Aneurin Bevan University Health Board

Standard Operating Procedure for Care of the Patient During a Therapeutic Venesection Procedure

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Contents

DO NOT PERFORM THE ABOVE PROCEDURE UNLESS YOU HAVE BEEN TRAINED AND EVALUATED AS BEING COMPETENT BY AN AUTHORISED TRAINER

Introduction:

Therapeutic venesection is the removal of blood from a patient, typically 450ml. Once a patient has been identified as requiring venesection based on Haematocrit, Ferritin & Haemoglobin (Hb) screening, they are called to the treatment area and escorted to an appropriate chair and prepared for the procedure.

Purpose:

Ensure all staff follow the correct procedure across the Health board, maintaining governance and safety for all involved.

Objectives:

The correct patient to receive a therapeutic venesection within a safe environment, minimising risks and ensuring comfort.

Scope:

Written to support nursing practice for venesections.
Relevant to Registered Nurses (RNs) and Health Care Support Workers (HCSWs) who perform venesection.

The Haematology department allows for RNs and HCSWs to perform the procedure, however it is a requirement that the HCSW is supervised indirectly by a RN at all times. This includes a registered professional delegating to an unregulated member of staff to perform the procedure in the first instance, and also completing the venesection as a one person procedure for staff who have received the appropriate training and completed the competency assessment. As registered professionals, the RN is accountable for all aspects of this extended scope of practice undertaken by the HCSW, including accountability for what they choose to delegate. It should be noted that all Health Care Professionals will be required to refer to other guidance, policies and procedures (local and national) in addition to this document.

Materials:

- Sphygmomanometer
- Basic Procedure Pack

- Chloraprep applicator
- Blood Letting kit
- Tourniquet
- Surgical tape
- Sterile Gauze
- Bandage
- Scales
- Appropriate Blood Bottles if samples required
- Orange Lid Sharps Bin
- Optional Ethanol Spray

Training Implications:

- Successful completion of venepuncture training and competency assessment.
- Aseptic Non-Touch Technique (ANTT) (2021) (See Appendix 1)

Safety Precautions

- Associated Risk Assessments:
- Venepuncture
- Collection of samples
- Documentation / Checking paperwork at bedside
- Thorough Patient identification checks
- Safe disposal of sharps
- ANTT (2021)

Procedure:

1.0 Escort the patient to a bloodletting chair.

1.1 When a chair is available, the RN/HCSW will prepare the area in readiness for the patient.

1.2 The staff member will identify the patient from the Venesection list, previously prepared by a qualified nurse. This list will have been devised using a proforma originally completed by a consultant.

1.3 Referring to the Venesection Clinic List, the patient can be identified by positive patient identification and escorted to the chair area. Staff member to introduce themselves to the patient.

1.4 Before inviting the patient to sit comfortably, establish with arm is to be used.

1.5 Ask the patient to remove any foodstuff from their mouth (i.e chewing gum).

2.0 Preparation for Venesection

2.1 Wash your hands thoroughly.

2.2 In accordance with positive patient identification; ask the patient to state their full name, first line of address and date of birth and check this against the patient's records.

If there is any uncertainty about the patient's identity or fitness to proceed, inform the RN supervising the clinic.

2.3 Written consent will have been obtained prior to attendance. At this stage, only verbal consent is necessary in accordance with the Nursing and Midwifery code of Conduct for RN's and the Code of Conduct for Healthcare Support Workers in Wales. (See appendix 3 & 4).

2.4 Assess patient's nutrition and hydration intake and engage the patient in general conversation.

2.5 Recline the chair into position for procedure.

2.6 Wrap the sphygmomanometer cuff around the patient's upper arm. Ensure that the tubes lie upwards towards their shoulder and above the antecubital fossa. Inflate the cuff. Record blood pressure and remove cuff.

2.7 Complete a bloodletting bag check for expiry date.

2.8 Ensure privacy and dignity is maintained at all times.

2.9 Visually examine the antecubital fossa which must be free from any inflamed areas or injuries. Examine the opposite arm if this is the case.

3.0 Palpate the antecubital fossa, applying a tourniquet if necessary to select a suitable vein for venesection. The vein must be palpated for:

- Direction
- Size

- Proximity of the artery
- Position

An artery is never used for the purposes of bloodletting, nor is a vein that is very close to an artery. If venous access is found to be poor after examination of both arms, a second opinion should be sought from an experienced colleague.

