Peripheral Intravenous Initiation

Self-Learning Module

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Picture provided courtesy of BD®
The 6th Edition (current) of this document replaces all previous versions.

The supplement "Pediatric Considerations for Peripheral IV Initiation (2012)" is also available on request.

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INTRODUCTION

Welcome to the “Initiation of Intravenous Therapy” Self Learning Module!

Infusion therapy has evolved from an extreme measure used only as a last resort with the most critically ill, to a highly scientific, specialized form of treatment used for greater than 90% of hospitalized clients.

Performing venipuncture is one of the more challenging clinical skills you will need to master. The Infusion Therapy Practitioner is a Healthcare Practitioner (HCP) who, through study, supervised practice and validation of competency, gains the acquired knowledge and skills necessary for the practice of infusion therapy.

Nurses provided with specialized training in peripheral vascular access, along with supportive organizational structures and processes, results in improved client outcomes and decreased complications .

Although we recognize that HCP other than Nursing may have intravenous (IV) insertion and therapy included in their scope of practice, this Self-Learning Module has been written based primarily on the scope of practice of a Registered Nurse (RN) and Licensed Practical Nurse (LPN).

Completing this Self Learning Module does not imply that you are competent in IV initiation and therapy. Competency assessment is multi-faceted (see pg.51). All HCPs must practice within their own level of competence. When aspects of care or skill are beyond the HCP’s level of competence, it is the HCP’s responsibility to seek education and/or supports needed for that care setting (CRNBC, 2005).

This Self Learning Module does not cover or imply the ability to administer medications by the intravenous route.

INSTRUCTIONS FOR USE

1. Read the information in the module and complete the self-test provided. If, while reading the information, you feel confident in your knowledge, proceed directly to the self-test. This workbook attempts to provide information for both the beginning and experienced Intravenous Therapy Practitioner. However, if questions arise that are not answered in the manual, please feel free to contact a Clinical Nurse Educator in your area or the Vascular Access Clinical Practice Committee for further explanation.

Standards, clinical guidelines, procedures, and protocols are referred to in the manual for your learning experience. When you need to review these for clinical decision making, it is important for you to refer to the Clinical Decision Support Tools (CDSTs) on the Clinical Policy Office. Of particular importance is the IV Therapy Clinical Practice Guideline. These can be found on the Fraser Health Intranet or from your Employer.

2. Once you have completed this theory, you will have the opportunity to:
   - Attend a learning lab
   - Practice venipuncture (under supervision) on an anatomic training arm.
   - Develop competency – a Mentor (an RN or Intravenous Therapy Practitioner educated and competent in the required knowledge and skills) will supervise you in the clinical setting until proficiency is determined to be acceptable and competency has been validated (a competency assessment tool [pg.53] will be completed by the Intravenous Therapy Practitioner and the Mentor).

If you have previous IV experience, your skill competency can be validated in the clinical setting; this can be arranged through a Clinical Nurse Educator. A Mentor will observe your venipuncture practice in the clinical setting and either validate your skill competency or discuss areas for improvement.
COMPETENCY AND SCOPE OF PRACTICE

COMPETENCY is defined as the knowledge, skill, attitude and judgment required to provide safe, compassionate and ethical care, and includes consideration of the context in which the care is provided. Competence should initially be validated at the time of employment, after orientation to the organization, on an ongoing periodic basis, when scope of practice changes, and with the introduction of new equipment and technology. The frequency of ongoing competence validation shall be determined by the setting and associated risk. (Infusion Nurses Society, 2011) All healthcare practitioners are legally responsible to be aware of, understand, and comply with their scope of practice and understand their level of individual competence before performing skills related to IV Therapy.

A Registered Nurse (RN) may perform the assessments and skills related to insertion, care, and maintenance of PIVs. The Registered Nurse providing infusion therapy shall be proficient in its clinical aspects, shall have validated competency in clinical judgment and practice, and shall practice in accordance with the Health Professions Act, the Scope of Practice for Registered Nurses in accordance with the College of Registered Nurses of British Columbia, and the Fraser Health’s Scope of Practice policy. (Canadian Nurses Association, 2008) (College of Registered Nurses of British Columbia, 2010) (Fraser Health Authority, Scope of Practice, 2010) (Government of British Columbia, 2009) (Infusion Nurses Society, 2011)

The Registered Nurse is authorized, per the Health Professions Act, to initiate a PIV catheter (with either a saline lock or an IV solution of 0.9% normal saline at a rate limited to keep the vein open) without an order from another health professional. However, an order from a regulated member of a health profession authorized by the employing agency (e.g. Physician, Midwife, nurse practitioner, dentist, podiatrist, or naturopathic physician) is required to initiate ongoing IV therapy (e.g. parenteral medications or treatments). (Government of British Columbia, 2009)

Other Intravenous Therapy Practitioners, including Licensed Practical Nurses, Registered Psychiatric Nurses, Medical Imaging Technologists, and Nuclear Medicine Technologists may be authorized to initiate, monitor, and remove a PIV with an order from regulated members of health professions authorized by the employing agency (e.g. Physician or nurse practitioner). Clinical Competency Validation of these skills may be required prior to practicing these skills.

Student Nurses who have completed education within their Nursing Program and under direct supervision of their Clinical Instructor or Preceptor may insert PIVs. It is not within the Scope of Practice for Employed Student Nurses (ESNs) to insert PIVs

Each Intravenous Therapy Practitioner needs to check with their registering body, regulatory body (i.e. College), and their employer for their specific scope of practice standards, limits, and conditions. (See also Education and Competency Guidelines – Appendix A)

An Infusion Therapy Practitioner’s scope of practice includes:
  o Specific knowledge and understanding of the vascular system and its relationship with other body systems and intravenous treatment modalities
  o Skills necessary for the administration of infusion therapies
  o Knowledge of psychosocial aspects, including recognition of a sensitivity to the patient’s wholeness, uniqueness, and significant social relationships, along with knowledge of community and economic resources
  o Interdisciplinary communication, collaboration and participation in the clinical decision making process.
OUTCOMES

Upon completion of this module the learner will be able to:

- Locate Clinical Decision Support Tools that contain standards, policies, and clinical practice guidelines related to IV Therapy (i.e. INS Guidelines, Clinical Policy Office, HPA regulation, etc.)
- Locate relevant learning material
- Describe and identify the anatomy and physiology of the venous system
- Describe precautions to use to prevent the spread of infection and avoid self-contamination
- Select appropriate insertion site for prescribed therapy (and understand why site selection will vary)
- Identify equipment used for venipuncture including IV cannula, start pack, needleless connector, IV extension set, and securement dressing/device
- Select appropriate cannula for prescribed therapy
- Identify equipment used for the delivery of intravenous therapy, including IV tubing and electronic infusion pump or flow control device
- Perform venipuncture on a training arm, secure, and dress the site
- Identify approaches to take to prevent, detect, and minimize complications
- Document appropriate information in the patient’s permanent health record
- Describe the procedure for discontinuing the IV
ANATOMY AND PHYSIOLOGY

The systemic circulation consists of the arterial and the venous systems.

The venous system channels blood from the capillary bed back to the vena cava and the right atrium of the heart. The blood travels to the right ventricle of the heart where it is pumped to the lungs, via the pulmonary artery, for oxygenation. The lungs oxygenate the blood and it flows via the left atrium to the left ventricle, which pumps the blood to the aorta and all parts of the body.

Arteries are a high pressure system and a pulse can be palpated. The muscle layer in arteries is stronger and they will not collapse like veins. Arteries are also deeper than veins and are surrounded by nerve endings, making arterial puncture painful.

The venous system consists of superficial and deep veins. The superficial or cutaneous veins are those used for venipuncture. Superficial veins and deep veins unite freely in the lower extremities. For example, the small saphenous vein which drains the dorsum of the foot ascends the back of the leg and empties directly into the deep popliteal vein. Because thrombosis of the superficial veins of the lower extremities can easily extend to the deep veins, it is important to avoid the use of these veins. Superficial veins are bluish in colour. The pressure within veins is low and therefore a pulse will not be palpated in a vein. Blood in the venous system is moved back to the heart by valves and the action of muscular contraction. Damage to the valves results in stasis of blood and varicocities. Initiation of an IV below a varicosity will result in reduced flow and decreased absorption of added medications, and should be avoided.

Knowledge of vein wall anatomy and physiology is necessary in understanding the potential complications of IV therapy. The vein wall consists of three layers and each has very specific characteristics and considerations involved in the introduction of IV catheters and the administration of IV fluid.
**Tunica Intima** (inner layer):
This is a smooth, elastic, endothelial lining which also forms the valves (arteries have no valves). Valves may interfere with the withdrawal of blood, as they close the lumen of the vein when suction is applied. Slight readjustment of the IV needle will solve the problem.
Complications including phlebitis &/or thrombus may arise from damage to this layer. Injury to the lining can result from:
- **MECHANICAL DAMAGE** - Tearing of the lining from a traumatic insertion or excessive motion of the IV catheter (due to frequent manipulation or inadequate securement)
- **CHEMICAL DAMAGE** - Caused by administering irritating medication/solution &/or not allowing the skin prep/cleansing solution to completely dry prior to venipuncture (skin prep enters vein with IV catheter).
- **BACTERIAL INTRODUCTION** - Related to contamination of the IV site or IV catheter during or after the venipuncture.

**Tunica Media** (middle layer):
The middle layer of the vein wall consists of muscle and elastic tissue. This layer is thick and comprises the bulk of the vein. This layer is stronger in arteries than veins, to prevent collapse of the artery. Stimulation or irritation of the tissue may produce spasms in the vein or artery, which impedes blood flow and causes pain. The application of heat promotes vasodilation and reduces pain. If venospasm occurs, apply heat above the IV site to help reduce spasm.

**Tunica Adventicia** (outer layer):
This consists of areolar connective tissue, which supports the vessel. It is thicker in arteries than in veins because of the greater blood pressure exerted on arteries.

![Figure 3](image-url)
**Digital Veins:**
The dorsal digital veins flow along the lateral portions of the fingers. If large enough they may accommodate a small gauge needle, however they are used as a last resort.

**Metacarpal Veins:**
The metacarpal veins are formed by the union of the digital veins. They are usually visible, lie flat on the hand, are easy to feel, and are easily accessible. The hand provides a flat surface for stabilization and as this vein is in the extremity it allows successive venipunctures to be performed above the site. These veins may therefore be the first choice for venipuncture. When using, however, the distance from the insertion site to the prospective catheter tip must be considered to avoid tip positioning in the wrist area. It is preferred that the wrist not be immobilized. One must consider the impact that limited ability to use the hand will present to patients requiring hands to support position changes, use crutches, walkers, and home infusion therapies.

**Cephalic Vein:**
The cephalic vein flows upward along the radial aspect of the forearm. Its size readily accommodates a large needle, while its position provides easy access and natural splinting. This vein can be accessed from the wrist to the upper arm (using the most distal region of the vein first). These veins tend to “roll” so “anchoring” the vein during venipuncture essential.

**Accessory Cephalic Vein:**
The accessory cephalic vein ascends the arm and joins the cephalic vein below the elbow. Its large size accommodates a large needle.

**Basilic Vein:**
The basilic vein originates in the dorsal venous network of the hand, ascending the ulnar aspect of the forearm. It is large and usually prominent that may be visualized by flexing the elbow and bending the arm upward. The vein will accommodate a large needle. It also tends to “roll” during insertion, therefore needs to be stabilized well during venipuncture.

**Median Veins:**
The median antibrachial vein may be difficult to palpate and the location and size of this vein varies. It is usually spotted on the ulnar side of the inner forearm. It is not used as a first choice as venipuncture in the inner wrist area may be more painful due to close proximity to the nerve.

**The Median Cubital Vein:**
This vein lies in the antecubital fossa and is used mostly for emergency, short term access or blood withdrawal. It is used as a last resort for routine IV therapy. Accidental arterial puncture is a concern in this area.
The large upper cephalic vein lies above the antecubital space and is often difficult to visualize and stabilize. It can accommodate 22- to 16-gauge catheters, but it should be reserved for a midline catheter or peripherally inserted central catheter.

The accessory cephalic vein branching off the cephalic vein is located on the top of the forearm. Medium- to large-sized, it's easy to stabilize and can accommodate 22- to 18-gauge catheters. Don't place the catheter tip in the bend of the arm.

The median vein of the forearm originates in the palm of the hand, extends along the underside of the arm, and empties into the basilic vein or median cubital vein. Medium-sized and easy to stabilize, this vein can accommodate 24- to 20-gauge catheters.

The median cubital vein lies in the antecubital fossa. This site is generally used to draw blood and to place a midline catheter or peripherally inserted central catheter. A short peripheral catheter in this site limits mobility, and I.V. complications, especially infiltration, are difficult to detect in this area. An I.V.-related complication here means you won't be able to use veins below this site.

