Trust Policy

University Hospitals Plymouth NHS Trust

Peripheral Venepuncture and Cannulation Policy

Issue Date	Review Date	Version
May 2021	May 2026	1

Purpose

The purpose of this procedure is to provide a standardised approach for the education; training and competence validation of all staff undertaking peripheral venepuncture and peripheral intravenous cannulation insertion.

This means that peripheral venepuncture and cannulation is performed safely and effectively by competent healthcare professionals eliminating risk of contamination and subsequent inaccuracy in results

These skills need to be performed by competent healthcare practitioners, eliminating the risk of complications as far as is reasonably practical

It will provide:

- An outline of the roles and responsibilities associated with implementing the clinical skill of peripheral venepuncture or peripheral intravenous cannulation.
- A standardised approach for education, training and competence validation for staff undertaking these skills.
- A blended learning approach, whereby the theoretical and assessment component of the programmes are provided in an eLearning module and is completed at the learner's own pace prior to attending classroom based training.
- A skill pathway approach which outlines the steps required for the Clinical Staff to obtain competence in the clinical skill.
- Guidance for educators and learners which includes the following:
    - An outline of the Health Services Executive's core requirements for the education, training and assessment and continuing competence.
    - Criteria and application process, programme duration and accessibility, assessment, evaluation, certification, ratification and learning resources.
    - The aims and learning outcomes for training programmes.

Who should read this document?

This procedure must be adhered to by all Clinical Staff caring for patients who may require venepuncture or cannulation for venous access to administer intravenous medication and/or fluids and by all clinical staff before attempting removal of a peripheral cannula.

Key Messages

Venepuncture and Cannulation is an invasive procedure that has potential risk to the patient and the health care professional. It is essential that all staff adhere to this policy in order to reduce these risks.

Core accountabilities	
Owner	Jo Hickey Clinical Skills and Apprenticeship Manager Colin Fairhurst Acute Care Team
Review	Nursing and Midwifery Committee (NMOC)
Ratification	Deputy Director of Nursing – Bev Allingham
Dissemination (Raising Awareness)	Trust wide
Compliance	Medical Devices Committee

Links to other policies and procedures

- UHPT Guidelines for aseptic technique
- UHPT Hand Hygiene Policy
- UHPT ANTT Peripheral Cannulation
- UHPT Prevention of Contamination incidents
- UHPT Management of Contamination incidents
- UHPT Decontamination guidelines and procedures
- UHPT Safe Handling and Disposal of Hospital Waste
- UHPT Acute Care Team Adult Lower Limb Cannulation and Venepuncture

Version History		
1	May 2021	Document created and approved

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Introduction

Venepuncture

The purpose of the policy is to ensure that University Hospitals Plymouth NHS Trust (UHPT) has a standardised approach for obtaining blood samples from a patient for accurate analysis in the laboratory. The policy recognises that the health practitioner must provide a high standard of practice at all times in line with NMC/HCPC and WHO guidelines for drawing blood and must have received training and have their knowledge and skills up to date. The health practitioner will work closely with other professionals to ensure that the patient's care is co-ordinated, of a high standard and has the best possible outcome.

This document identifies staff groups permitted to perform venepuncture/phlebotomy, the procedure they must adhere to and useful guidance for occasions when venous access is difficult to obtain**.**

Indications

Venepuncture is carried out for the following purposes:

- Baseline results
- Diagnostic purposes
- Establishing a prognosis
- Conformation or screening of diseases
- Ruling out clinical presentation problems
- Regulating therapies or treatments

Contraindications

Phlebotomy is not carried out for the following reasons:

- Patient does not consent or withdraws consent
- Previous surgery to an affected limb with axillary node clearance
- Lymphoedema
- Amputation, fractures or cerebrovascular accident affecting the limb
- If the patient has broken, bruised or erythematous skin

Potential issues with phlebotomy

By its very nature, phlebotomy has the potential to expose the health worker to bloodbourne pathogens. These pathogens can include human immunodeficiency (HIV), hepatitis B (HBV), hepatitis C (HCV), viral haemorrhagic fevers (Crimean Congo haemorrhagic fever, Ebola, Lassa and Marburg) and dengue.

If a blood samples are poorly collected, the results may be inaccurate and misleading to the clinician and the patient may have to undergo the inconvenience of repeat testing. The three major issues resulting from errors in collection are haemolysis, contamination and inaccurate labelling.

Factors that increase the risk of errors include:

- Lack of updated training
- Poor technique
- Failure to complete specimen labelling accurately
- Needle too small a gauge (23 or under) or too large a gauge for the vessel
- Depression of the syringe plunger to force the blood into the sample tube increasing the shear force on the red blood cells
- Blood specimens taken from an intravenous or central line
- Under filling specimen tubes so that the ratio of anticoagulant to blood is greater than 1:9
- Mixing a specimen tube too vigorously

- Failing to let alcohol or disinfectant dry
- Using too great a vacuum; for example, using too large a tube for a paediatric patient, or using too large a syringe (10–20 ml).

Serious adverse events linked with phlebotomy are rare but may include treatment (Or lack of treatment) based on the wrong results, loss of consciousness, pain and bruising/haematoma at the site of venepuncture, nerve damage, anxiety and fainting.

The use of poor techniques using tourniquets can also cause injuries to the patient, occluding of blood flow has led to loss of limbs and non-reversible nerve damage.

Key Duties

This policy is applicable to all staff who under-take phlebotomy as part of their duties on behalf of the Trust. Although phlebotomy/venepuncture can be seen as a relatively simple procedure it is an essential part of the patient pathway, ensuring accurate results and treatment. All staff undertaking phlebotomy duties must be trained in the procedure to prevent unnecessary risk of exposure to blood and reduce adverse events for patients.

Objectives are:-

- To improve knowledge and awareness of risks associated with phlebotomy
- Promote safe practice
- Improve patient comfort and confidence
- Work within the boundaries of Trust policies
- Ensure all equipment is checked, maintained and ready for use at all times
- Ensure the quality and validity of the blood samples for laboratory analysis

Peripheral Venepuncture should only be carried out by staff who have been appropriately trained and assessed as competent. UHPT e-learning must be completed prior to being allocated a space on the course. Staff wishing to utilise the training must first identify a service need as skills must be maintained.

It is the responsibility of staff performing Peripheral Venepuncture to ensure that patients understand the reason/rationale for the procedure and that the procedure involves minimum distress to the patient.

Infection control procedures must be adhered to.

Positive Identification of the patient must occur.

The sample/s must be labelled immediately at the patient's side, do not walk away from the 'Safe Circle' **(Appendix 5)** without labelling the specimens

Monitoring and assurance

Staff Groups able to perform venepuncture

- Staff permitted to apply for training are:
  - Registered healthcare professionals
  - Non-registered healthcare professionals, Medical Assistants
  - Phlebotomy staff

- Healthcare Professionals can apply for venepuncture training by contacting the Clinical Skills Team via e-mail: plh-tr.clinicalskills@nhs.net

- Staff must only attend training if there is a clinical need for them to have this skill in their clinical area and the skill will be used regularly to maintain user competence

- Healthcare professionals must complete the Trust's Venepuncture training programme and be assessed as competent before attempting the skill unsupervised. Assessment is by Registered Healthcare Professionals or non-registered professionals who have completed the Observational Assessors Course, who have been assessed as competent in this skill and have been using the skill regularly. Assessment should be repeated on a 2 yearly basis

- The venepuncture suite situated within outpatients on level 6 can offer supervised practice. Please contact and arrange a suitable date and time. Staff MUST complete the Trust study day before arranging this

- Healthcare Professional's appointed from outside the Trust, who regularly performed peripheral venepuncture must demonstrate the following;

    - Show evidence of previous training and recent practice
    - Complete UHPT e-learning package
    - Read the UHPT venepuncture procedure along with all other relevant policies
    - Be observed by an assessor, nominated by their manager.
    - Complete and sign the venepuncture competency. A copy of this should be placed on the individual's personnel record.

