7Q INTRAVENOUS ACCESS

PATIENT CARE GOALS

- Provide vascular access for patients in need of fluid or medication administration. [1]

EMT

1. Prepare the following equipment:
    - Saline lock primed with 1 mL normal saline from 10 mL saline flush. Leave flush attached once lock is primed.
    - Sterile occlusive dressing (Tegaderm), opened
    - Two 3" pieces of tape
    - Two alcohol prep pads, opened
    - One 2x2 gauze, opened
    - Tourniquet
2. Apply tourniquet to extremity, above the IV site.
3. Visualize and palpate vein.
4. Clean site with two alcohol swabs, both times using a circular motion. Allow the site time to dry prior to puncture[2].
5. Select appropriately sized catheter, open and inspect:
    a. Remove the protective cap
    b. Inspect catheter and needle for damage or contamination
    c. Never move the tip of the catheter over the bevel of the needle
6. Stabilize the vein by applying counter tension on the skin below the puncture site.
7. Insert the needle into the skin with the bevel up at approximately a 30-degree angle.
8. Observe flash back chamber for blood.
9. Once flash back chamber is filled, reduce angle of insertion to less than 20-degrees. Advance needle 2 millimeters further to ensure the bevel of the needle completely enters the vein.
10. Advance catheter into vein by pushing tab with index finger, then pull back on the body of the catheter to retract the needle. Once a "click" is heard the needle has been fully retracted.
11. Remove the tourniquet.
12. Tamponade the vein by applying pressure just above the tip of the catheter with fourth and fifth fingers of non-dominant hand.
13. Secure catheter with thumb and index finger of same hand and twist body of device to remove it from hub.
14. Remove cap from saline flush by pushing luer lock connection toward cap until it pops off.
15. Secure flush to catheter by screwing the luer lock tight.
16. Flush IV with at least 5 mL normal saline, watching for signs of infiltration. If signs of infiltration

occur, IV should be removed immediately.

17. If no signs of infiltration, place sterile occlusive dressing (Tegaderm) over the site ensuring that the dressing does not extend beyond the hub of the catheter.
18. Secure the flush to the skin with tape. The preferable method is to make a kink free loop with the catheter and place one piece of tape over the luer lock extending across to just under blue flush hub. Secure bottom portion of loop with second piece of tape.
19. Ensure that all sharps are disposed of properly.

DOCUMENTATION KEY POINTS

- Rationale for intravenous access.
- Location of access attempted.
- Number of attempts and successes.
- Complications, if any, to attempts.

NOTES

[1] A paramedic level provider may, without on-line medical control order, access a patient's PICC line (or port, if appropriate needle is available) for medication and/or fluid administration, instead of starting an IV. If a PICC line is accessed, normal saline should be run at a TKO or greater rate after administration of medication to prevent the line from clotting. Staff at the destination facility must be notified that the PICC line was accessed.

[2] Wet alcohol on the skin increases the pain of the venipuncture.