The basilic vein lies along the medial (little finger) side of the arm. Although large and easy to see, it rolls and is difficult to stabilize. Often ignored because its location makes it difficult to work with, it can accommodate 22- to 16-gauge catheters. Increase your success with this vein by placing the patient's arm across his chest and standing on the opposite side of the bed to perform the venipuncture.

The cephalic vein, lying along the lateral (thumb) side of the arm, is large and easy to access. Accommodating 22- to 16-gauge catheters, it's an excellent choice for infusing chemically irritating solutions and blood products. Because the radial nerve is close to this vein, perform venipuncture 4 to 5 inches (10 to 12.5 cm) above the level of the wrist, but not in the wrist.

The metacarpal and dorsal veins on top of the hand are good sites to begin I.V. therapy in some patients. Easily visualized, they can accommodate 24- to 20-gauge catheters. Don't use this site for vesicant medications.

Figure 5
FLUID AND ELECTROLYTE BALANCE

The concepts discussed in this section will alert the IV nurse to the potential dangers of electrolyte therapy and changes in the patient’s condition which might alter the therapy. Knowledge of fluid and electrolytes in the body will contribute to safe and successful therapy.

**Figure 6**

Total body fluid is about 60% of the body weight. The body fluid content in infancy is 70-80% of the total body weight. Aging reduces the total body fluid to about 52% after age 60 years. The proportion in newborn infants is approximately three-fifths intracellular and two-fifths extracellular, but changes to the adult ratio by the time the child is 30 months old.

**Figure 7**

Two basic fluid compartments

The intracellular and extracellular spaces are the body’s basic fluid compartments. The extracellular space is further divided into the intravascular and interstitial spaces.
Body Fluid Balance

When the volume or composition of body fluid is in the compartments deviates even a small amount, the cells and vital organs of the body suffer.

The intravascular compartment is the most accessible. Fluid is filtered from it to the kidney, lungs, skin; fluid can enter it from the GI tract and directly from IV fluids.

The interstitial space is next in accessibility, acting as a sort of storage area. The body can store extra fluid here (over time) or fluid can be borrowed from this space.

The intracellular space is the least accessible space and is protected by the cell membranes. Gains or losses of hypertonic or hypotonic solutions (to be discussed later) will affect this compartment, causing the cell to gain or lose fluid. Cells function best in a constant environment.

Composition of Body Fluids

Body fluid contains two types of solutes (dissolved particles): non-electrolytes such as glucose, creatinine and urea, and electrolytes (see Tables 1 & 2).

![Graph showing concentration of various ions in different compartments](image)

Table 1

<table>
<thead>
<tr>
<th>Ion</th>
<th>Intracellular fluid (ICF)</th>
<th>Interstitial fluid (IF) (part of ECF)</th>
<th>Plasma (ECF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Na⁺</td>
<td>160</td>
<td>140</td>
<td>140</td>
</tr>
<tr>
<td>Cl⁻</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>HCO₃⁻</td>
<td>80</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>K⁺</td>
<td>140</td>
<td>140</td>
<td>140</td>
</tr>
<tr>
<td>Ca²⁺</td>
<td>40</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Mg²⁺</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Protein</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: OpenStax College, Body Fluids and Fluid Compartments, [http://cnx.org/content/m46411/1.3/](http://cnx.org/content/m46411/1.3/)
Table 2: Electrolytes

<table>
<thead>
<tr>
<th>ELECTROLYTE</th>
<th>LOCATION</th>
<th>FUNCTION/SIGNS OF IMBALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potassium (K+)</td>
<td>Intracellular</td>
<td>• essential for normal function of muscle tissue, especially heart muscle tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• a low K+ will cause generalized decrease in muscular activity, apathy, postural hypotension</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• excess K+ causes heart irregularities, ECG changes and tingling or numbness in extremities</td>
</tr>
<tr>
<td><strong>HIGH RISK IV MEDICATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnesium (Mg++)</td>
<td>Intracellular</td>
<td>• enzyme action important for the metabolism of proteins and carbohydrates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• necessary to maintain osmotic pressure and neuromuscular stability (like calcium)</td>
</tr>
<tr>
<td>Sodium (Na+)</td>
<td>Extracellular</td>
<td>• essential for regulating water distribution in the body (water follows sodium)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• deficiency will cause weakness, dehydration and weight loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• excess sodium can cause oliguria, dry mucous membranes and convulsions</td>
</tr>
<tr>
<td>Chloride (Cl-)</td>
<td>Extracellular</td>
<td>• tends to follow sodium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• deficit leads to potassium defect and vice versa</td>
</tr>
<tr>
<td>Bicarbonate (HCO₃⁻)</td>
<td>Extracellular</td>
<td>• is the most important buffer in the body and helps to maintain acid base balance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• excess bicarbonate causes alkalosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• deficiencies result in acidosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Normal range 7.35 - 7.45</td>
</tr>
<tr>
<td>Calcium (Ca+)</td>
<td>Extracellular</td>
<td>• essential for blood clotting and required for muscular contraction (e.g. heart muscle)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• important for bone development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• deficit causes muscular irritability, cramps and convulsions</td>
</tr>
</tbody>
</table>

All of these electrolytes are available to be given intravenously to provide, maintain, or correct fluid and electrolyte balances or to treat other associated co-morbidities. Their use must be approached with caution, particularly when administered as a dedicated treatment or therapy, and follow the standards set out in the Parenteral Drug Therapy Manual (PDTM). It is not within the Scope of Practice of many Intravenous Therapy Practitioners and Nurses to administer IV medications. LPNs may, in certain settings, administer Potassium-containing commercially prepared IV solutions not exceeding 40 mmol/L with additional education and competency assessment. Please contact FHA Professional Practice for further information and for help clarifying your Scope of Practice.

**Movement of Body Fluids and Electrolytes**

Body fluid compartments are separated by a semi-permeable membrane that allows both body fluids and solutes to move back and forth. Movement of water and electrolytes between compartments occurs in four ways:

- **Diffusion** is the random movement of molecules and ions from an area of higher concentration to an area of lower concentration.

- **Osmosis** is the movement of water across a semi-permeable membrane in response to osmotic pressure. **Osmotic pressure** is regulated by electrolytes and non-electrolyte particles in the fluid. If the extracellular fluid contained a large number of particles and the intracellular fluid contained a smaller number of particles, the water would pass from the cell into the extracellular space, until the particle ratio was equal. In this case the cell might be deprived of needed water.
- **Active transport** is a mechanism used to move molecules across a semi-permeable membrane against a concentration gradient. This process requires cellular energy. An example is the sodium pump, which uses energy to keep the sodium in the extracellular space and the potassium in the intracellular space. Otherwise they would equalize over time.

**Filtration** is the movement of solute and water through semi-permeable membranes from an area of higher pressure to an area of lower pressure. This pressure called **hydrostatic pressure** and is the force exerted by a fluid against a wall, and causes movement of fluid between compartments. The hydrostatic pressure of blood is the pressure exerted by blood against the walls of the blood vessels by the pumping action of the heart. In capillaries, hydrostatic pressure (also known as **capillary blood pressure**) is higher than the opposing "**colloid osmotic pressure**" in the blood—a "constant" pressure primarily produced by circulating albumin—at the arteriolar end of the capillary (Figure 8). This pressure forces plasma and nutrients out of the capillaries and into surrounding tissues. Fluid and the cellular wastes in the tissues enter the capillaries at the venule end, where the hydrostatic pressure is less than the osmotic pressure in the vessel. Filtration pressure squeezes fluid from the plasma in the blood to the interstitial fluid surrounding the tissue cells. The surplus fluid in the interstitial space that is not returned directly back to the capillaries is drained from tissues by the lymphatic system, and then re-enters the vascular system at the subclavian veins.

Net filtration occurs near the arterial end of the capillary since capillary hydrostatic pressure (CHP) is greater than blood colloidal osmotic pressure (BCOP). There is no net movement of fluid near the midpoint of the capillary since CHP = BCOP. Net reabsorption occurs near the venous end of the capillary since BCOP is greater than CHP.

(OpenStax College, Body Fluids and Fluid Compartments, [http://cnx.org/content/m46411/1.3/](http://cnx.org/content/m46411/1.3/))

The balance of these two pressures keeps the fluids within the capillaries.

![Figure 8](http://cnx.org/content/m46411/1.3/)

Hydrostatic pressure is especially important in governing the movement of water in the nephrons of the kidneys to ensure proper filtering of the blood to form urine. As hydrostatic pressure in the kidneys increases, the amount of water leaving the capillaries also increases, and more urine filtrate is formed. If hydrostatic pressure in the kidneys drops too low, as can happen in dehydration, the functions of the kidneys will be impaired, and less nitrogenous wastes will be removed from the bloodstream. Extreme dehydration can result in kidney failure.

Fluid also moves between compartments along an osmotic gradient. Recall that an osmotic gradient is produced by the difference in concentration of all solutes on either side of a semi-permeable membrane. The magnitude of the osmotic gradient is proportional to the difference in the concentration of solutes on one side of the cell membrane to that on the other side. Water will move by osmosis from the side where its concentration is high (and the concentration of solute is low) to the side of the membrane where its concentration is low (and the concentration of solute is high). In the body, water moves by osmosis from plasma to the interstitial fluid (and the reverse) and from the interstitial fluid to the intracellular fluid (and the reverse). In the body, water moves constantly into and out of fluid compartments as conditions change in different parts of the body.
For example, if you are sweating, you will lose water through your skin. Sweating depletes your tissues of water and increases the solute concentration in those tissues. As this happens, water diffuses from your blood into sweat glands and surrounding skin tissues that have become dehydrated because of the osmotic gradient. Additionally, as water leaves the blood, it is replaced by the water in other tissues throughout your body that are not dehydrated. If this continues, dehydration spreads throughout the body. When a dehydrated person drinks water and rehydrates, the water is redistributed by the same gradient, but in the opposite direction, replenishing water in all of the tissues.

(OpenStax College, Body Fluids and Fluid Compartments, http://cnx.org/content/m46411/1.3/)

Because cells of the vital organs require precise and constant source of fluids and electrolytes and correct pH, IV therapy is important to replace losses caused by GI suction, burns, NPO, diuresis or diaphoresis.

Acid-Base Balance

The acidity or alkalinity of body fluid depends upon the hydrogen ion concentration expressed as the pH. The extracellular fluid **pH is 7.35 - 7.45**, which is the optimum for cells to function.

- **Acidosis** is a decrease in pH
- **Alkalosis** is an increase in pH

Both extracellular and intracellular fluids contain systems to buffer or maintain the proper acid-base balance. The **carbonic acid-sodium bicarbonate system** is the most important buffer system in the extracellular compartment. Other organs in the body also help to maintain fluid, electrolytes and acid-base balance. Healthy kidneys, skin and lungs are the main regulating organs, by selectively retaining or secreting electrolytes and fluid according to the body’s needs.

INFECTION CONTROL

Infection Control Principles

Phlebitis and Catheter Related Bloodstream Infections (CR-BSI) are a preventable nosocomial infections and adverse events. (Stevens & Schulman, 2012) These infections increase hospital length of stay and facility costs.

Infective organisms may access the vascular access device surface by either:

- Invasion of the percutaneous tract
- Contamination of the catheter hub
- Seeding from a remote source of localized infection

(Association for Professionals in Infection Control and Epidemiology, 2009)

Increased CR-BSI rates are associated with a PIV inserted in the antecubital fossa, a PIV placed in the Emergency Department, or a PIV placed outside of hospital (e.g. EHS). (Trinh, et al., 2011)

**Airborne bacteria** increase in number when the activity in the area increases. They interfere with aseptic technique and may also find their way into unprotected IV solutions, which hang during intermittent infusion.

**The skin** is the main source of bacteria responsible for IV infections. Resident bacteria adhering to the skin include: *Staphylococcus albus, Staphylococcus epidermidus*

In hospitalized patients the following may also be present: *Staphylococcus aureus, Klebsiella, Enterobacter, Serratia* (Most hospital-acquired infections are now of the gram negative type)
Blood may also harbour microorganisms such as:
- Hepatitis B and HIV; dangerous to the health care worker. Adhering to the Standard Precautions (Universal Precautions), including the use of recommended gloves for blood and body fluids, is essential. Needles or stylets should not be recapped, but should be disposed of in rigid, tamper-proof containers.
- Other bacteria from a distant site of infection may seed the cannulated area. Assessment is necessary to determine early signs of a low grade infection.

Cannula contamination can occur (see Figure 9):
- From skin during insertion. Carefully follow site preparation.
- At the hub by health care worker, breaking system during tubing changes. Perform Hand Hygiene and maintain strict aseptic technique during tubing and needleless connector changes.
- At the tip if a thrombus occurs and is seeded by a distant local infection.
- During manufacturing.

