# Venesection Procedure

## 1. Guiding Principles

Therapeutic venesection has been shown to be beneficial in patients with conditions such as haemochromatosis and polycythaemia.

There are risks associated with the procedure for both patients and healthcare professionals who can be exposed to blood borne pathogens.

The purpose of this document is to ensure that nursing staff are aware of the preadmission, procedural and discharge requirements when completing a therapeutic venesection on a patient. Only nursing staff working within their scope of practice may perform a venesection using venepuncture and cannulation techniques.

This procedure is applicable to **adult** patients undergoing therapeutic venesection only.

## 2. Procedure

### 2.1 Prior to Commencing Venesection

**Referral**
The patient must have a valid referral from a medical officer for the procedure to occur. If there is no referral or if the referral is greater than 6 months old, the procedure cannot proceed. A referral is valid for a six (6) month period.

Venesection should not be completed outside normal business hours, to ensure adequate staff are available to assist should an adverse event occur. A medical officer must be present onsite and available to attend within minutes in the event of an adverse event.

**Consent**
The patient must have a consent form completed every twelve (12) months in line with the Operational Directive OD 0657/16 WA Health Consent to Treatment Policy.

The medical officer is responsible for ensuring valid written consent has been obtained prior to the venesection.

**Nursing Admission and Assessment**

- Baseline physiological - Blood pressure, pulse, temperature, respirations and oxygen saturations
- Adequate pre-venesection hydration, recent hydration i.e. not fasting
- Current haemoglobin result – if less than 120 g/L, do not venesect, refer back to referring doctor

- Current serum ferritin must be greater than 300 (males) or greater than 200 (females) micrograms/L at first venesection in a series, falling to not less than 50 micrograms/L during a course of bleeds. 50 micrograms/L is the ferritin value below which a series of venesections should stop
- Patient identification (ID) band insitu and identity is confirmed
- Procedure has been explained
- Patient consent obtained

If any physiological observations fall within the colour-shaded area of the MR140A Adult Observation and Response Chart (A-ORC) care should be escalated following local facility procedures.

The venesection must **not commence** without authorisation of a medical officer if observations sit within the colour-shaded areas.

**Documentation**
Documentation relating to the procedure must be completed on an MR5 Outpatient Notes or MR55A.
Included in the documentation must be both an order for the procedure and the amount of blood to be removed (specified in mL). All observations must be documented on the Adult Observation and Response Chart MR140A.
If patient requires IV fluids pre or post venesection, order must be prescribed on MR176 Intravenous Fluid Treatment.

## 2.2 Venesection Procedure

### Required Equipment

- Electronic scales
- Closed collection system
- 16g needle (if not attached to collection bag)
- Peripheral Intravenous Catheter (PIVC) insertion kit
- Non-sterile gloves or sterile gloves if vein is palpated after antiseptic solution application
- Protective eyewear
- Puncture resistant (sharps) container
- Pillow as required for positioning limb
- Rubbish bag

### Procedure

- Formally identify and prepare the patient
- Perform hand hygiene
- Assemble equipment
- Perform hand hygiene and don gloves
- Select a site, preferably in the antecubital fossa

- **Do not** venesect arm with arteriovenous fistula (A-V fistula) insitu or prior axillary node surgery
- Apply tourniquet 7-10 cm above antecubital fossa, ensure arterial flow is not obstructed by checking for presence of radial pulse
- Disinfect the site using 70% isopropyl alcohol and 1% chlorhexidine and wait at least 30 seconds to allow for area to completely dry

**Perform procedure by:**

1. perform hand hygiene
2. donning sterile gloves if vein needs to be palpated
3. anchoring the vein below the insertion site
4. entering the vein swiftly and smoothly at an angle of less than 30 degrees until flash back obtained
5. asking the patient to open and close fist slowly every 10-12 seconds to promote blood flow. DO NOT pump the fist as it can elevate levels of potassium and ionised calcium in the bloodstream
6. removing the tourniquet once sufficient amount of blood is collected
7. ensuring the bag is placed on the scales so that the millilitres draining can be monitored (1g = 1mL)
8. once the required amount of blood has been removed, withdrawing the needle gently and applying gentle pressure to the site using gauze or cotton wool. Advise the patient to avoid bending their arm, as this increases the risk of developing a haematoma.

