

FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

Facility:

D.O.B. ____/____/____

M.O.

ADDRESS

**CENTRAL VENOUS
LINE INSERTION
RECORD**

LOCATION / Ward

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date ____/____/____ Time ____:____ Elective Emergency Rewiring

Patient:

Neonate: Weight: _____

Gestational age: _____

Consent Time Out Coags Pacemaker

ICU/HDU OT ED Radiology Other: _____

Local Sedation GA Monitoring: ECG SpO₂ BP CO₂

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 Dilution

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: _____

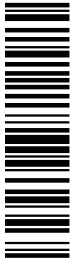
CLAB Detected:

Yes No

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

Isolate _____

File in patient's notes



SMR090200

Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING

CENTRAL VENOUS LINE INSERTION RECORD

SMR090.200

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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____

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For audit Purposes (at removal)



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NH606515 070910

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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: _____

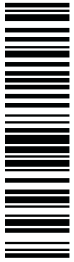
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Guidance for Central Line Insertion and Removal

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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