Solution contamination can occur:
- During admixture of drugs; use of a filtered needle is recommended.
- When accessing needleless connectors; should be cleansed for 30 sec with 70% alcohol and allowed to dry completely as per IV Therapy Clinical Practice Guideline.
- By improper protection of tubing of intermittent infusions; use single-use intermittent IV tubing.
- By allowing IV bag to hang for prolonged periods (> 24 hrs).
- On the shelf or during handling if small punctures occur to the bag.
- If using expired solutions.
- More frequently in nutrient-rich solutions such as TPN and blood. Use laminar hood to prepare TPN solutions and follow protocol re: tubing changes. Follow Clinical Practice Guidelines for Parenteral Nutrition and/or Blood and Blood Product Administration.

General Measures to Reduce IV-Related Infections
- Use of strict aseptic technique.
- Tourniquets and all insertion equipment are to be single patient use (i.e. IV Start Pack).
- Careful skin preparation.
- Careful site management.
- Examine equipment for integrity and expiry date.
- Use of filter needle for IV medications.
- Correct storage and handling of blood products.
- Schedule for change of IV tubing and solutions (see Table 3).
- Ongoing assessment to find signs of infection early (see Table 4).
- Use of safety engineered IV catheters.

Figure 9
Table 3: IV Tubing Line Setup, Configurations, and Change Frequency

**PRIMARY IV ADMINISTRATION SETUP ONLY** (e.g. 2/3 1/3 @ 125 mL/hr):

- **Acute Care & Residential:** Date and change primary administration tubing every 96 hours, when contaminated, or whenever indicated by the solution/medication that is being administered (e.g. Propofol, lipids), and/or after each use.
- **Community Care:** Change tubing every 24 hours in clinic setting, Change tubing every 72 hours and prn in home setting

**PRIMARY ADMINISTRATION SETUP WITH SECONDARY ADMINISTRATION SETUP** ("piggyback") (e.g. QID antibiotic, etc.)

- **Acute Care & Residential:** Date and change primary administration tubing every 96 hours, when contaminated, or whenever indicated by the solution/medication that is being administered (e.g. Propofol, lipids), and/or after each use.
- **Community Care:** Change tubing every 24 hours in clinic setting, Change tubing every 72 hours and prn in home setting
- **Secondary:** change Q24H

**PRIMARY ADMINISTRATION SET WITH PRIMARY INFUSION SETUP** (e.g. continuous infusion of heparin, nitroglycerin, etc.)

- **Acute Care & Residential:** Date and change primary administration tubing every 96 hours, when contaminated, or whenever indicated by the solution/medication that is being administered (e.g. Propofol, lipids), and/or after each use.
- **Community Care:** Change tubing every 24 hours in clinic setting, Change tubing every 72 hours and prn in home setting

**INTERMITTENT INFUSION** (with no Primary Continuous Infusion) (e.g. BID antibiotic, etc.)

- **Intermittent infusion:** change after each dose

**ADD-ON DEVICES** (Needleless Connectors, Extension tubing, dead end caps)

- **PIVs**
  - **Acute Care & Residential:** Change needleless connectors and/or extension tubing every 96 hours
  - **Community Care:** Change needleless connectors and/or extension tubing every 6-7 days

- **CVCs**
  - **Acute Care:** Change needleless connectors and/or extension tubing every 96 hours
  - **Residential & Community Care:** Change needleless connectors and/or extension tubing every 6-7 days

**SPECIALTY PRODUCTS**

- **Blood Products:** Change blood tubing after 4 hours or after 4 units of blood, whichever comes first. (Refer to Blood Administration Clinical Practice Guidelines for further details)

- **Parenteral Nutrition:** For infusions containing amino acids/dextrose, change the tubing every 96 hours.

- **Infusions containing lipid emulsion:** change the tubing with each dose (every 12 hours) or a minimum of every 24 hours.

* (IV Therapy Clinical Practice Guideline, 2014)
Infection Control Guidelines/ Policies

- All staff will follow the latest Infection Control Guidelines for Principles of Infection Prevention and control, Routine Practices (including hand hygiene, application of personal protective equipment, and sharps handling and disposal) and Additional Precautions, and blood and body fluid spills clean-up.
- All IV insertion sites will be cleansed with a vigorous fraction scrub using 2% Chlorhexidine with 70% alcohol solution, prior to insertion. Cleanse an area larger than the intended dressing and allow solution to air-dry completely prior to applying dressing.
- The site must dry completely prior to the catheter insertion.
- All needleless connectors will be cleansed with 70% alcohol for 30 seconds and allowed to dry completely before accessing.
- It is strongly recommended that all IV insertion sites will be covered with a transparent semi-permeable membrane dressing.
- A securement dressing/device must be used to stabilize the IV catheter. Some transparent IV dressings (Tegaderm IV Advanced®) are rated as a securement device. If a “stand-alone” securement device is used, (e.g. Statlock®) placed under a sterile dressing it must be changed at least every 7 days.
- The use of “IV baskets/trays” is strongly discouraged as the potential for cross-contamination between patients is greatly increased. Single patient use IV start packs should be used whenever possible. A minimum of IV supplies should be taken to the patient’s bedside. Unused supplies that have been in contact with the patient or their bedding can be wiped down with a disinfectant wipe provided there is no blood or body fluid contamination. If they are contaminated they should be discarded before leaving the patient bedside/room.

SKIN CARE

All interventions related to IV Therapy, have the potential to affect skin integrity; from the cleansing solution, to the friction scrub, to the securement device, to the application of the dressing. Catheter insertion also creates an unavoidable full-thickness wound at the entry site. Cleansing solutions and a friction scrub disrupt the skin and create shearing forces on the skin. Antimicrobial preparation of the skin is necessary, but disrupts the natural flora of the skin by design. Despite their accepted safety, alcohol, chlorhexidine gluconate (CHG), and povidone-iodine have all been shown to cause contact reactions in otherwise healthy individuals. Securement devices and dressings can contribute to shearing forces on the skin. Unfortunately, despite the prevalence of IV Therapy, little research has been done on the effects on the skin.

When erythema is present after application of cleansing solutions, it is generally presumed to be an allergic reaction. However, two forms of contact dermatitis have been reported in the literature. Allowing the cleansing solution to dry completely before dressing application and the use of new dressing products made for sensitive skin will help to alleviate this is a large sector of the population.

Adhesive trauma is also present, particularly skin stripping and tension blisters. Correct application and removal techniques for adhesive products are vital to avoid injury to the skin. Ensure you follow all of the manufacturer’s directions for use.

To prevent damage to the skin, a sterile barrier product can be applied to the skin after the cleansing solution has dried completely. In cases of skin damage, complete a Wound Assessment and consult with your Wound Care Clinician as required. (Thayer, 2012)
PIV INSERTION KEY POINTS

Approach to the Patient

The approach of the nurse is important in the patient’s ability to accept the therapy. Safety both physical and psychological is important to the patient. Although routine to the nurse, many procedures in hospital are frightening to the patient. Exaggerated fear triggers the “stress response” with a cascade of undesirable physiological events, including fluid retention and increased work of the heart. Avoid using words that might add to the patient’s apprehension, such as “needle” or “stick”. You might say “I’m going to put this soft plastic catheter in your arm to deliver your medication” (Hadaway, 2005).

- Check patient’s chart for IV order and pertinent history and allergies (e.g. to tape or cleansing solution)
- Identify the patient by identiband and by asking his/her name and birthdate (at least 2 identifiers)
- Address the patient by name
- The patient’s level of comfort should be assessed and pain controlled if possible, and positioning should be adjusted as needed for access to the desired insertion site.
- By calm explanation of the therapy and it’s expected benefits, the patient’s misinterpretations and fears may be alleviated
- Involve the patient in site selection (if possible)
- Draw bedside curtain and ensure privacy (as needed)

Key points to Site Selection

Many factors should be considered when choosing a vein for venipuncture:

- Patient’s age, body size, condition and level of physical activity
- Patient’s condition and medical history
- Vein condition, size and location
- Type and duration of prescribed therapy. If prolonged therapy is anticipated, preservation of veins is essential. Select most distal and appropriate vein first. If medication/solution has high potential for vein irritation, select the largest and most appropriate vessel to accommodate the infusion. Perform venipuncture proximal to a previously cannulated site, injured vein, bruised area or site of a recent complication (infiltration, phlebitis, infection) or where impaired circulation is suspected.
- Patient activity
- Your skill at venipuncture
- Surgery to be done, position of limb during surgery, or if orthopedic surgery, avoid hands (needed for crutch walking)

Points to Ponder on Insertion

- Do not routinely re-site PIVs. The decision to replace the PIV should be based on whether the PIV is still clinically indicated, functioning, the integrity of the insertion site, and whether it is a source of sepsis. (Infusion Nurses Society, 2012)
- No more than 2 attempts at insertion should be made by any one IV practitioner whenever feasible. Consider referral of the patient for the insertion of a central venous catheter (CVC). Rationale: Multiple unsuccessful attempts limit future vascular access and cause the patient unnecessary pain.
- Use strategies to "Save the Vein" when selecting a PIV site with Renal patients, including using the dorsum of the hand of the non-access limb for PIVs. See details in BC Renal Agency Chronic Kidney Disease: Vein Preservation Vascular Access Guideline.
- Avoid using areas of flexion, areas of pain on palpation, compromised veins, areas near valves, areas where there are planned surgical procedures, or the extremity on the side of breast surgery with axillary node dissection, after radiation therapy to that side, with the presence of lymphedema, or the affected side after a stroke. (Infusion Nurses Society, 2011, 2012)
- Use of the veins in the antecubital fossa should be used for emergent access only due to associated high rates of phlebitis and nerve injuries. Consider the use of alternate veins in the lower arm and hand before using the antecubital fossa or the inner aspect of the wrist. (Masoorli, 2007)
- Use of the veins in the inner aspect of the wrist should be avoided due to high rates of phlebitis and nerve injuries. Venipuncture should be initiated at least 2 in and/or 5 cm above the crease of the wrist in an adult patient and 1 in above the crease of the wrist of a baby. (Masoorli, 2007)
- The use of veins in the lower extremities does not require an Order. These veins should not be used routinely in the adult population and should be limited to emergent access. Any patient who requires an IV in a lower limb due to access problem with an upper limb should be considered for the insertion of a central venous catheter (CVC). This route should be considered with caution in patients with peripheral vascular disease (e.g. diabetes).
- Consider application of transdermal topical anesthetic cream, spray, or patch to intended insertion site as needed and when available. Remove anesthetic cream/patch after manufacturer recommended application time. Remove any residual cream with a gauze pad. The use of transdermal topical anesthetic cream, spray, or patch to intended insertion site by an RN does not require an Order.
- Obese patients are considered difficult vascular-access patients. IV site assessment should be conducted during the initial patient assessment or preoperative examination. Traditional methods of vascular access placement have low success rates in the obese population. Consider referral to a PICC RN or MRP for insertion using real-time ultrasonography in conjunction with longer peripheral IV cannulas to improve outcomes for obese patients. (Houston, 2013)
- External Jugular Peripheral Intravenous Catheters (EJ PIVs) (Infusion Nurses Society, 2008)
  - Are used for emergent access or for individual situations when other veins cannot be accessed.
  - May only be inserted by a Physician in FHA.
  - Contraindicated for use with power injectors or contrast media.
  - Dwell times must be limited to prevent formation of fibrin sheaths. Plan immediately to place an alternative vascular access device.
  - Patients with an EJPIV must have alternate access established before transfer to a non-Critical Care unit or staff on the receiving unit must have training and be assessed as competent in their use.

**Evaluating the Selected Vein**

Carefully examine both extremities using observation and palpation before selecting the most appropriate vein. By using the same fingers (not thumbs) consistently, palpation skills will become more sensitive. To palpate a vein, place one or two fingertips (not thumbs) over it and press lightly. Release pressure to assess the vein’s elasticity and rebound filling. To acquire a highly developed sense of touch, palpate before every cannulation – even if the vein looks easy to cannulate (Hadway, 2005).

**EQUIPMENT**

**The Cannula**

The selected cannulation device should be the smallest gauge and shortest length to accommodate the prescribed therapy. This allows better blood flow around the catheter, reducing the risk of phlebitis and promoting proper hemodilution of the fluid (Headway, 2005)

IV catheters are available in a range of sizes:

<table>
<thead>
<tr>
<th>Catheter Gauge Size</th>
<th>Use this size gauge for:</th>
</tr>
</thead>
</table>
| 16 – 18             | Trauma patients/Rapid Infusions  
|                     | High Viscosity Fluids                                                                   |
| 20                  | Pre-Operative Patients  
|                     | Blood Transfusions                                                                      |
| 22                  | General Infusions  
|                     | Blood Transfusions                                                                      |
|                     | Children and Elderly  
|                     | (Not suitable for rapid infusions)                                                     |
| 24                  | Fragile-Veined Patients  
|                     | Children                                                                          |
The IV Solution

- The Physician’s Order should be checked for type, amount and rate of solution
- The colour, clarity and expiry date of the solution
- The integrity of the container and the administration set should be inspected
- The IV administration set should be primed
- The fluid should be suspended approximately 3 feet above the site on an IV pole.

