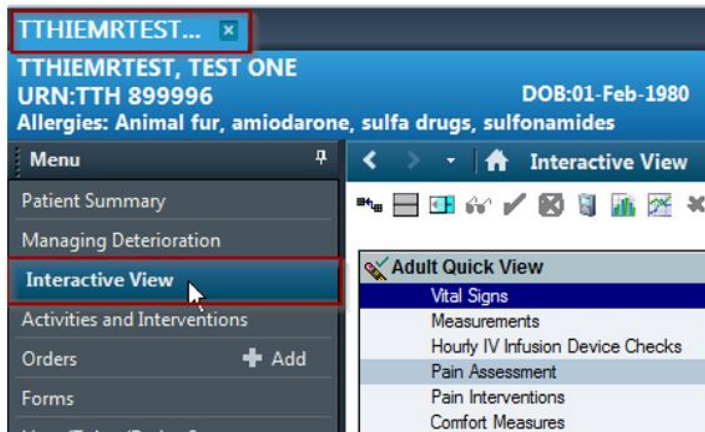


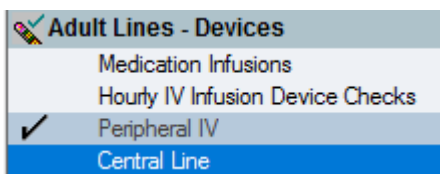


Documenting a Central Venous Catheter (CVAD /CVL)

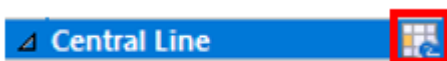
1. Open the patient's chart and go to *Interactive View* from the menu on the left-hand side



2. Select *Adult Lines – Devices* and *Central Line*



3. Click on the *dynamic group* icon beside the *Central Line* heading



4. Choose the appropriate *Access type, laterality, site, lumens and catheter size* and click *OK*



Documenting a Central Venous Catheter (CVAD /CVL)

Central IV access type:

Sheath
CVL - non-tunnelled
CVL - tunnelled
Dialysis - non-tunnelled
Dialysis - tunnelled
Implanted port
Intraosseous
Peripherally inserted central catheter (PICC)
Rapid Infusion Catheter
Other

Central IV laterality:

Right
Left

Central IV site:

Subclavian vein
Basilic vein
Brachial vein
Cephalic vein
External jugular vein
Femoral vein
Internal jugular vein
Median antebrachial vein
Median cubital vein

Central IV number of lumens:

1 lumen
2 lumens
3 lumens
4 lumens
5 lumens

Central IV catheter size:



Documenting a Central Venous Catheter (CVAD /CVL)

Documenting Insertion of a new Central Venous Catheter

The new central line that you selected will appear in iView with fields which you can now enter data into.

As a minimum, the following information should be entered:

1. Activity e.g. insert new site (this field requires data for the central venous catheter to appear on the LTD summary and patient summary view)
2. Procedure type e.g. emergency Name of person who performed procedure, if known
3. Patient identified
4. Procedure preparation
5. Sterile field
6. Procedure result e.g. successful
7. Radiographic confirmation
8. Indication
9. Centimetre marking at insertion site (cm)
10. Line Status

| Central Line | |
|--|-------------------------------------|
| < Peripherally inserted central catheter (PIC... | <input checked="" type="checkbox"/> |
| Activity | Insert new... |
| Procedure type | Emergency |
| Performing procedure | NURSE, NA... |
| Assisting insertion | |
| Assisting procedure | |
| Patient identified | Identificati... |
| Procedure preparation | Sterile tec... |
| Provider preparation | Sterile glo... |
| Sterile field | Maintained |
| Procedure result | Successful |
| Venous trace on CVL transduction | Yes |
| Tip position confirmed by | Radiograp... |
| Portacath accessed | Yes |
| Location | Chest |