- Apparent excessive rates of Haemolysis from any particular areas will be reviewed by the Blood Sciences Laboratory and fed back to the area for investigation

- Mis-labelling events will be recorded in DATIX and investigations undertaken by the area the error took place. Reports can be produced from the DATIX system to indicate levels of mis-labelling in the Trust and to highlight any specific areas of concern

- Should monitoring indicate a need for retraining and assessment it is the responsibility of the individual's line manager to arrange this.

Non-Medical Staff must only take blood from the veins in the arms and hands. If this cannot be done, medical staff or Acute Care Team must be called. All Trust staff should only have a maximum of 2 attempts at venepuncture on the patient. If attempts fail a more experienced practitioner must be sought.

Know your limits and ask for help if needed, even after 1 attempt. Repeated attempts to take a blood sample often result in pain and discomfort to the patient and poor samples for diagnosis.

Cannulation

The insertion of a peripheral intravenous cannula is one of the most common invasive clinical techniques used in a hospital setting. (Alexandrou, 2018). Despite their prevalence, they are associated with high rates of complications including insertion difficulties, phlebitis, infiltration/extravasation, occlusion, dislodgement and catheter-related blood stream infections (CRBSI), all of which are known to increase morbidity and mortality rates. Concerns regarding everyday practices, particularly relating to insertion site complications, substandard dressing, documentation, site assessment and flushing practices (Ray-Barruel et al 2018)

Cannulation is carried out for the following purposes:

- To gain access into a vein for the purpose of diagnostic testing or the therapeutic administration of medications, fluids or blood components to a patient
- Regulating therapies or treatments

Contraindications

Cannulation is not carried out for the following reasons:

- Patient does not consent or withdraws consent
- Previous surgery to an affected limb with axillary node clearance
- Lymphoedema
- Amputation, fractures or cerebrovascular accident affecting the limb
- If the patient has broken, bruised or erythematous skin
- Fistulas – unless had appropriate training

Potential issues with cannulation

By its very nature, cannulation has the potential to expose the health worker to bloodbourne pathogens. These pathogens can include human immunodeficiency (HIV), hepatitis B (HBV), hepatitis C (HCV), viral haemorrhagic fevers (Crimean Congo haemorrhagic fever, Ebola, Lassa and Marburg) and dengue.

If cannulation practices are not followed the patient may have to undergo the inconvenience of repeat cannulation causing pain and discomfort.

Factors that increase the risk of errors include:

- Tentative stop-start insertion (Usually associated with hesitant or new practitioners)
- Hitting artery, nerve or valve
- Poor techniques or lack of skill and/or competency
- Skin cleaning preparation not allowed to dry properly
- Re-use of bruised or frequently accessed veins
- Anxious patients with low pain thresholds
- Too large a device in too small a vein
- Positioned at a joint or sensitive area

Serious adverse events linked with cannulation are rare but potentially fatal and can include phlebitis, infection and sepsis. A Visual Inspection Phlebitis (VIP) is used to monitor signs of infection (APPENDIX) and documented minimum of every 24 hours and observed at every use prior to administration of medication or fluids.

Methods to help prevent infections include:

- Updated competency
- Adherence to the Standard ANTT principles and PPE principles
- Compliance with cannula site maintenance
- Use of adequate cleaning solutions (2% chlorhexidine in 70% alcohol) and ‘scrub the hub’ principles
- Dressing changes as per policy
- Maintaining patency with regular flushing
- Needle free connectors

The use of poor techniques using tourniquets can also cause injuries to the patient, occluding of blood flow has led to loss of limbs and non-reversible nerve damage.

Objectives are:-

- To improve knowledge and awareness of risks associated with cannulation
- Promote safe practice
- Improve patient comfort and confidence
- Work within the boundaries of Trust policies
- Ensure all equipment is checked, maintained and ready for use at all times
- Ensure the quality and validity of cannula placement
- To remove the cannula at the right time following the correct techniques

Cannulation should only be carried out by staff who have been appropriately trained and assessed as competent. UHPT e-learning must be completed prior to being allocated a space on the course. Staff wishing to utilise the training must first identify a service need as skills must be maintained. Competency updates every 2 years is essential to maintain knowledge, skills and behaviours

It is the responsibility of staff performing cannulation to ensure that patients understand the reason/rationale for the procedure and that the procedure involves minimum distress to the patient.

Infection control procedures must be adhered to

Positive Identification of the patient must occur

Any samples taken on first insertion of the cannula must be labelled immediately at the patient's side, do not walk away from the 'Safe Circle' **(Appendix 5)** without labelling the specimens. Once a cannula has been flushed with 5-10mls of normal saline, no further bloods samples can be taken from the line.

2 Purpose

This policy is relevant to all Health Care Practitioners involved in venepuncture and peripheral cannulation.

3 Definitions

Venepuncture is also known as Phlebotomy, drawing of blood, taking blood or venesection. The person performing phlebotomy is known as a Phlebotomist.

Blood sampling or peripheral venepuncture/phlebotomy is the collection of blood via a variety of methods with the purpose of testing and analysing the components of the blood (Keogh 2017. Pagana, Pagana 2017) or the procedure of entering a vein with a needle (Lister et al 2020).

Blood is the bodily fluid most commonly taken for analysis and treatments. Results will look at the body processes and disorders to help decision making for the patient treatments.

A vascular access device (VAD) is a flexible tube containing a needle (Stylet) that is inserted into a blood vessel. Cannulas are usually placed in the peripheral veins in the lower arm but can also be placed in other limbs* provided the placer has had appropriate training.

*Usually in paediatric setting. Not recommended in adults due to the risk of embolism and thrombophlebitis (Gorski et al 2016. RCN 2016b)

Regulatory background

The Health & Safety at Work Act 2015 states that "*an employer must make provision for securing the health, safety and welfare of persons at work and for protecting others against risks to health or safety in connection with the activities of persons at work." "No person shall intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare."*

European Directive on Safer Sharps systems (Directive 2012/32/EU) states that "*sharps injuries in the healthcare sector must be prevented. Systems must be in place by 11th May 2013 which include the use of equipment with a safety protection mechanisms."*

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 require employers to identify substances hazardous to health which include the risk of exposure to blood borne viruses. The risk of exposure is reduced by the use of safety engineered devices, safe systems of work and the provision of protective equipment.

Principles of Care are that regardless of the type of venous access device used, the principles of care remain the same:

- To prevent infection and sepsis
- To maintain a closed intravenous system with minimal connections to reduce any risk of contamination
- To maintain a patent and correctly positioned device

4 Duties

This policy is applicable to all staff who under-take venepuncture and cannulation as part of their duties on behalf of the Trust. Although venepuncture and cannulation can be seen as a relatively simple procedures it is an essential part of the patient pathway, ensuring accurate results and treatment. All staff undertaking venepuncture and cannulation duties must be trained in the procedure to prevent unnecessary risk of exposure to blood and reduce adverse events for patients.

5 Main Body of Policy

Staff permitted to apply for training are:

- Registered healthcare professionals
- Non-registered healthcare professionals, Medical Assistants

- Healthcare Professionals can apply for cannulation training by contacting the Clinical Skills Team via e-mail: plh-tr.clinicalskills@nhs.net

- Staff must only attend training if there is a clinical need for them to have this skill in their clinical area and the skill will be used regularly to maintain user competence

- Healthcare professionals must complete the Trust's Venepuncture and Cannulation training programme and be assessed as competent before attempting the skill unsupervised. Assessment is by Registered Healthcare Professionals or Non-registered Professionals who have completed the Observational Assessors Course (Band 3 and above), who have been assessed as competent in this skill and have been using the skill regularly. Assessment should be repeated on a 2 yearly basis

- Healthcare Professional's appointed from outside the Trust, who regularly performed venepuncture and/or cannulation must demonstrate the following;

- Show evidence of previous training/competency and recent practice
- Complete UHPT e-learning package
- Read the UHPT procedures along with all other relevant policies
- Be observed by an assessor, nominated by their manager.
- Complete and sign the competency. A copy of this should be placed on the individual's personnel record and ESR.

- Incidents involving venepuncture or placement or care of cannulas will be recorded in DATIX system monitored by Infection and Prevention and Control highlighted to the specific area for investigation

- Should monitoring indicate a need for retraining and assessment it is the responsibility of the individual's line manager to arrange this.