Electronic Infusion Devices

- To prevent or closely control fluid volumes an electronic or flow control infusion device may be used
- Examples may include a Large Volume IV pump, CADD pump (often used for epidural and subcutaneous infusions), or syringe pump
- Ensure you have completed the Infusion Pump Learning System at least every 2 years to maintain your competency and meet Accreditation Canada standards. [https://ccrs.vch.ca/Catalog.aspx?cid=3932](https://ccrs.vch.ca/Catalog.aspx?cid=3932)
- IV Infusion pumps shall be used for administration of all IV fluids and medications, including blood and blood products (except albumin). Appropriate tubing type and/or filter size should be considered when selecting the correct tubing for the intended purpose. See medication specific information in the PDTM and transfusion specific recommendations from FH Transfusion Medicine and FH Blood Administration Guidelines.
- Use of gravity flow-based IV fluid administration is limited to circumstances where an IV Pump cannot be used. These may include IV rates greater than 999 mL/hr when a Rapid Infuser is not used, during Medical Imaging procedures that do not allow for the use of a pump or where other infusion devices are used (e.g. Magnetic Resonance Imaging, CT Scans using pressure injection of contrast media, Nuclear Medicine injection of radioactive isotopes). Gravity flow-based medication administration is not recommended and should be avoided due to the risks of medication error and patient safety.)
- Unique or different infusion devices should be used for administration of fluids and/or medications via different routes (e.g. IV, epidural, subcutaneous, gastrointestinal). Using physically separate infusion devices for different routes prevents medication errors by making the routes and associated infusion devices separate and easily distinguishable. When using multiple infusion devices with the same patient, ensure you trace the line from the pump to the patient. Label each line at the connection nearest the patient with the fluid and/or medication and the route it is being administered. (Institute for Safe Medication Practices, 2003) (Koczmara, Hyland, & Cheng, 2007) (Mattox, 2012) (National Patient Safety Agency, 2007) (Reason, 2000)

Photo courtesy of Carefusion®
TECHNIQUES IN VENIPUNCTURE

GATHER EQUIPMENT

- Non-sterile Gloves
- IV Catheter
- Start Pack Kit/ Insertion supplies:
  - Chlorhexidine 2% with Alcohol 70% swab
  - Single use tourniquet
  - Transparent securement dressing
  - Tape
  - Sterile 2x2 gauze
- IV Catheter Extension set with needleless connector
- Pre-filled 5 mL NS syringe
- Stand-alone securement device (optional and primarily only used for some Pediatric and NICU patients)
- IV solution (prepared with appropriate primed tubing suspended on a pole)
- Electronic Infusion Device or Flow Rate Control Device (optional)

Figure 10

VENOUS DISTENTION

Perform hand hygiene and put on non-sterile gloves. Apply a single-use disposable tourniquet tightly enough to distend the vein, while still allowing an arterial pulse. Latex-free tourniquets are preferred as they can be a source of exposure to those with a latex allergy. The tourniquet is applied to the mid-forearm for use of hand veins, and to the upper arm for veins in the forearm. Apply the tourniquet flat, to avoid pulling hair or pinching skin. Venous distension may take longer in elderly or dehydrated patients.

Figure 11
If the vein fills poorly, try the following:

- Position the arm below heart level or hang arm down (before securing tourniquet) to encourage capillary filling
- Have the patient open and close their hand several times (the hand should be relaxed during venipuncture)
- Light tap of your finger over the vein (hitting it too hard will cause vasoconstriction)
- If necessary, cover the entire arm with warm compresses for 10 – 15 minutes to trigger vasodilation

![Figure 12](image12.png)

**SITE PREPARATION**

- *Shaving is not recommended* because there is a potential for causing micro-abrasions which increase potential introduction of microorganisms into the vascular system. If excess hair must be removed, clipping with scissors is recommended.
- Using friction, apply the facility approved antimicrobial solution in a back and forth using friction, 2 to 3 inches in diameter (CDC, 2002). The solution should be allowed to completely air dry prior to venipuncture. This may take up to 3 minutes.

![Figure 13](image13.png)

**FAILURE TO ALLOW THE SKIN TO DRY COMPLETELY BEFORE APPLYING THE TRANSPARENT DRESSING MAY CAUSE A CHEMICAL BURN ON THE PATIENT’S SKIN DUE TO THE CHLORHEXIDINE.**

![Figure 14](image14.png)
STABILIZING THE VEIN

Stabilizing or “anchoring” the vein prevents movement of the vein during insertion and minimizes the pain associated with venipuncture. Superficial veins have a tendency to roll because they lie in loose, superficial connective tissue. To prevent rolling, maintain vein in a taut, distended, stable position.

**Hand Vein** - Grasp the patient’s hand with your non-dominant hand. Place your fingers under his palm and fingers, with your thumb on top of his fingers below the knuckles. Pull his hand downward to flex his wrist, creating an arch (Hadway, 2005). Use your thumb to stretch the skin down over the knuckles to stabilize the vein.

**Forearm Vein** - Encircle the patient’s arm with your non-dominant hand and use your thumb to pull downward on the skin below the venipuncture site. If the skin is particularly loose, the vein may need to be held taut downward below the vein and to the side of the intended site.

Maintain a firm grip of the vein throughout venipuncture.

![Figure 15](image)

METHODS OF VENIPUNCTURE

**Direct Method** - performed by holding the skin taut and entering the skin directly over the vein at a 5 – 15 degree angle. This technique is useful for large veins. If inserted too far it may penetrate the back wall of the vein.

**Indirect Method** - the skin is entered beside the vein, and the catheter is redirected to enter the side of the vein. This motion reduces the risk of piercing the back wall.
INSERTING THE CANNULA

Before performing venipuncture, remove the cover from the IV catheter and examine the tip for smoothness. If any barbs are evident, discard the catheter. Rotate the catheter 360 degrees to release the catheter from the stylet as they are heat sealed during the manufacturing process. Once you have anchored the vein, press the vein lightly to check for rebound elasticity and to get a sense of its depth and resilience. Palpate the portion where the cannula tip will rest, not the point where you intend to insert the cannula. Note: If you touch the insertion site, you will need to re-clean the site and let it dry completely before proceeding.

Figure 16

- While holding the skin taut (and keeping the vein immobilized) with your non-dominant hand, grasp the cannula (bevel facing up to reduce the risk of piercing the vein’s back wall). Your fingers should be placed so that you can see blood backflow in the flash chamber or extension tubing. Some catheters are designed to provide early flashback of blood between the needle and the catheter

Figure 17

Images courtesy of BD®

- Encourage the patient to relax (breathe slowly in and out as you insert the cannula). Talk to the patient through the procedure to educate them and decrease their anxiety.

- Insert catheter at a 5 to 15 degree angle (depending on depth of the vein), about 1 cm below the point where the vein is visible

- Don’t always expect to feel a “popping” or “giving-way” sensation (not usual on thin walled, low volume vessels). Look for blood backflow to tell you that you have entered the vein lumen
• When you see continuous backflow (and you are confident the stylet tip is in the vein), lower your angle (almost to skin level) and advance slightly (approximately 1/8 inch) to ensure the cannula tip is also in the lumen of the vein. Continue to hold the stylet hub with your dominant hand.

• While immobilizing the vein, advance the catheter into the vein lumen. There are three methods of advancing the catheter:

**ONE-HAND TECHNIQUE** - While non-dominant hand maintains skin traction, advance the catheter using the push-off tab with one hand.

![Figure 18](image18.png)

*Figure 18 - Image courtesy of BD®*

**TWO-HANDED TECHNIQUE** - Release skin traction held by your non-dominant hand. Move dominant hand to the plastic catheter hub and hold the stylet hub with your non-dominant hand. Separate the plastic catheter from the stylet by pushing the catheter into the vein slightly. Continue to hold the plastic catheter with your dominant hand. Reestablish skin traction with your non-dominant hand.

• Advance the plastic catheter with your dominant hand until it is inserted completely. Avoid moving the stylet back into the catheter lumen (this can shear the catheter).

![Figure 19](image19.png)

*Figure 19*

![Figure 20](image20.png)

*Figure 20 - Images courtesy of BD®*
"FLOATING" THE CANNULA INTO THE VEIN – Connect the primed administration set to the catheter hub (when the catheter is only partly inserted into the vein). Flush catheter with IV solution while advancing the catheter.

- Once the cannula is totally advanced into the vein, apply digital pressure beyond the cannula tip and release the tourniquet.

- If using a cathalon with Blood Control® technology, the tourniquet may be released and the safety mechanism activated without applying digital pressure, due to the valve in the cathalon hub. The blood control valve will only function when initially connected to the IV tubing and will not function as a blood control mechanism afterwards.
- Stabilize the hub and activate the safety mechanism. Dispose of the shielded needle in a sharps container.
- Connect the pre-primed extension set with needleless connector with/without continuous IV tubing.
- Flush extension tubing with needleless connector use “positive pressure technique”:
  - Insert pre-filled 3-5 mL NS syringe into needleless connector and inject 2-3mL of NS or until 1-2 mL remains in syringe. While the plunger of the syringe is moving forward, clamp the extension tubing with the slide clamp.
- Apply dressing (see next page)
- If the IV is continuous, loop the administration set tight (without kinking tubing) and secure with tape. Set appropriate IV rate.

**Avoid circumferential taping!**
3 Hold dressing with adhesive side facing the skin, grasping the non-adhesive portion of the dressing frame. Bend slightly with thumb. Position clear portion of dressing over insertion site with notch ends of the dressing pointing distally toward fingers.

5 Apply firm pressure over film to establish adhesion to hub and skin. Wrap notched ends of dressing beneath catheter hub, one at a time. Apply firm pressure to entire dressing and frame.

6 Slowly peel back frame while simultaneously pressing down dressing edges.

7 Remove precut sterile tape strips from paper frame. Fold edge over itself making a small tab for easier removal. Apply large tape strip over the tubing by pinching tape around luer hub and applying firm but gentle pressure to maximize adhesion. Apply documentation tape strip to secure the J loop with the extension tubing.

**It is acceptable to place this tape strip over the connection if desired as it is designed to be removed and re-applied without damaging the dressing. However, any other kind of tape over a connection should be avoided.

8 Apply firm pressure to entire dressing to ensure optimal adhesion. Apply documentation label.

Figure 25 - Images courtesy of 3M®
TROUBLESHOOTING IV INSERTION

If the initial insertion attempt is unsuccessful, consider the following options:

Table 5  

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>POSSIBLE CAUSE</th>
<th>CORRECTIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approaching a palpable vein that is only visible for a short segment</td>
<td>Patient anatomy</td>
<td>- Insert the cannula 1 – 2 cm distal to the visible segment and tunnel the cannula through the tissue to enter the vein</td>
</tr>
</tbody>
</table>
| Missed Vein                                       | Vein rolled or moved with inadequate “anchoring” allowing stylet to push the vein aside | - Anchor vein, maintain traction and reposition catheter slightly  
- DO NOT excessively probe the area and NEVER RESINSERT STYLET BACK INTO CATHETER (can shear off a piece of the plastic). |
| Hematoma develops with insertion                  | - Failure to lower the angle after entering the vein (trauma to the posterior vein wall) | - Lower angle after entering skin  
- Decrease angle with insertion  
- Use a smoother approach (to avoid piercing posterior wall)  
- Release tourniquet once catheter has been “threaded”  
- Ensure angle is reduced once stylet is in the vein |
| Cannot advance the catheter off the stylet        | - Stopping too soon after insertion (so only the stylet, not the plastic catheter, enters the lumen, blood return disappears when you remove the stylet because the catheter is not in the lumen).  
- Heat seal on catheter not released prior to use | - Pull catheter back slightly  
- Rotate catheter 360 degrees on needle and re-seat before insertion |

- If still unsuccessful, remove the catheter, apply pressure to the site, and try again with a new catheter and a new site (preferably on the opposite arm). If you are unsuccessful after two attempts, have another RN or Intravenous Therapy Practitioner attempt insertion.
**IV FLOW RATE MAINTENANCE**

Although IV infusions should be run by an IV pump, understanding the basics of how to calculate rate manually is a foundation skill for IV therapy. Maintaining the IV involves planning and delivering nursing care to prevent problems, plus frequent assessment of the patient to identify problems or to treat them early.

1. **Calculating Flow Rate:**
   - Formula for calculating the flow rate using **Macro drip Tubing**
     \[
     \text{gtt/min} = \frac{\text{gtt/mL of adm set} \times \text{total hourly volume (mL)}}{60 \text{ min.}}
     \]
   - Calculating flow rate using **Micro drip Tubing**

   For microdrip tubing the **number of gtts per minute equals the number of mL/hr**

2. **To Monitor flow rate:**

   Connect administration set to an IV infusion pump or other flow-control device. If a pump is not available, prepare a “time tape” with the volume of fluid to be infused over one hour. Attach the tape next to the solution container.

