We can only hope that time will prove this being liberated, developed and rewarded. modernised healthcare science workforce, become. According to Lord Warner a new well-oiled machine the Health Service has part time job but a recognised part of the that Phlebotomy was no longer a little helping them progress the gateways for pay through a fair and objective framework thus the knowledge and skills that phlebotomists spoke about Knowledge and Skills (KSF) and Performance Review relates to KSF.

The first speaker, Ms Honess, KSF Facilitator, said, “Do not accept our invitation to host a North West phlebotomy science. I hope that the NAP will some time in the next twelve months. accept our invitation to host a North West afternoon in Wrexham. The Phlebotomy Manager spoke about Knowledge and Skills Framework) describes the 6 core dimensions that will be mandatory part of your Job Profile. As Phlebotomists, it is of paramount importance that we can be effective in our communication skills, and in order to do this we must be good communicators – we all know that this is not just about talking and listening, but let us explore some more: Facial expression, Body Language, Position, Dress and Gestures Remember the patient that fainted, with no prior warning, they did not tell you that they felt faint – it was all a big shock for everyone – or did they? How did the patient enter the room? What was the patient doing with their hands? Were they fiddling with their clothes, twisting their fingers, a signal of tension and worry? How did they sit? Where they tense or perched on the edge of the seat? As phlebotomists we encounter this type of human behaviour known as non-verbal communication in all aspects of our work, and by understanding the importance of it, we can use it to improve our skills. Test your skills - write down emotions on pieces of paper e.g. worry, anxiety, nervous, tense, anger etc. Let colleagues take one from the pile and through role play and non verbal communication express the emotion to you, for you to decide which emotion is being demonstrated and why. Then reverse roles.

More than just talking - Are you Listening? The K.S.F. (Knowledge and Skills Framework) describes the 6 core dimensions that will be mandatory part of your Job Profile. As Phlebotomists, it is of paramount importance that we can be effective in our communication skills, and in order to do this we must be good communicators – we all know that this is not just about talking and listening, but let us explore some more: Facial expression, Body Language, Position, Dress and Gestures Remember the patient that fainted, with no prior warning, they did not tell you that they felt faint – it was all a big shock for everyone – or did they? How did the patient enter the room? What was the patient doing with their hands? Were they fiddling with their clothes, twisting their fingers, a signal of tension and worry? How did they sit? Where they tense or perched on the edge of the seat? As phlebotomists we encounter this type of human behaviour known as non-verbal communication in all aspects of our work, and by understanding the importance of it, we can use it to improve our skills. Test your skills - write down emotions on pieces of paper e.g. worry, anxiety, nervous, tense, anger etc. Let colleagues take one from the pile and through role play and non verbal communication express the emotion to you, for you to decide which emotion is being demonstrated and why. Then reverse roles.

The final speaker was Mr Gordon Hurst, Chairperson of the National Association of Phlebotomists (NAP), he provided feedback on how the Association had progressed and their plans for the future. Launching an appeal for members to be patient and support the committee members. He told the delegates there were a number of changes being made to the NAP but these things all take time and at a cost, and whilst there had been an increase to these things all take time and at a cost, and whilst there had been an increase to annual subscriptions this year these barely covered overheads. This was an illuminating lecture for a first attended such as myself who questioned the differences due to the post “phlebotomist” means nationally.

The afternoon I felt covered a spectrum of topics, giving staff the opportunity to meet the experts. It imbedded me to go away and look more closely at certain aspects of phlebotomy science. I hope that the NAP will accept our invitation to host a North West Phlebotomy meeting here in North Wales some time in the next twelve months.
**Failure to Draw Blood**

It happens to us all. One day we are able to draw every patient on the first attempt. You feel invincible! You ARE super-phleb! It’s an exhilarating experience to be good at your job when your job is so challenging. But then it comes... like it or not... that one day that creeps up on you and no matter how hard you try, you can’t seem to draw even the easiest of veins. No one is immune to this phenomenon. If you stay in this field and work as a phlebotomist for any length of time, this will happen to you.

You know the feeling: your heart beats harder and faster, you feel the adrenaline run full force through your bloodstream and you begin to sweat. You just missed the vein and now you have to tell the patient. You have to attempt the draw again. The patient wants to know what happened and you may or may not know. What happened?

Needle positioning is a major consideration when you fail to draw the blood. There are many considerations as to the problem:

- Needle inserted too far
- Needle not inserted far enough
- May advance slightly to recover
- Needle not inserted far enough
- Needle is partially inserted
- This can cause a haematoma.

If a haematoma begins to form you must remove the needle and apply pressure to the site.

- Completely missed the vein
- Only two sticks per phlebotomic. An overall set number of sticks per patient should be addressed by your facility.
- Tubes should be considered as well:
  - It is pushed in the wrong side
  - Has the tube lost its vacuum, or has it expired?

