(A) Policy Statement

Performance of venipuncture is recognized as the responsibility of the Registered Nurse (RN), a member of the Phlebotomy Department, or ancillary professional staff, when documented competency is completed. In addition, these employees may also perform venipunctures with cannulation of IV catheters when training and documented competency of this skill is accomplished, but the management of IV therapy remains the sole responsibility of the RN.

NOTE: An IV therapy course is not required for a 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 IV therapy.

(C) Procedure

1. RN’s may perform venipuncture after they have completed the procedure 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 IV therapy.

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

4. Nursing staff may initiate IV 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 IVs when there is evidence of infection, infiltration, purulence or phlebitis, or after 96 hours. In specialty units where RNs have received additional training, and competency is documented, these RNs can remove central venous lines (subclavian, jugular, cut-down catheters, or arterial lines) when physicians are unavailable to complete task.

6. All patients receiving continuous IV therapy should be monitored on Intake and Output when indicated.

7. Irrigation of an occluded peripheral IV 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 Mosby Nursing Skills.

9. At the beginning of each shift, it is the responsibility of the RNs to assess all IV’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 Electronic Medical Record (EMR) the appearance/condition of the IV site.

11. Routinely, when any IV solution is hung it must be documented in EMR including solution, rate, additives, and time or as per unit procedure.

12. Initial documentation in EMR for initiation of IV therapy must include: IV site, size and type of cannula and number of attempts needed to successfully place.

13. A keep vein open (KVO) rate for all IV’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 IV Therapy

14. All pediatric IV 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. All pediatric patients receiving IV therapy must have hourly intake monitored and documented every eight hours.

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

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

19. Pediatric dressings will be changed every 72 hours, or more often as needed, unless ordered differently by the physician.

20. For pediatric patients, do not replace peripheral catheters unless clinically indicated.
21. T-connectors may be used on IV tubing for easy access.