   If the IV is not running properly, you need to check the entire system to determine the cause. Sometimes the problem can be corrected easily; other times you will need to discontinue the IV and manage complications.

   When evaluating patency, start at the venipuncture site and work up towards the IV bag. The chart on the following page outlines common problems that affect flow rate and corrective actions that can be taken.
## TROUBLESHOOTING IV INFUSION

<table>
<thead>
<tr>
<th>CAUSES</th>
<th>PREVENTION</th>
<th>CORRECTIVE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinked tubing</td>
<td>- Tape tubing without kinks</td>
<td>- Check IV tubing for kinks and re-tape if necessary</td>
</tr>
<tr>
<td>IV catheter kinked</td>
<td>- Securely tape after insertion</td>
<td>- Remove dressing and re-tape if necessary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Remove catheter if permanently kinked</td>
</tr>
<tr>
<td>Air trapped in tubing or injection sites</td>
<td>- Remove air from administration set when priming line</td>
<td>- Tap the tubing until the bubbles rise into the drip chamber, disconnect tubing and flush out, or withdraw from accessory port using a syringe</td>
</tr>
<tr>
<td></td>
<td>- Cold IV fluid is at greater risk for development of air bubbles</td>
<td></td>
</tr>
<tr>
<td>Improper height of container</td>
<td>- Suspend container a minimum of 1 meter above IV site</td>
<td>- Increase height of container</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Instruct patient to keep a minimum of 1 meter between container and IV site when ambulating</td>
</tr>
<tr>
<td>Drip chamber less than ½ full</td>
<td>- Fill drip chamber ½ full when priming administration set</td>
<td>- Fill drip chamber appropriately, removing air in line if necessary</td>
</tr>
<tr>
<td>IV positional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(catheter tip lying against vein wall)</td>
<td>- Avoid areas of flexion when inserting IV</td>
<td>- Remove tape, pull catheter back slightly 8/or adjust the angle of the catheter by placing a 2 x 2 under the catheter hub. - Watch for the IV to run @ acceptable rate and re-tape. <strong>Note: Never reinset a catheter that has been pulled back, as it is now contaminated</strong></td>
</tr>
<tr>
<td>IV blocked (clotted) due to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No remaining solution container</td>
<td>- Maintain continuous solution in container</td>
<td>- Remove IV catheter and replace</td>
</tr>
<tr>
<td>• Blood backed up during ambulation</td>
<td>- Instruct patient to maintain at least 1 meter between container and IV site when ambulating</td>
<td>- Increase height of pole during ambulation if necessary</td>
</tr>
<tr>
<td>• Blocked in-line filter or air lock in filter</td>
<td>- Prime IV filter and change as needed or change blood filter as per Blood Administration Guidelines</td>
<td>- Inspect and replace filters as needed</td>
</tr>
<tr>
<td>• Phlebitis or Infiltration</td>
<td>- REFER to pg. 35 - Complications of IV Therapy</td>
<td></td>
</tr>
<tr>
<td>• Administration of medication with very high or low pH or precipitates</td>
<td>- REFER to Parenteral Drug Therapy Manual (PDTM) and only infuse compatible and appropriate solutions and medications through a Peripheral IV</td>
<td>- REFER to PDTM. Consider obtaining physician referral for insertion of a central venous catheter (CVC) if appropriate.</td>
</tr>
</tbody>
</table>

If the problem of altered flow rate has not been resolved using these actions, IV cannula removal may be necessary. Consider consulting a more experienced IV Nurse/Practitioner prior to discontinuing IV.
PERIPHERAL IV DAILY ASSESSMENT

PIV sites should be routinely assessed for redness, tenderness, swelling, drainage, and/or the presence of paresthesias, numbness, or tingling at the specified frequency listed below. Assessment should minimally include visual assessment, palpation, and subjective information from the patient. Use the Phlebitis Scale and Infiltration Scales as warranted by the assessment and whenever the PIV is discontinued. If there is tenderness at the site, the dressing may be removed to more carefully visualize the site:

1) **At least every 4 hours:**
   a. Patients who are receiving non-irritant/ non-vesicant infusions and who are alert and oriented and who are able to notify the nurse of any signs of problems such as pain, swelling, or redness at the site.

2) **At least every 1 to 2 hours:**
   a. Critically ill patients
   b. Adult patients who have cognitive/ sensory deficits or who are receiving sedative-type medications and are unable to notify the nurse of any symptoms
   c. PIVs placed in a high-risk location (e.g. external jugular, area of flexion)

3) **At least every hour:**
   a. Neonatal patients
   b. Pediatric patients

4) **More frequently: every 5 to 10 minutes:**
   a. Patients receiving intermittent infusions of vesicants
      *(NOTE: The nurse should advocate for central vascular access administration of vesicant medications whenever possible. The peripheral infusion of vesicant agents should be limited to less than 30 to 60 minutes. In addition to visual assessment of the site, a blood return should be verified every 5 to 10 minutes during the infusion.)*
   b. Patients receiving infusions of vasoconstrictor agents.
      *(NOTE: The nurse should advocate for central vascular access administration of vasoconstrictor agents whenever possible as these agents can cause severe tissue necrosis with extravasation.)*

5) **With every Home/ Outpatient visit** - For patients receiving peripheral infusions at home as overseen by Community or Outpatient nurses, patient and family education should include:
   - What to look for: redness, tenderness, swelling, or site drainage
   - To check the site at least every 4 hours during waking hours
   - Ways to protect the site during sleep and activities
   - How to stop the infusion if signs/symptoms occur
   - To promptly report to the nurse
   - The organization’s 24-hour contact telephone numbers

6) For all patients who have a locked PIV for intermittent infusions, the site should be assessed with every catheter access/infusion or at a minimum of twice per day.

7) Temperature should be checked at a frequency according to Physician’s Orders, unit standards, and more often based on nursing clinical judgment. The possibility of Catheter-Related Bloodstream Infection should be considered when there is fever in any patient with a PIV even in the absence of site redness, tenderness, swelling, or drainage.

*(Infusion Nurses Society, 2012)*
**DISCONTINUING IV THERAPY**

An order from a regulated member of a health professions authorized by the employing agency is required to discontinue IV therapy (e.g. continuing order of IV fluids or parenteral medication). However, upon discharge of the patient from the healthcare facility, and when they will not be returning for outpatient IV therapy, the IV may be discontinued without an order.

IV catheters do not need to be re-sited at a pre-determined interval. They should be discontinued and re-sited upon suspected contamination or complications (e.g. interstitial, phlebitis, etc - see table pg. 35).

**Discontinuing a Peripheral IV**

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Verify physician’s or authorized prescriber’s written order</td>
</tr>
<tr>
<td>2.</td>
<td>Verify patient’s identification, using at least 2 independent identifiers, not including the patient’s room number</td>
</tr>
<tr>
<td>3.</td>
<td>Explain procedure to patient</td>
</tr>
<tr>
<td>4.</td>
<td>Position patient as condition allows. Recumbent or Semi-Fowler’s position is preferred.</td>
</tr>
<tr>
<td>5.</td>
<td>Perform hand hygiene and don gloves</td>
</tr>
<tr>
<td>6.</td>
<td>Select and assemble equipment</td>
</tr>
<tr>
<td>7.</td>
<td>Discontinue administration of all infusates in the IV line to be discontinued.</td>
</tr>
<tr>
<td>8.</td>
<td>Gently remove all adhesive materials, including dressing. Lifts tapes toward the catheter-skin junction by stabilizing skin surrounding venipuncture site. (see Figure 26)</td>
</tr>
<tr>
<td>9.</td>
<td>Assess site for any complication, such as infiltration or phlebitis. Send swab for Culture if infection suspected.</td>
</tr>
<tr>
<td>10.</td>
<td>Place sterile gauze above site and withdraw catheter, using a slow, steady motion. Keep the hub parallel to the skin.</td>
</tr>
<tr>
<td>11.</td>
<td>Apply pressure with sterile gauze to the insertion site for 1-2 minutes or until hemostasis is achieved.</td>
</tr>
<tr>
<td>12.</td>
<td>Assess integrity of the catheter that was removed. Compare catheter to original insertion length to ensure entire catheter is removed. If catheter is not removed intact, notify physician immediately.</td>
</tr>
<tr>
<td>13.</td>
<td>Once hemostasis is achieved, apply a sterile dressing to exit wound as needed.</td>
</tr>
</tbody>
</table>
| 14.  | Discard expended equipment in appropriate receptacles  
*Note: Do not discard catheter if it was not intact on removal.* |
| 15.  | Remove gloves, disposes in appropriate receptacle, and perform hand hygiene. |
| 16.  | Instructs patient as to:  
   a. Recommended activity level  
   b. Removal of dressing  
   c. Recognition and reporting of post-catheter removal complication(s) |
| 17.  | Documents removal procedure in patient’s permanent health record on PIV Insertion and Maintenance Record.  
   a. Site assessment pre- and post-catheter removal  
   b. Time IV was discontinued  
   c. Catheter condition and length  
   d. Achievement of hemostasis and dressing materials  
   e. Ancillary procedures such as culture of exit wound and catheter  
   f. Patient response and education  
   g. Name and title of clinician |

**Figure 26 – Dressing Removal**

Images courtesy of 3M®

1. Carefully remove tape strips from dressing.
2. Gently grasp soft cloth on both sides of notch and separate. Gently peel the dressing back toward the insertion site while stabilizing catheter.
3. Slowly peel dressing back over itself while stabilizing catheter and supporting surrounding skin.
**DOCUMENTATION**

*Always document in black ink.*

Documentation must include the number of insertion attempts, insertion vein location, extremity accessed, and removal. The preferred form for documentation is the **PIV Insertion and Maintenance Record**.

---

**Figure 26**

**PIV Insertion and Maintenance Record:**
- Date and time of insertion – start, re-site or removal
- If not original site (re-site) - describe condition of the previous IV site (phlebitis, infiltration, infection, etc.)
- Length and gauge of catheter inserted
- Location of site
- # of attempts, type of dressing applied and patient’s response to the procedure
- Daily assessments, cap and tubing changes, patency assessment
- NS flushes

**IV Flow Sheet/ Fluid Balance Record:**
- NS flush
- Amount and type of IV solution infusing

**Kardex:**
- Date IV extension tubing with intermittent IV cap is due (every 96 hrs)
- Date next tubing change is due (every 96 hrs)
COMPLICATIONS OF IV THERAPY

Complications of IV therapy include Phlebitis, Thrombophlebitis, Infiltration, Extravasation, Hematoma, Infection, Catheter-Related Thrombus, Air Embolism, Catheter Embolism, Pulmonary Edema, and Speed Shock:

**Phlebitis and Thrombophlebitis**

**Phlebitis** is inflammation of the wall of a vein. **Thrombophlebitis** is when a blood clot in the vein causes the inflammation.

The condition is characterized by pain, erythema, swelling, and palpable thrombosis of the cannulated vein. Risk factors for phlebitis include:
- Patients who are female
- Patients with poor-quality peripheral veins
- Insertion in the lower extremity, antecubital fossa, and points of flexion (particularly at the wrist)
- The presence of underlying medical conditions including cancer and immunodeficiency
- Insertion in an emergency

There are 3 major types of phlebitis: mechanical, bacterial, and chemical:
Inserting a vascular access device causes mechanical disruption to the skin, the body's first line of defense against infection. Movement of the cannula in the site also causes mechanical injury to the vein, as does using a catheter too large for the site.

When the skin is breached, patients are at risk for bacterial infection. Hand hygiene and cleansing the insertion site thoroughly before insertion and applying a dressing after are the major steps to prevent bacterial infection. The number of PIV restarts increases the risk of contamination and may also influence bacterial phlebitis.

**Chemical** phlebitis can be related to the tonicity of the fluid, the number and dosage of medications, the pH of the medications, or wet skin. In particular, 5% dextrose in water is isotonic in the bag but hypotonic in the body after the dextrose is infused and metabolized. Hypertonic fluids pull fluids from the endothelium, causing the cells to shrink and making them vulnerable to infiltrations and phlebitis. Chemical irritation also happens when the skin is not allowed to dry after cleaning and before insertion of the catheter.

The most frequent and under-reported complication of PIV infusion is phlebitis, which may occur at rates as high as 50% or even as high as 75% in patients with infectious diseases; however, the incidence rate in patients who do not have diabetes, burns, or a need for urgent catheter insertion is approximately 20%. This inflammation may occur while the catheter is in place and up to 96 hours after removal. The residual occurrence of phlebitis may still be a problem to the patient as long as 5 months after the incident.

All vascular access sites should be routinely assessed for the signs and symptoms of phlebitis. Due to the high rates in patients with a PIV, patients with a PIV will be assessed using the PIV Insertion and Maintenance Record, documented daily using a Phlebitis Scale, and further actions taken based on the Grade of Phlebitis (see Table 7 below).