3.0 *Arm cleansing for Blood Letting*

3.1 Ensure the sphygmomanometer cuff is removed prior to arm cleansing.

3.2 Clean hands again using hand sanitiser.

3.3 Open your sterile pack and place sterile towel under the donor's arm.

Once the sterile towel has been opened and placed under the patient's arm the venesection process has commenced and therefore the RN or HCSW must not leave the patient until the process is complete.

3.4 Remove the chloraprep applicator from the wrapper and hold it with the sponge facing downwards. Squeeze the applicator until it breaks.

3.5 Gently press the sponge against the patient's skin in order to apply the solution. Once the solution is visible on the skin, cleanse the area for 30 seconds using back and forth strokes covering an approximate area of 2 inches (5 cms) square around the proposed venesection site. Allow the area to dry for a minimum of 30 seconds or until dry.

3.6 Dispose of the chloraprep applicator into the sharps bin.

3.7 Do not re-palpate the chosen venesection site after cleansing. If further palpation is required, for instance if the vein has to be re-located, the area must be fully re-cleansed again.

4.0 Venesection process

4.1 Whilst the area is drying, remove the bloodletting procedure pack from the outer packaging.

4.2 Dispose of packaging outside of the sterile field.

4.3 Break off 8-10cm of surgical tape and ensure this is close to hand in readiness to secure the needle when in-situ.

4.4 Ensure all required materials are in close proximity.

4.5 Clean hands again using hand sanitiser and apply gloves.

4.6 Remove blue cap from needle, facing it away from yourself and the patient and avoiding any contamination of needle shaft.

The RN or HCSW may anchor the vein whilst inserting the needle but must ensure that no contact is made with the skin within approximately 1 inch of the venesection site.

4.7 The needle must be inserted with no major deviation from the line of entry. *Note- if slow flow is noted, the practitioner can use needle intervention **once only** by slightly rotating or retracting the needle. Once an initial intervention has been made, no further adjustment of the needle must be made by the practitioner. All practitioners must record and document any interventions.

The Clinic RN will be vigilant to the needs of the HCSW and use their own judgement to offer help and support.

4.8 As soon as the needle is correctly placed within the vein, secure with tape.

4.9 When good venous flow has been established, release tourniquet to a comfortable pressure.

Remove the needle immediately and call the RN if patient:

- Experiences severe pain or more than mild discomfort.
- Experiences pain that radiates up to shoulder or down into hand.
- Experiences paraesthesia (pins and needles) in the arm or hand.
- Develops a haematoma.
- Faints.
- Requests it.

5.0 *Care of patient during blood letting*

5.1 Remain vigilant of venesection site; do not cover site unless at patient's request.

5.2 Take blood samples if requested from the sample pouch via vacutainer. Always take in this order and label immediately.

1. Purple top (EDTA)
2. Yellow top (SST)

5:3 Observe the patient throughout the procedure.

5:4 If an adverse event occurs, HCSW to call for help / RN to follow the 'Deteriorating Patient Policy' (see appendix 2).

Thorough documentation is essential giving full details of the adverse reaction and outcome.

5:5 Bloodletting bag to be weighed throughout and discontinued at 450ml.

6.0 Completion of the donation

6.1 On completion of bloodletting:
(NB This process must be completed as one action once commenced. It MUST be fully completed before moving onto the next patient).

- Used hand sanitiser.
- Remove tourniquet.
- Lock both lines with blue clip.
- Gently remove needle until secure in needle guard (a click is heard), applying gauze
    - Immediately to apply pressure to site puncture site.
- Ask the patient to keep arm straight and press firmly on the site.
- Dispose of the blood collection bag in the orange lid sharps bin.
- Allow patient to rest for 10 minutes and offer fluids during this time.
- Clinical judgement should be used. If the clinician has any concerns, a repeat blood pressure check may be required.

References:

Reference 1 - Model Policy Aseptic Non-Touch Technique (ANTT): A national, standardised approach to aseptic technique- Accessed on 22nd June 2021

Reference 2 - ABUHB_Clinical_0455 Deteriorating Patient Policy with appendicies Issue 3.pdf – Accessed on 26th October 2021

Reference 3 - https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf - Accessed on 16th November 2021

Reference 4 - http://www.wales.nhs.uk/documents/Code_of_Conduct_for_Healthcare_Support_Workers_in_Wales.pdf - Accessed on 16th November 2021