   **DO not** re-sheath the needle unless the system is a safety device or cut the needle off from the closed system and discard separately.
9. discard the bag of blood and sharp into puncture resistant (sharps) container together
10. remove gloves
11. perform hand hygiene
12. repeat a complete set of vital signs. If any observations fall within the colour shaded area of the MR140A, care is to be escalated according to local facility procedures
13. complete post-procedure documentation including:
    - site of needle insertion
    - vital signs and patients general status during procedure
    - grams or volume (mL) of blood collected
    - duration of procedure and patient's tolerance to it
    - any adverse incidents that occurred.

**Possible Complications**

- Hypovolaemia
- Vasovagal syncope
- Venous scarring

- Phlebitis
- Adverse reaction to lignocaine if used

If the patient becomes tachycardic, hypotensive, restless or clammy
- **STOP the** procedure and review the patient and
- initiate medical emergency response procedures

**Post Procedure**

- Ask the patient to remain sitting or lying for 5-10 minutes
- Inspect venepuncture site for signs of haematoma
- Ask the patient to sit up slowly, ensuring they are not dizzy or light-headed
- Offer the patient some refreshment

**Discharge**

The patient may be discharged once they meet the following criteria:

- Vital signs are within normal limits for the patient and do not fall within the colour shaded area
- Have tolerated fluids
- Not dizzy when standing or walking
- IV site is not oozing or developed a haematoma.

## 3. Definitions

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| **A-V Fistula** | Arteriovenous fistula |
| **ANTT** | Aseptic non-touch technique |
| **HISWA** | Healthcare Associated Infection Surveillance in Western Australia |
| **LMS** | Learning management systems |
| **Hb** | Haemoglobin |
| **IV** | Intravenous |
| **PIVC** | Peripheral Intravenous Catheter |
| **SF** | Serum ferritin |

## 4. Roles and Responsibilities

**The Registered Nurse / Midwife / Nurse Practitioner** is responsible for

- the therapeutic collection and ensuring patient safety during and post procedure
- having completed the mandatory (once) Aseptic technique e-learning (**Capabiliti Learning Management Systems (LMS)** code ICATC EL2)
- working within their scope of practice when performing venepuncture or intravenous (IV) cannulation.

**The Medical Officer** is responsible for accepting the patient and ensuring valid written consent has been obtained prior to the venesection.

## 5. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

## 6. Evaluation

Compliance monitoring as part of Aseptic non-touch technique (ANTT) auditing via regional and site infection control. MP 0108/19 Healthcare-associated Infection Surveillance in Western Australia (monthly state wide HISWA monitoring) HISWA website.

## 7. Standards

National Safety and Quality Healthcare Standards (Second edition 2017): 7, 7.1

## 8. References

WA Hand Hygiene Program Guidelines
WACHS Specimen Collection (including Phlebotomy) and Pathology Results Clinical Practice Standard

Acknowledgement to the Pilbara Health service, Venesection Policy team

## 9. Related Forms

MR140A Adult Observation and Response Chart (A-ORC)
MR5 Outpatient Notes

## 10. Related Policy Documents

WACHS Hand Hygiene Policy
WACHS Specimen Collection (including Phlebotomy) and Pathology Results Clinical Practice Standard
WACHS Infection Prevention and Control Policy
WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response (MER) Policy
WACHS Blood Management Clinical Practice Standard
WACHS Vascular Access Devices Management Clinical Practice Standard
WACHS Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard

## 11. Related WA Health System Policies

MP 0108/19 Healthcare-associated Infection Surveillance in Western Australia
MP 0038/16 Insertion and Management of Peripheral Intravenous Cannulae in Western Australian Healthcare Facilities
OD 0657/16 WA Health Consent to Treatment Policy
OD 0651/16 Clinical and Related Waste Management Policy

## 12. Policy Framework

Clinical Governance, Safety and Quality Policy Framework

**This document can be made available in alternative formats on request for a person with a disability**

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