![Phlebitis Presentation](Image)

**Figure 28 - Courtesy of BD®**

<table>
<thead>
<tr>
<th>GRADE</th>
<th>CLINICAL CRITERIA</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No symptoms</td>
<td>No action</td>
</tr>
<tr>
<td>+1</td>
<td>Erythema at insertion site with or without pain</td>
<td>Observe, remove PIV and re-site if necessary</td>
</tr>
<tr>
<td>+2</td>
<td>Pain at insertion site with erythema and/or edema</td>
<td>Remove PIV and re-site if necessary on opposite arm, <strong>notify MRP</strong> if patient febrile</td>
</tr>
<tr>
<td>+3</td>
<td>Pain at insertion site with erythema, streak formation, palpable venous cord</td>
<td>Remove PIV and re-site if necessary on opposite arm, <strong>notify MRP</strong>, apply warm, moist heat to phlebitis site for 20 min periods, 3 to 4 times per day</td>
</tr>
<tr>
<td>+4</td>
<td>Pain at insertion site with erythema, streak formation, palpable venous chord greater than 3 cm in length, purulent drainage</td>
<td>Remove PIV and re-site if necessary on opposite arm, <strong>notify MRP</strong>, apply warm, moist heat to phlebitis site for 20 min periods, 3 to 4 times per day, if purulent drainage present, collect swab and send for C&amp;S.</td>
</tr>
</tbody>
</table>

Table 7 - PHLEBITIS SCALE ***adapted from (Infusion Nurses Society, 2011)***
Infiltration and Extravasation

**Infiltration** is defined as the inadvertent leakage of a non-vesicant solution into surrounding tissue. 

**Extravasation** is the inadvertent leakage of a vesicant solution into surrounding tissue.

Extravasation is associated with cytotoxic chemotherapy agents such as doxorubicin, paclitaxel, and vinca alkaloids, as well as a number of non-cytotoxic drugs, including phenytoin, sodium bicarbonate (>5%), calcium chloride and gluconate, amphotericin B, acyclovir, ganciclovir, digoxin, diazepam, potassium (>40 mmol/L), dextrose 50%, cefotaxime, IV contrast media, and mannitol, that can also cause tissue necrosis. The incidence of infiltration and extravasation is hard to determine because of limited reporting; however, extravasation injury from cancer chemotherapy is reported to be 11% in children and 22% in adults. One study found that, of all the complications associated with PIVs, 33.7% occurred as a result of infiltration. Rates of extravasation with cancer chemotherapy infused through implanted ports range from 0.3% to 6%. (Dychter, Gold, Carson, & Haller, 2012) (Hadaway, 2007)

Measures to prevent infiltration and extravasation include:
- Selection of an appropriate site for catheter insertion - Avoid areas of joint flexion such as wrist and antecubital fossa
- Selection of an appropriate size catheter - Use the smallest size catheter needed for the prescribed therapy
- Use of appropriate fluids depending on vascular access type – Medications/fluids with an osmolality of greater than 600, a pH of less than 5 or greater than 9, and vesicants need to be given via a CVC.
- Stabilization of the catheter – Always use a securement device/dressing. Avoid circumferential taping of the limb.
- Use of proper administration techniques - The patency of the catheter and vein should be assessed frequently so that infiltration or extravasation can be prevented. Before administering each dose of medication, the nurse should visually inspect and palpate the site, checking for vein cording, edema, skin temperature, and tenderness or discomfort. Check for a positive blood return. Flushing the catheter with normal saline while palpating the site also makes detection of swelling at the PIV catheter tip easier. Each drug should be diluted in a separate syringe. When dilution is done either in a syringe or by slow injection through an infusing, compatible IV fluid, according to the PDTM, the injection can be stopped if the patient complains of any problems. (Hadaway, 2007)

**Common signs and symptoms of IV infiltration include:**
- Cool skin temperature at the insertion site
- Skin that looks blanched, taut, or stretched or that the patient says feels “tight”
- Edema at the insertion site
- Discomfort and/or tenderness
- Change in quality and flow of the infusion
- Frequent IV infusion pump downstream occlusion alarms (do not rely on an IV infusion pump to alert you to an infiltration as this alarm is often a late sign; an IV infusion pump will exacerbate the problem until the IV infusion pump is stopped)
- IV fluid leaking from the insertion site

Signs and symptoms of extravasation are the same as those of infiltration but also include burning/stinging pain, redness followed by blistering, tissue necrosis, and ulceration. Both infiltration and extravasation can have serious consequences including full-thickness skin loss, compartment syndrome, and muscle and tendon necrosis. The patient may need surgical intervention resulting in large scars, experience limited function, or even require amputation. Another long-term effect is complex regional pain syndrome, a neurologic syndrome requiring long-term pain management.

All vascular access sites should be routinely assessed for the signs and symptoms of infiltration and extravasation. Due to the high rates in patients with a PIV, patients with a PIV will be assessed using the PIV Insertion and Maintenance Record, documented daily using an Infiltration Scale (see Table 7 pg.36), and further actions taken based on the Grade of infiltration (see table below).

Children and infants are vulnerable populations requiring special attention and the use of appropriate assessment tools. Pediatric assessment has been incorporated into this tool (See also "Pediatric Considerations for Peripheral IV Insertion – Supplement found on Clinical Policy Office Website).

<table>
<thead>
<tr>
<th>GRADE</th>
<th>CLINICAL CRITERIA</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No symptoms</td>
<td>No action</td>
</tr>
<tr>
<td>+1</td>
<td>Skin blanched, edema less than 3 cm in any direction or 1%-10% of the extremity above or below the insertion site, cool to touch, with or without pain</td>
<td>Discontinue infusion, remove PIV and re-site if necessary on opposite arm</td>
</tr>
<tr>
<td>+2</td>
<td>Skin blanched, edema 3-15 cm in any direction or up to ¼ of the extremity above or below the insertion site or 10%-25% of the extremity above or below the insertion site, cool to touch, with or without pain</td>
<td>Discontinue infusion, remove PIV and re-site if necessary on opposite arm, apply warm, moist heat to infiltrations site for 20 min periods, 3 to 4 times per day to alleviate discomfort and help absorb infiltration.</td>
</tr>
<tr>
<td>+3</td>
<td>Skin blanched, translucent, gross edema greater than 15 cm in any direction or ¼ - ½ of the extremity above or below the insertion site or 25%-50% of the extremity above or below the insertion site, cool to touch, mild to moderate pain, possible numbness</td>
<td>Discontinue infusion; determine type, concentration, and volume of solution infused. Notify MRP. Discontinue infusion, remove PIV and re-site if necessary on opposite arm, apply warm, moist heat to infiltrations site for 20 min periods, 3 to 4 times per day to alleviate discomfort and help absorb infiltration.</td>
</tr>
<tr>
<td>+4</td>
<td>Skin blanched, translucent; skin tight, leaking; skin discoloured, bruised, swollen; gross edema greater than 15 cm in any direction or greater than ½ of the extremity above or below the insertion site or greater than 50% of the extremity above or below the insertion site; deep pitting edema; circulatory impairment; moderate to severe pain; infiltration of any amount of blood product, irritant, or vesicant.</td>
<td>Discontinue infusion; determine type, concentration, and volume of solution infused. Notify MRP. Follow instruction in PDTM for treatment of extravasation from medication (see &quot;Potential Hazards of Administration&quot; in PDTM).</td>
</tr>
</tbody>
</table>

***EXTRAVASATION IS ALWAYS GRADED AS +4***

Table 8 - INFILTRATION SCALE

*adapted from* (Amjad, Murphy, Nylander-Housholder, & Ranft, 2011) (Infusion Nurses Society, 2011) (Simona Pop, 2012)
Hematoma

**Hematoma** – A localized mass of blood located outside the vessel, usually creating a hard, painful lump.

**Prevention:**
- Apply firm pressure to insertion site with sterile gauze after unsuccessful attempt start
- Do not reapply tourniquet to the same limb after an unsuccessful start
- Be aware of patients taking anti-coagulants

**Signs and Symptoms:**
- Swelling at the site
- Discomfort at site
- Raised area of ecchymosis
- Occasionally bleeding at the site

**Interventions**
- Discontinue IV and re-site IV in opposite limb if possible
- Elevate the affected limb and apply direct pressure to the site with sterile gauze
- Apply cold compress

---

**Figure 30** - Courtesy of BD®

**Figure 31** - Courtesy of BD®
Infection

Infection – Catheter Related Bloodstream Infections (CR-BSI) are a preventable nosocomial infection and adverse event. (Stevens & Schulman, 2012) These infections increase hospital length of stay and facility costs. Studies of CR-BSIs that control for the underlying severity of illness suggest that mortality attributable to these infections is between 4-20%. (Safer Healthcare Now, 2012)

Infective organisms may access the vascular access device surface by either:
- Invasion of the percutaneous tract
- Contamination of the catheter hub
- Seeding from a remote source of localized infection
(Association for Professionals in Infection Control and Epidemiology, 2009)

Increased CR-BSI rates are associated with a PIV inserted in the antecubital fossa, a PIV placed in the Emergency Department, or a PIV placed outside of hospital (e.g. EHS). (Trinh, et al., 2011)

The nurse and/or IV Therapy Practitioner shall assess patients for suspected infusion related and CR-BSIs and document signs and symptoms, interventions implemented and patient response to treatment in the patient’s permanent health record and the Patient Safety Learning System (PSLS). (Infusion Nurses Society, 2011)

Prevention:
- Use aseptic technique when caring for IV
- Thoroughly inspect medication and solution containers prior to use
- Inspect access site and equipment regularly
- Change administration set and solution according to IV Therapy Guideline (see Table 3 pg. 18)
- Utilize single-use intermittent medication tubing

Signs and symptoms of CR-BSI include:
- Erythema, edema, induration, or drainage at the vascular device insertion site
- Elevated body temperature

Diagnosis: Purulent drainage from the catheter-skin junction of a PIV or CVC should be collected using the Levine Technique (cleanse site with normal saline prior to collecting swab for culture and twirl the end of the cotton-tipped applicator on a 1-cm² area of the wound bed with enough pressure to cause minimal bleeding). (Spear, 2014)

Treatment: PIVs with purulent drainage present should be removed and re-sited based on patient need and condition. Send the catheter to Microbiology for culture if purulent drainage is noted on removal. When seen in conjunction with elevated body temperature, consult physician for order for Blood Cultures and treatment plan.

**Catheter-Related Thrombus**

**Catheter-Related Thrombosis (CRT) or Catheter-Associated Venous Thrombus** refers to a thrombus that has attached to the CVC and has also adhered to the vessel wall. CRT is associated with CR-BSI. CRT increases the risk and incidence of CR-BSI. Conversely, CR-BSI also increases the risk and incidence of CRT. (Canadian Vascular Access Association, 2013)

**Risk factors** for CRT include:
- Difficult, previous, or traumatic insertions
- PIVs with larger gauges or inserted in the ACF
- Children and adults over 60 years of age
- Chronic illnesses such as lupus, irritable bowel syndrome, or end-stage renal failure
- History of previous DVT

(Yacopetti, 2008)

**Prevention:**
Prophylactic anti-coagulation is controversial and compliance has been shown to be poor. Focus should therefore be on prevention of CRT:
- Insertion of a CVC in applicable patients (Treatment required for greater than 6 days) earlier in their course of treatment
- Use of advanced technology on insertion (e.g. ultrasound, modified Seldinger technique, tip placement technology)

(Campisi, Biffi, & Pittiruti, 2007)(Yacopetti, 2008)

**Signs and symptoms** are related to the obstruction of venous blood flow and include:
- Pain in the extremity, shoulder, neck, or chest
- Edema in the extremity, shoulder, neck, or chest
- Engorged peripheral veins in the shoulder, neck, or chest wall (Infusion Nurses Society, 2011) (Yacopetti, 2008)

**Treatment:** Flushing and locking procedures have no effect on CRT as the solutions and technique are directed at the internal lumen of the catheter rather than the vein lumen. Usual management of CRT includes thrombolysis and systemic anti-coagulation.

**Figure 32:** Dilatation of superficial collateral veins on the chest wall

**Figure 33:** Left-arm edema and erythema associated with an axillary vein thrombosis
**Pulmonary Embolism**

**Pulmonary Embolism** occurs when a substance (usually a blood clot) becomes free and circulates to the pulmonary artery causing occlusion. Even small recurrent emboli may cause pulmonary hypertension and right heart failure.