There are a variety of things to consider when you don’t get the blood. It is up to the phlebotomist to learn what the possibilities are, use their best judgment in determining what went wrong and respond appropriately. The phlebotomist should be a good diagnostician and to do it to the best of our ability, and to do it to the best of our ability, and to do it to the best of our ability.

**The Fainting Patient**

A Case Study and Discussion

A 25 year old female presents herself for routine blood work to an experienced phlebotomist working alone at a phlebotomy clinic. It is lunch time and the other phlebotomists are in the break room in the back of the patient. The patient announces to the phlebotomist that she has a history of fainting.

The phlebotomist, who is currently running behind and hasn’t eaten yet, tells the patient, “I’ll be fine. Just sit down and look the other way.” The patient, thinking that the healthcare professional knows best, does as she is told. The phlebotomist goes through her routine, takes the blood without any problems and tells the patient to hold the site while she writes on the tube.

The phlebotomist notices that the patient looks pale and is sweating right before fainting. The tubes are labelled. What to do?

The phlebotomist doesn’t want to put all the tubes down since they don’t have a name on them yet. So, she tells the patient, “We have a room where you can lay down. It’s two doors down on the left. You can go in there and I’ll be with you in a minute.” The phlebotomist points down the hallway.

The patient can hardly stand. She says she is too dizzy to carry her purse. The phlebotomist, put out because she’s now being interrupted, begrudgingly picks up the purse, tubes still in hand, and follows the patient to the designated room.

The room has a bed that protrudes from the wall. It’s a hard plastic with a thinly padded plastic covered cushion. Two feet from the bed the patient faints. The phlebotomist can only watch in mute horror. On the way down the hallway she hits her face, she reaches out in front of her to stop the fall. She lands with two broken fingers, a broken jaw, a fractured skull and a rip to her lower lip.

What could have been done differently in this case?

It is important to know your departmental policy and procedures. How to deal with a fainting patient should be something that every phlebotomist knows by heart. When a patient faints during a blood draw, you do NOT have time to run and get the manual to see what you should do about it. You must know that procedure in advance to draw any patient.

What does your laboratory policy say about fainting patients? Do you know? What do you know about fainting? Here is some information you should know about fainting. Read it carefully and ask the question again—what could have been done differently in this case?

Fainting (syncope):

- Occasionally a patient will faint during a draw. This can happen for a number of reasons, including fear, illness, or fasting.
- If the patient feels faint during the procedure you should take the following steps:
  1. Remove the tourniquet
  2. Withdraw the needle
  3. Talk to the patient to divert their attention from the procedure and to keep them alert
  4. Put the patient’s head down (usually to their knees) and have them breathe deeply. You should physically support them so they do not collapse and injure themselves.
  5. Loosе a tight collar or if possible
  6. Apply a cold compress or washcloth to the forehead and back of the neck.
  7. Use smelling salts (only if necessary)
  8. Alert the lab pathologist (or other designated authority) if the patient does not respond

- Note: Once the patient recovers they should remain in the area under supervision for at least 15 minutes or until they have fully recovered. They should be instructed NOT to operate a vehicle for at least 30 minutes.

**Document the incident**

- If the patient appears apprehensive you should inquire as to whether or not they feel they may faint. If they respond in the positive you should lay them down for the procedure.
- There are many things that could have been done. The first of which is to take a patient seriously when they say they have a history of fainting or feel faint. The phlebotomist should have laid the patient down to do the blood draw.
- The phlebotomist should have called for help. The patient should have never been told to walk to the other room. The patient should have been assisted to the room.
- There were a great number of opportunities afforded to the phlebotomist that could have prevented this from happening. The phlebotomist didn’t follow facility policy. The phlebotomist didn’t follow any common sense. What the phlebotomist did do was get the facility sued for hundreds of thousands of dollars.

Often we are pressed for time and overworked. We are asked to see patients in less than five minutes in many places. The fact is that WE are the people making the judgment call on how we treat our patients. It is up to US to determine if more time is needed with a patient. Issues such as those addressed in this case study can happen in an instant. It is our responsibility to be prepared for such events.

The case study above occurred in a hospital in California. The hospital was sued and had to pay the woman thousands of dollars. The young woman suffered pain and an injury that left a scar on her face. To add to the horrible event, this occurred the week before her wedding.

Patients rely on us to know how to treat them. They rely on us to know our job and do their best of our ability, keeping their health and best interest in mind.

**NB:** It is interesting to note that in California Phlebotomists now have to be state regulated.

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**Dennis J. Ernst MT (ASCP)**

**USA**

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* Manager of the Center for Phlebotomy Education, Inc.
* Author of Applied Phlebotomy (Lippincott Williams & Wilkins, 2005)
* Author of Phlebotomy for Nurses and Nursing Personnel (Healthline Press, 2001)
* Member of MLO’s “Tips From the Clinical Editors” column.
* Editor of Phlebotomy Today, an online phlebotomy newsletter.
* Chairperson/Participant in the revision of several CLSI (formerly NCCLS) specimen collection standards and guidelines.