Policy and procedure for venepuncture
## Document Control Sheet

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<thead>
<tr>
<th>Name of Document:</th>
<th>Policy and procedure for venepuncture</th>
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<td><a href="mailto:ecch.infectionprevention@nhs.net">ecch.infectionprevention@nhs.net</a></td>
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### Revision History

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Summary of changes</th>
<th>Author(s)</th>
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<tbody>
<tr>
<td>March 11</td>
<td>Updated reference</td>
<td>IPCT</td>
<td>4</td>
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<tr>
<td>February 13</td>
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### Approvals

This document requires the following approvals either individual(s), group(s) or board.

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>JICC</td>
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<td>4</td>
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1. **Introduction**

This policy is to ensure the safety of the patient and nurse during venepuncture and to ensure there is standardised practice across East Coast Community Healthcare CIC (ECCH).

Venepuncture is the introduction of a needle into a vein to obtain a blood sample for haematological, biochemical or bacteriological analysis.

It is an invasive procedure for which the practitioner must be suitably trained and competent to perform.

Venepuncture breaches the circulatory system, therefore standard infection control measures must be adhered to by all staff to minimise the risk of injury and/or infection to both patient and staff when undertaking this procedure.

The adoption of the European Directive requires the UK to bring in the requirements by 11/5/2013 to prevent staff exposure to sharps injuries. From 11/5/2013 safety products must be used. ECCH is committed to adhering to the EU directive on the prevention of sharps injuries (2010/32/EU), including the use of safer medical devices to prevent harm or injury to patients and staff as a result of undertaking venepuncture.

2. **Purpose and scope**

This document applies to all staff employed by ECCH. These staff may work within ECCH premises, patients own homes, or care settings owned by other agencies.

3. **Policy Statement**

This policy is recommended for best practice and providers are expected to implement wherever practicable or complete a written risk assessment if not applied.

4. **Responsibilities**

It is the responsibility of all staff to ensure that they adhere to best practice. Staff performing venepuncture during the course of their employment with the organisation are expected to equip themselves with the knowledge and skills required to undertake this procedure safely, by attending the relevant, currently approved, theoretical and practical training.

5. **Policy monitoring**

It is the responsibility of all department heads/professional leads to ensure that the staff they manage adhere to this policy.

6. **Review**

This policy will be reviewed by the Infection Prevention and Control Team.

7. **Procedure of venepuncture**

7.1 Identify patient using relevant identification details, confirmed with the patient identification wrist band (for inpatients), request form and where possible the patient themselves verbally.

7.2 Explain and discuss the procedure with the patient, gaining their informed consent.
7.3 Wash hands using soap and water and dry or use alcohol skin rub is a suitable alternative for clean hand decontamination.

7.4 Assemble equipment required, including non sterile nitrile gloves and apron. The use of the vacutainer system as a method of blood collection is considered best practice.

7.5 Check all packaging and expiry dates.

7.6 Wash hands using soap and water and dry or use alcohol skin rub is a suitable alternative for clean hand decontamination.

7.7 Check hands for any visible broken skin and cover with waterproof dressing.

7.8 Put on appropriate close fitting disposable nitrile gloves and apron.

7.9 Prepare the equipment.

7.10 Support the chosen limb in a downward position.

**Unsuitable Sites**
- Veins that are fibrosed, inflamed or fragile
- Bruised areas
- Sites close to infections
- On the affected side of post CVA or mastectomy patients
- Oedematous limb/haematoma
- Fistulae or vascular grafts
- If the patient has an intravenous infusion an alternative limb must be selected

7.11 Apply the tourniquet, ideally this tourniquet should be disposable, (if a reusable tourniquet is used the rational must be documented and it must be effectively decontaminated between each patient) ensuring that it does not obstruct arterial flow; approximately 7-10 cm above the puncture site, assess and select a vein, asking patient to clench and unclench their fist if required, release the tourniquet.

7.12 Select the appropriate device based on vein size.

7.13 **Best practice is then achieved by cleaning the patient's skin with a minimum 70% alcohol swab and allowing the area to passively dry for 30 seconds.**

7.14 Reapply tourniquet.

7.15 Remove needle guard and inspect the device for any faults.

7.16 Anchor the vein by applying manual traction on the skin below the site of insertion.

7.17 Insert the needle through the skin at the selected angle according to the vein.

7.18 If using a winged device, reduce the angle of the needle and advance slightly.

7.19 Withdraw the required amount of blood using a vacuumed blood collection system or syringe.
7.20 Release the tourniquet.

7.21 Hold low linting swab or cotton wool over the area, remove the needle do not apply pressure until the needle has been fully removed. Never re sheath needles. Do not allow the patient to bend their arm.

7.22 Apply digital pressure over the puncture site until the bleeding has ceased.

7.23 Fusing a syringe and needle, transfer the blood to appropriate bottles as soon as possible ensuring correct quantity is placed in each container.

7.24 Discard the needle and syringe immediately into a sharps bin- sharps containers must always be taken to the point of use.

7.25 Invert the bottles gently to mix.

7.26 Label the bottles with relevant details. Apply high risk labels as necessary.

7.27 Observe the puncture point before applying a dressing remembering to check any allergies the patient may have.

7.28 Discard waste appropriately.

7.29 Remove gloves and apron and wash hands.

7.30 Document procedure as necessary in patient’s notes (in patient areas) in the community the phlebotomist should make a note in their diary which arm was used.

8 References


9 Author
Infection Prevention and Control Team