**Risk Factors:**
- Irrigation of a clogged IV
- Use of veins in lower limbs (increased risk)
- Debris in IV solution (some may require filter - refer to PDTM)
- Debris caused by incompletely dissolved, reconstituted drugs
- Unfiltered blood or plasma

**Prevention:**
- NEVER irrigate the catheter if the IV is not flowing
- Use in-line filters where applicable (see PDTM)
- Avoid siting IV’s in the lower extremities in adult patients when possible
- Thoroughly inspect medication and solution containers for particulate matter prior to use

**Signs and Symptoms:**
- Apprehension
- Pleuritic discomfort
- Dyspnea, tachypnea
- Cyanosis
- Cough, unexplained
- hemoptysis
- Diaphoresis
- Tachycardia
- Low-grade fever
- Chest pain radiating to neck and shoulders

**Treatment:**
- Place patient on strict bed rest in semi-Fowler’s position
- Notify physician immediately
- Monitor vital signs
- Administer Oxygen
- Assess IV and re-site if needed (for emergency drugs)
- Document in permanent health record

**Figure 34:** [http://healthcare.utah.edu/healthlibrary/health-lib-image.php?imageid=125814](http://healthcare.utah.edu/healthlibrary/health-lib-image.php?imageid=125814)
**Air Embolism**

*Air Embolism* is the presence of air in the vascular system. (Infusion Nurses Society, 2011)

A venous air embolism occurs when air is introduced into the venous system and travels to the right ventricle and/or pulmonary circulation. An arterial air embolism results from air entry into the arterial system and can produce ischemia of and organ with poor collateral circulation. (Broadhurst, 2013, p. 17)

Air embolism is reported to occur more frequently during catheter removal than during insertion. (Truscott, 2013)

The minimum amount of air that is lethal to humans is not known, however, the risks from smaller amounts increase with a device closer to the central vasculature (CVC) or with pediatric and neonatal patients, particularly in presence of a patent foramen ovale. (Cook, 2013)

The introduction of microbubbles into the vascular system is also related to the development of an air embolism and may go unnoticed. Cardiopulmonary bypass, hemodialysis, mechanical heart valves, major surgeries, warming of cold infusates, and high IV infusion flow rates during trauma resuscitation can produce large amounts of microbubbles. (Broadhurst, 2013) (Cook, 2013)

**Risk Factors:**
- Failure to occlude the needle hub and/or catheter during insertion or removal
- An improperly primed IV administration set
- An incorrect technique when administering drugs via the IV route
- Inadvertent infusions of air
- An accidental disconnection at the catheter hub, connector, or IV administration set
- A stopcock placed in the wrong position
- A ruptured catheter
- Poor technique during needleless connector changes
- IV fluid infusions that are completed or rapid infusion through an air-filled drip chamber with an IV administration set that is unclamped

**Prevention:**
- Minimize PIV manipulations
- Remove all air from syringes, IV administration sets, needleless connectors, stopcocks, and all other devices added to a PIV
- Trace all IV lines from the catheter hub to the IV fluid container to prevent misconnections
- Remove air bubbles detected during an IV infusion. Infrequent tiny pinhead bubbles, even though not desirable, can be left but should be monitored.
- Never use scissors near a PIV to prevent accidental severing of the catheter.
- Carefully fill and prime IV administration sets and filters and ensure vented tubing in clamped off before the container is completely empty.
- Use IV infusion pumps with air sensing technology for IV fluid and medication infusions.
- Instruct patients and caregivers to not disconnect and reconnect any IV administration sets or connectors from the catheter hub to properly prime tubing, to check connections frequently, how to prevent displacement/disconnection, and actions to take in case of CVC displacement or damage. (Broadhurst, 2013) (Cook, 2013) (Infusion Nurses Society, 2011)

**Signs and Symptoms:**
- Sudden onset of dyspnea
- Continued coughing
- Breathlessness
- Agitation or irritability, often expressed as a feeling of impending doom
- Shoulder and chest pain
- Lightheadedness
- Hypotension
- Jugular venous distention
- Tachyarrhythmias
- Wheezing
- Tachypnea
- Altered mental status
- Symptoms that emulate stroke including altered speech, changes in facial appearance, numbness and paralysis (Cook, 2013) (Infusion Nurses Society, 2011)
Diagnosis:
Diagnosis may not be straightforward but prompt diagnosis and treatment will decrease potential mortality and morbidity. Radiological techniques including transthoracic echocardiography and precordial ultrasonography have been used to detect air embolisms. (Cook, 2013)

Treatment:
Treatment should begin immediately even if an air embolism is only suspected to prevent further air from entering the vasculature:
- Close, fold, or clamp the existing catheter to occlude entry of passive air.
- Occlude the puncture site of a catheter that had been removed.
- Place the patient in Trendelenberg left lateral decubitus position (left side, head flat, feet up, right side uppermost) if not contraindicated by other conditions such as increased intracranial pressure or respiratory illness. The goal of this positioning is to trap the air in the lower portion of the right ventricle and prevent it from travelling to the pulmonary arteries.
- Administer oxygen at 100%
- If possible, attempt to aspirate air from catheter.
- Monitor vital signs and start CPR as needed.
- Notify physician.


Catheter Embolism

Catheter Embolism – Catheter embolism is the result of catheter damage or rupture, resulting in the breaking off of a portion of the PIV or CVC into the bloodstream. (Canadian Vascular Access Association, 2013)

Prevention:
- Never use vascular access devices for power-injection that are not rated for this purpose.
- The size of the flush syringe should be in accordance with the type of vascular access device and its intended use.
- The most frequent cause for catheter embolism is re-insertion of the stylet into a PIV catheter (Infusion Nurses Society, 2011)
- Catheter dysfunction, such as the inability to aspirate blood or fluid with localized pain and/or subcutaneous swelling, may be a precursor to catheter embolism. Leaking at the catheter insertion may indicate catheter rupture. PIVs which exhibit these signs should be carefully discontinued and re-sited (note any damage to the PIV tip upon removal). (Infusion Nurses Society, 2011)
- Catheter embolism should be suspected when the patient exhibits symptoms such as palpitations, arrhythmias, dyspnea, cough, or thoracic pain not associated with patient’s diagnosis or comorbidities. (Infusion Nurses Society, 2011)
- Upon removal, inspect all catheters for damage and possible fragmentation. When vascular access device removal is difficult or if damage to the catheter is seen:
  1. Carefully assess the patient for signs and symptoms of catheter fragmentation and;
  2. Save catheter and report via PSLS and HSSBC Product Concern Form.
**Pulmonary Edema**

Pulmonary Edema is an increase in venous pressure with increased pressure in the right ventricle, pulmonary artery and subsequent fluid in the alveoli.

**Risk Factors:**
- Rapid or excessive fluid administration, especially in patients with impaired renal or cardiac function, or elderly or very young patients

**Prevention:**
- Maintain prescribed flow rate with regular patient assessment
- Use volumetric infusion pump for patients whenever possible to avoid accidental fluid overload

**Signs and Symptoms:**
- **EARLY Signs:**
  - Restlessness
  - Slow increase in pulse rate
  - Headache
  - Shortness of breath
  - Non-productive cough
  - Skin flushing
- **LATE Signs:**
  - Hypertension
  - Severe dyspnea with coarse crackles
  - Engorged neck veins (JVD)
  - Pitting edema
  - Pink, frothy sputum
  - Puffy eyelids
  - Shock, respiratory or cardiac arrest

**Treatment:**
- Place patient in high fowlers position
- Slow the IV to keep vein open
- Notify the physician
- Administer medications as requested by physician
- Monitor vital signs
- Administer high-flow Oxygen
- Document in permanent health care record
- Submit report via Patient Safety Learning System (PSLS) when due to accidental fluid overload

---

**Speed Shock**

Speed Shock is a sudden adverse physiologic reaction to IV medications or drugs that are administered too quickly.

**Risk Factors:** Caused by rapid infusion of drugs or solution causing toxic proportions to reach the heart and brain.

**Prevention:**
- Monitor gravity-flow administration sets closely to ensure correct prescribed flow rate
- Use volumetric infusion pump for medications as directed in the PDTM
- Follow recommended infusion rate for medication as per PDTM

**Signs and Symptoms:**
- **EARLY Signs:**
  - Dizziness
  - Facial flushing
  - Headache
  - Irregular Heart Rate
  - Chest pain/ tightness
  - Sudden onset of symptoms associated with particular medication being administered
- **LATE Signs:**
  - Syncope
  - Shock
  - Cardiac arrest

**Treatment:**
- Stop the infusion
- Maintain IV access for emergency treatment
- Notify physician immediately or Code Team if applicable
- Monitor vital signs
REVIEW QUESTIONS

1. A “Competency Assessed IV Nurse” will:
   A. Have successfully completed a theoretical and practical experience
   B. Have had at least two years of experience in IV therapy
   C. Be automatically certified if certified at another health agency
   D. Will receive more money because of this skill

2. IV related standards, procedures and protocols may be found in which of the following manuals?
   A. INS Infusion Standards of Practice
   B. FHA Clinical Policy Office
   C. Site-based policy manual
   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) All of the above

3. Which of the following statements are true of the arterial circulatory system?
   A. Arteries carry blood to the tissues
   B. Blood is under high pressure in the arterial system
   C. Arteries have valves to help blood flow
   D. Arteries have a palpable pulse
   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) All of the above

4. Which of the following statements are true of the venous circulatory system?
   A. The venous system is a low pressure system
   B. Veins have a weak pulse
   C. Superficial and deep veins unite in the lower extremities
   D. Damage to valves may result in varicosities
   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) B, C, D

5. Arteries and veins have:
   A. One layer
   B. Two layers
   C. Three layers
   D. Four layers
6. Name the veins and arteries on the following diagram:

7. The PIV catheter most frequently used today is:
   A. PICC
   B. Cutdown
   C. Needle-safe
   D. Internal jugular

8. The gauge of needle/cannula most commonly used for routine IV therapy is:
   A. #18g
   B. #20g
   C. #22g
   D. #24g

9. Prime factors to be considered when choosing a vein for infusion include:
   A. Location
   B. Condition
   C. Purpose
   D. Duration

   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) All of the above

10. Which of the following statements are true about a saline lock?
    A. The saline lock requires short extension tubing to be added
    B. The site should be assessed and changed as required
    C. The lock is flushed every 12 hours (and/or after medication) with 1-2 mL of normal saline
    D. After removal check site for bleeding, edema, signs of infection

    1) A, B, C
    2) A, B, D
    3) B, C, D
    4) All of the above
11. Which of the following are nursing actions to be done before starting the PIV?
   A. Check patient’s chart for allergies and doctor’s order
   B. Identify the patient by identiband and by asking their name
   C. Involve the patient in site selection
   D. Ensure privacy
   
   1) A & B
   2) A, B, D
   3) B, C, D
   4) All of the above

12. Venous distention may be achieved by which of the following?
   A. Tourniquet to mid-forearm for use of the hand veins
   B. Tourniquet tight enough to occlude an arterial pulse
   C. Position the arm below heart level
   D. Application of warm packs 10-15 minutes prior to IV start
   
   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) B, C, D

13. Stabilizing the vein minimizes the pain associated with venipuncture:
   A. True
   B. False

14. Factors affecting flow rate of the IV are:
   A. Phlebitis
   B. Height of the container
   C. Positional IV
   D. Air trapped in the IV tubing
   
   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

15. Signs of infiltration include:
   A. Sluggish flow rate
   B. Warm, reddened skin at the site
   C. Swelling of the limb
   D. Slow backflow
   
   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) B, C, D
16. Phlebitis is caused by injury or irritation from which of the following?
   A. Long term therapy
   B. Acidic or alkaline substances
   C. Trauma during insertion
   D. Poor aseptic technique
   
   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

17. Signs of Catheter-Related Bloodstream Infection (CR-BSI) include:
   A. Fever
   B. Increase in pulse rate
   C. Hypotension
   D. Sudden onset of chills
   
   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

18. To prevent Catheter-Related Bloodstream Infection (CR-BSI) which of the following are recommended?
   A. Examine solutions carefully
   B. Observe maximum solution hang time of 24 hours
   C. Mix solutions at the bedside
   D. Mix solutions in Pharmacy in a laminar flow hood
   
   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) B, C, D

19. Symptoms of Catheter Embolus include which of the following?
   A. Dyspnea
   B. Chest pain
   C. Diaphoresis
   D. Weak rapid pulse
   
   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

20. If an Air Embolus is suspected, the appropriate intervention is to:
   A. Turn patient on left side, head down
   B. Turn patient on right side, head down
   C. Turn patient on left side, head raised
   D. Turn patient on right side, head raised
21. Early signs of Pulmonary Edema include:
   A. Restlessness
   B. Headache
   C. Shortness of breath
   D. Fever
   
   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) B, C, D

22. Factors predisposing the patient to Catheter-Related Bloodstream Infection (CR-BSI) including all the following except:
   A. Age less than one year or more than 60 years
   B. State of immune system
   C. Increased red blood cell count
   D. Presence of distant infection

23. The most common source of bacteria responsible for IV infection comes from:
   A. Airborne sources
   B. The patient’s skin
   C. The cannula
   D. Healthcare worker’s hands

24. Which of the following measures help to reduce IV related infections?
   A. Handwashing prior to venipuncture
   B. Use of a laminar hood for IV admixtures
   C. Protection of intermittent infusion IV tubing
   D. Sterile dressing using aseptic technique
   