Non-Medical Staff must only place cannulas in arms and hands. If this cannot be completed, medical staff, Vascular Access Team or Acute Care Team must be contacted. All Trust staff should only have a maximum of 2 attempts at venepuncture or cannulation on the patient. If attempts fail a more experienced practitioner must be sought.

Know your limits and skills, ask for help if needed. Repeated attempts to cannulate often result in pain and discomfort to the patient and a lack of veins to access.

3 Procedure to Follow

It is the responsibility of staff performing peripheral venepuncture or cannulation to ensure that patients understand the reason for the procedure and that the procedure involves minimum distress to the patient.

Positive Identification of the patient must occur prior to any invasive treatment

Improving Venous Access

Application of a disposable* single use tourniquet promotes venous distention. The tourniquet must be tight enough to impede venous return but not restrict arterial flow. This should be placed above the insertion point 7-8cms without pinching the skin (WHO 2010, Lister 2020).

**Outpatient Phlebotomy Services on Level 6 at UHPT use elastic tourniquets that are cleaned between patients and sterilised to 60 degrees at the end of clinic. These must not be used by ward based phlebotomists who must continue to use disposable tourniquets*

Alternatives to a tourniquet must not be used as these cannot be released quickly and can cause tissue damage. Tourniquets can be in place for up to 3 minutes whilst finding the vein, but must be removed to allow circulation to return before being re-applied for 1 minute to take the blood samples to prevent haemolysis (Rupturing of the red blood cells) or haemoconcentration (pooling of the blood leading to inaccurate results. (Hoeltke 2018)

The following techniques can be used to try to improve venous access:

- Lowering the limb below heart level
- Applying a warm compress
- Gentle opening and closing of the fist (Not pumping as this affects the blood results)
- Ensure adequate hydration of the patient

- Ointment or patches containing small amounts of glyceryl trinitrate may be used to aid vasodilation – has to be prescribed and given time to work (Weinstein and Hagle 2014)

The following methods must NOT be used:

- 'Slapping' of the vein
- Vigorous pumping of the clenched fist
- Rubbing/tapping of the veins

Infection control procedures must be adhered to, including the use of needles and cannulae with incorporated safety protection mechanisms and the safe disposal of sharps as per Trust policy. Standard aseptic non touch technique must be adhered to throughout the procedure of needle insertion and any further manipulations of the cannulae.

Emergency cannulations where asepsis cannot be guaranteed must be indicated with a red dot on the dressing. They must be replaced within 24 hours.

The insertion and removal of peripheral cannula must be documented on the patients prescription chart and in patient notes (appendix A) or in outpatient areas in the patients safety questionnaire which is then scanned into CRIS.

If venepuncture or peripheral cannulation is unsuccessful after a maximum of 2 attempts (1 if the procedure is problematic) the health care professional must request a more experienced health care practitioner to undertake the procedure.

Peripheral Venepuncture Procedure

- The phlebotomist should work in a quiet, clean, well-lit area, whether working with outpatients or inpatients.

- The patient must be positively identified before obtaining a blood sample. This is by verbal questioning of the patients surname, first name and date of birth. If unable to verbalise, identity bands can be used with a second checker to ensure right patient.

- Pre labelling of samples must not occur under any circumstances (UHPT Transfusion Policy 2018).

- **All** equipment must be checked prior to use to ensure it is within its expiry date.

- Patients should be informed fully about the procedure and rationale for the testing. Consent must be gained prior to any venepuncture. A patient has the right to refuse a test

- The veins most commonly used for venepuncture are those found in the Antecubital Fossa (ACF) as they are of a good size and able to provide repeated blood samples

- If patients are needle phobic, a local anaesthetic cream may be used under direction of medical practitioner. This must be prescribed.

- The use of a Safety Engineered Device is essential for phlebotomy. If used incorrectly the phlebotomist is placed at risk from bloodbourne viruses. Current UHPT devices include the BD Eclipse safety needle and Vacutainer system, or Safety Lok Butterfly methods (Please check the equipment you are using is the same as the training you received, new equipment requires update of skill and reassessment)

- Syringe and needle methods must not be used unless very exceptional circumstances. This is usually emergency situations where access is poor or a femoral stab is needed where a vacutainer system cannot be used. Where syringe and needle methods are used a Blood Transfer device must be utilised to minimise haemolysis of the sample and personal risk whilst transferring the blood to the sample tubes.

- Median Cubital, cephalic and basilica veins should be used wherever possible. Other veins, including metacarpal veins can be used providing a suitable sized butterfly is used. Care must be taken around other structures at the phlebotomy site such as arteries, nerves and tendons

- Gloves and aprons must always be worn

- Skin does not currently need cleaning prior to venepuncture unless;

    1. Blood cultures are being taken – Use rectangle Choraprep 3ml in a 'criss-cross' pattern for 30 seconds and allow to dry for 30 seconds
    2. The patient is socially unclean – Use soap and water
    3. The patient is immuno-compromised – Use Chloraprep 1ml (Winged or SEPP design) in a 'criss-cross' pattern for 30 seconds and allow to dry for 30 seconds

- Blood should be taken from the non-cannulated side of the patient. If this is not possible the infusion should be stopped for at least 20 minutes and documented. If the infusion cannot be turned off then the line should be stopped, flushed, and the sample taken below (distal) to the cannula. This should only be undertaken by someone competent in IV drug administration and documented accordingly.

- Blood should be taken as per UHPT Order of Draw (See appendices 19/20).

- Once the needle is removed from the patient, a minimum of 2 minutes direct pressure should be placed onto the affected area. Do not bend the patients arm. If the patient is receiving treatment which will cause blood to take longer to clot e.g. anticoagulants, steroids, then at least 5-10 minutes of pressure will be required.

- An appropriate dressing should be applied to the venepuncture site after the procedure. The patient should be advised to keep the dressing on for a minimum of 30 minutes and given advice on what to if puncture site starts to bleed.

- ICM requests / forms and blood bottles should be completed with patient's details whilst by the side of the patient, using the patient's ID band. They should never be taken away from the patient to be labelled (UHPT Hospital Transfusion policy 2018). Please ensure that you do not share your login details with anyone as it can be tracked to you personally.

- When handwritten, the patient's details must be legibly written on to the sample in the appropriate area and should include: Forename, Surname, Unique Identification Number such as Hospital number **or** NHS number, Date of Birth, Date and time of sample, location where sample taken and the signature of phlebotomist

- All samples must be signed by the person performing the venepuncture, without obscuring other details or the barcode (in case of ICM specimens)

Taking Blood Cultures

Please refer to the following for guidance in this procedure:

- UHPT Policy Guidelines for the Management of Peripheral Intravenous Devices
- UHPT Pathology Handbook

Skin Preparation

Asepsis is vital when performing venepuncture as the skin is breached and a foreign device is introduced into the sterile circulatory system. The two major sources of microbial contamination are:

- Cross-contamination from the practitioner to the patient
- Skin flora of the patient

The use of good handwashing and Personal Protective Equipment (PPE) are essential. Where needed, prolonged firm rubbing of the skin with an alcohol-based solution, such as chlorhexidine 2% in 70% alcohol is advised (RCN 2017b). The cleaning should continue for 30 seconds and allowed to dry for 30 seconds. This ensures coagulation of any organisms and ensuring disinfection and prevents any stinging pain on insertion of the needle from the alcohol. (McCall, Tankersley. 2016)

Procedure for peripheral venepuncture

Safety of the phlebotomist is paramount to avoid occupational percutaneous injuries

Equipment

- Clinically clean tray containing prepared equipment – please follow the latest ANTT cleaning procedures for non-disposable tray
- A vacuum system that consists of a plastic holder attached to a double-ended needle adapter. Disposable equipment currently used is BD Eclipse safety needle or Safety Lok Winged Infusion Set.
- Appropriate, in date vacuumed specimen tubes
- Order of Draw Card
- Sterile dressing or swab for puncture site
- Disposable Tourniquet
- Gloves and aprons for standard precaution measures.
- Appropriate sized sharps bin.
- Specimen request form or appropriate Order Communications equipment (ICM laptop and printer)

Preparation

1. Introduce yourself to the patient and explain the procedure about to be undertaken to the patient
2. Positively identify the patient. Positive ID entails asking patient to state their surname, first name and date of birth, checking against identity band. (note: Where identity band is not available in places such as OPD Phlebotomy suite, check of address and postcode can be used to confirm)
3. Obtain informed consent
4. Allow the patient time to ask questions and discuss previous problems with blood taking
5. Wash hands using soap and water and dry thoroughly using the Ayliffe Technique
6. Operator should cover any visibly broken areas of own skin with a waterproof dressing.

