

## Initiation of Peripheral Intravenous (IV) Catheter

Student Name: \_\_\_\_\_ Student Signature: \_\_\_\_\_

Evaluator Signature: 1<sup>st</sup> attempt \_\_\_\_\_ Date: \_\_\_\_\_  Satisfactory\*  Unsatisfactory^

Evaluator Signature: 2<sup>nd</sup> attempt \_\_\_\_\_ Date: \_\_\_\_\_  Satisfactory\*  Unsatisfactory^

Evaluator Signature: 3<sup>rd</sup> attempt \_\_\_\_\_ Date: \_\_\_\_\_  Satisfactory\*  Unsatisfactory^

**\*\* Critical Behaviors that need to be stated or done in order to pass the skill.**

PERFORMANCE BEHAVIORS	S*	U^	COMMENTS
<u><b>Assessment</b></u> 1. Avoid distractions 2. Check physician's order for accuracy a. Date b. Patient name c. Identify order for initiation of peripheral intravenous catheter d. Time of initiation			
<b>3. ** Check for allergies, including sensitivity to latex and tape</b>			
<u><b>Planning</b></u> 4. Identify expected outcomes: special nursing considerations, appropriate selection of venipuncture site, frequency/duration of intravenous use, specific patient conditions that would cause avoidance of extremity			
5. Identify teaching that may need to be provided to the patient.			
6. Assemble equipment and supplies a. IV insertion kit b. Several IV access devices/angiocatheters c. Gloves d. Saline lock device e. 10mL 0.9% NS flush			
<u><b>Implementation</b></u> <b>7. ** Perform hand hygiene</b>			
8. Verify patient and order a. <b>** State the 6 rights of medication administration comparing the 0.9% NS flush to the MAR (First Check)</b> b. Check expiration date. c. <b>** Confirm order for initiation of peripheral IV catheter</b>			
9. Before entering patient's room a. Check all equipment to ensure clean/dry packaging and check expiration dates b. <b>** State the 6 rights of medication administration while comparing the 0.9% NS flush to the MAR (Second Check)</b> c. Ensure NS flush is not expired. Prime saline lock tubing with 0.9% NS flush.			
10. Upon entering room a. <b>** Perform hand hygiene</b> b. Be aware of your spatial safety and have a call light within reach c. Identify self d. <b>** Identify patient using two patient identifiers</b> e. <b>** Ask patient if they have any allergies and check for allergy band</b> f. Ensure privacy g. Explain what is about to occur h. Allow for the patient to ask questions i. Raise bed to comfortable working height			

PERFORMANCE BEHAVIORS	S*	U^	COMMENTS
11. Perform Procedure <ul style="list-style-type: none"> <li>a. Scan patient</li> <li>b. Scan 0.9% NS flush</li> <li>c. <b>**State the 6 rights of medication administration comparing the 0.9% NS flush to the MAR (Third Check)</b></li> <li>d. Select puncture site</li> <li>e. Place arm in a dependent position. Verbalize use of warm pack for 5-10 minutes, as needed.</li> <li>f. Apply tourniquet about 4-6 inches above the intended puncture site</li> <li>g. Assess distal pulse to ensure tourniquet is not too tight</li> <li>h. Anchor the chosen vein and lightly palpate vein for vein dilation</li> <li>i. Release tourniquet</li> <li>j. Don gloves</li> <li>k. Clean the site for at least 30 seconds and allow antiseptic to fully dry</li> <li>l. Reapply the tourniquet</li> <li>m. Using non-dominant hand, stretch the skin taut below intended puncture site to stabilize vein</li> <li>n. Grasp the venous access cannula and tell the patient that you are about to insert the device</li> <li>o. Insert the needle through the patient's skin and into the vein in one motion</li> <li>p. Check the flashback chamber for blood return</li> <li>q. Level the insertion device slightly and advance the catheter 2-3mm</li> <li>r. Remove the tourniquet while grasping the cannula hub to hold it in the vein</li> <li>s. Occlude the vessel above the level of the catheter prior to removing the needle</li> <li>t. Withdraw the needle and engage safety lock, then immediately attach the primed saline lock tubing to the hub</li> <li>u. Instill 2ml of saline into the saline lock, observing for patency</li> <li>v. Secure the catheter by taping, using the U-method</li> <li>w. Apply a transparent semipermeable dressing</li> <li>x. <b>** Discard used supplies in appropriate receptacles</b></li> <li>y. Label the site: type and gauge of the catheter, the date/time of insertion, and RN initials</li> <li>z. Remove gloves and perform hand hygiene</li> </ul>			
12. Instruct patient to report any pain, redness, drainage, or swelling that may occur at the site.			
13. <b>**Correctly document procedure</b> <ul style="list-style-type: none"> <li>a. IV site</li> <li>b. Catheter gauge</li> <li>c. Volume of flush administered</li> <li>d. Date and time started</li> <li>e. Signature and initials</li> </ul>			
14. Prior to leaving the room <ul style="list-style-type: none"> <li>a. <b>** Reposition patient for comfort and safety</b></li> <li>b. <b>** Lower bed</b></li> <li>c. <b>** Raise appropriate side rails</b></li> <li>d. <b>** Leave call light and belongings in reach</b></li> <li>e. <b>** Perform hand hygiene</b></li> </ul>			
<u>Evaluation</u> 15. Verbalize need to return to patient's room to reassess the site.			

\*S = Satisfactory, ^U = Unsatisfactory

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