   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

25. What percentage of the adult’s weight is body fluid?
   A. 5%
   B. 15%
   C. 40%
   D. 60%

26. What percentage of the adult’s weight is contained in intracellular fluid?
   A. 5%
   B. 15%
   C. 20%
   D. 40%

27. How often should primary administration tubing, needleless connectors, and extension sets be changed in acute care?
   A. Every 6-7 days
   B. Every 24 hours
   C. Every shift
   D. Every 96 hours
28. Body water and electrolytes move in which of the following ways?
   A. Colloidal
   B. Diffusion
   C. Active transport
   D. Osmosis

   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

29. Which electrolyte is responsible for regulating water distribution in the body?
   A. Potassium
   B. Calcium
   C. Sodium
   D. Chloride

30. Which electrolyte is essential for the normal function of the heart muscle?
   A. Potassium
   B. Zinc
   C. Sodium
   D. Chloride

31. Which statements are true about acid-base balance?
   A. Kidneys, lungs and skin are the main regulating organs
   B. The normal pH is 7.35-7.45
   C. Acidosis is a decrease in pH
   D. Alkalosis is an increase in pH

   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

32. Hypotonic is a term which means that a solution has:
   A. A higher osmotic pressure than the blood
   B. A lower osmotic pressure than the blood
   C. The same osmotic pressure as blood
   D. Ability to carry O₂ to the cells

33. Which of the following statements are true of a hypertonic solution?
   A. Draws water out of the cells and interstitial space and into the intravascular space
   B. Has a higher osmotic pressure than the blood
   C. Has a lower osmotic pressure than the blood
   D. Dextrose 10% and 50% in water are examples of a hypertonic solution

   1) A, B, C
   2) A, B, D
   3) B, C, D

34. 3% and 5% saline have been called dangerous solutions because:
   A. They move water out of the cell and interstitial space and into the intravascular space
   B. They cause imbalance in the intracellular water and sodium
   C. They are isotonic
   D. They contain a lot of potassium
35. Which of the following statements are true regarding Infusion Pumps?
   A. Only appropriate vendor-specific IV tubing should be used with IV Infusion pumps
   B. Different Infusion devices should be used when therapies are administered via different routes (e.g. IV, epidural, subcutaneous)
   C. IV Infusion pumps do **not** have a safety clamp (anti-free flow clamp) which is activated by opening the door
   D. An IV Infusion Pump should be used for all IV fluid and medication administration

   1) A, B, C
   2) A, B, D
   3) A, C, D
   4) B, C, D

36. Which of the following statements are true about extravasation?
   A. Rated as +3 on the Infiltration Scale
   B. Can cause full-thickness skin loss
   C. You should contact the physician immediately
   D. The patient may need surgical intervention

   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

37. Which of the following should be charted on the patient’s permanent health record?
   A. Length and gauge of the IV catheter
   B. Site of venipuncture
   C. Number of missed insertion attempts
   D. Patient’s response to the procedure

   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) All of the above

38. Which of the following statements are true about PIV Assessment?
   A. All PIV sites should be assessed routinely
   B. Neonatal and pediatric patients should have their PIV sites assessed every 4 hours
   C. PIV sites should be assessed every 5-10 min when administering vesicants
   D. PIV sites should be assessed with every Home or Outpatient visit

   1) A, B, C
   2) A, B, D
   3) B, C, D
   4) A, C, D

39. All patients with a PIV should be assessed daily using the Phlebitis Scale and the Infiltration Scale.
   A. True
   B. False

40. The most frequent cause for catheter embolism is re-insertion of the stylet into a PIV catheter.
   A. True
   B. False
ANSWERS TO REVIEW QUESTIONS

1. A
2. 2
3. 2
4. 3
5. C
6. See pg. 11
7. C
8. B
9. 4
10. 4
11. 4
12. 3
13. A
14. 4
15. 3
16. 4
17. 4
18. 2
19. 4
20. A
21. 1
22. C
23. B
24. 2
25. D
26. D
27. D
28. 3
29. C
30. A
31. 4
32. B
33. 2
34. B
35. 2
36. 3
37. 4
38. 4
39. 1
40. 1
REFERENCES

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Fraser Health Authority. (2010). Scope of Practice. Fraser Health Authority.


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Fraser Health Authority (2014) Intravenous Therapy Clinical Practice Guideline. Fraser Health Authority.


**APPENDIX A: EDUCATION AND COMPETENCY GUIDELINES**

### 1) PIV INSERTION EDUCATION AND COMPETENCY - ADULTS

<table>
<thead>
<tr>
<th>RDN/ RPN/ LPN</th>
<th>INTRAVENOUS THERAPY PRACTITIONER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Training:</strong></td>
<td>IV Insertion Skills Session</td>
</tr>
<tr>
<td>Self-Learning Module</td>
<td>Self-Learning Module</td>
</tr>
<tr>
<td>Emphasis on initiation, maintenance, and becoming clinical experts</td>
<td>Emphasis on initiation and maintenance</td>
</tr>
<tr>
<td><strong>Training done by:</strong></td>
<td>Clinical Nurse Educator or expert RN (may be provided during Nursing Orientation)</td>
</tr>
<tr>
<td><strong>Demonstration of competency to:</strong></td>
<td>Novice</td>
</tr>
<tr>
<td>3 successful starts with expert RN - expert RN would be defined as a person who can mentor, teach, observe.</td>
<td>Experienced</td>
</tr>
<tr>
<td>Demonstration x1 with expert RN</td>
<td>Demonstration x1 with expert IV Therapy Practitioner</td>
</tr>
</tbody>
</table>

**Note:** Use appropriate competency guidelines listed above, dependent upon skill requirements for clinical area and scope of practice.

<table>
<thead>
<tr>
<th>Peripheral IV Skill</th>
<th>RDNs/ RPNs</th>
<th>LPNs</th>
<th>IV Therapy Practitioners</th>
<th>ESNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIV initiation</td>
<td>Yes</td>
<td>Yes, <em>adults pts only</em></td>
<td>Yes (depending on care area)</td>
<td>No</td>
</tr>
<tr>
<td>PIV and Saline Lock discontinuation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IV Maintenance</td>
<td>Adjusts rates, changes bags &amp; tubing of all medicated IV solutions appropriate for practice area and scope</td>
<td>Adjusts rates, changes bags &amp; tubing of NaCl, D5W, 2/31/3 &amp; RL with NO added medications including KCL</td>
<td>Adjusts rates, changes bags &amp; tubing of NaCl, D5W, 2/31/3 &amp; RL with NO added medications including KCL</td>
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<tr>
<td>Maintenance of Saline Locks</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (extra training may be required)</td>
<td>Yes</td>
</tr>
<tr>
<td>Evaluates response to IV therapy and takes actions to prevent complications related to IV therapy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### APPENDIX B: CLINICAL COMPETENCY VALIDATION

**PERIPHERAL IV CATHETER INSERTION:**

<table>
<thead>
<tr>
<th>Decision Criteria</th>
<th>Met</th>
<th>Not Met</th>
<th>Not Applicable</th>
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</thead>
<tbody>
<tr>
<td>1. Purpose of prescribed infusion therapy</td>
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<tr>
<td>a. Intended outcome</td>
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<tr>
<td>2. Patient Assessment:</td>
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<tr>
<td>a. Physical assessment</td>
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<tr>
<td>b. Allergies</td>
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<tr>
<td>c. Education and consent</td>
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<tr>
<td>d. Infusion history</td>
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<td>3. Site selection based on:</td>
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<tr>
<td>a. Patient age and physical condition</td>
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<td>b. Patient education</td>
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<tr>
<td>c. Prescribed therapy</td>
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<tr>
<td>d. Anticipated device dwell time</td>
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<td>4. Equipment selection based on:</td>
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<tr>
<td>a. Patient age and physical condition</td>
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<tr>
<td>b. Prescribed therapy</td>
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</table>

<table>
<thead>
<tr>
<th>Performance Criteria</th>
<th>Met</th>
<th>Not Met</th>
<th>Not Applicable</th>
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</thead>
<tbody>
<tr>
<td>1. Verified Physician’s or authorized prescriber’s written order</td>
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<td>2. Verified patient’s identification, using at least 2 independent identifiers, not including the patient’s room number</td>
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<td>3. Explained procedure to the patient</td>
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<td>4. Obtained patient consent (if possible)</td>
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<tr>
<td>5. Positioned patient as condition allows (recumbent or semi-fowler’s is preferred)</td>
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<tr>
<td>7. Performed hand hygiene. Donned non-sterile gloves and any other PPE that will be required.</td>
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<tr>
<td>8. Assessed extremities for an appropriate venipuncture site. Ensured adequate arterial flow by palpating for a pulse distal to the intended venipuncture site.</td>
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<tr>
<td>9. Applied tourniquet to extremity, 10 – 15 cm above intended venipuncture site or applied blood pressure cuff instead of tourniquet (inflated to just below patient’s normal diastolic pressure and maintained at that pressure until complete).</td>
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<tr>
<td>10. Selected optimal site for catheter insertion.</td>
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<tr>
<td>Performance Criteria</td>
<td>Met</td>
<td>Not Met</td>
<td>Not Applicable</td>
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<tr>
<td>11. Removed excess hair as needed using single patient use clippers or scissors.</td>
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<td>12. Applied cutaneous antiseptic agent (CHG 2%/ Alc 70% in FHA) to intended venipuncture site and allowed it to dry completely.</td>
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<tr>
<td>13. Performed venipuncture:</td>
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<tr>
<td>a. One catheter per attempt</td>
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<td>b. Maximum two attempts</td>
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<tr>
<td>c. If unsuccessful catheter insertion:</td>
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<tr>
<td>i. Removed catheter</td>
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<tr>
<td>ii. Applied manual pressure to minimize bleeding</td>
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<tr>
<td>iii. Applied sterile gauze dressing to achieve hemostasis and wound protection</td>
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<tr>
<td>iv. Communicated procedure failure to appropriate resource</td>
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<tr>
<td>14. Obtained positive blood return through flashback chamber of catheter.</td>
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<tr>
<td>15. Advanced catheter into vein lumen</td>
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<tr>
<td>16. Stabilized catheter with one hand and released tourniquet or BP cuff with the other.</td>
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<tr>
<td>17. Removed stylet from IV cathalon according to manufacturer’s instructions.</td>
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<tr>
<td>18. Connected end of prepared saline lock with or without continuous infusion set to end of catheter and secured connection.</td>
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<tr>
<td>19. Flushed injection cap of saline lock with 1 – 3 mL preservative-free 0.9% sodium chloride using a positive pressure technique, or began continuous infusion by slowly opening the slide clamp or adjusting the roller clamp of the IV tubing.</td>
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<tr>
<td>20. Observed site for swelling, or patient complaints of discomfort or pain, removing the PIV if present.</td>
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<tr>
<td>21. Secured and stabilized the catheter using a transparent semi-permeable (TSM) dressing. If the TSM does not have securement properties, apply a manufactured securement device before applying TSM dressing.</td>
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<tr>
<td>22. Secured any tubing to the arm. Avoided taping over tubing connections. Avoided circumferential taping.</td>
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<tr>
<td>23. If patient will be receiving IV fluids, rechecked flow rate and correct drops per minute, and connected to electronic infusion device if applicable and when available.</td>
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<tr>
<td>24. Records date, time, and clinician’s initials on dressing margin.</td>
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<tr>
<td>Performance Criteria</td>
<td>Met</td>
<td>Not Met</td>
<td>Not Applicable</td>
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<tr>
<td>25. Discards used supplies in appropriate receptacles.</td>
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<tr>
<td>26. Removes gloves, disposes in appropriate receptacle, and performs hand hygiene.</td>
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<tr>
<td>27. Documents insertion procedure in patient’s permanent health record per organizational policy</td>
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<tr>
<td>a. Patient education and consent</td>
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<tr>
<td>b. Size, length, type of device</td>
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<td>c. Variations in procedures</td>
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<td>d. Use of local anesthesia and/or pre-medications</td>
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<tr>
<td>e. Location of vein used for venipuncture</td>
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<tr>
<td>f. Number of insertion attempts</td>
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<tr>
<td>g. Method, material for device stabilization dressing</td>
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<td>h. Saline lock with extension set used</td>
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<tr>
<td>i. Flushing procedure</td>
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<tr>
<td>j. Patient response</td>
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<tr>
<td>k. Name and title of clinician</td>
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<table>
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<tr>
<th>Date of Successful Start</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
</tr>
</thead>
</table>

**Clinician Name** ____________________________  **Designation** _____  **Unit** _______

**Start #1 Validated by** ____________________________  **Designation** _____  **Date** __ / __ / __

**Start #2 Validated by** ____________________________  **Designation** _____  **Date** __ / __ / __

**Start #3 Validated by** ____________________________  **Designation** _____  **Date** __ / __ / __

**Comments:**

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____________________________________________________________________________________