7. Check all packaging before opening, ensure equipment is in date and prepare the equipment on the clean tray. Devices must be selected appropriately for the size and position of the vein. Clean PPE to be taken to the side of the patient
8. Proceed to the patient and check identity, using their verbal discussion and identity band (OPD – use first line of address and postcode)
9. Ensure lighting, ventilation, privacy and positioning are adequate

Selecting a suitable Vein

10. Select and support the appropriate limb, avoiding sites where an infusion is present or signs of oedema, mastectomy /lymph node removal
11. Visual inspection of the veins of both arms is advised before choosing site. Areas of previous venepuncture should be avoided if possible due to scar tissue build up
12. Veins that are thrombosed feel hard and cordlike and should be avoided
13. Apply the tourniquet (if required) 7- 8cms from the puncture site to help with vein selection. Ensure arterial flow is not obstructed
14. Palpation of the vein is completed by 2 fingers, gentle pushing of the veins which should feel soft and bouncy and have good capillary refill
15. If there is difficulty feeling a suitable vein you may do the following;
    - Lowering the limb below heart level
    - Applying a warm compress
    - Gentle opening and closing of the fist (Not pumping as this affects the blood results)
    - Ensure adequate hydration of the patient
    - Ointment or patches containing small amounts of glyceryl trinitrate may be used to aid vasodilation – has to be prescribed and given time to work (Weinstein and Hagle 2014)
16. Once you have selected the vein of choice, remove the tourniquet until ready to proceed when it should then be re-applied again*

*Competent and confident phlebotomists will be able to establish the vein site and take the blood within the 60 seconds. The additional time is utilised by staff in training or if veins are difficult to locate to optimise the blood results.

Procedure:

17. Use hand rub to decontaminate hands
18. Put on gloves and apron
19. Reapply the tourniquet 7-8 cms above insertion site
20. Sample collection must be completed within 1 minute to optimise the quality of the results
21. Anchor the vein by applying manual traction on the skin a few centimetres below the proposed insertion site.
22. Insert the safety needle device smoothly at an angle of approximately 15 degrees, ensuring bevel of needle is pointing up.
23. Locate specimen bottles into the needle holder using firm but gentle pressure, ensuring the needle remains still. Bottles to be drawn in the order on the ‘Order of Draw’ card
24. You can release the tourniquet when blood is seen entering the first vacutainer tubes i.e. within 1 minute if you feel confident to do so
25. Ensure all bottles are filled to their fill mark and removed from the vacutainer prior to removal of the needle
26. Prepare swab ready to remove the needle, withdraw the needle fully and then apply pressure to the site, ensure the needle safety cover has clicked into place
27. Dispose of the needle safely into the sharps box immediately
28. Apply digital pressure directly over the puncture site until bleeding has stopped, approximately two minutes. Ensure you are aware of any clotting disorders

29. Patients should be discouraged from bending their arm if a vein in the ACF has been used.
30. Bottles must be labelled by the phlebotomist at the side of the patient with the relevant details (see general guidelines). Pre labelling of samples is not acceptable practice. Partial pre-labelling (Immediately prior to collection) is only permitted in exceptional circumstances for samples such as split bilirubin where the sample has to be kept in the dark and sent immediately to the laboratory
31. Inspect the puncture site to ensure bleeding has stopped and apply dressing (Remember to check allergies)
32. Discard waste into appropriate containers
33. Remove gloves and discard in appropriate clinical waste bag and wash hands thoroughly
34. Ensure the patient is comfortable
35. Follow hospital procedure for collection and transportation of specimens to the laboratory
36. Document actions in patient records

Taking specimens with a syringe and needle

37. In exceptional circumstances where blood is collected in a syringe, a blood transfer device with vacutainer must be used to transfer into specimen bottles. Do **NOT** push a syringe through the bottle tops (Risk of contamination incident and haemolysis of sample) or removal the bottle top (Risk of top coming off in transit or over/under filling of the tubes) Ensure contents of syringe are mixed using gentle inversion method as per guidelines on order of draw card before entering sample bottle

Trouble Shooting - Appendix

<u>Peripheral Cannulation Procedure</u>

Site of Insertion:

Antecubital Fossa veins should not be used for cannulation as these should be reserved for blood sampling. Lower limbs should not be used unless risk assessed and the practitioner has undertaken additional training and assessment of competence. Information is available from the Vascular Access Team

Choice of Cannula:

When selecting a cannula, the size and condition of the vein and the patient's treatment regime must be considered. Generally the smallest size cannulae for the patient's treatment and vein size is chosen. (FLOW GUIDE APPENDIX C)

Planned peripheral cannula's should be used if intravenous therapy is short term i.e. planned duration <7 days or prior to insertion of a longer term device. Advice regarding longer term IV access devices can be sought from the Vascular Access team

- Cannula incorporating a safety engineered device must be used.
- Stylets (Needle) should never be re-inserted after the first cannulation attempt.
- All equipment should be sterile and in date for every cannulation attempt. Single use devices should never be reused.

To Improve Venous Access:

A disposable single use tourniquet must be used. This should be placed 7-8cm above the insertion point. Alternatives to a disposable tourniquet must not be used as these cannot be released quickly and can cause tissue damage.

- Lower the limb below heart level
- Applying a warm compress/heating pad
- Gentle opening and closing of the fist

Equipment required

Clinically clean tray containing prepared equipment and attached sharps bin with temporary closure across

Safety engineered Cannula, smallest size and correct gauge for use (See Appendices)

Cannulation packs where available which contain the equipment listed below or where not available the practitioner will need to collect:

- Chloraprep 1ml applicator (70% alcohol / 2% chlorhexidine) (* See Below)
- Sterile cannula dressing (IV3000)
- 10ml 0.9% Sodium Chloride for flushing
- 10ml syringe and needle or pre-filled posi-flow 10ml syringe
- Needleless connector
- Clean gloves and apron for standard precaution measures
- Single use disposable tourniquet

*Allergy status of the patient must be checked prior to the use of chlorhexidine, where allergy is identified Iodinated Povidone must be used

Procedure

1 - Preparation

Introduce yourself and correctly identify the patient and explain the rational for the procedure. Answer any questions/concerns they may have. Ensure you have discussed allergy status prior to using topical creams and cleaning solutions

1. Obtain informed consent – do not assume that every patient will agree to this invasive procedure. Patients have a right to refuse and must not be put under duress to agree
2. If required apply local/topical prescribed anaesthetic in accordance with prescription and guidelines
3. Wash and dry hands thoroughly and apply PPE
4. Clean the tray using the Standard ANTT ladder technique and allow to dry
5. Collect all equipment in the clean tray (Although clean, the tray is not sterile - protect all key parts of the cannula and the extension set), checking equipment dates and packaging is intact
6. Draw up your 10ml flush and flush the needle free extension set, protect your key parts at all times (If using a pre-filled syringe, check date and contents)