11. Enter unexpected events if applicable



Documenting a Central Venous Catheter (CVAD /CVL)

| Unexpected events |
|---|
| <input type="checkbox"/> Accidental removal |
| <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> Catheter removed not intact |
| <input type="checkbox"/> Catheter rupture |
| <input type="checkbox"/> Difficulty with hemostasis |
| <input type="checkbox"/> Migrated from original position |
| <input type="checkbox"/> Pneumothorax suspected |
| <input type="checkbox"/> Neurovascular compromise |
| <input type="checkbox"/> Pain unanticipated |
| <input type="checkbox"/> Resistance on removal |
| <input type="checkbox"/> Respiratory distress unanticipated |
| <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Signs of infection |
| <input type="checkbox"/> Thrombosis |
| <input type="checkbox"/> Other |

12. Click *Sign* to finalise the entry.



Some of this data may be unknown if you are documenting a device that has been inserted by another Clinician.



There is no need to document unsuccessful attempts. Do not select “unsuccessful” in procedure result field. This will cause the cannula to appear on the patient summary view and LTD summary as being insitu.

Documenting an Existing Central Venous Catheter

Documenting a central venous catheter that your patient already has insitu (e.g. another department such as OT or ICU have inserted the central venous catheter but not documented in *PowerChart*).

The new central line that you selected will appear in *iView* with fields which you can now enter data into.

As a minimum, the following information should be entered:

1. Activity – select “present on admission/transfer”
2. Insert date of insertion – if known (if unknown document ED registration time) (found in the patient’s banner bar)



Documenting a Central Venous Catheter (CVAD /CVL)

| | |
|---|-------------------------------|
| Central Line | |
| Peripherally inserted central catheter (PICC) 4 Brachial v... | |
| Activity | Present on admission/transfer |
| Insertion date/time | 22-Aug-2017 7:36 |

Inpatient [22-Aug-2017 7:36 -
Unit: TTH ORT
Location:TTH WB L2 TSG1

3. If known, document location of insertion (e.g. ICU, ED)
4. Document line status and care
5. Once you have entered your data click sign to finalise your entry.

| | |
|---|-------------------------------------|
| Central Line | |
| Peripherally inserted central catheter (PICC) 4 Brachial v... | |
| Activity | Present on admission/transfer |
| Insertion date/time | 22-Aug-2017 7:36 |
| Inserted by: | ICU |
| Procedure type | Emergency |
| Performing procedure | |
| Assisting insertion | |
| Assisting procedure | |
| Indication | Central venous pressure measurement |
| Centimetre marking at insertion site | cm35 |
| Line status | Flushes easily, Good blood return |
| Portacath accessed | |
| Line care | Aspirated and flushed |
| Site condition | No complications |

Documenting Removal of a Central Venous Catheter

1. Click on the cell next to *Activity*.

| | | |
|----------------------|--|--|
| Activity | | |
| Performing procedure | | |

2. A menu will open.

| | |
|---|-------------------------------|
| Peripherally inserted central catheter (PICC) 4 Brachial v... | |
| Activity | Activity |
| Removal | Discontinued |
| Removal reason | Insert new site |
| Indication | Present on admission/transfer |

3. Select *Discontinued*
4. Click on the cell next to *Removal reason* and select from the list.



Documenting a Central Venous Catheter (CVAD /CVL)

| Removal reason |
|---------------------------|
| Blockage/leaking/bleeding |
| Death and septicaemia |
| Pleural effusion |
| Pericardial effusion |
| Malpositioned tip |
| Uncertain tip position |
| Line accident |
| Inflamed insertion site |
| Death |
| Septicaemia |
| Local oedema/infiltration |
| No further need |
| Suspected infection |
| Other |

5. Document in any other *fields* if relevant.
6. Click *Sign* in the *iView* toolbar to finalise the entry.
7. Follow steps to 'inactivate' the dynamic group.

Inactivating a Dynamic Group

Once the line is physically removed from the patient, the *dynamic group* must be *inactivated*. Inactivating a dynamic group will display the inactive fields with a grey background to prevent further data from being entered in the chart. This applies to any *dynamic group* when it is no longer required, for example, when a drain is removed or a wound has been assessed and no longer needs to be documented