(A) Policy Statement

Performance of venipuncture is recognized as a responsibility of the Registered Nurse (RN) or a member of the Phlebotomy Team. The Phlebotomists job is to do venipunctures only. The RN may immediately convert the device to an Intravenous (IV) or INT. Management of Intravenous Therapy is recognized as a responsibility of the RN.

NOTE: An IV therapy course is not required for an Licensed Practical Nurse (LPN) to perform the following procedures:
➢ Verification of the type of peripheral IV solution being administered.
➢ Examination of a peripheral infusion site and the extremity for possible infiltration.
➢ Regulation of a peripheral IV infusion according to the prescribed flow rate.
➢ Discontinuation of a peripheral IV device at the appropriate time.
➢ Performance of routine dressing changes at the insertion site of a peripheral venous or arterial infusion, peripherally inserted central catheter, or central venous pressure subclavian infusion.

Note: Refer to Policy #3364-110-05-15 for role of LPN’s who have successfully completed a state approved LPN IV therapy course.

(B) Purpose of Policy

To provide safe and consistent guidelines for the provision of I.V. therapy.

(C) Procedure

1. RN’s may perform venipuncture after they have completed instruction with clinical supervision. It may be done for obtaining laboratory specimens for diagnostic procedures or for the initiation of IV therapy.

2. Nursing service procedures must be followed for the management of all types of I.V. therapy.

3. All I.V. orders must contain the name of the desired solution, amount and rate of infusion.

4. Nursing staff may initiate I.V. therapy in adults in the upper extremities. Feet or lower extremities may be utilized only with physician approval. Central lines such as subclavian or jugular must be initiated by a physician.

5. Nursing staff may discontinue and restart any peripheral I.V. when there is evidence of infection, infiltration, purulence or phlebitis or after 96 hours. Central venous lines, subclavian, jugular, cut down catheters or arterial lines must be removed by a physician. Some specialty units may follow special policies regarding removal of central lines and arterial lines as long as competencies are current.
6. All patients receiving continuous I.V. therapy should be monitored on Intake and Output when indicated.

7. Irrigation of an occluded peripheral I.V. line using a bolus of solution may not be done by nursing staff. Aspiration to clear an occluded line may be attempted using extreme caution not to push any materials into the venous system.

8. To restore patency to central lines, after obtaining a physician’s order, refer to Elsevier: Clinical Skills.

9. At the beginning of each shift, it is the responsibility of the RNs to assess all I.V.’s for patency, solution, rate, amount remaining, expiration date/time of the solution, and IV tubing. Continued observation of the site with documentation should continue throughout the shift. Recommendation is every two (2) hours.

10. Once a shift, or more frequently if indicated, nursing staff must document in the patient’s medical record the appearance/condition of the I.V. site.

11. Routinely, when any I.V. solution is hung it must be documented in the patient’s medical record including solution, rate, additives, and time or as per unit procedure.

12. Initial documentation in HED for initiation of I.V. therapy must include I.V. site, size and type of cannula and number of attempts needed to successfully place.

13. A keep vein open (KVO) rate for all I.V.’s is recognized as 10 ml/hr of Normal Saline 0.9% sodium chloride unless rate or solution specified by prescribing physician.

14. Armboards may be utilized when appropriate according to the patient’s needs and condition.

Pediatric I.V. Therapy

14. All pediatric I.V. Therapy must be maintained with the use of a rate-regulating device; nursing discretion should be used to determine the necessity with older children. The fluid level in the buretrol is never to be more than the amount to be infused in two hours.

15. KVO rate for pediatric patients is recognized as a rate between 5 ml per hour of Normal saline 0.9% sodium chloride unless otherwise specified by the prescribing physician.

16. Selection of the appropriate site for pediatric I.V. therapy in order of preference are: arms, hands, feet or ankles, then scalp and as otherwise designated.

18. Needle size utilized for pediatric I.V. therapy may be between 25 and 19 gauge unless otherwise specified.

19. Pediatric dressings will be changed as often as needed, unless ordered differently by the physician. Nursing staff may discontinue and restart any peripheral I.V. when there is evidence of infection, infiltration, purulence or phlebitis or after 96 hours.

20. For pediatric patients, do not replace peripheral catheters unless clinically indicated.
Approved by:

Monecca Smith, MSN, RN
Director of Nursing/CNO

Review/Revision Date:

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