannot fulfill the requirements for the testing ordered, the nurse in charge of the patient is to be notified. It is the nurse’s responsibility to notify the physician. The physician will then determine if the testing will be canceled or decide on other action (IE, arterial order or foot vein).

18. It is important to pay attention to how the tubes are drawn. The order of draw is important for accurate values. You should draw a non-additive tube, coagulation, serum, plasma, EDTA when using the Vacutainer method. If drawing for coagulation only, draw a non-additive tube, just about 1 cc and discard and then draw coagulation tube. If drawing with a syringe, the order of filling tubes is coagulation, EDTA, SST or plain tube. This is achieved when using the transfer device.

For blood collections, the patient's sample must have the patient name in full, DOB, date drawn, time drawn and initials of person who collected it. Be sure that you know what type of tube is to be used for what tests and the proper handling of the specimen after collection.

IF AT ANY TIME YOU ACCIDENTALLY STICK YOURSELF AFTER STICKING A PATIENT (ANY PATIENT), REPORT THE ACCIDENT TO YOUR SUPERVISOR OR MANAGER. Follow the Post Exposure Incident Procedure in the Laboratory Safety Manual.