NSW HEALTH

Facility:

CENTRAL VENOUS LINE INSERTION RECORD

SMR090200

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION / Ward

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date / / **Time** : Elective ☐ Emergency ☐ Rewiring ☐

Patient:

Consent ☐ Time Out ☐ Coags ☐ Pacemaker ☐

ICU/HDU ☐ OT ☐ ED ☐ Radiology ☐ Other:

Local ☐ Sedation ☐ GA ☐ Monitoring: ECG ☐ SpO_2 ☐ BP ☐ CO_2 ☐

Neonate: Weight:

Gestational age:

Asepsis:

Hat, mask, protective eyewear ☐ Hands washed 2 min ☐ Sterile gloves and gown ☐

Prep: alcoholic chlorhex / ☐ Full sterile draping ☐ Asepsis maintained throughout ☐

INSERTION SHOULD STOP IF ASEPSIS IS BREACHED

Catheter:

Right ☐ Left ☐ Subclavian ☐ IJ ☐ EJ ☐ Femoral ☐ Basilic ☐ Cephalic ☐ Umbilical ☐ Long Saph ☐

Lumens: CVC ☐ PICC ☐ Vascath ☐ Other type / site:

Brand: Coating: Antibiotic ☐ Antiseptic ☐ Gauge: Catheter Length: cm

No. of passes: Image Int ☐ Ultrasound ☐ Depth inserted from skin: cm

Venous placement confirmed: Manometry ☐ Ultrasound ☐ Transducer ☐ Other Before Dilation ☐

Guidewire removed intact ☐ **Independently Confirmed** ☐

Complications: Nil ☐ Art Puncture ☐ Haematoma ☐ Pneumothorax ☐ Re-position ☐

Notes:

PICCs only: Stiffener removed intact ☐ Independently Confirmed: ☐ Mid-upper limb circumference cm

Final Tip position:

Confirmed by: CXR ☐ Image Int ☐ Name Pager

Proceduralist:
(name)

Sign: Pager:

Specialist / Fell / Reg / RMO / NP / RN Date:

Removal: Date: / / / 20

Authorised by:

Reason:

Local sepsis? Yes ☐ No ☐ Tip Cultured: Yes ☐ No ☐

Assistant:
(name)

Sign: Date:

Specialist / Fell / Reg / RMO / NP / RN / EN / Technician

Removed By:
(name)

Sign: Pager:

Specialist / Fell / Reg / RMO / NP / RN Date:

Supervisor:
(name)

Sign: Pager:

Specialist / Fell / Reg / RMO / NP / RN Date:

CLAB Detected: Yes ☐ No ☐

If Yes, date of positive blood culture: / / / 20

Isolate

File in patient's notes

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For audit Purposes (at removal)

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For audit purposes (at insertion)

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Guidance for Central Line Insertion and Removal

A Central Line Insertion Record should be completed by clinicians for each patient who has a central line inserted. The exception is where a line is inserted by direct surgical means or a non-Seldinger peripheral central line is inserted for perioperative pressure monitoring.

Site & Catheter Selection: The type of line and insertion site should suit the patient's needs. The insertion of a femoral line should be avoided but may be necessary.

Asepsis: Full aseptic technique should be used, including two-minute hand hygiene with an approved antiseptic solution and running water. The clinician performing the procedure should be gowned and gloved (including mask/hat/eye protection). Skin prep solution must be applied (alcoholic chlorhexidine is preferred unless contraindicated) and the patient should be fully draped for the procedure. The skin prep should be allowed to dry before inserting the line.

Breach of Asepsis: If aseptic technique is not maintained the procedure should be stopped unless doing so would compromise the patient's condition e.g. in life threatening emergencies.

Confirm Venous Access: Before potentially damaging a major artery with the dilator, the clinician should confirm that the guide wire is in a vein. This can be done in variety of ways such as by running a cannula over the wire, then removing the wire and attaching a short extension tube and then holding the tube vertically to act as a simple manometer; by use of a transducer on the cannula/needle; by use of ultrasound, or by use of contrast injection.

Guide Wire Management: To prevent embolisation of the wire into the patient, part of the guide wire should remain visible and the operator should hold or otherwise control it at all times. The operator should have control over the distal end of the guide wire before advancing the catheter through the skin. After the guide wire has been removed, where possible, two clinicians should confirm that it is complete and the tip has not been damaged.

Stiffening Wire Management: Peripherally Inserted Central Catheters (PICC) sometimes have a stiffening wire to aid advancement. The stiffening wire should never be trimmed or the PICC cut while the stiffening wire is in the catheter. The stiffening wire should be removed after PICC insertion. Where possible, two clinicians should confirm that it is complete and the tip has not been damaged.

Securing & Dressing: To prevent catheter migration the line should be secured: (a) at the site of skin insertion by a catheter clamp or suturing and (b) at its anchor point (except where (a) and (b) are close). A sterile transparent semi-permeable dressing should be used to protect the site from external contamination, to allow continuous observation of the insertion site, and to stabilise and secure the catheter.

Confirm Tip location: After insertion, a Chest X-Ray is required to confirm the tip is in the correct position except for short femoral catheters. Prior to this, other methods may be used to confirm venous placement (Refer to "Confirm Venous Access" above).

Escalation procedure: Multiple passes at an insertion site may increase the risk of complications. A clinician who fails to cannulate a vein after three passes (see definition below), or causes an arterial or lung puncture, should make no further attempts at cannulation at that site and seek assistance from a more experienced clinician, use ultrasound or radiological guidance and where necessary, seek insertion by a Radiologist or Surgeon.

Pass: Each complete insertion of the needle that is intended to cannulate the central vein. This excludes passes with a small gauge seeking needle (e.g. 21g or smaller).

Removal reasons should be documented as one of the following: Catheter no longer needed; catheter blocked; routine change of catheter; accidental removal; infection at site; systemic sepsis, intravascular thrombosis; other.

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