2 - Approach the patient

7. Wash and dry hands thoroughly or use hand gel
8. Put on gloves and apron

9. Ensure bed/chair height is suitable and patient is in comfortable position
10. Apply the single use disposable tourniquet and select the appropriate vein
11. Clean the area of the selected vein (Slightly larger than the dressing being applied once in place) with Chloraprep applicator, using a cross-hatch motion for 30 seconds and allow to dry thoroughly for 30 seconds. Do not re-palpate the area once cleaned
12. Remove the cannulae from packaging and inspect for any faults
13. Stabilise the vein by applying manual traction on the skin
14. Ensure the cannulae is in the 'bevel up' position, insert the device at the selected angle (10 – 30 degrees) according to the depth of the patient's vein
15. Wait for the first flashback to appear in the primary flashback chamber of the cannula
16. Level the device by decreasing the angle between the cannula and the skin and advance the cannula a few millimetres to ensure entry into the lumen of the vein
17. Withdraw the needle slightly and a second flashback should appear along the shaft of the cannula. NEVER attempt to reinsert the needle
18. Holding the needle still, slowly advance the cannulae off the needle into the vein
19. Release the tourniquet and occlude the vein above the cannula tip (And outside the area of the dressing), remove the needle and place directly into the sharps bin (sterile gauze may be placed under the cannula to absorb any blood leakage)
20. Blood samples can be taken at this stage prior to flushing (See below)
21. Attach a primed needle free extension set – these are essential to prevent mechanical phlebitis
22. Open sterile dressing and apply anchor tapes to wings of cannula to stabilise Flush with 5-10mls 0.9% Sodium Chloride using a 'push pause' technique to ensure patency, observe site for signs of swelling or leakage, asking patient if they feel any discomfort**
23. Once patency established, apply the rest of the sterile dressing, ensure the entry site is visible
24. Date and time to be written on label provided and this to be adhered to dressing – do not occlude the entry site
25. Thank the patient and give advice for care of the line if appropriate
26. Remove gloves and apron
27. Dispose of waste according to UHPT waste management policy and clean the tray
28. Wash hands with soap and water
29. Document date and time of insertion, lot number, flush, size/colour/site of cannulae, number of attempts and any complications/actions on VIP score in the patients prescription chart or via their e-prescription

**Unregistered staff who have undertaken formal training in cannulation and assessed as competent are permitted to administer a maximum of 10mls 0.9% Sodium Chloride at cannula insertion (This is checked with a Registered Healthcare Professional or Assistant Practitioner who is competent in IV Drug Administration), after initial flush it is the responsibility of the registrant to flush daily and when accessing.

Unregistered staff must not undertake subsequent flushing of the cannula unless they are Assistant Practitioners who have received additional training and assessment of competence and this is agreed in local protocols developed by pharmacy in conjunction with the clinical area.

Blood samples can be taken when cannula is being placed, once cannula flushed no further samples can be taken

30. Prior to attaching the needle free connector, attach a vacutainer adapter to the cannula end (Blue Leur Lock Adapter)
31. Using the vacutainer, take the samples in the correct order of draw, ensure fill lines are reached and samples are inverted as per manufacturer guidelines
32. Sample collection must be completed within 1 minute to optimise the quality of the results
33. Locate specimen bottles into the needle holder using firm but gentle pressure
34. Ensure all bottles are filled to their fill mark and removed from the vacutainer prior to removal of the needle
35. Samples must be labelled immediately at the side of the patient. Pre labelling of samples is not acceptable practice

Maintenance of cannulae patency

For intermittent intravenous drug administration:

- Cannula to be flushed minimum daily and recorded on the patients drug chart
- Cannula should also be flushed before, in between bolus drugs and after administration to confirm cannula position and prevent possible interaction between drugs
- 0.9% Sodium Chloride is the most common flushing solution; however this is not necessarily compatible with all drugs (See UHPT Medicines Management Monographs for more detail about specific drugs)
- A 10ml syringe is to be used for every flush being administered regardless of amount being administered as this helps prevent mechanical phlebitis
- Flushes MUST be prescribed and checked and documented by 2 Registered Healthcare Professionals or a Registered Healthcare Professional with an Assistant Practitioner who has been assessed as competent in intravenous administration.
- Heparin flushes are not required for peripheral cannula.

Ongoing Care of peripheral cannulae

Peripheral cannula provide a means of access to the patients vascular system for the administration of medication and fluids. In addition it also provides a potential route for micro-organisms to enter the vascular system. Cannulae must therefore only be inserted if there is a clinical need and removed as soon as this need is eliminated.

Whilst insitu an evaluation of the cannulae entry site is to be documented each time the cannulae is accessed.

Dressings must be checked to ensure they are securely fixed and clean. These can be replaced if needed:

- Wash hands
- Apply gloves and apron
- Hold the cannula steady without touching the ‘clean’ area and remove the dressing by elongating the clear end to avoid damage to the patient’s skin
- If the anchor tapes are clean, leave in place
- If skin is visibly contaminated, clean the skin using Chloraprep or FREPP
- Reapply the new sterile dressing ensuring there is no contamination of the site below the dressing
- Re-label using the date of insertion not the date of replacement

Removal of a Peripheral Cannula

Removal of peripheral cannulae should only be carried out by staff who have been appropriately trained and assessed as competent in this skill

Staff developing competence must be directly supervised by a member of staff who is competent in the skill.

Positive Identification of the patient must occur before commencing the procedure.

It is the responsibility of staff performing Removal of Peripheral Cannulae to ensure that patients understand the reason for the removal and that the procedure involves minimum distress.

Infection control procedures must be adhered to, including the safe disposal of clinical waste as per Trust policy. Standard aseptic non touch technique must be adhered to throughout the procedure.

There is no longer a minimum time limit for the placement of the cannulas. They should be removed when:

- No longer needed
- VIP score above 0
- Painful or signs of infection
- Patient is discharged from hospital

The removal of peripheral cannula must be documented on the Trust's Peripheral IV Cannula insertion record and monitoring chart **(Appendix 8)** or in outpatient areas in the patient's safety questionnaire which is then scanned into CRIS.

Entry site must be reviewed 24 hours post removal to ensure there are no further signs of infection/Phlebitis/Sepsis – this must also be documented on the Trust's Peripheral IV Cannula insertion record and monitoring chart

Equipment required

- Clinically clean tray containing prepared equipment
- Gloves and apron as required for standard precaution measures
- Sterile gauze/sterile
- Tape
- Clinical waste bag
- Sterile medical adhesive remover if required

Procedure

- Clean the Tray using the Ladder technique and allow to dry
- Collect appropriate equipment in clean tray
- Identify the patient and explain the procedure. Obtain informed consent
- Go to the side of the patient, ensure they are comfortable and ensure that you are also in a comfortable position
- Wash and dry hands
- Put on gloves and apron
- Prepare sterile gauze to place over site, protecting key part at all times. Ensure you have checked integrity of gauze packet and its expiry date.
- Use the 'stretch and pull' technique to activate the release properties of the dressing. This will reduce the trauma to the patient's skin. **DO NOT USE SCISSORS**

- Inspect cannulae site for redness, oozing, swelling and tenderness. If there is evidence of infection take a swab and request a medical review
- Using Standard ANTT remove the cannulae using a slow and steady movement, applying firm pressure to the insertion site for at least one minute – longer if needed
- Make sure that all components of the cannulae are present and intact when it is removed. Place this into the clinical waste bag. If cannulae not intact, keep faulty equipment and complete a Datix incident form. Log the LOT number of the cannula and do not dispose of it, ensure a Medical Practitioner is informed of the situation.
- When the site has stopped bleeding/oozing, apply a new sterile gauze dressing and fix with tape. This should be inspected within 24 hours and removed
- Make sure patient is comfortable and aware of any complications and appropriate actions
- Remove gloves and apron
- Clean tray
- Wash hands with soap and water
- Documentation should include the VIP score and the date and time of removal of the peripheral cannulae on the patient's prescription chart (**Appendix**) and in their clinical notes.

Record keeping

Insertion of peripheral cannulae must be fully documented by the Health Care Practitioner who has undertaken this procedure on the patients Prescription sheet/clinical records/EPMA

Adverse events are reported on DATIX and escalated to responsible clinician

Staff undertaking cannulation are to update competency every 2 years

Record of Competency to be store on ESR

6 Overall Responsibility for the Document

Jo Hickey – Clinical Skills and Apprenticeship Manager

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the NMOC and ratified by the Deputy Director of Nursing

Non-significant amendments to this document may be made, under delegated authority from the Deputy Director of Nursing, by the nominated owner. These must be ratified by the Deputy Director of Nursing.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation

will be restricted to named groups, or grades who are directly affected by the proposed changes.

