PURPOSE:
To obtain blood specimens from a central line for laboratory tests.

CONSIDERATIONS:
1. Confirm physician’s order for blood work and to use the central venous catheter for drawing the samples.
2. If aspiration of blood or fluid becomes difficult, have patient change position, take a deep breath or lift one or both arms above head.
4. Drawing blood for clotting studies from a heparinized line may falsely alter the results obtained.
5. Use sterile technique is when accessing central venous catheter.

EQUIPMENT:
Gloves
Alcohol
Heparin solution (10 units/mL or as prescribed)
Normal saline
10 mL luer lock syringes (3)
Needle less adaptor
Sterile syringes for drawing blood samples
Lab tubes
Puncture-proof container
Trash bag

PROCEDURE:
1. Perform hand hygiene.
2. Explain the procedure and purpose to the patient/caregiver.
3. Assemble the equipment on a clean surface close to the patient.
4. Place patient in comfortable position, making sure that site is accessible.
5. Ensure adequate lighting.
6. Draw up normal saline and heparin flushes, as ordered.
7. Clean needle less adaptor with alcohol, using friction. Allow to air dry.
8. Attach syringe filled with normal saline to needle less adaptor. Unclamp line and flush with 5 mL normal saline. If Total Parental Nutrition (TPN) is infusing, stop infusion and flush with 10 mL normal saline.
10. Attach empty collecting syringe, unclamp catheter and withdraw the amount of blood necessary for lab tests and reclamp.
11. Attach syringe of normal saline to line, unclamp and flush line vigorously with at least 5 mL to remove all blood from line. Reclamp line.
12. Attach new saline-filled needle less adaptor.
13. If continuous infusion is ordered, connect infusion line to needle less adaptor and start infusion.
14. If central line is used for intermittent injections, flush catheter via new needle less adaptor with 3 mL of heparin, 10 units/mL, in 10 mL syringe. Before syringe is completely empty, clamp line and apply pressure on plunger while withdrawing syringe.
15. Discard soiled supplies in appropriate containers.

AFTER CARE:
1. Label specimen with patient’s name, date of birth and time of blood draw.
2. Document in patient’s record:
   a. Date, time, procedure and observations.
   b. Blood samples drawn, identity and location of laboratory where specimens taken.
   c. Amount of normal saline and heparin flush, including strength of heparin.
   d. Type and appearance of venous access site.
   e. Patient’s response to procedure, side effects and management.
   f. Instructions given to patient/caregiver.
   g. Communication with physician, if needed.

REFERENCES:
Infection Control in Home Care and Hospice (2nd edition) Sudbury, MA. Emily Rhinehart & Mary McGoldrick, Jones and Bartlett Publishers.