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the Deputy Director of Nursing and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

- The policy will be monitored by audit using a combined tool checklist from IPC
- Analysis of the findings will be reviewed in conjunction with ICT and author to see key themes and areas
- Where deficiencies are identified, action plan including training will be put in place to support areas and staff

10 References and Associated Documentation

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Appendix | Appendix 1

Required documentation

Requests may be placed by using either paper request forms or by using the trust Order Communications system – ICM.

Blood Bank request form:

Blood Transfusion Request Form...

Combined Laboratory request form:

NEW Hospital Combined Pathology.

Microbiology request form:

[Untitled].pdf (107 KB)

Electronic processes and records

iCM eLearning Link:

http://nww.training.plymouth.nhs.uk/captivatetraining/icm/iCM%20-%20Orders%20and%20Results.htm

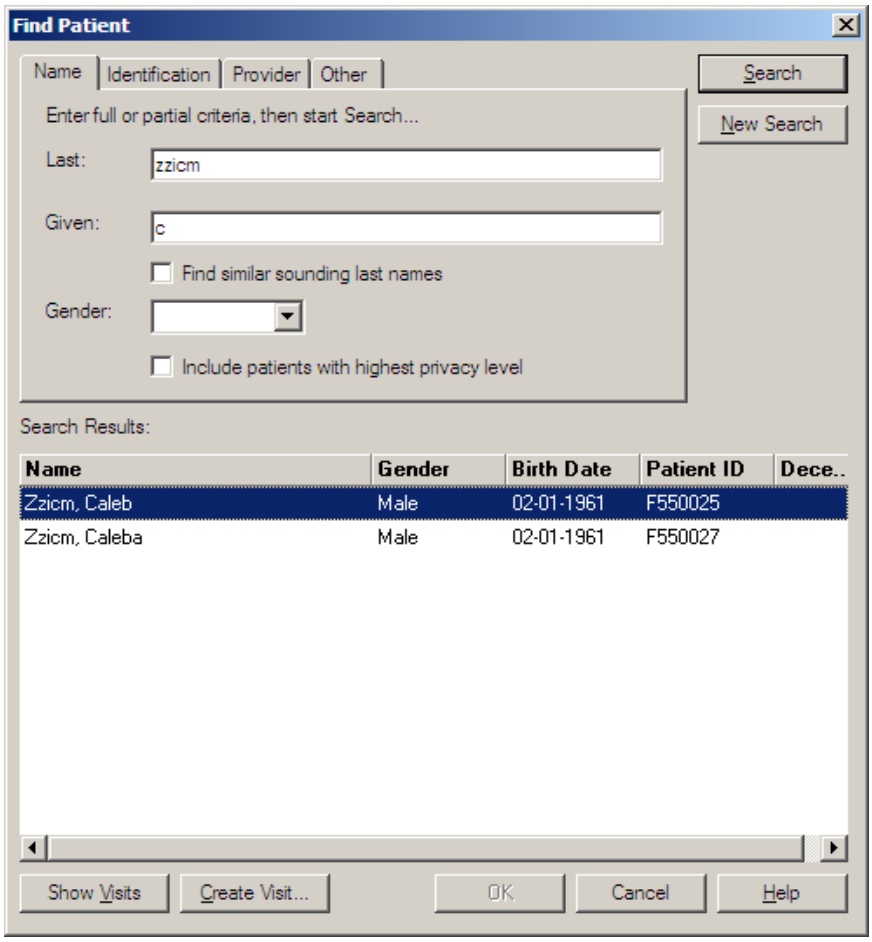
The user can also access the above link from Plymouth Healthnet selecting 'iCM eLearning – Full Access Training' under popular links.

Alternatively, staff can telephone the Clinical Systems Training Team on 37286 for an individual or group training session.

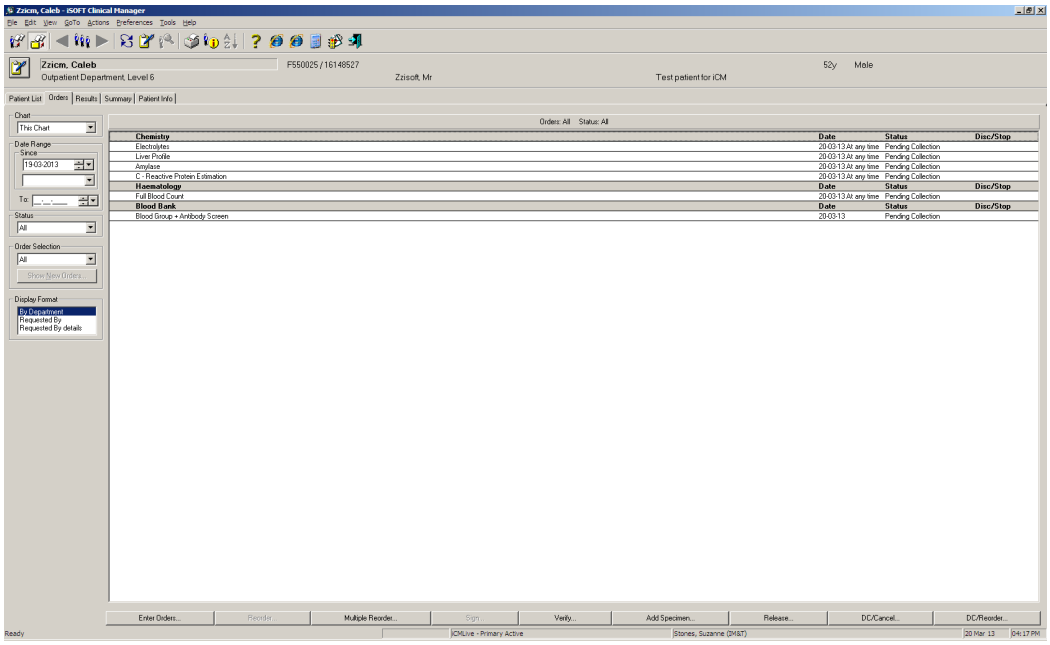
For the iCM Labelling Procedure, please see Appendix 5.

Searching for a patient in iCM.

You MUST ensure that you have selected the correct patient record in iCM before collecting a specimen.

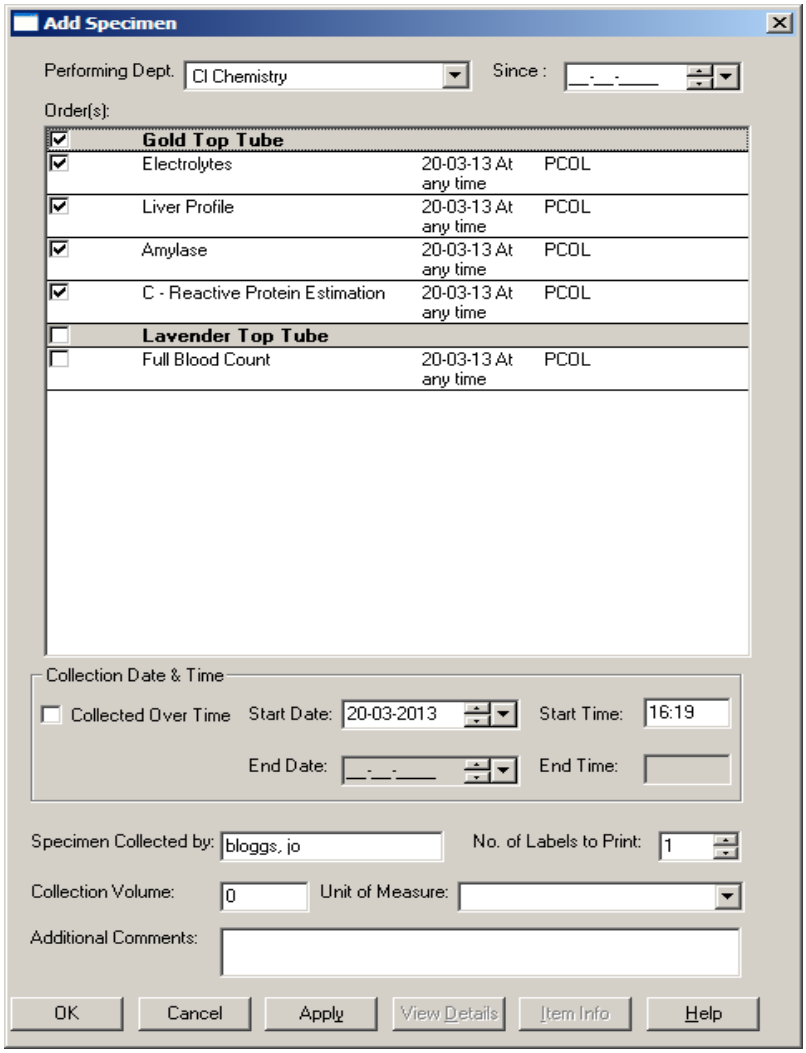


Review the orders for collection by selecting the 'Orders' Tab:



Select the ‘Add Specimen’ option.

Select the ‘Performing Department’ and a list of tests will be grouped by specimen tube type:

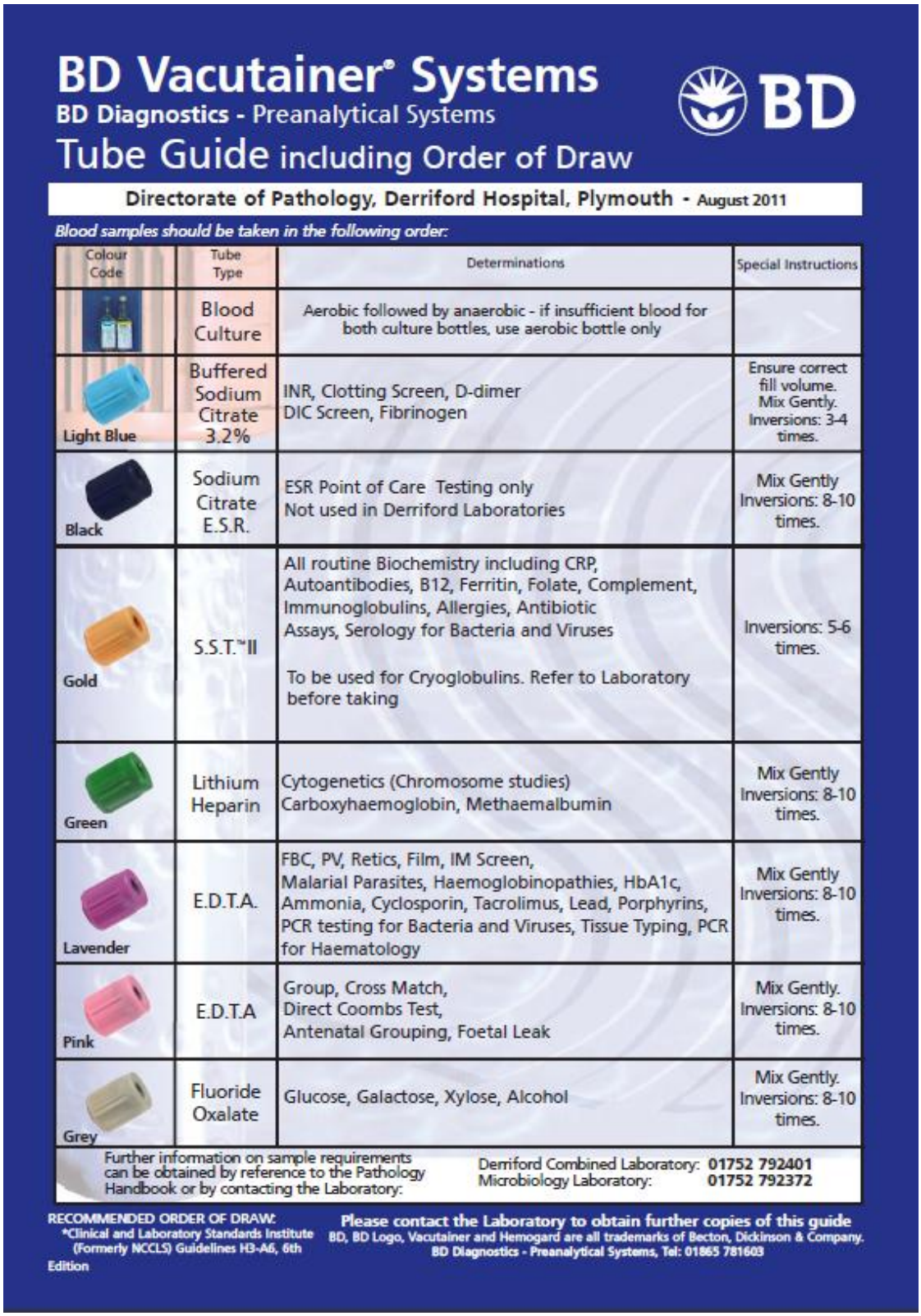


Select the relevant tests.

A printed label will now be produced:

Contingency: Utilise a Paper request form – BB, Chemistry & Microbiology ones and manually complete the container label.

Order of Draw and Mixing guidance:



BD Vacutainer® Systems

BD Diagnostics - Preanalytical Systems

Tube Guide including Order of Draw

Directorate of Pathology, Derriford Hospital, Plymouth - August 2011

Blood samples should be taken in the following order:

Colour Code	Tube Type	Determinations	Special Instructions
	Blood Culture	Aerobic followed by anaerobic - if insufficient blood for both culture bottles, use aerobic bottle only	
Light Blue	Buffered Sodium Citrate 3.2%	INR, Clotting Screen, D-dimer DIC Screen, Fibrinogen	Ensure correct fill volume. Mix Gently. Inversions: 3-4 times.
Black	Sodium Citrate E.S.R.	ESR Point of Care Testing only Not used in Derriford Laboratories	Mix Gently Inversions: 8-10 times.
Gold	S.S.T.™II	All routine Biochemistry including CRP, Autoantibodies, B12, Ferritin, Folate, Complement, Immunoglobulins, Allergies, Antibiotic Assays, Serology for Bacteria and Viruses To be used for Cryoglobulins. Refer to Laboratory before taking	Inversions: 5-6 times.
Green	Lithium Heparin	Cytogenetics (Chromosome studies) Carboxyhaemoglobin, Methaemalbumin	Mix Gently Inversions: 8-10 times.
Lavender	E.D.T.A.	FBC, PV, Retics, Film, IM Screen, Malarial Parasites, Haemoglobinopathies, HbA1c, Ammonia, Cyclosporin, Tacrolimus, Lead, Porphyrins, PCR testing for Bacteria and Viruses, Tissue Typing, PCR for Haematology	Mix Gently Inversions: 8-10 times.
Pink	E.D.T.A	Group, Cross Match, Direct Coombs Test, Antenatal Grouping, Foetal Leak	Mix Gently. Inversions: 8-10 times.
Grey	Fluoride Oxalate	Glucose, Galactose, Xylose, Alcohol	Mix Gently. Inversions: 8-10 times.

Further information on sample requirements can be obtained by reference to the Pathology Handbook or by contacting the Laboratory:

Derriford Combined Laboratory: **01752 792401**
Microbiology Laboratory: **01752 792372**

RECOMMENDED ORDER OF DRAW: *Clinical and Laboratory Standards Institute (Formerly NCCLS) Guidelines H3-A6, 6th Edition

Please contact the Laboratory to obtain further copies of this guide

BD Diagnostics - Preanalytical Systems, Tel: 01865 781603

BD Vacutainer™ Systems

BD Diagnostics - Preanalytical Systems

Mixing Guidelines and Order of Draw

All BD Vacutainer™ tubes require immediate mixing following collection

Colour Code	Tube Type	Inversions
 Light Blue	Sodium Citrate	3-4 Times
 Black	Sodium Citrate ESR	8-10 Times
 Red	Serum/Plastic	5-6 Times
 Gold	S.S.T.™ II	5-6 Times
 Green	Lithium Heparin & PST™ II	8-10 Times
 Lavender	E.D.T.A.	8-10 Times
 Pink	Cross Match	8-10 Times
 Grey	Fluoride Oxalate	8-10 Times
 Royal Blue	Trace Element	8-10 Times

Insufficient mixing can result in inaccurate test results and the need to re-draw

Trouble-shooting guide for Venepuncture

Problem	Cause	Prevention	Action
Pain, Anxiety	Sensitive area Previous Trauma or fear of needles	Avoid sensitive areas Minimise the risks	Complete the procedure as quickly as possible Approach the patient in a calm and confident manner If appropriate use of topical local anaesthetic to be prescribed and administered to the patient. Use distraction therapy and lay the patient down before commencing procedure.
Limited venous access	Repeated use of veins – scarring and thrombosis Peripheral shutdown or dehydration Poor technique or poor choice of veins	Limit access to veins Ensure correct devices being used Use alternative phlebotomist	Use alternative sites Keep patient warm and hydrated Consider support from colleague or retraining
No identity band in situ	Not in place or removed	Do not take blood	In a ward situation confirm identity and reattach identity band to the patient. In an OPD situation – if the patient is unable to competently confirm their name and date of birth, confirm identity via NOK or carer or by reference to appropriate documentation.
Red pulsing blood entering blood bottle under pressure	Needle penetrates artery instead of vein	Careful examination of site prior to needle placement	Remove sample bottle, remove tourniquet and carefully remove needle being aware that blood may splash you. At least 10 minutes of direct pressure should be placed onto the area. Explain to patient and document in patient's notes. Reattempt procedure with new equipment. If you feel confident to do so, otherwise gain assistance from a more experienced practitioner.
Altered sensation in patient hand/fingers	Needle penetrates nerve instead of vein	Careful examination of site prior to needle placement	Remove bottle, tourniquet and needle immediately, placing direct pressure for 2 minutes. Document in patients notes and complete a DATIX form. Reattempt procedure with new equipment
The needle enters the skin and stops	The needle has probably touched a valve	Careful examination of site prior to needle placement	Remove tourniquet and needle. Reattempt procedure with new equipment
No blood seen in bottle once needle is in patient	Needle is not in the vein or that the bottle has lost vacuum	Careful examination of site prior to needle placement Patient warm and hydrated	If subsequent bottle still shows no blood, then withdraw the needle slightly so that it does not come out of skin. If blood still not present, remove the needle and start again with new equipment.

The Sample Circle – must be used when labelling specimens

NHS
University Hospitals
Plymouth
NHS Trust

Surname:
First Name:
Hospital Number:
NHS Number:
DOB:
Affix patient label here

PERIPHERAL IV CANNULA INSERTION RECORD & MONITORING DOCUMENT

Daily assessment on Drug Round						
Cannula site, colour and batch number:	Date inserted:		DAY 1 24 hours post-insertion	DAY 2 48 hours post-insertion	DAY 3 72 hours post-insertion	DAY 4 Remove or resite
	Name of inserter: (please print name)	Date:				
		Time: (24 hour clock)				
		Cannulation score: (please circle)	0 1 2	0 1 2	0 1 2	
		Cannula examined by: (print name)				
	Emergency Insertion Yes / No	Cannula removed: (Yes or no) (print name)				
		24hrs post-removal inspection: (print name)				
Cannula site, colour and batch number:	Date inserted:		DAY 1 24 hours post-insertion	DAY 2 48 hours post-insertion	DAY 3 72 hours post-insertion	DAY 4 Remove or resite
	Name of inserter: (please print name)	Date:				
		Time: (24 hour clock)				
		Cannulation score: (please circle)	0 1 2	0 1 2	0 1 2	
		Cannula examined by: (print name)				
	Emergency Insertion Yes / No	Cannula removed: (Yes or no) (print name)				
		24hrs post-removal inspection: (print name)				
Cannula site, colour and batch number:	Date inserted:		DAY 1 24 hours post-insertion	DAY 2 48 hours post-insertion	DAY 3 72 hours post-insertion	DAY 4 Remove or resite
	Name of inserter: (please print name)	Date:				
		Time: (24 hour clock)				
		Cannulation score: (please circle)	0 1 2	0 1 2	0 1 2	
		Cannula examined by: (print name)				
	Emergency Insertion Yes / No	Cannula removed: (Yes or no) (print name)				
		24hrs post-removal inspection: (print name)				
Cannula site, colour and batch number:	Date inserted:		DAY 1 24 hours post-insertion	DAY 2 48 hours post-insertion	DAY 3 72 hours post-insertion	DAY 4 Remove or resite
	Name of inserter: (please print name)	Date:				
		Time: (24 hour clock)				
		Cannulation score: (please circle)	0 1 2	0 1 2	0 1 2	
		Cannula examined by: (print name)				
	Emergency Insertion Yes / No	Cannula removed: (Yes or no) (print name)				
		24hrs post-removal inspection: (print name)				

HRDM:1631/P 11.01.2021 Document Owner: Victor Sanchez Castrillon Approved: 06/10/20

KEY INSTRUCTIONS:

- All peripheral IV cannulae must be documented on this form and NOT on the paper drug charts.

All cannulae must be assessed during access AND/OR have at least a daily recorded assessment (VIP score).

Cannula Site Assessment Tool (VIP score)			
Score	0	1	2
Pain	Nil	Yes	Yes
Erythema / Swelling/ Induration	Nil	Nil	Yes
Action	None	Observe carefully, consider replacing.	Remove. Raise Datix.

Inform the medical team if any signs of infection, swelling, redness, pain or pus at the cannula site.

Pre-hospital cannulae or emergency cannulations where asepsis cannot be guaranteed should be removed/replaced at the earliest opportunity – but must be removed within 24 hours.

Where the PVC has not been removed in ED, or prior to transfer, the cannula must be communicated to the receiving ward/department.

- Remove the peripheral IV cannula as soon as it is no longer required:
  - Is the peripheral IV cannula still needed?
  - Could IV medication be switched to oral?

Dissemination Plan and Review Checklist | Appendix 7

Dissemination Plan	
Document Title	Venepuncture and Cannulation
Date Finalised	17/05/21
Previous Documents	
Action to retrieve old copies	N/A – New policy

Dissemination Plan

Recipient(s)	When	How	Responsibility
All Trust staff		Information Governance StaffNet Page	Information Governance Team

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	NA
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment | Appendix 8

Core Information	
Date	17/05/21
Title	Venepuncture and Cannulation
What are the aims, objectives & projected outcomes?	To promote the correct and safe venepuncture and cannulation insertion and the correct blood samples being taken.
Scope of the assessment	
Collecting data	
Race	There could potentially be an impact on staff whose first language isn't English, so this policy can be made available in alternative formats. Data will be monitored through workforce data reporting and feedback from staff and trade union representatives.
Religion	Religion There is no evidence to suggest there is an impact on religion regarding this policy.
Disability	There is no evidence to suggest there is an impact on disability regarding this policy
Sex	There is no evidence to suggest there is an impact on sex regarding this policy
Gender Identity	There is currently no data collected to show the impact in this area, however, this will be monitored through feedback from staff and trade union representatives
Sexual Orientation	There is no evidence to suggest this policy will have a negative impact on sexual orientation as adoption leave is available to any employee meeting the eligibility criteria regardless of sexual orientation
Age	There is no evidence to suggest there is an impact on disability regarding this policy
Socio-Economic	There is currently no data collected to show the impact in this area, however, this will be monitored through feedback from staff and trade union representatives
Human Rights	There is currently no data collected to show the impact in this area, however, this will be monitored through feedback from staff and trade union representatives
What are the overall trends/patterns in the above data?	No trends or patterns identified at this stage. However, data will be monitored and any trends or patterns will be identified and appropriate actions will be put in place.
Specific issues and data gaps that may need to be addressed through consultation or further research	There are no specific issues or data gaps identified at this stage

Involving and consulting stakeholders	
Internal involvement and consultation	Via peers and specialists within UHPT
External involvement and consultation	Use of contemporary and up to date evidence based research to inform policy
Impact Assessment	
Overall assessment and analysis of the evidence	

Action Plan				
Action	Owner	Risks	Completion Date	Progress update